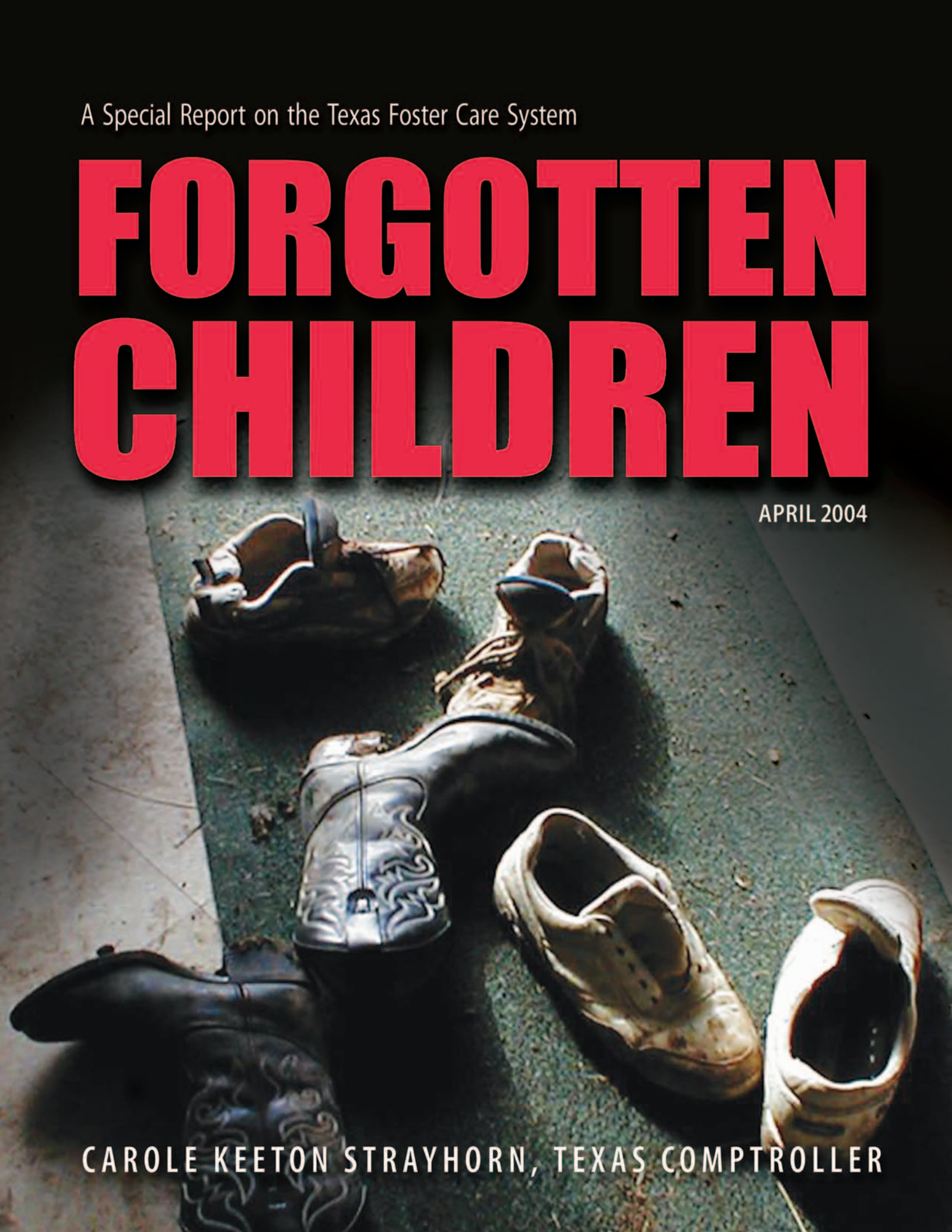
A Special Report on the Texas Foster Care System

FORGOTTEN CHILDREN

APRIL 2004



CAROLE KEETON STRAYHORN, TEXAS COMPTROLLER

Foreword

"They are everybody's children, and nobody's children. They are the forgotten children in the Texas foster care system. Some of them find homes with caring foster parents, or in treatment centers with experienced and caring providers. And some do not. Some foster children have been moved among 30, 40 or even more all-too-temporary "homes." Some have been sexually, physically and emotionally abused while in the system; some have run away and joined the ranks of the missing. A few have even died at the hands of those entrusted with their care. This report gives these children something they need—a voice."

—Carole Keeton Strayhorn
Texas Comptroller

Fellow Texans:

Like many other Texans, I have been disturbed by numerous published accounts alleging waste, fraud and abusive conditions in our state's foster care system. As Comptroller, I have a special obligation to consider such allegations, since it is my statutory duty to monitor the economy and the expenditures of this great state. Late last year, I launched an investigation in the hope of protecting these most vulnerable of our children. After many unannounced visits to foster care facilities and talking to children in the state's care, I realized that the scope of the problem goes far beyond what I had anticipated.

In Texas, we pride ourselves on taking care of our own. Today, we are failing at this task. Some Texas foster children receive the compassion and care they deserve, but many others do not. The heartbreaking truth is that some of these children are no better off in the care of the state than they were in the hands of abusive and negligent parents.

Each and every child in Texas deserves to be protected against violence and abuse. But too often, we are not meeting this minimum standard. Despite the untiring efforts of many well-meaning and caring individuals, a lack of effective oversight has allowed many Texas foster children to languish in care; to be shuttled among dozens of temporary residences; and even to suffer the same kinds of mistreatment they received in their own homes.

Our children are our most precious resource. We waste this resource when we do not nurture them and help them grow into strong and productive adults. Many of our foster children are physically and psychologically damaged. We must defend them against further injury.

It has been said that any society can be judged by how it treats its weakest members. My investigation shows that Texas can and must be judged harshly.

We are not doing all that is necessary to protect our children. Texas is great, but we can do better.

Sincerely,

Carole Keeton Strayhorn

Carole Keeton Strayhorn
Texas Comptroller

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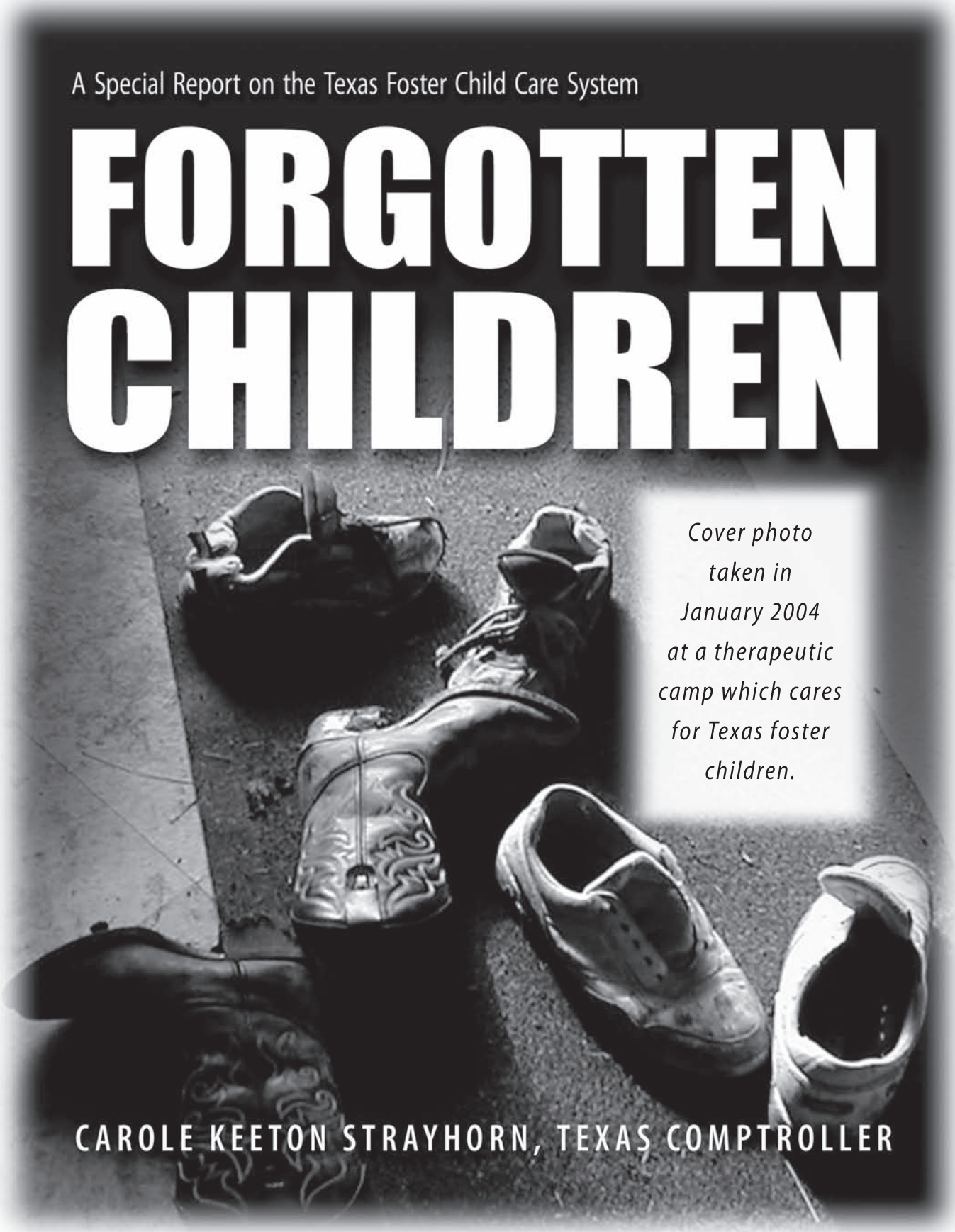


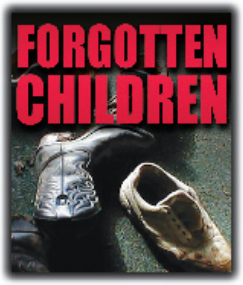
Cover photo taken in January 2004 at a therapeutic camp which cares for Texas foster children.

CAROLE KEETON STRAYHORN, TEXAS COMPTROLLER

PRIVACY NOTICE

This report was prepared to help Texas foster children. To ensure their privacy, their names have been changed and other information that might lead to their identification has been omitted. Concerned parents and foster parents provided much of the detail in the report's case studies.

Some of the information contained in this report is shocking, but is necessary to illustrate the dimensions of the problems facing Texas foster children so that we can do a better job of protecting them in the future.



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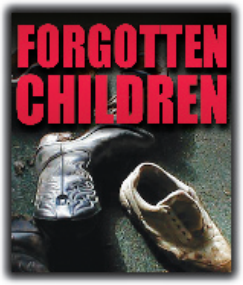


Crisis in Texas Foster Care

Introduction

They are everybody's children, and nobody's children. They are the forgotten children in the Texas foster care system.

Some of them find homes with caring foster parents, or in treatment centers with experienced and caring providers. And some do not.

Some foster children have been moved among 30, 40 or even more all-too-temporary "homes." Some have been sexually, physically and emotionally abused while in the system; some have run away and joined the ranks of the missing. A few have even died at the hands of those entrusted with their care.

This report gives these children something they need—a voice.

The mission of the Department of Protective and Regulatory Services (DPRS), now called the Department of Family and Protective Services, is to protect the unprotected—children, the elderly and people with disabilities—from abuse, neglect and exploitation. The system responsible for protecting our foster children sometimes is little better than the homes from which they were taken.

Some of these children are not safe, and their futures are uncertain. They didn't ask to be put in foster care, and many endured great suffering before entering the system.

Federal and state oversight agencies have reported on DPRS' troubles repeatedly, yet the problems remain. And simple patches will not fix them. Despite individual efforts by caring staff, foster parents and providers, the Comptroller's review team found that the foster care system is failing too many children, from their placement, care and monitoring to the business processes that support them.

The system reflects a legacy of weak leadership; an atmosphere of helpless acquiescence to the status quo; a reluctance to look too closely into dark corners; and a culture of self-protection and buck-passing.

DPRS' problems are many and varied:

- it uses limited taxpayer dollars inefficiently;
- it tolerates wide disparities in the quality of the services it purchases;
- it offers caregivers a perverse financial incentive to keep children in restrictive environments by paying them more money to provide children with expensive and restrictive placements, and offering them little incentive to help children return to their homes or become adopted;
- it operates an inefficient dual system of foster care, thus creating a conflict of interest in which the agency regulates itself;

- it fails to take advantage of opportunities to increase federal funding and develop innovative approaches to providing services;
- it frequently moves children from one caregiver to another, sometimes hundreds of miles apart, offering them little chance at stability;
- it relies on an antiquated placement system that requires caseworkers to make countless telephone calls to place children;
- it has a history of inadequate licensing standards, weak contract monitoring and ineffective licensing investigations that allow the same problems to continue festering at the same facilities for years, exploiting children as well as the state's finances;
- it holds some residential facilities to a lower standard than other residential facilities;
- it provides little accountability for disturbing amounts of psychotropic medications prescribed to foster children;
- its heavy caseloads and high caseworker turnover often prevent the agency from performing required visits with foster children;
- it mixes potentially dangerous children, such as sexual offenders and those with violent criminal records, with others;
- it often fails to adequately serve children with special needs, such as the medically fragile and children with mental retardation;
- it fails to address the educational needs of foster children;
- it has no good plan for preparing foster children for adulthood, or even for tracking what happens to them when they leave the system; and
- it does not survey foster children – their primary customers – as required by law.

On the bright side, there are facilities and providers in Texas that are doing good things for foster children. And it is important to highlight the bright spots.

Some facilities aggressively seek community support. Websites of these facilities list numerous ways "you can help or give." Ways to assist include monetary contributions, planned gifts, corporate partnerships, gifts in honor or memory and donations of clothing, books, shoes and diapers. Some providers sponsor golf tournaments, garage sales and other fund raising activities. These private providers also encourage community volunteers to assist children with activities, studies, holiday parties and meal preparation. One Emergency Shelter has the support of local professional chefs that prepare meals for foster children four times a week.

Yet other facilities have isolated themselves from their communities.

This report provides new and detailed information on a troubled agency. The Comptroller's office hopes that its findings and recommendations will gain the attention needed to make real changes in Texas foster care.

Texas taxpayers pay for foster care and have the right to expect that the state will do its part to ensure that foster children are safe and have a chance to build a prosperous future. The problems encountered while preparing this report run so deep and so wide that simple fixes will not work. And waiting will not do. The state must take *immediate* action, so that fundamental change can begin now.

CHAPTER 1

The Texas Foster Care System

The Texas Department of Family and Protective Services—until February 2004, the Texas Department of Protective and Regulatory Services (DPRS)—is charged with protecting Texas children from abuse and neglect. DPRS investigates reports of abuse and neglect and licenses and contracts with various providers to care for foster children.

The number of children in the Texas foster care system is growing each year. In fiscal 2003 alone, DPRS served 26,133 foster children. The pressures of a growing system, as well as the demanding and emotionally grueling nature of the work, have made it difficult for the agency to retain experienced caseworkers, and to ensure that each foster child receives regular caseworker visits.

Foster children often are moved from one placement to another, particularly those who remain in foster care for extended periods. The average foster child who remains in the system for ten or more years can expect to move about once a year. Some are moved even more frequently; in fiscal 2002, 12 foster children had been in 40 or more all-too-temporary "homes." Often, these placements are far away from their birth homes.

DPRS uses a system of "service levels" to categorize children according to their needs, and pays corresponding daily reimbursement rates for their care. The majority of foster children, 59 percent, are in the basic service level, most of them residing with foster families. Reimbursement rates range from $20 per day for children in the basic service level all the way up to $277 per day for children with the most complex needs.

In 2004, DPRS received $350.4 million in appropriations and supplemental funding for foster care reimbursements. These funds came from three roughly equal revenue sources: state general revenue, federal Social Security Title IV-E payments and federal Temporary Assistance for Needy Families funding.

The Texas Foster Care System

Texas state government has been formally charged with the protection of children since 1931, when the Legislature created a Child Protection Program within the Texas Board of Control. In 1974, the Texas Family Code was amended to make the Texas Department of Public Welfare responsible for providing services to abused, neglected, truant and runaway children. On September 1, 1992, such services became the responsibility of a separate agency, the Texas Department of Protective and Regulatory Services (DPRS).

To eliminate duplication and improve access to services, the 2003 Legislature approved a new law that consolidated 12 state health and human services agencies into five, and merged many of their administrative and support functions under the Health and Human Services Commission (HHSC), which manages and oversees the consolidated system. As part of this initiative, DPRS became the new Department of Family and Protective Services on February 1, 2004. The agency is still best known by its old name, however, and this report will retain the previous nomenclature.

DPRS is charged with protecting children, the elderly and persons with disabilities from abuse, neglect and exploitation. The agency has more than 6,300 employees working in more than 250 offices around Texas. It received $1.8 billion in appropriations from all funds for the 2004-05 biennium, of which General Revenue funds supplied nearly $484 million.

DPRS' Child Protective Services (CPS) Division is responsible for promoting the integrity and stability of Texas families; investigating reports of child abuse and neglect; and providing homes and various services for children who cannot safely remain with their own families. The CPS program is by far the agency's largest, accounting for $1.5 billion in all funds or more than 86 percent of DPRS' 2004-05 appropriations.[1]

DPRS licenses and contracts directly with foster parents, residential care facilities and child placement agencies (private entities that place children in foster homes on the state's behalf). It also manages various other programs intended to enhance the safety and well-being of Texas children.

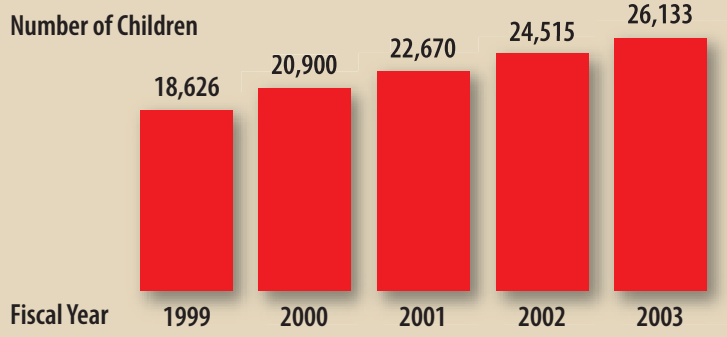
DPRS is charged with protecting children, the elderly and persons with disabilities from abuse, neglect and exploitation. The agency has about 6,800 employees working in more than 250 offices around Texas.

The Texas Foster Care Population

The annual number of Texas children in foster care has risen steadily in recent years (Exhibit 1). In November 2003, there were about 16,000 children in foster care and an additional 5,000 in other care, such as kinship care.[2]

Exhibit 1

Annual Number of Children In Foster Care Fiscal 1999 through 2003



Note: Totals include children in foster care paid from state and federal sources other than DPRS.

Source: Texas Department of Protective and Regulatory Services.

In fiscal 2003, DPRS spent $315.4 million on the daily care of foster children. These costs included daily room and board; medical expenses; and specialized therapeutic treatment for children needing extra attention.[3] An additional $30 million was spent for various services, such as evaluation, counseling and training, purchased exclusively for children in DPRS foster homes.

While DPRS attempts to find permanent placements for all of the foster children in its care, it does not always succeed. About 900 Texas foster children in state care "age out" of the system each year, leaving foster care when they become eighteen or upon graduation from high school.[4]

DPRS' foster care system includes both state-run and outsourced elements.

A Dual System

DPRS' foster care system includes both state-run and outsourced elements.

The state-run foster care system consists of foster families and group homes that are certified and maintained through contracts with DPRS. These contracts are administered through five district and 11 CPS regional offices. The regional offices function with a considerable degree of autonomy from the DPRS central office and can establish and manage contracts independently in accordance with agency rules and procedures. CPS employees directly recruit and train foster families and group home personnel for the state-run system.

Emergency shelters, residential treatment centers (RTCs) and therapeutic camps (for purposes of this report, therapeutic camps will be included in the RTC category, unless otherwise noted), and private child placing agencies (CPAs) that place foster children in family homes and foster group homes constitute the outsourced portion of foster care. Emergency shelters and RTCs provide training for the staff who work in their respective facilities. CPAs recruit and provide training for the foster families in their networks.

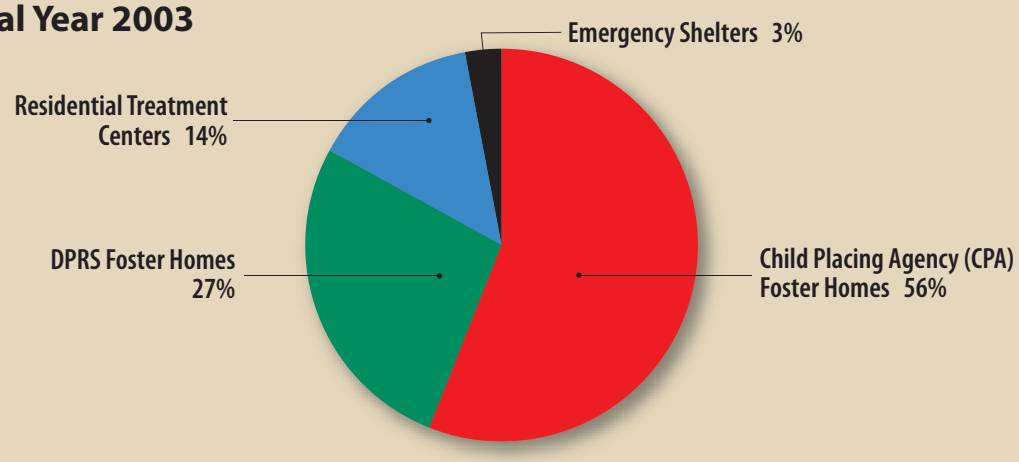
In fiscal 2003, the state-run side of DPRS' foster care operations provided 27 percent of total days of foster care delivered to individual children (Exhibit 2). Outsourced services provided the other 73 percent.[5]

Placement

CPS' policy is to place foster children in the "least restrictive" setting available that can meet their needs. For most children, this means a private home with foster parents.

When a court removes children from their homes because of abuse or neglect, it places them in DPRS' temporary managing conservatorship. The court reviews their cases

Exhibit 2
Total Paid Days in Foster Care
Fiscal Year 2003



Source: Texas Department of Protective and Regulatory Services.

through special "permanency hearings" held six months from the date on which DPRS received conservatorship and every four months thereafter, as long as the children remain in temporary managing conservatorship. If the court orders DPRS to be permanent managing conservator of a child, the court's oversight continues in the form of semiannual placement review hearings until the child is adopted or emancipated.

Foster care is meant to be a temporary situation, lasting only until the child can return home safely. The placement can become permanent, however, if a family cannot solve its problems sufficiently to allow its children to live in the family home without danger. In such cases, CPS can recommend to the court that the parent-child relationship be terminated and the child be placed with a permanent foster family, adoptive family or other caregiver.[6]

Some children enter the foster care system because their parents cannot meet their medical or behavioral needs. In such instances, the parents may voluntarily terminate their parental rights in order to place the children in DPRS' care. In fiscal 2002, 815 children fell into this "Refusal to Accept Parental Responsibility" category. From fiscal 1998 to 2002, an average of 772 children entered the system this way each year.[7]

Because many children coming into the foster care system have severe physical and emotional problems, DPRS first places them in an emergency home or emergency shelter for examination and assessment. Agency policy requires that each child entering its care receive physical, dental and psychological assessments within ten days. Other tests may be performed if deemed necessary by medical personnel.

According to DPRS, the agency tries to place children within the community from which they were removed to help ensure stability and facilitate family reunification, when appropriate.[8] This policy conforms to federal requirements that children be placed as close as possible to their city of origin, so that family and community ties can be maintained.[9]

DPRS, however, often places children well away from their hometowns. In theory, such placements should occur only when no closer provider is available or when a distant location is best positioned to respond to a child's specific needs. According to DPRS data, only 42 percent of children are placed in their home counties.[10] Interviews conducted by the Comptroller review team, however, indicate that many placement decisions are made by CPS caseworkers based on their relationships with providers.

Levels of Care and Service Levels

DPRS pays its care providers different rates for different types of service, depending largely upon each foster child's individual needs.

DPRS often places children well away from their hometowns.

DPRS contracts with Youth For Tomorrow (YFT), a nonprofit firm headquartered in Arlington, Texas, to assess children coming into the foster care system. YFT assigns them to service level categories that determine the environment in which they will be placed, the amount and intensity of services they will receive and how much the state will pay for their care.

YFT reviews the files of children referred to it by DPRS after their initial evaluation. In addition, YFT evaluates foster children's records periodically to determine if their service needs have changed. YFT performs these subsequent reviews at least annually, and quarterly in the case of children receiving more intense services.

DPRS selected YFT for this role through a competitive bidding process in 1990, and since then has retained the contract through three subsequent rounds of competitive bids. Its most recent contract, awarded in 2004, supplies the firm with $1.2 million annually.[11]

The organization completes about 3,900 initial service-level determinations and 21,400 service-level reviews each year.[12]

Exhibit 3
Level of Care Service System in Effect Until September 1, 2003

Level	Environment
LOC 1	Foster family environment that provides regular parenting.
LOC 2	Foster family environment with services that improve a child's functioning in one or more areas of occasional need.
LOC 3	Therapeutic foster family and group homes, residential treatment centers, therapeutic camps and halfway houses for children with repetitive minor problems in one or more areas of functioning.
LOC 4	Therapeutic foster family and group homes, residential treatment centers, therapeutic camps and residential programs licensed by the Texas Commission on Alcohol and Drug Abuse (TCADA) for children with substantial problems in one or more areas of functioning.
LOC 5	Residential treatment centers, therapeutic camps, residential group care facilities serving mentally retarded children and residential programs licensed by TCADA for children with severe problems in one or more areas of functioning.
LOC 6	Residential treatment centers, inpatient psychiatric hospitals or homes for mentally retarded or autistic children with one or more severe impairments, disabilities or needs and who are unable or unwilling to cooperate in their own care.

Source: Summarized from Texas Department of Protective and Regulatory Services, Child Protective Services Handbook, Appendix 6340.

In addition, YFT performs more than 200 on-site reviews of foster care providers each year to ensure that they can meet DPRS' standards for the provision of moderate, specialized and intensive services. These reviews typically involve a small number of interviews with caregivers and foster children.[13]

Until September 1, 2003, DPRS provided separate reimbursement rates for six "levels of care," or LOCs, reflecting increasingly difficult and correspondingly more specialized and expensive treatment needs for children (Exhibit 3).

The 2003 Legislature directed DPRS to redesign the LOC system to one based on services provided, in order to save $22.2 million annually in foster care payments. Effective September 1, 2003, DPRS consolidated the six levels of care into four "service levels"—basic, moderate, specialized and intense. To do so, the agency combined LOCs 1 and 2 (the lowest levels in terms of resource intensity and cost) to form the "basic" service level; combined LOC 3 with the less-aggressive population in LOC 4 to form "moderate"; combined the more-aggressive segment of the LOC 4 population with LOC 5 to form "specialized"; and renamed LOC 6 as the "intense" service level (Exhibit 4).

A child with a basic service classification typically will be placed with a foster family, the least restrictive environment DPRS offers, while a child with a specialized or intense classification usually will be placed in an RTC.

Exhibit 4
Service Level System Implemented September 1, 2003

Service Level	Corresponding Level of Care Classification
Basic	LOC 1, 2
Moderate	LOC 3, less aggressive children from LOC 4
Specialized	More aggressive children from LOC 4, LOC 5
Intense	LOC 6

Source: Texas Department of Protective and Regulatory Services.

Exhibit 5

Foster Children by Provider Classification and Level of Care Fiscal 2003

	LOC 1	LOC 2	LOC 3	LOC 4	LOC 5	LOC 6	TOTAL
DPRS Foster Homes	7,783	412	149	107	0	0	8,451
Residential Treatment Facilities	252	148	484	643	1,018	268	2,813
Child Placing Agency Foster Homes	3,454	1,736	4,164	2,697	1	0	12,052
TOTAL	**11,489**	**2,296**	**4,797**	**3,447**	**1,019**	**268**	**23,316***

*Note: 2,146 children were served in emergency shelters and homes; 671 children were served in placements outside the foster care system, such as nursing homes, mental health/mental retardation facilities, hospitals and juvenile justice facilities.
Source: Texas Department of Protective and Regulatory Services.

The state-run portion of the foster care system caters largely to children in the lowest service levels, who can be served by foster families and group homes. Children with greater needs generally are served at higher service levels, in facilities run or contracted by private child placing agencies and RTCs (Exhibit 5).

DPRS policy requires caseworkers to try to limit the movement of children from one placement to another. Even so, children may be moved due to changes in their service levels, behavioral or medical concerns, lack of permanent placement commitment from foster parents, violations of licensing standards by providers or specific court rulings.

At the end of fiscal 2003, Texas children in foster care had experienced an average of four different placements each. Those remaining in foster care for a decade or more could expect to be moved about once a year (Exhibit 6). In fiscal 2002, 12 children had 40 or more total placements.

Texas children in short-term foster care (temporary conservatorship), lasting up to 18 months, experience an average of 2.5 placements. Children in long-term foster care (per-

Exhibit 6

Snapshot of Average Number of Placements For Children in Foster Care As of August 31, 2003

Time in Care	Total Children	Average Number of Placements
0-12 months	6,320	1.9
13-18 months	1,903	2.9
19-24 months	1,326	3.7
2 years	1,841	4.4
3 years	1,247	5.6
4 years	801	6.5
5 years	550	7.3
6 years	365	7.8
7 years	283	8.8
8 years	252	8.7
9 years	230	8.2
10 years or more	591	9.7
Total	**15,709**	**4.0**

Source: Texas Department of Protective and Regulatory Services.

manent conservatorship), which can stretch from one to ten years or more, experience an average of 8.8 placements. The longer children are in foster care, the more placements they are likely to have.

DPRS pays providers of residential foster care a flat daily rate based on the intensity of service needed by a child. Reimbursement rates rise with levels of service. For fiscal 2004, the range of payments starts at $20 a day for basic care by a foster family and rises to $202 per day for intense services delivered in RTCs. Daystar, an RTC in Manvel, Texas, receives a special rate of $277 per day for children with the most intense needs.

Exhibit 7 details the rates DPRS will pay its care providers in fiscal 2004 and 2005.

Child placing agencies (CPAs), in turn, must pass through a portion of these payments to the foster families and group homes with which they contract, at the following minimum rates: basic, $20; moderate, $35; and specialized, $45.[14] With the remaining "administrative" portion of the rate, CPAs must also provide the supplemental therapies, respite care, training and other support for foster families.

CPS Funding

Over the past five years, DPRS expenditures for foster care payments and adoption subsidies; child and family services, including investigations and child placement; and purchased service contracts have increased. From 1999 to 2003, expenditures for foster care payments and adoption subsidies rose by 73 percent. Child and family services and

Exhibit 7

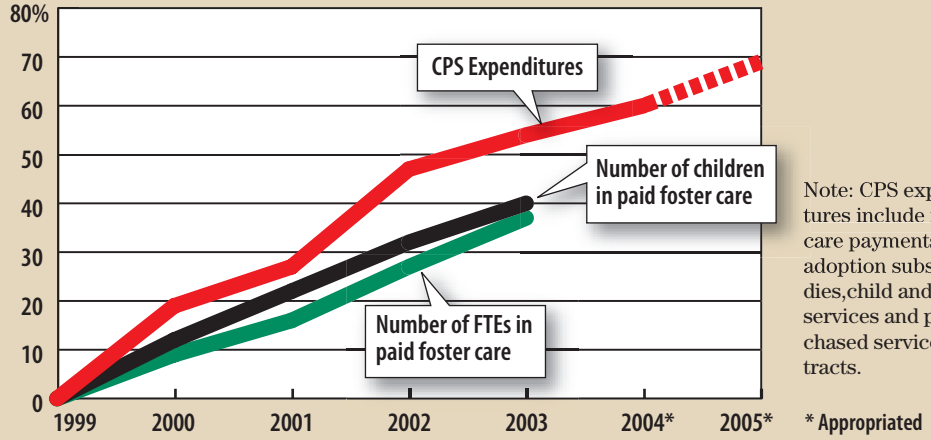
Foster Care Daily Reimbursement Rates For Fiscal 2004 and 2005

Rate Structure	FY 2004	FY 2005
Basic Foster Family	$20.00	$20.00
Basic Child Placing Agency	$36.00	$34.00
Basic Residential Treatment Center	$36.00	$34.00
Moderate Foster Family	$35.00	$35.00
Moderate CPA	$65.50	$65.00
Moderate RTC	$80.00	$80.00
Specialized Foster Family	$45.00	$45.00
Specialized CPA	$87.25	$85.00
Specialized RTC	$115.00	$115.00
Intense RTC	$202.00	$202.00
Six Plus/Exceptional Care	$277.00	N/A
Emergency Shelter*	$94.00	$90.00

*Temporary placements; not considered a separate service level.
Source: Texas Department of Protective and Regulatory Services.

Exhibit 8

Increase in CPS Expenditures and Number of Children



Note: CPS expenditures include foster care payments and adoption subsidies,child and family services and purchased service contracts.

* Appropriated

Sources: Legislative Budget Board and Texas Department of Protective and Regulatory Services.

purchased services spending rose by 31 percent and 37 percent, respectively.

The number of children in foster care has risen as well. From fiscal 1999 to 2003, the total number of children in foster care rose by 40 percent (Exhibit 8).[15]

Due to the fact that children spend varying lengths of time in foster care, however, a more appropriate measure of children for expenditure analysis is full-time equivalents (FTEs). For the purpose of this analysis, a single child in foster care for 30 days can be considered to represent one FTE, as would three children who each spend 10 days in foster care. Exhibit 9 shows the relation between total children and FTEs. Over the past five years, the number of FTEs has increased by 37 percent.

Foster care reimbursements have risen more rapidly than the foster care population, due in part to an increase in reimbursement rates in fiscal years 2000 and 2002 (Exhibit 10).

Purchased service contract expenditures increased by 36 percent between fiscal 1999 and 2000, due to the transfer of the Communities in Schools program from the Texas Workforce Commission to DPRS.

The 2003 Legislature increased 2004-2005 appropriations for foster care payments and adoption subsides while slightly reducing the amounts set aside for child and family services and purchased service contracts. The agency's appropriation for foster care payments is $350.4 million, including nearly $6 million in supplemental funding, for fiscal 2004 and $370.5 million for fiscal 2005.[16]

Exhibit 9

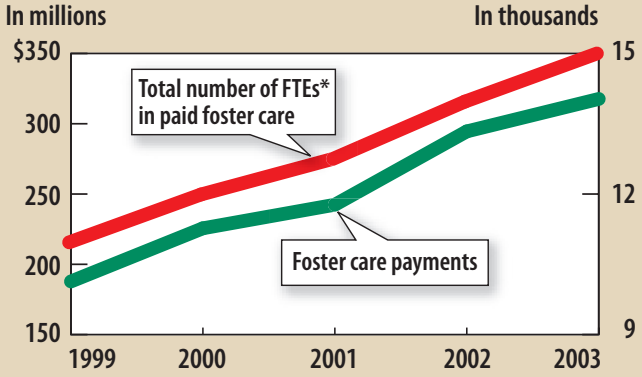
Children in Texas Foster Care, Based on Full-Time Equivalents (FTEs)* Fiscal 1999-2003

Fiscal Year	Total Number of Children in Paid Foster Care	Total Number of FTEs* in Paid Foster Care
1999	18,626	10,969
2000	20,900	11,991
2001	22,670	12,751
2002	24,515	13,973
2003	26,133	14,999

*One FTE equals one month's residence in foster care.
Source: Texas Department of Protective and Regulatory Services.

Exhibit 10

Foster Care Payments and Foster Care Population Fiscal Years 1999-2003



*One FTE equals one month's residence in foster care.
Source: Texas Department of Protective and Regulatory Services.

The appropriated amounts for foster care payments assume a savings of $22.2 million annually. To achieve these savings, Rider 21 of the 2003 General Appropriations Act required DPRS to redesign the level of care system to one based on the service needs of foster children.[17] In response, DPRS combined six levels of care into four service levels (Exhibit 4) and assigned new foster care rates (Exhibit 7).

While rates have increased for some children, others have decreased. Savings in foster care payments for fiscal year 2004 are projected to be greater than the required $22.2 million. DPRS has projected a savings totaling $35.2 million as a result of having fewer children in foster care than expected.[18] Youth for Tomorrow (YFT), however, has projected an even greater amount of savings for fiscal year 2004. YFT indicates that a total of $40.1 million will be saved as a result of the change in levels of care.[19]

Funding Sources

Texas foster care funding relies primarily on three roughly equal revenue sources: the federal Social Security Title IV-E program (Title IV-E), federal Temporary Assistance for Needy Families (TANF) block grants and state general revenue. Title IV-E is a matching program that pays room and board for children in foster care. The federal government provides 60 cents of every dollar spent for services, with the state supplying the remainder. DPRS administers Title IV-E in Texas. TANF, the current vehicle for federal welfare funding, provides assistance to needy families and support programs designed to strengthen families and promote job preparation, work and marriage.[20]

In addition, all children in foster care are eligible for Medicaid services. Specialized DPRS staff review cases and qualify children for Medicaid, Title IV-E funding and Supplemental Security Income (SSI), which provides cash assistance for the aged and disabled.[21]

Caseworkers and Case Plans

DPRS assigns a caseworker to each child entering foster care. These caseworkers are supposed to ensure that children are in safe and appropriate settings and receive the care they need. The importance of this role can hardly be overstated; caseworkers have an obligation to see that children's needs are met.

After children are assigned to a service level, their caseworkers work to find them appropriate homes. In some cases, children go to CPS foster homes. In others, DPRS contracts with private child placing agencies or RTCs to find an appropriate placement, including treatment options for the child. The caseworkers also must prepare a case plan for each child.

The case plan should contain a number of items, including a detailed "common application" describing the child's needs and case history and any other known facts about the child. The case plan also should specify the type of environment in which the child can be placed; a treatment regimen developed from physical and psychological assessments performed immediately after removal from the home; a parent-child visitation schedule, as determined by the court; and a "legal permanency goal," or the desired permanent disposition of the case.

Within 45 days of the child's initial placement, the initial case plan must be reviewed and ap-

proved by a permanency planning team (PPT) made up of any adult who provides care or services towards the child's treatment, as well as the person who can legally speak on the child's behalf, such as a guardian or attorney. Typically, a PPT will include the caseworker, the child's attorney, the foster parent or care provider, any therapists the child is seeing and the biological parent or parents, if the court has not terminated parental rights. A trained DPRS "convener" facilitates this review.

Subsequent PPT reviews are held after the child has been in care for five months, nine months and every six months thereafter, or more frequently if the child's circumstances change. When possible, these reviews precede court hearings.[22]

Caseworker visits and turnover

DPRS policy requires caseworkers to visit the children in their care at least once a month, and to visit them at their places of residence at least every three months.[23] Interviews with providers and DPRS statistics, however, indicate that caseworkers are not visiting children as often as they are required to. Caseworkers are responsible for ensuring that each child receives all treatment services deemed necessary by his or her case plan.

According to DPRS, the agency has a relatively low caseworker-to-supervisor ratio—six to one—to ensure that caseworkers have the supervisory and administrative support they need to do their jobs. For the most part, supervisors do not perform the direct client services provided by caseworkers, but instead supervise caseworkers and monitor their case files to ensure that they meet agency standards.

CPS caseworkers often are recent college graduates who find themselves in a very stressful environment with high caseloads. According to the 2002 DPRS State Plan, caseworkers handle an average of 21 cases each. Interviews with district directors, however, indicated that at times, some caseworkers are responsible for as many as 35 or more children.[24]

High workloads, coupled with the emotionally intense nature of the position and low salaries, often lead to "burnout," and many caseworkers do not stay with the job for long. In fiscal 2003 alone, 23.5 percent of DPRS' caseworkers left the agency.[25]

Licensing

DPRS can contract for residential foster care only with facilities licensed by the DPRS Child Care Licensing Division (CCL), which enforces minimum standards to ensure the basic health and safety of children in residential care.[26]

State law requires CCL personnel to inspect each facility caring for Texas foster children and to make at least one unannounced visit each year, to ensure that facilities meet DPRS minimum standards of care. The standards cover all facets of an operation, including organization and administration, staffing and training, service management, child behavior management, general child care and health and safety.[27]

DPRS statistics indicate that caseworkers are not visiting children as often as they are required to.

DPRS policies also require that CCL examine some facilities more frequently, such as those that have a higher frequency of violations.[28] In addition, state law requires that CCL investigate each report of a possible licensing violation, including instances of abuse and neglect. The division was responsible for inspecting more than 600 facilities and conducted investigations of about 2,800 complaints in fiscal 2003. Of these, nearly 1,000 investigations involved abuse and neglect allegations.[29]

DPRS has not significantly updated its licensing standards since the 1980s, but at this writing is drafting major revisions.[30]

Contracts

DPRS' Contract Management Division develops and manages statewide contracts for the agency. Legislation enacted by the 2003 Texas Legislature requires HHSC to absorb all health and human services contract functions into the Health and Human Services Commission, but it has not yet done so.[31]

Child Protective Services' contracts fall into two major categories: residential services contracts and purchase of services (POS) contracts.

Residential contracts require private caregivers to provide DPRS-referred children with an array of services including daily childcare, appropriate educational, recreational and vocational activities, behavior management and diagnostic services and medical care. The Contract Management Division managed 295 residential contracts across the state worth a budgeted $285 million in fiscal 2003.[32]

POS contracts are used to obtain services for DPRS staff, such as training for staff and foster parents and YFT evaluations, and services such as psychological counseling and psychiatric care for children under the agency's direct care. DPRS received $93 million in appropriations for POS contracts for 2004-05.[33]

DPRS, like all agencies under the administrative guidance of the Health and Human Services Commission, is exempted from most general state purchasing requirements. Since the September 1, 2003 reorganization of health and human services, agencies under the HHSC "umbrella" must follow the commission's guidelines, which require agencies to document that their purchasing decisions consider a number of factors including costs, quality, reliability, value and probable vendor performance.[34]

DPRS conducts "open-enrollment" contracting. In practical terms, this means that any individual or facility that meets minimum DPRS licensing requirements and receives a DPRS license can seek contracts to provide residential care without undergoing a bidding process.

DPRS policy states that contract managers must visit each contracted facility's site annually. In addition to this visit, their contract renewal decisions depend heavily on CCL inspections and investigations. Contract managers consult a computer database to review each facility's licensing status and violation history.

In addition, CCL workers may notify contract managers informally through email or telephone correspondence when serious licensing violations, such as incidents of child abuse, occur in a contract facility. CCL staff may place providers on probation when considering whether to revoke their licenses, but caseworkers do not always stop placing children there, depending upon whether they consider the children's health or safety to be at risk.[35]

Endnotes

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[20] U.S. Department of Health and Human Services, Administration for Children and Families, "Helping Families Achieve Self-Sufficiency: A Guide on Funding Services for Children and Families through the TANF Program," www.acf.dhhs.gov/programs/ofa/funds2.htm. (Last visited January 30, 2004).

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CHAPTER 2

Raise the Bar on Quality

Texas foster children receive care that often varies in quality from provider to provider. Some caregivers supply high-quality care and others do not—but every provider who meets DPRS licensing and contracting standards receives the same daily reimbursement rates for each level of service.

DPRS operates a dual system of foster care, one run directly by the state and the other provided by private contractors. Private caregivers dominate, providing 73 percent of all paid days of care delivered.

This dual system should be eliminated. DPRS should not be in the business of providing direct care when it also bears responsibility for regulating caregivers. The present situation creates a classic conflict of interest, in that the agency in effect is required to regulate itself. Eliminating this conflict would allow the agency to better focus on its all-important role of guaranteeing the health and safety of foster children. This transition should be phased in over a three-year period beginning in fiscal 2005.

Eliminating the relatively small state-run system would give private child placing agencies responsibility for placing all children in foster care. Case management activities should be shifted to the private sector as well, to allow DPRS to concentrate on improving the quality of care delivered to all foster children.

DPRS must strengthen its licensing and contract standards and monitoring activities immediately, before the elimination of the state-run system.

DPRS' contracts should require the delivery of high-quality foster care for all children; contractors that perform poorly should not again receive state contracts. A foster care performance team should develop criteria for outcome-based contracts and measurable outcomes for residential care. Payment methods should be revised to create financial incentives for reducing foster children's lengths of stay and institutionalization.

The Dual System

Eliminate the inefficient dual foster care system and direct savings to DPRS for system oversight.

Background

DPRS' foster care system includes both state-run and outsourced elements.

The private foster care system in Texas provides care at a lower cost than the public foster care system.

DPRS' Child Protective Services (CPS) Division is responsible for protecting children from abuse and neglect; promoting the integrity and stability of Texas families; and providing permanent homes for children who cannot safely remain with their own families.

To serve the needs of children in the state's custody, DPRS operates a dual public and private foster care system that contracts directly with foster parents as well as with private providers that obtain care for foster children on the state's behalf.

The dual—public and private—foster care system is duplicative and uses the agency's limited resources inefficiently. The public foster care system consists of foster families and group homes that contract directly with DPRS. DPRS employees recruit and train these caregivers. DPRS monitors all Child Placing Agencies (CPAs), RTCs and emergency shelters in private foster care. DPRS monitors children placed in the foster care system through its foster care caseworkers and DPRS case management activities which include:

- ensuring that children in foster care receive the services they need to become physically and emotionally healthy;
- placing children in foster homes or facilities;
- visiting children regularly;
- working with families to help resolve their issues so that all members can be safe from abuse or neglect;

Reasons to Complete the Outsourcing of DPRS Foster Care Provider Services

- DPRS should not be both service provider and regulator.
- The primary function of DPRS is to protect children through licensing and investigation; providing care blurs DPRS' focus.
- Outsourcing helps to establish local responsibility for foster children.
- Outsourcing will mean fewer contracts for HHSC and DPRS to manage and will promote efficiency.
- Outsourcing passes the Yellow Pages Test—the state should not provide services that the private sector can provide better and at a lower cost.
- There is excess capacity in the private sector to meet the needs of foster children.
- State-run care duplicates functions that are already performed in the private sector.
- By outsourcing the entire foster care system, the state can more effectively use its limited resources.
- By using quality contracting, services provided to children now in the state-run foster care will be focused on quality outcomes.

Exhibit 1

Number of Paid Days and Amount Spent on Foster Care
Fiscal 2003

	Paid Days	Percent of Paid Days	Amount Paid	Percent of Total Payments
Emergency Shelters	150,368	3%	$12,988,479	4%
Residential Treatment Centers	803,316	14%	$79,535,755	25%
Child Placing Agencies	3,094,482	56%	$191,845,354	61%
DPRS Foster Families and Group Homes	1,516,647	27%	$31,059,576	10%
TOTAL	**5,564,813**	**100%**	**$315,429,164**	**100%**

Source: Texas Department of Protective and Regulatory Services.

- helping to prepare children for placement with a relative or an adoptive parent or long-term placement in the foster care system when family reunification is impossible; and
- serving as an advocate for the child and speaking on his or her behalf in court hearings.

The private foster care system consists of nonprofits, for-profit entities and faith-based organizations. These entities recruit, train and monitor the caregivers with whom they place children.

Private foster care entities fall into three basic categories: child placing agencies (CPAs) residential treatment centers (RTCs) and emergency shelters. They provide a range of placement options including emergency shelters and assessment centers, foster families, group homes, therapeutic camps and institutional facilities.

CPAs and RTCs have caseworkers just like CPS. At present, however, their case management activities are restricted to providing daily care and advising on long-term planning for the child. CPAs and RTCs, for the most part, have not been allowed by DPRS to work with the children's biological families, present reports at court hearings or, most importantly, to have input on decisions about placement and treatment. Beyond providing daily care, the role of CPAs and RTCs is at best advisory even though they may have better information about the children in their care.

In fiscal 2003, CPAs, RTCs and emergency shelters accounted for about 73 percent of all paid days of foster care and 90 percent of all foster care payments. As Exhibit 1 shows, the Texas foster care system is largely outsourced today.

System Costs

CPA foster homes provide basic foster care at a lower cost than do DPRS foster homes. DPRS reimburses all foster caregivers on a per-day, per-child basis. Its payments to CPAs and RTCs, however, cover services that payments to DPRS-contracted foster homes do not.

For example, CPA and RTC payments cover the costs of services such as counseling, evaluation, testing, case planning, case management, foster home recruitment and foster family training. DPRS' payments to the foster families and group homes of the state-run side of the system do not cover such services; the agency must purchase services for its foster families separately.

In fiscal 2003, DPRS spent more than $30 million to purchase additional services for children in state-run foster care.[1] In addition, DPRS employs 128 caseworkers and seven

supervisors to recruit and train foster families and group home personnel, at annual payroll costs totaling more than $6,283,000 excluding benefits.[2] Another 814 caseworkers, 49 supervisors and 57 administrative technicians administer foster care and oversee children in both the public and private sides of the system, at an annual payroll cost totaling more than $30,421,000 excluding benefits.[3]

A March 2003 report by the Texas State Auditor's Office (SAO) compared the cost of public versus private foster care. SAO found that DPRS' use of private entities to provide foster care has doubled since 1998. SAO also concluded that, after accounting for all services and costs, CPAs provide basic foster care at a slightly lower cost than do DPRS foster homes.

The report indicated that CPAs provide basic-level foster care, including various additional services, for $1.21 to $2.29 less per day, per child than do DPRS foster homes, and yet tend to pay foster families more. According to the study, CPAs pay their foster parents an average of 17 percent more than the rate DPRS pays to the foster homes with which it contracts.[4]

According to one CPA, DPRS indicated in February 2004 that in response to budgetary cuts, it would attempt to first place children in DPRS foster care and adoptive homes because they believe it to be more cost efficient.[5]

While higher payments to foster parents do not directly translate into a higher quality of service, they do help guarantee that a reliable pool of caregivers will be available.

Unequal Accountability

DPRS certifies its 11 regional CPS offices as child placing agencies, which allows the agency to operate its own system of foster homes.[6] As with the private CPAs, CPS is subject to regular DPRS inspections of its homes.[7] And, again like the CPAs, the CPS regional offices recruit, train and monitor their own foster homes.

Private CPAs, however, have stated that DPRS does not enforce licensing standards with the same rigor for DPRS foster homes as it does for private CPAs and their homes. Private CPAs say this is especially true for therapeutic foster care.[8]

Other state agencies have separated these roles because when an agency provides both services and contracts for the same service, the agency tends to hold itself to lower standards than the contracts and to favor its own entities. For example, MHMR has separated the roles of provider and contractor for local mental health and mental retardation authorities. A task force formed to review this issue noted that when a local mental health and mental retardation authority acted as both a direct provider of services and a contractor for such service that a conflict exists that makes the playing field uneven and affects consumer choice. The local MHMR authorities both controlled the number and types of providers within their areas and had the last word on where a client would be served.[9]

Moreover, since CPS and CCL are divisions of DPRS, the agency in effect is regulating itself, creating a significant potential for conflicts of interest.

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Changing the System

In 2001, DPRS created a public/private initiative called the Strength Through External Partnerships (STEP) to develop a vision for the agency for the new millennium. Using funding provided by the Casey Foundation, DPRS, private foster care agencies and child welfare experts from the Child Welfare League of America (CWLA) recommended that all foster care services be delivered through contracted providers.[10] The DPRS response to the STEP report was that further study would have to be done on the issue of providing all foster care services through contracted providers.[11]

DPRS district directors told the Comptroller review team that they do not oppose the use of private foster care agencies and would not oppose outsourcing the entire foster care system if it proved to be cost-effective. They noted that DPRS attempted to outsource its

foster care activities in the Fort Worth area through its Permanency Achieved through Coordinated Efforts (PACE) program, which ran from September 1998 to March 2001.

DPRS paid a private child placing agency, the Lena Pope Home, Inc., a fixed per-diem amount to treat all foster children with therapeutic needs in a 10-county region of North Texas. The initial per-child, per-day rate (also called a capitated rate) of $72.40 was calculated based on historical payment data for the area. The pilot ended when the Legislature did not provide additional funding to make the program feasible for the PACE contractor.

The goals of the project were shorter stays in foster care, fewer moves between placements and the maintenance of "least-restrictive" placements.[12] PACE attempted to place foster children in foster care homes, rather than in shelters, and to provide therapeutic support to allow children with greater needs to stay in such homes rather than in residential facilities. PACE also arranged adoptions for children who had been in foster care for years.

The official program evaluation of the first two years of the PACE project did not show better outcomes for these children than for a statewide matched control group.[13] This comparison may have been flawed, however, given the difficulties inherent in creating such a "matched group," and the relatively small number of cases involved.[14] Numerous problems with DPRS' execution of the program also may have skewed the results.

The original PACE proposal projected a program population of 200 foster children per month. In reality, the project averaged 432 children per month because the contractor was required to take all children in the 10-county region and DPRS' projections underestimated the number involved.[15] This doubled the provider's costs and workload. In addition, the PACE provider was forced to establish an unexpectedly large network of providers to deliver therapeutic services.

Before the PACE project began, moreover, DPRS did not allow its private contractors to claim Medicaid reimbursements directly from the federal government. All medical costs were to be covered by the daily rate; DPRS then would pursue Medicaid reimbursement to defray the state's costs. As part of the PACE project, DPRS allowed the Lena Pope Home to claim Medicaid reimbursements, giving the contractor an additional source of revenue.

During the course of the project, however, DPRS changed its rules and began encouraging all foster care providers to claim Medicaid reimbursement. This allowed providers outside the PACE network to receive higher reimbursements than those in the PACE network, since the Lena Pope Home was retaining the Medicaid reimbursements for children in the project. From the caregivers' perspective, participating in PACE was less profitable than remaining outside the subcontractor network.[16]

Focus group participants in the PACE evaluation had other criticisms, noting that:

- the time period allotted for program planning and startup was insufficient;
- DPRS' Austin office conducted most of the planning for the project, and may not have considered or understood local conditions adequately, since court practices and procedures often vary considerably from county to county;
- community participants such as judges, advocates and volunteers often learned about PACE only when it affected a child or family with whom they were working. This lack of advance knowledge about the project caused some to view it negatively; and
- DPRS Child Protective Services staff worried that PACE might eliminate their jobs, and received little information or training on their roles in the project, while at the same time, their work responsibilities increased.[17]

The PACE pilot project ended when the Legislature declined to give DPRS additional fund-

ing to allow the Lena Pope Home to increase the rates it paid to its subcontractors.[18]

The DPRS district directors told the review team that the PACE project was a good idea but failed to produce anticipated savings for the state. Some of the project's benefits included the development of standardized forms and training for DPRS and the CPA. Moreover, DPRS and the Lena Pope Home successfully collaborated to ensure that the project addressed the best interests of each child in the project.

The district directors generally believe that outsourcing the entire foster care system is a good idea, but they noted that it could prove difficult to persuade CPAs to assume responsibility for basic-level children since the reimbursement rate is so low for this group.[19]

In interviews with Comptroller staff, however, some CPA representatives voiced no concern over the reimbursement rate and called it sufficient to provide the necessary care. They did, however, criticize the way DPRS handled the PACE project. Providers who participated in PACE said that the project simply added another layer of bureaucracy to the system while making participation financially undesirable.[20]

System Capacity

The private sector has sufficient statewide capacity to care for all children in the foster care system. Most foster care agencies around the nation use some sort of outsourcing to either supplement or provide all of their foster care. As noted above, in Texas 90 percent of all foster care dollars already go to private foster care agencies.

In fiscal 2003, the foster care system cared for more than 26,100 children; however, the average number of children in care per month in fiscal 2003 was 16,214.[21] According to DPRS, during fiscal 2003, CPA foster family and group homes cared for 8,250 children in August, the highest monthly total for that year. During that same period, CPS foster family and group homes cared for 4,155 children. In other words 12,405 children during this period were placed in either foster family or group homes.

As shown in Exhibit 2, the number of licensed beds in fiscal 2003 CPA foster and group homes was 19,720. Statewide, this means that the CPAs could have cared for all of the children in the foster care system that were placed in either a foster family or group home and still had more than 7,300 empty beds.[22]

This excess capacity was confirmed through a Comptroller review team survey of the nine largest CPAs, which showed they had capacity for another 2,270 children immediately.[23] According to the executive director of the Texas Alliance of Child and Family Services, a nonprofit organization representing private agencies and individuals that serve children and families in Texas, "Private non-profit agencies have increased the capacity of private foster homes by 20 percent over the past two years, while the number of state operated foster homes has remained stable."[24]

The private sector has sufficient statewide capacity to care for all children in the foster care system.

Since CPAs pay foster families more on average than does DPRS, their ability to recruit additional families is enhanced.[25] Many CPAs use charitable donations and fundraising to supplement the per-day rate they pay their foster care providers. DPRS has not been able to tap into these community resources effectively.

The use of CPAs and their community and philanthropic connections could provide augmented funding for services to children and allow DPRS to focus on its primary goal of protecting vulnerable populations.

Lessons from Kansas

Kansas was the first state in the nation to completely outsource its adoption, foster care and family preservation programs and shift them to a managed care or "capitated" payment method.[26] On March 1, 1997, private agencies assumed responsibility for all foster care services in Kansas. The Kansas Department of Social and Rehabilitation Services monitors these entities to ensure program quality.[27]

The state's effort included performance-based contracts with private service providers. Three large private, nonprofit agencies initially received contracts to provide foster care, adoption and family preservation services for a one-time payment of between $13,000 and $15,000 per child.[28] Today, five private lead agencies subcontract with 25 nonprofit providers to offer foster care services and programs in Kansas.[29] The University of Kansas works with the Department of Social and Rehabilitation Services to provide training and evaluation services for the private agencies.[30]

The change from state to privatized adoption and foster care was accompanied by considerable public controversy and systemic problems.[31] According to Kansas Action for Children, an advocacy group for children's welfare issues, the managed care model had several problems, the foremost being a lack of attention to prevention programs and services that keep children out of foster care in the first place. Other problems included:

- lack of an inclusive planning process involving all concerned parties;
- hurried implementation and no experimentation using pilot projects;
- lack of historical cost data to develop case rates; and
- lack of a pool of child welfare staff that could be hired by contractors.[32]

Kansas Action for Children recommended that the state strengthen its prevention programs; require service providers to offer a range of services, from foster family placement to residential treatment centers to specialized therapeutic services; give foster children better representation in the state court system; refine and strengthen outcome and performance measures; improve its communication with and training of foster parents; improve transition programs designed to ensure that foster children can enter the adult world successfully; and create initiatives to increase the adoption of special-needs children.[33]

In 2003, the Child Welfare League of America (CWLA) released a report analyzing Kansas' outsourcing efforts. The report found that the speed with which Kansas changed its foster care system—moving to full outsourcing in one year—caused significant cash flow problems for some private contractors. The report identified four major issues that should be taken into account by other states contemplating a similar system:

- rapid systemic changes are not advisable;
- reliable cost data are crucial;
- outsourcing will not necessarily control costs; and
- outcomes and performance measures are critical and must be refined based on experience.[34]

Exhibit 2

Number of Licensed Beds in the Texas Foster Care System Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
DPRS Foster Family and Group Homes	11,010	12,177	10,647	10,532	9,961
CPA Foster Family and Group Homes	11,857	13,351	15,371	18,131	19,720
Residential Treatment Centers	11,601	11,750	11,534	10,608	11,802
TOTAL	**34,468**	**37,278**	**37,552**	**39,271**	**41,483**

Source: Texas Department of Protective and Regulatory Services.

While the transition to outsourcing was difficult, Kansas now has one of the nation's best systems for collecting data and measuring the system's successes and shortcomings.[35] The "managed care" model, which paid a flat rate per child, was changed in July 2000 to a system that reimburses contractors monthly based on the number of children they serve, to help caregivers avoid cash flow problems. In addition, the state revised contract outcomes and performance goals to better focus on meaningful improvements in care.[36]

The CWLA report attributes many successes to Kansas' move to outsourcing. According to the CWLA, in the six years in which Kansas has operated its new system, service levels between rural and urban areas have become more equitable; children now move through the foster care system more quickly; the number of adoptions has increased; children and families surveyed report positive experiences with care providers; state employment has been reduced, lowering public costs; and data collection techniques and systems have improved.[37]

According to the Kansas Children's Service League (KCSL), one of the lead CPAs in Kansas, the new system has produced a number of positive outcomes:

- the use of residential and institutional facilities and group home settings has been cut in half, in favor of family homes;
- the number of adoptions has quadrupled;
- disruptions in placements and recidivism (return to foster care) have fallen by 50 percent;
- children are placed closer to their birth homes, so that family members can be involved in counseling efforts; and
- kinship care (full-time care by someone related to the child by family ties or a significant prior relationship) and kinship involvement activities have increased.

In addition, KCSL noted:

- the development of a 24 hour/seven-day-a-week system of placement, with a single point of contact for services within each region;
- significant reductions in social worker caseloads; and
- the creation of extensive management information systems to track data on child placement and service activities.[38]

Florida's Outsourcing

The Florida Legislature mandated the outsourcing of the state's foster care and related programs in 1998. The act required the Florida Department of Children and Families (DCF) to develop a plan for moving to a contracted model, including alternatives to total outsourcing, over a three-year period.[39] The legislation emphasized community participation, quality checks and annual evaluations of private providers.[40]

Each community designed its own system for local circumstances, according to an executive director of one of the lead foster care contractors. The state required communities to develop proposals to select lead contractors for their areas; these were then evaluated by DCF. Areas may have one or more lead contractor, depending on local conditions and DCF approval. For one year, localities receiveed funding for startup activities. "This enabled the state to work side by side with the lead agency to get them started," said the contractor.[41]

Each community selected a lead contractor to serve in much the same role as Kansas' lead agencies. The state then distributed a capped amount of foster care funding to these lead contractors, who arranged for the provision of a complete range of foster care services for their communities.

DCF continues to run the state's child abuse hotline and investigate complaints of abuse.

The contractor must accept all children agreed upon in the contract; must find a place for any child removed from his or her home within four hours, regardless of time of day; and must have the child assessed for services within 21 days of coming into care. The lead

contractors are free to conduct fundraising drives, partner with faith communities, pursue grants and use other community resources to help provide services for abused children.[42]

Texas

Texas' foster care system already is substantially outsourced. The findings of this report and the experiences of other states suggest that Texas should complete the transfer to the private sector, transforming DPRS' role into a quality contracting, licensing, financing and oversight agency that protects children and prevents child abuse. This shift would help capitalize on the strengths of Texas' nonprofit sector, including its faith-based community organizations. By eliminating the dual foster care system, the state could oversee a comprehensive set of services to children and their families.[43]

Texas' foster care system already is substantially outsourced.

Recommendation

Eliminate the inefficient dual foster care system, shift all daily care and case management activities to contracted providers and direct savings to DPRS for greater system oversight.

HHSC and the DPRS should begin shifting all DPRS foster care services, including all daily care and foster care case management activities, to the private sector by September 1, 2005, and should complete the transition by August 31, 2008.

Child placing agencies (CPAs) can care for children requiring basic care more efficiently than DPRS. CPA foster homes provide a high quality of care and are subject to more frequent monitoring than DPRS foster homes. The CPA network is growing and has significant additional capacity that DPRS should use to care for foster children. CPAs and RTCs have case managers who can do the same work as DPRS caseworkers.

An outsourced system offers an opportunity to guarantee positive results for children through the use of performance-based contracting. Meaningful performance measures would ensure child safety, reduce the number of placements, maintain familial connections, and shorten stays in foster care.

Foster care services should be outsourced through a competitive process phased in over a three-year period beginning September 1, 2005. The transition should be developed with local community participation, including input from providers currently under contract with DPRS. DPRS should seek the input of stakeholders throughout the state to promote dialogue and community involvement.

Under an outsourced system, DPRS would retain the responsibility for the quality of contracted services and programs. DPRS must ensure that services are delivered in accordance with applicable federal and state statutes and regulations. As such, DPRS would have to adopt written policies and procedures to monitor the delivery of services to address the evaluation of fiscal accountability and program operations. Monitoring should evaluate provider achievement of performance standards.

DPRS would be required to establish a quality assurance program for outsourced services based on standards established by a national accrediting organization such as the Council on Accreditation of Services for Families and Children, Inc. or the Rehabilitation Accreditation Commission.

The primary emphasis for DPRS and contractors should be outcomes.

Fiscal Impact

Outsourcing would generate savings that should be redirected back into the system to improve care for children, strengthen contract monitoring and licensing, improve management information systems, support kinship care (full-time care by someone related to the child by family ties or a significant prior relationship) and/or provide adoption subsidies. The shift to full outsourcing would require DPRS to train existing and/or hire personnel

to effectively monitor, license and audit the new foster care system and the private providers within it.

Shifting all daily care and case management activities to contracted foster care providers would allow the state to eliminate 814 caseworker, 49 supervisory and 57 administrative technician positions dealing with foster care case management, and 128 caseworker and seven supervisory positions dealing with foster and adoptive home development and recruitment. By eliminating a total of 1,055 FTEs – 942 caseworker, 56 supervisory and 57 administrative technician positions – DPRS would free $36,704,000 in annual salary costs, which could be redirected to build a foster care system with greater accountability.

In addition, in fiscal 2003, DPRS spent $30 million on purchased services for residential child care. According to DPRS, these purchased service dollars were spent primarily on public sector foster care homes and the children in those homes. Most of the purchased service dollars would not be needed in their current form in a completely outsourced system as the daily rate paid by DPRS to the private sector is a bundled rate which already includes these services. Conservatively, half of the purchased services expenditures, or $15 million, could be freed up for stronger accountability and better care.

To outsource the 1,516,647 days of care at the basic care rate, DPRS foster homes provided in fiscal 2003, $21,233,000 of the projected $51,704,000 should be applied toward the bundled daily rate paid to private sector CPAs. In addition, 150 qualified personnel should be added to the contract monitoring and licensing functions at DPRS, to bring DPRS staffing resources in these areas up to 200 FTEs. At an average salary of $45,000 per year, these new employees would cost $6,750,000 annually. The remaining $23,721,000 should be paid to contracted foster care providers through incentive grants for the express purpose of hiring more caseworkers to handle the additional children coming into the private system and the case management activities for which contracted providers will be responsible (Exhibit 3). In addition, it is expected that improved management information systems may be necessary and should be an allowable expenditure for this pool of money.

DPRS will retain $15 million of the $30 million it currently spends on purchased services. DPRS should direct these savings to enhancing their management information systems and improving contract management. Any remaining money could be used for promoting kinship care or providing adoption subsidies.

Many of the caseworkers affected by outsourcing could be hired by the private sector with the above mentioned grant funds. Interviews with providers in Florida indicated about 75 percent of state foster care employees were hired by the private sector when the state outsourced its system. The high level of turnover among CPS caseworkers, 23.5 percent in fiscal 2003, means that most if not all of the positions would be eliminated through attrition.

DPRS staffing levels and foster care provided by DPRS foster homes should be reduced gradually. One-third of the care provided by DPRS foster homes and the reduction of 302 full-time equivalent positions (FTEs) should occur by the beginning of fiscal 2006; an additional third of the care and 302 additional FTEs should be reduced by the beginning of fiscal 2007; and the final third of the care and 301 additional FTEs should be reduced by the beginning of fiscal 2008. In addition, purchased services should be reduced proportionate to the care and FTE reductions indicated above.

Even with a total reduction of 905 FTEs, DPRS would continue to have nearly 3,500 caseworker FTEs to investigate child abuse and neglect cases and to provide family preservation services. In addition to investigation and family preservation services, DPRS would continue to provide intake services through its statewide hotline which takes all abuse and neglect calls. DPRS' other divisions -- Child Care Licensing (CCL), Adult Protective Ser-

Exhibit 3
Fiscal Impact

Fiscal Year	Redirected Savings from Outsourcing	Payments to Contracted Providers for Increased Caseloads	Cost of Increased Monitoring and Licensing at DPRS	Incentive Grants to Providers for Added Responsibilities and Caseworkers	FTEs (DPRS)
2004	$0	$0	$0	$0	0
2005	$0	$0	$0	$0	0
2006	$17,235,000	($7,078,000)	($2,250,000)	($7,907,000)	-302
2007	$34,469,000	($14,156,000)	($4,500,000)	($15,813,000)	-604
2008	$51,704,000	($21,233,000)	($6,750,000)	($23,721,000)	-905

vices (APS) and Prevention and Early Intervention (PEI) Services -- would be enhanced or not affected by this recommendation.

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Quality Contracting

Contract for quality foster care.

Background

There is a wide disparity of care in Texas foster facilities. Some facilities provide high quality care for children; others do not. Yet every facility receives the same daily reimbursement rate for each level of service and conforms to the same licensing standards. "Raising the bar" on performance means setting objective measures to assess the care provided to all foster children. Poorly performing facilities should not receive state contracts. Texas also should remove financial disincentives that present barriers to improving outcomes for foster children.

The federal Adoption and Safe Families Act of 1997 addressed caseloads, costs and quality in state foster care programs.[1] Among other reforms, the law required the federal government to develop a set of outcome measures, such as length of stay in foster care and the number of foster care placements and adoptions, that could be used to assess how well states protect children. As a result, the U.S. Department of Health and Human Services (HHS) now reviews state programs against these measures.

The HHS Child and Family Service Review (CFSR) reviewed Texas' program in 2002 and found it lacking in six of seven safety, permanency and well-being measures (Exhibit 1). The single measure Texas passed was Permanency Outcome 4, in which Texas foster chil-

The HHS Child and Family Service Review (CFSR) reviewed Texas' program in 2002 and found it lacking in six of seven safety, permanency and well-being measures.

Exhibit 1

Child Welfare Outcomes Measured by the Child and Family Service Review

Safety
1. Children are, first and foremost, protected from abuse and neglect. (Texas failed this measure.)
2. Children are safely maintained in their homes whenever possible and appropriate. (Texas failed this measure.)
Permanency
3. Children have permanency and stability in their living situations. (Texas failed this measure.)
4. The continuity of family relationships and connections is preserved for children. (Texas passed this measure.)
Well-Being
5. Families have enhanced capacity to provide for their children's needs. (Texas failed this measure.)
6. Children receive appropriate services to meet their educational needs. (Texas failed this measure.)
7. Children receive adequate services to meet their physical and mental health needs. (Texas failed this measure.)

Source: U.S. Department of Health and Human Services, Administration for Children and Families.

dren were placed in foster homes or facilities close to parents or relatives, and caseworkers tried to place them with relatives.[2]

Outcome-Based Contracting

A 2000 U.S. General Accounting Office (GAO) study highlighted innovative financial approaches used in foster care in 27 localities across 14 states.[3] GAO found that a number of states and localities are using managed care initiatives. These jurisdictions set performance standards and incorporated financial incentives in their contracts to hold foster care providers accountable for performance and results.[4]

GAO found that a number of states and localities are using managed care initiatives. These jurisdictions set performance standards and incorporated financial incentives in their contracts to hold foster care providers accountable for performance and results.

For example, in Massachusetts' Commonworks initiative, contractors can earn bonuses for successful outcomes, such as a child who is discharged from foster care and does not return within six months. Contractors that incur expenses above a specified rate are liable for up to 3 percent of the excess costs; they may retain up to 3 percent of savings if costs are lower.[5]

Similarly, the contract used by the Illinois Department of Children and Family Services (DCFS) for 2004 specifies that, when private child placing agencies reunite foster children with their families, the reunification must last for at least 12 continuous months if the agency is to claim a positive performance outcome. Thus, the agency must work diligently to ensure that the reunification is successful. Otherwise, the agency will be expected to resume caring for the child without receiving additional funds for his or her care.[6] This measure helps meet one of the major goals of Illinois' performance contracting by increasing the number of children moved into permanent settings.[7]

Illinois' DCFS compares its child welfare measures, such as the number of children in out-of-home care, to similar data from other states and the national median to measure its own progress in serving foster children and identify best practices and programs in other jurisdictions. To do so, it uses information from the Child Welfare League's National Data Analysis System, a national database of child welfare data based on detailed information from each state.[8]

Child placing agencies in Michigan receive a higher rate for finding children adoptive homes within eight months. If the placement takes longer, the agency receives the lower, standard rate. Michigan's child placing agencies also can be rewarded for finding adoptive homes for children who are not in their care but appear on a state list of hard-to-place children.[9]

In 2003, Philadelphia's Division of Social Services (DSS) developed contract language directing foster care providers to measure their results through client outcomes.[10] DSS worked with providers to develop its model. The role of DSS contract monitors adapted to the new system, moving from simple checks of compliance with licensing criteria to assessments of whether providers meet specific performance targets. Now, Philadelphia foster care providers are paid based on how well they can achieve positive outcomes for foster children.[11]

The GAO study identified common outcome measures used to determine the success of performance-based contracting initiatives. These include safety, permanency, well-being, stability and customer satisfaction (Exhibit 2).[12]

GAO's initial evaluation of these initiatives found that about half of them moved greater numbers of children into permanent homes, and often more quickly, than conventional programs. The study also cited improvements in school performance, family relationships and parenting skills.[13]

A 2002 study by the U.S. Department of Health and Human Services (HHS) concluded that successful programs focus on how well foster children and families fare, rather than how well various administrative tasks are performed. In this study, no state had shifted entirely from focusing on processes to the use of outcome measures to monitor contract performance, but state administrators

(continued on page 32)

Exhibit 2

Examples of Child and Family Outcome Measures

Category	Outcome	Measure
Safety	Children are safe from maltreatment.	Confirmed reports of abuse and neglect in the general population.
		Recurrence of abuse or neglect while children are receiving in-home services.
		Reports of abuse or neglect while the children are in out-of-home care.
		Recurrence of physical abuse, sexual abuse or neglect after children have left care.
Permanency	Children are placed in a permanent home in a timely manner.	Children who are returned to their parents or relatives within a specified time.
		Finalized adoptions.
		Children who achieve permanency within a specified time.
		Average length of stay in out-of-home care.
		Children who stay in their homes and do not enter out-of-home care.
	Children maintain the permanent placement.	Children who reenter care within a specified time.
Well-being	Children function adequately in their families and communities.	Children's emotional and behavior crises that result in hospital use or police calls.
		Children's behaviors related to sexual misconduct, running away and suicide.
		Children's scores on standardized tests of childhood functioning.
		Children's movement to less restrictive placement settings.
		Youths discharged from care who have completed high school, obtained a general equivalency diploma or are participating in an educational or job training program.
	Families function adequately in their communities.	Families' adaptation to caregiving.
Stability	Children experience a minimum number of placements.	Number of placements while in out-of-home care.
	Children maintain contact with their family and community.	Children placed with at least one sibling.
		Children placed within their home county or a contiguous county.
		Children placed out of state.
Satisfaction	Clients are satisfied with services.	Youths who report satisfaction with services, as measured by a Client Satisfaction Survey.
		Children who report satisfaction with their foster care placement, based on exit interviews.
		Families who report that the initiative provided them with a valuable service.

Source: U.S. General Accounting Office.

and contractors indicated that doing so was a positive step.[14]

In Texas

In 1996, the Texas Sunset Advisory Commission, a legislative agency charged with reviewing Texas programs, found that the DPRS contracting process did not measure the quality or effectiveness of care provided, and offered caregivers no incentives to make improvements in their quality of care. Sunset recommended requiring DPRS to modify its contracting process to include quality measures and to hold contractors accountable for performance.[15]

DPRS has attempted to develop such outcomes, yet the measures that were adopted by the agency in December 2003 have raised some foster care providers' questions about their applicability, and doubts concerning the quality and interpretation of the data used to measure these outcomes.

The 1997 Texas Legislature responded to these recommendations by requiring DPRS client services contracts to include "clearly defined goals that can be measured to determine whether the objectives of the program are achieved."[16] To date, however, DPRS has failed to include specific, measurable goals in its residential child care contracts.

In 2003 foster care contracts, DPRS merely cites outcome measures found in rules adopted by the Texas Health and Human Services Commission (HHSC). These rules state that each child in care is required to have a service plan containing specific behavioral goals. The contracting agency (DPRS) is given the responsibility to develop goals in each child's individual service plan, in conjunction with the provider.[17]

Due to confusing language, DPRS' contracts do not clearly state who is supposed to monitor a child's progress. Even more perplexing, DPRS contract language measures children's behavioral goals based on whether the contractor meets licensing standards or complies with levels of services and contract monitoring performed by the agency, none of which effects an individual child's progress. The contractor cannot determine what constitutes a "passing grade," nor can DPRS, without meaningful or numeric results.[18] The contracts fail to differentiate between contract performance and the improvement of children.

Moreover, the HHSC goals are individually tailored to each child and have no meaning as to the overall performance of the contractor. Outcome measures should be aggregated and then evaluated on some objective basis, in order to determine how well the contractor is performing overall. HHSC has overall responsibility for health and human services contract management and can assist DPRS in devising meaningful outcome measures.[19]

DPRS has attempted to develop such outcome measures, yet the measures that were adopted by the agency in December 2003 have raised some foster care providers' questions about their applicability, and doubts concerning the quality and interpretation of the data used to measure these outcomes.[20] In addition, a DPRS Quality Assurance Workgroup, which included DPRS staff and external stakeholders, such as providers, developed a different set of 14 outcome measures and 37 indicators in mid-2003.[21] DPRS rejected most of the workgroup's measures in favor of the ones listed below.

In December 2003, DPRS' Advancing Residential Childcare Project finalized a series of outcome measures for foster care. These measures are:

1. The child is safe in care, measured by the percentage of children in placement with no validated abuse or neglect by caregivers.
2. The child moves toward permanency, measured by the percentage of moves that a child makes to a less restrictive or permanent placement.
3. The child is cared for in his or her own community, measured by the percentage of children cared for in the region of conservatorship.
4. The child is placed with siblings when appropriate, measured by the percentage of sibling groups in non-restrictive care in the same foster home or facility.
5. The child maintains/improves in adaptive functioning, measured by the percentage of children at the Basic Services Level or moving to a lower service level.

6. The child maintains behavior without the use of psychotropic drugs, restraints or seclusions, measured by the percentage of children maintaining behavior without use of these interventions.[22]

Foster care providers have expressed a number of specific concerns about these outcomes. For example, the placement of a child, as referenced in measures three and four, measures the performance of DPRS, not caregivers; DPRS and the court system have the final say in where a child is placed.

Additionally, the indicator proposed for measuring the outcome "children are safe" is misleading. The sole proposed indicator is the percent of children in placement with no validated abuse/neglect by caregivers; in fiscal 2003, DPRS had 98 validated allegations of abuse or neglect by caregivers, which means that 99 percent of children in foster care would be considered safe. This, however, ignores the fact that none of the children in a facility or foster home subject to a valid complaint of neglect or abuse are safe until the facility has taken action to prevent abuse. Moreover, DPRS data on incidents of abuse or neglect omit instances of child-on-child abuse and reports that were administratively closed without sufficient investigation. (See Chapter 5, Abuse and Neglect.) The indicator also ignores the fact that licensing standard violations can directly affect the safety of children.[23]

Providers also are concerned about the measure concerning the use of psychotropic drugs, restraints or seclusions. They note that the measure assumes that any use of a psychotropic drug, restraint or seclusion is inappropriate, and they disagree with this assumption.[24]

In general, foster caregivers worry that a performance-based contracting system may evaluate them at least in part based on outcomes that are controlled largely by school districts, doctors, therapists and DPRS caseworkers.[25]

Additionally, a 2003 study of more than 1,000 foster care alumni served by the Casey Family Programs found that there are factors that can help predict successful educational, income, and mental and physical health outcomes for former foster children. The Casey Family Programs is a Seattle-based national foundation that provides direct services for children, youth and families in the child welfare system and studies child welfare practices and policy. The factors identified in the study include such items as:

- life skills preparation;
- completing high school or earning a GED before leaving foster care;
- scholarships for college or job training; and
- participating in clubs and organizations for youth while in foster care.[26]

Such factors as these also may be considered in outcome measures. At this writing, DPRS plans to begin collecting data on foster care outcomes in 2004, and to incorporate some type of performance measures into its 2005 contracts for foster care.[27] Thus, DPRS plans to incorporate these measures more than eight years after state law required them.

In general, foster caregivers worry that a performance-based contracting system may evaluate them at least in part based on outcomes that are controlled largely by school districts, doctors, therapists and DPRS caseworkers.

Texas Payment Systems

Texas pays private providers of residential foster care a flat daily, per-child rate, based on the intensity of service each child needs. More intense levels of service are reimbursed at higher levels. For 2004, the range of payments starts at $20 a day for basic care by a foster family and rises to $202 per day for intense services delivered at a residential treatment facility.[28] For 2004, DPRS pays one provider a daily rate of $277 per child to care for a small number of children who require exceptional levels of care.[29]

Texas' system for reimbursing foster care providers does not create incentives to serve children in the most home-like environments, shorten their stays in foster care, find them adoptive homes or smooth their successful transition into adult life. A recent study by the U.S. Department of Health and Human Services found that per-diem payments such as Texas uses may encourage the inefficient use

of state resources because children may be categorized at a higher level of treatment—and cost—than is necessary.[30]

A recent study by the U.S. Department of Health and Human Services found that per-diem payments such as Texas uses may encourage the inefficient use of state resources, because children may be categorized at a higher level of treatment—and cost—than is necessary.

The present flat rate system gives providers no incentive to request a lower service level, which would reduce their payments. In effect, it creates a perverse incentive either to deliver more services than needed or to prolong treatment longer than necessary.

Payment Options and Incentives

States may incorporate financial incentives to improve the quality of care provided to foster children. The Adoption and Safe Families Act allowed states to request federal approval to waive certain federal requirements (and thus are called waivers), so that they can use Title IV-E federal funding to test innovative ideas. Other states continue to devise financial alternatives to improve foster care outcomes and encourage contractors to use state and federal funding cost-effectively.

Capitated foster care systems, also called managed care systems, the most common examples of which are health maintenance organizations, are intended to control costs while guaranteeing the delivery of necessary services. In a capitated system, states pay monthly fixed amounts to foster care providers who are expected to plan for and meet all the needs of all the children in their care. These amounts are calculated, in advance of providing services, to allow providers to meet a range of different needs. Usually, this rate is set at a specific monthly payment per member, called a "capitated" rate. One or a limited number of providers generally provide the services.

At least 17 states have used managed care (capitated) systems to provide foster care services.

Because capitated payments are calculated on an aggregated basis across the entire child population, the contractor may choose which services are appropriate for each individual child. Contractors then have an incentive to avoid losses; unnecessary treatments and overly-lengthy stays that will cost them money, rather than the state. Any excess can be used for children whose care costs more. Children with greater needs can receive the extra services they require because the contractor has no incentive to use resources unnecessarily on children with lesser needs.

Capitated payments are more flexible. Contractors are not locked into providing a certain set of services to receive a specific reimbursement. And contractors have the freedom to provide additional services or supports that can allow children to function in less-intensive placements. For example, a capitated system provides contractors with an incentive to serve children in foster homes rather than more expensive residential treatment facilities.[31]

Capitated systems might tempt some providers to deny some children appropriate services to maximize their return on the contracted amount. Such abuses, however, can be minimized by linking the renewal of provider contracts to outcomes, and by requiring providers to report and document the services they provide to each child.

In Other States

At least 17 states have used managed care (capitated) systems to provide foster care services. Georgia, Illinois, Kansas, Massachusetts and Tennessee have operated statewide models; county-based programs have been used in Indiana, Michigan, Wisconsin, California, Colorado, Florida, New York, Ohio and Wisconsin.[32] The federal government reports that Connecticut, Maryland and Washington also have tested managed care initiatives.

Some of these states have used waivers from the federal Title IV-E funding program to help pay for these programs. These waivers allow states to use federal funds to test different ways of serving foster children. Yet, waivers are not always required.[33]

From November 2001 to June 2003, Colorado used a Title IV-E waiver program in Arapahoe County (near Denver) to serve children aged 10 or older who were considered "at risk" or had experienced multiple placements, and who also were considered likely to age out of

the foster care system without a permanent family placement. This waiver covered both residential and non-residential services.

Arapahoe County negotiated a performance-based contract with a consortium of providers and paid its members a standard, capitated rate for care coordination and residential treatment. The county paid for nonresidential services on a fee-for-service basis. The county also established a control group of children who did not participate in the waiver program, to compare costs at the end of the program.

At the end of each contract period, the state calculates an average per-case cost for youths in the treatment and control groups. If the treatment group's costs were lower than those for the control group, the consortium receives reimbursement for 100 percent of these costs as well as a portion of the savings. If the treatment group costs were higher than the control group's, the consortium becomes responsible for a portion of the higher costs.

Arapahoe County continues to use this payment arrangement, although the state decided it did not need to continue using the Title IV-E waiver to fund it. Colorado has indicated that it wishes to contract with additional provider consortia to create a competitive bidding environment.

Michigan also has a managed care payment system funded through a Title IV-E waiver. The state has developed managed foster care contracts in six counties that provide "wrap-around" services—an extensive roster of services including counseling, in-home family services, parental education, training and support services, respite care and household management training—that are not ordinarily covered under Title IV-E payments. The state provides each contractor with a single payment of $14,272 for each child served, regardless of the amount of time over which services will be provided. Providers are responsible for managing these funds to provide the services required, and risk financial losses if their costs exceed the fixed amount paid for the population they serve.[34]

Washington state is testing alternate managed care approaches at different sites. Washington's Clark County is participating in a program targeting foster children needing relatively high levels of care. The county has been designated as a contractor to the state, managing the state's payments to provide services for foster children in the program, and assuming part of the risk for excessive costs.[35]

In Texas: Lessons from PACE

DPRS attempted to apply these principles to foster care in a 1998 pilot project. From September 1998 to March 2001, DPRS contracted with the Lena Pope Home, a nonprofit organization serving children and families in Fort Worth, to care for foster children with therapeutic needs and their siblings in a 10-county region of North Texas.[36] This program, called Permanency Achieved Through Coordinated Efforts (PACE), was intended to be a Texas model for outsourced foster care services, but was discontinued due to a number of problems, including an unexpectedly large caseload, insufficient funding and inadequate planning. Financial issues were at the heart of the project's failure and need to be addressed in future projects.[37] Since the end of the project, DPRS has not attempted to test or design similar innovations. (For a full discussion of the PACE project and additional recommendations, see pp. 19-21.)

Illinois' foster care system offers bonuses to contractors that move more than a specified percentage of their caseload into permanent living arrangements.

Bonuses and Penalties

Some states use systems of bonus payments or financial penalties to enforce quality contracting provisions. Illinois' foster care system offers bonuses to contractors that move more than a specified percentage of their caseload into permanent living arrangements.[38] Michigan uses a performance-based system that provides incentives to encourage and reward the adoption of children in the foster care system.[39]

Penalties are more difficult to administer, since they would be levied after services have been purchased. They may involve withholding all or part of future payments. In some instances, they could involve audits and recoupment of funds spent on unauthorized items. This would,

however, entail both administrative overhead for audits and significant delays before recoupment. Depending on their nature, penalties also could discourage potential contractors and thus reduce the capacity of the foster care system. For these reasons, they must be designed carefully and used judiciously.

The measures on which bonuses and penalties are based should be clear and easily measured. For foster care, the most common measures seem to be length of stay in foster care and length of time until adoption. Comparisons typically are made to past performance or to a control group. Deciding which children to compare, time periods for comparison and other factors should be weighed carefully and modeled in advance to ensure that performance goals are reasonable and achievable.

The licensing process alone, however, cannot determine the quality of services, according to the inspector general of the U.S. Department of Health and Human Services.

Licensing and Service Quality

DPRS relies mainly on its Child Care Licensing (CCL) Division to determine whether a contractor meets minimum standards and is qualified to provide services. CCL determines whether a provider has a poor performance history, and if any of its board members or employees have a criminal background.[40] DPRS has access to data from YFT and contract managers' reviews.

The licensing process alone, however, cannot determine the quality of services, according to the inspector general of the U.S. Department of Health and Human Services. The inspector general also found that states rarely revoke licenses or deny renewals to correct problems at residential treatment facilities. State licensing standards address basic issues of health, protection and safety, but are not intended to ensure the suitability of placements and the quality of care provided.[41]

Recommendations

A. HHSC should create a foster care performance team to develop criteria for outcome-based contracts and measurable outcomes for residential care.

HHSC has overall responsibility for health and human services contract management and can assist DPRS by drawing on expertise in other state agencies. The team should include foster care parents and providers, performance contracting experts from the State Auditor's Office or other state agencies and other stakeholders with relevant expertise in outcome-based contracts.

This team should develop clearly defined and measurable performance standards for foster care contracts. The team should rely on the recommendations of contracting experts and the experiences of other states that have already developed several generations of performance contracts.

The standards should directly relate to factors that a foster care provider can control. New contracts should encourage providers to provide quality foster care and should allow them flexibility in meeting performance standards. Standards should include critical elements that identify poor-quality providers who should not be awarded future contracts and whose existing contracts should be revoked.

B. The performance team's outcome measures should be used instead of the existing DPRS outcome measures.

Most of the existing measures are flawed for use in performance contracting because they do not measure actions under the direct control of the foster care contractor or because the performance indicators are inexact or inappropriate.

C. DPRS should use outcome-based contracts for all foster care services beginning in fiscal 2005.

The foster care performance team should adopt recommendations in time for DPRS to issue outcome-based contracts in fiscal 2005.

DPRS should compare its foster care programs and results to those in other states. Formal comparisons of Texas' foster care services and programs with those of other states would allow DPRS to measure its own success and identify model practices and programs it could adapt to its own operations. Illinois' effort could provide a model for this activity.

D. HHSC and DPRS should revise payment methods to create financial incentives for reducing the length of stay and institutionalization of children in foster care.

These payment methods could vary by region and for specialty services. Alternate methods of financial incentives are not mutually exclusive. A proposal may contain some combination of managed care, bonuses or penalties or other incentives. Financial models should be designed to coordinate with plans for foster care outsourcing so that Texas may realize both financial and organizational reforms.

HHSC, DPRS, local county officials, local providers and other stakeholders must work together to develop financial incentives that reinforce rather than undermine the foster care system. Consultant expertise, beyond that of DPRS or child welfare experts, may be required to build financial incentive programs that work. Texas needs to build on examples that work in individual communities rather than impose a statewide solution.

Fiscal Impact

These recommendations would improve contracting procedures and provide greater oversight for state spending.

HHSC could use existing funding to implement Recommendation A. For example, DPRS supports a Quality Assurance Workgroup; this funding could instead be used to develop the foster care quality assurance team.

The fiscal impact of Recommendation D would depend upon the structure and number of programs created and cannot be estimated in advance. If the length of stay in foster care, or the intensity of care is reduced, the state will realize savings.

If Texas uses federal Title IV-E funds to support incentive payments, waivers are not always required. The necessity of federal waivers may depend upon the nature of such incentives.

Title IV-E waivers are not a particularly advantageous funding source for incentive payments because eligibility for Title IV-E depends upon family income of the child at the time of placement, and those eligibility thresholds are not adjusted for inflation. Consequently, the number of Title IV-E-eligible children decreases each year.

Endnotes

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Different Facilities, Different Conditions

Some Texas foster children sent to residential facilities can find themselves in clean, safe engaging environments. Others are less lucky. Despite the fact that DPRS licenses and monitors all of these facilities, their conditions vary widely. Each child's fate seems to be left to the luck of the draw—to the decisions and opinions of individual caseworkers.

The review team visited facilities around the state to get a first-hand look at the conditions in which foster children live. Some locations are clean and welcoming, but others are far less suitable. Some display sound business practices and solicit community involvement, while others do not. Yet all of them receive the same daily reimbursement rates for each level of service. There are no photos of children due to privacy restrictions.

Photographs of Foster Care Facilities

- ***Kitchen, Dining and Food Storage***
- ***Bathroom and Bathing Facilities***
- ***Sleeping Facilities***
- ***Isolation Areas at Residential Treatment Centers***
- ***Recreation and Living Facilities***
- ***Medication Storage***
- ***Classrooms***
- ***Conflicts of Interest***
- ***Laundry and Clothing Facilities***

Kitchen, Dining and Food Storage

Perishable food storage at a therapeutic campsite.
Foster children at this therapeutic camp cook their own meals at night and on weekends. The Comptroller opened this "ice chest" during an unannounced visit in the middle of the day. There was no ice in the cooler. According to DPRS standards, when ice chests are used, adequate ice must be provided. Left-over meat patties were not wrapped. In addition to the daily rate that includes room and board, providers are reimbursed through the USDA free- and reduced-price lunch and breakfast program. This facility also receives charitable donations and weekly donations from the local food bank.

Food preparation area at a therapeutic campsite, littered with trash.

DPRS standards for permanent camps require trash to be stored in containers with lids. This facility receives a daily rate for each child ranging from $80 to $115.

Food preparation area at a therapeutic campsite.
This photo shows the cook site at this wilderness camp where children prepare 11 of their own meals every week. There was no dishwashing detergent. A local health inspector reported that individual campsite food preparation areas were unsanitary. This facility receives a daily rate for each child ranging from $80 to $115.

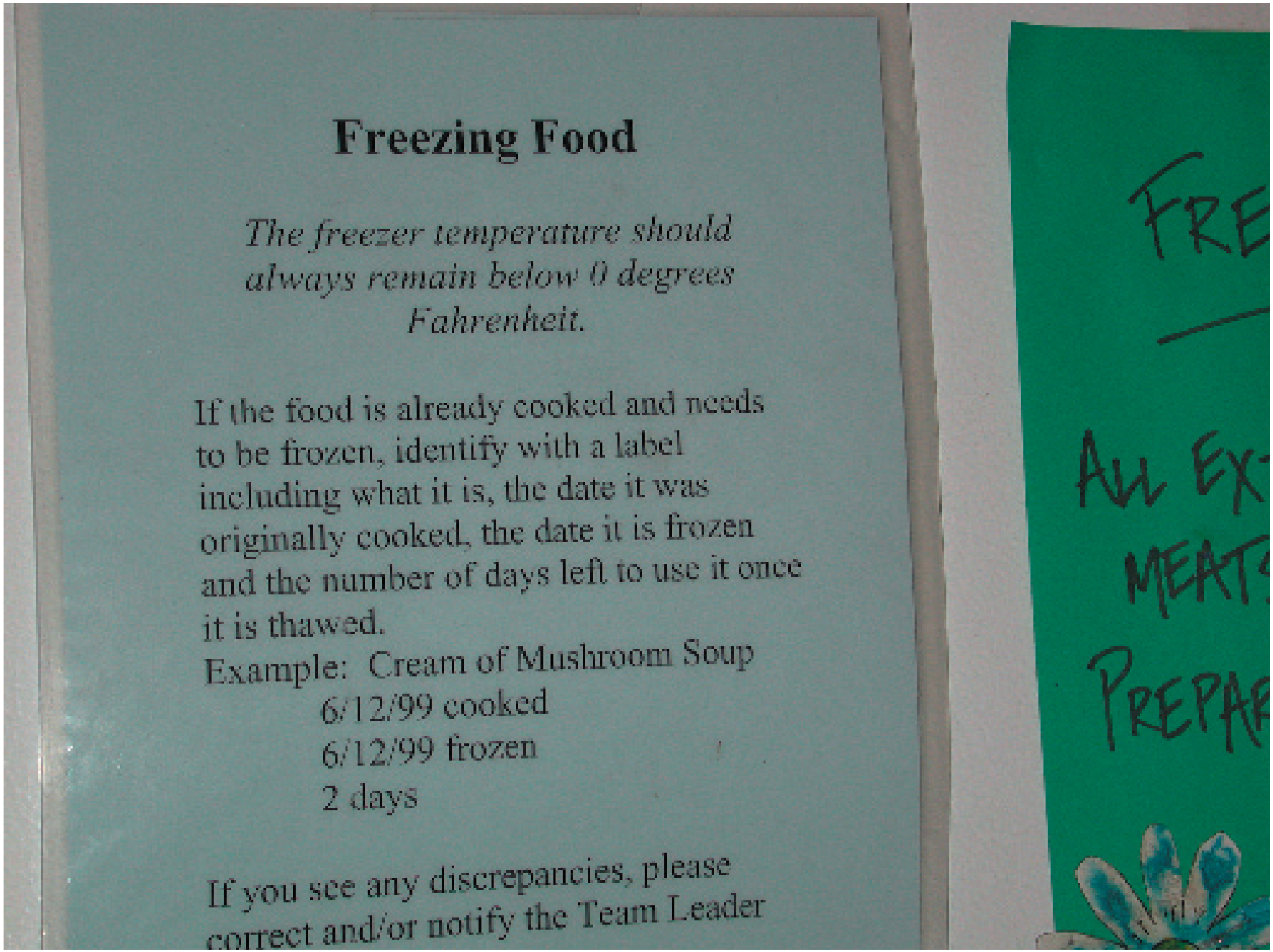
Food Preparation at a therapeutic campsite.
Children at this facility prepare their own meals at night and on weekends in this area. This facility receives a daily rate for each child ranging from $80 to $115.

Dirty dishes at a therapeutic campsite.
The Comptroller review team observed caked food on some of the dishes. There was no dishwashing detergent. According to the local health inspector, proper sanitation of the cookware and dishes was not evident.

Dining area at a residential treatment center that serves foster children.
The facility is making improvements based on recommendations from the local fire marshal. This facility receives a daily rate from DPRS for each child ranging from $80 to $115.

Freezer at a therapeutic campsite.
According to the National Dairy Council, freezing milk is not recommended. "It causes undesirable changes in milk's texture and appearance."

Informational chart on the door of a freezer at an Emergency Shelter that serves foster children.
This chart provides precise instructions for freezing food .



Freezing Food

The freezer temperature should always remain below 0 degrees Fahrenheit.

If the food is already cooked and needs to be frozen, identify with a label including what it is, the date it was originally cooked, the date it is frozen and the number of days left to use it once it is thawed.

Example: Cream of Mushroom Soup
6/12/99 cooked
6/12/99 frozen
2 days

If you see any discrepancies, please correct and/or notify the Team Leader

Inside the freezer at an Emergency Shelter which observes freezing guidelines.
This facility receives a daily rate from DPRS for each foster child of $94. This shelter receives widespread community support. Local professional chefs prepare meals for foster children four times a week.

Milk storage at a kitchen facility at a charter school that serves foster children.

Cookware that is left outside at a therapeutic campsite.
Permanent camp standards require kitchenware to be clean, sanitized and properly stored. This facility receives a daily rate from DPRS for each child ranging from $80 to $115.

A stove at a residential treatment center.
This is the only stove at the facility, which is licensed to care for more than 40 children. More than 10 children at this facility were treated for food poisoning.

Commercial style kitchen at a residential treatment center that serves foster children.
When the Comptroller review team entered the kitchen, they were told hairnets were required by the Health Code.

Kitchen at a residential treatment center that serves foster children.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115. This facility has been found to be deficient in meeting standards for food preparation.

Kitchen at a private group home serving foster children.
Foster parents at this home receive a daily rate from DPRS for each foster child ranging from only $20 to $45.

Cafeteria at a residential treatment center that receives strong financial support from the community.
Foster children may select from a wide range of foods.

Bathroom and Bathing Facilities

"Pee Wall" at a therapeutic camp.
According to DPRS rules for wilderness camps, toilet areas must be located at least 75 feet from sleeping areas. The adjacent sleeping area is only a few feet away. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115. DPRS standards for permanent camps require flush toilets if the water supply is available. There is water available through pipes at the campsites. DPRS has been licensing camps like this one for more than twenty years.

Makeshift outhouse at a therapeutic campsite.
Foster children use this facility rain or shine, 365 days a year. DPRS standards allow permanent camps to use privies only when a water supply is not available. Water is available at this campsite. This outhouse does not meet Texas Department of Health standards. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Bathroom at a residential treatment center that cares for both male and female foster children.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Commode at a therapeutic camp.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Outhouse at a therapeutic campsite.
This outhouse is a good distance from the campsites. The trail is dark at night and out of view of the "watch" staff. A local health inspector reported that latrines and outhouses at this wilderness camp were discharging raw sewage on the ground.

Bathroom at a residential treatment center.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $277.

Open showers at a therapeutic campsite.
These unheated open showers are the only type available to foster children who live at the facility year round.

Shower at a residential treatment center.
Many children at this facility have sought medical treatment for athlete's foot. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Cold-water showers used by foster children at a therapeutic campsite.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Storage for bath soap at a therapeutic camp shower.
There was no commercial bath soap or shampoo available at the shower—only this soap which appeared to be homemade. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

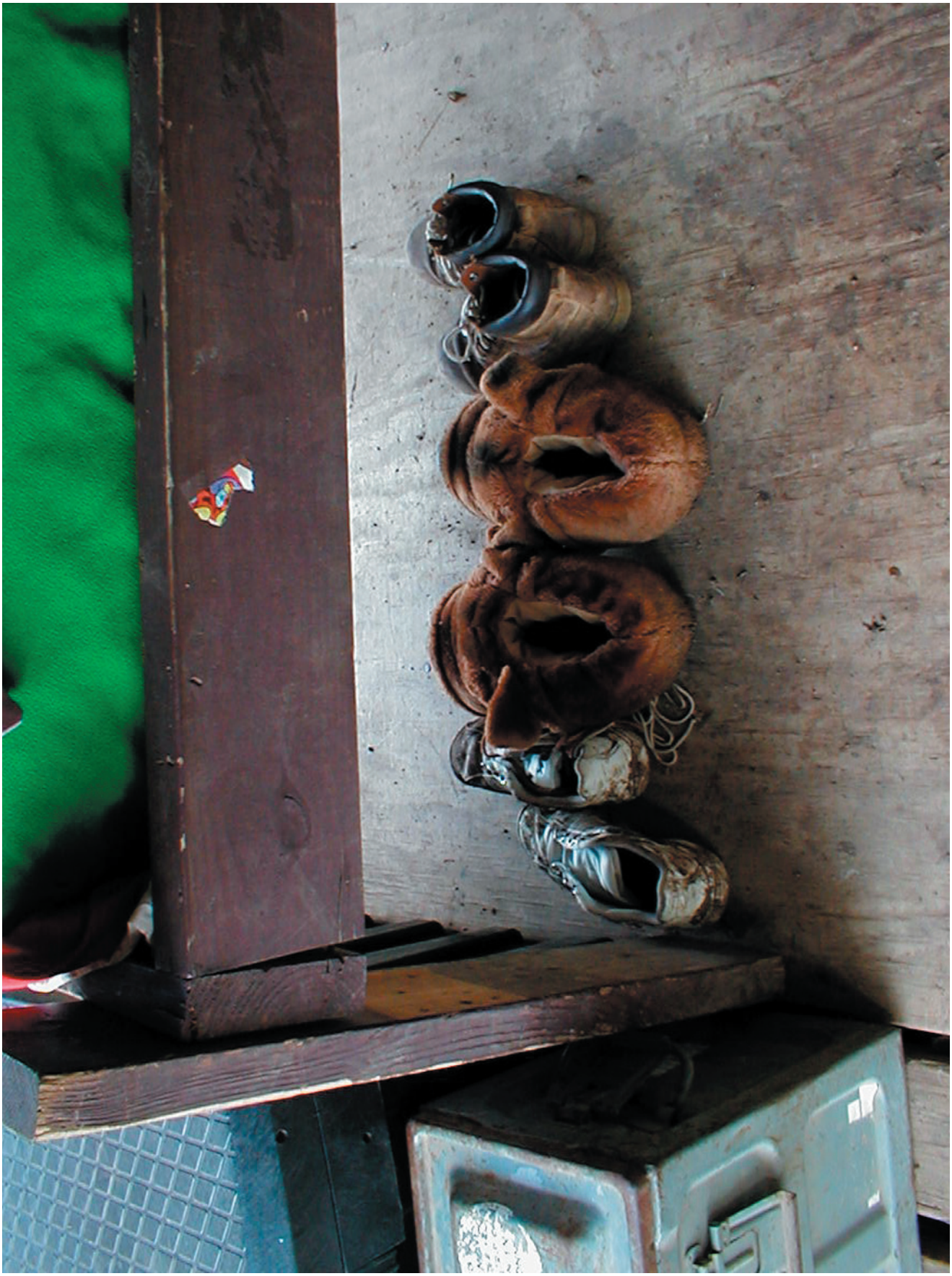
Bathroom at a "no pay" facility.
This facility offers care for foster children at no cost to the state. The state does not take full advantage of placing foster children in facilities that offer care at no charge. The state could redirect $1.3 million to foster care services by using "no pay" facilities.

Sleeping Facilities

Open fire pit and sleeping quarters for foster children at a therapeutic camp.
Foster children gather around the fire pit at night. There is no electricity or heat. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Sleeping platform at a therapeutic campsite.
DPRS standards require permanent camps to provide clean and sanitary bedding and clean mattresses. DPRS standards for wilderness camps do not address bedding or sleeping facilities. Foster children sleep in these conditions 365 days a year, during all types of weather.

Sleeping platform at a therapeutic campsite.
Foster children have limited space for their possessions. A toothbrush and tube of toothpaste lay on the floor near the door. During the winter, plastic sheeting is used to provide limited protection from the cold. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.



Children's shoes at a therapeutic campsite.
Foster children at this campsite are required to live outside 365 days a year. This facility is licensed to care for children as young as eleven.

Sleeping platform at a therapeutic campsite.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Bunkhouse at a therapeutic camp.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Beds at an emergency shelter.
This facility receives a daily rate from DPRS for each foster child of $94 . Each child receives a custom-made quilt like those below.

Beds at an emergency shelter.
This facility receives a daily rate from DPRS for each foster child of $94.

Bedroom at a residential treatment center.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Bedroom at a residential treatment center.
This facility receives a daily rate from DPRS for each foster child ranging from $80 to $202.

Bedroom at a "no pay" facility.
This facility offers care for foster children at no cost to the state. The state does not take full advantage of placing foster children in "no pay" facilities.

Isolation Areas at Residential Treatment Centers

Seclusion room at a residential treatment center.
This steel door can be locked and unlocked only from the outside. There is a small window in the door to observe children locked in the room. According to DPRS rules, no form of seclusion may be used without appropriate orders in the child's record. Only a licensed psychiatrist or licensed psychologist may write orders for the use of seclusion for a specific child.

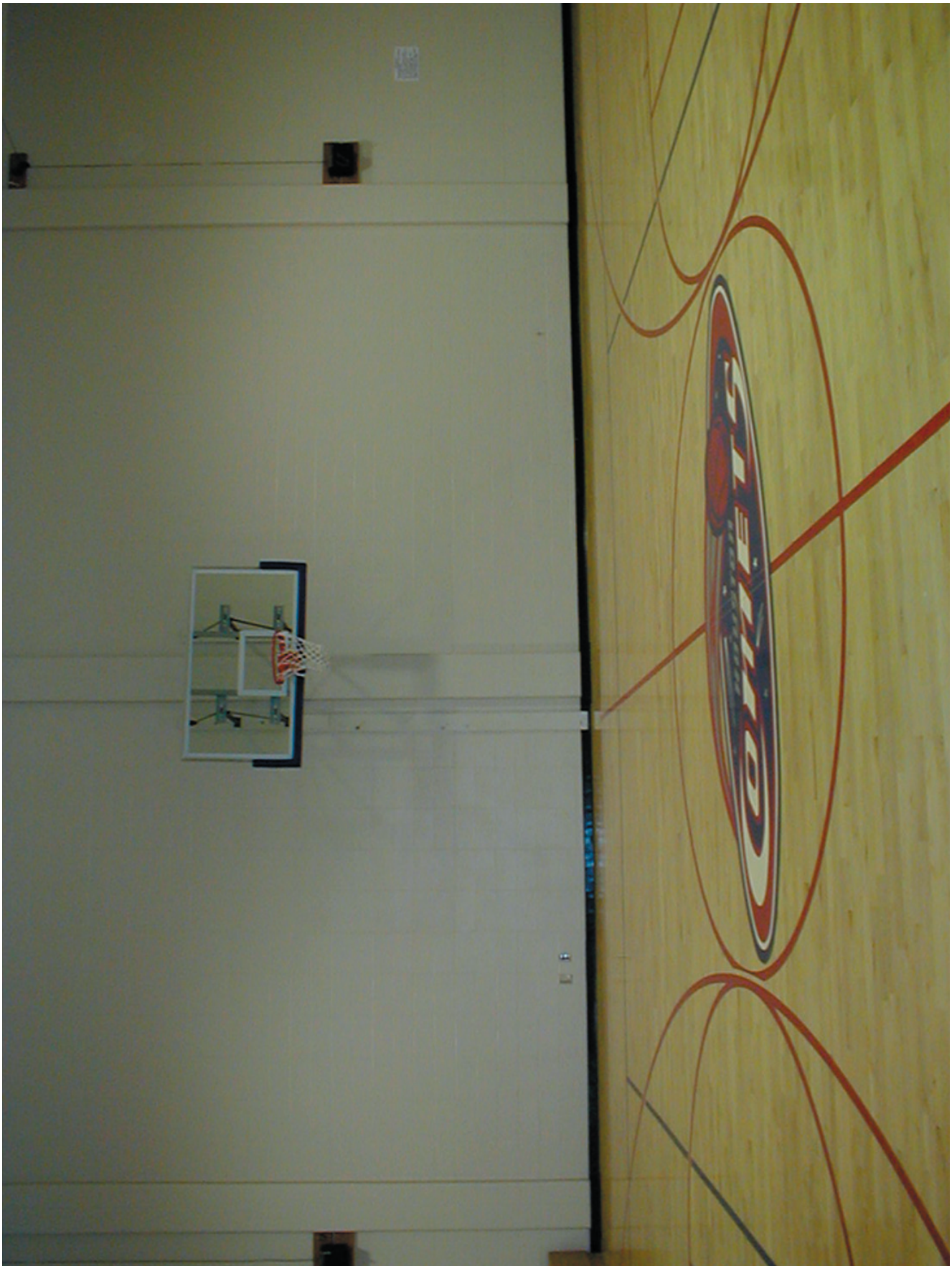
Peephole on door of attic room at a residential treatment center.
The door can be locked and unlocked only from the outside. The executive director of this facility told the Comptroller's review team that the facility did not have a seclusion room.

Inside of the same attic room in a residential treatment center.
This facility has been reported and investigated for several instances of abuse related to foster children locked in the attic room.

Recreational and Living Facilities

Recreation "type" area at a therapeutic camp for foster children.
A camp employee told the Comptroller review team this area was a "little fort" the foster children play in. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.

Wood cutting and recreation area at a therapeutic camp for foster children.
This facility has limited recreational facilities. For punishment the children cut and chip wood that is then used in campfires and for cooking . This facility receives a daily rate for each child ranging from $80 to $115.



Indoor gym at a residential treatment center.
This facility aggressively seeks community support and is a United Way funded facility. This facility receives a daily rate from DPRS for each foster child ranging from $80 to $202.

Living area at a residential treatment center that serves foster children. *This facility receives a daily rate from DPRS for each foster child ranging from $80 to $115.*

Living area at an emergency shelter that serves foster children.
This facility receives a daily rate from DPRS for each foster child of $94. There is widespread community volunteer and financial support for this facility.

Playground at an emergency shelter that cares for young foster children.
This play area is covered with astroturf to help provide a safe environment. This facility aggressively seeks community support. It receives a daily rate from DPRS for each foster child of $94.

Living area at "no pay" group home facility.
A volunteer gives free piano lessons weekly to girls at this facility. This facility has vacant beds. The state could redirect $1.3 million to foster care services by using "no pay" facilities.

Medication Storage

Locked medication cabinet at a residential treatment center that serves foster children.
This facility was found to be deficient regarding expired medications.

Locked medication cabinet at a residential treatment center.

Medicine bags for group foster homes were properly locked for containing controlled substances.

Classrooms

Play area and teacher's desk at a charter school that serves foster children.

Dust covered computers in a charter school classroom at a therapeutic camp.

Classroom and computers at a children's emergency shelter being fully utilized.

Classroom at a residential treatment center.

Charter school classroom located at a therapeutic camp.
This permanent camp has heated, enclosed sleeping quarters.

Conflicts of Interest

A privately-owned pharmacy at a residential treatment center.
A residential treatment center purchases all of its pharmaceuticals from this for-profit pharmacy owned by a related party. DPRS business practices allow contractors to buy and sell to themselves and do not prohibit business transactions between closely related parties.

A privately-owned grocery at a residential treatment center.
A residential treatment center purchases all of its groceries from this for-profit grocery store owned by a related party. DPRS business practices allow contractors to buy and sell to themselves and do not prohibit business transactions between closely related parties.

Laundry and Clothing Facilities

Orderly laundry area at a therapeutic camp that serves foster children.

Clothes storage area at a therapeutic camp, which is separate from the campsites at which the foster children live.
Placement changes are common for foster children. Their minimal belongings are placed in plastic trash bags, such as those below, as they move from place to place.

Clothes area at a residential treatment center.
This residential treatment center, which serves girls in foster care, has widespread community support and children are given the opportunity to select from a full range of donated clothing, shoes and accessories.

CHAPTER 3

Direct More Dollars into Care

Texas should direct more dollars into the care of foster children by using innovative funding techniques. By fiscal 2008, the recommendations of this report could save or generate more than $74 million annually for the improvement of foster care.

The Medicaid State Plan should be amended so that the state can use Medicaid Rehabilitation Services funds to pay for services delivered to foster children in residential treatment centers.

Additional federal Title IV-E funding should be obtained by increasing the amount claimed for preplacement services.

The delivery of Medicaid information for foster children should be expedited to make it easier to file for Medicaid reimbursement in a timely manner.

DPRS and HHSC should provide assistance and training to foster caregivers to help them claim Medicaid reimbursement for the services they provide.

HHSC also should request Title IV-E federal waivers to prevent the unnecessary institutionalization of foster children. At least 17 other states have created innovative foster care programs using such waivers.

Residential treatment center contracts with charter schools should include mandatory participation in the Medicaid School Health and Related Services program, which is administered by HHSC in cooperation with the Texas Education Agency.

Medicaid for Rehabilitative Services

HHSC and DPRS should pursue Medicaid funding for rehabilitative services delivered to foster children in RTCs.

Background

Each state must have a Medicaid State Plan defining which Medicaid services the state will provide and who is eligible for each service. In Texas, Medicaid Rehabilitative Service is an optional program in the Medicaid State Plan that reimburses expenditures for community support services provided to Medicaid recipients. Such services can include symptom management, living skills and employment skills training, among others.[1]

At present, DPRS does not use Medicaid Rehabilitation Services funds to pay for foster care.

Each year, DPRS places nearly 1,300 foster children needing intensive services in RTCs. All of these children are eligible for Medicaid and many have diagnoses involving mental health problems.[2]

Recommendation

HHSC and DPRS should pursue an amendment to the Medicaid State Plan specifically for foster care children served in RTCs.

The amendment for rehabilitative services should define providers, services, the eligible population and a rate-setting methodology, and should be coordinated with other changes occurring in state programs.

Fiscal Impact

About 40 percent of the services provided in residential placements are Medicaid-eligible. Children in higher levels of care are eligible for Medicaid reimbursement. Changing the state plan to accommodate these children would earn the state about $10.1 million annually in additional federal funding. When the initiative is fully implemented, HHSC and DPRS will need to shift TANF funds to other eligible services and replace those funds with General Revenue made available by shifting TANF funds.

At present, DPRS does not use Medicaid Rehabilitation Services funds to pay for foster care.

Endnotes

1 Texas Department of Mental Health and Mental Retardation, "TDMHMR Medicaid Rehabilitative Services," Austin, Texas, April 30, 2002, available in pdf format at http://www.mhmr.state.tx.us/CentralOffice/Medicaid/rehab_00.pdf. (Last visited February 2, 2004.)

2 Public Consulting Group, Inc., "Revised Assessment and Management Letter, State of Texas," Austin, Texas, December 8, 2003.

Title IV-E Funding

DPRS should pursue more federal Title IV-E funding for preplacement services.

Background

The federal government reimburses Texas for the cost of administering federal programs. Funding streams from multiple federal sources often are involved.

DPRS prepares an annual cost allocation plan that calculates how much reimbursement the agency can claim from various federal programs for its administrative costs. DPRS claims federal funds from Medicaid, Title IV-E and the Temporary Assistance for Needy Families (TANF) Program, the current incarnation of welfare.

One DPRS initiative funded through these programs is preplacement services—services provided to children who remain with their biological parent or parents but are considered at risk for foster placement. Preplacement services attempt to help children and their families remain together through marriage counseling, family therapy and other assistance.

Some of the administrative costs for preplacement services that DPRS currently claims under TANF could instead be pursued under Title IV-E.

TANF is a block grant—a fixed payment—provided to each state for social services spending through a number of state agencies. Title IV-E, by contrast, provides a 50 percent federal match for administrative costs and is not a fixed amount.

By amending its cost allocation plan to pursue Title IV-E funding for preplacement services before TANF money, DPRS could free TANF dollars for use elsewhere in DPRS or in other agencies.

Recommendation

DPRS should increase the amount it claims from Title IV-E for preplacement services.

This would allow the state to reallocate some TANF funds to other eligible services within DPRS or other state agencies.

...DPRS could free TANF dollars for use elsewhere in DPRS or in other agencies.

Fiscal Impact

TANF funds replaced by Title IV-E reimbursements could be assigned to other TANF-eligible services within DPRS or another state agency. Federal Title IV-E reimbursements would be matched from state general revenue currently allocated to DPRS or available from another state agency.

This initiative could increase federal funding by $7 million annually.

Medicaid Services

HHSC and DPRS should expedite the delivery of foster children's Medicaid information to caregivers.

Background

DPRS is supposed to qualify foster children for Medicaid. Foster care contractors must obtain Medicaid cards for each child for whom they plan to claim Medicaid reimbursement.

A South Texas RTC reports that Medicaid sends the cards (a sheet of paper each month) to each child's DPRS caseworker. Sometimes several months elapse before the contractor has a child's first card in hand; without the information on these cards, Medicaid-eligible services cannot be claimed from Medicaid. Foster children in this RTC stay for an average of six to eight months, so some children's stays may be half over before the RTC has their cards.

One survey respondent noted, "I had two different foster children with numerous medical appointments immediately necessary and it took weeks to get a Medicaid card...I spent hours on phones trying to get care for my foster children."

Providers pursuing Medicaid funds have 90 days to claim reimbursement. Because of delays in receiving Medicaid cards and the complexities of the reimbursement process, time can easily run out before providers successfully claim reimbursement.[1] Further delays occur if DPRS fails to qualify foster children for Medicaid. One San Antonio RTC reported that some foster children do not have Medicaid upon arrival, and the center must file for them.[2]

These delays follow a similar pattern to delays in Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) examinations documented in a recent federal Office of Inspector General (OIG) study on health care services for foster care children in Texas. The OIG report stated that 25 percent of the children in their sample of 50 Texas foster care children in care for at least six months did not receive an initial medical examination within the first 30 days of entering state custody. Some 34 percent of the children in their sample did not receive initial dental examinations within 90 days of placement as specified by state and federal guidelines.[3] Some of these delays may be a result of children not having Medicaid information when they are placed with a provider.

Because of delays in receiving Medicaid cards and the complexities of the reimbursement process, time can easily run out before providers successfully claim reimbursement.

The OIG report identifies other factors might delay the provision of these required examinations.

> The health care available for children in foster care is often characterized by lack of access, lack of information sharing among health providers, welfare workers, and foster care providers, and long delays in obtaining services.[4]

The report also recommends that the Medicaid office and DPRS work together to reduce these delays.

DPRS caseworkers may fail to qualify children for Medicaid for a number of reasons. They may not have the child's social security number or other information to file for Medic-

aid, or cards may be delayed in transfer from DPRS to the provider.

DHS manages a computer system that maintains Medicaid eligibility information for all Texans receiving these benefits. Medicaid providers can request access to this system to verify the eligibility of their charges for Medicaid services and obtain the information needed to make claims on their behalf. Many providers, such as hospitals and county clinics, have such access, but the Comptroller review team's interviews indicated that some foster care providers are unaware of this service.

Recommendations

A. HHSC and DPRS should expedite the delivery of foster children's Medicaid information to caregivers.

The agencies should expedite the process of sending Medicaid cards to foster care contractors and assist them in obtaining access to the DHS Medicaid eligibility database. This change would help prevent contractors from failing to make timely claims for reimbursement or delay services.

B. HHSC and DPRS should work together to obtain more timely medical and dental examinations of children.

The agencies should follow the recommendations outlined in the OIG report.

Fiscal Impact

This recommendation could reduce the cost of unreimbursed services for foster children. Increased Medicaid payments to providers would reduce the amount of allowable costs reported in the DPRS cost report. Lower reported costs could reduce the state paid reimbursement rate, which is paid to foster care providers. Increased Medicaid payments to providers will offset some of their costs.

Total unreimbursed expenditures in fiscal 2000 for case management, treatment coordination, direct care and medical care cost the state and its contractors $70.3 million. A five percent improvement in Medicaid reimbursements would generate $3.5 million in savings, of which 60 percent or $2.1 million would be federal funds.

Endnotes

1 Interview with residential treatment center staff, November 20, 2003.

2 Interview with residential treatment center staff, December 4, 2003.

3 Department of Health and Human Services, Office of Inspector General, *Children's Use of Health Care Services While in Foster Care: Texas*, (Washington D.C., February 2004), p. 10, http://oig.hhs.gov/w-new.html.

4 Department of Health and Human Services, Office of Inspector General, *Children's Use of Health Care Services While in Foster Care: Texas*, (Washington D.C., February 2004), p. 2, http://oig.hhs.gov/w-new.html.

Medicaid Reimbursement

HHSC and DPRS should provide foster care contractors with assistance and training to help them claim Medicaid reimbursement for foster care services.

Background

DPRS now requires contractors to pursue Medicaid reimbursement for eligible services delivered to foster children.[1] Many contractors, however, lack the expertise to do so. As a result, the state and its contractors end up paying for many medical services that should be covered by Medicaid.

In fiscal 2000, the most recent year for which foster care cost report data are available, DPRS foster care contractors reported spending nearly $2 million on unreimbursed medical care.[2] These expenses included services DPRS has identified as Medicaid-reimbursable, including the services of clinical social workers, psychologists, physicians and marriage and family therapists.

Providers certainly have a financial incentive to claim Medicaid reimbursements, particularly since the reimbursement rate DPRS pays often does not cover all their expenses. One RTC told the Comptroller review team that it stays in business only by billing Medicaid.[3]

Need for Technical Assistance

Until the recent consolidation with HHSC, DPRS had little readily available expertise on Medicaid reimbursement. Contractors in the field face even greater hurdles. They have been told to claim Medicaid reimbursement but are left on their own to do so, with no guidance on navigating the program's complex procedures and requirements.

Some contractors simply do not know which services are eligible for reimbursement. For example, the personnel of a South Texas RTC who spoke with the Comptroller review team did not know that they could claim reimbursement for a psychologist's services.[4]

In examining contractors' cost reports, DPRS identifies some services that are eligible for Medicaid reimbursement, but not all. A review of another RTC's 2000 cost report indicated that it had sought and received Medicaid reimbursement for a number of services that DPRS had not identified as reimbursable, including services provided by nurses, therapists and social workers.[5]

Some contractors simply do not know which services are eligible for reimbursement.

Many foster care contractors are relatively small operations; they are not medical providers and have little expertise in the area. For example, the comptroller of the South Texas RTC mentioned above told the Comptroller review team that she had called a toll-free number for Medicaid providers but was repeatedly put on hold and given misinformation on the reimbursement process.[6] The executive director of a West Texas RTC told the Comptroller review team that the RTC could not bill Medicaid for some of its services because they needed to obtain a Medicaid provider number.[7]

Recommendation

HHSC and DPRS should provide foster care contractors with assistance and training to help them claim Medicaid reimbursement for foster care services.

Fiscal Impact

This recommendation could produce a net savings for the state, but the amount of these savings would depend upon future events and cannot be estimated. Increased Medicaid payments to providers would reduce the amount of allowable costs reported in the DPRS cost report. Lower reported costs could reduce the state-paid reimbursement rate, which is paid to foster care providers. Increased Medicaid payments to providers will offset some of their costs.

Total unreimbursed expenditures in fiscal 2000 for case management, treatment coordination, direct care and medical care cost the state and its contractors $70.3 million. A five percent improvement in Medicaid reimbursements would generate $3.5 million in savings, of which 60 percent or $2.1 million would be federal funds.

Endnotes

1 Texas Department of Protective and Regulatory Services, 2002 Cost Report Guidelines and Specific Instructions (Austin, Texas, September 20, 2002), p. 74.

2 Texas Department of Protective and Regulatory Services, 2000 Cost Report database.

3 Interview with personnel at a residential treatment center, December 4, 2003.

4 Interview with personnel at a residential treatment center, November 20, 2003.

5 Texas Department of Protective and Regulatory Services, 2000 Cost Report data on Daystar Residential, Inc.

6 Interview with personnel at a residential treatment center, November 20, 2003.

7 Interview with personnel at a residential treatment center, November 24, 2003.

Funding Flexibility

HHSC should request federal waivers and increase funding flexibility to prevent institutionalization of foster care children.

Background

Texas could take advantage of a variety of funding sources that other states have used to improve their foster care services.

Title IV-E Waivers

Waivers within the federal Title IV-E program provide funding that states can use to test innovative ways to deliver foster care. At least 17 states have created such projects using Title IV-E waiver agreements.[1]

Waiver-funded foster care programs must be demonstrably cost-effective and must focus on reducing the length of time children spend in foster care, reducing the use of more restrictive and costly placement settings, reentry into foster care and instances of abuse and neglect. Some states use these programs to target a specific population (for example, behaviorally disturbed teenagers) while others implement systemwide reforms.

Illinois has used Title IV-E waiver funding to help eligible relative caretakers and licensed foster parents assume legal guardianship of the children in their care.[2] To assist with this transition, Illinois provides monthly subsidies and a variety of services including preliminary screenings, counseling and payments of one-time court costs and legal fees.

The state reports significant improvements in permanent placements through this waiver. The number of children placed permanently with relatives rose from 1,276 in 1998 to 2,199 in 1999. The state has used savings from these placements to reduce state social workers' caseloads.[3] Follow-ups with 2,276 children served under the waiver indicated that they were more likely than other foster children to be placed in permanent homes.[4]

Ohio has used Title IV-E waiver funding to help 14 counties use managed care strategies to promote adoption, reduce the number of children in foster care and decrease the length of their stays. The state has submitted a request to the U.S. Department of Health and Human Services to extend this waiver for five years.[5]

Indiana uses a Title IV-E waiver to serve abused and neglected children who have been placed in foster care or are at risk of foster placement. Waiver-funded services include child and family counseling and parental instruction in parenting and homemaking skills. The state implemented this waiver in 1998 and uses the funding in most counties. The state recently received a six-month extension of the waiver and is under review for waiver renewal. Counties receive $9,000 annually for each child in the program, which serves 4,000 children in all. Counties must cover any costs exceeding this amount.[6]

Federal standards for Title IV-E, however, have resulted in a decline in the number of eligible children over time. States receive Title IV-E funding only for children whose biological families would have been eligible for welfare—Aid to Families with Dependent Children (AFDC)—as the program existed on

Texas could take advantage of a variety of funding sources that other states have used to improve their foster care services.

July 16, 1996.[7] Without adjustment for inflation, this means that fewer families will be eligible for assistance.

Other Funding Opportunities

Improvements to foster care delivery do not necessarily require Title IV-E funding.

For example, Milwaukee County, Wisconsin has created a "wraparound" program that employs multiple funding sources to provide a wide variety of services. "Wraparound Milwaukee" relies primarily on funding from Medicaid; federal juvenile justice funds for the residential treatment of delinquent youths; and the Children's Health Insurance Program, a state/federal insurance program for low-income children whose parents do not qualify for Medicaid.[8]

The county's use of residential treatment for eligible children has fallen by 60 percent and inpatient psychiatric hospitalization has dropped by 80 percent.

Wraparound Milwaukee serves children with serious emotional and mental health needs who are at immediate risk of residential treatment, correctional placement or psychiatric hospitalization. The Children and Adolescent Services Branch of the Milwaukee County Mental Health District administers the program. Its care coordinators develop care plans for each child and arrange for services including day treatment; foster homes, group homes and other residential care; outpatient hospitals; parental support services; respite care (temporary care provided so that the usual caregiver can rest or take some time off); transportation; and crisis services.

Since the program began, the county's use of residential treatment for eligible children has fallen by 60 percent and inpatient psychiatric hospitalization has dropped by 80 percent. The average overall cost of care per child has fallen from more than $5,000 per month to less than $3,300.

According to the director of Wraparound Milwaukee, the main challenges to the program's implementation were the need to work across systems (such as juvenile justice and Medicaid) and to educate care providers on the program's goals and structure. Wraparound Milwaukee staff met extensively with the chief executive officers of residential treatment centers to discuss additional services needed (such as weekend respite care); the need for case managers and mentors to participate in the program; and opportunities to prevent potential revenue loss due to the anticipated decrease in reliance on residential treatment services.[9]

Medicaid 1915(c) Waiver

One promising Medicaid funding source for Texas is the 1915(c) home- and community-based services waiver, which supports projects designed to move patients out of institutional settings and into the community.

Michigan is developing a 1915(c) waiver program to provide residential treatment and wraparound services targeting high-need children in foster care or children at risk of entering the foster care system. The state anticipates that the care coordination resulting from the wraparound approach will decrease its need for inpatient hospital care, making the waiver cost-effective.[10]

Minnesota has used 1915(c) waiver funding to provide a wide array of services to disabled individuals under 65, including child foster care, habilitation and vocational services, therapies, transportation, home health and respite care.[11] The state uses the 1915(c) funds to pay for the treatment portion of residential treatment services (in other words, expenses other than room and board).[12]

New Jersey uses a 1915(c) waiver to serve children up to age 13 who test positive for the human immunodeficiency virus (HIV). Waiver services include case management, private nursing services, medical day care, personal care and intensive supervision for eligible children who reside in foster care homes.[13]

Texas has not used 1915(c) waiver funding specifically for foster care services. The state does, however, have multiple 1915(c) waiver programs serving children. One of these programs serves medically dependent children and aged and disabled individuals, offering services such as:

- residential care;
- skilled nursing;
- speech, hearing, language and psychological therapies;
- nutritional counseling;
- medical equipment and supplies;
- respite care;
- dental care;
- modifications to the living environment; and
- supported employment.[14]

Challenges in Waiver Implementation

While waiver programs allow states to use innovative approaches, they can present substantial political and organizational challenges. These include:

- designing waivers to meet existing child welfare goals;
- changing local and state agency structures to accommodate the new program; agencies may require extensive assis-

"Wraparound" Services in Floydada, Texas

One 15-year-old boy diagnosed with bipolar disorder and attention deficit hyperactivity disorder had been in three residential placements over a 22-month period. He was first placed in residential care due to an assault on a school teacher and previous impulsive and aggressive behavior, particularly at school. His placements had been unsuccessful due to continuing behavioral problems and his unhappiness at being away from his family.

The boy's mother, however, learned of a local program that provides "wraparound" services in the home. The child's mother and his probation officer approached a local community resources coordination group associated with the Texas Integrated Funding Initiative, a public/private consortium dedicated to improving the delivery of mental health services and support to minors. This group formed a team, with the child's help, to develop a plan for home treatment designed to help him learn to function in school and manage his impulses appropriately.

After nine months of home services, the child successfully completed a term of juvenile probation, resumed attending public school, making As and Bs, and became more socially active in the community.

The services the team provided included:

- a one-time payment to the family for phone service to allow communication with the team and school;
- one-to-one teacher assistance on a part-time basis;
- counseling;
- medical and neurological treatment;
- transportation to treatments;
- skills training (such as computer training and guitar lessons); and
- respite services for the family, allowing them a break from childcare.

The cost of the in-home care was $15,350 for nine months of treatment, not including case management costs. The team continues to monitor the child, but he no longer needs intensive services. By contrast, the boy's 22-month stay in residential foster care cost about $75,000 and failed to produce a positive outcome.[1]

Endnote

[1] Case scenario from Family Connections, Floydada, Texas, pilot site for the Texas Integrated Funding Initiative, SB 1234, 76th Leg., Reg. Sess. (1999).

tance and training to take advantage of waiver provisions; and
- determining how other initiatives affect waiver outcomes and cost-effectiveness.

States that create Title IV-E waiver programs must be prepared to involve local administrators and other stakeholders in the waiver development and implementation process; provide stakeholders with ongoing education and training; and seek feedback from program participants.[15]

Wraparound Services in Texas

The most promising feature of waiver programs is the opportunity they present to offer complex arrays of services from various providers in wraparound programs. In Texas, however, foster children eligible for current Medicaid waivers must go on waiting lists with hundreds of other children.

However, foster children eligible for current Medicaid waivers must go on waiting lists with hundreds of other children.

Texas has implemented two pilot programs to provide wider arrays of services for foster children in a family-based setting.

EveryChild Inc., a coalition of individuals and organizations dedicated to developing alternatives to institutional placement for children with disabilities, has received a Family-Based Alternatives Model Project grant from the Texas Council for Developmental Disabilities (TCDD) to place children with profound developmental or physical disabilities with families in the Austin and San Antonio areas. EveryChild Inc. works with several agencies, including DPRS and the MHMR, to serve these children. The organization recruits foster families and helps them obtain the services they need to keep the children in their homes. It has placed 10 children who were in institutions with families, reuniting two with their birth families and placing eight more with foster families.[16]

In May 2002, DPRS created a pilot project to place medically fragile children with severe mental retardation or mental health issues in family-based settings. The agency contracted with Texas Mentor, a child placing agency, to place nine children with a specialized or intense service level with families. DPRS paid Texas Mentor the residential treatment center rate for the children, and at least half of these payments were passed on to the families. Additional services for the children were purchased by Texas Mentor or paid for by other state agencies.[17]

Pooling Local Dollars

Funding for child services often is a mix of federal, state, local and private dollars. HHSC has initiated a series of pilot projects in several counties to pool funds from various sources and use them to provide mental health services to children and their families in their homes, with the intent of keeping the children out of foster care.

In 1996, community groups in Brownwood and Austin created initiatives to provide community-based mental health services through a grant from the Robert Wood Johnson Foundation and funding from the MHMR. In 2000, HHSC expanded this effort by creating the Texas Integrated Funding Initiative (TIFI), a program that pools a variety of revenue sources to provide family- and community-based services for children with multiple needs. From a group of 14 applicants, HHSC selected Harris County, Tarrant County, the Rural Initiative Project (headquartered in Floydada, Texas) and the Tri-County MHMR Services (headquartered in Conroe, Texas) to join the initiative.[18]

Children throughout the state could benefit from similar collaborative efforts and from examining opportunities to coordinate service delivery and maximize federal reimbursement.

Recommendations

A. HHSC should combine federal, state and local funding to create "wraparound" managed care programs for foster children.

This might involve:

- expanding an existing Medicaid 1915(c) waiver program or creating a new one;
- creating a Title IV-E waiver program;
- using savings from other efforts to maximize federal funding for these services; and
- targeting a particular population (such as teens with behavioral problems or children at risk of entering foster care) or geographic area (such as a region that has a high percentage of children switching placements).

As part of this effort, HHSC should conduct an in-depth, multi-agency analysis of Texas' current child welfare funding sources and organizational structures to determine how to obtain and coordinate funding more efficiently.

If HHSC officials decide to create a 1915(c) waiver program, they should define the waiver to target current, high-cost beneficiaries rather than serving a new set of beneficiaries. For example, the program could target children in foster care who have experienced multiple psychiatric hospital stays in the last 12 months, or those with a mental illness that may require intensive inpatient hospital services (such as severe depression). HHSC also could target foster children already in nursing home or inpatient psychiatric facilities.

In any case, the waiver should focus on high-cost, high-need children that are likely to benefit the most from increased coordination of care, resulting in positive clinical outcomes and reduced expenditures.

B. HHSC and DPRS should work with other state agencies and local communities to pool funding and provide preventive services designed to keep children out of foster care and in their own homes.

An expanded version of TIFI, or a similar collaborative effort, could be used to offer community-based services to foster children at risk of institutionalization throughout the state.

Fiscal Impact

The federal waivers will need to be revenue neutral to win approval from the federal government. Foster care dollars should be used as a match where appropriate. Any new Medicaid 1915(c) waiver should create new slots for foster care children. It should not place them ahead of other children on current waiting lists or use dollars available for the care of children with mental retardation on those lists.

Local dollars spent on children at risk of being removed from their homes could be matched by federal Title IV-E funds. The possibility of using private donations or local revenue as matching funds should be explored. It may create opportunities to draw down additional federal funds if private donations or local revenue can be used as matching funds for some programs.

Endnotes

1 U.S. Department of Health and Human Services, Administration for Children and Families, "February 2003 Summary of IV-E Child Welfare Waiver Demonstrations," http://www.acf.dhhs.gov/programs/cb/initiatives/cwwaiver/summary.htm. (Last visited January 21, 2004.)

2 U.S. Department of Health and Human Services, Administration for Children and Families, "Illinois: Assisted Guardianship/Kinship Permanence," http://www.acf.hhs.gov/programs/cb/laws/im/states/il1.htm. (Last visited February 20, 2004.)

3 Illinois Department of Children and Family Services, "Performance Contracting in Illinois' Child Welfare System," http://www.state.il.us/dcfs/library/com_communications_performance.shtml. (Last visited November 24, 2003.)

[4] Jennifer Miller, "Child Welfare Waivers: What are We Learning?" available in pdf format from http://www.aphsa.org/cornerstone/cwwlearning.pdf. (Last visited November 28, 2003.)

[5] U.S. Department of Health and Human Services, Administration for Children and Families., "Ohio: Capped IV-E Allocations and Flexibility to Local Agencies," http://www.acf.hhs.gov/programs/cb/initiatives/cwwaiver/oh.htm. (Last visited January 21, 2004.)

[6] U.S. Department of Health and Human Services, Administration for Children and Families, "February 2003 Summary of IV-E Child Welfare Waiver Demonstrations"; and interviews with Sandra Lock, program manager, State of Indiana ICWIS Project, Indianapolis, Indiana, November 14, 2003 and December 4, 2003.

[7] Pew Commission on Children in Foster Care, "The Child Welfare Financing Structure," by K.O. Murray, available in pdf format from http://pewfostercare.org/research/docs/MurrayPaper2.pdf. (Last visited January 21, 2004.)

[8] Milwaukee County Behavioral Health Division, "Wraparound Milwaukee 2002 Annual Report," available in pdf format from http://www.legis.state.ia.us/GA/80GA/Interim/2003/comminfo/childwel/milwaukee.pdf. (Last visited January 21, 2004.)

[9] Interview with Bruce Kamradt, director, Child and Adolescent Services for the Milwaukee County Mental Health Division, Milwaukee, Wisconsin, November 20, 2003; and Milwaukee County Behavioral Health Division, "Wraparound Milwaukee 2002 Annual Report."

[10] Interview with Jim Wotring, director, Programs for Children with a Serious Emotional Disturbance, Michigan Department of Community Health, Lansing, Michigan, November 23, 2003.

[11] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Overview of Home and Community-Based Services Programs (Children)," available in pdf format from http://cms.hhs.gov/medicaid/1915c/children.pdf. (Last visited January 21, 2004.)

[12] Interview with Maggie Friend, policy consultant, Minnesota Department of Human Services, St. Paul, Minnesota, December 4, 2003.

[13] New Jersey Department of Human Services, "Home- and Community-Based Service Programs," http://www.state.nj.us/humanservices/dds/njwaiver.html. (Last visited January 21, 2004.)

[14] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Home and Community-Based Services Summary Report," available in pdf format at http://cms.hhs.gov/medicaid/services/regular.pdf. (Last visited January 21, 2004.)

[15] Jennifer Miller, "Child Welfare Waivers: What are We Learning?"

[16] Interview with Nancy Rosenau, executive director of EveryChild Inc., Austin, Texas, December 3, 2003.

[17] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 8, 2003.

[18] Texas Health and Human Services Commission, "Texas Integrated Funding Initiative," http://www.hhsc.state.tx.us/tifi/communities.htm. (Last visited January 22, 2004.)

RTC Charter Schools

RTC contracts with charter schools should include mandatory participation in the School Health and Related Services program.

Background

A review of some charter schools located at Texas' RTCs indicated some are not seeking reimbursement for services they provide through Medicaid's School Health and Related Services (SHARS) program, which is administered in Texas by HHSC in cooperation with the Texas Education Agency.

SHARS allows Texas public schools, including charter schools, to receive federal Medicaid reimbursement for certain services provided through special education programs. These services include assessment, audiology, counseling, school health services, medical services, occupational therapy, physical therapy, psychological services, speech therapy and special transportation.

Children eligible to receive these services must be Medicaid-eligible, with one or more disabilities as defined in the federal Individuals with Disabilities Education Act, and have an individual educational plan prescribing the services they should receive.

Recommendation

RTC contracts with charter schools should include mandatory participation in the SHARS program.

Fiscal Impact

Medicaid reimbursement through SHARS would provide greater federal funding to cover services, such as counseling, provided by charter schools at foster care facilities. This amount would vary according to the number of children receiving services and the type and amount of services provided.

Federal reimbursement would reduce the impact of allowable costs reported in the residential centers' biennial cost reports, thus reducing the average cost per child used to calculate DPRS reimbursement rates. This could result in lower daily rates for services provided in RTCs and potentially a cost savings to the state.

A review of some charter schools located at Texas' RTCs indicated some are not seeking reimbursement for services they provide through Medicaid's School Health and Related Services (SHARS) program.

CHAPTER 4

Make the Foster Care System More Accountable

DPRS lacks accountability, compromising the quality of care received by Texas foster children. The agency should improve licensing, contracting and monitoring to ensure quality care.

DPRS caseworkers often fail to make required visits with the foster children assigned to them. This could be remedied through formal documentation requirements for such visits.

DPRS should ensure the integrity of the information in its databases by requiring all foster care providers and DPRS staff to report all serious incidents to the agency intake phone center immediately. All incoming reports relating to foster children should be flagged separately.

DPRS should strengthen and fully enforce its licensing standards. Its Residential Child Care Licensing Division should apply current licensing standards for permanent therapeutic camps to all therapeutic camps and immediately move foster children from camps that do not meet those standards. The Texas Department of Health and its affiliates should assume responsibility for health inspections of all foster care residential facilities. DPRS should revoke the licenses of facilities with repeated violations or those with ongoing patterns of allegations that may affect the health, safety and well being of the children in their care.

DPRS should add conflict-of-interest disclosure provisions to all contracts. The agency's policy of allowing providers to reject and eject foster children should be phased out, beginning in fiscal 2006.

DPRS should make greater use of charitable care providers who care for foster children. And the State Auditor's Office should conduct complete, on-site financial audits of selected providers to verify that they are spending state funds appropriately.

The Health and Human Services Commission should assume responsibility for setting foster care reimbursement rates.

Caseworkers

Until our recommendation eliminating the dual foster care system is implemented, DPRS should ensure that its caseworkers regularly visit their assigned foster children.

Background

DPRS caseworkers have the agency's most difficult, demanding and important job ensuring the safety and well-being of each foster child. To a large extent caseworkers accomplish this task by regularly visiting their charges. Unfortunately, due to low caseworker pay, immense caseloads, emotionally draining work and high caseworker turnover, caseworkers are not seeing foster children frequently enough.

DPRS policy states that foster care caseworkers must visit each child in their charge at least once a month. These visits can occur in a variety of places, including court, school, a therapist's place of business or the foster home. If for some reason a caseworker cannot visit each child each month, his or her supervisor must approve a reduced visitation schedule and note it in the child's case file.

Without exception, regardless of the frequency and location of other face-to-face contacts, DPRS stipulates that caseworkers must visit their charges in person at their residences once every three months.[1] These standards, however, are not always met.

DPRS has no guidelines or standard questions for caseworker-child visits. Caseworkers are required to document their visits in monthly case file notes, entering them into a central computer system for their supervisors' approval. Once the supervisor approves these notes, they become a part of the case file.

DPRS has a case review team that randomly chooses case files throughout the state to evaluate caseworker practices and document compliance with agency policy. Case files are rarely used or seen by anyone else.

Foster care providers are not required to document caseworker-child visits; however, providers typically make a note in each child's daily case file about the visit.

The U.S. Department of Health and Human Services' Child and Family Service Review (CFSR) of June 2002 gave DPRS a failing grade of 82 percent on caseworker-child visitation; 90 percent is necessary to pass. The CFSR indicated that 18 percent of the DPRS case files examined did not meet the DPRS standard for caseworker-child visitation. Assuming this is representative of the entire foster care system, 18 percent of the foster care population would be more than 4,400 children. The report cited high workloads and high caseworker turnover as possible causes for this problem.[2] According to DPRS, of the 14,309 children in the foster care system for all three months of the first quarter of fiscal 2004 just under 27 percent or 3,819 children received no caseworker-child visits at all.[3]

The Comptroller review team performed 18 site visits to emergency shelters, foster homes, residential treatment facilities, therapeutic camps and child placement agencies throughout the state. Each entity said that it had children in care that were not visited by caseworkers regularly. Several said they had

Without exception, regardless of the frequency and location of other face-to-face contacts, DPRS stipulates that caseworkers must visit their charges in person at their residences once every three months.

had children for more than a year who had not received a single caseworker visit.[4]

The starting salary for Child Protective Services (CPS) caseworkers is $2,409 per month. Seasoned caseworkers can make up to $2,718 per month. The minimum qualifications for a starting caseworker include a degree from an accredited four-year college or university; computer and typing skills; a valid Texas drivers license; access to reliable transportation; and three character references. Caseworkers must pass a criminal background check. They also must be willing to work in stressful environments and be willing to make visits in children's homes.[5]

Without regular visits, caseworkers cannot be certain that every child in their care is safe and cared for appropriately.

New CPS caseworkers often are recent college graduates who may have trouble coping with the stressful nature of the work and its large caseloads. According to the 2002 DPRS State Plan, caseworkers handle an average caseload of 21 cases. The Comptroller's review team visits to district offices, however, found that caseloads often are substantially higher, at times reaching 35 to 40 children.[6] The Child Welfare League of America recommends a caseworker to case ratio of 1 to 12-15.[7]

Many caseworkers find that they cannot cope with heavy workloads and the emotionally intense nature of the work. In fiscal 2003, 23.5 percent of DPRS' caseworkers left the agency. Turnover rates rose as high as 31 percent in some areas of the state.[8]

High turnover overburdens the system, guaranteeing that caseloads remain high and interfering with the caseworkers' most important responsibility to ensure through regular visits that foster children receive the help they need.

One respondent to the Comptroller's foster care survey said:

> Too many challenges, far too few resources. Older, experienced workers – who grew up in the 50s and 60s, in the midst of social change, and wanted to make a difference in the lives of children – have retired or were pushed into early retirement. Young, inexperienced women make up the majority of caseworkers partly because the pay and workload is so darn bad. The compassionate, caring workers are eventually beaten down by the overloaded system, or they seek other employment. DPRS state-level administration say their hands are tied...or, there are not enough resources...or, whatever to deflect any responsibility on them. No one appears to have the courage, knowledge and skills to push beyond the box, to find innovative methods that actually work.

Recommendations

A. DPRS should establish formal guidelines and documentation standards for caseworker-child visitation.

Caseworker visits are essential to guarantee that foster children are receiving proper care. Caseworker visits provide a link to the biological families and homes of foster children. In addition, caseworkers provide stability for foster children as they move through the foster care system.

Formal guidelines and prescribed questions would ensure that these visits are effective, while making it easier for the agency to objectively review its caseworkers' performance and evaluate the care children are receiving.

B. DPRS should use caseworker-child visitation as one of its performance measures.

DPRS should strive to ensure that caseworkers comply with the agency's rules on visitation. At minimum, DPRS should meet the federal standard and earn a passing grade on federal reviews. Including visitation as an agency performance measure would help ensure that DPRS applies its resources to reach this goal.

Fiscal Impact

These recommendations could be implemented with existing resources.

Endnotes

[1] Texas Department of Protective and Regulatory Services, *DPRS Handbook* (Austin, Texas, January 2003), Section 6511, Contact with the Child.

[2] Texas Department of Protective and Regulatory Services, Texas Child and Family Services Review, *Texas Program Improvement Plan*, response to the U.S. Department of Health and Human Services, Administration for Children and Families, *2002 Child and Family Service Review* (Dallas, Texas, April 2003), p. 16.

[3] Texas Department of Protective and Regulatory Services, ad hoc data request from the IMPACT database, (Austin, Texas, January 2004).

[4] Interviews with emergency shelter, RTC and CPA staff, November 2003 through February 2004.

[5] Texas Department of Protective and Regulatory Services, caseworker job posting found at www.tdprs.state.tx.us/jobs/C11277.htm. (Last visited January 19, 2003.)

[6] Interviews with Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 2, 2003.

[7] Child Welfare League of America, "Recommended Caseload Standards," www.cwla.org/newsevents/news030304cwlacaseload.htm. (Last visited January 19, 2003.)

[8] DPRS response to Comptroller data requests, Austin, Texas, December 8, 2003.

Licensing

DPRS should strengthen and fully enforce licensing standards.

Background

Licensing standards for 24-hour childcare are weak in certain important areas and are poorly enforced. In addition, they do not provide a means to trigger license revocation for patterns of repeated violations.

Licensing standards cover all aspects of a facility's operations, from the responsibilities of boards of directors to children's service and treatment plans to the buildings, grounds and equipment.

The strength of DPRS' facility licensing standards and the integrity of their enforcement are critical to ensure the basic health, safety and well-being of foster children in residential care. DPRS can contract only with facilities it has licensed, and the first requirement listed in its contracts states that providers must "comply with the minimum standards for any childcare license issued by the department…"[1]

The licensing standards for 24-hour childcare apply to child placing agencies, residential treatment centers, therapeutic camps, foster homes and other facilities.[2] DPRS has not significantly updated its licensing standards since the 1980s, but at this writing DPRS is drafting revisions.

To enforce licensing standards, state law requires DPRS to inspect residential facilities at least annually and to make at least one unannounced inspection per year.[3] Unfortunately, this is not happening for many facilities.

The agency's policies require even more frequent inspection visits for some facilities, such as those that have a higher frequency of violations.[4] This is not happening, either, and the small number of inspection employees allocated to the Residential Child Care Licensing (RCCL) division of CCL, only 26 FTEs to inspect, monitor and investigate complaints of licensing violations at more than 600 facilities, ensures that it never could happen.

State law also requires DPRS to investigate when a complaint of abuse or neglect is received; DPRS allocates 12 FTEs for this function.[5] According to DPRS records, however, the agency closes some serious complaints without investigating them, performs only cursory reviews of others and sometimes delays time-sensitive investigations (see Chapter 5, "Abuse and Neglect").

Licensing standards for 24-hour childcare are weak in certain important areas and are poorly enforced.

DPRS contract managers also must visit contracted facilities annually, according to agency policy, but depend heavily on the results of RCCL inspections and investigations when considering contract renewals. They access this information through an agency database and informally through communications with RCCL employees.[6]

Therapeutic Camps

Licensing standards set lower requirements in some important areas for therapeutic camps, which are supposed to provide rehabilitative services for foster youths in outdoor settings,

(continued on page 154)

A Therapeutic Camp[1]

One therapeutic camp serves troubled boys who have histories of physical or sexual abuse.

Some boys stay for years at the camp, living in questionable conditions. Exposed day and night in open shelters with little more than old blankets and sleeping bags, they endure extremes of hot and cold, wind, rain and insects. These children cook their own dinners and all meals on weekends. They walk down dark trails to makeshift outhouses that discharge sewage on the ground and have no ready access to hot water and soap.[2]

DPRS pays the camp $1.3 million annually for about 36 foster children to stay in these conditions. This amounts to about $97.65 per day, or $35,642 per year, per child.[3]

Life at Camp

The boys' shelters look like picnic pavilions, with four poles, a raised plywood floor and a tarpaulin roof. Three or four homemade wooden cots or rusty metal frame beds sit around the edges of the sleeping platforms.

The four campsites are set in a few secluded acres of woods, surrounded by 137 acres of forest. The campsites are home, often for years, to abused or neglected boys from ages 9 to 18 in DPRS' custody, and about 15 under county juvenile probation authority. The campsites sit well away from each other and from a central campus that houses the main office, a kitchen and dining facility, showers, laundry, storage, basketball court, workshop, guest quarters and a school.

Beginning December 1, the boys wrap sheets of plastic around their beds to keep out wind and rain. The pavilions are unheated, exposed to the elements, and the campsites have little light at night.

According to camp staff, for hot water at the campsites, the boys must chop wood and heat water on a barbecue pit. The children cook 11 of their own meals at the campsites every week. The Comptroller review team found perishable food in ice chests with no ice, dirty dishes, outdated food, rusty cans and trash strewn around the kitchen and dining pavilion on an unannounced visit in January 2004. The Comptroller review team did not observe detergent or soap at the kitchen pavilion in at least one of the campsites.

Each campsite also has a makeshift urinal located at the site, called a "pee wall." The urinal is a wooden, three-sided structure with a small ceramic bucket located near the back wall that has a pipe into the ground.

Each morning, the boys walk to an old shower facility at the main site and shower in several stalls. The facility is an open locker room with three lavatories.

Education and "Therapy"

The camp does not require its children to attend its school, an on-site campus of a local independent school district. According to camp employees, children who do not attend school pursue vocational activities or chop wood to occupy their time. The boys do not have homework after the school day, and return to their campsites after school.

Documentation in the contract manager's file related a parent's concern that her son was exposed to accounts of "abnormal sex acts" and that she was not told that sex offenders were not segregated from other residents. DPRS recently cited the camp for violating restraint standards by using "victim empathy therapy" in which the boys were held down on the ground against their will.

Although some of the younger boys and some of the older ones who are watched more carefully have their own campsites, boys with tendencies to act out sexually or who have violent or criminal backgrounds are intermixed with others who have no such histories, as well as some who have been physically abused. At one campsite, a nine-year old boy slept near a counselor "to protect him from the other boys," according to one camp staff person.

A History of Complaints

Despite a history of some serious incidents and complaints about the facility, the camp has remained a licensed "therapeutic camp" for about 22 years. In 2000, DPRS placed the camp on an evaluation status for license revocation because of a series of serious incidents involving sexual activity among the children at night while counselors slept, and the sexual abuse of one child by a staff member.

The camp's proposed response to the problem of not having staff who were awake at night was to have the counselors stay awake awhile longer to make sure the children were asleep first, and to make the roving night watches' schedule unpredictable. Instead, DPRS required the camp to have two employees awake at each campsite all night.

A pattern of allegations and incidents continues. Since January 2001, the camp and its affiliated foster group home have been the subject of about two dozen allegations of sexual activity between children, drug use by staff and children, sexual or physical abuse by staff members, neglectful supervision or licensing violations.

In September 2003, a Licensed Master of Social Work (LMSW) with access to the camp records called the statewide intake phone center to notify DPRS of "another serious supervision problem and abusive childcare practices as reported in the clinical record for a child" at the camp. The caller reported that a child was "inappropriately contained, taken to the ground in a rough manner, inappropriately restrained with his arm held up behind his back and cursed at by staff." The caller indicated that the restraint would not have been necessary had the children been under direct supervision as their levels of care would warrant and that the 11-year old child was unsupervised with two older boys who were sex offenders. The licensing investigator ruled out abuse and found the facility in compliance with standards involving staff supervision, staff qualifications and problem management, including compliance with a requirement that staff not make belittling or ridiculing remarks to children.

Another call to the statewide intake center earlier in September 2003 by the same LMSW who had found more evidence of "serious supervision problems and abusive childcare practices reported in the clinical record for a child" at the camp was never recorded in the system.

DPRS ruled most complaints about the camp invalid after an investigation, or "administratively closed" the complaints without investigation. According to DPRS, the camp corrected several practices that DPRS found violated standards.

Inspections: What Went Wrong?

Despite its record of repeated complaints, the camp did not have a licensing inspection from November 2001 to April 2003, even though state law requires an annual inspection. The April 2003 inspection included two sections of the standards involving a review of organizational and administrative policies, procedures, reports and records, and general child care. The general child care section includes items such as food and nutrition, medical and dental care, clothing and education. The licensing inspector found no violations.

The inspection did not include standards relating to personnel, such as staff-child ratio and training; service management, including admission policies and procedures and service plans; problem management, such as restraints and seclusions; and buildings, grounds and equipment.

DPRS has the camp on a monitoring plan calling for inspections every six to nine months. This level of inspection, according to DPRS, is for facilities that have a record of "a few deficiencies that do not place children at immediate risk and deficiencies are corrected on time." In any event, DPRS did not follow its own monitoring plan or state law.

Comptroller staff interviewed the county health inspector, who has records of annual health inspections of the kitchen and dining facility at the main site for the past four years, but no record at all of health inspections at the four campsites. The inspec-

(continued)

Therapeutic Camp (continued)

tor stated that he could not recall the campsites ever having had a county health inspection.[4]

He explained that under state law, county health departments inspect only what the facility or its licensing agency asks them to inspect, except when they are investigating a complaint. He added that he had not received any complaints about the camp.[5]

Comptroller staff interviewed the county health inspector again after he completed the annual inspection of the camp's kitchen and dining facility. After the inspection found the kitchen and dining facility in compliance with food preparation standards, the health inspector said he decided to tour the campsites. He made several observations that he forwarded to DPRS staff and the Comptroller's office.[6]

Although he did not conduct a formal inspection, the health inspector reported that:

> Latrines and outhouses were discharging sewage on the ground… The individual campsite food preparation areas were unsanitary. The wastewater from the kitchen is being discharged on the ground. Proper sanitation of the cookware and/or dishes was not evident. Campsites were exposed to potential airborne diseases...[7]

"Primitive" but Permanent

Comptroller staff also found that the camp living arrangements appear not to comply with DPRS licensing standards for "permanent" camps. These standards require living quarters to have heating equipment capable of maintaining a temperature of 68 degrees. The housing must protect its occupants against the elements, including screens on all of the outside openings.[8] (See Appendix 4.)

Licensing standards for "permanent" therapeutic camps also require that they have flush toilets if water is available at the site; water is available at all campsites at this facility. Where water is not available, standards require that privies must be built according to Texas Department of Health (TDH) standards, which require that privies, outhouses or latrines have only one seat, four sides, a door, a lidded, closed seat to keep out animals and insects and adequate ventilation.[9] An official with the TDH General Sanitation Division told Comptroller staff that long-term campsites without flush toilets are asking for an outbreak of infectious disease.[10]

TDH standards do not require "primitive" or "wilderness" camps to have flush toilets or privies, but the TDH official stated that camps identified in this way are intended to be temporary camps, used for only a

than for RTCs, which serve children with the same, and sometimes more severe, problems.

RTC personnel responsible for the overall treatment program and evaluating admissions assessments must have at least a master's degree in a mental health field or be a licensed master of social work. Therapeutic camps, by contrast, lack these standards. However, standards require the individual with overall responsibility for administering the facility to hold a child-care administrator's license, which requires a minimum educational level of high school equivalency.[7] At a therapeutic camp, this individual could perform these tasks.

In addition, licensing inspectors have applied a set of standards for therapeutic campsites that should apply only to short-term camping forays into the wilderness instead of to permanent camps that have children living in them for months and years. (See Appendix 4.)

The Comptroller review team found that RCCL has not coordinated adequately with the Texas Department of Health and local health departments concerning violations of health and sanitation regulations in therapeutic camps. This situation let one therapeutic camp avoid meaningful health and sanitation inspections for years; the accompanying case study tells this story in detail.

few days or weeks at a time.[11] In a recent interview, DPRS licensing officials agreed that the standards for "permanent" camps should be applied to the camp, including its campsites, and that the facility's use of the term "wilderness" to describe itself had no bearing on the agency's interpretation of its standards.[12]

The TDH official pointed out that, since DPRS is the licensing agency, it has ultimate responsibility for interpreting its regulations, even if it bases them on TDH health regulations. He also said that DPRS is responsible for health and sanitation inspections of every part of the facilities it licenses, if it does not request the local health department to conduct the inspections.[13]

Endnotes

1 The names in this document have been omitted for privacy reasons.

2 Comptroller review team observations and interviews with camp staff.

3 Data provided by DPRS.

4 Interview with local county health department director, December 8, 2004.

5 Interview with local county health department director, December 8, 2004.

6 Interview with local county health department director, January 20, 2004.

7 Letter from local county health department director to Texas Department of Protective and Regulatory Services staff, January 20, 2004.

8 Texas Department of Protective and Regulatory Services, *Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care* (Austin, Texas, January 2004), "Section VI: Specialized Standards for Therapeutic Camps," available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited February 5, 2004.)

9 Texas Department of Protective and Regulatory Services, *Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care* (Austin, Texas, January 2004), "Section VI: Specialized Standards for Therapeutic Camps," available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp (Last visited February 5, 2004); and Texas Department of Health, *Texas Community Sanitation Handbook* (Austin, Texas, January 1986).

10 Interview with Texas Department of Health staff, November 24, 2003.

11 Interview with Texas Department of Health staff, November 24, 2003.

12 Interview with Texas Department of Protective and Regulatory Services staff, January 5, 2004.

13 Interview with Texas Department of Health staff, November 24, 2003.

Inadequate Board Oversight

DPRS' licensing standards do not ensure adequate oversight of residential facilities by their boards of directors. A viable board is critical to the health of such an organization, providing community involvement and leadership. A strong board will take responsibility for an organization, oversee its management, generate community support and attract qualified employees.

A weak board, by the same token, may be composed mostly or entirely of related parties, such as relatives, vendors and other vested interests that rarely meet or simply rubberstamp the facility director's wishes.

DPRS' current licensing standards do not require boards to include enough unrelated individuals who do not benefit financially from the organization to ensure adequate oversight and prevent conflicts of interest or collusion.[8] For instance, the Comptroller review team learned of one residential facility board that was made up entirely of individuals receiving compensation from the facility. Another facility's board consisted almost entirely of related individuals.

DPRS' draft revisions to these standards would prohibit employees, family members and paid consultants from comprising a majority of the board, but would not prohibit the participa-

tion of others who benefit financially from the facility, such as subcontractors or vendors.[9]

In addition, the present and draft standards alike require board members to be responsible for the facility's programs and activities and for compliance with minimum licensing standards. They do not, however, require board members to receive notices of licensing violations and other correspondence to and from state agencies; receive progress reports on program and child outcomes; or to hire, fire and annually evaluate the performance of the executive director.

Infrequent Inspections

The review team learned of one residential facility board that was made up entirely of individuals receiving compensation from the facility. Another facility's board consisted almost entirely of related individuals.

Although state law and agency rules require annual inspections, DPRS' policy handbook interprets the law and rule to mean that a "partial" inspection—one that examines compliance with only a portion of DPRS' standards—must be made annually, and that facilities must be inspected for compliance with all standards at least once every two years.[10]

In other words, the agency interprets "annually" to mean "biennially." This interpretation seems to be a holdover from an earlier statute that required biennial licensing and inspection. When the law changed to require perpetual licenses with annual inspections, the old policy and practice continued.

The Comptroller review team examined the 2002 and 2003 inspection records pertaining to 24 residential facilities, mostly large ones; in all, the group accounted for 29 percent of all contractor payments in 2002. Among this group, five did not receive a single inspection visit from RCCL in one of the two years, and 14 did not receive a complete inspection in at least one of the two years.[11]

Furthermore, DPRS is not following its own policy calling for more frequent inspections of higher-risk facilities. Agency plans call for RCCL to inspect facilities every three to five months, six to nine months or 10 to 12 months, according to their compliance histories and other risk factors, but DPRS inspected only a third of the 24 facilities selected for this study according to this schedule.[12]

Repeated Violators

The Comptroller review team found that certain providers seem to have the same problems repeatedly. For example, the *Austin American-Statesman*, in an article about a camp, wrote:

> According to sheriff's department records, deputies have responded to more than 350 calls at the…camp over the past four years, an average of one call every four days. They have ranged in seriousness from assault with a deadly weapon to runaways.[13]

Even so, the agency does not have standards or policies that would automatically trigger action to address repetitive violations, such as ongoing problems with child supervision. DPRS places some facilities with an unresolved history of serious violations on "evaluation status" or probation to consider license revocation, but this is rare. Among more than 600 residential facilities operating in fiscal 2003, DPRS revoked only one license, suspended four, placed one on probation and six on evaluation status.[14]

If DPRS revokes a license, the facility may not reapply for two years; however, facilities can skirt this problem by voluntarily closing their facility and re-opening after fixing the problem of the moment.[15]

Prevention

RCCL inspectors review a wide variety of residential facilities and have substantial information about successful practices and policies, but the agency does not maintain a "best practices" database or any other systematic method of sharing this information.

In addition, DPRS does not train other DPRS workers who visit facilities on its licensing standards. Consequently, the agency is missing opportunities to obtain credible reports of possible violations from its own workers.

Recommendations

A. RCCL should apply current licensing standards for "Permanent Therapeutic Camps" to all therapeutic camps and their associated campsites and should immediately move children from camps that do not meet the standards. All areas of therapeutic camps, including associated campsites, should have a thorough health inspection by local health inspectors.

Licensing standards should specify that any wilderness camping excursion last no more than six weeks.

B. DPRS should upgrade the standards applied to therapeutic camps for personnel responsible for the overall treatment program and admissions assessments to make them comparable to those for residential treatment centers.

DPRS should upgrade educational standards for administrators of assessment programs and residential child care administrators.

C. TDH and its local affiliates should assume responsibility for complete health inspections of all foster care residential facilities.

DPRS should be required to begin revocation proceedings against facilities with health or safety deficiencies and to immediately revoke a license and close a facility on the recommendation of TDH or a local health department.

D. DPRS should develop rules and standards such that facilities with repeated violations would trigger full inspections and lead to license revocation.

DPRS should collect and review data concerning provider violations to allow it to revise the standards effectively. The standards should establish numbers, types and patterns of violations that will automatically place a facility on probation and lead to revocation unless the underlying issues were resolved quickly.

E. DPRS should revoke the licenses of facilities that have ongoing problems affecting the health, safety and well-being of children.

The elimination of repeated violators would free RCCL staff to inspect other facilities more frequently and investigate and resolve complaints more quickly, as well as to do both more thoroughly.

F. DPRS should permanently bar any board members, officers and lead administrators of a facility that has lost its license, or that voluntarily closes after an adverse action, from holding a license or operating a foster care facility in Texas.

This measure would ensure that facilities did not simply change their names and begin operating again under essentially the same management.

G. RCCL should complete at least one thorough inspection of each residential facility annually and make more frequent inspections, as required, according to their monitoring plans.

This recommendation would bring the program into compliance with state law and agency policy.

H. DPRS should promote quality care in foster care facilities by maintaining a best practices database for foster care facilities and caregivers.

I. DPRS should provide training on licensing standards to all staff who visit facilities.

Fiscal Impact

These recommendations could be completed with existing agency resources identified in Chapter 2. Local health departments already inspect most facilities. Recommendation C gives the Texas Department of Health and local health departments the authority and responsibility to ensure that health regulations are enforced in all facilities. Additional costs would be negligible.

Endnotes

[1] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, Clause 10, p. 2.

[2] Texas Department of Protective and Regulatory Services, "Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care," "Minimum Standards for Child-Placing Agencies," "Minimum Standards for Independent Foster Family Homes," "Minimum Standards for Independent Foster Group Homes," and "Minimum Standards for Emergency Shelters," Austin, Texas, January 2004, available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited January 28, 2004.)

[3] Tex. Hum. Res. Code, 42.044(b).

[4] Texas Department of Protective and Regulatory Services, "About Child Care Licensing," http://www.tdprs.state.tx.us/Child_Care/About_Child_Care_Licensing/default.asp#24hour. (Last visited January 28, 2004.)

[5] Tex. Hum. Res. Code, 42.044(c).

[6] Interview with Texas Department of Protective and Regulatory Services staff, November 12, 2003.

[7] Texas Department of Protective and Regulatory Services, "Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care," Austin, Texas, January 2004, available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited January 28, 2004.)

[8] Texas Department of Protective and Regulatory Services, "Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care," Austin, Texas, January 2004, available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited January 28, 2004.)

[9] Texas Department of Protective and Regulatory Services, "Chapter 748: Facility-Based Residential Child Care," Austin, Texas, September 1, 2003. (Draft document.)

[10] Texas Department of Protective and Regulatory Services, *Licensing Policies and Procedures Handbook*, §4400(B).

[11] Data based on 24 facilities reviewed from Texas Department of Protective and Regulatory Services, "Search for a Child Care Operation," http://www.txchildcaresearch.org/ppFacilitySearchResidential.asp.

[12] Data based on 24 facilities reviewed from Texas Department of Protective and Regulatory Services, "Search for a Child Care Operation," http://www.txchildcaresearch.org/ppFacilitySearchResidential.asp.

[13] Robert W. Gee, *Austin American-Statesman*, "Hays Residents Fight Proposal for Camp for Troubled Youths," December 20, 1999.

[14] Texas Department of Protective and Regulatory Services, *2003 Data Book*, p. 97.

[15] Tx. Hum. Res. Code, §42.072 (c) and interview with Texas Department of Protective and Regulatory Services staff, January 7, 2004.

Data Integrity

DPRS should ensure the integrity of the information in its databases.

Background

DPRS' contract managers depend on the Child Care Licensing Division's (CCL's) inspections and investigations to ensure the basic health, safety and well-being of foster children. Consequently, CCL must investigate all allegations involving violations of law or agency standards. The results of these investigations should give managers and caseworkers the information they need to make appropriate decisions concerning contracts and child placements.

By the same token, CCL depends upon the agency's contract managers, caseworkers and other employees to report possible licensing violations for investigation. The entire system, then, depends upon the completeness and accuracy of the information used for decision-making.

DPRS' licensing standards specify which incidents involving foster children that facilities must report to the agency. At present, however, the standards do not require caregivers to report runaways or other missing children who are under the managing conservatorship of other state agencies.[1]

For instance, one child under the conservatorship of the Texas Juvenile Probation Commission and placed at a DPRS-licensed therapeutic camp stole a facility staff member's truck, went to Mexico for several months and was arrested upon his return.[2] The facility did not report the incident to DPRS, and nothing in the agency's licensing standards required it to do so.[3] As a result, contract managers, foster care workers and anyone else who reviews this facility's record will not be aware that the incident occurred.

Other information gaps occur when facilities report incidents to their DPRS contract managers instead of the agency's statewide central intake phone center, which collects complaints about foster care facilities, reports of licensing violations and instances of abuse and neglect from across the state. DPRS policy requires all licensed facilities to report serious incidents involving their charges to the intake phone center.

Other information gaps occur when facilities report incidents to their DPRS contract managers instead of the agency's statewide central intake phone center...

A Comptroller review of one residential facility's contract notebook containing all the contract manager's documentation about each facility holding a foster care contract found two such serious incidents. In 2001, one boy ran away, burgled a neighbor's house and stole a shotgun. The owner came home and held him at bay until police arrived. In another incident, also in 2001, the facility director told the contract manager that four boys had been sexually "acting out," and that the facility was discharging one boy because of "repeated behavior of this nature." The CCL records for the facility did not reflect these incidents.[4]

Another example involves a letter that a local health inspector sent to DPRS on January 20, 2004, expressing serious concern about conditions at a therapeutic camp.[5] As of February 4, 2004, DPRS had not reported the concerns to the intake phone center to initiate an investigation. Instead, the licensing inspector reviewed the concerns as part of an inspection. Conse-

quently, the report is not listed in the DPRS public database that records complaints.[6]

One facility director told Comptroller staff that the CCL investigator instructed the facility to quit calling the intake phone center when incidents occur and to call the investigator instead.[7]

In general, the Comptroller review team found that the CCL database often omits relevant information that decision-makers should have to assess a facility's record. The agency's new licensing database, launched in 2002, is a significant improvement over the previous database. Even so, a Comptroller review of several facilities' records for 2003 found the information on facilities inadequate to accurately judge compliance with licensing standards.

The agency databases hold significant promise to provide useful management information for other divisions in the agency, as well as support to facilities; however, the lack of attention within the agency to ensure their integrity is undermining their strength.

Key problems involve the lack of information on why DPRS closes cases without investigating them and who authorized the closure, how the investigator reached the decision on cases that were investigated and what actions the facility will take to avoid repetitions of the same problem.

The agency databases hold significant promise to provide useful management information for other divisions in the agency, as well as support to facilities; however, the lack of attention within the agency to ensure their integrity is undermining their strength.

Recommendations

A. DPRS should require the facilities it licenses to immediately report all serious incidents involving runaways, missing children, arrests of children and all potential licensing violations to the agency's intake phone center.

These reports should be made regardless of which agency holds managing conservatorship of the children involved.

B. DPRS should require its contract managers and other staff to immediately report any findings or information concerning licensing violations to the intake phone center.

C. DPRS should develop a quality assurance system that performs sample audits of reports, investigations and inspections to ensure their completeness and validity.

D. DPRS should develop criteria and questions for licensing investigations and should require workers to fully document their inspections, investigations and administrative closures in the CCL database; the reasoning behind their decisions; and any follow-up actions taken thereafter.

Fiscal Impact

These recommendations could be implemented with existing agency resources.

Endnotes

1 Texas Department of Protective and Regulatory Services, *Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care*, Austin, Texas, January 2004, available in pdf format at http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited January 28, 2004.)

2 Texas Juvenile Probation Commission, "Year 2003 Case Summaries," http://www.juvenilelaw.org/CaseSummaries2003/03-3-04.HTM. (Last visited January 3, 2004.)

3 Texas Department of Protective and Regulatory Services, "Search for a Child Care Operation," http://www.txchildcaresearch.org/ppFacilitySearchResidential.asp. (Last visited March 4, 2004.)

4 Information provided by Texas Department of Protective and Regulatory Services, November 25, 2004.

5 Communication from county health inspector to Texas Department of Protective and Regulatory Services, January 20, 2004.

6 Information from DPRS, February 4, 2004 and March 16, 2004.

7 Interview with facility director, February 5, 2004.

Contracts

HHSC and DPRS should improve contracting practices.

Background

DPRS, through its central office, five semi-autonomous district offices and 11 regional offices, contracts with numerous foster parents, private residential care providers and professional services providers.[1] In fiscal 2003, DPRS spent more than $285 million on these contracts.

Since the mid-1990s, the Texas Sunset Advisory Commission and Texas State Auditor's Office (SAO) reports have repeatedly cited irregularities in DPRS contracting methods, oversight and payments.

While DPRS has made various changes to its contracting processes in response to these criticisms, the Comptroller review team found that many problems persist. These problems result in inefficient and inadequate monitoring, accountability and purchasing practices; most importantly, the process does not guarantee that foster children receive the care they deserve.

Contract Types

DPRS contracts fall into two major categories, those for residential care and those for the purchase of services (POS). These two categories reflect the division between the outsourced and state-run portions of the state's foster care system.

Residential care contracts are used for the outsourced side of the system. They pay child placing agencies and RTCs daily per-child rate to provide an array of services for foster children, including room and board; educational, recreational and vocational activities; behavior management and diagnostic services; and medical services.[2]

POS contracts are used to provide services to children and families served in the state-run side of the system, through foster families and group homes that contract directly with CPS. They are also used to purchase services for CPS staff such as training and continuing education accreditation.

Exhibit 1 lists the type and number of CPS contracts held in fiscal 2003.

Residential Contracts

In 2003, DPRS reorganized its contracting functions, creating within the Child Protective Services Division (CPS) an Office of Programs that replaced the former Contract Administration Division. The Office of Programs, in turn, has two divisions responsible for ensuring that vendors fulfill their contract requirements: the Contract Management Division (CMD) and Contract Policy Division (CPD).

CMD procedures require contract managers to conduct site visits before executing contracts with residential caregivers, to ensure that their facilities meet agency standards and contract requirements. A CMD contract manager assembles the contract package, including a standard "boilerplate" contract, a detailed service description, budget and a copy of all other completed forms and attachments required by DPRS. Before signing a contract,

While DPRS has made various changes to its contracting processes in response to these criticisms, the Comptroller review team found that many problems persist.

CMD checks to verify whether the vendor has paid its taxes or has any unresolved licensing violations. The contract is executed after all vendor and DPRS signatures are in place.[3]

CMD personnel also make on-site visits to monitor contractor operations. Before such visits, they review contractor records, including cost reports submitted by each contractor, the contractor's licensing history and any violations of licensing standards noted in the past.

After these visits, the contract managers compile reports summarizing their findings, conclusions and recommendations. The findings may include a breakdown of any fiscal errors identified, deficiencies in program operations and a calculation of questioned costs. The contract manager's report also identifies areas that require technical assistance or corrective action. Unresolved problems may be referred for alternative dispute resolution.[4]

Every two years, contractors that provide 24-hour residential child care are required to submit financial information reporting all expenses incurred in providing these services at licensed facilities. This information is provided in a document called the cost report. The Cost Reporting and Fiscal Analysis Unit

Exhibit 1

Types, Numbers and Amounts of DPRS Foster Care-Related Contracts Fiscal 2003

	Administered by	Contractor Type	Clients Served	Fiscal 2003	
				Number of Contracts	Total Expenditure
Residential Foster Care					
Statewide	DPRS central office	Child placing agencies, residential treatment centers, therapeutic camps	Foster children referred to DPRS and placed in private care	295	$285,000,000
CPS District	Each of the 11 regional offices within the five districts	Foster families and group homes	Foster children placed in public care	3,337*	$31,000,000
Purchased Services					
Statewide	DPRS central office	Training institutes; adoption services; Youth For Tomorrow assessments	DPRS staff training; foster children services	66	**No data available from DPRS**
CPS District	Each of five district offices	Medical, therapeutic, legal and training professionals	Children placed with a foster family or group home, adult family members, adult caregivers	606	$30,000,000

*These agreements to care for foster children may not be formalized in a written contract.
Source: Texas Department of Protective and Regulatory Services.

conducts desk reviews or selected on-site audits on each cost report to ensure that the financial and statistical information submitted conforms to all applicable federal and state rules, regulations and instructions.[5]

Contrary to standard governmental and private business practice, DPRS does not write the contracts it signs with providers of residential foster care. Each year, DPRS gathers selected providers to write—not simply comment on or negotiate, but write—key provisions in boilerplate contracts they will sign for the coming year.[6]

Most government and private business contracts are written in a businesslike environment, with one side proposing terms and conditions and the other responding. States also offer "take-it-or-leave-it" contracts with terms giving the state significant power over its relationship with its vendors. DPRS' practice of allowing providers to negotiate their own terms from the start certainly contributes to the general weaknesses of DPRS provider contracts detailed in this report, and places foster children and state and federal funding at risk of abuse.

In giving its vendors such control, DPRS has crippled its ability to enforce performance standards and other key contractual obligations. And DPRS' Contract Policy Division has only one attorney to review and approve hundreds of contracts and amendments.

Furthermore, the contracts are poorly written. They lack effective provisions to prevent conflicts of interest and are so out-of-date that current contracts still require all parties to meet obsolete year 2000 technology standards.[7]

No-Reject, No-Eject

More seriously, the contracts allow providers to reject or eject children placed with them.[8] Contractors can refuse admission to any child they choose and can require DPRS to remove a child with as little as 24 hours' notice to the caseworker.[9]

Allowing providers to pick and choose among foster children and the services they deliver undermines the entire foster care system. It prevents the state from ensuring that each child has a safe and appropriate care environment. It also puts caseworkers in a bind when contractors can dictate which children they will serve. For example, caseworkers sometimes have to make quick decisions and say desperate things to acquire emergency housing for a child. Some contractors told the Comptroller review team that it is not unusual for a caseworker to misrepresent a child's condition to gain admission.[10]

"No-reject, no-eject" contract clauses requiring providers to serve all children referred to them by DPRS could strengthen the system. Caseworkers would have no cause to misrepresent a child's condition and providers would be better prepared to care for the child. According to child welfare experts in Kansas, Illinois and Florida, the no-reject, no-eject clauses in their provider contracts are essential to providing daily foster care.[11]

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No-reject, no-eject clauses have caused some financial instability for providers in other states. Therefore, effective clauses must enable providers to serve all children while mitigating the financial consequences of difficult-to-serve children or unexpectedly high caseloads. A comprehensive study by the U.S. Department of Health and Human Services found that financial risks for providers could be limited by contracts stipulating the type and duration of children's treatment, and allowing providers some control over case referrals and decisions about children's care.[12]

Ohio uses a random assignment of cases to contractors so that no one contractor is overburdened with costly cases. Tennessee places maximum limits on the number of children a provider can reject and minimum limits on the number of children providers accept each month.

A no-reject, no-eject clause in DPRS foster care contracts is necessary for a successful,

completely outsourced foster care system. Several providers told the Comptroller review team that they have the desire and the capacity to care for more children, but also want to be more involved in management decisions.[13] An effective no-reject, no-eject clause that mitigates financial hardships and involves providers in the daily management of children would accomplish a successful transition to an effective, outsourced foster care system.

POS Contracts

The five district CPS offices manage most POS contracts, while CMD manages statewide POS contracts such as the one for evaluations performed by Youth for Tomorrow (YFT). Four CMD contract managers—only one of whom is an attorney—handle 66 statewide POS contracts. Each of the five district offices has at least one employee to manage district POS contracts.[14]

Open-enrollment contracts also are open-ended in terms of cost.

Children who require only the most basic level of care and are cared for in the state-run side of the foster care system receive services through POS contracts. These services include:

- evaluation and testing;
- individual, family and group counseling;
- adoption and post-adoption counseling;
- parent and caregiver training;
- substance abuse counseling;
- translation services; and
- counseling and support offered through DPRS' Preparation for Adult Living (PAL) program.[15]

In fiscal 2003, district-administered POS contracts for foster care services averaged less than $50,000 each, but 10 contracts exceeded $500,000 and one totaled $1.1 million (Exhibit 2).

Open Enrollment

State law exempts DPRS and all other agencies under the Health and Human Services Commission's (HHSC) oversight from many of the purchasing requirements that most other state agencies and institutions of higher education must follow. This exemption, however, also requires HHSC and each agency it oversees to establish their own procurement rules and regulations. HHSC agencies must document that their purchases consider a number of factors including costs, quality, reliability, value and probable vendor performance.[16]

One major difference between HHSC agencies and other state agencies is that HHSC allows "open-enrollment" contracting in the acquisition of residential services. That is, all providers licensed by DPRS are eligible to receive contracts, regardless of their past or present performance. The number of foster children referrals a provider will receive—and therefore the amount the provider will be paid—generally is decided by individual CPS caseworkers.[17] Numerous interviews conducted by the Comptroller review team with providers during site visits indicated that, in many instances, CPS caseworkers based their decisions about placements on their personal relationships with providers.

DPRS does not limit its number of potential contractors based on the number of slots it needs for specific types of care, such as that offered by residential treatment centers. Moreover, while DPRS caseworkers may encourage individual organizations to obtain licenses and become providers, the agency does not study regional or local needs for particular types of foster care.

Open-enrollment contracts also are open-ended in terms of cost. The only cost limitation specified in the residential child care contract is a "subject to the availability of appropriated funds" clause.[18] DPRS contracts may specify terms of service and, often, an agreed cost per unit of service, but generally do not limit the number of children to be referred or dollars to be paid, unless such limits are specified in subsequent contract amendments. In some recently expired contracts, the Comptroller review team found blanks where the dollar value of the original contract should have been.

Open-enrollment arrangements are most common in health and human services agencies. In 1998, for example, about 55 percent of

Texas' spending on health and human services was awarded to providers who received their contracts based simply on their enrollment in a program.[19] Most government agencies, by contrast, obtain services through public bidding processes.

A 1996 SAO review of contract administration at health and human service agencies noted that competition in contracting can help measure the quality and cost of public services and reduce the risk of bias or favoritism in the selection process. SAO found that use of open enrollment, by contrast, limits agencies' abil-

Exhibit 2

Ten Largest Purchase of Service (POS) Contracts for Foster Care Services Fiscal 2003

Contractor	City	Total Children Served	Total Adults Served*	Total Amount	Services Rendered
Spaulding For Children	Houston	449	1,039	$ 1,103,197	Adoption, camping, post-adoption
DePelchin Children's Center	Houston	2,870	283	$ 918,993	Adoption, camping, consultation, casework, counseling/therapy, evaluation/testing, parent/caregiver training, post-adoption
Lutheran Social Services South	Austin	1,873	143	$ 862,223	Adoption, camping, Preparation for Adult Living (PAL), post-adoption
Harris County Children's Crisis Care Center	Houston	4,564	1,507	$ 791,385	Consultation, casework, evaluation/ testing
Harmony Family Services Inc.	Abilene	4,439	2,893	$ 653,305	Casework
Catholic Charities	Fort Worth	1,231	1,384	$ 630,099	Basic needs, casework, counseling/ therapy, PAL, parent/caregiver training, translation
Lutheran Social Services Of Texas	Dallas	2,049	139	$ 626,089	Camping, PAL, post-adoption
Brenda M. Keller	Dallas	339	1,702	$ 538,579	Consultation, casework, counseling/ therapy, evaluation/testing, substance abuse, translator
Children's Shelter Of San Antonio	San Antonio	2,204	276	$ 521,234	Adoption, consultation, casework
High Sky Children's Ranch Inc.	Midland	2,641	1,134	$ 518,096	Casework, PAL

*Represents family members of foster children receiving services.
Source: Texas Department of Protective and Regulatory Services.

ity to objectively select the most qualified and efficient contractors. Without procedures for evaluating and selecting contractors, agencies may not receive the best value for the public's money.[20]

In Texas, contracting problems in other health and human service programs have led to reforms.

In Texas, contracting problems in other health and human service programs have led to reforms. A 2003 Comptroller report, *Limited Government, Unlimited Opportunity*, found that the state's nursing home contracting process, also based on open enrollment, provided insufficient controls to guarantee the quality of nursing home care.[21]

In response, state law now requires the Texas Department of Human Services (DHS) to include clearly defined minimum standards that relate directly to the quality of care in its nursing home contracts. DHS cannot award a contract to a nursing facility that does not meet the minimum standards, and will terminate the contractual arrangement if a facility's quality of care fails to meet them.[22]

Purchasing Methods

HHSC's purchasing rules and methods for the agencies under its governance, such as DPRS, are found in Title 1, Part 15, Chapter 391 of the Texas Administrative Code. They allow DPRS to acquire goods and services through four main methods:

- competitive purchasing,
- noncompetitive purchasing,
- alternative purchasing, and
- cooperative purchasing.

HHSC rules define competitive purchasing as including competitive sealed bidding, competitive proposals and competitive negotiations with more than one potential vendor.[23] Individual HHSC agencies may waive competitive requirements for purchases worth less than $100,000 but must obtain HHSC approval to do so if the procurement is expected to exceed that amount.[24] An important exception to these rules states that all professional services must be obtained through a competitive process.[25]

Noncompetitive purchasing may be used for purchases valued at no more than $5,000.[26]

Alternative purchases are those defined by rule either as "streamlined" or aggregated purchases that do not exceed certain dollar thresholds; multiple-award and blanket contracts; and open-enrollment contracts.[27]

Cooperative purchasing methods allow agencies to join purchasing cooperatives or groups to generate economies of scale.[28]

Signature Authority

DPRS often contracts with state agencies and universities for some services such as staff training. According to DPRS purchasing procedures, if such contracts are valued at or in excess of $100,000, they must be approved and signed by the agency's executive director. Contracts valued at less than $100,000 but more than $25,000 may be approved and signed by the deputy executive director. For interagency contracts worth less than $25,000, the district director may approve and sign them.

Signature approval rules for other types of purchases are much simpler. If a contract is for residential child care, private services such as counseling or the services of a local government—for education or community mental health services, for example—the only approval and signature required is that of a DPRS district director, regardless of the amount of the contract (Exhibit 3).

Reportedly, DPRS' executive director delegated signature authority to the district directors because most of these contracts provide client services and are therefore managed by the districts. Even so, the practice weakens the oversight for millions of dollars.

Purchasing in Other Agencies

In contrast to DPRS, most state agencies limit the amount they will pay on a specific contract, and specify the dollars per unit and number of units of service to be purchased. Most state contracts, moreover, are subject to multiple approvals.

For example, most non-HHSC agency purchases of consultant or professional services are subject to the following general conditions:

- for purchases valued at less than $2,000, no bids are required;
- for purchases valued between $2,000 and $10,000, three informal bids are required;
- for purchases valued at more than $10,000 and less than $25,000, a formal invitation for bid (IFB) must be issued publicly and vendors on the Texas Building and Procurement Commission's (TBPC's) Central Master Bidders' List must be notified;
- for all consultant or professional service procurement awards valued more than $14,000, the agency must notify the Legislative Budget Board (LBB);
- for all consultant or professional service purchases reasonably foreseen to exceed $15,000, the agency must receive prior approval from the Governor's Office of Budget and Planning and notify the LBB; and
- for purchases of goods or services valued at more than $25,000, a formal advertisement must be placed on the Electronic State Business Daily Web site.[29]

HHSC-agency open-enrollment contracts can be procured through an IFB, which is similar to a request for proposal (RFP) but provides less detailed specifications. HHSC agencies, however, often select all or most bidders who come reasonably close to HHSC standards for meeting costs, quality, reliability, value and probable vendor performance. Other state agencies select only the bidder offering the best value to the state, unless the IFB or RFP specifically states that multiple awards will be made.

Screening

Before signing a contract with a corporation or limited liability company, DPRS performs a financial background check to ensure that it is current on its state taxes. DPRS does not, however, check the business history of the corporation's principals—its executive and financial officers—to determine whether they are or have been principals in other entities doing business with DPRS or other state agencies, are current on their state taxes or are the subject of litigation directly related to a state contract.[30]

DPRS' failure to perform comprehensive background checks on corporate principals, to the extent the law allows, prevents it from ensuring that it does not contract with poor or fraudulent providers who may be doing business under a new name.

No-Pay Contracts

In June 2003, DPRS had non-financial ("no-pay") contracts with just 11 long-term residential childcare providers who were caring for 30 DPRS-referred children. These providers, most of whom offer long-term group

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Exhibit 3

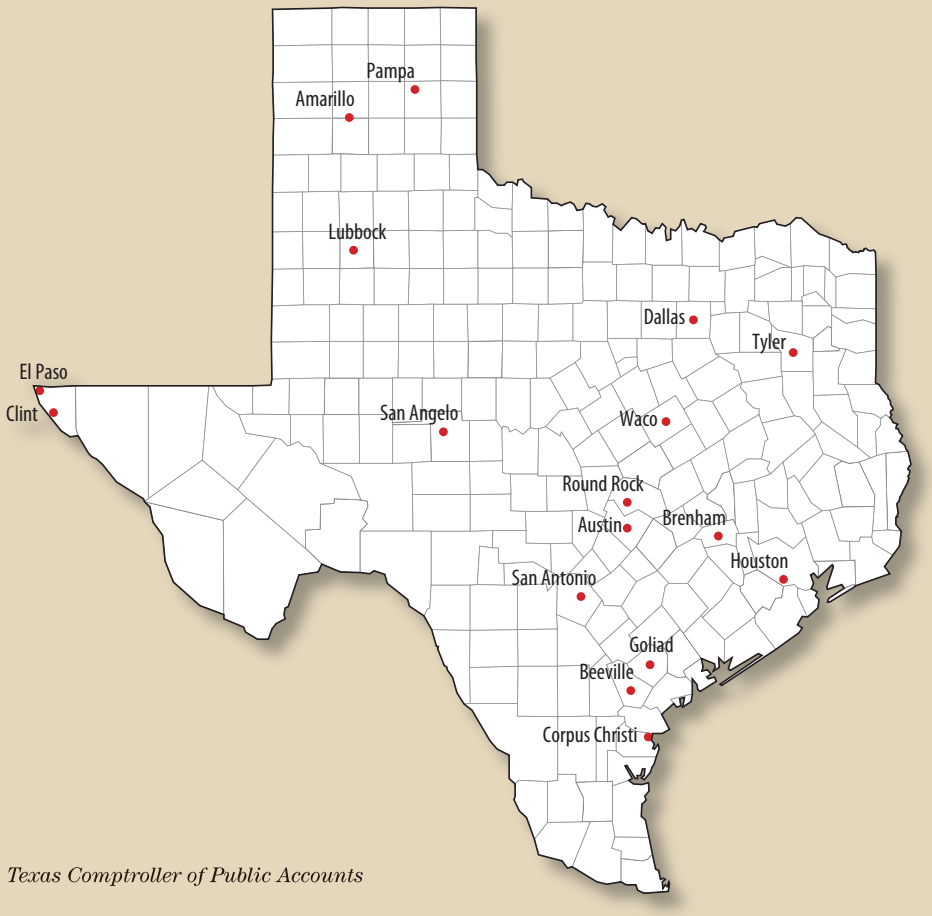
Current Signature Authority for DPRS Contracts

Dollar Amount	Type of Contractor	Authority to Approve Contract
$0 – 24,999	State agencies and universities	District Directors
$25,000 – 99,999	State agencies and universities	Deputy Director
$100,000 and up	State agencies and universities	Executive Director
Unlimited	Local governments	District Directors
Unlimited	Purchase of Client Services	District Directors
Unlimited	Residential Child Care	District Directors

Source: Texas Department of Protective and Regulatory Services.

Exhibit 4

Location of No-Pay Foster Care Providers



Source: Texas Comptroller of Public Accounts

home living arrangements, are licensed by DPRS and are, by law and contract, required to comply with DPRS terms and conditions. The only difference between them and other providers is that they are not reimbursed by DPRS for the services they provide.[31]

No-pay providers are charitable, nonprofit corporations organized under the federal Internal Revenue Code Section 501(c)(3). They receive financial support from a variety of sources including grants, gifts and donations; families who voluntarily place their children in these facilities; county juvenile probation departments; and Medicaid and private insurance.[32] Because they do not accept DPRS funds, they are exempt from its financial audits.

The Comptroller review team surveyed all no-pay providers identifiable through DPRS information to gauge their working relationship with DPRS and to determine their ability to accept more children (Exhibits 4 and 5).

The providers' responses were revealing. Several said that they had repeatedly notified DPRS that they had room to take more children, but had received no response. The providers were baffled by this silence, particularly in light of the state's current budgetary woes.

Many said they wished to be the first provider CPS contacted, not the last. One complained that CPS caseworkers acted rudely toward his staff. A few said that they had a good working relationship with CPS management, but rela-

tionships with caseworkers were more problematic, primarily due to frequent caseworker turnover and various differences of opinion about the care needed by specific children.

Another charitable care provider said that a CPS caseworker once told him that his facility didn't serve the "right kind" of children, but refused to explain the comment. Still another said that caseworker oversight and required paperwork is so burdensome that it prevents her from accepting DPRS children.

In all, charitable providers surveyed by the Comptroller review team said they could accept 108 additional DPRS-referred children at no cost to the state. These providers serve children with basic to moderate needs (Exhibit 5).

One no-pay provider said that a CPS caseworker told him that his facility was not in the CPS database, and therefore was not considered for placements, solely because it was under a no-pay contract with the agency. The caseworker said that, if the facility converted its no-pay contract to a for-pay contract, it would be placed in the database.

The provider did so, agreeing to charge the state instead of providing free care so that it could help the agency with its caseload.

If 108 DPRS children had been placed in these charity homes instead of state-paid child placing agencies, which in fiscal 2004 receive a $36 daily rate per child for basic services, the state could have redirected up to $1.4 million to other foster care services.[33]

Exhibit 5

Charitable Provider Capacity as of January 2004

Current Charitable Providers	Location	No. of Licensed Beds	Estimated Current Population	DPRS Children Currently Served	Potential for DPRS Placements
Children's Village	Tyler	32	18	9	14
Texas Baptist Children's Home	Brenham, Houston, Round Rock	56	50	2	4
West Texas Boys Ranch	San Angelo	40	20	0	20
Cal Farley Boys Ranch (3 facilities)	Amarillo, Pampa	392	372	0	0
Genesis House*	Pampa	16*	-	-	0
South Texas Children's Home	Beeville, Corpus Christi, Goliad	118	85	20	0
Casa De Esperanza De Los Ninos	Houston	49	49	0	0
Lee and Beulah Moor Children's Home (2 facilities)	El Paso, Clint	150	62	6	12
Methodist Children's Home	Dallas, Houston, Lubbock, San Antonio, Waco	408	350	7	58
Presbyterian Children's Home**	Austin	180 total	170 total	3	0
TOTALS		**1,425**	**1,176**	**47**	**108**

*Provides drug treatment care, not foster care, and therefore is not included in totals.
**Has both nonprofit and for-profit facilities.
Source: Texas Comptroller of Public Accounts.

An Escalating Contract

In May 1998, CPS issued a public RFP "to provide evaluation, testing and treatment services to eligible youth and their families on a time-limited basis…provide court testimony, and case specific consultation…" in Bexar County or its surrounding counties. The RFP specified the types of services and the professional accreditations sought, but did not place a maximum dollar amount on any potential contract, or specify a per-unit rate for services.

The official procurement file for this RFP, in keeping with standard CPS procedure at the time, does not contain responses from any vendor other than the one selected; it also lacks any evidence of how the RFP was issued, how responses were graded or who selected the winning bidder.[34]

The psychologist who submitted the winning bid initially received a contract valued at less than $10,000.

By 2002, however, this contract had been amended 12 times, so that the final contract had an annual dollar cap of $223,500. All of the amendment documents bore only one DPRS signature—that of the then-regional director—in addition to the vendor's signature, although internal records DPRS provided did appear to validate that it had received internal review. The dates the parties signed and executed amendments one through nine were missing from the amendments to the contract.

The authority cited for all of these amendments appears only in the 11th one: "(t)he procurement which resulted in this contract anticipated possible amendments and extensions of the contract, and no additional procurement process is necessary before entering into this amendment." No further authority was cited.

DPRS files provided a schedule and dollar value for the amendments to this contract. Neither the effective dates nor the contract amounts were in sequence (Exhibit 6).

Note that the amounts in Exhibit 6 do not sum to a total paid, but instead represent continual changes to the annual maximum that may be paid under the terms of the existing contract. A search for the vendor in Comptroller claims records indicated that the amended contract netted the psychologist $504,247 from 1999 through 2002.

During this period, DPRS had available to it the services of almost 300 licensed psychologists in Bexar County, according to the Texas State Board of Examiners of Psychologists.[35]

When questioned about this contract, DPRS explained that it has amended several procedures to tighten contract management, such as requiring contracts to show a date of signature and the dollar amount on the original contract.[36] Nevertheless, open-ended contracts such as this one are still the norm within DPRS, according to DPRS staff interviewed by the Comptroller review team and the team's review of existing contract language and procedures.

Evaluation of Vendor Services

All DPRS residential childcare providers abide by the same contractual terms and receive the same per-diem payment for the services they offer, yet DPRS makes no effort either to evaluate disparities in the services they provide or to provide incentives to those offering superior services.

Mental health services are one example. One contractor could offer superior mental health services by using evidence-based practices (EBP) specific to each child's needs—a range of treatments and services whose effectiveness is well documented—while another may not, yet both would receive the same per-diem payment.

Recreational services provide another example. Residential centers are required by contract to provide recreational activities for the children in their care. Comptroller review team visits to several providers revealed stark disparities among the recreational facilities provided. Several providers, both for-pay and

charitable, used fully equipped gyms, pools and/or buildings reserved especially for recreational activities. Others provided as little as a single outdoor basketball court. (See photos of these facilities in Chapter 2.)

Conflicts of Interest

DPRS contracts for residential services do not prohibit business transactions between closely related parties. The same individuals may own residential facilities, pharmacies and management companies as separate corporate entities, all buying from one another "at cost" and then passing those "costs" to DPRS that are added into the calculation of future rates. In addition, several providers are run by married couples and family members who approve each others' salaries.

These business practices allow contractors to buy and sell to themselves, marking up costs at each step, approving occasionally exorbitant salaries for themselves and their family members, thereby diverting hundreds of thousands of tax dollars from children into their personal accounts.

DPRS does not examine these relationships, but merely requires vendors to check a box on a form if related-party transactions are involved. The Comptroller review team found no evidence that DPRS has ever audited or investigated a related-party transaction as a result of this information.

The results of one series of related-party transactions were reported in an October

Exhibit 6

Bexar County Psychologist Contract History

	Effective Beginning	Effective Ending	Maximum Amount
Initial contract	September 1, 1998	August 31, 1999	$10,545
Amendment 1*	September 1, 1999	August 31, 2000	$ 9,400
Amendment 2	June 1, 1999	August 31, 1999	$ 14,045
Amendment 3	October 1, 1999	August 31, 2000	$ 49,400
Amendment 4	May 1, 2000	August 31, 2000	$ 86,500
Amendment 5*	September 1, 2000	August 31, 2001	$ 85,000
Amendment 6	May 1, 2000	August 31, 2000	$ 136,500
Amendment 7	September 1, 1998	August 31, 1999	$ 19,345
Amendment 8	September 1, 2000	August 31, 2001	$ 125,000
Amendment 9	September 1, 2000	August 31, 2001	$ 175,000
Amendment 10	September 1, 2000	August 31, 2001	$ 210,000
Amendment 11*	September 1, 2001	August 31, 2002	$ 175,000
Amendment 12	August 1, 2001	August 31, 2001	$ 223,500

*Amendments indicating an annual renewal of the contract.
Source: Texas Department of Protective and Regulatory Services.

2003 series of *Dallas Morning News* articles. The series highlighted the intricate corporate structure of Daystar Residential Treatment Center, a home for emotionally disturbed foster children near Houston, and its sister organizations, all of which were run by the same individuals, one of whom earned more than $1.5 million in 2002. (See the case study of Daystar on page 174.)

In a letter to the *News* responding to the articles, DPRS stated that, since it had no contractual agreement with businesses affiliated with Daystar's owner, it had no authority to examine their finances.[37] But an examination of Daystar's fiscal 2002 contract with DPRS—and its 2003 amendment and the DPRS draft 2004 contract for all vendors which feature the same terms—tells a different story.

The 2002 contract states, in section 31, subsection C:

> Contractor shall make available at reasonable times, at reasonable places within the State of Texas, and

Contracting Improvements at One State Agency

In the early 1990s, the Texas Commission on Alcohol and Drug Abuse (TCADA) had significant contracting problems—allegations of misuse and mismanagement prompted investigations.

On April 26, 1995, then-Governor Bush placed TCADA in state conservatorship. A joint inquiry by the Senate General Investigating Committee and House General Investigating Committee accused TCADA of gross fiscal mismanagement, finding that the agency had misused state funds and kept poor records of its transactions. The investigation also revealed widespread mismanagement of contracting procedures. In response, a Joint General Investigating Committee appointed by the Legislature reviewed state agencies' contracting procedures.[1]

Governor Bush appointed a leader with a strong business background to completely reengineer the TCADA contracting process. It was a formidable task and an unpleasant transition for contract providers and state personnel alike. TCADA remained in conservatorship for about a year.

Critics said the state would lose providers and clients would suffer if TCADA required and enforced appropriate contracting safeguards. They were proven wrong.

TCADA reviewed and rewrote all of its contracts, strengthening their language, and then improved its cost reporting and auditing procedures. The agency also began making greater efforts to identify its needs precisely before contracting so that it could contract only for those services. It established standards based on best practices and created outcome-based performance measures.[2] TCADA also established an online system to track clients and vacancies and to combine client and financial data to establish accurate per-client costs.[3] That system is being reviewed by other states and the federal government for replication.

At a conference in September 2003, TCADA's executive director reviewed the agency's history and presented the latest steps in its transformation of its contractual relationship with service providers. Texas received praise from the Robert Wood Johnson Foundation, the National Association of State Alcohol/Drug Abuse Directors and the Center for Health Care Strategies, as well as representatives of other states in attendance.

Endnotes

1 Executive Order GWB 95-2, http://texinfo.library.unt.edu/texasregister/text/1995/0512gov.txt (Last visited February 25, 2004.)

2 Texas Commission on Alcohol and Drug Abuse, *Statewide Service Delivery Plan* (Austin, Texas, February 1, 2002), p. 14.

3 Texas Commission on Alcohol and Drug Abuse, *Statewide Service Delivery Plan*, p. 11.

> for reasonable periods…financial records, books, reports, and supporting documents for reviewing and copying by the Department (of Protective and Regulatory Services), the United States Department of Health and Human Services, or their authorized representatives.

Section 42, subsection D says, "(t)he Contractor shall, and shall require any Subcontractors to abide by all the terms and conditions of the primary contract."

According to the terms of the contract, subcontractors such as those affiliated with Daystar also must abide by section 31, subsection C.

HHSC's uniform contract contains terms and conditions describing conflicts of interest and how they should be evaluated. DPRS contracts do not. HHSC's contractors are required

> …to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under this Agreement. Contractor warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Agreement.

Contractors also must "promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by Contractor or by HHSC as a potential conflict." If a question arises as to whether a conflict exists, contractors must request a determination from HHSC and must abide by its decision. Most importantly,

> (a) violation of the disclosure requirements applicable to this Agreement may constitute grounds for the immediate termination of this agreement…Furthermore, such violation may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.[38]

HHSC has not required DPRS to include these provisions in foster care contracts.

Legal Controls

SAO's 2000 review of DPRS found numerous problems with contracting and recommended that all contracts:

- define related parties;
- require contractors to maintain documentation sufficient to allow DPRS to ensure the appropriateness of these arrangements, including support for costs incurred as well as fair-market valuations; and
- make specific reference to applicable state regulations and federal circulars that govern related-party transactions.

SAO's 2000 review of DPRS found numerous problems...

SAO also recommended regular monitoring of primary contractors to ensure that they are monitoring their subcontractors adequately.[39] DPRS revised its standard residential child care contract in September 2003 and plans to update its residential childcare licensing standards by September 2005. The revised contract, however—like the ones it replaced—still does not explicitly prohibit self-dealing and other dubious practices.

The revised contract appears to prohibit DPRS from challenging questionable provider expenditures. Section 19B says, "(o)nce funds are paid to the Contractor for proper services provided, the Department does not control how they are expended so long as the Contractor expends them legally and accounts for them accurately in the cost report."[40]

The revised contract's language, moreover, is often vague, making it difficult for DPRS to enforce its provisions. For example, Section 42 of the new contract calls for the contractor to "refrain" from transferring or assigning the contract without written approval from

(continued on page 175)

Daystar Residential, Inc.

When a 15-year-old foster child died at Daystar Residential, Inc., a Texas residential treatment center (RTC), in February 2002, few could have realized that the case would reveal a labyrinth of questionable financial relationships that had made the center's owners millions on state contracts.

The questions over this girl's death are now the subject of a civil suit brought by her mother and have prompted official inquiries into the death of another 16-year-old girl at a sister facility in 2001. But questions about Daystar's finances continue, due in part to two articles in the *Dallas Morning News* in October 2003. Thomas Chapmond, the executive director of DPRS, declined to be interviewed for the *News* stories.[1]

The articles reported on the alleged interwoven corporate structures of the non-profit company that runs the RTC and several related, for-profit corporations, which together earned revenues just shy of $26 million in 2002. The exposé also raised questions about the companies' business practices, and about DPRS' inability to recover allegedly "unallowable" expenses.

The Comptroller team reviewed documents and tax forms pertaining to this case and found a truly tangled story.

Take, for example, the corporate structure of Daystar, the nonprofit corporation that owns the RTC where the 15-year-old died. Five for-profit corporations supplying Daystar are owned and managed by just two individuals. The wife of the majority owner is the corporation's president. The couple earned nearly $1 million from its operations in 2002.

Another company owned by the couple leases the RTC its facility and several vehicles. A pharmacy they own provides the RTC with prescription drugs for its children; this company paid the couple $32,000 in 2002.

The sister facility at which the 16-year-old died in 2001 is run by another corporation that paid the couple $433,000 in 2002.

Yet another company of the couple's provides administrative support services to both treatment centers. This netted them $33,000 in 2002. Still another of their companies provides emergency staff to both centers; this paid them $53,000 in 2002.

The *Dallas Morning News* investigation also found that the owners were leasing land to one of their companies, which in turn leased it for a higher amount to one of the RTCs.[2] In addition, one of the RTCs extended a $171,648 three-year line of credit to the company-owned pharmacy in 2002. One of the interlocking companies even purchased a $130,000 condominium and a $96,000 parking place for an RTC staff member when she could not qualify for financing.

The pharmacy's state license was put on probation, and a former employee was found guilty of Medicaid billing fraud in 2002.[3]

Daystar receives a higher per-day rate for some children in its care—$277.08 versus $202 for other, similar providers—by virtue of its selection by DPRS for participation in the Exceptional Care Pilot Project. The project, which began in March 2001 and is expected to continue until 2005, is intended to provide care for difficult-to-place children with severe emotional problems.[4]

Endnotes

1 Doug J. Swanson, "Owner Reaps Million through Foster Homes," *Dallas Morning News* (October 19, 2003).

2 Swanson, "Owner Reaps Million through Foster Homes."

3 "Pharmacist Pleads Guilty to Defrauding the State," *The Houston Chronicle* (July 20, 2002).

4 University of Texas, School of Social Work, "Evaluation of the Exceptional Care Pilot Project: Final Report," (Austin, Texas, 2002).

DPRS. The contract lacks integrity without language to prohibit this practice. The contract includes an obsolete provision that requires contractors to comply with year 2000 technology practices.

All too often, the revised contract's terms appear to favor providers over foster children. For example, either DPRS or the contractor can cancel a contract by giving a 30-day notice. Should a contractor exercise this option, children's stability could be at risk unless a suitable transition plan is put in place first. This provision could be removed without harm to the state because section 45 states the contract can be terminated at any time by mutual consent; if a contractor simply cannot continue providing services, the parties can mutually agree to terminate the contract and arrange a reasonable transition of services.

Contract Management

The Contract Policy Division conducts quality assurance assessments to evaluate whether the agency's contract policies are effective, and provides training and technical assistance to help DPRS contract managers improve the contract management and administration process. This process is intended to ensure selection of the best overall vendors and to establish risk management and monitoring procedures to ensure that contractors achieve performance objectives and outcomes.[41]

In spite of its quality assurance program, however, DPRS has a lengthy history of poor contract management and monitoring. In 1996, for instance, the Sunset Advisory Commission reported weaknesses in DPRS' contract administration.

Among other issues, Sunset noted that the agency's decentralized approach (which leaves much of the responsibility for contracting to district offices) created inconsistencies in contractor selection and monitoring. Sunset also found that DPRS lacked an effective contracting procedures manual and did not apply contract evaluation techniques consistently across the state. Moreover, DPRS did not maintain reliable information on contractor performance.

Sunset called for the DPRS board and executive management to establish objectives for contract administration and communicate them to staff and contract providers. It also recommended centralizing oversight of contract administration by placing primary responsibility for all contracting in the state office.[42]

A 2000 SAO review of DPRS also criticized contract management. SAO concluded that serious gaps in the agency's oversight of caregivers could undermine its efforts to protect the children in its care. Part of the problem, in SAO's view, was the way in which the agency parceled out responsibility for various contracting functions among multiple divisions, including Legal, Program, Internal Audit and district offices. For example, SAO found that no individual or group within the agency had specific responsibility for evaluating the measures used to assess residential caregivers' contract performance.[43]

All too often, the revised contract's terms appear to favor providers over foster children.

CPD's Contract Administration Handbook provides a considerable degree of information on the completion of paperwork, but little guidance on how to evaluate contractor performance. Contract managers are not trained to evaluate how well a contractor delivers services; their assessments of residential contractors tend to concentrate more on the specifics of licensing standards than broader issues of quality of care. SAO found that these assessments rarely present a useful discussion of contractors' strengths and weaknesses.[44]

Moreover, DPRS' contract managers give residential facilities a minimum of 30 days' notice before a site visit.[45] This gives contractors ample opportunity to present their operations in the best light. Surprise visits could avoid this possibility and give DPRS confidence that it is seeing a more accurate picture of how contractors actually operate.

DPRS established a Contract Administration Division to address contract administration

weaknesses identified by Sunset and SAO and established a Contract Task Force in April 2000 to accelerate progress toward better outcomes.[46] However, residential care contracts still lack measurable outcomes to hold providers accountable. As described below, DPRS' risk assessment and records management practices are still inadequate.

Risk Assessments

The Contract Policy Division uses a risk assessment instrument (RAI) to determine monitoring requirements for residential service contracts worth $10,000 or more; in theory, the higher the score, the more likely a contractor is to receive relatively frequent visits from a contract manager. The RAI results are used to prepare a monitoring schedule for higher risk contracts that is included in an annual statewide monitoring plan for Contract Management.

...despite allegations and findings of sexual misconduct at a therapeutic camp in 2000—allegations that resulted in the provider being considered for license revocation—the facility received a low risk rating in fiscal 2002 and 2003.

SAO urged DPRS to include more risk factors in its risk assessment process, noting that the RAI did not adequately assess the quality of care. DPRS has revised its RAI to include more risk factors, from 10 in fiscal 1999 to 18 in fiscal 2004. Even so, CMD's monitoring still seems to focus mostly on technical issues.

For example, despite allegations and findings of sexual misconduct at a therapeutic camp in 2000—allegations that resulted in the provider being considered for license revocation—the facility received a low risk rating in fiscal 2002 and 2003.[47]

The Comptroller's review team analyzed completed risk assessment instruments for a number of contracts to determine if high risk contracts were appropriately identified. One contractor received a score of 54 on its RAI, including a risk score of 16 (the highest) for "history of noncompliance" due to the death of a child at the facility. This overall score fell in DPRS' acceptable range, meaning that an in-depth monitoring visit would not be needed. Yet CMD did not include any risk points in the "Quality of Services" area. Clearly, it is reasonable to assume that the death of a child could be the result of poor services and inadequate oversight. A score just four points higher on this contractor's RAI would have triggered a more thorough review that might have identified potentially harmful deficiencies in the contractor's services.[48]

Poor Records

The Comptroller's review team analyzed numerous records related to contract management and found some out-of-date and irrelevant information. For example, audited financial statements for some contractors were more than four years old. One contractor file contained an RAI that provided no information in four risk categories. DPRS, in fact, provided no evidence that RAI instruments, and other assessment tools used to monitor contracts, are validated regularly to ensure that they effectively measure financial risk and quality of care.

HHSC Contracting Functions

The 2003 Texas Legislature, as part of a move to consolidate state health and human services, required HHSC to centralize contract administration and contract management systems for the agencies it oversees, including DPRS. In response, HHSC has transferred purchasing and contract administration staff from the health and human service agencies under its "umbrella" to its central office.

At present, however, HHSC has no plans to consolidate all contract management functions, as the legislation requires. After the 2003 legislation passed, HHSC negotiated with health and human service agencies and reached a consensus that only contract administration and some auditing functions would be consolidated at HHSC; contract monitoring would remain a duty of the individual agencies.[49]

State law requires HHSC to develop a contract management handbook "that establishes consistent contracting policies and practices to be followed by health and human services agencies."[50] HHSC does not yet have such a handbook, but an internal committee led by the agency's director of administration is de-

veloping one that will include procedures and policies for contract administration and management. Once the HHSC handbook is developed, the agency plans to "tweak" it at a later time to apply it to the other health and human service agencies under its authority.

State law also requires HHSC to develop a single, statewide risk analysis procedure for contract administration and monitoring, but it has not and has no plans to do so.[51] HHSC has not begun a review of DPRS' contracts for foster care services. Comptroller staff were told that the agency is concerned that modifications to these contracts could create disruptions in services for foster children. Instead, the office plans to address low-risk purchases first, such as office supplies, because these purchases present few challenges.

HHSC does plan to conduct a comprehensive review of contract language in client services contracts. The focus of this review, however, will be to develop consistent definitions and measures across agencies, not necessarily to review contract elements such as conflict-of-interest provisions.

Texas Building and Procurement Commission

As noted earlier, HHSC is exempt from TBPC rules and procedures for contract administration, management and monitoring that apply to most state agencies and institutions of higher education.[52]

TBPC has established contract management and monitoring rules and procedures for these agencies, and offers a variety of services designed to help them comply with its regulations. These services include vendor training, counseling, mediation and problem resolution, as well as a vendor tracking database to provide state agencies with information on vendors' past performance. TBPC also performs purchasing audits of the agencies and institutions under its authority and reviews proposed contracts and requests for proposals submitted by state agencies.[53]

TBPC rules and procedures could provide valuable guidance to DPRS and HHSC for contract management and administration.

State Auditor

SAO is the independent auditor for Texas state government charged with improving the performance and accountability of Texas state government. SAO helps state agencies by reviewing their operations, management and accountability systems and by assessing fiscal and management controls.

SAO could identify strategies to correct deficiencies in DPRS accountability systems. For example, the 2000 SAO review of DPRS found that foster care services used to develop rates are not controlled adequately.[54]

SAO also serves in a human resources advisory role to state agencies. As such, it could help DPRS identify monitoring staff and skill sets needed to establish more effective contract administration and management systems.[55]

An SAO review could help CPS staff to anticipate future problems with non-performance or noncompliance; identify program "triggers" that have caused problems; predict and address the impact of changes in program rules, changes in participant staff, and changes in program funding; and ensure that more of each foster care dollar goes to the direct care of children.

SAO also could review DPRS' technology systems and data input processes to improve reimbursement timeliness and accuracy. For example, several providers, including some survey respondents, complained of not being reimbursed for children in their care within the 30-day period required by the state's Prompt Pay Act. And some providers received payments for children who were not in their care.[56] One facility's accounts receivable records indicated that the facility was owed more than $100,000. The provider explained that once 90 days have passed on an overdue account, it is almost impossible to get the problem straightened out.[57]

The problem occurs because caseworkers do not always promptly enter the date that a child moves to a facility into the DPRS computer database that tracks children's placements. If the caseworker waits too long to enter a child's new placement into the database, the facility where the child previously resided may receive a payment that should go to the child's new facility, causing confusion and late payments. If the caseworker leaves the position without correcting the problem–and turnover is high at the agency–then reconciliation becomes more difficult.[58]

To address these and other billing problems, DPRS made changes to its programming in October 2003 to expedite processing. DPRS also increased its corrected payment runs from twice per month to weekly.

Recommendations

A. HHSC should immediately amend the DPRS care provider contracts to add a conflict-of-interest disclosure provision and strengthen financial accountability provisions.

HHSC should, at a minimum, adopt conflict-of-interest provisions already contained in its uniform contract for inclusion in foster care provider contracts.

All contracts for residential services should be amended to require full contractor disclosure of business and personal relationships between themselves and their principals and any employees, affiliates or subcontractors. Failure to disclose such relationships should be clearly established as a cause for contract termination. HHSC should also develop rules that would allow it to evaluate alleged conflicts of interest on a case-by-case basis.

HHSC should eliminate permissive language, such as "the contractor should refrain from…", and replace it with more definite statements, such as "the contractor shall…" or "the contractor shall not…" It also should eliminate any provisions that are obsolete or do not promote financial accountability.

Contractors unable to meet these new terms should be given a grace period to restructure their financial or corporate agreements, but in no case should that grace period extend past August 31, 2004.

B. HHSC should require DPRS to discontinue its practice of allowing providers to dictate contract terms.

Contracts should include provisions that require contractors to meet outcomes and financial accountability standards that protect the safety and well being of foster children.

C. HHSC should amend DPRS foster care provider contracts to eliminate clauses allowing providers to reject or eject foster children by fiscal 2008.

HHSC, in consultation with foster care providers, other stakeholders and state contracting experts, should undertake a financial review of the impact of no-reject, no-eject clauses in foster care contracts. HHSC should construct a no-reject, no-eject clause that mitigates the financial consequences to providers of caring for more children with high-end needs. The clause should also allow providers to negotiate with DPRS to modify placements that are not in the best interests of children.

The no-reject, no-eject clause should be included in all provider contracts by fiscal 2008 as Texas transitions to an outsourced foster care system.

D. The executive director of DPRS should revoke signatory approval previously delegated to CPS district directors for contracts with an anticipated value over $25,000 in one year.

This would help DPRS better manage its expenditures and provide greater oversight and accountability.

E. HHSC should direct DPRS to establish effective risk assessment procedures.

HHSC is responsible by law for developing a statewide risk analysis procedure for health and human service agencies. HHSC should advise DPRS on how to identify critical risk factors to be included in DPRS' risk assessment instrument (RAI).

The RAI should identify and evaluate the following risk factors to ensure that in-depth monitoring visits are conducted when needed:

- the quality of services provided, as assessed by objective outcome measures;
- any history of noncompliance with licensing standards, particularly if a child has been seriously injured in the contractor's care; and
- the contractor's overall financial condition, as identified by cost reports.

F. DPRS should direct its contract monitors to make periodic unannounced visits to contractor facilities.

This recommendation would help ensure that the monitors receive an accurate impression of the environment and the care children experience daily.

G. DPRS should ensure that all contractor files are complete and accurately reflect their performance on an ongoing basis.

H. HHSC and DPRS should fully use charitable no-pay caregivers to aid Texas foster children.

DPRS should establish and maintain an active database of placements offered by charitable providers under no-pay contracts, and attempt to place children with appropriate charitable providers before seeking placements with similar, for-pay providers.

I. SAO should conduct a management review of HHSC and DPRS to improve contract administration and management systems.

The SAO review should identify best practices and specific staff requirements and skill sets required to implement effective monitoring and contract administration practices. The SAO review should also identify rigorous and fair contract implementation strategies for DPRS, and should establish effective financial accountability provisions and processes to ensure effective and efficient expenditures of funds.

SAO's review should identify options for HHSC and DPRS to account more effectively for contractor expenditures, and to verify that services are in fact delivered.

The review should analyze rules and procedures established by TBPC in developing technical support services for its contract managers, other contract administration and management staff and the agency's contractors.

The review should ensure that HHSC's contract management handbook required by law includes best practices from other states and other state agencies in its purchasing and contract responsibilities, such as requiring annual independent financial audits of its contractors and their subcontractors.

J. HHSC, in coordination with SAO, should perform complete, on-site financial audits of selected providers.

The DPRS Residential Care contract includes a statement that any acceptance of funds by a contractor is also acceptance of the SAO's authority to audit or investi-

gate the expenditure of funds, including under any subcontract.

These audits should verify that state funds are spent appropriately and that children are receiving all of the services and care for which the state is paying.

K. SAO in coordination with the Comptroller of Public Accounts should review DPRS payments to contractors to ensure that the agency is paying contractors in a timely manner.

L. DPRS should consider enabling providers to go online to view their reimbursement accounts or provide detailed data so that providers can reconcile their accounts.

This would enable providers to identify and correct problems quickly.

Fiscal Impact

These recommendations would improve contracting procedures and provide greater oversight for state spending.

Contingent upon full implementation of the recommendations in Chapter Two, HHSC and DPRS could use existing funding to implement these recommendations.

The Comptroller review team found 108 additional placements with charitable caregivers available for foster children needing basic services. At current fiscal 2004 rates, the agency could redirect $1,423,000 to the care of 108 additional children who would otherwise be placed with child placing agencies that receive a daily $36 rate (a $34 basic rate plus a $2 supplement approved only for fiscal 2004). In fiscal 2005, the rate remains set at $34 and no supplement has been approved. As a result, in that year and subsequent years, the agency could redirect $1,340,000. In other words, these placements would allow DPRS to accept 108 more foster children at no additional cost to the state.

Endnotes

[1] The Texas Department of Protective and Regulatory Services revised its structure in September 2003 to create five district offices out of the 11 smaller, existing regional offices. For this reason, this report will reflect DPRS' own use of the terms "district" or "regional."

[2] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, (Austin, Texas, September 2003), pp. 1-2.

[3] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, November 12, 2003; and Texas Department of Protective and Regulatory Services, "Detailed Procedure for Contract Establishment," Austin, Texas, October 2, 2003, pp. 1-3.

[4] Texas Department of Protective and Regulatory Services, "Monitoring Report," September 1, 2003, p. 1.

[5] Texas Department of Protective and Regulatory Services, "2002 Cost Report Guidelines & Specific Instructions," Austin, Texas, September 20, 2002, pp. 1 and 8.

[6] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 2, 2003.

[7] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, (Austin, Texas, September 2003).

[8] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, (Austin, Texas, September 2003), pp. 4-5.

[9] Texas Department of Protective and Regulatory Services, Residential Child Care Contract No. 200295991 with Daystar, effective September 1, 2003 through August 31, 2004, Austin, Texas, September 2003, Section 15 A.1.

[10] Interview with Foster Care Provider, San Antonio, Texas, December 4, 2003.

[11] Telephone interviews with foster care experts, (Austin, Texas, January 14, 2004 through February 5, 2004).

[12] U.S. Department of Health and Human Services, *State Innovations in Child Welfare Financing*, by Westat and Chapin Hall Center for Children, Rockville, Maryland and Chicago, Illinois, April 2002, http://aspe.hhs.gov/hsp/CW-financing03/. (Last visited November 7, 2003.)

[13] Interviews conducted by Comptroller personnel at site visits from November 2003 through February 2004.

[14] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, November 20, 2003; and Texas Department of Protective and Regulatory Services, "State Plan – Foster and Adoptive Home Licensing," http://www.tdprs.state.tx.us/About/State_Plan/2003_4descriptionCPS.asp. (Last visited February 11, 2004.)

[15] Data provided by Texas Department of Protective and Regulatory Services, December 10, 2003.

[16] Tex. Gov't Code Ann. §2155.144.

[17] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, November 12, 2003.

[18] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, (Austin, Texas, September 2003), pp. 13 and 16.

[19] Texas Comptroller of Public Accounts, Study of Payment Methods, Austin, Texas, December 15, 1998, p. 5.

[20] Texas State Auditor's Office, Contract Administration at Selected Health and Human Services Agencies, Phase Three (Austin, Texas, February 1996), pp. 22-23.

[21] Texas Comptroller of Public Accounts, *Limited Government, Unlimited Opportunity*, "HHS 1: Contract for Quality Nursing Home Care," http://www.window.state.tx.us/etexas2003/hhs01.html. (Last visited February 11, 2004.)

[22] Tex. H.B. 2292, 78th Leg., R.S. (2003).

[23] 1 Tex. Admin. Code §391.101 and §391.151.

[24] 1 Tex. Admin. Code §391.109 and §391.131.

[25] 1 Tex. Admin. Code §391.36.

[26] 1 Tex. Admin. Code §391.103.

[27] 1 Tex. Admin. Code §391.105.

[28] 1 Tex. Admin. Code §391.107.

[29] Texas Building and Procurement Commission, "Bidding Requirements and Dollar Limits or Thresholds," http://www.tbpc.state.tx.us/stpurch/2-11.html (Last visited January 7, 2004); Texas Governor's Office, "Consultant Contract Guidelines," http://www.governor.state.tx.us/divisions/bpp/guidelines (Last visited February 11, 2004); and Tex. Gov't Code Ann. §2155.083 and §2254.006.

[30] Interview with Texas Department of Protective and Regulatory Services staff, November 12, 2003.

[31] Data provided by Texas Department of Protective and Regulatory Services, December 11, 2003.

[32] Texas Department of Protective and Regulatory Services, "Non Financial Residential Child Care Contract (form 2282NF)," Austin, Texas, July 2003, p. 5; and the University of Texas at Austin, School of Social Work, "2002 Texas Resource Manual of Facilities and Programs for Children and Youth," pp. 85-453.

[33] The Texas Department of Protective and Regulatory Services approved a rate of $34 per child for basic children in child placing agencies for fiscal 2004 and 2005. In addition, the department also approved a $2 supplement only for fiscal 2004, making the fiscal 2004 rate $36. The rate is expected to return to $34 for fiscal 2005.

[34] Interviews with active and retired Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 2003.

[35] Interview with Jennifer Noack, Texas State Board of Examiners of Psychologists, Austin, Texas, December 3, 2003.

[36] Interview with Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 16, 2003.

[37] Letter from board members, Texas Department of Protective and Regulatory Services, to the Editor, *Dallas Morning News* (October 29, 2003).

[38] Texas Health and Human Services Commission, Enterprise Project Office, HHSC Uniform Contract Terms & Conditions, Version 1.2 (Austin, Texas), p. 19, available in pdf format from http://www.hhsc.state.tx.us/about_hhsc/contracting/rfp_attch/General_TC.pdf. (Last visited February 5, 2004.)

[39] Texas State Auditor's Office, An Audit Report on the Department of Protective and Regulatory Services' Administration of Foster Care Contracts, Austin, Texas, August 2000, pp. 24 and 31.

[40] Texas Department of Protective and Regulatory Services, *Residential Child Care Contract*, Form 2282cx, September 2003, p. 6.

[41] Texas Department of Protective and Regulatory Services, Contract Policy Division, 2003 Quality Assurance Review Process.

[42] Texas Sunset Advisory Commission, Department of Protective and Regulatory Services: Staff Report, Austin, Texas, 1996, pp. 59-67.

[43] Texas State Auditor's Office, *An Audit Report on the Department of Protective and Regulatory Services' Administration of Foster Care Contracts*, pp. 1-2.

[44] Texas State Auditor's Office, *An Audit Report on the Department of Protective and Regulatory Services' Administration of Foster Care Contracts*, pp. 6 and 22.

[45] Interview Texas Department of Protective and Regulatory Services staff, Austin, Texas, December 2, 2003.

[46] Texas State Auditor's Office, *An Audit Report on the Department of Protective and Regulatory Services' Administration of Foster Care Contracts*, p. 3.

[47] Texas Department of Protective and Regulatory Services, risk assessment instruments for fiscal 2002 and 2003.

[48] "Critics Say State Oversight of Foster Homes Too little, Too late: Audits Not Designed to Recover Funds Paid for Disallowed Expenses," *Dallas Morning News* (October 19, 2003), p 23A; and Texas Department of Protective and Regulatory Services, Risk Assessment Instrument (RAI), Fiscal Year (FY) 2003.

[49] Tex. H.B. 2292, 78th Leg., Reg. Sess. (2003); and interviews with Texas Health and Human Services Commission staff, Austin, Texas, December 8, 2003 and January 16, 2004.

[50] Tex. Gov't Code Ann. §2155.144(j).

[51] Tex. Gov't Code Ann. §2155.144(i); and interview with Health and Human Services Commission staff, January 16, 2004.

[52] Tex. Gov't Code Ann. §2155.144.

[53] Texas Building and Procurement Commission, "Procurement," http://www.tbpc.state.tx.us/stpurch/index.html. (Last visited February 11, 2004.)

[54] Texas State Auditor's Office, *The Department of Protective and Regulatory Services' Administration of Foster Care Contracts*, (Austin, Texas, August 2000), pp. 11-12.

[55] Texas State Auditor Web site: http://www.sao.state.tx.us/Services/ (Last visited February 12, 2004.)

[56] Texas Comptroller foster care survey, interviews with various providers and Tex. Govt. Code, Chapter 2251 (Prompt Pay Act).

[57] Interview with provider.

[58] Interview with Texas Department of Protective and Regulatory Services staff.

Rate Setting

HHSC should assume responsibility for the residential foster care rate-setting process and ensure that the agencies under its oversight use consistent cost report audit policies.

Background

DPRS sets the reimbursement rates the state will pay for foster care services, including those offered by foster families, child placement agencies (CPAs), RTCs and emergency shelters. The agency sets these rates by provider type and the level of service provided, and then makes a final adjustment to the rates to match its level of appropriations.

Until September 1, 2003, DPRS provided separate rates for six "levels of care," or LOCs, reflecting increasingly difficult cases and correspondingly more expensive treatment. On September 1, 2003, in response to a directive of the 2003 Legislature, DPRS consolidated the six levels of care into four "service levels"—basic, moderate, specialized and intense.[1]

To do so, the agency combined LOCs 1 and 2 (the lowest levels in terms of resource intensity and cost) to form the "basic" service level; combined LOC 3 with the less-aggressive population in LOC 4 to form "moderate;" combined the more-aggressive segment of LOC 4 with LOC 5 to form "specialized;" and renamed LOC 6 as the "intense" service level. In addition, the agency reimburses emergency shelters for temporary placements according to a separate rate.

Basic care reimbursement rates are based on statistics calculated by the U.S. Department of Agriculture's (USDA) report, "Expenditures on Children by Families."[2] This report series estimates the expenditures involved in providing housing, food, transportation, clothing, health care, child care and education for children, and provides this information by income level, region, urban versus rural setting and two-parent versus single-parent households.

Various contractors provide 24-hour residential services for children with needs that cannot be met in basic care settings. These children are assigned to moderate, specialized and intense service levels. Subsequent references to "24-hour child care" should be understood as consisting of moderate, specialized and intense service levels.

DPRS sets the reimbursement rates the state will pay for foster care services, including those offered by foster families, child placement agencies (CPAs), RTCs and emergency shelters.

Cost Reports

DPRS requires contractors providing 24-hour care to submit a cost report every two years, providing financial information on all of their expenses during the previous year.[3] Contractors also must report cost information on all residential child care programs they operate that are not related to DPRS.

DPRS typically requires about 13 months after the end of each reporting period to prepare a database of cost data for analysis and rate determination. Providers are allowed 90 days after the end of their reporting years to complete cost reports; desk reviews and onsite audits of the reports by DPRS personnel typically require another 10 months.[4]

DPRS reviews each cost report submitted and segregates allowable from unallowable costs, as defined in state and federal law. Unallowable use of revenues include, but are not lim-

ited to inter-fund loans and transfers, interdepartmental loans and transfers, intercompany loans and transfers and employee loans not considered salary. Also, the value of donated goods and inkind services are unallowable.[5]

The details concerning the composition and calculation of rates for moderate, specialized and intense service levels are complex and are discussed in the technical appendix to this report, as are findings and recommendations related to the calculation.

Rate-Setting in Other Programs

Many Texas health and human services programs use rate-setting methods broadly similar to DPRS'. These methods vary according to the types of services delivered, types of providers delivering the services and applicable federal and state standards, rules and regulations. Even so, they share numerous common characteristics.

DPRS reviews each cost report submitted and segregates allowable from unallowable costs, as defined in state and federal law.

Most of the large programs use cost reports as a starting point for rate development. The cost reports used for Texas Department of Human Services (DHS) nursing facilities and Texas Department of Mental Health and Mental Retardation (MHMR) intermediate care facilities for the mentally retarded are similar in many respects to those required by DPRS for 24-hour child care. Furthermore, discussions with DPRS auditors indicated that the DPRS method used to audit cost reports is similar to those used by DHS and MHMR.

One notable exception is that the DPRS audit process is manual, relying on visual inspection of records by individual auditors. DHS programs, by contrast, rely on a largely automated cost reporting and auditing process developed by the Rate Analysis Department of HHSC. MHMR is also in the process of automating.

HHSC's Automated Cost Reporting and Evaluation System (ACRES) allows auditors to focus on areas requiring the exercise of greater professional judgment. The accurate and reliable detection of routine discrepancies allows agencies to target their audit efforts more effectively and, ultimately, to produce a more accurate cost report database for rate calculation.

A more detailed discussion of these issues can be found in Appendix 3.

Recommendations

A. HHSC's Rate Analysis Department should assume responsibility for the rate-setting process for residential foster care.

Although the DPRS' rate-setting specialist is capable, the numerous individuals and wide-ranging experience concentrated in HHSC could enhance the process. HHSC's rate-setting group provides opportunities for cross-training and continuity in the event of staff turnover and facilitates consistency in dealing with similar rate-setting issues across programs. HHSC's Automated Cost Reporting and Evaluation System (ACRES) could be used for 24-hour foster care cost reports.

This would require close interaction between HHSC rate-setting staff and DPRS financial services staff, particularly in light of the multiple funding sources used by the program and the need to properly identify specific types of costs that are funded from different sources.

B. HHSC should ensure that the agencies and programs under its oversight use coordinated and consistent cost report audit policies.

Closer coordination in resolving issues common to these various programs would improve the processes and their outcomes, and produce greater consistency in the treatment of cost reporting issues.

Some providers deliver services in two or more programs administered by more than one agency, and therefore must submit separate cost reports to these agen-

cies. The coordination of audits in such cases is especially desirable.

C. DPRS should make changes in the calculation it uses to set rates. Detailed recommendations are reported in Appendix 3.

Fiscal Impact

All recommendations could be implemented using existing resources.

Endnotes

1 Texas Department of Protective and Regulatory Services, "Foster Care Reimbursements," http://www.tdprs.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/foster_care_reimbursements.asp. (Last visited December 18, 2003.)

2 Reports for 1995 through 2002 are available in pdf format from the U.S. Department of Agriculture's Center for Nutrition Policy and Promotion at http://www.usda.gov/cnpp/using2.html. (Last visited December 18, 2003.)

3 Texas Department of Protective and Regulatory Services, "Legislative Briefing," Austin, Texas, October 27, 2003.

4 Interview with staff, Texas Department of Protective and Regulatory Services, Austin, Texas, November 14, 2003.

5 Allowable costs also are codified in the Code of Federal Regulations, 45 CFR, Part 74; 48 CFR, Part 31; and U.S. Office of Management and Budget Circulars A-87, A-122 and A-110. The state regulations are found in 40 Tex. Admin. Code §§732.240-732.256 and 40 Tex. Admin. Code §§700.1801-700.1806.

CHAPTER 5

Ensure the Health and Safety of All Foster Children

Many Texas foster children are reportedly being neglected or abused—some by their caregivers, some by other children. Some have died and others are missing. Still others who are medically fragile or mentally retarded may not be properly identified or receiving proper care.

DPRS should take decisive steps to stop the abuse and neglect of Texas foster children.

The agency currently places sexual predators and children with violent criminal histories alongside other foster children. This practice must stop. All child-on-child abuse must be reported and tracked, and all complaints and allegations should be thoroughly investigated.

DPRS should obtain FBI criminal history checks for all adults who work with foster children, and all such checks should be complete before these persons begin work. Foster caregivers should test their employees for drug use, and DPRS should consider requiring psychological testing of caregivers.

Many foster children receive psychotropic medications, sometimes in disturbing amounts and combinations. The Health and Human Services Commission should create a review team to examine the diagnostic services, medication, treatment and therapy delivered to Texas foster children. This team also should develop a best-practices manual for the appropriate use of medications.

Medical "passports" documenting medical and therapeutic treatment as well as all medications being administered should accompany each foster child to all foster homes and medical appointments.

More than a thousand Texas foster children are considered medically fragile and nearly 3,000 have mental retardation. DPRS should improve the assessments and services provided to medically fragile foster children and create a Medicaid catastrophic case management program to guide their care in an efficient and effective way. Children with mental retardation should be identified properly and their services coordinated with the appropriate health and human service agencies.

DPRS should require foster caregivers to use appropriate behavior management systems that incorporate safe personal restraints. All foster child deaths should be investigated thoroughly.

DPRS should intensify its efforts to find missing Texas foster children. As part of this effort, the agency should develop a Web site providing the public with information about these children.

Abuse and Neglect

DPRS should take decisive steps to stop the abuse and neglect of Texas foster children.

Background

Most foster children come into DPRS' care after their parents or others in their own homes abused or neglected them. To keep these children safe, DPRS removes them from their homes and places them in foster homes and other facilities.

These children have often lost trust in adults and need reassurance, understanding, nurturing and support. Many foster parents and facility staff members provide exactly this kind of extraordinary care. Unfortunately, some caregivers reportedly abuse, neglect or exploit the children whom the agency entrusts them to protect. Moreover, some children who have suffered abuse by an adult experience something new upon entering foster care—abuse by other children.

Child-on-Child Abuse

DPRS policies do not require that children with histories of sexual abuse, sexual predation or violent criminal records be separated from other children.[1] An in-depth review of investigations of abuse and neglect at ten facilities, as well as responses to the Comptroller's foster care survey and interviews with DPRS staff and facility employees, confirmed that DPRS may place such children among new victims, and that child-on-child abuse is a problem.

One survey respondent wrote, "One of the children I worked with as a therapist in residential care was a sex offender who reported to me that he had victimized several children in a foster care setting."[2]

DPRS policies do not require that children with histories of sexual abuse, sexual predation or violent criminal records be separated from other children.

The survey respondent, a licensed clinical social worker who has worked with sexually abused children and provided therapy in a residential treatment center, said that she had known children who were sexually abused after being placed into foster care, either by foster parents or other children. She expressed concern that DPRS places foster children with no known history of sexual abuse with others who have such histories. She stated that, "Children who have been sexually abused will likely attempt to 'act out sexually' with other children."[3]

Staff members at one residential treatment center specializing in children with severe behavioral problems said that nearly all of the children at the facility had been exposed to sexual behavior, if not in their own homes, then by others they encountered in the foster care system, including other children.[4]

One therapeutic camp deliberately mixes children with histories of sexual abuse or sexual predation with other children as part of their "therapy." The facility also mixes children on probation for various crimes, mostly sexual in nature, with foster children who have no criminal histories.[5] Although most of the younger boys sleep at a separate campsite, one boy sleeping at a campsite with older boys slept near a counselor "to protect him from the other boys," according to a staff member.[6] This same facility had to discharge a boy who had been there for about two years because of his

One therapeutic camp deliberately mixes children with histories of sexual abuse or sexual predation with other children as part of their "therapy."

"cruel sexual abuse of other children," according to a letter the facility's executive director wrote to a DPRS contract manager.[7]

At another therapeutic camp, the county sheriff charged a 17-year old and another teen with aggravated sexual assault of a younger boy in October 2003. The alleged rape was reported to staff; the camp director, however, did not report it to DPRS until after the younger boy ran away from the camp for the third time that week and contacted a sheriff's deputy. The sheriff's office placed the other boys under arrest after questioning them.[8]

DPRS investigative reports for ten facilities, including child placing agencies that operate foster homes, residential treatment facilities and therapeutic camps, from January 2002 to January 2004, include complaints of child-on-child sexual abuse. DPRS caseworkers, juvenile probation officers, child therapists and other professionals filed many of these complaints based on children's allegations; few resulted in a finding of abuse or neglect or licensing violations involving neglectful supervision.[9]

DPRS does not track or report on the extent of child-on-child abuse in foster care. If a DPRS investigator found that a child had abused another child, he or she would be required to enter the child's name into a DPRS central registry that identifies child abusers. Once entered

Angela's Story

Angela, (name changed to protect confidentiality), age 14, named the women she said had abused her and the other children at the facility. Angela said they punched girls in the stomach when they got mad at them, and that one of the women pushed her down the stairs.

She said it happened after one of the other girls shoved her off a bench, which hurt her leg. She said she was moving slowly because her leg hurt and that one of the staff became angry with her for being slow. She said the staff member told the other girls to go in their rooms and close their doors.

When Angela finally reached the top of a flight of stairs, she said the staff member told her she was going to "teach her a lesson." According to Angela, the staff member pulled her injured leg up and pushed her down the stairs. Then a staff member sat her in a chair downstairs because she was unable to climb the stairs. She said she slept in the chair for the next week.[1]

The facility's director, a registered nurse, said she took Angela to a medical clinic the next day, where a doctor said Angela's leg was not broken. A week later, she said she took Angela again to the clinic, and again the doctor said that her leg was not broken. The following day, the director took Angela to the clinic for a third time; the doctor then recommended sending her to an orthopedic specialist. Because it would take another week to see a specialist, the director took her to a hospital instead.[2]

The hospital immediately found that her leg was badly broken, and that the lack of medical treatment had caused a severe bone infection. After surgery, Angela had to spend six months in the hospital, several months of it in traction. According to hospital records, Angela was malnourished when she arrived and required a feeding tube for several months.[3]

The facility director reported Angela's injury to DPRS on April 2, shortly after she took her to a hospital. Her report indicated that Angela had injured herself "while playing" and would need surgery.[4]

DPRS began its investigation of the director's report on April 4, 2003. The same day, the agency received a second call, reporting that Angela said that a staff member had pulled her up the stairs by her hair and pulled her injured leg up for being slow. On May 20, DPRS closed this complaint as "not subject to regulation." The report is not listed on DPRS' public database of reports and investigations.[5]

In its investigation of the director's report, DPRS found that, since the facility had sufficient staffing

into the central registry, however, the record would stay with the child for life.

For this reason, DPRS employees often are reluctant to brand a foster child in this way, and state law actually precludes entering a child's name in the registry as a perpetrator before the age of ten. DPRS' databases do not provide any other avenues to track child-on-child abuse.[10]

Without solid information, the public and the state's leadership cannot know the true extent of the problem. DPRS, in turn, cannot identify which facilities have the most problems and which children may be dangerous to other children, or devise policies to combat the problem. Caseworkers cannot make informed placement decisions. And facilities accepting children into their care cannot know whether they are making their other children vulnerable.

Adult Abuse of Foster Children

Adult abuse of children also is a problem in some foster homes and facilities. In fiscal 2003, DPRS employed 12 investigators in its Child Care Licensing (CCL) division to look into 966 reports, most of which involved alleged adult abuse or neglect of children. Of these, the agency found 98 valid, or about 10 percent.[11]

The Comptroller review team, however, conducted an in-depth review of reports, com-

(continued on page 193)

when Angela was injured, sought medical treatment for her and documented it, that no breach of licensing standards had occurred. The agency closed this investigation on May 28.[6]

Because DPRS did not investigate the second report, which contained Angela's allegation of abuse, no one asked critical questions. No one asked the other girls if they saw Angela climb the stairs on the evening of the alleged incident. No one asked the girls or staff members if they had seen Angela sleeping in a chair downstairs, or being unable to walk without crutches. No one asked hospital staff members whether the injury to her leg was consistent with a playground injury. No one reviewed her medical records to learn that she had been malnourished when she entered the hospital.

The facility and DPRS also failed to request an FBI background check of other states for the staff member Angela said pushed her, even though this individual had only recently moved to Texas before starting work at the facility. As it happens, this person had a criminal record in her state of prior residence, including a 1997 third-degree felony conviction for grand theft, a 1999 probation violation and a charge of battery in August 2001.[7]

DPRS received yet another call about Angela's injury a few months later. This caller reported that children at the facility suffered from numerous medical conditions that may be related to abuse and neglect. DPRS investigated and ruled out abuse. According to DPRS' investigations to date, no one at the facility has done anything wrong, and the facility is in complete compliance with its standards.

On the DPRS Web site list of licensing investigations and violations, Angela's story is just one of the 90 percent of reports, complaints or allegations that DPRS does not find to be valid.[8]

Endnotes

1 Advocate's interview of child, September 7, 2003.

2 Texas Department of Protective and Regulatory Services.

3 Hospital records.

4 Texas Department of Protective and Regulatory Services.

5 Texas Department of Protective and Regulatory Services.

6 Texas Department of Protective and Regulatory Services.

7 State of Florida, Twentieth Circuit Court, Criminal Justice Information System, public database, 1997-2003.

8 Texas Department of Protective and Regulatory Services.

A Pattern of Allegations DPRS Found to be Invalid at One Facility

…[The reporting child] has been a resident at this treatment center [for nearly two months]. He has observed at least three incidents where staff have been abusive to youth. 1. [Staff #1] threw [another child] against a wall and kicked him. [This child] is a diabetic and had a seizure after this incident. 2. [Staff #2] kicked [a second child]. 3. [Staff #3] picked a boy up by the neck and held him against the wall by his neck. Although [the reporting child] has not been abused by the staff, he is concerned that he will be abused if anyone learns that he has made this report.

The facility has not had hot water for the past two weeks. The children are taking baths in cold water…. The hygiene products for the children are minimal. The children are using shampoo as soap to bathe. The toilets are backed up and the children are having to go to other places to use the bathroom…."

The electricity at the facility was turned off for at least 24 hours on Tuesday or Wednesday of last week due to nonpayment of the power bill…. Living conditions at the facility are deplorable. There was no air conditioning in therapy areas, in hot weather, for several weeks to months. From May to July, the rooms had dead cockroaches inside the facility, and no effort was made by staff to clean [them] up….

Staff hit and curse residents in care. Administrator ignores verbal reports of incidents and does not make notes of incidents.

On Friday… [the child] was observed with two purple bruises on each eye. When confronted about the injuries, [the child] stated that [a staff member] restrained him. Further specifics on the incident are unknown. [The child's] black eyes were still visible on the following Sunday.

There is also concern regarding [a staff member] who works at the facility. On Saturday… [the staff member] was observed purchasing a bag of marijuana outside the facility. [The staff member] brought the bag into the facility. [The staff member] smelled like marijuana. This incident was brought to [the director's] attention. [The director] was angry at the staff member who reported the incident and called [the accused staff member] in to confront this worker. This [reporting] staff member quit soon after in fear of retaliation.

[The child] stated that she ran away because of the treatment of all of the children. The children were told to "shut up" and had shoes and books thrown at them. They were also forced to eat, by having the food "shoved" down their throats.… [Another child] confirmed that the staff threw shoes and books at the residents. She stated that she had been put into the [seclusion room] for five weeks and was only fed bread and water. [The child] also said that about two weeks ago she was in the laundry room when [a boy] asked her to go upstairs. [The child] asked him why and he said that it was a surprise. When they got upstairs he took her to his room and raped her. [The boy] told her not to say anything, as he would kill her. [The girl] tried to tell [staff name] who told [the girl] "get out of my face, I don't want to talk to you."

[…they are frequently short handed and have left two individuals to monitor 23 clients. Individuals are being placed on the work roster who no longer work in the facility…. It is noted that the facility's paychecks to its employees are "bouncing."

The majority of the boys living in the [facility] have athlete's foot. They need cotton socks and foot powder. The children are not receiving the needed treatments. The athlete's foot appears painful.... The heater is not working in the [facility].

On [date], 10 or 15 children from the [facility] had food poisoning…. Children from the [facility] are regularly being examined…for different reasons, such as ringworms and rashes.

plaints or allegations and their ensuing investigations involving ten facilities dated from January 2002 through December 2003, and found that the public database and published information underreport complaints, including abuse and neglect complaints, and do not paint a true picture of the situation.

The CCL division closes some cases without investigation. These cases are "administratively closed—not subject to regulation." However, for CCL to administratively close a case, the complaint has to fall outside the regulations of the agency or the CCL, be a report that did not provide enough information to investigate or be duplicative of other complaints that have already been investigated.[12]

The Comptroller review team found instances of allegations of abuse and serious licensing violations that were administratively closed but did not meet the criteria for administrative closure. State law charges DPRS with investigating all such complaints. Some of these cases involve multiple children and series of incidents over time.[13] Listed below is an example of one complaint about a foster home that DPRS did not investigate due to administrative closure:

> [The child] was enrolled on Tuesday at [high school] by the foster mother. The foster mother repeatedly berated and warned [the child] not to be going to the nurse's office because "there's nothing wrong with you." However, [the child] has end-stage renal failure and has dialysis three times a week. [The child] takes numerous medications…. [The child] "shuts down" however when the foster mother begins to berate [the child]. Today [the child] came to school, after having been absent yesterday, presumably for dialysis. [The child] became ill shortly after coming to school and began throwing up. [The child] was brought to the nurse's office and the foster mother was called. The foster mother came to the school briefly, but the foster mother merely berated [the child] for coming to the nurse's office and then flatly refused to take [the child] home or to take [the child] for medical attention.… At the time of the report [the caller] was considering calling 911. [The child] appears to be very ill.

Although this incident happened at a school and not at a licensed facility or foster home, the CCL division still must investigate if the foster caregiver is involved or if abuse or neglect may be happening at a facility or foster home. This foster mother continues to care for up to six children in her therapeutic foster home and has a clean record with CCL.[14]

Those allegations that the CCL division investigates are rarely ruled valid, even when the complaint and complainant appear credible, such as when teachers, medical clinics, law enforcement and facility employees report eyewitness evidence that is documented.

The CCL division closes some cases without investigation.

To determine if a complaint is valid, DPRS policy uses a standard called "a preponderance of evidence," also called "the 51 percent rule." This phrase means that the evidence simply must be judged more valid than not.[15] In situations where children allege that adults abused them, the evidence often boils down to a child's word.

Many reports originate with children, although some reports derive from observations by employees at foster care facilities, medical staff at clinics or hospitals, teachers, law enforcement, DPRS caseworkers and others. The Comptroller review team found allegations of physical and sexual abuse, medical neglect and drug use by staff. Numerous professionals, as well as the children themselves, made serious allegations of abuse, neglect and exploitation to DPRS, to little avail.

Some incidents were never investigated; those investigated were rarely found valid.[16] Some of the allegations that DPRS investiga-

tors found invalid at one facility are listed in the accompanying text box (see page 192).[17]

Of 47 such complaints called in to DPRS about this facility from January 2002 through December 2003, CCL administratively closed 10 and did not investigate them. Among the remaining 37, DPRS found four complaints at least partially valid and rejected 32. One was never investigated.

Of the four complaints DPRS found at least partially valid, one involved a personal restraint resulting in serious injury to a child. Another involved neglectful supervision when staff slept, allowing children to engage in sexual activity. The third involved withholding food as punishment, but the allegation itself involved serious staff abuse of a child who ran to police and was found to have sustained a bite mark on his arm, choke marks on his neck, severe bruising on his left arm and a hit on his left temple. The licensing investigator was "unable to determine" if abuse had occurred. The fourth involved not reporting a serious incident to DPRS when a staff member was fired for having sex with a child.[18]

Some incidents were never investigated; those investigated were rarely found valid.

According to the investigative reports, DPRS investigators generally rely on interviews and reviews of facility documents to determine the "preponderance of evidence," even when other documents like medical records, police reports or utility bills might substantiate an allegation.

Investigators also appear to give more weight to the statements of facility staff than to those of children and other adults, even though clear patterns often exist that might corroborate their stories, such as similar complaints from different children over time.[19]

"Although these children sometimes fabricate stories, children's complaints should be taken seriously. Investigators should look for patterns in allegations of children's complaints," according to a child abuse expert.[20]

In addition, it should be noted that facilities control the content of the facility documents investigators review, and children may fear retaliation when answering questions during an investigation. Moreover, many children are simply too young to complain. These factors weight the investigations heavily in favor of the facility.

DPRS also might be compromising some of its investigations by delaying them. Although DPRS initiated investigations on seven of the 47 complaints within one day of the complaint, 18 took as long as six or more days to begin. In one complaint involving a child who said she was becoming suicidal, citing taunts and threats from staff members, DPRS did not open an investigation for 14 days. In another incident in which police transported a bruised child to a hospital, DPRS did not begin its investigation for six days.[21]

Evidence may disappear during such delays. Both incidents, and others, occurred after January 2003, when HHSC established rules concerning investigations to require timely responses in order to preserve evidence.[22]

Finally, none of the reports of allegations that are administratively closed are listed on the DPRS public Web site on facilities. This incomplete picture of facilities' track records can be misleading to the public.

Need for Screening

DPRS rules and standards require Texas criminal background checks for foster parents and staff providing direct care for children. They also require a check of the DPRS central registry for abuse and neglect for any history of having abused or neglected a vulnerable person. However, DPRS rules and standards require a FBI criminal history check of records in other states only if the individual currently lives outside of Texas or if there is reason to believe other criminal history exists.[23]

DPRS also does not check abuse and neglect central registries in other states, and no national registry exists.

DPRS rules require completed background checks before child placing agencies and other private foster homes can have access to foster children. Facilities such as residential treatment centers, however, do not have to wait until DPRS completes background checks before they hire staff and give them access to children.

DPRS prohibits individuals with felony convictions involving criminal homicide, kidnapping, sexual and assaultive offenses, robbery and offenses against the family from employment with a residential facility. DPRS performs a risk assessment for misdemeanor convictions for these crimes or any other type of felony to determine a person's fitness to work with children. However, DPRS does not inform facilities of other misdemeanor convictions, such as criminal trespass, weapons, arson and others.[24]

The new CCL database on facilities tracks information on background checks, which must be conducted every two years. This information provides a track record of foster care employment to some extent, but DPRS does not provide this information to facilities automatically; facilities must request it. Few do. Individuals sometimes attempt to work at other foster care facilities when they are fired and may not provide an accurate employment history to prospective employers.

DPRS policies do not require any psychological screening or testing to determine the mental health status and stability of foster parents and other direct caregivers. Psychological testing is becoming common for professions with frequent access to children and those that involve stressful situations. Many police and fire departments now require some form of psychological testing.[25] In addition, some foster care operations are using psychological tests to rule out prospective employees or foster parents with serious psychological problems.[26]

All contracted foster care facilities have psychologists on staff or on contract who can combine the results of psychological tests with other background and interview information on prospective caregivers to assess their suitability. In order to comply with federal requirements involving non-discrimination, facilities can use psychological testing as a conditional requirement after making an employment offer to someone.[27]

Recommendations

A. DPRS should prohibit the placement of sex offenders, sexual predators and children with violent criminal histories with other children.

DPRS also should place sexually abused children separately from other children unless a licensed therapist determines it is in the best interests of the children involved to do so. DPRS should review all current placements and make necessary adjustments.

B. DPRS should track and report the number of reports it receives concerning child-on-child physical and sexual abuse by facility.

C. DPRS should thoroughly investigate all complaints, allegations or reports and should list the dates and outcomes on its public Web site on facilities. These should be randomly reviewed by HHSC to ensure that investigations are timely and thorough.

D. DPRS should arrange advanced training for residential licensing investigators on investigative protocols and techniques.

E. DPRS should require an FBI check of criminal records in other states for all prospective facility staff, foster parents and others who come into frequent or regular contact with children, and as part of an investigation into allegations of abuse.

F. DPRS should work with other states to develop agreements to check central registries of abuse and neglect in states where applicants have lived previously.

G. DPRS should require complete background checks before staff or others have access to children.

Facilities could provide staff with training and administrative duties away from children while awaiting results.

H. DPRS should provide information to prospective foster care employers of all criminal convictions of individuals submitted for a background check.

I. DPRS should perform a risk assessment on anyone who has been convicted of a crime before they are allowed access to children.

J. DPRS should assure the places of prior foster care employment are available in its database to facilities as part of the background check for prospective foster caregivers.

K. DPRS should require that foster care providers test for drugs as a condition of employment and that facilities randomly test their employees for drugs.

L. DPRS should consider requiring psychological testing of facility staff and prospective foster parents to identify individuals who are mentally unsuitable to care for children.

Fiscal Impact

Costs for these recommendations cannot be estimated.

Endnotes

[1] Texas Department of Protective and Regulatory Services, *Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care* (Austin, Texas, January 2004), available in pdf format from http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp. (Last visited February 5, 2004.)

[2] Texas Comptroller of Public Accounts, Foster Care Survey 2003-2004.

[3] Interview with survey respondent, November 30, 2004.

[4] Interview with residential treatment center staff, December 3, 2003.

[5] Interview with therapeutic camp staff, November 20, 2003.

[6] Interview with therapeutic camp staff, January 16, 2004.

[7] Data provided by DPRS, February 8, 2000.

[8] Glenda Taylor, "Arrests made in sexual assault at facility," *Kerrville Daily Times*, November 4, 2003, and Texas Department of Protective and Regulatory Services.

[9] Data provided by DPRS.

[10] Interview with Texas Department of Protective and Regulatory Services staff, January 5, 2004.

[11] E-mail from Texas Department of Protective and Regulatory Services staff, January 21, 2004 and February 18, 2004.

[12] Texas Department of Protective and Regulatory Services, *Licensing Policy and Procedures Handbook*, §6200, 6400, 6612; Tex. Fam. Code, §261.301, 261.304, 261.401; and interview with Texas Department of Protective and Regulatory staff, January 7, 2004.

[13] Texas Department of Protective and Regulatory Services and *Tex. Hum. Res. Code Ann.* §42.044(c).

[14] Data provided by DPRS.

[15] Texas Department of Protective and Regulatory Services, *Licensing Policies and Procedures Handbook*, Section 6610 and Glossary.

[16] Data provided by DPRS.

[17] Data provided by DPRS.

[18] Data provided by DPRS.

[19] Data provided by DPRS.

[20] Interview with Ben G. Raimer, M.D., Professor of Pediatrics, The University of Texas Medical Branch in Galveston, February 3, 2004.

[21] Data provided by DPRS.

[22] 1 Tex. Admin. Code §351.503.

[23] 40 Tex. Admin. Code §745.627, and Texas Department of Protective and Regulatory Services.

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Medication

HHSC should create a Foster Care Medical Review Team to review the diagnostic services, medication, treatment and therapy delivered to Texas children in foster care.

Background

Texas' foster children in all service levels receive psychotropic drugs—that is, drugs that affect the mind through action on the central nervous system—for depression, schizophrenia, attention deficit hyperactivity disorder (ADHD), seizures and a variety of other conditions. Any caregiver, from foster families to residential treatment centers, may obtain these medications from the physicians treating their children.

DPRS exercises little meaningful oversight over these medications.

Many observers, including physicians, children's advocates and foster parents, have expressed concern over the types and amounts of psychotropic medications prescribed to foster children. Respondents to a recent Comptroller survey regarding foster children concurred. Among their comments:

> I adopted a child that had been 80 pounds overweight because the system felt it was easier to overmedicate him than…to work with him on his issues.

> Our foster sons were completely misdiagnosed in foster care and unnecessarily medicated. Kids are medicated for higher-level ratings (more money for agency & parent) instead of assisting foster parents in making these kids good citizens.

> Children were given astronomical amounts of medication. Diagnoses were altered to accommodate hallucination[s] which may have been induced by overmedication.

Many foster children have psychological problems and are being treated with an array of medications to manage their symptoms. But even fundamentally normal children who have been taken from their homes and families can become aggressive and "emotionally reactive" due to a lost sense of trust and their conditions are only worsened by multiple placements and frequent caseworker turnover. As their feelings of instability increase, their emotions may erupt, and their caretakers then are, in the words of one child psychiatrist, "just chasing an untreatable problem with more medication."[1]

Many foster children have psychological problems and are being treated with an array of medications to manage their symptoms.

In Other States

Concerns about the medications foster children receive have been raised in other states. In Minnesota, for instance, a University of Minnesota study for Saint Louis County found that nearly 35 percent of the county's foster children were receiving psychotropic medication, compared to 15 percent of the general population of children.[2]

In Florida, the use of psychotropic medications prescribed to foster children has been a source of controversy for several years. In July 2003, the state's Statewide Advocacy Council (SAC) released a report, *Psychotropic Drug Use in Foster Care*, which found

that more than 9,500 Florida foster children had received psychotropic drugs in 2000.

The report cited as one "disturbing discovery" the use of psychotropic drugs on preschoolers; the federal Food and Drug Administration has little data on the possible long-term effects of such drugs on young children. The report lists possible side effects from these medications as:

- decreased blood flow to the brain;
- cardiac arrhythmia;
- disruption of growth hormone, leading to suppression of growth in the body and brain;
- permanent neurological tics;
- psychosis;
- depression;
- insomnia;
- agitation and social withdrawal;
- suicidal tendencies; and
- Tardive dykinesia (central nervous system disorder characterized by twitching as a side effect of prolonged anti-psychotic drug use).

No formal investigation related to psychotropic medication given to Texas foster children has ever been conducted.

SAC also found that many of the medication records they reviewed lacked adequate or accurate information on how consent for the medication was obtained and what sort of information was provided to children and their parents or guardians. SAC learned that primary care physicians, rather than pediatric psychiatrists, prescribe many of these medications. In the sample group of 1,180 case files examined, 67 percent lacked any documentation of monitoring for side effects. The drugs most often administered were stimulants and atypical antipsychotics.

SAC recommended the following reforms:

- creation of a quality assurance program to monitor the use of psychotropic drugs in children;
- creation of a standardized, written consent form to be obtained before starting any child on psychotropic medication, providing information about risks, benefits, possible side effects and alternative treatments;
- examination by a qualified pediatric psychiatrist before any use of these drugs;
- improved, readily accessible medical records for each foster child;
- efforts to ensure that everyone administering psychotropic medication to foster children can recognize the side effects of such medications; and
- creation of "Medical Passports" containing complete and current treatment histories for each foster child that are made available to each physician they see.[3]

In response to the SAC report, the Florida Department of Children and Families created a telephone hotline staffed by seven psychiatrists to respond to questions from foster parents, caseworkers and judges about medications and possible side effects.

In Texas

No formal investigation related to psychotropic medication given to Texas foster children has ever been conducted.

Youth for Tomorrow (YFT), the private contractor responsible for assigning foster children to DPRS' service levels, has no physicians, nurses or pharmacists on its staff, and does not attempt to assess the appropriateness of medication.[4] DPRS investigations have revealed that some children are not getting therapy as directed, medications are not properly locked, there are missed doses of medication and poor medication documentation.

The Comptroller review team asked DPRS how its caseworkers would know if a child is being overmedicated. DPRS responded as follows:

> The caseworker observes the behavior and appearance of the child and reads the progress and facility records if the child appears to be in a stupor, slow to respond and has lethargy. When the records are checked, the physician's orders and dosages and medication compliance is [sic]

> noted. The caseworker is not a medical doctor, however, and does not have the extensive training on medications that a medical staff would have. There is some training for CPS staff on medications, but [caseworkers are] not expected to be the medical expert for the child.[5]

The review team collected Medicaid data from DPRS and provided them to the HHSC's Drug Utilization Review Program to determine the types, dosages and cost of medications given to foster children. The data were for the month of November 2003. While there were data constraints (due to some invalid Medicaid numbers), the results were nevertheless revealing.

One child, for instance, had 14 prescriptions for 11 different medications, at a cost for the month of $1,088.03. These included:

ABILIFY 15MG TABLET*
FLUVOXAMINE MAL 100MG TAB*
TRILEPTAL 600MG TABLET*
CONCERTA 36MG TABLET SA*
REMERON 15MG SOLTAB*
REMERON 30MG SOLTAB*
STRATTERA 40MG CAPSULE*
STRATTERA 25MG CAPSULE*
LITHIUM CARBONATE 300MG CAP*
LITHIUM CARBONATE 150MG CAP*
CLOBETASOL 0.05% CREAM
DE-CONGESTINE TR CAPSULE
GUAIFENESIN LA 600MG TAB SA
DOCUSATE SODIUM 100MG CAP

*Indicates medication is psychotropic drug. Two of the medications are from the same class (antidepressant), and two are used to treat ADHD.

Three children received 30-day prescriptions for 90 tablets (three tablets per day) of Zyprexa (20MG) at a cost per prescription of $1,559.70 each. Zyprexa is an "atypical antipsychotic" drug used in the treatment of schizophrenia.[6] The same physician prescribed this drug for all three children and all were filled at the same pharmacy.[7]

Physicians must carefully monitor many of the medications prescribed to foster children, and some drugs can be accurately monitored only with blood tests. An assortment of physicians are prescribing these types of medications to foster children, and while some are child psychiatrists, others are family practitioners and pediatricians.

A leading child psychiatrist has expressed concern regarding children receiving multiple medications of the same class, such as two stimulants or antidepressants.[8] Data show this may be the result of a child seeing more than one physician, but may also be due to individual physicians providing multiple prescriptions.

The existing data cannot specify the total number of foster children taking each medication, but can be used to identify the most common psychotropic drugs administered to Texas foster children (Exhibit 1).

A leading child psychiatrist has expressed concern regarding children receiving multiple medications of the same class, such as two stimulants or antidepressants.

In addition, many children are receiving antibiotics and Guanfacine, an antihypertensive medication used to treat high blood pressure and aggressive behavior in children.

A professor of Pediatrics at the University of Texas Medical Branch in Galveston observed the following after reviewing the medication data:

1) There appears to be an aggressive use of multiple psychotropic medications.
2) Prescribing practices would suggest that these children are likely severely disturbed, raising questions such as:

   - What diagnostic testing was done to confirm these diagnoses?
   - What are the qualifications of those making these diagnoses?
   - Are these foster parents appropriately trained to manage these patients?
   - Are appropriate laboratory tests being done to monitor potential side effects of these medications?

(continued on page 204)

Exhibit 1

Psychotropic Drugs Commonly Prescribed to Texas Foster Children

Medication	Class of Medication	Uses	Side effects/warnings
Abilify	Antipsychotic	Abilify is used to treat schizophrenia. It has not been studied in children under 18 years of age.	Common side effects include headache, weakness, nausea, vomiting, constipation, anxiety, problems sleeping, lightheadedness, dizziness, sleepiness, restlessness and rash.
Adderall	Central nervous system (CNS) stimulant	Adderall is a mixture of different amphetamine salts that can help to reduce or improve the symptoms of ADHD (Attention Deficit Hyperactivity Disorder).	Although generally well tolerated, the main side effects include loss of appetite, insomnia, weight loss, abdominal pain and depression.
Clonidine	Antihypertensive	Clonidine is a common antihypertensive agent. Other reported clinical uses include the treatment of opiate and alcohol withdrawal. It is also used as a pediatric preanesthetic; for pediatric postoperative pain management; and the treatment of migraine headaches, nicotine addiction, menopausal flushing, attention deficit disorder, Tourette's syndrome and pediatric panic and anxiety disorders.	Common side effects include dry mouth, sedation, dizziness and constipation. While generally safe, toxic doses can cause serious cardiopulmonary instability and central nervous system depression in children and adults. Children are particularly susceptible to toxic reaction from relatively small doses (i.e., normal adult therapeutic doses).
Concerta	CNS stimulant	Concerta is used to treat ADHD, it contains methylphenidate, the same medication found in the brand-name drug called Ritalin, but the Concerta tablet is formulated with a special drug-release system that allows the medication to be released slowly over time.	Should not be taken by patients with significant anxiety, tension or agitation; allergies to methylphenidate or other ingredients in Concerta; glaucoma, Tourette's syndrome, tics or family history of Tourette's syndrome; or current/recent use of monoamine oxidase inhibitors (MAOI). Should not be taken by children under six years of age.
Depakote	Anticonvulsant	Depakote has been proven effective in the treatment of manic episodes associated with bipolar disorder, also known as manic depression.	Depakote can cause serious or even fatal liver damage, especially during the first six months of treatment. Children under two years of age are the most vulnerable, especially if they are also taking other anticonvulsant medicines and have certain other disorders such as mental retardation. Caution should be taken when Depakote is administered with other medications, including aspirin.

Medication	Class of Medication	Uses	Side effects/warnings
Lexapro	Antidepressant	Lexapro, the newest member of a family of medications known as selective serotonin reuptake inhibitors (SSRIs), is used to treat anxiety symptoms associated with depression.	The most common side effects reported are nausea, insomnia, sexual dysfunction, increased sweating and fatigue.
Risperdal	Atypical antipsychotic	Risperdal is used to treat schizophrenia and psychotic disorders. It may also be useful in treating acute mania and severe depression in combination with antidepressant medications.	Common side effects include anxiety, sleepiness, restlessness, tremors, muscle stiffness, dizziness, constipation, nausea, indigestion, runny nose, rash and rapid heartbeat.
Seroquel	Antipsychotic	Seroquel is used to manage the manifestations of psychotic disorders including schizophrenia.	Reported side effects include sleepiness; hypotension (abnormally low blood pressure); digestive problems (constipation, dry mouth, indigestion); and dizziness. Such effects generally are mild and improve without specific treatment. Seroquel should be used with particular caution in patients with known cardiovascular disease, cerebrovascular disease or conditions associated with hypotension.
Trazodone	Antidepressant	Trazodone is used in the treatment of depression and to reduce the symptoms of agoraphobia, drug-induced insomnia, essential tremor, repetitive screaming and some pain syndromes.	In rare cases, may cause liver damage; can cause dizziness and drowsiness.
Trileptal	Antiepileptic	Trileptal is used to treat partial seizures in adults and children, when taken alone or with other seizure medicines.	Trileptal can cause low sodium in the blood. Signs of low levels of blood sodium include nausea, extreme drowsiness and discomfort, headache, confusion and "dullness."
Zoloft	Antidepressant	Zoloft is prescribed for major depressive disorders, a persistently low mood that interferes with everyday living. Zoloft also is used to treat obsessive-compulsive disorder and panic disorder.	Common side effects include abdominal pain, agitation, anxiety, constipation, decreased sex drive, diarrhea or loose stools, dizziness, dry mouth, fatigue, gas, headache, decreased appetite, increased sweating, indigestion, insomnia, nausea, nervousness, pain, rash, sleepiness, sore throat, tingling or "pins and needles," tremor, vision problems and vomiting.
Zyprexa	Antipsychotic	Zyprexa is used to treat schizophrenia and acute mania associated with bipolar disorder.	Common side effects include headache, agitation, drowsiness, constipation, dry mouth, upset stomach, vomiting and diarrhea.

Source: Medline, U.S. National Library of Medicine.

- Are these children receiving appropriate counseling services?
- Are these children receiving appropriate interventions in our public school systems?
- Are there "trends" among physician prescribers?
- Are there "trends" among foster homes?

The physician went on to say:

> …to be perfectly blunt, have these children been "medicated" into compliance for home expectations, or are these children's behaviors sufficiently aberrant to warrant these medication practices?[9]

Costs and Cost Containment

An October 2003 article in WebMD Medical News reported that the cost of treating mental illness in children has risen sharply, due to the increasing use of new and more expen-

What the Experts Say

Dr. Mark Simms, medical director and professor of Pediatrics at the Medical College of Wisconsin in Milwaukee

Dr. Simms has written a report, *The Crisis in Health Care for America's Foster Children*, which documents serious health concerns for foster children.[1] Key points of the report include the following:

- mental health surveys of children in foster care have found extremely high rates of depression, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder and attachment and anxiety disorders;
- given the high prevalence of psychological and behavioral symptoms among these children, the overuse of psychotropic medication has become a significant concern;
- children in foster care are the least healthy and most needy group in the U.S.;
- in addition to abuse and neglect, foster children may have experienced poverty, inadequate prenatal care and family and neighborhood violence;
- many children are at risk of HIV infection because of maltreatment, sexual exploitation and parental substance abuse. Each child's risk for HIV, hepatitis and sexually transmitted disease should be assessed and confirmed to ensure prompt treatment;
- unfortunately, foster children are unlikely to receive appropriate care while in foster care; and
- Florida and San Diego have created "medical passports" to ensure that each physician seeing a foster child has a complete record of his or her medical treatment. This medical passport stays with each child as they change placements and/or physicians. In San Diego, all of the passport information is also automated and placed into a database.

U.S. Food and Drug Administration / National Consumers League

A pamphlet on food and drug interactions co-produced by these organizations notes that medicines "must be taken properly to ensure that they are safe and effective." The consumption of certain foods and caffeine as well as the age, weight, sex and overall health of the patient can change the effect of medication. All doctors and pharmacists should know about every drug a person is taking, including nonprescription drugs.[2]

American Academy of Child and Adolescent Psychiatry and Foster Children

An American Academy of Child and Adolescent Psychiatry (AACAP) publication, *Psychiatric Medications for Children and Adolescents, Part III: Questions to Ask*, states that:

> Parents and guardians should be provided with complete information when psychiatric medication is recommended as part of their child's treatment plan. Children and adolescents should be included in the discussion about medications, using words they understand.

sive drugs such as Risperdal, Wellbutrin and Celexa—drugs being marketed briskly to the medical community.

From 1997 to 2000, the use of medications to treat mental illness in children rose by about 5 percent, but the costs of those medications rose by 65 percent over the same time period. The article also notes that, in most instances, the newer medications have not been specifically approved by the Food and Drug Administration (FDA) to treat mental illness in children and teens.[10] In March 2004, the FDA issued a public health advisory regarding antidepressant medications. The agency asked manufacturers of ten antidepressants including Zoloft and Lexapro (commonly given to Texas foster children) to include in their labeling a warning statement that recommends close observation and monitoring of adults and pediatric patients treated with these drugs for worsening depression or emergence of suicidality.

The document lists questions children and their parents should ask:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. What are the rare or serious side effects, if any, which can occur?
6. Is this medication addictive? Can it be abused?
7. What is the recommended dosage? How often will the medication be taken?
8. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?
9. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
10. Are there any other medications or foods which my child should avoid while taking the medication?
11. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?
12. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?
13. How long will my child need to take this medication? How will the decision be made to stop this medication?
14. What do I do if a problem develops (e.g. if my child becomes ill, doses are missed, or side effects develop)?
15. What is the cost of the medication (generic vs. brand name)?
16. Does my child's school nurse need to be informed about this medication?

In conclusion, AACAP states:

> Treatment with psychiatric medications is a serious matter for parents, children and adolescents. Parents should ask these questions before their child or adolescent starts taking psychiatric medications.[3]

Endnotes

1 Mark D. Simms, M.D., "The Crisis in Health Care for America's Foster Children," available in pdf format from www.igpa.uiuc.edu/events/confHighlights/pdf/simms.pdf. (Last visited January 26, 2004.)

2 U.S. Food and Drug Administration National Consumers League, "Food & Drug Interactions," http://vm.cfsan.fda.gov/~lrd/fdinter.html. (Last visited January 19, 2004.)

3 The American Academy of Child and Adolescent Psychiatry and Foster Children, "Psychiatric Medications for Children and Adolescents, Part III: Questions to Ask," March 2001, http://www.aacap.org/publications/factsfam/medquest.htm. (Last visited February 4, 2004.)

Overmedication, which may be detrimental to the child, is an unnecessary expense to the state. Medicaid pays for the health care costs of Texas foster children, including their prescription costs. To address the rising cost of pharmaceuticals, some states have created Medicaid preferred drug lists (PDLs), which are lists of preferred generic and cost-effective brand-name drugs. Commercial health plans and employers have used PDLs to manage their drug costs for many years.

The 2003 Legislature directed that the Texas Medicaid program create a PDL and require prior authorization for prescriptions of drugs not on the PDL. The first phase of the PDL was to be implemented on February 9, 2004. After this date, physicians must obtain authorization from Texas Medicaid's Vendor Drug Program before a pharmacy can dispense a drug not on the PDL.

This measure will allow physicians to prescribe drugs not on the list if Medicaid deems them medically necessary; otherwise, they must use either clinically appropriate generics or a preferred brand-name drug.

Medical Records

Federal law states that a foster child's health care record is to be reviewed, updated and given to the foster care provider at the time of placement. A recent health care study of children in foster care in Texas by the federal Office of Inspector General (OIG) reported that the foster care providers of 46 percent of the children studied never received medical histories for the children in their care.[11] This study noted that children in the lower levels of service were less likely to have their medical records at the time of placement.

Foster care providers stated that not having a child's medical records made it difficult for them to effectively care for foster children.

A Doctor's Viewpoint

Ben G. Raimer, M.D., is a professor of Pediatrics at the University of Texas Medical Branch in Galveston. Dr. Raimer has worked with children with developmental disorders for more than 25 years and has served as an expert witness in cases related to child abuse and neglect. According to Dr. Raimer:

"I noted in my own practice several months ago four young children placed into adoption in a family for whom I provide care. The adoptive father brought the children to my attention because he felt that, although they likely had some behavioral problems associated with family drug abuse and environmental neglect, none of them seemed sufficiently disturbed and/or exhibited troublesome behaviors [sufficient] to warrant the large dosages of multiple psychotropic medications that had been prescribed to all of them during foster care.

On further examination of the children and [a] review of the scanty medical histories that were provided, I agreed with him. We cautiously decreased the medications in all four of the boys and then treated them appropriately as indicated. The adoptive father told me that he had noted it to be a fairly common practice…that "some" foster parents sought out medications for children to:

(1) make them more submissive during care and

(2) be able to draw down more financial reimbursement for the care.

Apparently, DPRS provides additional funding for the care of children who are on multiple medications and/or carry a diagnosis related to psychological problems.…

If I may, I would suggest that a panel of pediatricians and child psychiatrists be convened to review the diagnostic services, the medication practices and the treatment interventions of children in foster care."

Other foster parents identified in the OIG report stated that children with serious medical conditions were placed in their care, but that the foster parents did not receive medical records for those children.

Recommendations

A. HHSC should create a Foster Care Medical Review Team to review the diagnostic services, medication, treatment and therapy delivered to Texas children in foster care. The HHSC Deputy Commissioner for Health Services should coordinate the team.

This group should include child psychiatrists, psychologists, pediatricians, pharmacologists, pharmacists and staff from the HHSC Drug Utilization Review Program, the Texas State Board of Medical Examiners and state medical schools. The team should report its results to the Legislature and should develop a best practices manual for the appropriate use of medications for foster children. The team should advise the DPRS Advancing Residential Care staff as to how to appropriately evaluate the use of psychotropic medication as an outcome for foster children.

B. Foster care caseworkers, foster parents and parents (if they have not lost or surrendered their parental rights) should be required to sign authorizations for psychotropic medications to be given to foster children.

Furthermore, children and their caretakers should receive information on their prescribed medications, in accordance with the guidelines of the American Academy of Child and Adolescent Psychiatry.

C. DPRS should develop "Medical Passports" for foster children.

The passport would accompany the child on every doctor and therapist visit and would provide information on their complete medication, medical and therapy history. This passport would stay with the child during their entire time in foster care, even if they change placements, physicians, therapists, etc.

Currently, HHSC is testing the viability of using smart card technology to help authenticate Medicaid recipients in several pilot areas around the state. If the pilot is successful, this technology could be expanded to not only assist in eligibility determination, but could be used to contain medical histories for foster children as well.

Fiscal Impact

These recommendations could be accomplished with existing state resources.

Reviewing the medications of foster children should save money. To the extent that the number of medications is reduced, the cost of providing drugs paid for by the Medicaid program, which is about 40 percent state dollars and 60 percent federal dollars, may decrease.

Endnotes

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2 University of Minnesota at Duluth, "The Prescription of Psychotropic Medications in Foster Care Children: A Descriptive Study in St. Louis County—Executive Summary," by Stacy Hagen and Laurie A. Orbeck, http://www.d.umn.edu/sw/executive/hstacy.html. (Last visited January 25, 2004.)

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4 Interview with Youth for Tomorrow staff, San Antonio, Texas, December 4, 2003.

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[9] E-mail communication from Ben G. Raimer, M.D., professor of Pediatrics, University of Texas Medical Branch in Galveston, February 3, 2004.

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Medically Fragile Children

DPRS should improve the assessment and services provided to foster children who are medically fragile.

Background

In fiscal 2003, DPRS reported that it had conservatorship of 680 children who were medically fragile and an additional 109 who were both medically fragile and mentally retarded.[1]

Medically fragile children are defined by DPRS as those who have a serious, ongoing illness or chronic condition for at least a year, require prolonged hospitalization and ongoing medical treatments and monitoring and require the use of devices to compensate for the loss of bodily function.

Medically fragile children are relatively easy to identify—certainly more so than those with mental retardation—but a recent report by Youth for Tomorrow (YFT), the contractor that assesses children for DPRS' service levels, indicates that DPRS data underestimated their numbers by more than 40 percent. Adjusting the DPRS data with the more complete YFT figures, the data suggest that an estimated 1,127 Texas children in DPRS' care, or more than 4 percent, are medically fragile.

Based on the adjusted numbers, the medically fragile tend to be young—45 percent of them below the age of five and 29 percent from 6 to 12 years old.[2]

The adjusted data indicate that in fiscal 2003, 160 medically fragile children were placed in residential facilities to which DPRS made foster care payments.[3] Others are in nursing homes managed by the Texas Department of Human Services and in hospitals.[4] Foster families care for almost 86 percent—or 967—of the state's medically fragile foster children.[5]

Children who are medically fragile may die if they are not treated properly. Nevertheless, DPRS places most of them in foster care at the basic service level, raising the highly pertinent question of whether these foster families can provide appropriate care and have ready access to the necessary medical facilities. (The accompanying case study of Hanna gives an example of the complex needs of one such child.)

...an estimated 1,127 Texas children in DPRS' care, or more than 4 percent, are medically fragile.

The Comptroller review team found medically fragile children placed with families caring for multiple children, with foster parents who had not received adequate training in their medical needs and in homes located far from medical facilities.

One respondent to the Comptroller review team's foster care survey reported he had been invited to a peer review on a foster mother whose home was being closed due to allegations of neglectful supervision.

> She was a single foster mother who had six children placed in her home. The last two children placed had special needs (drug exposed infants). The overwhelmed foster mother allowed her teenage son to help her parent the smaller children. The son

(continued on page 211)

Hanna's Story

(Names have been changed to preserve confidentiality.)

In September 2003, DPRS changed its level of care system to the present service levels. One stated purpose for this change was to help the agency focus more intently on the needs of its foster children.

Hanna was born in 2002. She is a foster child currently being cared for by a foster mother in a small Texas town. Her foster mother, Mackenzie, loves working with children with special needs and has adopted several children with Down's Syndrome. Mackenzie contracts directly with DPRS to care for Hanna.

Following the adoption of the service level system, Hanna was reclassified as needing basic services only, the lowest of the service levels. Her foster mother was astounded by this decision.

After months of complaints to DPRS, the foster mother asked the child's pediatrician to intervene. In December 2003, the pediatrician wrote a letter to DPRS containing the following information:

> Hanna is an 18 month old Down's Syndrome baby who had recently been downgraded to a "Basic Baby" status. I was alarmed to hear this decision. Anyone who knows her true medical condition would not consider her to be anything but medically fragile requiring high maintenance on a daily basis.
>
> Her diagnoses include: Trisomy 21, gastroesophageal reflux syndrome, discoordinated swallow, history of repeated aspiration causing pneumonias, heart murmur, laryngomalacia, hypotonia, left dacryostenosis, astigmatism, reactive airway disease requiring frequent nebulizer treatments, periventricular leukomalacia, and seizure disorder.
>
> She is currently on the following medications: Phenobarb, Prilosec, Xopenex nebulizer treatments every 4-6 hours around the clock, Pulmicort, Cefzil, and Pediasure for nutrition.
>
> Additionally, she receives physical therapy from a therapist 5 days per week, plus from her foster parents. She routinely requires visits to seven subspecialists, all more than one hour away from the parents' home. These specialists include a neurologist, a cardiologist, an otolaryngologist, pulmonologist, developmentalist, gastroenterologist, and an ophthalmologist. She is also seen in our office one to two times per week.
>
> I do not see how one could label her basic when she requires so much work to keep her fed, give her medications, physical therapy plus all of the hours they spend in physician offices. Please have a medical specialist look at her requirements so that you can reappraise her care.

In January 2004, Hanna was raised to the moderate service level. Mackenzie says she does not understand why Hanna isn't classified at a still-higher level, but is grateful for the small increase. She does not believe that the contractor responsible for assigning children to service levels examined all the information on Hanna that was sent to them. (The review team contacted the contractor regarding Hanna's service level; the organization stated that it believes the moderate level is appropriate for her medical diagnosis.)

To make matters worse, Hanna's caseworker did not see the child for seven months and would not return telephone calls. Now the caseworker sees Hanna every month, but only at the CPS office; he has never been to the child's foster home. Mackenzie is now changing to a child placing agency, instead of contracting directly with DPRS, so that she can receive more support.

> spanked the children. The foster mother now has child abuse charges on file, her home was closed and the children were removed. DPRS overloaded this woman and then took no responsibility when inadequate care was provided. Because it is cheapest to place children in basic foster homes, children are not receiving the assessments needed to make the most appropriate match.[6]

Case Management

Also in the survey, an educator reported concerns over the placement of special needs children in foster care homes.

> I have grave concerns about the foster homes many special needs students are placed in. They are overcrowded and the children are often left with caregivers while the parents take cruises and live the high life on the large income they receive from the state for serving up to 9 children... Someone needs to monitor foster homes without blinders on. There is a foster family in our school district with as many as nine special needs students living with them at a time. As you can imagine this many special needs children can really tax a small school district when additional special education teachers, teacher aides, therapists, etc. have to be added to the staff. I raised three very normal children and to give them the attention they needed was difficult. Someone in foster care services needs to explain to the public how one person can tend to nine or more special needs children at one time.[7]

Catastrophic case management is a series of techniques designed to provide patients with quality care while avoiding lengthy hospitalizations. Catastrophic case management uses nurse coordinators to arrange for home-based services; to monitor patients, usually by phone; and to review their medical reports, all with the goal of reducing hospitalizations. California's Medicaid program and the private sector use catastrophic case management to ensure quality care and save money. Many private companies provide case management services.[8]

The 2001 Texas Legislature required catastrophic case management on complex Medicaid cases. The state's Medicaid office implemented it only in their Primary Care Case Management Program (PCCM). Foster care children are in fee-for-service Medicaid and receive no castastrophic case management.[9]

If catastrophic case management were used for medically fragile foster children, the children would be better served, their foster families could depend upon expert care and assistance in managing their children's condition, while the state would benefit from oversight stressing cost-effectiveness.

Catastrophic case management is a series of techniques designed to provide patients with quality care while avoiding lengthy hospitalizations.

High Drug Costs

Drugs supplied to medically fragile children can be expensive.

The Comptroller's review of prescriptions given to foster children, for instance, found that one child had received three prescriptions for a drug called Benefix in November 2003, at a total cost of $26,724.38. This medication is used to treat hemophilia. Another child was prescribed Nutropin AQ, a growth hormone, at a cost of $2,157.35 for a single prescription.

Medical costs for fragile children continue to increase because of the high costs of medication and treatment. Some parents are choosing to give up their parental rights because they simply cannot afford to care for their children.

Treatment and Care

DPRS and foster care providers have reported that there are a number of extremely medically fragile children in foster care. These children suffer from a variety of medical conditions including cerebral palsy, HIV, hepatitis, hemophillia, organ transplants, ventilator dependency, gastrointestinal feeding tubes and others. Informal efforts are made to link

children to resources specific to their particular conditions, but there is no systematic procedure or approach to do so. DPRS, furthermore, does not collect data on the number of children with these specific conditions, raising concerns about the appropriateness of treatment these children are receiving and whether the state is taking advantage of Medicaid programs designed for specific conditions.

Recommendations

A. HHSC should implement a Medicaid catastrophic case management program for medically fragile foster children in DPRS care.

B. The Foster Care Medical Review Team recommended in the previous issue should review the cases of medically fragile foster children and establish best practices guidelines for their evaluation, placement and care.

Fiscal Impact

Catastrophic case management for high-cost cases could save the state money, depending on how many children can benefit from this service. HHSC would need to shift funds from acute care services to establish the program in Recommendation A. These expenditures would be recouped through savings. In California, the program realized about $12.02 in net savings for every administrative dollar spent in 1999.[10] The program did this by avoiding hospitalizations.

Endnotes

1 Texas Department of Protective and Regulatory Services, management statistics for November 7, 2003 compiled by the Comptroller review team.

2 Texas Department of Protective and Regulatory Services, *A Report on the Placement Patterns of Children in Private Contract Residential Care Fiscal Year '03*, by Youth for Tomorrow, Inc. (Austin, Texas, November 2003). Count does not include children whose care is not paid for by DPRS and who are in foster homes or MHMR facilities.

3 Texas Department of Protective and Regulatory Services, *A Report on the Placement Patterns of Children in Private Contract Residential Care Fiscal Year '03*, by Youth for Tomorrow, Inc.

4 Texas Department of Protective and Regulatory Services, Management Reporting and Statistics 1/30/2004. In November 2003, 7 foster care children were in nursing homes and 28 were in hospitals.

5 Texas Department of Protective and Regulatory Services, management statistics for November 7, 2003 compiled by the Comptroller's office.

6 Texas Comptroller review team foster care survey.

7 Texas Comptroller review team foster care survey.

8 Texas Comptroller of Public Accounts, *Smaller, Smarter, Faster Government* (Austin, Texas, December 2000), "HHS 16: Improve the Quality of Care and Reduce Costs of Complex Medicaid Cases," pp. 219-222.

9 Tex. S.B. 1, 77th Leg., R.S. (2001), Art. II-130, Sec. 33.

10 Texas Comptroller of Public Accounts, *Smaller, Smarter, Faster Government* (Austin, Texas, December 2000), "HHS 16: Improve the Quality of Care and Reduce Costs of Complex Medicaid Cases," pp. 220-222.

Foster Children with Mental Retardation

HHSC and DPRS should improve the assessment and services provided to foster children with mental retardation.

Background

In fiscal 2003, DPRS paid for 25,462 children in the Texas foster care system (another 671 children were served outside the DPRS foster care system). According to DPRS figures, 1,017 children, or 4 percent, have mental retardation. Some 109 children have mental retardation and also are considered medically fragile, meaning that they require ongoing medical treatment including hospitalizations.[1]

Even this relatively high proportion of mentally retarded children underestimates the problem. DPRS traditionally has focused on abused and neglected children who may have emotional or behavioral troubles, rather than developmental problems such as mental retardation. The foster care system was not designed to address mental retardation, which can be difficult for a nonspecialist to identify, particularly in young children.

DPRS reporting depends on information caseworkers record when a child first enters the system, information that often is incomplete. Although caseworkers can update and add to this information later, doing so is not a high priority.

Youth for Tomorrow (YFT) has somewhat greater knowledge of the developmental status of newly arrived foster children; during initial classifications, it obtains assessments by other professionals, often psychologists, of the children's mental and physical characteristics, which often require an IQ testing. For children who are too dysfunctional or too immature for an IQ test, the professional still gives an opinion of the likelihood of mental retardation. These professionals, however, are not likely to be specialists in developmental disabilities.

YFT produced a report on placement patterns for the 9,515 children it evaluated in fiscal 2003, based on data reported by foster care providers.[2] The report included children placed in foster homes contracted by child placing agencies and residential facilities at the higher service levels.[3] The YFT data are not in DPRS' computer system and are rarely used by DPRS to help determine the needs and characteristics of the children in DPRS' case.

...of all Texas foster children paid for by DPRS, 2,779 of them, or 11 percent, have mental retardation.

The YFT numbers suggest that mental retardation is far more common among foster care children than DPRS' statistics indicate. Adjusting the figures for YFT data where appropriate, of all Texas foster children paid for by DPRS, 2,779 of them, or 11 percent, have mental retardation.[4] By contrast, only 2.7 percent of the total Texas population has been diagnosed with mental retardation.[5]

According to DPRS data, Texas foster children who are mentally retarded tend to be teenagers; 9 percent are 5 or younger, 32 percent are aged 6 to 12 and 59 percent of them are 13 or older. When the data are adjusted for YFT figures, the percentage of those under 5 with mental retardation grows to 17.7 percent. This suggests that the assessments given to YFT identify more young children with mental retardation than those initially reported by DPRS caseworkers. The YFT

data, moreover, do not include all the children in CPS-contracted foster homes, at the basic service levels. Thus, there may be even more young foster children with mental retardation whose conditions have not been identified.

Inadequate Assessments

DPRS' caseworkers and the personnel of its contractor for child evaluation, YFT, often have little or no experience in assessing children's developmental disabilities. This can result in inappropriate assignments to the various service levels, leading in turn to inadequate support and services. Similarly, treatment plans developed by therapists and caseworkers lacking experience in children's developmental disabilities may be inappropriate for a child's needs.

In fiscal 2003... 667 children with mental retardation were receiving DPRS-paid care in residential facilities.

Advocacy Inc., a group that supports the rights of people with disabilities, has expressed concern about the adequacy of foster children's assessments. A representative of the group told the Comptroller review team that the foster care system "lacks expertise about what types of supports children with significant developmental disabilities need to be successful in families."[6]

A disability expert at the Texas Center for Disability Studies explains:

> For children with significant developmental disabilities, or children with special health care needs, expertise in abuse and neglect is not enough. We must develop expertise within the system to identify who these children are, appropriately assess the functional supports and services they need, assign appropriate levels of care, and match these kids with families who have the experience and skills to meet the challenges of raising a child with disabilities.[7]

State bodies that assess children with developmental disabilities include DPRS, the Texas Department of Mental Health and Mental Retardation (MHMR), the Texas Department of Human Services (DHS) and the Texas Council on Early Childhood Intervention Services (ECI). Local school districts provide such assessments as well.

Institutionalization

In fiscal 2003, the YFT data showed that of the 2,779 children diagnosed, 667 with mental retardation were receiving DPRS-paid care in residential facilities.[8]

A June 1999 U.S. Supreme Court decision, *Olmstead v. L.C.*, requires states to work to deinstitutionalize children. The court ruled that states should serve persons with disabilities in community settings rather than institutions whenever possible, stating that "unjustified institutional isolation of persons with disabilities is a form of discrimination."[9] In response, the HHSC created a "Promoting Independence Plan" to meet the requirements of the *Olmstead* decision by providing community-based services for persons with disabilities, including children.[10]

Texas' foster children, however, thus far have largely been left out of this effort. In fact, the Comptroller review team found that HHSC and MHMR staff and private advocacy groups were *largely unaware* of the hundreds of institutionalized foster children, despite efforts on their part to obtain this information.[11]

Coordinating and Finding Resources

DPRS, ECI, MHMR and DHS have related responsibilities toward Texas' children with mental retardation. ECI identifies and provides assistance to young children with developmental disabilities; MHMR assists those with mental retardation; and DHS provides developmentally disabled children with health-related assistance through Medicaid community waiver programs.

These agencies do not work closely enough to maximize federal, state and local revenue for foster care and see that funds are used efficiently to help foster children with developmental disabilities.

MHMR and DHS have Medicaid waiver programs that can provide various community-based services for a limited number of children who otherwise would be institutionalized. DPRS foster children must go on a waiting list to obtain these services, like anyone else. These waiting lists currently have thousands of families with children waiting for care. Children who leave state schools currently go to the top of the MHMR waiting lists.

It may make more financial and clinical sense, however, to use current state foster care funds to draw down more federal Medicaid funding for community-based programs for foster children and consider adding new waiver programs and new waiver slots. This would allow more children under DPRS conservatorship to leave institutional settings such as MHMR intermediate care facilities and nursing homes for placements in the community.

Supplemental Security Income (SSI) payments these children receive could be used to pay for room and board in community-based care. For foster children requiring more intense services, costs may be covered for many children by a combination of Medicaid

...use current state foster care funds to draw down more federal Medicaid funding for community-based programs for foster children...

Janie's Alternatives

Note: The following fictional example illustrates possible alternative care arrangements for a child with mental retardation.

Janie is a 12-year-old girl with mental retardation living in a foster care facility.

The facility makes few allowances for Janie's condition and instead seems to ignore her. She is in the company of other children who are likely to make fun of her "slowness" and who may mistreat or abuse her. Janie shares a room with five other girls; she has learned to be as "invisible" as possible.

If her caregivers follow DPRS procedures, they will arrange for her to receive a monthly Supplemental Security Income (SSI) check when she "ages out of the system" at 18. If Janie is lucky, she may be put in touch with a local Texas Department of Mental Health and Mental Retardation (MHMR) caseworker, who can help her find affordable housing and put her on a waiting list for other services.

If Janie lived in one of MHMR's small intermediate care facilities (such as a six-bed home), by contrast, she would have shift staff trained in dealing with mental retardation to monitor her well-being and help her with a variety of needs including guidance and training in the skills of daily living, such as personal hygiene. Her days would be somewhat regimented: meals, recreation and activities are scheduled for the group as a whole.

If MHMR enrolled Janie in its Home and Community-based Services Waiver program, she could receive services while living in a family home, either that of her own parents or with foster parents. She would have a caseworker to check on her and make sure that she received services appropriate to her needs, such as counseling, therapy, minor home modifications, dental treatment, nursing, residential assistance, respite care for her parents or foster family and supported employment opportunities. Services would be flexible and individualized.

Janie would spend her days in classes appropriate to her age and ability, probably in a public school system near her home where she could develop enduring relationships in her community. As an adult, she could stay in a group home setting or, with her caseworker's help, could move into an apartment, her own home or a shared household, depending on her wishes and her independent living skills. She could pay for her room and board either with her SSI check or other personal resources.

She could also work to earn some money, either in "supported" employment or through work in a sheltered environment. Through the local MHMR center, she could engage in social and recreational activities, and a caseworker would remain available to her for the rest of her life.

dollars and SSI payments, additional changes in the Medicaid program (such as a revised Medicaid rehabilitation waiver discussed in a succeeding recommendation), and a more sophisticated packaging of Medicaid services.

Community-based approaches depend upon the state's ability to recruit, train and monitor foster parents who can take care of children with developmental disabilities. If insufficient numbers of such parents are found, placements in small, Medicaid-funded group homes serving six or fewer children are a better choice than DPRS' large institutional settings.

The use of Medicaid funding for foster care is financially advantageous to the state. The federal government supplies just over 60 percent of Medicaid funding, and nearly all children in foster care are eligible.[12]

Foster care children with mental retardation should be cared for in a system that is designed for their special needs.

Foster care children with mental retardation should be cared for in a system that is designed for their special needs. "Janie's Alternatives" shows the difference that community placements in settings that provide services to children with mental retardation can make in the life of a child.

Recommendations

A. HHSC should design an assessment system that ensures that children with developmental disabilities are identified properly.

DPRS caseworkers should be trained to screen all foster children for potential developmental disabilities as soon as they enter the foster care system. HHSC should assist in developing procedures across agencies to ensure that young children are screened appropriately by professionals experienced in children's developmental disabilities, and receive an array of educational, social, behavioral and medical services tailored to suit their needs. In the case of children likely to be eligible for mental retardation services, the assessment team should include a representative of the local mental retardation authority.

B. HHSC should maximize federal reimbursements for the care of foster children with mental retardation.

HHSC should expand the number of slots for the Medicaid waiver program whether expanding existing waivers or creating a new one for foster care children. HHSC should use the DPRS foster care funds as match. SSI funds could be used for room and board.

For those children who cannot be served in foster families, HHSC should use DPRS funds as match for small group homes rather than place children with mental retardation in residential treatment facilities.

C. HHSC should appoint a task force on foster care children with developmental disabilities to obtain input from expert advocates on the development of a more comprehensive and "seamless" service system for such children.

The task force should provide advice on implementation of the above recommendations. It should include representatives of HHSC, other relevant state agencies, child placement agencies, mental retardation providers, foster families, youths and young adults who have received services from DPRS and foster care facilities, as well as mental retardation/developmental disability experts, disability advocates, medical professionals and family members of children with disabilities to review the agency efforts and make recommendations for guidelines. They should develop guidelines to reduce residential institutional placements and to revise current DPRS service levels to ensure that foster care families who take care of developmentally delayed children are adequately trained and supported to properly take care of such children and that their care is carefully monitored. They also should

review or arrange a review of children identified by DPRS or YFT as having mental retardation to ensure that the type of care they are receiving is appropriate.

The task force may review other issues related to improving services for foster care children with mental retardation; strategies to recruit foster families for children with developmental disabilities; contract requirements for child placing agencies and families caring for children with developmental disabilities; and modifications to the qualifications and training of DPRS' disability specialists.

Fiscal Impact

To accomplish Recommendation A, some of the savings from Chapter 3 should be directed to amplify the training for caseworkers on identifying children with mental retardation and the resources to address their needs.

Using Medicaid funds wherever appropriate to pay for the care of children with mental retardation could result in savings for the state and better services for foster care children with mental retardation as suggested in Recommendation B. Existing foster care funds could be used as match for Medicaid to draw down more federal dollars. Medicaid provides federal reimbursement at the rate of about 60 cents per dollar spent. Federal IV-E dollars cover only about one third of the foster care budget because not every child is eligible for IV-E and IV-E covers only room and board. Texas children with mental retardation who are not foster children currently participate in similar Medicaid programs. Any additional use of Medicaid dollars for foster care children should be designed using existing foster care dollars as match. It should not displace other children waiting to receive Medicaid services from current programs.

Endnotes

1 Texas Department of Protective and Regulatory Services, management statistics for November 7, 2003 compiled by the Comptroller's office. For ease of analysis from this point forward, children with both mental retardation and who are medically fragile conditions are counted with children with mental retardation.

2 Texas Department of Protective and Regulatory Services, *A Report on the Placement Patterns of Children in Private Contract Residential Care Fiscal Year '03*, by Youth for Tomorrow Inc. (Austin, Texas, November 2003).

3 YFT data excluded children in DPRS foster homes, children at levels 1 and 2 in CPA foster homes and residential facilities and children in emergency shelters, homes and assessment centers.

4 Texas Department of Protective and Regulatory Services, *A Report on the Placement Patterns of Children in Private Contract Residential Care Fiscal Year '03*. This figure does not include children whose care is not paid for by DPRS who may, for example, be in ICFMR facilities.

5 Texas Department of Mental Health and Mental Retardation, "Mental Retardation Facts," http://www.mhmr.state.tx.us/FrequentlyAskedQuestions/MentalRetardationFacts.html. (Last visited January 19, 2004.)

6 E-mail communication from Susan Murphy, Advocacy Inc., January 14, 2004.

7 E-mail communication from Colleen Horton, Texas Center for Disability Studies, the University of Texas at Austin, January 15, 2004.

8 Texas Department of Protective and Regulatory Services, *A Report on the Placement Patterns of Children in Private Contract Residential Care Fiscal Year '03*.

9 Kaiser Commission on Medicaid and the Uninsured, *The Olmstead Decision: Implications for Medicaid* (Washington, D.C., March 2000), pp. 1-3.

10 Texas Health and Human Services Commission, "The Revised Texas Promoting Independence Plan," Austin, Texas, December 2, 2002, http://www.hhsc.state.tx.us/pubs/tpip02/02_12tpiprev.html. (Last visited January 16, 2004.)

[11] Interview with HHSC staff, Susan Murphy, Advocacy Inc., and Colleen Horton, Texas Center for Disability Studies, the University of Texas at Austin, Austin, Texas, January 12, 2004 and phone interviews with MHMR staff, November 14, 2003, January 8, 2004, January 20, 2004 and January 27, 2004.

[12] Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, Fourth Edition (Austin, Texas, May, 2002), p. 1-1.

Foster Child Fatalities

DPRS should thoroughly investigate the deaths of foster children.

Background

As with other children, foster children sometimes suffer from medical problems, accidents, abuse or neglect and, unfortunately, some of them die. Unlike other children, foster children must rely on a state agency to speak for them, and to investigate their deaths.

The dimensions of the problem are hard to gauge. According to the U.S. Department of Health and Human Services (HHS), 18 children died of child abuse or neglect by a foster caretaker in 48 states in 2001. These numbers, however, do not include deaths in the populous states of California and Michigan, which did not report to HHS.[1]

Federal agencies do not separately track the deaths of foster children caused by other factors, such as accidents or medical conditions. Since the federal government does not require it, states generally fail to collect such data as well.

When Foster Children Die

When DPRS determines that a Texas foster child dies from a clear case of abuse or neglect, the case receives substantial review both inside and outside of DPRS. In addition to regional investigations and reviews, the DPRS state risk director and the DPRS Child Safety Review Committee (CSRC), comprising state-level DPRS staff and a representative of the Texas Council on Family Violence, also review these cases. The risk director and CSRC focus on DPRS internal policies, procedures and other factors that may affect child deaths.

On the other hand, when a foster child dies from other causes, the case usually receives little or no review beyond the initial investigation, unless the DPRS district office decides to refer it to the state level. A medical examiner or another authority outside of DPRS may refer the death to a local Child Fatality Review Team (CFRT), or the team may select it for review from local child death certificates. CFRTs are multi-disciplinary, multi-agency teams, including representatives from DPRS, the Texas Department of Health, law enforcement, emergency services and others, which focus on identifying problems with services and interagency coordination that may contribute to child deaths; they do not review DPRS internal policies, procedures and practices.

A Comptroller staff review of the case files of 28 of the 44 foster children who died in fiscal 2002 found that the agency referred only the child abuse and physical restraint deaths to the state level for review. DPRS confirmed that agency policy is to refer only those deaths in which the foster caretaker is believed to have abused or neglected the child, unless a district director decides otherwise.[2]

The Texas Record

In Texas, 44 children in DPRS conservatorship died in fiscal 2002, which is the most recent year of completed investigations data available.[3] The Child Care Licensing (CCL) Division investigated 28 of these deaths, since

In Texas, 44 children in DPRS conservatorship died in fiscal 2002, which is the most recent year of completed investigations data.

the children died after being placed at a residential facility. Child Protective Services investigated the remaining cases.

Of the fatalities for which data on the cause of death were provided, two were due to abuse and neglect by a foster caregiver; three were from unknown causes; three were suicides; five were the result of traffic accidents; and 18 deaths were the results of medical conditions or complications, including one death from Sudden Infant Death Syndrome (SIDS). (SIDS is the sudden death of an infant under one year of age that cannot be explained after a thorough case investigation, complete autopsy, examination of the death scene and clinical history review.)[4]

Of the 18 deaths from medical complications or natural causes, 10 were the result of abuse or neglect injuries received before the children entered foster care.

Part of the problem is that states define abuse, neglect and child homicide differently, but the studies also noted that incomplete investigations may rule some deaths actually due to abuse and neglect as accidents, homicides or SIDS.

Abuse and Neglect

A 1999 study conducted in North Carolina, and another performed in Colorado in 2002, found that states do not record as many as 60 percent of child deaths due to abuse or neglect. The studies found that neglect is the most under-recorded form of fatal maltreatment.

Part of the problem is that states define abuse, neglect and child homicide differently, but the studies also noted that incomplete investigations may rule some deaths actually due to abuse and neglect as accidents, homicides or SIDS.[5] No one has conducted similar studies in Texas.

One of the deaths indicated in the chart below as caused by foster caregiver abuse was a two-year old boy who died of blunt head trauma in 2002. A coroner ruled the death a homicide. Despite substantial bruising over much of his body, the child's foster mother denied doing anything to hurt the

Exhibit 1

Child Deaths in DPRS Conservatorship 1999-2002

DPRS-Stated Cause of Death	Fiscal Years			
	1999	2000	2001	2002
Foster Caregiver Abuse or Neglect (includes restraints)	2	2	4	2
Suicide	1	3	0	3
Drowning	2	1	0	0
Vehicle Accidents	4	0	0	5
Other Accidents	1	0	1	0
Medical Conditions or Complications or Natural Causes	5	12	18	17
Medical - Sudden Infant Death Syndrome	0	2	4	1
Unknown or Undetermined	1	1	1	3
Uncategorized	*	*	10	13
Total	**16**	**21**	**38**	**44**

*Data unavailable
Source: Texas Department of Protective and Regulatory Services.

child, insisting that she was playing with him and that he simply went limp. The District Attorney presented charges of murder against the foster mother to the Grand Jury. DPRS removed the other three foster children in her care from the home.

The Texas foster parent of the child who died of SIDS in 2002 had a prior DPRS record of emotional abuse and medical neglect of an elderly woman whom she cared for in her home. Before the baby died, DPRS received allegations that this person had abused the baby. According to two witnesses, the foster mother repeatedly pushed the child's face into stroller cushions to muffle his crying. The DPRS investigator ruled out abuse or neglect regarding these allegations due to "a lack of evidence." Concerning the child's death, the investigator determined that, since the medical examiner ruled that the child died of SIDS, no abuse or neglect occurred.[6]

Physical Restraints

Some deaths related to "physical restraints"—as the name implies, the act of immobilizing a child by holding him or her tightly—have been highly publicized over the past decade across the country.

The *Hartford Courant*, in a five-part 1998 series on physical restraints that drew national attention, estimated that "Fifty to 150 people die every year as a result of being physically restrained or put in seclusion in institutional settings."[7] The federal government is currently considering legislation on restraints.

Children who die from restraint usually asphyxiate, either because of excessive pressure on the chest or due to pressure on the stomach that causes them to choke on their own vomit; some have heart attacks.[8]

Two Texas foster children died during or soon after restraint in fiscal 2000. In addition, a 2001 death at a residential treatment facility, labeled an accident, also occurred after physical restraint. One foster child who died in fiscal 2002 did so after several employees restrained her at a residential treatment center; another died after a restraint at a school. Two children who were not foster children also died in residential childcare in fiscal 2003 after being restrained.[9]

Texas' licensing standards and their enforcement do not adequately protect children from death and injury from restraints. Although the standards prohibit certain restraint actions, such as placing a child face down and placing pressure on the child's back, these standards have not been sufficient to prevent deaths and injuries.[10]

In addition to these deaths, DPRS found 155 licensing violations related to physical restraint in residential facilities while investigating abuse complaints in fiscal 2003, including injuries, inappropriate or excessive restraints and inadequate training or supervision. Most occurred in residential treatment centers, which treat many children with severe behavioral problems.[11]

Texas' licensing standards and their enforcement do not adequately protect children from death and injury from restraints.

To learn about safer restraints—and find some protection from liability—some providers have purchased and used materials for "Prevention and Management of Aggressive Behavior (PMAB®)," a training program designed by the Texas Department of Mental Health and Mental Retardation (MHMR) for use with adult patients, to reduce the chance of death and injuries from physical aggression.[12] Although the program has been successful in MHMR facilities, it is not without risk, and the agency cautions that:

> Although it is designed to reduce the danger inherent in any attempt to manage aggressive behavior, there is a risk of serious injury or death when teaching, learning, demonstrating, and using PMAB®, even when the procedures are performed correctly.[13]

MHMR sells the manuals, tapes and training materials for $600, but does not provide train-

(continued on page 223)

Melissa's Story[1]

Melissa, a blind two-year-old foster child regularly kicked her portable crib "until she tire(d) herself and (fell) asleep," according to her foster mother.[2] Family members said that Melissa spent most of her days in a walker, since she was unable to support herself sitting up, but stayed in a portable crib at naptime and at night.

According to Melissa's foster mother, when Melissa was younger, she was medically fragile due to CHARGE Syndrome, a rare disorder often resulting in blindness, profound hearing loss, heart malformations, retarded growth, blocked sinuses, lung congestion and physical deformities.[3] Since becoming older, the foster mother said Melissa required only basic care, was not medically fragile and did not need surgery for a hole in her heart.

Besides her foster mother and grandmother, Melissa lived with five foster siblings and the foster mother's two biological children. Her foster brothers' ages were 2, 1 and 4 months. Her foster sisters' ages were 9 and 2. The foster mother's biological children were 14 and 12 years old.

One Saturday evening, as part of a regular routine, her foster mother put Melissa to sleep at 6:30 p.m. The foster mother had a monitor and could hear Melissa's usual "pattern of noises and kicking." The foster grandmother said she checked on Melissa about 7 p.m. and found her sleeping. The foster mother said the door to Melissa's room is always open, and people are always passing by and looking in. About 9 or 9:30 p.m., the foster grandmother decided to wake Melissa and "finish feeding her." She found Melissa motionless in a collapsed crib.

According to the foster mother, she put Melissa on the kitchen table and began CPR, and when there was no response, they called EMS. When EMS arrived, Melissa was "somewhat stiff" and pronounced dead at the scene. Melissa did not appear to have any trauma, except that there was blood and stool in her diaper.

A detective at the scene reported that he observed the crib and found that the bottom, wooden part of it had been dismantled. He said that the crib appeared to have been assembled incorrectly or that its screws were not tightened. He said "the lower portion of the crib where [Melissa] was supposedly lying was on the ground." He also noted that the pillow and blanket that the foster mother said the child was using in the crib were in the next bedroom on a double bed.

The foster grandmother said she found Melissa face up with her head sideways at an angle, with part of her body on the floor and part on the crib mattress. The foster mother and grandmother said that the screws had been loose before and that a handy man tightened them. The 12-year-old biological daughter could not remember when she last saw Melissa, but said that she had heard her banging on her crib that morning. That evening, however, no one heard the bed collapse. The foster mother speculated that the child suffocated when the crib fell.

DPRS closed an investigation for neglectful supervision with a finding of "unable to determine." The licensing investigator had not received the medical examiner's findings, but reported that the examiner said that no abuse was found. The licensing investigator did not find any violations.

According to the detective involved in the case, the autopsy found the cause of death to be "undetermined," meaning that the medical examiner could not find a cause and did not find any signs of abuse; he ruled that the blood in the diaper was not caused by abuse. The county medical examiner refers all child deaths to an expert local death review committee, but DPRS did not refer the case to any of its internal or external review personnel or committees. Agency policy requires only that deaths determined to be from abuse or neglect be referred to a death review committee.[4]

Consequently, no one asked questions that could lead to improvements in DPRS policies, standards and procedures, or that could improve care of children in this foster home. For instance, no one asked why Melissa was "finishing being fed" at 9 p.m., when she already had been fed at 6 p.m. and left in her crib awake. No one asked why the foster mother could not hear a crib collapse over the monitor when she had no problems hear-

ing Melissa's "noises and kicking" when she was awake. No one asked why the foster mother noticed nothing amiss when she put the younger children to bed earlier.

The foster mother's use of a portable crib with loose screws was not cited as a violation, though standards require equipment and furniture to be safe for children. CribSafe.net recommends that portable cribs not be used as permanent beds. They are not subject to as many safety requirements, are smaller than regular cribs, are "not suitable to the rigorous wear and tear of daily crib use" and should not be used at all after a child is 18 months old. The organization also cautions that children have suffocated due to extra mattresses placed in cribs; Melissa's had two.[5]

No one questioned the appropriateness of placing a medically fragile child in a house with seven other children and only two caretakers. Despite the fact that DPRS' licensing investigator found "no violations," the foster home exceeded the number of children allowed according to the agency's licensing standards. These require that a foster family shall not care for more than six children, nor more than two infants under 18 months old, including biological children.

Melissa's death file contains a report form, the intake call report, a contact log with summaries of interviews with witnesses, the police report, a letter to the foster parent announcing the findings and a misfiled form belonging to an unrelated case file.

The CCL investigator referenced police photographs but did not include them in the file. The investigator ordered CPS medical records, physician records and a copy of the autopsy and medical examiner's report, but these were not in the file because DPRS closed the case before the investigator received them.

Endnotes

1 The child's name has been changed for privacy reasons.

2 Except as otherwise noted, all information is from the Texas Department of Protective and Regulatory Services.

3 WebMDHealth.com, "CHARGE Syndrome," http://my.webmd.com/content/healthwise/8/1944.htm?lastselectedguid={5FE84E90-BC77-4056-A91C-9531713CA348. (Last visited February 1, 2004.)

4 Texas Department of Protective and Regulatory Services, CPS Handbook (Austin, Texas), Section 2313.

5 ChildSafe.net, "Non-Full Size Cribs and Portable Cribs," http://www.childsafe.net/for_parents/portable.html. (Last visited January 8, 2004.)

ing outside of its facilities. MHMR's PMAB® trainers are certified to teach PMAB® only within the MHMR system and only for so long as they work in the system. Residential foster care providers who purchase the program with the intent of applying it in their facilities, then, do so without certified trainers and without the endorsement or the legal or organizational support of MHMR.[14]

PMAB® staff at MHMR caution that the agency developed the system for adults, not children, and that it does not take into account the psychological aspects of the physical and sexual abuse that many foster children have experienced. Furthermore, reading the materials and watching the videos do not provide aspects of training that a certified instructor gives verbally during the training session, such as accommodations that a person's size may require.[15]

In sum, residential child care providers who attempt to use this system may increase children's risk of injury or death, as well as their own liability.

Although some providers use other systems available on the market that provide certified trainers, the Child Welfare League of America states that "physical restraint techniques, including the positions, holds and the number of staff involved, vary widely as do the points of view on the safety of particular strategies."[16]

In Texas, policies even differ between agencies. For example, TDMHMR policies allow a maximum of 15 minutes for a personal re-

straint, but DPRS standards allow a maximum of 30 minutes for a child under 9 and one hour for other children.[17]

Medically Fragile Children

Of the 44 children who died in fiscal 2002, 18 had medical conditions or complications, including the SIDS death. The Comptroller's review of the files of 28 of the children who died in fiscal 2002 found that two of them were medically fragile yet placed in foster homes located in rural areas where medical care may be more difficult to obtain.[18]

In one case, a foster mother in a rural area drove a child with a high fever to a doctor and then to a local hospital, which called an ambulance that then took an hour to find a hospital that could meet the child's needs. The child died soon after arrival. In another case, a child had to be taken by ambulance from West Texas to Lubbock for treatment.[19]

At times, however, DPRS takes no action at all against facilities where children have died under questionable circumstances.

Response to Preventable Deaths

DPRS' response to children's deaths related to preventable causes, such as physical restraint or a lack of supervision, has varied. DPRS rarely revokes a facility's license for a child's death, but may start the process by placing a facility on probation.

For example, DPRS placed one facility on probation in May 2002, after a coroner ruled a February 2002 restraint-related death a homicide. DPRS lifts probation when a facility makes changes to comply with its standards; in the 2002 case, the facility changed its behavior management and restraint system, made training and supervisory improvements and was released from probation in January 2003.[20]

At times, however, DPRS takes no action at all against facilities where children have died under questionable circumstances.

For instance, DPRS took no action against a residential treatment center when a boy prone to self-mutilation managed to run away and burn himself to death at a nearby gas station. The incident occurred even though the facility supposedly had the child under close watch, since he ran away three days before the incident. Employees at the facility knew the child was gone for an hour before he set himself on fire. The facility's policy was to wait two hours before notifying anyone that a child had run away. DPRS ruled out neglectful supervision in this case and did not find any licensing violations because the facility followed its approved policies.[21]

Inadequate Investigations, Files

Most of the files on child deaths in 2002 lacked adequate documentation on the cause of death, contributing factors, culpability, the basis for investigators' decisions, the reason for the case closure or any recommendations that might prevent such deaths in the future. The only document common to all files reviewed was the intake form from the phone center concerning the incident. Most files included the DPRS child death report forms and licensing investigation reports, but some did not contain even these items.

Most of the files did not provide any evidence of referrals to child death committees; medical examiner reports and autopsies; hospital, doctor and ambulance records; police reports; or related photographs or tape recordings. Most files did not record the child's facility admissions, treatment and service plans, including medications; the foster home placement history; the foster home and facility history of licensing violations; the background on any prior allegations of abuse or neglect by the caregiver; or logs and progress notes concerning the child.[22]

The DPRS Web site, annual report and data book have no information on child deaths in foster care. Although DPRS' reports on total deaths of children in its conservatorship as a performance measure, the agency provides no other public information about the deaths, such as cause of death or whether abuse or neglect for a caregiver was involved.

Concerning the restraint that precipitated one child's death, the DPRS public Web site

for licensing violations explains that "the use of force during a restraint of resident at [facility] was not reasonable and did not minimize risk of physical discomfort, harm or pain," and says "excessive force was used during a restraint." The Web site fails to mention that the child died after the restraint.[23]

Recommendations

A. DPRS should identify behavior management systems that incorporate safe personal restraints appropriate for use with children and require that contractors use only approved systems.

DPRS should consult with experts and other agencies to identify the systems and should ensure that licensed facilities use trainers certified to teach the systems that facilities select. DPRS should adopt licensing standards that reflect the selected systems.

DPRS should ban the use of Prevention and Management of Aggressive Behavior (PMAB®) materials at facilities not operated by the Texas Department of Mental Health and Mental Retardation. Other commercial systems exist that providers can purchase.

B. DPRS should thoroughly investigate each foster child death, refer every foster child death case to the state risk director and internal and external child-death review committees, and should place the results of the reviews in the child's death investigation file.

DPRS should maintain all child death investigation files at both the state and regional levels.

C. DPRS should standardize the forms, information and documentation required in child death files.

To allow reviewers the opportunity to recommend policies and procedures that could prevent child deaths, files must be complete.

The files should include all forms and information related to the case, including the agency's child death report forms; intake and licensing investigation reports; referrals to child death committees; medical examiner reports and autopsies; hospital, doctor and ambulance records; police reports; and related photographs or tape recordings.

The files also should contain each child's facility admissions, treatment and service plans, including medications; the foster home placement history; the foster home and provider history of licensing violations; the background on any prior allegations of abuse or neglect by the caregiver; and any logs and progress notes concerning the child.

Fiscal Impact

These recommendations could be implemented with existing agency resources.

Endnotes

1 U.S. Department of Health and Human Services, "Child Maltreatment 2001, Table 5-2: Child Fatalities in Foster Care, 2001," http://www.acf.hhs.gov/programs/cb/publications/cm01/table5_2.htm. (Last visited February 6, 2004.)

2 Interview with Texas Department of Protective and Regulatory Services staff, January 13, 2004.

3 Texas Department of Protective and Regulatory Services, Operating Budget for Fiscal 2004 (Austin, Texas, December 1, 2003), p. III.A.3.

4 U.S. Department of Health and Human Services, National SIDS/Infant Death Resource Center, "What is SIDS?" http://www.sidscenter.org/SIDSFACT.HTM. (Last visited January 3, 2004.)

5 National Clearinghouse on Child Abuse and Neglect Information, "Child Abuse and Neglect Fatalities: Statistics and Interventions," (Washington, D.C., August 2003), p. 1.

[6] Data provided by Texas Department of Protective and Regulatory Services, December 10, 2003.

[7] Eric M. Weiss, "Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended to Care for Them," *Hartford Courant* (October 11, 1998).

[8] Eric M. Weiss, "Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended to Care for Them," *Hartford Courant* (October 11, 1998) and Jonathan Osborne and Mike Ward, "When Discipline Turns Fatal: Texas Lacks Tough Law on Prone Restraint that's Banned in Three States," *Austin American-Statesman* (May 18, 2003).

[9] Data provided by Texas Department of Protective and Regulatory Services, December 10, 2003.

[10] Texas Department of Protective and Regulatory Services, "Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care," (Austin, Texas, January 2004), available in pdf format from http://www.tdprs.state.tx.us/Child_Care/pdf/MS-24H-January-2004.pdf. (Last visited January 5, 2004.)

[11] Texas Department of Protective and Regulatory Services, "Personal Restraint Violations as a Result of a Residential Care Abuse/Neglect Investigation for Fiscal Year 2003," Austin, Texas, January 21, 2004. (Excel spreadsheet.)

[12] Texas Department of Mental Health and Mental Retardation, "Prevention and Management of Aggressive Behavior (PMAB®)," http://www.mhmr.state.tx.us/centraloffice/humanresourcesdevelopment/shrdpmaboverview.html. (Last visited December 17, 2003.)

[13] Texas Department of Mental Health and Mental Retardation, "Prevention and Management of Aggressive Behavior (PMAB®)," http://www.mhmr.state.tx.us/centraloffice/humanresourcesdevelopment/shrdpmaboverview.html; and Texas Department of Mental Health and Mental Retardation, "PMAB® Purchasers" (internal document).

[14] Interview with Texas Department of Mental Health and Mental Retardation staff, December 12, 2003 and Texas Department of Mental Health and Mental Retardation, "Prevention and Management of Aggressive Behavior (PMAB®)."

[15] Interview with Texas Department of Mental Health and Mental Retardation staff, December 12, 2003.

[16] Child Welfare League of America, "Fact Sheet: Behavioral Management and Children in Residential Care," http://www.cwla.org/advocacy/secresfactsheet.htm. (Last visited January 3, 2004.)

[17] Texas Department of Protective and Regulatory Services, *Consolidated Minimum Standards for Facilities Providing 24-Hour Child Care*, (http://www.tdprs.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp) and 25 Tex. Admin. Code §415.263.

[18] Data provided by Texas Department of Protective and Regulatory Services, 2002.

[19] Data provided by Texas Department of Protective and Regulatory Services, 2002.

[20] Data provided by Texas Department of Protective and Regulatory Services and residential treatment facility, January 20, 2004.

[21] Data provided by Texas Department of Protective and Regulatory Services, 2002.

[22] Data provided by Texas Department of Protective and Regulatory Services, 2002.

[23] Texas Department of Protective and Regulatory Services, "Search for a Residential Child Care Operation," http://www.txchildcaresearch.org/ppFacilitySearchResidential.asp#Operation. (Last visited January 5, 2004.)

Missing Foster Children

DPRS should intensify its efforts to find missing foster children.

Background

Across America, thousands of foster children are missing. More than 5,000 are runaways; some have been abducted.[1] And then there are the children who simply disappear—or at least the state agencies responsible for their care cannot find them.

In Texas, according to DPRS, 142 children in the agency's conservatorship were missing from care at the end of November 2003; of these, 133 were on runaway status and another nine were in an unknown location with individuals known to the department. To arrive at the number, DPRS staff reviewed cases of about 250 children that the agency's database identified as runaways, having an unauthorized absence or living in an unauthorized placement. The agency eliminated children from the count whose location was known but unauthorized. The agency also reduced this number to account for children who aged out or returned to care within six to ten weeks from the end of November 2003.[2]

In Florida

The case of Rilya Wilson, a Florida foster child who was missing for more than a year before anyone noticed, received national attention in April 2002. Authorities now presume she is dead.[3] Rilya Wilson's caseworker filed false reports of monthly visits with the child, and a supervisor failed to review the case.

An investigation of the Florida Department of Children and Families revealed that her case was far from unique; some caseworkers failed to visit foster care children monthly as required, falsified records to cover it up and knowingly placed children in abusive foster homes.

The Florida legislature responded to the Rilya Wilson case with a law making the falsification of documents concerning children under state care punishable by up to five years in prison. A death or serious injury to a child resulting from such records fraud is now a second-degree felony punishable by up to 15 years in prison.[4]

Shortly after the Rilya Wilson case became national news, officials in several states including Michigan, Tennessee and California disclosed that hundreds of children were missing from their foster care systems. Some states have responded to this publicity by increasing their efforts to locate these children.

DPRS claims that its system would prevent a problem like Florida's from occurring.[5] The Comptroller review team found evidence to cast doubt on this claim.

In Texas

The Comptroller review team found that Texas caseworkers do not see every child every month, despite a DPRS policy requiring them to do so unless they have supervisory permission to visit less frequently.[6] In site visits conducted by Comptroller staff, foster care providers said that while some caseworkers see their assigned children regularly, others do not, and some workers have not seen their assigned

...foster care providers said that while some caseworkers saw their assigned children regularly, others do not, and some workers have not seen their assigned children for lengthy periods.

children for lengthy periods. Several caregivers reported that they had called caseworkers to request visits because more than a year had passed since they had last seen their charges.[7]

According to DPRS, the problem is common. Among 14,309 children in foster care for all three months of the first quarter of fiscal 2004, 27 percent of the children were not visited by a caseworker.[8]

The Comptroller review team also found that some foster care providers receive payments for children who are not in their care, but are caring for other children without receiving reimbursement.[9] This problem indicates that the database that tracks children and their location is inaccurate, since DPRS' accounting system depends on it to generate payments.

DPRS licensing standards do not require foster care facilities to immediately report all missing children to DPRS.

Since caseworkers are not actually seeing all children and the database on their location is inaccurate, DPRS cannot know with any certainty that it does not have children experiencing the same sort of peril as Rilya Wilson faced.

Reporting Missing Children

Caregivers report a missing child by calling the agency's statewide intake phone bank, a hotline for all reports and complaints. The computerized intake form, however, does not include a field for identifying the child as a foster child. This omission makes the immediate tracking and reporting of missing foster children impossible.

DPRS licensing standards do not require foster care facilities to immediately report all missing children to DPRS. Instead, they require facilities to have a written policy stating when they will report children as missing to law enforcement and the managing conservator, which may or may not be DPRS. Consequently, providers may wait hours before notifying anyone.

Even then, if another agency, such as a juvenile probation authority, is the managing conservator of the child, the facility may not notify DPRS at all, but simply place a written report of the incident into its files.[10]

DPRS also does not require its caseworkers to notify law enforcement about missing foster children immediately. The agency's current policy only requires caseworkers to notify law enforcement within 24 hours after a facility reports a child missing. The National Center for Missing and Exploited Children (NCMEC) recommends calling law enforcement as soon as a child is noticed as missing.[11]

According to the NCMEC, those first few hours can be critical in finding a missing child. In July 2002, one boy who ran away from a Texas residential treatment center was known to be missing for an hour before law enforcement, and the facility, learned that he had set himself on fire at a nearby gas station. The facility's policy was to wait two hours before notifying police of runaways; an immediate call might have saved the boy's life.[12]

In addition, DPRS does not have any policies or standards requiring it to notify the NCMEC, which publicizes information on missing children on the Internet.

DPRS does not track information on how many missing children are found, how long they were missing or the circumstances in which they were found. According to DPRS:

> …the percentage of children returned from runaway status, abductions or unauthorized absences is not tracked and neither is the length of time children were away from the authorized placement. The placement type from which children have run away or gone to an unauthorized placement has not been tracked and is not available.[13]

The statewide intake form, filled out when calls come in to the phone center, also does not include a field that identifies foster children so that data on these children can be tracked.

DPRS policy requires caseworkers to attempt to persuade children in unauthorized living situations to return to their approved placements, and to assess the risk of abuse or neglect in the unauthorized living situation. The policy also requires caseworkers to provide notice of such situations to their supervisors, the licensing division and any other affected parties, such as the courts. It does not require caseworkers to attempt to learn why the child left the authorized arrangement or to identify an alternative approved placement.[14] Furthermore, DPRS does not track or report on children's stated reasons for leaving authorized care.

In October 2002, DPRS began requiring caseworkers to increase their efforts to find missing children. Besides checking with law enforcement, Texas caseworkers now must make other attempts to locate the child, such as contacting relatives, former caregivers or other social service agencies. If a missing child is younger than 16, the appropriate Child Protective Services regional director must review the case on a quarterly basis. DPRS also has begun researching trends and patterns that may predict who is at risk of becoming a missing foster child, including information on facilities and the characteristics of missing children.[15]

Even so, the agency's efforts are not as aggressive as others around the country.

In Other States

On September 17, 2002, Michigan became the first state to establish a Web site listing the names and photographs of missing foster care children.[16] The state posted information on 198 missing foster care children, and the postings helped to locate five missing children.[17] Initial objections to revealing information about the children faded when it became apparent that the program worked.[18]

Illinois also has taken steps to find missing children as quickly as possible, and once found, to place them in settings that meet their needs. In November 2003, the state opened a Child Location and Support Unit to oversee 24-hour statewide efforts to locate the state's 362 missing foster children. The new unit uses a missing child database that offers information, including photographs and medical information, to law enforcement, the medical community, schools and others. In addition, the agency enlisted the NCMEC to train its staff in the investigation of reports of missing and abducted children.[19]

Recommendations

A. DPRS should capture accurate, timely information in the agency's foster child database.

B. DPRS should upgrade licensing standards to include a requirement that foster care providers notify the agency and law enforcement immediately of missing children.

DPRS should refer all missing children's cases to the NCMEC. DPRS should partner with NCMEC to provide training for its staff on investigating reports of missing and abducted children.

C. DPRS should develop a missing child database.

The database should include information such as photographs and medical records, and when children are found, it should track the children's stated reasons for leaving. DPRS should share appropriate information with authorities and organizations.

D. DPRS should develop a page on its Web site providing the names and photographs of missing foster children.

This page should link to agencies and organizations searching for missing children and should publicize DPRS' statewide intake hotline number.

E. DPRS should include a field in its statewide, computerized intake sys-

tem that clearly identifies calls involving foster children.

Fiscal Impact

Recommendations A, B, D and E should involve minimal cost if they cannot be implemented within existing resources. Recommendation C's fiscal cost cannot be estimated.

Endnotes

1 U.S. Department of Health and Human Services, Administration for Children & Families, "The AFCARS Report: Preliminary FY 2001 Estimates as of March 2003," http://www.acf.hhs.gov/programs/cb/publications/afcars/report8.htm. (Last visited December 17, 2003.)

2 Data provided by Texas Department of Protective and Regulatory Services, January 30, 2004, February 9, 2004 and March 17, 2004, and interview with Texas Department of Protective and Regulatory Services staff, March 17, 2004.

3 Pamela Brogan, "Lawmakers Seek to Improve U.S. Foster Care System," *South Jersey Courier Post Online* (November 20, 2003), http://www.southjerseynews.com/issues/november/m1120003c.htm. (Last visited December 17, 2003.)

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11 National Center for Missing and Exploited Children, "If My Child is Missing," http://www.missingkids.com/missingkids/servlet/PageServlet?LanguageCountry=en_US&PageId=244. (Last visited January 7, 2004.)

12 Information provided by Texas Department of Protective and Regulatory Services, February 13, 2004.

13 Information provided by Texas Department of Protective and Regulatory Services, December 30, 2003.

14 Texas Department of Protective and Regulatory Services, *Child Protective Services Handbook*, §6342.2.

15 Information provided by Texas Department of Protective and Regulatory Services, December 30, 2003.

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17 Shawn Windsor, Ben Schmitt and Jim Schaefer, "Agency's Web Post Helps Free Press Find 5 Youths," *Detroit Free Press* (September 18, 2002), http://www.freep.com/news/childrenfirst/miss18_20020918.htm. (Last visited February 2, 2004.)

18 Jack Knesnak and Emilia Askari, "Michigan's Missing Children: Help Find These Kids," *Detroit Free Press* (September 18, 2002), http://www.freep.com/news/childrenfirst/child18_20020918.htm. (Last visited February 2, 2004.)

19 Illinois Department of Children and Family Services, "DCFS Launches New 24-Hour Missing Child Unit," DCFS News (November 5, 2003) http://www.state.il.us/dcfs/library/com_communications_pr_nov52003.shtml. (Last visited February 2, 2004.)

CHAPTER 6

Provide a Brighter Future for Texas Foster Children

The problems of foster children do not end when they reach adulthood. Studies have repeatedly shown that foster children are prone to poor educational attainment, homelessness, criminal behavior, drug addiction, mental illness and health problems.

Texas should do everything it can to help these children make a successful transition to adult living.

The Health and Human Services Commission and DPRS should seek "nontraditional independent living funds" from multiple federal sources to help foster children survive and thrive in the adult world. DPRS should partner with local work force development boards to expand their services for foster teens.

The Texas Public Education Information Management System (PEIMS) should track information on students in foster care and include it in district and campus report cards. The Texas Education Agency (TEA) should include information on the education of foster children in its statewide dropout plan. Caseworkers should be required to consider the educational needs of foster children when making placement decisions. And TEA and the Higher Education Coordinating Board should jointly develop outreach programs for foster children.

DPRS should partner with volunteer and advocacy organizations to develop a Foster Grandma and Grandpa program that recruits seniors to mentor and support Texas foster children. The goal of the program should be to provide every foster child with a grandma or grandpa volunteer.

Longterm Outcomes

DPRS should improve the transitional services offered to foster children who "age out" of the foster care system.

Background

Nearly 900 Texas foster children in state care leave the system at age 18 each year, almost 32 percent of them without a high school diploma or its equivalent.[1] Many of them will lead lives blighted by poor education and employment prospects, early parenthood, poverty, homelessness, criminal behavior, mental illness and health problems.[2] Studies of the homelessness experienced by former foster children have reported rates ranging from 10 percent to more than 60 percent.[3] A study of former Texas foster children reported that 41 percent had been homeless one or more times.[4]

A 1988 study commissioned by the U.S. Department of Health and Human Services found that children who turn 18 in foster care and thus "age out" of the system do not fare well afterward.

According to the report, 38 percent of the youths it studied were emotionally disturbed; 50 percent had used illegal drugs; and 25 percent had had some kind of involvement with the legal system. Only 48 percent had graduated from high school. Only 48 percent had held a full-time job within two years of leaving the foster care system, and their median weekly salary was $205, or just 37 cents an hour above the minimum wage at the time.[5]

A 2003 study conducted by Stanford University for the William and Flora Hewlett Foundation, a charitable and research foundation, echoed the earlier study, finding that adolescent foster children were one of four groups of children who are less likely to make a successful transition to adult living. The three other groups were high school dropouts, youths in the juvenile justice system and young unmarried mothers.[6]

Such reports, as well as federal limitations on the use of traditional foster care funding, led to the federal Foster Care Independence Act of 1999 and the creation of the John H. Chafee Foster Care Independence Program. The act broadened eligibility requirements for independent living programs—programs that help adolescents enter the job market or institutions of higher education, find housing and learn the basic skills of daily living—to include youths as young as 14, and enabled states to extend Medicaid coverage for youth leaving foster care until the age of 21.[7]

In Texas

Texas' foster children need assistance to make the transition to young adulthood successfully. One former foster child who responded to the Comptroller's foster care survey wrote, "My worst experience is turning 18 and getting ready to leave custody but had no where to go, no job experience either."

"My worst experience is turning 18 and getting ready to leave custody but had no where to go, no job experience either."
– Former Texas Foster Youth

In 2001, the Texas Foster Care Transitions Project, a research initiative managed by the Center for Public Policy Priorities, published a report on foster youth in the Austin and San Antonio area. The report found that these children are not adequately prepared to enter adult life. Many report profound feelings of fear and loneliness and suffer from physi-

cal and mental illness; nearly half have been homeless at least once. Their low educational levels and job skills are likely to ensure ongoing financial hardship. Many youths in the study have reacted to their precarious circumstances by refusing any additional assistance or engaging in risky behaviors such as illegal drug use and criminal activity.[8]

The Texas Foster Care Transitions Project and Texas Department of Criminal Justice have studied the number of former Texas foster children in the criminal justice system. Among a sample of 513 such persons, 26 (5 percent) had been or were currently incarcerated in a state prison. This figure, moreover, does not include those in city or county jails or incarcerated in other states.[9] A comparison of data provided by the Texas Department of Criminal Justice and DPRS found that over 10 percent of former foster children have been incarcerated or are still incarcerated in Texas prisons.

For 2004, DPRS expects to receive $5.4 million in Chafee funds, which will be supplemented by another $1.3 million in state and local matching funds.

Preparation for Adult Living

In Texas, federal Chafee program funding supports DPRS' Preparation for Adult Living (PAL) Program. PAL provides independent living services—life skills training, vocational and educational services, supportive services, financial benefits and case management—to youths who age out of foster care.

For 2004, DPRS expects to receive $5.4 million in Chafee funds, which will be supplemented by $1.3 million in state and local matching funds.[10] DPRS also uses Chafee funding to develop conferences for teens leaving foster care, provide newsletters and establish community partnerships with organizations that can assist teens.

In 2002, Texas provided PAL services to nearly 4,300 youth aged 16 to 20, and another 500 aged 14 and 15.[11] About 5,300 were eligible for services in 2002, but about 700 of these received independent living services prior to 2002. Twenty-nine DPRS employees are assigned to PAL, with one PAL coordinator in each agency district. The agency contracts with various organizations to provide direct services.[12] For 2004, DPRS has 31 contracts with local groups, as well as several others for statewide events.[13]

Casey Family Programs, a Seattle-based national foundation that provides direct services for children, youth, and families in the child welfare system and studies child-welfare practices and policy, has formed a partnership with Texas' PAL program. DPRS can take advantage of initiatives and research the foundation has conducted at the national level and in other states. Casey Family Programs is collaborating with DPRS to design new transitional services for youths who will age out of foster care. This effort, called the Texas State Strategy Systems Improvement Effort (TSS), is developing independent living training models and tools for foster parents and DPRS staff. For example, DPRS uses the Ansell Casey Life Skills Assessment (ACLSA), a tool for assessing a child's abilities.[14]

In addition, TSS plans to begin a data collection effort in 2004 that will allow DPRS to track what happens to children who leave foster care, producing information comparable to data collected by other states and enabling Texas to meet expected federal reporting requirements.[15]

DPRS embarked upon a similar effort in 2000, attempting to track former foster children by matching their Social Security numbers against higher education, employment and state prison databases, but privacy issues raised at the last minute caused DPRS to simply drop the effort.[16]

Even without such problems, tracking youths who have left foster care is difficult at best. They often change jobs and residences frequently, and many become homeless.[17]

One-Stop Center In Bexar County

Bexar County has a model independent living program supported by the Casey Family Programs. The Community Transition Services Center is a "one-stop" service center for foster youth aged 14 to 21. The center offers these youth help with finding jobs, planning

careers, enrolling in community college and finding housing. Program alumni offer peer support to current participants.[18] DPRS' state plan for independent living states that the agency will consider using similar centers in other parts of the state.[19]

The one-stop approach appears to be more successful than other Texas independent living programs. In a recent evaluation of the Community Transition Services Center, the Casey Family Programs found that participants improved their overall "life skills" by, on average, 25 percent. Improvement in money management skills was estimated as high as 72 percent.[20] By contrast, DPRS reports that, on average, foster teens completing the general PAL curriculum demonstrated only a 6.5 percent improvement in life skills.[21]

Another indicator of the center's success is that 35 percent of Texas foster youth recorded as receiving assistance from local workforce development boards are located in the San Antonio region. Yet the area's Alamo Workforce Development Board serves only 10 percent of the state's total number of youths in work programs.[22] While data on foster youths served by such local work programs are sketchy at best, it appears that meaningful linkages between the one-stop center and local work programs are solid.

Dallas has developed a similar one-stop center for teens, the Transition Resource Action Center, and the city of Houston may join with faith-based groups to start a similar center. Foster teens in rural areas, however, have transportation problems and may not be able to benefit from existing urban facilities. DPRS may need specially-designed efforts to reach rural areas.[23]

Federal Funding for Transitional Services

Federal work force funding could be used to help other communities offer similar services. The federal Workforce Investment Act (WIA) makes foster children eligible for its youth services. Participants aged 14 to 21 and who face a barrier to employment are eligible for WIA. Those eligible include foster children, school dropouts, runaways, pregnant and parenting teens, those with criminal records and the illiterate.

Texas' 28 local work force boards use WIA funding to provide employment and training services. Some areas have developed collaborative initiatives to help foster children prepare for departure from DPRS care.[24] Beaumont's effort involves the Texas Education Agency (TEA) and the Texas Rehabilitation Commission as well as local work force board staff.[25]

In addition, some states have used Medicaid to support independent living services. New Jersey, for example, uses state and federal Medicaid funds to finance independent living activities for youths in group foster homes and residential treatment centers.[26] These services are financed under Medicaid because they are considered rehabilitation services. A wide range of independent living and other services can be added to the state Medicaid plan to benefit foster children. Another issue in this report fully discusses the Medicaid rehabilitation options.

The one-stop approach appears to be more successful than other Texas independent living programs.

Recommendations

A. HHSC and DPRS should seek non-traditional independent living funds from multiple federal sources.

Under state law, HHSC must submit any necessary changes to the state Medicaid plan for obtaining additional Medicaid funding for foster care. HHSC's guidance may also be helpful as DPRS works with the Texas Workforce Commission (TWC), TEA and other relevant agencies

B. DPRS should form partnerships with the state's local work force development boards to expand transitional services for Texas foster teens and create one-stop centers for foster care youth, using existing workforce funds.

These partnerships could use work force funding to supplement federal Chafee funding. To form these partnerships, DPRS should execute memoranda of understanding (MOUs) with local Texas workforce boards and with TWC. The MOUs should define the employment and training services that would be most beneficial to foster children and, if made directly with TWC, indicate that agency's intention to communicate these needs to each local board. Each local PAL coordinator could build a more detailed MOU with individual boards.

DPRS should redirect some Chafee funding to create one-stop centers for foster care youth across the state. Strategic partnerships with local or nonprofit groups could help DPRS create new centers.

One-stop service centers have proven successful for other state agencies. For example, TWC has consolidated its job training programs into a "one stop" approach. Successful models could be duplicated across Texas to provide services to foster youths.

Fiscal Impact

Recommendation A could result in a gain of federal funds. To the extent that some independent living services, particularly those provided in group homes and residential treatment centers could be covered by Medicaid, Texas could receive additional federal Medicaid dollars. The issue on Medicaid rehabilitation services includes this amount. Recommendation B could be completed with existing resources by redirecting WIA and Chafee funding.

Endnotes

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[13] Texas Department of Protective and Regulatory Services, "Active/Open PAL Contracts As of 1/20/2004," Austin, Texas, January 20, 2004. (Excel spreadsheet.)

[14] Texas Department of Protective and Regulatory Services, "Chafee Foster Care Independence Program, 2002-2003 Progress Report and Application for 2004 Funds."

[15] Interview with Texas Department of Protective and Regulatory Services staff, January 14, 2004.

[16] E-mail communication from Texas Department of Protective and Regulatory Services staff, January 20, 2004.

[17] Interview with Peter J. Pecora, senior director, Research Services, Casey Family Programs, Seattle, Washington, January 11, 2004.

[18] "Who Else is Making a Difference for Foster Youth in Transition? Four Models Worth Watching," *Advocasey* (Fall 2001), pp. 26-27.

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[21] Data provided by Texas Department of Protective and Regulatory Services, December 10, 2003.

[22] Texas Workforce Commission, "Foster Children Request," Austin, Texas, January 22, 2004. (Excel spreadsheet.)

[23] Interview with Texas Department of Protective and Regulatory Services staff.

[24] Interview with Roger A. Smith, program specialist, Contract Management Department, Workforce Development Division, Texas Workforce Commission, Austin, Texas, January 14, 2004.

[25] Interview with Texas Department of Protective and Regulatory Services staff.

[26] Dick Mendel, "Fostered or Forgotten," *Advocasey* (Fall 2001), p. 11.

Academic Needs

TEA should provide the Legislature with information on the educational needs of foster children. Caseworkers should consider foster children's educational needs when making placement decisions. Outreach programs should ensure awareness of state funding for foster children's college expenses.

Background

In Texas, foster children who attend school may be served by independent school districts, charter schools or special educational programs within or managed by a school district, charter school or residential treatment facility.

Educational research has repeatedly established that foster children tend to do poorly in school. Many eventually drop out—twice as often as their peers, according to the Casey Family Programs' National Center for Resource Family Support.[1] Unfortunately, Texas does not collect separate data on foster children in its data collection system, the Public Education Information Management System (PEIMS), so little can be said definitively about the educational success of foster children.

Foster children experience frequent interruptions in their schooling, often due to changes in placement or care arrangements. Some are transferred repeatedly to different homes or facilities, finding themselves in a new classroom each time. They also must cope with frequent court appearances, counseling and medical appointments.

Foster children are more likely to attend special education classes and are less likely to participate in college preparatory programs. Moreover, they are more likely to end up in the juvenile justice system. They often have emotional and behavioral problems that affect their classroom performance. Such problems can spring from their separation from their birth families as well as the neglect or abuse that led to their placement in foster care.[2]

The Washington State Legislature commissioned a study of the educational barriers facing foster children. The November 2001 report found that Washington's foster children scored 15 to 20 percent lower than their peers on state achievement tests. Just 59 percent of them completed high school, compared to 86 percent of their peers, and they were much less likely to report plans to attend college (38 percent versus 58 percent of their peers). Foster children were twice as likely to repeat a grade, change schools during the academic year or be enrolled in special education. The report also found little evidence of information sharing about foster children's educational progress among school personnel, foster parents and social workers.[3]

Foster children were twice as likely to repeat a grade, change schools during the academic year or be enrolled in special education.

A 2002 Education Law Center study of 23,000 Pennsylvania foster children found similar barriers to academic success. More than half of the foster children in the study faced delays of more than a week simply enrolling in school, due to an inability to meet enrollment requirements, incomplete immunization records and difficulties in transferring enrollment and other paperwork from former schools. School administrators tended to place large numbers of foster children in alternative education programs, and a majority of the children received little academic or social support from school personnel.[4]

Too many foster children leave the system with inadequate education and job skills. One Texas study of 513 former foster children found that almost half had no high school diploma and nearly 40 percent were receiving welfare assistance.[5]

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Higher Education

The Texas Higher Education Coordinating Board provides leadership for and coordination of the public higher education system in Texas.

Texas students who are in foster care when they become adults are eligible for free tuition and fees at Texas public colleges and universities. To receive this benefit, students must:

- have been in the care or conservatorship of DPRS on the day before their 18th birthdays, the day of their graduation from high school or the day they received a General Educational Development (GED) certificate;
- enroll in a public college or university in Texas within three years of the relevant date mentioned above, but no later than their 21st birthdays; and
- enroll in classes for which the college receives tax support (tax-supported classes typically concern "core" subjects such as math and science).[6]

The report concluded that Texas does not meet federal standards for educational services.

There are no time limits on the use of these benefits. In fiscal 2002, a total of 639 postsecondary students received this benefit at a cost of $758,832.[7] Of those receiving these awards, 207 used them at a public university; two at a public health-related institution; 21 at a public technical institute (Texas State Technical College or the Lamar Institute of Technology); 25 at a public state college (Lamar State College at Orange and at Port Arthur); and 384 used the award to attend a public community college.[8]

Each year, more than 700 Texas foster children are "emancipated" from the system because they turn 18. All of these young adults are eligible for free tuition, but the fiscal 2002 data indicate that many do not take advantage of the benefit, with only 639 students enrolled anywhere in the state's college and university system. With 700 students aging out of the foster care system each year, thousands of former foster children each year would be at an age at which they could be eligible for this benefit.

The 2003 Texas Legislature extended this benefit to Texans who were in foster or residential care at some point and later were adopted. As of fall 2003, Texas now offers these students free tuition and fees at any public university or community college, without limit as to when the benefit can be used or for how long.[9]

Federal Findings

The U.S. Department of Health and Human Services (HHS) is conducting a national review of child welfare services in every state.[10] These reviews are designed to monitor state compliance with federal law and rules, to examine child and family outcomes due to welfare services and to provide assistance to the states' efforts to improve the lives of children and families.[11]

In June 2002, HHS issued a final report on its review of welfare services for Texas children and families.[12] The report concluded that Texas does not meet federal standards for educational services. For example, it found that in 16 percent of the cases studied, DPRS, the agency responsible for Texas' foster children, had not met children's educational needs.[13]

Two major problem areas cited in the review were poor assessment of foster children's educational needs and a lack of follow-up by caseworkers to determine if recommended educational services for these children were actually being provided. Community comments gathered as part of this review indicated that, while foster parents often are strong advocates for the academic needs of their children, caseworkers need additional training on educational issues.

Comptroller review team site visits to foster care facilities across the state reinforced the federal findings. For example, staff members at one site reported that caseworkers attend-

ed special education Admission, Review and Dismissal meetings only about 30 percent of the time.[14] DPRS reports that it has developed a plan to improve the deficiencies identified by the federal review.[15]

Children with Special Needs

TEA coordinates with eight other state agencies on issues related to residential care for foster and other children with disabilities. These agencies include DPRS, the Texas Department of Human Services, MHMR, TDH, Texas Interagency Council on Early Childhood Intervention, Texas Commission on Alcohol and Drug Abuse, Texas Juvenile Probation Commission and the Texas Youth Commission. The memorandum of understanding that formalized this arrangement defines responsibilities for each agency regarding children with disabilities served by residential treatment centers, foster care and medical, emergency or correctional facilities.[16]

Texas foster children who are placed in special education programs can receive educational and support services from a school district or another facility contracting with the district. These services can be provided as part of a day program or in a residential treatment facility. Children may be placed in residential treatment settings by their school district, their parents or a state agency.[17] TEA estimates that school district Admission, Review and Dismissal committees have placed about 80 Texas students in residential treatment. A majority of these students are diagnosed as emotionally disturbed.[18]

Other states may send foster children to Texas residential treatment facilities. Texas school districts are required to charge tuition for educational services provided to out-of-state students in a public school setting, including those served in residential care. TEA's Division of Special Education also maintains a list of approved nonpublic schools that serve foster children with disabilities on its Web site at <http://www.tea.state.tx.us/special.ed>.

In recent years, Texas school districts have served an increasing number of severely disturbed or disabled students in their own classes rather than sending them elsewhere for services. TEA provides financial incentives to encourage the early return of disabled students in residential care to the public school system. School districts can increase their revenues by providing educational services to RTCs that serve foster children within their boundaries. Students placed in these facilities receive the state's "residential care and treatment" funding weight, which provides the highest amount of state funding per child.

TEA reports the majority of Texas foster children who receive special education services are served by local school districts.[19]

Recommendations

A. TEA should include information on the education of Texas children in foster care in its state dropout plan and annual reports to the Legislature; TEA also should provide this information to DPRS.

TEA should use its research and evaluation funding targeted for low income, at-risk and homeless students to study the current conditions of foster children and should develop recommendations for improving their social, academic and vocational futures.

As part of this effort, TEA should investigate the effectiveness of emerging educational settings, such as Internet-based curricula and charter schools, including charter schools that are part of, or provide services through, residential treatment centers.

TEA should report this information to the Texas Legislature and DPRS, and make it available on the agency's Web site so that it can be used by college and university departments of education and social work and the state's 20 regional education service centers in their staff training programs.

TEA reports the majority of Texas foster children who receive special education services are served by local school districts.

B. DPRS caseworkers should consider foster children's educational needs, and the education services available from each foster care facility, when making placement decisions.

C. TEA and the Texas Higher Education Coordinating Board should develop outreach programs for foster children to ensure that they are aware of the availability of state funding for their college expenses.

Fiscal Impact

No additional funds would be needed to implement Recommendation A. TEA could incorporate information on foster children in its existing state dropout plan and comprehensive annual report to the Legislature on Texas public schools. Federal and state funds allocated to TEA for issues related to at-risk, low-income and homeless children (for example, Title I, Part A; McKinney Homeless Education funds; Career and Technology Education and state compensatory education) could be used for this activity.

No additional funds would be needed to require DPRS caseworkers to consider foster children's educational needs and the educational services available from foster care facilities when making placement decisions.

No additional funds would be needed to publicize the availability of funding for foster children's college expenses.

Endnotes

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[12] U.S. Department of Health and Human Services, Administration for Children and Families, *Child and Family Services Review: Summary of Findings—Texas* (Washington, D.C.: U.S. Government Printing Office, June 2002.)

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[16] 19 Texas Admin. Code, Chapter 89, Subchapter AA, Division 3.

[17] Interview with Gene Lenz, deputy associate commissioner for special education, and Laura Taylor, director, special education monitoring, Texas Education Agency, Austin, Texas, November 17, 2003.

[18] Interview with Linda Crawford, director, and Tommy Cowan, assistant director for interagency coordination, Texas Education Agency, Austin, Texas, November 20, 2003.

[19] Interview with Gene Lenz and Laura Taylor.

Academic Data

The state's Public Education Information Management System should track information on students in foster care. Education services provided by foster care facilities should be included in district and campus report cards.

Background

Any effort to improve the lives of Texas' foster children requires reliable information on their circumstances. Federal information on children in foster care is collected through the U.S. Department of Health and Human Services' Adoption and Foster Care Analysis and Reporting System (AFCARS). States first submitted data on adopted children and children in foster care to AFCARS in 1995, and currently must do so twice a year.[1] The federal government reimburses states for 50 to 75 percent of the cost of collecting this information.

AFCARS offers states the opportunity to improve their foster care systems, practices and programs by providing detailed information on the children served in foster care. For example, Illinois used AFCARS to develop a statewide system of foster care information that includes an automated database linking data on children in foster care with model practices and programs.[2]

Several states have implemented other initiatives to improve their tracking of foster children. Kentucky conducted a statewide census of all children in foster care that verified the placement and safety of each child. The Kentucky Cabinet for Families and Children collected the information with assistance from eight public and three private universities across the state. Student census-takers from these colleges and universities visited every foster home in the state to collect this information.[3] California has developed an automated Child Welfare Services/Case Management System, which allows state and county child welfare agencies to share electronic information about individual foster children.[4]

PEIMS

TEA collects data on children in public schools through PEIMS. Children who are awaiting foster care placement are included in the PEIMS count of homeless students.[5] The Texas Education Code, Section 29.081(d)(13), defines students at risk of dropping out of school as including those who:

> …resided in the preceding school year or resides in the current school year in a residential placement facility in the district, including a detention facility, substance abuse treatment facility, emergency shelter, psychiatric hospital, halfway house, or foster group home.

…pertinent information on Texas foster children appears to be scarce.

Foster children who reside in group homes and medical, correctional or treatment facilities are included in PEIMS as part of the at-risk student population. Foster children in other types of care, such as those with foster families, are not included.

Nevertheless, pertinent information on Texas foster children appears to be scarce. A 2001 Center for Public Policy Priorities study of Texas youths leaving foster care attempted to assess the challenges and barriers facing these young people. The center reported that data requests to relevant state agencies, foster homes

and residential treatment programs produced little information about these children.[6]

The current draft of TEA's state dropout plan for 2003-2014 contains no strategies to address the needs of foster children, because no data are available on their academic performance or high school graduation rates.[7]

...TEA's state dropout plan for 2003-2014 contains no strategies to address the needs of foster children, because no data are available on their academic performance or high school graduation rates.

Recommendations

A. TEA should include "foster care" as a separate data element in the state's PEIMS.

Accurate data on the academic achievement and progress of foster care children should be available to educators, counselors, caseworkers and other service providers through PEIMS. Students served in any foster care setting should be readily identifiable through the system.

B. TEA should include educational services provided by all of the state's foster care facilities in district and campus report cards.

Research on foster children highlights their fragility and vulnerability. Service providers should be subject to ongoing public scrutiny on the quality of the educational services they provide to foster children. DPRS caseworkers should use these data in making placement decisions.

Fiscal Impact

Recommendation A could be incorporated into TEA's ongoing management of PEIMS data elements with existing funds. TEA already collects data on foster children in PEIMS as part of the larger "at-risk" and homeless student populations.

Recommendation B could be incorporated into TEA's ongoing district and campus report card system. No new funds would be needed.

Endnotes

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3 Kentucky Cabinet for Families and Children, "The Kentucky Foster Care Census," http://www.trc.eku.edu/fostercare/. (Last visited October 27, 2003.)

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Foster Grandmas and Grandpas

DPRS should partner with volunteer and advocacy organizations to develop a "Foster Grandmas and Grandpas" Program to recruit senior volunteers to mentor and support foster children.

Background

Foster children often experience a number of barriers to success in school and in life. Volunteer mentors can provide the nurturing, stability and support foster children need to overcome these barriers.

Education research consistently supports the importance of parental involvement in the schools for improved student academic achievement.[1] Mentoring by adults or older volunteers also has been demonstrated to improve student achievement. Senior volunteers in particular can offer students the benefit of the experience and skills that they have acquired throughout their lives.[2]

For instance, the University of Pittsburgh has developed a Senior Citizens School Volunteer Program to increase cross-generational relationships. The program uses senior volunteers to promote students' emotional and social growth. It has improved student achievement and provided valuable support for classroom teachers while helping senior volunteers feel valued and needed. The Pennsylvania Department of Education and the National School Volunteer Program both have praised the initiative.[3]

Advocacy Organizations

Several national advocacy organizations that combat child abuse and neglect operate in Texas. One such group, the National Children's Advocacy Center, provides prevention, intervention and treatment services for children who have been physically or sexually assaulted. This nonprofit agency, which began in Alabama in 1985, is recognized for its national leadership on this issue.[4]

Its Texas branch, Children's Advocacy Centers of Texas, provides services such as staff training, funding and technical assistance to 58 local advocacy centers across the state. These local centers bring all parties in child abuse investigations to a single site to better serve the needs of abused and neglected children, and work to ensure that information and therapeutic services are available for them.[5]

The Court Appointed Special Advocate (CASA) program recruits and trains community volunteers to act as advocates for abused and neglected children in the courts. CASA was formed by a Seattle judge who was worried about the status of abused and neglected children in his state's court system.[6] The U.S. Congress recognized CASA's contributions with the Victims of Child Abuse Act of 1990, which provides funding for local CASA programs.[7] Across the nation, more than 70,000 CASA volunteers assist abused and neglected children with legal issues.[8]

Mentoring by adults or older volunteers has been demonstrated to improve student achievement.

Texas CASA trains special advocates to assist foster children in the state's court systems, and provides funding and technical assistance to local chapters. In Texas, 3,918 CASA volunteers assisted 15,195 abused and neglected children in 2003.[9]

Federal Foster Grandparents Program

One national initiative that harnesses the power of senior volunteers is the Foster

Grandparents Program. This effort began as a national demonstration project in 1965.[10] Today, it is part of Senior Corps, which includes the Retired and Senior Volunteer Program and Senior Companion Program. Foster children are eligible to receive mentoring through the program, but the majority of its volunteers are concentrated in elementary schools and early childhood centers.[11]

Foster Grandparents recruits low-income persons, aged 60 or above, to serve as foster grandparents to children with disabilities or chronic health conditions; children who are in the hospital or homes for dependent and neglected children; or who receive services through day care centers, schools, early intervention programs, Head Start programs or other programs serving children with special needs.[12]

An additional Texas initiative is needed to harness the power of senior volunteers and improve the lives of foster children so that they may all have a brighter future.

Program volunteers must meet age and income eligibility requirements and provide 20 hours or more of service per week, and receive small stipends in exchange. All volunteers must undergo a background check and telephone interview and receive both pre-service and in-service training.[13]

A 1998 study of foster grandparenting in Head Start (preschool) programs found that senior volunteers provide emotional support and encourage the development of children's social, behavioral, language and academic skills.[14]

A 2001 progress report indicated that these program volunteers serve primarily in elementary schools (34 percent), Head Start programs (16 percent), day care programs (13 percent), preschools (8 percent) and middle schools (5 percent). The report did not list foster care facilities as a specific area of service, although volunteers did serve in homeless/battered women shelters (2 percent) and social service agencies (2 percent). The largest group served by the program was learning-disabled children (10,900), followed by developmentally delayed children (7,000) and abused and neglected children (3,300)—all conditions common among foster children.[15]

Texas has 18 local Foster Grandparent programs and one statewide program sponsored by the Texas Department of Mental Health and Mental Retardation and headquartered at the Austin State School.[16]

An April 16, 2002, editorial in the *Boston Globe* reported that when the Foster Grandparent Program began, a third of the nation's elderly were living in poverty. At present, with just 10 percent of the country's seniors living in poverty, the program is having difficulty recruiting volunteers. The editorial recommended that Congress eliminate income restrictions so that all seniors can participate.[17]

The national Foster Grandparent Program, while certainly a worthwhile effort, cannot by itself meet the needs of Texas' foster children, since it is limited to low-income senior volunteers and primarily serves early childhood programs and elementary schools.

An additional Texas initiative is needed to harness the power of senior volunteers and improve the lives of foster children so that they may all have a brighter future.

Recommendations

A. DPRS should partner with volunteer and advocacy organizations to develop a Texas Foster Grandmas and Grandpas Program.

DPRS should work with volunteer organizations that address issues related to senior citizens, volunteerism, advocacy and foster children, such as the Children's Advocacy Centers of Texas, American Association of Retired Persons and Texas Court Appointed Special Advocates to develop the program.

The goal should be to provide a foster grandma or grandpa volunteer for every foster child. All volunteers should be subject to a criminal background check using state and national databases.

B. DPRS should work with nonprofit organizations to solicit contributions for the Texas Foster Grandmas and Grandpas Program.

DPRS should publicize the existence of the program through interviews and news releases and work with other organizations to attract monetary donations as well as resources, such as staff volunteers and facilities, from public, private and university foundations.

C. DPRS should work with the Texas Education Agency to seek funding for the Texas Foster Grandmas and Grandpas Program.

The agencies should seek appropriate funding sources, such as federal funds under the No Child Left Behind Act, federal funds for homeless children and youth and state compensatory education funds for at-risk students.

D. TexasOnline and all Texas state agencies that serve children, youth and families should publicize the Texas Foster Grandmas and Grandpas program on their Web sites.

TexasOnline is the official state of Texas Web site.

E. DPRS should work with nonprofit organizations to recognize Texas Foster Grandmas and Grandpas program participants through annual volunteer service awards.

Fiscal Impact

These recommendations could be implemented with existing resources.

Endnotes

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[16] Corporation for National and Community Service, "Joining Senior Corps Foster Grandparents Program: Foster Grandparent Programs in Texas," http://www.seniorcorps.org/joining/fgp/state.asp?usestateabbr=tx. (Last visited February 5, 2004.)

[17] Alan Solomont and Marc Freedman, "Helping Elders Help the Country and Themselves," *Boston Globe* (April 16, 2002), Op-Ed Section, p. 21.

APPENDICES

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Appendix 1
Survey Results

DPRS Customer Service

The 1999 Texas Legislature enacted new legislation (S.B. 1563) requiring all state agencies to inventory their customers, survey them concerning customer satisfaction and set standards for customer service. DPRS' most recent report on customer service, prepared in response to this legislation, is for the 2001 and 2002 fiscal years.

In preparing this report, DPRS chose to survey residential care providers (including shelter and residential facility directors and DPRS foster parents) but *not* children in foster care. (The DPRS Preparation for Adult Living Program conducts surveys of foster children, but only those who are older and preparing to exit the system; this information is not included in the agency report on customer service.)

The U.S. General Accounting Office has cited examples of child and family outcome measures used by other states and localities that gauge youths' satisfaction with foster care services and their placements. Since foster children are indeed among DPRS' primary customers, Texas' legislation in fact requires the agency to survey foster children.

DPRS' report on customer service also fails to mention or include complaints made to its Ombudsman's Office. In fiscal 2003, the ombudsman received more than 2,500 complaints about DPRS' Child Protective Services and Residential Child Care Licensing divisions. Most of these complaints were from consumers, but more than 300 came from Texas legislators.

DPRS should confidentially survey all children in foster care aged 10 and above. The children should be asked questions regarding the quality of their care and their living conditions, food and recreational opportunities, and asked what could be done to make their life in foster care better. These survey results should be reported to the Legislative Budget Board and the Governor's Office of Budget and Planning, as required by state law.

DPRS also should include data from its Ombudsman's Office in its report to better depict the opinions of its customers.

Comptroller's Foster Care Survey

As part of this review, the Comptroller's office developed an online survey to gauge the opinions of persons participating in the foster care system. The survey was discussed in the *Dallas Morning News* and publicized by advocacy groups. It was not a random sample of those involved in the foster care system; participants were self-selected, which may influence the results.

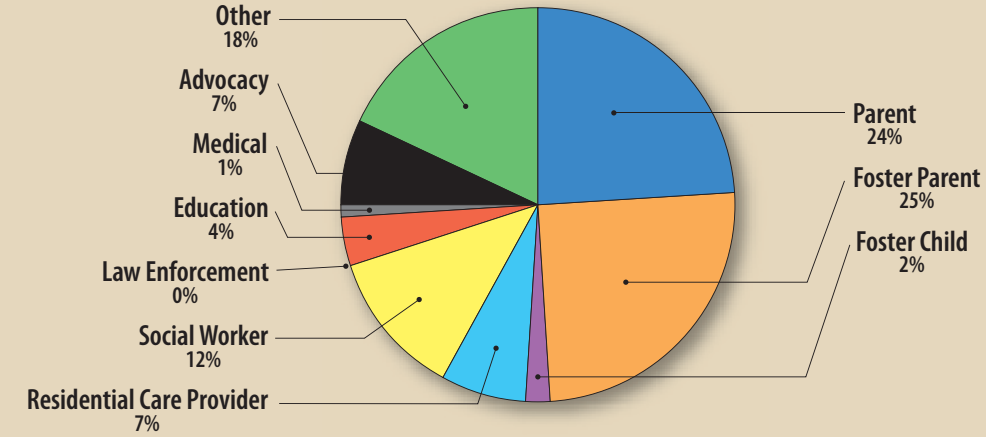
A total of 243 people responded to the survey. Forty-nine percent of the respondents identified themselves as parents or foster parents; an additional 19 percent were residential care providers or social workers. Eighteen percent classified themselves as "other," with the remaining respondents representing foster

children, advocacy groups and persons in law enforcement, education and medicine.

In all, the foster care system received poor marks. Seventy-six percent of respondents indicated that they do not think that Texas' foster care system works well; 57 percent said the same about the residential treatment system. When asked how they would rate the service provided by DPRS, 49 percent responded "bad" and an additional 30 percent rated them as fair. Only 4 percent found DPRS' service excellent.

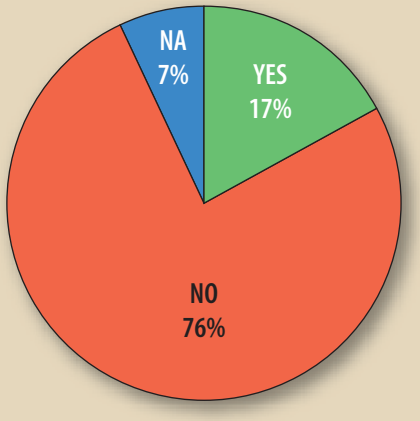
When respondents were asked about the DPRS foster care Web site, only 33 percent said it provided useful information. A total of 31 percent thought telephone access to the agency was helpful, with 59 percent finding telephone access unhelpful.

Exhibit 1
Survey Respondents by Type



Source: Comptroller Online Survey Results.

Exhibit 2
Foster System Care Works Well



Source: Comptroller Online Survey Results.

Appendix 2
Foster Care in Other States

California

State Agency: California Department of Social Services

State Agency Web Site: http://www.dss.cahwnet.gov/cdssweb/default.htm

Overview: The California Department of Social Services administers the state's human services programs. The department's Division of Children and Family Services oversees foster care services and programs. The state also employs an ombudsman for children in foster care.[1]

The California legislature has required counties to automate the functions of their child welfare offices; this mandate resulted in the state's Child Welfare Services/Case Management System (CWS/CMS), which allows state and county child welfare agencies to share information about individual cases.[2]

Demographic Profile: The Children's Defense Fund reported that there were 112,807 California children in foster care as of January 2003.[3] The Casey Foundation estimates that California's foster care population is 34.6 percent African American, 32.2 percent Hispanic and 29.5 percent white.[4]

History: A 2002 investigation by the *San Francisco Chronicle* found that California state and local authorities receive about 535,000 charges of child neglect or abuse each year. County social workers review these complaints and, if they determine that an investigation is needed, assign them for investigation by an emergency response caseworker. About 32,130 California children are placed in foster care annually as a result of these investigations.

Courts must develop plans for each child in foster care, as well as his or her family, usually with the goal of reuniting them. If reunification is not feasible or unsuccessful, the courts must hold a permanency hearing to determine placement. Of children who entered foster care in 2000, 43 percent returned to their families, 53 percent remained in foster care, 1 percent were adopted and 3 percent exited for other reasons (e.g., became an adult).[5]

In December 2002, California's report on its foster care program to the U.S. Department of Health and Human Services (HHS) was heavily criticized in the media. According to this report, while California has about 12 percent of the total U.S. population, it has 20 percent of the nation's foster care population. The number of California foster children has more than doubled since 1988, due both to social issues, such as rising levels of substance abuse, and increased state interventions.

The state reported massive shortages of foster parents, caseloads of 60 to 70 children per social worker and a 200 percent increase in state spending on foster care. Other statistics in the 2002 report added to the picture of a system in serious distress:

- California children were 50 percent more likely than the national average to be removed from their families by the state after an abuse or neglect report;
- California children stay in foster care longer than children in other states (a median of 26 months compared to a national median of 20 months);
- 10 percent of all California children who had experienced a verified instance of abuse or neglect experienced an additional episode within six months; and
- 1 percent of California foster children were abused by their caregivers.[6]

HHS released its review of California's foster care system in January 2003. California failed all seven federal monitoring measures for foster care. HHS criticized the state for allowing children to stay in foster care too long; allowing them to be abused repeatedly by their own or foster parents; failing to meet their mental health needs and failing to provide assistance for families in crisis.[7]

Funding Issues: The California Department of Social Services' Foster Care Rates Bureau sets reimbursement rates for foster care, and posts them on the department's Web site at <http://www.hwcws.cahwnet.gov/programres.asp>. Rates vary by setting such as group home, foster family and intensive treatment program.[8]

The federal government has threatened to levy an $18.2 million penalty against the California Department of Social Services if it does not develop and implement an acceptable foster care plan by 2005.[9]

Title IV-E Waiver: California has an Intensive Service Options Title IV-E (of the Social Security Act) waiver that allows seven counties to develop intensive foster care programs including "wraparound" services. Children served include those at risk of placement in foster care and those moving towards rejoining their families, adoption or guardianship.[10]

Model Programs and Initiatives: None identified.

Policy, Advocacy and/or Parental Issues: California failed all seven measures in the federal HHS review of its foster care program and faces federal penalties if it does not develop and implement a corrective plan by 2005.[11]

Florida

State Agency: Florida Department of Children and Families

State Agency Web Site: http://www.state.fl.us/cf_web

Overview: The Florida Department of Children and Families administers the state's health and human services, substance abuse, mental health and veterans programs.[12] In April 2003, the department announced a new child protection information system designed to help local investigators determine the level of risk to children in abuse/neglect investigations and convey that risk more efficiently to their supervisors. The system includes an automated checklist and an assessment to help determine whether termination of parental rights is warranted in cases of abuse or neglect. The system automatically generates a decision summary narrative. It should be complete in 2005.[13]

Demographic Profile: The Children's Defense Fund reports that 35,656 Florida children were living in foster care in January 2003.[14] The Casey Foundation estimates that the Florida foster care population is 46.7 percent white, 46.5 percent African American and 5.3 percent Hispanic.[15]

History: The 1998 Florida legislature privatized the state's foster care program. The state created a pilot program in three counties (Pasco, Pinellas and Manatee) to transfer child protective services from the Department of Children and Family Services to local sheriffs' offices, and transfer responsibility for child welfare legal services in four coun-

ties (Pasco, Pinellas, Manatee and Sarasota) from the Florida Department of Children and Families to the state attorney or Attorney General's office. A three-year phase-in period was scheduled for these efforts. Local nonprofit agencies can bid to provide child welfare services as part of this initiative. Local sheriffs may elect to perform child abuse or neglect investigations themselves or subcontract these services.[16]

Florida's foster care system has been criticized for removing children from their biological parents too quickly and too often. National children's advocacy groups cited the disappearance of five year-old Rilya Wilson from foster care in January 2001 as an example of the need for systemic reform.[17]

The 2001 death of a 17-month-old child (Latiana Hamilton) in a crowded foster home, and the arrest of her foster mother for first-degree murder, added to existing concerns about the Florida foster care system. A February 2001 report indicated that 16 percent of the state's foster homes had more children than were allowed by their licenses; 62 foster homes across the state were caring for more than 10 children.[18]

In May 2002, the Department of Children and Family Services was ordered to pay $5 million in damages to a group of six siblings who had been starved and physically as well as sexually assaulted while in foster care. These siblings were placed in a foster home from which the parents' own biological child had been removed due to sexual assault. The state department was found to have not visited these foster children for more than a year.[19]

In 2002, an oversight committee appointed by the governor issued a report criticizing the Department of Children and Families for keeping such poor records that they were endangering children. Their review of more than 1,000 foster children's cases found that almost all of them were incomplete and disorganized. In addition, the state's record keeping violated various state and federal laws relating to issues such as sibling files and informed consent.[20]

Gov. Bush has appointed a blue-ribbon panel to investigate child protection issues in Florida and make recommendations for improvement. This panel held public hearings, made recommendations and issued a progress report in January 2003.[21]

Funding Issues: The Florida Department of Children and Families reports that it received a $524 million increase in funding for children's protective services under the state's current governor. The department is requesting $1 billion for fiscal 2005 to increase children's safety and shift to a community-based system of foster care.[22]

Title IV-E Waivers: None.

Model Programs and Initiatives: In November 2003, Gov. Bush and Children and Family Services Secretary Jerry Regier announced a new initiative, titled *No Place Like Home*, designed to increase adoptions by raising public awareness. The initiative focuses on recruiting adoptive parents and streamlining adoption procedures. Florida received $3.5 million from the federal Department of Health and Human Services in October 2003, more money than any other state, for its efforts to increase adoptions.[23]

Policy, Advocacy and/or Parental Issues: Children's advocates have filed a federal lawsuit against the Florida Department of Children and Family Services (*Bonnie L. v. Jeb Bush*) asserting that the state runs crowded and poorly supervised foster homes that put children at risk of abuse and neglect.[24]

Children who are missing from the state foster care system are an ongoing public concern in Florida. The Florida Department of Children and Families listed 489 missing foster children on its Web site as of February 25, 2004. Rilya Wilson, whose 2001 disappearance was cited as an example of the need for systemic re-

form in Florida's foster care system, remains on this list.[25]

Child advocates also have expressed concern about the amount of psychotropic drugs given to children in foster care, asking whether these drugs are being prescribed to control behavior rather than to address mental health problems. An internal Department of Children and Families memo reported in the *Palm Beach Post* estimated that more than a fourth (28 percent) of all Florida foster children ages 13 and older were being overmedicated. On November 19, 2003, Children and Families Secretary Jerry Regier called for a complete investigation into this matter.[26]

Another continuing issue has been the backlog of cases. Children and Families Secretary Jerry Regier announced in February 2003 that the agency's backlog had been reduced to fewer than 15,000 cases for the first time since 1999. The caseload was at 30,038 in December 2002, when the effort to reduce the backlog began.[27]

Illinois

State Agency: Illinois Department of Children and Family Services

State Agency Web Site: http://www.state.il.us/dcfs

Overview: The Illinois Department of Children and Family Services administers child welfare programs, including foster care services. The department oversees six field offices, including three for Cook County and one each for the state's northern, central and southern regions. At present, the Cook County central regional office is being eliminated, and its services moved to the Cook County North and South regional offices.[28]

The state's six (soon to be five) service regions are in turn divided into field service areas. These areas are partitioned into local area networks (LANs), which administer child welfare services and programs. The state's field service areas provide child protection and other direct services.[29]

The Department of Children and Family Services participates in the federal Statewide Automated Child Welfare Information System (SACWIS), which was authorized by the U.S. Congress in 1993. The U.S. Department of Health and Human Services reimburses states for 50 to 75 percent of the cost of developing and implementing the system.

The director of the Illinois Department of Children and Family Services has used this initiative to develop the Best Practice Integration Project, a statewide system for the dissemination of model child welfare practices.[30] The information system is designed to help ensure statewide excellence and consistency in case management. The Department of Children and Family Services reports that the incorporation of best practices in casework has been highly successful.[31]

The department maintains a foster parent hotline (1-800-624-KIDS) in addition to its child abuse hotline (1-800-25-ABUSE). The department also develops materials for local agencies to use in recruiting adoptive and foster parents.

Demographic Profile: The Illinois Department of Children and Family Services reports that 19,719 Illinois children were in foster care as of October 31, 2003. Of these children, 12,140 (62 percent) resided in Cook County. In Cook County, the majority of the children in foster care (10,055 out of 12,140, or 83 percent) were African American. In the rest of the state, there were 4,047 white, 3,057 African American and 216 Hispanic children in foster care. Slightly more foster children were males (10,535) than females (9,176). The distribution of children in foster care across age levels was fairly even.[32]

History: Illinois faced a statewide crisis in its child welfare programs in the early to mid-1990s. The state reported that 17.1 out of every 1,000 Illinois children were living in foster care, the highest rate in the nation. Foster

care caseloads averaged 50 to 60 per social worker. By 1996, children in Illinois spent an average of 56 months in foster care, and the foster care system had become a source of considerable controversy.

The Illinois Department of Children and Family Services concluded that one major problem was the state's contracting system. The department reports that its former fee-for-payment system worked against permanent adoption, since local agencies lost money for each child adopted unless a new child became available at the same time. Thus, the foster care service provider system received rewards for keeping large numbers of children in foster care. Under this system, only 8 percent of all children in foster care were being moved to permanent homes each year.

Illinois changed its contracting system to performance-based contracts that reward activities supporting and encouraging permanent adoption. The state also provides financial incentives linked to accountability. For example, all Cook County providers now are expected to accept 24 percent of their cases as new referrals and move 24 percent of them into permanent homes annually. This change has increased adoptions and led to improvements in local agency performance.[33]

The Department of Children and Family Services' fiscal 2004 budget request indicates that foster care caseloads have dropped dramatically, from 50,044 in fiscal 1996 to 20,719 in fiscal 2003. The state has begun assessing the degree to which children are in danger of neglect and abuse more accurately through the use of a standardized risk assessment instrument, which in turn has lowered foster care placements. Illinois also has increased its investment in "front-end" or prevention services, to address abuse or neglect in their earliest stages. These achievements have occurred within a statewide emphasis on increasing child safety.[34]

Funding Issues: The Illinois governor's proposed budget for fiscal 2004 includes $838 million in general revenue (out of $1.4 billion total) for the Department of Children and Family Services. This proposal includes $13 million in new dollars for training private child welfare agency staff; $20.9 million in new money for adoptions and guardianships and a reduction of $30.1 million in foster care services, which mirrors the fall in the state's foster care population. The state expects an 8 percent decrease in foster care caseloads for fiscal 2004.[35]

Title IV-E Waivers: Illinois received a Title IV-E waiver from the federal government for its subsidized guardianship program, which allows children in kinship (extended family) care to be placed permanently with their relatives. The state has reported significant improvements in permanent placements through this waiver; the number of children placed permanently with relatives rose from 1,276 in 1998 to 2,199 in 1999.

These placements are managed through performance contracts. The state has used savings from these placements to reduce state social worker caseloads.[36] Six other states have received this waiver.[37] Evaluation of this waiver program suggests positive effects. Follow-ups with 2,276 children indicate that children served under the waiver were more likely to be placed in permanent homes.[38]

A second Title IV-E waiver allows Illinois to provide services to families with substance abuse problems. The state has used this waiver to hire "recovery coaches" who work with families upon completion of substance abuse programs. Program participants include custodial parents with substance abuse problems and parents whose infants were exposed to harmful levels of drugs and alcohol before birth.

The state's third Title IV-E waiver provides enhanced training for private agency foster care staff and an evaluation of the results of this training. This training program is designed to increase the number of children placed in permanent homes. Illinois is the only state with this type of waiver.[39]

Model Programs and Initiatives: Illinois has received a number of national awards and recognition for its foster care programs.

The Illinois Department of Children and Family Services reports that it is the country's largest state agency for children's welfare to receive accreditation from the Council on Accreditation for Children and Family Services.[40] Illinois also received the White House's Adoption Excellence Award in 1998 and 1999 for its efforts to increase the number of children moving from substitute care into permanent homes.[41]

The National Adoption Information Clearinghouse of the Administration for Children and Families reports that, from 1995 to 1998, Illinois realized the largest percentage change (101 percent) in finalized adoptions of any state. (Texas reported a 75.9 percent improvement in adoption rates over the same period.).[42]

By 1999, Illinois tripled its number of adoptions (7,113) over the prior year's results. The state estimates that nearly 40,000 Illinois children were placed in permanent homes between 1997 and June 2003.

Benchmarking. Illinois' Department of Children and Family Services benchmarks its child welfare measures, such as the number of children in out-of-home care, to other states and the national median. Data analysis is based on information from the National Data Analysis System.

Foster Care, Out of Home Placement and Residential Care. The Illinois Department of Children and Family Services' 2003 report on progress in child welfare reform indicates that the state has reduced the number of children served in foster care (a 60 percent drop since the 1990s); the average length of time spent in foster care (25 months versus 44 months); the use of residential and group settings (60 percent fall from 1995 to 2003); and use of out-of-state residential programs (fewer than 20 children). These reforms allowed the department to reduce caseloads to its current average of 16 per caseworker.[43]

Performance Contracting. Illinois began performance contracting in 1997. The state credits this system with making it a national leader in child welfare reform. The performance contracting program received an award from the Harvard Innovations in American Government program in 2000. One of the criteria for this award is that the program can be easily replicated by other states.[44]

Prevention. A key element of Illinois' successful restructuring of its foster care program is to provide prevention services to reduce the number of children entering foster care. The early intervention program provides services to families in crisis before a child abuse or neglect investigation is finalized. The state also has developed the goal of "early permanency," meaning that a child is placed in a permanent living situation as soon as possible. This effort has reduced the number of children in foster care from 51,331 in 1997 to 20,508 in 2003, a decrease of 60 percent.[45]

Wraparound Services. Illinois uses the "wraparound" service concept, which stresses interagency coordination as a primary part of the planning process. Wraparound services are coordinated through a child and family team. Each foster child's wraparound plan is reviewed and modified on an ongoing basis. The goal of the wraparound approach is to return children to the community with a minimal level of specialized support services. Parents are included as important members of the child and family team. Services are community-based, while more restrictive settings are used only to stabilize children in crisis.[46]

Policy, Advocacy and/or Parental Issues: State Representative Jim Meyer (R-Naperville), hosted an October 21, 2003 forum for Illinois foster parents. The group's most frequent concerns were combative administrators, lack of mental health support and bureaucratic "red tape." Foster parents also reported that Medicaid restrictions (e.g., on dental and

eye care) create barriers to adequate health care for their children. An additional concern was a lack of support for foster children who "age out" of the system. Foster care personnel at the meeting reported that their needs include more funding, a larger pool of foster parents and more staff training.[47]

Kansas

State Agency: Kansas Department of Social and Rehabilitation Services

State Agency Web Site: http://www.srskansas.org

Overview: On March 1, 1997, private agencies took responsibility for all foster care services in Kansas. The Department of Social and Rehabilitation Services monitors these agencies to ensure program quality.[48]

Kansas operates a statewide data system for foster care, the Family and Child Tracking System (FACTS). A federal review of the system described it as "fragmented," and criticized it for being unable to easily generate management reports. Many state department managers maintain their own data systems that are incompatible with FACTS.[49]

Demographic Profile: According to the Children's Defense Fund, 6,569 Kansas children were in foster care in January 2003.[50] The Casey Foundation estimates that Kansas' foster care population is 68 percent white, 22 percent African American and 7 percent Hispanic.[51]

History: Kansas is the first state in the nation to completely privatize its adoption, foster care and family preservation programs.[52] In 1996, the state contracted for adoption services with strict performance-based incentives that quickly produced improvements. During the first year of privatization, adoptions increased by 26 percent.[53]

Kansas' privatization effort included performance-based contracts with private service providers. Three large, private, nonprofit agencies initially received contracts to provide foster care, adoption and family preservation services for a set ("capitated") fee of between $13,000 and $15,000 per child.[54] This "managed care" model, which paid a flat rate per child, was changed in July 2000 to a system that reimburses contractors monthly based on the number of children served. Contract outcome and performance goals also have been revised.[55]

The Heartland Institute reports that private service providers have surpassed the state's performance goals in several areas, including safety, number of placements, continuation of family and community relationships and sibling placement. Kansas state administrators view privatization and performance-based contracting as the keys to improving child welfare programs.[56]

The department purchases adoption and foster care services as well as administration, placement, counseling and follow-up services from a network of private service providers. Kansas' performance standards for private providers are very strict, particularly when compared to those previously used in the state's adoption and foster care program.[57]

Five contractors and 25 nonprofit providers currently offer foster care services and programs in Kansas.[58] The University of Kansas works with the Department of Social and Rehabilitation Services to provide training and evaluation services for private foster care agencies.[59]

The Children's Alliance of Kansas (http://www.childally.org) is a statewide association representing all of the private agencies that deliver foster care services. Member agencies work to coordinate services, programs and issues. This organization offers a variety of services and programs, including case management; training for foster and adoptive parents, state agency staff and local service providers; foster parent recruitment; advocacy; residential and emergency care and transition services.[60]

Funding Issues: The Kansas Department of Social and Rehabilitation Services' fiscal 2004 budget of $2 billion will be spent on administrative costs (7 percent), direct service delivery (10.6 percent) and direct assistance, grants and benefits (82.1 percent). Of the direct assistance grants and benefits expenditures, $184 million will be spent on children and family services.

Like many other states, Kansas has struggled with budget shortfalls and program cuts. The fiscal 2004 Social and Rehabilitative Services budget has had some funds restored by the governor. The department anticipates eliminating one out of every six central office positions and one out of every eight field office positions.[61]

The state department combines federal and state funds to offer a single, one-time fixed rate per child to foster care service providers. Researchers at the University of Kansas report that this approach has led to effective, integrated foster care programs. The prior state payment system was a fee-for-service model that provided no incentive for moving children into permanent homes. Under the current system, children who remain with agencies for long periods of time cost the agencies money, so an incentive is created to move children to permanent placement.[62]

Title IV-E Waivers: None.

Model Programs and Initiatives: Researchers at the Heartland Institute describe the privatization of foster care in Kansas as a great success. The state's performance-based contracts have been praised by these researchers for ending cycles of abuse and neglect that kept thousands of Kansas children lingering in foster care for years.[63]

Policy, Advocacy and/or Parental Issues: In February 2002, the Kansas Appleseed Center for Law and Justice released a study that accused the Department of Social and Rehabilitation Services of misusing $2.5 million in federal funds from the John Chafee Foster Care Independence Program. These funds, which were intended to help foster care teenagers make the transition to independence, instead were used to provide direct services to foster children under the age of 18, according to the report.[64] The Department of Social and Rehabilitation Services responded that it is examining this issue, but denied any wrongdoing.[65]

The December 2002 death of a child in foster care (nine-year-old Brian Edgar) resulted in public questioning of the state's privatized system. Brian's foster parents and babysitter were charged with suffocating him. A total of 37 children have died in foster care in the six years since the state system was privatized, but obviously there is no way to know what would have happened if the children had remained in state care.[66] Spokespersons for the state maintain that the privatized foster care system continues to serve children safely.[67]

Michigan

State Agency: Family Independence Agency

State Agency Web Site: http://www.michigan.gov/fia

Overview: The Family Independence Agency administers foster care as well as the state's other public assistance and welfare programs. The state office oversees more than 100 county-level family independence agencies that in turn provide child and family welfare services.[68]

Demographic Profile: The Michigan Family Independence Agency reports that it had identified 19,549 children as abused or neglected at the end of fiscal 2003. Of these, 17,342 (89 percent) were living in out-of-home care. This caseload includes 10,224 African American children (52 percent); 8,310 white children (42 percent); 692 multi-racial children (4 percent); and 188 American Indian children (less than 1 percent). The agency reports a substantial increase in kinship (extended family) care for foster children, from 3,365 in 1990 to 6,348 at the end of 2003.[69]

History: Child and family services in Michigan went through a federal review in September 2002. Michigan met the federal criteria for four of the standards measured (rate of recurrence of child maltreatment, maltreatment of children in foster care, foster care re-entry rates and percentage of finalized adoptions within 24 months of entry into foster care), and failed to meet two—the percentage of children reunited with their families and the percentage of children experiencing no more than two placements during their first 12 months in foster care.[70]

Funding Issues: Michigan's payment rates are based on the U.S. Department of Agriculture's estimated cost of raising a child. The Family Independence Agency reviews the rates annually and makes cost-of-living adjustments. Supplemental funds also are available for special-needs children.[71]

Title IV-E Waiver: Michigan has a Title IV-E managed care payment system waiver. The state has developed "wraparound" managed care contracts for children in foster care. The state pays a single case rate of $14,272 for each foster child, regardless of the amount of time over which services are provided. An additional bonus payment of $1,586 is available for each child that is adopted, reunited with his or her family, moved to an independent living situation or placed in a permanent foster care home. Four other states have similar waivers.[72]

Model Programs and Initiatives: The Michigan Family Independence Agency issues annual report cards for every public and private child placing agency in the state, based on factors including the number of children moving from one placement to another; the number of temporary court wards in out-of-home care for 0-11 months, 12-15 months, 15-24 months or more than 24 months, by age; average length of time from termination of parental rights until adoption; number of sibling groups split in placement; number of children placed outside of the county of jurisdiction; number of caseworkers per child; experience levels of state caseworkers; and percent of adoptions in the permanent foster care population.[73]

In 1984, Michigan established foster care review boards to review services and programs provided to foster children. The initiative is administered by the Michigan Supreme Court and staffed by citizen volunteers who serve on 30 local review boards throughout the state. These boards review local court and agency actions, services and programs for foster children.[74]

Michigan has implemented a pilot pay-for-performance project to reimburse private agencies for foster care services. The goals of the project are to reduce the time children spend in foster care and increase the number of permanent placements.[75]

Policy, Advocacy and/or Parental Issues: In September 2002, almost 40 percent of the Michigan Family Independence Agency staff accepted early retirement packages. Many of these positions were eliminated as part of the agency's transition to a greater use of technology; for example, any complaints about day care or nursing facilities now must be made online. Advocacy organizations have expressed concerns that the state's most vulnerable populations, including those in foster care, will suffer a decline in services as a result of this move.[76]

In December 2002, the *Detroit Free Press* reported that 302 foster children were missing. The *Free Press* reviewed the court files for these missing children and found that many of them could be located if someone actually made an effort to find them. The Family Independence Agency responded by saying that it is trying to track down these missing children.[77]

In May 2003, a Wayne County prosecutor filed criminal neglect charges against social workers and doctors in the state's foster care system over the beating deaths of two four-year-old boys in foster care. Advocates claim the state foster care system is poorly managed and places children at risk of further neglect and abuse. The prosecutor in the case had previously in-

vestigated a case in which a 15 year-old female died of malnutrition while in foster care.[78]

Minnesota

State Agency: Minnesota Department of Human Services

State Agency Web Site: http://www.dhs.state.mn.us

Overview: Minnesota's Department of Human Services administers health care, economic assistance and other human service programs for low income and disabled persons. Its Child Safety and Permanency Division administers emergency and transitional housing, family preservation services, child protection services, foster care and adoption programs.[79]

Minnesota children removed from their families by the Department of Human Services may be placed in foster care homes, group residential homes or institutional care facilities.[80] More than 5,100 licensed family foster homes provide services to foster children. The state department licenses relatives of children in foster care to provide services, and encourages the use of extended family caregivers.[81]

Minnesota operates a Social Services Information System that meets all federal standards for a Statewide Automated Child Welfare Information System. The system is used by caseworkers for intake, screening, investigations, placements and foster care licensing. Managers at the state level use the system for case management and oversight and to track performance indicators. The system also is used to generate management reports.[82]

Demographic Profile: In 2000, an estimated 8,530 Minnesota children were in foster care. This population was 52.5 percent white, 21.5 percent African American, 10.8 percent American Indian and 5.8 percent Hispanic.[83]

History: The Minnesota Department of Human Services reports that about 66 percent of the state's foster children in out-of-home placements are in family foster care.[84]

The state's children and family services programs were reviewed by the U.S. Department of Health and Human Services Administration for Children and Families and a report issued in August 2001. The state was rated as "in conformity" in the area of foster and adoptive parent licensing, recruitment and retention. The state's standards, including quality standards, for foster family homes and child care institutions were identified as an area of strength.[85]

Funding Issues: The Minnesota Department of Human Services reports that it gives foster parents $17 to $21 a day to care for a foster child, plus additional funds, if needed to address special needs. The state bases these rates on the U.S. Department of Agriculture's estimates of the costs to raise children to adulthood.[86]

Like other states, Minnesota has struggled with a state budget shortfall, estimated to be from $4.2 to $5.2 billion for the 2004-05 biennium. Spending cuts will affect services for children and families.[87] The state budget for 2004-05 was balanced in May 2003 using a combination of budget shifts, fees and cuts to services and programs, including a $1 billion cut to health and human services programs including foster care and adoption.[88]

Title IV-E Waivers: None.

Model Programs and Initiatives: The Annie E. Casey Foundation has ranked Minnesota first in the nation for the quality of its child welfare services.[89]

In September 2003, Minnesota received an $82,000 bonus from the U.S. Department of Health and Human Services for its efforts to increase the number of adoptions of foster children.[90]

Policy, Advocacy and/or Parental Issues: State budget cuts to address the 2004-05 deficit have created concerns among advocacy groups that families and children, and dis-

abled Minnesotans in particular, will bear the impact of the loss of state services.[91]

Tennessee

State Agency: Tennessee Department of Children's Services

State Agency Web Site: http://www.state.tn.us/youth

Overview: The Tennessee Department of Children's Services administers the state's foster care program. The department places foster children with relative caregivers, who must meet the same criteria and receive the same level of support as other caregivers; shared homes, which are run by private agencies approved by the state; foster homes for medically fragile children and emergency foster homes for children who need immediate shelter.[92]

The U.S. Department of Health and Human Services reports that the Tennessee foster care program does not comply with any of its seven outcome measures for children's safety, permanency and well-being. Of greatest concern is the lack of permanent placements for children in foster care; only 31 percent of children in cases reviewed by HHS had been placed in a permanent home. HHS also found that the department did not respond to child abuse reports in a timely manner in almost a third (29 percent) of the cases reviewed.[93]

Tennessee's automated child welfare information system, TN KIDS, has been implemented in several installments. The first supports the state agency's intake and referral activities. This system includes information on all foster children's status, demography, placement and goals. Substantial future enhancements are planned.[94]

Demographic Profile: According to the Children's Defense Fund, 10,144 Tennessee children were in foster care in January 2003.[95] The Casey Foundation estimates that the state's foster child population is 58 percent white, 39.2 percent African American, and 1.5 percent Hispanic.[96]

History: On May 10, 2000, local and national children's advocates, including private attorneys and Children's Rights Inc., filed a civil rights suit, *Brian A. v. Sundquist*, against the state of Tennessee, alleging that it was endangering thousands of foster children. Eight foster children were named as plaintiffs. The suit asked the district judge to order the governor to fix what was described as a "grossly mismanaged and overburdened child welfare system."[97]

This lawsuit provided numerous allegations of the state's failure to care for foster children, despite a series of audits, legislative hearings and local news investigations. Evidence gathered from public records indicated that some foster children remain in emergency shelters for as long as six months; others spend several years in foster care without adoption and that white foster children receive better treatment than African American foster children.[98]

In July 2001, a settlement in the *Brian A.* case mandated substantial changes in the state's foster care program. The reforms were to be overseen by an independent panel of child welfare experts and an external monitor. The settlement will be monitored until 2006.[99]

Funding issues: Like other states, Tennessee has faced budget shortfalls that have created challenges in serving children and families. In November 2003, Gov. Bredesen reported that a rise in the state's welfare rolls would greatly increase its budget challenges. Among proposed cuts are subsidies for kinship care, which may increase the number of children in state foster care.[100]

Title IV-E Waivers: None.

Model Programs and Initiatives: The TN KIDS data system has received an award from the National Association of State Information Officers. It was designed to create a single data system for children's welfare services in the state.[101]

In September 2003, Tennessee was among the 25 states that received a federal bonus

for increasing its number of adoptions of foster children. The state received a bonus of $1,148,000 as part of this initiative.[102]

Policy, Advocacy and/or Parental Issues: A November 2003 report by the court-appointed monitor in the *Brian A.* case indicates that the state is not making enough progress in complying with the settlement. The monitor reported that the state is in full compliance with only 24 out of 136 provisions of the settlement. Among other findings, the monitor stated that the state makes timely investigations of only 37 percent of the abuse or neglect reports it receives.[103]

On November 20, 2003, the plaintiffs in the original *Brian A.* lawsuit filed a motion charging the governor and commissioner of the Department of Children's Services with contempt of court for their failure to follow the terms of the settlement.[104]

Wisconsin

State Agency: Wisconsin Department of Health and Family Services

State Agency Web Site: http://www.dhfs.wisconsin.gov

Overview: The Wisconsin Department of Health and Family Services administers programs related to children and family services, disability and elder services, public health and health care financing.[105] Its Division of Children and Family Services administers programs and services in the areas of child welfare, child protective services, foster care and adoption, substance abuse, domestic violence, teen pregnancy and licensing of children's facilities. The division also oversees the Brighter Futures Initiative, a state-local partnership designed to ensure a better future for every child in the state.[106]

The Department of Health and Family Services reports that 84 percent of the foster children it placed in out-of-home care in 1996 were placed in family foster homes.[107] Statewide, about 5,100 families are registered as foster care providers.[108]

Demographic Profile: According to the Children's Defense Fund, 10,148 Wisconsin children were in foster care in January 2003.[109] The Casey Foundation estimates that the state's foster care population is 49.6 percent African American, 40.8 percent white, 5.1 percent Hispanic and 3.2 percent American Indian.[110]

The Department of Health and Family Services reports that more than 95 percent of the Wisconsin children in foster care have juvenile court-ordered placements. About half of these children return to their homes within six months. Almost 80 percent of the state's special-needs adoptions are by foster parents who want to provide a permanent home for their foster child.[111]

History: A 1993 lawsuit (*Jeanine B. et. al. v. Scott McCallum et. al.)* charged that the Milwaukee County foster care program did not comply with federal law. The state department took over the Milwaukee County foster care system in 1998, but additional charges were filed in 1999 and 2000, and the case became certified as a class action suit. A settlement negotiated in 2002 includes foster care provisions related to permanent homes, child safety and well-being, monitoring and enforcement.[112] The settlement was hailed by children's advocates as unique in that a government agency is being held accountable for producing specific outcomes for foster children, such as placement with permanent families.[113]

Funding Issues: Wisconsin has adopted a uniform monthly reimbursement rate for foster caregivers. Supplemental and/or exceptional payments may be made based on the needs of the individual child. The rate varies by age group, from $302 monthly for infants to four-year-olds to $391 monthly for 15- to 18-year-olds. The department also publishes guidelines for expenditures on food, clothing, housing and personal care, which are based on the cost of raising a child as calculated by the U.S. Department of Agriculture. Chil-

dren who come into foster care with little or no clothing may receive a clothing allowance ranging from $150 for infants to four-year-olds to $200 for 15- to 18-year-olds.[114]

The Department of Health and Family Services recently developed a new estimate of its funding needs for foster care and adoption assistance in fiscal 2004 and 2005. The new estimate is designed to fully fund the cost of special-needs foster care and adoption assistance, based on the department's projected caseloads for the coming biennium. No changes are proposed to eligibility or benefit levels. The rationale for additional funding is that the state has become more successful in finding adoptive parents for special-needs children (those considered hard to place due to factors such as physical or mental disabilities).[115]

Title IV-E Waivers: None.

Model Programs and Initiatives: In February 2003, *Time* magazine spotlighted the Children's Service Society of Wisconsin and Innovative Family Partnerships. These organizations worked with staff from the Milwaukee County Bureau and Wisconsin Department of Health and Family Services to pilot a program on shared family care, in which an entire family group receives services. These families are placed in a supervised setting, including around-the-clock monitoring for families in crisis. Preliminary results show this approach to be effective in reducing the need to separate children from their families.[116]

In September 2003, Wisconsin received $1,158,000 from the U.S. Department of Health and Human Services for its efforts to increase the number of foster children adopted into permanent homes.[117]

Policy, Advocacy and/or Parental Issues: A 2001 study by the Children's Research Center in Madison, Wis. concluded that the state's foster care system was not meeting minimum federal standards and placed foster children at risk. The study was funded by Children's Rights Inc. as part of the *Jeanine B.* lawsuit.[118]

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Appendix 3
Technical Recommendations Concerning Rate Setting

1. *DPRS should calculate separate rate components for direct care and for other cost centers such as administration, facility and other operating costs.*

Background

Until September 1, 2003, DPRS provided separate reimbursement rates for six "levels of care," or LOCs, reflecting increasingly difficult cases and more expensive treatment needs.

In fiscal 2004 and thereafter, this system was converted to one based on four service levels. LOCs 1 and 2 (the lowest levels in terms of resource intensity and cost) were combined to form a "Basic" level; LOC 3 was combined with the less-aggressive segment of LOC 4 to form "Moderate;" the more-aggressive segment of LOC 4 was combined with LOC 5 to form "Specialized;" and LOC 6 became "Intense."

DPRS, however, still calculates its reimbursement rates according to the previous system. The following discussion, therefore, refers to LOCs rather than service levels.

DPRS calculates benchmark daily reimbursement rates for residential care facilities and child placing agencies according to LOCs 1 through 6. Its rate-setting method involves three groups of costs:

- direct care staff compensation and certain direct care non-labor costs;
- other direct care non-labor, property, transportation, tax, net educational and net vocational costs; and
- administrative and foster family development costs.[1]

Direct care staff compensation and certain direct care non-labor costs: Because facilities often serve clients at different LOCs, some direct care costs, such as staff compensation, must be allocated across the different levels to determine the appropriate reimbursement rate. DPRS is required to perform time studies every other biennium to determine how to allocate these costs. For example, an on-staff counselor that works with children of levels three to six probably spends more time with LOC 6 children than those in LOC 3, and therefore more of the counselor's salary and benefits should be included in reimbursements for LOC 6. The time study determines how to allocate such costs across the different levels.

DPRS, however, still calculates its reimbursement rates according to the previous system.

Other direct care non-labor, property, transportation, tax, net educational and net vocational costs: Facility and other operating costs are simply divided by days of service and a uniform per diem amount is assigned across all levels of care. Direct care and facility and other operating costs then are summed by level of care.

Administrative and foster family development costs: Costs are calculated as percentages of total costs for the facility; these percentages are used as weights or factors to allocate administration costs. For example, if costs for LOC 6 are 50 percent of total direct care and facility costs, 50 percent of administrative costs are added to level six. Total costs are calculated as the sum of allocated costs by level of care for each facility.

To adjust for changes in costs between the historical cost reporting period and the prospective rate period, DPRS rules specify that a general inflation index, the federally prepared

Implicit Price Deflator-Personal Consumption Expenditures, be applied to the rates.

DPRS prescribes the following screening criteria for selecting cost reports to be included in rate calculations for residential services:

- Average occupancy rate is at least 50 percent (30 percent for emergency shelters).
- State placements represent at least 40 percent of days of service for LOCs 5 and 6.
- At least 30 percent of days of service must be delivered in a given LOC for a facility to be included in rate calculations for that level (LOCs 3 - 6).
- Total costs must be less than two standard deviations above or below the mean.[2]

In fiscal 2002 and 2003, DPRS was unable to adopt rates based fully upon its methodology due to funding shortfalls.

These criteria presumably are intended to limit the effect of extremely low occupancies on reimbursement rates and to ensure that those rates adequately reflect the costs of serving state-placed residents classified at appropriate levels of care.

The rates derived from this methodology, however, are subject to further adjustments based upon appropriations and "professional judgment."

In fiscal 2002 and 2003, DPRS was unable to adopt rates based fully upon its methodology due to funding shortfalls. For fiscal 2004 and 2005, at the direction of the Legislature, DPRS compressed its six levels of care to four service levels in an effort to save more than $22 million in the foster child system.[3]

As previously noted, DPRS continues to calculate rates based on the six LOCs; these levels then are weighted based on an estimate of the distribution of days of service (during a prior six-month period, allowing a reasonable time lag for completion) to clients with characteristics corresponding to the four new levels. In calculating rates, administration costs are reduced to stay within appropriations, focusing most of the effect on the lower levels and minimizing the impact on the higher levels (LOCs 5 and 6) due to "market demand" considerations—that is, to ensure client access to facilities.[4]

DPRS' rate-setting methodology differs from those used for nursing facilities and intermediate care facilities for the mentally retarded, both of which also offer 24-hour residential facilities.

Nursing Facilities

For nursing home reimbursements, HHSC uses case mix indexes (CMIs) based upon time studies. In developing the CMIs, measured periods of the time of key direct care staff were allocated to clients; the times were weighted to reflect the relative compensation of different types of direct care staff; and clients were grouped largely according to similar weighted staff times, with some consideration given to particular clinical issues. Direct care costs are adjusted for inflation and summed across all providers; the resulting grand mean is multiplied by a set of CMIs (standardized for the particular case mix during the cost reporting period under consideration) corresponding to the various care levels.[5]

The nursing facility methodology includes average costs for all providers in the rate calculation for all care levels, and the case mix allocation occurs at the end of the process. Rate categories were developed by grouping clients' resource usage, based on a time study.

Private ICFs-MR

In the case of private (non-state) intermediate care facilities for the mentally retarded, (ICFs-MR), the rate system includes five levels of need, each broken down by three facility sizes. Rates for the 15 payment categories are based on a direct care component model that reflects assumed staffing levels needed for each level of need and facility size; uniform wages for each of several staff types (with a factor for employee benefits); and a component for indirect costs based upon a percentage of direct care costs.[6]

Key distinctions of interest between the ICF-MR and foster care methodologies in-

clude the source of information used for making level-of-need distinctions (HHSC uses assumptions based upon consultation with industry, advocates and state representatives, while DPRS uses time studies); the development of ICF-MR rates based upon staffing assumptions versus foster care rates derived directly from statistics derived from cost reports; and HHSC's recognition of cost differences among different facility sizes.

DPRS' 24-hour residential child care methodology calculates rates based upon one statistic representing aggregate or total (allocated) costs for each level of care. It also bases the entire rate on an unweighted mean statistic, with providers whose costs are greater than or equal to two standard deviations above or below the initial mean excluded from the final calculation. Once costs are allocated to levels of care for each facility, no distinction is made between cost centers such as direct care, administration, facility or operating.

Other rate methodologies typically recognize such distinctions—at least the distinction between direct care and other costs—and calculate individual rate components corresponding to these cost centers. Under the latter approach, the resulting rates are less likely to be inflated by some providers' relatively high administration, facility, or operating expenses and individual components are clearly defined for purposes of designing incentives, funding and so forth.

ICF-MR rates consist of two basic components, direct care and indirect. The nursing facility rate method groups costs into four cost centers: direct care staff, other direct care, dietary and general and administrative. The rates for the direct care components are based on grand means, but the other two components are based on medians. In addition, nursing facility rates include a "use fee" component, based on appraised property values, to cover facility costs.

Recommendation

DPRS should calculate separate rate components for direct care and for other cost centers such as administration, facility and other operating costs, as do other long-term care methodologies.

Rates based on statistics representing each of several cost centers tend to limit the effect of extreme values in each, resulting in a more conservative measure of central tendency than does the current methodology.

Fiscal Impact

This recommendation could change rates for each service level. It would have no overall fiscal impact because the total appropriation amount is capped, and rates would continue to be adjusted to meet the appropriated level.

2. DPRS should use either medians or means, weighted by days of service, to calculate direct care rate components by level of care.

Background

Given the distribution of days of service and costs within LOCs, unweighted mean statistics tend to be higher than weighted medians and therefore tend to produce higher rates even when extreme outliers are excluded.

DPRS staff indicated that the choice of the unweighted mean statistic, rather than the alternative of a weighted mean or median, may reflect concern among providers and others who participated in developing this methodology that the sometimes-higher costs of small-scale providers would tend to be over-shadowed by the often-lower costs of larger providers.

If, however, the underlying concern is that rates must reflect higher costs of smaller-scale providers, paying higher rates to providers of all sizes may be an inefficient way of addressing that concern.

A more efficient way to address this issue is through separate rates by facility size, such as those used in the ICF-MR program. Although different facility size groups may be appropriate for these distinct programs, the underlying principle is the same. If staff-to-resident ratios vary significantly by size of operation, separate weighting factors may be appropriate for each level of care and for each bed-size category, a determination that would require another time study.

Of the different statistics that might be employed as cost benchmarks in calculating rates for any of these programs, the unweighted mean across providers, whether by level of care as in foster care or across all providers as in nursing facilities, tends to produce higher rates than alternatives such as a mean weighted by days of service or a median so weighted. Weighted medians tend to be the most conservative measure of central tendency.

Changes in this statistic from one reporting period to the next tend to reflect cost factors affecting a broad spectrum of providers. In other long-term care programs, the mean or median statistics used as cost benchmarks for rates are enhanced by a percentage adjustment to allow for additional variation in costs due to any number of factors. The percentage adjustment factor in residential programs such as nursing facilities and assisted living is 7 percent, while the factor applied to the median statistics in community care programs is 4.4 percent.[7] The factor appropriate for residential foster care may be determined to be something different based on any number of considerations deemed significant by policymakers.

The residential foster care method also differs from the approaches applied in other long-term care programs in that facilities are included in the rate calculation for a given LOC only if they deliver at least 30 percent of their days of service in that level. This excludes a large portion of facilities from rate calculations. In LOC 3 and 4, excluded facilities represent about a third of the residential days of service delivered, and in LOC 6, the figure is nearly 39 percent.

A brief examination of the distribution of service volume and costs among facilities delivering LOC 6 services as reported in the year 2000 cost report database illuminates some key issues. A total of 20 residential facilities included in the year 2000 database delivered some LOC 6 days of service. The LOC 6/Intensive rate benchmark derived from these data was based only on four facilities that delivered 61.3 percent of LOC 6 days, since LOC 6 days of service did not represent at least 30 percent of total days in any of the remaining 16 facilities.

The unweighted mean representing these four facilities and constituting the benchmark rate for 2004 under the current method is $179.22. The weighted median, by contrast, is $164.51, which also is the cost of the highest-volume provider. Moreover, the weighted median remains the same based on all 20 providers reporting LOC 6 services for the year 2000. This latter result is somewhat unique to LOC 6, which is characterized by a higher concentration of volume among a few facilities than is the case with other LOCs.

In 2000, the highest-volume provider delivered 26.4 percent of total LOC 6 days of service among the 20 providers in the database, and 43.1 percent of the days reported by the four facilities included in the benchmark rate calculation. The next highest-volume facility delivered 25 percent of the days and the other two delivered less than 20 percent each. As a result of the relative volume of the highest-volume provider and the distribution of costs and volume among the others, the weighted median rate benchmark in this case would cover the projected costs of providers delivering 69.2 percent of the LOC 6 days of service.

Although the unweighted mean LOC 6 rate benchmark was $179.22, a figure that would cover projected costs of providers delivering 73.5 percent of LOC 6 days of service, the DPRS Board adopted a Level 6/Intensive daily rate of $202. This action reportedly reflects

"market demand" factors—presumably the belief that this rate is necessary to ensure client access to facilities with costs significantly greater than $179.22. If the perceived issue is to ensure access to the two facilities delivering 11.1 and 15.3 percent of LOC 6 services at costs of $200.76 and $221.26, respectively, paying all providers $202 may not be the most cost-effective way to achieve this end.

For example, a basic LOC 6/Intensive rate might be determined at the weighted median of $164.51, with an additional provision in the rate method for premium payments to high-volume LOC 6 facilities with costs exceeding the basic rate. If high-volume facilities were defined as those delivering 10 percent or more of LOC 6 services, for instance, and the current $202 rate extended only to the two qualifying high-cost facilities, the annualized savings, based on the days of service in the year 2000 cost report database, would be slightly over $2 million (in funds from all sources).[8]

In the other LOCs, days of service are less concentrated among a few facilities, but costs still vary over a wide range within each level. This variation within levels, in conjunction with the recent reconfiguration of service/payment levels, suggests the need to examine the underlying sources of cost variation within and among levels before concluding that simple modifications, such as those outlined in the example above for Level 6/Intensive, are all that is needed. A more thorough analysis should focus not only on aggregate costs, but also should address the rationale for allocating administration, facility and other operating costs by level of service.

The ICF-MR rate methodology, for example, is based on a model in which such indirect costs vary more by facility size than by level of care. It is noteworthy that the Home and Community-Based Services program, which is the community care counterpart of ICF-MR, includes foster care rates by levels of need, developed through the same type of modeling procedure. Since the setting is a foster family home, however, facility size distinctions are not applicable.

Recommendations

A. DPRS should use either medians or means, weighted by days of service, to calculate the direct care rate components by level of care.

The State Auditor's Office recommended using a weighted rather than an unweighted mean in August 2003.[9] This would be partially consistent with the direct care components of the nursing facility rate calculation, which also produces differential rates by level of service. For costs other than direct care in nursing facilities, however, and for all costs in most other Texas long-term care programs, rate components are based on median statistics. In these cases, the mean or median statistic that is used as a cost benchmark for rates is enhanced by a percentage adjustment to allow for additional variation in costs due to any number of factors.

The factor appropriate for residential foster care may be consistent with the seven percent used for nursing facilities, or may be determined to be something different, based on any number of considerations deemed significant by policymakers.

B. DPRS should incorporate more provider cost report data in the rate calculation process.

DPRS should use the existing time and motion study and cost report data to adjust the cost allocation process so that it can incorporate providers that do not meet current rate calculation thresholds because of their proportion of days in each level. In evaluating the structure of the rate classes, DPRS should take into account not only levels of care, but other potential sources of cost variation such as facility size (at levels below 6/Intensive), and evaluate alternatives for screening facilities to be included in rate calculations for each level and adjusting for low usage of resources.

By incorporating more costs or more providers into the rate-setting method, DPRS could produce a more statistically sound calculation.

Fiscal Impact

This recommendation could change rates for each service level. It would have no overall fiscal impact because the total appropriation amount is capped, and rates would continue to be adjusted to meet the appropriated level.

3. DPRS should use an objective means to adjust rates to appropriation limits.

Background

Although much of DPRS' rate-setting method is objective, the final rates do not necessarily reflect the outcome of the rate calculation. DPRS uses the outcomes of the calculation and applies two layers of adjustments.

First, DPRS applies a process of "professional judgment."[10] This is a process whereby DPRS staff determines whether some rates should be adjusted by a higher percentage than others, based on their expert judgment of reimbursements needed by service level.

Then the rates are adjusted to meet appropriation requirements.

Recommendation

DPRS should use an objective means to adjust its rates to appropriation limits.

DPRS either should exclude the "professional judgment" process in favor of proportional adjustments, or more clearly specify criteria by which adjustments should be made by level of service.

Fiscal Impact

This recommendation could be implemented with existing resources.

4. DPRS should cap funds for administration and require recovery of funds expended above the cap.

Background

DPRS has not capped the amount of dollars providers can spend on non-direct service.

Instead, DPRS identifies 24-hour residential service providers with administrative costs exceeding 25 percent of total costs. Exceeding this threshold places providers at risk of receiving an on-site audit.

MHMR, by contrast, has capped expenditures on non-direct services by community centers at 10 percent.[11] While MHMR has not set this cap in its rules, it has included it in its contracts with the community centers.

Recommendation

DPRS should cap funds for administration and require recovery of funds expended above the cap.

It should be noted that this recommendation is for the recovery of administrative funds above a determined threshold, not for "unallowable costs." Under the current system, rates are prospective prices to be paid for services delivered. These prospective rates are based on historical expenditures identified by federal statute and state rule as "allowable costs." Any expenditures identified as "unallowable costs" are not considered in the de-

velopment of the prospective rate. Any unallowable costs are at the providers' expense, not the state's and therefore, there is nothing to recover.

Fiscal Impact

This recommendation would not result in a fiscal impact to DPRS. It would, however, direct more dollars into direct care.

Endnotes

1 40 Tex. Admin. Code §700.1802.

2 40 Tex. Admin. Code §700.1802.

3 Rider 21, Tex. H.B. 1, 78th Leg. R.S. (2003), Texas Department of Protective and Regulatory Services, p. II-110, states that the appropriation for foster care assumed $22,231,477 in savings "due to the redesign of the Foster Care Levels of Care (LOC) system to one based on services provided." Rider 21 expressed a legislative intent that DPRS work with the Health and Human Services Commission "to create a LOC rate system that merges certain of the current LOCs used in fiscal year 2003 to attain greater efficiencies in classifying of foster children and reduce costs." In addition, Rider 21 specified that the modified rate system was to be in effect no later than October 1, 2003.

4 Interview with staff, Texas Department of Protective and Regulatory Services, Austin, Texas, November 14, 2003.

5 1 Tex. Admin. Code §§355.306-355.307.

6 1 Tex. Admin. Code §355.456.

7 1 Tex. Admin. Code §§355.503, 355.505, 355.5902, 355.6907, 355.307; 40 Tex. Admin. Code §46.27.

8 1 Texas Department of Protective and Regulatory Services, Rate-Setting Database, Austin, Texas, 2003.

9 State Auditor's Office, "New Foster Care and Adoption Subsidy Rates Proposed by the Department of Protective and Regulatory Services," Austin, Texas, January 25, 2003.

10 Interview with staff, Texas Department of Protective and Regulatory Services, Austin, Texas, November 14, 2003.

11 Interview with staff, Texas Department of Mental Health and Mental Retardation, Austin, Texas, December 1, 2003.

Appendix 4
Comparison of Therapeutic Camp Standards

The standards for "primitive or wilderness" camps are far less strict than the standards for "permanent" camps and do not adequately protect children's health.

Excerpts from *DPRS' Consolidated Minimum Standards for Facilities Providing 24-Hour Care*, "Section VI, §7300 Additional Specialized Standards for Therapeutic Camps"

Permanent Camps vs. Wilderness or Primitive Camps

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
	The camp must be located to promote at all times the health, safety, and well-being of the persons it accommodates. *DPRS Rules, 40 TAC §720.572*	Primitive campsites shall be maintained and operated in a safe and healthful manner. *DPRS Rules, 40 TAC §720.573*
1. Housing Site	a. All camp sites must be well drained and free from depressions in which water may stand. Natural sinkholes, pools, swamps or other surface collectors of water within 200 feet of the camp's periphery must be either drained or filled to remove still surface water. Mosquito breeding must be prevented in those areas containing water that are not subject to draining or filling. b. Housing must not be near or subject to conditions that create, or are likely to create, offensive odors, flies, noise, traffic or any similar hazards. c. Grounds within the housing site must be free from debris, noxious plants [poison ivy, etc.], and uncontrolled weeds or brush. d. [The housing site shall provide] a space for recreation ... reasonably related to the size of the facility and the type of occupancy.	
2. Water Supply	When planning a drinking water supply system for a camp, the plans must be submitted to the Texas Department of Health [TDH] for advice and approval before construction. All water systems serving camps are to be constructed according to the Board of Health's current "Rules and Regulations for Public Water Systems" and maintained and operated according to the following minimum acceptable operating standards, [which are based upon state statutes, regulations and good operating practices]: a. A common drinking cup must not be used. b. The camp must be connected to an acceptable existing public water supply system, if possible...[*additional standards here*]	1. Drinking water used at primitive camps and on hikes and trips away from permanent campsites must be from a source known to be safe (free of coliform organisms) or must be rendered safe before used in a manner approved by the Texas Department of Health. An adequate supply of water, under pressure where possible, must be provided at the cooking area for handwashing, dishwashing, food preparation, drinking and so on.

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
3. Excreta and Liquid Waste Disposal	a. Adequate and safe sewerage facilities with flush toilets must be provided if water supply is available. Raw or treated liquid waste must not be discharged or allowed to accumulate on the ground surface. b. Where public sewer systems are available, all facilities for disposal of sewage or wastewater must be connected to it. c. Where public sewers are not available, a subsurface septic tank seepage system or other type of liquid waste treatment and disposal system must be provided. If a wastewater treatment plant is to be used and discharge is to occur, a waste control order must be secured from the Texas Water Quality Board. d. Where a water supply is not available, sanitary-type privies or portable toilets must be provided. These facilities must be constructed as required by [TDH]. Privies, if provided, must be constructed according to the standards set forth in TDH's "Texas Community Sanitation Handbook" and maintained to prevent access of flies and animals, fly breeding and contamination. e. All facilities provided for excreta and liquid waste disposal must be maintained and operated in a sanitary manner to eliminate possible health or pollution hazards.	2. Primitive campsites that are not provided with approved toilet facilities must have a separate toilet area designated for each sex at a minimum ratio of one toilet seat per 15 persons. Slit trenches or cat holes with a readily available supply of clean earth backfill or other disposal methods approved in writing by the [TDH] must be used for disposing of human excreta in these areas. Toilet areas must be located at least 150 feet from a stream, lake, or well and at least 75 feet from a campsite, tent or other sleeping or housing facility. 3. Solid wastes generated in primitive camps must be disposed of at an approved sanitary landfill or similar disposal facility. Where such facilities are not available, solid wastes must be disposed of daily by burial under at least two feet of compacted earth cover in a location that is not subject to inundation by flooding. Burning is not recommended.
4. Housing	a. Housing must be structurally sound, in good repair, and in sanitary condition and must protect the occupants against the elements. b Housing must have flooring constructed of rigid materials, smooth finished, readily cleanable and located to prevent the entrance of ground and surface water. c. Each habitable room must be adequately ventilated. d. Therapeutic camps must have an annual pressure test for all gas pipes performed by the local gas company or a licensed plumber.	
5. Screening	a. All outside openings must be protected with screening of 16 mesh or less. b. All screen doors shall be tight, in good repair and equipped with self-closing devices.	

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
6. Heating	a. All living quarters and service rooms must have properly installed, operable heating equipment capable of maintaining a temperature of at least 68 degrees Fahrenheit if during the period of normal occupancy the temperature in these quarters falls below 68 degrees Fahrenheit. b. Any stoves or other sources of heat that use combustible fuel must be installed and vented to prevent fire hazards and a dangerous concentration of gases. No portable heaters other than those operated by electricity may be used. If a solid or liquid fuel stove is used in a room with wooden or other combustible flooring, a concrete slab, insulated metal sheet or other fireproof materials must be on the floor under each stove and must extend at least 18 inches beyond the perimeter of the base of the stove. c. Any wall or ceiling within 18 inches of a solid or liquid fuel stove or a stovepipe must be made of fireproof material. A vented metal collar must be installed around a stovepipe or vent passing through a wall, ceiling, floor or roof. The vent or chimney must extend above the peak of the roof. d. When a heating system has automatic controls, the controls must be of the type that cut off the fuel supply when the flame or ignition fails or is interrupted, or whenever a predetermined safe temperature or pressure is exceeded. All steam and hot water systems must be provided with safety devices arranged to prevent hazardous pressures and excessive temperatures. e. All heating equipment must be maintained and operated in a safe manner to eliminate possibilities of fire.	
7. Electricity and Lighting	a. All housing sites must be provided with electric services when available. b. When available, each habitable room—and all common use rooms and areas such as laundry rooms, toilets, privies, hallways and stairways—must have adequate ceiling or wall-type light fixtures. At least one wall-type electrical convenience outlet must be installed in each individual living room. c. When available, adequate lighting must be provided for the yard and pathways to common-use facilities. d. All wiring and lighting fixtures must be installed and maintained in a safe condition.	

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
8. Toilet Facilities	a. Toilets must be constructed, located and maintained to prevent any nuisance or public health hazard. b. Privies must be located at least 150 feet from a stream, lake or well; and at least 75 feet from a sleeping or housing facility. c. The number of water closets or privy seats for each sex must be no fewer than one unit for each 15 occupants, with a minimum of one unit for each sex in common-use facilities. d. Separate toilet accommodations for men and women must be provided. If toilet facilities for men and women are in the same building, they must be separated by a solid wall from floor to ceiling. Toilets must be distinctly marked "Men" and "Women." e. Urinals, constructed of nonabsorbent materials, may be substituted for men's toilet seats on basis of one urinal or 24 inches of trough-type urinal for one toilet seat up to a maximum of one-third of the required toilet seats. The wall and floor space to a point of one foot in front of the urinal lip and four feet above the front and at least one foot to each side of the urinal must be faced with nonabsorbent material. Privy structures and pits must be fly proof. Privy pits must have adequate capacity for the required seats. f. Common-use toilet facilities and privies must be well-lighted and ventilated and kept clean and sanitary. g. An adequate supply of toilet paper shall be provided.	2. Primitive campsites that are not provided with approved toilet facilities must have a separate toilet area designated for each sex at a minimum ratio of one toilet seat per 15 persons. Slit trenches or cat holes with a readily available supply of clean earth backfill or other disposal methods approved in writing by the [TDH] must be used for disposing of human excreta in these areas. Toilet areas must be located at least 150 feet from a stream, lake or well and at least 75 feet from a campsite, tent or other sleeping or housing facility. 3. Solid wastes generated in primitive camps must be disposed of at an approved sanitary landfill or similar disposal facility. Where such facilities are not available, solid wastes must be disposed of daily by burial under at least two feet of compacted earth cover in a location that is not subject to inundation by flooding. Burning is not recommended.
9. Washrooms, Bathrooms, and Laundry Rooms	a. Bathing and hand washing facilities, supplied with hot and cold water under pressure, must be provided for all occupants to use. The facilities must be clean and sanitary and maintained in good repair. b. There must be a minimum of one showerhead per 15 persons. Showerheads must be spaced at least three feet apart, with a minimum of nine square feet of floor space per unit. Adequate dry dressing space must be provided in common-use facilities. Shower floors must be constructed of nonabsorbent, nonskid materials, and sloped to properly constructed floor drains. Separate shower facilities must be provided for each sex. When common-use shower facilities for both sexes are in the same building, they must be separated by a solid nonabsorbent wall extending from the floor to ceiling or roof, and must be plainly designated "Men" and "Women." c. Lavatories or equivalent units shall be provided in a ratio of one per 15 persons. d. If laundry service is not provided, laundry facilities supplied with hot and cold water under pressure must be provided for all occupants to use. Laundry trays or tubs must be provided in the ratio of one per 25 persons. Mechanical washers may be provided in the ratio of one per 50 persons in lieu of laundry trays, although a minimum of one laundry tray per 100 persons must be provided in addition to the mechanical washers.	

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
10. Swimming Pools	New swimming pools shall be constructed in accordance with Texas Department of Health design standards. All pools must be maintained and operated are required by local regulations and the standards of the [TDH] for swimming pools. [*See Appendix II, Statutory References.*] a. There must be one unit of water safety equipment for each 2,000 square feet of water surface area. b. The outdoor swimming pool must be enclosed by a fence. All entrances and exits to outdoor pools must be closed and locked when not in use. Machinery rooms must be locked to prevent children from entering.	
11. Sleeping Facilities	a. Bedding provided by the operator must be clean and sanitary. All bedding must be laundered or otherwise sanitized between assignment to different campers. b. Linens must be changed as often as required for cleanliness and sanitation, but no less frequently than once a week. c. Bedwetters must have their linens changed whenever they are wet. d. Clean mattresses and mattress covers must be provided. e. Adequate personal storage area must be available for each person to separate his [or her] clothing from others' personal belongings. f. Boys and girls must not share the same sleeping unit. g. The operator must ensure that a separate bed, bunk or cot is available for each person. Double-deck beds are permissible, but triple-deck beds are prohibited. Beds must be spaced to provide a walk space on at least one side and one end of each bed.	

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
12. Food Sanitation	a. Food must be from approved sources and must be properly identified. b Milk products must be pasteurized. c. Food must be protected from contamination. d. Thermometers must be placed in refrigeration facilities. e. Potentially hazardous foods must be stored at proper temperatures. (1) Refrigerated food must be stored at 45 degrees Fahrenheit or below. (2) Frozen food must be stored at 0 degrees Fahrenheit or below. (3) Hot foods must be held at 140 degrees Fahrenheit or above. f. The handling of food must be minimized through the use of utensils. g. Fruits and vegetables must be properly washed before use. h. Food and food containers must be covered and stored off the floor and on clean surfaces. Refrigerated food must also be covered. i. Sugar must be served in closed dispensers or packaged. j. Poisonous and toxic materials must be properly identified, stored separately from food and properly used. Poisonous polishes must not be used on eating and cooking utensils. k. Persons with wounds or communicable diseases are prohibited from handling food. l. Food handlers must practice good hygiene. m. Food handling equipment must be properly designed, installed and maintained. n. Tableware and kitchenware must be clean to the sight and touch. o. Eating and cooking ware must be washed and sanitized according to the "State Sterilization Law." When using the chlorine method of sanitizing, a three-compartment vat is required. p. Food contact surfaces must be clean. q. All eating and cooking ware must be properly stored. Single-service articles must be properly stored, handled and used only once. r. Toilet facilities for the kitchen area must be properly equipped and maintained. s. Flies, rats, roaches and other pests must be controlled. t. Floors, walls and ceilings must be kept clean and in good repair. u. Adequate lighting must be provided and properly protected from breakage. v. The kitchen area and cooking equipment must be properly vented. w. Pets are not allowed in the food storage, preparation or dining area.	4. All food and drink must be of safe quality and stored to prevent spoilage. Only the foods that can be maintained in a wholesome condition with the equipment available must be used at primitive camps. Perishable foods must be refrigerated where possible. Where ice and ice chests are used, adequate ice must be provided; meats and other highly perishable foods must not be stored over 24 hours; ice chests must be drained to prevent accumulation of water from melted ice. 5. Hot water and detergent must be used to wash all food utensils after each meal at primitive campsites. Where group dishwashing is practiced, all utensils shall be immersed for at least two minutes in a lukewarm chlorine bath containing at least 50 ppm of available chlorine at all times. Where chlorine is used, a three-compartment vat or three containers are required for washing, rinsing and immersing. 6. No dish, receptacle or utensil used in handling food [may] be used or kept for use if chipped, cracked, broken, damaged or constructed so as to prevent proper cleaning and sanitizing. 7. Disposable or single-use dishes, receptacles or utensils used in handling food must be discarded after one use. 8. Eating utensils must not be stored with foods [or] other materials [or] substances, and must be stored in clean, dry containers. 9. Persons who handle food and/or eating utensils for the group must maintain personal cleanliness, must keep hands clean at all times, and must thoroughly wash the hands with soap and water after each visit to the toilet. They must be free of local infection commonly transmitted through the handling of food or drink and free of communicable disease. 10. Food must be stored in clean and dry containers that provide protection from insects, rodents and wildlife. Hazardous substances and medicines shall not be stored in containers with food.

	7310 Permanent Camps	7320 Primitive or Wilderness Camps
13. Garbage and Other Refuse	a. Durable, clean containers of adequate size and tight-fitting lids must be conveniently located to each housing unit for storing garbage and other refuse. When mechanical equipment is available, bulk-type containers may be used. When containers of 32-gallon capacity are used, a minimum ratio of one container per 15 persons is required. b. Provisions must be made for collecting refuse at least twice a week, or more often if necessary. The disposal of refuse, which includes garbage, must be in accordance with requirements of the Texas Department of Health. c. Storage facilities and areas must be maintained in a sanitary condition.	
14. Insect and Rodent Control	a. A vector control program must be maintained to ensure effective control of all insects and rodents in the buildings and on the premises. b. If chemical control is needed to supplement good sanitation practices, proper pesticides must be used in strict accordance with label instructions.	
15. Farm and Domestic Animals	a. Horses and other animals maintained in any camp must be quartered at a reasonable distance from any sleeping, living, eating or food preparation area. b. Stables and corrals must be located to prevent contaminating any water supply. Manure must be removed from stalls and corrals as often as necessary to prevent a fly problem. c. Horses, dogs or other domestic animals or pets must not be permitted on a bathing beach or in the water in the area used for waterfront activities. d. All dogs, cats and other warm-blooded pets owned or supervised by an occupant of any camp must be currently vaccinated against rabies in compliance with Texas law. (1) Written records must be kept on the type of vaccinations and the date of vaccinations. (2) The premises must be kept free of stray domestic animals. e. Dogs and other small pets and their quarters must be kept clean and free of ectoparasites. Pens must be cleaned daily, but not less than each 24 hours, and droppings properly disposed of.	

Fiscal Impact Tables

Increased Federal Funds to be Directed into Direct Care

Chapter	Page	Issue Name	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008	Change in FTEs 2008
2	37	Contract for quality foster care.	-	Increase CBE	Increase CBE	Increase CBE	Increase CBE	0
3	129	Pursue Medicaid funding for rehabilitative services delivered to foster children in RTCs.	-	$10,100,000	$10,100,000	$10,100,000	$10,100,000	0
3	131	Pursue more federal Title IV-E funding for preplacement services.	-	$7,000,000	$7,000,000	$7,000,000	$7,000,000	0
3	134	Expedite the delivery of foster children's Medicaid information to caregivers.*	-	$2,100,000	$2,100,000	$2,100,000	$2,100,000	0
3	136	Provide foster care contractors with assistance and training to help them claim Medicaid reimbursement for foster care services.*	-	$2,100,000	$2,100,000	$2,100,000	$2,100,000	0
3	143	Include mandatory participation by charter schools in the School Health and Related Services program.*	-	Increase CBE	Increase CBE	Increase CBE	Increase CBE	0

Fiscal Impact Table

Chapter	Page	Issue Name	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008	Change in FTEs 2008
5	212	Improve the assessment and services provided to foster children who are medically fragile.	-	Increase CBE	Increase CBE	Increase CBE	Increase CBE	0
5	217	Improve the assessment and services provided to foster children with mental retardation.	-	Increase CBE	Increase CBE	Increase CBE	Increase CBE	0
6	236	Improve the transitional services offered to foster children who "age out" of the foster care system.	-	Increase CBE	Increase CBE	Increase CBE	Increase CBE	0
Total Increase in Federal Funds for Direct Care			**-**	**$21,300,000**	**$21,300,000**	**$21,300,000**	**$21,300,000**	**-**

* Reimbursed directly to medicaid provider.

Saved Funds within DPRS to be Redirected into System Oversight

Chapter	Page	Issue Name	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008	Change in FTEs 2008
2	24	Eliminate the inefficient dual foster care system.	-	-	$17,235,000	$34,469,000	$51,704,000	-905
4	180	Improve contracting practices to safeguard the state's responsibilities to foster children and Texas taxpayers.	-	$1,340,000	$1,340,000	$1,340,000	$1,340,000	0
5	230	Improve efforts to find missing foster children.	(Cost CBE)	(Cost CBE)	(Cost CBE)	(Cost CBE)	(Cost CBE)	0
Total Redirected into System Oversight			**$0**	**$1,340,000**	**$18,575,000**	**$35,809,000**	**$53,044,000**	**-905**

NOTE: CBE - Could not be estimated.

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