Texas CHC Coalition
Meeting Minutes

February 17, 2017

Present:
Helen Kent Davis, Texas Medical Association
Kit AbneySpelce, Central Health
Adriana Kohler, Texans Care for Children
Alice Bufkin, Healthy Futures of Texas
Clayton Travis, Texas Pediatric Society
Shannon Lucas, March of Dimes
Mary Allen, Texas Association of Community Health Centers
Mary Dodd, Community Advancement Network
Angelica Davila, CommUnity Care Health Centers
Stephanie Lopez, CommUnity Care Health Centers
Annoora Garner, League of Women Voters - Texas
Christina Phamvu, Methodist Healthcare Ministries
Sebastian Laroche, Methodist Healthcare Ministries
Moss Hampton, American Congress of OB/GYN – Texas
Charlie Brown, American Congress of OB-GYN – Texas
Tony Dunn, American Congress of OB-GYN - Texas
Billy Millwee, former Texas Medicaid director
Wayne Salter, HHSC-AES
Erika Ramirez, HHSC-AES
Gina Perez, HHSC-AES
Paige Marsala, HHSC – OO
Patrick Randall, HHSC
John Banaszak, HHSC
Magdalena Blanco, HHSC
Kristen Perros deGuex, HHSC

On the phone:
Paul Townsend, Children's Hospital Association of Texas
Chris Velasquez, Driscol Health Plans
Sara Gonzales, Texas Hospital Association
Sister J.T. Dwyer, Daughters of Charity
Diane Rhodes, Texas Dental Association
Jaylin Collins, Texas Children's Hospital
Kelly Dees, Texas Pediatric Society
Linda Litzinger, Texas Parent2Parent
Elana Bolton, Central Health
Peggy Gomez, Maximus

Kathy Eckstein, Children's Hospital Association of Texas
T. D. Sesinger, Maximus
Rose Valdez, Children's Medical Center of Health Plans
Marylyn Varerra, South Texas Health Plans
Jennifer Banda, Texas Hospital Association

Chair: Helen Kent Davis, Texas Medical Association
Minutes Scribe: Kamia Rathore, Center for Public Policy Priorities
Next meeting: March 24, 2017

I. Discussion of Optional Medicaid Services/Cost Containment *(Billy Millwee, former Texas Medicaid Director)*

- *See slides below*
- **Helen:** We've asked Billy Millwee to provide some perspective on optional Medicaid benefits, given that the Senate Finance subcommittee on healthcare costs is considering cutting or limiting optional benefits for adults. The ACA currently protects these benefits for children, but they may be reduced for adults.
- **Billy**: There are certain state flexibilities around benefits, as well as some exceptions. The Social Security Act says that all states must cover a certain set of benefits and allows for optional services. It might be surprising what's optional—one of those benefits is prescription drugs. Benefits, when covered, must define three factors: amount, duration, and scope. The state must also allow freedom in choice among providers. When a state puts in place managed care, there are some limits on freedom of choice. Choice moves from providers to freedom of choice among plans.
- *See slides for full list of federal mandatory benefits*
- *See slides for full list of covered optional benefits in Texas*
- I wanted to touch on the Early, Periodic, Screening, Diagnosis and Treatment Services (EPSDT) program, or Texas Health Steps. It says that any service that is determined as medically necessary for a child has to be provided. It includes vision, hearing problems, and preventative dental care. The state is required to have a standard screening schedule as identified by groups like APS and ADA. Effectively, it creates separate benefits for children compared to adults. The issue is that as people grow up with Medicaid, particularly kids with disabilities, the same robust package is no longer available.
- There's a process for adding optional benefits. Generally, they're added because they are cost effective. It requires an agreement between the states and the federal government called a Medicaid state plan. In practice, benefits aren't typically changed without legislation. In a year where there is a tight budget, typically the legislature will go through optional benefits. There's an assumption that cutting or reducing optional benefits will save money, but if you look at the history, there's a cost-benefit reason these optional benefits were originally covered. For example, if you want to eliminate covering hearing aids, you're going to get a downturn in opportunities for work and the ability to make progress in other areas of individual's lives—effectively, you pick up the costs somewhere else.

- We'll probably see attempts to put more controls on how many benefits you can access without authorization. There's more flexibility with managed care. In managed care there's something referred to as "services in lieu of." A family could receive a bill for services through the MCO if the services are not covered by Medicaid and they sign of indicating they understand that.
- **Helen**: One thing that was brought up was to reduce coverage for pregnant women in the optional population, so adult women above 133 percent of the FPL that Texas covers. There's discussion about completely eliminating the optional population or cutting it back. But based on what you're saying, they could also direct MCOs to limit the number of visits?
- **Billy:** Yes, but typically that's really just for the fee-for-service program. Managed care plans are not as obligated as the fee-for-service directed programs. They also understand the cost tradeoffs of not covering prenatal visits. The fee-for-service program is very rigid. The managed care programs have more flexibility to determine if the directives are really cost-effective or not.
- **Helen:** CHIP Perinatal is protected by Maintenance of Effort provisions because the benefit accrues to the unborn child. They have to maintained eligibility but they could cut benefits even within that program.
- **Billy:** Right. The savings potential for CHIP is less that that of Medicaid because of the more generous match rate. It would require more significant cuts to get meaningful savings to general revenue. This is an issue in general- most of the real cost saving ideas have already been implemented. There's just not a lot on the table. The benefits and eligibility groups in Texas are already fairly narrow.
- Since 2011, members have learned that its often cost-shifting, not cost–saving by cutting benefits. I think it's important to emphasize and re-emphasize that, especially to members who might not have expertise or knowledge of how Medicaid really works. It's often a political talking point to say that Medicaid is wasteful, but I think we're spending money very effectively in this state.
- **Clayton**: We've handed more and more of Medicaid to managed care plans over the years, at about 95% now. It's their job to manage costs and understand what services should be provided in a cost-effective manner. It's frustrating because this responsibility was handed over to managed care, but the state legislature comes in on top of that trying to do the same thing they tasked managed care plans with doing. It's like a duplication of responsibility.
- **Billy:** I agree. This cost-containment rider started in 2009—in my mind it stifles innovation. It gives a laundry list of actions to take, but you're hiring these managed care plans to be innovative. The better discussion is probably to talk to these plans about spending trends. When you look at the data, there are areas where costs can be cut, but without impacts to quality. Areas like the ER, re-admissions, unnecessary services. Benefits aren't driving costs—the focus should be on unnecessary services and how to emphasize efficiency and effectiveness.

II. The Role of Prenatal Care in Improving Birth and Maternal Outcomes *(Dr. Tony Dunn, American Congress of Obstetricians and Gynecologists – Texas)*

- **Helen:** The perception among lawmakers is that prenatal care hasn't changed low birth weights, but prenatal care is also about the mother's health. Given the maternal health report from last year, we think prenatal care is one way to promote health.

- **Dunn:** Prenatal care is something that we've learned in the medical community to be incredibly important. Prenatal care is still relatively new, starting around WWII. In 1992, the US Public Health Service set a goal of at least 90 percent of women starting prenatal care in the first trimester. We still haven't met that goal 25 years later.
- With the advent of prenatal care, infant mortality has declined by 90 percent through the 20th century. Maternal mortality declined by 99 percent. But, as Helen pointed out, there do continue to be significant problems with preterm births and low birth weights. Part of the reason is because of the successes of prenatal care – for example, women who have type I diabetes can carry a birth to term, which didn't really happen before the advent of insulin, and a lot of those babies will be born early. There is also a significant racial disparity in outcomes. Black infants are twice as likely to die as white infants before their first birthday; black women are three times more likely to die of complications than white women.
- Estimates of custodial care for a low birth weight child can be as much as half a million dollars. Patients with no prenatal care are nearly three times more likely to have a low birth weight child. So as Billy pointed out, cutting prenatal care means costs downstream will rise. A lack of prenatal care means lost or delayed opportunities to identify and intervene. Conditions that need special care such as medical issues like hypertension and diabetes, obstetric issues, societal issues or others, need to be identified in a timely manner. In Texas, we know the number two cause of maternal death is drug overdose—that requires early identification. Additionally, if a patient receives no prenatal care, they are less likely to get postpartum care.
- Currently prenatal care is covered at 185 percent of the FPL. There's discussion of cutting that to 133 percent. That would cut roughly 40 to 50 percent of the currently covered population. There's been a significant increased in maternal deaths, as well. It been two years since the Maternal Mortality commission was established, and there's certainly a lot of work to do in that area. One of the best ways to address this is to make sure patients have access to prenatal care. The racial disparity is really overwhelming, and a pullback on eligibility will have a disproportionate impact on minorities.
- **Alice**: Are there any particular studies you think really emphasize the importance of prenatal care?
- **Tony:** Unfortunately, this is one of those things that has become so accepted that there's not a lot of up to date studies in the literature. The importance of prenatal care is accepted among medical community, so the emphasis of studies is on specific elements of prenatal care. Emerging work is on identifying high-risk pregnancies. It's not clear currently what is a high-risk pregnancy; there are lots of vulnerable populations, but there's no guarantee. We can't identify at the very beginning which patients are going to develop complications, which is why you need regularly scheduled visits because issues can develop quickly. These frequent visits are the only way to see and intervene to protect maternal and child health. It's a false economy to think you can save costs by cutting benefits here, it really just shifts the costs further down the line.

III. Update on Coalition Areas (*Multiple speakers)*

Early Childhood Intervention (Clayton Travis, Texas Pediatric Society)

- **Clayton:** Early childhood intervention has been identified as one of the best ways to affect the developmental trajectory for kids with disabilities. The ECI program in Texas, which moved from

DARS to HHSC, covers children with developmental delays and disabilities under the age of three. It's a federal-state program; the state determines eligibility criteria and then every child regardless of income is eligible. The family's primary insurance is billed and then state-federal funding is used. Texas does not currently serve all kids and there was a significant funding cut to the program. Our first ask is to fund the base request, but that does not include caseload growth, which is why we're asking for the exceptional item to be fully funded. In addition, there are two other policy issues. The LBB staff report recommend an eligibility reduction for developmental delays—instead of displaying 25 percent developmental delay in one area , a 30 percent delay would be required to be eligible. According to our physicians, without intervention, those children falling in the five percent would have developmental deterioration to the higher level further down the line without the early intervention, raising costs at a later time. We are opposed to any eligibility changes within the ECI program.

- The second LBB recommendation is to create a task force to discuss mandating commercial insurance to cover ECI. Commercial plans don't typically cover it like Medicaid, so the costs get passed on to the state. We're looking at a budget rider to require that in statute. We think it's a win for contracted providers, children, and the state.

Mental Health (Adriana Kohler, Texans Care)

- **Adriana:** We've been working on coverage for perinatal and post-partum depression screening. We're working with House offices to introduce a bill to cover screening of moms at the Well Child visit under Medicaid and CHIP. There has been a Senate bill filled in that area and the language looks similar to what we would have suggested. We also believe other representatives will introduce bills on screening and coverage for treatment, but they have not been filed yet.

Medicaid cost-containment (Helen Kent Davis, Texas Medical Association)

- **Helen**: The Senate and House budgets have a rider with instructions on how to achieve savings in Medicaid. These riders have been in the budget for several sessions, ranging from 375 to 500 million in GR. We have already made significant cuts to provider payments and services in previous sessions. Currently what's being discussed is cutting optional benefits and services, which includes eligibility for pregnant women, limiting services for adults, and also cutting provider categories. There was an example of this in 2003: podiatrists were cut as an eligible provider and there was a subsequent increase in gangrenous diabetic patients who had to receive amputations. There weren't any real savings achieved, just a shift in costs to hospitals. Eventually the provider category was reinstated. So, we've been down this road before and we're optimistic that some of these options will be taken off the table.
- There could be some other options discussed. There's talk of consolidating managed care plans in the state, perhaps limiting the number to two in a region, which is the current federal minimum. The concern we have is the impact on community based plans. Additionally, reducing health plans' profit margins is being discussed. That might mean rate cuts on the provider side, which could reduce participation in Medicaid.

- The Comptroller report on health care costs found Medicaid's expense growth to be mostly due to caseload growth, not per person costs which have remained relatively flat. More people are coming into Texas, which is increasing the caseload. Something to emphasize is educating lawmakers on the effects of cuts and make sure they understand why benefits matter.

Maternal and Child Health (Helen Kent Davis, Texas Medical Association)

- **Helen**: We're working on a report that walks through the challenges for pregnant women in Texas and how health programs impact the outcomes of this population. We're also highlighting how to improve programs. A lawmaker may be specifically concerned by a particular health issue, like Zika, chronic disease prevention, or opioid abuse, and we would like to lay out how exactly health programs can improve to address those issues. Lawmakers may not realize how public programs specifically work to prevent poor maternal and child outcomes and this would make that clearer.

Workforce and Access (Clayton Travis, Texas Pediatric Society)

- **Clayton:** This area covers the provider workforce. There is a provision to increase investment in graduate medical education in the Senate budget. Last session made good progress on a bill to increase the number of physicians through a loan fund.
- There's also the issue of increasing mental health providers. There's a small loan repayment program for mental health providers set up last session and we want that to continue and there's also a bill relating to fast-tracking certification for psychiatry.

IV. Discussion of state legislation and federal reform *(Group discussion)*

- **Helen:** The discussion on health care reform on the federal level has been very fluid. The big issue for Texas aside from the ACA is the MOE provision for Medicaid and other areas. Texas didn't elect to expand Medicaid, so if the ACA is repealed does that permanently remove the option for Texas? Is there another mechanism to obtain dollars to improve coverage?
- Of course, there's the issue of block grants. HHS Secretary Price and Speaker Ryan are proponents. TMA and THA have a task force to figure out how to make block grants into something that would work for Texas and ensure sufficient funding. If you look at previous block grant proposals, it's a trillion dollar cut over ten years. So there's either a cut in benefits or services, or you increase what the state spends. The question is whether a block grant or per capita cap plan can be designed that doesn't penalize Texas for its population growth and allows it to respond to public health disasters, like Zika or natural disasters.

V. OTA Meeting
Updates from the Office of the Ombudsman
Office of the Ombudsman (Paige Marsala, HHSC)

- *See slides below*

- **Paige:** For the period between September 2016 and January 2017, the Office of the Ombudsman received 6,520 complaints and 35,133 inquires. We've displayed the information in graphical form, broken down by contact types. There's a rise in contacts in January, which is typical of most programs. November and December has fewer business programs and clients also tend to be busier with the holidays.
- CHIP has a higher number of contacts in September. Most contacts were general inquiries, but there were several inquires related to IRS notices about missing months of coverage and whether clients could apply coverage retroactively. CHIP Perinatal doesn't have a typical volume of contacts, so it's a bit of a dynamic graph. The contacts were mostly inquiries, verifying coverage, status of the case, or how to change doctors.
- SNAP and TANF contacts decreased, with no identifiable reasons why. There was a lowering of the standard utility allowance, meaning less would qualify, but complaints went down.
- When you look at Medicaid related programs, there was a large increase in contacts for dual demonstration. The rise occurred in January—most were inquiries, verifying health plans, questions about prescriptions, and how to un-enroll and go back to STAR Plus.
- On the slides, you'll see top three reasons for contact for Medicaid, SNAP, and TANF—mostly inquires about application status, case denials. In Medicaid, a lot of the inquires have to do with accessing prescriptions.
- **Rachel:** How broadly do you get the word out that you're a resource?
- **Paige:** Anytime anyone applies and receives a notice of an action, that notice has information about how to contact the office. We also capture complaints about 211.
- **Rachel:** One woman reached out to me saying she tried to apply for SNAP and was told to not bother because she wouldn't qualify. I told her to talk to 211, but how could she find out about that resource in another way?
- **Paige:** That's alarming, that she wasn't able to even fill out the application. It takes some form of action on someone's case for get the notice that has 211's info. We have a website and some outreach, but it is tough. I'll take that back to the office and make sure we're talking about how to better outreach to clients.

Foster Care Ombudsman update

- **Paige:** We had a total of 281 contacts, which might include someone following up on earlier complaint. 55 were specifically from foster care youth, so about 20 percent of the contact volume. Out of the 55, complaints were mostly about their DFPS caseworker, needing medical attention, or filing a complaint about the shelter. We continue to do outreach at Preparation for Adult Living (PAL) conferences and DFPS seminars.
- **Rachel**: For kids who have aged out, can they still use hotline?
- **Paige**: No, it's only for children under the age of 17, but they can always use 211. I know there are a lot of services for those aging out and there is definitely improvement to be made around reaching out in those areas.
- **Helen**: Can providers call?

- **Paige**: Yes, they can call regarding billing issues, authorization, things like that, and we'll help.

Managed care assistance team update

- **Paige:** We've been doing outreach along with the Medicaid/CHIP services division on inclusion of adoption assistance and Medicaid for breast and cervical cancer, which will transition to managed care as of September 2017. We're tagging along at those sessions to let clients know about the Office of the Ombudsman. The Managed Care Support Network is on hold for the legislative session and will start up again in April.

Updates from Access and Eligibility Services **(***Wayne Salter, HHSC; Todd Byrnes, HHSC; Erika Ramirez, HHSC)*

AES leadership introductions and overview

- *See slides below*

Wayne Salter, HHSC-AES Associate Commissioner

- **Wayne:** We wanted to give an update on AES's mission and structure. Our mission with AES is to connect people, services, and supports. Our vision is to provide holistic and integrated support to reduce institutionalization and encourage self-sufficiency.
- Our organizational chart shows how we've restructured. We have a cross-division coordination director, Kim Bazan, who leads communication and encourages collaboration across the four divisions. Gina Perez, who you all know, is our new Policy, Strategy, Analysis, and Development director. Those four divisions under AES are: Community Access, Eligibility Operations, Disability Determination Services, Community Supports.

Todd Byrnes, HHSC-AES Eligibility Operations

- **Todd:** I have a team that determines eligibility for Medicaid, CHIP, SNAP, and TANF. We have a regional structure composed of 10 regions. Every day, people apply either online or in person, and our division determines eligibility. That's the largest function of the division. We also have quality management and control teams, administer the Lone Star electronic benefits services, and have a data operations team. Additionally, the state operations team is responsible for training workers.

Lisa Akers-Owen, HHSC-AES Community Supports (presented by Wayne Salter)

- **Wayne:** Community Supports has oversight over the 28 local Area Agencies on Aging, as well Contracted Community Services. Contracted Community Services helps individuals stay in their homes, through meal assistance, care assistance, and other services a person would have in a care institution. Community Care Services Eligibility includes assistive support programs in the community aimed towards helping an individual not become institutionalized.

Elisa Hendriks, HHSC-AES Community Access

- **Elisa:** Community Access incorporates the Aging & Disability Resource Centers (ADRC) and Community Access & Engagement. ADRC provides long term services and supports, respite services for caregivers, and the Foster Grandparent Program. Community Access & Engagement is responsible for the Community Partner Program, support for SNAP education, 211 information, and other functions. Partnerships are comprised of faith-based and other community organizations.

Mary Wolfe, HHSC-AES Disability Determination Services (presented by Wayne Salter)

- **Wayne:** Disability Determination Services moved to HHSC from DADS as part of the sunset transition, and consists of the staff that makes medical decisions on the disability claims of individuals applying for social security benefits. Those claims are then returned to SSA for a final case decision.

Community Partner Program update (Fedora Galasso, HHSC)

- *See slides below*
- **Fedora:** I'll give an update from the Fall and the regional partner support transition. It's been six months since the transition and in that time we've worked with our community partner support specialists from AgriLife. We've hired about 20 specialists to work in every region, supplementing the community relations teams and providing technical assistance and ongoing support to the network of community partners.
- We've also been working to improve the program and get external stakeholder input through the Statewide Community Partner Group. They've been helping us on issues such as the redesign of our website and other programmatic improvement including a training revamp. HHSC has a site visit effort to meet with community partners and held community partner forums across the state to make sure partners and regional staff were aware of the transition. We'll have another round of forums from April to August in all 11 HHSC regions.
- **Rachel:** There was some discussion of changes to Level 3 partners—are there any updates about that?
- **Wayne:** We're starting new platform with our new vendor, and we're to relook at that. It has not happened yet.

Refugee Medical Assistance update (Patrick Randall, HHSC)

- **Patrick:** The Texas Refugee Program State Plan was not approved for FY 2017 by the US Office of Refugee Resettlement (ORR), which is the federal funder of the state program. HHSC notified ORR that it would withdraw from administering federal refugee services on January 31, 2017. As of February 1, the state does not administer Refugee Social Services, Cash Assistance, Health Screening, Medical Assistance, and the unaccompanied refugee minor program.
- I would like to emphasize that those programs continue, but under the designated federal entities, not HHSC. We are working to provide a seamless transition between the state and federal groups to minimize client impact. Regarding the refugee medical assistance transition, we have worked with ORR to provide technical assistance, notified all affected clients, updated TIERS to remove the program, and provided training to workers on the changes. The US Committee for Refugees and Immigrants (USCRI) is designated to provide health and medical services through federally funded refugee programs and refugees apply through their local resettlement agencies.
- It's important to note that mainstream benefits continue through HHSC, such as Medicaid, CHIP, TANF, and SNAP. Refugees remain eligible if they meet the requirements.

OTA questions (Erika Ramirez, HHSC and Gina Perez, HHSC)

Shifting Employment and Training components of SNAP from Texas Workforce Commission to HHSC

- **Wayne:** FNS has directed HHSC to move the E&T components of SNAP from Texas Workforce Commission over to HHSC and we are trying to figure out the timeline and impact. The current waiver expires August 2017, and we are still in the initial phases of figuring out what this means after 20+ years of TWC administering E&T. We've had several meetings between the agencies and as we get more details, we will provide more updates.
- **Rachel:** So it's potentially not just the policy folks who are moving over? It could be the staff that work with clients?
- **Wayne:** There are different options that FNS gives the states. One option is to shift people and another is to enact memorandums of understanding. We're trying to figure out how to do this in the least disruptive way and identify what pieces we want and are necessary to move over. The directive makes HHSC the administrative driver of the program. It may be possible to move over budgetary and policy functions, but contract the work out. With each option we are scoping out the risks and impacts.

SSI solution for five check population

- **Gina:** When the fifth check is sent, the Social Security Administration (SSA) sends a notice to us that the individual will be denied. HHSC then sends a notice to the individual that their Medicaid will be denied and informs them to submit an application if they will need it. That allows HHSC to help with that gap month. We're trying to see which groups in our system we can help based off the information provided by SSA. From there, we want to create a more substantial notice to make it more informative and proactively educate individuals that they should submit an application to cover the gap month.

Access to Medicaid for newborns born to mother with private insurance and not named at hospital. Pregnancy centers and adoption agencies have had issues with SSA and getting a SSN, which delays access to Medicaid.

- **Gina:** This is a question that's going to take more discussion. There is a good cause for allowing the baby to have a number and providing Medicaid eligibility because SSA is not providing a number. We can give the child a good cause for that, but I have some additional questions for when the baby leaves the hospital. My concern is that if the child doesn't have a name, you may have a lot of babies with the same DOB, no SSN, and there's nothing that specifically identifies the child in the system. We can absolutely remind staff of the good cause exemption, but we will need to provide more information, just to narrow it down in the system.

Updates on TIERS fix for kinship TANF applications

- **Gina**: The update has been pushed back and may be in August or December, depending on the priorities coming out of the legislative session. We have done the staff reminders and training updates; it is just the automated pieces that are pending.

Anne Dunkelberg from the Center for Public Policy Priorities will chair the March 24th meeting, which is a regular 2-hour meeting.

Overview of Medicaid Benefits

Billy Millwee & Associates, LLC

Austin, Tx

Medicaid Benefits

- Federal Requirements
- State Flexibility
- Texas Medicaid
- EPSDT

Medicaid Benefits

- **Federal Requirements**
  - Social Security Act specifies a set of benefits that state Medicaid programs **must** provide; and
  - Allows for optional benefits that states may **choose** to provide
  - Benefits must be:
    - Equivalent in amount, duration, and scope for all enrollees (comparability rule), with the expectation of benefits for children;
    - The same throughout the state (the statewideness rule); and
    - Allow freedom of choice among providers or managed care plans participating in Medicaid
  - States define amount, duration, and scope of Medicaid benefits

Medicaid Benefits

- **Federal Mandatory Benefits**
  - Inpatient hospital
  - Outpatient hospital
  - Laboratory and x-ray services
  - Physician services
  - EPSDT
  - Family planning
  - FQHC/RHC
  - Nurse-midwife services
  - Nurse practitioner services
  - Home health care
  - Nursing Facility
  - Tobacco cessation counseling for pregnant women
  - Freestanding birth centers
  - Non-Emergency Medical Transportation

Medicaid Benefits

- **Optional Benefits *red = Texas covers**
  - Prescribed drugs*
  - Intermediate care facility services for individuals with intellectual disabilities*
  - Personal care services*
  - Clinic services*
  - Private Duty Nursing* (under age 21 only)
  - Occupational Therapy*
  - Program of All-Inclusive Care for the Elderly (PACE) services*
  - Optometry services*
  - Chiropractic services*
  - Physical therapy services*
  - Critical access hospital services*

Medicaid Benefits

- **Optional Benefits** (continued)
  - Targeted case management services* (children and pregnant women)
  - Respiratory care for ventilator dependent individuals*
  - Prosthetic devices*
  - Primary care case management services
  - Hospice services*
  - Services furnished in a religious non-medical health care institution
  - Inpatient psychiatric services for individuals under age 21*
  - Tuberculosis-related services*
  - Dental services* (children only)
  - Home and community based services* (waiver)
  - Eyeglasses*

Medicaid Benefits

- **Optional Benefits** **(continued)**
  - Health homes for enrollees with chronic conditions
  - Community First Choice (Attendant Care) *
  - Speech, hearing, and language disorder services*
  - Other licensed practitioners' services*
  - Inpatient hospital and nursing facility services for individuals age 65 or older in institutions for mental diseases
  - Other diagnostic, screening, preventive, and rehabilitative services*
  - Emergency hospital services in a hospital not meeting certain Medicare or Medicaid requirements ([prevent death or serious impairment)

Medicaid Benefits

- **Early, Periodic, Screening, Diagnosis and Treatment Services (EPSDT)**
  - In Texas known as Texas Health Steps (THSteps)
  - States must provide all services described in the Medicaid statute necessary to correct or ameliorate physical or mental conditions
  - Includes treatment for any vision and hearing problems, as well as eyeglasses and hearing aids
  - Regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health, as well as orthodontia
  - States must establish schedules for screening, vision, dental, and hearing services
  - Effectively establishes separate benefit package for children in Medicaid
    - Child in Medicaid is under age 21
  - States must cover all benefits regardless of mandatory or optional

Medicaid Benefits

- **State Process to Add Optional Benefits**
  - Generally a cost/benefit analysis is completed
  - Optional benefits usually allow for more efficient operation of the program
  - Requires a Medicaid State Plan Amendment and Federal approval
  - In practice, optional benefits are not added or eliminated without some legislative discussion
  - Greater flexibility in managed care

Medicaid Benefits

- **Questions?**
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Importance of Prenatal Care

All The Right Reason$

CARL A (TONY) DUNN, MD

CHAIR – ACOG DISTRICT XI - TEXAS

History of Prenatal Care

Early 1900s – for every 1000 live births – 9 women died of pregnancy related complications and 100 infants died before the age of one year

1901 Mrs. William Lowell Putnam – Boston Infant Social Service Department began a program of nurse visits to women enrolled in the home delivery service of the Boston Lying-In Hospital

1911 – First organized prenatal clinic at Johns Hopkins Hospital

1913 – US Children's Bureau began to study factors influencing infant mortality

1986 – IOM / NIH report on the importance of prenatal care in reducing the incidence of LBW infants. US DHHS panel to review the content of prenatal care first recognized the importance of pre-conceptional care

1992 – USPHS sets goal for year 2000 for at least 90% of women to start prenatal care in the first trimester (still not met)

History of Prenatal Care

RESULTS

By 1997, infant mortality declined by over 90%, to 7.2 per 1000 live births, and maternal mortality declined by 99% to 7.7 deaths per 100,000 live births

HOWEVER

There continues to be a significant problem with preterm births and LBW infants

Racial disparities continue to persist. Black infants are more than twice as likely to die before their first birthday, and black women are three times more likely to die of pregnancy / childbirth complications.

Lack of Prenatal Care = Lost Opportunity

National Commission to Prevent Infant Mortality estimates the cost of lifetime custodial care for a LBW infant to be as much as $500,000 per child (1991)

Patients who receive no prenatal care are 2.6 to 3.9 times more likely to have a LBW infant

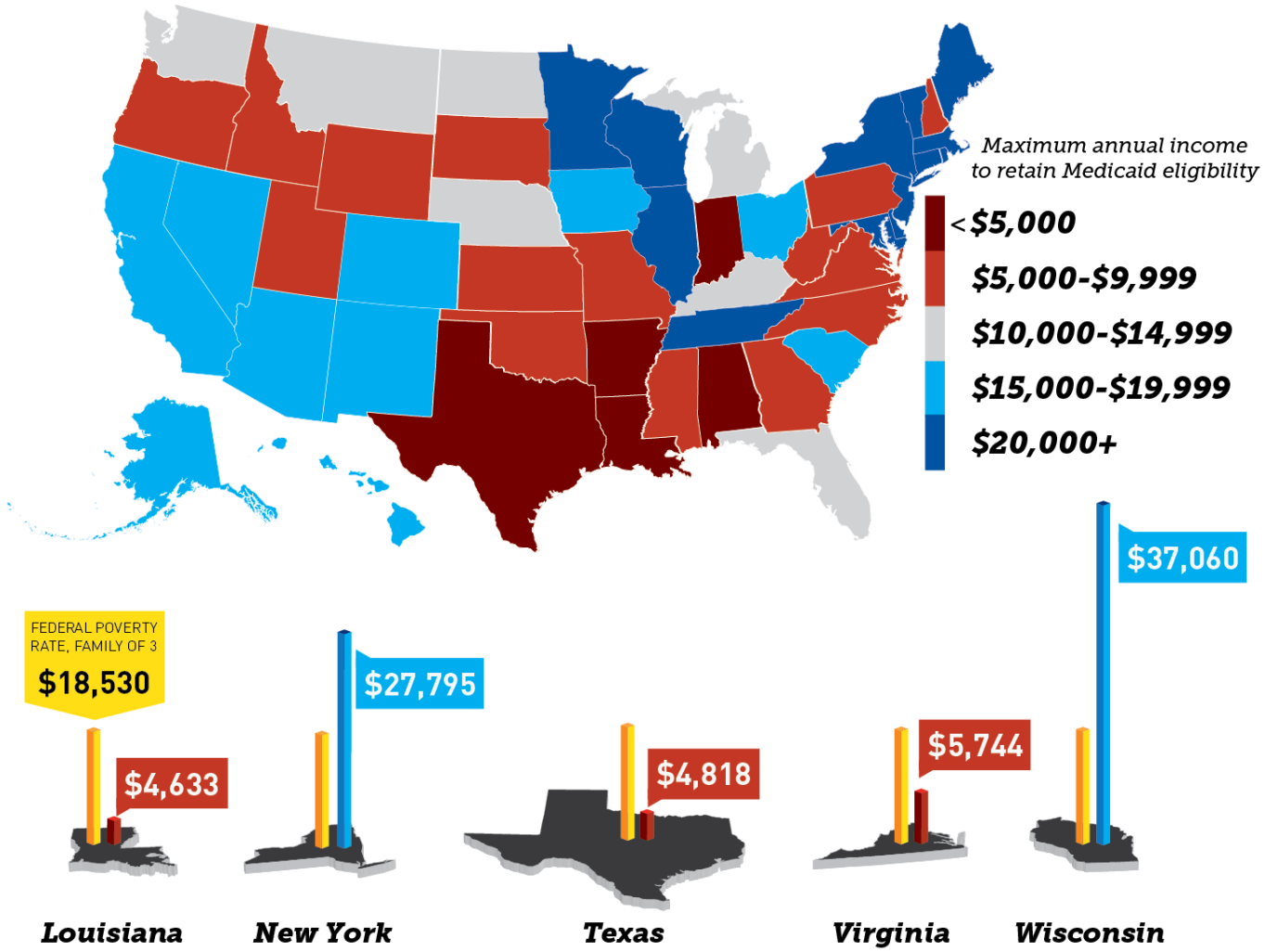
Institute of Medicine (Droste 1988) – for every dollar spent on prenatal care, $3.38 is saved in the cost of caring for LBW infants.

Lost / Delayed Opportunity to Identify and Intervene For Multiple Issues

- Medical Conditions – HTN, DM, STDs, Congenital Heart Disease, Neurologic Disease
- Obstetric Issues – proper dating, history of preterm labor / delivery, history of pre-eclampsia
- Societal Issues – drug / alcohol abuse, domestic abuse, problems with housing / nutrition
- Postpartum Care – interval contraception / family planning, postpartum depression

Medicaid Ineligibility

Several States Set Impossibly Low Income Thresholds, Leaving Thousands of People Without Any Insurance Aid at All



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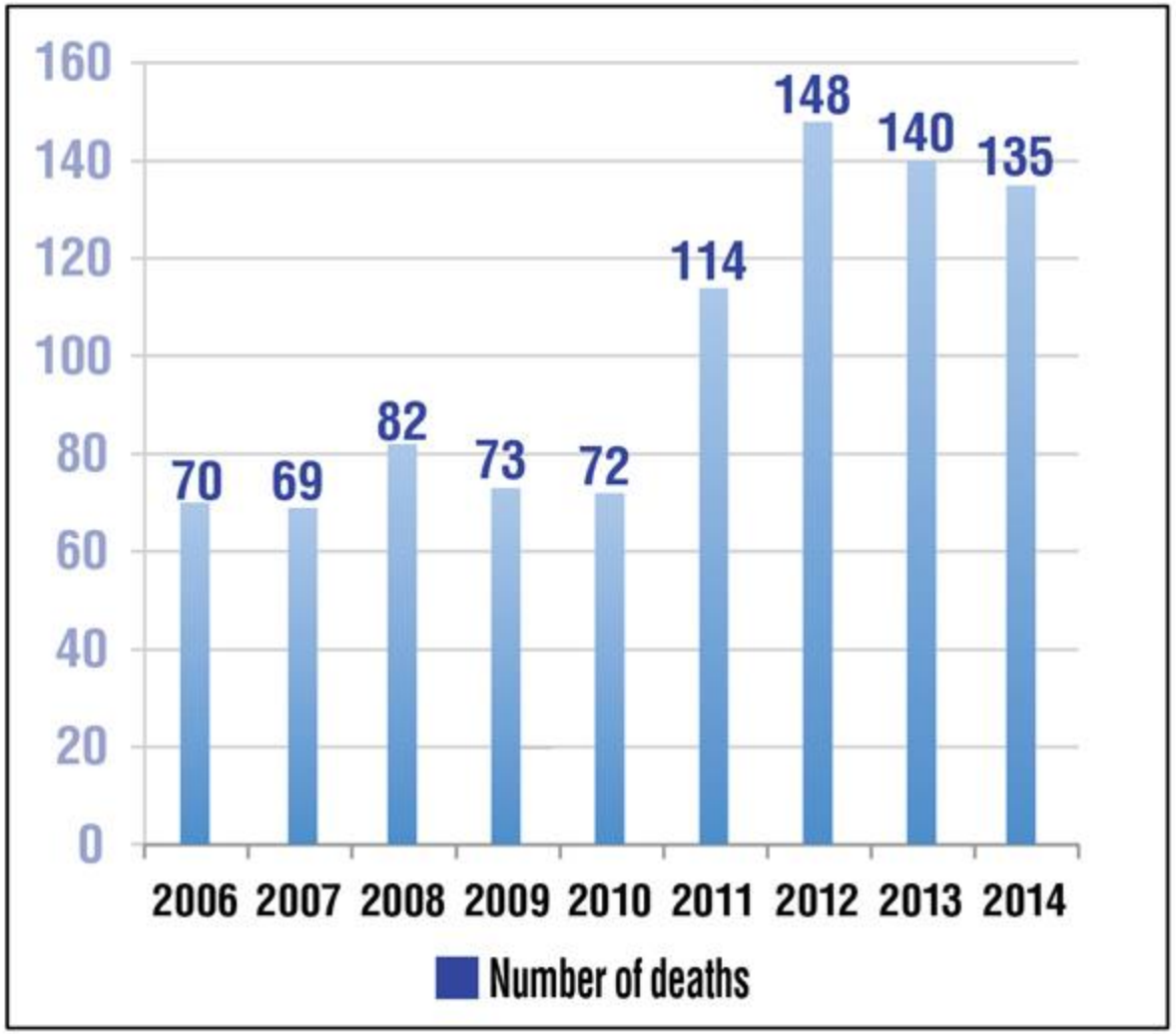
THINK PROGRESS

Maternal deaths in Texas, 2006-2014



THE HEALTH BENEFITS AND COST-EFFECTIVENESS OF PRENATAL CARE

Prenatal care monitors the health of women during pregnancy, when special health problems can arise. It may include smoking cessation programs and nutrition counseling. Preconception care for women with certain medical conditions ensures that the woman is in good health before she conceives, reducing her risks during pregnancy. Preconception care and prenatal care also ensure that women have healthy babies.

✓ Providing women with prenatal care reduces their risk of maternal mortality.

✓ Prenatal care results in about $3 in savings for every $1 spent on high-risk women.

✓ One perinatal care program in California resulted in net savings of $2,200 per participant.

Pregnant women have special health care needs that can be met through prenatal care.

- Women with diabetes, anemia, hypertension, and sexually transmitted diseases require prenatal care to decrease their risk of maternal mortality and improve birth outcomes (National Center for Health Statistics, 1994).

- Together, preeclampsia and eclampsia (illnesses related to hypertension) occur in five to seven percent of all deliveries and are the second most common source of maternal mortality, after infection; both are associated with lack of prenatal care (Kasper, 1994).

- About eight percent of women develop hypertension as a result of becoming pregnant (Harlap et al., 1991). Their conditions should be monitored through prenatal care.

Prenatal care, including smoking cessation programs and nutrition counseling, can prevent low birth weight, which is associated with poor infant health and infant mortality:

- **The majority of infant deaths occur among low birth weight babies** (Shapiro et al., 1980).

- **Low birth weight babies have longer hospital stays and more medical complications** (Shapiro et al., 1980; Leveno et al., 1985).

- **The nation spent between $2.4 and $3.3 billion dollars on neonatal intensive care in 1985**, most of it attributable to low birth weight babies. This is an average of $14,287 per infant (U.S. General Accounting Office, 1987). In that same year, the average cost for a baby of normal weight was approximately $720 (Schwartz, 1989).

HEALTH BENEFITS OF PRENATAL CARE

Pregnant women with specific medical conditions require prenatal care to reduce their risk of medical complications or mortality:

- **Preconception and prenatal care help diabetic women to stabilize their blood sugar level before and during pregnancy**, reducing their risk of maternal and fetal complications (Elixhauser et al., 1993).

Because many women do not see a doctor regularly, prenatal visits can be used to educate women about health risks and improve health:

- A Canadian study of 224 pregnant non-smokers found that immediate smoking cessation interventions during the prenatal care visit have two to three times the rates of success as programs that refer women elsewhere (O'Connor et al., 1992).

- **Women can be treated for syphilis and other sexually transmitted diseases during prenatal care visits**, improving maternal health and preventing miscarriages, premature birth, and transmission to the offspring (Ernst et al., 1993). Pregnant women at high risk of syphilis who are not receiving prenatal care can be screened in emergency rooms (Ernst, 1993).

Prenatal care reduces the likelihood that a woman will die during pregnancy:

- A study of all maternal deaths in the United States between 1979 and 1986 found that **a woman who received no prenatal care was 5.7 times more likely to die in child birth than a women who receives adequate care** (Koonin et al., 1991; Syverson et al., 1991).

Prenatal care is the most effective way to reduce low birth weight and infant mortality:

- **Between 27 and 66 low birth weight births would be averted for each 1,000 additional prenatal care recipients and between five and eight lives would be saved,** according to a study of county level data representing 80 percent of the U.S. population (Joyce et al., 1988).

• **Rates of low birth weight could be reduced by 15 percent among whites and 12 percent among blacks** if all pregnant women began prenatal care in the first trimester of pregnancy and continued with the schedule of visits recommended by the obstetric profession, according to a 1981 analysis of single live births in the United States (Brown, 1985).

• A study of 4,619 primarily low-income women in Dallas who gave birth in 1980 found that prenatal care improves birth outcomes:

- **Those women receiving prenatal care delivered low birth weight babies at one third the rate of women who received no such care** (Leveno et al., 1985).

- **The perinatal mortality rate for the women in Dallas who received prenatal care was 16 per 1,000, less than one-fourth the rate of 73 per 1,000 for women who received no prenatal care** (Leveno et al., 1985).

DESPITE THE CLEAR BENEFITS OF PRENATAL CARE, MANY WOMEN GO WITHOUT IT:

• Financial constraints and lack of insurance coverage are two important factors that reduce a woman's ability to receive adequate prenatal care (Brown, 1985).

• The role of insurance in increasing access to prenatal care was demonstrated by a General Accounting Office study, finding that **only 46 percent of Medicaid recipients and 41 percent of uninsured women began prenatal care in their first month of pregnancy, while 84 percent of insured women with uncomplicated pregnancies received such care** (U.S. General Accounting Office, 1987).

• The OB Access program aimed at low income women in California **reduced the incidence of low-weight births. Only 4.7 percent of the 5,244 participants gave birth to a low-weight baby, compared to 7.1 percent** of a comparable group of non-participants. The health benefits of this program are greater than those found in other studies that conclude that prenatal care is cost-effective (Korenbrot, 1984).

POTENTIAL COST SAVINGS OF PRENATAL CARE

• If use of prenatal care services provided to high risk women were to **reduce low birth weight births to 10 percent (from the current rate of 11.5 percent), the net savings in medical costs would equal $12.4 million a year in 1985**, according to an Institute of Medicine study. If the percent of low birth weights was reduced to nine percent, the savings would be $28.9 million (Brown, 1985).

• If the prenatal care provided to all high risk women receiving public assistance reduced the low birth weight rate by only 0.7 percentage points, the program would pay for itself (Brown, 1985).

COST-BENEFITS

- A study by the Institute of Medicine analyzed the costs and benefits of enrolling a population of high-risk pregnant women in prenatal care programs found that in the first year after birth, the **savings would be $3 for every $1 spent on prenatal care** (Brown, 1985).

- A study of all women giving birth in New Hampshire between 1981 and 1984 found that the state would have **saved $2.57 for each $1 spent on prenatal care** (Gorsky and Colby, 1989).

- Both these studies note their figures are conservative because they do not include longer term costs that occur if there is a disability.

- **The State of California saved $2,200 on mother-baby in-patient hospital care for each woman who participated in the Comprehensive Perinatal Program** when compared to expenditures on mothers and babies who did not receive prenatal care even when the cost of providing the prenatal care was taken into consideration (Moore et al., 1986).

- **The University of San Diego Medical Center would have had net savings of $877,600 per year between 1981 and 1984** if all women who gave birth there had received prenatal care (Moore et al., 1986).

- **The immediate savings would be $96 million (1985 dollars)** if 20 percent of low birth weight infants cared for at major urban hospitals increased their weight into the next birth weight category, based on data from a 1985 stratified sample of urban hospitals (Schwartz, 1989).

- **The GNP would have increased between $6.4 and $12 billion due to increases in the future earnings of children and their parents over the children's projected lifetimes** if, in 1985, the U.S. rate of infant mortality and the rate of disabled low birth weight infants had been cut in half (National Commission to Prevent Infant Mortality, 1988).

This Research-in-Brief is part of IWPR's Research and Resource Kit on ***Preventive Health Services for Women: Benefits and Cost-Effectiveness***, produced by Stephanie Aaronson and Nicoletta Karam with the assistance of Ellen Cutler in August 1994. The project was funded by the Nathan Cummings Foundation, with additional funds for dissemination provided by The Ford Foundation. A related annotated bibliography is available from the Institute for Women's Policy Research, describing the studies cited in this fact sheet as well as additional studies that are of interest.

IWPR has produced eight fact sheets and annotated bibliographies on the benefits and cost-effectiveness of women's preventive health services relating to breast cancer, cervical cancer, domestic violence, family planning, mental health, prenatal care, osteoporosis, and sexually transmitted diseases. Each fact sheet/bibliography pair is available from IWPR for $5.00; the entire Kit, which includes all topics and comes in a three-ring binder, is available from IWPR for $20.00. Members of IWPR receive discounts on this kit and all publications. Please contact IWPR for information on membership and bulk order discounts.

The Cost Effectiveness of Prenatal Care

Article *in* Health care financing review · February 1994

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Baylor University
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The Cost Effectiveness of Prenatal Care

James W. Henderson, Ph.D.

This study uses hospital records for 7,000 births in McLennan County, Texas, during the period June 1987-July 1989 to examine the association between prenatal care and birth outcome and the implications for hospital costs of newborn infants. After controlling for a variety of maternal and birth factors, a significant relationship between prenatal care and birth outcome remained. Females who failed to receive prenatal care were almost three times as likely to have a low-birth-weight infant (weighing less than 2,500 grams) than females who did. Using an ordinary least squares (OLS) estimating equation (R^2 = .24), the net expected hospital cost savings for females who received prenatal care was over $1,000.

INTRODUCTION

During the past two decades, medical research has provided substantial evidence supporting the hypothesis that length of gestation and birth weight affect infant mortality and childhood morbidity (Gortmaker, 1979; Showstack, Budetti, and Minkler, 1984). Infants weighing less than 2,500 grams (or 5.5 pounds) have a mortality rate that is 40 times greater during the neonatal period than infants weighing more than 2,500 grams (McCormick, 1991). Not only do infants weighing less than 750 grams have lower survival rates, but they have an increased risk of serious neurologic and developmental impairment (Hack and Fanaroff, 1989).

Despite the importance of birth weight in birth outcome, the primary cause of perinatal mortality in the United States is preterm birth (Kleinman and Madans, 1991). Although this is an issue of individual medical importance, it is also a matter of national policy concern. Even though infant mortality rates by birth-weight category in the United States are among the lowest in the developed world, the overall infant mortality rates are among the highest. This statistical anomaly is because of the higher rates of preterm infants born in the low-birth-weight categories (Behrman, 1987).

Perhaps even more troubling is the mounting evidence that the incidence of low-weight births is rising. Joyce (1990) estimated that by 1990 the percentage of low-weight births among black females in New York City would exceed the rates of 20 years earlier, with most of the increase in the late 1980s. Although data limitations make conclusions tentative, Joyce offered the increase in substance abuse, particularly cocaine and crack, as the most likely cause of the increased incidence of low birth weight.

The challenge to medical practitioners is to develop programs that reduce the incidence of preterm delivery and low birth weight, especially among females of lower socioeconomic status, both white and black. Evidence seems to indicate that a comprehensive prenatal care program focusing on prematurity prevention may be able to reduce the incidence of low birth weight among females of all ages (Buescher et al., 1988). In fact, early prenatal care (beginning in the first trimester) among white teenagers has been shown to be associated with a 27-percent reduction in low-weight births (Frank et al., 1989).

The author is with Baylor University. The views expressed are those of the author and do not necessarily reflect those of the Health Care Financing Administration or Baylor University.

Although the association between prenatal care and birth outcome is indisputable, there is still no clear cut causal relationship between the two. The primary issue addressed in this study is the cost effectiveness of prenatal care. Although proponents of prenatal care programs stress the potential cost savings, estimates vary widely depending on the population studied and the methodology used. Murray and Bernfield (1988) have estimated that the annual cost savings of adequate prenatal care is approximately $230 per mother (1986 dollars). This includes the cost savings from neonatal intensive care and rehospitalization within the first year. Monmaney (1988) reported that a Virginia program, if adopted statewide, could save the State almost $50 million annually by reducing the incidence of certain types of mental retardation due to low birth weight. If this program were adopted nationally, it would save between $14,000 and $30,000 for every low-birth-weight baby avoided.

Lifetime and aggregate estimates of savings tell an even more dramatic story. The National Commission to Prevent Infant Mortality (1991) has estimated the cost of lifetime custodial care of low-birth-weight babies to be as much as $500,000 per child. Additionally, this report estimated that 80 percent of the females at high risk for low-birth-weight babies can be identified in the first prenatal visit. The Congressional Office of Technology Assessment (1987) has estimated the cost of caring for babies who weigh less than 1,140 grams (2.5 pounds) at birth to be an average $140,000 per patient, bringing the annual cost of neonatal intensive care in the United States to a total of $1.5 billion. A survey conducted by the Institute of Medicine and reported by Droste (1988) estimated that for every dollar spent on prenatal care, $3.38 is saved in the cost of caring for low-birth-weight infants.

Despite the evidence that high quality prenatal care is associated with improved pregnancy outcomes (and lower overall costs), only 76 percent of all pregnant females receive care in their first trimester. For black and Hispanic females, the corresponding figure is 61 percent (Health Resources and Services Administration, 1991). If the cost savings have not been overstated, utilization of prenatal care programs appears to be at suboptimal levels.

Previous research into the cost effectiveness of prenatal care has been limited because of the lack of individual cost data. Most of the studies previously cited use birth certificate data to examine the relationship between prenatal care and birth outcome, and payment rate schedules to estimate cost savings. This study develops a simple model of birth outcome measured by the infant's birth weight. From this model, the hospital cost differential between females who received prenatal care and those who did not is estimated. An estimate of the cost differential can be more accurate than before because of the availability of a detailed microdata base that contains individual observations on birth outcome and hospital costs incurred.

METHODOLOGY

Data for this study were provided by Hillcrest Baptist Medical Center and Scott and White Hospital. More than 7,000 records for infants and mothers were obtained, representing virtually all births in McLennan County from June 1987 through July 1989.[1] The procedure for matching

[1]Approximately 100 babies are born annually in the West Community Hospital in McLennan County. As many are born at Scott and White Hospital in Bell County, and have not been included. Thus, this sample represents approximately 95 percent of the babies born in the county. A relatively small number of females were included in the data base twice, representing two separate pregnancies—one early in the study period and one late in the period.

babies to mothers resulted in the loss of fewer than 20 records for the period under study. For each record, the relevant demographic data, including age, race, marital status, and ZIP Code, were obtained. In addition, diagnosis and cost information for the infant and mother are included. Actual hospital procedures were also recorded, controlling for cesarean delivery, premature labor, and whether the infant died or was discharged to the home or to another hospital with a neonatal intensive care unit (i.e., Scott and White Hospital in Temple, Texas). Finally, mothers who did not receive prenatal care were identified from a survey conducted by the nursing staff of the hospital nursery at the time of admittance into labor and delivery.[2] Prenatal care is described as any type of medical care received by a prospective mother, such as physician visits or any organized prenatal program provided by a medical practitioner.

RESULTS

The Study Population

Characteristics of the study population are summarized in Table 1. The data are presented to provide easy comparison with those used in previous studies. Mean birth weight for McLennan County babies was 3,365 grams (7.4 pounds), compared with that of the California study cohort reported by Showstack, Budetti, and Minkler (1984) of 3,388 grams (also 7.4 pounds). Factors important in determining birth outcome (Kessel et al., 1984) are: the ethnic group and marital status of the mother (60.6 percent white and 70.1 percent married); the percentage of the population in the high-risk age groups (13.7 percent are either under age 18 or over 34 years of age); the type of delivery (20.7 percent cesarean); the percentage premature (4.9 percent); the percentage of multiple births (6.2 percent); and the percentage of females who received no prenatal care (5.4 percent).

Differences between the white and non-white populations are also recorded. These follow the same pattern reported in Murray and Bernfield (1988). The data reveal that non-white infants are smaller (3,265 grams versus 3,430 grams), and non-white mothers are younger (23.3 years versus 25.8 years of age) and more likely to be unmarried (52.4 percent versus 15.2 percent).

Prenatal Care and Birth Outcome

The first task was to examine the relationship between prenatal care and birth outcome. The mean birth weight for babies whose mothers received prenatal care was 3,380 grams (7.4 pounds). Those babies whose mothers received no prenatal care weighed an average of 3,100 grams (6.8 pounds). These mean birth-weight differences remain when the data are divided according to race and marital status.

Table 2 presents the characteristics according to race and marital status. In all eight categories, mothers who received prenatal care gave birth to babies who weighed more. The differences ranged from 105 grams for non-white married females to 379 grams for white single females. The distribution of birth weights shows the same basic pattern: Females with prenatal care are more likely to give birth to babies weighing more than 2,500 grams and less likely to have babies weighing less than 1,500 grams.

The odds of having a low-birth-weight baby are substantially higher for females who do not receive prenatal care. Using the

[2]Data on the duration and scope of the prenatal care received are not available. Females who had no admitting physician or whose admitting physician was a resident at the Family Practice Center (a family practice residency program affiliated with the University of Texas Southwestern Medical School) were screened to determine if they had received prenatal care. This information was cross-referenced with the labor and delivery survey for the final determination.

Table 1

Characteristics of McLennan County Births: June 1987-July 1989

Characteristic	Total	White	Non-White
Sample Size	7,055	4,263	2,775
Birth Weight			
Mean Grams	3,365	3,430	3,265
		Percent	
More Than 2,500 Grams	89.4	91.0	87.0
1,500-2,500 Grams	5.0	4.0	6.5
Less Than 1,500 Grams	5.6	5.0	6.5
Sex			
Male	49.0	49.2	48.9
Female	51.0	50.8	51.1
Ethnic Group			
White	60.6	100.0	0
Non-White	39.4	0	100.0
Age			
Mean Years	24.8	25.8	23.3
		Percent	
Under 18 Years	8.4	4.2	14.2
18-34 Years	86.3	89.7	81.7
Over 34 Years	5.3	6.1	4.0
No Prenatal Care	5.4	2.4	9.9
Marital Status			
Married	70.1	84.8	47.6
Not Married	29.9	15.2	52.4
Type of Delivery			
Normal	79.3	76.9	82.8
Cesarean	20.7	23.1	17.2
Other Data			
Premature Birth	4.9	4.2	5.9
Multiple Delivery	6.2	6.0	6.1

SOURCE: Henderson, J., Baylor University, 1994.

approach suggested by Wartenberg and Northridge (1991) for calculating an odds ratio, females who receive no prenatal care are 2.68 times more likely to give birth to a low-birth-weight infant (one weighing less than 2,500 grams) than females who receive at least some care. In fact, white females increase their risk of having a low-birth-weight infant 3.92 times by failing to obtain prenatal care; the increase for non-white females is only 1.85 times. The cause of this white and non-white differential is open to speculation. Several confounding factors may contribute to it, including intracategory differences in socioeconomic status, alcohol and cigarette use, and drug abuse. The small sample sizes for the no-care groups may also play a role. At any rate, there is no way to know for sure because data on these variables were not collected.

Another observation worth noting is the apparent association between prenatal care and the likelihood of cesarean delivery. Does prenatal care increase the odds of having a cesarean section, or is some other mechanism at work? The high incidence and related causes of cesarean deliveries have been the object of considerable medical research (Taffel, Placek, and Liss, 1987; Myers and Gleicher, 1988). It is unlikely that females who receive prenatal care have a higher incidence of factors that are the primary indicators for

Table 2

Characteristics of McLennan County Births, by Race and Marital Status

Characteristic	White Single		White Married		Non-White Single		Non-White Married	
	Care	No Care	Care	No Care	Care	No Care	Care	No Care
Total	603	44	3,556	60	1,278	177	1,222	98
Birth Weight								
Mean Grams	3,283	2,904	3,468	3,206	3,203	3,024	3,360	3,255
				Percent				
More Than 2,500 Grams	87.7	81.8	91.8	81.7	85.6	79.1	89.4	89.8
1,500-2,500 Grams	4.8	4.5	3.7	11.7	6.8	13.0	5.6	4.1
Less Than 1,500 Grams	7.5	13.6	4.5	6.7	7.7	7.9	5.1	6.1
Premature Birth	5.3	9.1	3.9	5.0	6.2	13.6	4.6	5.1
Multiple Delivery	7.1	9.1	5.7	10.0	6.5	6.2	6.1	1.0
Transferred	0.8	9.1	0.7	3.3	0.6	1.1	0.7	1.0
Infant Death	0.3	4.5	0.3	3.3	0.7	1.7	0.2	1.0
Cesarean Delivery	18.6	4.5	24.3	8.3	14.8	9.0	21.3	11.2
Age								
Mean Years	22.1	21.8	26.5	24.8	21.7	22.4	25.3	22.8
				Percent				
Under 18 Years	17.6	13.6	1.8	5.0	23.5	16.9	4.7	8.2
18-34 Years	79.9	84.1	91.4	91.7	74.1	79.7	89.3	90.8
Over 34 Years	2.5	2.3	6.8	3.3	2.4	3.4	6.0	1.0

SOURCE: Henderson, J., Baylor University, 1994.

cesarean section (i.e., previous cesarean section, dystocia, breech presentation). One avenue worth future exploration is the impact of defensive practices by caregivers to avoid possible malpractice lawsuits.

Females who received prenatal care had fewer babies transferred to acute-care facilities, fewer infant deaths, and a higher incidence of cesarean deliveries. Although this does not rule out intrinsic differences between females who receive and those who do not receive prenatal care, it does demonstrate a clear association between prenatal care and birth outcome within narrowly defined demographic cohorts.

Because other factors also contribute to differences in birth weights, OLS regression was used to adjust for the following characteristics. Equation 1 shows the estimating equation for birth outcome.

$$BWT = a_0 + a_1 Age + a_2 Male - a_3 MB + a_4 Married - a_5 Premat - a_6 Non\text{-}White - a_7 No\text{-}Care + u \quad (1)$$

where:

BWT = birth weight (in ounces);
Age = maternal age upon admission to hospital;
Male = dummy variable equal to 1, if child is male;
MB = dummy variable equal to 1, if multiple birth;
Married = dummy variable equal to 1, if mother is married;
Premat = dummy variable equal to 1, if labor is premature;
Non-White = dummy variable equal to 1, if mother is black or Hispanic; and
No-Care = dummy variable equal to 1, if mother did not receive prenatal care.

Table 3 presents the regression results of birth weight (measured in ounces) on these explanatory variables. All coefficients have the expected signs. The data suggest that the lack of prenatal care has a negative effect on birth outcome. Even after adjusting for the other independent variables, babies born to mothers who received no prenatal care weighed about 145 grams (5.09 ounces) less than those whose mothers received prenatal care.

Increased maternal age is associated with bigger babies. For each additional year of the mother's age at delivery, the baby's weight increases by 6 grams (0.20 ounces). The use of age categories, though not reported in Table 3, displays a similar pattern. Females who are under 18 years of age give birth to babies who weigh an average of 60 grams (2.2 ounces) less than those of females between 18 and 34 years of age. The age coefficient for females more than 35 years of age is insignificant, indicating that the relationship between age and birth weight is likely to be non-linear. Age may serve, in part, as a proxy for birth order, with a higher incidence of first births (and thus smaller babies) to those in their early teens.

Birth weight is also associated with marital status. Married females have babies who weigh 140 grams (4.09 ounces) more. Marital status may be a proxy for healthy behavior. For example, it is well documented that single females have a higher incidence of cigarette smoking than married females. Multiple births reduce birth weight by 659 grams (23.06 ounces) and premature delivery is associated with birth weights that are 943 grams (33.02 ounces) lower. After adjusting for all these characteristics, non-white females still give birth to babies who weigh 80 grams (2.79 ounces) less than white females. Additionally, when the population is divided into white and non-white cohorts, the regression results are quite similar. However, several coefficients differ significantly. The impact of multiple births is more pronounced on white than non-white babies. Birth weights are 740 grams (26 ounces) lower for white multiple births and only 456 grams (16 ounces) lower for non-white multiple births. Prematurity has the opposite impact. White premature babies weigh 884 grams (31 ounces) less than those born at term; non-white premature babies weigh 1,026 grams (36 ounces) less than those born at term.

One of the more interesting differences is the impact of prenatal care between the two groups. White females who receive prenatal care give birth to babies who

Table 3

Ordinary Least Squares Regression Coefficients: Dependent Variable Birth Weight in Ounces

Independent Variable	Total	White Persons	Non-White Persons
Age	0.20	0.23	0.15
	(4.04)	(3.98)	*(1.65)
Baby's Sex	4.63	4.94	4.07
(If Male=1)	(9.09)	(8.71)	(4.26)
Multiple Birth	-23.06	-26.42	-16.26
	(13.20)	(14.22)	(4.54)
Marital Status	4.90	5.39	4.48
(If Married=1)	(7.66)	(6.42)	(4.45)
Premature Labor	-33.02	-30.75	-35.77
	(27.29)	(21.06)	(17.44)
No Prenatal Care	-5.09	-8.40	-3.54
	(4.45)	(4.56)	**(2.21)
Non-White Infant	-2.79	—	—
	(4.86)	—	—
Intercept	110.88	109.69	109.68
R^2	0.1866	0.2064	0.1475
Number of Observations	6,702	4,075	2,626
F-value	219.46	176.33	75.57

* Significant at the .10 level.
**Significant at the .05 level.

NOTES: *t*-values in parentheses. All coefficients significant at the .01 level except as previously noted.

SOURCE: Henderson, J., Baylor University, 1994.

weigh 326 grams (11.49 ounces) more than those who do not. The effect of prenatal care on non-white birth outcome is much less pronounced. Non-white females who receive prenatal care give birth to babies who weigh about 172 grams (6.05 ounces) more.

Prenatal Care and Hospital Costs

As previously stated, prematurity and its resulting low birth weights are major contributing factors leading to complications that result in higher costs, such as transfers to intensive-care unit (ICU) facilities. There was a much higher incidence of prematurity, low birth weights, and transfers to acute-care facilities among females who did not receive prenatal care. Only 4.60 percent of the females who received prenatal care experienced premature labor, whereas 9.50 percent of those who did not receive prenatal care delivered prematurely. Transfers to acute-care facilities involved 0.71 percent of the babies whose mothers received prenatal care, and 1.85 percent of those whose mothers did not receive prenatal care. Infant mortality was more pronounced among mothers who did not receive prenatal care; 2.11 percent of their babies died in the hospital, compared with 0.38 percent of those babies born to mothers who received prenatal care. Hospital charges for infants with prenatal care are on average $1,198.42 less than those without prenatal care ($1,045.69 versus $2,244.11).

The regression equation for hospital charges was estimated using birth weight (Equation 2.1) as an independent variable, and birth-weight categories (Equation 2.2). Three birth-weight categories were defined: BWT1 for normal birth weights greater than 2,500 grams, BWT2 for low birth weights from 1,500 to 2,500 grams, and BWT3 for very low birth weights less than 1,500 grams.

$$\text{Charges} = b_0 - b_1\text{BWT} + b_2\text{Transfer} + b_3\text{Stay} + b_4\text{Died} + u \quad (2.1)$$

$$\text{Charges} = c_0 + c_1\text{BWT2} + c_2\text{BWT3} + c_3\text{Transfer} + c_4\text{Stay} + c_5\text{Died} + u \quad (2.2)$$

where:

Charges = hospital charges for infant (in dollars);
Transfer = dummy variable equal to 1, if infant was transferred to an acute-care facility;
Stay = length of infant's hospital stay (in days); and
Died = dummy variable equal to 1, if infant died in hospital.

Regression results for these two equations are reported in Table 4. As expected, birth weight and hospital charges are negatively associated. The hospital charge for the infant was lowered by $10.24 for every ounce the baby weighed. The use of birth-weight categories in estimating Equation 2.2 shows a somewhat different perspective on this relationship. Other things equal, coefficient estimates indicate that infants in the BWT2 category (from 1,500 to 2,500 grams) had charges that were $1,065.41 lower than normal-birth-weight infants (more than 2,500 grams). This may be because of the large proportion of infants in this category that can be classified "small-for-term," weighing between 2,240 and 2,500 grams.[3] The added expense for very low-birth-weight infants (less than 1,500 grams) was $13,638.32 because of the medical complications evident in extremely low-birth-weight infants.

Infants who were transferred had charges that were more than $48,091 higher than those who were not. Each extra day in the hospital increased the charges by $438.55.

[3]The remainder of the infants in this birth-weight category have a much higher incidence of ICU transfers and longer hospital stays. Overall, this makes this category of infants more expensive.

Table 4

Ordinary Least Squares Regression Coefficients: Hospital Charges for Infant

	Total Sample		White Infants		Non-White Infants	
Independent Variable	(2.1)	(2.2)	(2.1)	(2.2)	(2.1)	(2.2)
Birth Weight in Ounces (BWT)	-10.24	—	-19.45	—	-6.02	—
	*(2.00)	—	*(2.04)	—	(2.40)	—
Birth Weight 1,500-2,500 Grams (BWT2)	—	-1,065.41	—	-1,876.65	—	149.53
	—	*(2.04)	—	*(2.03)	—	**(0.57)
Birth Weight Less Than 1,500 Grams (BWT3)	—	13,638.32	—	26,077.08	—	8,364.34
	—	(8.29)	—	(8.31)	—	(10.74)
Transferred	48,091.43	47,119.67	52,919.93	52,099.91	35,864.35	34,760.26
	(31.80)	(31.25)	(23.37)	(23.16)	(36.79)	(36.01)
Stayed	438.55	335.13	511.97	341.07	317.90	219.90
	(12.98)	(8.88)	(9.78)	(5.90)	(15.63)	(9.55)
Died	-7,084.12	-16,891.20	-10,371.15	-29,261.59	-3,982.25	9,966.78
	(4.10)	(8.01)	(3.35)	(7.55)	(4.61)	(9.79)
Constant	692.74	-228.82	1,647.20	-228.73	499.80	34.67
R^2	0.2381	0.2466	0.2223	0.2366	0.5228	0.5422
N	6,702	6,702	4,075	4,075	2,626	2,626
F-value	523.4	438.5	290.9	252.3	718.1	620.7

* Statistically significant at the .05 level.
**Not statistically significant at the .10 level.

NOTES: *t*-values in parentheses. All coefficients significant at the .01 level except as previously noted.

SOURCE: Henderson, J., Baylor University, 1994.

Goodness of fit as measured by R^2 is greater than .23, depending on the specification of the equation.

DISCUSSION AND CONCLUSIONS

Although the results of this study do not demonstrate a causal relationship between prenatal care and birth outcome, they do suggest an association between prenatal care and positive birth outcome. The independent effect of prenatal care on birth weight, adjusted for differences in other regressors in Equation 1, is 145 grams (5.09 ounces). In other words, even after adjusting for other differences, infants born to females who receive prenatal care weigh about 145 grams more than those whose mothers do not receive prenatal care. Referring to Table 5, these babies also are less likely to fall into the low- and very low-birth-weight categories (10.23 percent versus 17.42 percent), proportionately fewer are born prematurely (4.60 percent versus 9.50 percent), the incidence of transfer to an acute-care facility is less than one-half (0.71 percent versus 1.85 percent), and the incidence of early death is much lower (0.38 percent versus 2.11 percent).

The main contribution of this study is that it brings into the analysis for the first time cost information based on actual hospital charges rather than estimates based on surveyed prices. The predicted value of the cost of care can be determined using the results presented in Table 4 from Equation 2.1. Babies whose mothers received prenatal care have a predicted hospital cost of $1,064.61, compared with $2,068.66 for those whose mothers did not receive care prior to the onset of labor—a difference of $1,004.05.

Table 5

Mean Values for Predictive Variables

Variable	Received Care	No Care
Birth Weight in ~~Ounces~~ grams (BWT)	3,380	3,100
	Percent	
Birth Weight More Than 2,500 Grams (BWT1)	89.82	82.59
Birth Weight 1,500-2,500 Grams (BWT2)	4.76	9.50
Birth Weight Less Than 1,500 Grams (BWT3)	5.47	7.92
Premature	4.60	9.50
Transferred	0.71	1.85
Died	0.38	2.11
	Days	
Length of Stay	2.90	3.99
Mean Charges	$1,045.69	$2,244.11

SOURCE: Henderson, J., Baylor University, 1994.

The basis of the cost savings associated with prenatal care seems to be in the associated lower incidence of extremely low-birth-weight babies among females who receive prenatal care. As previous studies have indicated (e.g., Lennie, Klun, and Hausner, 1987), low-birth-weight infants have significantly higher medical expenses than normal-birth-weight infants. Table 6 provides a breakdown of the average hospital charges and proportion of births in each of the three birth-weight categories. For females who received prenatal care, the hospital charges for low-birth-weight infants (1,500 to 2,500 grams) were more than 4 times those of normal-birth-weight infants. Very low birth weights resulted in charges of more than 33 times those for normal birth weights. For females who did not receive prenatal care, the results were worse. Low-birth-weight infants had almost 6 times the charges of normal-birth-weight infants, and very low-birth-weight infants had charges of more than 70 times normal.

Fortunately, only 5.72 percent of the births to females with prenatal care fall into the two low-birth-weight categories. However, this contrasts with more than 14 percent of the births in these low-birth-weight categories to females who received no prenatal care. Although it is unreasonable to expect that low and extremely low birth weights will be eliminated completely, it seems reasonable to expect that were they to receive prenatal care, the distribution of birth weights for the mothers who received no prenatal care would converge toward that of the mothers who received prenatal care. Using this as a working assumption, if the 364 mothers who received no prenatal care had the same birth-weight distribution as the 6,344 mothers who received prenatal care, their average hospital charges would fall from $2,297.42 to $926.19, a reduction of $1,371.23. Note that this calculation holds constant the average charges within each category, to allow for differences in the distribution of charges within each category.

This figure is actually $103.31 less than the charges for those infants whose mothers had prenatal care. One reason for this phenomenon may be that women in this category had fewer cesarean deliveries and thus the infants with normal birth weights had shorter average hospital stays. Females delivering normal-sized babies had lower cesarean-section rates than females delivering extremely low-birth-weight babies (23.0 percent versus 40.7 percent for white females; 17.2 percent versus 20.6 percent for non-white females). If the rate for non-white females adjusts to the higher rate for white females within each birth-weight category, overall the non-white group would have 154 more cesarean deliveries. Using the coefficient on length of stay from Equation 2.1 in Table 4 (i.e., 317.90), the average cost would increase by approximately $20 per infant for every day the average stay increased. Thus the average stay for babies

Table 6

Mean Hospital Charges by Birth-Weight Categories for Females With and Without Prenatal Care

Birth Weight	With Prenatal Care		Without Prenatal Care	
	Charges	Percent Distribution	Charges	Percent Distribution
Average	$1,029.50	100.00	$2,297.42	100.00
More Than 2,500 Grams	735.14	94.28	534.91	85.99
1,500-2,500 Grams	3,215.19	5.00	3,080.01	9.89
Less Than 1,500 Grams	24,395.90	0.72	37,204.90	4.12

SOURCE: Henderson, J., Baylor University, 1994.

delivered by cesarean section would have to be more than 5 days above the average for normally delivered babies.[4]

The use of population-based data is an important addition to the analysis of cost-of-care questions. Although the study sample is regionally isolated and too small to make sweeping generalizations, the demographic characteristics of the McLennan County population are representative of those of metropolitan areas across the country. This includes age and ethnic composition, socioeconomic characteristics, and, unfortunately, drug use and abuse. The possible net cost savings attributable to prenatal care are substantial. A savings of $1,371.23 per birth for this group of women translates into a group savings of more than $499,000. With more than 3.8 million births annually in the United States, if the same percentage of females fail to receive prenatal care nationally (5.43 percent), this translates to 208,000 births for this group. Prenatal care for this group could potentially save $285 million nationally in hospital charges in the perinatal period alone. Thus, to the extent that prenatal care can be provided for less than $1,371 per patient, there will be a net system savings because of the better care.[5]

Despite the evidence that prenatal care is associated with desirable birth outcomes, it is not an easy step to conclude cost effectiveness. Although the incidence of low and very low birth weights, premature labor, transfers to acute-care facilities, and early death was significantly greater for those women who had no prenatal care, the combined impact on total cost of care is not large in an absolute sense.

This is not meant to imply that prenatal care is unimportant from an economic perspective. Because the most important prenatal visit is the first one, it is important that it be early in the pregnancy. If the medical data gathered during this examination can identify those women who are most at risk for premature labor and its associated low birth weights, then these women can be targeted for special treatment. Prenatal care cannot control for the socioeconomic and environmental differences that result in poor birth outcome. However, it has proven its worth in identifying factors that affect birth outcome, such as cigarette smoking, alcohol consumption, drug use, and poor diet. Once these confounding factors have been identified, a strict regimen can be prescribed to eliminate or reduce the compromising activity. By carefully screening prospective mothers' medical histories, factors such as health status, emotional well-being, and attitudes toward the pregnancy can be used to identify those at risk for problems later on.

[4]Another interesting issue is the observed higher rate of cesarean deliveries among females with private insurance compared with those without it, which may also be a contributing factor to this differential.

[5]During the study period, the Family Practice Center provided prenatal care (excluding labor and delivery charges) for around $400. This indicates a net savings to the system of approximately $1,000 for each woman shifting from the no-care group to the care group.

Further study should be undertaken to determine whether prenatal care is an important factor in preventing prematurity, or whether it is merely a proxy for health status or some other socioeconomic consideration. More information on medical histories, occupation, and education is needed to better understand this relationship.

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REFERENCES

Behrman, R.E.: Premature Births Among Black Women. *New England Journal of Medicine* 317(12):763-765, September 17, 1987.

Buescher, P.A., Meis, P.J., Ernest, J.M., et al.: A Comparison of Women In and Out of a Prematurity Prevention Project in a North Carolina Perinatal Care Region. *American Journal of Public Health* 78(3):264-267, March 1988.

Congressional Office of Technology Assessment: *Neonatal Intensive Care for Low Birthweight Infants: Costs and Effectiveness.* OTA-HCS-38. Washington, DC. Office of Technology Assessment, December 1987.

Droste, T.: Prenatal Care Education Insures Healthy Future. *Hospitals* 62:74-76, February 20, 1988.

Frank, R., Strobino, D., Salkever, D., and Jackson, C.: *Poverty Programs, Initiation of Prenatal Care, and the Rate of Low Birthweight Births.* NBER Working Paper No. 3215. Cambridge, MA. National Bureau of Economic Research, December 1989.

Gortmaker, S.L.: The Effects of Prenatal Care Upon the Health of the Newborn. *American Journal of Public Health* 69(7):653-660, July 1979.

Hack, M., and Fanaroff, A.A.: Outcomes of Extremely-Low-Birth-Weight Infants Between 1982 and 1988. *New England Journal of Medicine* 321(24):1642-1647, December 14, 1989.

Health Resources and Services Administration: *Healthy Children 2000: National Health Promotion and Disease Prevention Objectives Related to Mothers, Infants, Children, Adolescents, and Youth.* DHHS Pub. No. HRSA-M-CH-91-2. Washington, DC. U.S. Department of Health and Human Services, September 1991.

Joyce, T.: The Dramatic Increase in the Rate of Low Birthweight in New York City: An Aggregate Time-Series Analysis. *American Journal of Public Health* 80(6):682-684, June 1990.

Kessel, S.S., Villar, J., Berendes, H.W., and Nugent, R.P.: The Changing Pattern of Low Birthweight in the United States: 1970-1980. *Journal of the American Medical Association* 251(15):1978-1982, April 20, 1984.

Kleinman, J.C., and Madans, J.H.: The Effects of Maternal Smoking, Physical Stature, and Educational Attainment on the Incidence of Low Birth Weight. *American Journal of Epidemiology* 121:843-855, 1991.

Lennie, J.A., Klun, J.R., and Hausner, T.: Low-Birth-Weight Rate Reduced by the Obstetrical Access Project. *Health Care Financing Review* 8(3):83-86, Spring 1987.

McCormick, M.C.: The Contribution of Low Birth Weight to Infant Mortality and Childhood Morbidity. *New England Journal of Medicine* 312(2):82-90, January 10, 1985.

Monmaney, T.: Preventing Early Births: Prenatal Care Not Only Works, It's a Bargain. *Newsweek* 111(2):70, May 16, 1988.

Murray, J.L., and Bernfield, M.: The Differential Effect of Prenatal Care on the Incidence of Low Birth Weight Among Blacks and Whites in a Prepaid Health Care Plan. *New England Journal of Medicine* 319(21):1385-1390, November 24, 1988.

Myers, S.A., and Gleicher, N.: A Successful Program to Lower Cesarean-Section Rates. *New England Journal of Medicine* 319(23):1511-1516, December 8, 1988.

National Commission to Prevent Infant Mortality: *Infant Mortality within Minority and Rural Communities: A Global Perspective on Causes and Solutions.* A Symposium Sponsored by the Select Committee on Hunger, U.S. House of Representatives and the National Commission to Prevent Infant Mortality. Washington. U.S. Government Printing Office, 1991.

Showstack, J.A., Budetti, P.P., and Minkler, D.: Factors Associated with Birthweight: An Exploration of the Roles of Prenatal Care and Length of Gestation. *American Journal of Public Health* 74(9):1003-1008, September 1984.

Taffel, S.M, Placek, P.J., and Liss,T.: Trends in the United States Cesarean Section Rate and Reasons for the 1980-85 Rise. *American Journal of Public Health* 77(8):955-959, August 1987.

Wartenberg, D., and Northridge, M.: Defining Exposure in Case-Control Studies: A New Approach. *American Journal of Epidemiology* 133(10):1058-1071, 1991.

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HHS Office of the Ombudsman Update

Presented to
CHC Coalition
December 16, 2016

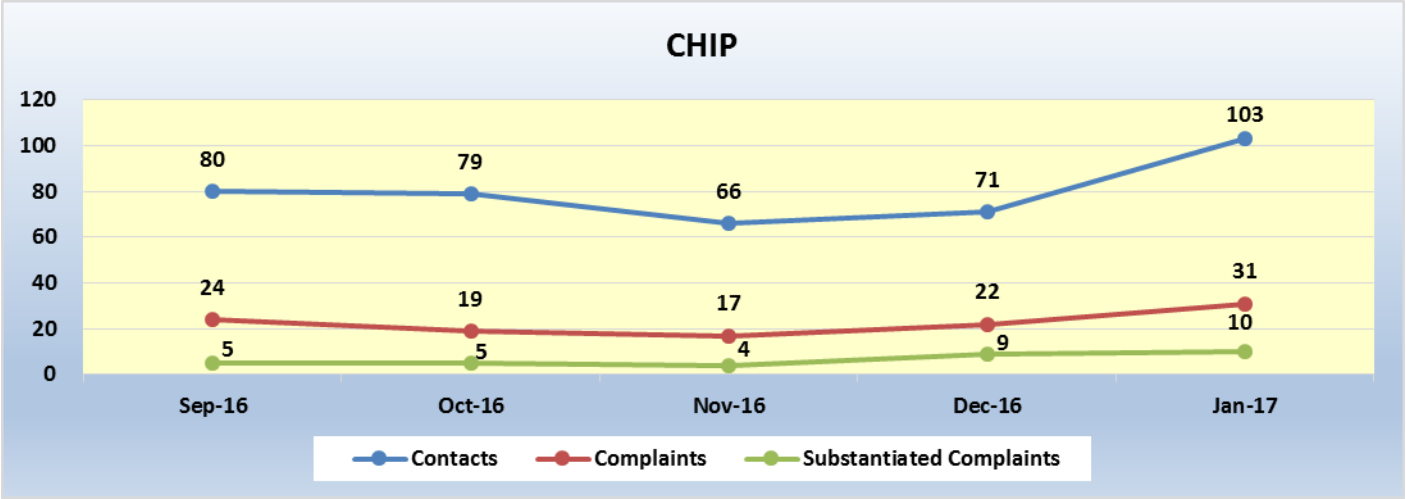
TEXAS
Health and Human Services

Total Ombudsman Contacts for September 2016 - January 2017

- Complaints – 6,520
- Inquiries – 35,133

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2016 – January 2017



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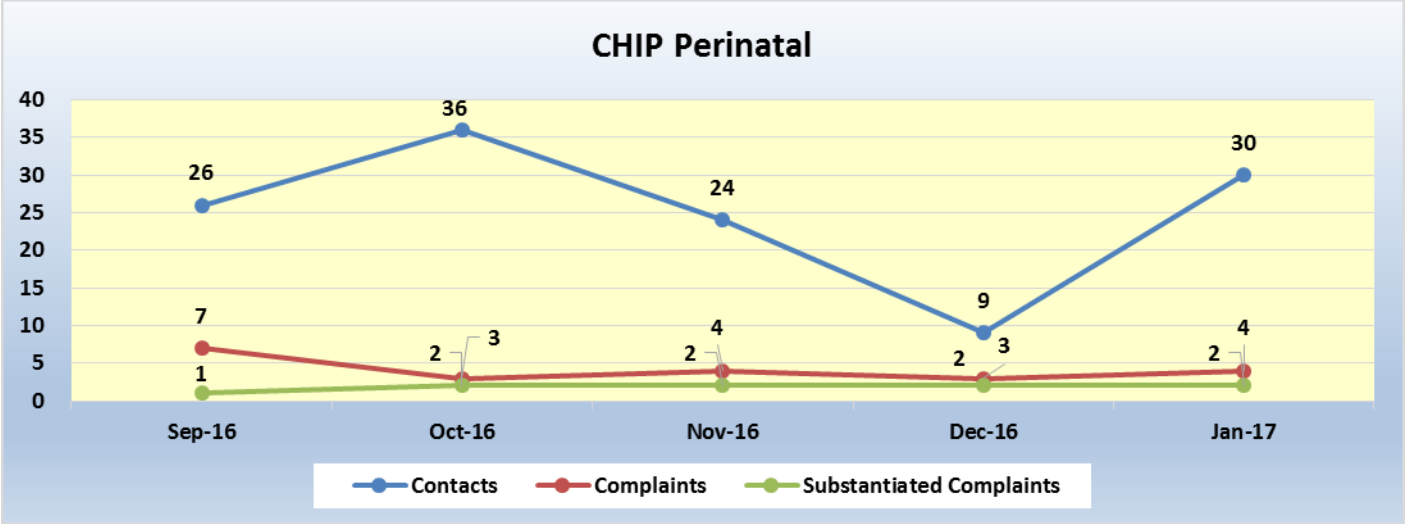
Contact Volumes by Program Type
September 2016 – January 2017



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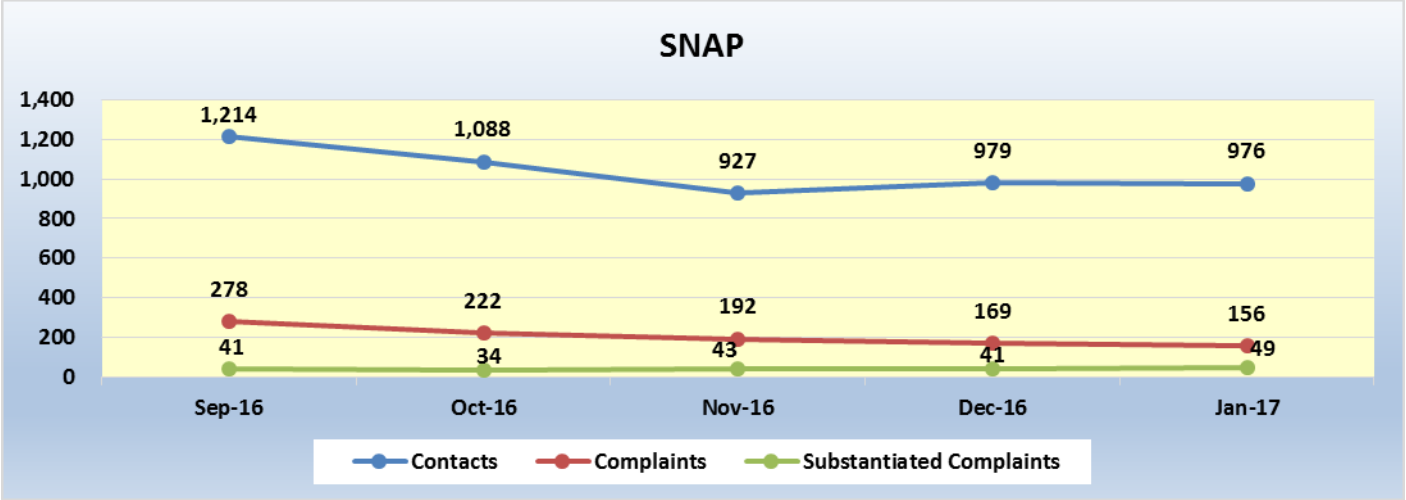

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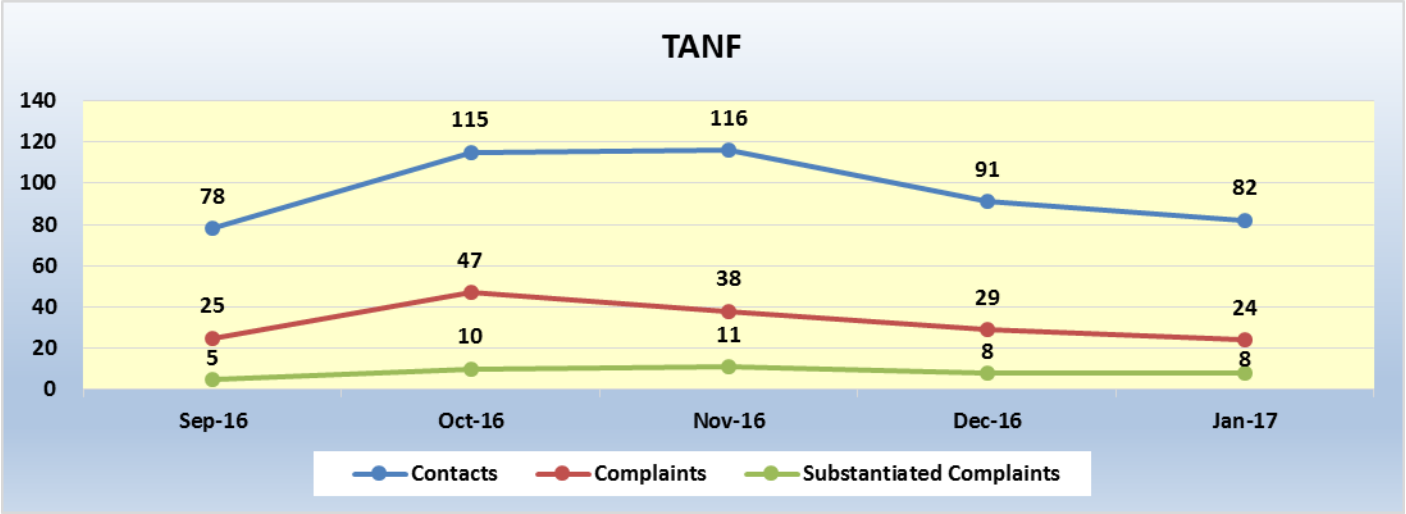

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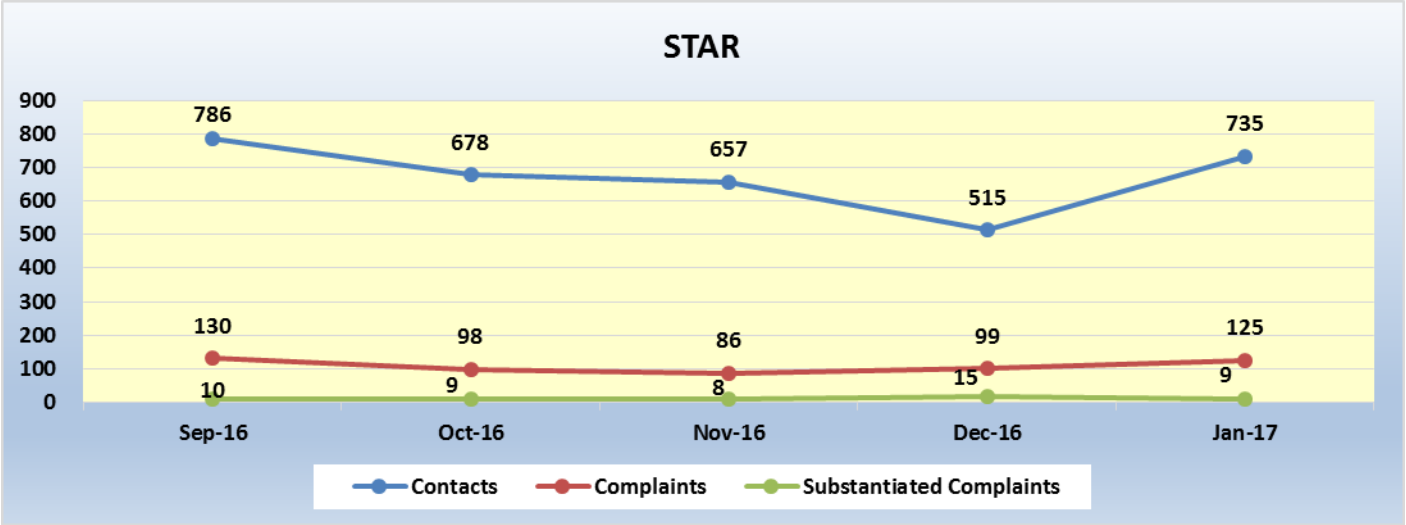

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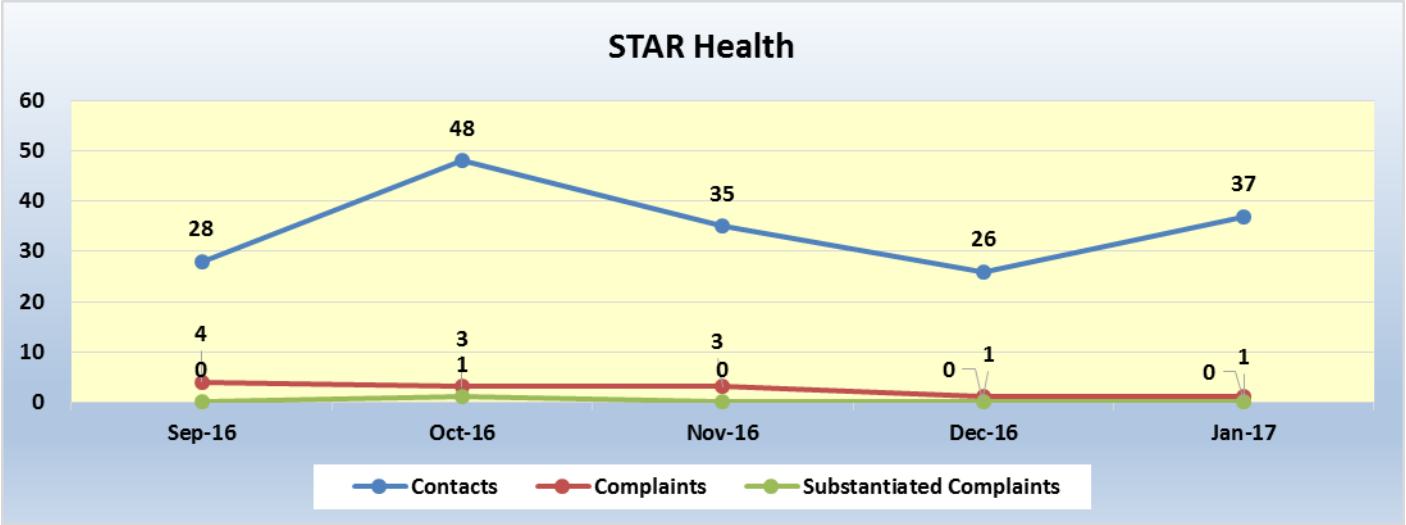

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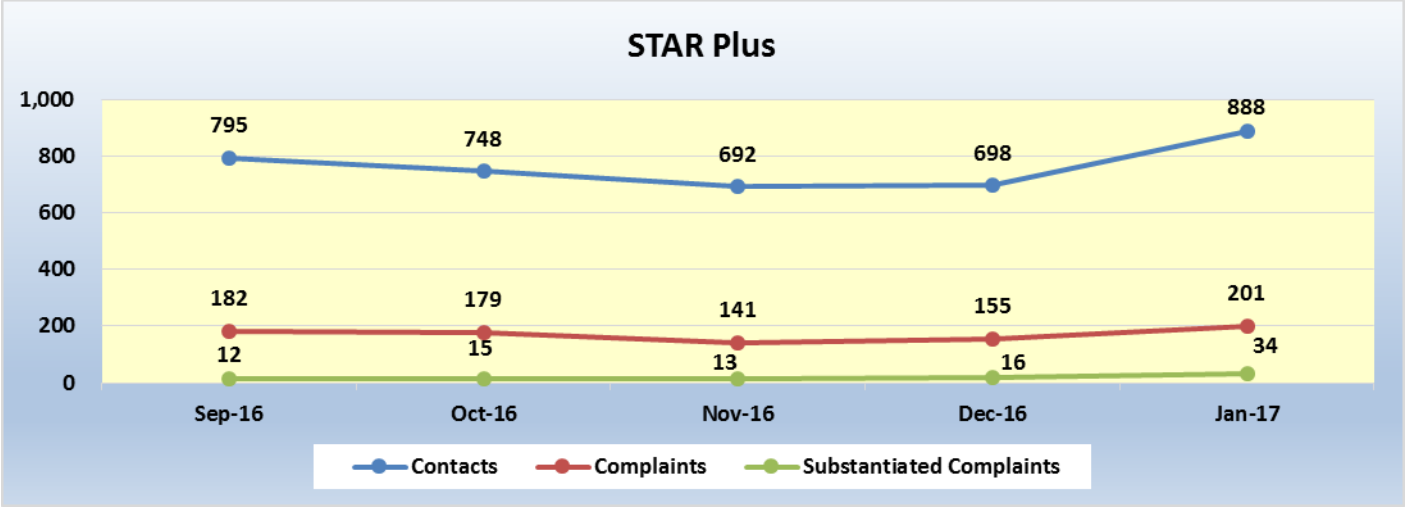
September 2016 – January 2017



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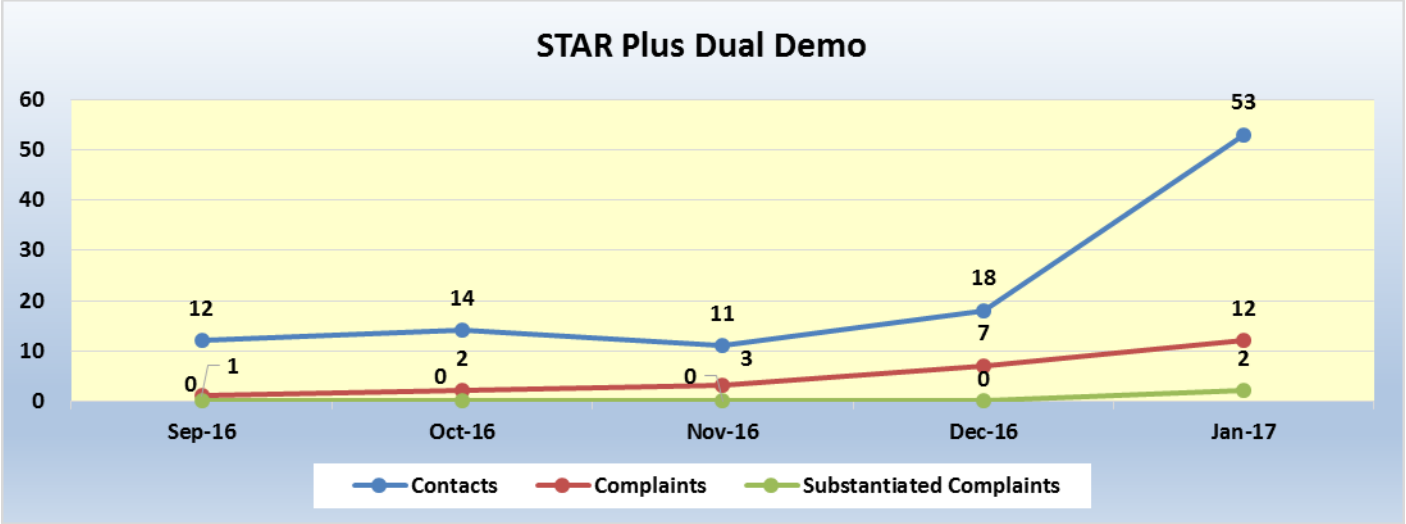
September 2016 – January 2017



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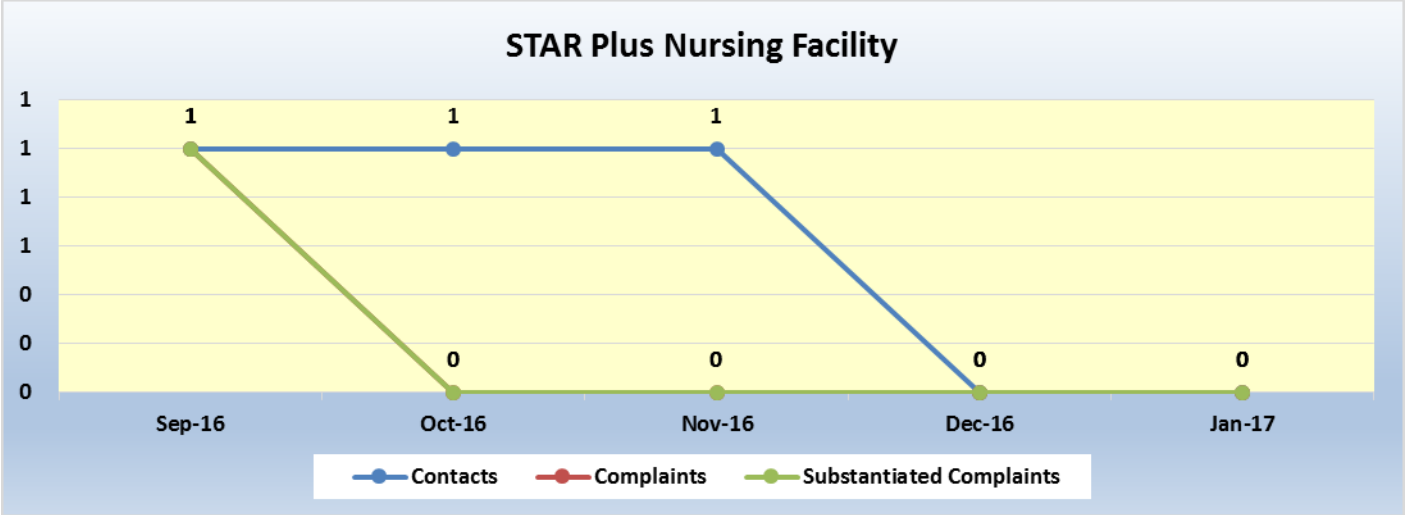

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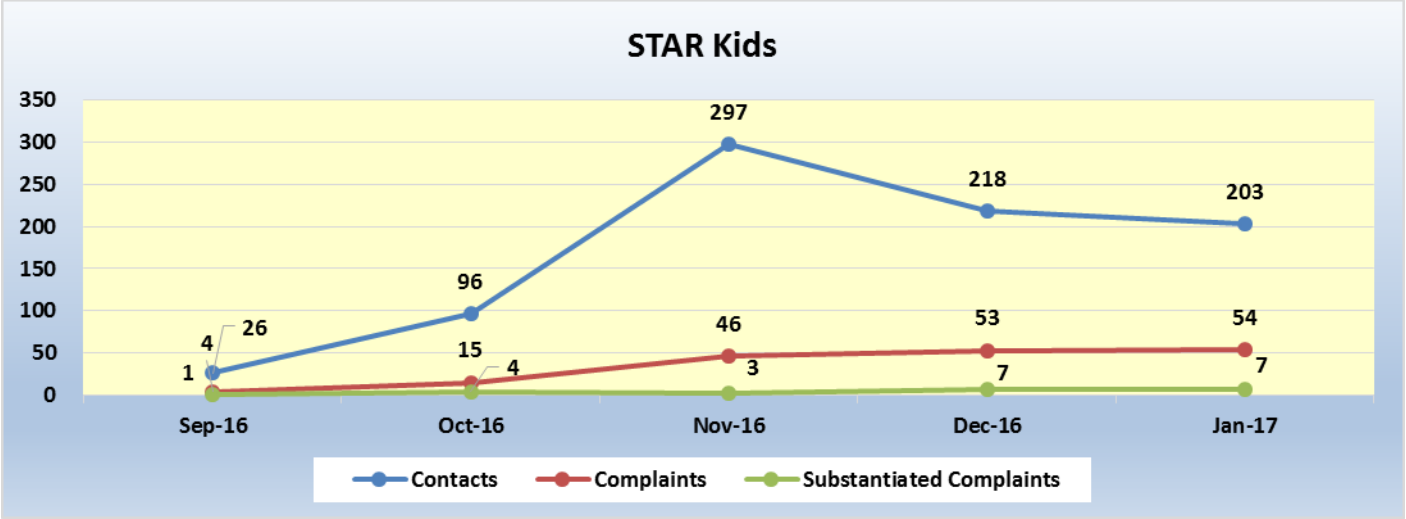

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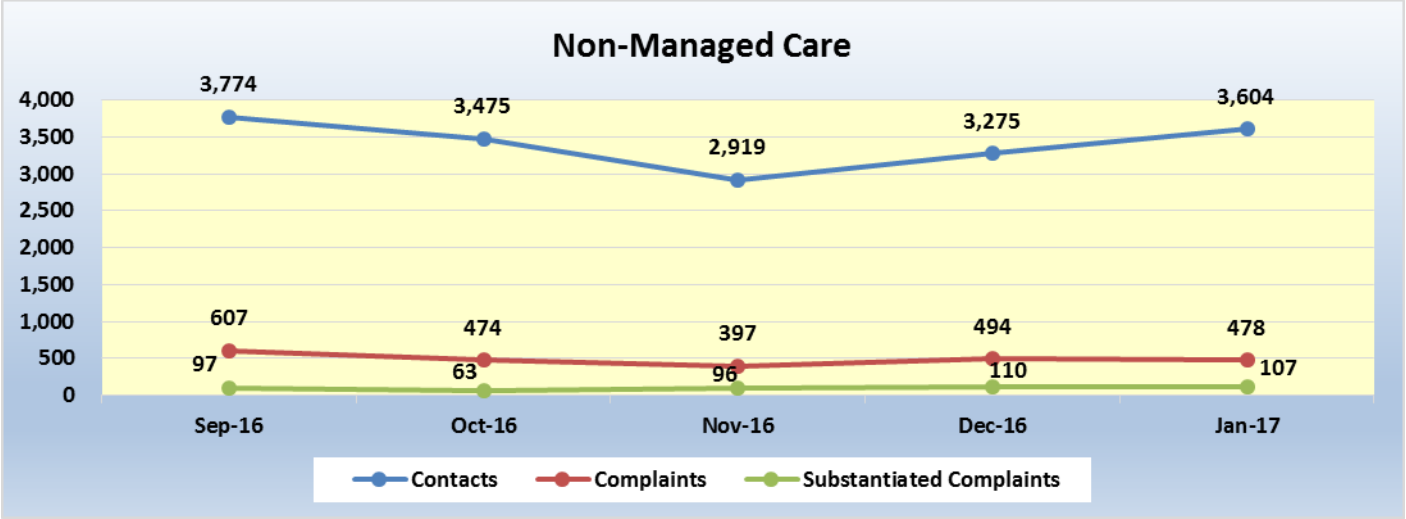

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Top Three Reasons for Contact by Program Type September 2016 – January 2017

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Top Three Reasons for Contact by Program Type
September 2016 – January 2017

CHIP	CHIP - Perinatal
Application Case/Denied	Application Not Completed
Contact Info Request	Check Status
Check Status	Client Billing
SNAP	**TANF**
Application Case/Denied	Application Case/Denied
Check Status	Check Status
Benefit Amount	Application Not Completed

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type
September 2016 – January 2017

STAR	STAR Health
Access to Prescriptions	Access to PCP/Change PCP
Access to PCP/Change PCP	Verify Health Coverage
Verify Health Coverage	Access to Prescriptions
STAR Plus	**STAR Plus DD**
Access to Prescriptions	Change Plan-Provider (PCP, Facility, DME)
Verify Health Coverage	Verify Health Coverage
Access to Long Term Care	Billing Inquiry

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type
September 2016 – January 2017

STAR Plus NF	STAR Kids
Contact Info Request	Access to Prescriptions
Changes Not Processed Timely	Verify Health Coverage
Explanation of Benefits/Policy	Change Plan-Provider (PCP, Facility, DME)
Non Managed Care	
Access to Prescriptions	
How To Apply	
Application/Case Denied	

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FOSTER CARE OMBUDSMAN

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Contact Volume FCO Program
September 2016 – January 2017

Contact Volume FCO Program September 2016 – January 2017	
Foster Care Youth	55 (20%)
Total Contacts	281

Information Shared

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

TEXAS Health and Human Services

Ombudsman Managed Care Assistance Team

UPDATE

- Outreach
- Managed Care Support Network
- Medicare Training

TEXAS
Health and Human Services

Contact us

Phone (Toll-free)

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

Online

hhs.texas.gov/ombudsman

Fax (Toll-free)

888-780-8099

Mail

HHS Ombudsman
P. O. Box 13247
Austin, Texas 78711-3247

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Access & Eligibility Services

February 17, 2017

Access & Eligibility Services

TEXAS Health and Human Services

Mission

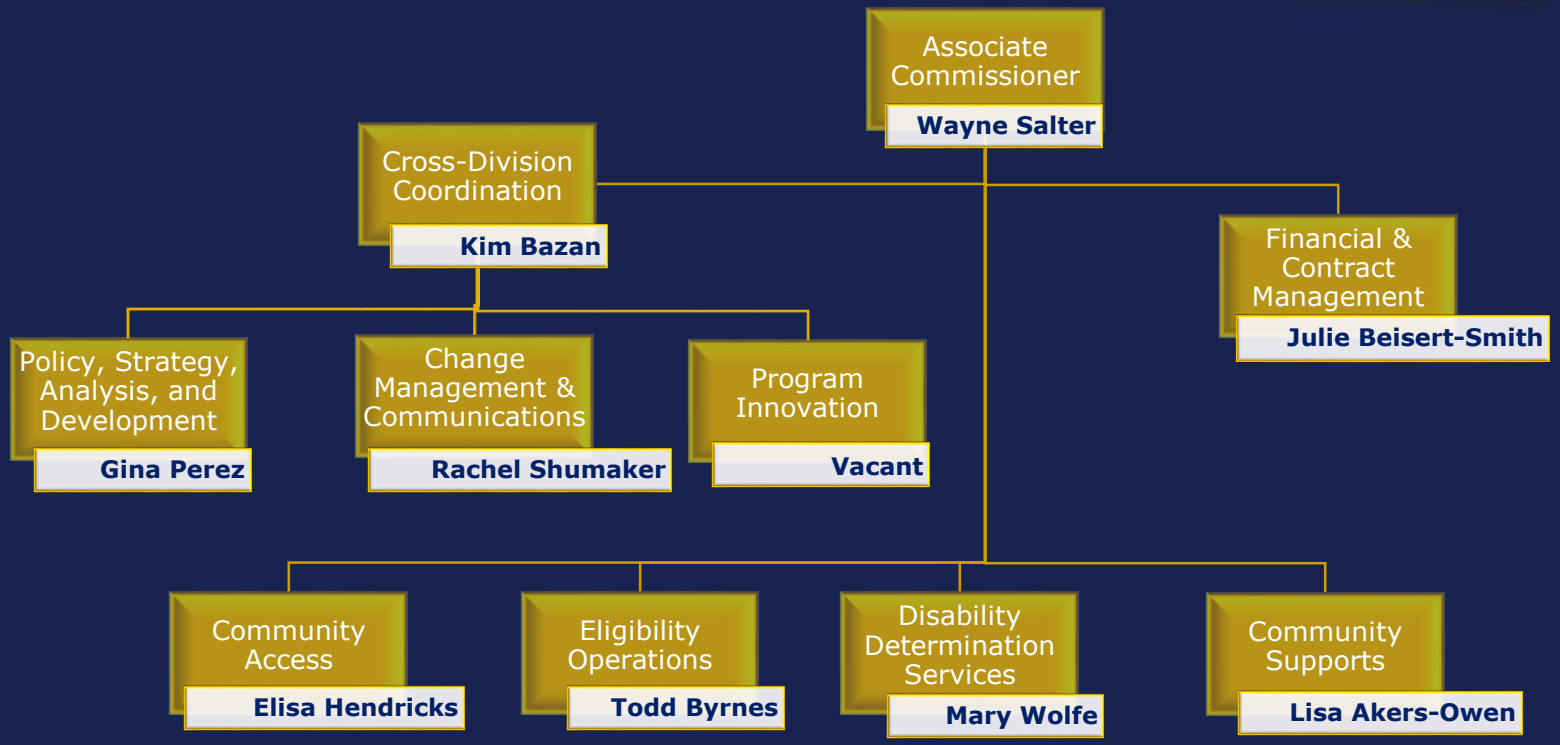
- To connect people, services, and supports.

Vision

- Provide an integrated and streamlined approach to connect individuals and supports that:
  - Reduce institutionalization;
  - Allow individuals to remain in their communities; and
  - Promote economic and personal self-sufficiency.

Meet Access & Eligibility Services

TEXAS Health and Human Services



Eligibility Operations

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Administration of financial eligibility for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, and the Children's Health Insurance Program (CHIP).

Field Operations

- Determines eligibility for SNAP, TANF, Medicaid, and CHIP.
- Serves as centralized management of eligibility determinations.
- Provides oversight and support to the field staff.

Operations Support

- Responsible for Quality Management, Lone Star Benefits Services, and Data Management and Reporting Operations.

State Operations

- Responsible for training development and delivery, program support, and vendor operations.

Community Support

TEXAS Health and Human Services

Aging Services

- Administers programs and services under the federal Older Americans Act (OAA) of 1965.
- Monitors fiscal and programmatic support and oversight for 28 local Area Agencies on Aging (AAA) subrecipients.
    - Subrecipients provide services directly or through provider agreements, such as care coordination, caregiver support, benefits counseling, home-delivered meals and transportation.

Contracted Community Services

- Processes contract applications and performs contract enrollment, maintenance, and monitoring activities for existing contractors.
    - Contractors serve individuals living with their families, in their own homes or in other community settings, who need assistance with health, social and related services.

Community Care Services Eligibility

- Includes services that are tailored to assist individuals who are older or have disabilities live independent lives in their communities.
- Regional staff perform intake, eligibility determination, enrollment, and case management for programs such as:
    - Primary Home Care.
    - Community Attendant Services.
    - Medically Dependent Children Program.
    - Day Activity and Health Services.

Community Access

TEXAS Health and Human Services

Aging & Disability Resource Centers

- Provides Aging and Disability Resource Center (ADRCs) program management. ADRCs serve as a key point of access to person-centered long-term services and supports (LTSS) information, referral and assistance.
- Responsible for the Texas Lifespan Respite Program (TLRCP) which supports informal caregivers (such as family members) by increasing awareness and the availability of respite services.
- Responsible for the Foster Grandparent Program (FGP) which offers income eligible men and women, age 55 or over, the chance to provide one-to-one companionship and guidance to children with exceptional or special needs in a variety of child-centered, non-profit community agencies.

Community Access & Engagement

- Responsible for the Community Partner Program, Regional Community Relations, SNAP-Education, SNAP Application Assistance, Presumptive Eligibility Program, Community Resource Coordination Groups, and the 2-1-1 Texas Information & Referral Network.
- Supports partnerships with faith and community based organizations.

Disability Determination Services

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Disability Operations

- Responsible for adjudicating Social Security Disability Insurance (SSDI) (Title II) and Supplemental Security Income (SSI) (Title XVI) Social Security disability claims for the Social Security Administration (SSA).
- Makes medical decisions and returns the claim back to SSA for final case decisions.

Disability Infrastructure Support

- Provides Information Resource and Facility support compliance with SSA policies and directives.
- Manages the SSA Local Area Network, communication/data lines, and the receipt/closure of all incoming/determined claimant applications for SSA disability.
- Responsible for ensuring the facility infrastructure is well maintained in compliance with the SSA continuity plan and homeland security directives.

Disability Policy & Program Support

- Oversees program support areas to assist in the overall processing of disability claims.
- Areas include Policy, Federal Quality Reviews, Medical Consultation Services and Medical Relations, all in accordance with SSA policy and directives to ensure program outcomes are consistently delivered.

Disability Resource Management

- Responsible for managing the DDS operating budget and the DDS portion of the Legislative Appropriation Request (LAR) in collaboration with the SSA.
- Liaison to Parent Agency Accounting, Budget, Internal Audit, Purchasing and Payroll Offices', as well as SSA Budget staff in the SSA Dallas regional office.

Community Partner Program

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

In its fourth year the CPP is focused on ways to develop, support, and retain Community Partners. Relevant activities include:

- Regional Community Partner support transition
  - Community Partner Support Specialists (CPSS)
  - Regional & Community Relations (RCR)
- HHSC training and support for regional support staff
- Statewide Community Partner Group
- HHSC Community Partner site visits
- Community Partner forums
- Community Partner communications and training

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Health and Human Services

Refugee Medical Assistance

CHC Coalition and OTA Meeting

Feb. 17, 2017

Texas Refugee Program Transition

- The U.S. Office of Refugee Resettlement (ORR) did not approve the Texas Refugee Program State Plan for Fiscal Year 2017.

- The Texas Health and Human Services Commission (HHSC) notified ORR that without an approved State Plan HHSC would withdraw from the administration of federal refugee services and benefits after a 120 day transition period ending January 31, 2017.

TEXAS
Health and Human Services

Impacted Refugee Programs and Benefits

As of February 1, 2017, the state does not administer:

- Refugee Social Services
- Refugee Cash Assistance
- Refugee Health Screening
- Unaccompanied Refugee Minor
- Refugee Medical Assistance

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Refugee Medical Assistance Transition

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HHSC:

- Provided ORR with technical assistance
- Provided ORR with active client information
- Notified active clients of termination of state administered program
- Updated eligibility system
- Provided training to HHSC eligibility workers

Refugee Access to Services and Benefits

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Health and Human Services

Mainstream Benefits:

- Refugees remain eligible for mainstream benefits, e.g. Medicaid, CHIP, TANF, and SNAP if they meet all program requirements.
- Refugees apply for mainstream benefits through HHSC. Applications are routed to local benefit offices for processing.

Refugee Access to Services and Benefits

TEXAS
Health and Human Services

Refugee Medical Assistance:

- Administered by U.S. Committee for Refugees and Immigrants.
- Refugees apply through local resettlement agencies.

Questions?

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Thank you