Texas CHC Coalition
Meeting Minutes

August 19, 2016

Present:	Laura Guerra-Cardus, CDF Adriana Kohler, Texans Care for Children Mary Allen, TACHC Clayton Travis, TPS Anne Dunkelberg, CPPP Monica Villareal, CPPP Rachel Cooper, CPPP Helen Kent-Davis, TMA Peter Hofer, Disability Rights TX Susan Murphree, Disability Rights TX Alice Bufkin, Health Stacy Wilson, CHAT Michelle Romero, TMA Karen Palombo, DSHS Kellice Dees, TPS Kaitlyn Clitfon, TPS Juanita Gutierrez, Community Care Melissa McChesney, CPPP RexAnn Shotwell, TACHC Aaron Herrera, Hunger Free Texas Fabian Gutierrez, Hunger Free Texas
On the phone:	Diane Rhodes, TDA Sarah Rayburn, AACOG Jennifer Banda?, THA Kathy McDonald, Children's Health Plan? Monica Montez, Central Health Betsy Coats, Maxims Sister J.T. Dwyer, Daughters of Charity Kit Abney, Central Health
Chair:	Clayton Travis, TPS
Minutes Scribe:	Julia Von Alexander, Center for Public Policy Priorities
Next meeting:	August 19, 2016

I. Efforts to Reduce the Severity of Neonatal Abstinence Syndrome *(Karen Palombo, DSHS)*

- Opiate use in TX (and the US) is increasing in every demographic. Deaths and addiction increasing
- DSHS funded treatment has doubled in 4 years for pregnant women entering treatment.
- NAS- withdrawals baby goes through after exposure. Increasing, but not as much as the rest of the nation (but DSHS only has Medicaid data).

- Child born with NAS- direct linkage with mom's usage? 55-74% of babies exposed to opiates can display symptoms with NAS. Can decrease the severity and not need pharmaceutical treatment.
- Why is length of stay in TX longer? Some states have done a better job of identification and outreach. Working on this. See slide 6.
- Reached out to 500 high-risk women and those who were pregnant got to treatment. 60 found out pregnant with DSHS providers.
- Definition of high risk? Homeless, drug-using, sex workers, etc. See slide 8.
- Issue-Now that met how get into services? Working on the barriers to treatment for women. Not interested because of past episodes of treatment/CPS involvement, Stigma of pregnancy denial. Trauma-informed treatment.
- Pregnant postpartum intervention- 19 throughout state in co. with highest incidence. Street outreach, etc. Nonprofit contractors (community/ob-gyn clinics, Planned Parenthood, treatment, etc)
- 2013- requirement for outreach (including birth control/condoms/safer sex and safer drug kits).
- Is this reported to CPS? Technically child abuse hasn't occurred until a baby is born. Lots of time to remedy before birth. Holistic approach. How does this work if have children in home? CPS is an issue but tell them it can be different. Many women don't think methadone is allowed (drug courts and CPS won't let them use it). Overdose is the 3rd leading cause of pregnancy.
- Methadone-long acting. Mom withdrawing on street and has miscarriage/stillbirth- methadone addresses this issue.
- Why does rate of overdose increase after 28 day treatment? B/c metabolism has increased, but more sensitive to the drug?
- Fentanyl- more lethal/pure and easier to get than heroin. Alternative b/c no pill mills. Often these women are still in pain, initial legal dose and then addition over time. Not many MDs can prescribe Vicodin. No legitimate prescription so heroin is the option b/c is working.
- Women on Medicaid are more likely to get higher doses of all pain medication for longer time (more likely to doctor shop). Report at a higher level. Prescriptions from non-traditional health (e.g. dentist).
- CPS education? Top referral source. Number 2 state in removing children because of parents' substance use (rate)
- When Medicaid ends concern since women are dropped from methadone treatment. Can get to up 18 months of postpartum treatment (12 providers throughout the state). Working with Family Planning Providers? Yes.
- More than 1 substance use- many facilities can't take them. This month they started Center for health care services- LMHA in San Antonio. Only 1 in state, and 3 in nation. Women are often on Depression meds too so more likely to overdose.
- Child goes home with parent more often with the above model.
- Kangaroo care- skin to skin mom and baby during NICU stay.
- 3-4 doses of naloxone b/c of fentanyl when overdosing (and ambulances only have 2 on board). Doing training with anyone who comes- 1000 people. Law enforcement not required to do the training so don't have it. Naloxone only works on an opiate receptor, no negative effects.
- Highest counties with NAS- based on TX Medicaid data. NAS isn't a reportable diagnosis.
- Texas poison control- must be called if more that 2 vials of naloxone delivered. EMS is trained in the first 1-2 doses, but call poison control after 2 (especially for pregnant women).
- Cost of naloxone has tripled recently. Even needles for Narcan/naloxone are getting people locked up.

- Can a woman be transferred to a hospital that is doing this? Yes, the state center does that. Have outreach workers to do this. (e.g. Beaumont to San Antonio) Pregnant woman calls must be housed that day. Cannot have a waiting list. Must give as many options as possible.
- Gaps? Asking anything of legislature? Asking for renewal (this was a 2 year plan). Positive results-12 women had symptoms but 8 didn't have to go to NICU (in one hospital).
- 2015 data? Won't see impact until 2016 data. Will get data 9 months after baby left (so soon). Looking at total continuum of care. Do have data (10 women on methadone pregnant in state, 2 months later 65, now about 110) on output. Planning to compare rates b/w hospitals doing interventions in and ones they aren't. List of hospitals working on it? On page 4 of handouts. No children's hospitals, difficult to impact pregnancy b/c don't deliver there.
- Advocates should ask for? 1. Add 5 more counties (already identified)- not funded yet. May be an exceptional item. 2. Cannot intervene with a father currently- would like to be able to assist them too. Funding issue.

II. Medicaid and Autism Therapy for Kids *(Peter Hofer, Disability Rights TX)*

- See slides. Will make the legal argument.
- Applied Behavior Analysis (ABA) is considered effective and evidence based. ~130,000 kids on the autism spectrum.
- EPSDT provision- to beneficiaries under age of 21. Called TX Health Steps b/c of the Frew Lawsuit.
- People confused as to what EPSDT means.
- Kids- mandatory and optional (state elects to provide). Benefit medically necessary, should be able to get under TX Health Steps. States discretion to exclude medically necessary- not allowed unless less costly but equally effect alternative or experimental treatment.
- ABA- federal court in FL is required under EPSDT. Does it help kids? Does it fit under EPSDT? Yes. 11th circuit affirmed that decision. All courts have found ABA is a covered benefit.
- CMS issued guidance- not endorsing a specific treatment. Must make individual determinations of medical necessity.
- Just last week HI decided to cover in the middle of litigation. Still found that didn't inform beneficiaries of the change.
- Client looking for ABA provider in Houston- HHSC wrote with pilot program (not Medicaid funded). ABA is not currently a defined benefit of the TX Medicaid program. Need budget authority from the TX legislature. Will involve stakeholders if get direction.
    - Flawed argument- Not a new benefit.
- Also said that they cover speech, physical, and other therapies. However, these are services are undergoing cuts.
- 2016 Complaint to CMS with NHELP- similar response to guidance.
- HHSC says need money appropriated from the legislature $100 million, telling advocates to say they want ABA to legislature.
- Private insurances are now covering ABA, very expensive. Believe required to cover in Texas, but $4,000-6,000 deductible.
- Some kids were approved for ABA-single case agreement with ABA provider. When HHSC changed mind, lots of issues (couldn't find ABA and couldn't figure out how to get it).

- Court in FL ordered FL to immediately provide it. Irreparable harm to these children. 38 states covering it now.
- Moving forward with a lawsuit in Texas? Or just presenting the case/request to do it? Can't say if will sue yet. Wanted to try through CMS first, since this would be quicker.
- HHSC asking for an exceptional item? Unsure, not much transparency so far. Has been discussed. Should know soon.
- Arguing that autism benefits and services provide the same kind of care as ABA but less expensive? Only speech, OT, and PT, so can't argue this.
- Referral to a pilot program- was it an 1115 waiver program? Check with 1115 waiver program process director to see- put best practices into Medicaid Managed Care. In negotiations around waiver renewal- CMS is clear that it shouldn't be a waiver service.
- Universities offering an ABA certification? Bill didn't pass last session for licensing. Difficult to get accreditation. Who will provide this benefit? Unsure.
- Any lawmakers aware and who could ask questions of HHSC too? Those who are interested in children's issues and disability related issues. Should educate/brief lawmakers so it isn't a surprise.
- Potential for ABA to save money down the road through education/healthcare later on. How LBB scores -savings to MCOs vs. the state, may be incorrect.
- Managed care and EPSDT difficult models to combine.

III. Update on Legislative Agenda *(Laura Guerra-Cardus, CDF-TX & Adriana Kohler, Texans Care)*

- Will discuss on steering committee call.
- 3 categories of issues and 5-6 priorities.
- Will be keeping people updated.

IV. Update on Name Change Next Steps *(Clayton Travis, TPS)*

- Thanks to Peter Clark and Jay Moreno for putting together the logos!
- Asked to add a byline with "Formerly the CHIP Coalition"
- First 2 with kids preferred. The one closest to our current one preferred.
- Advice from Peter on byline- unsure if we should include. Size- might be too hard to read.
- Press release- draft from Peter Clark.
    - Not new, will focus on rebranding. Change title. Working on coverage still, but also access to quality care too.
    - Quotes- physician and historical expert.
- Email Clayton.Travis@txpeds.org with any feedback on the press release.
- Next 2 items for rebranding- website (paid for by CHAT, own process to change URL)
    - Need all of the things we need to change to send to the web host. Who would like to do this?
- How/when to do the press release? Venue or virtual? Update at next meeting.
- Opportunity to discuss social media platforms. None currently. Need to make sure people have time to use this platform.

V. Voter Campaigns in Texas *(Grace Chimene, League of Women Voters- TX, Laura Guerra-Cardus, CDF-TX)*

- **See slides**.
- Child health is an issue at the LWV. Voting is very important and non-profits are allowed to promote voting as long as non-partisan. www.nonprofitvotes.org if you have questions.

- Have posters and flyers to put up in businesses. Share on social media too!
- Still must print/sign/mail in voter registration form, but can download online.
- Statewide Text to Register coming up.
- Look for the non-partisan Voters Guide from the LWV.
- More information and many non-partisan materials at www.LWVTexas.org
- Susan M- involved in Rev Up the Vote focused on getting the disability vote out. Also working with LWV.
- Laura G. - CDF- TX: has partnered with a number of groups to be intentional about role of increasing civic participation. Policymaking is falling short of what Texans want.
- Have come up with a way for non-profits to do voter outreach, similar to Marketplace outreach. Voter Navigator project- piloting in Travis and surrounding counties in Sept and Oct. Measuring effectiveness. Close to finalizing partnership with Foundation Communities, also working with El Buen Samaritano, and neighborhood centers. Room for many more- feel free to join the effort.
- Univision is developing PSAs with 1-800 # for people to call to speak with a voter navigator. CDF and others are training the voter navigators. How text to register, see a sample ballot, etc.
- Non-profit already helping people get into programs can also education on voter registration/voting.
- Studies have shown non-profits are one of the best messengers. B/c trusted community member and non-partisan, also since clients return to non-profits. Replaces need to knock on doors multiple times.
- Community health centers have been able to improve voter registration by 20%.
- If you work at an organization or know someone who might be, get in touch with Laura Guerra-Cardus (LGuerraCar@childrensdefense.org)

VI. OTA Meeting & Update from HHSC Office of Social Services, Policy Strategy, Analysis, and Development Division

OSS and the Office of the Ombudsman

- **See slides.**

Office of the Ombudsman (Paige Marsala & Tina Pham HHSC)

- Most contacts for Medicaid, but highest percentage of substantiated complaints in CHIP. 17-28% substantiated complaints b/w programs.
- Complaints through health plan division and through OO. The slide is just for OO contacts. Health plan division would be a separate report. Monthly report to exec commissioner includes contacts w/in many different areas (e.g. VDP, Medical transportation program, DADS, DARS, DSHS, DFPS).
- Why does CHIP have more substantiated complaints than Medicaid? Enrollment (e.g. into a health plan). Unsure why the percentage is higher. Will do a breakdown
- Melissa M- anecdotal- more likely to ask if denied entirely vs. because of getting put into CHIP instead of Medicaid.
- Numbers include eligibility complaints, but not only these complaints.
- Kit- When talk about CHIP, include CHIP-P? Yes. Kit- CHIP-P: Top complaint is checking status in CHIP - challenge is around difficulty finding people because of lack of SSN.
- Going forward breaking complaints and substantiated complaints down into Medicaid program (STAR Health, STAR Kids, etc.) and into CHIP and CHIP-P would be great.
- Can also talk about smaller chunks instead of entire FY so we can see spikes.
- See slide 6. Top issues are similar (all contacts) to the past. Top 3 issues-for substantiated complaints too? Yes.
- Do discuss problem trends with program areas. Some things may be difficult to fix.

- 211 complaints- OSS tracks this to some degree. (Able to resolve, length of time on the call) Usually call 211 first, and if not resolved then reach out to OO.
- Foster Care Ombudsman- opened May 2nd. 114 calls, with 35 from foster youth. Concerns are usually about the facility, foster care mom/dad, where to get funding for college?
- Other contacts parents, physicians, lawyers, doctors- just to know more about the program.
- Working on spreading the word.
- Youth having trouble making the transition to former foster care youth Medicaid coverage? No calls yet. Very minimal. Likely reaching out to Centralized Benefit Services more than us.
- OMCAT- doing lots of outreach and presentations on helpline; going with Medicaid and CHIP Division for STAR Kids presentations.
- Many clients with SSI, so now have a contact. Working with local areas on aging and other groups. Medicaid Managed Care training for benefits counselors. Reviewing/finalizing curriculum for Medicare training (2 day training in October).

Introductions: Erika Ramirez- new and working with Valerie Eubert.

Community Partner Program Update and Overview (Fedora Galasso, HHSC)

- Currently focusing on developing, supporting and retaining partners.
- Community Partner Group- assembling to inform improvement efforts. Sent out call for participants in July. Many applicants, now vetting to form the group. Will have 10 in the group.
- Group will inform YourTexasBenefits.com redesign issues, data analysis, etc.
- Sept. 1st announcement- who is a part of the group.
- Visits to partners to see how can improve program & forums for training and learning from each other.
- Regional Community Relations (RCRs) can offer community support- in transition with contractors. Can help with MOU process, and website. First line point of contact for partners from August to December. Taking on the role of some contractors (THI and TACHC). In October will announce new points of contact from the contractors' staff and start the transition. Will contract again. Named in October, starting in Jan. similar to before? Focus no longer on recruitment, now more on training/developing/creating partnerships, fostering relationships with community partners. RFP process? No.
- How many RCRs are there? 13 people (one in each region). 2 in Houston, 1 in DFW, 1 in Tyler, 1 in Abilene, 2 in RGV, etc. How many vacant? 1 filling and 1 more vacancy.
- RCRs are very qualified. Have done lots of work with similar programs. Local support to community partners.
- Aaron H- this is a lot of work to take on for the RCRs. Community Partners need a lot of support. Fedora- working with community partners will be their full time job through the end of the year. State office also has dedicated staff for technical support (3-5).
- Do all government contracts require a RFP? Generally correct, but can provide more information on the process intend to follow. Anne- may be that it depends on cost of the contract. However, know that stakeholder input was not sought.
- Rachel C- Data uploads from partner programs? Share those? Yes.
- Data needs of partners? Working with the community partner group to understand this. Reevaluating statistical reports- Negative feedback on these. How to reflect community partner activity in a better way. Training on how to track their data.
- RFP process for the community partners at a later time.
- Coalition was disappointed not to have more a head's up on the change in direction.

- 450 survey responses. Good feedback. Information on trainings desired. Majority of partners have been with the program for 3 years or more. Will send results to community partners in few months. Melissa M- could you bring this summary to the coalition?
- Working to build peer-to-peer learning efforts and best practices.
- Switched from distribution list to Govdelivery, so newsletters may go into your junk/spam mail.

YourTexasBenefits.com Update (Ryan Albert, HHSC)

- Growth in Texas means we will likely have increased caseload. Emphasis on self-service, since 2012.
- Doing better than other states, but plateaued at 60%. What is the target? 80% of clients have access and of those 70-80% only through smart phone.
- Website scheduled to roll out on **8/29/16.**
- Device responsive (will be able to go to it on a phone or tablet)
- Planning to get a content management system. Currently tied to a TIERS build.
- Accessible for people with disabilities? Yes, Spanish and English; screen reader tested.
- Aaron H.-With more devices, might see a lot more traffic. Mel M- Especially b/c have access to mobile devices. Still issues with age related access.
- New landing page. Pre-screeners are on the bottom.
- Application assisters thoughts? Need for support? Demos over the last month to community partners.
- Will be a learning curve and have developed in depth training. Available to advocates? Training department is looking for a way to make that available. Will take it back. Melissa M-Community partner program training modules? Are interactive, but not a sandbox. Melissa M- this program has historically been available to the public. Fedora- will include all of the trainings for partners and onto the website.
- Easier to pick benefit program to apply for and read about. More streamlined navigation through the process. Additional icons for more information needed. Better/less confusing instructions.
- New site- can answer 1 question for multiple people. More efficient process.
- Can you upload documents on the phone? Yes, through the mobile app or through the website. Take a picture and upload.
- CMS and/or FNS approval required b/c updated content? Very slight wording changes. Not a functionality change. Policy has been participating the whole time. Unsure if it needed that, will follow up.

Are working on the questions and will have an update before the next coalition meeting. Melissa would like to stress the kids with SSI and Medicaid denials for them are a big issue. Appreciates case-by-case assistance, but happening across the board and addressed in April 2015 federally. Would love to see that addressed.

Diane Rhodes of Texas Dental Association will chair the September 16th meeting, which is a regular 2-hour meeting.

DRAFT LEGISLATIVE AGENDA 2017

CHILDREN'S HEALTH COVERAGE COALITION

Budget:

- Monitor Appropriations process to advocate for adequate funding for Medicaid and CHIP, and to identify and oppose proposals to reduce services or payments that will adversely affect children's and mothers' access to care.
  Background should include: For the 2017 session, we need to ensure that Medicaid and CHIP programs are funded adequately. Medicaid and CHIP budget reductions jeopardize access to and the quality of care in Texas. Ultimately, Texas needs to create a sustainable process in which professional fees within Medicaid and CHIP increase each biennium to match the cost of doing business and delivering services and ensure provider networks in managed care are adequate.

Outreach and Enrollment:

- Seek ongoing modernization and streamlining of eligibility and enrollment for children and pregnant women. Seek legislation if needed to improve on current policy.
- Sustain and improve on Texas' historical engagement in supporting community-level outreach and application assistance resources to help families enroll eligible children, expectant mothers, and adults in insurance coverage. Seek legislation if needed to update or revitalize current systems.
  Background can include: Texas is home to X million uninsured children who are currently eligible, but not enrolled, in Medicaid and CHIP. Historically, HHSC's Community Partners Program has supported local faith and community-based organizations across the state to help families apply and enroll eligible children and family members in coverage. For the 2017 session, Texas must modernize eligibility and enrollment systems and restore support for community-based outreach. Specifically, legislative possibilities include 12-month continuous coverage for children in Medicaid; and establishing a strong system, with a local funding component, that allows community-based organizations to continue doing outreach and enrollment assistance with families across the state.

Access to Quality Care:

- Ensure continued funding for and monitor implementation of Texas' state-funded women's health care programs to ensure they are designed to maximize maternal and infant health before, during, and after pregnancy. Seek legislation if needed to correct any barriers to optimal care. In particular:
  - Enable HHSC to evaluate options for streamlining enrollment systems and programs to maximize access to interconception care, such as streamlined enrollment between CHIP-Perinate and the state's Family Planning Program.

- Support policies for coverage to improve health outcomes for moms and infants, interconception care, and address perinatal depression. Specifically:
    - Address coding and procedural issues that are impeding coverage of postpartum depression screening and treatment. Texas must make clear that perinatal depression screening and treatment is a covered benefit for women in Medicaid and women receiving services through Healthy Texas Women.
    - Ensure pediatricians can screen and refer mothers for perinatal depression as part of a well-child visit -- and bill for this screening as part of the Medicaid well-child visit.
    - Clarify that women may dually enroll in CHIP-Perinatal program and Marketplace coverage.

    Background on bullet 1: Early screening and treatment of perinatal depression is critical for a mom's mental health and a child's healthy development. There is a significant connection between a mom's mental health and children's wellbeing and long term success. Perinatal depression has adverse effects on children's cognitive, socio-emotional, and behavioral development, as well as academic achievement and employment opportunities throughout their lifetime. While about 5 to 25 percent of pregnant, postpartum, and parenting women have some type of depression, for women with low incomes and parenting teens, rates of depressive symptoms are between 40 and 60 percent.

    Background on bullet 2: Pediatricians play a vital role in screening new mothers for postpartum depression. Many other states, such as Virginia, Illinois, North Dakota, and Colorado, have clarified in their Medicaid billing and coverage policies that maternal depression screening is a covered service when performed as part of a Medicaid well-child visit.

    Background on bullet 3: CHIP-Perinatal provides prenatal and pregnancy-related services to pregnant women who do not qualify for Medicaid. Many immigrant women -- legal permanent residents and green card holders -- are eligible for CHIP-P are also eligible for Marketplace coverage, which provides full medical coverage. But HHSC rules do not allow women to enroll in CHIP-P if she is enrolled in any other private health insurance. This leads to a difficult decision for many pregnant women – either keep their Marketplace coverage or enroll in CHIP Perinatal (that covers only pregnant care). Allowing women to dually enroll in Marketplace coverage and CHIP Perinatal could result in state savings because Marketplace insurance must be the primary payer and the state would be the "payer of last resort."

- Support legislation to create comprehensive coverage for Texas' low-income adults, to improve maternal health and the ability for parents to do the best job of raising their children and providing for their families.

  Background to include: Parents' health access matters for kids' health and family financial security.

- Overall health and health care access for women before, during and after pregnancy is critical to babies' health. More than 1.5 million Texas women between the ages of 15 and 44 lack health insurance (41 percent).
- Children are more likely to be insured if their parents are insured. Most children have the same health insurance status as their parents, and previous expansions in health insurance for adults have been connected to better insurance rates for children, increasing consistency of regular check-ups and preventive care.
- When parents have untreated mental health conditions, children are negatively impacted. Medicaid provides important access to mental health screenings and treatment for low-income adults. Untreated perinatal depression is associated with poorer physical and behavioral health in children, lower cognitive and academic performance and increased risk of child maltreatment, and nearly 11 percent of mothers in Texas reported frequent postpartum depressive symptoms.
- More than half of births in Texas are covered by Medicaid, but most mothers do not qualify for Medicaid to promote good health before pregnancy, and Medicaid maternity coverage ends two months after birth. Because of Texas' low eligibility for parents, most are unable to access affordable insurance after that. A randomized, controlled study showed that expanding Medicaid for uninsured, low-income adults increased screenings for depression, provided access to treatment and reduced observed rates of depression by 30 percent.
- Health insurance coverage for adults has been shown to improve overall family economic security. A randomized study showed that being insured through Medicaid reduced by more than 50 percent the chances of having to borrow money or skip paying other bills because of medical expenses. Texas' uninsured rate has dropped significantly since the Affordable Care Act was enacted, but more than 5 million Texans remain uninsured.

  An estimated 864,000 Texas adults fall into the "Coverage Gap," where income is too low to qualify for health insurance subsidies, and too high to qualify for Medicaid. Fifty five percent of people in Texas' health insurance "Coverage Gap" are female. About a third are adults with dependent children.

TEXAS
Health and Human
Services Commission

Community Partner Program

Office of Social Services

August 19, 2016

Community Partner Program

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

- In its fourth year CPP is focused on new ways to develop, support and retain partners. Relevant activities include:
  - Formation of a Community Partner Group for guidance and input
  - HHSC Community Partner site support visits
  - Community Partner forums
  - Regional Community Relations (RCR) Community Partner support
  - Community Partner survey and program improvement
  - Evaluation of Community Partner data needs
  - Updates to program materials and trainings

TEXAS
Health and Human
Services Commission

Change Management

Office of Social Services

August 19, 2016

TEXAS
Health and Human
Services Commission

A Preview of the New YourTexasBenefits.com

Self Service is Critical

TEXAS Health and Human Services Commission

Positive Outcomes All Around

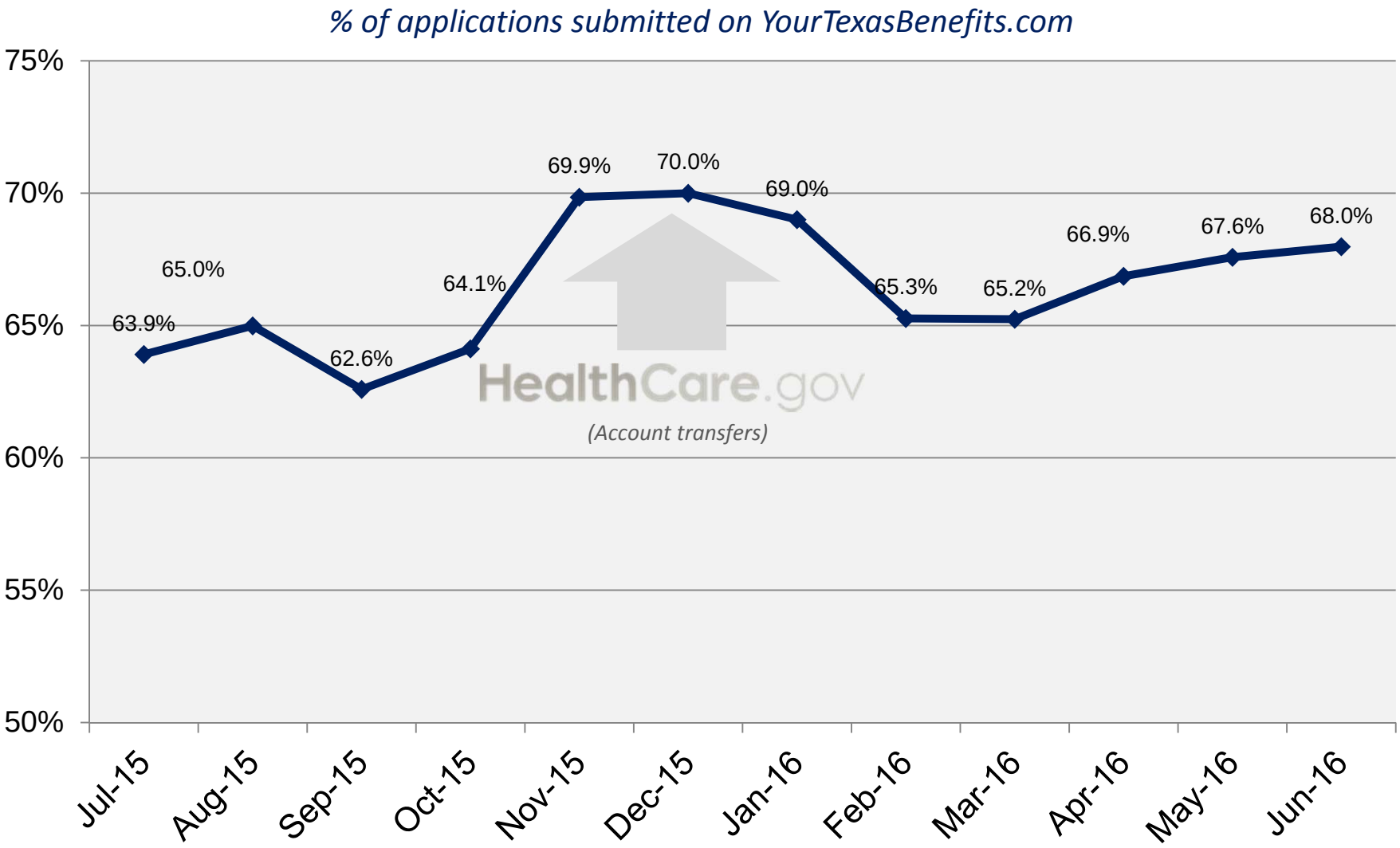
For clients

- Faster
- Convenient
- Empowering
- Trackable

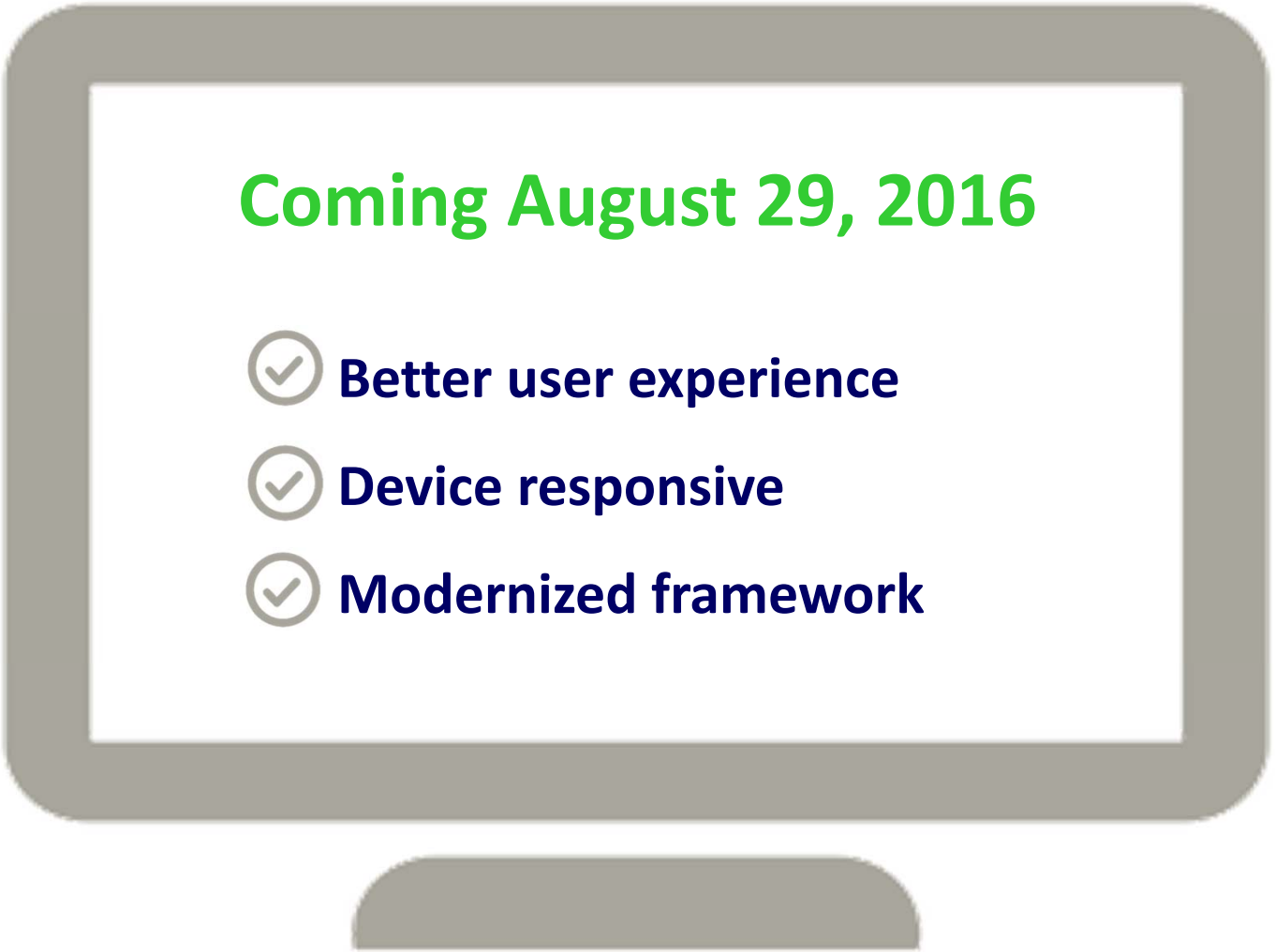
For staff

- Faster
- Less paperwork
- Less lobby traffic
- Less handwriting

Stable but…Plateaued



The New YourTexasBenefits.com



Success Elements

User Experience Expert

Design Expert

Client Input

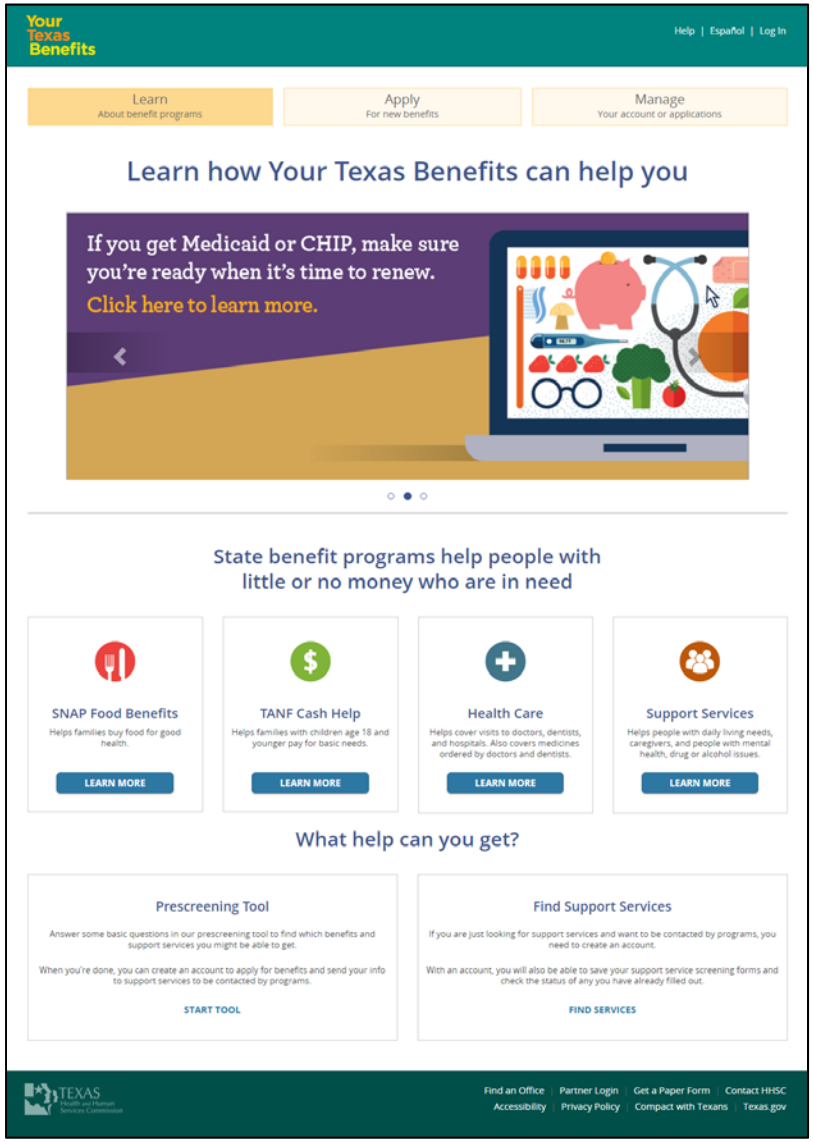
Summary of High Level Changes

6

TOTAL

- #1 New Look & Feel
- #2 Streamlined Navigation
- #3 More efficient information entry
- #4 Searchable Help Center
- #5 Quick Access Points
- #6 Improved Instructional Text

#1 New Look & Feel



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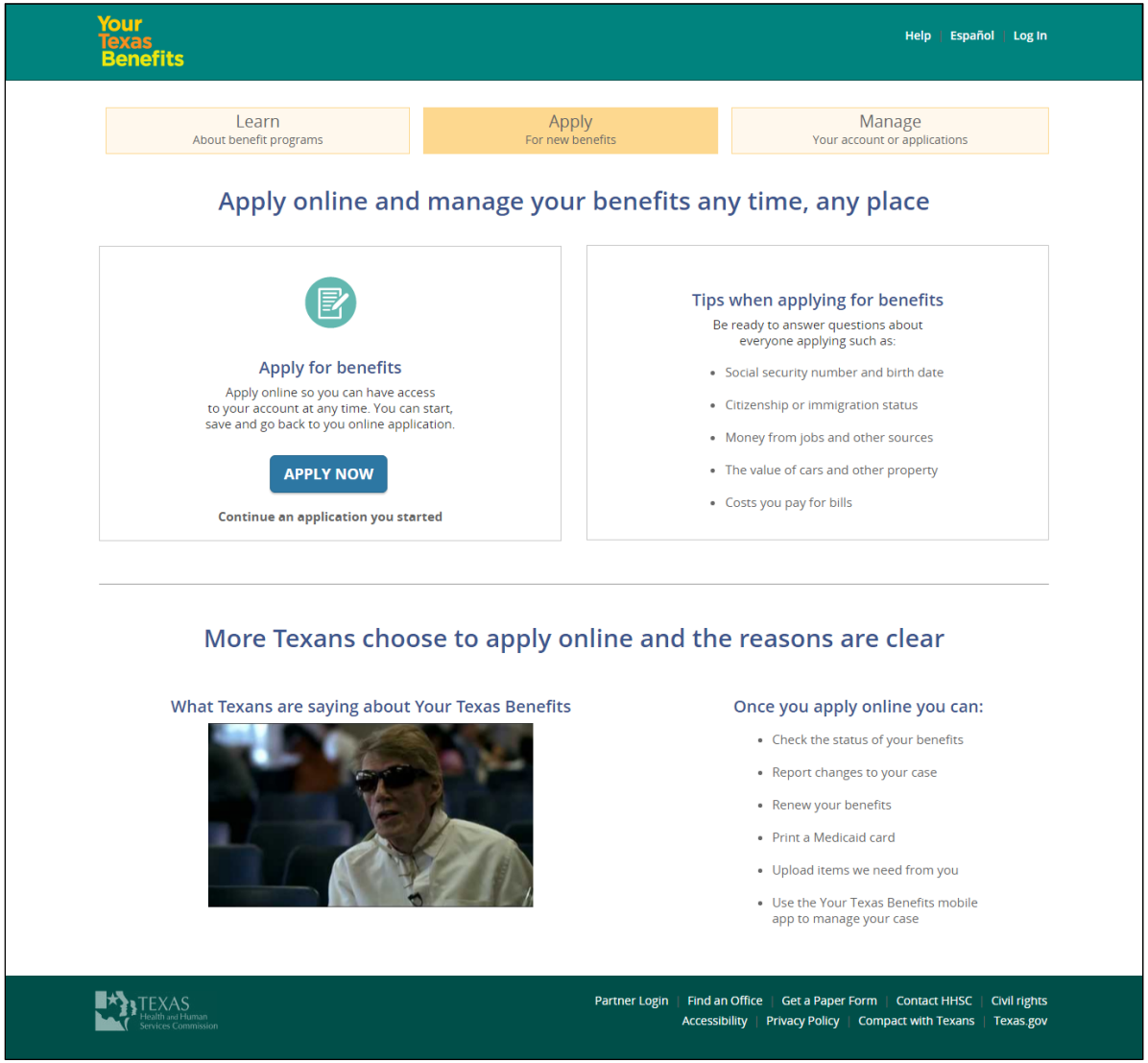

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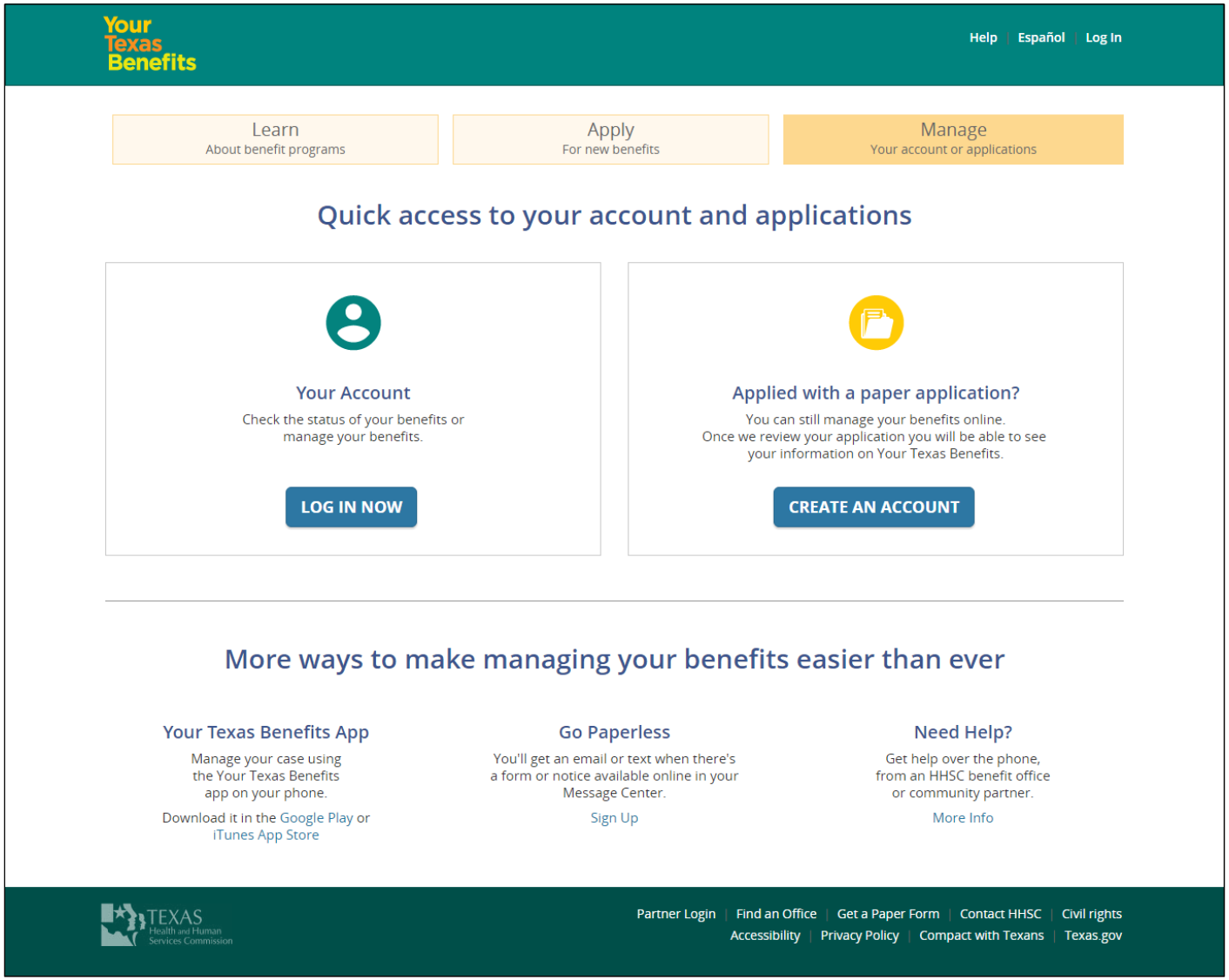

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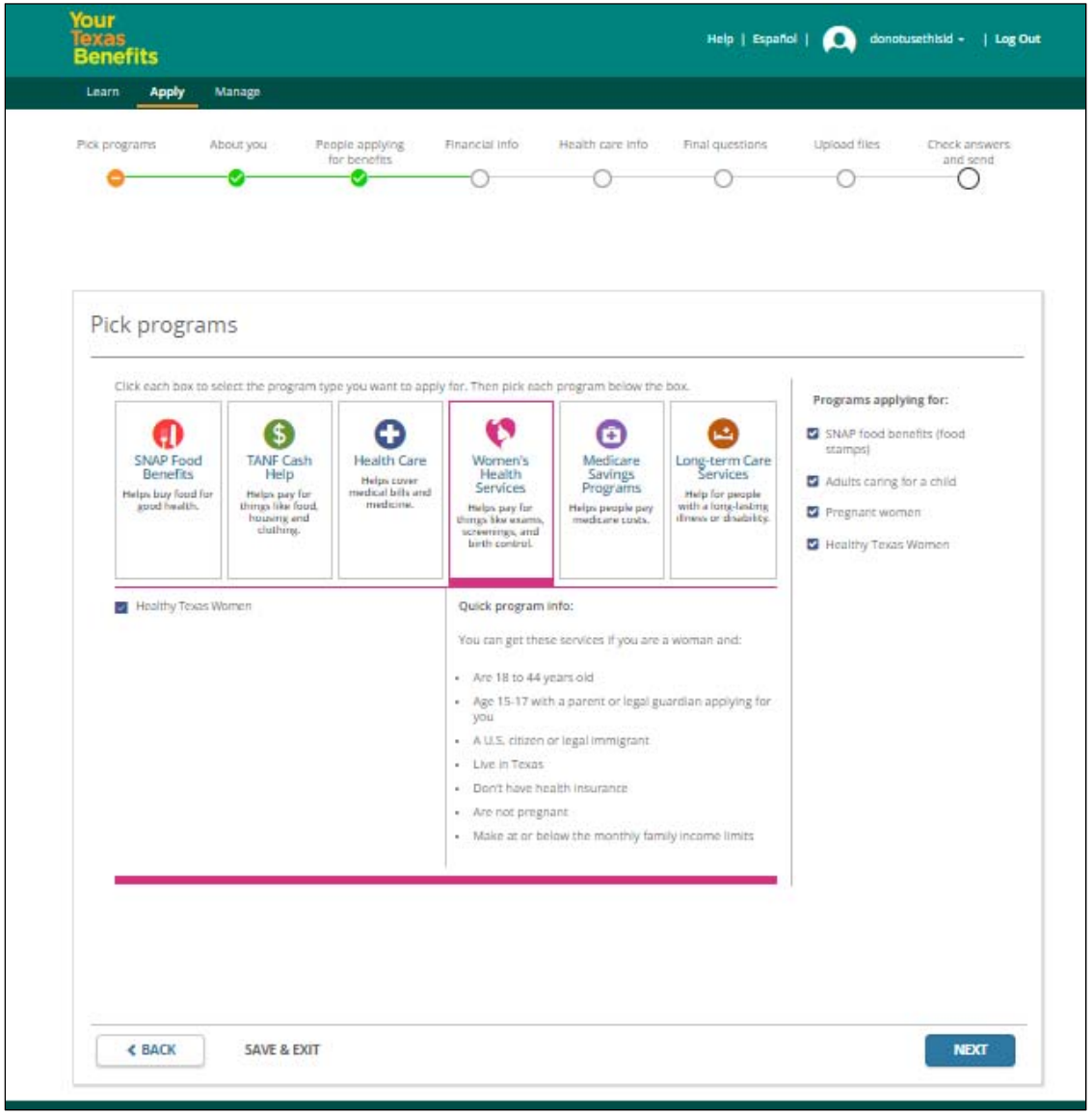
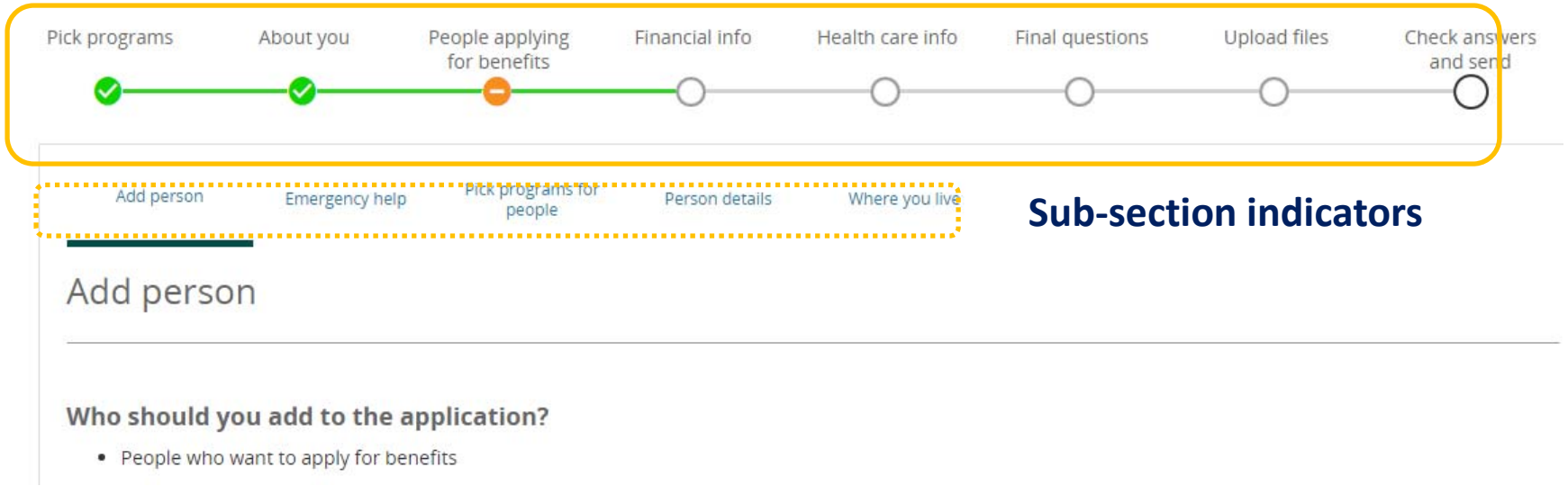


#2 More Streamlined Navigation

Progress Bar

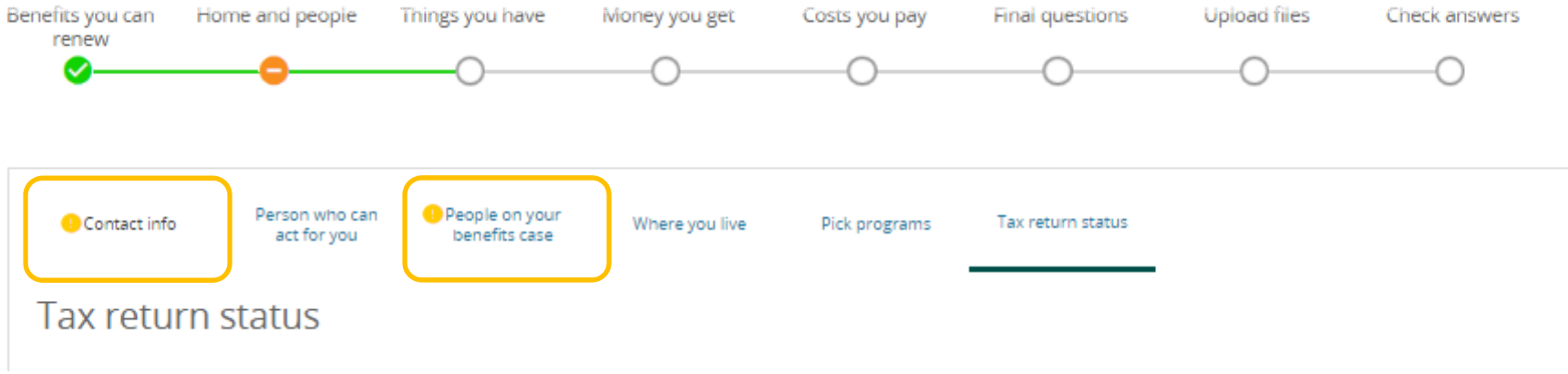


Sub-section indicators

#2 More Streamlined Navigation

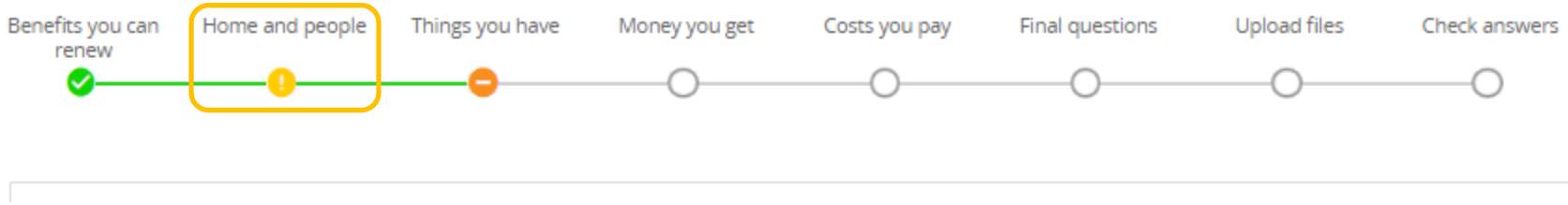
Incomplete sub-section cautions

(items needed for renewal or change report submission)

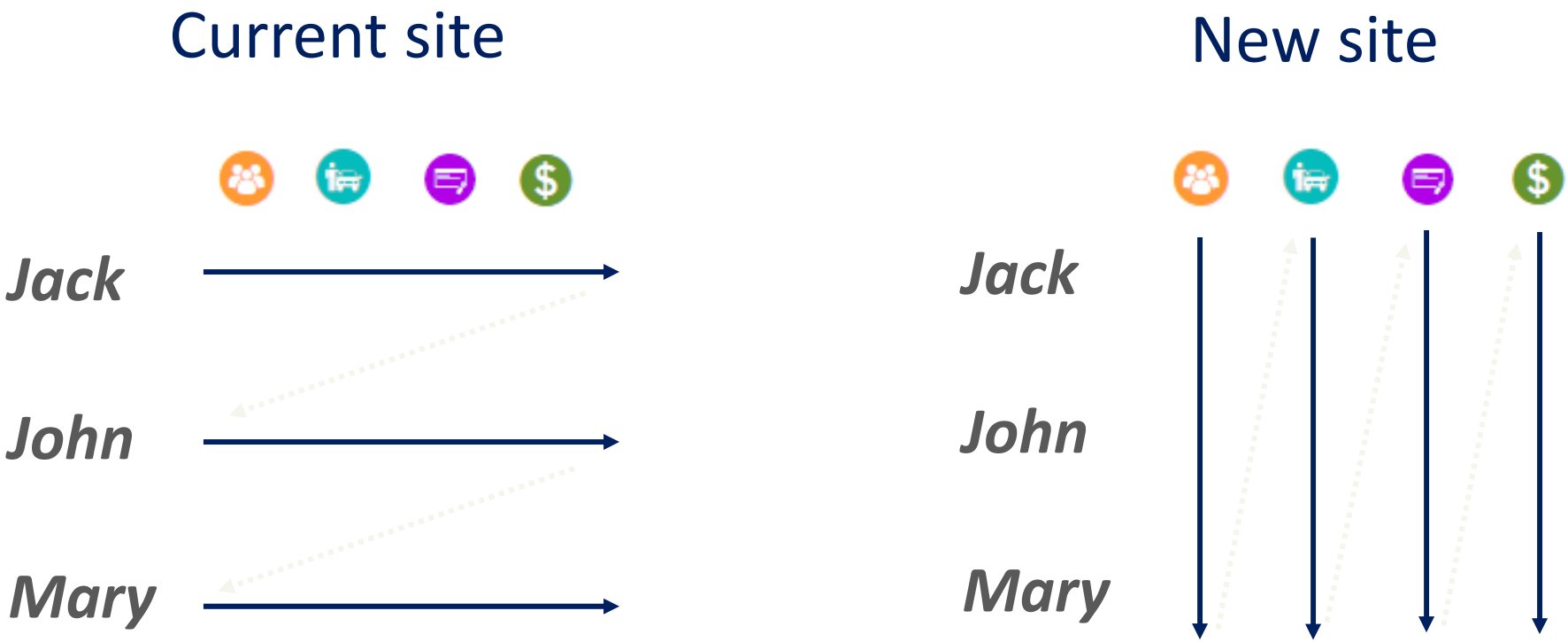


Cautions at progress bar level

(items needed for renewal or change report submission)



#3 More Efficient Info Entry



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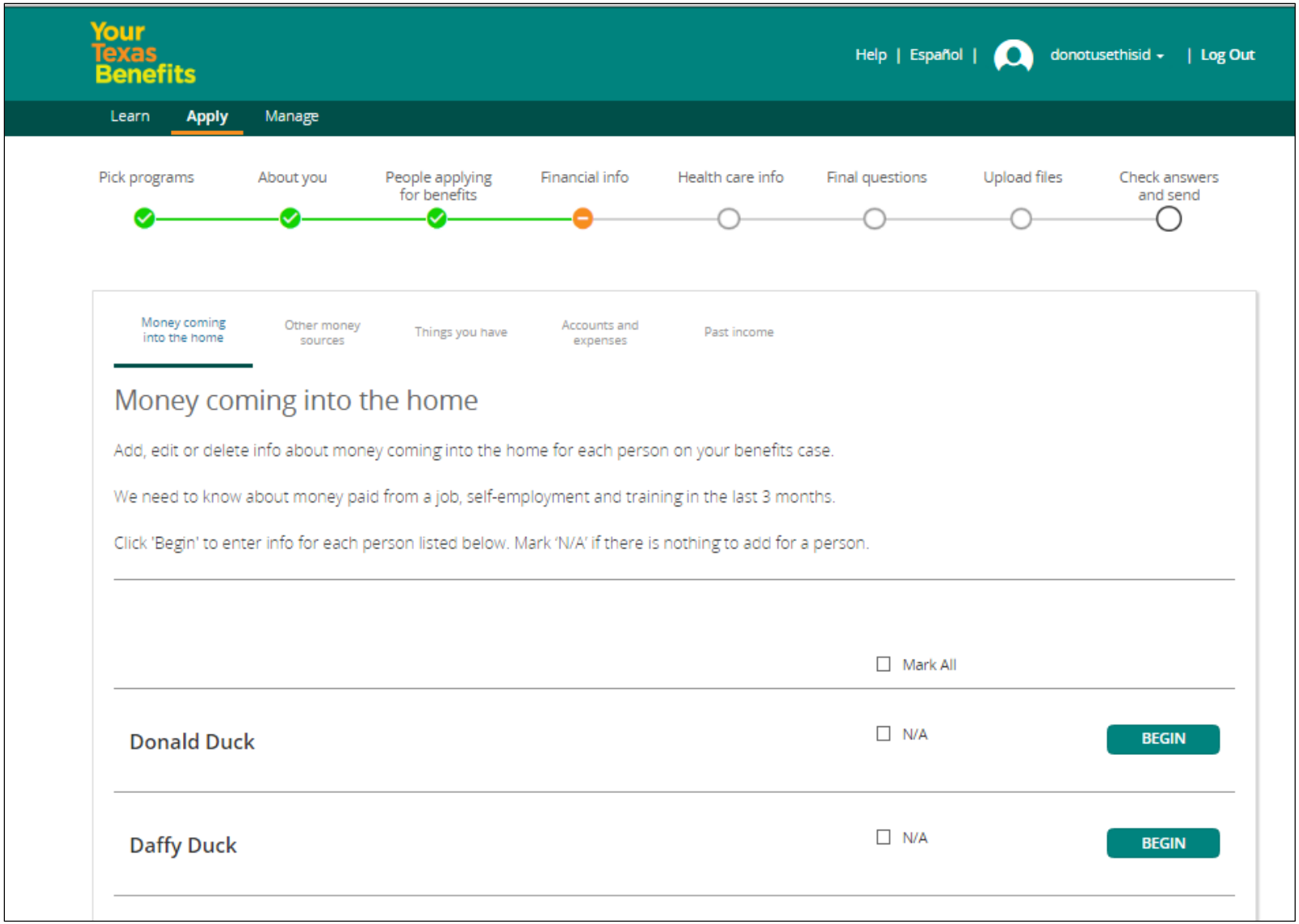
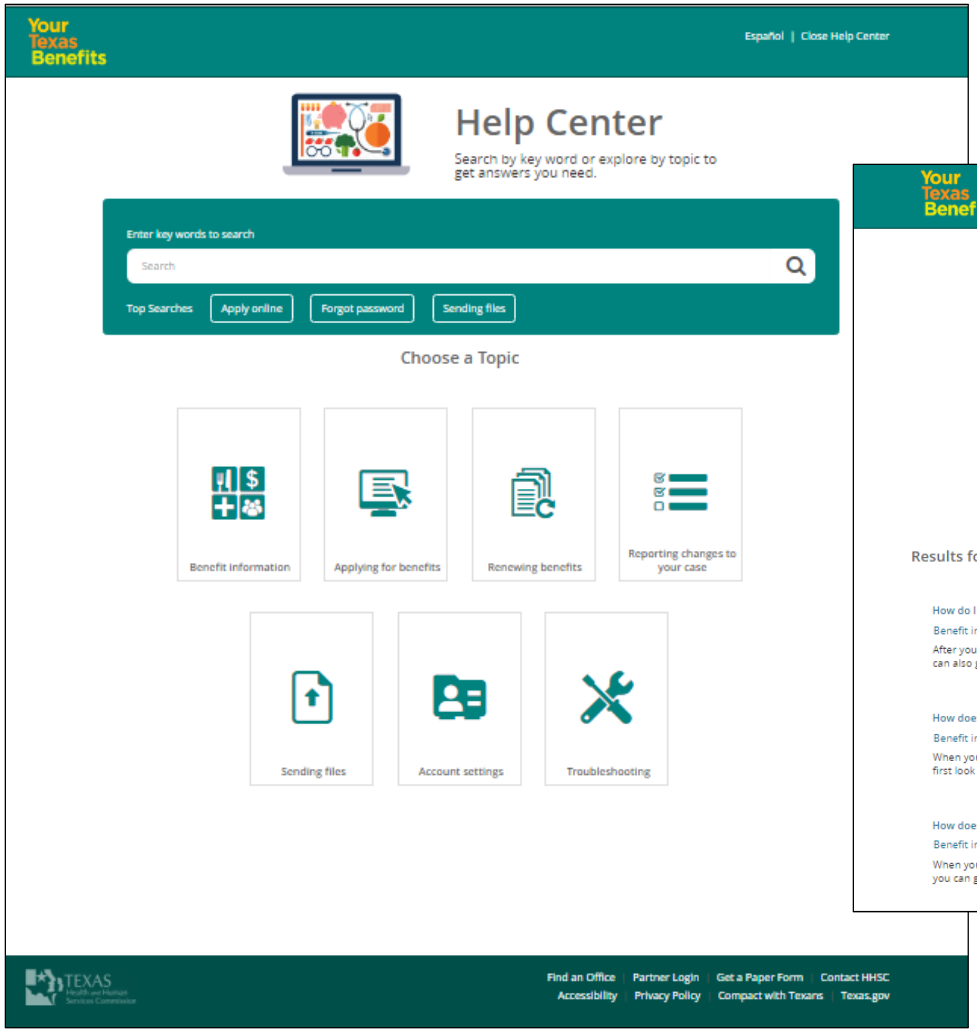
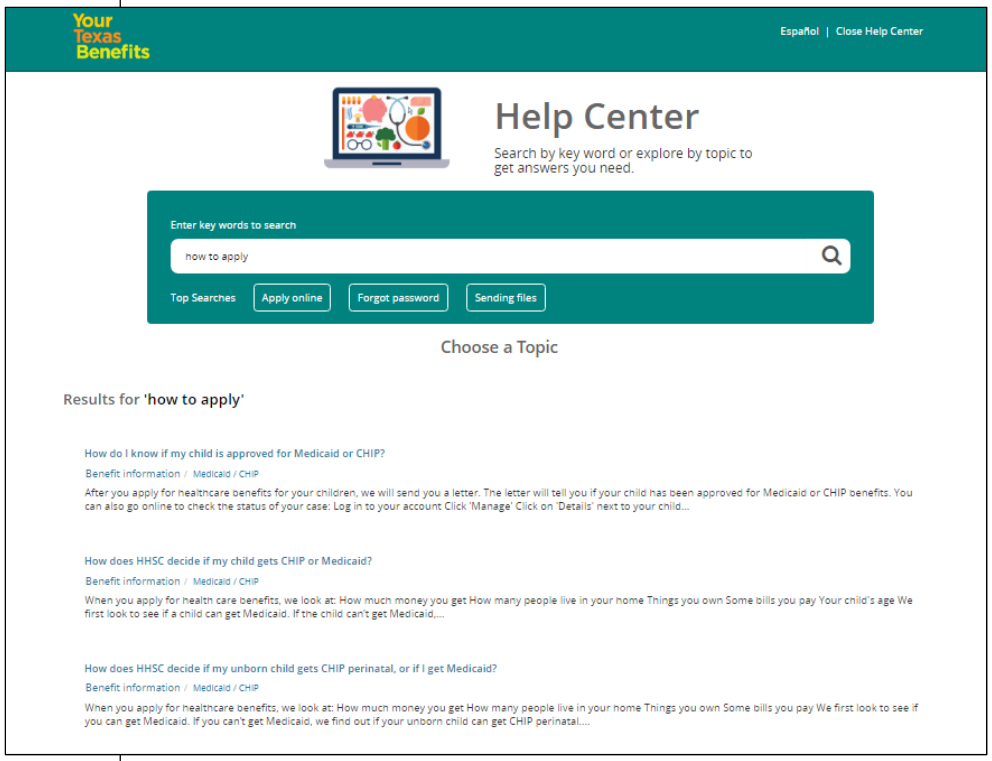
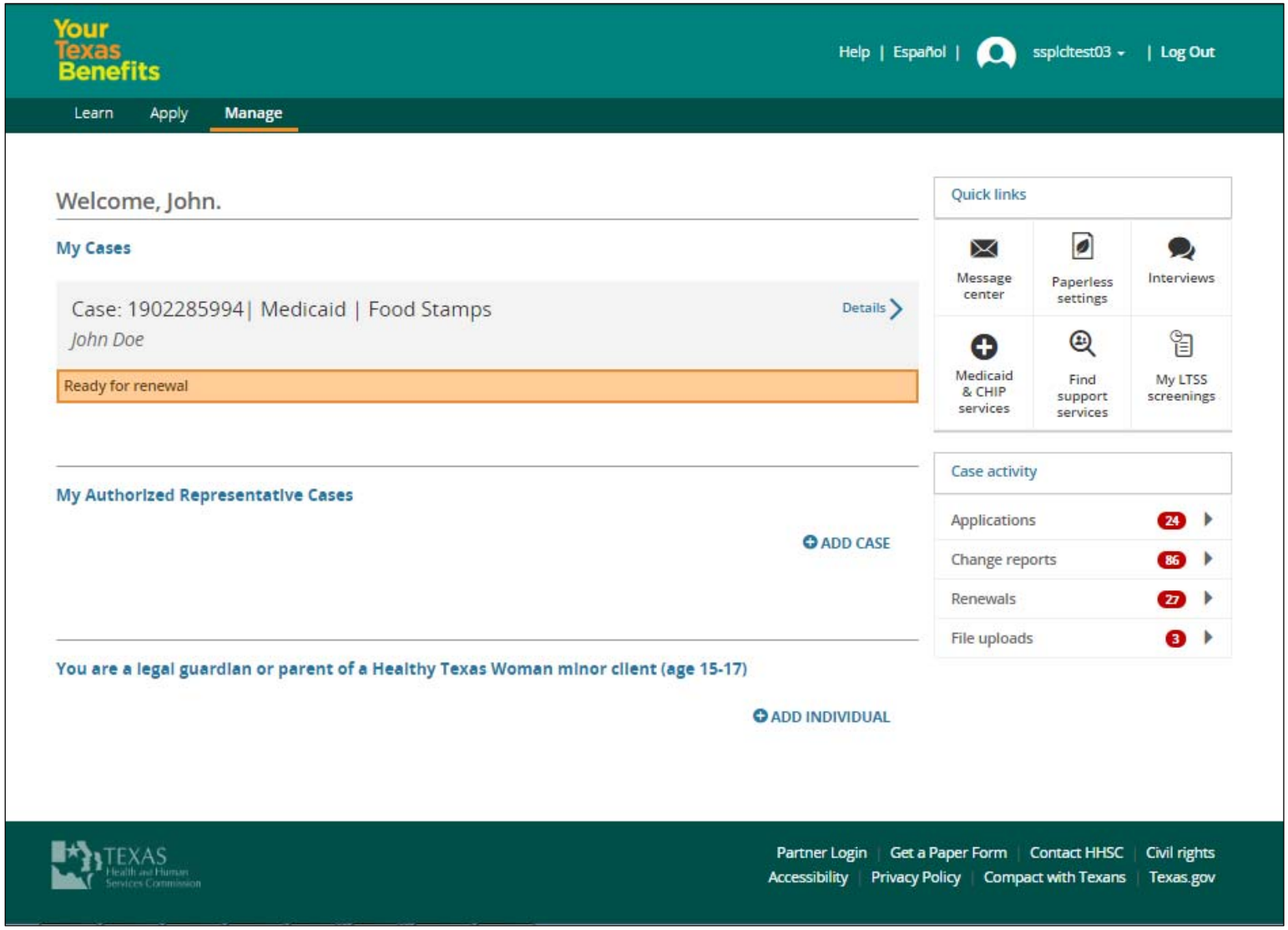


#4 Searchable Help Center





#5 Quick Access Points



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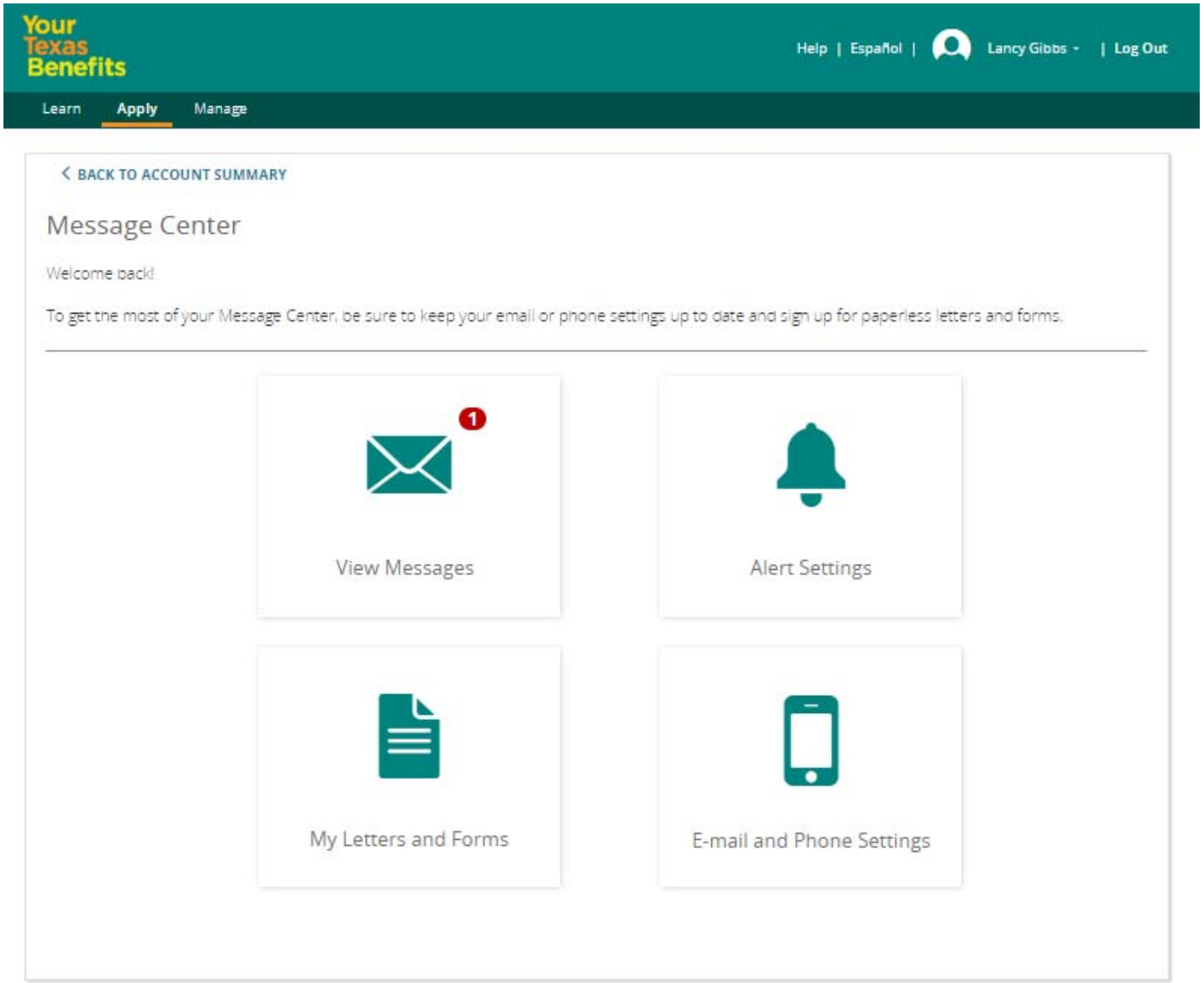
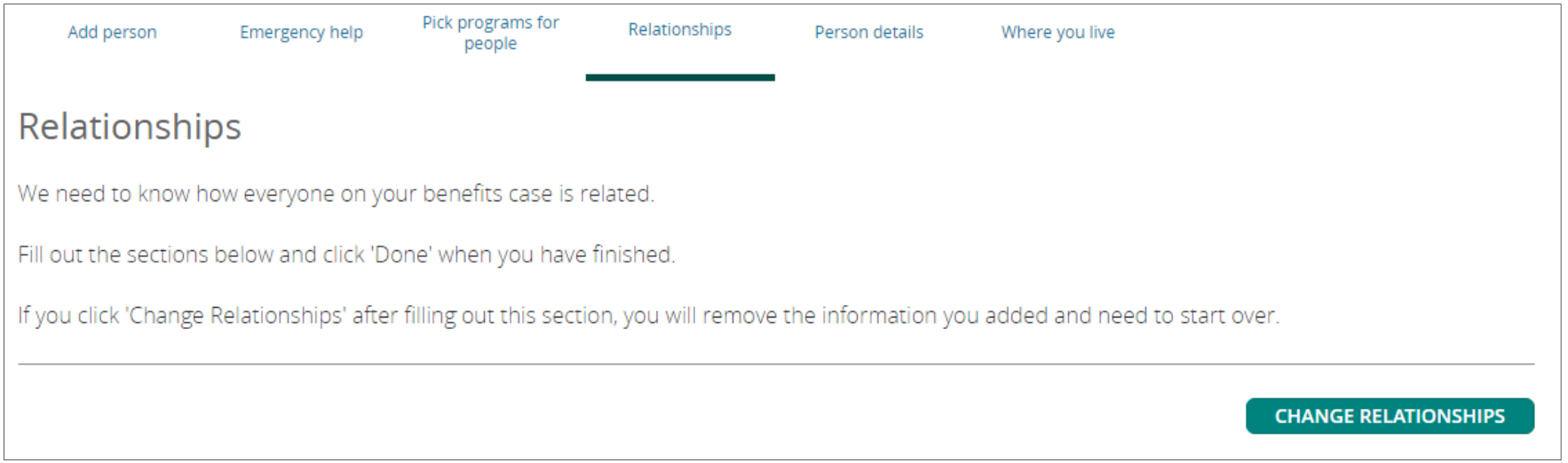
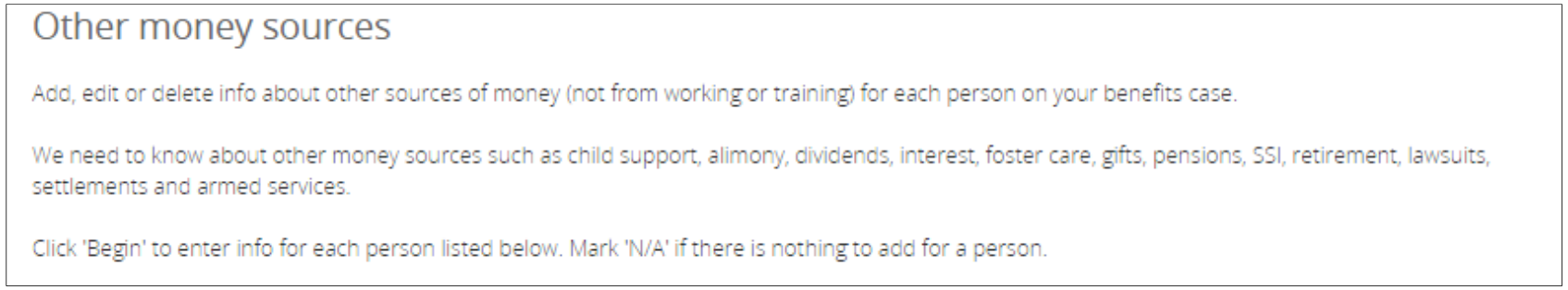


#6 Improved Instructional Text





What Happens Next?

- Training released mid-August

- Site launches August 29, 2016

Applied Behavior Analysis for children with ASD

Status of Medicaid coverage in Texas

What is ABA?

- According to Autism Speaks, ABA is based on the science of learning and behavior. This science includes general “laws” about how behavior works and how learning takes place. ABA therapy applies these laws to behavior treatments in a way that helps to increase useful or desired behaviors. ABA also applies these laws to help reduce behaviors that may interfere with learning or behaviors that may harmful. ABA therapy is used to increase language and communication skills, and to improve attention, focus, social skills, memory, and academics. ABA can be used to help decrease problem behaviors.
- ABA is considered an evidence-based “best” practice treatment by the US Surgeon General and by the American Psychological Association. “Evidence based” means that ABA has passed scientific tests of its usefulness, quality, and effectiveness.

Background—EPSDT

It is well-settled that once a state like Texas has chosen to participate in the federal Medicaid program, it must comply with federal Medicaid statutory and regulatory requirements. *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 915 (5th Cir. 2000).

The Medicaid Act "requires that each state plan provide EPSDT health care and services as a mandatory category of medical assistance." *S.D. v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004).

The Act further defines EPSDT services as "[s]uch other necessary health care, diagnostic services, treatment and other measures described in [§ 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan*. 42 U.S.C. § 1396d(r)(5)." *Id. (emphasis added).*

Background—EPSDT

- In examining the scope of the EPSDT benefit, the Fifth Circuit Court of Appeals in *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004), found that every Circuit that has considered the issue "has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under 1396d(a)." *Id.* at 590, *citing Collins v. Hamilton*, 349 F.3d 371, 376, n. 8 (7th Cir. 2003) ("a state's discretion to exclude services deemed 'medically necessary' . . . has been circumscribed by the express mandate of the statute")

ABA coverage by Medicaid—court decisions

- In 2012, the federal court in *Garrido v. Dudek* explained, "in determining if [Florida Medicaid's] decision not to cover ABA for children with autism and ASD violates the EPSDT provisions in the Medicaid Act, [the] statutory framework presents two questions: (1) is ABA among those services which can be covered under 42 U.S.C. § 1396d(a), and (2) is ABA necessary to correct or ameliorate an illness for a Medicaid recipient under age 21?" *Garrido v. Dudek*, 864 F.Supp.2d 1314, 1318 (S.D. Fla. 2012), *aff'd* 731 F.3d 981 (11th Cir. 2013), *on remand* F.Supp.2d 1275, 1280 (S.D. Fla. 2013) (permanent injunction).
- The *Garrido* court answered both questions in the affirmative, finding that ABA falls within the scope of 42 U.S.C. § 1396d(a)(13) (as a preventative or rehabilitative service) and that ABA is "an effective and significant treatment to prevent disability and restore developmental skills to children with autism and ASD." *Id.* at 1280, 1287.

Court decisions

- Similarly, the court in *Chisholm ex rel. CC v. Kliebert,* 2013 WL 3807990, at *22 (E.D. La. July 18, 2013), found that "ABA therapy, when recommended by a physician or licensed psychologist, constitutes 'medical assistance' under Section 1396d(a)(13) . . ." and that "ABA therapy is medical assistance that was necessary to correct or ameliorate the debilitating effects of [the plaintiffs'] autism." *See also Parents League for Effective Autism Treatment v. Jones-Kelly*, 339 Fed. App'x 542 (6th Cir. 2009) (affirming preliminary injunction holding that ABA was likely mandated in Ohio EPSDT as either a rehabilitative or preventative service); *Hummel v. Ohio Dep't of Job & Family Servs.*, 844 N.E.2d 360 (Ohio App. 6th 2005) (ABA must be covered by Medicaid when medically necessary).

Agency for Healthcare Research and Quality

- In 2014, the federal Agency for Healthcare Research and Quality published a report on autism. The report discussed carious autism treatment studies, and concluded that (1) ABA is evidence-based, and (2) “early behavioral and developmental intervention based on the principles of ABA delivered in an intensive (>15 hours per week) and comprehensive (i.e., addressing numerous areas of functioning) approach can positively affect a subset of children with ASD.”

CMS issues guidance on ABA coverage

- CMS's July 14, 2014 Informational Bulletin entitled "Clarification of Medical Coverage of Services to Children with Autism," while not endorsing any particular treatment modality for ASD, reaffirmed that EPSDT is "intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under the age of 21, including for those with ASD, *based on individual determinations of medical necessity*…" (emphasis added).

Hawaii decision—August 12, 2016

- Just last week, a federal court in Hawaii, in *J.E., et al. v. Wong*, issued a decision finding that Hawaii Medicaid failed to inform beneficiaries eligible for EPSDT services that ABA is a covered service. The Court ordered Hawaii Medicaid to inform such beneficiaries "that ABA is now recognized as a covered treatment for autism under the State Medicaid program."
- Hawaii Medicaid changed its position on ABA coverage following the federal agency report on autism and CMS's guidance on medical coverage for children with autism.

Texas Medicaid's position on ABA coverage

- On September 28, 2015, almost 14 months after CMS issued its Information Bulletin on Medical Coverage for Children with Autism, Disability Rights Texas, on behalf of its client, N.D., wrote to HHSC's State Medicaid Director asking for "a list of Medicaid ABA providers in Houston, the largest city in Texas and fourth largest in the United States." N.D. is a three-year old Medicaid beneficiary who has been diagnosed with ASD. N.D.'s neurologist, the Director of the Autism Center at the Children's Learning Institute at the University of Texas Health Science Center at Houston, has ordered ABA therapy for N.D. because it is medically necessary for him.
- Nevertheless, despite N.D.'s medical need for ABA, Texas Medicaid responded to the September 28 letter by suggesting only that N.D. try a non-Medicaid-funded pilot program run by another agency.

Texas Medicaid's position on ABA coverage

- In his November 2015 response, the Texas Medicaid Director expressly rejected CMS's July 14, 2014 Information Bulletin, stating that "ABA is not currently a defined benefit in the Texas Medicaid program."
- The Texas Medicaid Director explained that Texas Medicaid has determined that ABA is a "new service[]," and as such Texas Medicaid must get budget authority from the Texas Legislature before it will authorize the service for any beneficiary, even if it is medically necessary.
- The Texas Medicaid Director concluded that "[a]s with all new benefits, should HHSC be directed by the Legislature to offer intensive behavior therapy in Medicaid," stakeholders would have opportunities to comment on the new benefit's development.

Texas Medicaid's position on ABA coverage

- The Texas Medicaid Director also stated that "Texas Medicaid currently provides medically-necessary services to clients with ASD, such as physical, occupational, and speech therapy and nutrition counseling."
- In 2015, however, the Texas Legislature directed HHSC to cut $250 million in state and federal funding over two years for those same therapies. Those cuts to PT, OT, and ST are currently stayed due to a court order.

2016 Complaint to CMS

- Disability Rights Texas and the National Health Law Program (NHELP) submitted a complaint to CMS on March 21, 2016 concerning Texas Medicaid's refusal to cover ABA for children who have a medical need for such preventative or rehabilitative services.
- CMS responded on June 13, 2016, and confirmed that "[u]nder the EPSDT benefit, all medically necessary services coverable under the Medicaid program must be provided to eligible children. While states determine medical necessity, that determination must be made on a case-by-case basis. In addition, a state may not arbitrarily refuse to cover a specific treatment service if it is coverable under section 1905(a) [42 USC 1396(d)] of the Act."

Other clients with a medical need for ABA

- N.N, a six year-old boy with ASD who has been prescribed ABA as medically necessary and who, for four months (June to September 2015), was approved ABA as medically necessary by Texas Medicaid. Texas Medicaid, however, reneged on its approvals, leaving N.N. and the ABA provider with a $30,000 medical bill. When N.N.'s guardian asked Texas Medicaid Director Gary Jessee about the rescission of the approvals for ABA, Mr. Jessee responded that "cases with approvals were mistakes."
- A.B., a thirteen year-old boy with ASD who has been prescribed ABA as medically necessary, but who cannot get the therapy from Texas Medicaid, despite his mother making some two-hundred calls trying to find a Medicaid provider (there are no Medicaid-funded providers of ABA, of course, because Texas Medicaid has decided not to cover ABA).
- J.I., a seven year-old boy with ASD who has been prescribed ABA as medically necessary but who cannot get the therapy from Texas Medicaid.
- And, B.B., a nine year-old boy with ASD who has been prescribed ABA as medically necessary but who, despite his mother "trying and trying," could not get the therapy from Texas Medicaid.

Impact of lack of ABA coverage

- According to a 2014 report by the Texas Council on Autism and Pervasive Developmental Disorders: *"The Texas Health and Human Services Commission (HHSC) Center for Strategic Decision Support (SDS), using Centers for Disease Control and Prevention (CDC) prevalence data and U.S. Census Bureau information, estimated in 2014 that 399,915 Texans have an ASD diagnosis, including 130,316 children below 22 years of age."* No doubt a substantial number of those 130,316 children with ASD are Texas Medicaid beneficiaries and have a medical need for ABA.

Urgency

- The court in *Garrido,* in issuing its permanent injunction requiring Medicaid coverage of ABA, recognized that it was imperative that children with ASD in Florida "*receive ABA immediately to prevent irreversible harm to these children's health and development.*" *Garrido*, 864 F.Supp.2d at 1327 (emphasis added).
- Texas is an outlier. Currently, 38 state Medicaid programs are covering, or are in the process of covering, ABA

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- Register Texas voters online with lwvtexas.turbovote.org Don't forget to print, sign, stamp, and mail! Get voting reminders!
- Promote and share the League of Women Voters of Texas Voters Guide. The nonpartisan LWV-TX Voters guide will be available by early voting. Post/share a link to LWV-TX or your local League Voters guide. Call the LWV-TX office to order printed copies of the Voters Guide 512-472-1100.
- Ask your nonprofit or community organization to provide voter registration and to promote voting! Use the Be a Texas Voter Toolbox for Community Organizations to learn how. Find registration and voter engagement information to promote nonpartisan voter education and registration material. Nonprofits are allowed to encourage their clients to register and to vote!
- Share LWVTexas.org Voter and Election Information section of our website which provides voter education information including...voter id, registration, mail-in ballot etc.
- Share VOTE411.org app! Provide voters with candidate information and an opportunity to create a personalized ballot!
- Give a voting presentation to a group with the Vote It Counts power point! Covers voter turnout in your county (or counties) compared to Texas and the nation, the impact of low voter turnout, and why an individual's vote counts. It includes important dates for the November election and voter information websites (state, county, and League).
- or Contact your Local League for a Vote It Counts presentation, to request a volunteer deputy registrar or for local voter needs!
- Print up and hand out Voter bookmarks/cards with important voter information.
- Print and post Be a Texas Voter Voter Education Posters and flyers
- **Print and share copies of the "Handy Dandy Voters Information for the 2016 General Election" and the Voter bookmarks, Both have the updated Voter ID info!**
- English
- Spanish
- Share LWV-TX Voter Education Videos

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Be a Texas Voter Campaign 2016

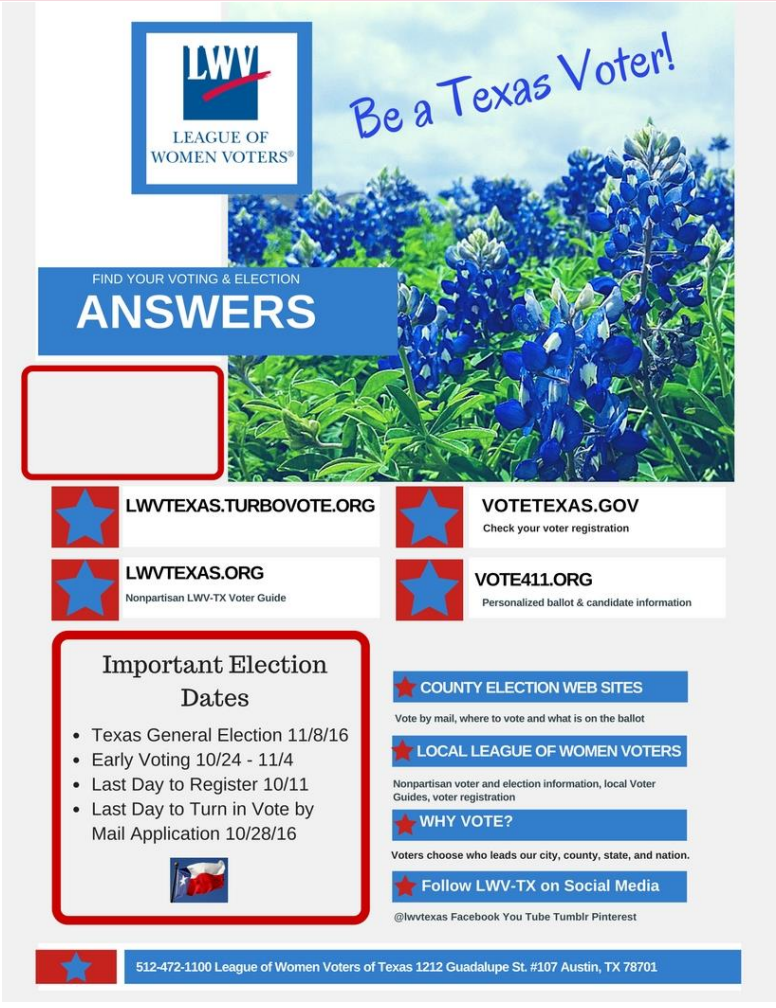
RESOURCES

Be a Texas Voter!

Voter Engagement Toolbox

for Community Organizations

Posters and Flyers



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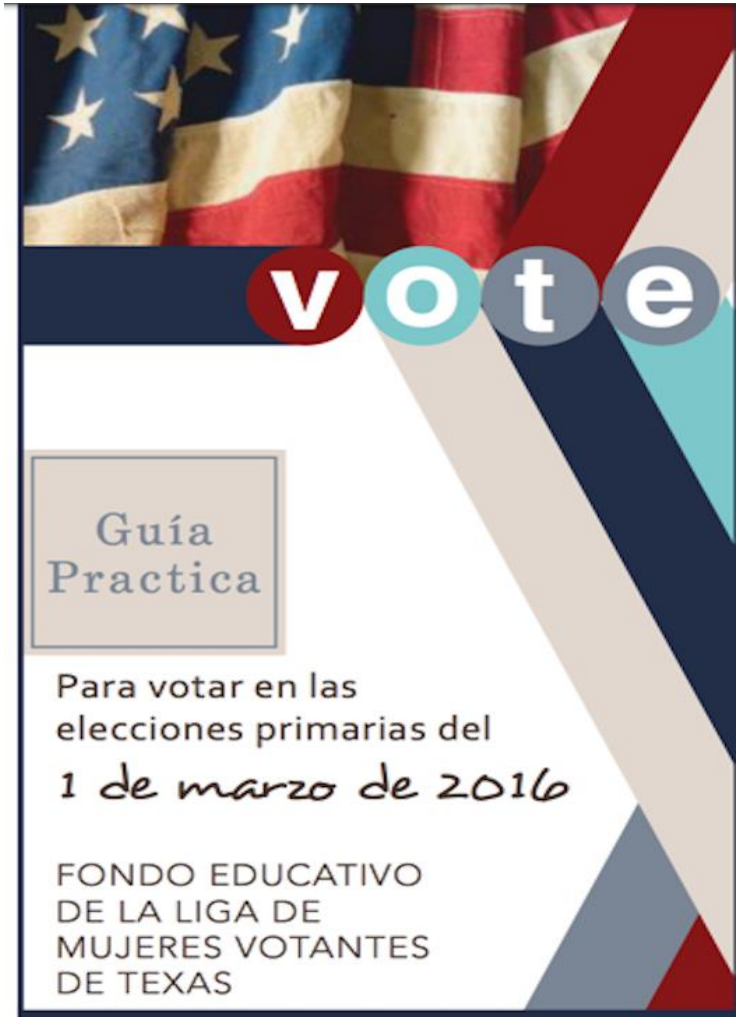

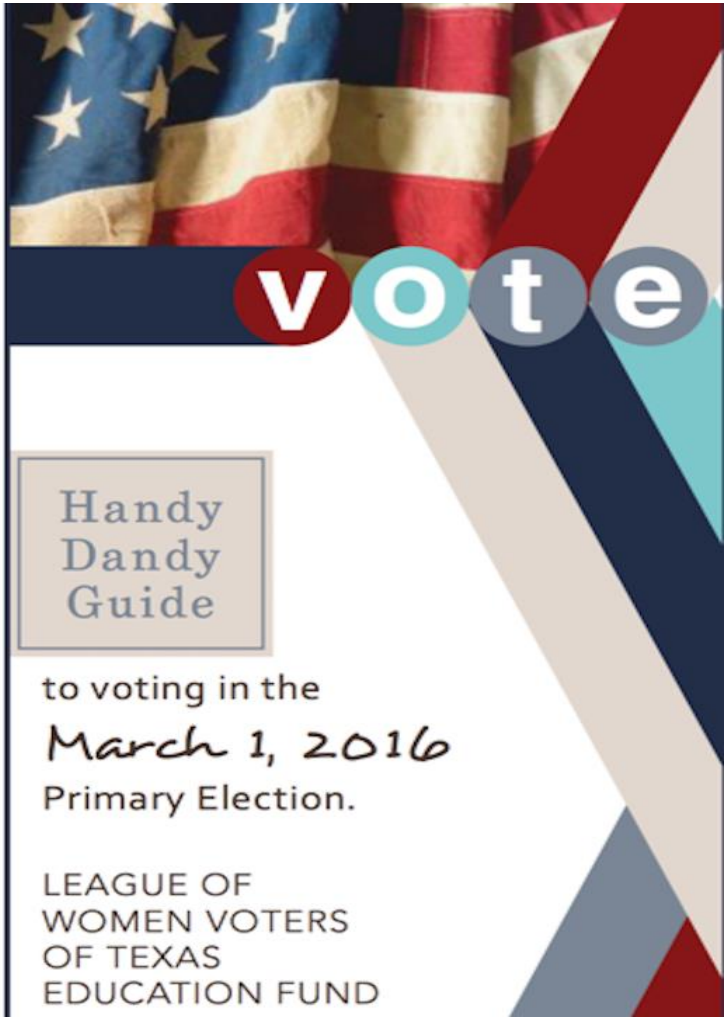

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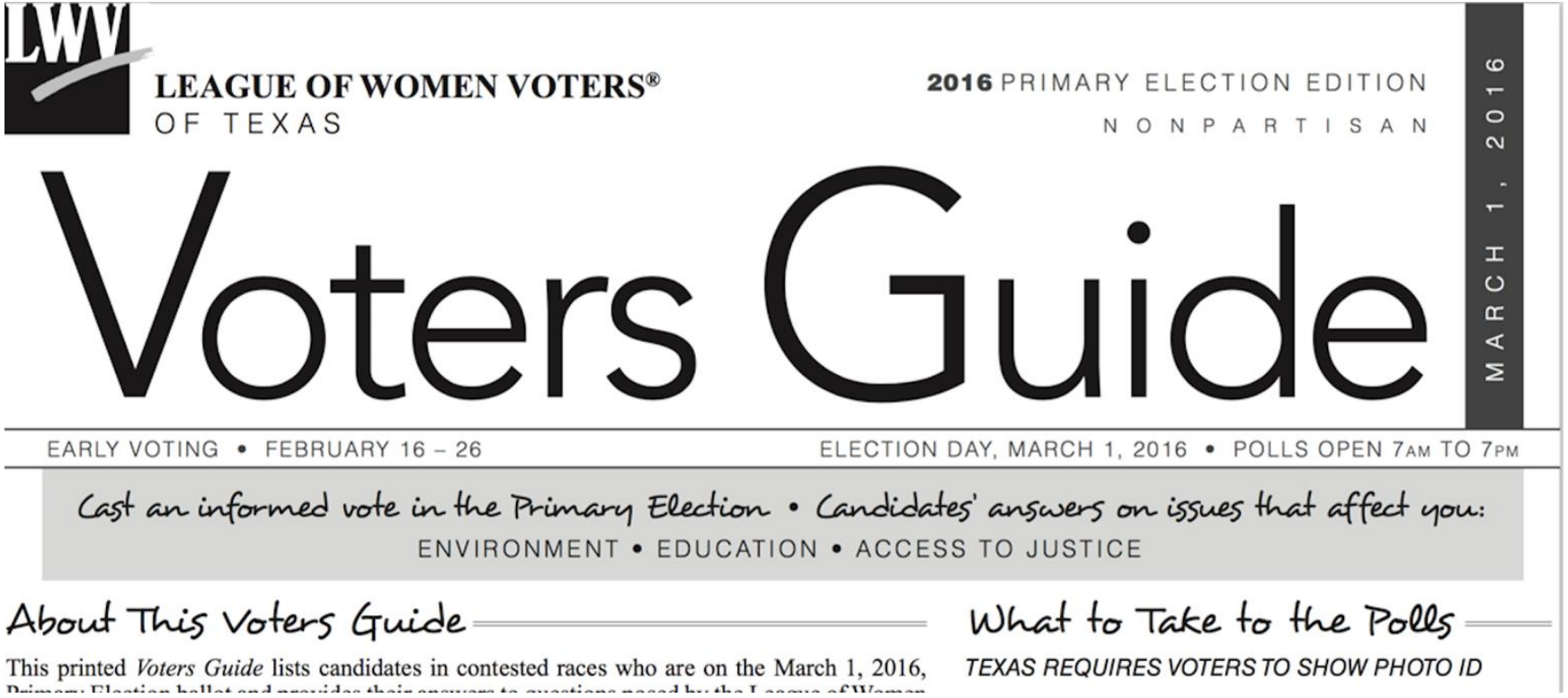

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OF TEXAS

2016 PRIMARY ELECTION EDITION
NONPARTISAN

MARCH 1, 2016

Voters Guide

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This printed *Voters Guide* lists candidates in contested races who are on the March 1, 2016,

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Texas Neonatal Abstinence Syndrome Initiatives

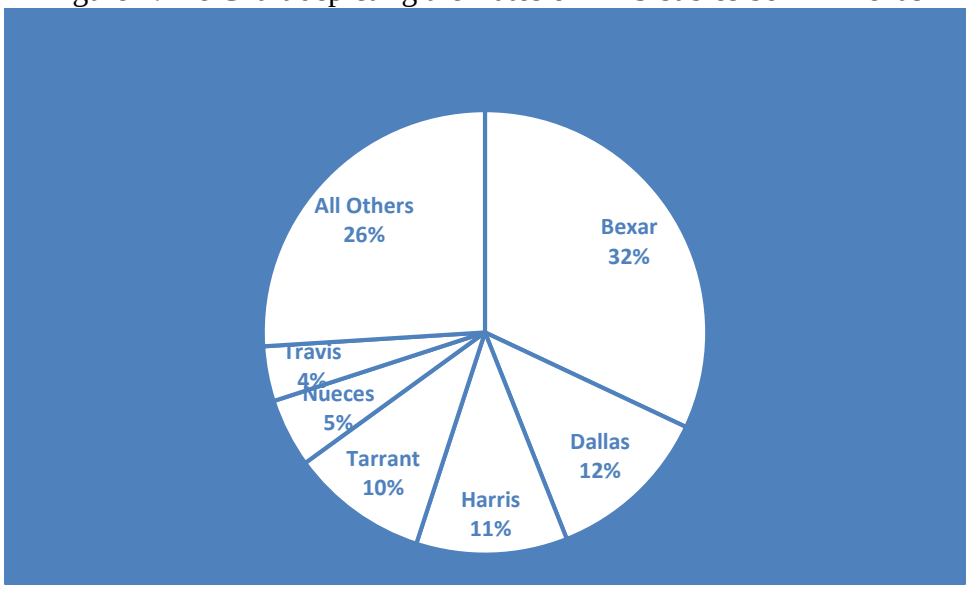
Background: Over the last decade, increased attention has focused upon the parallel rise in two trends: an increased prevalence of prescription opioid misuse and an increased incidence of NAS. Use of opioids such as prescription painkillers and heroin by pregnant women can result in NAS. NAS is a group of problems that may occur in a newborn exposed to substances in utero via maternal substance use, typically opioids. Cases of NAS increased by almost 300 percent in the U.S. between the years 2000 and 2009. Approximately 55-94 percent of exposed newborns will experience NAS.

Opioid use among pregnant women has increased in Texas, and approximately one out of four pregnant women admitted to DSHS-funded treatment services are dependent on opioids. Currently, Bexar, Harris, Dallas, Tarrant, and Nueces Counties have the highest reported rates of NAS in the state, with these five counties encompassing nearly 70% of the NAS cases.

Figure 1: Twenty-six (26%) of NAS babies were born in Bexar County in 2014.

Figure 1: NAS Percentage of Texas Claims per County						
County	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Bexar	**34**	**30**	**32**	**33**	**30**	**26**
Harris	11	12	12	13	9	7
Tarrant	8	8	9	10	10	10
Dallas	11	9	9	12	14	14
Nueces	8	7	5	4	5	7

Figure 2: Pie Chart depicting the Rates of NAS babies born in Texas



In 1998, a National Institutes of Health consensus panel recommended methadone maintenance as the standard of care for pregnant women dependent on opioids. Methadone substantially reduces fluctuations in maternal opioid levels, and serves to protect the fetus from repeated withdrawal episodes. Comprehensive services including methadone maintenance, counseling, and prenatal care reduces the risk of obstetrical and fetal complications, fetal morbidity, and fetal demise. Opioid Substitution Therapy (OST) is treatment for opioid addiction that includes regular (often daily) administration of medications such as methadone and buprenorphine that should not result in intoxication, euphoric effects, or sedation when administered at the optimal dose for the individual.

Pilot Program

Currently, San Antonio has been piloting a program that utilizes an integrated model of care between primary and behavioral health providers to address NAS called The Mommies Program, this initiative has reduced Neonatal Intensive Care Unit (NICU) lengths of stay and reduced the rate of removal by the Department of Family and Protective Services (DFPS). The Mommies model developed in San Antonio has shown to reduce NICU lengths of stay by 33% and newborns remain home with their biological mother 87% of the time diverting costs associated with kinship and foster care and increase family preservation.

Through collaboration with Center for Health Care Services, University Hospital System (UHS) has: prioritized reducing stigma among staff; increased opportunities for pregnant patients to develop relationships with hospital staff; and the treatment families receive in the NICU is supportive and focused on keeping the family together whenever possible by engaging parents in the care of their newborns. The hospital has built trust among a highly stigmatized and vulnerable population drawing more patients into much needed care earlier in pregnancy and moms are having healthier babies that require fewer interventions in the NICU as a result.

Rates of children removed from homes by the child welfare system are low for those enrolled in "Mommies". UHS' highly qualified staff have developed expertise in the treatment of Neonatal Abstinence Syndrome (NAS) and providing care for individuals affected by substance use disorders. Researchers staffed by UHS have published studies showing the impact of the NICU experience on women with substance use disorders and continue to research the impact of non-pharmacologic treatment of NAS on the maternal/infant dyad. There exists a growing compelling argument for integrated and collaborative care. More than two thirds of American families are touched by addiction and we know that behavioral health and physical health are interwoven. We also know that only a small fraction of those with substance use disorders receive treatment but through integrated approaches to care, there is an opportunity to help engage families earlier to assist them in accessing the treatment they need. Cultural barriers and operating in silos continue to impede progress toward integrated care but the value of breaking through these barriers is immense and the Texas Department of State Health

Services is prepared to assist communities across the state in implementing this integrated model of care. Educational services for the MOMMIES program include 13-2 hour sessions that address:

Preparation for labor & delivery
Prenatal Care and Nutrition/Health
Premature Labor
Child safety including infant CPR
Stress management
Breastfeeding guidelines
Shaken Baby Syndrome (SBS)
Parenting newborns to age 3
Tobacco exposure
Sudden Infant Death Syndrome (SIDS)
NAS soothing techniques
Non-Pharmacologic interventions
Infant massage
Home safety
Domestic violence
Family planning
The Neonatal Intensive Care Unit (NICU) experience

The 84th Legislature appropriated $11.2 million to DSHS to reduce the incidence and severity of neonatal abstinence syndrome (NAS) in Texas. The funding for this Exceptional Item (EI) supports new and existing services aimed at reducing incidence, severity, and costs associated with NAS. This EI takes a multi-pronged approach to addressing NAS by:

- increasing targeted outreach services to engage women earlier in care,
- increasing the availability of intervention and treatment services to pregnant and postpartum women to improve birth outcomes, and
- implementing specialized programs to reduce the severity of NAS.

The following includes more details about the projects funded by the NAS EI:

Opioid Treatment Services and Pregnant and Post-partum Intervention

DSHS is expanding the number of opioid treatment slots by 635 specifically designated for pregnant and postpartum women throughout the state by enrolling methadone and buprenorphine providers as vendors.

This new approach integrates Opioid Treatment Services (OTS) with Pregnant and Post-partum Intervention (PPI) providers to better serve this vulnerable population. PPI providers, located onsite at the OTS provider sites, perform clinical and financial eligibility screenings to determine eligibility for methadone and buprenorphine. PPI staff provide case management and counseling services including referrals to other programs and assistance. PPI providers provide onsite education through a 16-week curriculum specifically tailored to pregnant and post-partum women with substance use disorders providing clients with information regarding how to have a healthy pregnancy, labor & delivery, postpartum care, parenting a newborn and more.

In addition to medication provision, counseling, and case management services onsite, these services are made available to pregnant and postpartum women in jail, women in residential treatment facilities, and home visitation to those restricted to bed rest. This project also designates treatment slots for pregnant and post-partum women, who have exhausted their pregnancy-related Medicaid coverage, for a seamless transition to avoid any disruption in their opioid treatment.

Statewide Pregnancy Stabilization Center

The Statewide Pregnancy Stabilization Center allows pregnant women to enter a single substance use disorder (SUD) treatment and recovery program that can address all their needs by providing them a full continuum of care for themselves and their children in areas that may not be able to provide all the care opioid dependent pregnant women require. The services range from clinical services such as opioid treatment services to recovery support services such as recovery housing. Once stabilized, women, with the help of a recovery coach, will transition back to their county of residence or a new community that supports long term recovery goals and family safety.

Mommies Program Implementation and Support

The Mommies Program is implemented through the collaboration of PPI programs and hospital systems along with opioid treatment providers to create local NAS Response Teams in the five counties with the highest incidence of NAS. NAS Response Teams include representatives from multiple systems working together to provide consistency in clinical standards for identification, management, and follow-up care for NAS diagnosed newborns and their families.

The program prioritizes reducing stigma among hospital staff, increasing opportunities for pregnant patients to develop relationships with hospital staff, and focusing on supportive, family-focused treatment in the NICU. The model, developed in San Antonio, has demonstrated reductions in Neonatal Intensive Care Unit lengths of stay by 33%, and newborns are able to remain home with their biological mother 87% of the time.

DSHS, in collaboration with University Health System in San Antonio in collaboration with the Center for Health Care Services, and University of Texas Health Science Center (UTHSC) developed an online training module on the Mommies integrated model of care toolkit. The online training module will enable DSHS-funded contractors and other professionals to better understand NAS, recognize the importance of using an integrated model of care for pregnant and parenting women with substance use disorders, and identify the key components of a successful integrated model of care for pregnant and parenting women with substance use disorders.

Targeted Outreach

The PPI providers are conducting community needs assessments to determine strategies to better engage and conduct outreach to women with high risk behaviors that can lead to substance exposed pregnancies. The goal is to engage high risk women earlier in OB/GYN care, substance use disorder treatment, and to increase access to healthcare information such as pregnancy and HIV status in the outreach setting.

Neonatal Abstinence Syndrome Trainings

Trainings were available for community NAS response teams including DSHS-funded contractors and other professionals working with pregnant and postpartum women with substance use disorders and their children. Trainings provided support to the implementation of targeted outreach and recovery support services as well as clinical management strategies for providers on caring for moms with substance use disorders and babies with NAS.

Neonatal Abstinence Syndrome Special Projects

As a result of the implementation of efforts to increase provider awareness and proper diagnosis of NAS. Increased awareness and proper diagnosis of NAS will likely lead to identifying more incidences of NAS around the state. A portion of these funds may be provided to areas of the state that were not previously identified as having high rates of NAS, and may be used for treatment or other NAS-related efforts. Additionally, these funds may be used to provide support for research efforts to identify effective strategies related to the management of non-pharmacologic newborn care.

Collaborative Partnerships are happening across the state to address NAS:

Highest Incidence Counties		**PPI Providers**	**Hospital Systems**
Counties	**NAS**		
Bexar	376	Alpha Home	Baptist Health System
Harris	100	Santa Maria Hostel, Houston Council on Recovery	Memorial Hermann Hospital System
		Behavioral Health Alliance of Texas	Harris Health System
Tarrant	139	Tarrant County Hospital District	John Paul Smith Hospital
Dallas	199	Nexus Recovery Center	Parkland Hospital System
		University of Texas at Arlington	Baylor Medical Center
Nueces	97	Coastal Bend Wellness Foundation, Council on Alcohol and Drug Abuse-Coastal Bend	Corpus Christi Medical Center-Bay Area

Collaborative Commitments to be included in the Response Team the following:

- Hospital Educator (including *if possible and available* Lactation Consultant, Physical Therapist, NICU Educator) to provide MOMMIES toolkit information to participants once per quarter.
- Collaboration with PPI staff access to clients within the Hospital system if client allows
- Implement a Family Centered NICU experience supporting MOMMIES participants increasing Non-Pharmacological intervention (Kangaroo Care, Rooming In, Breastfeeding)

Potential Benefits

- Free In-Person and On-Line training and education for communities responding to NAS
- Membership in the NAS Texas collaborative with peers to discuss with other hospital systems protocol and recommendations for care for this Infant Texas population
- Future Research Opportunities to decrease NICU length of stays in other hospital systems and provide a standardized protocol of NAS Treatment

Utilizing this NAS Initiative in Texas across the Continuum has the potential impact to reduce number of substance use disorder related miscarriages, fetal deaths, and maternal deaths, improve outcome for mothers and babies, reduce NICU lengths of stay, increased return to biological mother, and a more comprehensive and integrated treatment model in Texas.

Texas Efforts to Reduce the Severity of Neonatal Abstinence Syndrome (NAS)

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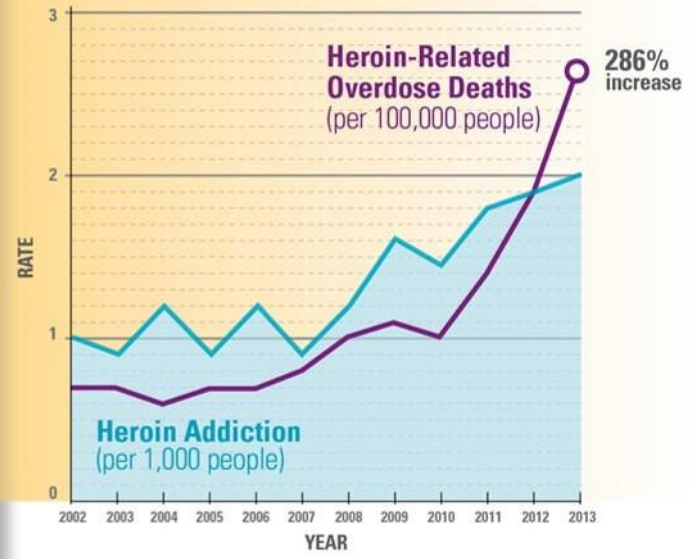
Opioid Use Among ALL Demographics

Heroin Use Has INCREASED Among Most Demographic Groups

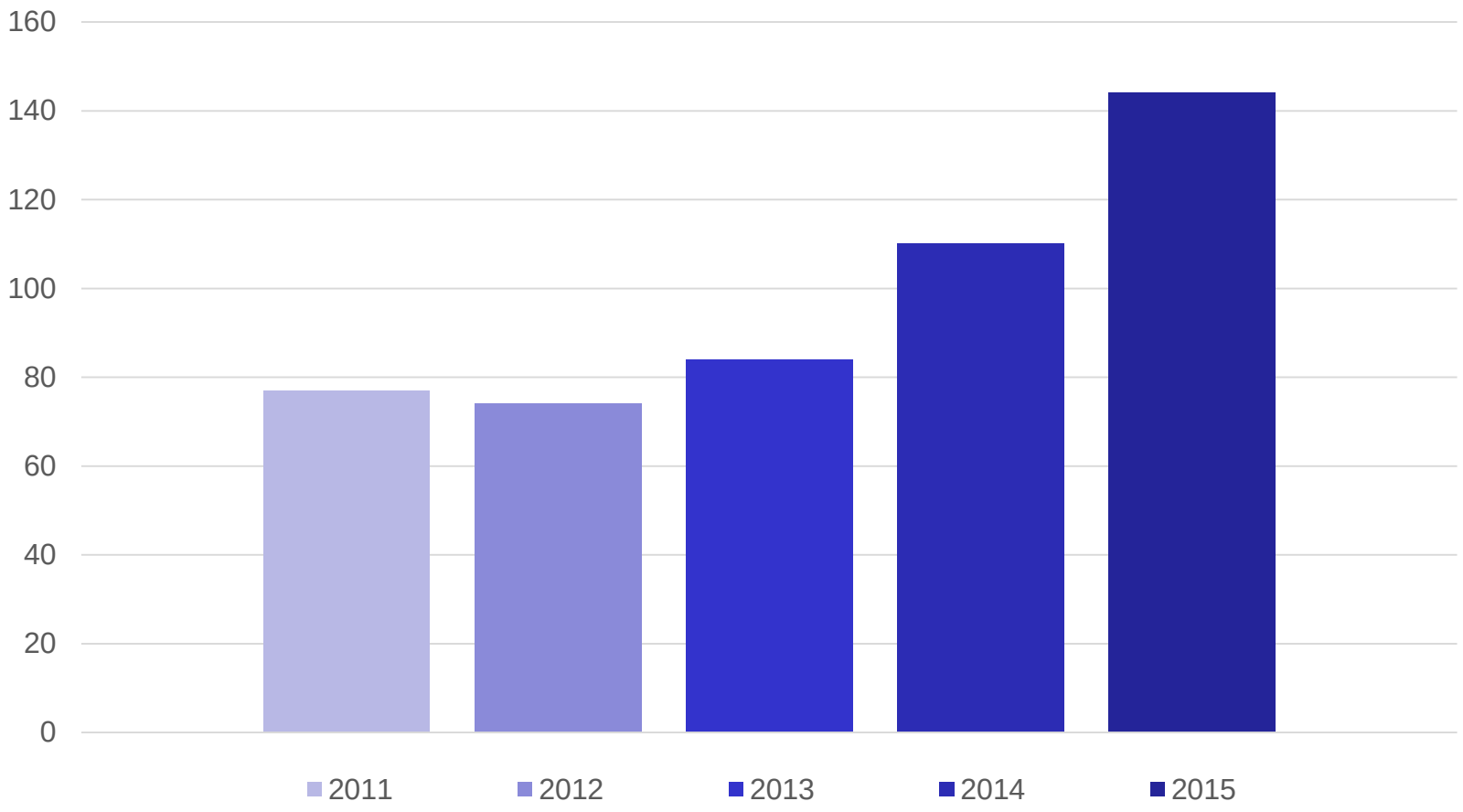
	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than $20,000	3.4	5.5	62%
$20,000–$49,999	1.3	2.3	77%
$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

Heroin Addiction and Overdose Deaths are Climbing

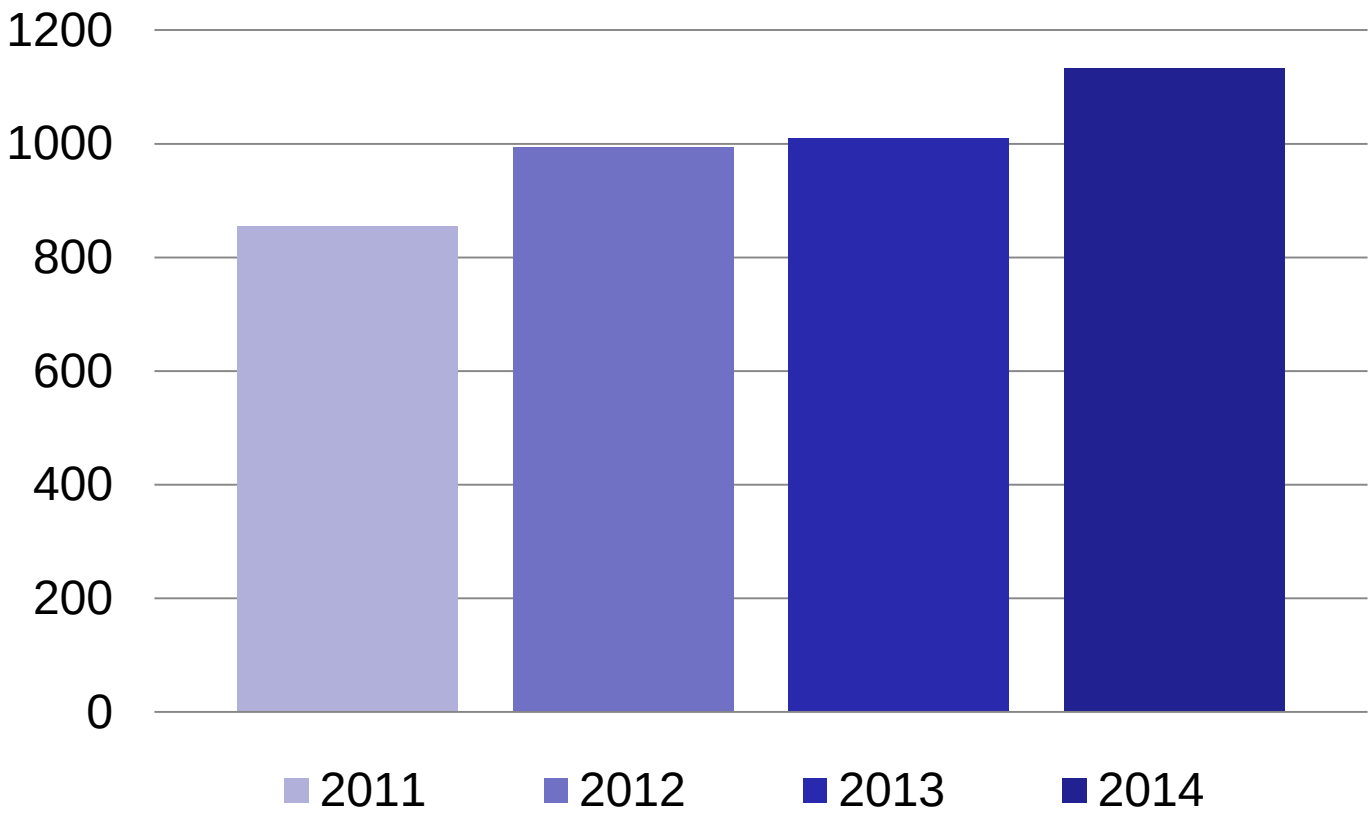


SOURCES: National Survey on Drug Use and Health (NSDUH), 2002-2013.
National Vital Statistics System, 2002-2013.

Pregnant Women in DSHS-funded Treatment



Texas Medicaid NAS Births



Texas Medicaid NAS Costs

- Texas LOS for NAS NICU stay averages 21 days vs. National LOS for NAS NICU stay averages 16 days. The national average length of hospital stay for all other births is 3 days.
- NAS hospital inpatient hospital average cost was $32,000, nearly 10 times the cost of an average newborn hospital stay.

NAS Exceptional Item

- This Exceptional Item (EI) would appropriate $11.2 million in General Revenue to DSHS over the course of the 2016-2017 biennium to fund new and existing services aimed at reducing incidence, severity, and costs associated with NAS.
- This EI would take a multi-pronged approach to addressing NAS by:
  - enhancing screening and outreach to women of childbearing age to reduce the number of opioid dependent women that become pregnant
  - increasing the availability of intervention and treatment services to pregnant and postpartum women to improve birth outcomes
  - implementing specialized programs to reduce the severity of NAS

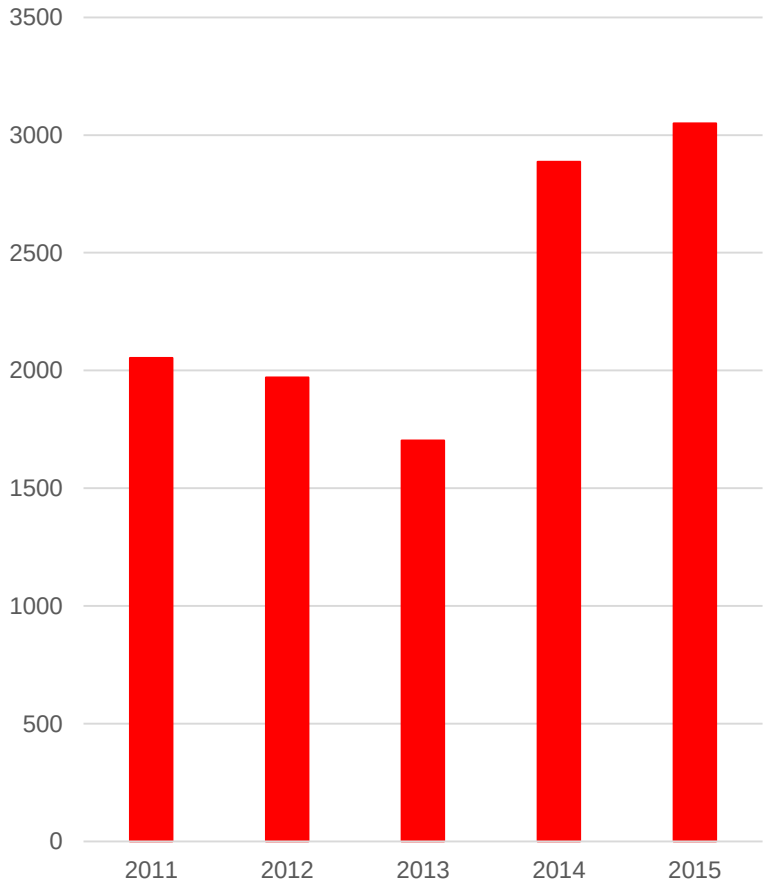
Targeted Outreach

- Step # 1: Targeted Outreach to High Risk Women who are of Child-Bearing Age
- Step # 2: Address Barriers to SUD Treatment for Pregnant Women
- Step # 3: Provide Trauma-Informed, Person Centered, Culturally Competent, Integrated and Comprehensive Care for Pregnant Women using Substances

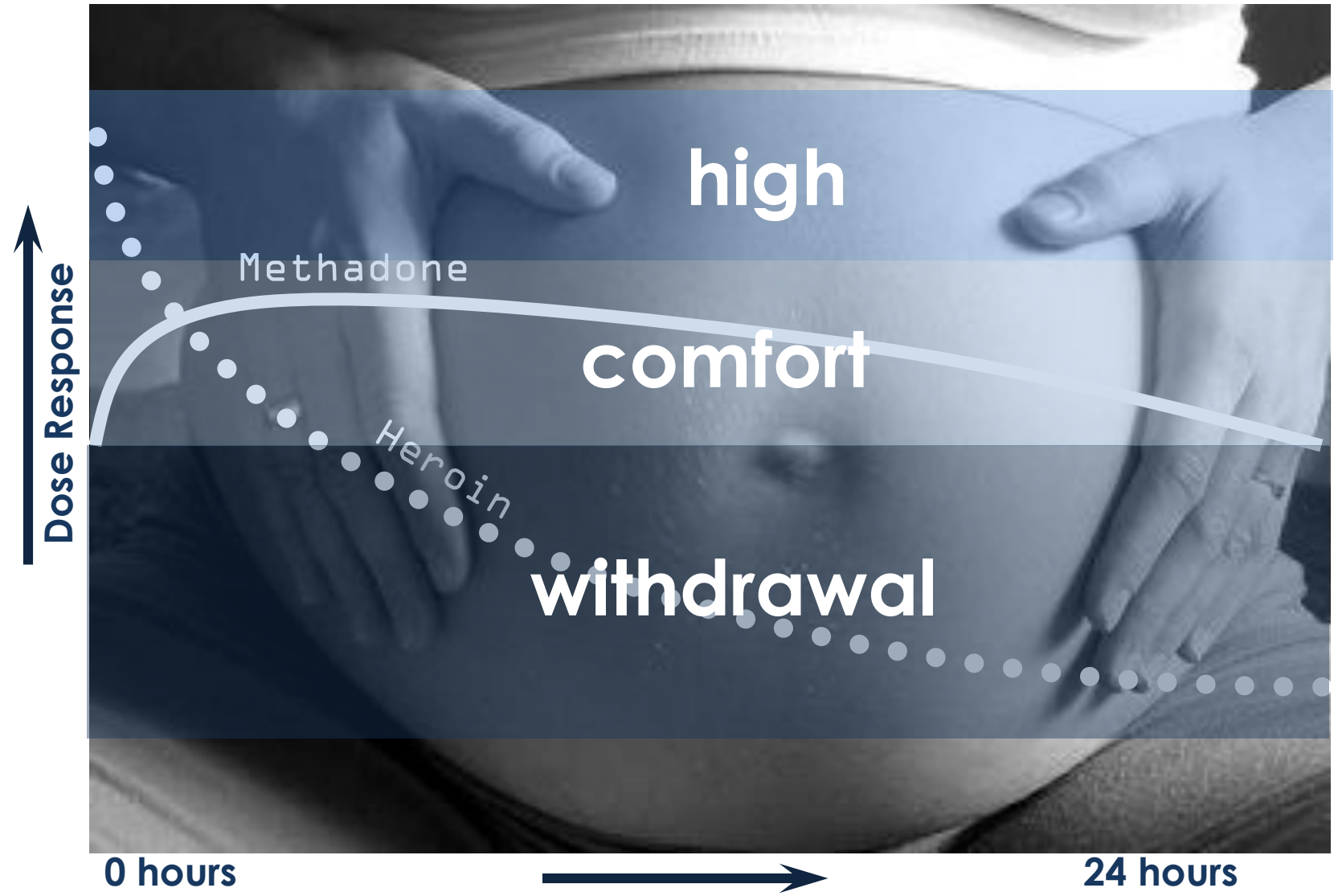
Pregnant, Postpartum Intervention (PPI) Programs

- **PURPOSE:** to provide community based, gender specific outreach and intervention services for pregnant and postpartum females with substance use disorders or who are at risk of developing substance use disorders.

- **ELIGIBILITY:** Risk Factors include the following: Teen Pregnancy, Current or Past involvement with the DFPS, Current or Past Substance Use, Current or Past Intimate Partner Violence, Current or Past Mental Health Problems, Living in a Household with a Person who uses alcohol or drugs, Current or Past History of Sexual, Emotional or Physical Abuse, Insufficient and/or Late (third trimester) or No Prenatal Care, Financial Distress.



Methadone protects the fetus from risk of repeated withdrawal



Expansion of Opioid Treatment Services (OTS)

- **PURPOSE:** To provide OTS to adult pregnant and/or postpartum opiate/opioid-dependent women to reduce risk of fetal morbidity and fetal mortality, and the risk of parental substance use.

- **ELIGIBILITY:** Adult pregnant and/or postpartum opiate/opioid-dependent women with moderate or severe opiate use disorder.

Co-Located Services

- NAS-Pregnant, Postpartum Women Residential Program
- NAS-Residential Recovery Housing
- NAS-Recovery Support Services

Educational Initiatives

- Mommies Toolkit
- Online Modules
- NAS Symposium 1st Annual: 212 providers
- Cortisol Stress Research
- Overdose Prevention Education

Integrated Approach

- Contractor shall organize monthly NAS Response Team meetings designed to understand and address the problem of opioid dependence and NAS in the community comprised of community members implementing Mommies. Community members should include but are not limited to:
    - Neonatal Intensive Care Unit staff
    - CPS staff
    - Obstetrical staff
    - Opioid Treatment Services staff
    - Substance Use Disorder treatment services staff
    - PPI staff
    - Recovery Support staff

Texas NAS Initative Across the Continuum

Purpose: Education of the multi-pronged approach to address NAS at Preconception and Interconception Health Continuum

Background: The 84th Legislature appropriated $11.2 million general revenue to DSHS Mental Health and Substance Abuse Division to reduce the incidence and severity of neonatal abstinence syndrome (NAS) in Texas. This Exceptional Item (EI) appropriation will fund new and existing services aimed at reducing incidence, severity, and costs associated with NAS. This EI would take a multi-pronged approach to addressing NAS: by increasing targeted outreach services to engage women earlier in care, increasing the availability of intervention and treatment services to pregnant and postpartum women to improve birth outcomes, and implementing specialized programs to reduce the severity of NAS.

Details: Integrated treatment models are essential for addressing the many needs of pregnant and parenting women with Substance Use Disorder. These programs combine Medication Assisted Treatment (MAT), pregnant-related education (PPI programs) and services with additional services to assist pregnant women with substance use disorders. DSHS appropriated $11.2 million in General Revenue through a Neonatal Abstinence Syndrome (NAS) Exceptional Item (EI) over the course of the 2016-2017 biennium to fund new and existing services aimed at reducing severity and costs associated with NAS. This EI takes a multi-pronged approach to addressing NAS by: enhancing outreach to women at risk for having a substance exposed pregnancy, increasing the availability of intervention and treatment services to pregnant and postpartum women to improve birth outcomes and prevent future prenatal exposure, and implementing specialized programs to reduce the severity of NAS and improve family preservation.

The following includes more details about the projects funded by the NAS EI: 1) Expansion of the PPI program include Targeted Outreach with the goal of engaging high risk women earlier in OB/GYN care, SUD treatment, and increase access to healthcare information such as pregnancy and HIV status in the outreach setting; 2) Opioid Treatment Services to expand opioid treatment slots specifically designated for pregnant and postpartum women throughout the state; 3) Statewide Pregnancy Stabilization Center will allow pregnant women to enter one program that can address all their needs providing a full continuum of care for themselves and their children from clinical services such as OTS to recovery support services such as recovery housing; and 4) The Mommies Curriculum.

Impact: The potential impact could be a reduced number of substance use disorder related miscarriages, fetal deaths, and maternal deaths, improved outcome for mothers and babies, reduced NICU lengths of stay, increased return to biological mother, and a more comprehensive and integrated treatment model in Texas.

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