An Update from the Capitol Domes

Texas Medicaid and Legislative Updates

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September 2011

Your Texas Legislature

- 82nd legislative session
- 140 days, plus specials
- Two-year terms & four-year terms
- Must pass: state budget
  - Biennial budget
  - Balanced budget required
- "Hot button" issues set tone
  - Redistricting, social issues

2

2012-2013 State Budget

- **Shortfall approximately $27B**
- Projected $72B in available revenue to fund an estimated $99B in current services
  - Current services impacted by Medicaid caseload growth, public school enrollment, etc.
  - Loss of federal stimulus funding
- Historically dire budget situation – 2003 shortfall was "only" $10B resulting in significant cuts
- House and Senate both filed initial versions of budget that assumed no new revenue

3

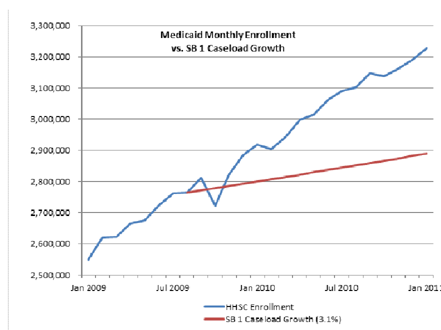
Factors Driving the Shortfall

- Structural deficit – business margins tax
- Sales tax projections down over biennium
  - Sales taxes are 56% of state revenue
- Teacher and state employee retirement and health care costs have skyrocketed
- Increased demand for services as state population grows, ages
- Loss of enhanced FMAP under federal stimulus act

4

Factors Driving the Medicaid Shortfall

- Missed projections for Medicaid caseload, service utilization in 2010-2011



5

No Political Will to Address Revenue

- Nov. 4, 2010 elections
  - 101/150 Republicans in House
- Tea Party effect: "No new revenue," no Rainy Day Fund was the mantra
- RDF only used for 2010-11 biennial shortfall
- Focus on temporary "non-tax revenue"
- Payment deferrals
- Unwillingness to modify margins tax
- Focus on "administrative efficiency":
  - Higher and public education
  - Medicaid

6

Medicaid Overview in Texas

Medicaid expenditures comprise about 15% of all personal health care spending in Texas, and certain essential health care services are particularly reliant on Medicaid funds:

- *Medicaid assists two-thirds of Texans in nursing homes.*
- *Medicaid pays for more than half of all births in the state.*
- *Medicaid provides billions of dollars to hospitals to help cover the cost of care to indigent, uninsured Texans and unauthorized immigrants.*
- *Medicaid and its companion Children's Health Insurance Program (CHIP) provide insurance to 3.8 million low income Texans each month.*

With a 9% annual rate of growth in Texas, the Medicaid program, according to the Congressional Budget Office, is unsustainable at the state and federal level:

- *In SFY 2011, Texas Medicaid expenditures (state and federal) will exceed $30 billion, up from $11 billion in SFY 2000. This 170% increase in just 11 years far exceeds growth in state tax revenue.*
- *The program now consumes more than 25% of the state budget and increasingly strains funding available for other budget priorities.*
- *New Medicaid spending mandated by the ACA will exacerbate the program's financial imbalances, especially beyond 2019, when the federal government transfers more of the cost of complying with the ACA to the states.*
- *Texas has implemented initiatives to contain costs but has been limited by federal Medicaid policies that overly restrict the application of client cost sharing and do not reinforce individual responsibility in the health care decision making process.*

7

Telling the Hospital Story

- "Some Cuts Don't Heal" campaign

STATE CUTS TO HOSPITALS =
Cost Shift to Local Taxpayers + Lost Federal Funds
= WRONG POLICY!

Some Cuts Don't Heal
Protect State Funding for Our Local Hospitals, Doctors and Nurses
Legislative advertising paid for by Texas Hospital Association.

- Capitol press conferences

Some Cuts Don't Heal
Protect State Funding for Our Local Hospitals, Doctors and Nurses

www.SomeCutsDontHeal.org

8

Fighting the Budget Cuts

- Collaboration on mainstream media
- Editorial board visits, extensive local hospital involvement
- Capitol blogs
- Twitter
- YouTube
- Postcards at Capitol
- Chambers, counties

Spreading the Pain?

- $4 billion cut from public schools
- $4.8 billion unfunded in Medicaid
- $1 billion cut to higher education, including financial aid and institutional funding
- $2.2 billion "smoke and mirrors" deferred payments to the Foundation School Program
- $0 appropriated from $6.6 billion Rainy Day Fund for the current biennium

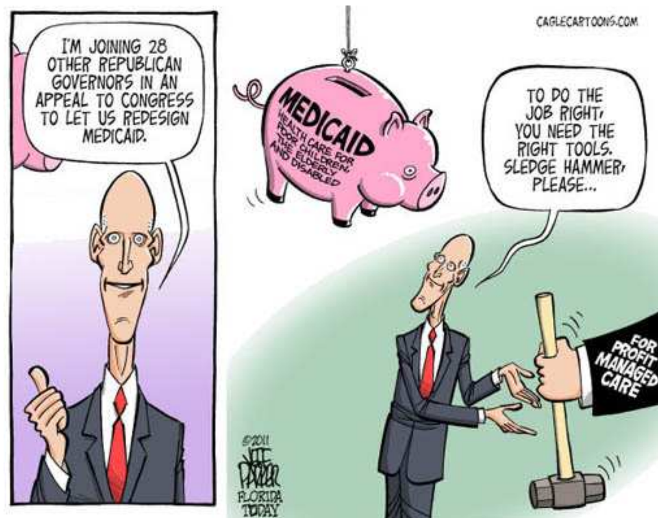
6

How Did They “Balance” Art. II?

- Substantial $4.8B under-funding of Medicaid
  - Expected to be made up through supplemental appropriation in 2013 (Rainy Day Fund)
- Spending reductions
  - Cost-containment initiatives
  - Medicaid managed care expansion statewide
- Gray area
  - Cost-containment for federal “flexibility”

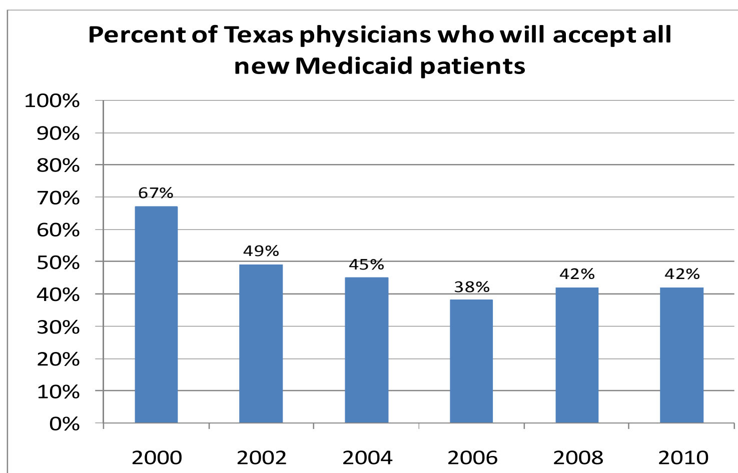
11

Balancing the HHS Budget



12

Budget – Physician Impact



13

Budget – Physician Impact

- Physician rates cut cumulative 2%
  – No rate cut in 2012-2013 but 2011 2% cut retained
- Coinsurance for dual Medicaid and Medicare eligibles eliminated if payment exceeds Medicaid levels
- Loan repayment and workforce funds slashed
  – Shortage area loan program cut 78% ($25M to $5M)
  – Children's Medicaid loan repayment eliminated
  – GME and medical student formula funds slashed
  – Family medicine residency program funds slashed

14

Hospital Payment System Concerns

- "Inability" of state to adequately fund program
  - Hospitals paid 61% of costs in Medicaid today
- Unequal ways to access supplemental payments (UPL through local IGTs)
- "Transparency" of local UPL programs questioned
- Need to protect UPL under Medicaid managed care expansion
- Impact of system that pays similar hospitals differently led to SDA discussion
- Provider tax had limited interest

15

Budget – Hospital Impact

- 8% rate cut for hospitals (added to 2% cut in 2010-11)
  - Rurals and children's paid at cost
- Statewide hospital SDA implementation for 9/1 ($30M savings - $20M mitigation)
- Expansion of Medicaid managed care ($272M in savings)
- Medicaid cost savings implemented (non-emergent care, OB, NICU)

16

Statewide SDA

- THHSC directed in H.B. 1 Rider 67 to implement a statewide SDA by 9/1/11.
- Incorporates 8% cut in hospital rates
- Adjustments for trauma, teaching and reclassified wage index
- Trauma federal match to fund trauma add-on:
  - $63M all funds into SDA;
  - $31M in trauma fund at TDSHS remaining
- Establishes a ceiling of $4,684
- Funds a “hold harmless” at 87% of 9/1/11 rate

17

Overview of Transforming Former UPL Funding Streams

- Expansion of managed care statewide threatened supplemental Upper Payment Limit (UPL) payments
- THHSC is pursuing an 1115 Medicaid waiver to continue UPL-type funding
- Expands managed care, protects current level of funding while providing for a transition to a hospital performance and quality-based payment system
- THHSC will continue to manage the state matching share (IGTs), secure federal match and distribute funds to hospitals

18

THHSC Proposed Managed Care Initiatives

- Expand existing service delivery areas to contiguous counties (9/11)
- Expand STAR+PLUS to Lubbock and El Paso (3/12)
- Expand STAR and STAR+PLUS to South Texas (3/12)
- Convert PCCM areas to the STAR program model (3/12)
- Include in-patient hospital services in STAR+PLUS (no carve-out) (3/12)

19

MCO Players (as of 3/1/12)

- **Bexar Service Area:** STAR- Aetna, Community First , Superior Healthplan Network; STAR+PLUS- Amerigroup, Molina Healthcare of Texas, Superior Healthplan Network; CHIP- Aetna, Superior Healthplan Network, Community First
- **Dallas Service Area:** STAR- Parkland Community Health Plans, Amerigroup, Molina Healthcare of Texas; STAR+PLUS- not part of the RFP; CHIP- Amerigroup, Parkland Community Health Plans, Molina Healthcare of Texas
- **Harris Service Area:** STAR- Amerigroup, Texas Children's, Community Health, Molina Healthcare of Texas, United Healthcare Community Plan; STAR+PLUS- Molina Healthcare of Texas, Amerigroup, United Healthcare Community Plan; CHIP- Amerigroup, Community Health, Molina Healthcare of Texas, Texas Children's, United Healthcare Community Plan
- **Tarrant Service Area:** STAR- Amerigroup, Aetna, Cook Children's; STAR+PLUS- not part of the RFP; CHIP- Aetna, Amerigroup, Cook Children's
- **Travis Service Area:** STAR- Amerigroup, Superior Healthplan Network, Seton; STAR+PLUS- Amerigroup, United Healthcare Community Plan; CHIP- Seton, Superior Healthplan Network, Amerigroup

20

MCO Players (as of 3/1/12) cont'd

- **El Paso Service Area:** STAR- El Paso First, Superior Healthplan Network, Molina Healthcare of Texas; STAR+PLUS- Molina Healthcare of Texas, Amerigroup, CHIP- El Paso First , Superior Healthplan Network
- **Lubbock Service Area:** STAR- Superior Healthplan Network, FirstCare, Amerigroup; STAR+PLUS, Amerigroup, Superior Healthplan Network; CHIP- FirstCare, Superior Healthplan Network
- ***Hidalgo Service Area:*** *STAR- United Healthcare Community Plan, Superior Healthplan Network, Molina Healthcare of Texas, Driscoll Children's; STAR+PLUS- Molina Healthcare of Texas, Superior Healthplan Network, Health Spring; CHIP- not part of the RFP*
- ***Jefferson Service Area:*** *STAR- Amerigroup, Texas Children's, Community Health, Molina Healthcare of Texas, United Healthcare Community Plan; STAR+PLUS- Amerigroup, Molina Healthcare of Texas, United Healthcare Community Plan; CHIP- Amerigroup, Community Health, Molina Healthcare of Texas, Texas Children's, United Healthcare Community Plan*

21

MCO Players (as of 3/1/12) cont'd

- ***Medicaid Rural Service Areas (MRSA): MRSA West Texas:*** *STAR- Amerigroup, Superior Healthplan Network, First Care; STAR+PLUS- not part of the RFP; CHIP- not part of the RFP*
- ***MRSA Central Texas:*** *STAR- Amerigroup, Superior Healthplan Network, Scott & White; STAR+PLUS- not part of the RFP; CHIP- not part of the RFP*
- ***MRSA Northeast Texas:*** *STAR- Amerigroup, Superior Healthplan Network; STAR+PLUS- not part of the RFP; CHIP- not part of the RFP*
- **Nueces Service Area:** STAR- Superior Healthplan Network, Driscoll Children's, Christus; STAR+PLUS- Superior Healthplan Network, United Healthcare Community Plan; CHIP- Driscoll Children's, Superior Healthplan Network, CHRISTUS

22

Overview of Medicaid1115 Waiver

- The 1115 waiver will protect UPL funding as the state expands managed care to more than 3 million Texans statewide
- The waiver will increase federal supplemental Medicaid funds to Texas providers
- The waiver also will promote critical systemic design
- Continued IGT for state match

23

1115 Waiver Funding – Sources

- **Funds in the pools**
  - –Current trended UPL based on aggregate limit
  - –New funds associated with UPL from current STAR managed care areas
  - –New funds associated with managed care savings

24

1115 Waiver Funding – Overview

Two sub-parts to the funding pool:

- **Uncompensated Care (UC)** – more payments from this pool in first years of five year waiver
- **Delivery System Reform Incentive Payments (DSRIP)** – shifting to more payments from this pool in later waiver years

25

Uncompensated Care (UC) Pool

UC will include:

- –Medicaid shortfall not covered by DSH;
- –Medicaid hospital UC costs and costs of services to uninsured patients not covered by DSH; and Medicaid non-hospital UC costs including physician, clinic and pharmacy

26

Access to UC Funds

- Completion of waiver application including:
  - Certification of data as basis for potential UC pool funding; application is being developed by THHSC
- State would make UC payments based on IGT provided and UC reported in waiver application
- THHSC is requesting a transition period

27

Waiver Pool and Access to Funds

- With the waiver, Texas can offer increased revenues for non-hospital unreimbursed costs from the UC pool (e.g. professional, clinic, pharmacy). Through the incentive payment, hospitals will have the chance to access additional federal funds related to managed care savings.
- THHSC will work with hospitals to create pool distribution criteria and methodologies acceptable to the Centers for Medicare & Medicaid Services (CMS).

28

Delivery System Reform Incentive Pool

- DSRIP pool is based on the principles of CMS' overarching triple aim:
  - Improving the experience of care, improving the health of populations and containing costs.
- Central structure for DSRIP:
  - Regional Health Partnerships led by the public hospitals and local governments providing IGT

29

DSRIP Categories

- Initiative categories are modeled after the California DSRIP program, but there will be additional projects, interventions and clinical improvements that are unique to Texas.
  - Category 1 - Infrastructure development (Lays the foundation for delivery system transformation through investments in people, places, processes and technology.)
  - Category 2 - Program innovation and redesign (Includes the piloting, testing and replicating of innovative care models.)
  - Category 3 - Population-focused improvement (Hospitals report on measures across four domains: 1. the patient's experience; 2. the effectiveness of care coordination; 3. prevention; and 4. health outcomes of an at-risk populations.)
  - Category 4 - Urgent clinical improvements
- Hospitals achieve improvement in targeted quality and patient safety measures.

30

Regional Health Partnerships (RHP)

- THHSC proposed to CMS the creation of Regional Health Partnerships that:
  - Are organized through public/transferring hospitals;
  - Create regional assessment, planning and redesign infrastructure; and
  - Include private hospitals and health stakeholders in regional health assessments, system redesign, system investments and reporting on outcomes.

31

RHP 5 year plan

- The Regional Health Partnership would be responsible for developing a five-year coordinated regional health plan that:
  - Includes regional health assessments of needs, resources and potential improvements to serve as the basis for planning;
  - Outlines projects and interventions that support delivery system reforms tailored to the needs of the communities and populations served by the hospitals, aligned with Categories 1-4, adopted from California;
  - Identifies the goals, rationale for projects, annual milestones, associated metrics and expected results from the interventions;
  - Incorporates private hospitals via RHP agreements that identify their roles, contributions and associated outcome metrics.
- During the first year, regional entities develop and submit five-year plans. THHSC proposed to CMS that initial incentive payments will be made for FY1 planning.

32

Defining Regional Healthcare Partnership Areas

THA
TEXAS HOSPITAL ASSOCIATION

- Principles: Anchor RHP with IGT-providing entities
  - 16 large IGT providers – mostly in urban areas
  - Most are the sole IGT provider in an MCO service area
  - Some areas are exceptions and THHSC will follow up individually -
    - Lubbock/Amarillo
    - Midland/Odessa
    - Electra
    - Houston
  - THHSC will survey these 16 on what RHP area each would propose as a starting point:
    - Included: counties; affiliate hospitals; other key partners and stakeholders

33

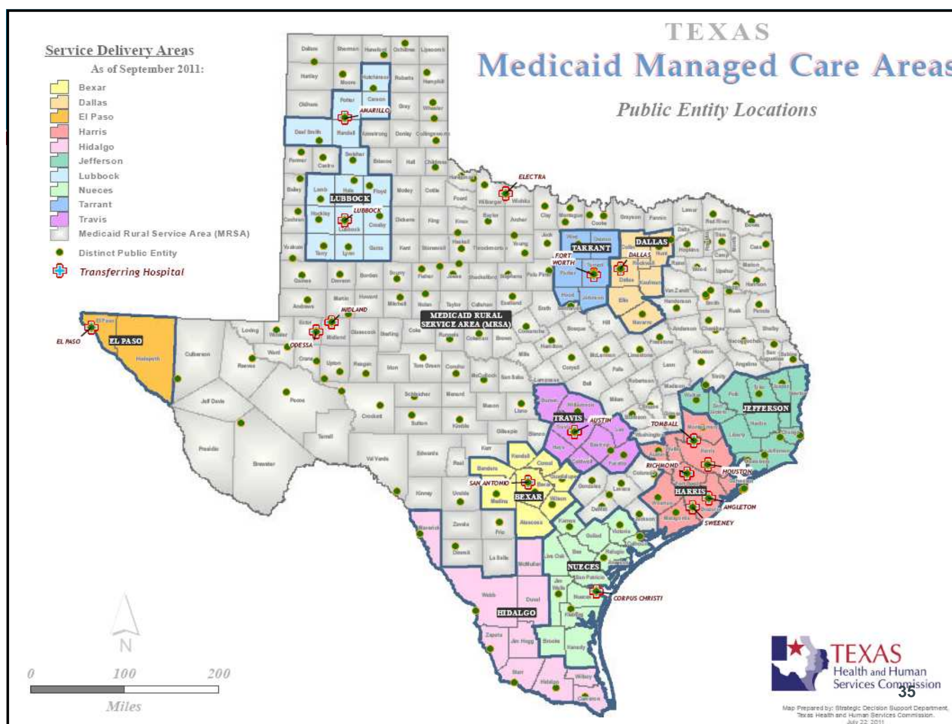
Medicaid Transferring Hospitals and Affiliated Private Hospitals

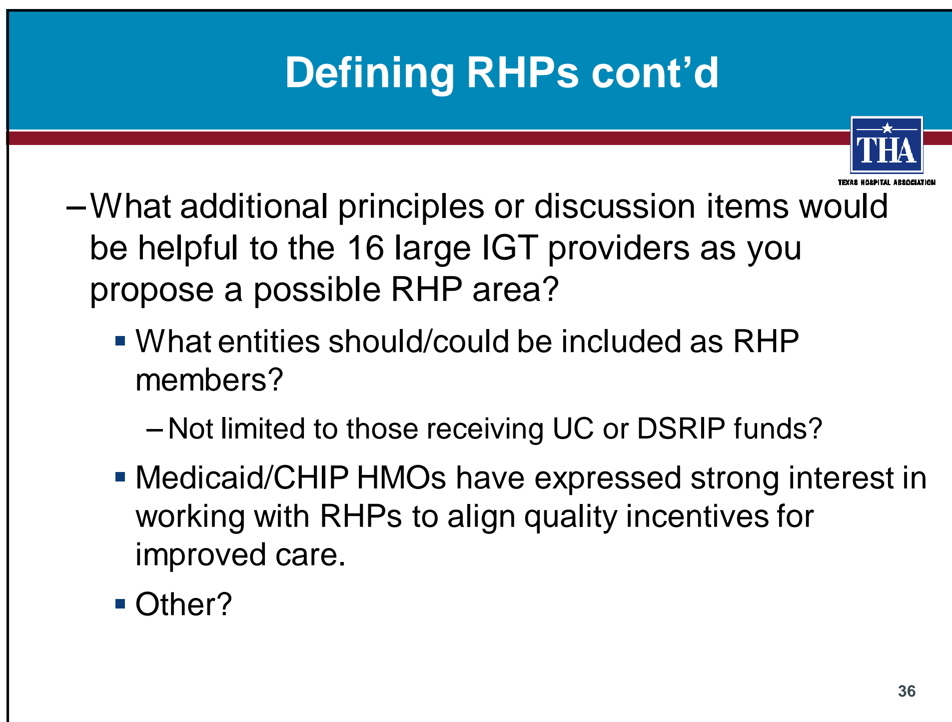
Service Delivery Areas
As of March 2011:
- Bexar
- Dallas
- El Paso
- Harris
- Hidalgo
- Jefferson
- Lubbock
- Nueces
- Tarrant
- Travis
- Medicaid Rural Service Area (MRSA)

Hospital Affiliation:
- Angleton Danbury Hospital District
- Bexar County Hospital District (Univ Hlth Sys)
- Dallas County Hospital District
- Ector County Hospital District
- El Paso County Hospital District dba University Medical Center of El Paso
- Harris County Hospital District
- Tarrant County Hospital District (John Peter Smith Hosp)
- Tomball Hospital Authority
- Travis County Hospital District
- Transferring Hospital with No Private Affiliates
- Transferring Hospital

TEXAS Health and Human Services Commission

34


TEXAS
Medicaid Managed Care Areas
Public Entity Locations
Service Delivery Areas
As of September 2011:
Bexar
Dallas
El Paso
Harris
Hidalgo
Jefferson
Lubbock
Nueces
Tarrant
Travis
Medicaid Rural Service Area (MRSA)
Distinct Public Entity
Transferring Hospital
0
100
200
Miles
TEXAS
Health and Human
Services Commission
35


Defining RHPs cont'd
THA
Texas Hospital Association
– What additional principles or discussion items would be helpful to the 16 large IGT providers as you propose a possible RHP area?
▪ What entities should/could be included as RHP members?
– Not limited to those receiving UC or DSRIP funds?
▪ Medicaid/CHIP HMOs have expressed strong interest in working with RHPs to align quality incentives for improved care.
▪ Other?
36

Defining RHPs cont'd

- Areas without a large IGT-providing public hospital
  - South Texas – no single, large public hospital
    - Work with affiliates
    - Coalition of South Texas Hospitals
    - TAC; TORCH
  - Rural Texas –
    - TAC; TORCH
    - What existing collaboratives can be leveraged as possible RHP areas or consortia?
- THHSC/Stakeholder Discussion –
  - What urban/rural coordination makes sense?
  - Other considerations for rural RHP development?

37

RHP Proposed Timeline

Protocols	Urban RHP Implementation Date	Rural RHP Implementation Date
Program / funding Mechanics and Definition of RHP areas	December 1, 2011	January 1, 2011
Categories 1, 2, 4 (Infrastructure; Program Redesign; Clinical Improvements)	January 1, 2011	January 15, 2011
Category 3 Population Focused Improvements (clinical or health status metrics)	March 1, 2012	March 1, 2012
Plan Submission to THHSC	May 1, 2012	July 1, 2012

1115 Waiver Next Steps

- Preliminary survey
- Follow up with “exceptional” areas
- Focused work with South Texas and Rural Texas
- Development of Program and Funding Protocols

- Slides regarding 1115 Waiver were created by THHSC. For additional information on the waiver, see http://www.hhsc.state.tx.us/

39

Cost Containment Riders in Budget

- Rider 59 requires THHSC to save $700M GR funds by pursuing a waiver from CMS to allow Medicaid flexibility including:
  - Greater flexibility in standards and levels of eligibility
  - Better designed benefit packages to meet demographic needs of Texas
  - Use of co-pays
  - Consolidation of funding streams for transparency and accountability
  - Assumed responsibility by the feds of 100% of the health care costs of unauthorized immigrants

40

Cost Containment Riders in Budget

- Rider 61 requires THHSC to achieve $450M GR funds through: (of 30 items)
  - Payment reform and quality based payments
  - Increasing neonatal intensive care management
  - More appropriate ER rates for non-emergent care
    - Resulting in 40% cut in reimbursement (see next slide)
  - Maximizing copays in Medicaid
  - Improving birth outcomes by reducing birth trauma and elective inductions
    - Resulting in OB modifier requirement for all Medicaid births (see next slide)
  - Increasing fraud, waste and abuse detection

41

OB Modifier on Medicaid Deliveries

- THHSC requires a modifier on each physician delivery claim in Medicaid, effective 10/1/2011
- Denial on physician and hospital claim for mother.

OB Delivery Code
59409
59410
59514
59515
59612
59614
59620
59622

Modifier	Indication	Claim Status
U1	Medically necessary delivery prior to 39 weeks of gestation	Covered Service
U2	Delivery at 39 weeks of gestation or later	Covered Service
U3	Non-medically necessary delivery prior to 39 weeks of gestation	Claim Denied, payment subject to recoupment
Modifier Not Present		Claim Denied, payment subject to recoupment

42

Non-Emergent Patients in the ED

- THHSC is implementing a rule to lower reimbursement of non-emergent emergency room visits by 40%
- Effective 9/1/2011
- THHSC will lower the reimbursement on claims with the lowest three levels of acuity based on E&M codes

43

Cost Containment Riders in Budget

Article II Special Provisions Sec. 17

- THHSC Medicare equalization
- THHSC implementing rule that limits payments of deductibles and coinsurance for Medicare-Medicaid dually eligible clients
  - Capped amount will be “what Medicaid would have paid”
  - Can capture as part of bad debt?
- Alternative was further rate reductions

44

Nursing & Trauma Funding

- Nursing Shortage Reduction Fund = $30M total for the biennium – will allow nursing schools to maintain increased enrollment
- Nursing education received $5-6 million from tobacco settlement funds
- Provides for $57.5 million per year in funding for designated trauma facilities, which is a 23 percent reduction from the $75 million per year originally appropriated for the current biennium.

45

Health Care Reform – Integrating Care

- Health Care Collaboratives (Accountable Care Organizations) state certification process and regulatory requirements created in S.B. 7:
  - Collaboratives may enter into alternative payment arrangements with public and private payers on behalf of participating physicians and health care providers
  - Collaboratives must establish policies to improve quality and control the cost of health care services provided
  - TDI and AG will review proposed plan of operation, size and composition of proposed collaborative to determine if organization meets regulatory requirements and does not pose antitrust risks
  - Receipt and distribution of payments to participating providers will not violate state laws that prohibit fee-splitting or corporate practice of medicine

46

Anti-Washington Sentiment in Austin

- Texas joins Interstate Health Care Compact and seeks Congressional approval to administer Medicare and Medicaid programs (H.B. 5).
- H.B. 636 created a Texas Health Insurance Connector; bill had strong health care, insurance and business support, but failed.
- H.B. 32 would have allowed individuals to not comply with federal mandate to obtain health care coverage; bill failed.
- H.B. 335 would have prohibited state agencies from implementing provisions of federal health care reform unless a report is filed with Legislature stating cost estimates of implementation. Bill was vetoed.

47

Nursing Workforce Improvements

- S.B. 192 passed and creates increased:
  - Immunity from criminal liability for reporting unsafe care
  - Nursing peer review confidentiality for nurse advocates
  - Administrative penalty up to $25,000 for retaliation against protected patient advocacy activities under Nurse Practice Act and rules
- S.B. 193 passed and creates:
  - Voluntary, confidential error reporting system for peer review

48

Nursing Issues for the Future

These will be back:

- Bills filed on expanding scope of practice of APRNs – none passed, but anticipate House interim study
- Bills filed to address violence in ED or in hospital – none passed
- Bill providing limited sovereign immunity for reporting unsafe care in public hospitals did not pass

49

Physician Employment Passed!

- S.B. 894 by Sen. Duncan gives hospitals in counties of 50,000 or less, sole community hospitals & critical access hospitals the option to directly employ physicians. Effective on 5/12/11.
- Physician employment legislation also passed for hospital districts in El Paso, Fort Worth, Houston and San Antonio; bill also passed for Texas Scottish Rite Hospital for Children in Dallas

50

Hospital Operational Issues

- S.B. 1661 by Sen. Duncan places some of the same protections from S.B. 894 (rural physician employment) in the statute for 5.01(a) corporations:
  - Requires 5.01(a) corporations to have policies related to credentialing, quality assurance, UR and peer review.
  - Policies must preserve independent medical decision-making by physicians in 5.01(a).
  - The Texas Medical Board may impose a range of penalties against the 5.01(a). Current statute only allowed refusal to certify or revocation of certificate as TMB penalty.

51

Defensive Actions

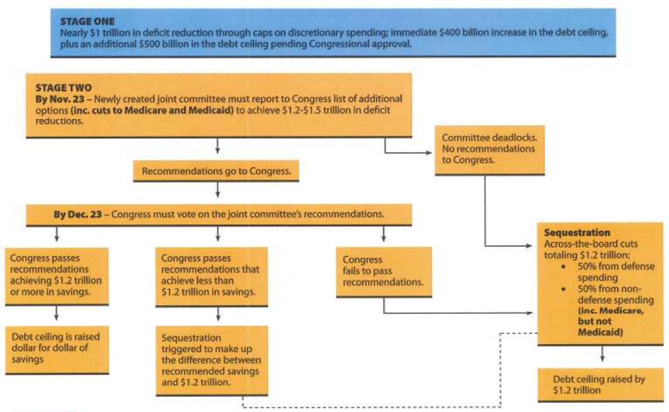
- Kept bad advance directives bills in committee, no "treat 'til transfer"
- Kept Driver Responsibility Program intact
  - Funds the trauma fund
- Mitigated potentially negative hospital impacts on ideologically-driven legislation
  - Sanctuary cities
  - Abortion / sonogram
- No undermining of liability reforms
- No union-friendly legislation passed

52

Meanwhile, in Washington, D.C….

53

Debt Ceiling Debate Continues



54

Key Dates for Future Negotiations

Key Dates in the Budget Control Act of 2011 (P.L. 112-25)

On August 2, the President signed into law the Budget Control Act of 2011, which provides for a total debt ceiling increase of between $2.1 trillion-$2.4 trillion, sets ten-year caps on discretionary spending, creates a Joint Select Committee on Deficit Reduction, and requires both houses of Congress to vote on a Balanced Budget Amendment. Below are key dates to keep in mind with regard to the legislation:

August 16, 2011: Deadline for Members of the Joint Select Committee on Deficit Reduction to be appointed.

September 16, 2011: Date by which the Joint Select Committee on Deficit Reduction must hold its first meeting.

September 22, 2011: Deadline for Congress to consider a resolution of disapproval for first tranche ($900 billion) of debt limit increase.

October 1-December 31, 2011: Timeframe in which both houses of Congress must vote on a Balanced Budget Amendment.

October 14, 2011: Deadline for House and Senate committees to submit recommendations to the Joint Select Committee on Deficit Reduction.

November 23, 2011: Deadline for the Joint Select Committee on Deficit Reduction to vote on a plan with the goal (not a requirement) of $1.5 trillion in deficit reduction.

December 2, 2011: Deadline for the Joint Select Committee to submit report and legislative language to the President and Congress.

December 23, 2011: Deadline for the House/Senate to vote on the Joint Select Committee on Deficit Reduction's bill.

January 15, 2012: Date that the "trigger" leading to $1.2 trillion of future spending cuts goes into effect, if the Joint Select Committee on Deficit Reduction's legislation has not been enacted.

February 2012: Approximate time when the first $900 billion of debt ceiling increase runs out.

February/March 2012: Sometime in this period—15 days after the President uses his authority under the bill to increase the debt ceiling a second time—is the deadline for Congress to consider a resolution of disapproval for the second tranche ($1.2-$1.5 trillion) of debt limit increase.

Fall/Winter 2012: The additional $2.1-$2.4 trillion of borrowing authority from this law runs out.

January 2, 2013: OMB orders sequestration in the defense and non-defense categories of spending necessary to meet spending cuts required by the "trigger."

55

Questions?

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