Adriana Kohler, Senior Health Policy Associate
Kate Murphy, Senior Child Protection Policy Associate
Josette Saxton, Children's Mental Health Policy Director
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Funding Strategic Health & Human Services Priorities for Texas Kids

Testimony to the Senate Finance Committee Regarding Article II

SB 1 provides a starting place for the Senate to identify ways to make strategic investments in children and families as the budget is revised over the course of the legislative session. This testimony identifies a number of specific HHSC, DSHS, and DFPS budget items that require the Senate's attention in the areas of Early Childhood Intervention (ECI) for toddlers with disabilities; Medicaid and CHIP for children, pregnant women, and Texans with disabilities; women's health programs; additional initiatives to address maternal mortality and morbidity; substance use disorder treatment; children's mental health; efforts to prevent entries into foster care; efforts to ensure children are safe in foster care; and implementation of the federal Family First Prevention Services Act.

This testimony provides several recommendations for improvements to make to SB 1, including providing the additional $71 million requested by HHSC for ECI; investing in substance use disorder treatment to help improve maternal health and keep children out of foster care; providing funding to auto-enroll young women in the Healthy Texas Women program when they exit CHIP or Children's Medicaid; and providing funding to address the rising rate of youth suicide in Texas.

We appreciate the hard work that the Senate and Legislative Budget Board have put into crafting Senate Bill 1 to provide a starting place for budget deliberations. As the Senate Finance Committee considers the FY 2020-2021 Article II budget, we respectfully offer the following recommendations regarding funding for critical children's policy priorities. We look forward to working with the Senate on these issues over the course of the legislative session.

For additional information on the issues discussed in this testimony, please contact Adriana Kohler at akohler@txchildren, Kate Murphy at kmurphy@txchildren.org, Josette Saxton at jsaxton@txchildren.org, or the Texans Care for Children office at 512-473-2274 or through our website, www.txchildren.org.

Health and Human Services Commission

Early Childhood Intervention

We are concerned that the Senate budget draft excludes the additional $71 million HHSC requested to shore up the state's Early Childhood Intervention (ECI) program for babies and toddlers with Down syndrome, autism, speech delays, and other disabilities and developmental delays. Underfunding of ECI since 2011 has contributed to 18 non-profit ECI contractors dropping out of the program in the last eight years and thousands of babies and toddlers missing out on critical supports when they are most effective.[1] Texas already taps more than 17 funding sources for ECI and efforts to maximize Medicaid dollars have paid off.

HHSC made clear in its LAR that an additional $71 million is needed to sustain this federal-state program, yet the budget only includes a small $4 million increase for ECI. As we documented in our recent report, state funding for ECI has already fallen from $484 per child in 2012 to $412 in 2018.[2]

When children are able to enter ECI, the program produces results. In fact, for enrolled children, our state's ECI program is among the most high performing in the country. It is now time for the Legislature to commit to sustained support for ECI. Otherwise, we'll see higher taxpayer costs down the road as kids who missed out on ECI need more costly school-based special education services.

Recommendation

- **Fund HHSC Exceptional Item #6 to Maintain ECI Services:** HHSC's EI-6 request of $71 million is a critically-needed step in strengthening ECI.

Medicaid and CHIP

Strong investment in Medicaid and CHIP is vital for Texas' efforts to improve maternal and child health. Three out of four enrollees in Texas Medicaid are children. Medicaid and CHIP insurance help children get check-ups, eyeglasses they need for school, dental care, speech and physical therapies, and other health services to make sure they stay healthy and are ready to learn in school. Costs are reduced in the health care system and other programs like special education if children get needed services and interventions early on.

Likewise, Medicaid and CHIP Perinatal is a cost-effective tool that helps avoid bad outcomes for pregnant women and infants, such as preterm birth and maternal mortality, by identifying and managing potential

[1] Texans Care for Children, New Data Show Decline in Funding for Texas Early Childhood Intervention (ECI), November 2018.
[2] Ibid.

complications early. For instance, smoking cessation interventions and diabetes and hypertension treatment during pregnancy help prevent pregnancy complications, premature births, infant death, and birth defects.[3] While progress has been made, still 1 in 10 babies is born too early in our state and 1 in 12 Texas babies is born too small.[4] About 70 percent of Medicaid costs for hospitalized newborns are related to prematurity.[5] The average cost to Medicaid for premature infants is 200 times higher than the cost of healthy, full-term births.[6] Investing in prenatal and postpartum care leads to substantial cost savings and ensures healthier moms and children.

Medicaid and CHIP are a lifeline for many Texans – programs that deserve to be protected, adequately funded, and effectively managed.

Recommendations

- **Fund Exceptional Item #1 to account for anticipated cost trends in Medicaid and Exceptional Item #2 to account for anticipated cost trends in CHIP and CHIP Perinatal.** We appreciate that the Senate based budget accounts for projected growth in the number of children, pregnant women, and people with disabilities eligible for Medicaid and CHIP in 2020-2021. However, approval of EI-1 and EI-2 is vital to maintain adequate Medicaid and CHIP client services funding and account for projected cost trends, such as increased costs due to medical inflation, higher utilization, and increased medical acuity in 2020-2021. This action is crucial to ensure a sufficient number of health care providers continue to participate in Medicaid and serve pregnant women, infants, and children across the state.

- **Account for additional funds needed to implement twelve-month continuous eligibility for children in Medicaid as proposed in the children's health coverage bill.** Texas has the highest rate and number of uninsured children in the country – and the problem is getting worse.[7] Twelve-month continuous eligibility for children in Medicaid reduces workload and administrative costs for the state, improves continuity of care, and prevents eligible children from cycling on and off of insurance during the year. Allowing children to stay in Medicaid for a year is Texas' policy for CHIP and the single most effective step state leaders can take to keep kids connected to care. **Currently, with extra paperwork and income checks at months 5, 6, 7, and 8, the combined effect of this excess red tape can cause eligible children to lose their Medicaid coverage.** Children who go without coverage, even for a brief period, may end up seeking more expensive health care services, like an emergency

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[3] Centers for Disease Control and Prevention, Type 1 and Type 2 Diabetes and Pregnancy. http://www.cdc.gov/pregnancy/diabetes-types.html. National Institutes of Health, National Heart, Lung, and Blood Institute. High Blood Pressure in Pregnancy. https://www.nhlbi.nih.gov/health/resources/heart/hbp-pregnancy. See 2017 Healthy Texas Babies Data Book. Johnson, Kay. et. al., Recommendations to Improve Preconception Health and Health Care: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. Centers for Disease Control and Prevention. 55 (RR06); 1-23 (Apr. 2006) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm. Roland JM, et. al. The pregnancies of women with Type 2 diabetes: poor outcomes but opportunities for improvement. Diabet Med 22:1774-7 (2005).

[4] Texas Department of State Health Services. Healthy Texas Babies: 2017.

[5] Lesley French and Evelyn Delgado. "Presentation to the House Committee on Public Health: Better Birth Outcomes." Health and Human Services Commission and Department of State Health Services. May 19, 2016.

[6] Ibid

[7] 2017 U.S. Census data. See Cover Texas Now. "Census: TX Uninsured Rate Now Even Worse, Still Highest In US." (Sept 2018). Available at https://covertexasnow.org/posts/2018/9/13/census-tx-uninsured-rate-now-even-worse-still-highest-in-us. See Center for Public Policy Priorities. "Why 272,000 More Texans Were Uninsured in 2017 — and How We Can Fix This." (Sept. 13, 2018). Available at http://bettertexasblog.org/2018/09/why-272000-more-texans-were-uninsured-in-2017-and-how-we-can-fix-this/

department visit for a preventable asthma attack. The majority of these children are re-enrolled, and thus Medicaid retroactively pays for this more expensive avoidable care anyway.

- **Improve maternal and child health by funding initiatives to ensure women of reproductive age receive twelve months of continuous coverage for preventive, primary, and specialty care before, during, and after pregnancy.** Texas has the nation's highest uninsured rate for children and for adults – and the problem is getting worse. About 1 in 4 (24.3 percent) adults in Texas did not have health insurance in 2017. The challenge is worse in the state's rural communities and small towns, where the uninsured rate among low-income Texas adults is 36 percent.[8] The high uninsured rate contributes to many challenges our state faces, including maternal mortality and infant health, mental health, substance use disorders – including the opioid epidemic – and subsequent child removals by CPS, property taxes, rural hospital closures, and families' financial security. In particular, after implementing an enhanced method to confirm maternal deaths, the Texas Maternal Mortality and Morbidity Task Force found that the majority of maternal deaths between 2012 and 2015 occurred *more than 60 days postpartum* – after Medicaid coverage cuts off for low-income women in Texas. The Task Force also found that the vast majority (80 percent) of maternal deaths were potentially preventable.[9] **The Task Force's number one recommendation for combating maternal mortality is to ensure women have access to health care before, during, and after pregnancy to stay healthy and identify issues before they lead to tragedy.** Moreover, Texas' federal Delivery System Reform Incentive Payment Program (DSRIP) funding for innovative local health programs is already declining and will expire in October 2021. Additionally, 2022 is the last year that the federal government has committed to provide Texas with Uncompensated Care funding to help make up for the unpaid hospital bills resulting from our high uninsured rate. This funding cliff is an urgent reason why Texas leaders must take action to address the state's sky-high uninsured rate.

Women's Health

The Legislature's continued commitment to Texas' women's health programs is critical for the state's fiscal health and for ensuring more Texas mothers and babies are healthy. Every $1 spent to offer contraceptive care to a woman saves over $7 in public costs.[10] When women and couples are able to plan and space their pregnancies, babies have less risk of prematurity and low birth weight, and mothers experience healthier outcomes too.[11] Providing preventive and preconception care — including health screenings and contraception — saves money by helping women avoid unplanned pregnancy and reducing the Medicaid costs associated with unintended pregnancy, birth, and infant complications. In fact, Medicaid pays for 53 percent of the births in Texas, resulting in Texas spending $3.5 billion per year for birth and delivery-related services for mothers and

[8] Georgetown University Center for Children and Families and the University of North Carolina NC Rural Health Research Program. "Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion." (Sept 2018). Available at https://ccf.georgetown.edu/2018/09/25/health-insurance-coverage-in-small-towns-and-rural-america-the-role-of-medicaid-expansion/.
[9] Texas Department of State Health Services. "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report." September 2018. Accessed at https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD022.pdf.
[10] Frost J, et al. Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. New York, Guttmacher Institute, 2014.
[11] Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birthspacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA 2006; 295(15): 1809-1823. Zhu BP. Effect of interpregnancy interval on birth outcomes: findings from three recent US studies. International Journal of Gynecology and Obstetrics 2005;89 (Supplement 1): S25-S33.

infants in the first year of life.[12] In fiscal year 2017 alone, it was estimated that the Family Planning Program saved $44.2 million in state General Revenue and $8.5 million in net savings to the state.[13]

With the Legislature's continued funding over the last few years, the women's health programs have been able to serve more low-income Texas women. In fiscal year 2017, Healthy Texas Women (HTW) and the Family Planning Program (FPP) provided women's preventive care, including family planning services and contraception, to 219,400 Texas women.[14] This is an increase of 29 percent from fiscal year 2016.

While progress has been made, more work is needed. Texas still has a large unmet need for women's preventive care: while HTW and FPP served 219,400 Texas women in FY 2017, roughly 1.8 million Texas women need publicly funded family planning.[15] Increased funding for HTW and FPP will help the state realize even more cost savings and ensure a stronger provider network in both rural and urban areas of Texas.

Recommendations

- **Fund the Family Planning Program at $103 million, the level requested in HHSC's LAR, to account for anticipated growth in the number of women served by the program in 2020 and 2021.** The Family Planning Program is a cornerstone of our women's health safety net. We are disappointed that the Senate budget proposal maintains the same funding level as 2018-2019 ($80.8 million) and does not include the funding HHSC requested for the program to meet the anticipated 20 percent growth in average monthly number of women served through 2021. Because of the Family Planning Program's success, more women are able to receive preventive care and contraception. Funding family planning to account for this anticipated growth will lead to cost savings for the state, ensure more Texas mothers and babies are healthy, and ensure the program continues to be successful in future years.

- **Include a budget rider and account for additional funds needed to auto-enroll young adult women into Healthy Texas Women as they age-out of Children's Medicaid or CHIP. Funding for a rider would be included in the HHSC D.1.1. budget strategy for Women's Health Programs.** State leaders have an opportunity this biennium to maximize Texas' women's health programs to reach more women and save taxpayer dollars. Auto-enrolling young adult women into Healthy Texas Women as they age-out of Children's Medicaid or CHIP would improve continuity of care, reduce teen and unplanned pregnancies, improve maternal and child health, and save Texas money. Currently, Texas has the fourth highest teen birth rate in the nation and 70 percent of teen births are to older teens (age 18 and 19).[16] Pursuant to HHSC Rider 106, 85th Legislative Session, HHSC analyzed feasibility and costs associated with auto-enrollment. **HHSC projected that the state would save $58.7 million in**

[12] French, Lesley and Delgado, Evelyn, "Presentation to the House Committee on Public Health: Better Birth Outcomes," Health and Human Services Commission, May 19, 2016.
[13] Health and Human Services Commission, "Texas Women's Health Program Report Fiscal Year 2017," May 2018. Available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/womens-health-program-savings-performance-report-may-2018.pdf.
[14] Texas Health and Human Services Commission. "Texas Women's Health Programs Report Fiscal Year 2017: As Required by Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 97)." May 2018.
[15] Frost J, et al. "Contraceptive Needs and Services, 2014 Update." New York: Guttmacher Institute, 2016.
[16] United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Natality public-use data 2007-2017, on CDC WONDER Online Database, October 2018. http://wonder.cdc.gov/natality-current.html.

General Revenue ($102.6 million All Funds) between Fiscal Years 2020 – 2025 due to averting an estimated 11,275 unintended pregnancies. Despite significant savings in the next five years, there may be a cost in this biennium because auto-enrolling young adult women would increase caseloads in the HTW program. We ask state leaders that, in the event that auto-enrollment policy change is pursued, funding for the HHSC D.1.1. budget strategy (Women's Health Programs) should include the full cost associated with projected caseload increase to avoid reduction in the provision of services within the program. Associated cost savings could be projected in the Medicaid Client Services A.1.3 or A.1.5 strategies.

Substance Use Disorder Treatment

Substance use disorder is a chronic illness affecting nearly one in ten Texans.[17] When not addressed, substance use disorders have devastating effects on families and communities and are responsible for costs to our state budget related to health care, public safety, foster care, and criminal justice, among other areas. Tragically, overdose is the leading cause of maternal death among Texas mothers during pregnancy and one year after birth of a child. **Additionally, the effect on Texas children and our state's foster care system is clear – in 2017, 68 percent of children who were removed from their homes and placed in substitute care had a caregiver whose substance use contributed to the removal.**[18] Additionally, in fiscal year 2017, 52 percent of child fatalities caused by abuse or neglect included a caregiver using and/or under the influence of a substance that affected their ability to care for the child.[19]

There is a significant unmet need for substance use intervention, treatment, and recovery services among Texas children and adults. **Only 5.8 percent of low-income Texas adults with a substance use disorder (and only 8 percent of low-income Texas youth ages 12-17 with a substance use disorder) are able to receive treatment services through a community-based treatment provider.**[20] This has real-life impacts for youth and adults in need of substance use treatment. Based on HHSC data:

- In 2017, there were 13,177 low-income Texas adults and 163 Texas youth on a waitlist for a spot at a community-based substance use treatment provider;
- Texas youth waited an average of 45 days on a waitlist to receive outpatient substance use treatment services;
- Texas youth with mental and behavioral health challenges waited an average of 80 days on a waitlist to be part of Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) services, which provide case management and integrated mental health and substance use services;

[17] Substance Abuse and Mental Health Services Administration, "2015 – 2016 NSDUH State Estimates of Substance Use and Mental Disorders," Dec. 2017. https://www.samhsa.gov/data/population-data-nsduh/reports.

[18] Interim Report to the 86th Texas Legislature 11 (House Select Comm. on Opioids & Substance Abuse 2018) *available at* https://house.texas.gov/_media/pdf/committees/reports/85interim/Interim-Report-Select-Committee-on-Opioids-Substance-Abuse-2018.pdf.

[19] Texas Department of Family and Protective Services. "Fiscal Year 2017 Child Maltreatment Fatalities and Near Fatalities Annual Report," Figure 11, Table 5, 2017.

[20] Includes adults and youth with income under 200% of the federal poverty level ($24,280/year for an individual). Includes services funded through Texas' substance abuse and prevention block grant, which helps fund treatment services for individuals who do not have insurance and make income of less than 200% FPL. Texas Health and Human Services, Behavioral Health Services, Office of Decision Support, Jan. 2018.

- Texas adults waited more than two weeks (on average) for intensive residential treatment, four weeks for outpatient treatment, and four weeks for Medication Assisted Therapy (MAT). In 2017 alone, there were over 6,600 Texas adults on a waitlist for intensive residential treatment.

- There are only ten Women and Children residential treatment providers in Texas that contract with HHSC and allow pregnant women/mothers and their children to stay together during the course of recovery. In 2017 there were over 100 mothers on a waitlist for a spot at a Women and Children residential treatment center – waiting an average of 18 days before a spot became available.[21] Community-based substance use treatment and recovery supports are a lifeline for many Texans. Yet, resources and provider capacity for substance use services lag behind the need in Texas. These programs deserve increased investment so Texas can tackle the opioid epidemic, avoid costs to foster care and criminal justice, and ensure youth and families can recover successfully.

Recommendation

- **Fund HHSC Exceptional Item #21 to Increase Substance Use Disorder Treatment:** HHSC's EI-21 request of $44.8 million over the biennium is critical for maintaining current services with rate increases. It is not currently included in the Senate base budget.

Children's Mental Health

We're pleased to see the Senate budget includes a $12 million increase for Children's Community Mental Health. Half of all cases of chronic mental illness across the lifespan begin to emerge by age 14, yet identification and treatment often does not occur until many years later – often a decade – when interventions tend to be less effective and costlier.[22] National surveillance efforts show that the prevalence of behavioral disorders in children is increasing.[23] When children and their families are unable to access mental health services, children are at heightened risk for dropping out of school or entering the juvenile justice or foster care systems. Children and families need access to a continuum of mental health services, including a range of mental health services that support children's ability to function at home, in school, and in their community, including – *but not limited to* – psychiatric treatment when necessary.

While Article III is outside of the scope of today's hearing, it is important to note that schools must be part of the state's approach to student mental health. The Texas Education Agency's commendable $54 million proposal to address school safety and student mental health is funded in the House base budget but is not in the Senate budget yet.

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[21] Analysis of substance use treatment waitlist data provided by the Texas Health and Human Services Commission via data request. Numbers used refer to the total unduplicated number of people on a waitlist during the course of fiscal year 2017. Note: data includes Substance Abuse Prevention and Treatment block grant-funded providers.

[22] Kessler, R.C. et al. (2005). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." Archives of General Psychiatry. 62(6):593-602

[23] Centers for Disease Control and Prevention. (2013). Mental Health Surveillance Among Children — United States, 2005–2011

Recommendations

- **Provide HHSC with additional funding to support enhanced youth suicide prevention efforts**. One out of eight (12 percent) of high school students in Texas attempted suicide in the last year, exceeding the national prevalence rate.[24] There is only one FTE at HHSC to lead state efforts and assist communities in addressing suicide, which is the second leading cause of death for youth in Texas. This is inadequate. HHSC (formerly the Department of State Health Services) partnered with the Texas Suicide Prevention Council to support the development of *Texas Suicide Safer Schools* toolkit that was released in 2015. Additional funding is needed to support the dissemination and implementation of best-practice strategies, including the *Texas Suicide Safer Schools* toolkit, to improve efforts across HHS and other state agencies to prevent and address suicide-related behaviors in children in youth.

- **Provide HHSC with funding to include family peer services provided by Certified Family Partners in the scope of services provided under Medicaid for children with serious emotional disturbance (SED).** Children with SED are at high risk of negative personal and societal outcomes, including dropping out of school, being unemployed, living in correctional facilities, engaging in substance abuse, or experiencing homelessness.[25] The Centers for Medicare and Medicaid Services (CMS) recognize family and youth peer support as approved services that can be included in states' Medicaid plans as part of children's behavioral health treatment.[26] Family peer support services are not currently included in the Texas Medicaid plan, even though state health and human services agencies have noted that family peer support services "can be essential to parents considering parental relinquishment" and family peer support services were rated among the most useful services in Texas for addressing children with SED (second only to having mental health professionals in schools).[27] A U.S General Accountability Office report found it is not uncommon for families, across all financial levels, to place a child with SED in the child welfare or juvenile justice system because of unmet mental health needs.[28]

- **Fund HHSC's Exceptional Item request of $2 million to increase access to psychiatric residential treatment services for children at risk of entering the foster care system.** This request was not included in the base budget. This level of funding would enable HHSC to increase the number of residential treatment beds provided through Local Mental Health Authorities (LMHAs) for children identified by the Department of Family and Protective Services (DFPS) as being at risk of parental relinquishment due to children's unmet mental health needs. The increase would bring the number of statewide "relinquishment" beds to 50, compared to the 40 beds currently available to divert children in

[24] Centers for Disease Control and Prevention. Texas High School Youth Risk Behavior Survey 2017. https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=TX

[25] Wagner, M. (1995). "Outcomes for Youth with Serious Emotional Disturbance in Secondary School and Early Adulthood." Critical Issues for Children & Youth. 5(2).

[26] CMS and SAMHSA Joint Bulletin (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

[27] Dept. of Family and Protective Services & Dept. of State Health Services Joint Report on Senate Bill 44 (2014) 23 SB 44 Needs Assessment: Examining The Relinquishment of Children with Serious Emotional Disturbances

[28] U.S. General Accounting Office. (2003). CHILD WELFARE AND JUVENILE JUSTICE: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services. http://www.gao.gov/new.items/d03397.pdf

need of psychiatric treatment from entering foster care solely due to an inability to access residential treatment services through other systems.

- **Include a budget rider directing HHSC to evaluate psychiatric residential treatment services contracted by state agencies**, including the use of evidence-based and trauma-informed treatments and practices, linkages to community-based services, rates of family reunification, and rates of readmission. Several agencies (DFPS, HHSC, and TJJD) purchase residential psychiatric treatment services for children with serious mental illness. When children do require this more restrictive and costly residential treatment, the state should be assured the services are effective and promote successful transitions back into homes and communities. Some families have expressed concerns about the quality of care in these facilities.

Department of State Health Services

Maternal Mortality and Morbidity

Maternal deaths and severe pregnancy complications remain a significant concern in Texas, resulting in tragedy and long-term health issues for many mothers and children. Complications during and after pregnancy – which are much more common than a maternal death – can result in higher Medicaid-paid neonatal costs and can interfere with a mother's ability to care for her baby. The Department of State Health Services has implemented an enhanced method to confirm maternal deaths and the Texas Task Force on Maternal Mortality and Morbidity has completed extensive case reviews to understand underlying factors contributing to maternal deaths and pregnancy complications in Texas.

The Task Force identified 382 maternal deaths between 2012 and 2015, with the majority of maternal deaths occurring more than 60 days after childbirth.[29] Doing an in-depth review of 2012 cases, the Texas Task Force found that black women were 2.3 times more likely to experience maternal death and the vast majority (80 percent) of maternal deaths in 2012 were potentially *preventable*.[30] Although there are many factors that contributed to these poor health outcomes and racial disparities, we know that one of the best strategies to reverse these trends is to ensure women have access to health care before, during, and after pregnancy – as recommended by the Texas Task Force on Maternal Mortality and Morbidity.

Recommendation

- **Fund the Department of State Health Services Exceptional Item #3 to Combat Maternal Mortality and Morbidity in Texas.** EI-3 is not currently included in the Senate base budget. New mothers should receive high-quality care when they enter the health system so they have healthy, safe pregnancies

[29] Baeva S, Saxton DL, Ruggiero K, Kormondy ML, Hollier LM, Hellerstedt J, Hall M, Archer NP. Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012. Obstet Gynecol 2018;131;762-769.

[30] Texas Department of State Health Services. "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report." September 2018. Accessed at https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD022.pdf.

and births. DSHS submitted an Exceptional Item request for vital funding to implement *TexasAIM* maternal safety initiatives statewide, to implement a maternal care coordination pilot for women, and to increase public awareness and prevention activities. **These critically-needed initiatives are in line with the recommendations released by the Maternal Mortality and Morbidity Task Force and will help Texas keep mothers and babies healthy.**

Department of Family and Protective Services

The Legislature has made progress on Child Protective Services (CPS) challenges the last two years, but it has much more work to do adequately fund CPS, keep more children safely with their families rather entering foster care, and ensure that when children do enter foster care they are safe, recovering from trauma, and thriving. There is an overall increase of $137 million over the 2018-19 biennial base for CPS including an increase in funding for Community Based Care, contracted day care services, and relative caregiver monetary assistance payments. Community Based Care and other contracted services require additional funding each session to simply maintain existing services due to our state's growing population and inflation. Further, for this session DFPS requested $324 million in Exceptional Items to cover CPS priorities, which are excluded from SB 1. These Exceptional Item requests do not include efforts to implement the new federal Family First Prevention Services Act (which only has a placeholder in the DFPS LAR) or comply with the pending federal court order (which is excluded from the DFPS LAR altogether). **In other words, the current version of SB 1 essentially maintains the status quo for children involved with CPS rather than making the improvements necessary to build on the state's recent progress.**

Keep More Families Safely Together and Prevent Entries into Foster Care

Pregnant and Parenting Youth

Helping through Intervention and Prevention (HIP) provides voluntary support services to current and former foster youth who are pregnant or parenting a child under the age of three. HIP is proven to help pregnant and parenting youth establish stable, thriving families and can help end a cycle of future involvement with CPS.

Recommendation

- **Provide funding to expand HIP statewide.**

Substance Use

Data from DFPS show that a majority of families who interact with CPS have substance use challenges. For example, in 2017, 68 percent of children who were removed from their homes and placed in substitute care

had a caregiver whose substance use contributed to the removal.[31] DFPS purchases substance use services for parents involved in a CPS case that are not covered by another funding source. According to the DFPS LAR, the number of "clients who will need substance abuse purchased services is expected to grow by 7.7% in FY20 and by 15.4% in FY21 compared to FY19." **Since at least 2016, about two-thirds of the dollars appropriated to and spent by DFPS for purchased substance use services have been used for drug testing instead of therapeutic services.** We are encouraged to see the current DFPS LAR allocate more money for therapeutic services ($8.6 million) than for drug testing ($7.7 million). Although the DFPS base budget request includes a 38 percent ($10 million) cut to substance use purchased services, we are also encouraged that the Exceptional Items request seeks an additional $24.2 million to maintain substance use purchased services over the next biennium.

Recommendations

- **Invest more in substance use purchased services to reduce entries into foster care and increase reunification of families involved with CPS.**

- **Allocate more funding for therapeutic services than drug testing to meet the needs of parents involved in the CPS system.**

Ensure Children are Safe in Foster Care

Caseloads

Caseworkers make life and death decisions about the children in their care every day. However, if caseworkers are responsible for too many cases at once, the children under their care are at greater risk of harm. The Legislature's previous investments reduced caseloads for those caseworkers assigned to abuse and neglect investigations, but the state still has dangerously high caseloads for those caseworkers assigned to support youth in foster care. In 2016, the average foster care caseload in Texas was 29.7 per caseworker.[32] In 2017, it dropped to 27.8 and DFPS estimated a 2018 average caseload of 26.5.[33] National standards suggest a safe conservatorship caseload range is 8-15, indicating that Texas caseloads are still at dangerously high levels.[34]

[31] Interim Report to the 86th Texas Legislature 11 (House Select Comm. on Opioids & Substance Abuse 2018) *available at* https://house.texas.gov/_media/pdf/committees/reports/85interim/Interim-Report-Select-Committee-on-Opioids-Substance-Abuse-2018.pdf.

[32] Child Protective Services: Average Daily Caseload, Texas Department of Family and Protective Services (2016) *available at* https://www.dfps.state.tx.us/About_DFPS/Data_Book/Employee_Statistics/CPS/CPS-Caseload.asp.

[33] DFPS Legislative Appropriations Request 96 (Tex. Dep't of Family & Protective Services Aug. 30, 2018) *available at* https://www.dfps.state.tx.us/About_DFPS/Budget_and_Finance/LAR/FY20-21/documents/20-21-LAR.pdf

[34] *M.D. v. Abbott*, No. 18-40057 at 25 (5th Cir. Oct. 18, 2018) *available at* http://www.ca5.uscourts.gov/opinions/pub/18/18-40057-CV0.pdf.

Texas must also establish guidelines for appropriate caseloads. The Fifth Circuit judges asserted that Texas' reliance on high-volume hiring has not effectively reduced caseloads[35] and the state should set a target caseload range to ensure child safety.

Recommendations

- **Support the DFPS LAR Exceptional Item #1** ($116.7 million in All Funds) to maintain current caseloads and projected caseload growth.
- **Increase investment to reduce caseloads** to a safe level based on national best practices.
- **Invest in a workload study that will set target caseloads** that ensure child safety in the Texas foster care system and support DFPS compliance with the District Court order.

Data System

SB 1 includes an overall reduction of $16.5 million in All Funds for various information technology projects for Information Management Protecting Adults and Children in Texas (IMPACT). For caseworkers to ensure child safety, they have to be able to access information about a child's placement, history, health, education, any juvenile justice involvement, and more. The Fifth Circuit panel noted DFPS' haphazard record-keeping makes it unreasonably difficult for caseworkers to navigate a child's case file and assure each child's safety.[36] As part of the lawsuit, DFPS will likely be required to develop a new integrated computer system to keep all records in a centralized electronic database so that caseworkers and others involved in a child's case can easily locate the information they need to ensure they are meeting the needs of each child.

Recommendation

- **Invest in a new interoperable data system that contains each child's "complete records**, including but not limited to a complete migration of all medical, dental, educational, placement recommendations, court records, mental health and caseworker records"[37] as required by both the District Court and the Family First Prevention Services Act (FFPSA), and ensure that the new system maximizes child safety by meeting the needs of providers and caseworkers in Texas' evolving child protection system.

[35] *M.D. v. Abbott*, No. 18-40057 at 35 (5th Cir. Oct. 18, 2018) *available at* http://www.ca5.uscourts.gov/opinions/pub/18/18-40057-CV0.pdf.
[36] *M.D. v. Abbott*, No. 18-40057 at 5 (5th Cir. Oct. 18, 2018) *available at* http://www.ca5.uscourts.gov/opinions/pub/18/18-40057-CV0.pdf.
[37] *M.D. v. Abbott*, No. 18-40057 at 66-67 (5th Cir. Oct. 18, 2018) *available at* http://www.ca5.uscourts.gov/opinions/pub/18/18-40057-CV0.pdf.

Family First Prevention Services Act

SB 1 currently does not account for costs and investments associated with preparing to implement the new Family First Prevention Services Act (FFPSA), which restructures federal financing for child welfare. The new federal law opens up key opportunities to fund prevention programs, but it also restricts the spending of federal dollars for certain types of congregate care.

Recommendations

- **Provide DFPS with funding for the following items related to prevention:**

    - ➔ Develop capacity and workforce to deliver prevention services that meet certain evidence-based thresholds;
    - ➔ Reporting of services provided and performance-based outcomes at the child level;
    - ➔ State match; and
    - ➔ Train staff on foster care candidacy and prevention planning.

- **Provide DFPS with funding for the following items related to the new restrictions on foster care placements eligible for federal reimbursement:**

    - ➔ Develop Qualified Residential Treatment Provider capacity (including aftercare support, on-site nursing and clinical staff, and accreditation);
    - ➔ Loss of federal financial participation for currently eligible placements that do not meet the new standards;
    - ➔ Develop foster home capacity;
    - ➔ Increased staff time dedicated to the workload associated with performing required assessments of placements; and
    - ➔ Information technology revisions based on new federal data exchange and reporting requirements.