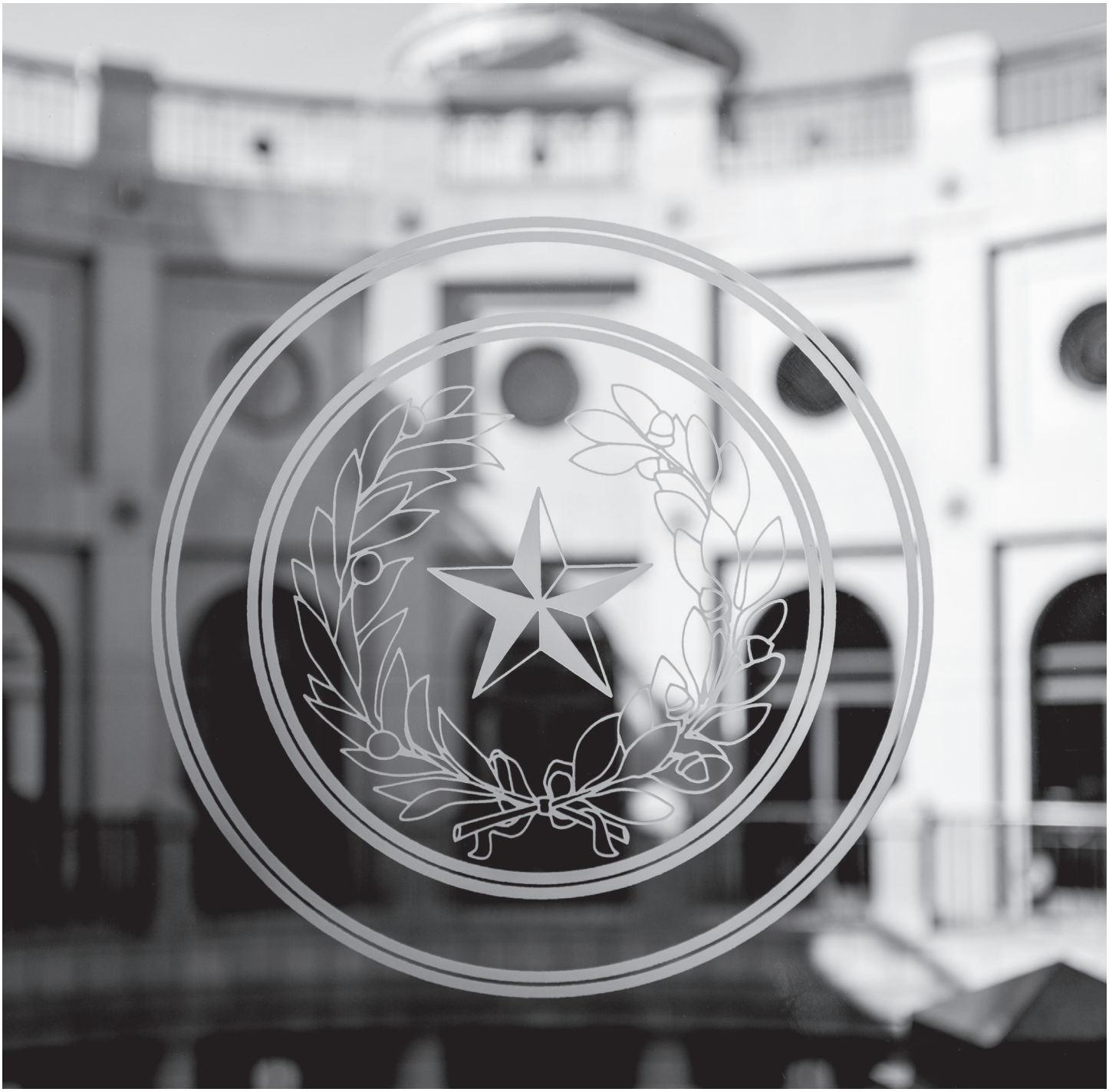

Interim Report

TO THE EIGHTY-NINTH TEXAS LEGISLATURE

HOUSE COMMITTEE ON HUMAN SERVICES INTERIM REPORT

NOVEMBER 2024

HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2024

A REPORT TO THE
HOUSE OF REPRESENTATIVES
89TH TEXAS LEGISLATURE

JAMES B. FRANK
CHAIRMAN

COMMITTEE CLERK
NOELLE ROBERTS

Committee On
Human Services

November 18, 2024

James B. Frank
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Dade Phelan
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Eighty-eighth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-nineth Legislature.

Respectfully submitted,

James B. Frank

Liz Campos

Lacey Hull

Stephanie Klick

Christian Manuel

Candy Noble

Ana-María Rodríguez Ramos

Toni Rose

Matt Shaheen

Toni Rose
Vice-Chairman

Members: Liz Campos, Lacey Hull, Stephanie Klick, Christian Manuel, Candy Noble, Ana-María Rodríguez Ramos, Toni Rose, Matt Shaheen

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INTRODUCTION

At the beginning of the 88th Legislature, the Honorable Dade Phelan, Speaker of the House of Representatives, appointed nine members to serve on the House Committee on Human Services (Committee). The following members were appointed to the committee: James B. Frank (Chairman), Toni Rose (Vice-Chairman), Elizabeth "Liz" Campos, Lacey Hull, Stephanie Klick, Christian Manuel, Candy Noble, Ana-María Rodríguez Ramos, and Matt Shaheen.

Pursuant to House Rule 3, Section 17 (88th Legislature)[1], the Committee has jurisdiction over all matters pertaining to:

> (1) welfare and rehabilitation programs and their development, administration, and control;
> (2) oversight of the Health and Human Services Commission and the Texas Behavioral Health Executive Council as it relates to the subject matter jurisdiction of this committee;
> (3) intellectual disabilities and the development of programs incident thereto;
> (4) the prevention and treatment of intellectual disabilities; and
> (5) the following state agencies: the Department of Family and Protective Services, the Texas State Board of Social Worker Examiners, and the Texas State Board of Examiners of Professional Counselors.

In May of 2024, Speaker Phelan assigned the Committee three interim charges to study, report on, and provide recommendations for the 89th Legislature.[2]

The publication of this interim report marks the Committee's completion of its hearings, findings, and collection of recommendations. The provided recommendations do not necessarily reflect the individual positions of each committee member but are based on the information provided to the Committee throughout the interim hearing process.

The Committee would like to thank the state agencies, organizations, stakeholders, and advocates who testified at the hearings and advised throughout the interim on these charges.

INTERIM STUDY CHARGES

CHARGE I: Monitoring

Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

- HB 1575, relating to improving health outcomes for pregnant women; and
- SB 24, relating to the powers and duties of the Health and Human Services Commission and the transfer to the commission of certain powers and duties from the Department of Family and Protective Services.

CHARGE II: Medicaid Contracting

Evaluate the appropriate role of the state in overseeing Medicaid managed care.

CHARGE III: Support for Texans with Intellectual Disabilities

Evaluate access to Home and Community-based Services (HCS) waivers, including the interest list, effects of inflation on the cost of services, and availability of services and service providers. Consider the long-term stability of long-term services and supports in waiver programs and consider alternative delivery models.

CHARGE I: Monitoring

Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

- *HB 1575, relating to improving health outcomes for pregnant women; and*
- *SB 24, relating to the powers and duties of the Health and Human Services Commission and the transfer to the commission of certain powers and duties from the Department of Family and Protective Services.*

BACKGROUND

During the 88th Legislative Session, the Committee considered legislation related to the health and welfare of Texans, particularly regarding either or both the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (HHSC). Senate Bill 24 required changes from both DFPS and HHSC, particularly changes to the formerly named Prevention and Early Intervention services and the Alternatives to Abortion program.

Speaker Phelan also created the House Select Committee on Health Care Reform during the 87th interim which was maintained during the 88th Legislature.[3] This committee was tasked with considering issues with the health care delivery system across the state. One of the bills this committee considered and passed was House Bill 1575. The Committee was tasked with reviewing the implementation of this bill during the 88th interim, as its subject matter is within the jurisdiction of Human Services as well.

SUMMARY OF COMMITTEE ACTION

The Committee met on August 27, 2024 at the Texas Capitol in Extension, Room E2.014 to discuss the progress made by the agencies and programs under its jurisdiction since the conclusion of the 88th Legislative Session. Specifically, the Committee heard an agency status update from DFPS and heard updates on the implementation of HB 1575 and SB 24 from HHSC. The Committee heard invited testimony only from the two agencies. Below are the witnesses for each bill that testified at this hearing on Charge I:

DFPS Agency Status Update

1. Stephanie Muth, Department of Family and Protective Services
2. Audrey O'Neill, Department of Family and Protective Services

House Bill 1575

1. Valerie Mayes, Health and Human Services Commission

Senate Bill 24

1. Crystal Starkey, Health and Human Services Commission

DFPS AGENCY STATUS UPDATE

Background
DFPS is the state agency in charge of protecting Texas children and vulnerable adults from abuse, neglect, and exploitation. It does this by conducting investigations and providing services and referrals to families and individuals in the community.[4] Because the Committee was not charged with monitoring the implementation of any particular bills relating to DFPS, the Committee heard an update from them on the status of their agency and the work they have been doing to continue to promote safe and healthy families and Texans.

Findings
DFPS Commissioner Stephanie Muth and Deputy Commissioner for Programs Audrey O'Neill provided detailed testimony of what the agency has been doing throughout the 88th interim to the Committee on August 27. They shared updates on key data points, including the following improvements in census data: increase in number of children in care currently residing in family-like setting and decrease in overall children in substitute care placements.[5] Data improvements in Statewide Intake, Child Protective Investigations, and Child Protective Services were also provided to the Committee.[6]

Additional key findings elaborated on by Commissioner Muth and Deputy Commissioner O'Neill were improvements made in the area of Children Without Placement (CWOP). Overall, CWOP numbers have drastically declined. Over 40 percent of CWOP were removed due to Refusal to Accept Parental Responsibility (RAPR).[7] Data was shared that showed that CWOP youth often have some sort of complex needs, which may include physical aggression, psychiatric hospitalization, running away, suicidal ideation, and juvenile justice involvement. Through individual child intensive focus, interagency collaboration, and dedicated staffing and facility, DFPS has seen much better outcomes regarding CWOP.

The witnesses also provided the Committee with updates on the Community-Based Care (CBC) implementation, on DFPS compliance to the federal lawsuit remedial orders, and on Adult Protective Services (APS). DFPS shared that CBC implementation has progressed in almost 50 percent of the state, and eight regions now have active Single Source Continuum Contractors (SSCC) procured and operating. On compliance to the federal lawsuit remedial orders, the witnesses testified that DFPS regularly measures 40 data points pertaining to compliance with 31 remedial orders. Over half of these 40 data points are at or above 90 percent compliance.[8] Court Monitors reports note similar findings. Finally, DFPS reported that APS average daily caseloads and staff turnover have both declined since last fiscal year.

PASSED LEGISLATION

House Bill 1575

Background
House Bill 1575 provides increased support for Texas pregnant women in three ways: it enhances screening for nonmedical health-related needs; it provides case management to coordinate services for high-risk pregnant women; and it expands the provider types available to serve as case managers to assist pregnant women. This bill creates a standardized screening tool to be used by all MCOs and Thriving Texas Families (TTF) providers upon intake of a pregnant client to collect information on non-medical needs and assist in determining if the woman is eligible to be referred to case management services. It also stipulates that if a woman is determined high-risk upon screening, MCOs may enroll the woman into the Case Management for Children and Pregnant Women Program (CPW). It expands who is considered an eligible provider for the CPW program from social workers and nurses to also include community health workers and doulas.

Findings
In April 2024, HHSC finalized a non-medical needs screening tool to be used by MCOs and TTF providers for pregnant women who come to them for services. Eleven MCOs are currently participating in a pilot program that allows them to conduct the screening with consenting members. All MCOs and TTF providers will be required to begin using this screening on consenting pregnant women starting September 1, 2024. The first full report of screening data collected by MCOs will be available January 2025, and updates will be released monthly after that. The first full report of screening data collected by TTF providers will be available October 2024 and updated monthly subsequently.

HHSC is currently working to add doulas and community health workers (CHWs) as CPW providers. When looking at the addition of doulas to the program, HHSC conducted a review of how other states made this transition, gathered stakeholder feedback on what should be included in doula services, and determined that a core set of competencies should be used as the pathway to becoming a provider rather than one existing certification. A few examples of competencies that will be included are years of experience as a doula, their age, and the number of births they have attended. In adding CHWs, HHSC worked with the Department of State Health Services to ensure that proof of certifications are available for existing CHWs and that sufficient resources are available to train new CHWs. HHSC has worked to ensure all interested doulas and CHWs are aware of the new CPW case management opportunity. They are also working to improve existing trainings and create new trainings for all CPWs. They will be ready to accept new CPW providers by December 2024.

In July 2024, HHSC submitted a State Plan amendment to the Center for Medicare & Medicaid Services (CMS) which details the new provider types to ensure they will be allowed as Medicaid service providers. They are awaiting approval but testified that the process seems to be moving along.

On December 1, 2024, HHSC will publish a report which includes implementation activity, what

they have learned about onboarding the two new provider types, and all data from the MCO pilot project. They are looking to provide additional information to the legislature on the implementation of this bill in January 2025. On December 1, 2026, HHSC will provide an ongoing report which details data on non-medical needs, the number and type of non-medical referrals, and birth outcomes for women receiving services from CPW providers.

Senate Bill 24

Background
Senate Bill 24 had two main objectives. First, it directed the transfer of Prevention and Early Intervention (PEI) programs at DFPS to HHSC. In this transition, PEI was renamed Family Support Services (FSS). The FSS program promotes healthy families through parent education, home visiting for parents of infants, toddlers, and preschoolers, and supports positive youth development.

The bill's second objective was codifying the Alternatives to Abortion program, housing it within HHSC and renaming it the Thriving Texas Families program (TTF). The program previously was not in statute and was instead existing only through budget rider. The bill identifies and specifies the purpose of the TTF program as well as eligibility requirements for clients and required services for providers, program outcome requirements, minimum grantee requirements, and a requirement of HHSC to procure for an impact evaluation.

Findings
On August 16, 2023, the transition of PEI at DFPS to FSS at HHSC was kicked-off. The transition was anticipated to be completed by September 1, 2024 at the time of the hearing. There were over 200 deliverables associated with the transfer that were completed by this date. To assist in transition for PEI grantees to FSS, HHSC took a number of steps including participating in RFA evaluations for new PEI funding, participating on a panel with DFPS at the Partners in Prevention grantee day, and conducting joint local site visits to PEI grantees. HHSC is currently working on the bills required five year strategic plan.

HHSC partnered with the current TTF program grantees to develop a framework which measures program goals, outcomes, and associated metrics to demonstrate the impact of services on clients. To support this new framework, HHSC also developed a comprehensive database which details program activities, services, client needs, and outcomes. While maintaining all contracts with current grantees, HHSC also released a Request for Application (RFA) for the Thriving Texas Families Pilot Program for potential new grantees. Approximately $7.5 million were awarded to 18 new program grantees through the pilot program, which are scheduled to last from May 2024 to August 31, 2025. At the time of the hearing, HHSC testified that it was their plan to post the Request for Proposal for the required external third party impact evaluation of the TTF program required by the bill in September 2024. HHSC also testified that a pre-solicitation notice for procurement of TTF providers was available on their website, as a new RFA is expected to be released December 2024. This is in anticipation of the expiration of both original TTF provider contracts and the pilot project contracts on August 31, 2025.

RECOMMENDATIONS

- Continue to monitor the implementation of legislation pertaining to the health and welfare of Texans.
- Review the biennial report required by HB 1575 to further understand the nonmedical needs that impact the health of pregnant women and their babies.
- Continue to monitor the transition of the previously named Prevention and Early Intervention services—renamed Family Support Services—from DFPS to HHSC, as instructed by SB 24.
- Continue to monitor the codification of the Thriving Texas Families program and the pilot program that the agency was instructed to conduct by SB 24.

CHARGE II: Medicaid Contracting

Evaluate the appropriate role of the state in overseeing Medicaid managed care.

BACKGROUND

Medicaid Managed Care
At the direction of the Texas Legislature, HHSC has transitioned the majority of the Medicaid population and areas of the state to the managed care model over the past 25 years. This model entails a contractual agreement between a managed care organization (MCO) and HHSC, wherein an MCO agrees to provide coordinated health delivery to individuals insured by Medicaid and the Children's Health Insurance Program (CHIP) in exchange for a monthly, capitated rate per member per month (PMPM) enrolled in their health plan. The MCO then operates as a health plan for those on Medicaid, just as a private insurer operates as a health plan for its members.

The state currently operates five different managed care programs, each serving a different demographic and amount of the overall Medicaid/CHIP population[9]:

1. STAR
    a. Demographic: Children, pregnant women, and some families
    b. Total: 75%
2. STAR Kids
    a. Demographic: Children and youth with disabilities
    b. Total: 3%
3. CHIP (note this program has been 100% managed care since day 1 of the program)
    a. Demographic: Children and youth of low income families who do not qualify for Medicaid due to lower income requirements
    b. Total: 5%
4. STAR Health
    a. Demographic: Children who get Medicaid through DFPS and young adults previously in foster care
    b. Total: 1%
5. STAR+PLUS
    a. Demographic: Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer
    b. Total: 12%

All five managed care programs are offered statewide, and the state is divided into 13 service delivery areas (SDAs). Per federal law, the state must offer Medicaid members the choice of at least two MCO options per managed care program in each SDA. Texas did receive a waiver around this requirement in order to operate the STAR Health program state-wide with only one health plan due to the nature of the population served in the program. HHSC conducts a formal procurement process to decide which health plans will be awarded contracts to be an MCO in any of these SDAs or programs.

Managed Care Procurement
While the original roll out of managed care was gradual and not statewide (except for STAR Health), HHSC now conducts statewide procurements for all managed care programs when it is time for them to be reprocured. The timeline of this is variable, but generally the contract terms are for an initial six years and includes an option for HHSC to extend the contract for two-years, up to three times, for the potential of up to 12 years total.

The procurement process begins with HHSC issuing a request for public comment to seek information and comments on the "Best Value Evaluation Criteria," a list of criteria developed by the agency and used to evaluate and select a quality option for potential future members. HHSC is required by Section 2155.144 of the Texas Government Code to acquire goods and services that provide best value to the state and the agency.

At least 30 days before posting the final Request for Proposal (RFP). HHSC posts a draft RFP, which includes the contract requirements, procurement rules, scoring processes and examples, technical questions, and the Best Value Criteria, along with a description of what the plan would have to demonstrate to prove they meet best value criteria, and ultimately can provide that value to the member. The informal comment period allows plans and the public to comment on RFP elements, processes and the criteria the agency will use to score health plan bids.

After the draft RFP comments have been collected and reviewed, the official RFP is posted on the Comptroller's Electronic State Business Daily (ESBD). Health plans have the opportunity to respond to the RFP by submitting a proposal that includes responses to the technical questions and other information required to bid on the RFP. These responses are then evaluated by 20 subject matter expert evaluators on five teams from a range of departments at HHSC. For the recent STAR and CHIP procurement the scoring was based on an 1800 total point scale. Those plans that scored well on the technical questions are asked to complete an oral presentation at HHSC. The oral presentation includes four priority topics and is scored on a 200-point scale. Presentation teams are limited to individuals identified as key personnel or those who are responsible for direct oversight of the program in Texas.

Concurrent with oral presentations, HHSC conducts a financial review of all respondents to assess whether the respondents are financially capable of meeting the statement of work and can meet financial requirements of the proposed contract. Per Texas Government Code 533.0035, HHSC also evaluates and certifies that the MCO is reasonably able to fulfill the terms of the contract. Respondents receive a series of questions and a specific set of time to respond to certification questions that include operational requirements.

Finally, the bidding health plan's written and oral scores are added together, and the cumulative score out of 2000 is verified and used by HHSC to make final decisions on what plans will receive notice of intent to award a contract with the state for the particular managed care program being procured. HHSC also makes decisions on what SDAs each MCO will serve. While this has not always been the case, in the most recent managed care STAR and CHIP procurement, HHSC made the decision to cap the number of SDAs one particular MCO can operate in at seven SDAs. There is also a cap on how many contracts will be given in each SDA

per managed care program based on the population demand for a program in an SDA. For example, if SDA 1 has a much higher STAR+PLUS population than SDA 2, there may be more MCOs awarded STAR+PLUS contracts in SDA 1 than in SDA 2.

For health plans that were not offered contracts as a result of the procurement, or that are displeased with the results of the procurement, there is a ten business day period after the notice of intent to award has gone out to protest the award decisions. After HHSC responds to their protest, plans have an additional ten business day opportunity to appeal the determination to the HHSC Executive Commissioner. Health plans that remain disgruntled by the results have the option to sue HHSC for the procurement process they conducted and for whatever legal decency or flaw they believe prevented them from achieving their desired outcome.

For health plans that were offered contracts, negotiation of contracts begins with HHSC, a contract is executed, and a final notice of award is posted on ESBD. Once final contracts are awarded and before MCOs begin serving members, HHSC conducts a robust readiness review to ensure MCOs are operationally ready to fulfill obligations under the contract and can provide all contracted services. One year after readiness reviews begin, so long as readiness is confirmed, a plan may start operations as an MCO in their contracted managed care program.

Community Health Plans
Although not defined in statute, the term 'community health plan' has been in the Texas health insurance nomenclature since the 1990s, used for Medicaid MCOs established by Texas-based hospitals and health care systems. As the state began moving to the managed care model, these hospital systems extended their mission of serving low-income Texans through the creation of affiliated community health plans.

There are several conditions that characterize community health plans:1) community health plans are not publicly traded, thereby avoiding the influence of shareholders to maximize profits; 2) community health plans are anchored in Texas public and non-profit health systems and do not seek to expand into other states; and 3) primary corporate offices and operations are located in Texas.

Both community and national health plans have successfully operated as MCOs in Texas' various managed care programs since their conception.

STAR & CHIP Procurement
On December 7, 2022, HHSC posted an RFP to contract for the STAR and CHIP managed care programs. The notice of intent to award went out on March 7, 2024. At this time, it became evident to the health plans and to the Legislature that many of the current STAR and CHIP MCOs would not be receiving new contracts. Significantly, three community health plans that have long operated as STAR and CHIP MCOs in their SDAs learned they would not be maintaining their current contracts with the state and therefore, not be STAR or CHIP health plan providers at all.

Eight health plans protested HHSCs decision, and three filed lawsuits against the procurement process. In addition to this, 29 state House Representatives and 7 state Senators wrote to the commissioner of HHSC expressing concern over this procurement. The reasoning behind their letters varied anywhere from wanting additional information about the procurement to requesting a full cancelation of the procurement altogether.

At the time of this publication, due to a court agreement, HHSC has continued to delay any negotiations and finalizations of contracts with the health plans that were selected to be awarded contracts until after an injunction hearing scheduled for late September. Although the start of operation for new STAR and CHIP MCOs was anticipated to be sometime in Quarter 1 of Fiscal Year 2026, the requirement for a year-long readiness review and the ongoing legal battles may delay this start date.

SUMMARY OF COMMITTEE ACTION

The Committee met in a public hearing on June 4, 2024 to discuss this charge. The hearing was held in Austin, Texas in the Capitol Extension, Room E2.030. The testimony taken was invited only, and it was divided into three sections: Medicaid managed care quality metrics, HHSC Medicaid and CHIP procurement, and Models for state Medicaid and CHIP contracting.

The following organizations/individuals provided testimony in the noted sections of the hearing:

Medicaid managed care quality metrics:

1. Emily Zalkovsky, Texas Health and Human Services Commission
2. Chris Coffey, Molina Healthcare of Texas
3. Salil Deshpande, UnitedHealthcare Community Plan
4. Craig Smith, Driscoll Health Plan
5. Victoria Mora, Parkland Community Health Plan, Inc.

HHSC Medicaid and CHIP procurement:

1. Kay Molina, Texas Health and Human Services Commission
2. Cecile Young, Texas Health and Human Services Commission
3. Emily Zalkovsky, Texas Health and Human Services Commission

Models for state Medicaid and CHIP contracting:

1. Kevin Bagley, Self
2. Jennifer Kent, Self
3. Jeffrey Ingrum, Baylor Scott and White
4. Michael Murphy, Texas Children's Health Plan
5. Mark Sanders, Superior Health Plan

FINDINGS

Medicaid Managed Care Quality Metrics
In this section of the hearing on June 4, 2024, the Committee heard first from HHSC and then from a panel of STAR and CHIP health plan providers, including Molina Healthcare of Texas, UnitedHealthcare Community Plan, Driscoll Health Plan, and Parkland Community Health Plan. From the agency's presentation, the Committee learned that HHSC monitors around 150 MCO quality measures for state and federal purposes.[10] These measures and others are a part of HHSC's many quality tracking mechanisms, including the Texas Healthcare Learning Collaborative (THLC) Portal, the Performance Indicator Dashboard, the Performance Improvement Projects (PIPs), the Managed Care Report Cards, the Value-Based Enrollment methodology, and the Pay-for-Quality Program.

From the MCOs, the Committee found that each health plan also has individual ways they quantify providing a quality experience and care to their members. Though the programs they have implemented to do so vary, ultimately, all of the plans agreed that quality—in some capacity—should be taken into account when HHSC is procuring managed care contracts.

HHSC Medicaid and CHIP Procurement
Despite collecting all of the quality data they testified to aggregating and maintaining, HHSC testified that they are not able to take into account past performance of managed care plans when navigating the procurement process. They shared that they are unable from taking this data into consideration when scoring the plans RFPs because it would put potential new plans—those not currently operating in Texas and/or in this managed care program—at a disadvantage. Instead, HHSC stated that they use Best Value Criteria to determine the quality of a health plan during the procurement process. HHSC also clarified the decision to limit the number of SDAs a health plan may be awarded per managed care program to seven was made internally, not as a result of legislative direction.

Models for State Medicaid and CHIP Contracting
The Committee heard from two panels in the final portion of the June 4, 2024 hearing. The first panel had two witnesses: former Director of the California Department of Health Care Services, Jennifer Kent, and former Director of Medicaid and Long-Term Care at the Nebraska Department of Health and Human Services and the former Bureau Director for Long-Term Services and Supports at the Utah Department of Health and Human Services, Kevin Bagley. The objective of this panel was for the Committee to learn how other states have gone about contracting with MCOs, what benefits have been seen, and what potential problems have arisen from those approaches.

The state of California contracts with MCOs by county in three different ways: through County Organized Health Systems (COHS), through Geograhic Managed Care (GMC), and through the Two-Plan model.[11] Those plans operating through GMC contracts are similar to the "file-and-compete model," in which all a plan must do to receive a contract for this part of the state is meet a qualification requirement. The Two-Plan model also requires a plan meet a list of requirements; however, a county contracting through this model may only offer two health plans (one Local Initiative and one commercial health plan). The County Organized Health Systems

model is most similar to the procurement model in Texas. One difference in this model is that all local health plans—what Texas would call community health plans—are exempt from procurement.

The state of Nebraska operates a procurement process similar to Texas. They do not, however, have SDAs; an MCO is instead contracted to serve the entire state. The state of Utah operates an application state model for their Medicaid managed care contracting. In this model, a plan must meet a minimum requirement of abilities, and they can begin operating as an MCO in the state.

The Committee found that changing the current procurement model to emulate more of a file-and-compete or application state model may ultimately shift the role of HHSC from managing contracts to managing a marketplace. Both Utah and California experienced issues navigating how to ensure only the highest quality plans were able to serve their populations in application areas.

The second and final panel of this hearing was made up of representatives from three MCOs: Baylor Scott & White Health Plan, Superior Health Plan, and Texas Children's Health Plan. The objective of this panel was to inform the members of improvements and alternatives Texas may consider making to its Medicaid managed care contracting process. The Committee was provided with numerous alternative models including the file-and-compete model, the open application state model, and the split model; however, no evidence that these models would be *improvements* to the current Texas procurement process was provided. Witnesses also stated that they feel the caps HHSC placed on how many SDAs one health plan may be awarded was arbitrary, and that removing these caps would allow for greater competition in the market. Most notably, one witness stated their belief that Texas law does allow HHSC to give preference to certain plans in the procurement process, contrary to HHSCs previous testimony. For this reason, they argued that past performance and quality measures should be taken into account in any future managed care procurements as an improvement to Texas' current procurement model.

RECOMMENDATIONS

- Consider legislation that provides the Health and Human Services Commission with additional clarifying direction on how to proceed in managed care procurements, including but not limited to specifications on market share and past performance.
- Consider legislation that requires existing performance of a health plan be taken into account during the Health and Human Services Commission procurement process.
- Consider legislation that establishes a preference for community and hospital district health plans during the Health and Human Services Commission procurement process.

CHARGE III: Support for Texans with Intellectual Disabilities

Evaluate access to Home and Community-based Services (HCS) waivers, including the interest list, effects of inflation on the cost of services, and availability of services and service providers. Consider the long-term stability of long-term services and supports in waiver programs and consider alternative delivery models.

BACKGROUND

In 1981, the federal government began allowing states to provide Home and Community Based (HCBS) waivers through Medicaid to individuals that would have previously required long-term care through institutional settings.[12] These waivers allowed individuals to remain living within the community rather than being separated in institutions.

Texas currently has seven HCBS waivers: STAR+PLUS HCBS, Medically Dependent Children Program (MDCP), Community Living Assistance and Support Services (CLASS), Home and Community-based Services (HCS), Texas Home Living (TxHmL), Deaf-Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES). STAR+PLUS HCBS and MDCP services are delivered by the managed care organizations (MCOs). All of the other waiver programs are funded through the fee-for-service model of reimbursement.

Before becoming enrolled in an waiver program, an individual must place their name on an "interest list." There are no restrictions on who can put their name on these lists, and there are individual interest lists for each waiver program. While an individual may be on multiple lists simultaneously, they may only receive services from one waiver at a time. An individual's eligibility for a waiver program is determined once a slot becomes available. Though there may be specific eligibility requirements that vary based on the waiver, general eligibility for all waivers is determined through the financial need and medical necessity of the next person on the list when a slot opens up. If the individual is deemed ineligible due to failure to meet one of either the financial or medical need criteria, they are removed from the list. Emergency slots are made available in the HCS waiver program which allows individuals to skip the interest list in dire situations (example: caregiver or parent dies).

Over the years, there have been legislative changes made to these waivers and their interest lists. Most recently, House Bill 3720 of the 87th Legislature revised the interest list questionnaire that is given to all individuals upon placing their name on a list. This was applicable to all interest lists and has allowed HHSC to have an overall better picture of who is waiting on these lists. This includes a better understanding of the timeline in which an individual may be requiring services, the types of services they anticipate they will need, whether or not an individual anticipates losing a caregiver at a particular time, etc. An individual has the ability to change their questionnaire responses at anytime through their Your Texas Benefits online portal account. This feature was a modernization done as a result of Rider 41(c) of the 87th Legislature.

Once enrolled in a waiver, many of the services an individual may receive in the program are provided by community attendants and direct care workers. The rates these individuals are paid are set each legislative session through the budget process. House Bill 1 of the 88th Legislature,

Regular Session, increased the base wage for community attendants from $8.11 an hour to a minimum of $10.60 an hour, an increase of 30.7 percent.[13]

SUMMARY OF COMMITTEE ACTION

The Committee met in a public hearing on August 27, 2024 to discuss this charge. The hearing was held in Austin, Texas in the Capitol Extension, Room E2.014. The testimony taken on this charge was invited only.

The following organizations/individuals provided testimony at the hearing:

1. Emily Zalkovsky, Texas Health and Human Services Commission
2. Sabrina Gonzalez Saucedo, The Arc of Texas
3. Cathy Cranston, ADAPT of Texas
4. Jeffrey Miller, Disability Rights Texas
5. Carole Smith, Private Providers Association of Texas
6. Sandra Batton, Providers Alliance for Community Services of Texas
7. Erin Lawler, Texas Council of Community Centers
8. Donna Martin, ANCOR

FINDINGS

The Committee heard testimony from four perspectives: from HHSC, from advocates, from providers, and from a national organization. From HHSC, the Committee learned about how Texas has come to the state of its current interest list. They shared the current statistics for each waiver program's interest list, which are listed in the following section. Overall, the agency provided an overview of the landscape of the interest lists in Texas right now and approaches other states have made to address interest list issues. Some of these approaches included prioritizing individuals based on urgency of need, enrolling individuals in a non-waiver Medicaid services if they can meet an individuals needs, and limiting the most comprehensive waivers to only those individuals whose assessed needs cannot be met with other lower cost options.[14]

From the advocates who testified—The Arc of Texas, ADAPT of Texas, and Disability Rights Texas—the issue of lack of providers was a finding of the Committee. The witnesses testified that these service providers are for individuals on waiver programs, both for those with only physical disabilities and also those with intellectual and developmental disabilities (IDD). While this request is outside of the jurisdiction of the Committee, all of the advocates recommended to the Committee that they increase appropriations for waiver services overall, and specifically increase appropriations for attendant and direct care worker wages. The Committee was also encouraged to reconsider House Bill 729 of the 88th Legislature, which would have established a statewide intellectual and developmental disability coordinating council.[15] While the Committee did pass this bill during session, the Governor later vetoed the legislation, arguing that its efforts would be duplicative of preexisting councils.[16]

The Committee heard similar testimony from a panel representative of providers of IDD services in Texas. This panel of witnesses reiterated the issue of workforce shortages for waiver service providers, specifically for individuals requiring IDD services. Like other witnesses, their primary recommendation was to increase the direct support professional wages. They also suggested that the Committee conduct an analysis on current services provided to these populations to identify potential unused capacity and opportunities for expansion of services.

Finally, the Committee heard testimony that validated that this workforce crisis is a national issue. Donna Martin from ANCOR—a national nonprofit representing the interests of long-term service providers for individuals with IDD—testified that the turnover rate of direct support workers is approximately 44 percent nationally, and this problem was only exacerbated and accelerated by the COVID-19 pandemic.[17] Overall, the position of this witness gleaned by the Committee was that while Texas could reform its IDD service delivery and waiver interest lists, the system will not significantly improve without a robust increase in investment.[18]

STATISTICS & DATA TRENDS

At the August 27, 2024 hearing, HHSC testified on waiver enrollment data, interest list count data, take up rate data (meaning an individual came up for an open slot, was eligible, and enrolled in the waiver), data on the percentage of individuals on a list receiving other services, and the average time on the interest list for each waiver program:[19]

- HCS
    - Total enrolled: 29,135
    - Interest list count: 124,345
    - Take up rate: 35%
    - Receiving other services: 47%
    - Average time on list: 8.3 years
- TxHmL
    - Total enrolled: 2,672
    - Interest list count: 111,782
    - Take up rate: 10%
    - Receiving other services: 46%
    - Average time on list: 7.5 years
- CLASS
    - Total enrolled: 6,115
    - Interest list count: 89,917
    - Take up rate: 21%
    - Receiving other services: 47%
    - Average time on list: 8.5 years
- DBMD
    - Total enrolled: 304
    - Interest list count: 2,134
    - Take up rate: 3%
    - Receiving other services: 42%
    - Average time on list: 3.2 years

- STAR+PLUS HCBS
    - Total enrolled: 62,359
    - Interest list count: 7,660
    - Take up rate: 11%
    - Receiving other services: 34%
    - Average time on list: 0.2 year

- MDCP
    - Total enrolled: 6,267
    - Interest list count: 5,785
    - Take up rate: 13%
    - Receiving other services: 29%
    - Average time on list: 1.3 year

RECOMMENDATIONS

- Consider legislation that takes additional steps towards prioritizing the needs of people on the waiver interest lists instead of basing their position solely on the date they applied for services.
- Consider legislation that creates a tiered waiver waitlist, determined by an individual's urgency of needs.
- Direct HHSC to assess financial eligibility of an individual on the waitlist when it comes their turn for evaluation then, only after financial eligibility has been verified, require diagnostic and functional eligibility.
- Consider ways to carry out the functions intended by the Statewide Intellectual and Developmental Disability Coordinating Council that would have been created by House Bill 729 of the 88th Legislature in a manner not duplicative of existing entities.

ENDNOTES

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[8] Department of Family and Protective Services. Presentation to the House Human Services Committee: DFPS Agency Status Update. August 27, 2024.
[9] Health and Human Services Commission. Medicaid Managed Care Oversight and Quality. June 2024.
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https://tlis/tlisdocs/88R/billtext/pdf/HB00729F.pdf?lastUpdate=20230523231924#navpanes=0
[16] Proclamation by the Governor of the State of Texas. June 16, 2023.
https://lrl.texas.gov/scanned/vetoes/88/HB729.pdf
[17] Martin, Donna. ANCOR Testimony. August 27, 2024. https://house.texas.gov/videos/20655
[18] Martin, Donna. ANCOR Testimony. August 27, 2024.
[19] Health and Human Services Commission. Overview of Texas Medicaid Waivers. August 2024.