Center *for* Public Policy Priorities

THE POLICY PAGE

An Update on State and Federal Action

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HB 2292: READ IT AND WEEP

HB 2292 was signed into law by the Governor on June 10, setting in motion extensive reorganization of state health and human service agencies and functions, as well as a lengthy list of health and human service policy changes which are too wide-ranging to be easily summarized. This Policy Page provides a general description of the bill that is now law, but ***a more detailed analysis is posted on our web page at http://www.cppp.org/files/2292final-analysis.pdf The version on our website consists of (1) a more detailed discussion of the reorganization portion of the bill, plus (2) a section-by-section listing of the 231 additional pages of policy changes unrelated to reorganization.***

Comments Due on Proposed Rules Soon. Because many provisions of HB 2292 take effect on September 1, 2003, the Texas Health and Human Services Commission (HHSC), the Texas Department of Human Services (DHS) and other affected state agencies are engaged in a rushed process of rule development. A number of proposed rules will be presented to the Medical Care Advisory Committee (MCAC) on July 9 and 10, and the DHS Board will hear proposed rules on July 11 (agenda for MCAC is at www.hhsc.state.tx.us/news/meetings, and DHS board agenda will be posted at www.dhs.state.tx.us/about/board). HHSC is expected to schedule public hearings on many of the same rules on July 14-16. At this time, it is expected that rules related to CHIP benefits and eligibility and Medicaid Fair Hearings will be heard on July 14 from 8-12 at HHSC's Brown-Heatly Building, Room #1420 (4900 N. Lamar Blvd.); Medicaid benefits on July 15 from 8-12 in the Texas Department of Health's (TDH) Board room, M739 (1100 West 49th Street); and Medicaid reimbursement rules on July 16th from 2-5 p.m. in Brown-Heatly, room 1410. Readers should look for the publication of proposed rules in the June 27 issue of the Texas Register, available online at www.sos.state.tx.us/texreg.

GENERAL COMMENTS:

HB 2292 bulldozed its way to the governor's desk with insufficient public and legislative scrutiny and little regard for the impact such a massive downsizing of the safety net would have on state employees, clients, and local communities. Proponents of the bill depicted the present HHS delivery system in Texas as a vast and unwieldy network of agencies, programs, and services in grave need of repair, afflicted by duplication of effort and the red tape of "big" government. While there may be room for reform in these agencies and programs, and a carefully conceived plan to restructure how health and human services are delivered in Texas would have been welcome, this is not what this bill represents. Such a sweeping reorganization should have been preceded by an interim study, with specific recommendations to be delivered to the next legislature.

HB 2292 was promoted as consolidating and streamlining the delivery of health and human services in Texas in order to create a more efficient network and save the state money. However, the bill goes far beyond simple reorganization. The reorganization of agencies and programs is accompanied by a massive centralization of power at HHSC, whose commissioner is given total authority over the rulemaking and policy direction of HHS agencies, while individual agency directors and boards are stripped of these responsibilities. Agency boards are replaced with "advisory councils"—with no rulemaking authority—and most advisory committees are abolished. The consolidation of power with the commissioner raises the concern that HHS policy decisions will become less open to the public—in particular, the advocates who look out for the interests of the people these programs serve—more subject to the exclusive priorities of the governor, over those of the legislature, and more susceptible to political considerations.

Explicit in the streamlining of HHS programs and services is the intent to privatize—to the extent that it is cost-effective—many of the services state employees now perform. Privatization raises concerns about client access; the loss of state employee jobs, particularly in rural areas; and the state's ability and commitment to protect client

rights and hold private companies accountable for their performance in operating these programs.

The makeover of HHS agencies is complete by Page 79 of HB 2292, leaving 231 pages filled with policy changes and program cuts. Many of these provisions limit access to HHS programs, including significant changes to CHIP eligibility and enrollment, cutbacks in Medicaid benefits and coverage, and imposing a form of full-family sanctions in the TANF program. Several provisions also commit the state to pursuing policies that conflict with federal law, signaling the Legislative leadership's intent to seek waivers of federal standards. For example, the bill mandates the use of call centers to determine eligibility for the major health and human services programs in the state and requires private contractors to operate these centers, if deemed cost-effective. Given that federal law still requires Food Stamp and Medicaid eligibility determinations be performed only by state employees, the Bush administration would have to grant a waiver of this law before any privatization could occur. Such a waiver would establish a significant precedent that could influence whether other states will ask for similar waivers and whether federal authorities will approve them. Since certain federal laws cannot be waived, Texas' pursuit of these policies may also take the form of pressure for permanent changes in the relevant laws. Similar conflicts with current federal law related to Medicaid cost sharing and a Medicaid-CHIP choice waiver are described below (sections 2.112 and 2.153).

Finally, HB 2292 became more and more of a "Christmas tree bill" as it moved through the process, adorned at each stage with controversial provisions, whole bills that had failed to move during the session, pet projects of various members, etc. One egregious example was the last minute addition of a provision that essentially guts longstanding state requirements that children in schools and child care must be immunized and that the immunization status of all children be known and tracked.

STATE WORKER FTE CUTS

The last fiscal note on HB 2292 (May 24, 2003) is based on the Senate Committee substitute (i.e., the version of the bill approved by the Senate Finance committee); however, it does not appear that the final changes made in the bill would have substantially altered the fiscal impact or reduction in state employees. HB 2292 makes the following **staffing changes**:

- Article I and Section 2.06 in Article II (call centers for eligibility determination) would reduce the number of state workers by 1,102.1 in 2004, 2,162.5 in 2005 (consolidation of administrative functions; moving all eligibility determinations to HHSC), and 2,412.5 workers in 2006-2008.
- In an earlier fiscal note, two sections would have added 200 state workers per year to address changes in the investigation of Medicaid fraud and abuse (see Sections 2.19 to 2.22), and 190 employees to DHS by 2004 (196 by 2005) to implement the use of third-party information for asset verification. These sections no longer appear to require additional employees.
- **The net combined effect of FTE changes in the May 24 2003 fiscal note would be 1,175.6 fewer state workers in 2004, and 2,312.5 fewer workers by 2005. Reduction in the following 3 years increases to 2,562.5 fewer workers.**

Although defenders of the reductions suggest that most can be achieved through attrition, the bottom line is that by the end of the 2004-2005 biennium there will be 2,312.5 fewer state workers available to conduct eligibility determinations and provide services for HHS clients. It should also be noted that this number is related strictly to HHS agencies and the provisions of HB 2292, other legislation will reduce state FTEs in other agencies, and may result in additional HHS reductions.

ARTICLE I: REORGANIZATION

Reorganization: At present, 12 separate agencies provide an array of health and human services to Texans. The new law will consolidate the functions of these 12 agencies into five agencies by grouping somewhat similar programs and services (see "transition process" below for timelines). The five agencies are:

- **Health and Human Services Commission.** The commission is made responsible for policy development and rulemaking for all HHS agencies and oversees the general operations of each agency. The administrative functions for all HHS agencies are centralized at HHSC. HHSC is given the responsibility for eligibility determination for all HHS programs via the use of call centers (see below). The largest core programs that serve low-income Texans—CHIP, Medicaid, TANF, and Food Stamps—are all transferred to HHSC. In addition, domestic violence programs and coordination of early childhood services are transferred to the commission.
- **Department of State Health Services.** DSHS is made responsible for health and mental health care programs and services; administering state health and mental health facilities and hospitals (other than long-term care facilities) and community health and mental services; and substance abuse programs.
- **Department of Aging and Disability Services.** DADS is made responsible for mental retardation programs and services; administering state schools and community mental retardation services; nursing homes

and community care services; and services for the aging.

- **Department of Assistive and Rehabilitative Services:** DARS is made responsible for rehabilitation services, services for the deaf, blind and visually impaired, and early childhood intervention services.
- **Department of Family and Protective Services:** DFPS is made responsible for providing adult and child protective services, including investigating abuse and neglect in MH/MR facilities; and licensing and regulating child care facilities.

Centralization of Power with HHSC commissioner: The reorganization of HHS agencies is accompanied by a massive centralization of power at HHSC, whose commissioner is given total authority over the rulemaking and policy direction of HHS agencies. The law replaces current agency boards with advisory councils and strips these bodies of all rulemaking authority. Individual agency directors are permitted to assist in the development of rules and policies at the request of the HHSC commissioner (an improvement over the original House version of the bill). In another improvement over the original bill, the HHSC commissioner is given the authority to appoint agency directors who serve at the pleasure of the commissioner (the House version gave this authority to the governor and set one-year terms for agency directors).

Timeline and Transition process: The law directs the HHSC commissioner to develop a transition plan that includes a schedule for the consolidation of agencies. A public hearing is required before November 1, 2003, on the plan, which must be presented to the governor no later than December 1, 2003. While the consolidation of administrative support services has already begun, the consolidation of agencies is not expected to be complete for 4-6 years. The law creates a HHS Transition Legislative Oversight Committee to facilitate a smooth transition, hold public hearings on the transition process, and oversee the development of work plans by each agency to guide them through the transition process.

ARTICLE II: EVERYTHING ELSE

As noted before, Article II of HB 2292 is three times the length of the reorganization portion of the bill. Included in the article are provisions affecting:

- **Medicaid** (managed care expansion; children's eligibility policies; drug purchasing and management; nursing home care, accreditation, oversight, and reimbursement; nursing home personal needs allowance reduced; community-based long-term care; co-payments and other cost sharing; de-funding of medically needy program; elimination of podiatry and mental health professional services for adults; estate recovery; regulation of community care waiver providers).
- **CHIP** (elimination of income disregards; established an asset limit for children in families above 150% FPL; shorter coverage period; reduced benefit package; increased premiums and co-payments; CBO outreach no longer required; Regional Advisory Committees abolished).
- **TANF** (Moved to HHSC from DHS; PRA and sanctions applied to TANF child-only cases; TANF "Payment of Assistance for Performance," a.k.a. full-family sanctions); temporary exclusion of new spouse's income; Healthy Marriage Development Program; employment plans, work support services, and post-employment strategies).
- **Cross-Cutting policies** (HHS transportation moved to TXDOT; fraud and abuse prevention and intervention; call centers).
- **Mental Health and Mental Retardation** (ICF-MR quality assurance fees; ICF-MR rate cut responses; mandatory privatization of ICF-MRs; potential privatization of state schools and state hospitals; re-definition of waiver provider and LMHMRA roles; change in LMHMRA priority population definitions).
- **Miscellaneous policy provisions** include: elimination of the requirement that children be vaccinated as a condition of school and day care attendance; expanded powers of quarantine, etc., in public health emergencies; transfer of Communities in Schools to TEA; provisions for an election to propose a Travis County hospital district; authority for hospital districts and other entities to choose to provide comprehensive health care to undocumented residents using local funds; and elimination of the TCADA compulsive gambling hot line (compulsive gamblers are good for state revenues).
- **Miscellaneous provisions related to fees, reimbursement rates, and funding of programs** include: blanket authority for HHSC to reduce provider rates; increases in TDH licensure fees; creation of a sliding scale for ECI; authority to de-fund GME Medicaid payments in the budget; authority for add-on fee for divorces to be dedicated to family violence and child abuse prevention, mental health services, legal assistance, and marriage preservation; and changes in the names and allowed uses of a number of state permanent funds.

Provided below is information about selected provisions. Readers interested in other provisions or additional detail are directed to ***http://www.cppp.org/files/2292final-analysis.pdf*** where our more detailed summary of the final bill can be found.

CALL CENTERS

Section 2.06 provides for the use of up to four call centers statewide to determine eligibility, certify, and re-certify applicants for Food Stamps, Medicaid, CHIP, TANF, SSI (to the extent permitted by federal law), long-term care, and community-based support services. The bill directs

the commissioner to contract with up to four vendors to operate the call center, if cost-effective. The use of private contractors to operate these call centers would substantially reduce the state's role in operating HHS programs. The final law includes several improvements adopted by the Senate, including public hearing requirements, customer service and performance standards, methods for measuring call center performance, and requirements that call centers be located in Texas, provide translation services as required by federal law, and that HHSC maintain a local network of HHS offices to assist clients who cannot access a telephone-based system.

CHILDREN'S MEDICAID

The final bill reflects compromises related to Children's Medicaid eligibility processes negotiated in the process of writing HB 1 – the state budget bill. These would preserve some key elements of Children's Medicaid Simplification in the face of major budget cuts. Sections 2.85, 2.99, and 2.101 contain language consistent with SB 1522 by Zaffirini (the author of the 77th Legislature's SB 43 on Children's Medicaid Simplification).

Section 2.99 clearly continues to allow both initial application and renewal of Children's Medicaid by mail and telephone, but also allows DHS to establish requirements for in-person interviews if the information needed "cannot be obtained" via mail or phone. The standards for requiring face-to-face meetings must be based on "objective, risk-based factors" for a "targeted group of re-certification reviews for which there is a high probability that eligibility will not be re-certified."

Section 2.101. The final bill postpones 12-month continuous coverage in Children's Medicaid to September 2005, (as provided for in SB 1522 by Zaffirini and HB 728 by Delisi). By holding continuous eligibility at the current level of 6 months until 2005, the next legislature can determine whether or not to phase in 12-month coverage.

Section 2.85. DHS may use third-party databases to verify the accuracy of asset and resource information provided by applicants for Medicaid, TANF, or Food Stamps. Databases include consumer reporting agencies, appraisal district data, and TXDOT vehicle registration records. DHS has historically used such third-party reviews for some other administered benefits and groups, and under this provision it will also be used in children's Medicaid.

It is not entirely clear how this last provision will be implemented. This statutory language represents the only written description of an enhanced verification of assets; HHSC officials have indicated verbally in budget hearings that the policy change would entail only increased verification of information, as opposed to increased documentation requirements for parents and applicants. Official fiscal notes on earlier versions of the bill assumed that this asset verification policy would require 190 more eligibility workers in 2004 and 196 in 2005, but this assumption was not included in the most recent fiscal note.

Projected Impact. HHSC projects that these changes will slow growth in children's Medicaid enrollment to a very low rate, reducing 2005 Medicaid enrollment by 332,198 children below the numbers they projected under current law and policy. In addition, the conference committee adopted House budget Medicaid caseload assumptions (which the House used to reduce Medicaid state General Revenue funding by $524 million), which actually assume child Medicaid caseloads even below those projected to result from the changes to Medicaid simplification (i.e., more than 408,000 below projections). In sum, child Medicaid enrollment, projected in February 2003 to grow by 17.3% in 2004 and 8.4% in 2005, is now assumed in HB 1 to grow by only 2% and 1%.

Between September 2002 (the first month of simplified processes for children) and February 2003, child Medicaid enrollment increased from 1.29 million to 1.66 million, or more than 29%. While some leveling of this steep growth is to be expected, it is also likely that the rate may not drop to the 1-2% assumed in the budget. It is important to note that children's Medicaid (unlike CHIP) remains an entitlement program, so the state will be obligated to enroll children and pay for their health care services regardless of whether or not the caseload (and cost) projections for children's Medicaid turn out to be accurate.

Section 2.153: Federal waiver to "opt into" CHIP coverage instead of Medicaid. This section directs HHSC to request a waiver from the U.S. Department of Health and Human Services, to allow parents of children on Medicaid to "opt into" CHIP coverage instead of Medicaid. The state would still only get the Medicaid match rate for such children. Both the state's entitlement to federal matching funds, and the child's entitlement to Medicaid coverage is to be retained under any such waiver. Also, any waiver must allow (on at least an annual basis) parents who previously opted to move a Medicaid-eligible child into CHIP to return the child to Medicaid. A waiver of this sort would not likely be approved under current federal law, but recent Bush Administration proposals for major changes in the Medicaid program include a similar concept.

This concept is much improved over the original bill language. Because the state and child must retain entitlement to Medicaid matching funds and eligibility, any such waiver cannot convert Texas children's Medicaid entitlement coverage to a Block Grant. Because so many important benefits have been eliminated from CHIP under this bill and HB 1 (the budget), parents would now be far less likely to choose CHIP over Medicaid for their children, if given a choice. Still, ensuring that parents who choose CHIP over Medicaid will be able to change their mind later and return to Medicaid is a key improvement.

It will remain important to ensure that children's Medicaid simplification is preserved reasonably well, so that Medicaid process hassles do not force parents into CHIP.

OTHER MEDICAID CHANGES

Medicaid Medically Needy Program is not funded (Section 2.96). Amends Human Resource Code to make Texas Medicaid's Medically Needy spend-down program optional, "subject to availability of appropriated funds." In September 2003, Texas will become the 16th state that offers no "Medically needy spend-down" program. All other states (plus D.C.) have these programs, and unlike Texas, their programs are available not only to poor families with children, but also to aged and disabled persons.

Eliminates mental health professional services (and others) for adults on Medicaid. Deletes statutory directive for Medicaid coverage of podiatry, and services of licensed psychologists and licensed marriage and family therapists is deleted (Human Resources 32.027(b) and (e)). Other Medicaid services that were eliminated for adults were not mandated in statutes, and thus no repealer language was required (e.g., hearing aids and eyeglasses for elderly and disabled clients, and services of licensed professional counselors and social workers) (**Section 2.156**).

Mandates HHSC to impose Medicaid cost sharing to extent allowed under federal law. Options for cost sharing are listed, including enrollment fees (not currently allowed or even "waivable" under federal law), deductibles, coinsurance, and premium sharing (there are no references to co-payments). It is expected that HHSC will now propose more extensive Medicaid co-payments than those proposed in rules in 2002, which were never implemented. It is not yet known whether HHSC will pursue options not allowed under current federal law (**Section 2.112**).

Reduces the personal needs allowance of Medicaid nursing home residents (the monthly amount that Medicaid nursing home residents may retain from the SSI, Social Security or other pension income, the remainder going to the nursing home) from $60 to $45 (**Section 2.207**).

Estate recovery from Medicaid clients using Long-Term Care services. Requires Texas to implement a program of "estate recovery" from Medicaid clients using long-term care services (this would mean that in some circumstances, the state would seek reimbursement from the estate of a deceased recipient for the costs of Medicaid nursing home or community-based long term care). Creates an account for funds recovered, and provides for their re-appropriation for long-term care. Estate recovery has been mandatory under federal law for a decade, but never implemented in Texas for political reasons. Federal law defines a number of situations in which estates must be exempted, and states have some latitude to define additional exemptions (**Section 2.17**).

MEDICAID PRESCRIPTION DRUG BENEFITS

- **Supplemental drug rebates.** HHSC must pursue supplement rebates from drug manufacturers for drugs provided by Medicaid, CHIP, and other state health programs (community mental health centers and mental hospitals specifically included). (Note: All states receive rebates under federal Medicaid law, a number of states have negotiated additional rebates to increase their savings.) (**Section 2.11.**)
- **Preferred Drug Lists (PDL) for Medicaid and CHIP.** Requires HHSC to establish a PDL favoring drugs for which supplemental rebates have been negotiated. A Pharmaceutical and Therapeutics Committee would be created to make recommendations about the contents of the PDL (**Section 2.13**).
- **Prior authorization.** HHSC must require prior authorization for drugs not on the PDL (**Section 2.14**).
- **Pharmaceutical and Therapeutics Committee.** This "P & T" Committee would be created to make recommendations about the contents of the PDL (**Section 2.15**).
- HHSC must determine the most cost-effective way to distribute **over-the-counter medications** and supplies to Medicaid clients (**Section 2.107**).

MEDICAID MANAGED CARE

- **Statewide expansion.** HHSC must pursue managed care implementation if it is found to be cost-effective. Managed care models include HMO (including acute care portions of StarPlus), primary care case management (PCCM), pre-paid health plans, exclusive provider organizations, and "others" (**Section 2.29**).
- **Payment for out-of-network services.** Contracts with Medicaid Managed Care organizations must include standards for maximum allowable proportions of services that may be provided by out-of-network providers (in other words, provider networks must be large enough so that very large percentages of enrollees will not have to access services out of network) (**Section 2.35**).

Blanket authority for HHSC to reduce Medicaid provider rates. Authorizes HHSC to cut Medicaid provider rates in response to "available levels of appropriated state and federal funds." (**Section 2.03.**) While this statutory language technically allows the commission to either increase or reduce provider rates, the intent of adding this provision is to ensure that rate cuts made by the 78th legislature have a legal basis.

Medicaid payments to hospitals for Graduate Medical Education (GME) Optional, subject to the availability of appropriated funds. This allows add-on payments for teaching hospitals to be eliminated under HB 1. HB 1 budget riders allow for restoration of these payments using

federal fiscal relief funds or unclaimed lottery receipts, but in both cases it appears likely that other programs and priorities will consume all of any such funds, leaving none for GME (**Section 2.100**).

Medicaid fraud and finger imaging of clients. There are a number of provisions are related to re-organization and intensification of anti-fraud activities. **Sections 2.18-2.22** create a new Office of Inspector General (OIG) for Health and Human Services to investigate Medicaid fraud and abuse and outline the relationship between this office and the AG's fraud unit on Medicaid. **Section 2.23** establishes an anti-fraud pilot program that involves the use of "smart cards" and electronic finger imaging to verify the identity of Medicaid recipients and providers. **Section 2.25** requires Managed Care Organizations to establish special investigative units, or contract for those services. **Sections 2.141-2.142** enhance the Attorney General's powers for pursuit of fraud. **Section 2.143** mandates a study of identity verification for public benefits and requires the Public Assistance Fraud Oversight Task Force to produce a report by 12/2004 to identify any improvements in identity verification procedures needed to prevent fraud.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

HB 2292 also reflects decisions about CHIP made by the conferees on HB 1, the state budget bill. CHIP eligibility remains at 200% FPL, but an **asset limit** was added at the last minute to CHIP (**Section 2.46**), and **income disregards** were eliminated (**Section 2.45**). The budget also assumes policy changes to CHIP, which were built into HHSC's original budget request in February, and which are put into law in HB 2292: (1) imposing a 90-day waiting period before new coverage takes effect (**Section 2.51**), (2) reducing continuous eligibility to 6 months (from the current 12 months) (**Section 2.48**), and (3) requiring higher co-payments and premiums from clients (**Section 2.50**). While rules have not been proposed at this writing, HHSC staff indicate that proposed rules are expected to have CHIP children in families below the poverty level (about 21% of CHIP enrollees) pay no premiums, children in families with income from 101-150% of FPL pay $15 per month (still per family), those in families with income from 151-185% of FPL pay $20 per month, and those with income from 186-200% of FPL pay $25 per month.

These changes, plus the impact of the asset test and removal of income disregards, are projected by HHSC to reduce the number of children enrolled by 169,295 below projected enrollment in 2005 (or, 166,168 below June 2003 enrollment, see table below).

HHSC Estimates of CHIP Enrollment: Impact of HB 1 and HB 2292

	Monthly Average	% Drop
Projected Enrollment in 2005, before HB 2292 and HB 1	516,113	
Projected Enrollment in 2005, after HB 2292 and HB 1	346,818	
Difference	169,295	32.8%
June 2003 Enrollment	512,986	
Difference (gap between current enrollment and projected 2005 enrollment)	166,168	32.4%

CHIP benefit reductions. CHIP funding levels were further reduced in the budget by eliminating most benefits that are not explicitly mandated under federal CHIP laws (**Section 2.49**). CHIP funding per child in HB 1 assumes that the following benefits are eliminated: dental, durable medical equipment (wheelchairs, crutches, leg braces, prostheses, etc.), chiropractic, hearing aids, home health, hospice, mental health, physical therapy, speech therapy, substance abuse services, vision care and eyeglasses. Within the lower per-child funding amount, HHSC and the health plans are allowed to provide limited coverage of some of these eliminated services, but this would only be done by reducing costs (coverage) in other services. For example, annual or lifetime caps on the dollar value of coverage could be imposed, in return for a more limited durable medical equipment benefit than is in the current package. Rider language also proposes to have Community MHMR authorities provide mental health services to CHIP children, using their existing funds to draw the CHIP federal match. (**See HB 1, Article II HHSC rider 53**).

HHSC is working to identify such possible "better-than-nothing" benefit changes quickly, because the reduced premium per child will take effect September 1, regardless of where the agency is in the policy development process.

While the federal CHIP statute clearly encourages states to cover mental health, vision, and hearing services, and there is no precedent for a state offering such a limited CHIP benefit, it appears to be possible to gain federal approval of a bare-bones package. The only option among the 4 federal law "benchmark" standards for CHIP programs that does not require a dollar-value actuarial equivalence to an existing benchmark insurance package is the "Secretary-approved coverage." By changing Texas' CHIP State Plan to this option, Texas can strip out the proposed benefits from CHIP, leaving "federal minimum benefits, plus drug coverage." However, USDHHS has never approved such a bare-bones package before, and to date, this option has only been used to approve broader coverage packages (such as packages mirroring Medicaid EPSDT benefits). Texas

could be the only state not covering mental health in CHIP, but the proposed MHMR authority carve-out, coupled with a proposal HHSC is exploring to include coverage of a limited number of psychiatric medication evaluation visits per year, may prevent our state from earning that title—barely.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CHANGES

PRA and sanctions applied to TANF "child-only" cases (Section 2.86). A significant policy change will be made regarding expectations of TANF child-only or "Payee" cases. A "payee" is an adult who is not himself/herself receiving any cash assistance, who is caring for a child who is receiving TANF. These include many grandparents or other relatives, as well as parents who have hit their state TANF time limits and are no longer receiving assistance for themselves. Section 2.86 defines a "payee" and adds a new requirement that these caretakers sign a limited version of the Personal Responsibility Agreement (PRA) requiring them to: cooperate with child support enforcement, keep children up to date with health screens and immunizations, not abuse drugs or alcohol, and meet school attendance requirements for themselves and/or the children in their care. ("Payee" cases are not currently subject to the requirements of the PRA; only custodial parents receiving TANF are.) With this change, "payee" cases will also be subject to the increased sanctions policies contained in **Section 2.88,** which will end all TANF assistance to the entire household when there is noncompliance with PRA requirements (see below).

Payment of Assistance for Performance (Section 2.88). This section implements a full-family sanction process in the TANF program for the first time in Texas. Currently, when a TANF client does not comply with the requirements of the work and child support requirements of the Personal Responsibility Agreement (PRA) only the adult caretaker's assistance is terminated. Assistance is reduced by a fixed dollar amount for violations of all other PRA requirements. **Under current law and policy, TANF children cannot lose all financial support, but under HB 2292, their family's entire benefit can be terminated.**

The new "payment of assistance after performance" policy will terminate all cash assistance to both adults and children for any infraction of program requirements contained in the PRA – this is defined as "non-cooperation." Additionally, Medicaid benefits will also be cut off for any non-pregnant adult who does not "cooperate" with program requirements (children's Medicaid may not be terminated, per federal law). (**Section 2.87** changes the defined standard for deciding the imposition of PRA-related sanctions and penalties from "comply" to "cooperate." It is unclear exactly how this will change the determination or imposition of sanctions.)

- This new full-family sanction will be imposed for a minimum of one month, or until a client "demonstrates" cooperation (whichever is longer).
- Failure to "cooperate" for two consecutive months will result in the TANF case being closed. A sanctioned client and their family may reapply but must first demonstrate "cooperation" for a one-month period before assistance is reinstated.
- This section also includes language requiring client notification of the imposition of these sanctions, clarifies that sanctions under this policy do not prohibit the delivery of other social or support services, and directs that procedures be developed for determining "non-cooperation."
- There is a "good cause" process described in this section that outlines how (and within what timeframes) a client may request a hearing to challenge a ruling that they did not "cooperate" with program requirements and will be sanctioned. A client must continue to receive assistance if they have initiated a request for a good cause hearing. If the hearing upholds the agency's decision to impose a sanction, benefits will then be terminated. Additionally, good cause reasons for non-cooperation with child support enforcement activities are limited to situations that could endanger the parent or child or that result "from other circumstances the person could not control." It is not yet clear if this language will encompass current agency policies or be more restrictive.
- Information about the number of persons sanctioned under this policy will be added to a required annual report on welfare reform efforts.

Temporary exclusion of new spouse's income (Section 2.89). In response to recent Congressional interest in "marriage promotion" activities in the TANF program, this section creates a new policy that will disregard the income of a new spouse of a TANF recipient for six months – thus allowing the family to continue receiving an assistance payment (as long as the combined income of the recipient and new spouse is less than 200% of the federal poverty level).

Creates a new **Healthy Marriage Development Program for TANF recipients (Section 2.91)** that will offer an ongoing monthly supplemental incentive payment to TANF clients who participate in classes offered through this program; outlines course topics and purposes.

Employment plan, work supports and post-employment strategies (Section 2.93, 2.94). This section includes several new welfare-to-work related strategies and initiatives for implementation by the Texas Workforce Commission (TWC) and Local Workforce Development Boards (LWDBs). Each of the elements of this section had been developed as interim committee recommendations in the Senate Health and Human Services Committee and/or

the House Human Services Committee and had been filed as separate pieces of legislation.

- Details requirements that an employment plan and specific post-employment strategies be developed for TANF recipients with the goal of employment at wages adequate for self-sufficiency; includes referral to additional education and training if necessary (SB 68).
- Requires that TWC and Local Workforce Boards develop a referral program for TANF client with barriers to employment. Referrals will be for pre-employment and post-employment services provided by community-based organizations (SB 69).
- Requires that TWC and LWDBs provide transportation assistance to TANF recipients and maximize the use of any available federal transportation funds for welfare-to-work efforts (SB 66).
- Emphasizes the importance of addressing housing problems faced by TANF recipients that may be creating barriers to their transition into stable employment. Also requires cooperation and cross-training with local housing authorities and other low-income housing programs and services in order to address housing barriers (SB 67).
- Adds "mentoring" to the post-employment strategies employed by LWDBs for assisting TANF recipients in improving wages and maintaining stable employment.

TANF resource upper limit reduced to $1,000 (Section 2.201). Conforms statutory references regarding TANF asset limits to the changes assumed in the FY 04-05 budget; that is, rolls back asset limits used for determining eligibility for TANF to pre-1995 levels of only $1,000. Current policy allows $2,000 in assets, or $3,000 if there is an elderly or disabled person in the household. **This lower limit is for TANF only; the higher resource limits in Medicaid and Food Stamps stay the same.**

MENTAL HEALTH AND MENTAL RETARDATION

Privatization of ICF-MRs (Section 2.74). Mandates that local mental health and mental retardation authorities (MHMRAs) may only serve as a provider of direct services (i.e., rather than a purchaser and coordinator of such services) as a "last resort," and only if the MHMRA has been unable to locate sufficient willing providers with which to contract for services. TDMHMR must develop a plan (with the local MHMRAs) to "**privatize all services" of Intermediate Care Facilities for persons with mental retardation (ICF-MRs), as well as "all related waiver service programs."** Services may not be transferred to private providers "on or before" 8/31/2006. This plan is to provide for consumer choice, least possible disruption for consumers, and no loss of level of service, and must be implemented by the MHMRAs in a "fiscally responsible manner."

Reduction of community mental health priority population to three (3) disorders (Section 2.75). This section re-defines the priority population for Local MH Authorities' services to include only persons with Schizophrenia, Bipolar disorder, and/or Major Depression. Local MH Authorities must create jail diversion disease management programs for adults with major psychiatric disorders (bipolar disorder, schizophrenia, severe depression) and for children with serious emotional illness. TDMHMR must enter into performance contracts with the MHMRAs for 2004 and 2005 related to these practices.

A December 2004 report is required, which must evaluate the impact of disease management, as well as the impact of per capita funding disparities for the MHMRAs on the new programs.

This provision may mean that persons with other serious illnesses such as psychosis, non-suicidal depression, anxiety, autism, or personality disorders will no longer be served by the MHMRAs. According to the Mental Health Association in Texas, other diagnoses such as these accounted for over 12% of community center services in 2002, or services for over 16,890 persons out of about 139,000 served.

"Disease Management"? This term is not defined in statue or rule, and therefore the intensity of services assumed per client (and the associated cost of providing these services) varies dramatically depending on who you are talking to. Some mental health advocates assert that the aggregate funding for MH services is simply not enough to support full-fledged disease management. They are concerned that if MHMRAs are required to provide more intensive services to "first-come" clients with one of the three disorders (schizophrenia, bipolar disorder, major depression), they will have to turn away other persons who also have one of these diagnoses, as well as clients with other disorders.

MHMRA overall funding is reduced in the state budget, and Medicaid coverage of most mental health professional services have been eliminated as well. Serious reductions in access to care for chronically mentally ill persons, as well as for those experiencing acute MH crises, seem likely to develop in the next 2 years.

Mental retardation local authority waiver program: this amendment changes the distinct duties of the MHMRA, waiver providers, and TDMHMR (**Section 2.76**). A concern of advocates is that waiver providers (not the MHMRA) will now get to decide what array of services their clients will get—and what they will get paid for.

Privatization of state schools and state hospitals (Sections 2.77-2.78A). Authorizes privatizing a state school (for persons with mental retardation) and a state hospital (for persons with mental illness) after 8/31/2004 and by 9/1/2005, IF a contractor makes an acceptable proposal

that is at least 25% below the cost to TDMHMR to operate that facility. Cost-benefit calculation must include employee benefit costs, and any contractor would be required to serve the same clients at equal "quality level" of care and treat a population of the same characteristics and need levels as the facility operated by TDMHMR.

MISCELLANEOUS POLICY CHANGES

Prior authorization for high-cost medical services (Section 2.16). Authorizes HHSC to implement a prior authorization requirement for certain high-cost medical services (to be defined later) in Medicaid (and presumably CHIP and other programs); also this function may be **contracted out**. **Program shall recognize** any prohibitions in federal law on limits in the amount, duration, or scope of benefits for children in Medicaid.

Creates a Border Health Foundation (Section 2.54). This foundation is created to raise private sector money for health programs in the US-Mexico border area. A board of five directors is to be appointed by the TDH Board (while it still exists) based on TDH Commissioner recommendations. The board shall meet at least twice per year, and will be staffed by TDH under MOU. TDH or any other state agency is authorized to contract with the foundation to finance border health programs.

Licensure of facilities performing abortions (Section 2.63). Amends Health & Safety Code 245.004(a) to lower the threshold for requiring licensure as an abortion clinic from 300 abortions performed per year to 50.

Authorization of government entities and hospital districts to provide medical care to undocumented immigrants (Sec. 2.70). Clarifies that local governments (including hospital districts) can provide non-emergency care to residents without regard for citizenship status, provided the services are locally funded. Says that persons who establish residency "solely" to obtain health care assistance are not considered residents. This provision removes any legal obstacle for Texas local governments choosing to provide comprehensive health care to undocumented residents. Montgomery, Nueces, and Tarrant County Hospital Districts have limited care to this population based on legal interpretation that federal law prohibited that care. With passage of this provision, there is no such federal prohibition. Districts may now choose to limit care, but there is no legal impediment to the provision of care.

Community Attendant Services Program (Sec. 2.110). Re-names the Frail Elderly program, which serves persons with incomes above the SSI limit for provision of attendant care for elderly or disabled persons.

HHS transportation functions to be operated under contract with Texas Department of Transportation (Sections 2.127-2.134). Makes contracting with TXDOT for transportation programs OPTIONAL for Protective and Regulatory Services only, but mandatory for all other HHS programs. General language encourages the continued use of existing transportation providers, non-profit providers, and private sector transportation resources. Allows contracting with private providers including regional transportation brokers.

Only federally mandated advisory committees or those related to licensure/certification will be continued (all others abolished) (Section 2.151). Would abolish Aged and Disabled, Physician Payment, Hospital Payment, Texas Works advisory committees, to name a few. Any advisory committees NOT abolished, or any newly created in future, must make recommendations to the appropriate agency director and the HHSC commissioner regarding the elimination or reduction of overlapping functions or duties among HHSC agencies.

Allows parents to opt out of immunizing their children as a requirement of public school or day care attendance (Sections 2.160-2.164) based on either a physician's statement that the immunization "poses a significant risk" to the child or a family member, or a parent's statement of objection based on conscience or religious belief. This exemption is also available for attendance at day care facilities. The Commissioner of Health may declare situations of epidemic or emergency during which un-immunized children may be excluded from school or day care.

An official affidavit form for the parent or guardian will be developed, but the only record the state will have of these affidavits will be the number of forms mailed out. The state is expressly forbidden to maintain a record of the parents who have requested the affidavits. Because the state will have no record of which children have opted-out of immunizations, any such action taken by a Commissioner during an epidemic or other health emergency will essentially be on the "honor system."

Public health disasters, powers of quarantine, etc. (Section 2.167-2.191). Governor or health Commissioner may declare disaster if high risk of death, or disability from communicable disease. See detailed analysis at cppp.org for listing of enhanced powers.

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