Greg Bonnen
Chairman

Mary González
Vice Chair

TEXAS HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS

HEARING AGENDA

SEPTEMBER 8, 2022
8:00 AM
CAPITOL EXTENSION, E1.030

I. CALL TO ORDER

II. CHAIRMAN'S OPENING REMARKS

III. SPACE EXPLORATION AND SPACE ECONOMY

PANEL 1
- Vanessa Wyche, Director, NASA Johnson Space Center
- William Harris, President, Space Center Houston
- Dr. Rob Ambrose, Professor, Texas A&M University
- Dr. Tom Killian, School of Natural Sciences Dean, Rice University

PANEL 2
- Joan Higginbotham, Former Astronaut, President Ad Astra
- Tim Kopra, Former Astronaut, President OneWeb Technologies
- Gwen Griffin, Executive Director, Club of the Future at Blue Origin
- Jack Fischer, Senior Vice President, Intuitive Machines

IV. EMPLOYEE RETIREMENT SYSTEM
- Porter Wilson, Executive Director, Employee Retirement System

V. TEACHER RETIREMENT SYSTEM

PANEL 1
- Brian Guthrie, Executive Director, Teacher Retirement System

PANEL 2
- Tim Lee, Executive Director, Texas Retired Teacher Association
- Dr. Scott Muri, Superintendent, Ector County Independent School District

VI. HEALTH AND HUMAN SERVICES COMMISSION; MEDICAID, HB 133, AND ALTERNATIVES TO ABORTION

PANEL 1
- Stephanie Stephens, State Medicaid Director, Health and Human Services Commission
- Trey Wood, Chief Financial Officer, Health and Human Services Commission

- Molly Lester, Deputy Chief Program and Services Officer, Health and Human Services Commission
- Rob Reis, Deputy Executive Commissioner of Family Health Services, Health and Human Services Commission

PANEL 2

- Debbie Simmons, CEO/Founder, Anchor Point
- Sylvia Johnson, Executive Director/CEO, Houston Pregnancy Help Center
- Chelsey Youman, Texas State Director and National Legislative Advisor, Human Coalition

VII. INTERIM CHARGE # 4: MONITOR EFFORTS BY THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES TO IMPLEMENT SECTION 11, HB 5 (87 S2), RELATING TO FOSTER CARE CAPACITY IMPROVEMENT.

PANEL 1

- Andrea Nikic, Budget Analyst, Legislative Budget Board

PANEL 2

- Jamie Masters, Commissioner, Department of Family and Protective Services
- Lea Ann Biggar, Interim Chief Financial Officer Department of Family and Protective Services
- Jillian Bonacquisti, CPS Director of Placement Services, Department of Family and Protective Services

PANEL 3

- Katie Olse, Chief Executive Officer, Texas Alliance of Child and Family Services

VIII. CLOSING REMARKS

IX. ADJOURN

AGENDA ITEM III: SPACE EXPLORATION AND THE SPACE ECONOMY

NO TESTIMONY SUBMITTED

AGENDA ITEM IV: EMPLOYEE RETIREMENT SYSTEM OF TEXAS

House Committee on Appropriations

September 8, 2022

Porter Wilson, Executive Director

ERS®
Employees Retirement System of Texas

ERS Plan
Actuarial Valuation Results

Funded Status	8/31/2020 valuation	8/31/2021 valuation
Unfunded Liability	$14.7 B	$14.1 B
Funded Ratio	66.0%	68.0%
Projected Depletion Date	2061	Never

	Meets Funding Guidelines and Priorities	
Cover Normal Cost	✓	✓
Avoid Trust Fund Depletion	✗	✓
Meet Statutory 31 Year ASC Rate	✗	Approx. 2024
Meet Additional Funding Standards	✗	100% funded in 2054

As of August 31, 2021 Valuation

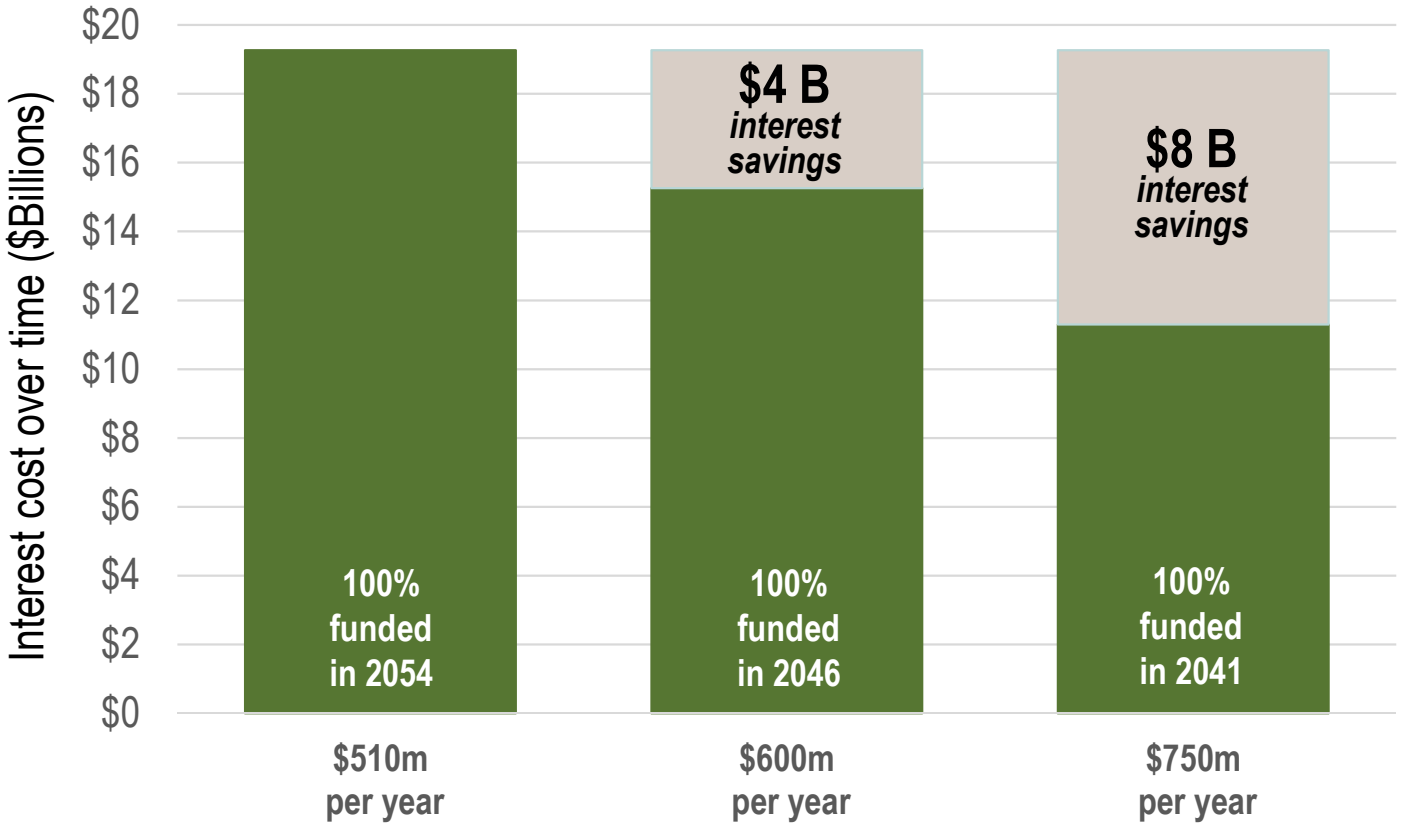
All of the funding goals will be met following the Legacy Payment Schedule

SB 321 changed ERS Plan trajectory

Created long-term solutions to address the critical funding status and mitigate future unfunded liability for the ERS Retirement Plan

- Legacy Payment Schedule
  - Annual, actuarially determined payments to address unfunded liabilities within at least 33 years
  - Currently $510 million per year
- Established Group 4 for new employees hired on or after 9/1/22
  - Guaranteed lifetime benefit using a Cash Balance structure
  - Maintains enhanced benefit for LECOS members
  - Reduced employee contributions (6% vs 9.5%)
  - Shorter vesting period (5 years)
  - Annual Interest (4%) and Gain Share (0-3%) structure
  - State match of account balance at retirement (150% ERS / 300% LECOS)

Accelerated legacy payments eliminate debt sooner



Projected as of 8/31/21 valuation with 0% return in FY22.

LECOS and JRS 2 Membership

ERS®

LECOS

- **Total Members, Retirees & Beneficiaries 77,467**
  - DPS Troopers
  - TPWD Game Wardens
  - TABC agents
  - TDCJ Correctional Officers
- Employees make additional payroll contributions
- LECOS members are also members of the ERS plan

JRS 2

- **Total Members, Retirees & Beneficiaries 1,304**
  - Judges that began service on September 1, 1985 and later

LECOS and JRS 2 Actuarial Valuation Results

Funded Status	LECOS	JRS 2
Unfunded Liability	$653 M	$95 M
Funded Ratio	60.5%	84.6%
Projected Depletion Date	2050	2076
	Meets Funding Guidelines and Priorities	
Cover Normal Cost	✗	✗
Avoid Trust Fund Depletion	✗	✗
Meet Statutory 31 Year ASC Rate	✗	✗
Meet Additional Funding Standards	✗	✗

As of August 31, 2021 Valuations

With projected depletion dates, none of the vital funding goals are being met.

Funding Options for LECOS and JRS2

Requires two steps

Provide funding for ongoing normal costs and an additional payroll contribution increase to address unfunded liability

Fund Normal Cost	LECOS	JRS2
Increase State Contribution	+1%	+3.587%
Annual Cost to the State	**$20 million**	**$3 million**

Address Unfunded Liability (31 yrs)	LECOS	JRS2
Increase State Contribution	+1.89%	+4.17%
Annual Cost to the State	**$37 million**	**$4 million**

	LECOS	JRS2
Annual Total	**$57 million**	**$7 million**

Costs are projected as of 8/31/21 valuation and will be updated for the 8/31/22 valuation and FY24-25 payrolls.

Funding Options for LECOS and JRS2

Requires two steps

Provide funding for ongoing normal costs and a one-time payment to address the unfunded liability

Fund Normal Cost	LECOS	JRS2
Increase State Contribution	+1%	+3.587%
Annual Cost to the State	**$20 million**	**$3 million**

Address Unfunded Liability	LECOS	JRS2
One-time Payment	**$750 million**	**$105 million**
One-time vs Payroll Option **Savings to the State**	**$1.2 billion** (over 31 years)	**$175 million** (over 31 years)

Costs are projected as of 8/31/21 valuation and will be updated for the 8/31/22 valuation and FY24-25 payrolls.

ERS®

Thank you.

AGENDA ITEM V: TEXAS RETIREMENT SYSTEM OF TEXAS

Teacher Retirement System of Texas

TRS
TEACHER RETIREMENT SYSTEM OF TEXAS

September 8, 2022

TRS and 88th Legislative Session

- **SB 12 (86R) the TRS Pension Reform Bill** provided for gradual contribution increases from the state, public education employers, and active employees to make the pension fund actuarially sound.

- The last phase of the contribution increases will be determined during the 88th legislative session.

					Current Rates	FY 2024-25 LAR	
	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
STATE	6.80%	7.50%	7.50%	7.75%	8.00%	8.25%	8.25%
MEMBERS	7.70%	7.70%	7.70%	8.00%	8.00%	8.25%	8.25%
PUBLIC ED EMPLOYERs	1.50%*	1.50%	1.60%	1.70%	1.80%	1.90%	2.00%

**Prior to SB 12, only public education entities that did not contribute to Social Security were required to pay the 1.50% contribution. Beginning 9/1/2019 all public education employers began contributing.*

Investment Return Assumption

- An experience study is a regularly scheduled review of assumptions about future membership behavior and economic realities and methods every four years. One of those assumptions is the Investment Return Assumption (IRA).

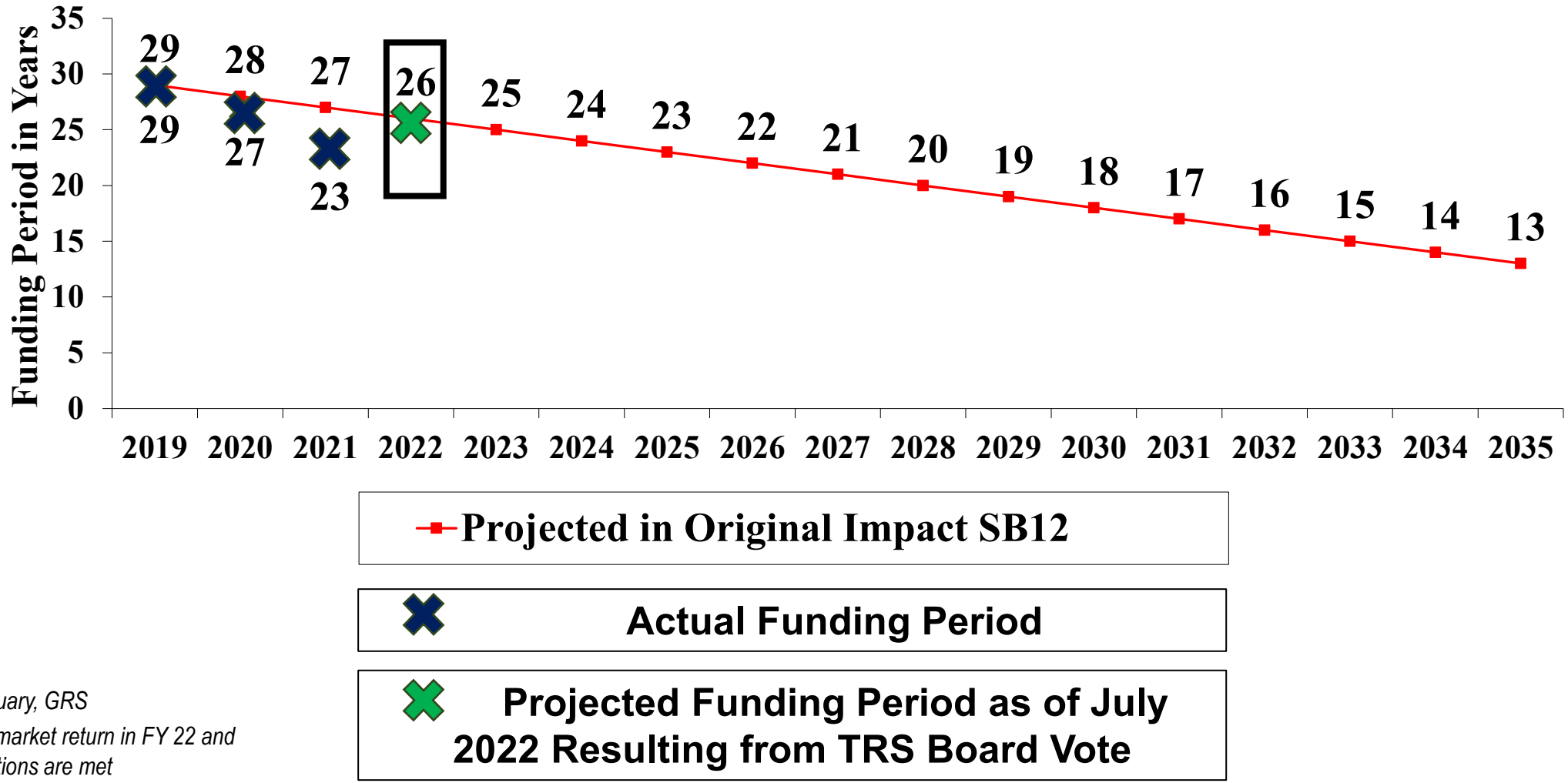
- The IRA is used to predict what percentage of future benefit payments will be covered by investment returns and what percentage by contributions.

The TRS Board of Trustees (Board):

- Discussed the Experience Study recommendations during the April board meeting and
- Adopted the study's recommendations during the July board meeting, including a recommendation **to lower the investment return assumption from 7.25% to 7.00%.**

- The Board also voted to use $7B of the $21.2B in deferred gains in conjunction with lowering the investment return assumption to stay on the SB 12 (86R) funding path (the SB 12 (86R) impact statement projected TRS to have a 26-year funding period in fiscal year 2022).
- **The vote does not impact the scheduled contribution increases set forth in SB 12 (86R).**

Funding Period Compared to SB 12 (86R) Projections for FY 22



Source: TRS actuary, GRS

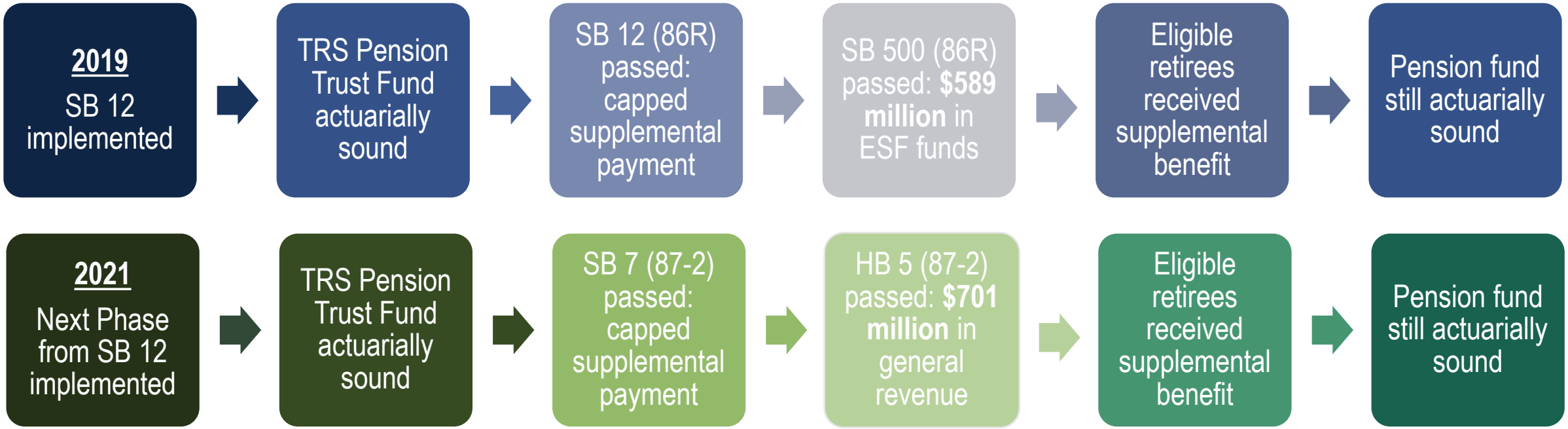
Assumes a -7% market return in FY 22 and all other assumptions are met

Assumes no changes to benefit policy

Assumes SB12 contribution policy remains throughout projection period

Recent Supplemental Payments

- In 2019, the legislature authorized and directly paid for a supplemental payment capped at $2,000 for eligible retirees who retired on or before Dec. 31, 2018.
- In 2021, the legislature authorized and directly paid for a supplemental payment capped at $2,400 for eligible retirees who retired on or before Dec. 31, 2020.



87(R) COLA Estimated Costs

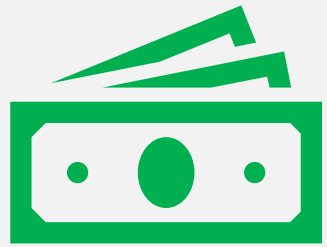
Estimated cost of 3% COLA, capped at $100 for all who retired on or before 8/31/2020	"Seeded" lump sum cost:* $2.8 billion	Cost to finance:** $17.2 billion
Estimated cost of 6% COLA, capped at $100 for all who retired on or before 08/31/2019	"Seeded" lump sum cost: $3.6 billion	Cost to finance: $22 billion

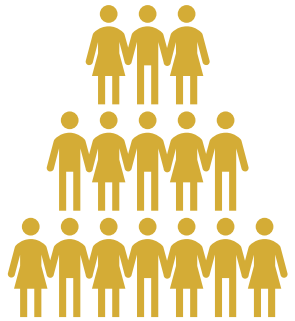
*The **lump sum** for the COLA is the amount necessary to invest and pay out the COLA over the expected life of the retirees who will receive the COLA.

The cost to **finance assumes no additional payment into the fund and that the cost is paid after all current liabilities are paid.

State Funding to TRS Health Plans

- The State provided TRS with a total of **$721** million in one-time federal funding.
- **ARPA**: Senate Bill 8 (87th 3rd Special)
  - **$203M** for TRS-ActiveCare
  - **$83M** for TRS-Care
- **CARES Act**: Governor Abbott and State Legislative Leadership
  - **$435M** of appropriated funds for TRS-ActiveCare
- Improved TRS-Care fund balance enabled a one-time payment of **$448.12** to TRS retirees or surviving spouses in March 2022 and premiums will not increase for 2023 plan year.
- Additional one-time funding enabled participants in TRS-ActiveCare to have same or reduced premiums for 2022-2023 school year.



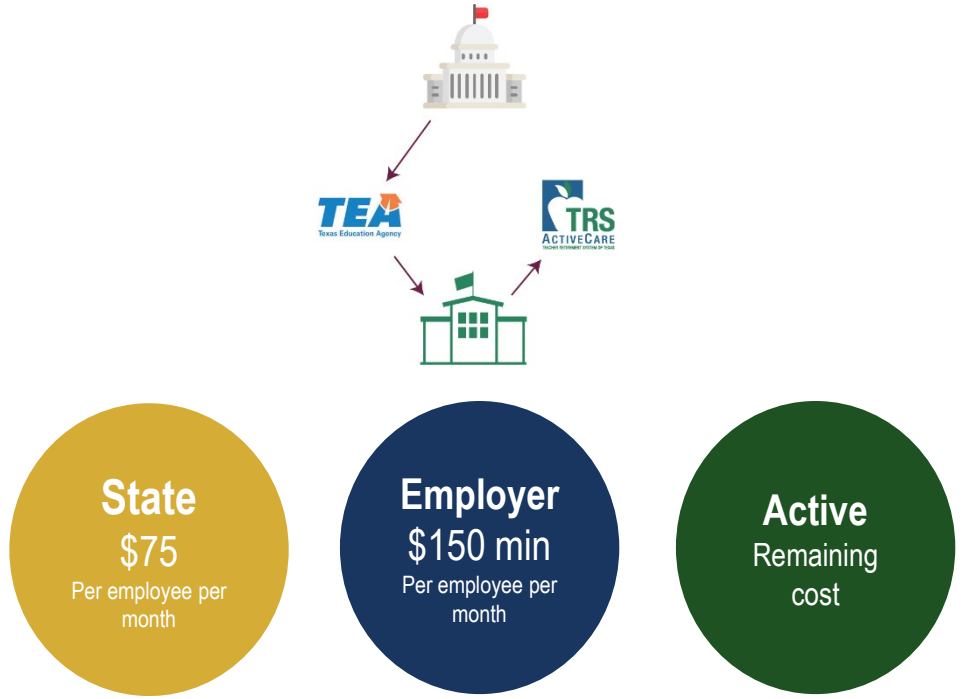


Future Legislative Considerations: TRS-Care

- TRS-Care (retiree health care program) is funded by a percentage of payroll and is not related to health care costs.
- TRS-Care fund remains strong and healthy due to diligent management and additional funding from the legislature. TRS-Care will not experience a shortfall for the upcoming legislative session.
- New enhancement for the 2023 plan year: **the deductible for TRS-Care Medicare Advantage is decreasing from $500 to $400.** No premium increase and rates remain at 2018 levels.
- No premium increases or benefit changes for TRS-Care Standard, and the plan will continue to offer no-cost coverage for certain generic preventive drugs.

Future Legislative Considerations: TRS-ActiveCare

- Funding for the health care benefits is derived from state, employer, and active member contributions. State and employer costs are based on fixed contributions developed in 2001 rather than based on actual health care costs and are funded directly through the school finance formula.
- 2001 law set total contribution from the state ($75) and district (minimum $150) at $225 per person and required funding to flow through schools to TRS.
- In 2001, a $225 contribution covered the cost of the premium for the member; this contribution no longer covers the premium, and our members cover the remaining cost.
- The use of one-time federal funds to maintain and reduce premiums creates a need for **significant** premium increases for the 2024-2025 plan year.



Texas Legislature created TRS-ActiveCare in 2001 to provide a health care program for public school employees and dependents. TRS-ActiveCare provides employee health care benefits to nearly 1,000 districts.

Moving Forward Together: New Headquarters and Red River Disposition

New Headquarters: Improving The Member Experience

- Increase availability of in-person counseling office visits.
- Continue virtual counseling across all areas in Texas.
- Enhance service to members.
  - Certain non-member facing departments will move in Summer 2023.
  - Member facing departments and remaining departments will move in late 2024.

Red River Disposition: Final Negotiations

- Recommended the maximum value to TRS is through fee simple sale.
- Cost-benefit analysis of pursuing additional entitlements revealed poor risk-adjusted returns and ground lease was least optimal.
- The Board voted unanimously to proceed forward with Bidder A and Bidder B and to delegate authority to TRS staff.
- Negotiations will continue with the finalists until the transaction closes.

APPENDIX

Benefit Enhancement History (1993-2021)

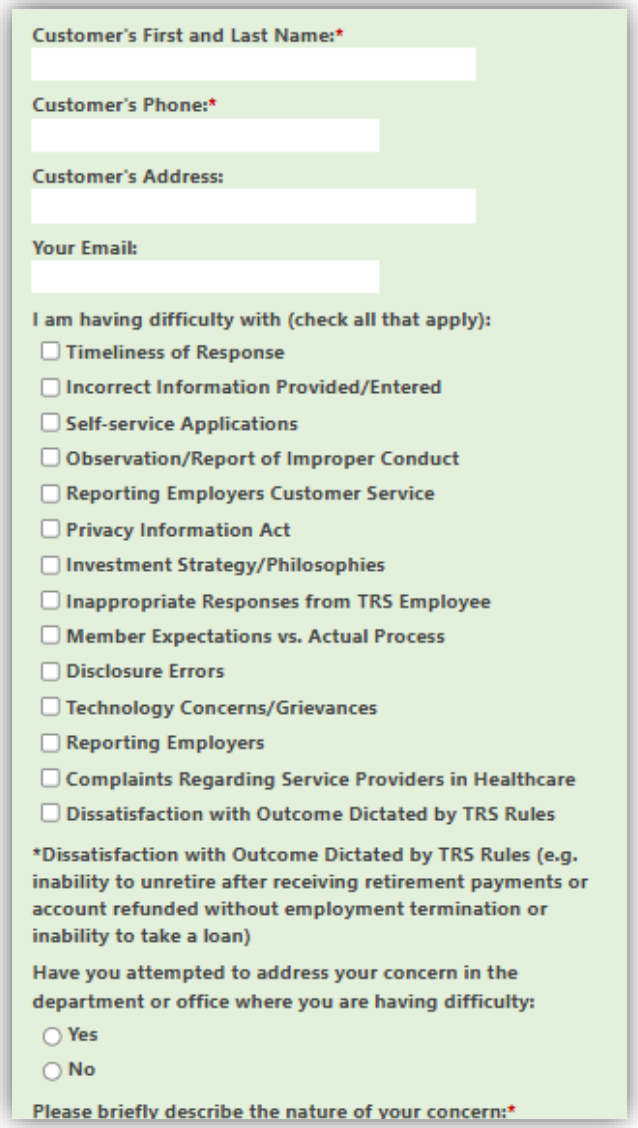
Year	Funding Period	Type	Benefit Enhancement
2021	27 years as of 8/31/20; Legislation included the next phase of contribution rate increases per statute. The state rate increased to 7.75% in FY22 and 8.00% in FY23. The active member rate increased to 8.00% for FY22 and FY23 and the employer rate increased to 1.7% for FY22 and 1.8% for FY23.	Supp Payment (capped 13th check)	Members who retired on or before 12/31/2020 received a one-time supplemental check in the amount of their monthly annuity payment or $2,400, whichever was less. HB 5 provided direct funding from the state to pay for the supplemental annuity check not as to not impact the actuarial soundness of the pension fund.
2019	87 years as of 8/31/18; Legislation phasing-in increased state, employer, and member contribution rates brought the funding period down to 29 years as of 8/31/19.	Supp Payment (capped 13th check)	Members who retired on or before 12/31/2018 received a one-time supplemental check in the amount of their monthly annuity payment or $2,000, whichever was less. The legislature provided a lump sum appropriation of $589 million out of the Economic Stabilization Fund (Rainy Day Fund) to pay for the supplemental annuity check.
2013	Never as of 8/31/12 valuation; Legislation increasing state, employer, and member contribution rates brought the funding period down to 28 years as of 8/31/13 valuation.	COLA	Members who retired prior to 9/1/04 received a 3% COLA (capped at $100 per month).
2007	Never as of 8/31/06 valuation; State contribution increase to 6.58% brought the funding period down to less than 31 years; 27.4 years as of 8/31/07 valuation.	Supp Payment (capped 13th check)	Payment equal to the August 2007 monthly annuity but capped at $2,400. Paid in January 2008.
2001	Overfunded.	COLA	Members who retired between 9/1/00 and 8/31/01 received a 4.5% increase in their annuities, which was equivalent to the multiplier increase. Members who retired prior to 9/1/00 received a 6% inflation adjustment plus the 4.5% multiplier equivalent.
1999	Overfunded.	COLA	Members who retired between 9/1/98 and 8/31/99 received a 10% increase in their annuities, which was equivalent to the multiplier increase. Members who retired prior to 9/1/98 received an inflation adjustment between 2 – 7% based upon the member's retirement date and the 10% multiplier equivalent.
1997	Overfunded.	COLA	Members who retired prior to 9/1/96 received an inflation adjustment ranging from 2 – 14% based upon the member's retirement date.
1995	2.2 years as of 8/31/94 valuation; 14 years as of 8/31/95 valuation.	COLA	Members who retired before 9/1/93 were paid the greater of two options: • Current annuity with an inflation adjustment ranging from 2 – 17% depending on the member's retirement date; or • Recomputation of the annuity using the current minimum annual salary ($18,500) for a classroom teacher or full-time librarian if the actual average salary was less than the current minimum.
1993	28.8 years as of 8/31/92 valuation; 25.1 years as of 8/31/93 valuation.	COLA	Members who retired prior to 9/1/91 received an inflation adjustment ranging from 5 – 15% depending on the member's retirement date. This was the first in a series of "catch ups," for retirees whose annuity-purchasing power lagged behind the Consumer Price Index.

TRS Office of the Ombuds

- The Office of the Ombuds provides TRS members and retirees with an additional contact for addressing concerns or issues.
- The Ombuds may be contacted when a member or retiree has been unable to obtain information through normal TRS channels or is dissatisfied with the customer service received through normal TRS channels.
- The Ombuds serves as an escalated resource for members as opposed to a first point of contact, like the telephone counseling centers.
- The Ombuds is an independent office designed to offer a neutral and impartial review of member and retiree concerns and will provide an initial response to outreach within 5 business days.

ombuds@trs.texas.gov

1-833-873-2331



Customer's First and Last Name:*

Customer's Phone:*

Customer's Address:

Your Email:

I am having difficulty with (check all that apply):

- ☐ Timeliness of Response
- ☐ Incorrect Information Provided/Entered
- ☐ Self-service Applications
- ☐ Observation/Report of Improper Conduct
- ☐ Reporting Employers Customer Service
- ☐ Privacy Information Act
- ☐ Investment Strategy/Philosophies
- ☐ Inappropriate Responses from TRS Employee
- ☐ Member Expectations vs. Actual Process
- ☐ Disclosure Errors
- ☐ Technology Concerns/Grievances
- ☐ Reporting Employers
- ☐ Complaints Regarding Service Providers in Healthcare
- ☐ Dissatisfaction with Outcome Dictated by TRS Rules

*Dissatisfaction with Outcome Dictated by TRS Rules (e.g. inability to unretire after receiving retirement payments or account refunded without employment termination or inability to take a loan)

Have you attempted to address your concern in the department or office where you are having difficulty:

- ○ Yes
- ○ No

Please briefly describe the nature of your concern:*

TRS-ActiveCare: Senate Bill 1444 (87R)

September 1, 2022: DOI Loophole Closed	Prohibits employers from offering alternative coverage in addition to TRS-ActiveCare.
December 31: Annual Opt-Out Deadline	Districts wanting to exit ActiveCare and districts currently not in ActiveCare wishing to join must provide notice. Once a district opts-out, it must wait 5 years to reenroll. A new enrollment requires a 5-year commitment. Current districts that stay can still evaluate their decision in later years.
November 1, 2022: Study	Each education service center must establish a regional school district health coverage advisory committee.

TRS-ActiveCare: Regional Rating

Regional Rates Calculation

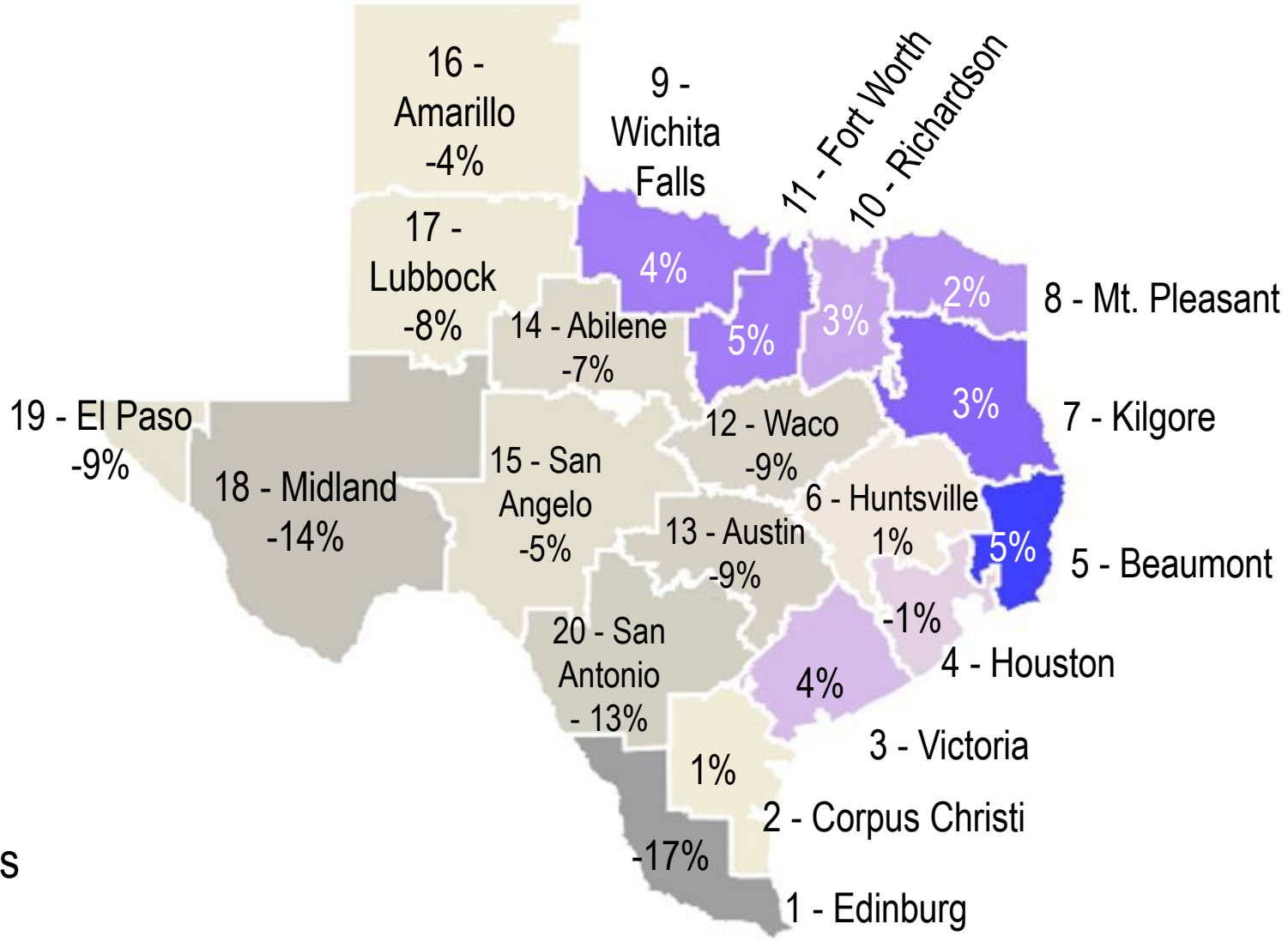
Calculations are based on TRS-ActiveCare participants and claims, not local population.

Step 1: Calculate state average rate.	
Step 2: Adjust regional rate based on regional cost of care.	Based on costs for medical services in the region. Those costs vary by the number of doctors, hospitals and how much people access care.
Step 3: Adjust for demographics (age, gender, risk).	If the region has an older population, or more people with diabetes than the statewide average.
Step 4: Evaluate Historical costs.	Review the region's historical health care costs and mix with expected costs.
Step 5: Account for benefits & network.	A plan with a higher deductible will be adjusted to have a lower rate than a plan with lower deductible. A plan with a broad network of doctors and hospitals would reflect the plan's rate.

TRS-ActiveCare: Statewide Ave. Rate & Regional Rating

- The average statewide rate increase reduced to 0% and **no region of the state experienced a premium increase.** Most regions will experience a reduced premium based on the application of the regional rates.

- Percentages on this map reflect regional costs of healthcare for the TRS-ActiveCare population relative to the statewide average **without the federal funding.** TRS rates are a product of the specific cost for participating public education employers in the region.



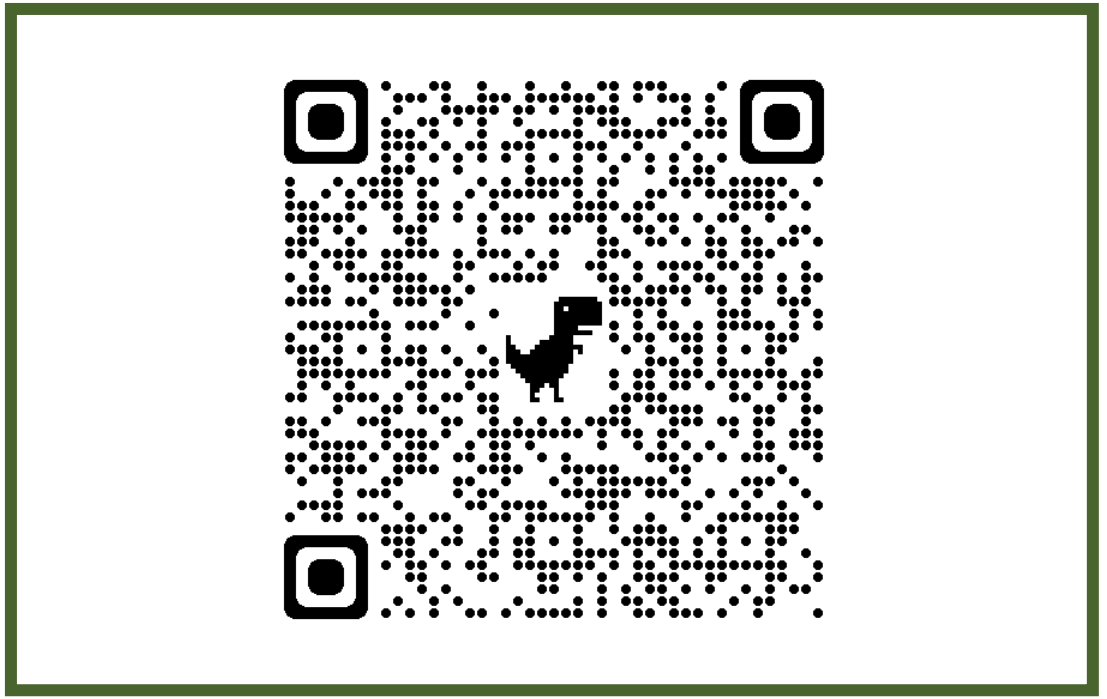
Investment Return Assumption FAQs

Why was the investment return assumption changed?

TRS is required by law to conduct an Experience Study at least once every five years. Additionally, TRS' Pension Funding Policy provides that an Experience Study will be conducted every four years. The purpose of such a study is to examine changing patterns of retirement behaviors, plan provisions, and investment returns, and whether adjustments are needed. The 2022 Experience Study found that while most assumptions have remained accurate, the investment return assumption is at the upper end of the range of expected returns. In July, TRS' Board of Trustees reviewed the results of the study and voted to approve a recommendation to lower the investment return assumption from 7.25% to 7.00%.

How would lowering the investment return assumption impact the likelihood of a COLA during the next legislative session?

State law provides that the Legislature may only consider issuing benefit enhancements if the fund is actuarially sound and remains actuarially sound after issuing an enhancement. The fund is expected to remain actuarially sound as of the end of fiscal year 2022 due to the use of deferred investment gains from the previous fiscal year.



TRS Member Education Video

Thinking about returning to work after retirement for a TRS-covered employer?

This **interactive video** will help you find the information you need to comply with the rules on working after retirement.

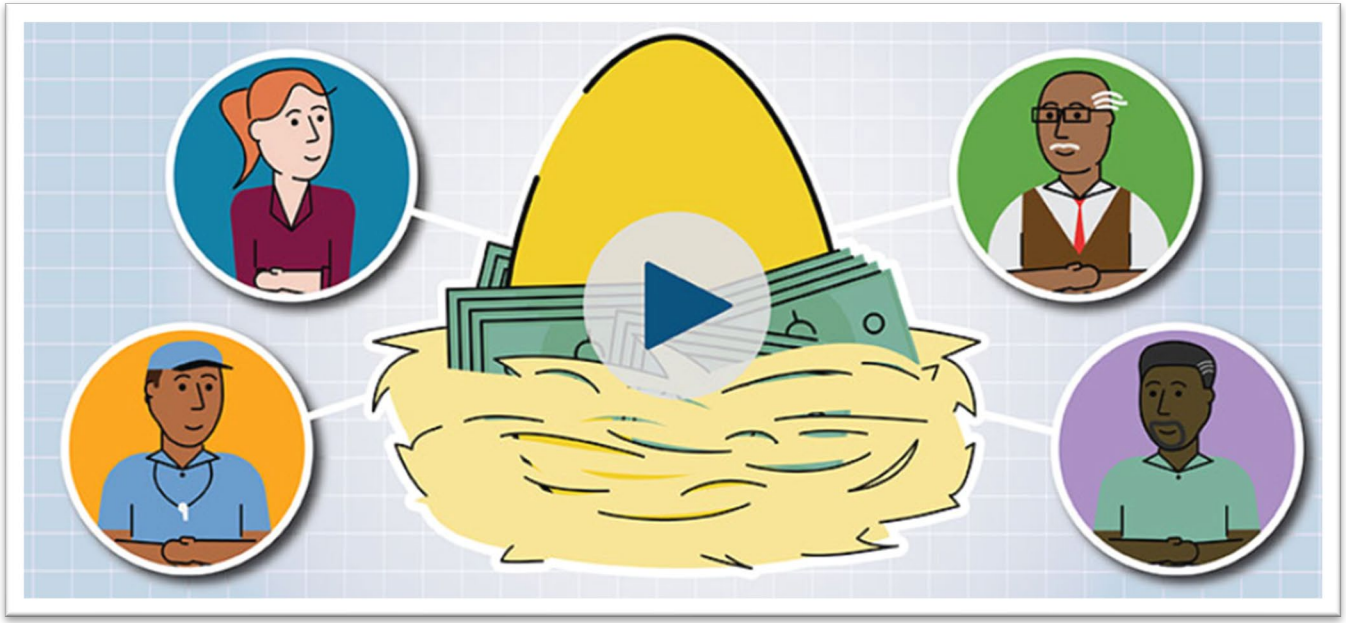
With this tool, you can conveniently navigate to the information you need based on your situation.

All you need to do is choose your path for service or disability retirement and information will unfold based on your retirement date.

You will also find **helpful practice scenarios to test your knowledge and understanding.**

New! Employment After Retirement Video

https://www.trs.texas.gov/Pages/pension_benefits_members_videos.aspx



AGENDA ITEM VI: HEALTH AND HUMAN SERVICES COMMISSION

Presentation to the House Appropriations Committee

September 8, 2022

TEXAS
Health and Human
Services

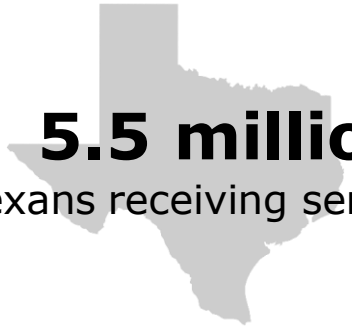
TEXAS
Health and Human Services

Medicaid and CHIP Services

Stephanie Stephens, State Medicaid Director

TEXAS
Health and Human Services

Impact Perspective



5.5 million
Texans receiving services

- **18%** of Texans covered
- **51%** of Texas births covered by Medicaid
- **50%** of Texas children on Medicaid or CHIP
- **57%** of nursing home residents covered by Medicaid

Medicaid is an entitlement program
Federal funding is open ended to provide eligible services to eligible persons

CHIP is not an entitlement program
Federal funds are capped -when a state's CHIP funds are spent, no more are available

Numbers are approximate. This information is as of May 2022.
The Families First Coronavirus Response Act requirement to maintain eligibility for enhanced federal match has increased caseload.

TEXAS
Health and Human Services

Who is Eligible for Medicaid?

Federal law

- Requires coverage of certain populations and services
- Gives flexibility for states to cover additional populations and services

Financial Criteria

How the applicant's income compares to the definition of the federal poverty level (FPL) for annual household incomes

Non-Financial Criteria

- Age
- Residency
- Citizenship or alien status

Varies by program

Eligible Population Categories

 Children and Youth

 Parents and Caretaker Relatives

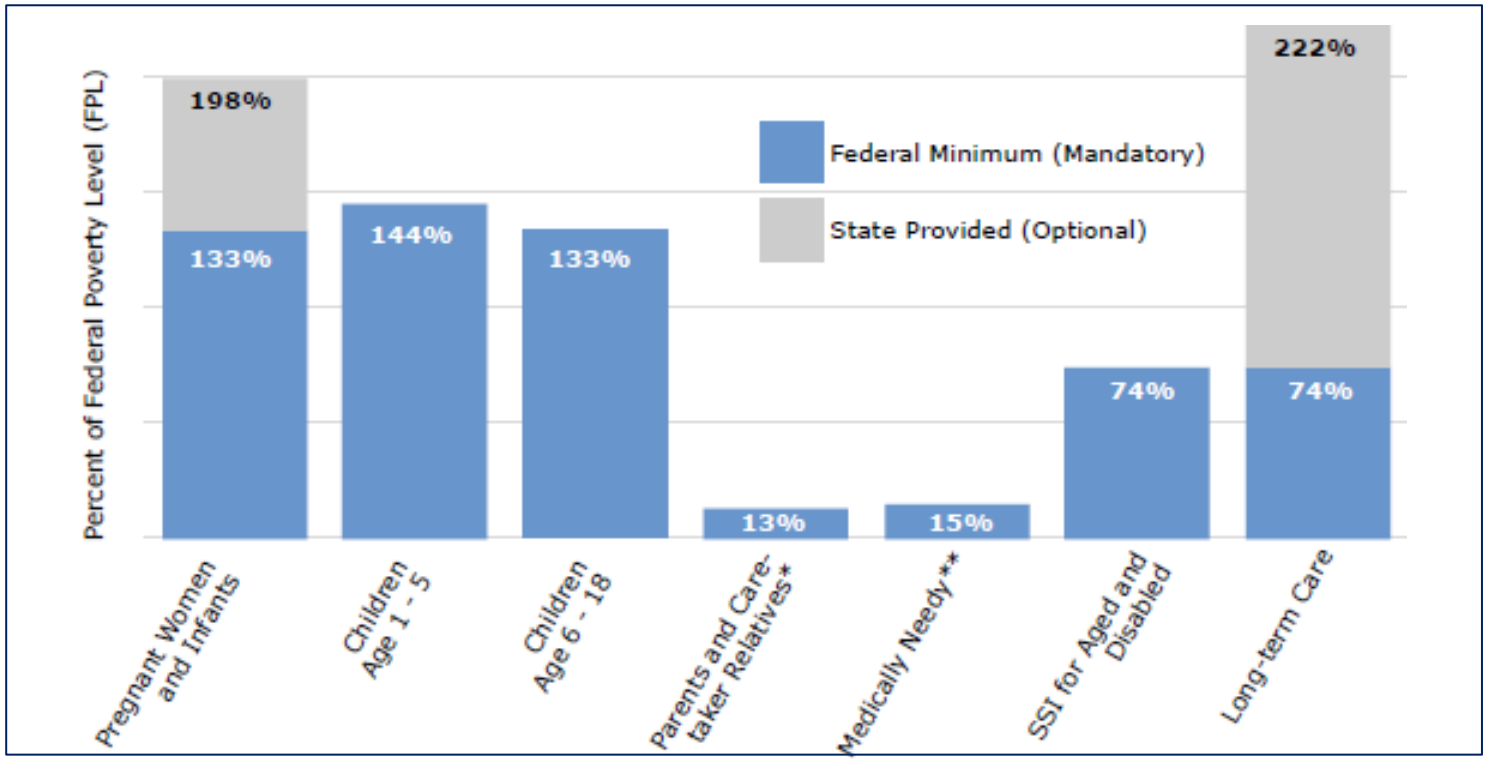
 Women

 People Age 65 and Older

 Children and Adults with Disabilities

TEXAS
Health and Human Services

Texas Medicaid Income Eligibility Levels



This figure reflects eligibility levels as of March 2020.
*For Parents and Caretaker Relatives, the monthly income limit in SFY 2020 was $230 for a family of three or about 13 percent of the FPL.
**For Medically Needy children and pregnant women, the monthly income limit in SFY 2020 is $275 for a family of three or about 15 percent of the FPL.
Healthy Texas Women (HTW) is a demonstration waiver program with an income limit of 204.2% FPL.

More information on eligibility criteria for Medicaid and CHIP can be found in Chapter 1 of the Texas Medicaid and CHIP Reference Guide.

TEXAS
Health and Human Services

Primary Medicaid and CHIP Services

	Acute Care Services	Preventative care, diagnostics and medical treatments *Examples: Physician, inpatient and outpatient hospital services, laboratory, x-ray services*
	Long-term Services and Supports	Support with ongoing, daily activities for individuals with disabilities and older adults *Examples: Community-based care, personal assistance with activities of daily living (cleaning, cooking), nursing facility services*
	Behavioral Health Services	Screening and treatment for mental health conditions and substance use disorders (SUD) *Examples: Mental health rehabilitation, medication assisted therapy for SUD, psychological and neuropsychological testing*
	Medical Transportation Services	Non-emergency medical transportation (NEMT)
	Pharmacy Services	Coverage for prescription drugs

TEXAS
Health and Human Services

Two Models for Service Delivery

1 Managed Care

95% of clients

- A managed care organization (MCO) is paid a capitated rate for each member enrolled
- MCOs provide a medical home through a primary care physician (PCP) and referrals for specialty providers, when needed
- MCOs negotiate rates with providers
- MCOs may offer value-added services

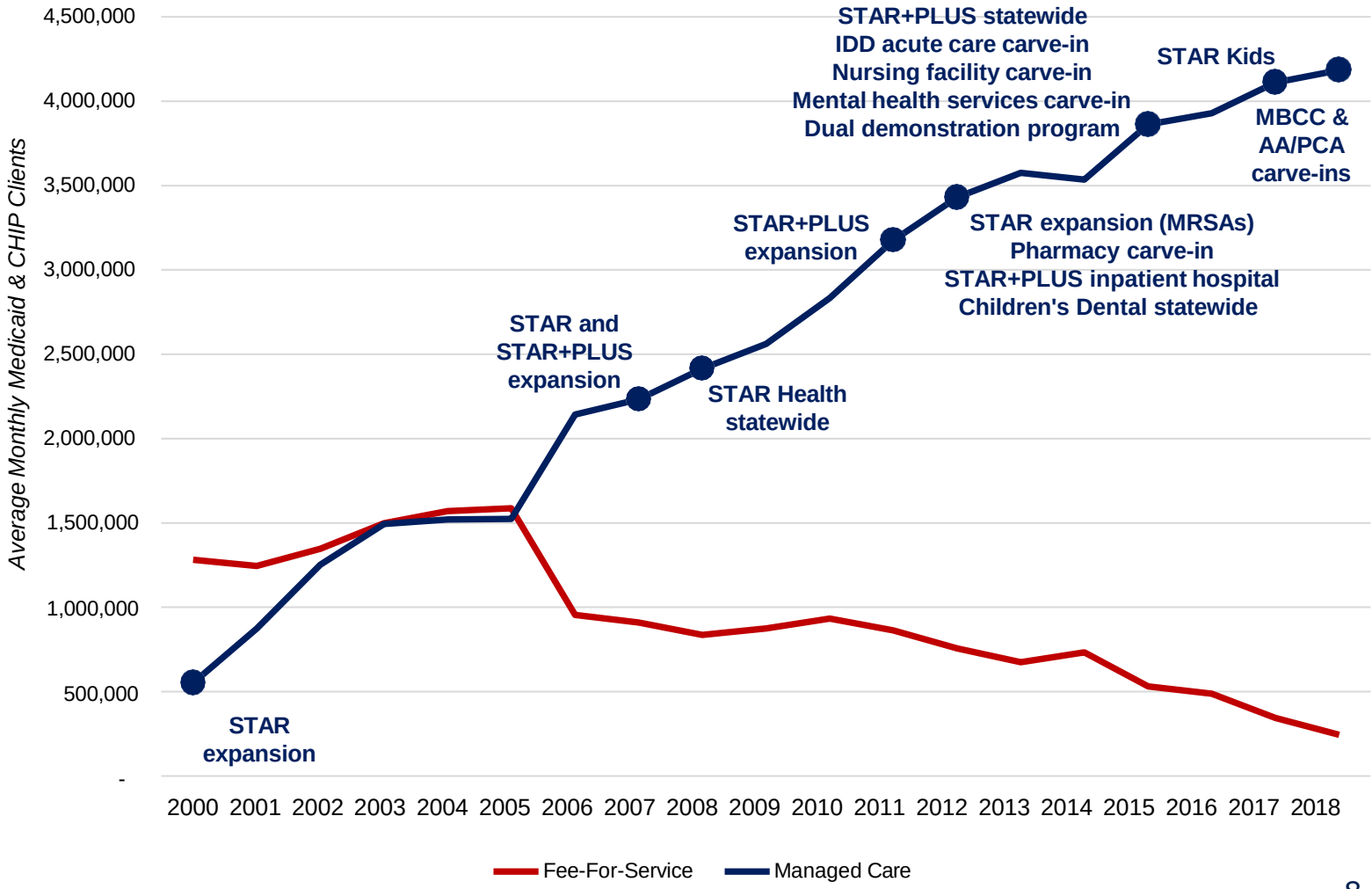
2 Fee-for-Service (FFS)

5% of clients

- Clients go to any Medicaid provider
- Providers submit claims directly to HHSC's administrative services contractor for payment
- Providers are paid per unit of service
- Most FFS clients do not have access to service coordination

TEXAS
Health and Human Services

Managed Care Growth



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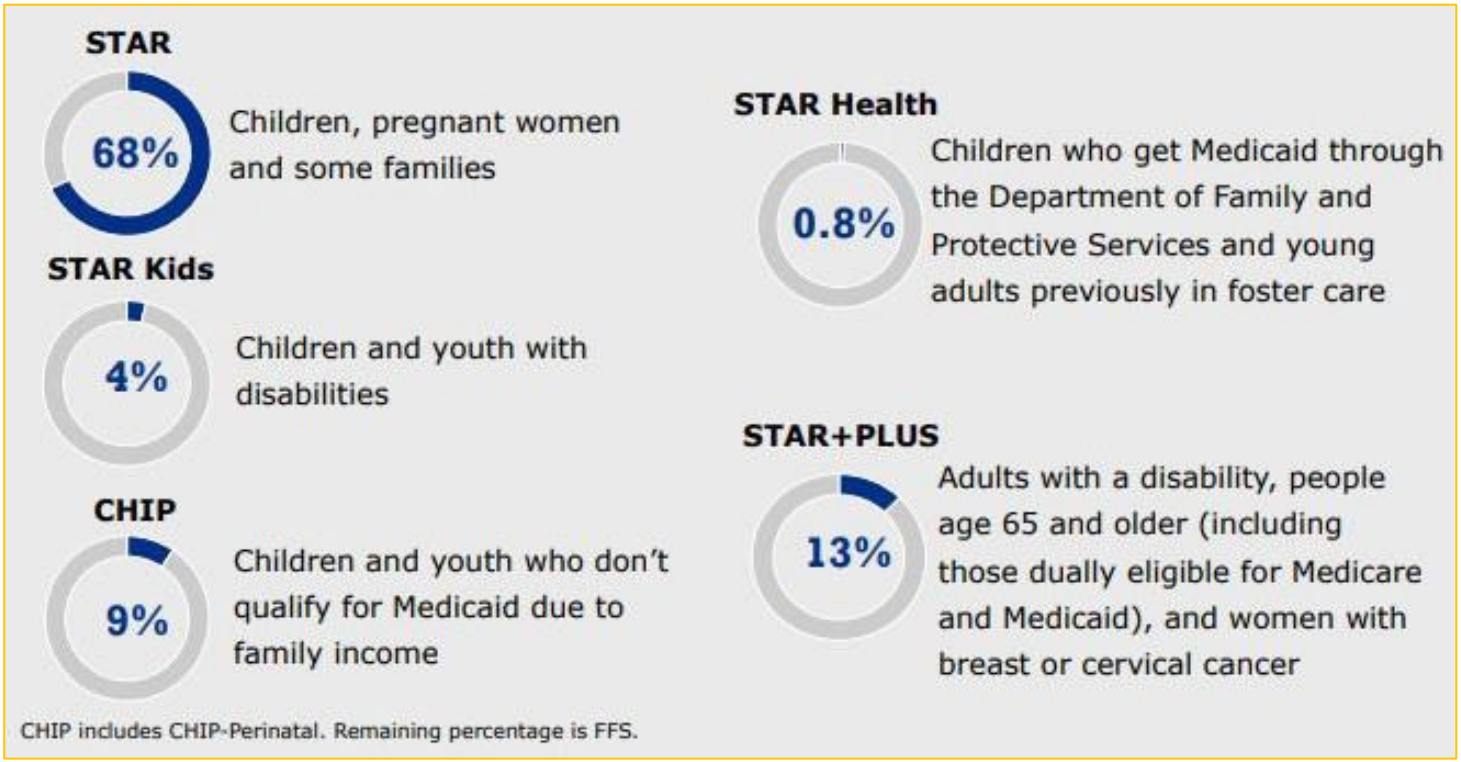
Managed Care Programs



✚ *Dental for most children and young adults enrolled in Medicaid*

Source: Texas Medicaid and CHIP Reference Guide, 13th Edition

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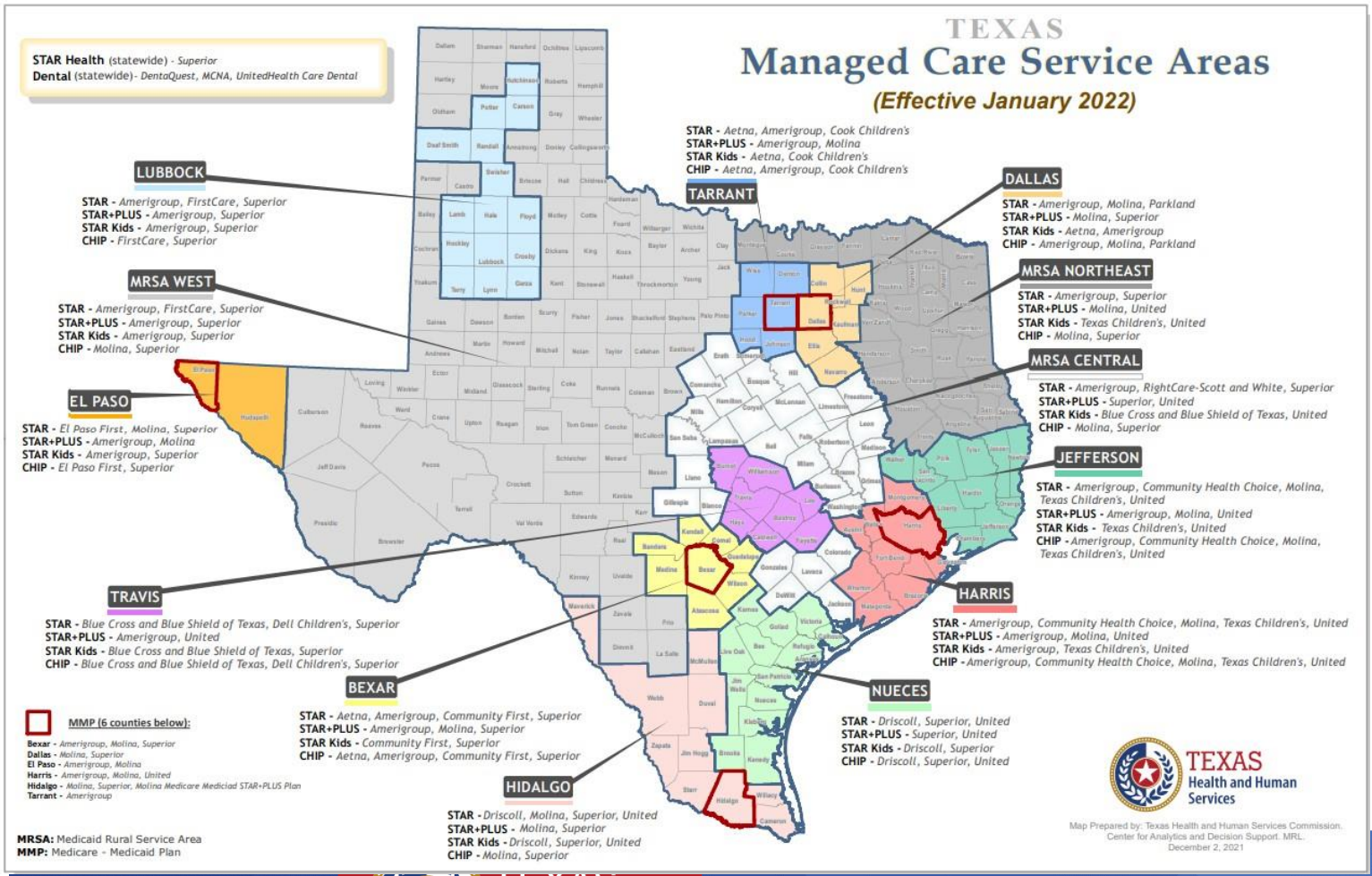
Managed Care Service Areas



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Health and Human Services

Contract Oversight Tools

Access to services
Network adequacy, appointment availability, member satisfaction

Service delivery
Acute care utilization reviews (UR), long-term services and supports URs, drug UR, electronic visit verification

Quality of care
Performance dashboard, custom evaluations, improvement projects, pay-for-quality, alternative payment models, MCO report cards

Financial
Financial statistical reports (FSRs) validation, administrative expense and profit limits, independent auditing

Operations
Readiness reviews, biennial operational reviews, targeted reviews

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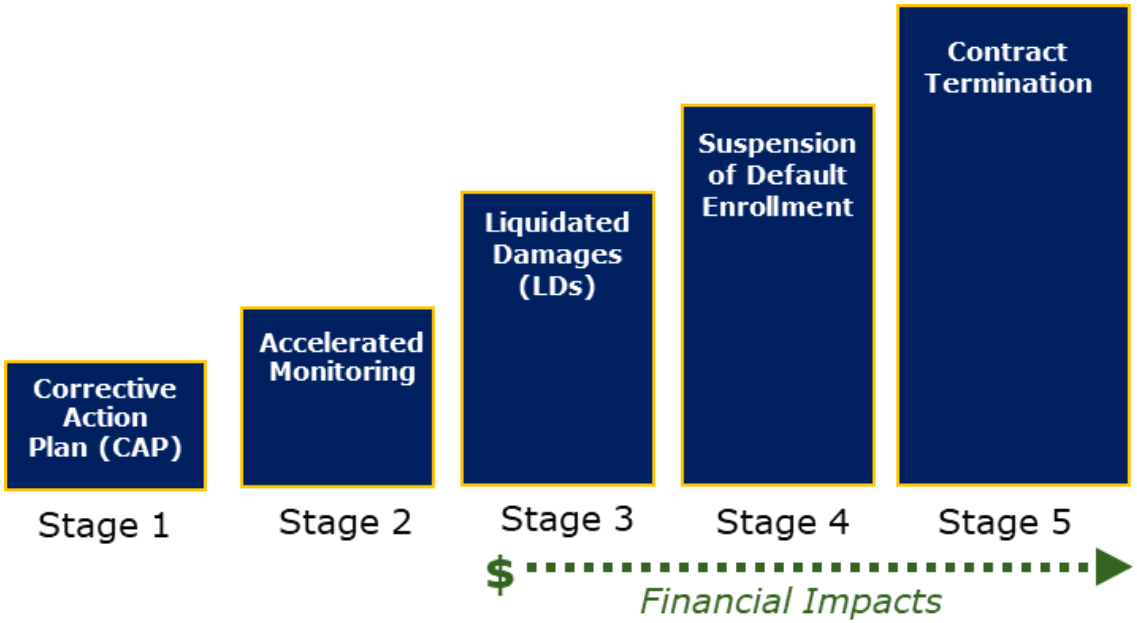
Addressing Non-Compliance

- Multiple stages to address non-compliance discovered via oversight and monitoring
- Increased levels of impact for MCOs
- Remedy issued is contingent on type of non-compliance and not necessarily sequential



TEXAS
Health and Human Services

Program Improvements

Texas Medicaid

Enhancements focus on four major areas

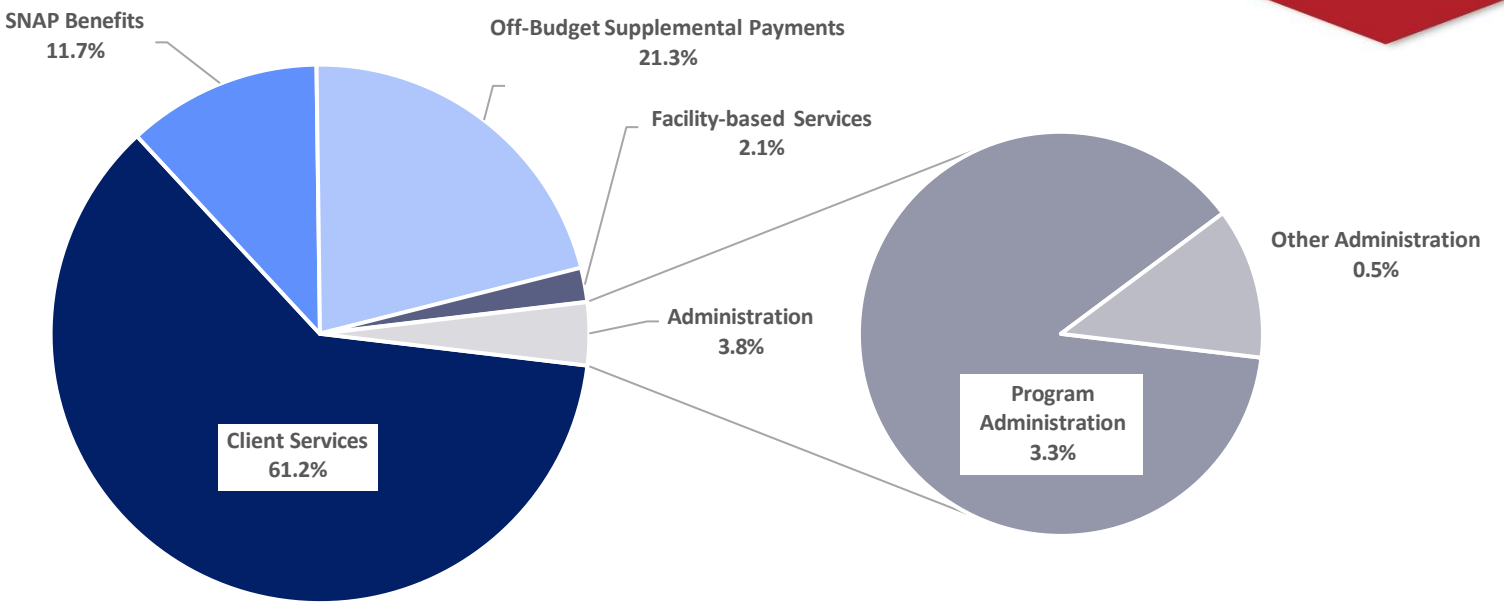
1. Leveraging the managed care integrated delivery system
2. Increasing access to services and the type of services available
3. Using innovation and incentives to improve quality of care
4. Strengthening operations and oversight

TEXAS
Health and Human Services

Medicaid Funding & Cost Drivers

Trey Wood, Chief Financial Officer

Health and Human Services Commission - Overview



Health and Human Services Commission (HHSC) – Percentages of Estimated Total Available Funds (2022-23 Biennium)

Does not include Interagency Contract Funds in Goal K, Office of Inspector General ($10.6 million), and Goal L, System Oversight and Program Support ($294.0 million). SNAP benefits are shown using fiscal year 2020 estimates and Off-Budget Supplemental Payments are shown using fiscal year 2021 estimates.

Medicaid Federal Funds

Medicaid is an entitlement program

There is no cap on federal funding to provide eligible services to eligible persons

- Federal Medical Assistance Percentage (FMAP) is derived from each state's average per capita income
- The Centers for Medicare & Medicaid Services (CMS) updates the rate annually
- For federal fiscal year (FFY) 2022, Texas' Medicaid standard FMAP is 60.80 percent
  - The FFY is on a different calendar cycle than the state fiscal year (SFY)
  - The standard SFY 2022 FMAP rate is 60.88 percent (one month of the FFY 2021 rate of 61.81 and 11 months of the FFY 2022 rate of 60.80)

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Health and Human Services

6.2% FMAP Increase

Program	Amount
Medicaid	$5,744,873,193
Children's Health Insurance Program (CHIP)	$132,240,594
Healthy Texas Women (HTW)	$6,279,135
Total	**$5,883,392,923**

- The Families First Coronavirus Response Act (FFCRA) provided qualifying states with a temporary 6.2 percentage point increase to FMAP for certain Medicaid and CHIP expenditures
- The estimates above represent the state's share of savings from the increased match rate to existing caseload and services and excludes cost impacts related to COVID-19
- To receive the increased FMAP, HHSC must maintain Medicaid coverage for most people enrolled in Medicaid until the end of the month in which the Public Health Emergency (PHE) ends
- The tipping point, or the point at which all monthly COVID-19 impact costs associated with the PHE maintenance of eligibility requirements begin to exceed the monthly benefit of the increased FMAP, was expected to have occurred in May/June 2022

6.2% FMAP Increase Plan Summary

States must:

- States have 12 months to complete pending eligibility actions, which can begin up to 60 days before the first disenrollments will begin.
- Disenrollments cannot be effective before the first of the month after the PHE ends.
- Conduct a full redetermination (as outlined in 42 Code of Federal Regulations 435.916) and allow members a minimum of 30 days to respond to renewal packets or requests for information.

Timeline

- The federal government has committed to giving states at least 60 days notice before the end of the PHE.
- HHSC is working under the assumption that the PHE will end in October 2022, which would result in:
  - Eligibility to receive the increased FMAP through December 2022.
  - Disenrollment beginning in November 2022.

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Health and Human Services

Key Budget Drivers

The following assumes the Public Health Emergency (PHE) and related policies end December 2022:

- Medicaid entitlement caseloads are projected to increase by 12.9 percent in SFY 2022 and decrease by 5.2 percent in SFY 2023
- CHIP caseloads are expected to decrease by 51.3 percent in SFY 2022 and increase by 86.9 percent in SFY 2023
- Cost (per client) growth is projected to decrease by 3.7 percent in SFY 2022 and increase by 3.2 percent in SFY 2023 due to changing case mix resulting from the PHE
- Cost growth is impacted by:
  - Utilization trends
  - Case mix distribution
  - Benefit changes
  - Population acuity factors
  - Aging and births
  - Evolutionary and revolutionary advances in medicine

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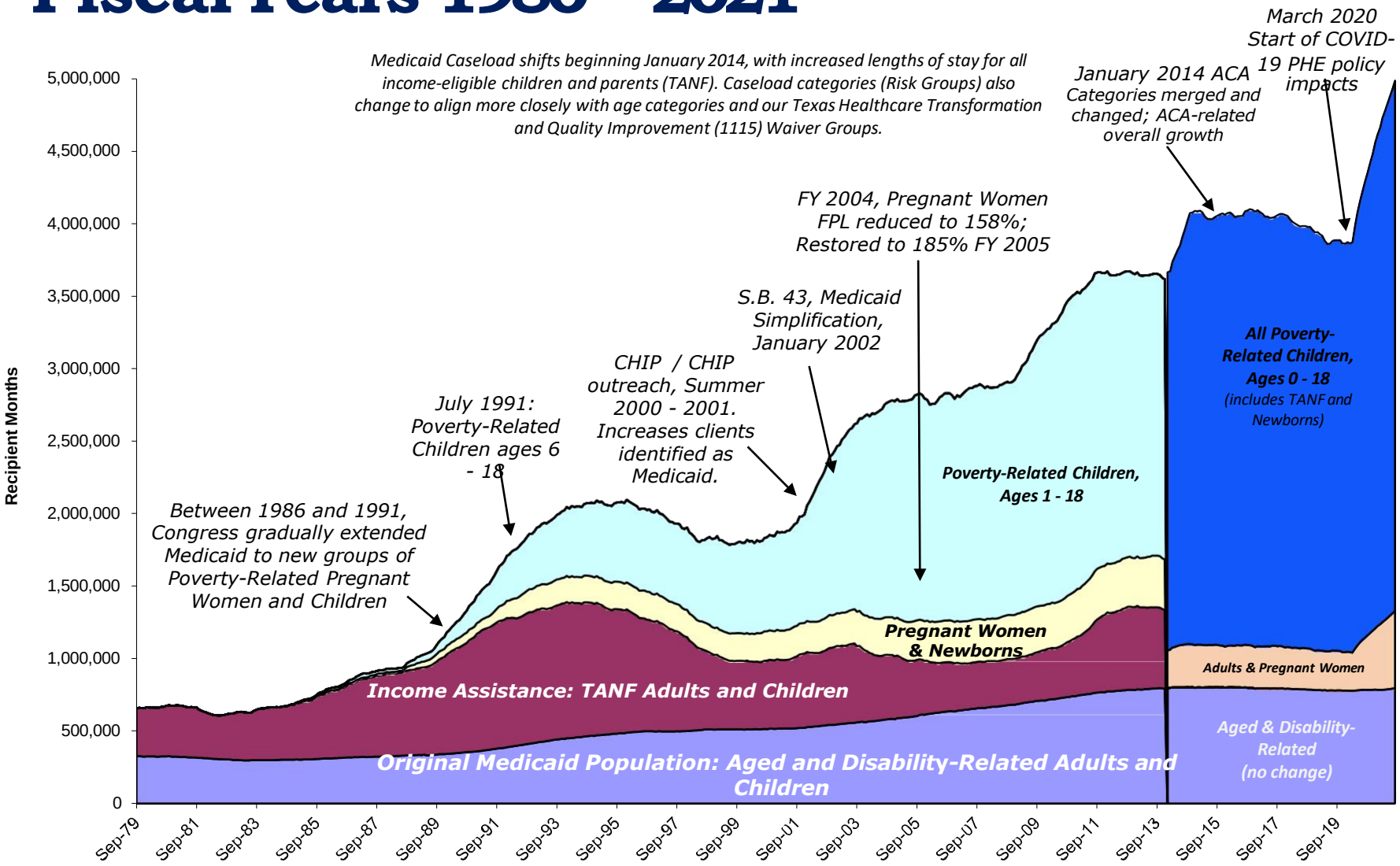
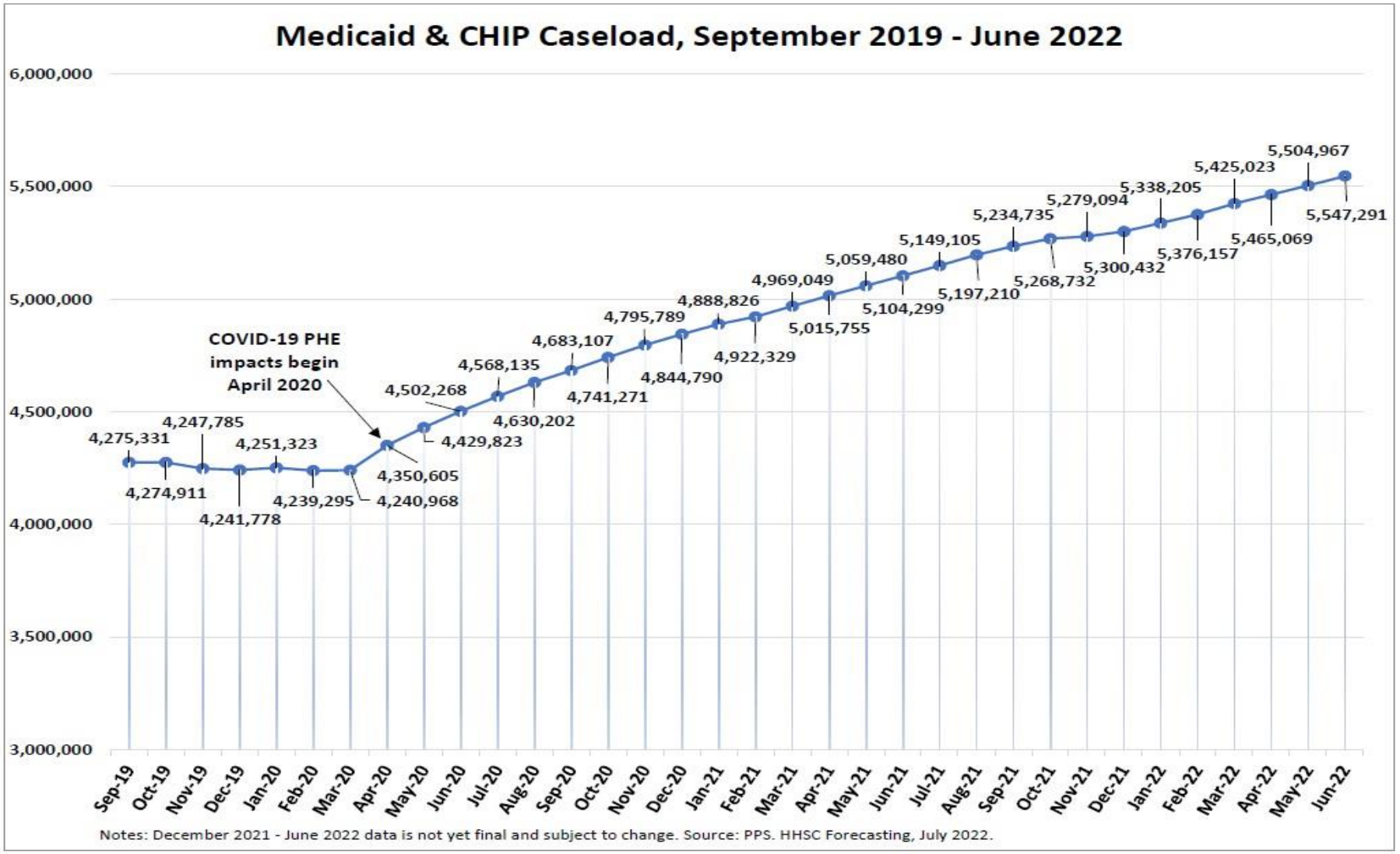
Health and Human Services

Texas Medicaid Caseload by Group from Fiscal Years 1980 – 2021



Medicaid & CHIP Caseload Growth

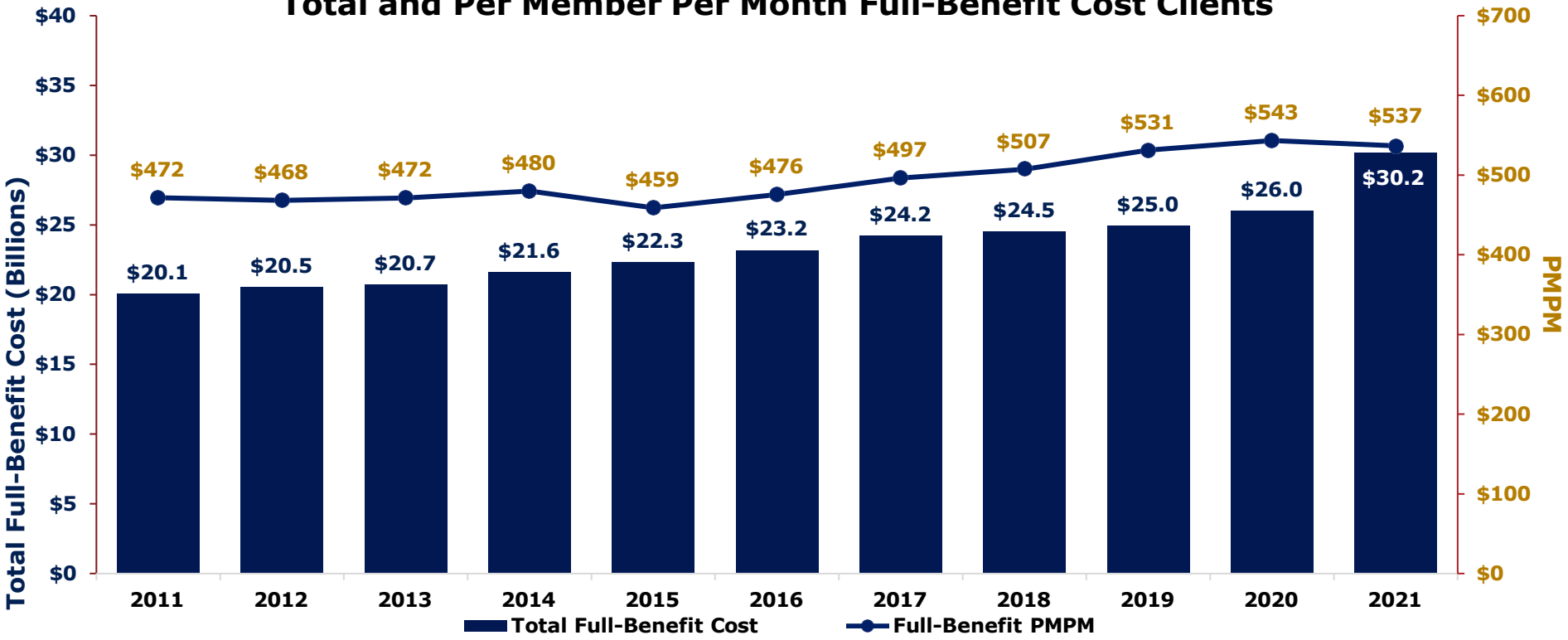


Notes: December 2021 - June 2022 data is not yet final and subject to change. Source: PPS. HHSC Forecasting, July 2022.

TEXAS Health and Human Services

Medicaid Cost Growth

Texas Medicaid Acute and Long-Term Services Costs, FY 2011-2021: Total and Per Member Per Month Full-Benefit Cost Clients

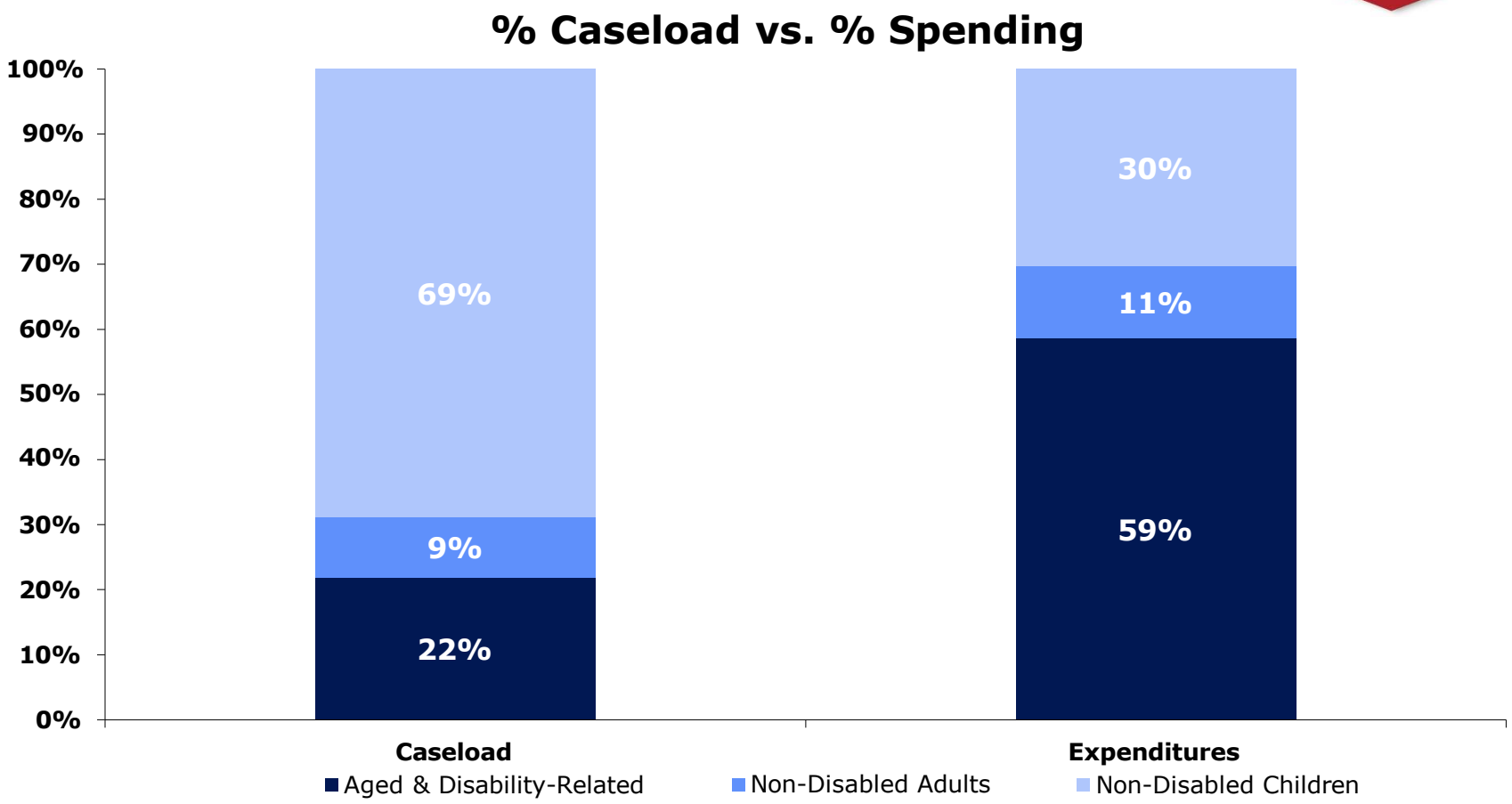


Medicaid Caseload (Recipient Months) and Per Member Per Month Costs with Trends

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
RMs	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702	4,060,564	4,067,380	4,021,686	3,915,011	3,984,967	4,682,819
RM Trend	*7%*	*3%*	*0%*	*2%*	*8%*	*0%*	*0%*	*-1%*	*-3%*	*2%*	*18%*
PMPM	$472	$468	$472	$480	$459	$476	$459	$507	$531	$543	$537
PMPM Trend	*1%*	*-1%*	*1%*	*2%*	*-4%*	*4%*	*-4%*	*11%*	*5%*	*2%*	*-1%*

Notes: Excludes Supp. & Directed Payment Progs, SHARS, Medicare premiums, clawback, drug rebates, and agency admin. Source: PPS, CMS-37 Historical (FFY). HHSC Forecasting, July 2022.

Major Category Spending



Medicaid Shortfall

HHSC projects a net supplemental appropriation need of approximately $3.7 billion in General Revenue for the 2022-23 biennium.

Supplemental Need	2022-23 Biennium (in millions)
Medicaid Acute Care for Full-Benefit Clients	$(898.8)
Medicaid Long Term Care Entitlement	$0.0
Medicaid Long Term Care Non-Entitlement	$23.4
Medicaid Other Medical Services	$(171.4)
Other Impacts to Medicaid	$(2,647.9)
Children's Health Insurance Program (CHIP)	$239.8
Disaster Transfer to Department of State Health Services (DSHS)	$(200.0)
Current Projected HHSC Shortfall as of May 2022	**$(3,654.9)**

Notes:

1. Current supplemental impact assumes the PHE will end in mid-October 2022 with the enhanced FMAP continuing through December 31, 2022.
2. HHSC currently estimates the "Tipping Point" in which the monthly costs associated with receiving the increased FMAP begin to exceed the monthly benefit of FMAP to have occurred in May/June 2022.
3. Cash Flow projections estimate HHSC will not be able to make payments to Medicaid providers beginning May 2023.

1115 Texas Healthcare Transformation and Quality Improvement Program

Since 2011, the waiver has enabled Texas to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals.

The goals of the demonstration are to:

- Expand risk-based managed care statewide
- Support the development and maintenance of a coordinated care delivery system
- Improve outcomes while containing cost growth
- Transition to quality-based payment systems across managed care and providers.

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Health and Human Services

1115Waiver - January 2021 Approval

CMS approved a 10-year extension

- January 15, 2021 – CMS approved a 10-year extension of the 1115 Transformation Waiver
- April 16, 2021 - CMS rescinded their approval letter issued on January 15, 2021
- May 14, 2021 - Texas Office of the Attorney General sought legal redress and filed a complaint in federal court
- August 20, 2021 - Court ordered, through a preliminary injunction, that the waiver approval was in effect
- April 22, 2022 - CMS withdrew their rescission letter and confirmed the January 2021 Special Terms and Conditions as in effect
- May 10, 2022 - Stipulation of Dismissal was filed with the court, closing out the litigation

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1115 Waiver - Financial Support for Providers

Supplemental Payment Programs

- Delivery System Reform Incentive Payment Program (DSRIP) – ended on September 30, 2021
- Uncompensated Care Program (UC) – Maintained through 2030; pool will be resized twice
- Public Health Provider Charity Care Program (PHP-CCP) – New funding pool from 2022-2030; pool will be resized twice

Directed Payment Programs (DPPs)

- Comprehensive Hospital Increased Reimbursement Program (CHIRP)
- Quality Incentive Payment Program (QIPP)
- Texas Incentives for Physicians and Professional Services (TIPPS)
- Directed Payment Program for Behavioral Health Services (DPP BHS)
- Rural Access for Primary and Preventive Services (RAPPS)

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1115Waiver - Financial Support for Providers

Supplemental Payment Programs

- Fixed pool sizes
- Reimburses costs for uninsured/charity care

Directed Payment Programs

- Fluctuating size (dependent upon caseload, utilization)
- Reimburses for Medicaid services for Medicaid beneficiaries
- Advances a quality goal or strategy

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Health and Human Services

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Texas Medicaid FFY 2022 DPPs

Quality Incentive Payment Program (QIPP)
$997 Million
Nursing Facilities
Started SFY18

Comprehensive Hospital Increased Reimbursement Program (CHIRP)
$5.9 Billion
Hospitals
Started as UHRIP SFY18
CHIRP started SFY22

Directed Payment Program for Behavioral Health Services (DPP BHS)
$188 Million
CMHCS, LBHAs
Started SFY22

Texas Incentive for Physicians and Professional Services (TIPPS)
$670 Million
Physician Groups
Started SFY22

Rural Access to Primary and Preventive Services (RAPPS)
$12.5 Million
Rural Health Clinics
Started SFY22

Financial Support for Providers

Texas Transition Plan 2022 and Beyond

	DY 10 (FFY 21)	DY 11 (FFY 22)	DY 12 + (FFY XX)
UC Pool Payments	$3,873,206,193	$3,873,206,193	$4,512,075,400
DSRIP Payments	$2,490,000,000		
PHP CCP Payments		$500,000,000	$500,000,000
NAIP	$537,693,283	$491,375,364	$250,000,000
QIPP	$971,897,174	$997,322,319	$1,100,000,000
DSRIP Transition Programs:			
UHRIP & CHIRP	$3,178,431,342	$5,956,281,077	$5,200,000,000
TIPPS		$670,123,256	$696,000,000
RAPPS		$12,583,984	$33,000,000
DPP BHS		$188,443,115	$238,000,000
Totals	**$ 11,051,227,992**	**$ 12,689,335,309**	**$ 12,529,075,400**

Both Network Access Improvement Program (NAIP) and Uniform Hospital Rate Increase Program (UHRIP) are larger than initially projected for FY 2021 as a result of increased caseload associated with the Public Health Emergency enhanced FMAP.

UHRIP reflects 11 months of costs for FFY21. FFY22 DPP figures are estimated based on SFY22 premiums since rates are developed on SFY basis.

DPP sizes for Demonstration Year (DY) 12 are baseline estimates and will vary depending on caseload growth.

TEXAS
Health and Human Services

HB 133 Implementation

Stephanie Stephens, State Medicaid Director

Postpartum Eligibility Extension

- Extends Medicaid for Pregnant Women coverage from 60 days to six months following birth or an involuntary miscarriage.
- HHSC submitted an 1115 waiver amendment in May 2022 for federal approval.
- Eligibility system changes are in process while the waiver amendment is pending federal approval.

Case Management for Children and Pregnant Women

- Case management for children and pregnant women (CPW) is a Medicaid state plan benefit currently delivered through fee-for-service.
  - Provides health-related case management to children and young adults under age 21 and high-risk pregnant women.
- H.B. 133 requires HHSC to transition the service to a managed care delivery system.
- HHSC plans to implement CPW in managed care effective September 1, 2022.
  - HHSC submitted an 1115 waiver amendment in May 2022 for federal approval.

Healthy Texas Women

- Healthy Texas Women (HTW) provides health and family planning services to low-income women through a fee-for-service delivery model.
- HHSC is incorporating requirements for HTW in the STAR and CHIP managed care request for proposal (RFP).
  - RFP posting- Second quarter of FY 2023
  - Notice of award- Second quarter of FY 2024
  - Operational start- Second quarter of FY 2025
- Transition will require an amendment to the 1115 waiver.

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Health and Human Services

End of Public Health Emergency Activities

Molly Lester, Deputy Chief
Program and Services Officer

TEXAS
Health and Human Services

Background

The Families First Coronavirus Response Act (FFCRA) was passed by U.S. Congress in March 2020.

Allowed states to qualify for a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase, provided states **maintain Medicaid coverage** for most people enrolled in Medicaid as of or after March 18, 2020, until the end of the month in which the federal public health emergency (PHE) ends.

HHSC implemented the federal directive effective March 18, 2020

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Health and Human Services

Federal Guidance

Based on the most recent guidance from the Centers for Medicare and Medicaid Services (CMS), major parameters for unwinding include:

States have up to 12 months to complete pending eligibility actions, which can begin **up to 60 days** before the first disenrollments will begin.

Disenrollments cannot be effective before **the first of the month after the PHE ends**.

States must conduct a full redetermination (as outlined in 42 Code of Federal Regulations 435.916) and allow members **a minimum of 30 days to respond** to renewal packets or requests for information.

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Health and Human Services

Current Landscape

Estimated PHE End Date

- The PHE is currently slated to end on **October 13, 2022**; it can be extended in increments up to 90 days.
- The federal government has committed to giving states at least 60 days notice before the end of the PHE.
- The federal government should have informed states of the end of the PHE by **August 14, 2022**, if the PHE will end as assumed. States did not receive notification.

Redetermination Population

- HHSC has extended Medicaid coverage for as many as **2.7 million members** due to the continuous Medicaid coverage requirement in the FFCRA.
- All these members will need to have their Medicaid eligibility redetermined when continuous coverage ends.

HHSC Plan to End Continuous Enrollment

- HHSC's unwinding approach **staggers** Medicaid redeterminations for continuous coverage over multiple months.
- The continuous coverage population will be distributed into **three cohorts** to best accomplish the goals of:
  - Maintaining coverage for eligible individuals; reducing churn
  - Prioritizing redeterminations for those most likely to be ineligible or to be eligible for another program
  - Reducing the risk of overwhelming the eligibility system or workforce during the unwinding period
  - Establishing a sustainable renewal schedule for subsequent years

HHSC Plan to End Continuous Enrollment

First Cohort

- Includes individuals most likely to be ineligible or transitioned to CHIP.
  - Pregnant women who may transition to Healthy Texas Women Program
  - Members who aged out of Medicaid
  - Adult recipients who no longer have an eligible dependent child in their household

Approximately 1.4M members (as of April 2022)

Second Cohort

- Includes individuals likely to transition to a different Medicaid eligibility group
- Medicaid children, parent/caretaker and waiver groups pending information
- Certain MAGI population groups (e.g., children, people under Transitional Medical Assistance).

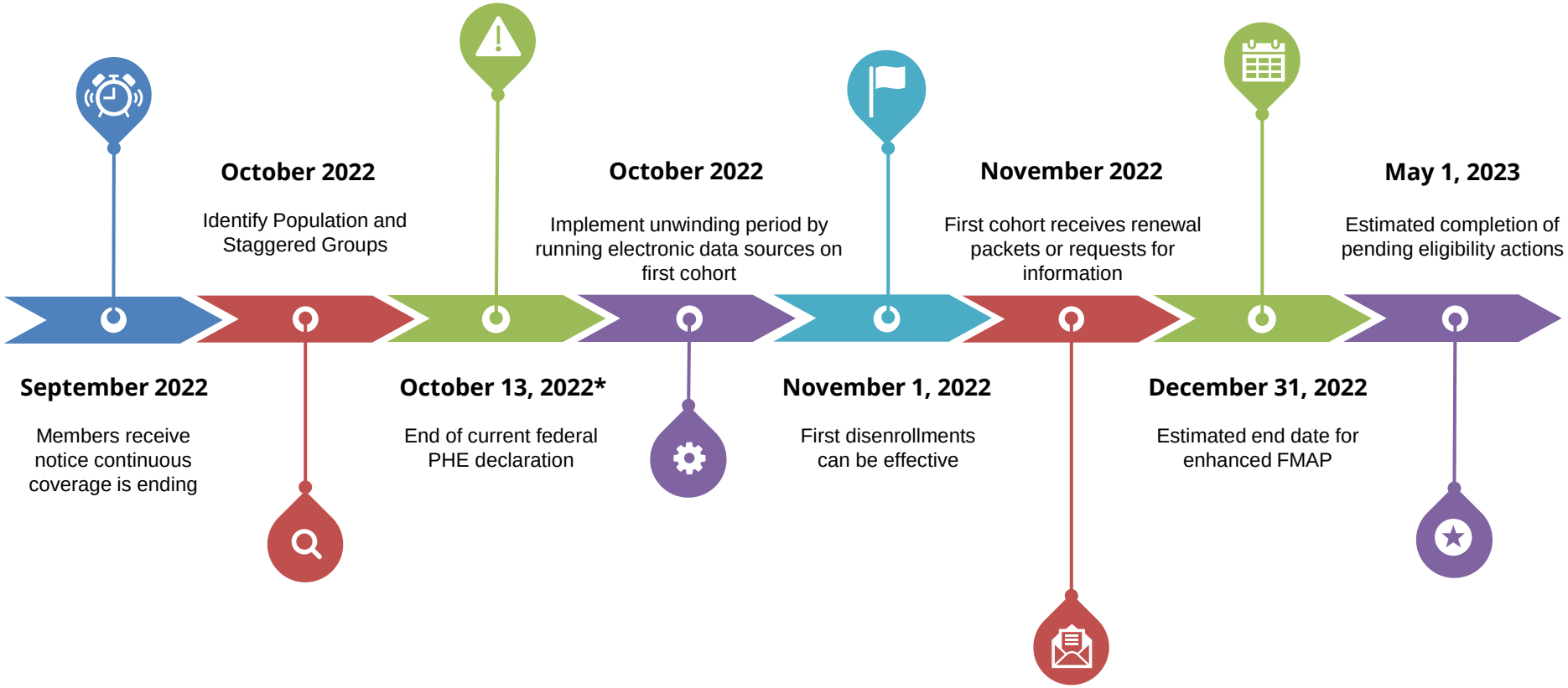
Approximately 500K members (as of April 2022)

Third Cohort

- Includes everyone remaining from the previous groups, including those most likely to remain eligible (i.e., Children in Medicaid).

Approximately 640K members (as of April 2022)

Timeline for Ending Continuous Coverage



**Timeline assumes the Public Health Emergency will end on October 13, 2022. Awaiting federal confirmation of this date.*

Ambassador Program

HHSC created the **Ambassador Program** for external partners, providers, health plans, and advocates to support members and prepare for the end of continuous Medicaid coverage.

Key Messages – Actions Members Can Take Now

Sign up for the YourTexasBenefits account and mobile app.
Report any changes in contact information to ensure members receive important notices when needed.
Return renewal packets or requests for information as soon as possible after they are received by the member.

These key messages aim to **reduce member confusion,** increase likelihood of **eligible members maintaining coverage** and **minimize call center volume.**

Ambassador Program Toolkit

Actions Ambassadors Can Take Now

- Download Ambassador Toolkit from https://www.hhs.texas.gov/services/health/coronavirus-covid-19/end-continuous-medicaid-coverage-ambassador-toolkit
- Share toolkit items with members in offices or electronically.
- Share toolkit items with other stakeholders to ensure consistent messaging.

TEXAS
Health and Human
Services

Alternatives to Abortion

Rob Ries, Deputy Executive Commissioner of Health and Family Services

Legislative Authority

The Alternatives to Abortion program was created by the 2006-07 General Appropriations Act, Senate Bill 1, 79th Legislature, Regular Session, 2005 (Article II, Special Provisions Relating to all Health and Human Services Agencies, Section 50)

Currently, the 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission [HHSC], Rider 68), authorizes the program

TEXAS
Health and Human Services

Alternatives to Abortion Goals

Reduce abortions and improve pregnancy outcomes by helping women practice sound health-related behaviors and improve prenatal nutrition

Improve child health and development by helping parents provide responsible competent care for their children.

Improve families' economic self-sufficiency by helping parents continue their education and secure employment

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Health and Human Services

Services Available

- Counseling, mentoring, educational information, and classes on the following: pregnancy, parenting, adoption, life skills, and employment readiness
- Material assistance such as car seats, clothing, diapers, and formula
- Care coordination through referrals to government assistance programs and other social service programs
- Call center for information or to schedule appointments
- Housing and support services through maternity homes

Client Eligibility

Texas residents who are:

- Pregnant and up to three years post-partum.
- Clients who have suffered a miscarriage or loss of a child, up to 90 calendar days after miscarriage or loss.
- Adoptive parents up to two years post-adoption finalization, regardless of the age of the child.
- Beginning in fiscal year 2021, the parent, legal guardian, or Adult Caregiver of a minor (under the age of 18) who is a program client is also eligible for services.

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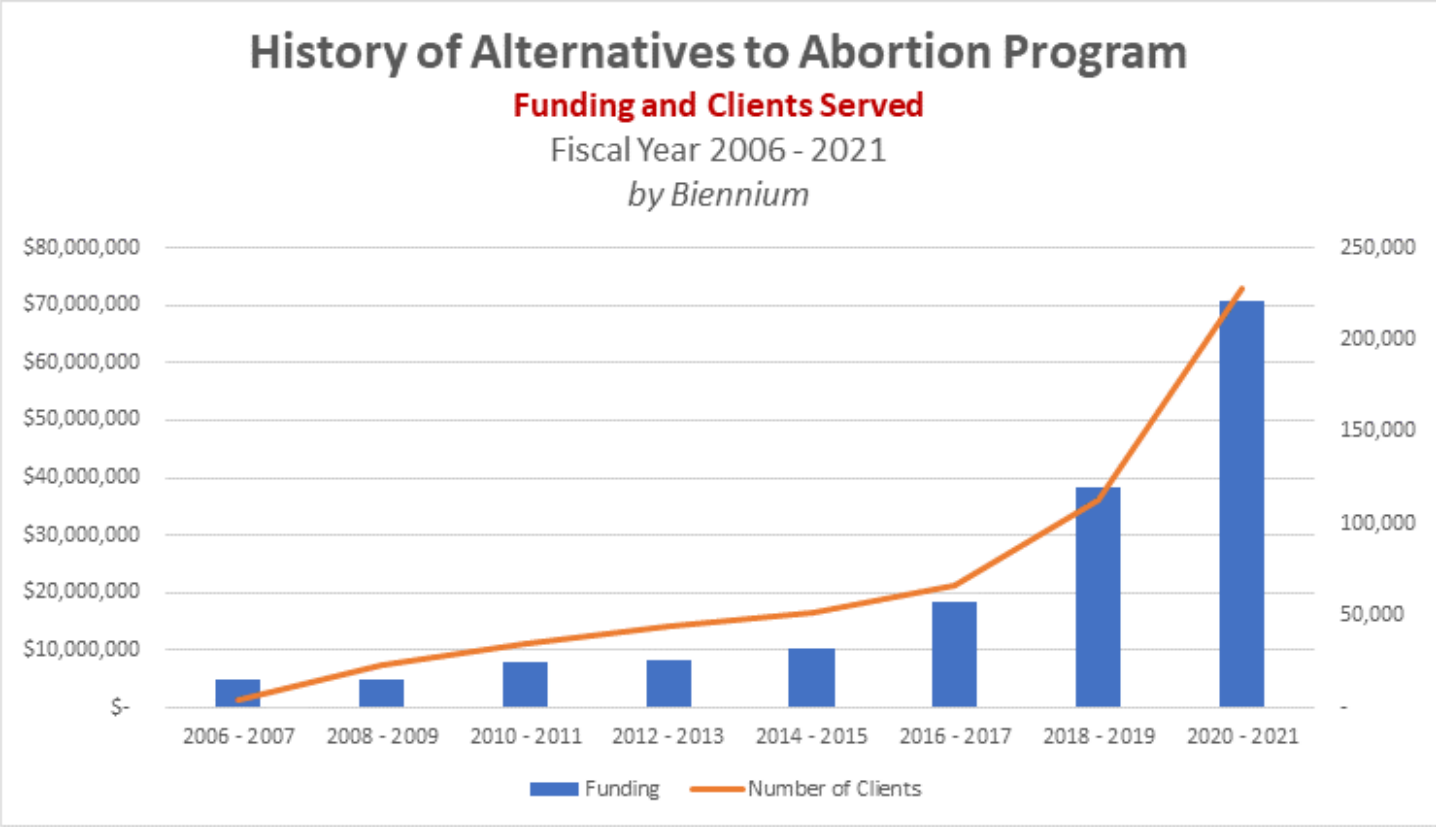
Funding and Clients Served



Contracted Providers

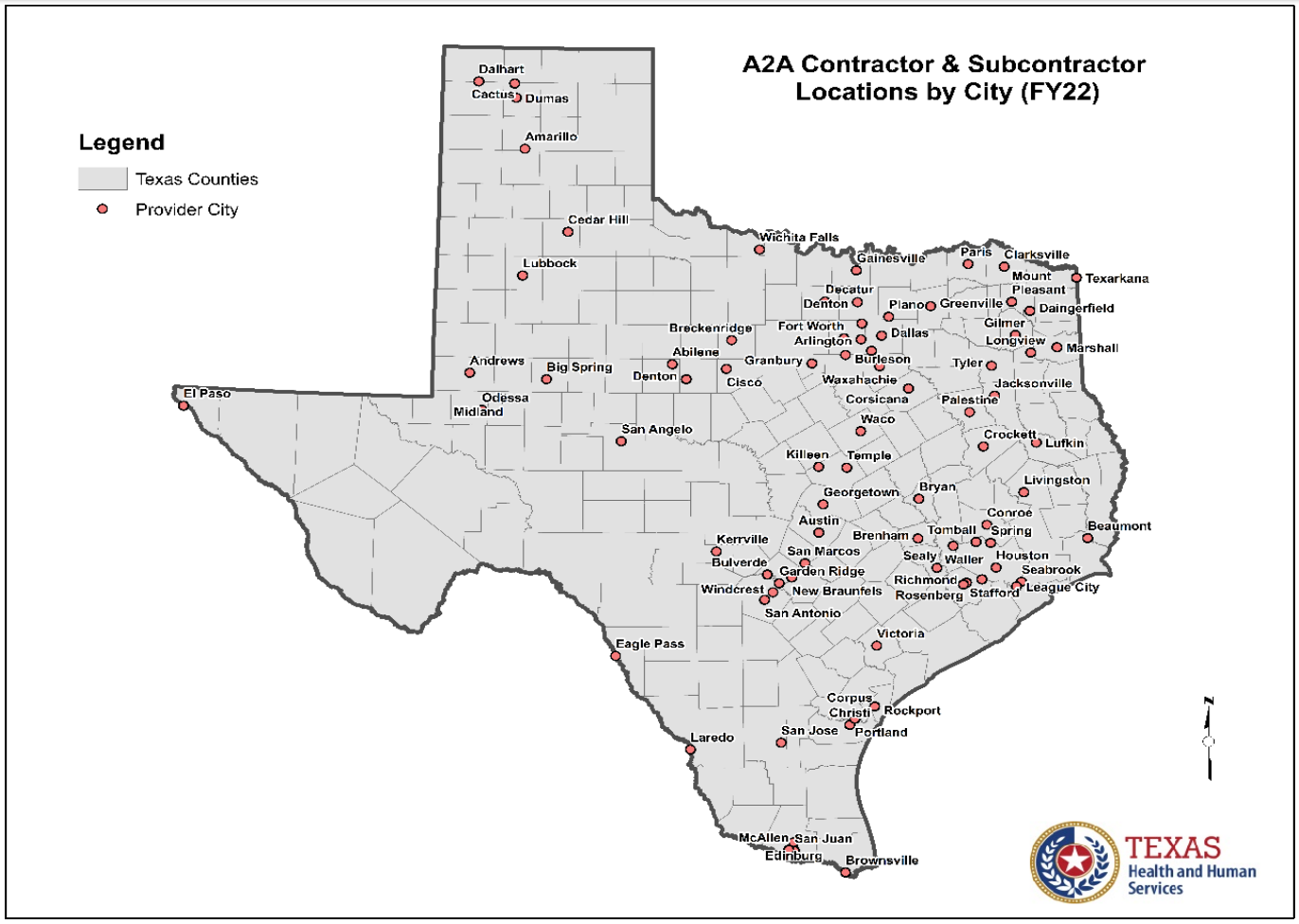
Texas Pregnancy Care Network
Contractor for the program since fiscal year 2006

Human Coalition
Contractor for the program since fiscal year 2018

Austin LifeCare
Contractor for the program since fiscal year 2021

Longview Wellness Center
Contractor for the program since fiscal year 2021

Contractor and Subcontractor Locations



Major Programmatic Changes

Beginning in fiscal year 2021, Alternatives to Abortion:

- Expanded the definition of a client to include the parent, legal guardian, or adult caregiver (as defined in Texas Family Code) of a minor who is a program client
- Enhanced connection to other HHSC programs, such as referrals to HHSC women's health programs and mental health services
- Added classes on substance abuse, parenting, and healthy relationships
- Required contractors to provide employment readiness services, based upon needs of the clients
- Extended maternity home eligibility from 90 days to up to 180 days postpartum
- Refined programmatic reporting requirements to better capture services provided

Looking Ahead: Pilot Projects

Maternal Health Disparities:

Proactively reach high-risk mothers early in their pregnancies to ensure they receive a timely start to prenatal care, address identifiable risks, and receive personalized support

Modern Adoption:

Raise the profile and desire of considering adoption as an equally viable and acceptable alternative for unwanted pregnancy

APPROPRIATIONS COMMITTEE

ALTERNATIVES TO ABORTION

HUMAN COALITION

HUMAN COALITION

Watch Jaqueline's story here:

Thank you, Chairmen Bonnen and Capriglione and the Committee for the opportunity to speak with you today about the life changing services Alternatives to Abortion provides. My name is Chelsey Youman and I am the National Director of Public Policy for Human Coalition, one of the contracting vendors serving vulnerable women in need through Alternatives to Abortion ("A2A"). I am here today to testify in support of the A2A program.

Texas has an unprecedented infrastructure to support women seeking abortion and assist with their needs. The State spent decades building systems to empower women and their children with comprehensive care to alleviate obstacles to parenting and reliance on abortion. The State also uniquely incorporates public and private resources into a wide-ranging care system for pregnant women seeking abortion.

By funding services for women and families in need, Alternatives to Abortion enables non-profits like Human Coalition to empower women to a place of socio-economic stability, to help improve pregnancy outcomes and child health, and save countless lives in the process. Looking forward to a post-Roe landscape, it's imperative that we not only maintain this program's track record of success, but also improve it to meet the pressing needs of Texas women and children.

In the 2021 fiscal year alone, A2A provided more than 126,000 clients with nearly 2.7 million services. These included tangible resources for expectant mothers, such as diapers and car seats, as well as long term stabilizing support like gynecological care, safe housing, employment and affordable child care. The ripple effects from such

individualized assistance is a prime example of what good can come from state partnerships with community leaders on the ground.

Throughout the recent pandemic, the enactment of the Heartbeat Act, and the Dobbs ruling, pregnant women in Texas have consistently engaged in the program for material assistance, counseling, and social support.

The program enables a "tele-care" model of outreach to residents in traditional healthcare "deserts" - often urban or rural areas without access to quality, affordable health care. Through this method, the A2A reaches women in all 254 Texas counties. It connects them with local assistance, public programs and OB care that in turn can help ensure their material and medical needs are met.

We reach women where they are at and serve them on their terms. Our licensed nurses begin caring for pregnant women by listening to what her priorities and needs are. They also inform mothers of their options relating to abortion, adoption and parenting.

This may be the most important thing I tell you today—we ask every single woman seeking abortion if her circumstances were different, would she prefer to parent. And three out of four say yes. These women most often feel they have no choice or pressured into an abortion because of their economic or social problems. Studies indicate that 64% are coerced to abort by their partner or a family member. Abortion isn't empowerment.

Of the women we see, their most common emotions are fear, sadness, anger, and panic. Fear of the abortion procedure, of keeping her baby, of the future, of her partner or any family members pressuring her—her circumstances. Women commonly state that their "head" tells them to have an abortion but that their "heart" says to keep the child. There are no happy abortions. Abortion always ends the life of an innocent human child.

And abortion harms women. Their mothers are left in the aftermath with an 81% greater risk of suffering from a psychiatric disorder like post-traumatic stress disorder, depression, anxiety, substance abuse, and suicidal behaviors.

Abortion also poses physical risks for women—both during and after the procedure. Some risks never go away: Modern research shows that abortion increases the risk of death from all causes. In one international study, women were 3.5 times more likely to die within one year of an abortion as women who gave birth. And in the United States she is more than twice as likely to commit suicide. These harms present grave public health concerns and can persist longer than ten years following her pregnancy loss.

A2A enables her to begin receiving support when she needs it most. We may be the first to tell her she is capable. She is not alone. She has support to make choices she wants, on her terms. We believe she is intelligent, adaptable and able. And hearing her voice shift from fear to hope is one of the most important moments in her and her growing child's life.

Our licensed nurses may also be the only medical professional to provide women who do go on to have an abortion medically accurate information about the abortion procedure itself.

For over a decade, droves of clients reported back to us nightmarish and misleading experiences at abortion clinics, "I had no idea that the [abortion] pill was going to be as painful as it was. They told me it was like taking medicine," one client told us. "I bled way more than I was told. The whole procedure was more painful than I was led to believe," another client said. Women are told the procedure is as easy as taking an aspirin, that they can forget about it that day, and are given little details about what they may experience, see or feel during and after the abortion.

This is particularly dangerous because one longitudinal study revealed women who take the abortion pill will go to the emergency room 35% of the time and that there was a 500% increase in ER visits between 2002 and 2015.

The Alternatives to Abortion program helps put these mothers back in the driver's seat and provides them information and resources they need to make well-informed decision and hopefully one that they will not regret.

One client told us, "It's amazing to know that single mothers have so many more support systems out there than they think." Another client told us that in talking to our staff, she found out "about benefits I didn't know existed."

This program is here to empower women and help fill those gaps, connecting them to the tangible care and support they need to welcome a child into the world through both public and private assistance. Many women we see aren't aware of the 17 public programs that they may be eligible for including affordable housing, food and nutrition, child care, and health insurance.

We help them apply for this critical assistance and lead them to a place of stability. The program also enables her to be cared for by non-profit charitable organizations near her that assist with employment, safe housing, domestic violence, substance abuse, counseling or any resource she may need. Finally, by connecting pregnant women with early gynecological care, many health risks such as maternal or infant disparities are mitigated.

When women exit abortion clinics, they return to the very set of circumstances that compelled them to enter in the first place.

When they walk out of our doors - and the doors of so many other centers that contract with the Alternatives to Abortion program - they leave better off than when they discovered us.

In our experience, the women who accepted social services assistance choose to continue their pregnancy because of the tangible support they received. Of the women we've surveyed, 97% would recommend our services to a family or friend and 95% state they felt cared for. We have countless testimonies from women who were scared or felt helpless, but who overcame to bring a child into the world. They don't regret their decision, and we're happy to have played a part in empowering them.

A2A vendors are knowledgeable, committed to serving women, and able to drive innovation. For example, in partnership with HHSC we developed a pilot program designed to reach and assist women who are specifically high at risk in Texas for maternal disparities. It began last month. I'm happy to discuss that incredible program or other services we provide to women in need across the state.

This program has saved and transformed hundreds of thousands of lives. I would like to thank you for your foresight and commitment to assisting vulnerable women in Texas. For years, you prepared and created an infrastructure to serve these women for this moment in history. It is working and serves as an example to other states who are ready to prioritize pregnant women in need. We've been in contact with many states seeking to serve women like this. The Alternatives to Abortion program serves a critical mission and ready to serve women in a post-Roe world. Thank you very much for your time, and I look forward to your questions.

Chelsey D. Youman, Esq.
National Director of Public Policy
PO Box 250514 Plano, TX 75025
Telephone: 214.295.7401
Email: Cyouman@huco.org
humancoalition.org

AGENDA ITEM VII:
DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

LEGISLATIVE BUDGET BOARD

Department of Family and Protective Services

Historical Appropriations and Expenditures

PRESENTED TO HOUSE COMMITTEE ON APPROPRIATIONS

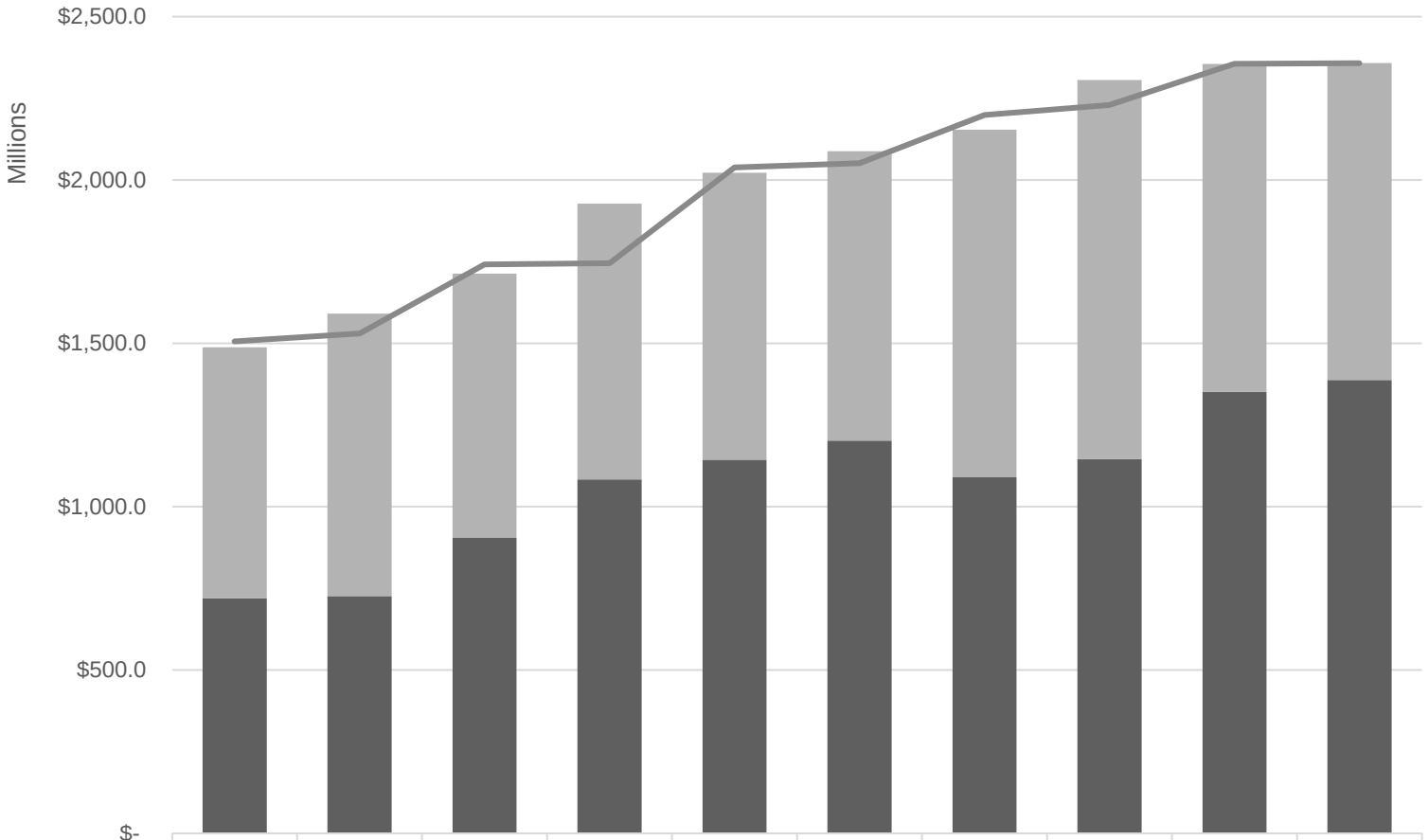
LEGISLATIVE BUDGET BOARD STAFF

September 2022

Agenda

- Agency-wide Expenditures Compared to Appropriations
- Full-time Equivalent (FTE) Appropriations
- Non-Child Protective Services Expenditures
- Child Protective Services Expenditures
- Children Served in Child Protective Services
- Child Protective Services Investigations
- Exceptional and Supplemental Appropriations

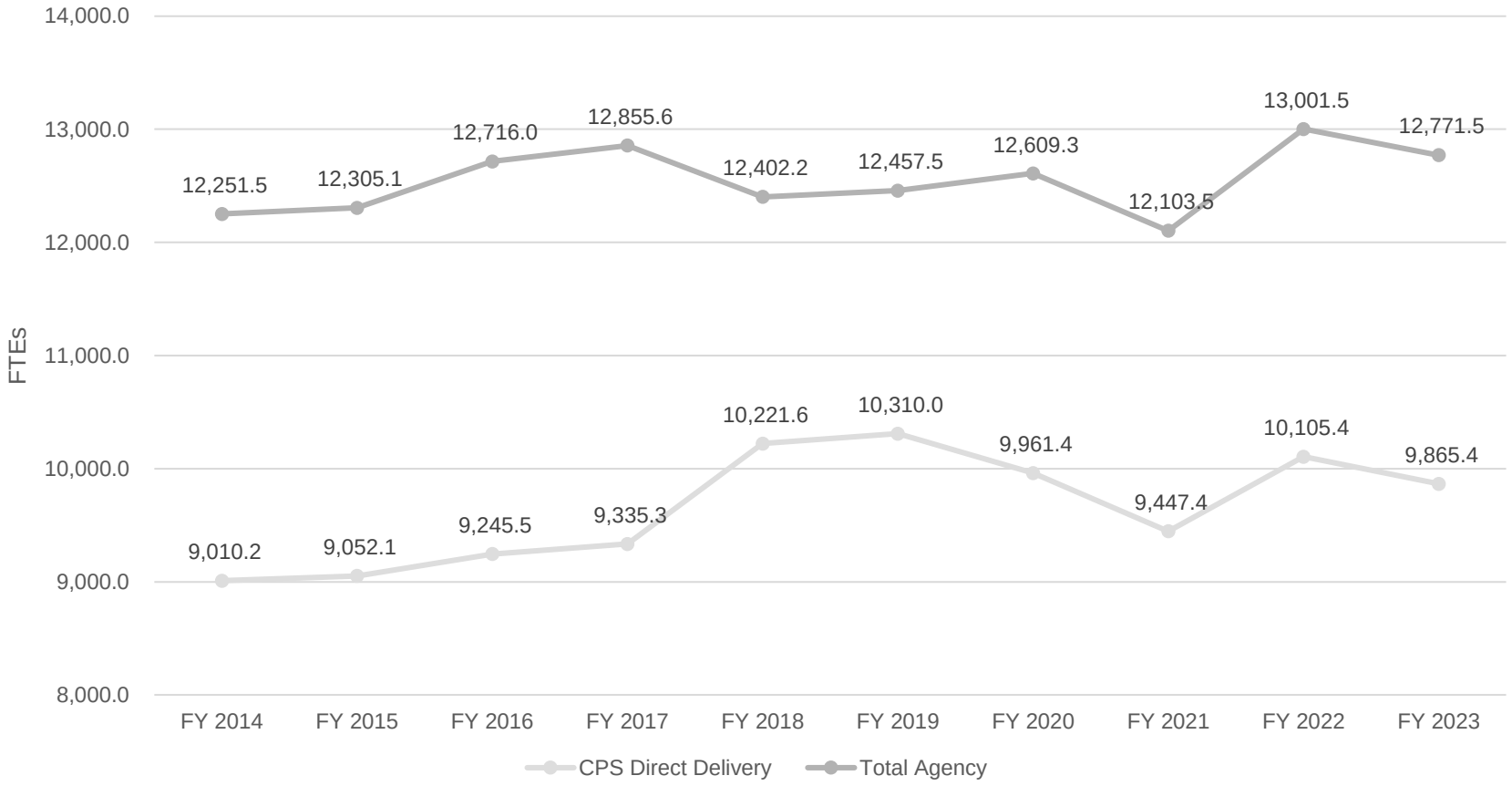
Agency Expenditures Compared to Appropriations



	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
All Other Expenditures	$768.0	$864.8	$809.3	$845.1	$878.4	$886.4	$1,063.9	$1,160.4	$1,004.5	$970.0
GR Expenditures	$719.9	$725.9	$904.3	$1,082.9	$1,143.7	$1,201.7	$1,089.9	$1,145.8	$1,351.3	$1,388.0
All Funds Appropriations	$1,505.7	$1,530.4	$1,741.5	$1,745.7	$2,038.3	$2,051.1	$2,199.2	$2,230.0	$2,355.7	$2,358.0

Source: Legislative Budget Board and Department of Family and Protective Services

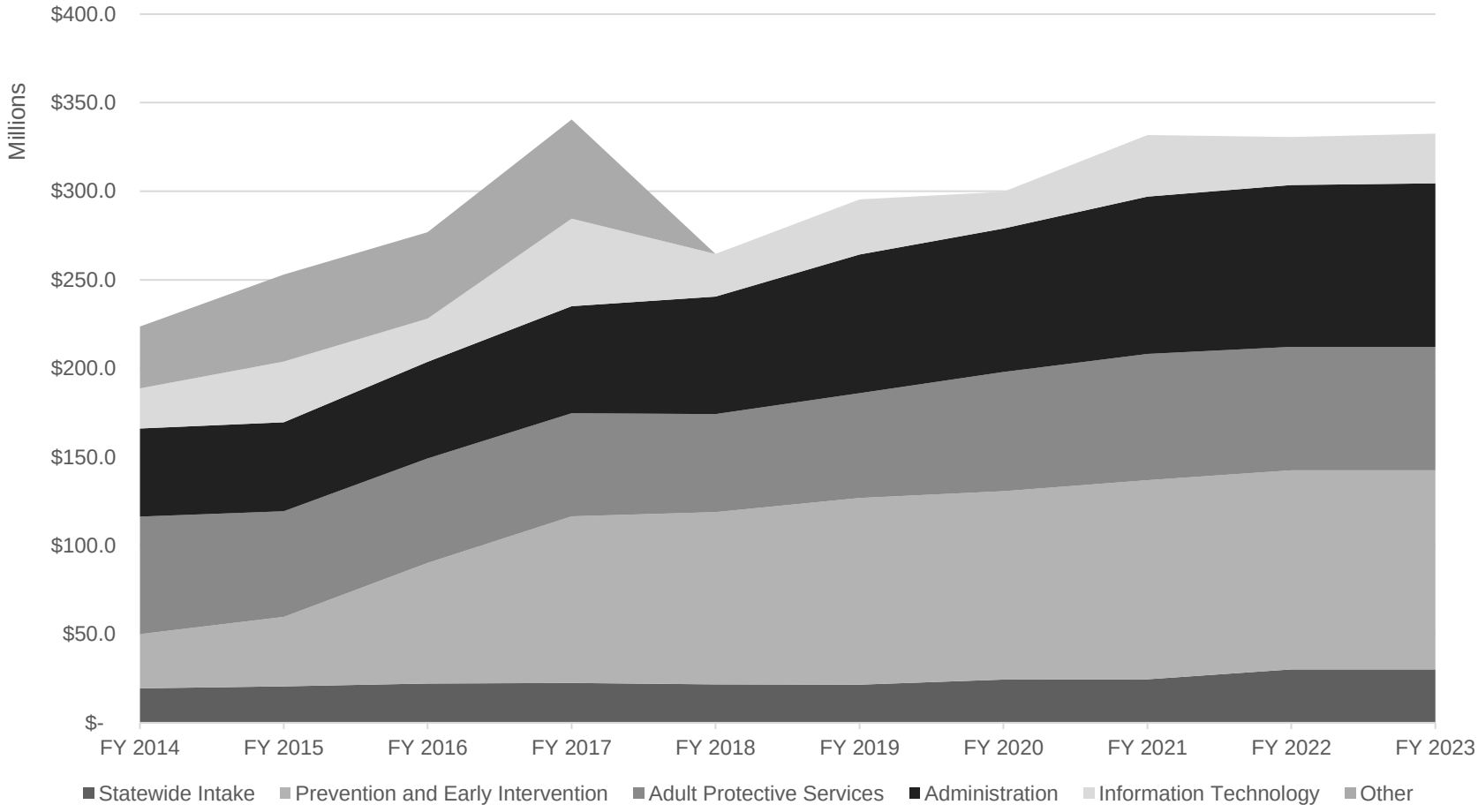
Historical Full-time Equivalent Appropriations



	FY 2019	FY 2020	FY 2021	FY 2022	TOTAL
FTE Reductions due to Community-based Care	61.0	409.0	0.0	265.0	735.0

Source: Legislative Budget Board and Department of Family and Protective Services

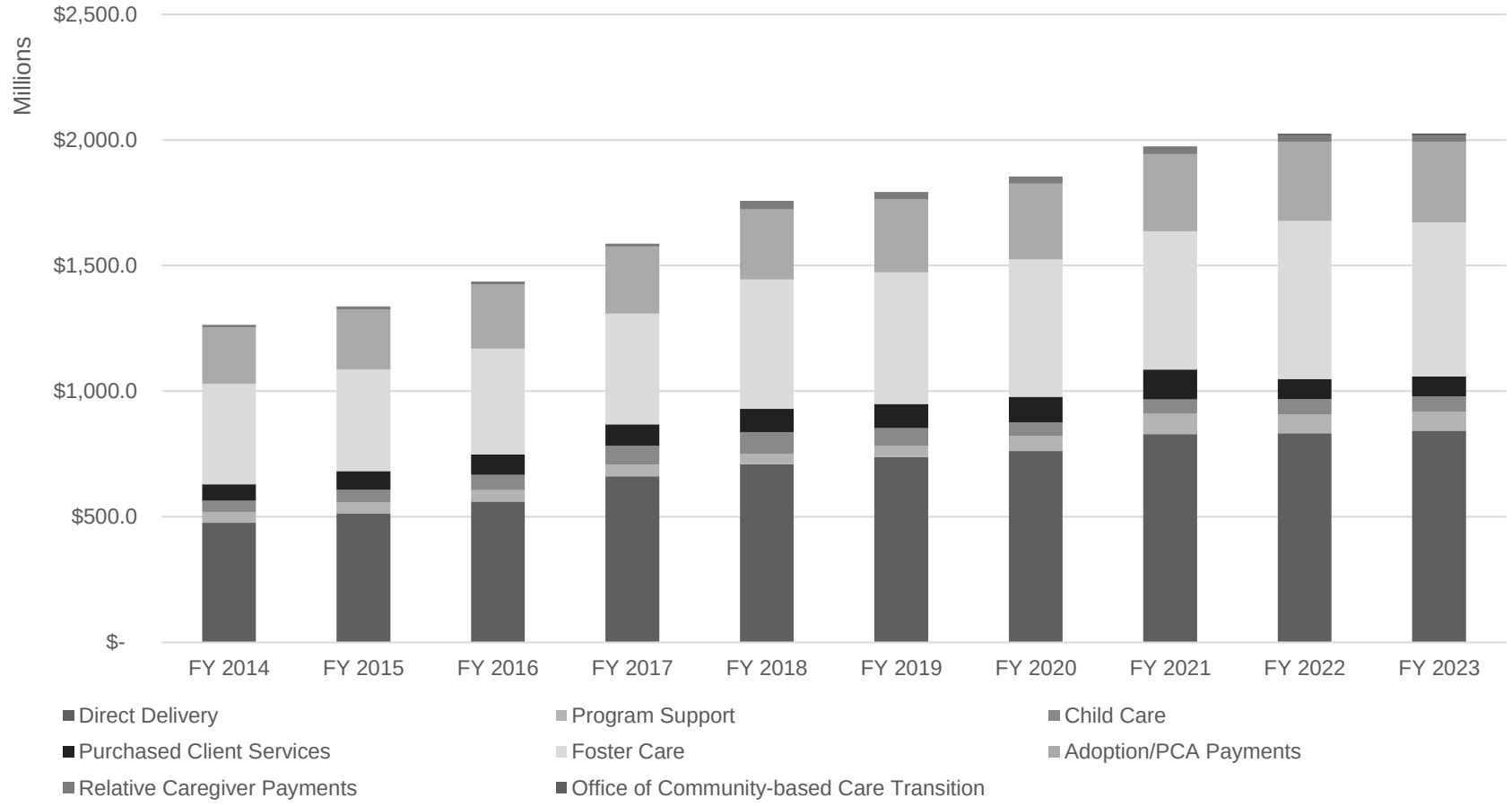
Non-Child Protective Services Expenditures



Note: The Other category includes funding for Child Care Regulation and APS Facility and Provider Investigations transferred to the Health and Human Services Commission, pursuant to Senate Bill 200 in the Eighty-fourth Legislative Session and House Bill 5 in the Eighty-fifth Legislative Session.

Source: Department of Family and Protective Services

Child Protective Services Annual Expenditures



Note: Purchased Client Services includes purchased services for Adoption, Post-Adoption/Post-Permanency, Preparation for Adult Living (PAL), Substance Abuse, and other services provided by the agency.

Source: Department of Family and Protective Services

Child Protective Services Biennial Expenditures

	FY 2014-15	FY 2016-17	FY 2018-19	FY 2020-21	FY 2022-23
Direct Delivery	$ 989.5	$ 1,221.0	$ 1,446.1	$ 1,591.4	$ 1,675.0
Program Support	$ 87.0	$ 93.7	$ 88.6	$ 140.4	$ 150.2
Child Care Services	$ 95.7	$ 134.2	$ 155.6	$ 111.4	$ 121.8
Purchased Client Services	$ 138.9	$ 166.2	$ 188.2	$ 219.3	$ 159.8
Foster Care	$ 803.2	$ 863.0	$ 1,039.9	$ 1,097.9	$ 1,242.6
Adoption/PCA Payments	$ 465.5	$ 521.6	$ 568.4	$ 609.8	$ 636.5
Relative Caregiver Payments	$ 22.3	$ 24.4	$ 63.3	$ 58.5	$ 49.3
Office of Community-based Care Transition	$ -	$ -	$ -	$ -	$ 15.4
TOTAL	**$ 2,602.1**	**$ 3,024.2**	**$ 3,550.2**	**$ 3,828.7**	**$ 4,050.6**

Note: Data reflected in millions.

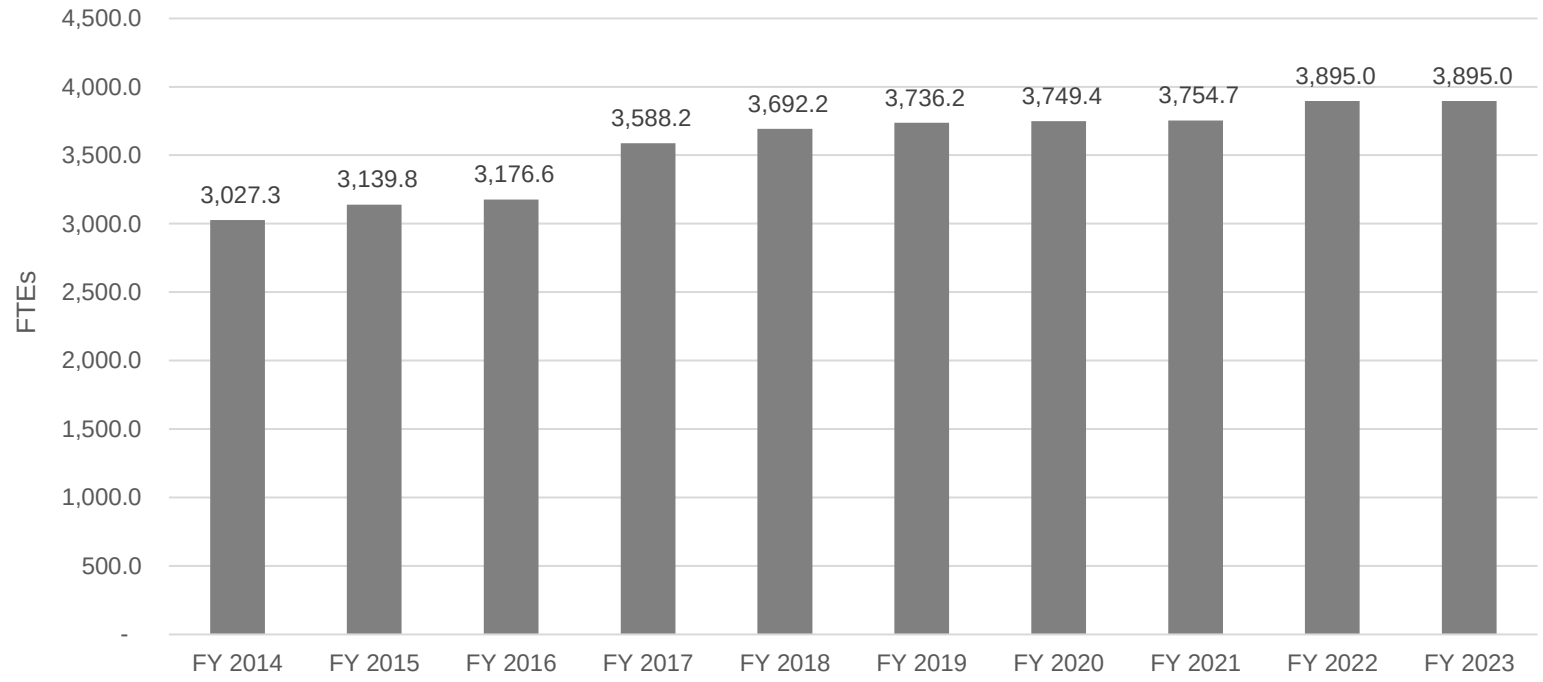
Source: Department of Family and Protective Services

Children Involved in Select Stages of Service

	Conservatorship	Family Preservation	Investigations
FY 2014	46,823	85,688	273,089
FY 2015	47,348	85,205	290,471
FY 2016	48,795	90,593	276,763
FY 2017	50,293	98,723	289,795
FY 2018	52,397	82,866	280,977
FY 2019	51,417	74,092	266,611
FY 2020	47,913	76,869	253,274
FY 2021	45,870	64,151	262,420

Source: Department of Family and Protective Services

Child Protective Services Investigations



	2014-15	2016-17	2018-19	2020-21	2020-23
Legislative Appropriations to CPS Direct Delivery Staff	$ 958.4	$ 1,099.8	$ 1,526.0	$ 1,629.9	$ 1,675.0
Agency Allocation to Investigations Subfunction	$ 370.1	$ 465.2	$ 520.4	$ 495.6	$ 506.8

Note: Legislative funding is appropriated to the agency for all Child Protective Services staff (Strategy B.1.1, CPS Direct Delivery Staff). The agency then has the discretion in allocating those funds among the subfunctions.

Source: Department of Family and Protective Services

Exceptional Item and Supplemental Funding

- **$113.2 million** and **828.8 FTEs** for critical needs funding beginning in FY 2017
  - $61.6 million for salary increases for existing Child Protective Services staff
  - $51.6 million to fund the additional staff
- **$292.8 million** to build the critical funding needs into the agency's base appropriations in FY 2018-19
- **$88.0 million** and **597.9 FTEs** for additional caseworkers in FY 2018-19
- **$32.5 million** for increased payments provided to Relative and Other Designated Caregivers in FY 2018-19
- **$30.5 million** and **98.2 FTEs** for additional staffing support in FY 2020-21, including
  - $2.7 million and 17.9 FTEs for Contract Oversight and Monitoring staff
  - $3.6 million and 30.0 FTEs for additional Child Protective Services frontline staff
  - $1.7 million and 13.0 FTEs for additional Child Care Investigations staff
  - $1.1 million and 7.0 FTES for additional screener staff
- **$88.8 million** and **478.0 FTEs** to address the Foster Care Litigation in FY 2022-23
- **$6.4 million** and **42.0 FTEs** for Community-based Care oversight staff in FY 2022-23
- **$124.8 million** in General Revenue for to address foster care capacity in FY 2022-23
- **$21.9 million** in General Revenue for temporary emergency placements (TEP) in FY 2022-23

Note: All amounts reflected are All Funds unless otherwise specified.

Contact the LBB

Legislative Budget Board
www.lbb.texas.gov
512.463.1200

Texas Department of
Family and Protective Services

Presentation to the House Committee on Appropriations

Commissioner Jaime Masters, MS, MFT
Interim Chief Financial Officer Lea Ann Biggar
CPS Director of Placement Services Jillian Bonacquisti

September 8, 2022

TEXAS
Department of Family and Protective Services
Child Protective Services

Children Without Placement

Jillian Bonacquisti, LMSW, LCPAA

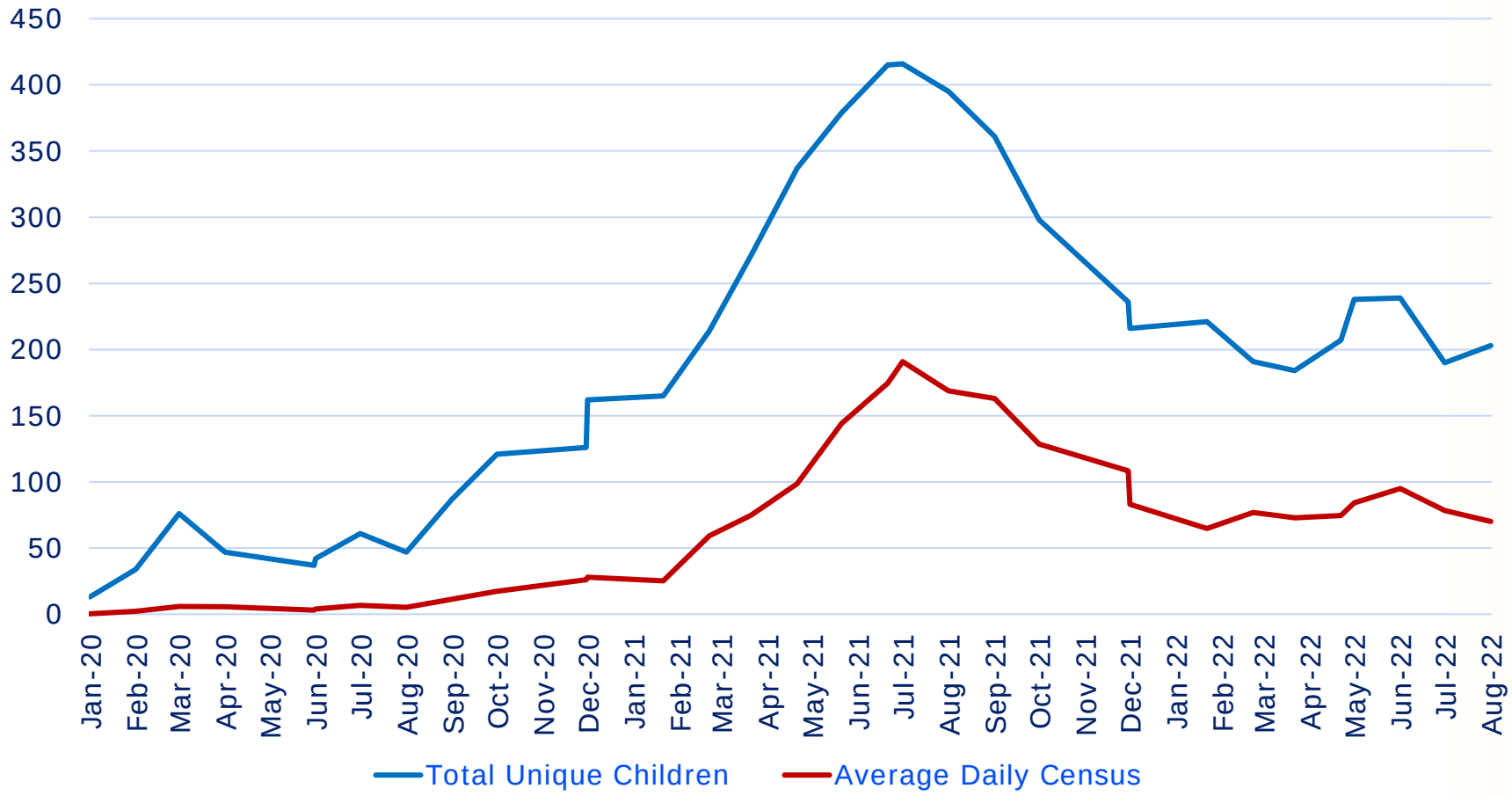
CPS Director of Placement Services

September 8, 2022

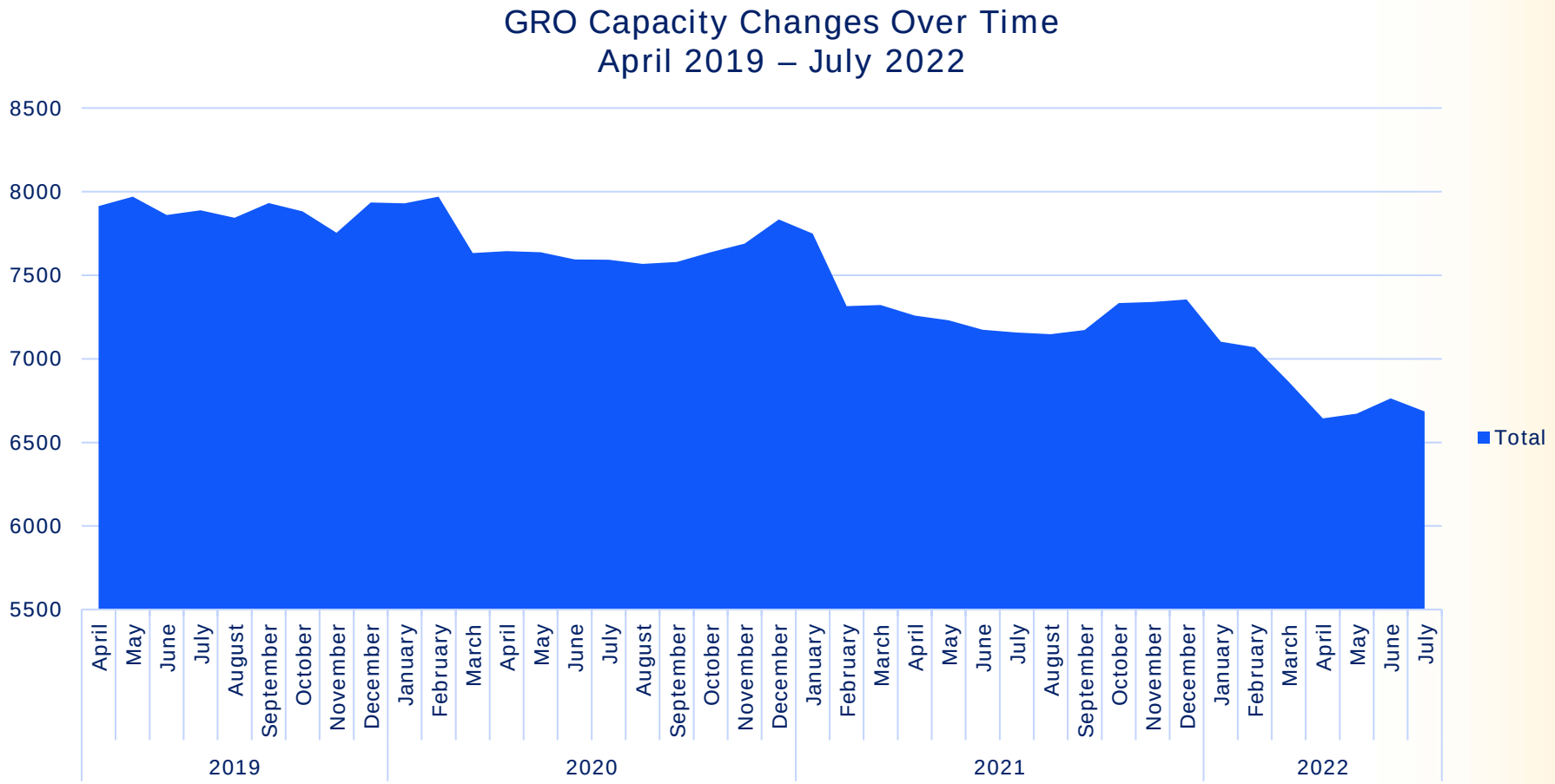
TEXAS
Department of Family and Protective Services
Child Protective Services

Children without Placement

Trends over Time – December 2019 through August 2022



General Residential Operation (GRO)
Capacity Over Time



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Child Protective Services

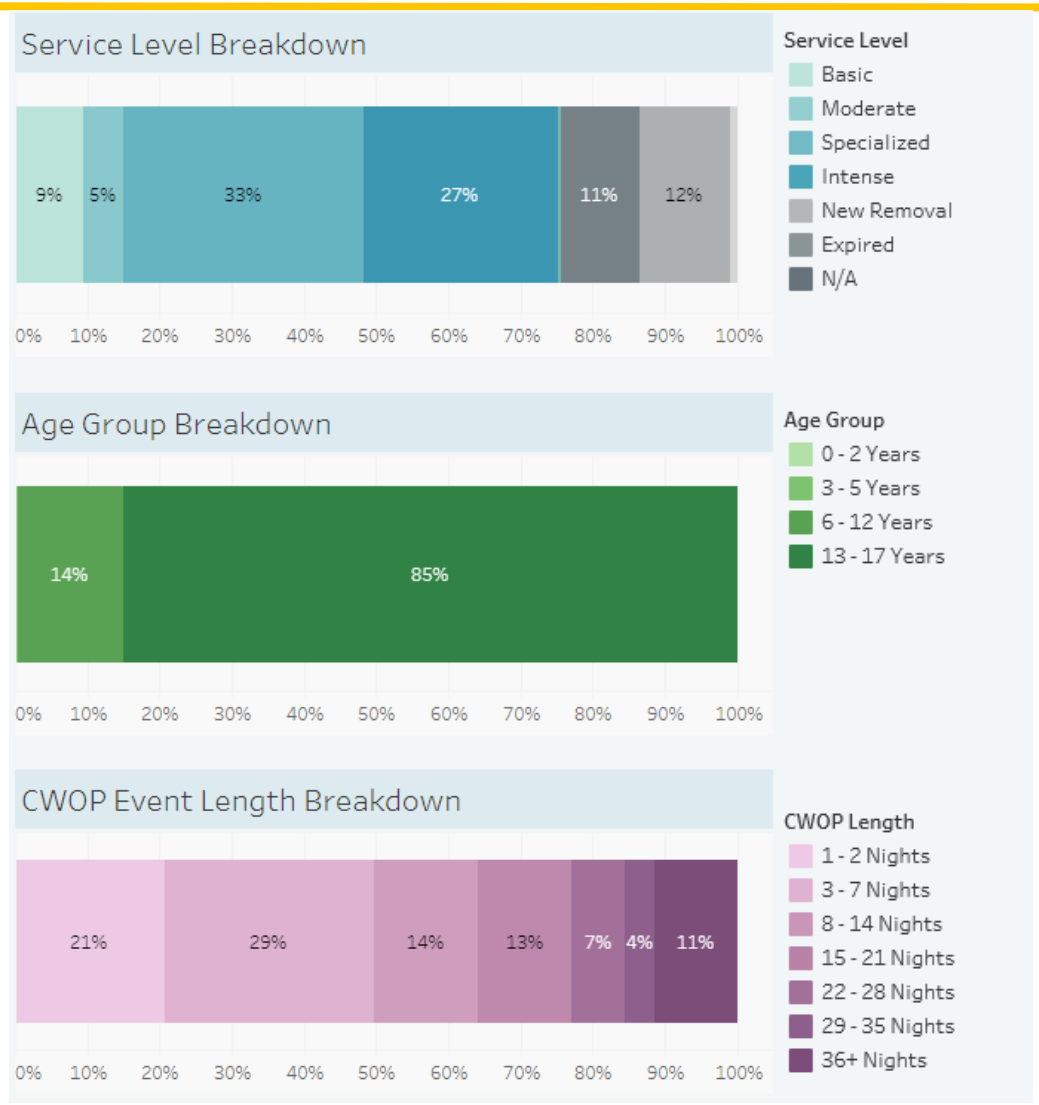
Children without Placement

September 2, 2022

Panhandle (1)	0
Big County / Texoma (2)	0
Metroplex West (3W)	1
Metroplex East (3E)	9
Piney Woods (4)	3
Deep East (5)	3
Harris County (6A)	8
Bay Area / Montgomery (6B)	6
Central Texas / Waco (7A) and Capital Area (7B)	15
Bexar County (8A)	5
South Central / Hill Country (8B)	0
Permian / Concho (9)	1
El Paso (10)	3
South Texas / Corpus Christi (11A) and Rio Grande Valley (11B)	7
Total	61

Children without Placement

Trends - August 2022



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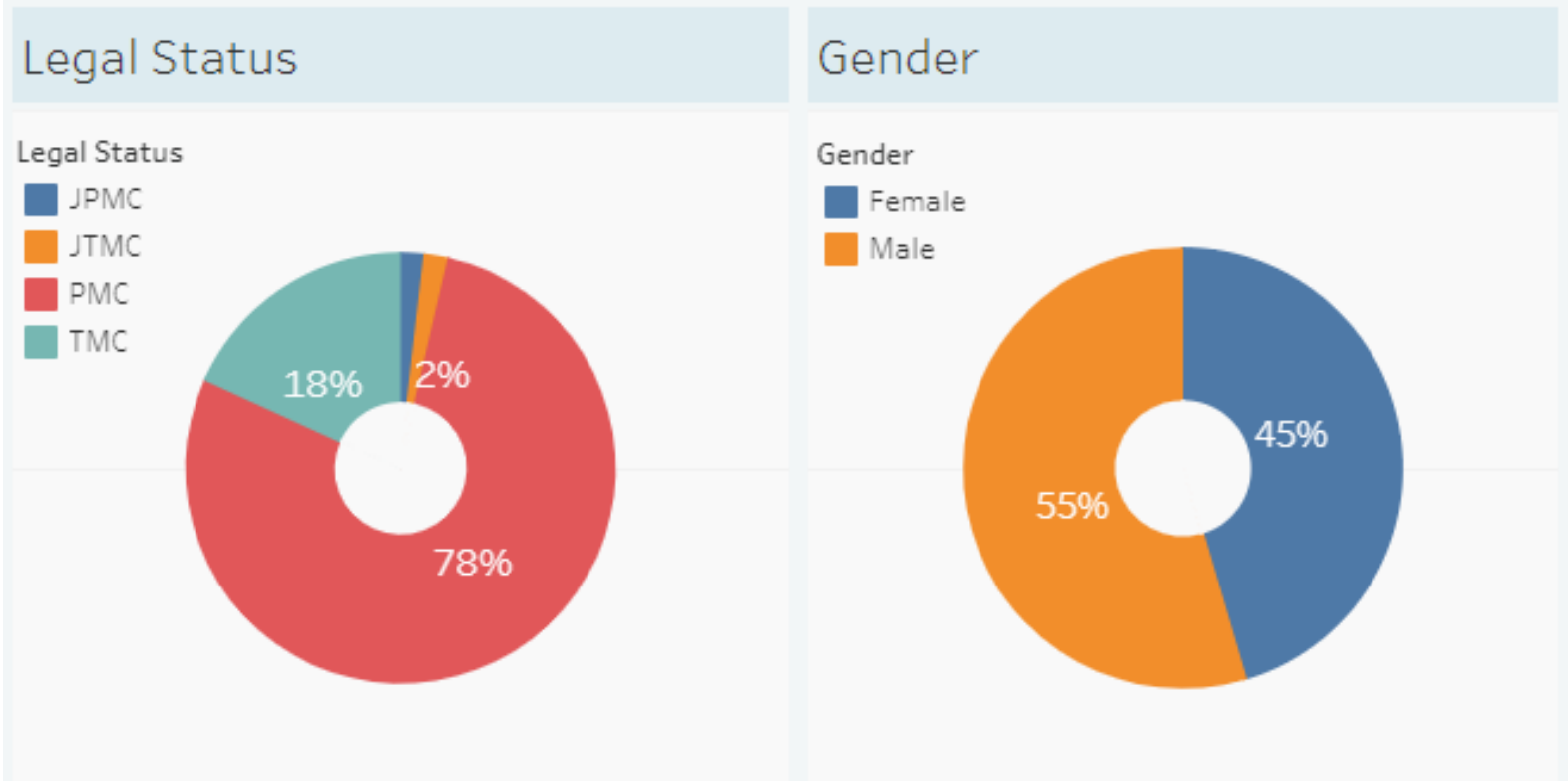
Child Protective Services

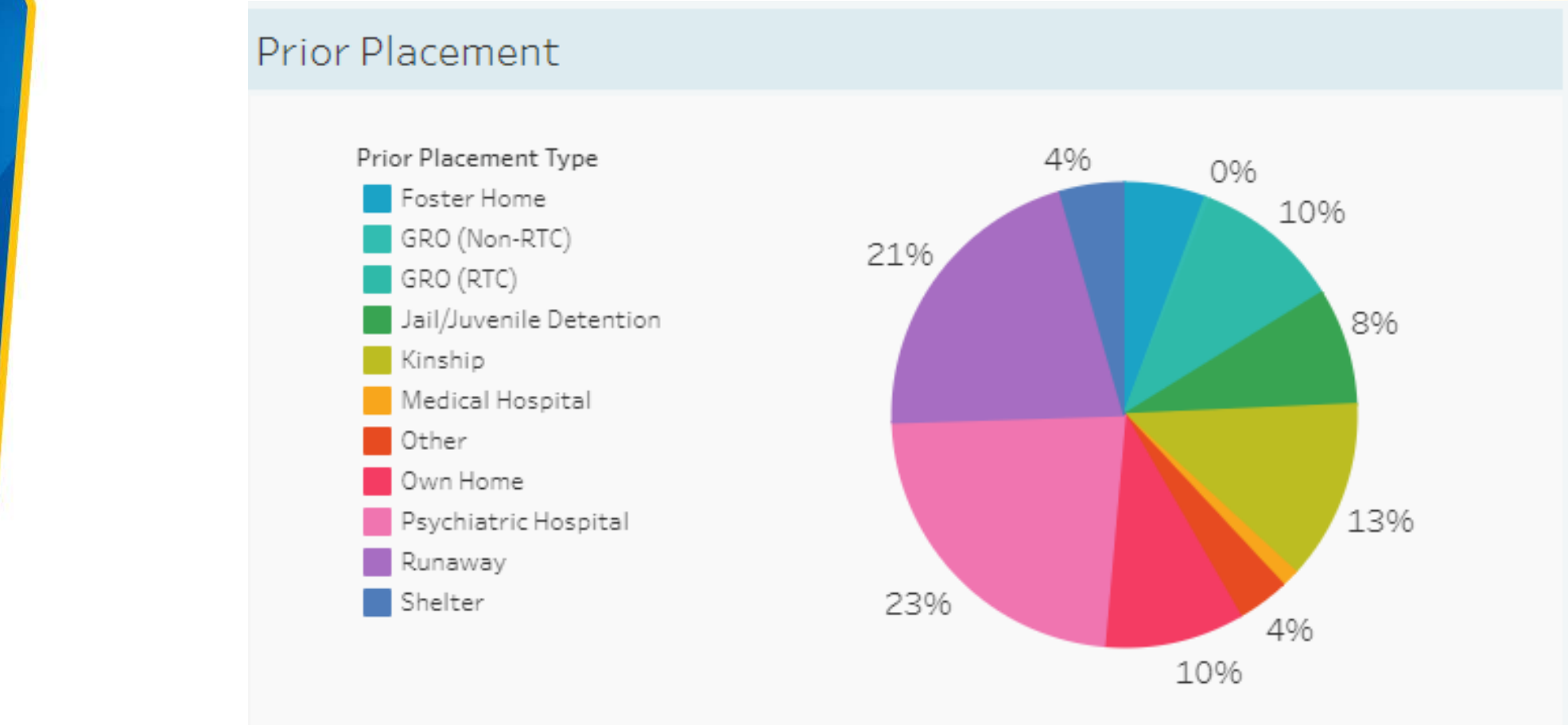
Children without Placement

Trends – August 2022



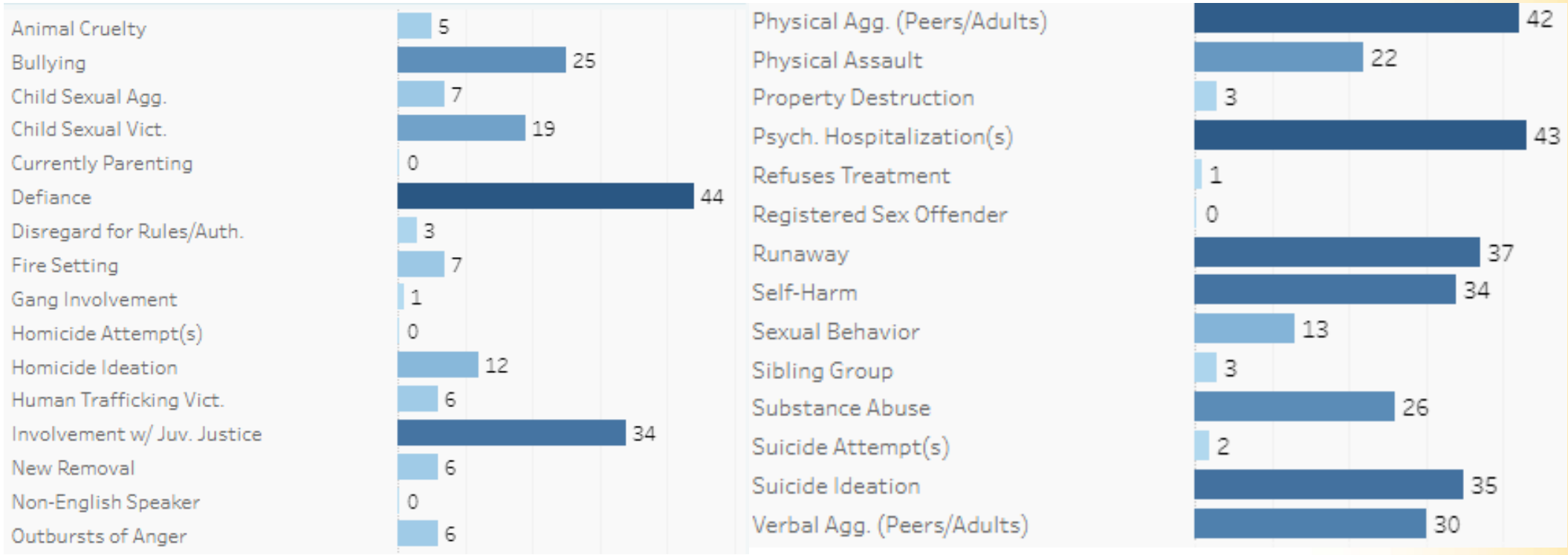
Children without Placement

Prior Placement - August 2022



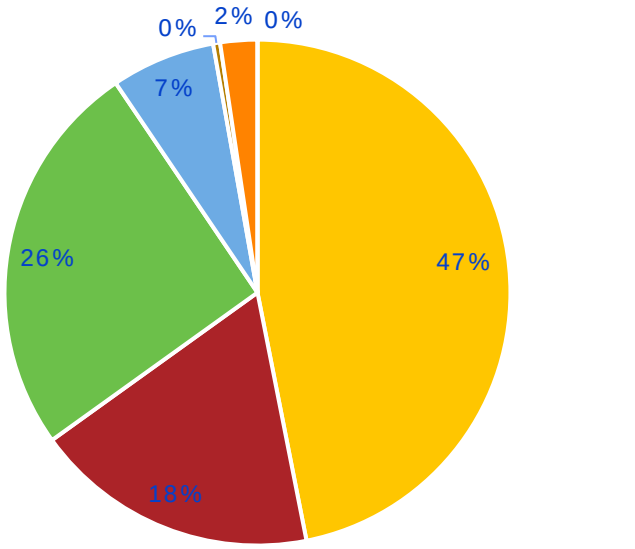
Children without Placement

Behaviors/Characteristics – August 2022

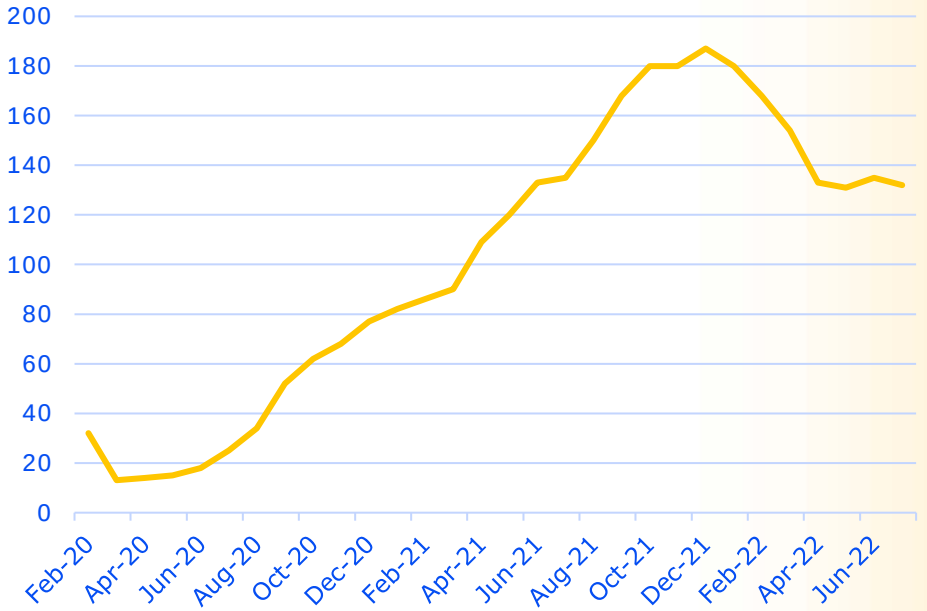


Out of State Placements

Out of State Placement Settings

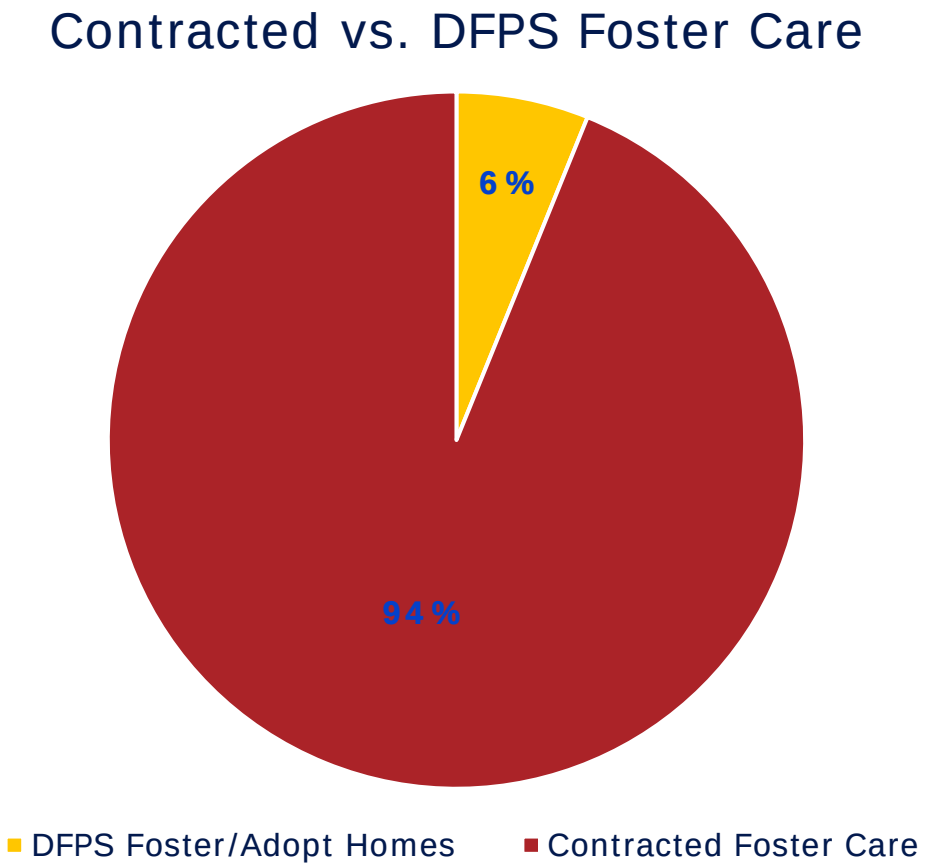


Children Out of State in RTC settings



Data Sources: PP_26 as of 9.2.22, sa_27

Capacity Building

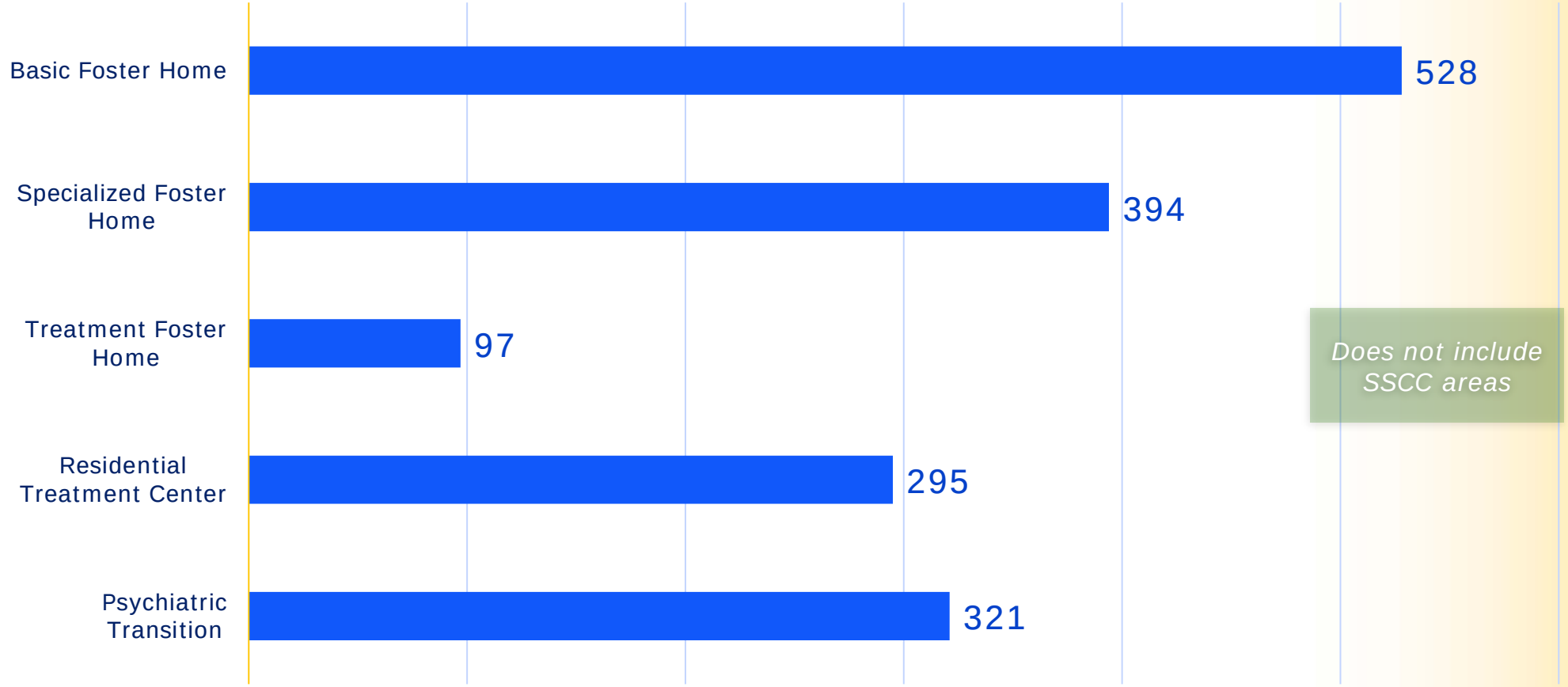


Source: fad_09sx as of 9.2.22

Current Foster Care Needs

(as of start of FY22)

- *Based on utilization (or "true" capacity)*



https://databook.dfps.state.tx.us/views/FosterCareNeedsAssessment/Story?:embed=y&:isGuestRedirectFromVizportal=y&:display_count=n&:showAppBanner=false&:origin=viz_share_link&:showVizHome=n

Capacity Building

- **Qualified Residential Treatment Programs**
- **Treatment Foster Care Expansion**
- **Psychiatric Stabalization Programs**
- **Capacity Building Grant Opportunity**

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Child Protective Services

Capacity Stabalization

- **Inter-Agency Foster Care Tiger Team**
  - Clinical Coordinators
  - Community Liaisons
- **Evaluation of Residential Providers**
  - Identifying At-Risk Providers
  - Evaluating Treatment Models
- **Limitations on Capacity for New Providers**
- **Supplemental Payments to Residential Providers**
- **Rate Modernization**

TEXAS
Department of Family and Protective Services
Child Protective Services

TEXAS Department of Family and Protective Services

Substitute Care

DFPS and Single Source Continuum Contractors (SSCC) provide substitute care when a child cannot remain safely in their home.

Substitute care consists of a full range of services provided to ensure safety, well being, and permanency of a child in the conservatorship of DFPS or a young adult in extended foster care, including:

- Case management services
- Kinship services
- Residential care services
- Placement services
- Services to parents, caregivers, or prospective adoptive parents
- Adoption Services
- Transitional Living Services
- Other supportive services

TEXAS Department of Family and Protective Services

DFPS Census of Children in Care

Of the 21,790 children in care (ages 0-17) at the end of July 2022 Statewide:

11,995/ 59%
were in foster care

- **8595/ 42.3%** Child Placing Agency Foster Homes
- **706/ 3.5%** DFPS Foster Homes
- **1,184/ 5.8%** Residential Treatment Centers
- **652/ 3.2%** GRO Child Care Only
- **474/ 2.3%** Emergency Shelters
- **384/ 1.9%** Other Foster Care

8,322/ 41%
were in other types of substitute care

- **7375/ 36.3%** Kinship Care (unverified)
- **556/ 2.7%** Independent Living and Other
- **335/ 1.6%** CPA Adoptive Homes
- **56/ 0.3%** DFPS Adoptive Homes

Data Source: CAPS Sub/Adopt Data Warehouse SA_05s

TEXAS Department of Family and Protective Services

SSCC Capacity-Related Grants

During the 87th Regular Session (2021), the Legislature appropriated $32.9M to increase capacity in Community-Based Care (CBC) areas, and in the second Special Session, appropriated another $20M for capacity-related grants that must be spent in compliance with requirements outlined in Special Provision 26 related to Foster Care Rate Modernization.

Status of the $32.9M Grants

As of August 31, 2022, DFPS had paid out $16.4M to the SSCCs in the capacity grant funding.

Catchment	November 2021	December 2021	March 2022	June 2022	August 2022
Panhandle (1)	$ 2,117,127.00	$ 705,850.14	$ 705,850.14	$ 705,426.74	$ 194,882.31
Big Country / Texoma (2)	$ 2,092,769.50	$ 697,729.35	$ 697,729.35	$ 697,310.80	$ 192,640.19
Metroplex West (3B)	$ 2,641,458.50	$ 880,662.26	$ 880,662.26	$ 880,133.97	$ 243,147.21
Hill Country / South Central (8B)	$ 1,012,318.50	$ 337,506.99	$ 337,506.99	$ 337,304.52	$ 93,184.29

SSCC's have a variety of capacity building efforts underway, including:

- Enhancing support services to caregivers;
- Creating a Stabilization and Assessment Center;
- New emergency bed contracts; and
- Request for Proposals (RFPs) for residential services.

TEXAS Department of Family and Protective Services

DFPS Capacity-Related Grants

The Legislature appropriated $20M for the purpose of providing targeted foster care capacity grants across the state to address the existing foster care capacity shortage.

DFPS is currently in process of awarding grants of varying sizes, with a range of eligible awards, up to $1M each:

- 27 total applicants were reviewed by HHS Procurement.
- 25 of the 27 applicants are now undergoing Kick-Off Meetings with DFPS.
- Anticipated grant contracts executed: September/October 2022.

Examples of some of these grants include:

- Converting existing space into a Stabilization and Assessment Care center within a General Residential Operation (GRO) to better serve youth with high acuity needs and aftercare services built in that will follow the youth after discharge.
- Child Placing Agency (CPA) adding a branch in an underserved area to recruit foster families for children with moderate, specialized, and intense level of care.

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Capacity Funding: Temporary Supplemental Payments

In addition to funds to support capacity-related grants, during the second Special Session, the 87th Legislature (2021) appropriated additional funding to support capacity growth and stabilization.

The $70 M is ***currently*** allocated through 11.5% increases in the daily payment for all children with service needs that are moderate and above in both the Legacy and CBC systems.

Current CBC Supplemental Payments for Providers				
Rate	Panhandle (1)	Big Country / Texoma (2)	Metroplex West (3B)	Hill Country / South Central (8B)
Current Blended Rate	$83.05	$85.72	$88.04	$83.05
Supplemental Add-On	$6.11	$6.31	$6.48	$6.22
Total Payment	**$89.16**	**$92.03**	**$94.52**	**$89.27**

TEXAS Department of Family and Protective Services

Capacity Funding: Temporary Supplemental Payments

Legacy Supplemental Payments for Providers as of September 2022			
Provider Type	**Current Legacy Rates**	**Supplemental Add-On**	**Total Payment**
CPA - Basic	$49.54	N/A	$49.54
CPA - Moderate	$87.36	$10.05	$97.41
CPA - Specialized	$110.10	$12.66	$122.76
CPA - Intense	$186.42	$21.44	$207.86
CPA - Treatment Foster Care	$277.37	$31.90	$309.27
GRO/RTC - Basic	$45.19	N/A	$45.19
GRO/RTC - Moderate	$108.18	$12.44	$120.62
GRO/RTC - Specialized	$197.69	$22.73	$220.42
GRO/RTC - Intense	$277.37	$31.90	$309.27
GRO/RTC - Intense Plus	$400.72	$46.08	$446.80
Intensive Psychiatric Program	$374.33	$43.05	$417.38
Emergency Shelter	$137.30	$15.79	$153.09
Temporary Emergency Placement (TEP)	$400.72	$46.08	$446.80

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Foster Care Census

Conservatorship Census

Foster Care Census

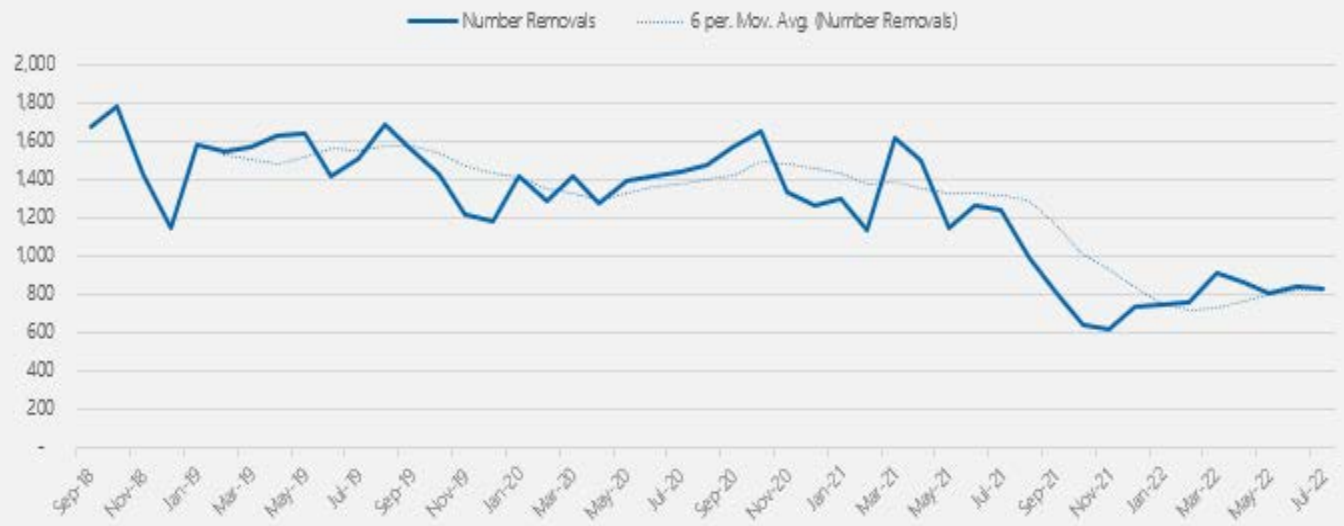
FY22 DATA IS PROVISIONAL

Data Sources: PP_03, SA_05

TEXAS
Department of Family
and Protective Services

Removals

Removals since FY19



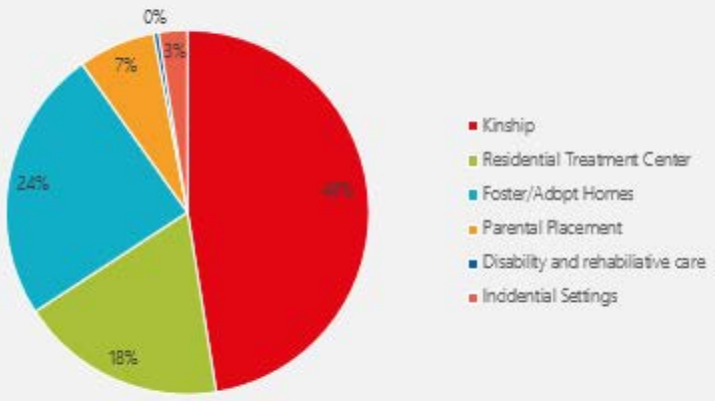
FY22 DATA IS PROVISIONAL

Data Sources: sa_19

TEXAS Department of Family and Protective Services

Out of State Placements

Out of State Placement Settings



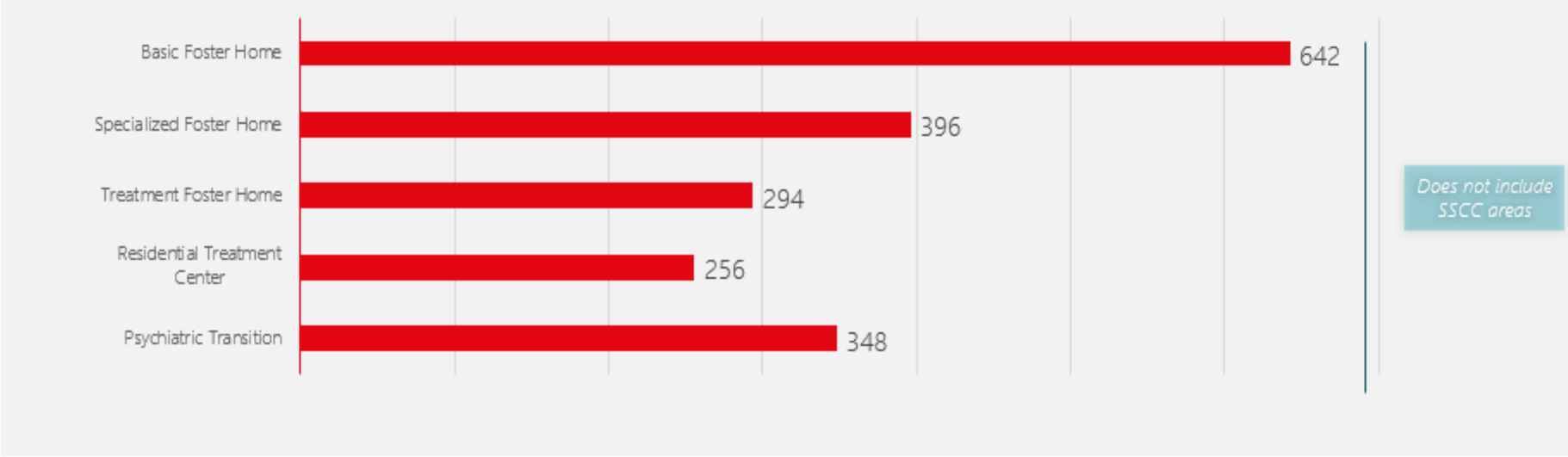
Children OOS in RTC settings

Data Sources: PP_26 as of 8.31.22, sa_27

TEXAS Department of Family and Protective Services

Foster Care Capacity Needs

Current Foster Care Needs



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Capacity Funding: Temporary Supplemental Payments

Due to the decline in census, there remains unexpended funding that was dedicated to Temporary Supplemental Payments in FY 2022.

DFPS is in process of requesting authority to move the unexpended funds forward in FY 2023. When combined with the FY 2023 funding, the appropriation of $35M will be used to:

- Prevent children without placement and divert children from having to leave and be placed out of the state in order to have their individual treatment needs met;
- Safely transition children currently placed out of state back home; and
- Offer continued support to providers who develop the needed infrastructure and treatment services designed to serve the high needs population of children in care.

Capacity Funding: FY 2023 Strategic Plan for Use of Temporary Supplemental Payments

DFPS has developed three targeted strategies for use of the temporary supplemental funds in order to address the state's most pressing capacity needs.

1. Utilize a tiered approach to compensate providers that offer services based on capacity type:

- Increase the SSCCs supplemental add-on to 11.38% for each of the blended rates.
- Sustain the 11.5% add on to the daily rate for Legacy providers offering Moderate and Emergency Shelter Services.
- Increase the supplemental add-on rate for Legacy providers offering Specialized Services to 15%.
- Increase the supplemental add-on rate for Legacy providers offering Intense Services and Treatment Foster Family Care to 17%.
- Increase the supplemental add-on rate for Legacy providers offering Intense Plus, Intensive Psychiatric Treatment Services, and Temporary Emergency Placements to 20%.

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Capacity Funding: Proposed Temporary Supplemental Payments

FY 23 Proposed Plan for Supplemental Payments for Providers				
Category	**Base Contract Rate**	**FY 22 Supplemental Payment**	**FY 23 Supplemental Payment**	**FY 23 Combined Total Rate**
CBC Blended Rate – Panhandle (1)	$83.05	7.36%	11.38%	$92.50
CBC Blended Rate – Big Country / Texoma (2)	$85.72	7.36%	11.38%	$95.47
CBC Blended Rate – Metroplex West (3b)	$88.04	7.36%	11.38%	$98.06
CBC Blended Rate – Hill Country / South Central(8b)	$83.05	7.49%	11.38%	$92.50
CPA - Moderate	$87.36	11.5%	11.5%	$97.41
CPA - Specialized	$110.10	11.5%	15.0%	$126.62
CPA - Intense	$186.42	11.5%	17.0%	$218.11
CPA - Treatment Foster Care	$277.37	11.5%	15.0%	$318.98
GRO/RTC - Moderate	$108.18	11.5%	11.5%	$120.62
GRO/RTC - Specialized	$197.69	11.5%	15.0%	$227.34
GRO/RTC - Intense	$277.37	11.5%	17.0%	$324.52
GRO/RTC - Intense Plus	$400.72	11.5%	20.0%	$480.86
Intensive Psychiatric Program	$374.33	11.5%	20.0%	$449.20
Emergency Shelter	$137.30	11.5%	11.5%	$153.09
Temporary Emergency Placement	$400.72	11.5%	20.0%	$480.86

2. New Program: Inpatient Psychiatric Stabilization Program (IPSP)

Provides a continuum of intensive psychiatric services to assist needs of children who do not have placements available to them in current foster care continuum and who require highly structured support and treatment, as well as have a history of psychiatric hospitalizations.

Who will be served?

- Children with the highest of acute needs and exhibit symptoms which include delusions, hallucinations, obsessive-compulsive behavior, debilitating depression, uncontrolled anxiety, self-injurious or assaultive behavior or other serious emotional disorders or mental illness.

How will they be served?

- The program will provide daily structure and care, supervision, assessment, training, education and treatment services that meet the needs of children. Promote healthy well-being and community interaction to prepare the child for transition to a less restrictive setting upon successful completion of the program.

This time-limited (90-day) program is intended to increase capacity in the foster care system to assist and provide more stability to a child in the psychiatric hospital who is no longer considered acute but needs more supports in order to transition to a less restrictive placement setting (i.e. Residential Treatment Center or Treatment Foster Family Home).

3. Provider Performance Incentive Program:

This program will incentivize providers who develop the programming and infrastructure necessary to:

- Admit children who are transitioning from out of state treatment programs; or
- Who are exiting a temporary stay under DFPS staff supervision (commonly referred to as a child without placement).

The scope and logistics for this program are being finalized now.

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Appendices

1. DFPS Child Census Data
2. Child Outcomes
3. Children Without Placement Data

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Appendix: Child Census Data

Populations Involved in Various Stages of Service							
FY16 - FY22 YTD							
	2016	2017	2018	2019	2020	2021	2022
Children in DFPS Legal Responsibility (Last day of FY)	30,540	31,776	32,797	31,408	29,818	28,753	21,943
Children in FBSS Services (Last day of FY)	34,656	31,858	26,490	25,156	26,655	11,496	10,696
Families in FBSS Services (Last day of FY)	12,262	11,568	9,736	9,444	10,218	4,385	4,027
Opened CPI INV and AR Stages	n/a	240,182	248,433	244,900	227,313	256,972	255,588
Opened RCI Investigation	2,372	2,539	1,924	2,272	3,334	4,774	3,216
Opened DCI Investigation	2,408	2,489	2,195	1,984	1,610	1,795	1,531

Data Source: DFPS Databook (FY16-FY21) DFPS Data Warehouse (SA_05,PP_03, FAM_05, EXD_03)

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Appendix: Child Outcomes

Conservatorship Outcomes							
FY 16-FY 22 YTD							
	2016	2017	2018	2019	2020	2021	2022
Average Placements for Children in Foster Care	3.1	3.1	3	3	3.1	3.1	3.5
Relative Placements	43%	45%	46%	45%	43%	44%	44%
Sibling Groups Placed Together	65%	64%	65%	67%	66%	64%	63%
Children Placed in County	40%	39%	38%	38%	39%	37%	35%

Permanency Outcome Measures							
FY 16 - FY 22 YTD							
	2016	2017	2018	2019	2020	2021	2022
Adoption within 12 months of TPR	54%	56%	56%	58%	58%	53%	73%
Average Months to Permanency	20.7	19.8	19.1	19.3	19.9	20.6	19.6
Permanency for Children in Care 2+ years	32%	34%	34%	34%	35%	33%	36%
12-month recidivism (INV)	7%	6%	5%	5%	4%	4%	n/a
12-month recidivism (FBSS)	11%	12%	12%	10%	10%	11%	n/a
12-month recidivism (CVS)	20%	21%	20%	21%	21%	22%	n/a

Data Source – DFPS Databook (FY2016-FY21) DFPS Data Warehouse (EXD_03, TED, PMAT) (FY22 YTD)

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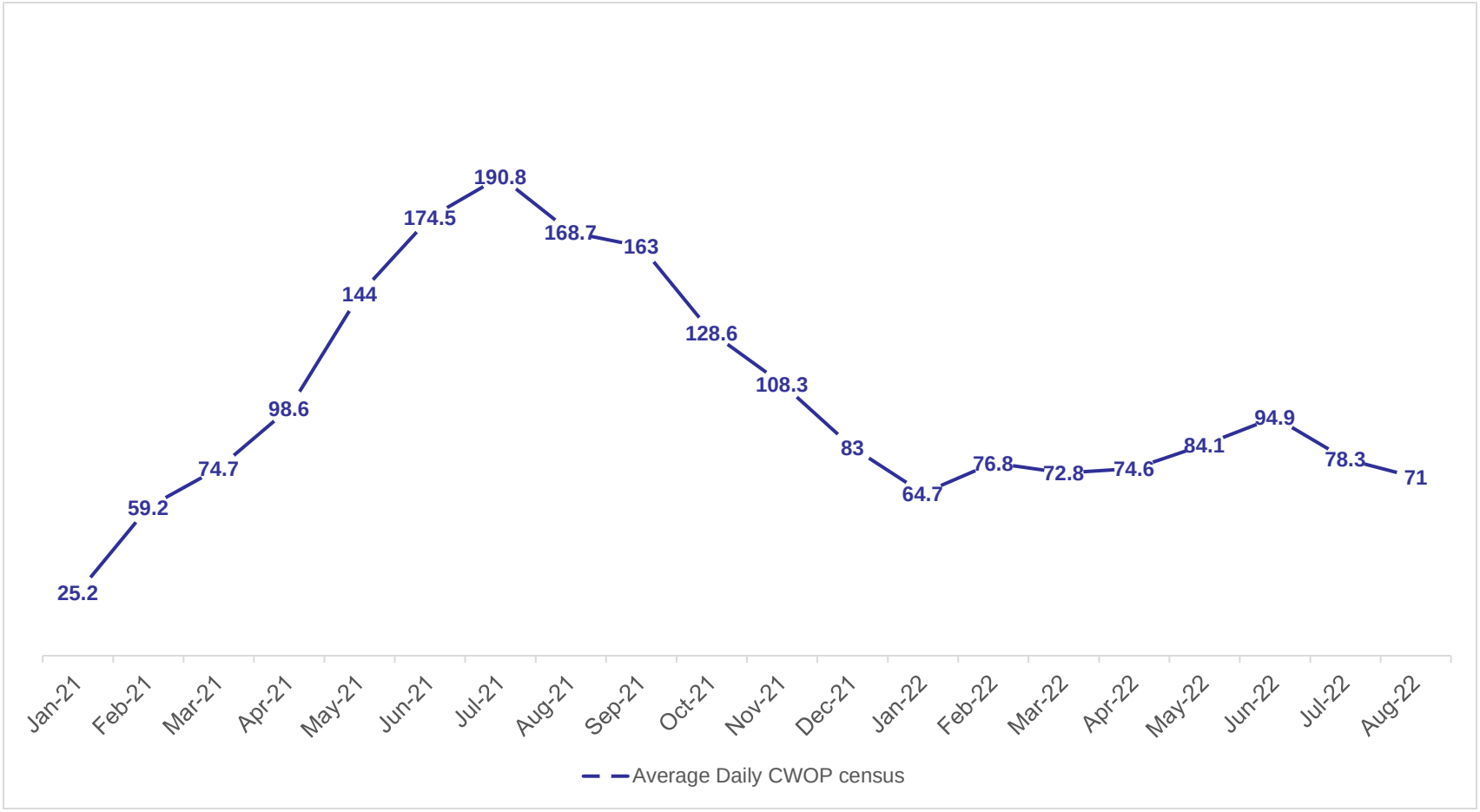
Appendix: Children Without Placement



*as of September 1, 2022

Foster Care Funding and Capacity Building Updates

House Appropriations Committee | September 8, 2022

Katie Olse, CEO, Texas Alliance of Child and Family Services

How did the Legislature address foster care capacity?

- **Supplemental funding**: Rate add-ons included in House Bill 5 (87th 2nd Special Session) were critical to sustain capacity
  - Supported increased workforce and inflation costs
  - Not a rate increase, funding is limited to current biennium
- **Legacy System capacity building grants** (included in House Bill 5, 87th 2nd Special Session): not yet distributed
- **Community Based Care capacity building funds**: efforts well underway
  - Funding passed in regular Session, limited to biennium
  - Concerted efforts on kinship care, workforce credentialing, and targeted foster home recruitment
- **Rate methodology modernization** (required by General Appropriations Act, Art. II Special Provision 26) work ongoing, focus on quality outcomes rather than service levels

Operational perspective on children without placements and out-of-state placements

- Kids in unlicensed settings such as hotels and offices – need placements that can offer treatment, but that's only a portion of capacity needs…
  - Kids are still placed out of state, region, county
  - Child-specific contracts have increased
  - Hospitalization beyond medical necessity
- Not every bed can serve every child, particularly those with the most complex needs – not every setting is equipped for therapeutic services
- These are the kids that are harder to place and maintain placement

What still inhibits capacity growth?

THE BIG THREE

1. The complex needs of children

2. A competitive workforce environment

3. A complex and frenetic regulatory environment

Who are the kids without placement?

- Older youth and teens
- Children with complex or high acuity – *over 40% in CWOP were previously in a psychiatric setting*
- Refusal to Accept Parental Responsibility – *40-50% of CWOP*

High acuity *or* ***complex needs*** *may represent children or youth with aggressive or self-harming behaviors, suicidal ideation, or children that runaway often. Complex needs can also mean children with primary medical needs that need highly trained care and even a dedicated caregiver.*

Complex Needs = Unique placement challenges

- Many foster homes may prefer a baby or younger child
- Larger sibling groups can be more difficult to place
- Complex needs such as aggressive or self-harming behavior, require a significant training and experience, high level of supervision
- Require additional, skilled staff and operational support

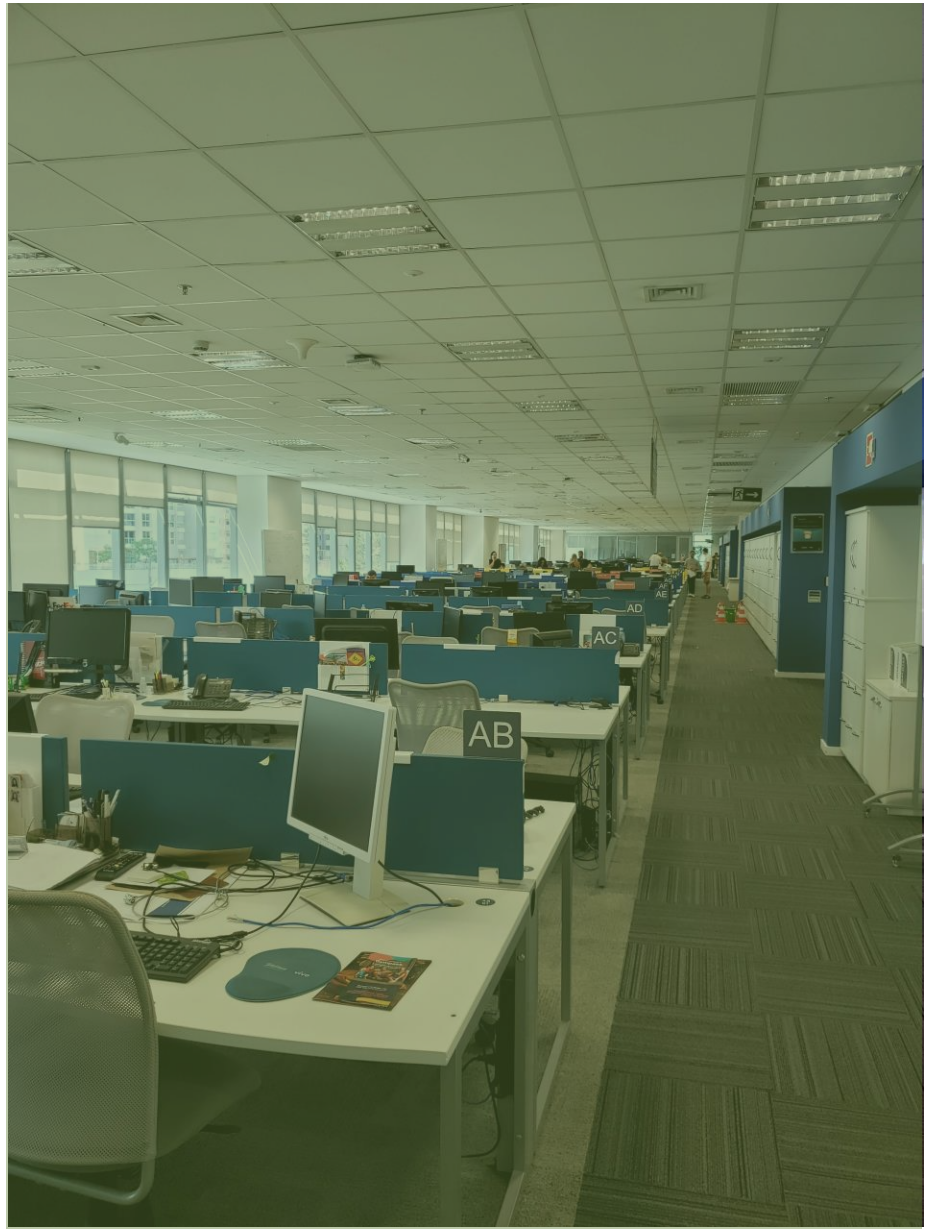
Supporting Complex Needs: What can we do?

- Sustain supplemental funding while foster care rate methodology reforms are implemented
- Support high quality trauma-informed programming and invest in an array of IV-E eligible settings (foster family homes, Qualified Residential Treatment Programs, trafficking/at-risk trafficking programs, Supervised Independent Living, pregnant & parenting, etc.)
- Increase investment in developing and supporting licensed kinship care to increase ability for kin to support children with complex needs
- Continued support of family preservation and post adoption and permanency and successful implementation of bills that support development of therapeutic services across the continuum of care -- SB 1896, SB 642, SB 910 (87th Legislature)
- Removing barriers and maximizing children's mental health services through Medicaid

Workforce: Challenges & Impact

- Salary competition within social services and from other sectors
- Desire to work from home or flexibly
- Difficult jobs by nature
- Increasing professional liability
- Increased need for mental health professionals

Impact: lower census but more staffing needs, more difficult to staff for children with higher needs, harder to build new capacity, forces competing priorities and resources



Supporting Workforce: What can we do?

- Sustain and grow funding/rate increases to support child-serving workforce
- Increases to support for child psychiatrists, therapists, and other mental health professionals billing Medicaid
- Ability to bill for supervised clinical internship hours to attract and retain mental health workforce and build clinical capacity

Regulatory: The Texas Environment

- Texas is clearly prioritizing child safety and accountability – that's good – but the licensing and oversight system was created and added onto over many years -- it is complex and should be reviewed with the goal of child safety and outcomes
- The goal is to be able to identify and act on true safety concerns, but we continue to hear examples of citations for minor infringements, *ex. cleaner left on the counter or moldy bread*
- The current regulatory environment is confusing and sometimes punitive, which can lead to a reluctance to take children with more complex needs
- Organizations and professionals may be held accountable for behaviors that are trauma-related or known by the agency and provider, such as running away or self-harming
- Corrective action should be constructive and help drive improvements, not only penalize. It is important to keep oversight child-centered
- Penalties are assessed by DFPS and HHSC, but are they yielding the intended outcome?

Regulatory: How can we help?

- Direct and fund HHSC to hire an independent expert to review, re-envision, and build minimum standards that make sense and are adaptable to changing needs of children and the industry learning more and more
- Ensure resources for training and technical assistance from experts with practical experience in child safety and well-being
  - Elevate best practices and trainings statewide
  - Fill gaps needed for organizations
  - Help organizations with less resources develop

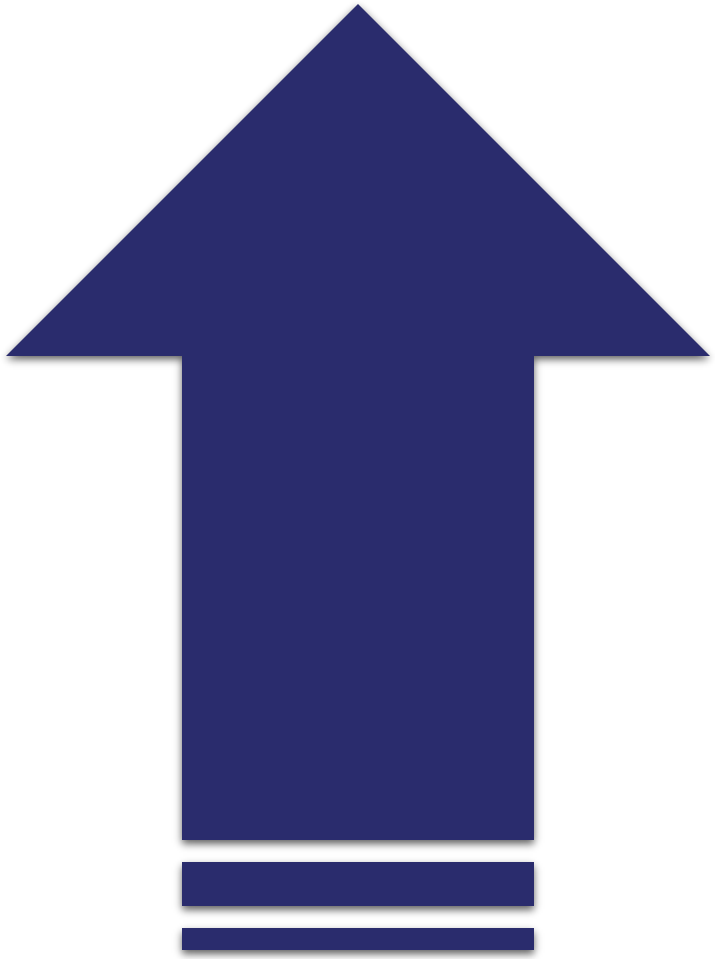
TOP 3 TAKEAWAYS

1. Capacity growth is inhibited by the **complexity of older and high needs children** and can be addressed with sustained funding, more support for family preservation and post-adoption/permanency, support for treatment based programs, increased investment in kinship care.
2. Capacity growth is inhibited by a **competitive workforce environment** and can be addressed with funding and by broadening clinical workforce.
3. Capacity growth is inhibited by a **complex regulatory environment** and can be addressed with child-centered flexibility and focus on improved outcomes.

Continuum of Care Updates: Resources and Reference Materials

This section will not be discussed in prepared remarks but is provided for broader reference. Please reach out with any questions.

Texas Leads the Way in Prevention and Early Intervention

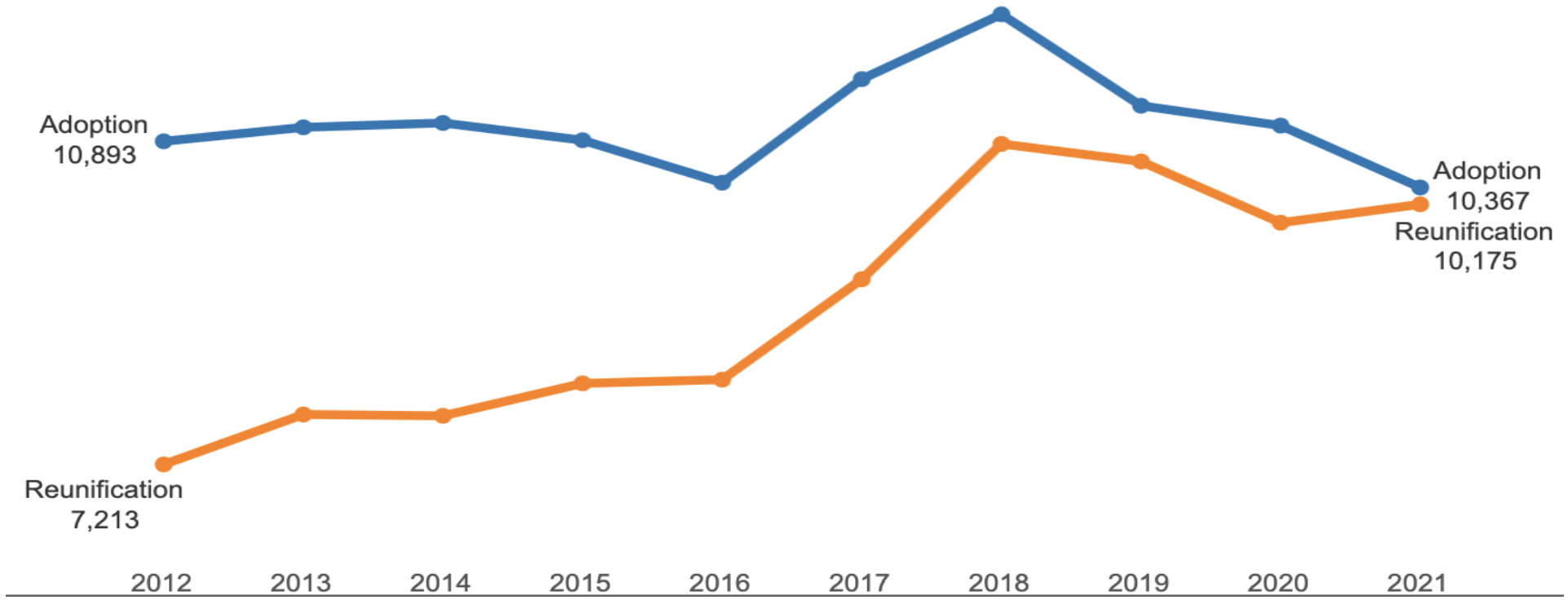


- 54,000 families served
- HOPES at an all-time high
- Family Resource Center development
- Home visiting programs

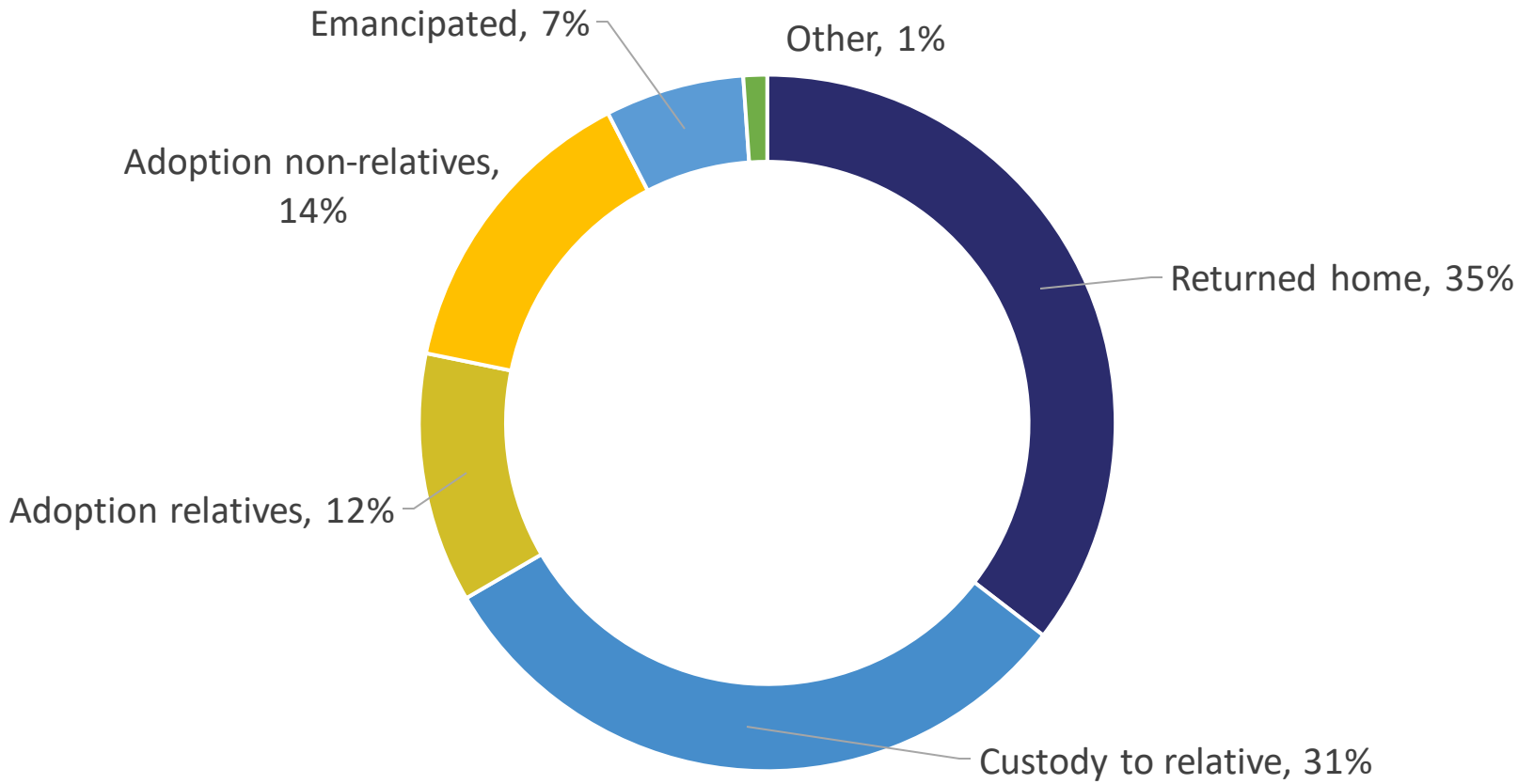
Foster and Kinship Care

- **Kin as the First Placement**
  - 40% of first placements in 2021 were with kin/relatives - this is an increase
  - Other settings are seeing a decline - including emergency shelters and foster homes
- **Sibling groups placed together** saw a slight decline in the last year
- **Proximity to home**
  - 82% of children in foster homes or with relatives were placed within their home region in 2021 –a slight decrease from previous years.
  - Of the 1,333 kids placed in an RTC, 31% were placed in their home region.
- DFPS reports that the most common reason caseworkers identified for a **disruption in a kinship home** was the child's behavior and the caregiver being unable to meet the child's needs, followed by risk or actual abuse/neglect (18%).

For the first time, family reunification as a permanency goal is equal to that of adoption, which remains steady



When they leave care, 35% of children return home and another 43% live with a relative



Permanency, Adoption, and Post-Adopt Services

- Post-adoption and post-permanency services support families once permanency or adoption is reached, but they still need support
  - Services are limited by appropriations and contractual restraints and resources are targeted for highest need populations
- Permanency Care Assistance has continued to grow since Legislature implemented, able to pull down a federal match
  - PCA has doubled in almost ten years, but still underutilized (less than 20% of kids who exit to permanency kin exit with PCA)
  - The data shows outcomes are better for kin with PCA
- Adoption subsidy also continues to grow
- The need for high quality post-adopt services that can support families and prevent re-entry to foster care has seen incremental growth over the last several years.

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