CHIP Coalition Meeting 9/16/11

Attendees: Helen Kent Davis- TMA, Courtney Weaver-CPPP, Laura Guerra-Cardus-CDF, Cheasty Anderson- CPPP, Mimi Garcia- Engage Texas, Laura Martin- TACHC, Sonia Lara- TACHC, Anne-Marie Price, Kit Abney Spelce-Insure a Kid, Ellen Delgado-DSHS, Selena Xie-Texas Impact, Yvonne Vaughan,-San Antonio Foodbank and Others.

Department of State Health Services Healthy Babies Initiative

- DSHS Healthy Babies Initiative- Dr Lakey was concerned about infant mortality and addressing health disparities.

- During 2011 session DSHS requested funding based on the premise that if they could reduce infant mortality they could decrease Medicaid costs. This was determined by working with HHSC to review claims, etc.

- DHS got 4.1 million and also worked with private insurers to get them engaged.

- The primary goal is to reduce preterm birth by 8% over the next biennium to save 7.2 million in health cost Medicaid costs.

- The project began with a 2 day meeting in January. DSHS convened an expert panel of about 45 community professionals including 4 neonatologists, 4 pediatricians, 4 Ob/Gyns, teen pregnancy experts, epidemiologists, Medicaid experts, March Of Dimes, breastfeeding advocates, early childhood intervention and more.

- Largest disparity is in the African American population.

- The panel then split into three workgroups- steering committee, community group and payer group.

- Steering committee includes DSHS, MOD, Dr. Richard? Who is the the dean of UNT school of public health.

- Community work group looked at education of women, families and maternal health providers. Elective preterm birth (inductions and c-sections) were studied. Educating support systems to encourage going full-term, as well as educating physicians about need for full-term is important.

The group is also looking at improving access to care and addressing the need for local and regional coalitions, and fatherhood involvement.

- Payer Workgroup- Hospitals should have a "healthy babies" certification. Breastfeeding friendly, etc. Also systemized prenatal care. (including preconception and inter-conception.)

- DSHS convened another full day meeting in July and the expert panel has agreed to stay on another year.

Deliverables and Next Steps:

- DSHS will continue partnering with March of Dimes.
- DSHS will move forward with WIC who is taking MOD messaging and materials and incorporating it into their education program.
- Currently looking at a cohesive strategy for communicating to general public, parents and providers the importance of these factors in healthy babies, pregnancies, etc.

- Now lead partner of the Text4Baby campaign

    - A text messaging campaign where pregnant women and new moms can get text messages about health reminders, local resources, etc.

- DSHS is encouraging partnership by not directly promoting Text4Baby with clients, but encouraging the program through partners. Many promotional materials such as fliers and posters are available.

- Developing a website first housed in DSHS and later an external site with social media capability.

- DSHS working with HHSC on helping develop the "Health Texas Babies" hospital certification. It will not duplicate the Texas ten steps breastfeeding piece, but add to it with reduction in birth trauma, preterm birth, etc. and it will integrate the father.

    - Currently developing an RFI to go out to local communities to encourage coalitions to form within communities.

    - Looking at MH/SA, other services for pregnant women, have been sharing information at conferences, etc. Working with OAG on a father survey.

- DSHS would also like a private partner to help with the media, communication, PSAs, etc. or house the website that would help contribute to the campaign.

Cheasty Anderson from CPPP on the New Census Report Released Sept. 22nd

- Black and Hispanic children are 3x as likely to live in poverty. 23% live in food insecurity. 1.5 million live without health insurance. We have 3rd worst teen birth rate which is 50% higher than the U.S. average.

- Children at 200% of the federal poverty levels have a much higher insurance rate than they previously did.

- Adults have continued to lose insurance. 24.6% are now uninsured.

- 41% of people who live below poverty are uninsured.

- The 24.6% is for everyone, including the lack of Medicaid for working adults.

- There has been a 10 year decline in job-based insurance. Even during good economic times employers have been either dropping coverage or raising costs.

- 17% of children are uninsured.

- 68% of uninsured Texans are native born. 6% are naturalized citizens. 26% are undocumented.

- *Since the beginning of 2008 we have added more than 800,000 children to the CHIP and Medicaid rolls. We are doing what we can do to address the population. We were at 22% uninsured rate just a few years ago.*

Laura Guerra-Cardus on Deficit Reduction Committee

- Jeb Henserling is the only TX rep on the committee.

- Budget Control Act works to reduce the deficit in two stages by capping discretionary spending for 10 years (Medicaid, Medicare, Social Security are excluded.) Phase II is the Super Committee and everything is on the table including the entitlement programs (and raising revenue.)

- If they agree on half of the deficit and then agree to restructure half of these programs, whatever they do come into agreement for will go into effect. The trigger will only affect the remainder of the cuts. Any deal brokered will have an impact on spending and services.

- This committee is unique because it can write legislation directly. Spending caps, decreasing Medicaid investment (block grant or not), et. Have been on the table.

- If they broker any kind of a deal that is not at least 50% revenue we are going to see major changes to the programs.

- These threats are more realistic than they have been in a long time. Originally the committee was charged with finding 1.2 trillion, but the president has asked they find over 2 trillion.

- Speaker Boehner has also said that from the Rep point of view revenue is off the table.

- California had pushed very hard for administration to allow restrictions on number of doctor visits, to allow for copays at levels that have previously never been approved ($100 for an ER visit, $5 for office, etc.) Also limiting adults to 7 visits, etc.

- While Medicaid and ALL healthcare costs are going up, they are not rising at the same rate as other programs.

- Limiting how much the federal gov't spends on Medicaid will do little to limit total costs- will just transfer to individuals and states.

- In the trigger, Affordable Care Act premium subsidies can't be touched, but cost-sharing subsidies can.

Gary from HHSC Team on behalf of Maureen Milligan:

(See attached powerpoint presentation for details on the waiver from HHSC's perspective.)

- 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program

- Based on California's approved program (See attached summary.)

- The goal is to increase amount of federal funding available, including for uncompensated care and also to create regional health care partnerships.

- The 1115 as with other waivers has to be budget neutral.

- Hospitals will be funded through 2 pools- uncompensated care pool and a pool based around performance incentives.

- 5 year demonstration
    - 1st year- transition payments will be made to hospitals with the same methodology as UPL payments.

- Payments will be based on Medicaid shortfall not covered by DSH.

- Questions around potential metrics and infrastructure development.

- CMS has agreed in general to the structure of the funding, etc.

- CMS wants to see something in place for regional healthcare partnerships by March 2012.

Legislation

- **HB 2636**- Creates a NICU Council- will release a list of nominations for stakeholders that want to participate. Neonatologists, Obgyns, types of hospitals that need to be involved, levels of nurseries (1-3), etc. The work dovetails with the Healthy Babies initiative.

- **HB 1983**- The bill tries to reduce the incidence of elective c-sections. Came up with new coding requirements for doctors that will indicate the babies' gestational age and whether or not it is medically necessary vs. elective induction. The idea is that if that modifier is used they wouldn't pay for the delivery.

    - Hospitals and doctors could have money recouped if they are saying c-sections were medically necessary and they weren't.
    - Frustrating for doctors because them modifier is non-standard. Goes into effect on 10/1. TMA and HHSC will be out educating doctors. A lot of hospitals and staffs have already implemented these programs.

    - There is some disagreement statewide about what constitutes medically necessary and this has been a concern among doctors. HHSC has assured they will defer to the clinical knowledge.