TACHC

The Heartbeat of Texas Community Health Centers | **Weekly Wrap-up - June 14, 2013**

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Mobile Medical Unit
Harris County Hospital District,

Upcoming Events

TACHC June CPI Webcast: Cancer Screening-Highlighting Improvement (Part 2)

June 21, 2013, 9am to 11am

We will review the homework assignment from Part 1 and discuss how centers can leverage this data for improvement. We will also highlight the screening work from other community health centers. To register for this event, click **HERE**. If you

Healthcare for the Homeless *Houston, TX*	have any questions, please contact Verne LaGrega, Clinical Coordinator at TACHC. **NOTE: Registration for all CPI Webcast Trainings is for two webcasts, Parts 1 and 2, at once. If you missed part 1 of the training, you will be able to access a recording of it via the TACHC Community Health Learning Network (CHLN) website.** NACHC-sponsored Training for **New** Medical Directors Hosted by TACHC *June 26-27, 2013; Sheraton Arlington Hotel, 1500 Convention Center Drive, Arlington, Texas 76011* Are you new to your role as Medical Director of your health center? This training will be a foundational and essential building block in your career development, providing core knowledge and competencies that all health center Medical Directors need to function as effective managers, leaders, and advocates for their centers and communities. In addition to providing contextual knowledge regarding the history, political evolution, regulatory expectations, and terminology of the health center movement, course content focuses on developing competency in evolving health care issues such as the patient centered medical home, electronic health records, and meaningful use. For registration and hotel information, click **HERE**. For additional information about the training, contact Dr. Davelyn Eaves Hood, Director of Clinical Affairs at TACHC. TACHC Clinical Director Institute *June 28-29, 2013; Sheraton Arlington Hotel, 1500 Convention Center Drive, Arlington, Texas 76011* Attention all Chief Medical Officers, Chief Dental Directors, and Behavioral Health Directors, please join your colleagues this year for an interactive network and learning event. Sessions include an update on TACHC Clinical Initiatives, FQHC Billing for Clinical Directors, Better Documentation and Coding, Patient Termination in the Safety Net Setting and UDS from Audit to Submission to Improvement, What Does it Mean for Your Center and Health Home, How Well Do you know your Health Care Community. There will be specialized breakout sessions for the Medical, Behavioral and Dental providers on topics such as: Moving HIV Care into the Primary Care Setting, Quality Metrics in the Dental Setting, Models of Integration that Work, How Do Medical and Dental Providers Complement Each Other and Teaching the Care Team about Screening and

	Brief Behavioral Health Interventions. For hotel information and to register for the conference, click **HERE**. For additional information, contact Dr. Davelyn Eaves Hood, Director of Clinical Affairs at TACHC. Information regarding all upcoming events hosted by TACHC can be found **HERE**.

Governance and Finance

1. Medical Care Advisory Committee Proposed Rules: Please click **HERE** to see the proposed rules and see the attached document for our suggested amendments for publication.

2. Primary Care Emergency Rules for Publication: See the attached rules and our testimony.

3. HHSC Community Partner Program Enrollment: Due to HRSA's recent announcement about the availability of Outreach & Enrollment funds for health centers to increase in-reach, as well as outreach activities, it is even more critical that your health center sign up for the Community Partner Program. Both CMS and HHSC are advocating for online systems to facilitate enrollment in affordable insurance coverage either through the Marketplace and/or CHIP and Medicaid. This is also a prerequisite if you are a participating health center in TACHC's proposal for the CMS Federal Navigator grant. Open enrollment for the federal health exchanges begins October 1st; therefore, it is important to get your health center signed up for the Community Partner Program *now* to be onboard and ready to utilize both systems. To submit your request, simply fill out an online interest form. If you have more than one site that you would like to sign up, please be aware that **a separate interest form will be needed for each site**. For more information about the Community Partner Program, contact RexAnn Shotwell, Community Partner Program Project Manager at TACHC.

4. TACHC Executive Leadership Initiative: TACHC has been funded by the Bureau of Primary Health Care (BPHC) to conduct another round of the TACHC Executive Leadership Initiative. This will be the 13th year of this very successful program. We are in the process of recruiting up to seven new teams from community health centers for this year's program (July 2013 through March 2014). The program has been completely restructured to be more focused on specific leadership challenges including employee engagement and change management, provide on-site health center consulting services to support and address individual health center challenges and to support your center's efforts to prepare for and/or maintain PCMH accreditation. This year, we will also be incorporating mid-level management training to support your Executive team's efforts to "push down" effective management and employee engagement strategies throughout your organization. The program has been designed to minimize time away from your center and is heavily subsidized by grant funds to support training costs, on-site leadership consulting, and will cover the majority of team travel costs associated with the three face-to-face learning sessions. Specific information on project design, time commitment, and program costs are attached. If your center is interested in participating in the program, please email or call Jana Blasi, Deputy Director at TACHC.

1. NASHP/HRSA Webinar "Improving Cervical Cancer Screening: What You Can Do Today (and Tomorrow!) to Improve Cervical Cancer Screening—A Medical Home Framework for Increasing Cervical Cancer Screening Rates—Best Practices for FQHC's" Improving outcomes related to cervical cancer screening for health center patients is a high priority for HRSA's Bureau of Primary Health Care and the Office of Women's Health. The webinar, to be conducted **Thursday, June 20, 2013, from 2:00-3:00 pm (CT)**, is intended for FQHCs, other practices that provide women's health care services, and state PCAs, will provide useful short-, medium-, and long-range strategies for practices to improve cervical cancer screening rates. Learn from rural and urban FQHC leaders about steps taken to promote the early detection of cervical cancer. With funding from HRSA, the National Academy for State Health Policy will moderate this webinar and present findings from research they conducted on the attributes and functions of high performing health centers. Join Seiji Hayashi, BPHC Chief Medical Officer and representatives from three health centers (including Charles B Wang (New York) and El Centro de Corazon (Texas)) to learn about useful strategies to addressing this preventable and curable form of cancer. If you have questions regarding this webinar, please contact Christina Miller. To register for this event, click **HERE**.

2. New AHRQ Treatment Options Initiative Web Conference "Treatment Options: Explore. Compare. Prepare." If you have not participated on an earlier Web conference, you may still attend the final Web conference to be held on **Tuesday, June 18 at 1:30-2:30 p.m. (CT)**. The initiative promotes reliable resources that help patients talk with their health care providers about the benefits and risks of treatment options for a variety of health conditions, and also features companion health care professional outreach efforts. The speaker, Kathryn Friedman of Ogilvy Washington will provide an overview of the consumer initiative and components of the health care professional outreach efforts. She will explain the audience research that informed its development, unveil new materials, and explain how they are being shared with consumer and health professional audiences nationwide. Friedman will also lead a discussion about how your organization can join us in connecting patients and caregivers to information they can use to improve their health and health care experiences. For more information contact Karen Costa. To register for this event, click **HERE**.

TACHC Recruitment & Retention Mid-year Update: With great enthusiasm, TACHC continues to support member organizations in fulfilling their clinical and administrative staff workforce needs. **This year, the department has already assisted with nineteen (19) candidate placements at member centers.** In addition to our online job board, opportunities are advertised by TACHC on Practice Link, 3RNet and several other online marketing venues in order to reach as many qualified candidates as possible, nationwide, and attract them to your opportunity. **So far during this quarter, 40 member organizations have posted job opportunities with TACHC, offering prospective candidates an average of over 100 opportunities in various specialties at any given time.** Does your center have openings for clinical providers or executive management that you would like us to help you recruit for? Click **HERE** and complete the quick and easy online position profile. Contact April Sartor, Recruitment Dept. Program Assistant at TACHC if you have questions or need assistance.

Other News

1. New TACHC Staff: Please join us in welcoming Andrea Abel, TACHC's new Director of Communications!

2. Gulf Coast Health Center Expanding Medical Services in Port Arthur: On Thursday, June 13th, GCHC held a ribbon cutting ceremony for its new satellite location on the West-Side of Port Arthur. GCHC will begin operating the newly built health center at 601B W. Rev. Dr. Ransom Howard in Port Arthur, TX beginning Monday, July 1, 2013. The 5028 square foot facility, constructed with the assistance of Valero Refinery and the City of Port Arthur, will be staffed Monday – Friday 8am-5pm. The facility will offer family, pediatric, and women's health services in addition to Lab and Pharmacy. GCHC is honored to begin serving West-Side, El Vista, Port Acres, Lakeside, and Sabine Pass residents at the new facility.

3. TACHC Member News: To learn what your fellow health centers are involved in or read news that may affect your health center, click **HERE** for news coverage. We also encourage you to post your news, questions and comments to each other on the TACHC members listserv (members@tachc.org), where only TACHC executives or their designees are recipients.

http://www.hhsc.state.tx.us/hhsc_projects/Innovation/faqs/index.shtml

Frequently Asked Questions: Texas State Innovation Models Initiative

What is the State Innovation Models initiative?

The State Innovation Models initiative is an initiative created by the federal Centers for Medicare & Medicaid Services (CMS) to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

What will the Texas initiative include?

Under this project, Texas will design innovative multi-payer delivery and payment models that move away from a traditional fee-for-service payment system to base payment on quality outcomes. Potential models include:

- Accountable care organizations (ACOs)
- Shared savings arrangements
- Bundled or episodic payments
- Medical or health homes

To design innovative models, HHSC will:

- Convene public and private payers, providers and other stakeholders through webinars and meetings to develop a common understanding and consensus around the design of innovative models and determine the elements needed to successfully implement that model.
- Research actuarial and financial models and determine policy options.
- Design innovative and meaningful payment and delivery models specific to the needs of Texans.

What are the differences between the models under consideration?

Accountable or Integrated Care Models

- Bring together groups providers and at times, other community entities that accept clinical and financial responsibility for a defined population.
- Can be structured as virtual integrated delivery systems— incentivize providers outside a capitated risk contract or salaried practice to provide high quality care without focusing on generating billable transactions.
- Generally involve both down-side and up-side risk.
- Often build off of existing medical/health home.

Shared Savings Arrangements

- Payers and providers share savings in health care costs that accrue as a result of reforms in health care delivery.
- Can vary depending on contracts between payers and providers.
- May stand-alone or be in conjunction with other quality improvement initiatives.
- Commonly included in accountable care organizations.

Medical or Health Homes

- Offer processes and services not ordinarily provided by primary care practices and often not reimbursed under fee for service payment systems.
- Examples include:
  - Expanded access through extended office hours, open scheduling, telephone or e-mail communications.
  - A strong primary care foundation coordinating care across the entire health care system.
  - Use of health information technology, evidence-based medicine and clinical decision-support tools.
  - A multi-disciplinary team-based approach.

Bundled or Episodic Payments

- Reimburse providers based on performance and ability to achieve satisfactory outcomes in the most efficient manner.
- Generally accompanied by other efforts to improve quality and coordination of care.
- Establish aligned payments for most services, using value-based purchasing approaches to reward high-quality, efficient care.

Is this initiative statewide or limited to certain regions?

Because Texas is large and diverse, HHSC is seeking flexibility from CMS to design models specific to a region's needs rather than implementing any one model statewide.

What payers will be involved in the initiative?

CMS requires that models be multi-payer and involve Medicaid or CHIP. CMS expects commercial payer participation and encourages Medicare involvement. CMS also encourages including state employee benefit programs and state insurance exchanges.

Who should become involved in the Texas initiative?

A major goal of the Texas initiative is to convene stakeholders to reach consensus on the gaps in technical knowledge and resources needed to determine how to pay for health care services based on quality rather than quantity. HHSC invites a diverse group of stakeholders—representing payers, providers, consumers, and other health care interests—to participate, including those who:

- Already have fully implemented innovative models (such as large system accountable care organizations, medical/health homes, bundled payment arrangements).

- Started implementing components of an innovative model (such as health technology utilization, strong care coordination, expanding access).
- Are interested in moving toward a quality-based model but are not yet ready.
- May not desire or be ready to implement such a model but want to work towards improving quality of care and containing costs.

What is the timeline for the Texas initiative?

April 1, 2013: Initiative officially began.
May – June 2013: Stakeholder meetings throughout the state to identify and develop design concepts.
June 2013: A statewide survey developed to get information to be used to design innovative models.
August 2013: A conference in Austin; commends accepted on draft model design.
September 2013: Model design will be finalized for submission to CMS.

Does the initiative end in September?

The CMS model design process officially ends September 30, 2013. However, HHSC plans to continue working with stakeholders on innovative models. CMS has indicated that following the model design stage, another opportunity to apply for model testing will become available. No details concerning timing or requirements have yet been released.

How will this initiative address health information technology?

Health information technology is a critical component of this project. HHSC will solicit feedback at the stakeholder meetings and through the online survey to gauge existing infrastructure, evaluate existing needs, and determine what gaps currently exist. This project cannot duplicate funding or resources available through existing initiatives as a variety of electronic health record and health information exchange grants and other opportunities currently are available to providers from the state and federal governments. HHSC plans to work with stakeholders to ensure they are aware of existing opportunities and may be able to assist in determining how to best use technology in designing and implementing an innovative model.

How does this initiative address behavioral health, long-term services and supports, and pharmacy services?

A quality-improvement component focusing on behavioral health, long-term services and supports, or pharmacy could be included in any of the potential innovation models. CMS has not stated that any particular service or provider could not be included in an innovation model. HHSC encourages stakeholders to submit proposals or suggestions, including what aspects would be most beneficial to communities and how payment systems may be structured to improve health outcomes at stakeholder meetings, through the online survey later this year or via email at any time.

Legend:
Single underline = Proposed new language
[~~Strikethrough and Brackets~~] = Current language proposed for deletion
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TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 354 MEDICAID HEALTH SERVICES
SUBCHAPTER A PURCHASED HEALTH SERVICES
DIVISION 23 FEDERALLY QUALIFIED HEALTH CENTER SERVICES
RULE §354.1322 Provider Participation Requirements

(a) Participation requirements. To participate in the Texas Medicaid [~~Medical Assistance~~] Program, a federally qualified health center (FQHC) must:

(1) be receiving a grant under the Public Health Service Act §§329, 330, or 340, or be designated by the secretary of the Department of Health and Human Services as meeting the requirements to be receiving such a grant;

(2) comply with all federal, state, and local laws and regulations applicable to the services provided;

(3) be enrolled and approved for participation in the Texas Medicaid [~~Medical Assistance~~] Program;

(4) sign a written provider agreement with the Health and Human Services Commission (HHSC) [~~Texas Department of Health (department~~)] or its designee;

(5) comply with the terms of the provider agreement and all requirements of the Texas Medicaid [~~Medical Assistance~~] Program, including regulations, rules, handbooks, standards, and guidelines published by HHSC [~~the department or its designee~~]; and

(6) bill for covered services in the manner and format prescribed by HHSC [~~the department or its designee~~].

(b) Affiliation agreements. Notwithstanding any other provision, HHSC will not reimburse an FQHC for services performed on behalf of the FQHC by ~~another~~ a health-care provider, listed in TAC 355.8261 (b)(12), under an affiliation agreement with the FQHC unless the FQHC has submitted to HHSC an attestation justifying the affiliation as required by paragraphs (2) and (3) of this subsection and HHSC has deemed the affiliation justified.

(1) For purposes of this subsection, the term "affiliation agreement" means an agreement that establishes a relationship between an FQHC and a health-care provider ("affiliate"), listed in TAC 355.8261 (b)(12), under which the affiliate agrees to provide health-care services within the FQHC's scope of services on behalf of the FQHC and to be reimbursed by the FQHC for such services. The term does not include an employment agreement or an agreement formalizing an arrangement in which an individual physician either temporarily substitutes for a member of the FQHC's staff of physicians or temporarily fills a vacancy in the FQHC's staff of physicians.

(2) The FQHC must justify the need for the affiliate to perform services on the FQHC's

behalf because the affiliation increases access to care, expands the types of services offered by the FQHC, or costs less than the employment of a physician.

(3) The FQHC must submit to HHSC an attestation, signed by an individual with authority to sign documents on the FQHC's behalf, explaining the need for the affiliation. The attestation must answer and must explain the answers to the following questions:

(A) Does the affiliation governed by the agreement increase access to care?

(B) Does the affiliation governed by the agreement add services to the FQHC's scope of services~~?~~ or

~~(C) Does the affiliation governed by the agreement~~ enable the FQHC to maintain access to care or the services currently within the FQHC's scope of services?

(~~D~~C) Would a provider employed by the FQHC be ~~more~~ less expensive than the affiliation governed by the agreement?

(4) Once HHSC receives an attestation, it has 30 days to review the attestation and determine that the affiliation is justified. If the FQHC does not receive information to the contrary from HHSC within 30 days, the affiliation is deemed justified.

(5) The FQHC may submit claims to HHSC for services provided by the affiliate whose attestation is under review, but HHSC will not pay the claims until HHSC deems the affiliation to be justified.

Department of State Health Services
Council Agenda Memo for State Health Services Council
June 12 - 13, 2013

Agenda Item Title: Amendments to rules concerning the provision of primary health care services in Texas

Agenda Number: 4.a

Recommended Council Action:

____ For Discussion Only

__X__ For Discussion and Action by the Council

Background:

Primary Health Care (PHC) Services is located in the Preventive and Primary Care Unit in the Community Health Services Section, Division for Family and Community Health Services. The current program provides access to primary health care services for individuals with incomes at or below 150 percent of the Federal Poverty Level (FPL), who reside in Texas, and are unable to access the same care through other funding sources or programs. DSHS helps fund 57 PHC contractors who serve women, children, and men at 145 clinic sites across the state.

The current PHC program is funded at approximately $12 million annually.

Summary:

The purpose of the amendments is to reflect the new appropriation and the programmatic changes necessary to expend the new funding, as well as to implement legislative guidance regarding the appropriation. The amendments will implement the requirements of the 2014-2015 General Appropriations Act, 83rd Legislature, Regular Session, 2013.

The rule changes raise the income eligibility requirement from 150 percent of the FPL to 200 percent and emphasize primary and preventive services for women age 18 and above. Clarification of policies, procedures, and the definition of primary health care are also included in the rule changes.

Key Health Measures:

Key outcomes of the new appropriation and rules changes include an increase in clients served, cost savings, and the number of contractors. The exact amount of the increase will be determined by the total appropriated by the 83rd Legislature. DSHS anticipates a significant increase in the number of clients served and significant cost savings, although the exact numbers will be contingent upon the total appropriation. The current PHC program statistics are listed in the chart:

Clients served	64,338
Number of contractors	57
Cost per client	$164

DSHS will require providers to report the following:

- Demographic information on eligible individuals;
- The number of unduplicated clients receiving services, types of services, and the cost of services per individual recipient;
- Fiscal and financial management reports of expenditures; and
- Networking and coordination of services with other providers.

DSHS will routinely review this information to evaluate program effectiveness and efficiency and to ensure that the rule changes do not have unintended consequences on service delivery. Feedback on the effectiveness of services is also expected by daily communication with clients, stakeholders, and local primary health care program staff.

Summary of Input from Stakeholder Groups:

A series of regional stakeholder meetings were held April 30 – May 16. The Division worked with DSHS Regional Medical Directors on outreach to relevant clinics and other health care providers in preparation for the meetings. Locations of the meetings were in El Paso, San Angelo, Dallas, Houston, Lubbock, McAllen, Austin, and San Antonio.

Overall, the stakeholder feedback on the rule changes has been positive. While DSHS has received some comments on the overall administration of the PHC program, there have been no issues or concerns with the proposed rule changes. Stakeholders understood that some of the language was intended for DSHS to maintain compliance with the statute if proposed legislation related to PHC passed.

Proposed Motion:

Motion to recommend that HHSC proceed with the rulemaking process for rules contained in agenda item #**4.a.**

Approved by Assistant Commissioner/Director:			Evelyn Delgado	**Date:**	5/21/2013
Presenter:	Imelda M. Garcia, Director	**Program:**	Community Health Services Section	**Phone No.:**	(512) 776-2009
Approved by CCEA:		Carolyn Bivens		**Date:**	5/21/2013

Title 25. Health Services
Part 1. Department of State Health Services
Chapter 39. Primary Health Care Services Program
Subchapter A. Primary Health Care Services Program
Amendments §§39.1 - 39.4, 39.6 - 39.9, 39.11

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§39.1 - 39.4, 39.6 - 39.9, and 39.11, concerning the provision of primary health care services in Texas.

BACKGROUND AND PURPOSE

Health and Safety Code, Chapter 31, authorizes the department to establish a program to provide primary health care services in Texas. The current Primary Health Care Services Program provides access to primary health care services for individuals with incomes at or below 150% of the Federal Poverty Level residing in Texas who are unable to access the same care through other funding sources or programs. The expanded Primary Health Care Services Program will emphasize primary and preventive care to women age 18 and above and will expand access to services by increasing the income eligibility to 200% of the Federal Poverty Level.

The amendments are necessary to implement an anticipated increased legislative appropriation in the 2014 - 2015 General Appropriations Bill, Senate Bill 1, 83rd Legislature, Regular Session, 2013.

SECTION-BY-SECTION SUMMARY

An amendment to §39.1(b) includes an emphasis on women's primary and preventive care services.

Section 39.2 is amended for consistency by removing the examples of services provided in the definitions of "other benefit" and "Primary Health Care Services."

Changes are made to §39.3 to remove redundancies in the criteria for determining unmet needs; this rule is also updated for consistency with §39.2.

An amendment to §39.4(a) removes language regarding the provision of services by the department to clarify that the department does not provide direct services. Language regarding eligible individuals receiving services close to their home is also removed, as ensuring geographic coverage is included in §39.3.

Section 39.6 is amended to reflect the income eligibility increase from individuals at or below 150% of the Federal Poverty Level to those at or below 200% Federal Poverty Level.

An amendment to §39.7 allows program recipients 30 days instead of 14 days to notify providers of changes in eligibility.

An amendment to §39.8 replaces the word "Act" with the name "Primary Health Care Services Program."

Amendments to §39.9 clarify that the department does not provide direct services and therefore contractors, not the department, may deny, modify, suspend, or terminate services if the recipient/applicant is no longer eligible or provided false or incomplete information.

An amendment to §39.11(c) references Health and Safety Code, Chapter 31, and the Primary Health Care Services Policy Manual regarding providers' reporting requirements for the purpose of consistency.

FISCAL NOTE

Jan Maberry, Program Manager, Primary Health Care Services Program, has determined that each year of the first five years that the sections are in effect, there will be no new fiscal implications to state or local governments as a result of administering the amendments as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Maberry has also determined that there will be no effect on small businesses or micro-businesses required to comply with the sections as proposed, because neither small businesses nor micro-businesses participate in the Primary Health Care Services Program. Small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated impact on local employment.

PUBLIC BENEFIT

In addition, Ms. Maberry has also determined that for each year of the first five years that the sections are in effect, the public benefit anticipated as a result of the proposed amendments will be an increase in primary and preventive health care services to women age 18 and above. Also, contractors will have more clarity on program requirements.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from

environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed sections do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Imelda M. Garcia, Community Health Services Section, Mail Code 1923, Department of State Health Services, P. O. Box 149347, Austin, Texas 78714-9347 or by email to chss@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §31.004, which requires the department to adopt rules necessary to administer the Primary Health Care Services Program; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The amendments affect Health and Safety Code, Chapter 31.

Legend: (Proposed Amendments)
Single Underline = Proposed new language
[Bold, Print, and Brackets] = Current language proposed for deletion
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§39.1. Introduction.

(a) (No change.)

(b) The Department of State Health Services seeks to fund local projects that emphasize primary and preventive services to women. **[utilize early intervention and prevention of health problems.]** Access to appropriate levels of health care can reduce health expenditures, mortality, morbidity, and improve individual productivity, health status, and economic growth.

§39.2. Definitions.

The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (6) (No change.)

(7) Other benefit--A benefit, other than a benefit provided under the Act, to which an individual is entitled for payment of the costs of primary health care services, including:

(A) benefits available from:

(i) (No change.)

(ii) Title XVIII or Title XIX of the Social Security Act; and

(iii) any other compulsory insurance program;

[(iii) the Veterans Administration;]

[(iv) the Civilian Health and Medical Program of the Uniformed Services; and]

[(v) workers compensation or any other compulsory employer's insurance program;]

(B) - (C) (No change.)

(8) Primary Health Care Services **[health care services]**--may **[which]** include the following:

(A) (No change.)

(B) emergency medical services;

(C) (No change.)

(D) preventive health services**[, including immunizations]**;

(E) (No change.)

(F) laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services; and

(G) other services provided in Health and Safety Code, Chapter 31. **[nutrition services;]**

[(H)] [health screening;]

[(I)] [home health care;]

[(J)] [dental care;]

[(K)] [transportation;]

[(L)] [prescription drugs and devices and durable supplies;]

[(M)] [environmental health services;]

[(N)] [podiatry services; and]

[(O)] [social services.]

(9) - (14) (No change.)

§39.3. General Program Requirements.

(a) Because budgetary limitations exist, all program providers shall offer at least the following priority services:

(1) (No change.)

(2) emergency medical services;

(3) (No change.)

(4) preventive health services**[, including immunizations]**;

(5) - (6) (No change.)

(b) The department, through approved providers, shall provide for the delivery of primary health care services to those populations that demonstrate unmet needs due to the inaccessibility and/or unavailability of primary health care services. Unmet needs may be determined by, but are not limited to, the following criteria:

(1) - (3) (No change.)

(4) key health indicators; and **[cultural factors affecting the health status;]**

[(5) health problems; and]

(5) **[(6)]** health resources available in the community.

(c) - (d) (No change.)

§39.4. Provision of Contracts for Primary Health Care Services.

(a) Primary health care services will be delivered through a network of contractors. **[providers, directly by the department, or by the department and providers in combination. Unless otherwise necessary, eligible individuals should receive services close to their home.]**

(b) - (f) (No change.)

§39.6. Eligibility Requirements and Provision of Services to Recipients.

(a) Individuals covered under the Primary Health Care Services Program **[Act]** are those who are not eligible for other benefits. Individuals eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service may be eligible for other program services, and for prescription drugs not covered by Medicare, Part D.

(b) (No change.)

(c) In accordance with program policy, providers: **[In order for an individual to be eligible for primary health care services, the individual must:]**

(1) be in financial need based on a family income that does not exceed 200% **[150%]** of the current Federal Poverty Level guidelines; and

(2) (No change.)

(d) - (h) (No change.)

§39.7. Maintaining Eligibility.

To maintain eligibility for program benefits, the recipient must continue to reside in Texas, be in financial need as defined by these sections, and inform the provider in writing or by telephone within 30 **[14]** days of changes in the following:

(1) - (5) (No change.)

§39.8. Coordination of Benefits.

(a) An individual is not eligible to receive services delivered under the Primary Health Care Services Program **[Act]** when the individual, or a person with a legal obligation to support the individual, is eligible for some other benefit that would pay for all or part of the services, unless coverage for those services has been denied.

(b) - (c) (No change.)

§39.9. Denial/Modification/Suspension/Termination of Services.

The contractor **[department]** may deny, modify, suspend, or terminate services to an applicant or recipient after written notice **[and an opportunity for a fair hearing]** if:

(1) - (2) (No change.)

§39.11. Program Review.

(a) - (b) (No change.)

(c) The department will require providers to report information on service delivery as required by Health and Safety Code, Chapter 31, and the Primary Health Care Services Policy Manual. **[to the department the following:]**

[(1) demographic information on eligible individuals;]

[(2) the number of eligible individuals receiving services and the average cost per recipient;]

[(3) fiscal and financial management reports of expenditures;]

[(4) program accomplishments; and]

[(5) networking and coordination of services with other providers.]

[(d) The department may request other data and/or reports upon prior notification.]

Testimony Given by

José E. Camacho

before

State Health Services Council Work Session
Department of State Health Services (DSHS)
909 West 45th Street, Austin, Texas
Building 2, Public Hearing Room 164
June 12, 2013
1:00 p.m.

My name is José E Camacho; I am the Executive Director and General Counsel of the Texas Association of Community Health Centers, Inc. (TACHC). The association represents 71 Federally Qualified Health Centers (FQHCs). In 2012, health centers served 1,078,325 Texans, 94% of whom were under 200% of poverty. 51% of our patients are uninsured.

The FQHCs have historically served as contractors for the Primary Health Care Services Program.

We would suggest several changes and clarifications to the proposed rules.

1. §39.1 (b) - we would suggest that the section be changed to read as follows:

   The Department of State Health Services seeks to fund local projects that emphasize primary and preventative services to women and **utilize early intervention and prevention of health problems**. Access to appropriate levels of health care can reduce health expenditures, mortality, morbidity, and improve individual productivity, health status, and economic growth.

This change would recognize that the current program will continue with an added focus on primary and preventative women health services.

2. §39.2 (7)(A)(iii) –be changed by adding the underlined as follows:

   (iii) any other compulsory insurance program unless the service, co-pay or deductible is not covered by the program.

As currently written, the Section would exclude coverage of services provided by the Primary Health Care Services (PHC) Program based on the premise that those services would be covered if the person is insured. Additionally, the change would allow for coverage of the deductible and co-pay in those situations where the services are covered but the deductibles and co-pays are so high that they become a barrier to the patient obtaining care.

3. §39.2 (7) (C) this section provides:

   "Benefits resulting from a cause of action for medical, facility, or medical transportation expenses, or a settlement or judgment based on the cause of action, if the expenses are related to the need for services provided by the Act."

This provision should be deleted or at least more specifically limited to those situations where services under the program could be the subject of a cause of action. In its current form the provision is a barrier to qualifying for the Program. For example, if a person has a pending lawsuit and it somehow relates to the services provided under the PHC program that person would not qualify for services. If the provision is to be retained, the provision should be further limited to emergency medical services or services resulting from an accident. To retain it in its present form could have the impact of terminating services under the Act.

Additionally, Pursuant to Texas Administrative Code, Title 1, part 25, Chapter 371, Subchapter G, Division 3, Rule §371.1711, the OIG has broad power to recoup overpayments to providers. As opposed to Section 39.2 (7)(C), Rule 371.1711 addresses overpayment to any person and does not act to disqualify a patient from services.

4. §39.3 (b) (4) should be amended to add the underlined to read:

   "Key health indicators <u>identified by the community</u>."

   Currently the statute does not identify key health indicators; this will add needed focus to the regulations.

5. §39.6 (c) should be changed in order to incorporate the change into the structure of the current regulation. Subsection (c) to read as follows:

   "In accordance with the program policy, providers shall assure that each individual is: ".

   In addition the "be" at the start of each sentence should be deleted.

6. §39.9 If the proposed change is made to 39.9 a conforming change must be made to Sec 39.10 (b) to delete "by the department" and replace it with "to the department".

TACHC Leadership Initiative

Team Composition

For the purposes of the project, TACHC defines the leadership "team" as the Chief Executive Officer or Executive Director, Chief Financial Officer, Clinic Manager (or similar position), and Chief Medical Officer. It is mandatory that at least these four individuals from your center participate in the program. However, many of the centers that have participated in the past have also included, at their discretion, their Human Resource Director, Nursing Director, Dental Director and/or other leaders in their center as part of their team. Unlike many other leadership programs that are available, the emphasis of the TACHC Executive Leadership Initiative is on developing the health center leadership "team" rather than solely focusing on individual leadership development for the Executive Director or CFO, for example. As a result, we hope to provide opportunities for participating centers to improve communication, cohesion and effectiveness of the individual participants as well as the core group that is responsible for leading their health center.

Project Design

The project design has evolved over the last 12 years based on feedback from past health center participants and strategies that have been particularly effective. The leadership program objectives are achieved through three face-to-face learning sessions, on-site leadership consulting, 2 webinars, supplemental reading materials, 360 Degree assessments of individual and team leadership skills, and the provision of leadership tools that that can be utilized in the day-to-day work at your community health center. Additionally, individual leadership plans and goals are developed for each of the participants.

Time Commitment

The time commitment and resources required of participating centers is minimal but it is critical that each of the participating team members actively participate and be committed to attend the learning sessions and coaching calls. There are three face-to-face meetings and six coaching calls. **The first face-to-face learning sessions will be held in Austin on July 19-20, 2013.** The other two face-to-face learning sessions will be held in November 2013 and February 2014. Locations for these two sessions will be determined by the location of the participating health centers. Typically, face-to-face sessions are held on Fridays and Saturdays to minimize time away from your health center. There will also be a follow up webinar in March 2014 and will require two hours with your center's team members.

Project Costs

TACHC receives funding from BPHC that subsidizes a majority of the costs associated with this program and will cover all consulting costs, speaker fees and material costs. TACHC will also pay $150 for four hotel rooms at the conference hotel for the participating teams for each of the three face-to-face learning sessions and up to $150 for four team members for reasonable travel costs associated with attending the three learning sessions. Thus, participating centers are only

required to pay a registration fee of $250 to cover the costs of food at the three, two day learning sessions and the second night of hotel expenses at the conference hotel. If a participating team has more than four leadership team members, the center will also be responsible for covering any hotel rooms and travel costs beyond the four rooms and travel costs paid for by TACHC.