The Texas Medicaid Program: Opportunities and Challenges for Psychologists

Bonny Gardner, Ph.D., M.P.H.

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A Note From the Editor

Cynthia de las Fuentes, Ph.D.
Independent Practice
Austin, Texas

It's been a 100 degrees for weeks and I'm ready for a break. The idea of a sun setting, to give us some respite from the blistering day, seems so inviting to me. Alas, that metaphor may not be as welcoming for our colleagues at the Texas State Board of Examiners of Psychologists (TSBEP) and TPA's Sunset Task Force. Mr. Spinks and Dr. Branaman share with us an important overview on the Sunset Commission and TSBEP's perspective on the issues facing the Board during Sunset Review. Their counterpart, Dr. Grothues, TPA's president elect, chairs TPA's Sunset Task Force and writes about what the issues are for the Association during this review. Like a Venn diagram, there is some overlap in the issues (including those echoed in Dr. Simonsen's column), but there are important differences psychologists need to be aware of related to the different functions and interests of both entities.

I am grateful for Dr. Gardner’s “In Depth” contribution to this issue on the opportunities and challenges for psychologists working with the Texas Medicaid program. She spent countless hours researching and consulting with colleagues and Texas Health and Human Services Commission representatives to provide us with a very thorough and informative overview of the program and the role of psychologists working with this high service need population.

Finally, I couldn't let this issue go to press without sharing with you my grief and outrage over the shootings in Orlando and what I implicate as two of its complicit antecedents: hate speech and the proliferation of assault style weapons. I am tired, and not just of heat and murders, but of bigotry and hate, of police using lethal force inappropriately, and of lawless vigilantes targeting our sisters and brothers in blue. If, like me, you are as tired and frustrated of vicarious trauma as I am, my opinion piece offers a couple of options for action.

The articles represented in this issue exemplify the value of membership in TPA. These authors are advocating for our working with high service needs populations, and are watching out for our profession and the shirts on our backs. After reading your copy of the Texas Psychologist, please share it with a non-member colleague and encourage them to come to our annual convention in Austin (November 10-12).

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Submit an article

The Texas Psychologist is soliciting submissions for it’s upcoming Fall 2016 issue “The Good that Psychologists Do,” President Simonsen’s convention theme. Do you do volunteer work or consult with nonprofits? We want to celebrate how you use your education and training towards the goals of promoting human welfare and social justice. Collaborations with students are encouraged. Deadline: September 9, 2016. 1000-2000 word count; APA Style. Send to CynthiaDLF@gmail.com.
From the President

Serafine v. Branaman: What Does It Mean and What Are We Doing About It?

Gregory Simonsen, Ph.D.
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Although much has been reported of late regarding the Serafine v. Branaman 5th Circuit Court of Appeals (“5th Circuit”) opinion regarding the Licensing Act (“the Act”) for psychologists in Texas, and at the risk of repeating what has already been said in a variety of contexts, I feel it is important to continue the dialogue. It’s vital to educate TPA members regarding this important issue, its implications for the profession, and TPAs’ response in the aftermath of the ruling especially in the context of Sunset review.

In Review
Mary Louise Serafine ran unsuccessfully for Texas Senate in 2010. In her campaign materials (website), she identified herself as both a lawyer and a psychologist. It came to light that she wasn’t actually licensed in Texas to practice psychology. The title “psychologist” is protected by the state’s licensing act to describe doctoral-level licensees. Under its authority, the TSBEP took action and sent two requests to Dr. Serafine to stop identifying herself as a psychologist. Indeed, the Attorney General of the State of Texas additionally sent a letter threatening her with prosecution if she didn’t comply with the cease-and-desist order from the TSBEP.

Dr. Serafine stopped using the title “psychologist” and removed it from her website. But she sued the TSBEP in federal court for infringing on her political speech, commercial speech, equal protections rights, and her right to earn a living. She also stated that the definition of psychologist in the licensing act was vague and overbroad.

In federal district court, Dr. Serafine lost her case as the court deemed that the state does have a right to protect the public from the unauthorized practice of psychology. Dissatisfied with this ruling, she appealed to the 5th Circuit and its ruling reversed the lower court’s decision. This is where we find ourselves today.

The Act’s definition of the practice of psychology was found to be overbroad and unconstitutional, being too restrictive of individual freedom of speech. The current Act defines the practice of psychology in the Texas Occupations Code (see www.statutes.legis.state.tx.us/Docs/OC/htm/OC.501.htm). I highly recommend that you read the 5th Circuit’s opinion online (see www.ca5.uscourts.gov/opinions%5Cpub%5C14/14-51151-CV0.pdf). It describes the arguments used in coming to the decision to overturn the lower court’s ruling in favor of the TSBEP.

Here is a summarization of the arguments the 5th Circuit used to determine that the Act is overbroad:

1. The opinion states that the court agrees with Serafine that her political speech cannot be muted by the section 501.003(b)(1) of our licensing act. Campaign statements (political speech) are entitled to full First Amendment protection. This means we cannot prevent someone from using “psychological,” “psychology,” or “psychologist” in campaign speech. Individuals have the freedom of speech to say anything they want in political speech.

2. The appeals court uses (b)(2) as the portion of the licensing act that is overbroad. The opinion refers to Sec 501.003 (c) (1)(2)(3)(4) as the data necessary to show overbreadth in (b)(2). They determined that this section of the act must be read conjunctively; this means that all sections 1-4 must be met in order for the practice of psychology to be occurring.

3. They make the point of saying that the definition of psychology becomes narrower with each progressive number, but that it isn’t narrow enough given that many human
interactions are related to advice-giving with respect to mental health or emotional issues. For example, many diet programs and companies provide advice on the emotional aspects of losing weight. The Act could be used to prevent these types of interactions as they are encompassed in its definition of psychology.

4. The opinion also focused on (4)(A), which states a systematic body of knowledge and principles acquired in an organized program of graduate study are part of the definition of psychology. While this is considered the narrowest part of the definition of psychology, the opinion states that this could be construed as suggesting that any kind of educational experience after an undergraduate degree could be evidence of the practice of psychology. Many people engage in post graduate coursework and then engage in helping others via a broad range of activities, like a blog or a parenting advice column, or a self-help group. Therefore, the Act could be used to prevent these kinds of interactions if the TSBE] decided to go after these activities as the practice of psychology.

5. The opinion cites an example of this when the Kentucky Board of Examiners of Psychology attempted to stop a newspaper columnist from offering parenting advice because the columnist wasn't a licensed psychologist. The court sees this outcome or the possibility of it as an opportunity for abuse of free speech.

6. The TSBE] argued that exemptions are listed in the Occupations Code that would provide protections against this kind of abuse of freedom of speech, but the 5th Circuit opinion stated that even though the Occupations Code gives exemptions to certain groups, it could actually be construed that anyone not listed in that specific code would be susceptible to this Act.

7. The opinion concludes by saying that subsection (c) (1)(2)(3)(4) “chills and prohibits protected speech” and is thus overbroad in its application.

**TPA’s Response to the 5th Circuit’s Ruling**

The ruling by the 5th Circuit sent many at the TSBE] and at TPA scrambling to determine the best way to address the situation and bring our licensure act into constitutional compliance. The 5th Circuit was clear that no group, organization, government entity or act can restrict a person’s freedom to say what they want when they are running for office (“political speech”). While this may seem odd to many of us, this is how the court interpreted our constitution. But, what about the “overbreadth” issue? How do we define the profession of psychology without casting such a wide net that we end up defining the simplest personal interaction, like a grandmother giving grandaughter marital advice, as the practice of psychology?

TPA partnered with the Texas Association of School Psychologists (TASP) and Texas Association of Psychological Associates (TAPA) in an effort to solve this problem. The memberships of these professional organizations are stakeholders whose professions are also at risk as a result of this opinion. TPA hosted a Stakeholders Summit in Austin in April to revise the definition of the “practice of psychology” in the Act to make it more precise.

While I have never heard anyone say they were looking forward to a Sunset review year, it turns out that it has come at an incredibly opportune time. We have the ability to make changes to our Act through the Sunset Commission recommendations. At the TPA-hosted Stakeholders Summit, leaders of all the respective organizations worked through a new definition. TPA also invited the TSBE] and other interested parties. This new definition attempts to answer the concerns of the 5th Circuit by not only narrowing it, but also including a section that describes exemptions to the practice of psychology that are above and beyond current exemptions. The TSBE] also formed a separate advisory committee with the mandate to determine that a definition of psychology would not be overbroad. You can find a side-by-side comparison chart of the original definition, the Stakeholder’s Summit definition, and the TSBE] advisory committee definition on the TPA website (www.texassyc.org/resource/resmgr/Legislative/2016/Stakeholder_Summit_Psycholog.pdf). In the end, the Sunset Commission will make its own recommendations to the state legislature about which definition is best.

Given that the Sunset Commission recommendations are being prepared even now, we have a great opportunity to include the changes to the definition of psychology in our Sunset report. Our Sunset Legislative Taskforce (see Update on Sunset 2017, this issue) is hard at work compiling TPA’s recommendations for the Sunset Commission. The new definition of psychology will be included in these recommendations.

Conversations around this issue will surely continue as the Sunset Commission reviews the need for the TSBE] and our Act. TPA is taking this opportunity to play a part in educating the Sunset Commission, the public, and legislators on the importance of licensure of psychologists and the incredible benefit this brings to the citizens of Texas.

The Sunset Commission gives us an opportunity for public comment prior to making its recommendations to the legislature and TPA has sent email blasts to membership to provide us with information pertaining to public comment opportunities. The protection of our profession and the public falls upon us. We need every psychologist to tell the Sunset Commission about the need for the TSBE] and continued licensure of psychologists with a licensing act that is constitutional. TPA will continue to diligently work on behalf of all Texas psychologists to protect your license, your title, and your profession. I hope this more in-depth discussion of the Serafine case illuminates the issues for you as an interested member of TPA and a psychologist.

To communicate with President Simonsen: drsimonsen@spirisgroup.com
In my last article, I summarized the recent TSBEP lawsuit that was overturned by the 5th District Court in New Orleans. This ruling ultimately required that TPA and other TSBEP stakeholders develop a new, more detailed definition for the profession of psychology. Dr. Gregory Simonsen, TPA’s current President, has done a great job leading TPA in this process, and his presidential article in this issue provides a good update on where we stand with this effort.

However, there is another federal lawsuit that could have an even bigger impact on our profession. That is the lawsuit brought on by the Federal Trade Commission against the North Carolina Dental Board (hereinafter referred to as “Board”). In short, the Board sanctioned individuals (non-dentist) who started a teeth whitening kiosk in the local shopping malls and were charging a lower price than the dentist did for this service. Many dentists complained to their board about this practice, claiming these individuals were practicing dentistry, even though “teeth whitening” was not in their definition of dentistry, and alleging they were providing this service at a cheaper rate than dentists typically charged. As a result of these complaints, the Board sent cease-and-desist letters to these non-dentist individuals.

Several years later the Federal Trade Commission filed an administrative complaint charging the Board with violating the antitrust statute (The Sherman Antitrust Act). Their argument was that the Board was excluding non-dentists from the market of teeth-whitening services, which constituted an anticompetitive and unfair method of competition. The Board countered and argued that the State (the North Carolina Dental Board) had immunity from such complaints as they were acting in their state sovereign capacity in protecting the public, and therefore were protected from anticompetitive conduct. They actually cited a lawsuit Parker v Brown 317 US 341 (1943), known as the Parker immunity.

The courts ruled, however, that an entity may not invoke the Parker immunity unless the actions are an exercise of the State’s sovereign power. In this case, the Board attempted to control market participants in a market that the Board regulates. So, in essence, the Board was not protected because the authorities, the “decision makers,” were actually the market participants themselves. In order to be protected and claim Parker immunity, the Board’s actions must 1.) be clearly articulated and affirmatory expressed in State policy and 2.) the actions (of the Board) be actively supervised by the State. They satisfied the first requirement as their policy was clearly articulated (i.e. rule book, website, etc.) but they failed on the second requirement, as they lacked a mechanism to provide active supervision.

The court defined active supervision as:
1. The supervisor must review the substance on the anticompetitive decision.
2. The supervisor must have the power to veto or modify the particular decisions to ensure they accord with state policy.
3. The mere potential for supervision is not an adequate substitute for a decision by the State.
4. The state supervisor may not itself be an active market participant

The Board’s action failed the active supervision requirement when the Board interpreted the Act as addressing teeth-whitening as the practice of dentistry. Whether or not the Board exceeded its power when determining that the practice of dentistry included teeth-whitening, there was no decision by a higher state authority to concur or reject the Board’s actions against the non-dentists. Without active supervision from the state, the Board’s actions cannot be deemed a state action, and therefore were not afforded Parker immunity.

So, how does this impact Texas psychologists? Simply put, this is EXACTLY how our state Board (TSBEP) operates. Active market participants are regulating and interpreting the statutes and rules on what constitutes the practice of psychology and who may practice in our profession.
There is no higher authority that oversees the Board’s actions.

The state of Texas, through its Sunset review, is reviewing all aspects of our Board, and I have firsthand knowledge they want to protect TSBEP and all other state agencies by creating a process that encompasses the “active supervision” outlined in the North Carolina Dental case. I have recommended some solutions to the state on how that might be accomplished, but they regularly seem to revisit the option to combine all mental health professions under one umbrella board. Since the beginning of our profession, we have always had our independent board and the best thing for psychology is to KEEP OUR INDEPENDENT BOARD.

The outcome of the North Carolina Dental Board case has ramifications for our own board and every other psychology board in the country that does not have a process in place for a neutral third party to oversee the actions of their board. As a matter of fact, it has implications for EVERY STATE AGENCY that does not have this protection in place. Legislators will ultimately make this decision. I encourage all of you to continue to monitor TPA’s Action Alerts and prepare to call and email your legislators when we determine how they will handle this situation.

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It’s On the Horizon: TSBEP and Texas Sunset Review

Darrel Spinks, J.D.
Executive Director, Texas State Board of Examiners of Psychologists

Tim F. Branaman, Ph.D.
Independent Practice

Anyone familiar with the rich heritage of this great state will find it hard to write about her governance and people without succumbing to some measure of pride in living here or romantic notions about her history. When writing about Texas, authors often wax poetic about her war for independence, years as a republic, conflicts with the Comanche, or the heritage of her people. Those authors, however, have never had to write about the Sunset review process, a topic sure to disabuse even a favored son such as Larry McMurtry, the author of Pulitzer Prize winning novel Lonesome Dove, from penning any words of romanticism about our great state. And though virtually everyone enjoys the warm glow of a Texas sunset amidst the sounds of the evening, the sunset described in Chapter 325 of the Government Code bears no resemblance to that treasured time of day or its accompaniment of whip-poor-wills and cicada.

With that being said, we hope this article may provide some measure of understanding of the review process itself, as well as a better understanding of what the future of psychology in Texas may look like once the sun has set.

What It’s About: The Background and the Process

As many may know, the Texas State Board of Examiners of Psychologists was established in 1969 with the passage of the Psychologists' Certification and Licensing Act. Then, in 1977, the Sunset Advisory Commission was created following passage of the Texas Sunset Act, and the Board was made subject to the Commission’s review upon the enactment of S.B. 54 in the 65th Legislature. Texas was the second state in the country to create a sunset process, and since its creation, more than 130 agencies have been placed under review by the Commission. The stated purpose of the Commission is to question the need for each agency, look for potential duplication of other public services or programs and consider new and innovative changes to improve each agency's operations and activities.

The Commission itself consists of five Senate members appointed by the Lieutenant Governor, five House members appointed by the Speaker of the House, and two public members; the Lieutenant Governor and Speaker of the House select one public member each. The current Commission members are Representative Larry Gonzales, Chair, Senator Van Taylor, Vice Chair, Representatives Cindy Burkett, Dan Flynn, Richard Peña Raymond, and Senfronia Thompson, Senators Juan “Chuy” Hinojosa, Robert Nichols, Charles Schwertner, and Kirk Watson, and public members Allen B. West and William Meadows. Additional information regarding each member, including their term and where they are from, may be found on the Commission's website.
The Commission also employs numerous staff drawn from a large variety of educational and professional backgrounds to perform agency reviews and assist in the legislative process. The Sunset Commission staff assigned to review TSBEP this review cycle includes Joe Walraven, Assistant Director, Robert Romig, and Julie Davis. Both Mr. Romig and Ms. Davis are staff attorneys with the Commission. These staff members attend meetings held by the Board, including board meetings and informal settlement conferences; observe agency operations, e.g. the oral examination; review agency-specific data and information, and meet with Board staff to gain a detailed understanding of how the agency operates, as well as to discuss any issues or areas of concern together with possible solutions.

To say that the level of review conducted by Sunset staff is broad or generalized would be to grossly misstate the truth.

Since 1977, the Board has undergone Sunset review on four separate occasions, with the current review cycle being the fourth instance. Various recommendations have arisen out of the three prior review cycles. The following are just a few of the prior recommendations made either by the Commission or its staff concerning the Board.

- The Act be changed to a title act only;
- Regulation be eliminated for psychologists not involved in critical client relationships; and
- Transfer of agency functions to the Department of Health.

1992-1993 Review Cycle, 73rd Legislature
- Consolidation of the Board with the regulatory agencies governing professional counselors, social workers, and marriage and family therapists;
- Expand the definition of the “practice of psychology” and increase the Board’s enforcement authority;
- Require both licensure and supervised practice for psychological associates, and
- Mandatory continuing education.

2004-2005 Review Cycle, 79th Legislature
- Elimination of the Oral Examination;
- Authorize Board to Conduct Quarterly Criminal Record Checks;
- Authorize the issuance of temporary licenses; and
- Allow psychologists licensed in other states to apply via a streamlined process without showing a specific number of years of independent practice in the other state.

A compilation of prior Sunset recommendations can be found by reviewing the Sunset materials on the Board’s website at www.tsbep.texas.gov/additional-information. One may wonder after reviewing this brief list of prior recommendations what steps are involved in the review process and how the Commission arrived at those recommendations. Those recommendations are formulated based upon information provided by agency staff, as well as by Commission staff members’ observation of agency processes at work. The review process itself, while seemingly straightforward, is extremely time consuming and demands a great deal of attention from agency staff. To be fair though, Sunset staff are very conscientious about this impact and attempt to minimize its effects where possible. The following outline provides an overview of the review process from beginning to end.

1. Agency submits its self-evaluation report
2. Sunset staff begin meeting with agency staff to gather input and gain better understanding of agency operations, and request information from agency
3. Sunset staff begin evaluating agency operations based on input received and information gathered
4. Sunset staff develop their recommendations to the Commission
5. Report containing staff recommendations is published. Any public input received up to this point is confidential. However, any public input received after this point is not confidential and will be published on the Commission’s website.
6. Commission conducts a public hearing at which Sunset staff present their recommendations, followed by the agency’s response and public testimony
7. Commission meets again to consider and vote on recommendations
8. Sunset bill continuing an agency is drafted and filed, and goes through the normal bill processes
9. Sunset bill passes or fails adoption
10. If bill passes, Governor signs, vetoes, or allows bill to become law by operation of law

In the event no bill is introduced in the Legislature continuing an agency, or an agency’s Sunset bill fails or is vetoed by the Governor, the agency is abolished. See Section 501.005 of the Psychologists’ Licensing Act.

Presently, the Board is in step three of the review process with agency staff answering follow-up questions posed by Sunset staff as they review their meeting notes and information produced by Board staff.

Individuals who might like to take part in the review process by offering comments, but do not know what issues are ripe for recommendations from the Commission or its staff, are encouraged to study the Board’s self-evaluation report together with the other Sunset materials available for download from the Board’s website as listed above. History is often the best indicator of what to expect in the future, and good preparation and a concerted effort by involved stakeholders will be necessary to impact the Commission’s recommendations and ultimately the legislative decision on whether to continue the Psychologists’ Licensing Act. In the event you think it unlikely that this agency or the Act could be discontinued, it is important to recall that in 1979 the Florida Board of Examiners of Psychologists ceased to exist as a regulatory agency following its Sunset review.

Substantive Issues and Other Matters of Concern
While by the very nature of the Sunset review process, the necessity of the Act which governs the use of the title “psychologist,” as well as what constitutes the practice of psychology would be subject to review. Due to the recent federal lawsuit, Serafine v. Branaman and the attention that it has drawn, scrutiny will be greater perhaps than would have otherwise been the case. One might anticipate that the justification for regulatory oversight of the professional practice of psychology and a licensing act to empower that oversight will be challenged.

In addition to title and range of practice, other substantive matters will also be considered. The Board has submitted, as part of its Self-Evaluation Report prepared for the Sunset Advisory Commission, major areas that it believes would serve to enable the Board to more effectively carry out its mission.
Below, we identify those issues that we anticipate will be central to the review process, as well as those that the Board recommends for consideration for review.

Central Substantive Issues

Title of Psychologist and Practice of Psychology. As the Federal Appeals Court held in *Serafine v. Branaman*, the title of psychologist may be used as a descriptive characterization in the context of political speech. Otherwise, with regard to commercial contexts, individuals may be required by the State to be licensed to refer to themselves by that title. However, the Federal Appeals also held that the manner in which Texas has previously defined the practice of psychology is overly broad and infringes on speech that may be utilized in other contexts where licensure is not required. To that end, we anticipate that the psychology practice act will be altered.

Upon having learned of the Court’s ruling, the Board set about developing language that it believed would serve to inform the Sunset Advisory Commission as well as legislators considering what constitutes “practice of psychology.” To that end, the Board authorized formation of an Advisory Committee to facilitate the development of language that defines the “practice of psychology.” The committee was to consist of a designee from each of the two major professional associations, Texas Psychological Association (TPA) and Texas Association of School Psychologists (TASP), and an “at-large” member to be designated by the Board Chair. The Board Chair also had the option of appointing an *ex officio* member that might bring specialized knowledge to the committee. The committee included the designated members as well as the Board’s Chair and its Executive Director. The active members of the committee included Dr. Thomas Shanding designated by TASP, Dr. Ron Palomares designated by TPA, Dr. Floyd Jennings appointed as the member at-large, and Professor Brian Shannon. As an *ex officio* member, Professor Shannon was important to the process as he is not a licensee of the Board and brought an outsider’s perspective to process as well as being a lawyer and academician with an understanding of mental health law and regulatory processes. The four members external to the Board who served on this committee provided invaluable insight and assistance in developing the recommended language for a modification of the Act.

The Advisory Committee developed language that it believes describes the professional practice of psychology and comports with the concerns expressed by the Federal Appeals Court opinion. The language of the act that was struck down by the Federal court and the alternative language recommended by the TSBEP Advisory Committee can be found on the Board’s website.

Freestanding Agency Status. The Board believes that its ability to effectively carry out its mission of protecting the public is contingent on it remaining a freestanding agency. Having sufficient staff and resources for the processes of licensing, license renewal, and enforcement are critical to the viability of the license and most importantly fulfilling the mission of protection of the public.

Oversight of regulatory boards and how rules are made and enforced may be a factor that is likely to be considered due to regulatory agencies exposure to being in violation of federal antitrust laws. This is a product of the recent U.S. Supreme Court ruling in the matter of *N.C. State Bd. of Dental Examiners v. FTC*. In that ruling, the court held that that a state agency governed by a controlling number of market participants might claim immunity from federal antitrust laws if the state has articulated a clear policy to allow the anticompetitive conduct, and the state provides active supervision of anticompetitive conduct. What constitutes such “active supervision” remains to be determined.

Oral Examinations. The efficacy as well as the necessity of the licensure requirement for successfully passing an oral examination is likely to once again be challenged. The Board believes that the oral examination is important in assessing entry-level functional professional competence as well as is integral in maintaining reciprocity agreements with other jurisdictions that require an oral examination for licensure. However, the Board’s ability to effectively continue the oral examination process is questionable due to the increasingly large number of applicants that our Board must examine. This number is ranging from 100 to nearly 150 annually at this time. This is a concern with regard to having access to a physical facility that can handle such a number, as well as decreasing availability of psychologist examiners who are willing to contribute their time for a minimal stipend.

Major Concerns Posed by TSBEP for Sunset Commission Consideration

Removal for Requirement of Annual Printed Roster

As most are likely aware, the Board has not printed or distributed copies of an annual roster for quite some time. Instead the public may access a listing of the Board’s licensees via the Public Licensee Search function, which can be accessed through the Board’s website. This search function allows an individual to search the Board’s licensees by name, license type, license number, city, or county. This is much more cost effective and also improves the accuracy of the information available to the public. The change in the Act recommended for consideration would address this requirement.

Clarification of Exemption and Use of Title “Psychologist” in Exempt Settings

This recommendation suggests that the relevant section of the Act be modified to correctly reflect that governmental employees performing exempt activities or services who are also licensed as psychologists may use the title “psychologist.”

Reconfiguration of Sequence of Appointment for Board Members

The Board believes that efficiency of representation on the Board by appointed members would be improved by staggering the dates on which psychologists, psychological associates, licensed specialists in school psychology, and public members are appointed. It recommended that consideration be given to reappointments being made in such a manner that no more than one of any appointed member role be made at the same time. This would facilitate the continuity of experience by Board members.

Inclusion of the Term “Diagnoses” as an Element of the Practice of Psychology

This recommendation speaks to the rationale for considering inclusion of the term “diagnose” or a derivative of that term in the language that defines the practice of psychology. The Board believes that the term is consistent with current language of the act that includes evaluating, assessing, testing, and treating patients and clients. We believe that consideration of the change is important due to the matter having been raised in recent Texas litigation concerning whether chiropractic doctors or licensed marriage and family therapists may diagnose their patients/clients.
Clarification of Requirements for Billing for Services Provided by Extenders

This recommendation grows out of concern by the Board that Chapter 35 of the Texas Penal Code might place in jeopardy a psychologist billing only under their name for services delivered by an extender without identification of that extender. In this recommendation, the Board seeks to bring to the attention of the Commission the potential unintended consequence of a psychologist provider being charged with insurance fraud while acting in a manner that is consistent with Tex. Occ. Code Ann. §501.351(b).

Where We Are and What the Future Holds

This legislative session is possibly the most critical that has been faced by TSBEP since its inception in 1969 by the 61st Texas Legislative Session. Concerns range from having a licensing act to what defines the practice of psychology, as well as how the practice of psychology is regulated with appropriate oversight. Additionally, issues of concern important to Board licensees as well as the public, which the Board is tasked with protecting in its mission statement, will be considered. In carrying out its mission TSBEP will continue to seek to inform and be available as a resource as needed to the Sunset Advisory Commission and legislative committees as may be requested.

To communicate with the authors: Mr. Darrel Spinks (darrel@tsbep.texas.gov) and Dr. Tim Branaman (drtimbranaman@gmail.com)

* Editorial Comment: The authors recognize there are alternative narratives to this perspective which can be found here: https://refusingttoforget.org/the-history/ and http://www.slate.com/articles/news_and_politics/history/2016/05/texas_finally_begins_to_grapple_with_its_ugly_history_of_border Violence.html and https://www.thestoryoftexas.com/visit/exhibits/life-and-death-on-the-border-1910-1920

Update on Sunset Review 2017

Carol A. Grothues, Ph.D.
President-Elect, Texas Psychological Association
Chair, TPA Sunset Task Force

In 1977, the Texas Legislature enacted the Sunset review process in order to regularly review the need and success of approximately 130 state agencies, including the Texas State Board of Examiners of Psychologists (TSBEP). Every 12 years, agencies are evaluated primarily on the basis of whether they are still needed, and if so, whether they need to run more efficiently or effectively. If the agency is not deemed as necessary, it will be eliminated or abolished, unless continued by legislation. In this next session, about 20-30 agencies will be under review by the Sunset Commission; the process actually initiated in 2015 in preparation for the 2017 Legislative Session. During the initial review, the Commission gathers information from the agency, the stakeholders, and the public to make recommendations for improvement or changes in law, including the possibility of combining the functions of two or more agencies in order to save money and streamline state government. According to the Sunset website (www.sunset.Texas.gov), Sunset reviews have abolished 37 agencies and consolidated 46 agencies, which has resulted in savings of almost a billion dollars.

The Texas Psychological Association developed a Sunset Task Force (“Task Force”), chaired by Dr. Carol Grothues, and consisting of Drs. Michael Flynn, Ron Palomares, Paul Andrews, Pete Stavinoha, and Alice Ann Holland. The charge of the Task Force is to develop in writing areas of concerns regarding the TSBEP and the current statutes of our Title and Practice Acts. This document will be completed by early July, and members will testify, along with TPA Executive Director, David White, later this year, in hearings scheduled prior to the start of the legislative session. Additionally, representatives from TASP and TAPA will also testify, and public testimony is welcome.

The TSBEP completed their self-evaluation and shared it with their licensee agencies at the end of 2015 [for more information, see It’s on the Horizon, this issue]. Of specific importance to psychologists is their recommendation to add “diagnosis” to the definition of the practice of psychology. Additional recommendations to improve overall functioning of the Board and deleting obsolete requirements, like the printing of a roster, are also included. Their evaluation was extensive and comprehensive and will hopefully result in continuation of their independence in regulating the practice of psychology in Texas.
Of significant note is the need to address concerns resulting from two critical lawsuits: Serafine v. Branaman and North Carolina Board of Dental Examiners v. Federal Trade Commission. Legislation to address the impact of these cases will be a priority for the Sunset Commission and TSBEP.

The 2017 TPA Sunset Task Force identified six areas of importance to licensed psychologists to be proposed to the Sunset Commission in July. These issues were presented to the TPA Board of Trustees for approval prior to being sent to the Sunset Commission. Some are recommended changes and some argue against changes proposed by other groups. While we can submit our concerns in writing at this time, our future testimony is even more crucial to this process, where we will be allowed to elaborate further on the impact of any changes.

1. The Definition of the Practice of Psychology
   Given the recent court decision in the Serafine case that found the current practice definition to be overbroad and therefore unconstitutional, TPA representatives met with representatives from TASP and TAPA to develop a new practice definition to recommend during Sunset review. This definition was proposed during a Summit Meeting with representatives of all licensed stakeholders and is based primarily on the APA Model Practice Act. It is a substantial change from the current definition and hopefully addresses the problems inherent in the current format. It is designed to address the emphasis on professional application of psychology in areas of remediation as well as growth, in clinical, forensic, academic, and work settings.

2. Maintain the Doctoral Standard for the Independent Practice of Psychology
   The Task Force spent a great deal of time in this section explaining why this is a critical standard for independent practice, including reasons for maintaining the distinction between school psychologists and Licensed Specialists in School Psychology (LSSPs). There continues to be a push from LSSPs to change their license to “school psychologist” and also to provide services outside of public schools. A primary argument for the name change away from LSSP is the reported difficulty trying to explain the difference between a school psychologist and an LSSP with parents of school children and the tendency for laypersons to refer to them as “school psychologist” because they do not understand the LSSP title. However, this is not unlike the frequent need to explain to the public the difference between psychologists and psychiatrists, and psychologists and Licensed Professional Counselors. There will always be need to take time to delineate these distinctions and the rationale that is “just easier” to call oneself a school psychologist is a poor justification allowing confusion regarding levels of training and education to continue. Psychologists are the only non-physician mental health provider with doctoral training. Failure to recognize that standard and argue that there is no difference between doctoral and specialty training establishes a dangerous precedent for our profession.

   Additionally, maintaining the doctoral standard for independent practice of psychology outside of public schools is crucial. LSSPs provide important services and the development of this license helped address the critical needs of children in our public schools. However, LSSPs use a nomenclature and participate in a team process for identifying student educational needs established through IDEA, not clinical psychology. Rather than employing common clinical taxonomies for student needs, such as from DSM-5 and ICD-10, special education categories are specific to public schools, which is why school psychologists are required to maintain a dual licensure (LP and LSSP). The team-based process, by which student needs and appropriate interventions must be identified, as governed by IDEA and regulated by the Texas Education Agency, is unique to public schools. Given that there is no analogous system for team-based identification of educational needs and interventions under IDEA outside of a public school setting, and given that LSSPs proficiency is in IDEA-based identification and intervention of student educational needs, there is no appropriate scope of independent practice for LSSPs outside of a public school setting. Movement of practice outside of the public schools in any way is the same as independent private practice, which requires doctoral level training.

3. Maintain the Oral Exam as Requirement for Licensure as a Psychologist
   During the last sunset year, the question of abolishing the oral exam requirement was raised given the high pass rate and the difficulty in scheduling oral exams with experienced examiners. The reasoning for maintaining this requirement continues today. We have no other way of evaluating clinical competency, and the oral exam provides a critical means of protecting the public and profession from those who may be able to pass written measures but fail to demonstrate the competency required for independent practice.

4. Adopt PSYPACT (The Psychology Interjurisdictional Compact)
   Arizona became the first state to adopt this legislation and we hope that Texas will follow. This legislation will allow for provision of in-person psychological services on a limited basis across state lines and will also allow for electronic interstate practice in other states who adopt such legislation (through an “E.Passport”). It is a way for state agencies to control the psychological services provided in their states, as well as increasing access to care through telepsychology. TSBEP will be able to continue to set rules and guidelines for how this will be used and implemented, but the state must first allow the compact to be an option in statute.

5. Maintain the TSBEP as an Independent Board
   This may actually need to be moved up in priority as there continues to be talk of combining boards in similar areas, such as mental health – a frequent goal of the Sunset Commission. The Sunset Commission recommended this change during the last review in 2005, but TSBEP was ultimately maintained as an independent board. The result of the North Carolina Board of Dental Examiners v. Federal Trade Commission increases the concerns regarding independent state agencies. The Supreme Court’s findings in this case calls into question the belief that state agencies are exempt from federal antitrust laws, clarifying that this is only the case when there is active supervision from the state. There will clearly be increased scrutiny on addressing this vulnerability in state agencies and creating a superboard that has additional oversight will likely be considered as a proactive strategy.

TPA lobbied hard during the last Sunset review to maintain TSBEP as an independent board and it is clear that changes to our Board will result in grave concerns for timeliness of applications, reviews, complaint dismissals, rule changes, and all other regulatory aspects. TSBEP has successfully
maintained all operations with monies collected from its approximate 9000 licensees and will continue to do so, allowing for continued efficient processing of tasks, as well as efforts from TSBEP to improve timelines. Additionally, rules and regulations specific to psychologists require specialized knowledge not applicable to other mental health professionals, including school psychology, neuropsychology, forensics, and managing the addition of an interstate compact that deals specifically with other licensed psychologists (if adopted). Oversight by a consolidated board would be diffused with psychology's issues having to compete for resources (staff time and attention) based on crisis management with a board having more broad responsibilities. The results would likely be neglect of planning and preventive actions and education of licensees. The current Board takes much time for thoughtful development of rule revisions and proposals (e.g. having taken more than two years to review and revise supervision rules for the profession). It maintains these efficiencies within its own budget, making it unnecessary for the state to seek ways to decrease costs. However, the antitrust issues may still need to be addressed. It is hoped that the differences between TSBEP and the North Carolina Board of Dental Examiners continue to allow for the exemption. For example, one-third of TSBEP is made up of non-psychologists (where the NC dental board was composed of six dentists, one hygienist, and only one consumer) and the Board is required to conduct a mini-fiscal note on any proposed rule changes to determine its effects on stakeholders, small businesses, and the public.

6. Clarify the Role of SOAH Regarding Complaint Dismissals
The current statute specifies the procedures for the TSBEP to deal effectively with complaints, including the option to seek a hearing from the State Office of Administrative Hearings (“SOAH”). While this is true for most practicing professions, including physicians, the current act allows for the TSBEP to propose a penalty, regardless of outcome. While it makes sense that the appropriate board identifies penalties for judged violations, the TSBEP can do so even when the SOAH judge fails to find a violation based on the evidence presented. The Medical Act clarifies this with more extensive language, and we recommend changing the language in the psychology practice act to more closely align with this act and the intended process of fair review.

TPA will continue to have additional items on its legislative agenda for 2017, which focus more on addressing additional practice related issues. To say we have a full legislative agenda for 2017 would be a vast understatement. It is a critical year for psychology and we need to start planning for increased involvement and support for legislative action from all Texas psychologists. We will have more legislative days than ever before, including one this year, in 2016, and one each month in March, April, and May of 2017 during the session. Make the time to attend as many legislative days as you can to educate legislators about psychology, psychologists, and mental health care in Texas.

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The Texas Medicaid Program: Opportunities and Challenges for Psychologists

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The Texas Medicaid Program, administered by the Texas Health and Human Services Commission, is a large potential source of patients for practicing psychologists in Texas while also offering an opportunity to “make a difference” by providing mental health services to a vulnerable and seriously underserved population. Yet for many psychologists, the workings of the program remain mysterious and dauntingly bureaucratic. Both the Texas Health and Human Services Commission (“HHSC”) and the delivery of Medicaid health services are now undergoing significant restructuring and change designed to improve agency management and make service delivery more efficient and effective. Traditional fee for service Medicaid services are being replaced by a system of private Managed Care Organizations (“MCOs”) through which most services are delivered. Service providers must now enroll in the Medicaid program and also enroll in the MCOs serving their geographic areas. The HHSC has newly appointed Executive Commissioner: Charles Smith, an attorney formerly serving as its Chief Deputy Executive Commissioner and prior to that, as a Deputy Director in the Texas Attorney General’s Office. Stuart Bowen, also an attorney, is the new Inspector General for the Commission. HHSC is absorbing two other large agencies, the Department of Aging and Disability Services and the Department of Assistive and Rehabilitative Services. Some mental health and substance abuse services from the Department of State Health Services and some functions from the Department of Family and Protective Services are being transferred to HHSC also.

This article attempts to inform the readership of changes in the Medicaid program, to provide an overview of how it works, and to generate interest in Medicaid participation.

In June 2015 the 84th Texas Legislature increased funding for behavioral health and substance abuse services across several state agencies, although not directly for Medicaid. However, there is increased public pressure for funding of mental health services as waiting lists for services grow, and there is growing awareness by legislators and policy makers of the role that limited access to mental health and substance abuse care play in social problems and increased law enforcement and prison costs. Mental health issues will most likely be highlighted in the upcoming 2017 legislative session. Ensuring that psychologists stay involved in delivery of mental health services in publicly funded programs and help “shape the conversation” about mental health issues in Texas is important.

Medicaid program administrators uniformly say that they are eager to enroll psychologists as providers. Testimony at public hearings suggests that there is a chronic shortage of qualified Medicaid health care professionals, of many types, relative to need. However, some psychologists have reported obstacles or difficulties enrolling and participating in Texas Medicaid. Telephone interviews with Texas Health and Human Services Commission executives, a rate analyst, and managers have been a chance to gain current information on the Medicaid program, to provide input on these difficulties, and hopefully will allow participation to go more smoothly. My thanks are extended to the following Texas psychologists who have provided me with valuable insights into how Medicaid works and suggestions for making participation easier: Megan Mooney, Ph.D., Joseph McCoy, Ph.D., Dan Roberts, Ph.D., Paul Andrews, Ph.D., Kim Arredondo, Ph.D., and Anne Morton, Ph.D. My thanks are also extended to Texas HHSC representatives who were willing provide information for this article: Deanna Naranjo, Gwen Spain, Reuben Leslie, Robert Patterson, Greta Rymal, and Stuart Bowen, Jr.

The Demographics of the Medicaid Program
To understand the enormity of the Texas Medicaid program, in fiscal year 2015, there was a cumulative, unduplicated count of 5,061,363 individuals, according to information provided through the office of Robert Patterson, Coordinator of Open Records for the Texas Health and Human Services Commission. (This total includes clients who could enroll and then unenroll, all within 2015.) Available data on the total number of individuals covered by full benefit Medicaid in a specified month are drawn from August 2015: in that month, there were 4,044,330 clients enrolled in full benefit Medicaid and an additional 342,558 children enrolled in the CHIP program. This yields a total of 4,386,888 of individuals enrolled in either full benefit Medicaid and CHIP in August 2015. These data are drawn from Texas HHSC System Forecasting and are posted on the Texas HHSC website under “HHSC Facts.” According to the U.S. Census, the population of Texas in July 2015 was 27,469,114 (U.S. Census, 2015) and this suggests that in July 2015, about 16% of the Texas population participated in Medicaid and CHIP. This estimate is consistent with the data in Texas Medicaid and CHIP in Perspective, Tenth Edition, a report produced by the Texas HHSC in February 2015 (“PinkBook, 2015”), which states that in state fiscal year 2013 about 17.5% of the

IN DEPTH
Medicaid Program Finances
The Texas Medicaid program involves enormous amounts of money. Combined federal and state dollars spent on Texas Medicaid in federal fiscal year 2013 totaled about 25.6 billion dollars, not including disproportionate share hospital costs, uncompensated care, and some other expenditures (PinkBook, 2015). When all State of Texas and federal Medicaid funds are combined, in FFY 2013, total Medicaid expenditures were 33 billion dollars. The state’s share of Medicaid money was about 26% of the total state budget.

While most Medicaid clients are children, the bulk of Medicaid monies are spent on older adults and disabled persons (PinkBook, 2015). While 67% of Texas Medicaid clients were non-disability related children, they constituted only 31% of total Medicaid expenditures. Those who were 65 and over and who had disabilities comprised 26% of the Medicaid population but accounted for 60% of Medicaid program spending. Adults without disabilities, including pregnant women and parents were 9% of the Medicaid population and 9% of Medicaid expenditures. Nursing home care for older and disabled adults is a large category of Medicaid spending and in State Fiscal Year 2012, 64% of nursing home residents were covered by Medicaid (PinkBook, 2015).

The Texas Medicaid program is a jointly funded state-federal health care program that was first implemented in Texas in 1967, following the 1965 passage of Title IX of the federal Social Security Act, which established Medicaid programs nationwide. Texas Legislative Budget Board data from 2015 indicated that in 2016, the federal government was expected to cover about 57% of the cost of the Texas Medicaid program with the state supplying the other 43%. This match is adjusted over time when there are changes in the state’s average per capital income. There are different matching rates for certain services, client groups, and administrative costs, however, which can range from 50 to 100%. Texas Medicaid expenditures can be expected to increase over time, given development of newer, more expensive medical technologies, population growth, especially of children, and an expansion of the segment of the population 65 and over, who tend to utilize health services more heavily. Concerns about Medicaid costs are a driving force in state policymakers’ decisions to contract with Managed Care Organizations for service delivery.

Medicaid Program Eligibility and Groups Served by Medicaid and CHIP
The federal government establishes minimum standards requiring that certain populations be eligible for Medicaid and that certain health services be provided in all state Medicaid programs, allowing states some flexibility to cover other groups and provide additional services, subject to federal approval. States can also apply to the federal Center for Medicare and Medicaid Services for a waiver of federal law in order to expand health coverage to certain groups or to try more innovative methods of service delivery.

Eligibility for the Texas Medicaid program can be complex and there are some exceptions to the descriptions that follow. In general, Texas Medicaid patients must meet specific income eligibility criteria and fall into several broad categories. The first major category includes: low income families, pregnant women, children, and those who are caring for a related Medicaid eligible dependent child. A second major category of Medicaid eligible people are those who are on the federal Supplemental Security Income (SSI) cash assistance program. Federal law requires their coverage. A third major category includes people 65 and over and those with physical, emotional, or intellectual disabilities who meet program income eligibility criteria. While a fourth category is foster children who are categorically eligible until age 18. The federal 2014 Affordable Care Act extended Medicaid coverage to most former foster children age 18 and older until they are 26. Certain former foster children who were not receiving Medicaid at age 18 may now be eligible for Medicaid until they are 21 if they meet income requirements and some children who are adopted out of foster care may remain covered by Medicaid until age 18.

Limited Medicaid benefits are extended to some non-citizen legal permanent residents and to undocumented persons who are not eligible based on citizenship status for emergency services. Limited Texas Medicaid benefits are also available to women who are at or below 200% of the federal poverty line and who are diagnosed with breast or cervical cancer, who are uninsured, not eligible for Medicaid otherwise, and ages 18 through 64.

For people age 65 and over, and those with disabilities not receiving federal Supplemental Security Income, given income levels, Medicaid may be available to

According to the Texas HHSC report (PinkBook, 2015), in state fiscal year 2013, the majority of Medicaid enrollees were children under 18, with 65% being 14 or younger, and 77% were under 21 years of age. Medicaid enrollees 65 and over comprised only about 6% of the total Medicaid population and those age 21 through 64, were only about 17%. In calendar year 2013, about 43% of all Texas children were on Medicaid or CHIP. In state fiscal year 2013, Medicaid covered 53.2% of all births in Texas. About 55% of Medicaid clients were female and 45% male; 50% identified as Hispanic, 15% as African American, and 20% Caucasian, with 15% unknown or unspecified.

At the same time, according to the Texas HHSC Open Records Office, there were only 1187 providers identified as psychologists enrolled in the Medicaid program for at least one month in fiscal year 2015. (Any psychologists who had moved to other states, did not have current address, or were under sanctions, were not included in this number.) There is clearly an overall shortage of psychologists relative to the Medicaid/CHIP population. According to an article in the Texas Tribune (Keller, 2015), per 100,000 residents, Texas has 76 psychologists (national average is 129) and 253 licensed social workers (national average is 402); while 207 of 254 of Texas counties are formally designated as mental health shortage areas, 241 counties have some level of shortage and 40 counties in Texas have no resident psychologist at all. Most mental health professionals are concentrated in Bexar, Dallas, Harris, Tarrant, and Travis County so the shortages are most acute in rural areas. Only a fraction of psychologists in Texas are enrolled in the Medicaid program. More data on the geographic distribution of Medicaid enrolled psychologists across the state are currently being sought from HHSC through an open records request and can help highlight areas of extreme shortage.
cover long term care services and supports through skilled nursing homes and through intermediate care facilities or through community based in home care programs. For those individuals who are both eligible for Medicare and full Medicaid benefits, Medicaid pays the premiums, deductibles, and coinsurance for Medicare. Some limited assistance under Medicaid is also available to some Medicare beneficiaries who don't qualify for full Medicaid benefits. There are also programs to allow some workers with disabilities to buy into the Medicaid program and disabled children up to 19 whose families make under 300% of the poverty line to buy into Medicaid to offset otherwise prohibitive costs.

The Texas Medicaid program pays for a full range of health services including: physician, pharmacy, laboratory and x-ray services, skilled nursing services, podiatry services, dental and chiropractic services, nutritional services, and speech, occupational therapy, and physical therapy services. Medicaid also covers health facilities services, including hospitals and clinics, and long term care services, including both skilled nursing home and Intermediate Care Facilities for people over 65 or for those with intellectual or other disabilities. Group homes and institutional settings for those with intellectual disabilities and community clinics and health centers are also covered as are some home and community based health care services and some in home supports and assistance for people who are elderly and/or disabled. Other covered critical services include medical transportation and medical supplies and equipment. The Texas Medicaid program covers mental health services, including clinical diagnostic and testing services, and individual and family therapy services. Psychiatrists, psychologists, social workers and LPCs may participate in the Texas Medicaid program.

Since its inception in 1967, and given changes in federal law, especially in the 1980’s, Texas Medicaid coverage has gradually expanded to include populations in addition to the traditional coverage of those on cash assistance or Supplemental Security Income, or the poorest of the poor. Still, according to a Texas Tribune article by Edgar Walters (2015), Texas has the second strictest eligibility criteria, based on income, of any state. Effective January 2014, the Affordable Care Act, required states to adjust the income levels they set for qualifying for Medicaid to allow for increased participation. Texas has chosen to expand Medicaid coverage to more pregnant women and infants and elderly in long term care than is required by federal law. In 2014, pregnant women and infants who are up to 198% of the federal poverty level can receive Medicaid. The eligibility standard for children 1 to 5 is 144% of the federal poverty limit, and for children 6 to 8, 133% of the federal poverty limit. Parents and caretaker relatives can enroll in Medicaid if they are at 15% of the federal poverty limit, and medically needy persons at 17% of the federal poverty limit. Those on SSI for persons who are elderly and disabled can enroll in Medicaid if their income does not exceed 74% of the poverty level and those in long-term care are eligible if their income does not exceed 222% of the federal poverty limit.

The Child Health Insurance Program (CHIP) is a federal program created in 1997 under Title XXI of the Social Security Act (Social Security Administration, n.d.). The Texas CHIP population is much smaller than the Texas Medicaid population. CHIP allows for health care for those under 19 whose families are at or below 201% of the federal poverty guidelines but who have too much money to qualify for Texas Medicaid. Most families pay an annual enrollment fee and also copays for health services. The range of services available to them is similar but not identical to those of Medicaid. The federal government, in 2014, funded about 71% of the CHIP program with the state funding the rest and the federal matching portion of CHIP will increase until 2019.

**Populations Currently Excluded from Medicaid Coverage in Texas**

About 5 million people still remained uninsured under private or public coverage in Texas in 2014, despite some expansion of Medicaid and the Affordable Care Act and that was a drop from 22.1% of Texans in 2013 to 19.1% in 2014, according to Anne Dunkelberg (2016), Associate Director of the Texas based Center for Public Policy Priorities. However, there are still adults who are not elderly, disabled, pregnant, or parents of children whose incomes are too high to qualify for Medicaid and too low to qualify for subsidies for insurance under the Affordable Care Act and who have no health care coverage. Most of these are the “working poor.” This is a group who could be covered if Texas Medicaid eligibility criteria were expanded to allow non disabled adults with incomes under 133% of the poverty level, or less than $16,105 per individual to be covered. The federal government has offered Texas over 100 billion dollars for the first decade, with the federal government covering 100 % of costs for the first three years and 90% after that, but Texas policy makers have refused to accept federal dollars to extend coverage to this group of low income adults, at great cost to health care facilities, especially public hospitals like Parkland Memorial in Dallas or Ben Taub in Houston, which must absorb the cost of unreimbursed care. Texas taxpayers ultimately cover these costs through their property taxes or through rising health insurance premiums (Hawryluk, 2015). A Supreme Court decision in 2012 said that the federal government couldn't force states to expand their Medicaid programs (Russell, 2012). Using 2014 data, Anne Dunkelberg estimated that about 1.5 million people in Texas could qualify for Medicaid if Texas chose to accept federal dollars for further expansion of the program.

**The Transition to Managed Care Organizations for Service Delivery**

In the past most Medicaid services were delivered in the traditional fee for service model where clients could go to any service provider participating in Medicaid. However, by the early 90’s, the Texas Legislature began encouraging efforts to try new models of service delivery, to improve efficiency of service delivery, to coordinate care, to allow for prevention and earlier intervention, and provide some services which may not be available through the traditional service delivery system. According to Greta Rymal, Deputy Executive Commissioner for Financial Services, the Medicaid population became so large, it wasn’t feasible for the state to be managing all aspects of service delivery. Clients were having trouble navigating the system. Cost containment was also a driving concern, with the notion that privatization might curb waste and inefficiency. In 2013, the Texas Legislature directed Texas HHSC to develop a performance based Medicaid system, which rewards good outcomes and efficiency. Over time, the Texas Medicaid program has transitioned Medicaid clients to Managed Care Organizations (MCOs). According to data from the Texas HHSC, in August of 2014, 82% of Medicaid enrollees were in managed care. At present, according to Katherine Ligon, M.S.S.W., Mental Health Policy Analyst at the Texas Center for Public Policy Priorities, from 87% to 93% of Medicaid enrollees are now in MCOs. Those
remaining in fee for service Medicaid are mainly foster children and "medically needy" enrollees but more medically needy children will be moved to MCOs later this year. Most Medicaid clients who have not yet enrolled in a MCO will be assigned to one by November 2016.

The MCOs are health plans paid a monthly amount by the state to coordinate care and reimburse providers for services to Medicaid clients enrolled in a specific plan (PinkBook, 2015). The monthly amounts are calculated on estimated per capita use of services, with the incentive being to maintain and optimize the health of enrollees. The idea is that earlier intervention and better coordination of care can prevent deferred treatment seeking, deteriorating health status, and higher medical expenses. In general, the MCOs retain the difference between their own administrative costs, their outlay for health expenditures, and the sum of their capitated fees. (The MCOs contract with service providers in their regions of the state who must first meet the Texas Medicaid Health Program (TMHP) criteria for participation in Medicaid and who then must apply separately to participate in MCOs.) MCOs are free to set their own rates of reimbursement to providers, which may be more or less than the traditional Medicaid rate and can establish some of their own conditions for participation. At present, MCO reimbursement rates are similar to those of traditional Medicaid, per Reuben Leslie, Senior Rate Analyst within HHSC. The MCOs have some flexibility re: services they will approve and pay for and can establish prior authorization requirements for some services. They are all required by federal Medicaid law to provide certain core services and all "medically necessary services," however. The MCOs are responsible for payment to providers.

How well MCOs deliver services to vulnerable low-income populations is a public concern. How do you ensure quality of care? Is there adequate access to both routine and specialist care? How do you measure and report outcomes? What systems are used for oversight? How do you contain costs while providing necessary care? In the last Texas legislative session there was increased emphasis on providing behavioral health services and ensuring a "whole person" focus in service delivery (Texas State of Mind, 2015). According to Greta Rymal, the Legislature directed HHSC to hire a behavioral health lead who would help oversee integration of care, and HHSC Associate Commissioner Sonja Gaines has assumed this role.

At both the federal and state level, there is now a stronger emphasis on "value based contracting" in Medicaid service delivery. According to Gwen Spain, who handles special projects within Health Plan Management, the Texas Health and Human Services Commission is responsible for overseeing MCO performance in Texas. Within the MCOs, there are required internal quality review areas, and the Texas HHSC also assigns plan managers to monitor operations of specific MCOs, thereby offering another level of quality review. According to Gwen Spain, feedback from consumer groups (patients) is also sought. It is a requirement of Texas Medicaid that data are gathered on network adequacy and other managed care contract standards, including the ratio of enrollees per provider, how many miles clients must drive to a service provider, how long it takes to get a routine or urgent appointment, proximity of hospitals, number of specialists available, whether there is a readily found helpline or complaint line for Medicaid enrollees, and other measures. These data, including network maps, are then reported to the federal Center for Medicare and Medicaid Services. The Texas HHSC also contracts with an organization for external quality review, the Institute for Child Health Policy in Florida, which rates Medicaid plans in various states. According to Gwen Spain, based on data analysis by this Institute, Texas HHSC evaluates MCO performance and takes corrective action when needed. The MCOs must also meet Texas Department of Insurance readiness requirements to operate as an MCO in Texas and have standards that are aligned with those of the Texas HHSC and the federal government.

According to Sam Donaldson, Ph.D., a psychologist and former CEO of a Texas Medicaid HMO, oversight of the MCOs by Texas HHSC has been tightened up. In the 1990's, there were some questionable practices, such as MCOs terminating providers abruptly with no right to an appeal. This practice has been stopped. Dr. Donaldson now sees Texas MCOs as held strictly accountable by HHSC plan management for having adequate numbers of providers. Per Dr. Donaldson, HHSC staff will call up various service providers to see if appointments are available for patients and how soon. According to Dr. Donaldson, the state also wants MCOs to report outcome data for treatment of specific disease states. Gwen Spain, within Texas HHSC, indicates that if there appears to be a problem of accessibility, single case agreements can be established with providers to ensure coverage. There have been instances when specialists have been flown into more rural areas of the state to provide specialist care. Providing adequate access to care in Texas can be challenging, given vast areas of the state with low population levels and few health care professionals. Currently, across the state, there is a very severe shortage of physicians, mental health practitioners, and hospitals equipped to treat patients with eating disorders, for example.

Enrolling as a Medicaid Provider
The initial step in enrolling as a provider in the Texas Medicaid program involves going to the Texas Health and Human Services Commission website (www.hhsc.state.tx.us) and the Texas Medicaid Health Partnership website (TMHP, www.TMHP.com). Both are comprehensive and fairly easily navigated. (TMHP contracts with the Texas HHSC to enroll providers in the Medicaid program.) The federal government also requires current providers to revalidate their enrollment data every three to five years. In accordance with this mandate, The Texas Medicaid program is requiring all providers enrolled before January 1, 2013 to reenroll by September 25, 2016. Deanna Naranjo, Operations Coordinator for Medicaid/CHIP within the Texas HHSC, explained that there are representatives listed on the website who are specifically assigned to assist psychologists in various parts of the state if they are having enrollment difficulties. Provider enrollment representatives can also be reached at the TMHP Contact Center at 1-800-925-9126, Option 2 and 3. (This line is answered between 7:00 AM and 7:00 PM). A provider may call this number and also request a “walk through line” to get step-by-step assistance. Workshops are also being held around the state to provide personalized assistance with reenrollment. The date, time, and place of these workshops will be posted on the TMHP website. Some Texas psychologists have had difficulty enrolling or reenrolling in Medicaid however, even when they complied with instructions. Some paper work has been lost in the mail, some faxes seem to not work, and they report intermittent problems reaching the right person by phone. If licenses are about to expire within 30 days, the applications may be kicked

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Once the TMHP Medicaid application is approved, psychologists may decide to only see traditional Medicaid clients, dwindling in numbers, or they may choose to enroll in Managed Care Organizations operating in their geographic area. The Texas Health and Human Services Commission and TMHP websites provide links to MCOs across the state and contact persons for each MCO. There have been some difficulties with the list of contacts for the MCOs. The list was created in 2012 and contains some phone numbers no longer working and the names of some provider representatives have changed. However, HHSC is now addressing this problem. Having to apply first to Medicaid, and then to the MCOs, can be time consuming and frustrating. The MCOs may have varying participation requirements and many want their own documentation of credentials, using primary sources. Some standardizing and streamlining of this process would facilitate more psychologists participating in the MCOs. Texas psychologists having trouble with being added to the MCO Provider Networks or with claims reimbursements from MCOs can receive assistance by emailing HHSC@HPM_Complaints@hhsc.state.tx.us.

Providing Psychological Services through Medicaid and MCOs

A significant stumbling block cited by psychologists, both for Medicaid managed care and to a lesser extent, traditional Medicaid, can be prior authorization requirements, especially for testing. As of June 6, 2016, traditional Medicaid has established a new electronic portal for getting approval for testing, which may help speed the process. Within the MCOs, non-psychologists may review testing requests and denials of testing may be difficult to appeal. Prior authorization forms are often different for each MCO. Contacting the MCO Medical Director to discuss reasons for denials and to appeal is an option, per Gwen Spain, but may be time consuming and with an uncertain outcome. One Texas psychologist noted that the MCOs often recommend relying on school based psychological testing rather than allowing individually administered IQ and academic achievement testing using the most valid and reliable instruments. However, school based testing is often outdated, and the instruments used don’t yield the best data. Testing time approved may be based on metrics that apply to a standardization sample, but aren’t relevant to children with combined cognitive, social, and emotional impairments who are difficult to test. The time needed for testing, scoring, and interpretation, may be much longer. One psychologist believes that unrealistic limits on testing time, interpretation, and report writing may lead to reports that are shorter and less informative than they could be. Several psychologists have confided that they see Medicaid patients at a financial loss. Given the time involved in seeking authorizations and low reimbursement for testing, some psychologists have given up seeing Medicaid patients out of frustration. The MCOs may also require authorizations and reauthorizations for therapy services, for a certain number of sessions, and the time to fill out authorization forms is not reimbursable. Psychologists have noted that some plans cover family therapy and some do not, some may allow seeing a family member without the child present and others not.

One psychologist noted that the Psychological/Neuropsychological Testing Request Form, for traditional Medicaid, which became effective on 04/01/2016 requires a signed certification with each testing request that the provider is aware of prior authorization requirements and that the information being supplied is true, under penalty of perjury. While observing program rules is a reasonable expectation, the tone of the form may have a “chilling effect” on provider eagerness to participate in Medicaid.

Some Texas psychologists have complained about nonpayment or late payment of claims. According to Gwen Spain, within Health Plan Management in the Texas HHSC, MCOs are responsible for paying for “clean” or error free claims within 30 days of receipt or they must pay interest on the claim amount. Each MCO has a website, which includes information on policies and procedures, offers provider manuals, phone numbers for provider lines, and complaint lines. MCOs are required to report complaints by both patients and providers to HHSC. If complaints to MCOs don’t get results, providers can report problems to HHSC.

The Texas Medicaid Health Partnership (TMHP) provides information on submission of traditional Medicaid claims and provides an option for electronic submission of claims. The TMHP website also allows providers to call in at 1-800-925-9126 Option 2 to check on eligibility for services and on claims payments. Automated service is available 23 hours a day and live representatives are available 5 days a week from 7:00AM to 7:00PM. This line is working well. Deanna Naranjo, Operations Coordinator for Medicaid/CHIP has generously offered her assistance to any psychologists who, after using the call in system, are still having difficulty getting claims paid. She can be reached at 1-512-730-7406.

Traditional Medicaid payment rates are reassessed biennially and public hearings are held where providers can register concerns about changes in rates either in person or on the record by mail. In a 2015 hearing, the following psychologists provided testimony and deserve recognition: Dan Roberts, Ph.D., Joseph McCoy, Ph.D., Megan Mooney, Ph.D., Paul Andrews, Ph.D., Bonny Gardner, Ph.D., Stephen Tate, Ph.D., Michelle Rhodes, Ph.D., Sophia Tani-Prado, Ph.D., Adam Schmidt, Ph.D., Joanna Snider Anderson, Psy.D., Clare Clarke, Clin.Psy.D, Cynthia Orrego, Ph.D., Tanya Banda, Ph.D., Dinorah Zanger, Ph.D., Kimberly Rennie, Ph.D., Lindsay Asawa, Ph.D., Lauren Grodin, Psy.D., Nancy Peskin, LCSW, Michael Ghormley, Ph.D., Brad Frank, Ph.D., Richard Connell, Ph.D., Angela Mitchell, Ph.D., Kimberly Booker, Ph.D., Kirk Coverstone, Ph.D., and David Zimmerman, Ph.D. Sometimes proposed fee cuts have been averted after testimony demonstrated that fees did not, or barely covered minimal operating costs for psychologists, especially when the time involved in testing and report writing and the cost of testing materials was considered. Also, testimony indicated that fee cuts would exacerbate an existing shortage of psychologists in the Medicaid program and limit access to care. Information on traditional Medicaid reimbursement rates is available through the TMHP website. Questions about traditional Medicaid rate structures, and how they are set, (but not about payment of any specific claims)
can be obtained through the Rate Setting division within the Texas Health and Human Services Commission. Tim Villasana is the Texas HHSC Rate Analyst to whom psychologists across the state are referred. He can be reached at 1-512-707-6092, and Reuben Leslie, a senior rate analyst, at 512-707-6075, is an excellent resource on how rates are calculated for traditional Medicaid. According to Reuben Leslie, the “capitated” rates on which MCOs base their contracts with the Texas Health and Human Services Program are partially based on the fee structures and past operating costs of the traditional Medicaid program and the MCOs. Medicare rates also are a factor in Medicaid fee structures.

Control of Fraud, Waste, and Abuse within Texas Medicaid

In 2003, the Texas Legislature created the Office of Inspector General (“OIG”) to strengthen the efforts of the Texas HHSC to prevent, detect, and combat fraud, waste, and abuse within the Medicaid program. The OIG is responsible for ensuring the proper use of any federal funds that go to state administered programs providing health and human services. Over the years, questionable practices by some human service provider groups involving billing or unnecessary provision of services have been investigated by the OIG. Unfortunately, for some physicians, investigations involved payment holds and dragged on for as long as three to ten years, often with the physician not fully understanding the reasons for the investigation (Berlin, 2015). Given a lack of transparency and some degree of dysfunction in the OIG’s dealings with provider groups, physicians and some other providers became wary of participation in Medicaid.

A year ago, Governor Greg Abbott appointed a new Inspector General, Stuart Bowen, to revamp the OIG and to repair relations with physicians and other health care providers. Mr. Bowen was formerly the Special Inspector General for Iraq Reconstruction from 2004 to 2013 and before that, served as Deputy Assistant to the President and Deputy Staff Secretary to President George W. Bush (Berlin, 2015). As the article in Texas Medicine notes, he has experience handling problems as tough or tougher than those in the OIG. Inspector General Bowen indicated in a telephone conversation that he is working closely with the Commissioner of the Texas HHSC as he develops new initiatives in the Office of the Inspector General. He is committed to maintaining the integrity of Medicaid program finances, but also to ensuring due process during investigations and audits. He is interested in establishing ties with and getting input from stakeholder groups. He wants to promote effectiveness in the use of Medicaid funds and to improve the quality of health care delivery. His office will be working in close partnership with the leaders of the MCOs to provide them with guidance and help oversee MCO operations. This type of oversight is more important than ever, given the billions of dollars involved in the Texas Medicaid program, and the proliferation of private groups contracting with Medicaid.

Some psychologists are apprehensive that they may inadvertently not follow a required procedure or make an error in billing and come to the attention of either MCO auditors or audits by the Inspector General’s Office. Inspector General Bowen emphasized that “fraud” under federal and state law is quite different from a mistake: fraud requires an intent to mislead to gain an unauthorized benefit. He indicated that the concept of “waste” applies more to carelessness or inefficiencies in use of resources within the service delivery system. These inefficiencies may be identified by MCO auditors, but they are not usually considered a criminal offense. The concept of “abuse” refers more to “practices that are inconsistent with sound fiscal, business, or medical practices” per an explanation on the OIG website and lead to excessive program costs, per Inspector General Bowen. Trainings for providers will be developed for the OIG website and quarterly reports will be made available to all providers. The Texas Legislature now requires that investigations be completed within a timely fashion, within 180 days, or an explanation must be provided as to why not. Inspector General Bowen’s office will generally not use payment holds unless a pattern of fraud is conclusively established. The new Inspector General discovered an enormous backlog of cases when he took office about a year ago and has been clearing them out. The OIG has, in the second quarter of fiscal year 2016, recovered more than 22 million dollars for the Medicaid program. The OIG does conduct background checks on providers enrolling or reenrolling in Medicaid. Greta Rymal, Deputy Executive Commissioner for Financial Services in HHSC noted that this is a new era in the OIG and that it does not operate from a “gotcha” mentality. Also, providers can challenge an investigation of fraud.

Psychologists in Partnership with the Medicaid Program

There is increased interest in mental health service delivery by the Texas Legislature and the public in general. According to the National Survey on Drug Use and Health (NSDUH), in 2014, using representative population samples of persons 18 and over, 18.1% of the U.S. community resident adult population had Any Mental Illness (AMI). This survey measured clinically significant mental health symptoms, diagnosable currently or within the past year, under DSM-IV criteria. Persons with diagnoses of developmental disorders or substance abuse disorders were excluded from this count. The same NSDUH survey indicated that the prevalence of serious mental illness (SMI) in the 18 and older community resident population in 2014 was 4.2%. These data are drawn from the National Institute of Mental Health website at www.nimh.nih.gov. All families know someone with a mental health issue. As the public becomes better educated about mental health issues, stigma associated with seeking help or even discussing mental health concerns is diminishing. Within major research centers across the country and at the federal and state level, behavioral health is now viewed as an essential component of the health care system. Legislators and public policy makers are more receptive to input from psychologists and other mental health professionals on how to make human service programs more responsive to need. Now is an ideal time for Texas psychologists to join any Behavioral Health Advisory Groups associated with the Texas Medicaid Program, to participate in stakeholder meetings, and to respond to requests for public comment. Psychologists can also report to policy makers on how well they see MCO based service delivery working, both for their patients and themselves. In this way, they can contribute to quality review. Now is also an optimal time for psychologists to talk with public policy makers and explain the role that adequately funded mental health services within Medicaid can play in helping Texas children and adults lead more productive and independent lives. All of us have seen lives transformed by timely use of mental health services and we need to share these stories, to make sure that the research data and outcome measures we also can offer take on a more human dimension.
My heart aches with sorrow in the aftermath of the attack at the Pulse Orlando Nightclub & Ultra Lounge, which left 49 people dead, 53 physically injured and, countless millions of us around the world, horrified. I grieve for our friends, families, and communities and stand firmly in solidarity with them because we are all affected by hate crime and gun violence. The fact that the assailant specifically targeted our Latinx communities during a season especially dedicated to celebrate and rejoice with our LGBTQ+ communities, and did so in an assumed “safe place,” seems especially cruel.

While I mourn, I am acutely aware that we, as psychologists, must also protest the (re)conceptualization of this senseless act as used to threaten and blame Muslim people and immigrants (for let us not be fooled that even though the assailant was born in New York, he is perceived as being “foreign”) in general for the actions of one man. This hostility towards our people of Muslim faith and our immigrants serves to distract us from those factors our science tell us contribute to violence perpetrated upon marginalized groups, including those within the Muslim, Latinx, and LGBTQ+ communities.
Hate speech, one of the factors contributing to hate crime, is a special plague inflicted upon marginalized people. Like a debilitating malignancy, it can cause targeted people to suffer greatly both psychologically and physically (Mullen & Smyth, 2004), while the untargeted often remain oblivious and indifferent. The current political rhetoric, epitomized by inflaming a social climate of hate speech (“They’re bringing drugs. They’re bringing crime. They’re rapists.”), encouraging acts of violence (“…knock the crap out of them, would you? Seriously, just knock the hell — I promise you, I will pay for the legal fees.”), threats to minority communities (“We need to empower law enforcement to patrol Muslim neighborhoods before they become radicalized.”), and outright distortions (e.g., the purported risk to cis-women if trans-women used the same bathrooms) provides part of the climate for hate crimes against our LGBTQ+, Muslim, and Latinx people. Online forums such as YouTube, Facebook and Twitter have contributed to “a sudden and rapidly increasing wave of bigotry-spewing videos, hate-oriented affinity groups, racist online commentary, and images encouraging violence against the helpless and minorities – blacks, Asians, Latinos, gays, women, Muslims, Jews – across the Internet and around the world” (Foxman & Wolf, 2013, p. 31).

Not surprisingly, the proliferation of hate speech is matched with an increasing rise in hate crimes. According to the FBI’s 2014 hate crime statistics, over 20% of the documented hate crime incidents in 2013 were anti-LGBT; and, violence against trans people, in particular, is on the rise (FBI, 2015). What ever happened to E pluribus unum?

We all know (right?) that another contributing factor that contextualizes this atrocity is the uncontrolled proliferation of, and access to, assault weapons. Coupled with a climate that tolerates hate speech, civilian access to rapid-fire, large capacity magazine fed, automatic weapons whose sole design was intended for infantry use and killing of humans, has increased the threat and danger to those of us already located at the intersection of bigotry and social and political powerlessness. These are the weapons of choice for domestic terrorists and violent extremists. Indeed, an analysis of domestic extremist attacks between 2009 and 2015 found that 64 percent were perpetrated with firearms (Southern Poverty Law Center, 2015). Some people would have you know that knives kill more people than guns, and that is undoubtedly true. But, a machete-wielding assailant could not have possibly done to Pulse, Columbine High, Sandy Hook Elementary, the Aurora theatre, or Mother Emanuel what was done via the use of an assault rifle.

Unless we say, “¡BASTA!,” and actively oppose hate speech, make our state and federal legislators do the right thing and not cower to the gun lobby, and not patron stores selling these types of firearms, easy access to assault-style weapons means these tragedies targeting our most vulnerable populations will surely continue.

In memory of Tai Cook
A son, brother, and friend murdered via a gun shot while on the job

What Can I Do?

- Understand more about the psychological science behind gun violence:

- Read APA’s responses about the Orlando shooting:
  www.apa.org/pi/about/newsletter/2016/06/lgbt-orlando-shooting.aspx

- Read APA Initiatives to Prevent Gun Violence:
  www.apa.org/topics/violence/gun-violence-initiatives.aspx

- Find 100+ Resources for the aftermath of the Orlando shooting:
  www.apadivisions.org/division-44/resources/orlando-massacre.pdf?_ga=1.186295598.664515961.1460402254

- Take action:
  csgv.org/take-action/
  www.bradycampaign.org
  campaigntostopgunviolence.org/index.html

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Does she need more than just medicine?

When she needs help getting medical equipment, refer her for case management services, a Medicaid benefit for children birth through age 20 and high-risk pregnant women. Case Managers help patients navigate the health system by providing access to medical, dental, behavioral health, educational, and social services related to their health conditions.

Anyone can make a referral.
Call 1-877-THSTEPS or request a new Referral Pad by visiting https://secure.thstepsproducts.com.