



CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

Texas CHC Coalition

Meeting Minutes

May 19, 2017

Present: Kit AbneySpelce, Central Health
Adriana Kohler, Texans Care for Children
Clayton Travis, Texas Pediatric Society
Kellie Dees, Texas Pediatric Society
Anne Dunkelberg, Center for Public Policy Priorities
Stephanie Stevens, THA
Hannah Buccars, NASW-Tx
Helen Kent Davis, Texas Medical Association
Mary Allen, Texas Association of Community Health Centers
Leah Gonzales, Healthy Futures of Texas
Clare Seagraves, HHSC
Tara McKinley, HHSC
Janna Zumbrun, Associate Commissioner, DSHS

On the phone: Kathy Eckstein, Children's Hospital Association of Texas
Betsy Coates, Maximus
Sister JT Dwyer, Daughters of Charity
Alice Bufkin, Healthy Futures of Texas
Melissa McChesney, Center for Public Policy Priorities

Chair: Kit AbneySpelce, Central Health
Minutes Scribe: Kamia Rathore, Center for Public Policy Priorities
Next meeting: June 16, 2017

I. Discussion of Federal Reform (*Anne Dunkelberg, CPPP*)

- **Anne:** One concern we should keep in mind about the federal debate as it evolves is whether the Senate bill 'dilutes' the issues in the House bill and makes them acceptable. We shouldn't just accept proposed modifications just because they are less drastic than they could be. The House may have to re-vote on the AHCA, depending on technical rules surrounding the process and by that time, the



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revised CBO score will be out. It's not expected to look better than the previous CBO score, but it gets complicated based on what assumptions are made about states.

- There's been a clear effort to get the public educated on Essential Health Benefits and pre-existing conditions, but the challenge remains to put the focus of this bill on Medicaid and CHIP. National consumer and provider advocates are working on messaging about capped funding for Medicaid and the effects on all groups of people—seniors, people with disabilities, kids, women, rural areas. There's been a focus on the impact to children. We will coordinate and compile the best talking points, research, and work in this area to serve as a useful resource in outreach and strategy.
- It may be worth thinking about how to frame advocacy on CHIP, as discussion about reauthorization may get caught up in the debate about repeal. Several congressional members have mentioned the program as a means of leverage in negotiating on ACA reform.

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

Maternal and Child Health (Alice Bufkin, Healthy Futures of Texas)

- **Alice:** The intent to apply for the 1115 waiver for the state women's health programs has been made public by HHSC. This is tied to the legislature because the Senate budget assumes that the state will receive the increased matching rate from the federal government. We're waiting to hear about the budget and hoping to incorporate language that ensures no reduction in coverage of the HTW program. The submission period for comments on the waiver application is open until early June. We're also tracking SB790 which would extend the women's health advisory committee, as well as HB2561 that could affect contraceptive access.
- Our primary concern is the budget and what the waiver application could mean—a couple of media outlets are picking up the story as a 'tester' for how state women's health plans can exclude Planned Parenthood.
- **Mary:** HB 3151 is largely stalled—we're currently looking for alternative avenues to pursue the change, but we haven't found any particular bills we'd like to amend the demonstration project onto. There are limited vehicles for pursuing this further like an interim study or regulatory change, so we are examining these options.
- **Adriana:** We're pushing for SB 1929 to expand the duties of the maternal mortality taskforce and evaluate proposals to reduce mortality and depression; currently pushing to get it on Calendars before the deadline passes.
- **Kathy:** SB 11, which is the foster care reform bill is now moving to conference. We're pushing for timelier doctor's visit for foster care kids, which has been changed in the bill from a three- or five-day period to a triage system which can take up to 21 days. We're working to improve this.

Medicaid cost-containment (Anne Dunkelberg, CPPP)

- **Anne:** We've put out a side-by-side analysis of the House and Senate budgets for Medicaid and CHIP that goes in-depth on the differences. Both budgets went into conference about three billion short in



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GR on Medicaid; there's a subset of that which is riders with a shopping list of reductions. This will be the fourth session with a cost-containment rider. The 2015 version of the rider included the deeply unpopular and devastating reductions to children's therapy rates. The new versions of the cost containment rider this session include a 410 million GR reduction on the Senate side and a 110 million GR reduction on the House side. The House has another rider that is a 459 million GR reduction to Medicaid.

- **Adriana:** There was one amendment to a rider to restore the reductions in the therapy rates from last session.
- **Anne:** Right, the House used their supplemental bill to reverse the therapy rate cuts and repeal HHSC's policies as well. Advocates should continue to point out the effects of these cuts in this program, particularly when connecting it to the larger cuts that Medicaid could be facing. We should encourage all members to have public discussion on Medicaid funding and get their intention on fully fund the program. We know there will be a shortfall based on this budget, it just isn't clear how big it will be.

Early Childhood Intervention (Adriana Kohler, Texans Care)

- **Adriana:** We've been following two bills on this issue during the session, but neither seem to be moving. The one bill that would have required private insurers to cover certain ECI services was left pending in committee, while the taskforce bill to study financing options for ECI did not receive a hearing.

III. Regional Data on Developmental Screenings and Well-Child Visits *(Adriana Kohler, Texans Care)*

- *Presentations available here and here*
- **Adriana:** A child is referred to ECI through a developmental screening or through another treatment program—so understanding referrals to ECI requires understanding developmental screening rates across the state.
- We decided to look at not only developmental screening rates, but also how many kids on Medicaid and CHIP are going to the doctor.— We looked at the rate of kids who received six or more well-child visits within their first 15 months, and how many kids between ages 1-2 and 2-6 had seen their doctor within the last year. The measures are approved by NQF and NCQA, which are quality approval agencies, and are tracked by Medicaid and CHIP plans and reported to the state and often CMS. The regions reporting data are the 13 Medicaid managed care regions, county level data is not tracked to our knowledge.
- The main takeaway is a large number of children are going to the doctor, especially in the first 15 months. But not all are being screened for developmental delays—only about one-third of those who should be getting screened are receiving developmental delay screenings.
- **Anne:** Is it expected that every kid should be screened?
- **Adriana:** Yes, the American Academy of Physicians recommendations include specific age intervals for every child to receive a developmental delay screening. One question that emerged from this was whether pediatricians were doing screenings but not reporting. Overall, the regions had a high



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percentage of children going to the doctor, but there is a regional variation between 30 and 50 percent of kids receiving developmental screenings.

- **Adriana:** The main question this raises is: why are kids not being screened? Is it because the doctor is dealing with a more serious medical issue the child is facing and there isn't time to do a screening? Is more education about the screening tool required for pediatricians? Is it a reimbursement issue?
- **Kit:** Depending on how the data is tracked, reporting could be a large issue.
- **Adriana:** Our next step is to do interviews with providers and look at provider claims—whether it's easy to check yes or no, whether there are ways to streamline reporting of the screening. We don't want to conclude that doctors are not doing the screening; it's that the measure is not showing screenings.

IV. Mosquito Repellant Benefit for Zika Prevention (*Clare Seagraves and Tara McKinley, HHSC*)

- **Clare:** We'll be giving an update on HHSC's reauthorization of the Medicaid mosquito repellant benefit to prevent Zika transmission. We were last here at the Coalition's July meeting before the benefit initially launched. Last year, CMS approved mosquito repellant as a Medicaid benefit and we were one of the first states to release the benefit. Texas is offering the benefit again this year, and it has been in place since May 1st.
- The benefit is only available to certain Medicaid clients: Pregnant women, women ages 10 – 55, and males 14 and up. It is being offered within the same programs as last year: Medicaid, CHIP, CHIP Perinatal, Healthy Texas Women, and the Family Planning Program. The benefit last year ended in October but in certain areas with a particularly high risk of Zika transmission, such as Cameron County, the benefit was left in place year round. This year the benefit will be available until December. HHSC will re-evaluate whether to extend the benefit as we get closer to the end of the year.
- The benefit has the same allotment as last year. Eligible individuals can get one can per visit, with up to two per month. Dr. Pareek has filed a standing prescription only for beneficiaries on Medicaid and CHIP. This allows eligible individuals to go directly to the pharmacy and receive the repellant, rather than having to go to the doctor. CMS requires this benefit to have a prescription, and the standing order from Dr. Pareek simplifies this process for many of the eligible beneficiaries. This does not apply to all potential individuals who may be eligible for the benefit, and a chart online at texaszika.org goes through which groups the standing order is applicable.
- Clinics have asked if they can receive a case of approved repellants, but we have told them it must go through a pharmacy. We've received good feedback from the pharmacies and we do recommend to beneficiaries calling a pharmacy beforehand to make sure the approved repellants are in stock.
- **Tara:** Before we rolled out the benefit on May 1st, we updated the list of approved repellents and more than doubled the available products. We hope this also helps with access. We're keeping an eye on reports of difficulties getting repellant; we didn't get feedback that the benefit was difficult to access last year. We're also working closely with DSHS to make sure folks are aware of the benefit.
- **Kit:** Do you have any data on utilization?
- **Tara:** It is available – to summarize, the majority of people who took advantage of the benefit last year were pregnant women, largely in the southern region of Texas. Utilization of the benefit was low overall, but we hit the two target populations where we hoped the benefit would be most effective.



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This year, we have local transmission in Texas, so Zika and prevention are on people's radar. We're hoping that means expanded use of the benefit this year.

V. Update on Response to Zika (*Associate Commissioner Janna Zumbrun, DSHS*)

- **Janna:** Zika spreads through a mosquito biting an infected person and then spreading the disease through a bite to another individual. The *Aedes aegypti* species is usually the main culprit, though there are other mosquito vectors. *Aedes aegypti* are commonly human disease vectors because they feed exclusively on humans, meaning they tend to cluster near human populations. The best way for transmission is in close, dense housing situations and the problem is exacerbated by un-air-conditioned housing, open windows, or poor screens. Some effective prevention means include using insect repellent, fitting windows with screens, and destroying breeding habitats. *Aedes aegypti* can lay eggs in a tablespoon of water, so I recommend regularly checking gardens for any pools of water, especially around potted plants.
- The first case of Zika was reported in January 2016, with symptoms in reported in November 2015. There have been 344 cases to date, the majority of those from individuals who travelled out of the country and were infected abroad. Two cases have been confirmed as sexually transmitted from a partner who travelled and got Zika abroad. Six are confirmed as maternal to fetal cases. We've had six confirmed cases of local transmission in Cameron County. The first case of microcephaly was in July. 80 percent of Zika cases have no symptoms.
- We are focusing resources on pregnant women. It's also important to note that a woman infected with Zika can have a child born with no apparent defects who then goes on to develop defects in the course of a year.
- The Texas public health system includes us—the statewide department—working on disease control, prevention, and disaster response alongside local departments that work with complete independence. Local departments can provide a full range of public health services or a limited range depending on their resources. The regional offices act like a local department in areas without a local office. DSHS's job is to coordinate responses when an issue goes beyond the jurisdiction of one area.
- An executive steering committee for the Zika response was created in 2015 for coordination with local departments and other state agencies. We are also working with Mexico to coordinate to whatever extent possible.
- The cases of Zika in Texas are largely related to travel. We have not seen local transmission in urban areas, but our attention on local transmission has been in the Rio Grande Valley (RGV). In April, we revised testing guidelines for six counties in the lower RGV for pregnant women to get tested at their first prenatal visit, in the second trimester, and at any point when there are signs of major symptoms. For non-pregnant individuals in the Valley, if they exhibit a rash and one other common symptom sign of Zika, we recommend they be tested. For the rest of Texas, the guidelines recommend testing for pregnant women who have travelled to high-risk countries, or have a partner who has, or has shown three major symptoms of the disease. Local health offices are helping providers sort out when and whom to test.



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- In our labs, we use either a PCR test or IgM testing that looks for antibodies. The IgM test can show if the infection occurred in the last few months but does not confirm the current presence of a Zika infection, like the PCR test does. We also conduct surveillance using our zoonosis control program focusing on diseases travelling from animals to humans. Mosquito trapping and surveillance is used in some local areas, but it is unlikely to find any large numbers of Zika infected mosquitos until there is a large reservoir of Zika in humans.
- Our birth defects surveillance branch does active surveillance, abstracting information from medical charts and determining if birth defects have occurred. It can take up to a year to gather data on an infant and determine what birth defect they have. With Zika, we started rapid ascertainment to speed up the data gathering process to up to three months. There's about a nine percent rate of defects among Texas births in which the mother had Zika and we know the outcome of the pregnancy—this is similar to the national level of Zika birth defects. For these infants who have Zika-related birth defects, they will need a system of intensive care. We are working on coordinating a system of integrated support using existing service networks such as the Children with Special Health Care Needs program, our own case management program, and the large non-profit Texas Parent2Parent. We're working on setting up a state-wide pilot for infants with Zika-related defects. DSHS' Maternal and Child Health program has applied to CMS for a grant related to a Zika Health Care Services Program we'd implement in two projects. One project will use community health workers and case managers to focus on education about accessing services and prevention counseling. The second project will be training and educating providers to increase their ability to respond to Zika.
- We have gotten federal funding from CDC to support Zika work in Texas and a large deal of that funding has been pushed out to local departments to support their work. Virtually every area of the agency is involved on the response to Zika.
- **SJT:** Because Zika defects can develop up to over a year after birth, is the agency following up with pregnancies they've identified as being at risk?
- **Janna:** It's not quite in our tool box to follow up after delivery but we're doing the best to our ability to identify those instances of birth defects. The first birth with a Zika-related birth defect was identified in July of 2016, so it has not been entirely one year since our first documented case.
- **Clayton:** Could you discuss how funding cuts for DSHS could affect the Birth Defects Registry? It's clearly a key component to care for these children.
- **Janna:** The appropriations conference committee is still working on their bill, and I have no special insight into what will be in the ultimate bill. Going into conference, we were aware of proposed administrative reductions – this could affect core activities such as billing, finance, so on. We did analyze what those cuts would do and provided the legislative leadership with information about what funding levels we believe we need for both administrative purposes and critical operations. I don't know to what extent the Birth Defects Registry might be affected by potential reductions. We did receive a CDC grant for one year for Zika-defect surveillance.

Anne Dunkelberg of the Center for Public Policy Priorities will chair the June 16th meeting, which is an OTA meeting.

First Steps: A Spotlight on Health and Developmental Screenings for Young Texans

BY ADRIANA KOHLER AND REBECCA HORNBACH

Every family looks forward to their child's first smile, first step, and first words. Routine well-child visits and developmental screenings allow doctors and families to monitor a child's health and development and celebrate these kinds of milestones. Ongoing screenings for young children also help identify possible social, behavioral, and developmental delays that can be addressed with early intervention services. Through regular check-ups and strong developmental surveillance systems, families can be referred to the services and supports their children need, as early as possible, giving them a greater opportunity to learn, socialize, and thrive.

The American Academy of Pediatrics (AAP) recommends eight well-child visits within the first 15 months of life and developmental screenings for children at 9 months, 18 months, and 24 or 30 months. How well are states and communities following through on these recommendations?

Texans Care for Children collected state and regional data to find out how many young Texas children are getting recommended check-ups and developmental screenings. We recently put together an interactive map showing the percent of children enrolled in Medicaid and Children's Health Insurance Program (CHIP) who received the recommended developmental screens and well-child and primary care visits in 2015. In Texas, this data is available statewide and for each of Texas' 13 geographic managed care regions. Fortunately, Texas Medicaid and CHIP health plans track and make publicly available specific measures for children's health and development, including:

- **Developmental Screening:** The rate of children screened at the recommended age interval (9 months, 18 months, and 24 or 30 months) for risk of developmental, behavioral, and social delays. Screening rates are tracked for children under age three and also separated by age group (kids under 12 months, kids age 12 to 24 months, and kids age 24 to 36 months);
- **Infant Well-Child Visits:** The rate of children who had six or more well-child visits within the first 15 months of life (AAP recommends 8 well-child visits in the first 15 months);
- **Primary Care Visits for Young Children:** There are two measures in this area – the rate of children age 12 to 24 months and rate of children age 25 months through 6 years who had a primary care visit in the last year.

We found some good news but also clear room for improvement. As our issue brief highlights, rates varied widely across regions of Texas, particularly for developmental screenings and the rate of kids with six or more well-child visits in the first 15 months of life. At the state level, 51 percent of Texas children in Medicaid/CHIP received six or more well-child visits during the first 15 months of life. Among slightly older children, 96 percent of kids age 12 months to 24 months and 89 percent of kids age 25 months through 6 years had at least one visit with their primary care physician in the last year. This is great news – the vast majority of children are seeing their doctor during the first few years of life.

However, not every child who visited the doctor received a developmental screen. Among children under age 3 in Medicaid/CHIP, only one-third (37 percent) were reportedly screened with a standard tool for risk of

developmental, social, or behavioral delays. The rate varies widely across regions of Texas. For example, only 1 in 4 children under age three (28 percent) received a developmental screen in the Lubbock Managed Care Service Area (i.e. Texas Panhandle), while 58 percent of children under age three received a developmental screen in the Travis Managed Care Service Area, which includes Austin and surrounding counties. It's important to note that this developmental screening measure is endorsed by National Quality Forum and takes into account the number of kids eligible for a developmental screen. So we know that this screening rate is out of the number of young children in Medicaid/CHIP who should have been screened.

Identifying possible development issues early will help ensure more children receive the early intervention services and supports they need to grow and thrive. For instance, children may be referred to Early Childhood Intervention or Part C of IDEA programs. Known in Texas as ECI, the program provides targeted high-quality interventions for children under age 3 with disabilities and developmental delays, such as Down syndrome, speech and language delays, and autism. Unfortunately, as our recent report shows, over the past several years Texas lawmakers made budget cuts and policy changes to the ECI program that left thousands of eligible babies and toddlers without the early intervention supports they need. This legislative session, the proposed budget misses the mark by underfunding ECI again, even though ECI providers continue to withdraw from the program due to the financial strain of state budget cuts.

Texas Care for Children looks forward to exploring a number of issues and questions raised by these data, including:

- Why kids might not be screened for developmental delays when they receive well-child visits;
- Whether more education about developmental screening tools is needed among clinicians;
- What steps Medicaid and CHIP health plans can take to ensure more children receive well-child visits and developmental screenings at the appropriate intervals; and
- What are effective ways to encourage follow-up visits for recommended screenings when primary care visits that occur are mainly to address a specific medical issue or illness.

Access to developmental screenings, well-child visits, and ECI must be considered within the context of federal policy discussions around health care and Medicaid/CHIP. As the President and Congress consider significant changes to the way the federal government works with states to support children and families, changes to Medicaid/CHIP policies could drastically cut or eliminate health benefits for children. For instance, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (known in Texas as Texas Health Steps) ensures that children enrolled in Medicaid are covered for individualized screenings and treatments, such as vision and hearing screens, developmental screens, and treatments to address conditions discovered through screenings and diagnostic tests.

The EPSDT benefit is one of the hallmarks of the Medicaid program, but this critical benefit is under great risk. Debates in Congress to repeal the Affordable Care Act have included proposals to radically restructure Medicaid to a "block grant" or per capita cap. Under these plans, Congress would cut Medicaid funding and provide states with a set amount of federal funds to operate their Medicaid programs. If a block grant or per capita cap option were to pass, it would shift the costs of health services from the federal government to the states and counties. **In practical terms, children would no longer be guaranteed the EPSDT benefit, which has been in place for decades to ensure that kids are able to access needed screenings and treatment.** Governors and state legislatures would have to decide what benefits a child could get through Medicaid. It is clear that decisions made by federal policymakers will have ripple effects on Medicaid and children's access to health care and screenings they need to stay healthy, succeed in school, and grow up to fulfill their potential.

Check-Ups & Developmental Screenings: How Many Texas Kids in YOUR Community Get Them?

Background

Routine well-child visits and developmental screenings allow physicians and families to monitor a child's health and identify developmental, behavioral, and social delays that can be treated with early intervention services. The American Academy of Pediatrics (AAP) recommends eight well-child visits within the first 15 months of life and developmental screenings at 9 months, 18 months, and 24 or 30 months.¹ In order to track whether kids are getting the health care they need to grow and thrive, health plans, as well as states, are encouraged to collect and use data on nationally-recognized quality of care measures.

Texans Care for Children collected state and regional data on the percent of children enrolled in Medicaid (STAR and STAR+PLUS) and Children's Health Insurance Program (CHIP) health plans who received developmental screens and well-check and primary care visits in 2015 across Texas' 13 geographic managed care service areas.²

- **Developmental Screening:** The first four measures (DVS Total, DVS 12 mos., DVS 24 mos., DVS 36 mos.) reflect the rate of children screened at the recommended age interval for risk of developmental, behavioral, and social delays.³ Health care providers use a standardized screening tool to perform this screening. The DVS measure has been endorsed by the National Quality Forum (NQF). It was developed in conjunction with national quality experts and based on learning from state Medicaid-led initiatives. The DVS measure is one of the 26 indicators in the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, which states voluntarily report to the Centers for Medicare and Medicaid Services each year.
- **Primary Care Visits:** The next three measures (W15 6+, CAP 12-24 mos., and CAP 25 mos. - 6 years) reflect the rate at which children receive well-child visits and primary care visits during specific age intervals. These measures were established by The National Committee for Quality Assurance (NCQA) and are part of the HEDIS® Quality of Care measures, which are widely used among health plans.

Texans Care for Children is a statewide, non-profit, non-partisan, multi-issue children's policy organization. We drive policy change to improve the lives of Texas children today for a stronger Texas tomorrow. We envision a Texas in which all children grow up to be healthy, safe, successful, and on a path to fulfill their promise.

Information in this interactive map is based on Calendar Year 2015 data available through the Texas Healthcare Learning Collaborative public portal.⁴

Description of Measures

1. DVS Total – Percentage of enrolled children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
2. DVS 12 mos. – Percentage of enrolled children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first birthday.
3. DVS 24 mos. – Percentage of enrolled children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their second birthday.
4. DVS 36 mos. – Percentage of enrolled children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their third birthday.
5. W15 (6+ visits) – Percentage of enrolled children who had six or more well-child visits within the first 15 months of life.
6. CAP (12-24 mos.) – Percentage of enrolled children age 12 months to 24 months who had a primary care visit in the last 12 months.
7. CAP (25 mos. - 6 years) – Percentage of enrolled children age 25 months through 6 years who had a primary care visit in the last 12 months.

Key Findings

At the state level, 51 percent of enrolled children received six or more well-child visits during the first 15 months of life (W15). Among slightly older children, 96 percent of kids 12 months to 24 months and 89 percent of kids 25 months through 6 years had at least one visit with their primary care physician in the last year (CAP). However, not every child who visited the doctor received a developmental screening. Among enrolled kids under age three, 37 percent received a developmental screening (DVS Total). One-year-olds had the highest rate of screening, at 40 percent, while only 35 percent of kids under 12 months and 35 percent of two-year-olds received developmental screenings (DVS by age). The data shows that the majority of infants, toddlers, and young kids enrolled in Medicaid or CHIP are getting primary care visits – at least to some degree. Since AAP recommends developmental screenings at 9 months, 18 months, and 24 or 30 months in order to identify the risk of possible delays, it's important that these screenings are performed when young children visit their doctor.

Summary of State Averages and Comparison across Texas Managed Care Regions

	Statewide Weighted Average*	Range Across Texas Regions
Developmental Screening		
Percentage of kids age 0 up to 36 months receiving developmental screening (DVS Total)	37 percent	29 – 58 percent
Percentage of kids age 0 up to 12 months receiving developmental screening (DVS 12 mos.)	35 percent	29 – 52 percent
Percentage of kids age 12 up to 24 months receiving developmental screening (DVS 24 mos.)	40 percent	30 – 64 percent
Percentage of kids age 24 up to 36 months receiving developmental screening (DVS 36 mos.)	35 percent	24 – 59 percent
Primary Care Visits		
Percentage of kids receiving six or more well-child visits during the first 15 months of life (W15)	51 percent	42 – 66 percent
Percentage of kids age 12 through 24 months who had primary care visit in last 12 months (CAP 12-24 mos.)	96 percent	94 – 99 percent
Percentage of kids age 25 months through 6 years who had primary care visit in last 12 months (CAP 25 mos. – 6 years)	89 percent	88 – 95 percent
* Given that the data is only available at the regional level and that Texas' 13 managed care service regions comprise a wide-ranging number of counties (as few as two and as many as 99), we calculated a weighted average that weights each health region by the number of counties it represents.		

Across regions of Texas, the rates of primary care visits and screenings varied significantly, particularly for developmental screening (DVS) and the rate of kids receiving 6 or more well-child visits in the first 15 months of life (W15 measure). For example, the range of service rates for DVS 36 mos. stretched from 24 percent in the Lubbock Managed Care Service Area to 59 percent in the Travis Managed Care Service Area, a difference of 35 percentage points.

Certain Managed Care Service Areas consistently underperformed or outperformed state averages. The Lubbock Managed Care Service Area, in the Texas Panhandle, ranked last in three of seven measures: W15, DVS Total, and DVS 36 months. The Jefferson Managed Care Service Area, in East Texas, had low scores across the seven measures and ranked last in DVS 12 months and DVS 24 months. On the other end of the spectrum, the Travis Managed Care Service Area ranked highest in all four DVS measures, and the Hidalgo Managed Care Service Area, in northeast Texas, ranked first in W15 and the CAP measure for 25 mos. through 6 years.

Next Steps:

Over the next year, Texans Care for Children will be exploring the following questions. We welcome collaborative efforts to ensure more children are healthy and on a path to succeed in school.

- If the majority of kids enrolled in Medicaid and CHIP health plans are going to the doctor for well-child visits, what are reasons they might not be screened for risk of social, behavioral, or developmental delay? Are physicians conducting some other type of developmental surveillance but not using the recommended screening tool? Does the reimbursement rate for developmental screens pose a barrier?
- If a visit is to address a specific medical issue or child's illness, what can be done to schedule a follow-up visit to ensure a child receives the recommended screening?
- Why do one-year-olds have the highest rates of developmental screening? What can be gleaned from this information to improve the screening rate for children under 12 months and for two-year-olds?
- Why are some managed care service regions performing so much better or worse than others? What best practices can be identified from high performers?
- What steps can Medicaid and CHIP Managed Care Organizations (MCOs) take to increase the rate of children receiving well-child visits and developmental screenings at the appropriate age intervals? How can the state and MCOs engage families and health care providers in their networks to encourage screenings and underscore the importance of well-child visits and developmental screenings?
- Given that these rates only account for kids enrolled in Medicaid and CHIP, how are other Texas children (e.g., those uninsured and privately insured) faring with respect to these measures?
- How do these rates compare with other states and national averages?
- Beyond screening, what are strategies to track and ensure children receive the follow-up referrals, evaluations, and early intervention services needed to treat identified delays?

¹ American Academy of Pediatrics and Bright Futures. Recommendations for Preventive Pediatric Health Care: Periodicity Schedule. Available at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

² Texas' thirteen managed care service areas are designated by Texas Health and Human Services Commission (HHSC). The managed care service area identifies the area of the state in which a Medicaid or CHIP health plan operates and has a provider network.

³ Based on the Bright Futures recommendations of the American Academy of Pediatrics, the DVS measure tracks screens occurring in the 12 months preceding a child's first, second, or third birthday, if there is 12 months of continuous coverage with no more than a 45-day gap.

⁴ Managed Care Organizations (MCOs) in Texas serving Medicaid and CHIP beneficiaries submit quality measure data to HHSC for state and public use. Quality and performance measure data submitted by MCOs to HHSC are available through the Texas Healthcare Learning Collaborative public portal here: <https://thlcportal.com/index.php/public>.



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

DSHS Response to Zika in Texas

**Janna Zumbrun, M.S.S.W., Associate Commissioner
Disease Control and Prevention**

May 19, 2017

Zika Virus



TEXAS
Health and Human
Services

Texas Department of State
Health Services

- Mosquitoes (particularly *Aedes aegypti*) can become infected with Zika when they bite a person infected with Zika virus.
- Infected mosquitoes can transmit Zika to uninfected humans.
- This transmission cycle is fostered by densely-populated areas and by housing without air conditioning and/or window screens that keep mosquitoes out.
- The most effective methods to avoid Zika, in addition to air conditioning/screens, is use of insect repellent and destruction of mosquito breeding habitat.



Zika in Texas

- First case reported in January 2016.
- As of May 17, 2017, 334 total cases (8 in 2015; in 2016; 12 in 2017) in 49 Texas counties:
 - 323 cases in travelers to areas where local transmission is occurring
 - 2 cases sexually transmitted
 - 3 maternal to fetal transmissions
 - 6 local mosquito transmissions (2016 in Brownsville, Cameron County)
- The first Texas infant born with Zika-related microcephaly occurred in July 2016 and the first Zika-related infant death was in August 2016.



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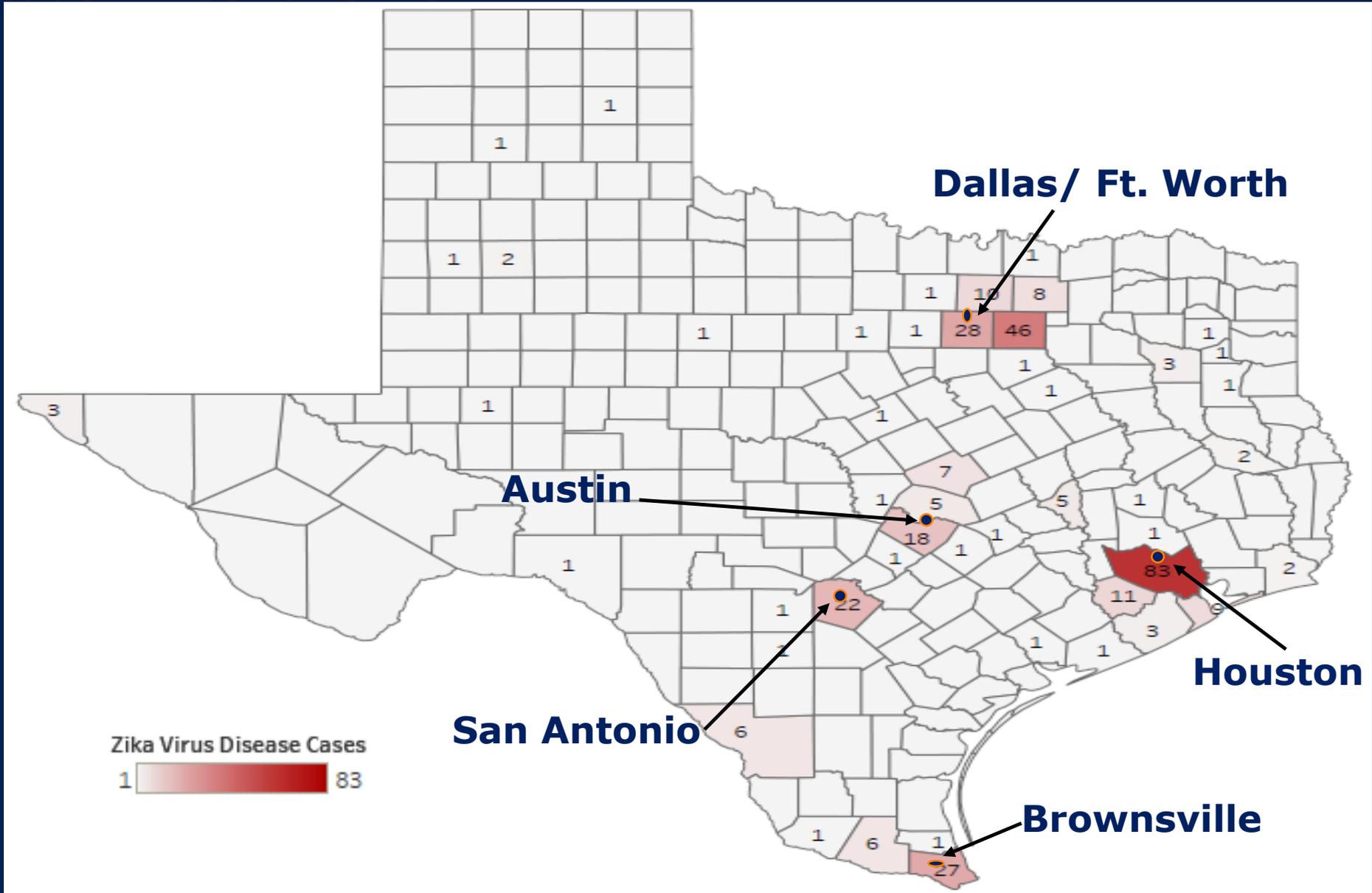
Cases of Zika Virus Disease by County, Texas



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Zika's Impact

- Zika disease – relatively mild. An estimated 80% of those infected experience no symptoms.
- Zika infection during pregnancy can cause microcephaly and other severe fetal brain defects.
- Other problems detected among fetuses and infants infected with Zika before birth include eye defects, hearing deficits, and impaired growth. Some of these effects are delayed and not apparent at birth.

Therefore our core public health purpose for addressing Zika in Texas is protection of pregnant women from Zika infection



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Public Health System In Texas

- DSHS – overall responsibility for public health in the state:
 - Prevention, health promotion, surveillance and epidemiology, consumer protection, and disease and disaster response.
 - 8 Health Service Regions (HSR) that act as the health department and health authority in the many Texas counties without a local health department (LHD).
- LHDs operate in about 60 Texas counties, are independent of DSHS, and have primary responsibility for responding to public health threats in their areas.
- LHDs and HSRs have primary responsibility for responding to public health threats in their areas.
- DSHS provides statewide leadership and guidance, coordination of response when multiple jurisdictions are involved, and provision of resources when local resources are inadequate.



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DSHS Response to Zika

- DSHS – lead state agency for preparing for, coordinating, and responding to public health and medical incidents involving Zika.
 - Coordination with the Office of the Governor, other state leadership, federal Centers for Disease Control and Prevention (CDC), HSRs, LHDs, and local mosquito control entities
 - Public awareness campaigns and educational materials
 - Information sharing with public health officials in Mexico
 - Establishment of www.TexasZika.org as a one-stop information site for the public and healthcare providers
 - Development of Zika Virus Preparedness and Response Plan and guidance for vector control
 - Provision of information and guidance to local officials, media, and provider associations
 - Establishment of Strike Teams to assist local areas as needed for surveillance, environmental assessment, and community education



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Zika Testing

- In April 2017, DSHS issued revised guidance for testing for residents of the Lower Rio Grande Valley:
 - Recommended for pregnant women at 1st prenatal visit, again in 2nd trimester, and at any time if symptomatic
 - Recommended for other residents who exhibit a rash and one other common Zika symptom
- For other areas of Texas:
 - Pregnant women who have traveled or have a sexual partner who has traveled to a country or area with ongoing Zika transmission, who regularly cross the U.S.-Mexico border, or exhibit 3 Zika symptoms
 - Non-pregnant persons with 3 Zika symptoms or who have traveled to a country or area with ongoing Zika transmission and have one or more symptoms
- Testing is available through commercial laboratories and public health laboratories, including the DSHS Laboratory.



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DSHS Laboratory Testing of Human Specimens

- PCR testing detects Zika virus, indicating an active infection. A positive result is final. The Lab can test about 450 specimens per week.
- IgM testing detects antibodies to Zika virus, indicating an infection within the last several months. The Lab can test about 125 specimens per week. Positive or equivocal results require confirmation by CDC.
- Contact the LHD or HSR in your area with questions about testing of patients.



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Zika Surveillance

- The DSHS Zoonosis Control program reviews case reports, applies case definition criteria, and reports cases to CDC and the U.S. Zika Pregnancy Registry (USZPR).
- Zoonosis Control provides subject-matter expertise on both human and mosquito surveillance.
- Local areas may submit trapped mosquitoes to the DSHS Laboratory, where they are identified by species. The Lab tests *Aedes* mosquitoes for the presence of Zika virus.



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DSHS Birth Defects Surveillance

- Investigates incidences of birth defects with the goal of identifying patterns that may lead to understanding the causes, and operates the Texas Birth Defects Registry (TBDR).
- Routine Ascertainment – Usual method of getting records into the TBDR (takes up to two years after birth).
- Enhanced Ascertainment:
 - Rapid Ascertainment – Speeds up getting infants with any Zika-related birth defect into the TBDR (can be done within 3 months of birth)
 - Real-Time or Neonatal Ascertainment – Obtains information about birth defects in infants born to women with evidence of Zika virus infection while pregnant (as quickly as possible)



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Zika Pregnancy Outcomes in Texas

(5/3/2017)

192 Pregnant women with evidence of Zika virus infection

115 Known pregnancy outcomes

10

Infants/fetuses with birth defects consistent with Congenital Zika Syndrome

6

Infants/fetuses with other birth defects

99

Infants/fetuses with no apparent birth defect at delivery

9% of all pregnancy outcomes have birth defects consistent with Congenital Zika Syndrome



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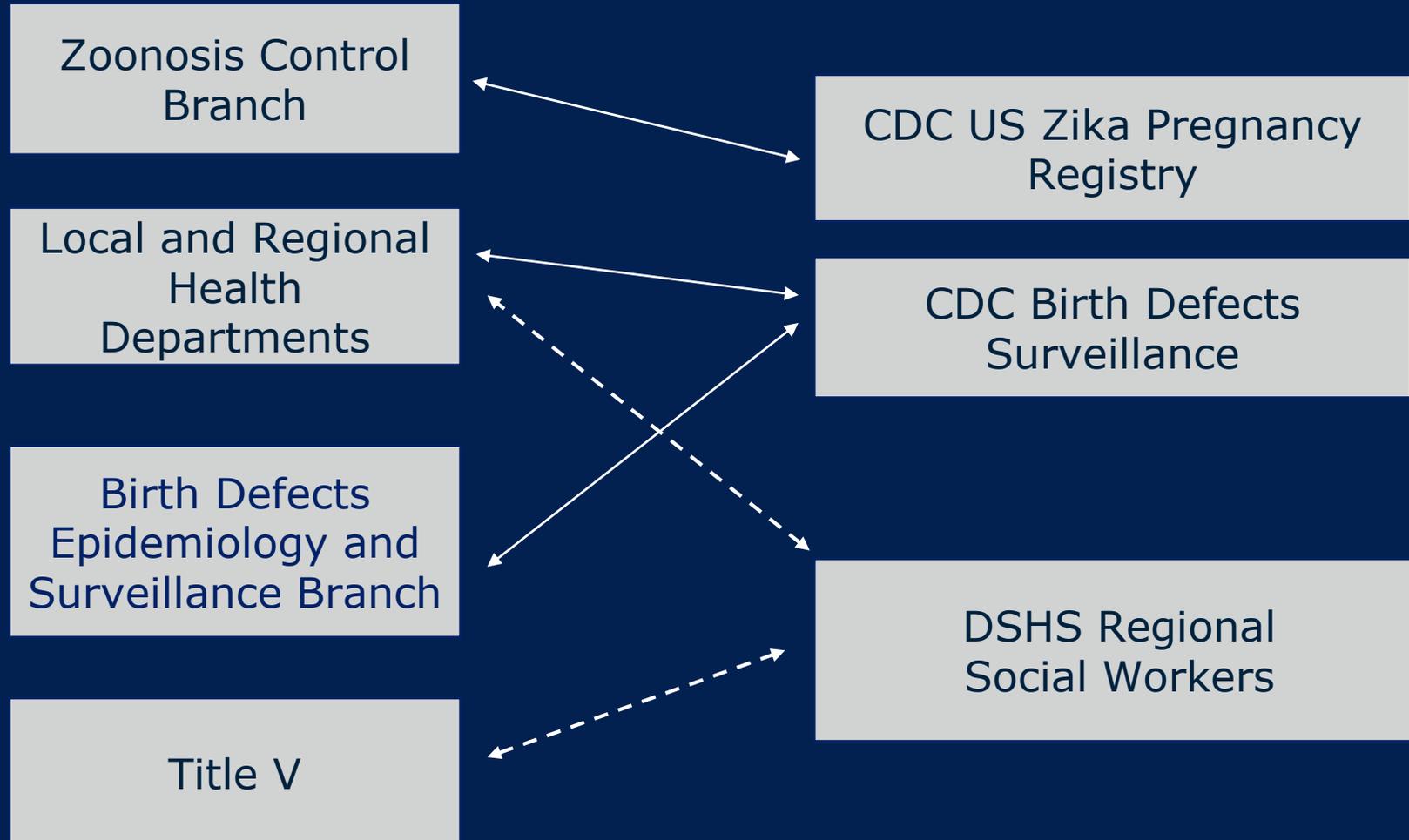
Enhanced Surveillance for Birth Defects Consistent with Congenital Zika



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Zika System of Care

- DSHS is initiating a pilot to connect infants with severe microcephaly and evidence of Zika infections to HSR case management services
- These families will be connected to local resources including parent support from Texas Parent to Parent.



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Zika Health Care Services Program

- DSHS has applied for funding from the Centers for Medicare and Medicaid Services (CMS)
- Project Components:
 - LHDs along the Texas-Mexico border will hire community health workers (CHWs) and case managers to assist with patient education and with accessing services
 - Education and resources to improve provider capacity and capability
- Additional activities funded by Title V Maternal and Child Health



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Community Health Worker Education

- Partnership between DSHS Title V Maternal and Child Health and the Office of Border Services (OBS)
- CHWs will work locally to help residents prevent Zika infection and access appropriate testing.
- OBS began trainings in April
- CHW instructors will be training 500 CHWs along the Texas-Mexico border this summer



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DSHS Zika Contracts



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- With federal CDC funds, DSHS contracts with 17 LHDs and 2 universities for Zika activities:
 - Surveillance, outreach and education, response planning/exercise, mosquito control (vector control), and Laboratory Response Network testing support. Three counties (Cameron, Dallas and Harris) receive funds for activities in support of the USZPR
- Vector Control – contracts with vendors capable of aerial spraying and ground spraying of pesticides to kill adult and larval mosquitoes. These services can be made available when local resources are unavailable or insufficient.
- Parent to Parent program to support families with children affected by Zika – education and educational materials, provision of resource lists for clinical and specialized care.
- Anticipated contracts with 4 Local Health Departments along the border to provide education, counseling, and assistance with navigating community resources to patients seeking clinical services within LHDs.



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Thank you

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Disease Control and Prevention

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