



CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

Texas CHC Coalition

Meeting Minutes

January 20, 2017

Present:

- Adriana Kohler, Texans Care for Children
- Stephanie Rubin, Texans Care for Children
- Clayton Travis, Texas Pediatric Society
- Kellie Dees, Texas Pediatric Society
- Anne Dunkelberg, Center for Public Policy Priorities
- Leah Gonzales, Healthy Futures of Texas
- Jennifer Banda, Texas Hospital Association
- Paul Townsend, Children's Hospital Association of Texas
- Helen Kent Davis, Texas Medical Association
- Mary Allen, Texas Association of Community Health Centers
- Renee Poisson, Texas Nurse Practitioners
- Evelyn Delgado, DSHS
- Manda Hall, DSHS
- Karen Ruggiero, DSHS
- Kari Brock, HHSC

On the phone:

- Angelica Davila, Community Care
- Monica Montes, Central Health
- Erica Laredo, Texas Children's Health Plan
- Betsy Coates, Maximus
- Sister JT Dwyer, Daughters of Charity
- Marilyn Barrera, Driscoll Health Plans

Chair: Adriana Kohler, Texans Care for Children
Minutes Scribe: Kamia Rathore, Center for Public Policy Priorities
Next meeting: February 17, 2017



I. Maternal Mortality and Morbidity Task Force Report (*Evelyn Delgado – Associate Commissioner of Family and Community Health Services; Manda Hall – Medical Director of Maternal and Child Health; Karen Ruggiero – Director of the Office of Program Decision Support, DSHS*)

- *See slides below*
- **Evelyn:** Our division, Family and Community Health Services, primarily oversees women's and children's health programs under the Title V office. Dr. Hall is the director of Maternal and Child Health and she'll discuss those programs further. Dr. Ruggiero is our epidemiologist and her staff worked on the data that the task force is looking at.
- The task force has been working on maternal health since last session. A recent article published by MacDorman et al indicated a dramatic increase in maternal mortality between 2010 and 2011 and received a lot of attention. DSHS had also identified an increase in the Maternal Mortality Rate (MMR). We are still looking at the data to identify the exact level of increase. A more thorough analysis can be done internally rather than externally, and depending on methodology there could be a 25 to 75% increase in the MMR from 2010 to 2011. 2013 to 2014 data indicated a decrease in the MMR for both the MacDorman and DSHS analysis. The magnitude of the decrease differs depending on the methodology, which Dr. Ruggiero will go into.
- Texas MMR rise is consistent with the national trend of increased maternal mortality. California has a different model of analysis and has a collaborative program, so their results are better. We are looking to learn from what other states are doing.
- In response to the increase in maternal mortality in 2009, the legislature established the Maternal Morbidity and Mortality Task Force in 2013. The task force is charged with examining statewide trends, reviewing individual cases, and making recommendations. The task force is comprised of physicians, medical examiners, OB-GYNS, social workers and psychiatrists. The legislature granted us the authority to reach out to hospitals and anyone who delivered care during birth and up to one year after birth.
- Our staff internally de-identifies records and from there, the task force review the case. Task force subgroups determine if the outcome was preventable and what could have been in place to avoid the death. This is a complex issue—there are a multitude of reasons for maternal death. It may be a community issue, prenatal care, the hospital system, how the patient is discharged, post-natal care, and so on.
- *Refer to slides to see data trends for maternal mortality racial disparities*
- **Evelyn:** We can see a recent downward trend in mortality among black women, but we also see an increase among Hispanic women. We also see a consistent underreporting of smoking during pregnancy, so our analysis might not get full picture of how maternal smoking relates to maternal mortality. The top five causes of maternal death were identified as
 1. Cardiac event
 2. Drug overdose
 3. Hypertension/Eclampsia
 4. Hemorrhage
 5. Sepsis



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- **Karen:** To go back to the maternal mortality rate, Texas shows the sharpest single year increase in 2010-2011. The attached appendix shows four different methods for calculating various magnitudes of the rate, but all indicate an increase.
- The first three methods define maternal deaths as occurring within 42 days after pregnancy, while the fourth defines it as one year. The first method is that used by McDormand and the 2011 MMR is a trend line projection. Method two has a lower rate for 2011, and it is based on available CDC Wonder system data. The CDC receives all of our death certificate data and comes up with an ICD-10 code to indicate an obstetric death. That is used to create a count of obstetric deaths and then a maternal mortality rate.
- Method three uses DSHS data, which may be different from CDC data, as we have different cutoff dates that allow us to investigate some pending causes of deaths. The CDC is also able to include Texas resident maternal deaths, even if they did not occur in Texas. Method four examines maternal deaths within and beyond a year following pregnancy. As such, the MMRs vary for each year, as do the percent changes. This, along with our legislative report, show a need for improvement in death certificate data. We'll talk a bit about what we have planned for this area.
- For the confirmed deaths cohort, we confirmed by linking a death certificate to a birth or death certificate for the child. This is because the death certificate and the ICD code is often not enough. When we expand the cohort to unconfirmed deaths, the top five causes vary by race. The cohort of unconfirmed deaths includes cases where we were able to link a death certificate to a fetal record, in addition to cases where only the ICD code was used. Drug overdose deaths are the second leading cause among white women only, and third overall. For black women, cardiac events and hypertension are the leading causes.
- **Evelyn:** ICD coding improvement is a big initiative. Medical examiners, physicians, and others are involved in identifying and entering the cause of death. Other states like California and Ohio have improvement programs to educate those who enter in the data to improve information accuracy, a we are looking at similar initiatives that Texas can take on.
- **Helen:** Will that be something the legislature is asked to fund?
- **Evelyn:** We haven't estimated the costs of what that might look like. We know some states have modules that data submitters are required to take. There are also changes to IT to capture data more accurately.
- **Karen:** We're also in the process of changing the DSHS electronic system for recording deaths, births, divorces, and marriages. That has already been budgeted and we're identifying areas that can change to improve data entry, such as modifying drop down menus. We'll see if all our recommendations can be made within the budget.
- **Manda:** Title V is a partnership between the federal government and the state to address maternal and child health. It is funded by federal dollars and GR funds, with a five year needs assessment. The most recent assessment occurred in 2015. Around maternal and women's health, our performance measures look at the well women's visit, with a focus on the preconception and inter-conception. One component of the Healthy Texas Babies initiative is the Texas Collaborative for Healthy Mothers and



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Babies. It is a perinatal quality collaborative that work on specific quality improvement projects. We have a neonatal, data, obstetrics, and community subcommittee.

- Another initiative is our Healthy Texas Babies coalitions across the state, and supporting improvement projects in their communities. Someday Starts Now is our awareness initiative about modifiable risk factors impacting maternal health. Our preconception peer education program is a National Office of Minority Health initiative to reduce infant mortality in the black community, working with historically black colleges in Texas.
- The Maternal Morbidity and Mortality Task Force was passed by the legislature, but there wasn't funding attached to it. Title V facilitates support for the task force and we are looking to increase the infrastructure of the group. We want to increase the number of cases reviewed so that more recommendations can be made. We're in the process of contracting with a Texas university to do the redaction and abstraction work necessary to increase the number of cases examined by the task force. The differences between the case reviewing methods of the Maternal Mortality Task Force and others is based heavily in statute – DSHS epidemiologists have to ask for medical records, and so there is a limitation on who can do the work.
- **Helen:** One focus of this report is preconception and inter-conception care. But often an issue is that high risk women can't get the specialty care need due to insurance. We hear from OB/GYNs they can't manage these cases because they need more intensive care. How does the agency approach the issue to make it clear that we have to cover women who have the highest risk? We have built in better preventative care, but some women need specialty care – if you need cardiac services or opioid intervention, that won't be covered with HTW.
- **Evelyn:** Our role is to put information out that makes it clear what time periods where interventions would most impact maternal health. Hopefully that information will educate everyone at the table as to what they can do to improve health, wherever their role may be. We want our report to help all groups improve maternal health.

II. Legislative Briefing Discussion (*Group discussion*)

- Potential improvements:
 - Creating a central communication channel to cross-promote events; could be coordinated through a website or email
 - Targeting promotion of event
- Highlights:
 - Clear but firm tone on funding issues, both with provider rates and at the federal level
 - Medicaid 101 piece could be converted to a handout for offices
 - Block grant introduction combatted a lot of the misinformation currently circulating
 - Emphasize that block grants shift costs to the states and raise the concerns of county governments who may have to take on more costs

III. Update on STAR Kids enrollment and outreach (*Kari Brock, HHSC*)

- *See slides below*



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- **Kari:** STAR Kids was announced two sessions ago as a transition to managed care for health care for children and young adults under the age of 21 with disabilities. It began implementation this November, with a current population enrollment of 163, 000. SSI and MDCP populations receive their waiver services through STAR Kids.
- There are three levels of service coordination, based off member need determined by the STAR Kids Screening and Assessment (SK-SAI)
- Level 1 presents the greatest needs, including the MDCP population. They have a named service coordinator, receive four face-to-face visits with a provider, and monthly phone calls. If a member decides they want less or more, they can always request that.
- Level 2 is for moderate need, which includes a named service coordinator, two face-to-face visits and six calls per year.
- Level 3 is the lowest level of needs, including one face to face contact and three calls per year.
- All levels have access to a service coordinator. Only levels 1 and 2 have named service coordinator, but level 3 members can request a named coordinator
- The SKSAI is a comprehensive needs assessment that is done at least annually. It is a holistic assessment of the member composed of four modules.
 - The Core is required for all members to identify most needs and may trigger other modules.
 - The PCAM is for a member in a waiver other than MDCP
 - NCAM looks at nursing services and determines Medical Necessity level for a member
 - MDCP determines the potential need for members in this waiver program
- The components drive the Individual Service Program (ISP) – the ISP can change as needed and is completed annually or more frequently if requested.
- The first six months of the transition has some provisions in place to protect continuity of care. Any authorizations that ended in October or November of 2016 have been extended for 90 days. Existing prior authorizations were extended for six months for acute and long term services. For six months, members can continue to see their out of network providers and MCOs voluntarily extended that provision to 12 months for physicians and specialists.
- We also have an operational dashboard that collects information to provide to the legislature to track information and see trends. Some indicators are the number of complaints received by the MCOS, in addition to assessments scheduled and calls received.
- We have begun to look at the preliminary results for the ICHP STAR Kids quality survey. This is an external quality review of pre- and post-implementation. We hope to present that information at the March STAR Kids advisory meeting.
- A few questions were sent over, so I'll address those now:

How does STAR Kids plan to address their duplication of coordination of care services for their kids enrolled in ECI?

- **Kari:** There will be two coordinators for individuals in this situation, which should prevent duplicative services. A STAR Kids coordinator reaches out the ECI coordinator and they determine if the child is eligible for ECI services. The idea is that the two coordinators will be able to determine service eligibility, which prevents duplication of services.

Do HHSC-MCO contracts require contracting with a sufficient number of ECI providers?



- **Kari:** Yes – I have provided a document of the contract and the portion that discusses an adequate network of providers.

We have heard from several organizations that children on SSI-based Medicaid who are part of the 'fifth check population' are experiencing disruptions in care. Is there an update on steps being done to address this issue?

- **Kari:** This is an issue that goes beyond STAR Kids. HHSC is working with SSA and there should be a fix or start to a fix in March to address this. SSA has also been working on their side to address the issue, but I don't have an indication of a timeline on their side.
- **Kelly:** Is it still a manual process to reach out to those about to be cut off to get them to reapply?
- **Kari:** Yes, in December we issued some guidance to MCOs to encourage the members to reapply. March is the next fifth check month, and we're already working to get on this.

IV. Discussion on State Legislation, Budget Bills (*Group discussion facilitated by Adriana Kohler, Texans Care*)

Upcoming

- Article II will have invited testimony for the Senate Finance Committee on the 30th and public testimony on the 31st. This is an opportunity to talk about funding for Medicaid and CHIP. Call hosted every Thursday to go through maternal and child health priorities for CHCC agenda.
- **Details:** Thursdays, 12:30 – 1:00 pm
 - Call 866-740-1260; access: 3399042
 - If at Capitol, meet in E2.018

Moving and proactive bills

- Streamlining eligibility
- Access to care
 - Actual bills are related to post-partum depression screening and budget elements to ensure continued funding
- Comprehensive coverage
 - May play out on a larger scale than this coalition has bandwidth for CHCC. This priority may take the backburner compared to the other priorities.
 - Continue to make case that block granting will cut funding

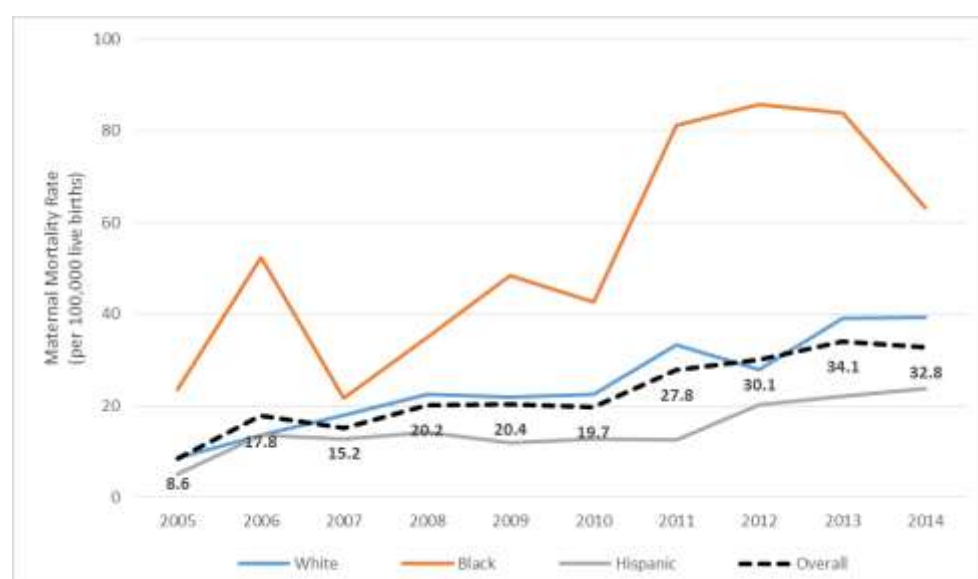
Helen Kent Davis of Texas Medical Association will chair the February 17th meeting, which is an OTA meeting.

MATERNAL MORTALITY IN TEXAS

Using Precision Public Health to Improve Maternal Outcomes

- In an article by MacDorman et al. appearing in the 2016 September issue of *Obstetrics and Gynecology*, MacDorman's data analysis purports to show a dramatic increase in maternal mortality in Texas between 2010 and 2011. (see MacDorman article attached)
- The TDSHS analysis of the Maternal Mortality Rate (MMR) in Texas does document a sharp increase from 2010 to 2011. However, the percent change or the magnitude of the increase in MMR from 2010 to 2011 in Texas differs depending on the statistical methods used to compute and display it, ranging from an increase of 77% to 25% depending on the method. (see Appendix)
- Both MacDorman and TDSHS analysis of MMR in Texas demonstrate a decrease from 2013 to 2014. However, as with the increase, the statistically calculated percent change or the magnitude of the decrease in MMR from 2013 to 2014 in Texas differs depending on the method used to compute it, ranging from a decrease of 1% (MacDorman) to 12% (TDSHS - Method 4 in the Appendix).
- It is important to note that maternal mortality has increased throughout the United States over the past decade. The trends seen in Texas are similar to those national trends. Steady and pervasive increases in chronic diseases are to blame, especially comorbid conditions that complicate pregnancy, such as obesity, Type II diabetes, and hypertension.
- The risk for maternal death in Texas is highest among Black women. (Figure 1)

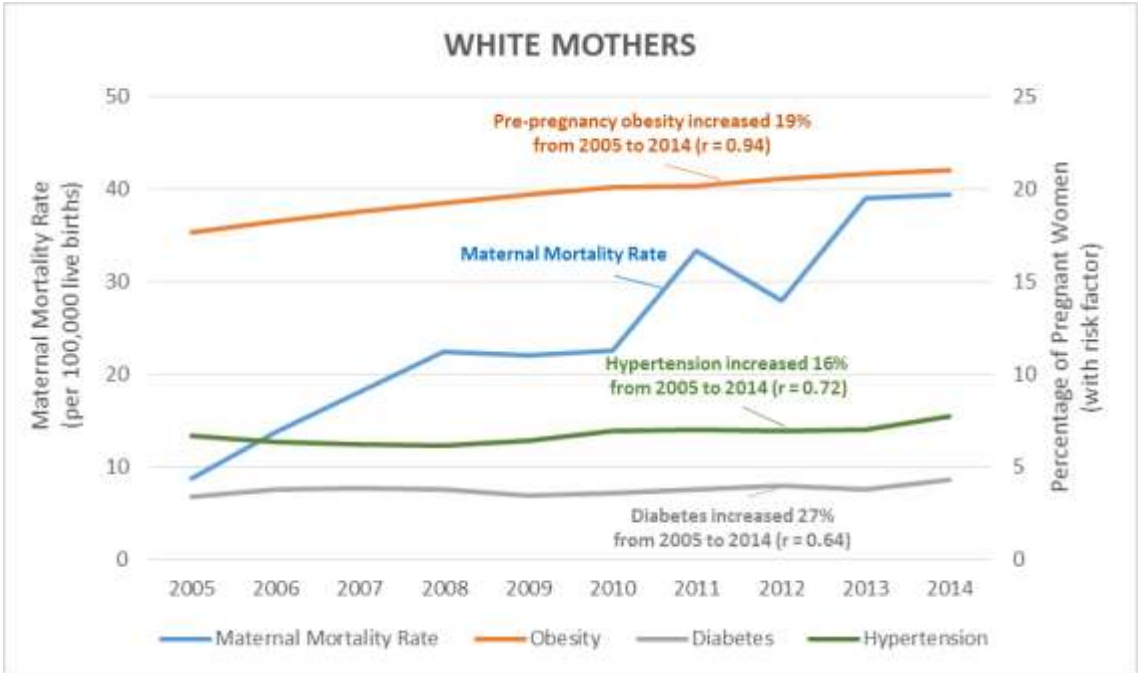
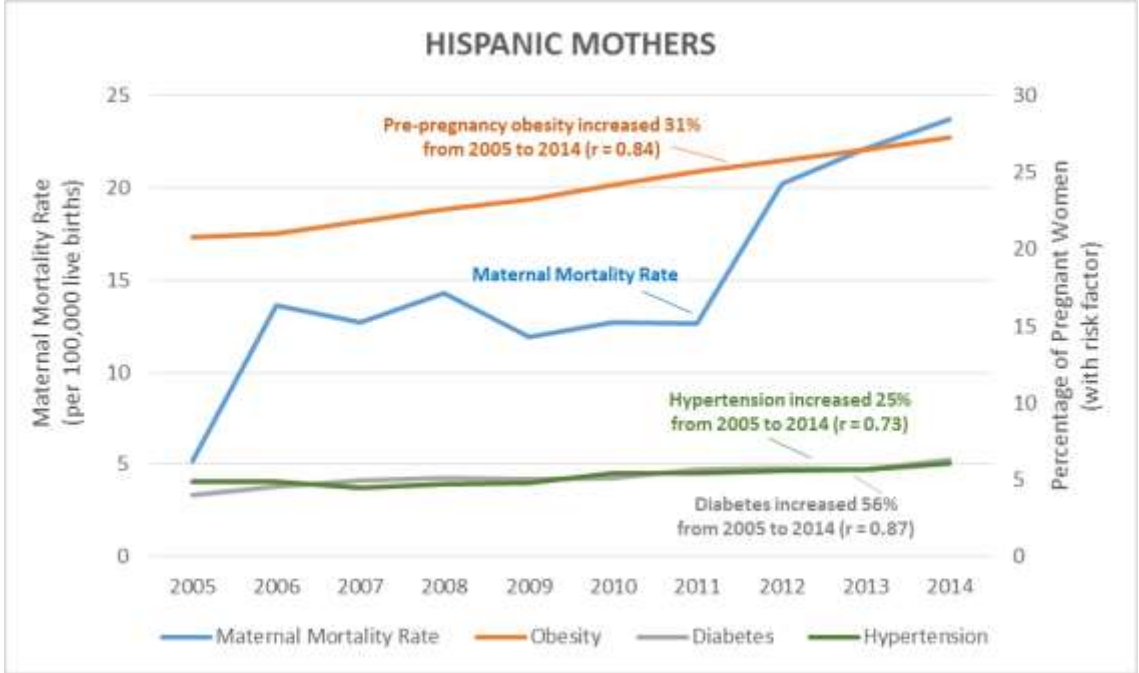
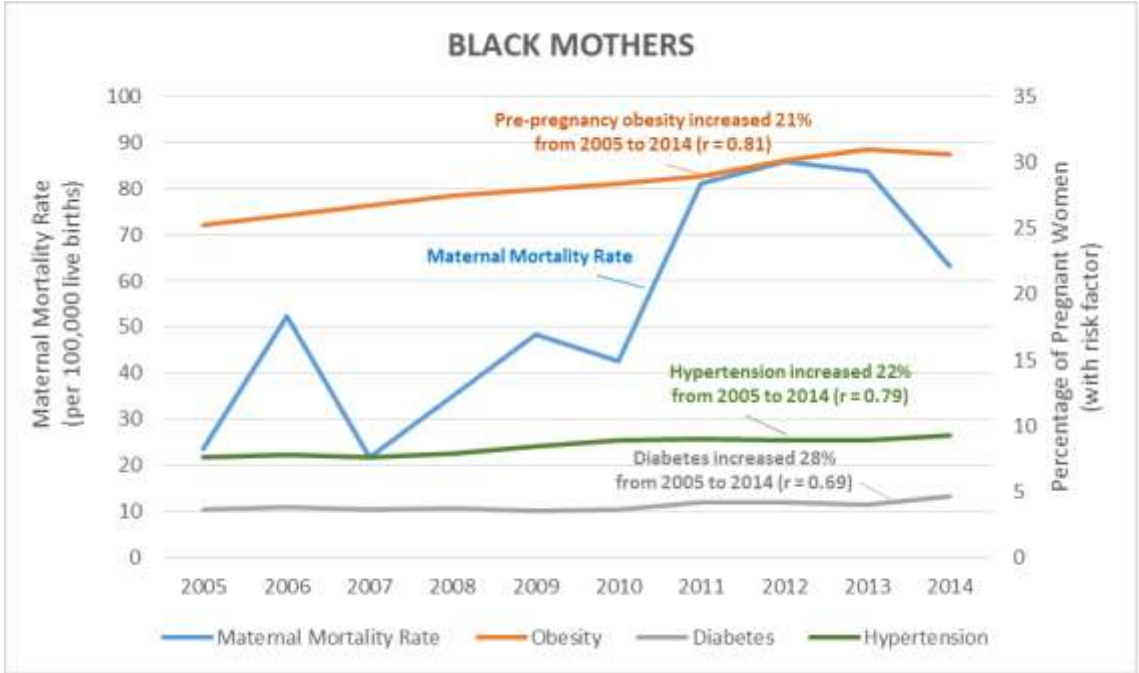
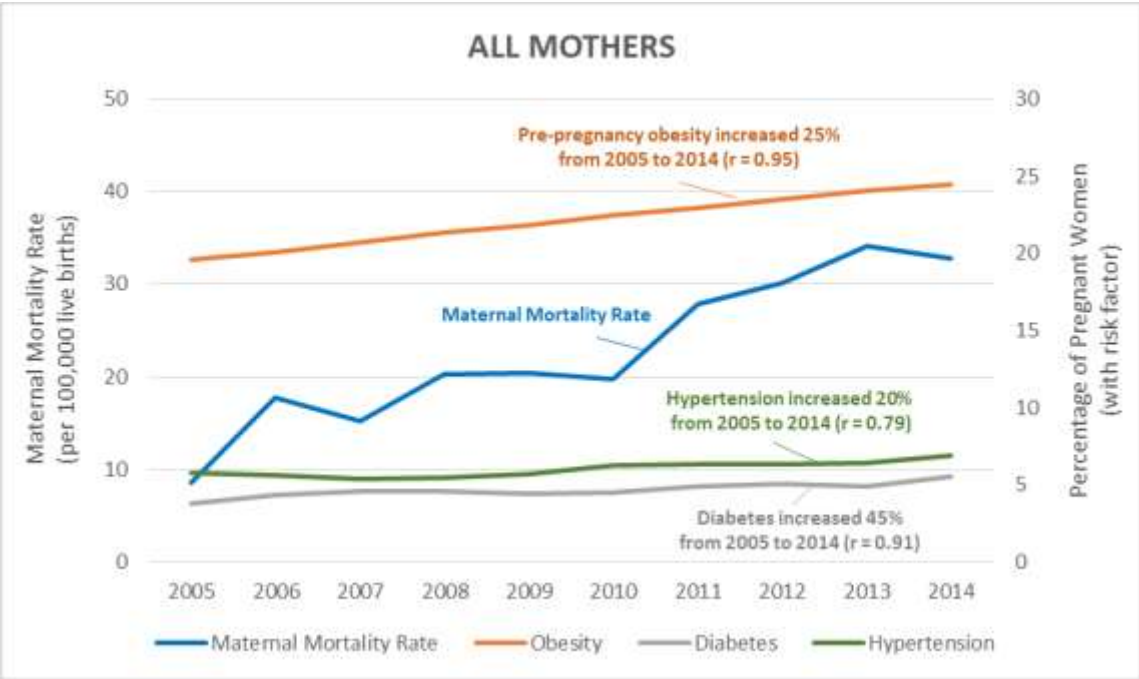
Figure 1. Maternal mortality rate by racial/ethnic group, 2005-2014.



Prepared by: Office of Program Decision Support, Division for Family and Community Health Services, Texas Department of State Health Services, 08/24/2016.
Data Sources: Death and Birth Files, Center for Health Statistics, Texas Department of State Health Services.
MMR — computed within 42 days following the end of pregnancy, using ICD-10 codes A34, O00-095, O98-O99.

- In response to the steadily increasing maternal mortality rate from 2000 to 2009, Texas House Bill 1133, establishing a Maternal Mortality and Morbidity Review Board, failed to pass in 2011.
- In 2013, Senate Bill 495 did pass, and established the multi-disciplinary Maternal Mortality and Morbidity Task Force to:
 1. Study statewide trends in maternal mortality and severe maternal morbidity;
 2. Review individual cases of maternal deaths; and
 3. Make recommendations with the goal of reducing the incidence of maternal mortality and morbidity in the future.
- Maternal mortality is a complex issue and the increase is likely due to a multitude of factors.
- The scientific literature clearly shows that pre-pregnancy obesity, hypertension, and diabetes place women at much greater risk for maternal death.
- Indeed, an analysis of Texas data for all mothers and for each racial/ethnic group shows that these chronic disease risk factors are highly related with maternal mortality, such that increased pre-pregnancy obesity, diabetes, and hypertension are each significantly correlated with an increased maternal mortality rate. (Figures 2-5)

Figures 2-5. Maternal mortality and risk factors, 2005-2014.



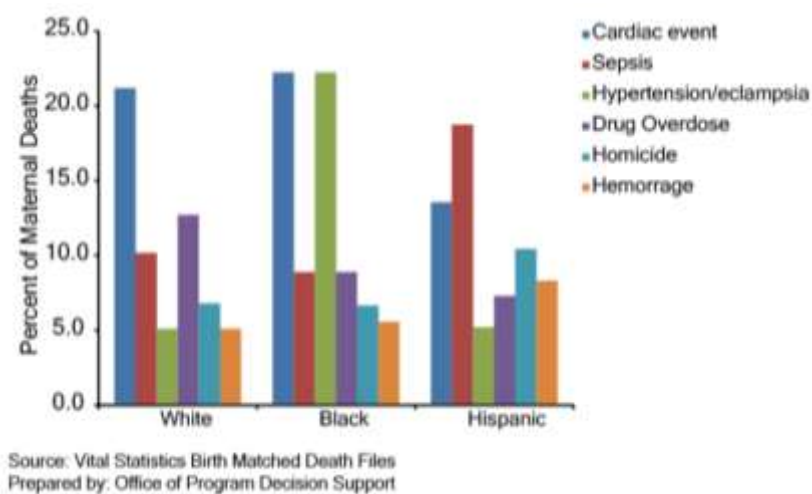
Prepared by: Office of Program Decision Support, Division for Family and Community Health Services, Texas Department of State Health Services, 08/24/2016.
Data Sources: Death and Birth Files, Center for Health Statistics, Texas Department of State Health Services.
MMR — computed within 42 days following the end of pregnancy, using ICD-10 codes A34, O00-095, O98-099.
Pre-pregnancy obesity; diabetes before and/or during pregnancy (including diabetes mellitus and gestational diabetes); and hypertension before and/or during pregnancy (including chronic hypertension, pre-eclampsia, and eclampsia) — Birth file.
Note: r = correlation coefficient between MMR and each risk factor.

- While the recent downward trend in maternal mortality among Black mothers since 2013 is welcome, we are concerned that maternal mortality among Hispanic mothers has increased over the same span of time, in parallel with the increasing prevalence of pre-pregnancy obesity, diabetes, and hypertension among Hispanic mothers.
- Smoking further increases the risk for maternal death, although consistent underreporting of smoking during pregnancy by women limits the ability to examine statewide trends of maternal smoking and their relation to maternal mortality. However, only Hispanic women in Texas meet the Healthy People 2020 target of abstaining from smoking during pregnancy.
- As described in the newly released 2016 Joint Biennial Report for the Legislature by TDSHS and the Task Force, the top five causes of death among a cohort of women (N = 189) confirmed to have experienced a maternal death in 2011 and 2012 (by linking their death record with a live birth or fetal death) are as follows:
 1. Cardiac event
 2. Drug overdose
 3. Hypertension/Eclampsia
 4. Hemorrhage
 5. Sepsis

(see attached Legislative report)

- When the cohort of women is expanded to also include unconfirmed maternal deaths in 2011 and 2012 (per *Scientific Analysis of the Current State and Needs of the Maternal and Child Health Population in Texas*, Office of Program Decision Support, TDSHS, 2015, p. 62), drug overdose remains the second leading cause of death only among White women, and becomes the third leading cause of death overall. Among Black women, cardiac events and hypertension/eclampsia are the leading causes of death. (Figure 6)

Figure 6. Maternal death (confirmed and unconfirmed) cohort, 2011 and 2012, six most prevalent causes of Death



- Per the 2016 Legislative report by TDSHS and the Task Force, a review of individual cases of maternal deaths that occurred in 2012 (including detailed case abstraction of patient records) also uncovered substance use as an explanatory factor for maternal mortality, in addition to prenatal and post-partum depression. Increased screening and treatment are recommended to address each of these risk factors. Regarding substance use, opioids are the most commonly abused substances both in Texas and nationwide. One way to estimate the prevalence of substance use as a contributing factor to poor maternal health outcomes is to examine the rate of Neonatal Abstinence Syndrome in newborns, which is the result of prenatal opioid use. Funding was provided through an exceptional item over the course of the 2016-2017 biennium to fund services to reduce the incidence, severity, and cost associated with NAS. Through this NAS Prevention Pilot, which includes enhanced screening and outreach, increased access to intervention and treatment, and specialized programs to reduce the severity of NAS, improved health outcomes are anticipated. TDSHS will continue working with THHSC regarding mental health and substance abuse services.

- Also, since the majority of the confirmed maternal deaths in 2011 and 2012 occurred more than 42 days after delivery, the Task Force is recommending extending the period in which women can access health services to a full year after delivery, which the new Healthy Texas Women program (launched July 1st, 2016) has since done, via a robust benefit package, streamlined Medicaid enrollment, and extensive outreach. The Healthy Texas Women program, administered by the Texas Health and Human Services Commission (THHSC), provides access to family planning services as well as certain health care services, such as screening for and treatment of hypertension and diabetes. Screening and referral for postpartum depression is also available. Women can access services through www.healthytexaswomen.org. With the funding provided by the Texas Legislature for the inception of this program, improved preconception and interconception outcomes for Texas women are anticipated.
- The Task Force also recommends increased provider and community awareness of health inequities and to implement programs that increase the ability of women to self-advocate. TDSHS will continue to leverage funding (\$2.5 million in FY2017) for the five public health components of the Title V-funded Healthy Texas Babies (HTB) program to increase provider and community awareness related to disparities in maternal and infant mortality:
 - 1) ***The Texas Collaborative for Healthy Mothers and Babies (TCHMB)*** — a multi-disciplinary perinatal quality collaborative whose mission is to advance health care quality and patient safety for all Texas mothers and babies through the collaboration of health and community stakeholders in the development of joint quality improvement initiatives, the advancement of data-driven best practices, and the promotion of education and training.
 - 2) ***Provider Education*** — through TDSHS Grand Rounds, the Preconception and Prenatal Health suite of Texas Health Steps Online Provider Education modules, and the annual HTB conference (November 15-16, 2016, in Austin).
 - 3) ***Someday Starts Now*** — a bilingual public awareness campaign to increase awareness of the modifiable risk factors that impact infant mortality and preterm birth among the general public, with particular attention focused on men and women of childbearing age.
 - 4) ***Preconception Peer Education*** — a national Office of Minority Health initiative to reduce infant mortality in the Black community. Young men and women are trained on a peer-educator model to educate peers and members of their community on the importance of preconception health, seeking regular preventive care, having a reproductive life plan, and the impact of social determinants of health on their wellbeing.
 - 5) ***HTB Community Coalitions*** — supporting the creation and strengthening of 6 local perinatal coalitions in the state through funding and programmatic technical assistance. HTB coalitions are responsible for implementing evidence-based interventions based on Perinatal Periods of Risk analysis conducted by TDSHS. Focusing on Black and Hispanic women of childbearing age, these interventions promote integration of preconception and inter-conception care into routine primary care, using evidence-based tools including the Someday Starts Now Life Planning Tool.
- Furthermore, through the work of Title V (approximately \$1 million in FY2017), TDSHS will build upon prior successes in programming designed to increase initiation and continuation of breastfeeding, a protective factor for maternal mortality. TDSHS implements a multi-component breastfeeding support program to increase breastfeeding initiation, continuation, and exclusivity. Current breastfeeding support initiatives include efforts to:
 - Educate and support families (e.g., Breastmilk: Every Ounce Counts campaign; Statewide Lactation Support Hot Line);
 - Educate health care professionals about breastfeeding management and support (e.g., continuing education trainings; Health Care Provider Guide to Breastfeeding app);
 - Support improvement in maternity care practices for lactating mothers and their babies (e.g., Texas Ten Step Program; Star Achiever Breastfeeding Learning Collaborative);
 - Reduce employment-related barriers to breastfeeding (e.g., the Texas Mother-Friendly Worksite Program; child care provider training); and
 - Improve coordination and planning for breastfeeding support (e.g., the TDSHS Infant Feeding Workgroup, TDSHS/Medicaid Lactation Support Workgroup; Texas WIC Infant Feeding Practices Survey).

- Better quality/more accurate death certificate data and greater staff resources are also needed to assist in requesting patient records, patient record redaction, case abstraction, and case synthesis, as TDSHS and the Task Force continue to examine and strive to reduce maternal mortality and morbidity in Texas. In terms of staff resources, options to increase infrastructure include contracting with a public university and the addition of one Program Specialist to redact and abstract patient records for all cases. Estimated cost is approximately \$902K annually — an amount that may change based on itemized costs detailed in contract proposals during procurement. Another option is to increase staff resources through 8 additional FTEs, including nurses, program specialists, and an epidemiologist, at an estimated cost of \$1.2 million annually.
- In addition, the Vital Statistics Unit (VSU) at TDSHS, together with the Center for Health Statistics (CHS), are in the process of replacing the existing electronic system for registering and collecting birth, death, fetal death, marriage, and divorce records in Texas (i.e., Texas Electronic Registrar or TER) with a new electronic system (i.e., Texas Electronic Vital Events Registrar or TxEVER; \$16.5 million budgeted for this effort). This new electronic vital events registration system (to be launched on January 1, 2018) will allow for additional data quality checks (by VSU, CHS, and a third-party vendor), as well as improved and more efficient receipt and recording of out-of-state deaths of Texas residents.
By ensuring that programming is data driven and utilization of evidence-based/ evidence-informed strategies, Texas has the ability to measure the impact of programming and to demonstrate “moving the needle in Maternal and Child Health (MCH) outcomes” related to the Maternal & Women’s Health and the Perinatal & Infant Health Domains. Within the Maternal & Women’s Health Domain, work focuses on the preventative visit looking at the pre-conception and inter-conception time periods to impact the effects of chronic disease. The programming within the Perinatal & Infant Health Domain supports performance measures related to breastfeeding, safe sleep, and infant mortality disparities. The Title V MCH Section has identified the opportunity to engage key stakeholders to participate in a newly developed Maternal, Women, Perinatal, and Infant Health Strategic Workgroup that will focus in participating in strategic planning process to implement strategies to address maternal morbidity and mortality and other key public health priorities.

Appendix

Maternal Mortality in Texas: A Comparison of Maternal Mortality Rate Change Using Different Methods

Year	MATERNAL DEATHS WITHIN 42 DAYS FOLLOWING END OF PREGNANCY												MATERNAL DEATHS WITHIN AND BEYOND 1 YEAR FOLLOWING END OF PREGNANCY			
	METHOD 1 MacDorman et al. (2016), Fig. 4 Trendline-Estimated Rates for 2011 and 2014				METHOD 2 CDC, National Center for Health Statistics				METHOD 3 Texas Department of State Health Services (TDSHS)				METHOD 4 Texas Department of State Health Services (TDSHS)			
	Deaths (CDC Wonder)	Live births (CDC Wonder)	Maternal Mortality Rate (per 100,000 live births)	Percent Change	Deaths (CDC Wonder)	Live births (CDC Wonder)	Maternal Mortality Rate (per 100,000 live births)	Percent Change	Death File (TDSHS, CHS)	Birth File (TDSHS, CHS)	Maternal Mortality Rate (per 100,000 live births)	Percent Change	Death File (TDSHS, CHS)	Birth File (TDSHS, CHS)	Maternal Mortality Rate (per 100,000 live births)	Percent Change
2010	72	386,118	18.6	+77%	72	386,118	18.6	+62%	76	385,746	19.7	+41%	95	385,746	24.6	+25%
2011	114	377,445	33.0		114	377,445	30.2		105	377,274	27.8		116	377,274	30.7	
2012	148	382,727	38.7	-1%	148	382,727	38.7	-7%	115	382,438	30.1	-4%	121	382,438	31.6	-12%
2013	140	387,340	36.1		140	387,340	36.1		132	387,110	34.1		153	387,110	39.5	
2014	135	399,766	35.8		135	399,766	33.8		131	399,482	32.8		139	399,482	34.8	

Prepared by: Office of Program Decision Support, Division for Family and Community Health Services, Texas Department of State Health Services, sb, na, kr, 08/29/2016.

Percent Change = (Later Rate - Earlier Rate)/Earlier Rate x 100

METHOD 1: Using data from CDC Wonder, compares **estimated MMRs based on a trendline** for a later year to an actual MMR for an earlier year, yielding a percent change in MMR within **42 days** following the end of pregnancy (as determined by ICD-10 codes A34, O00-O95, O98-O99) among Texas residents. The maternal death count in CDC Wonder could include: a) Texas residents whose death did not occur in Texas, which might not have been reported to TDSHS; and/or b) initial cause of death as pregnancy-related but is later updated by TDSHS not to be pregnancy-related or vice versa.

METHOD 2: Using data from CDC Wonder, compares an **actual** MMR for a later year to an actual MMR for an earlier year, yielding a percent change in MMR within **42 days** following the end of pregnancy (as determined by ICD-10 codes A34, O00-O95, O98-O99) among Texas residents. The maternal death count in CDC Wonder could include: a) Texas residents whose death did not occur in Texas, which might not have been reported to TDSHS; and/or b) initial cause of death as pregnancy-related but is later updated by TDSHS not to be pregnancy-related or vice versa.

METHOD 3: Using data from CHS at TDSHS, compares an **actual** MMR for a later year to an actual MMR for an earlier year, yielding a percent change in MMR within **42 days** following the end of pregnancy (as determined by ICD-10 codes A34, O00-O95, O98-O99) among Texas residents.

METHOD 4: Using data from CHS at TDSHS, compares an **actual** MMR for a later year to an actual MMR for an earlier year, yielding a percent change in MMR **within and beyond 1 year** following the end of pregnancy (as determined by ICD-10 codes O00-O95, O98-O99, **and O96 and O97, but excluding A34**) among Texas residents.

- **The Maternal Mortality Rate (MMR) in Texas increased from 2010 to 2011.**
- **However, the percent change or the magnitude of the increase in MMR from 2010 to 2011 in Texas differs depending on the method used to compute it:**
 - **METHOD 1** by MacDorman et al. (2016) uses counts of live births and maternal deaths among Texas residents from the CDC Wonder system, that occur within 42 days following the end of pregnancy, if one or more of these codes from the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) are present on the death certificate: A34, O00-O95, O98-O99. The maternal death count in CDC Wonder could include: a) Texas residents whose death did not occur in Texas, which might not have been reported to TDSHS; and/or b) initial cause of death as pregnancy-related but is later updated by TDSHS not to be pregnancy-related or vice versa. This maternal death count is then used to compute the MMR each year, except for years 2011 and 2014, for which METHOD 1 instead uses trendline-estimated MMRs (these MMRs are based on a linear trendline calculated using actual MMRs from 2011 through 2014, and assumes there is a linear relationship between MMR and calendar year). METHOD 1 then compares the *trendline-estimated* MMR for 2011 (33.0 maternal deaths per 100,000 live births) to an actual MMR for 2010 (18.6 maternal deaths per 100,000 live births), yielding a **77% increase** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 2** by the CDC is identical to METHOD 1, except that METHOD 2 compares an *actual* MMR for 2011 (30.2 maternal deaths per 100,000 live births) to an actual MMR for 2010 (18.6 maternal deaths per 100,000 live births), yielding a **62% increase** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 3** by TDSHS uses counts of live births and maternal deaths among Texas residents from its Center for Health Statistics, that occur within 42 days following the end of pregnancy, if one or more of these codes from ICD-10 are present on the death certificate: A34, O00-O95, O98-O99. METHOD 3 then compares an *actual* MMR for 2011 (27.8 maternal deaths per 100,000 live births) compared to an actual MMR for 2010 (19.7 maternal deaths per 100,000 live births), yielding a **41% increase** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 4**, also by TDSHS, uses counts of live births and maternal deaths among Texas residents from its Center for Health Statistics, that occur within and beyond 1 year following the end of pregnancy if one or more of these (natural death) ICD-10 codes are present on the death certificate: O00-O95, O98-O99, *and O96 (obstetric cause of death occurring more than 42 days but less than one year after delivery) and O97 (death from sequelae of direct/indirect obstetric cause occurring 1 year or more after delivery), but excluding A34 (obstetric tetanus)*. METHOD 4 then compares an *actual* MMR for 2011 (30.7 maternal deaths per 100,000 live births) to an actual MMR for 2010 (24.6 maternal deaths per 100,000 live births), yielding a **25% increase** in MMR *within and beyond 1 year* following the end of pregnancy among Texas residents.
- **The MMR in Texas decreased from 2013 to 2014.**
- **Like the increase, the percent change or the magnitude of the decrease in MMR from 2013 to 2014 in Texas differs depending on the method used to compute it:**
 - **METHOD 1** by MacDorman et al. (2016) compares the *trendline-estimated* MMR for 2014 (35.8 maternal deaths per 100,000 live births) to an actual MMR for 2013 (36.1 maternal deaths per 100,000 live births), yielding a **1% decrease** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 2** by the CDC compares an *actual* MMR for 2014 (33.8 maternal deaths per 100,000 live births) to an actual MMR for 2013 (36.1 maternal deaths per 100,000 live births), yielding a **7% decrease** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 3** by TDSHS compares an *actual* MMR for 2014 (32.8 maternal deaths per 100,000 live births) to an actual MMR for 2013 (34.1 maternal deaths per 100,000 live births), yielding a **4% decrease** in MMR within *42 days* following the end of pregnancy among Texas residents.
 - **METHOD 4**, also by TDSHS, compares an *actual* MMR for 2014 (34.8 maternal deaths per 100,000 live births) to an actual MMR for 2013 (39.5 maternal deaths per 100,000 live births), yielding a **12% decrease** in MMR *within and beyond 1 year* following the end of pregnancy among Texas residents.

STAR Kids

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Medicaid and CHIP Services Department



TEXAS
Health and Human
Services

January 19, 2017

Overview

- ◆ Senate Bill (S.B.) 7, 83rd Legislature, Regular Session, 2013
- ◆ Capitated Medicaid managed care program
 - ◆ Children and young adults (under age 21) with disabilities
- ◆ Implemented November 1, 2016

Population and Enrollment

- ◆ November 2016 member total – **163,662 lives**
 - ◆ Supplemental Security Income (SSI)
 - ◆ Medically Dependent Children Program (MDCP)
 - ◆ Intellectual and Developmental Disability (IDD) waivers
 - ◆ Home and Community-based Services (HCS)
 - ◆ Texas Home Living (TxHmL)
 - ◆ Deaf Blind with Multiple Disabilities (DBMD)
 - ◆ Community Living Assistance and Support Services (CLASS)
 - ◆ Youth Empowerment Services (YES)



Service Coordination

- ◆ Levels 1 to 3 determined by member need
 - ◆ Level 1 – greatest need (includes MDCP)
 - ◆ Level 2 – moderate need (includes personal care, nursing)
 - ◆ Level 3 – lowest need
- ◆ Named service coordinator
- ◆ Face-to-face and telephonic contact frequencies

STAR Kids Screening and Assessment (SK-SAI)

Comprehensive Needs Assessment

- ◆ Goals for care
- ◆ Acute services, including behavioral health
- ◆ Long term services and supports (LTSS)
- ◆ School, work, and caregiver supports
- ◆ Medical Necessity and RUG (replaces MN/LOC assessment)
 - ◆ Approved by Texas Medicaid Health Partnership (TMHP)
- ◆ Completed annually, at minimum



STAR Kids Screening and Assessment (SK-SAI)

A Modular Assessment

- ◆ The Core
 - ◆ Required, identifies most needs, may trigger other modules
- ◆ Personal Care Assessment Module (PCAM)
- ◆ Nursing Care Assessment Module (NCAM)
 - ◆ Also helps determine Medical Necessity (MN) for select programs
- ◆ Medically Dependent Children Program Module (MDCP)
 - ◆ Calculates RUG level only for member's budget



STAR Kids Screening and Assessment (SK-SAI)

The Core Module – Sections

- A. Identification Information
- B. School and Work
- C. Goals for Care
- D. Diagnoses and Health Care Utilization
- E. Caregivers and Social Supports
- F. Strengths and Challenges in Performing Daily Tasks
- G. Nutritional Status/Concerns
- H. Current Treatment and Procedures
- I. Mental Health and Behavioral Health Concerns



STAR Kids Screening and Assessment (SK-SAI)

The PCAM – Sections

- J. Cognition and Executive Functioning
- K. Communication and Vision
- L. Additional Behavioral Considerations
- M. Functional Status
- N. Continence
- O. Sleep
- P. Habilitation Needs

STAR Kids Screening and Assessment (SK-SAI)

The NCAM – Section Q

- ◆ Neurological
- ◆ Airway Management
- ◆ Nutritional
- ◆ Medication
- ◆ Elimination
- ◆ Integumentary
- ◆ Other Nursing Services



STAR Kids Screening and Assessment (SK-SAI)

The MDCP – Section R

- ◆ Cognitive Patterns
- ◆ Mood
- ◆ Behavior
- ◆ Functional Status
- ◆ Bladder and Bowel
- ◆ Diagnoses and Conditions
- ◆ Skin Conditions
- ◆ Nutritional Status
- ◆ Physician Care
- ◆ Special Treatments,
Procedures, and Programs



STAR Kids Individual Service Plan (ISP)

Comprehensive Person-Centered Plan

- ◆ A “living” document that changes as needs change
- ◆ Includes findings from SK-SAI
- ◆ Short and long-term care goals
- ◆ Member and family preferences
- ◆ Uses in MDCP
 - ◆ Replaces previous Individual Plan of Care (IPC)
- ◆ Completed annually, at minimum



Continuity of Care

- ◆ Authorizations ending October and November 2016
- ◆ Existing prior authorizations
- ◆ Out of network providers
- ◆ Young adults turning 21 before January 2017

Operational Dashboard

Key Indicators

- ◆ Number of complaints received by MCO
- ◆ Number of assessments scheduled by MCO
- ◆ Number of calls received at MCO call centers
- ◆ HHSC-tracked member and provider complaints

Successes

- ◆ A Service Coordinator's Perspective
- ◆ SK-SAI

What is next?

- ◆ Completion of SK-SAI for all members
- ◆ MCOs will continue to identify and contract with providers
- ◆ HHSC will continue monitoring the MCOs and assisting providers and families
 - ◆ ICHP STAR Kids Quality Survey
- ◆ STAR Kids Advisory Committee

Resources

- ◆ Medicaid and CHIP Services STAR Kids website
 - ◆ <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>
- ◆ STAR Kids Managed Care Contract
 - ◆ <https://hhs.texas.gov/sites/hhs/files//documents/services/health/medicaid-chip/programs/contracts/star-kids-contract.pdf>
- ◆ STAR Kids Screening and Assessment Instrument PDF
 - ◆ <https://hhs.texas.gov/sites/hhs/files//documents/services/health/medicaid-chip/programs/star-kids/sai.pdf>
- ◆ SK-SAI Training Webinar by Texas A&M University
 - ◆ <https://sph.tamhsc.edu/pdrcc/training/index.html>



Questions

- ◆ Please submit any questions or comments related to the managed care regulations to:
managed_care_initiatives@hhsc.state.tx.us



Open Discussion & Questions

8.1.10 Early Childhood Intervention (ECI)

8.1.10.1 Referrals

The MCO must ensure Network Providers are educated regarding the federal laws on child find and referral procedures (e.g., 20 U.S.C. § 1435(a)(5); 34 C.F.R. § 303.303). The MCO must require Network Providers to identify and provide ECI referral information to the LAR of any Member under the age of three suspected of having a developmental delay or otherwise meeting eligibility criteria for ECI services in accordance with 40 Tex. Admin. Code Chapter 108 within seven calendar days from the day the Provider identifies the Member. The MCO must permit Members to self-refer to local ECI Providers without requiring a referral from the Member's PCP. The MCO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing a self-referral to ECI providers. The MCO must use written educational materials developed or approved by the Department of Assistive and Rehabilitative Services—Division for Early Childhood Intervention Services for these child find activities.

The MCO must inform the Member's LAR that ECI participation is voluntary. The MCOs is required to provide medically necessary services to a Member if the Member's LAR chooses not to participate in ECI.

8.1.10.2 Eligibility

The local ECI program will determine eligibility for ECI services using the criteria contained in 40 Tex. Admin. Code Chapter 108.

The MCO must cover medical diagnostic procedures required by ECI, including discipline specific evaluations, so that ECI can meet the 45-day timeline established in 34 C.F.R. § 303.342(a). The MCO must require compliance with these requirements through Provider contract provisions. The MCO must not withhold authorization for the provision of such medical diagnostic procedures. Further, the MCO must promptly provide relevant medical records available as needed.

8.1.10.3 Providers

The MCO must contract with an adequate number of qualified ECI Providers to provide ECI Covered Services to Members under the age of three who are eligible for ECI services. The MCO must allow an Out-of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the Individual Family Service Plan (IFSP).

8.1.10.4 Individual Family Service Plan (IFSP)

The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is developed by an interdisciplinary team that includes the Member's LAR; the ECI service coordinator; ECI professionals directly involved in the eligibility determination and Member assessment; ECI professionals who will be providing direct services to the child; other family members, advocates, or other persons as requested by the authorized representative. If the Member's LAR provides written consent, the Member's PCP or MCO staff may be included in IFSP meetings. The IFSP is a contract between the ECI contractor and Member's LAR. The Member's LAR signs the IFSP to consent to receive the services in amount, duration, scope, and service setting established by the IFSP. The IFSP contains information specific to the Member, as well as information related to family needs and concerns. If the Member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the Member with the MCO and PCP to enhance coordination of the plan of care. These sections may be included in the Member's medical record or service plan.

8.1.10.5 Covered Services and Reimbursement

The interdisciplinary team, including a licensed professional of the healing arts (as defined in 40 Tex. Admin. Code § 108.103) practicing within the scope of their license, determines Medical Necessity for ECI Covered Services established by the IFSP. The IFSP will serve as authorization for program-provided services, and the MCO must require, through contract provisions with the Provider, that all Medically Necessary health and Behavioral Health program-provided Services contained in the Member's IFSP are provided to the Member in the amount, duration, scope and service setting established by the IFSP. "Program-provided" services refers to services that are provided by the ECI contractor.

The MCO cannot create unnecessary barriers for the Member to obtain IFSP program-provided services, including requiring prior authorization for the ECI assessment or additional authorization for services, or establishing insufficient authorization periods for prior authorized services.

ECI Providers must submit claims for all covered services that are program-provided included in the IFSP to the MCO. The MCO must pay for claims for ECI covered services in the amount, duration, and scope and service setting established by the Individual Family Service Plan (IFSP).

ECI Targeted Case Management services and Early Childhood Intervention Specialized Skills Training are Non-capitated Services, as described in Section **8.1.24.8**.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in 8.1.13. MCOs must offer Service Management and develop a Service Plan as appropriate for these Members. With the consent of the Member's authorized representative, the MCO must include key information from the IFSP in the development of the Member's Service Plan.