Children's Health Coverage Coalition
January Meeting Minutes
Friday, January 19, 2018

Present:

Christina Hoppe, CHAT
Stacy Wilson, CHAT
Julia Hoffman, NASW
Kayla Sohns, NASW
Joanne Sanchez, NAM
Julia O'Hanlon, CDF-TX
Aliyah Conley, CDF-TX
Laura Guerra-Cardus, CDF-TX
Rey De La Garza, TNP
Grace Chimene, LWV- TX
Helen Kent Davis, TMA
Leah Gonzales, HFTX
Anne Dunkelberg, CPPP
Adriana Kohler, TCFC
Mimi Garcia, TACHC
Clayton Travis, TPS
Cheasty Anderson, CDF-TX
Jennifer Banda, THA
Jessica Giles, CPPP

On Conference Line:

Christina Phamvu, Methodist Healthcare Ministries
Celia Kaye, LWV TX
Shannon Lucas, March of Dimes
Sarah, Texas Council on Family Violence
Alice Bufkin, Healthy Futures of Texas
Melissa McChesney, CPPP

Chair: Mimi Garcia, TACHC
Meeting Scribe: Jessica Giles, CPPP

1. Federal Updates (11:10 a.m. – 11:20 a.m.)

Anne Dunkelberg on CHIP:

- The CBO scored latest *Kids Act* over a 10-year period, largely because it included a phase down of the matching rate. The scoring indicated a saving of $6 billion over 10 years,

which is creating more momentum to move forward with a 10 year extension. There has not been an agreement on DACA yet.

Mimi Garcia on Community Health Center Funding:

- Odds of any continuing resolution passing seem up in the air as of today. If CHIP and Health Center Funding, National Health Service Corp, Teaching Health Center Corps, and other small programs get separated, the other smaller items are less compelling and the chances of getting anything passed is far less likely. Two more chances to get these items passed which are February 16th and March 31st, March being a hard deadline.
- In 2016 1.3 million Texans served by community health centers. So this is huge. Rural and border communities have the smallest operating margins and will struggle to weather a loss.

Laura Guerra-Cardus:

- Email from *Community Catalyst:* Preempting attacks on ACA and Medicaid is really important. House and Senate Republicans are will be attending a joint retreated January 31- Feb 2 where they will plan priorities, which is an important moment to take preemptive action.

2. Work Requirement Guidance (11:20 a.m. – 11:35 a.m.)

Anne Dunkelberg:

- States are being invited to submit 1115 Waivers, which allow states to depart from existing federal Medicaid laws. Many states are pursuing work or community engagement requirements for adults who are not elderly, disabled, or pregnant. In the letter, they walk through the right way to do these things, such as providing transportation, child care, job training, and placement, but the belief is that work requirements are intentional acts to reduce access to Medicaid.
- Blog post on *Georgetown CCF*: Already 4 states that do not have Medicaid expansion and are asking for/talking publicly about imposing work requirements
- In Texas, work requirements would target 150,000 poor parents.

Helen Kent Davis:

- Senator Schwartner issued a press release about wanting Texas to pursue a work waiver.

Anne Dunkelberg:

- Legal challenges will absolutely happen. The letter also refers to three different potential ways that people can get locked out of coverage. Kansas and Arizona that are asking for lifetime limits on adult's Medicaid coverage, ranging from 3 months to 5 years. There is a relationship between how likely children are to get covered if their parents have coverage. Adult coverage affect children's coverage and wellbeing.
- *Kaiser Family Foundation* has a waiver tracker: LINK
- Part of the campaign has to be distilling key truths about Medicaid, because much of these waivers operate under a powerful false narrative.

Helen Kent Davis:

- Washington State has a waiver promoting work, which is an example of how states can support people who want to work, but have legitimate barriers that prevent them from doing so.

Anne Dunkelberg:

- Some are exempting former foster care under 26 and some are not.
- [See attached PowerPoint] *Kaiser Family Foundation* has some good graphics about what percentage of the potentially affected population are already working. Majority of people who aren't working are ill or disabled, taking care of their homes and families, or going to school.
- HHSC staff has agreed to give a presentation to consumers, advocates, and stakeholders sharing the process of parity implementation and compliance and what it looks like for Texas Medicaid, and the agency's new duties under HB**. HHSC on MH/SUD Parity in Texas Medicaid** on **February 12 from 1:00 pm – 3:00 pm at THA.**

3. 1115 Waiver Renewal (11:35 a.m. – 12:00 p.m.)

Stacy Wilson:

- [see attached PowerPoint and Summary]
- In 2011, Texas received an 1115 Waiver which:
    - Expanded managed care
    - Established Uncompensated Care (UC) and Delivery System Reform Incentive Payments (DRIP) pools
- In December 2017, Texas received a five-year renewal of the waiver
    - [see Timeline Table]
    - DSRIP goes down over time. This was supposed to be transformative and projects were supposed to become self-sustaining.
    - Timelines are very tight. If we don't meet these timelines, they can reduce by our pools by 20%..

Jennifer Banda:

- HHSC is having separate workgroups with different hospitals. HHSC has walked through a description of all the questions that they don't have answers to: sizing pool, distributing, change dollars of programs that are participating.

Anne Dunkelberg:

- Most of the work that happens around the waiver is hospital-centric. The state is shrinking contributions to Medicaid, which is making property taxes rise. Local government is paying more than half of the State's share.
- It is important to pay attention to how Medicaid is getting paid for. Every time that the legislature shoves something onto local governments, this is what drives up property taxes.

Jennifer Banda:

- This is part of the challenge of legislators saying that Medicaid is broken and taking up a huge part of budget, when Medicaid is primarily federal and local, not general revenue.

Stacy Wilson:

- Abbott wants to cap property taxes at 2.5 percent increase a year. This could affect coverage, as well as other funding at the local level.

4. Healthy Texas Women Draft Rules (11:59 a.m. – 12:15 p.m.)

Melissa McChesney on Eligibility and Enrollment:

- In January of 2013, a Medicaid funded women's health program was converted into Texas Women's Health Program. Eligibility and enrollment rules have carried forward through the many transitions. The program is now Healthy Texas Women. Summer of this year went back to HHSC requesting the same questions as 2011, excluding Planned Parenthood. First request was before ACA. New request was made in a post-ACA world, but the program itself has not changed. Some changes, but how income is counted has remained the same. MAGI methodologies are not used to determine Medicaid eligibility and they cannot be waived, but because the state wanted to keep the program, they kept all of the eligibility enrollment rules, regardless of the fact that they don't match ACA eligibility rules. Amendments are all contingent on the waiver getting approved.

Laura Guerra-Cardus:

- What's the expectation of the waiver being approved?

Alice Bufkin:

- There is nothing official or public yet, but the decision will be coming soon and it will likely be approved. If approved, it will continue to exclude Planned Parenthood and other providers, which violates federal Medicaid law, resulting in a flurry of lawsuits and other states trying to follow in Texas's path.
- Trump administration just released new guidance rescind Obama era guidelines opening up for other states to exclude providers. Shows a clear willingness to allow states to exclude certain providers

Melissa McChesney:

- [see handout]

Jennifer Banda:

- THA submitted a comment letter. The proposed rules change definition of elective abortion to where termination of a lethal, fetal abortion is elective. This changed definition could take hospitals out of the program and all of their affiliated hospital clinics.

5. Postpartum Depression Screening Rules & HB 2466 (12:15 p.m. – 12:27 p.m.)

Adriana Kohler:

- [See PDF of PowerPoint Slides]

- The screening alone is not enough and there is a lot of room for improvement. One screening is not consistent with the recommendations set by the American Academy of Pediatrics. It is important for us as advocates to look at the feasibility of allowing payment and reimbursement at additional visits. There are some screening tools that can capture other conditions, but some may not capture other issues that new moms face. Additionally, there is not much that gives guidance to pediatricians of how to set up an effective referral.

Mimi Garcia:

- From a FQHC perspective, there is needed information about how much can be shared of the screening between the clinic and the referral, and a general concern about where uninsured women being screened will receive treatment.

Adriana Kohler:

- Need to make sure that local mental health authorities are prepared. There is no official PPD diagnosis. The mother would get a different diagnosis. Historically MDD has been given priority, but that may not be given for other diagnosis. These specific diagnosis should not restrict timely care.

6. Interim Charges (12:32 p.m. – 1:00 p.m.)

Clayton Travis:

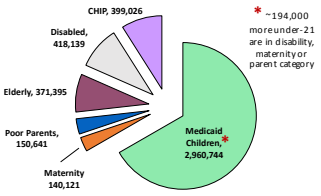
- [see handout for descriptions of Interim Charges and CHCC's Drafted Positions]
- Several hearings have been scheduled now, including Senate Health and Human Services **February 5th-** Deadline to submit comment on the Quick Glance Guide to allow for editing time before the next meeting.
- The Quick Glance Guide will be finalized and voted on at the next meeting.

Grace Chimene:

- REMINDER: Last day to register for the primary is Feb. 5th.
- Voters' guide will be out by early voting.
- Early voting starts on February 20th.
- The actual primary is March 6th.

Next Meeting: February 16, 2018

Texas Medicaid/CHIP: Children, Texans with Serious Disability, Poor Seniors, Pregnant Women, Very few Parents



* ~194,000 more under-21 are in disability, maternity or parent category

Total Enrolled:
(as of June 2017)
4.4 million Texans

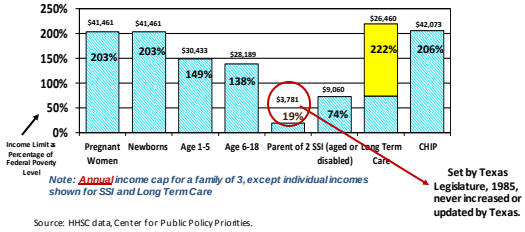
Of these,

3.4 million are children (~45% of Texas kids)

June 2017, HHSC data
Source: Center for Public Policy Priorities, HHSC data.

Why 3 million children, only 150,000 Parents?

Income Caps for Texas Medicaid and CHIP, 2017



Note: Annual income cap for a family of 3, except individual incomes shown for SSI and Long Term Care

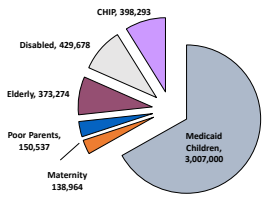
Set by Texas Legislature, 1985, never increased or updated by Texas.

Source: HHSC data, Center for Public Policy Priorities.

2

Use the TEXT from slide #3 but the pie chart is OLD, use #1

Texas Medicaid/CHIP: Mostly Children



February 2017, HHSC data
Source: Center for Public Policy Priorities, HHSC data.

Texas Medicaid and CHIP cover many Texas Children, but Texas Medicaid coverage for adults is much more limited. ***Most low-income uninsured adults will not qualify for Medicaid in Texas today.*** *Here's who can get Medicaid as an adult in Texas:*

- *Low-income pregnant women*
- *Low-income women with Breast or Cervical Cancer*
- *VERY-low income adults caring for a child*
- *Former Foster Care Children (ends at age 26)*
- *People age 65+ and people with disabilities, who are below or near poverty:*
  - *Includes people who need long-term care*
  - *Includes people who get Supplemental Security Income (SSI)*
  - *Medicaid pays some costs for low-income Medicare beneficiaries through the "Medicare Savings Program"*
  - *Some working adults with disabilities can "Buy-In" to Medicaid*

4

TEXAS Health and Human Services

1115 Demonstration Waiver Extension Summary

Health and Human Services Commission

January 11, 2018

1115 Extension Overview

Budget Neutrality (handout)

- Uncompensated Care pool funding
- Delivery System Reform Incentive Payments (DSRIP) pool funding

Uncompensated Care Pool & Payments

Payment Protocol & Rules development timeline

- Draft UC protocol is due to CMS by March 30, 2018. Approval expected in 90 days.
- Draft Texas Administrative Code rule on UC payments to be published by July 31, 2018.
- Revised draft UC applications to CMS by May 1, 2019. Approval required by August 31, 2019.
- Revised UC protocol to be implemented by October 1, 2019.
- Final Texas Administrative Code rule on UC payments to be published by January 30, 2019, and effective by September 30, 2019.
- Failure to meet any of these deadlines will result in a 20% reduction in expenditure authority from the UC pool for the program year. The reductions are cumulative.

Uncompensated Care Pool & Payments

Allowable costs and payments (S-10)

- Beginning in DY 9, UC pool payments will be based on charity costs incurred by qualifying providers and must exclude amounts for Medicaid shortfall as CMS prefers that reimbursement rates be adequate to cover Medicaid costs. Providers receiving both DSH and UC payments cannot be paid more than total eligible uncompensated costs.
- The UC payment protocol must include precise definitions of eligible uncompensated provider charity care costs for each qualifying provider type.

Uncompensated Care Pool & Payments

Pool Sizing (Demonstration Years 9-11)

- The UC pool size may temporarily default to a reduced amount of $2.3 billion for DY 9 - 11 until all charity costs are accurately reported. The pool will ultimately be reconciled to reflect the final charity care data and may be more or less than $2.3 billion depending on the data.
- Charity care costs will be determined by information in Worksheet S-10 of the Medicare hospital cost report (Form CMS-2552-10). For hospitals not required to complete the S-10, which are primarily children's, cancer, and rehabilitation hospitals, and Institutions of Mental Disease and for non-hospital qualifying providers, an alternate methodology using CMS-approved cost reports will be used to determine charity costs.

5

Cost-Based Payment Requirement

"The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share as specified in Attachment H."

STC 33

6

Cost-Based Payment Requirement

Example of CMS-approved approach used in Florida:

- Hospitals may be divided into tiered subgroups based on ownership, UC ratio, or ownership and UC ratio
- Ownership categories include local government, state government, and private and may be further grouped by the hospital's publically owned, statutory teaching, and freestanding children's hospital status
- All hospitals within the same subgroup that are eligible for a UC payment must receive the same percentage of their charity care cost.

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf

7

Other Issues

- Definition of Charity Care
- Non-Hospital qualifying providers
- Methodology to comply with the STC 33 requirement that payments be distributed without any relationship to the source of the non-federal share.

8

Tentative Timeline

January 16 – February 1: Conference Call/Meeting with provider groups

February 2: Begin drafting initial protocol

February 12: Share draft with stakeholders

February 14 – March 21: Review and revise draft

March 30: Draft submitted to CMS

9

Waiver Renewal - DSRIP

CMS approved four additional years for the Texas DSRIP program.

- Two years of level funding, followed by two years of funding that will decrease each year.
- The fifth year of the waiver extension does not include any funding for DSRIP.

CMS is still negotiating with HHSC on the DSRIP implementation protocols

- Attachment J – Program Funding and Mechanics Protocol (PFM)
- Attachment R – Measure Bundle Protocol (MBP)

10

CMS Requirements for DSRIP

- Strengthen the measurement set
- Define and incorporate an attribution model
- Proportional distribution of Category C
- Accountable performance measurement and payment methodology for providers with high baselines
- Link Core Activities to selected Measure Bundles and Category C

11

Sustainability/Transition Plan

Texas will be required to submit a transition plan outlining how it will further develop its delivery system reforms without DSRIP funding and/or phase out DSRIP-funded activities and meet mutually agreeable milestones to demonstrate ongoing progress.

- Required by the Special Terms and Conditions
- Draft due by October 31, 2019
- Milestones may relate to the use of alternative payment models, the state's adoption of managed care payment models that support providers' delivery system reform efforts, and other opportunities.

12


TEXAS
Health and Human
Services
Thank you
13

1115 Waiver Timelines

Table 1: 1115 Waiver Timeline

	Date	DSRIP	UC	Items	CHAT Issue	Waiver Section
DY 7	**January 21, 2018**	⊕		CMS must approve DSRIP Protocols • RHP Planning Protocol (Attachment I) • Program Funding and Mechanics Protocol (Attachment J); and • Measure Bundle Protocols (Attachment R)*	• Participation in multiple Regional Healthcare Partnerships (RHP) • Ability to meet minimum point threshold and reduced valuation • Clinical appropriateness of statewide reporting measure bundle for children	Page 44/ STC 34 (d)(i)
	March 30, 2018		🩺	HHSC must submit UC Payment Protocol and Application (Attachment H). Approval is expected in 90 days.	• Children's hospitals and the use of S-10/Charity Care for UC • Ability to claim physician, clinic, and pharmacy uncompensated care costs • UC reconciliation process	Page 41/STC 33(e)(i)
	July 31, 2018		🩺	HSHC must publish proposed Texas Administrative Code (TAC) rules. Final rules must be published by January 30, 2019 and effective September 30, 2019.		Page 41/STC 33 (e)(iii)
DY 8	**May 1, 2019**		🩺	HHSC must submit the revised UC Application Tools for all providers. Approval is required by August 31, 2019		Page 41/STC 33(e)(ii)
	September 1, 2019		🩺	HHSC should submit 2017 charity care data for CMS to resize the UC Pool		Page 45/STC 35 (a)
DY 9	**October 1, 2019**	⊕		HHSC must submit DSRIP draft transition plan.		Page 46/STC 37 (a)
	October 1, 2019		🩺	CMS and HHSC start using new UC protocol and resized UC Pool		Page 41/STC 33(e)(i)

*Attachment H is likely due on January 21, 2018, based on the waiver language. We are confirming this with HHSC.

Table 2: Demonstration Year Definitions and Funding

Demonstration Year (DY)	Extension Year	Timeframe	Funding	
			UC	DSRIP
DY 7	1st Year	October 1, 2017 – September 30, 2018	$3.1 Billion	~$3.1 Billion
DY 8	2nd Year	October 1, 2018 – September 30, 2019	$3.1 Billion	~$3.1 Billion
DY 9	3rd Year	October 1, 2019 – September 30, 2020	Resized with 2017 charity care data*	$2.91 Billion Cap
DY 10	4th Year	October 1, 2020 – September 30, 2021	Resized with 2017 charity care data*	$2.49 Billion Cap
DY 11	5th Year	October 1, 2021 – September 30, 2022	Resized with 2017 charity care data*	$0

* $2.3 Billion if reassessment is not complete

Janet P. Realini, MD, MPH
Steering Committee Chair
The Texas Women's Healthcare Coalition
2300 W. Commerce St. #212
San Antonio, TX 78207

TO: Stephanie Muth
State Medicaid Director, Medicaid and CHIP Services
Texas Health and Human Services
4900 Lamar Boulevard
Austin, TX 78751

CC: Lesley French, Associate Commissioner for Women's Health
Texas Health and Human Services

DATE: December 22, 2017

SUBJECT: Texas Women's Healthcare Coalition (TWHC) Comments on the proposed draft rules for the Healthy Texas Women Program

Thank you for this opportunity to provide comments on the proposed draft rules for the Healthy Texas Women program. The Texas Women's Healthcare Coalition (TWHC) and its 77 healthcare, faith, and community-based member organizations are dedicated to improving the health and well-being of Texas women, babies, and families by assuring access to preventive healthcare for all Texas women. Access to preventive and preconception care—including health screenings and contraception—means healthy, planned pregnancies and early detection of cancers and other treatable conditions.

Included below are the TWHC's recommendations related to the proposed draft rules for the Healthy Texas Women program. Recommended changes for each section are indicated in red, with additional comments following.

The TWHC thanks the Texas Health and Human Services (HHS) for their time and consideration of these issues.

Ensure an Adequate Network of Qualified Providers

Though the state has made important investments in women's healthcare in recent years, Texas continues to struggle to ensure an adequate provider network to serve the hundreds of thousands of women in Texas in need of preventive health services.

According to the state's 2017 Savings and Performance Report for the Texas Women's Health Program (TWHP), the average number of clients receiving services per provider fell from 150 clients per provider during Fiscal Year 2011 to 103 clients per provider during Fiscal Year 2015. As the report notes, there was a significant decline during this period in the number of providers seeing large numbers of clients.[i]

The effect of this decline in high-volume providers can be seen in the decline in services provided in this program. The Savings and Performance Report indicates that there was a dramatic drop in the provision of injections, oral contraception, condoms, and other forms of contraception in TWHP. As the report notes, some of this decline can be attributed to the increase in Long-Acting Reversible Contraception (LARC) methods, which reflects important efforts by HHSC to increase access to these longer-lasting methods. However, increase in LARC use cannot entirely explain the decline in contraceptive use experienced by clients between 2011 and 2015.

Moreover, data from HHSC indicates that there has been a significant decline in total clients served across the state's women's health programs in recent years.[ii] This indicates that the state's women's health programs have more work to do to build adequate provider capacity in Texas.

Given these challenges, the TWHC encourages HHS to ensure Texas has an adequate provider capacity prior to moving forward with the waiver. Texas must have a strong family planning network prior to implementing changes that might further disrupt the current family planning safety net.

§382.7. Client Eligibility.

(a)(6) does not currently receive benefits through a Medicaid program that provides full benefits, ~~Children's Health Insurance Program, or Medicare Part A or B~~; and

(a)(7) does not have other creditable health coverage that covers the services HTW provides, **with no cost sharing,** except as specified in subsection (c) of this section. **A female is eligible for HTW preventive services if her creditable health coverage requires cost-sharing for these services.**

(f) Auto-enrollment from Children's Medicaid and the Children's Health Insurance Program. At age 19, a female who is receiving Children's Medicaid or CHIP and is not otherwise eligible for a Medicaid group will automatically be enrolled into HTW at the end of their CHIP certification period to ensure that there is no gap in health coverage. HHSC will not auto-enroll a female to HTW if she chooses to opt out of receiving HTW.

Additional Comments:

- TWHC appreciates HHSC's clarification that for Medicaid to disqualify a client from participating in HTW, it must provide full benefits.
- HHSC should take steps to streamline enrollment of minors in Pregnant Women Medicaid into the Healthy Texas Women program, if they are not otherwise eligible for any other Medicaid group.
- At the end of their Pregnant Women's Medicaid certification period and after being determined not eligible for any other Medicaid group, women's information should be transferred to the federal Health Insurance Marketplace (as is required by 42 CFR 435.1200(e)) even if those women are auto-enrolled into HTW.
- Women with Medicare are able to receive contraception and sterilization if these services are medically necessary, but not if they are used for contraceptive purposes. Enabling women in Medicare Part A and B to enroll in HTW will help reduce the chances of high-risk pregnancies and improve infant and maternal health outcomes.

§382.9 Application and Renewal Procedures

(f) Identity. An applicant**'s identity** must **be** verifi**ed~~y her identity~~** the first time she applies to receive covered services. **HHSC must use available electronic resources to verify identity and citizenship before requesting documentation from the client.**

(g) Citizenship. If an applicant is a United States citizen, she must provide proof of citizenship. **HHSC must use available electronic resources to verify identity and citizenship before requesting documentation from the client.**

§382.11 Financial Eligibility Requirements

(b) Adjunctive eligibility. An applicant or client is considered adjunctively eligible at an initial review or renewal application, and therefore automatically financially eligible, if:

(5) She is in a Children's Health Insurance Program (CHIP) budget group for someone receiving CHIP.

Additional Comments:

- HHSC should prioritize changes to the TIERS system that would enable TIERS to accept Healthy Texas Women clients who are enrolled in CHIP. Even if the TIERS system is not yet able to accommodate the change, HTW rules should indicate that clients eligible for CHIP may receive HTW services.
- All child support received should be excluded from countable income for Healthy Texas Women and the Family Planning program. Excluding all child support received from countable income will better align HTW with other healthcare systems, and will ensure that the receipt of child support does not disqualify certain clients from receiving services. In a previous iteration of comments, HHSC responded that child support payments *paid* are already excluded from countable income. However, here we are referencing the value of excluding child support payments *received* by the applicant.

§382.15. Covered and Non-covered Services.

(a)(1) health history and physical**, including family planning exam, follow-up visits related to the chosen contraceptive method, and follow-up visits related to sterilization, including procedures to confirm sterilization;**

(a)(2) counseling and education**, including counseling on specific methods and use of contraception**;

(a)(3) laboratory testing**, including pregnancy testing and screening for sexually transmitted infections (STIs), diabetes mellitus, and hypercholesterolemia**;

(a)(4) provision of a contraceptive method **and removal of temporary contraceptive methods. Methods include female sterilization**;

…

(b) Non-covered services. Services not provided through HTW include:

(b)~~(2) counseling on and provision of emergency contraceptives; and~~

(b)(2~~3~~) other services that cannot be appropriately billed with a permissible procedure code.

§382.25. Confidentiality and Consent.

(b) Written release authorization. Before an HTW provider may release any information that might identify a particular client, that client must authorize the release in writing**, except reports of child abuse required by Texas Family Code, Chapter 261, and as required or authorized by other law**. If the client is 15 through 17 years of age, inclusive, the client's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release.

(g~~f~~) Consent for minors. HTW services must be provided with consent from the minor's parent, managing conservator, or guardian only as authorized by Texas Family Code, Chapter 32, or by federal law or regulations.

§382.28 Freedom of Choice

Clients have the right to freely choose family planning methods and sources of services. Clients shall not be coerced to accept services.

§382.29 Abuse Reporting

Texas Family Code, Chapter 261, requires child abuse reporting.

(1) The department may distribute appropriated funds only to providers that show good faith efforts to comply with all child abuse reporting guidelines and requirements as interpreted by department policy.

(2) Additionally, providers must develop an agency specific policy for Human Anti-Trafficking and Intimate Partner Violence to comply with abuse reporting guidelines and requirements.

§382.30 Civil Rights

Providers shall make family planning services available without regard to marital status, parenthood, handicap, age, color, religion, sex, ethnicity, or national origin. The provider must comply with Title VI of the Civil Rights Act of 1964 (Public Law 88 – 352); §504 of the Rehabilitation Act of 1973 (Public Law 93 – 112); The Americans with Disabilities Act of 1990 (Public Law 101 – 336), including all amendments to each; and all regulations issued pursuant to these Acts.

Thank you for your time and consideration, and for your support for women's preventive healthcare. If you have any questions or we can provide further information, please contact Janet Realini at JRealini@TexasWHC.org.

Respectfully,

Janet P. Realini, MD, MPH
Steering Committee Chair, Texas Women's Healthcare Coalition

Texas Women's Healthcare Coalition Steering Committee Members

Texas Medical Association
District XI (Texas) American Congress of Obstetricians and Gynecologists
Texas Academy of Family Physicians
Texas Association of Community Health Centers
Methodist Healthcare Ministries
Teaching Hospitals of Texas
Women's Health and Family Planning Association of Texas
Texans Care for Children
Center for Public Policy Priorities
Healthy Futures of Texas

Texas Women's Healthcare Coalition General Members

Access Esperanza Clinics Inc.
Amistad Community Health Center
Austin Advanced Practice Nurses
Austin Physicians for Social Responsibility
AWHONN Texas
Brazos Valley Community Action Agency, Inc.
Brazos Valley Nurse Practitioner Association
Cardea
Center for Community Health, UNTHSC
Central Texas Nurse Practitioners
Children's Hospital Association of Texas
Coalition for Nurses in Advanced Practice
Coastal Bend Advanced Practice Nurses
Coastal Bend Wellness Foundation
Community Healthcare Center
Consortium of Texas Certified Nurse Midwives
Department of Ob/Gyn of UNTHSC and the ForHER Institute
El Buen Samaritano
El Centro De Corazón
El Paso Area Advanced Practice Nurse Association
Food Bank of the Rio Grande Valley
Fort Worth Region Nurse Practitioners
Gateway to Care
Good Neighbor Health Center
Haven Health
Hill Country Advanced Practice Nurses & Physicians Assistants Association
Houston Area Chapter of NAPNAP
Houston Area Nurse Practitioners
League of Women Voters of Texas
Legacy Community Health Services
March of Dimes - Texas
Mental Health America of Greater Houston
National Council of Jewish Women—Texas State Policy Advocacy Network
National Latina Institute for Reproductive Health
North Harris Montgomery Advanced Practice Nurse Society
North Texas Alliance to Reduce Teen Pregnancy
North Texas Nurse Practitioners
Panhandle Nurse Practitioner Association
Pasadena Health Center
People's Community Clinic
Port Arthur Housing Authority
Pregnancy and Postpartum Health Alliance of Texas
SALVERE (Striving to Achieve Literacy via Education, Research, and Engagement)
San Antonio Metropolitan Health District
San Antonio Nurses in Advanced Practice
Schneider Communications
South Plains Nurse Practitioner Association
South Texas Family Planning & Health Corp.
Southeast Texas Nurse Practitioner Associates
Special Health Resources
St. David's Foundation
Texas Association of Obstetricians and Gynecologists
Texas Campaign to Prevent Teen Pregnancy
Texas Council on Family Violence
Texas Health Institute
Texas Hospital Association
Texas Medical Association Alliance
Texas Nurse Practitioners
Texas Nurses Association
Texas Pediatric Society
Texas Unitarian Universalist Justice Ministry
The Contraceptive Initiative
The SAFE Alliance
The Women's Fund for Health Education and Resiliency
University Health System
Valley AIDS Council
Women's & Men's Health Services of the Coastal Bend, Inc.

[i] Texas Health and Human Services Commission. *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance: House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 41).* March 2017.
[ii] Texas Health and Human Services Commission. *HHS Women's Health Update*. May 15, 2017.

2018 "Quick Glance" Interim Charge Guide

(A) Medicaid and CHIP (AD, CT, LGC, MG, KG, HKD, AK)

House Committee on Appropriations

4. Monitor the ongoing implementation of S.B. 20 (84R), S.B. 533 (85R), and S.B. 255 (85R), as well as Article IX, Sections 7.04, 7.10, and 7.12 of the General Appropriations Act. Study the ***processes by which state agencies award, execute, manage, and monitor state contracts****, and make recommendations on whether any changes are necessary to safeguard the best interest of the public and state. Evaluate measures utilized to determine vendor performance, and make recommendations on how to improve vendor selection and performance. When reviewing the Health and Human Services Commission's (HHSC) managed care contracts, determine if HHSC has adequate data, staff, and processes to provide appropriately rigorous contract oversight, including but not limited to the use of outcome metrics. Consider whether HHSC properly enforces contractual sanctions when managed care organizations (MCOs) are out of compliance,* ***as well as how HHSC uses Medicaid participants' complaints regarding access to care to improve quality.***

Coalition positions:

1. This review should include analysis of current Texas Medicaid Managed Care (TMMC) standards for and oversight of network adequacy, including how ongoing compliance is verified and including classes of providers serving Medicaid enrollees with behavioral health needs, long term services and supports needs, and medically fragile enrollees.
2. To be comprehensive, the review should analyze findings from tmmc consumer and provider satisfaction surveys, and examine detailed breakouts of the subjects about which enrollees make inquiries to/request help from MCOs and HHSC that are ultimately not categorized as complaints.
3. This review should include a review of the how HHSC handles complaints filed through the Office of the Ombudsman and uses those complaints to improve quality. Evaluate the status of implementation of the Behavioral Health Access to Care Ombudsman position created through HB 10 (85R).

11. ***Monitor Congressional action on federal healthcare reform and CHIP reauthorization.*** *Identify potential impacts of any proposed federal changes. Identify short- and long-term benefits and challenges related to converting Texas Medicaid funding to a block grant or per capita cap methodology. Determine how Texas should best prepare for federal changes, including statutory and regulatory revisions, as well as any new administrative functions that may be needed. Explore opportunities to increase the state's flexibility in administering its Medicaid program, including but not limited to the use of 1115 and 1332 waivers.*

Coalition positions:

1. New Congressional proposals for Medicaid block grant or per capita cap funding should be analyzed to determine the the near- and long-term aggregate and per-recipient reductions in funding and the impact on health outcomes for Texas children and families.
2. Per-capita caps on Medicaid should be compared to Medicare and private market average per capita costs for comparable beneficiaries in Texas. Per capita growth rate caps should not be adopted that lock Texas Medicaid into historical spending patterns that fall below the actual costs of meeting contemporary medical standards of care. An acceptable per-capita growth limit should be only be imposed on Medicaid if it is also imposed on Medicare, federal employees, and members of Congress and their staff.
3. To maximize the return of Texans' federal tax dollars, optimize the health of Texans, prevent damaging cuts to the medical safety net programs on which all Texans rely, and provide robust support for addressing mental health, maternal health, and addiction challenges facing Texas, the Legislature should study and adopt new financing structures that can comply with federal Medicaid policy, aggregate the current patchwork of special funding and payment systems supporting hospital services (including trauma care) and Delivery System Reforms, and ensure that millions of working poor Texas adults (currently excluded from both Medicaid and the ACA Marketplace) can access affordable medical coverage.
4. When considering proposed models of health coverage, including under 1115 or 1332 waiver authorities, Legislators should ensure that cost-sharing obligations are tailored to match family incomes to ensure access to needed care, and that families are protected from medical debt that will prevent them from advancing economically.
5. If the Legislature is faced with federal changes that will reduce Medicaid funding in exchange for "flexibility" (such as block grant or per capita cap), lawmakers should define clearly what beneficiaries, services, or payment rates they propose to cut to accommodate the new funding limits. Critical benefits for children should remain intact, including, but not limited to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit -- known as Texas Health Steps in Texas -- which ensures that children can receive health screenings and treatments to address conditions discovered through screens and diagnostic tests..

18. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature. In conducting this oversight, the Committee will also specifically monitor:

- ***All activities and expenditures related to Hurricane Harvey;***
- *Any lapses in funding at the Department of Family and Protective Services (DFPS) or the Health and Human Services Commission (HHSC) f****or prevention and early intervention, and/or behavioral health services;***
- ***Implementation of therapy rate increases and policy changes at HHSC;***
- ***Medicaid cost-containment efforts***

Coalition positions:

1. The review of Medicaid-specific funding relief related to Hurricane Harvey should include inquiry into the adequacy of the response for non-hospital health care providers, and for non-urban Harvey-affected counties.
2. Review of any Medicaid cost-containment efforts should include analysis of the comparability of Medicaid payment rates for an affected service to those of Medicare, and whether proposed cost containment constraints on spending for a service may contribute to higher costs in hospitalization or long term services and supports.

House Committee on Human Services

2. Review the history and any future roll-out of Medicaid Managed Care in Texas. Determine the impact managed care has had on the quality and cost of care. In the review, determine: ***initiatives that managed care organizations (MCOs) have implemented to improve quality of care; whether access to care and network adequacy contractual requirements are sufficient; and whether MCOs have improved the coordination of care. Also determine provider and Medicaid participants' satisfaction within STAR, STAR Health, Star Kids, and STAR+Plus managed care programs****. In addition, review the Health and Human Services Commission's (HHSC) oversight of managed care organizations, and make recommendations for any needed improvement.*

Coalition positions:

1. This review should include analysis of current TMMC standards for and oversight of network adequacy, including how ongoing compliance is verified by HHSC and including adequacy of the supply of classes of providers serving Medicaid enrollees with behavioral health needs, long term services and supports needs, and medically fragile enrollees.
2. To be comprehensive, the review should analyze findings from TMMC consumer and provider satisfaction surveys, and also examine detailed breakouts of the subjects about which enrollees make inquiries to/request help from MCOs and HHSC that are ultimately not categorized as formal complaints.
3. The committee should request a table or matrix from HHSC detailing the unique care coordination and case management features and standards of each category of TMMC. Testimony from beneficiaries and their caregivers should be sought to solicit independent perspectives on the adequacy of or gaps in care coordination.
4. The committee should investigate efforts to streamline credentialing requirements for providers seeking to offer targeted case management and rehabilitative services to children, adolescents, and their families. This analysis should include a review of changes in the number of providers offering these services, as the intent of SB 58 (83R) and SB 74 (85R) was, in part, to increase statewide capacity for targeted case management and rehabilitative services for high-needs children, adolescents, and their families.
5. Legislators should examine strategies for improving efficiency in Medicaid/CHIP eligibility and renewal processes in order to decrease gaps in coverage, avoid related costs to managed care system, and promote quality-based value initiatives through managed care.

Senate Health and Human Services Committee

Medicaid Managed Care Quality and Compliance: Review the Health and Human Services Commission's efforts to ***improve quality and efficiency in the Medicaid program, including pay-for-quality initiatives in Medicaid managed care. Compare alternative payment models and value-based payment arrangements with providers in Medicaid managed care****, the Employees Retirement System, and the Teachers Retirement System, and identify areas for cross-collaboration and coordination among these entities. Evaluate the commission's efforts to ensure Medicaid managed care organizations' compliance with contractual obligations and the use of incentives and sanctions to enforce compliance. Assess the commission's progress in implementing competitive bidding practices for Medicaid managed care contracts and other initiatives to ensure the best value for taxpayer dollars used in Medicaid managed care contracts.*

Coalition positions:

1. Review in detail the rate-setting process for TMMC premiums, and analyze the relationship between allowable retained profits for MCOs and the adequacy of primary care physician, physician specialist and provider reimbursement rates. Identify aspects of the methodology which may provide financial disincentives for adoption of delivery system reforms and best practices broadly by all MCOs.
2. This review should explore how value-based payment models can incorporate evidence-based maternal health and safety bundles -- which are best practices and protocols for maternity care -- in order to reduce maternal mortality and improve infant health.
3. Review the role of evolving Local Provider Participation Funding (LPPF) mechanisms and Uniform Hospital Rate Increase Program (UHRIP) mechanisms in supplementing the adequacy of state-budget-funded MCO premiums. Explore how changing federal Medicaid policies regarding the sources of matching funds and the methods by which the gap between Texas Medicaid and Medicare rates can be financed may create incentives for adopting new uniform statewide funding approaches. Explore how Texas could comply with changing federal Medicaid policy regarding funding for Delivery System Reform Incentive Payment (DSRIP) projects, specifically the directive that the innovations be "built into" TMMC benefits and premiums, to allow Texas retain successful DSRIP innovation as well as the related federal funding.

Senate Finance Committee

Monitoring: Monitor the implementation of the following funding initiatives:

- *Health Care Costs Across State Agencies, Monitor coordination efforts among state agencies to **improve health care and reduce costs** pursuant to Article IX, Section 10.06 and Section 10.07*
- *Behavioral Health, Monitor the state's **progress in coordinating behavioral health services and expenditures** across state government, pursuant to Article IX section 10.04, including the impact of new local grant funding provided by the 85th Legislature.*

Coalition positions:

1. Examine the extent to which new local behavioral health grant funding serves children. Consider a requirement that a certain percentage of local behavioral health grant funding go towards early intervention.
2. To be comprehensive, the review should examine strategies for improving efficiency in Medicaid/CHIP eligibility and renewal processes for children in order to decrease gaps in coverage, avoid related costs to managed care system, and promote quality-based value initiatives through managed care.

(B) Maternal Health and Birth Outcomes (AK, TWHC, TCHM, HKD)

Senate Health and Human Services Committee

Monitoring Charge: Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:

- ***Initiatives to better understand the causes of maternal mortality and morbidity, including the impact of legislation passed during the first special session of the 85th Legislature. Recommend ways to improve health outcomes for pregnant women and methods to better collect data related to maternal mortality and morbidity;***

Coalition positions:

1. Enhance investments in critical health programs that support pregnancy health, infant health and reduce maternal mortality, including but not limited to funding for Medicaid, CHIP, women's health programs, and mental health and substance use treatment and recovery programs.
2. To maximize the return of Texans' federal tax dollars, prevent damaging cuts to the medical safety net programs, and reduce maternal mortality and morbidity, the Legislature should study and adopt new financing structures that aggregate the current patchwork of special programs and payment systems and ensure more Texans can access affordable medical coverage. Continuous health coverage before, during, and after pregnancy enables more Texans to access primary care *before and after* pregnancy and manage health issues that could cause dangerous pregnancy complications or even death for mom or baby.
3. Expand the reach of current campaigns and initiatives to educate families about prenatal/ postpartum care and primary care before and after pregnancy. Assess the extent to which the state can utilize multiple points of contact (including home visiting programs, community health workers, and health plans) to increase access to prenatal and postpartum care.
4. To be comprehensive, this review should include ways to incentivize maternal health safety bundles in health settings; ways to utilize telehealth to improve prenatal and postnatal health and safety, including in rural areas and areas with transportation barriers; and specific strategies to reduce turnaround time for Medicaid/CHIP Perinatal applications and receipt of insurance cards.

Senate Health and Human Services Committee

*Substance Abuse/Opioids**: Review substance use prevention, intervention, and recovery programs** operated or funded by the state and make recommendations to enhance services, outreach, and agency coordination. **Examine the adequacy of substance use, services for pregnant and postpartum women enrolled in Medicaid or the Healthy Texas Women Program and recommend ways to improve substance use related health outcomes for these women and their newborns**. Examine the impact of recent legislative efforts to curb overprescribing and doctor shopping via the prescription monitoring program and recommend ways to expand on current efforts.*

Coalition positions:

1. Analyze the extent to which devising coverage options for low-income Texas adults could most effectively support optimal access to adequate substance use disorder treatment, mental health, and postpartum care while maximizing the return of federal tax dollars to Texas and reducing the shift of costs to local taxpayers.
2. Continue sustainable funding for health programs that prevent and treat substance use disorders, including but not limited to funding for Medicaid, CHIP, and substance use treatment and recovery programs. This includes increasing state investments (state match) in treatment/recovery providers funded under Texas' Substance Abuse and Prevention Block Grant.
3. Continue robust funding for Texas' women's health programs as clinicians participating in these programs may be the only provider a woman sees in a year for routine preventive care and

screenings. This presents a vital opportunity to screen for opioid use and refer women to additional behavioral health and substance use services.

4. Fully fund and expand successful, cost effective services aimed at reducing the incidence, severity, and costs associated with fetal alcohol spectrum disorder and neonatal abstinence syndrome, including but not limited to the Mommies Program and the Pregnant, Postpartum Intervention Program (PPI).
5. To be comprehensive, this review should include examining waitlist and capacity challenges at HHSC-funded substance use treatment providers; examining barriers to accessing Medication-Assisted Treatment (MAT) including provider shortages and transportation barriers, and assessing ways to expand the reach and capacity of female-specialized substance use treatment/recovery programs that keep parents and children together.
6. Review in detail DFPS policies for investigation and child removal as a result of parental substance use and compare with clinical best practices to support infant health and maternal outcomes for pregnant and postpartum women.

House Select Committee on Opioids and Substance Abuse

2. ***Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness.*** *In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served.* ***Consider whether the programs have the capacity to meet the needs of Texans****. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans.* ***Recommend strategies to increase the capacity to provide effective services.***

Coalition positions:

- *See above*

House Committee on Public Health

1. Review state programs that provide women's health services and recommend solutions to increase access to effective and timely care. During the review, identify services provided in each program, the number of providers and clients participating in the programs, and the enrollment and transition process between programs. Monitor the work of the Maternal Mortality and Morbidity Task Force and recommend solutions to reduce maternal deaths and morbidity. ***In addition, review the correlation between pre-term and low birth weight births and the use of alcohol and tobacco.*** *Consider options to increase treatment options and deter usage of these substances.*

Coalition positions:

1. Continue robust funding for Texas' women's health programs, which further our state's efforts to improve maternal and child health and reduce Medicaid and public health costs. Healthy Texas Women and the Family Planning Program offer preventive care and health screenings that help improve pregnancy health, reduce risks of pre-term and low-birth weight births, and help women manage health conditions before they become pregnant. HTW and FPP providers may be the only provider a woman sees in a year for routine care, presenting a vital opportunity to screen and refer women to additional behavioral health and substance use services.
2. If data indicates inadequate provider capacity or quality of care within the state's women's health programs, legislators should work with HHSC to address gaps in health coverage and to ensure

that all providers offer services that meet quality family planning standards as recommended by the Centers for Disease Control and Prevention. [For group consideration]

3. Increase awareness of and access to the state's women's health programs by utilizing multiple points of contact -- such as community health workers, health plans, or peer services.
4. Though women from Medicaid for Pregnant Women are auto-enrolled in Healthy Texas Women 60 days after delivery of a child, legislators should identify ways to ensure more women receive health services after being auto-enrolled into HTW, including more outreach to inform clients and health providers about this opportunity.
5. Legislators should also study and adopt ways CHIP Perinatal health plans can connect women to Texas' Family Planning Program in their service area after the birth of their child.
6. Examine extent to which CHIP health plans can help connect youth who are aging out of CHIP coverage (e.g., turning age 19) with the state's women's health programs in order to support continuity of care.
7. Legislators should examine the extent to which devising coverage options for low-income Texas adults could most effectively support optimal access to primary care before, during, and after pregnancy, improve birth outcomes, and reduce maternal deaths and morbidity while maximizing the return of federal tax dollars to Texas and reducing the shift of costs to local taxpayers.

(C) Early Childhood Intervention (CT, ECI Advocacy Coalition)

House Committee on Appropriations

10. Examine the Early Childhood Intervention Program (ECI) in Texas, including a review of historical funding levels, programmatic changes, challenges providers face within the program, and utilization trends. Evaluate ECI's impact on reducing the long-term costs of public education and health care. Identify solutions to strengthen the program.

Coalition positions:

1. Increase the per child allotment to ECI contracted entities to cover the actual (or closer to actual) costs of providing services to one child who qualifies for services
2. Highlight the lack of appropriations to fund Child Find efforts and caseload growth within ECI session after session. Possibly explore a policy mechanism to ensure future funding of Child Find efforts and caseload growth.
3. Mandate commercial insurance to cover services provided by the credentialed Early Intervention Specialists (EIS staff) for Specialized Skills Training (SST) to assist ECI contractors to increase revenues from third party sources and alleviate the need to use GR contract funds.
4. Further restore therapy rate reductions and/or hold ECI harmless from previous rate reductions due to the program's best practice status for children 0-3

House Select Committee on Opioids and Substance Abuse

1. Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and

health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.

Coalition positions:

1. [*Also see section above on Maternal Health and Birth Outcomes*]
2. Highlight the impact of parental substance use on newborn children and the availability of ECI as resource for children with disabilities as a result.
3. Increase investment in ECI (see above ECI asks) to ensure access to services for all children who need them.
4. Evaluate insurance practices and coverage requirements regarding substance use treatment for children.