Texas CHIP Coalition
Meeting Minutes

June 17, 2016

Present:	Laura Guerra-Cardus, CDF Adriana Kohler, Texans Care for Children Andrea Meza, RAICES Lou Seyler, Social Worker, volunteer, RAICES Jenny Hixon, Texans Care for Children Mary Allen, TACHC Olga Rodriguez, TACHC Clayton Travis, TPS Will Francis, NASW Leah Gonzalez, Healthy Texas Futures Kathy Eckstein, CHAT Anne Dunkelberg, CPPP Melissa McChesney, CPPP Rachel Cooper, CPPP
On the phone:	Greg Hansch, NAMI Sister J.T. Dwyer, Daughters of Charity Betsy Coats, Maxims Claudia Calderon, Texas Children's Health Plan TDA Johnna Carlton, Texas Children's Hospital Chris Yanas, Methodist Healthcare Ministries Monica Montez, Central Health Summer Stringer, Feeding Texas
Chair:	Laura Guerra-Cardus, CDF-TX
Minutes Scribe:	Julia Von Alexander, Center for Public Policy Priorities
Next meeting:	June 17, 2016

I. Health Care Access for Pregnant Women and Children in Detention Centers *(Laura Guerra-Cardus, CDF-TX, Jenny Hixon, Texans Care, Lou Seyler & Andrea Meza, RAICES Equal Justice Works)*

- Some CHIP coalition members working on this issue for a while. Concerning reports from pediatricians (NASW, TPS, CDF) showing children were suffering physical and mental health issues.
- Texas Conference of Bishops testified at an injunction challenging the state agency's authority to license these detention centers as childcare facilities.
- Andrea Meza- visits detention centers to provide legal services to the mothers and their children. Karnes has been licensed as a childcare facility (licensed before lawsuit). Dilley has a license under litigation (temporary injunction). If judge finds state agency can't do it, would remove Karnes too.
- RAICES includes advocacy for other issues besides legal issues. Maintain a temporary shelter that receives women who have been released.

- Families- from northern triangle of Central America, fleeing violence in home countries. 64,505 families in removal proceedings since January. Similar number of unaccompanied children.
- Family detention practice stopped in 2009, but recently began again. Converted Karnes into a center for mothers and children. Built Dilley specifically for mothers & children. Run by private prison companies.
- Immigrants asking for protection, by law must be allowed in. Wait for or seek out border patrol agents. Holding cells at the border- "ice boxes", bad conditions stay 1-4 nights. All within homeland security, don't know how they make decisions. Might be released straight from "ice box", others go to "dog kennel". Then may be released or go to detention center.
- Lots of health problems and when mothers take their children to the medical facilities told that they must come back or make an appointment. But the medical director claims that is 24/7 walk-in and assisted in timely manner. Also, often mothers and children are told to drink more water regardless of the health issue.
- Breastfeeding is hard. Had forced, unannounced, and unexplained vaccinations. All given adult dose of hepatitis vaccination. There are kids with pre-existing health issues (e.g. epilepsy, severe UTIs) there.
- Clayton T.- medical professionals' qualifications? Don't know, repeated information requests. Only information from mothers and whistleblower. Don't even know the number of healthcare providers.
- Woman with renal failure - took legal intervention to get her out, and she had not gotten adequate care. No gynecologist on site.
- Most released from detention within 2-3 weeks to family members throughout the U.S. Wait time for hearing on asylum could be months or years. Leave with untreated medical and mental health issues to metro areas in Texas. Ineligible for ACA, and government funded cash benefits can cause issues with immigration proceedings/application.
- Jenny H- surprised by lack of data collection. Baseline issue is that need transparency with data collection. Need to make informed decisions and recommendations. Currently just anecdotal.
- Lou S.- mental health professional, evaluated mothers and seeing PTSD/adjustment disorders due to the violence they have witnessed/experienced (fleeing threats of violence/rape by gang members). Children coping with mothers who have these disorders. Lack of mental health providers there, not getting help. Coming because there is a threat against their life or their children's life.
- Laura G.- U.S. has had refugees coming to this country for a long time. Children are being harmed in these facilities. Dean of UT School of Social Work put out a good report- Interviewed 20 families including the children. Kids reverting to infantile states, older kids were listless/suicidal thoughts. These periods cause lifelong issues for these kids. Why CDF-TX is involved. Report from American Academy of Pediatricians is also good and says this is not ok for children.
- Karnes/Dilley are only mothers with children. Unaccompanied minors not with Department of Homeland Security, with Office of Refugee Settlement instead. Will F.- Investigations and staff aren't trained to deal with CPS type cases. Cite as infraction on minimum standards, even though is an abuse/neglect problem. No resources to really do anything about the complaints.
- Lou S.- some mothers/children are "removed" (sent home) from the U.S. and returned to the violence/threats. Through Homeland Security.
- Jenny H.-Not fleeing for economic reasons. Human rights crisis. Lumped into larger immigration debate. Far worse consequences than any declared war in this area.
- Sister JT- stories heard today please spread that word to people you know.
- If you have any questions, feel free to contact the presenters.

II. Updates & Discussion on Public Forums & Meetings *(Clayton Travis, TPS)*

- SB 760 public forum- ways to strengthen Medicaid managed care provider networks. Public input on HHSC proposals on network adequacy standards changes. Documents online? Here.
- All presentations and recommendations from HHSC are **here.** September rule for comment
- Network adequacy standards are better. Tailoring time (time is new)/distance standards/appointment availability by provider type.
- 3 tiers (each with 3 different services areas based on geography= major metro, micro, rural): 1. PCP 2. Therapy 3. Specialty care (behavioral health, ob-gyn, dentist)
    - Unclear on public transportation. We can comment on this.
    - TPS- behavioral health, ob-gyn- should probably be in tier 2.
    - Will F.- asked at meeting: why didn't just replicate Medicare? They had no answer. Might be a good recommendation to make. Medicare is in 5 geographic standards. One managed care plan- prefers using Medicare standards.
    - New standards for dentists and behavioral services
- Provider access for long term services/supports
    - Clayton-Attendant services network adequacy standards? Anne-think so, but they should say it directly that is attendants. Never any standards around this before.
- Telemedicine-had to look at CMS rule.
    - Questions on if telemedicine access addresses network adequacy.
- Publish MCO provider info on HHSC website.
- Provider directory
    - Secret shopper calls.
    - Standard template for provider directory.
    - Include MCOs phone number for service coordination/finding a provider/making an appointment in the provider directory.
    - Whether accepting new patients or not?
    - Where to find online directories.
- Expedited credentialing (joining a practice that is already credentialed and enrolled in Medicaid. Can start billing before credentialing process is complete.)
    - Some providers already have this ability. Expanding to dentists, nursing facilities, social workers
        - Talk on including other mental health professionals.
    - 1 page FAQ outlining the process
    - Hope to get a box to check that want it expedited on credentialing forms.
- Kathy E.- at STAR Kids advisory said will allow out of area providers to be in-network. This is really helpful. Clayton T- difference between that and 1 child agreement? Better for health plan? Olga R. Simpler. And a lot easier for patient perspective. Clayton T.-Willingness of providers? Olga R- hard.
- Stakeholder hearing July 26th (agenda **here**)- catch all. Biannual meeting to go over everything managed care. Title in agenda. Highlight upcoming contractual changes to MCO contracts. Not really available for comment, but next time around will be able to provide comment on the contract changes.

IV. Report on Florida's Health Care Quality Performance for Children in Medicaid and CHIP *(Anne Dunkelberg, CPPP & Adriana Kohler, Texans Care)*

- Georgetown CCF posted a **report** on "how is Florida's Medicaid Managed Care Working for Children". Includes info from the Child Core Set.
- CCF- asked if anyone wants to work with them on a report on Texas. FL had funding from local philanthropies to do a survey of physicians. Who is interested?
- Adriana K.- Medicaid and CHIP must report measures. Long complex report with TX data in it but is hard to get through. Would be nice to see how we measure up. Includes developmental screenings, well child checks, etc.
- Any ideas on who you would like to join the report? Rice University's healthcare policy center and Texans Children's Center for Policy might be interested. Funding would be a separate issue.

V. Update on Name Change Vote Outcome *(Clayton Travis, TPS)*

- Officially the Children's Health Coverage Coalition.
- Voted last meeting, and opened it up through email.
- Need to do a branding campaign, starting now. Volunteers to join a workgroup on branding. Laura G, Melissa M, Peter Clark, Kathy E, and Julia.
- Send ideas on what to change.

VI. Legislative Agenda for Upcoming Session *(Laura Guerra-Cardus, CDF-TX)*

- Working group for legislative agenda. Categories last year were eligibility, workforce/provider networks, catch-all (against mini cuts all over Medicaid program), healthy moms/babies, and maximizing opportunities to connect whole families.
- March of Dimes priority- women in CHIP are automatically enrolled into Healthy Texas Women. Like Medicaid moms are now.
- Volunteers to look at last year's agenda- what keep and what add? Time next month to talk through and present ideas to the group. Involved in past CPPP, Texas impact, TACHC, TMA, TPS, CHAT, provider groups, MoD, Texans Care, CDF-TX (liaison to CTN). Will cc steering committee.
- Anne-Need to move to something much narrower and need a commitment from a minimum number of coalition members. More focused this next time.

General Announcements-

- 5 groups in TX were awarded Connecting Kids to Coverage funding. CDF-TX got it to work in East TX and Rio Grande Valley. Others include: Gateway to Care, The Community Council of Greater Dallas (CCGD), Lone Star Legal Aid (LSLA), and Bexar County Hospital District (doing business as University Health System.
    - Clayton T.-let these groups know that any barriers identified, bring the coalition. CHIP is a good avenue to complain.
- Preferred dates for legislative briefing in legislative conference center? End of Jan. on Tuesday-Thursday and November Tuesday-Thursday. Anne to check on it.
- Closing the coverage gap advocacy day- March 7, 2017. Partnering with NASW. Also, white coat day (have done in past years). 1000+ individuals. Hope you will participate through funding or attending.

VII. OTA Meeting & Update from HHSC Office of Social Services, Policy Strategy, Analysis, and Development Division
OSS and the Office of the Ombudsman

- **See slides.**

Office of the Ombudsman (Paige Marsala, HHSC)

- Complaints are a smaller percentage of their contacts.
- Most complaints in Medicaid. On average ~25% of complaints substantiated.
- Clayton T. – good level of substantiated complaints? Paige M.- Consider complaint as any expression of dissatisfaction. Could be about a barrier or delay.
- Clayton T. -Is there a goal to bring down substantiated complaints? Paige M.- Have managed care support network. Addressing issues there. There will always be complaints. Communicate substantial problems to leadership, often working on addressing problem trends. Major issues (delivery of services, application for programs)- will tackle as soon as hear of them. Not sure that there is a major issue that is affecting the complaints showed. But tends to be around 20% in other states too.
- Laura G- substantiated rate for applications denied within CHIP? Don't have it here, will follow up.
- Rachel C.-Audits to check for correct processing for TANF and other cases? Have quality assurance and HHSC has its own QC/QA process. Will follow up.
- Laura G.- On Medicaid how often do clients call because their application was denied? Likely within top 10.
- Sister J.T. could you also show % of cases wrongly denied on TANF/SNAP/Medicaid? Yes, will follow up.
- Tina Pham- Foster care ombudsman- 5/2/16 opened the foster care help line. Toll free line- received 45 calls. 14 from the youth. Purpose is for the **youth to call**. Others were teachers, attorneys, foster care parents, birth parents. Referred non-youth calls to DFPS. Foster care youth complaints- need documents (id, birth cert), haven't seen caseworker, visitation arrangements. Have closed 4 cases.
- When you refer the case do you consider it closed or follow up with those agencies? Required to follow through from beginning to end that the youth get what they need. Non-youth just do a referral and get outcome from that agency.
- How long to work to close a case? New program, still testing the water.
- Child problem with STAR Health- should they reach out to foster care youth line? Can reach out to foster care ombudsman, perhaps better than OMCAT in case there is anything affecting them outside of the health care issues. Number hasn't been published broadly, reaching out through seminars/word of mouth, updating the websites. CASA is helping to spread it to youth/facilities. Required to have posting with information about the ombudsman at foster care facilities. Youth are referred to them.
- OMCAT updates- community liaison very busy. Focused on children with disabilities in ISDs around state, family orgs for children w/ disabilities. Going to some conferences this summer to spread the word (NASW, nursing, aging)
- Rick Castillo- managed care support network from SB760. Narrowed scope to 1. Access to care 2. Delivery of care 3. Resolving issues that prevent enrollment of eligible people in managed care HHSC programs that is Medicaid/CHIP (Choosing plan or enrollment? Any type of eligibility issues).
- Have had a few meetings with HHSC agencies (any that work on managed care), ARDCs, Area Agency on Aging Centers, etc. Nearly 30 attendees. Monthly meetings for now.
- TX legal services center already offers Medicare training. Looked at their modules and provided feedback to make a customized Medicaid training for dual eligible clients.
- CHIP program parent- refer to OMCAT? Yes. If ever unsure, feel free to contact anyone of them.
- Adriana K.- could the managed care support network meetings be open to the public/for advocates? Anne- Intention is to create internal groups. Paige- Rick attends all of the stakeholder meetings on Medicaid.

HHSC Office of Social Services Introductions and Transitions (Interim Deputy Executive Commissioner of Social Services Wayne Salter) Christina Hoppe & Kate Volti

- Introducing the new DEC. Working during transformation and is taking over Stephanie Muth's role. Before he came to Texas, worked 19 years in the field in Florida.
- Things we worked with on Kate Hendrix are transitioning to Valerie Eubert.

Presumptive Eligibility (Kate Volti)

- Not many changes since last overview. Not a high volume of determinations. (see slide)

Community Partner Program Update (Kate Volti)

- Focused on trying to better support partners to come up with plans, training, documents, etc.
- Using partners as consultants to guide the support provided. Would meet over the phone quarterly.
- Trying to do 30 site visits/year. Leveraging regional community relations staff.
- 200 responses so far to community partner survey. More to come next time on program rules. Improvements to yourtexasbenefits.com-working to inform partners
- Looking to recruit active partners. How many are active? Most are pretty active. What do you mean by active? That they have been in the program have for at least 2 years.
- Volume of applications from CPP? Has it plateaued? In future reports will provide, as well as types of partners. Shifted from recruiting to trying to keep partners in the program, and to make it worthwhile.
- Laura G.- It would be helpful if could give individual data on if their clients were denied. Allow outreach assistants to provide additional assistance to clients. Can go back and see if the client got coverage or if it is pending. (Sister J.T agrees that this would really improve partner satisfaction.)
- Kate V.- have heard that before. Most partners don't have the level of authorization that they would need to do that. Would have to look at major systems changes. Would need a lot of HHSC oversight/monitoring. Could explore a pilot.
- Laura G.- could even have another level of client consent for worker or organization.
- Olga R.- Initially allowed partners with a high volume of applications to see if their clients were denied. Client already has to give consent for everything. Could do it with partners who have been in the system for a long time.
- Kate V.- newer team, will have a conversation about this and report the progress.

Healthy Texas Women (Christina Hoppe)

- Eligibility that will be updated. Age is changing, currently 18-44, July 1st will be 15-44. 15-17 will need a parent/guardian to sign the application. Income limit is increasing to 200% FPL. Also, sterile women will be able to get coverage on July 1st.
- Texas Women's Program is now Healthy Texas Women program, same goal.
- Coordinating enrollment with pregnant women's Medicaid. Also, will be referred to the Marketplace.
- Melissa M.-Problem that married minors are not found eligible due to TIERS. Even with parental consent, not eligible to be in the program. Concerned that policy is driven by systems constraints. Same thing happened with children have CHIP can't have Health Texas Women too.
- Wayne S.- Will go back and look at it. Policy drives and systems support.
- Issue: 2 federal programs, TIERS will kick it out, even though Healthy Texas Women isn't a federal program. CHIP doesn't cover contraceptive coverage, so how do you get these children that coverage?

Telephonic Signature for Applicants (Christina Hoppe)

- Update in August, can sign application over the phone. Can also sign to recognize authorized representative over the phone.
- Rachel C.- If someone calls 2-1-1, do an interview call back for SNAP. Can they then sign? No.
- Wayne S.- Not taking the option to do telephonic signatures for SNAP, due to other implications. Many people on SNAP and if they all decide to use that option 2-1-1 would be flooded.
- Telephonic signatures are a federal requirement for Medicaid and CHIP from ACA, but not for SNAP.

OSS Rule Updates (*Christina Hoppe*)

- 3 proposed rules from last session: SNAP/drug offense; school based savings accounts; same sex marriage.
- 2 groups of proposed rules around aligning rules on ACA and 1-time TANF for caretaker adult with current process.
- Recommended for approval at the last meeting.

Babies in CPS custody?

- Following up on that.

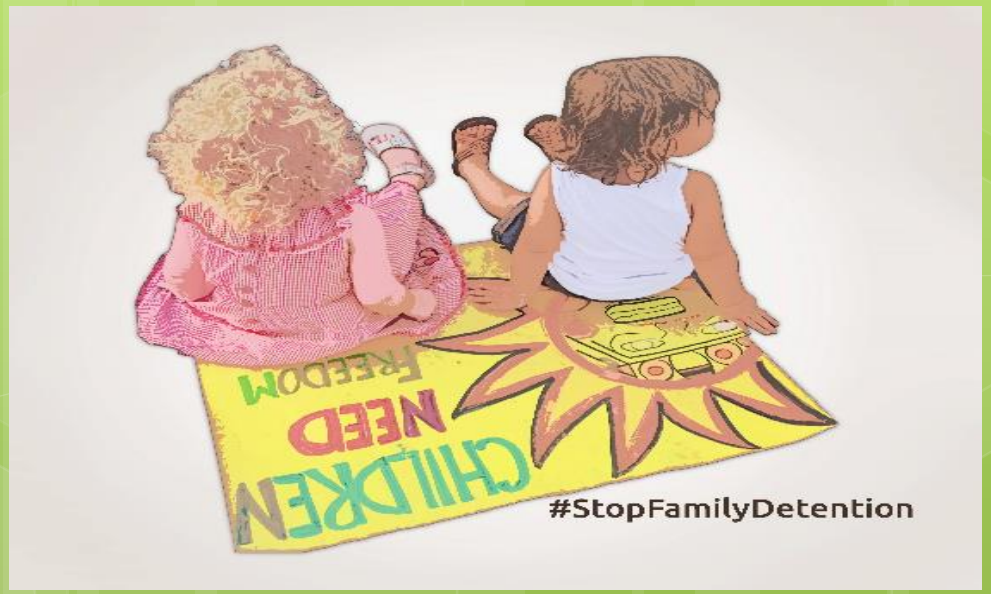
Finding a short-term solution for children with Social Security benefits getting denied Medicaid/CHIP for over income.

- Survivor's benefits counted for Medicaid when shouldn't be and so clients are denied. Then they can't get Marketplace coverage because they are under income.
- HHSC doing case by case assistance and we appreciate it. But even these are getting dropped on renewal.
- Christina H.- Pending a response from CMS for clarification. Want to be able to update the system and make a long term fix. CMS guidance will likely come soon.

Child-Only TANF eligibility determination process for children in kinship caregiver households & the TANF One-Time Grandparent payment

- Kinship care cases that should qualify for TNAF, but denied regularly because the system doesn't have a way to say is a child only case. System fixes status?
- Wayne S.- Expect that when reach out and do interview, the family lets HHSC know.
- Rachel- Cases denied and workers aren't asking if it is kinship family. No box to check that specifies is child only. Grandparent payment is also rejected because don't realize that kid must be on TANF first.
- May need to educate more on the line of "who are you applying for."
- Will research this and will follow up in writing.

Kathy Eckstein of Children's Hospital Association of Texas will chair the July 15th meeting, which is a regular 2-hour meeting.



Health Care Access for Detained Refugee Children

Andrea Meza
Equal Justice Works Fellow, Attorney
RAICES

About RAICES

- The Refugee and Immigrant Center for Education and Legal Services (RAICES) is a non-profit, legal services agency serving indigent immigrants throughout Texas.
- RAICES opened in 1986 to serve the high number of refugees fleeing the civil wars in Central America. Since that time, we have expanded from one office with one staff person to seven offices with over 75 staff.
- RAICES utilizes legal services, social services, advocacy, litigation, and policy to achieve its goal of a fair and just immigration system.

Family Detention

- Who are the families?
- Why are they fleeing?
- Where are they going?

Customs and Border Protection processing stations

"Freezer/Ice Box"

"Dog Kennel"

Karnes

- Capacity for 800+ mothers and children. Recently expanded from about 550.
- "Northern Triangle" of Honduras, El Salvador, Guatemala
- 54 miles SE of San Antonio
- Controlled by ICE, Operated by GEO Group

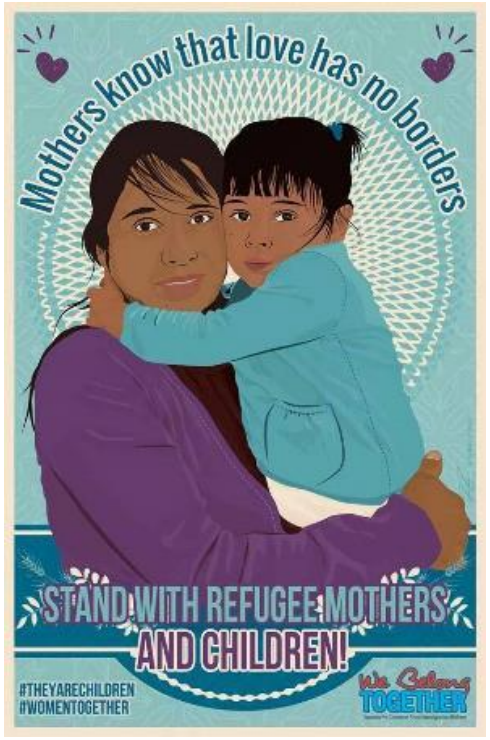
Dilley

- Capacity for 2400 mothers and children
- "Northern Triangle" of Honduras, El Salvador, Guatemala
- 73 miles south of San Antonio
- Controlled by ICE, Operated by CCA Group

Health Concerns in Detention

- "drink more water"
- Colds & stomach problems are the norm
- Breastfeeding challenges
- July 2015 forced vaccinations at Dilley
- Detention of children with serious pre-existing health issues
- Sexual Assault
- Detention induced health problems
- Lack of transparency

Post-Release



- Houston, DFW, San Antonio, Austin
- Untreated medical and mental health conditions
- Not eligible for care under the Affordable Care Act
- Legislative & county based solutions – California and Montgomery County, MD
- Government funded cash benefits may complicate immigration cases
- Privately funded community resources
- Refugee Advocate Program

Thank You

Andrea.Meza@RAICESTexas.org

TEXAS
Health and Human Services System

HHS Office of the Ombudsman Update

Presented to

CHIP Coalition

June 17, 2016

TEXAS Health and Human Services System

FY 2016

Contacts

OFFICE OF THE OMBUDSMAN

TEXAS Health and Human Services System

FY 2016

Total Ombudsman Contacts for FY2016	
Complaints	14,827
Inquiries	49,377

TEXAS Health and Human Services System

FY2016

Contact Volumes by Program Type September 2015 -May 2016

	Contacts	Complaints	Substantiated Complaints
TANF	**784**	**314**	**67 (21%)**
CHIP	**851**	**295**	**82 (28%)**
SNAP	**8484**	**2533**	**670 (26%)**
MEDICAID	**48,395**	**10,520**	**1879 (18%)**

TEXAS Health and Human Services System

FY 2016

Top Three Reasons for Contact

by Program Type

September 2015 – May 2016

TEXAS Health and Human Services System

FY 2016

MEDICAID	CHIP
Access to Prescriptions	Application Case/Denied
How to Apply	Check Status
Verify Health Coverage	Case Information Error
TANF	**SNAP**
Application Case/Denied	Application Case/Denied
Application Incomplete	Check Status
Explained Benefits/Policy	Explained Benefits/Policy

TEXAS Health and Human Services System

FY2016

Timeliness of Pregnant Women Eligibility Determinations

Since 09/01/2015, the OO has received one complaint from a client whose Pregnancy Medicaid had not been completed.

TEXAS Health and Human Services System

FY 2016

FOSTER CARE OMBUDSMAN

TEXAS Health and Human Services System

FY 2016

Contact Volume FCO Program May 2016 - June 2016	
Foster Care Youth	14 (31%)
Total Contacts	45

Information Shared

- Preparation for Adult Living (PAL)
- Court Appointed Special Advocates (CASA)
- Department of Family Protective Services (DFPS)

TEXAS Health and Human Services System

Foster Care Ombudsman

Toll-free phone: 1-844-286-0769

Toll-free fax: 1-888-780-8099

Online Submission:

http://www.hhsc.state.tx.us/ombudsman/foster-care.shtml

TEXAS Health and Human Services System

FY 2016

Ombudsman Managed Care Assistance Team

UPDATE

TEXAS Health and Human Services System

FY 2016

Ombudsman Managed Care Assistance Team (OMCAT)

- Outreach
- Managed Care Support Network
- Medicare Training

TEXAS Health and Human Services System

Contact Us

Phone (Toll-free):

Main Line:1-877-787-8999
Managed Care Help: 1-866-566-8989
Foster Care Help: 1-844-286-0769
Relay Texas: 7-1-1 or 1-800-735-2989

Fax (Toll-free):

1-888-780-8099

Mail

HHS Ombudsman
Mail Code H-700
P. O. Box 13247
Austin, Texas
78711-3247

Online

http://www.hhsc.state.tx.us/ombudsman/ managed-care.shtml

TEXAS
Health and Human
Services Commission

Presumptive Eligibility and the Community Partner Program

Office of Social Services

June 17, 2016

Presumptive Eligibility (PE)

- The PE website, www.TexasPresumptiveEligibility.com, launched December 3, 2014. The PE website includes a wealth of information about the program including: general information, access to required trainings, program updates, policy requirements, and a link to submit PE determinations.
- QH/QEs began submitting PE determinations effective February 1, 2015.
- As of June 9, 2016:
  - 41 QH/QEs have joined the program.
  - 0 hospitals/entities are in the PE enrollment process.
- As of June 9, 2016, QHs and QEs submitted 506 PE determinations.
  - QHs submitted 252 determinations
  - QEs submitted 254 determinations

Community Partner Program

- Through the Community Partner Program (CPP), HHSC partners with community-based organizations to assist individuals applying for public benefits through the YourTexasBenefits.com website.

- In its fourth year CPP is focused on new ways to support and retain partners. Relevant activities include:
  - Formation of a Community Partner Group for guidance and input
  - HHSC site support visits
  - Community Partner survey
  - Program rules
  - Updates to program materials and trainings

TEXAS
Health and Human
Services Commission

Policy Strategy, Analysis, and Development

Office of Social Services

June 17, 2016

Healthy Texas Women

(Formerly Texas Women's Health Program)

- July 1, 2016, HHSC will launch changes to the Texas Women's Health Program and the program will now be called the Healthy Texas Women program.

- This program offers women's health and family planning services to women across the state.

- The Healthy Texas Women program updates certain eligibility factors including age and income limits.

- As part of the project, HHSC will transition certain mothers who receive Medicaid for Pregnant Women to the Healthy Texas Women.

HEALTHY TEXAS WOMEN

Telephonic Signature Updates

- The Affordable Care Act (ACA) requires that individuals have the option to submit and sign applications, renewals, and authorized representative designations for Medicaid and CHIP by telephone.

- Effective August 2016, individuals will be able to:
  - Complete and sign an application or renewal over the phone for Medicaid and the CHIP; and
  - Sign an authorized representative change over the phone for Medicaid, CHIP, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP).

OSS Rules Update

- In May 2016, the following proposed rules were recommended for approval by the Medical Care Advisory Committee and HHSC Council:
  - Senate Bill 200, 84th Legislature, Regular Session, 2015;
  - Senate Bill 1664, 84th Legislature, Regular Session, 2015;
  - House Bill 3987, 84th Legislature, Regular Session 2015;
  - Supreme Court Decision: Obergefell v. Hodges, 576 U.S. 135, June 26, 2015;
  - ACA updates to align state rules with federal law and current HHSC policy; and
  - TANF update to clarify eligibility requirements for a caretaker adult to receive one-time TANF.

SCHOOL OF SOCIAL WORK
Office of the Dean

1925 San Jacinto Blvd., Stop D3500 · Austin, Texas 78712-1405 · 512-471-1937 · FAX 512-471-7268

DECLARATION OF LUIS H. ZAYAS

I, Luis H. Zayas, declare as follows:

I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

I. Qualifications

1. I am a licensed psychologist and licensed clinical social worker in the State of Texas. Previously, I held psychology licenses in New York and Missouri and a clinical social work license in New York. I hold a master of science degree in social work (1975), and a master of arts (1984), master of philosophy (1985), and PhD (1986) in developmental psychology, all from Columbia University in the City of New York. I have been a practicing clinician since 1975 in child and adolescent psychiatry and primary care medicine.

2. I am presently the Dean of the School of Social Work at the University of Texas at Austin. I also occupy the Robert Lee Sutherland Chair in Mental Health and Social Policy. A copy of my curriculum vitae is attached hereto as Exhibit A.

3. Previously, I was the Shanti K. Khinduka Distinguished Professor of Social Work and Professor of Psychiatry, School of Medicine at Washington University in St. Louis. I was also founding director of the Center for Latino Family Research. Prior to my ten years at Washington University, I was professor of social work at Fordham University where I also directed the Center for Hispanic Mental Health Research; visiting associate professor of family medicine and visiting associate professor of psychiatry at Albert Einstein College of Medicine; and assistant

professor of social work at Columbia University in the City of New York.

4. My background encompasses clinical practice, teaching and research in child and adolescent mental health, child development, child-rearing, and family functioning. I have been a clinician in general acute care hospitals and in outpatient mental health clinics in inner city settings. My specialty has been on minority and immigrant families and their children. I have conducted research in prenatal and postpartum depression, child-rearing values, alcohol use among Hispanic men, the influence of ethnicity on psychiatric diagnosis, and the suicide attempts of young Hispanic females. My research has been funded by the National Science Foundation and the National Institutes of Health (National Institute of Mental Health and National Institute of Child Health and Human Development). Since 2006, I have focused my clinical and research attention on the U.S.-born and foreign-born children, undocumented children of undocumented immigrants, mostly from Mexico and Central America.

5. I have published over 100 papers in scientific and professional journals and two books, *Latinas Attempting Suicide: When Cultures, Families, and Daughters Collide* (Oxford University Press, 2011), and *Forgotten Citizens: Deportation, Children, and the Making of American Exiles and Orphans* (Oxford University Press, 2015). A complete list of my publications issued in the last ten years is included in my CV.

6. I have previously testified as an expert witness in the following cancellation of removal cases in immigration court:

In the Matter of Jose Alejo (Kansas City, 2012)

Cristina Carlos (Kansas City, 2011)

Reyna Canseco-Ibañez (Kansas City, 2011)

Fernando Garcia Cruz (Kansas City, 2011)

German Garcia (Kansas City, 2011)

Delio Lemuz-Hernandez (Kansas City, 2012)

Salvador Licea (San Antonio, 2014)

Ismael Limon (Kansas City, 2011)

Jose Rosario Lira-Correa (Orlando, 2013)

Ricardo Lopez (San Antonio, 2014)

Arturo Lopez Arrellano (Kansas City, 2006)

I also provided an affidavit as expert witness but did not testify In the Matter of Fuentes (San Antonio, 2014) on children's psychological functioning, Attention-Deficit/Hyperactivity Disorder, and childhood trauma.

7. I am making this declaration to provide my considered opinions concerning the psychological and developmental impact of detention on the immigrant families that I observed at the Karnes Detention Facility. My opinions derive from my interviews on August 19 and 20, 2014, with immigrant families detained at the Karnes County Residential Center.

8. My opinions are also based on 39 years of experience as a licensed social worker and psychologist conducting evaluation and treatment of children, adolescents, and families. This includes experience conducting evaluations for immigration courts since 2006 and conducting federally funded research on the mental health effects of the deportation of undocumented Mexican immigrants on their U.S.-born children since 2011. This research is currently being published in scientific journals and the aforementioned book.

9. I also reviewed relevant scientific literature in forming my conclusions, including the

following publications:

Abram, K.M., Zwecker, N.A., Welty, L.J., Hershfeld, M.A., Dulcan, M.K., & Teplin, L.A. (2014). Comorbidity and continuity of psychiatric disorders in youth after detention: A prospective longitudinal study. *Journal of the American Medical Association.*

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders, fifth edition.* Washington, DC: American Psychiatric Press.

Byrne, M.W., Goshin, L., & Blanchard-Lewis, B. (2012). Maternal separation during the reentry years for 100 infants raised in a prison nursery. *Family Court Review.*

Dallaire, D.H., Zeman, J.L., & Thrash, T.M. (2014). Children's experiences of maternal incarceration-specific risks: Predictions of psychological maladaptation. *Journal of Clinical Child and Adolescent Psychology.*

Evans, G. W., & Kim, P. (2013). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives, 7,* 43-48.

Foster, H., & Hagan, J. (2013). Maternal and paternal imprisonment in the stress process. *Social Science Research, 42,* 650-669.

McLaughlin, K.A., Sheridan, M.A., & Lambert, H.K. (2014). Childhood adversity and neural development: Deprivation and threat as distinct dimensions of early experience. *Neuroscience and Biobehavioral Reviews, 47,* 578-591.

Murray, J., & Farrington, D.P. (2005). Parental imprisonment: Effects on boys' antisocial behaviour and delinquency through the life-course. *Child Psychology and Psychiatry, 46,* 1269-1278.

Nesmith, A., & Ruhland, E. (2008). Children of incarcerated parents: Challenges and

resiliency, in their own words. *Children and Youth Services Review, 30,* 1119-1130.

II. Summary of Findings and Opinions

10. Detention has had serious and long-lasting impacts on the psychological health and well-being of the families I interviewed at Karnes. This was evident even though the families I interviewed had been detained at Karnes for a relatively limited period of time—i.e., two to three weeks. In general, mothers and children showed high levels of anxiety—especially separation anxiety for the children—symptoms of depression, and feelings of despair. Children showed signs that detention had caused developmental regression, such as reversion to breastfeeding, and major psychiatric disorders, including suicidal ideation. Teenagers showed signs of depression and anxiety and, in some cases, major depressive disorders. The impacts of detention are exacerbated by the fact that families have already experienced serious trauma in their home countries and in the course of their journey to the United States.

11. The psychological traumas experienced by these mothers and children—in their home countries, during their travel to the United States, and upon their detention in the United States—will require years of mental health services to alleviate. Moreover, the ongoing stress, despair, and uncertainty of detention—for even a relatively brief period of time—specifically compromises the children's intellectual and cognitive development and contributes to the development of chronic illness in ways that may be irreversible. Detention at Karnes puts children at risk of recurrent and distressing memories, nightmares, dissociative reactions, prolonged psychological distress, and negative alterations in cognition.

III. Background of Evaluation

12. On August 19 and 20 of 2014, I met with ten families (mothers with children) detained at the Karnes County Residential Center in Karnes City, Texas in order to assess their mental health status and evaluate the impact that their detention was having upon their psychological, educational, and emotional development. Without divulging confidential or client-specific data, I am able to share the following information.

13. Typically, my assessments began with a family meeting to get an overall picture of the family's pre-migration conditions and experiences; the conditions they experienced in traveling to the United States; and their post-migration encounters and experiences with U.S. Customs and Border Protection (CBP) and Immigration and Customs Enforcement (ICE) officials and employees of GEO Group, Inc., the private company that operates the Karnes County Residential Center.

14. In all, I evaluated ten mothers, ranging in age from 24 years to 47 years, and their children, who ranged in age from 2 years to 17 years. Eight of the families were from El Salvador. One was from Guatemala and one was from Honduras.

15. There were 23 children in these families; I interviewed or spoke with and asked some questions to 21 of the children, which includes all of the children who were able to speak. There were 13 males, ranging in age from 2 years to 17 years. The two 2-year-old children were breastfeeding, although one had apparently been weaned but reverted to breastfeeding after being placed in detention, according to his mother.There were 10 female children, ages 9 to 17 years.

16. In most instances, the families were first detained by U.S. officials near the border and subsequently transferred to the Karnes detention center. Those families with older children—

adolescent boys and girls—were separated at Karnes such that the older children slept in other rooms with young people their age rather than sleeping near their parents.

17. At the time of my interviews, most families had been in the Karnes detention center for two to three weeks but had entered the United States some time earlier. All families identified at least one family member who resided in the United States, in such places as Texas, Ohio, Maryland, Virginia, Colorado, and other locations, with whom they could stay if released from detention.

IV. Findings

18. Without divulging confidential or client-specific information, I am able to describe the families' post-migration experiences that they encountered upon reaching the United States and, in most instances, their detention by U.S. border patrol agents and other law enforcement at the border and their processing by U.S. officials to their arrival and detention in Karnes.

19. In all cases, the families I interviewed fled severe violence in their home countries in order to seek refuge in the United States. The pre-migration histories of most the families included domestic violence and sexual abuse of the mothers by their partners. Several of the mothers also reported being raped, robbed, and/or threatened by gang members. The teenage children appeared to suffer the greatest difficulties because of the gangs. Adolescent girls reported being accosted by gang members who insisted on forcibly taking them as their "girlfriends," while adolescent boys reported being told that they must become members of the gangs. In both cases, the teenagers reported that the consequence of refusal would be their own death or the death of a parent or sibling. (Teenage females were naturally more reluctant to discuss the situations of their sexual assaults with a male interviewer.) As for younger children,

mothers I spoke to reported that their younger children were exposed to gang and street violence, or the aftermath, such as cadavers on the street.

20. At the time that I interviewed them, all of the families had been held at the Karnes detention facility for between two to three weeks. Their fears were not allayed by CBP or ICE; on the contrary, the families I interviewed all exhibited signs of elevated levels of anxiety, depression, and despair. Most mothers described elation when they were apprehended by U.S. officials because they initially felt safe in their hands. However, thereafter, the mothers and adolescents told of verbally rough treatment by U.S. border officials, such as being spoken sternly to and told to move faster, and admonished when they did not. Families stated that they did not always understand the orders given as they were told in English or in limited Spanish by some U.S. officials. All mothers and older children provided relatively uniform descriptions of the conditions in the *hieleras* (roughly translated as ice boxes) in which they were placed early in detention. The *hielera* is a large, very cold cell housing large groups of immigrants (women, girls, and younger children) that provides no privacy, including a toilet used by everyone that was exposed to the view of everyone in the cell. The hielera was also intensely cold. Most told of being held in this setting for 48 hours or so. After that stop, the immigrants told of going to another location in which they were given aluminum-foil-like blankets that did warm them.

21. From there, they were moved to Karnes detention facility. While some families reported initially receiving friendly and caring treatment by U.S. officials, they also described punitive and verbally abusive treatment. They described the employees of the detention facility as "mean," "rude," "bullies," along with other negative terms. Staff at Karnes called for census counts three times a day and if a child, typically an adolescent, was found in her or his mother's

cell and not in the one assigned to the teenager, they were given some sort of demerit. This was the case with one teenage female who was separated from her mother and two younger female siblings and was often weepy and fearful of being separated from her family. When I met her, the girl had received two warnings and was told that a third time would bring upon her a serious penalty (one that neither her mother nor she could describe).

22. In each conversation I held with mothers and older children, the feelings of despair and uncertainty were quite evident and voiced by them. Among the younger children I detected high levels of anxiety, especially separation anxiety (fear of being away from their mother; fearful that they would be moved and children not told; fear of losing their mother). The mothers showed mostly signs of depression with such vegetative signs as lack of sleep, loss of appetite and weight loss, and hopelessness. Some of the same symptoms were evident in the adolescents, especially girls.

23. Mothers and older children expressed varying levels of despair about their futures: how long they would be detained; what would be the conditions of their release; and whether they would ever see their families in the U.S. or back home again. Mothers exhibited anxiety about the health of their children, who they reported had lost weight, become listless, and in some cases had reverted to infantile behaviors. At least three mothers with young children were distraught in thinking that they brought their children from one nightmarish situation to another.

24. Among the children, I witnessed signs that detention had caused regression or arrests in their development and major psychiatric disorders, including suicidal ideation. One of the two infants I observed had regressed developmentally: although he had previously been weaned, he had reverted back to breastfeeding and needed to be held by his mother constantly. Older

children showed separation anxiety and regressions in their behaviors (e.g., staying attached to their mothers, worrying if their mother did not return from an errand). Several children reported nightmares.

25. Teenagers who were detained showed, primarily, signs of depression and anxiety. At least three of the teenagers with whom I spoke showed signs of major depressive disorders. At least one teenage male I interviewed expressed suicidal ideation, telling me that he would rather take his life than to return to his hometown and face the gangs that had tried to recruit him. In my clinical experience, and supported by scientific literature, suicidal ideation is not uncommon among detained or incarcerated persons. Research shows that suicidal ideation and attempts are most commonly emerge in during even brief periods of incarceration, in the early days and weeks of the person's imprisonment. This young man at Karnes showed classic symptoms of major depression: anhedonia (i.e., marked loss of interest or pleasure); psychomotor retardation (i.e., slow cognitive, verbal, and physical responses and movements); fatigue; feelings of worthlessness; and diminished ability to concentrate. His depressed mood was evident to me through these signs as well as his flat affect and "lifelessness" in his eyes.

26. In addition, both mothers and children expressed concern about the impact of detention on their educational development. One mother related that she had asked to organize a school for the children with other mothers but was rebuffed. Inasmuch as they did not know how long they would be in detention, several older children who had educational aspirations to go to college expressed concern about their future education.

V. Opinions

27. Based on my professional experience and background, and on the interviews and

evaluations I conducted while at Karnes Family Detention Center, I conclude that the psychological traumas experienced by these mothers and children—in their home countries, during their travel to the United States, and after their arrival in the United States when they found themselves locked up in immigration detention facilities—will require years of mental health services to alleviate. The ongoing stress, despair, and uncertainty of detention compromises children's intellectual and cognitive development and contributes to the development of chronic illnesses. Institutionalized children and the threats they face are similar to those of trauma, and result in recurrent, distressing memories, nightmares, dissociative reactions, prolonged psychological distress, and negative alterations in cognition. My conclusions are well supported by medical and psychiatric research.

28. The scientific literature is very uniform in its findings about the impact of maternal incarceration or detention on children. Research (Byrne et al., 2012) shows that infants and children who live in detention with their mothers often have more maladaptive social and emotional development, academic failure, and later criminal involvement compared to other children. With infants, the disruption of their emotional attachment to their mothers can lead to insecure bonding of the infant with the mother. Since attachment also predicts future behavior, insecure levels of attachment will result in suboptimal development. Indeed, disruptions in attachment affect general growth and development of the brain as well as social functioning, aggression, and reactions to stress. Children of incarcerated parents face many adverse outcomes and show difficulties in social interactions, such as making friends and navigating social situations, and research shows that maternal incarceration predicts the children's future antisocial and delinquent outcomes (Murray & Farrington, 2005; Nesmith & Ruhland, 2008).

29. Detention or institutionalized living, and child-rearing in prisons, is a major childhood traumatic stressor, even under conditions of short or brief detentions (Foster & Hagan, 2013). Findings show that the childhood trauma from maternal incarceration increases depressive symptoms among children. Specifically, children 5 to 10 years and 11 to 14 years show increased risk for dropping out of high school while the risks for children birth to 5 years and 11 to 16 years show high levels of depression and other internalizing behaviors (i.e., withdrawal, rumination) as well as externalizing behaviors (i.e., aggression, defiance and oppositionalism, fighting, vandalism, cruelty). Such externalizing behaviors in children often mask clinical depressive symptoms and suicidality (often seen in aggressive, provocative behavior toward persons in authority often police and law enforcement that can lead to fatal encounters, commonly known as "suicide by cop").

30. Likewise, the scientific literature shows the negative effects of children's detention or incarceration on their future psychological health. Of 1,829 youth who were in juvenile detention during their teen years, 27% of males and 14% of females had what are known as "co-morbid" psychiatric disorders, that is, co-occurring problems (Abram et al., 2014). Most commonly, the comorbidity involved major depression and anti-social behavior (oppositional defiant disorders) with alcohol abuse among males. The comorbidities for females were post-traumatic stress, anxiety, and anti-social personality disorder and substance abuse. Note that in this comorbidity, depression occurs with an externalizing disorder (oppositionalism). We see therefore that both internalizing and externalizing disorders are likely to be the outcomes of maternal and/or child detention. This has led researchers to conclude that incarceration-specific experiences place children at higher risk for maladjustment than exposure to general

environmental risk in community settings (Dallaire et al., 2014).

31. However, there are more than the external indicators of the effects of detention—even short periods—on children that should give us great reason for concern and worry. Rather, adverse childhood experiences, such as trauma and detention, have detrimental effects on children's brain growth and neural development. Research in the neurobiology of trauma and brain development shows that as childhood adversity increases, the likelihood of psychopathology also increases (McLaughlin, Sheridan, & Lambert, 2014).

32. Institutional rearing, that is, growing up in detention even for short periods of time—and particularly following the traumatic circumstances of migration—is one of the most adverse environments that scientists have studied, commonly called in the literature "complex adverse experiences." The two distinct but powerfully determinant elements of the trauma of these adverse experiences are *deprivation* (i.e., absence of expected developmentally appropriate environmental inputs and complexity) and *threat* (i.e., the presence of experiences that represent an immediate or ongoing threat to the child's physical integrity and psychological security). Under the conditions of prolonged and intense stress, the body's natural stress responses (and release of specific hormones that aid in the flight-fight response and coping) are over-used. The condition of chronic deprivation and threat stresses affect neural or brain development which in turn determines cognitive and behavioral functioning in children. Stress under prolonged and intense conditions activates the release of hormones that lead to structural and functional changes of some brain regions that are essential for self-regulation and other behaviors. As a result of the ongoing stress, despair, and uncertainty of detention, children's brain development is compromised, impairing not just their intellectual and cognitive development but also

contributing to the development of chronic illnesses which can last into adulthood (Evans & Kim, 2013). The deprivation common in institutionalized children and the threats they face are similar to those of trauma as defined in the Diagnostic and Statistical Manual of Mental Disorders (2013) that include recurrent and distressing memories, nightmares, dissociative reactions, prolonged psychological distress, avoidance of people or other reminders of the trauma, and negative alterations in cognition such as not being able to remember important events or aspects of the traumatic events.

33. For adolescent development when the sense of autonomy is emerging in preparation for adult roles, the loss of any autonomy—not just from the parents which all adolescents complain about but by being detained and lacking basic freedom—will have devastating effects on the adolescents once they enter the world outside the detention center. Unlike other adolescents in the communities they will be released to or returned to, they will have lost a part of their key developmental time in confinement with younger children and adult women.

34. Although I was not privy to any allegations of sexual abuse at the hands of the detention guards and employees by any of the mothers or children at the time of my interviews, I understand that such allegations have been made and that formal complaint or complaints were lodged. Should an investigation confirm the allegations of sexual abuse, that abuse will likely cause more maternal depression, signs of which will be evident to the children. Should a mother have experienced a sexual groping, rape, or coerced sexual favor near her children or within minutes of seeing their children, it is likely that the mothers will "reveal" their distress visibly which will be detected by their children. This can be very confusing to children and leave them feeling more vulnerable as well.

35. Taking this scientific background into consideration and combining it with the impressions I gathered in my interviews with mothers and children in the Karnes facility, I can unequivocally state that the children in the Karnes facility are facing some of the most adverse childhood conditions of any children I have ever interviewed or evaluated. Untold harm is being inflicted on these children by the trauma of detention. What is more is that the children at Karnes are experiencing *trauma upon trauma upon trauma*. That is, they not only suffered the trauma of having their lives threatened and disrupted by fleeing their native countries but they also experienced, witnessed, and heard of violent, traumatic events in their crossing through Mexico. On top of these serial and often long-term traumatic experiences, the children are exposed to the deprivation and constant threat of living in a facility in which they have no sense of their future. Complicating the children's development are the disrupted family roles and dynamics in which children see their mothers treated very poorly by staff and witnessing their mothers' vulnerability and helplessness. Children need the security and protection of their parents and the conditions of detention militate against mothers' capacity to provide that kind of comfort for their children.

36. Based on my professional background and expertise, my knowledge of the scientific literature on child development and psychopathology and parenting and family functioning, and based on my conversations with mothers and children detained at Karnes, I can say with certainty that detention is inflicting emotional and other harms on these families, particularly the children, and that some of these effects will be long lasting, and very likely permanent as adduced by the scientific literature.

37. The healing process, in my view, cannot begin while mothers and young children are

detained. Indeed, my interviews led me to conclude that even a few weeks of detention has exacerbated the trauma experienced by these families and added a new layer of hardship that, with respect to the children in particular, may be irreversible.

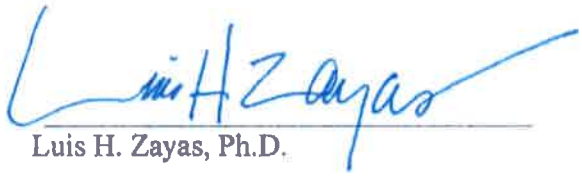
VI. Compensation

38. I have received no compensation for my participation in this case.

39. I reserve the right to amend or supplement this report as appropriate upon receipt of additional information or documents.

I declare under penalty of perjury under the laws of the United States and the District of Columbia that the foregoing is true and correct.

Executed this 10th day of December, 2014, at Austin, Texas.



Luis H. Zayas, Ph.D.