Health Price Transparency Improvements for Texas Consumers

April 15, 2014
Texas Department of Insurance Stakeholder Meeting
Agenda

- Progress to date
- Statutory requirements
- What are others doing to promote transparency?
- Project goal
- How has TDI implemented SB 1731?
- Data call limitations – UT audit findings
- Future efforts
• Long history of working with stakeholders to implement SB 1731 and promote transparency in the health care market
• Grant and partnership with UT has provided opportunity to revisit this effort, evaluate progress to date, and make improvements to enhance consumers’ ability to obtain meaningful and relevant information on health care prices
Website Updates: Home Page

Welcome

As a consumer, it can be hard to know how much different health care services and procedures usually cost. Even if you get an estimate from your doctor and insurance company, what can you compare it to?

That’s why the Texas Department of Insurance has put together a Health Insurance Reimbursement Rates Consumer Information Guide. Using the billing codes for many common medical procedures, you can compare both in-network and out-of-network claims data. You can also see the average costs for different regions in Texas.

You could use this guide to:

- Estimate costs before you have a procedure.
- Understand cost variations across regions.
- Help you make informed decisions when you are able to plan for medical services.

To use this tool, you will need to know the city or county where your medical procedure takes place. You will also need the medical code for the procedure. No personal data will be collected.

Terms & Conditions

Additional AMA Notice

The five-character codes and lay descriptions included in the Health Insurance Reimbursement Rate Consumer Information are obtained from Current Procedural Terminology (CPT), copyright 2008 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms.
Website Updates:
Search Interface

Search Reimbursement Rates

This guide will allow you to look up average rates for health care procedures and services in the regions throughout Texas. The information used in this search is based on claims data from 2012.

1. Choose the county or city where your doctor is located:
   - Choose County ▼
   - Or  Choose City ▼

2. Choose the medical specialty that best describes the service you’re looking for:
   - Choose Specialty ▼

3. Choose your search results:
   - View the reimbursement rates for a specific procedure and CPT code in the selected specialty
   - View the reimbursement rates for all procedures and CPT codes in the selected specialty

Get Results
Website Updates:
Region Map
Legislating Transparency

- **SB 1731**, enacted by the 80th Texas Legislature, includes the following statutory provisions to promote transparency:
  - Insurers must submit reimbursement rates
  - Health plans must notify enrollees regarding the risk for balance billing
  - Upon request, health plans must provide enrollees with cost estimates
  - Upon request, physicians must provide uninsured and out-of-network patients with charge estimates

- **HB 1342**, enacted by the 81st Texas Legislature, built on enrollees’ rights to information:
  - Health benefit plan issuers must use information technology to provide enrollee cost estimates
The 82nd Texas Leg. enacted SB 7, which created the Institute for Health Care Quality and Efficiency (IHCQE) and issued several charges, including:

- Assess all state-collected health data and develop a plan to streamline, enhance, and improve transparency of state-collected health data.
Institute charges, continued:

- Consider establishing a centralized database for health care; determine whether this would reduce the need for certain data currently submitted by payors
- Evaluate how to promote a consumer-driven health care system
- Examine the issue of price discrimination for health care services to understand the degree of the differences in the amounts accepted as payment in full, why this variation exists, the availability of price information for consumers, and the effect on consumers;
- Evaluate methods for improving consumers’ access to price information, including the feasibility and desirability of requiring providers to publicly post and adhere to prices
IHCQE Recommendations

- Build on SB 1731 reforms to increase information available to consumers
- Promote efforts in the private sector to increase availability to Texans of information on health care quality, costs, outcomes, and patient safety
- Create a consumer-friendly website offering health care quality information to consumers, including a dashboard of publicly reported health outcome measures and tools to assist consumers with navigating available information on health care quality and cost
- Study consumer behaviors, preferences, and best ways to maximize consumers’ use of health care information
IHCQE Recommendations

- Work collaboratively across state agencies, academic centers, and stakeholders to collect and analyze all-payer data on health care quality and cost-effectiveness in Texas
- Integrate claims data collected by state agencies, including Medicaid, Medicare, public employees
- With regards to a comprehensive claims database, Texas should promote public/private partnerships, including voluntary agreements with insurers to increase data available for public purposes on the commercially insured population
- Encourage ERS and TRS to require plan administrators to provide participants with price and quality information tools to help guide health care purchasing decisions
Current Efforts in Price Transparency

- National health plans
- State agencies and non-profits working with states
- Third-party vendors working with health plans
  - Castlight, Change Healthcare, Compass, Truven Health, HealthSparq,

*Becoming widely available & functionality is improving*


Most payer transparency tools:

- Display price information for treatment events labeled with consumer-friendly terms
- Allow price comparisons across nearby in-network providers
- Integrate price information with enrollee-specific cost sharing data to display enrollee’s likely cost, in addition to total cost
- Include some quality measures alongside provider options
  - Internal & external quality metrics

Some tools have unique features:

- Appointment scheduling, enrollee satisfaction surveys, information on medical procedures, recovery time
Payer Transparency Tools

Primary Care for Adults

Your cost: $81 - $165

Cost estimates are for first visit at the office, medium complexity or 30 minutes.
Note: New labs, tests, imaging studies or procedures are not included.
Cost savings tips for primary care for adults | How to choose a doctor

Refine your results

Type of care: Help with a problem ▼
First visit:  Yes  No  ?
Consultation: Yes  No  ?
Distance:  5 miles ▼

Your plan status

Deductible  Coinsurance  Covered
Health cost websites provide consumers with average costs for common procedures

- **Geography:** statewide | regional | hospital/facility | physician
- **Cost:** charge | allowed amount
- **Procedure:** CPT code | professional/facility | treatment event

State laws require insurers to maintain websites and phone lines to provide consumers with cost estimates.

State laws require hospitals to disclose charges for common health care procedures.
State Efforts on Price Transparency

**Maine**

- All plans submit standardized claims data
- Produces annual hospital price reports
  - Onpoint Health Data is vendor
- Maine Health Data Organization (MHDO)
  - hospital financial and organizational data, inpatient, outpatient, emergency department, and nonhospital ambulatory service data, and quality data
- Independent executive agency and multi-stakeholder board
- Employer-targeted
Maine HealthCost

Maine HealthCost
Cost Compare: Compare Average Procedure Costs
by Maine Health Care Facilities

Let's get started

Procedures are grouped by the following categories: emergency visits, lab tests, office visits, outpatient procedures, and radiology and diagnostic imaging. First, select a procedure category (Step 1), and then select a specific procedure from the drop-down list in Step 2. You'll see the average cost of that procedure at different health care facilities in Maine. If you'd like to see your distance from these facilities, you can enter your zip code in Step 3.

Step 1: Select a Procedure Category

Outpatient Procedure

Step 2: Select a Procedure

Breast Biopsy (auto-vacuum) (19103)

Step 3: Enter your ZIP code to find distance to facility (optional)

For a definition of the terms used in the table heading, hover your mouse over the term or visit the Definitions page. If you would like the phone number for a particular facility or hospital, please visit the Facilities page. If you want to sort each column, click on the column name.

Average Cost for Breast Biopsy (auto-vacuum) (19103)

<table>
<thead>
<tr>
<th>Lead Facility</th>
<th>Avg Professional Cost</th>
<th>Avg Facility Cost</th>
<th>Avg Total Cost</th>
<th>Patient Complexity</th>
<th>Distance to Facility</th>
<th>Number Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>$382.56</td>
<td>$2,756.50</td>
<td>$3,859.06</td>
<td>N/A</td>
<td>N/A</td>
<td>612</td>
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<tr>
<td>Cary Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Maine Medical Center</td>
<td>$591.48</td>
<td>$2,540.40</td>
<td>$3,137.88</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>52</td>
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<tr>
<td>Eastern Maine Medical Center</td>
<td>$1,271.45</td>
<td>$2,777.70</td>
<td>$4,049.15</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>102</td>
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<tr>
<td>Franklin Memorial Hospital</td>
<td>$997.78</td>
<td>$2,310.18</td>
<td>$3,307.96</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>10</td>
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<tr>
<td>Hermitage D Goodall Hospital</td>
<td>$800.47</td>
<td>$3,882.25</td>
<td>$4,480.72</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>14</td>
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<tr>
<td>Maine General Medical Center</td>
<td>$611.48</td>
<td>$3,360.45</td>
<td>$3,971.93</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>146</td>
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<tr>
<td>Maine Medical Center</td>
<td>$629.89</td>
<td>$3,222.66</td>
<td>$3,852.55</td>
<td>3 - Medium</td>
<td>N/A</td>
<td>91</td>
</tr>
</tbody>
</table>
New Hampshire:

- All plans must submit standardized claims data
- Produces annual hospital price reports
  - UMass Medical School is vendor
- NH Comprehensive Health Care Information System (NHCHIS)
  - [http://www.nhhealthcost.org/](http://www.nhhealthcost.org/)
  - Comparative cost information to consumers, employers, and uninsured
  - Benefit Index Tool to compare carriers health plan premiums and benefits
Virginia:

- Health insurers provide price data via survey
  - Similar to Texas, different approach – treatment events
  - Stakeholders (providers, insurers) created recommended list of services and codes
- Website provides average allowed amount for 31 services and links to consumer information on the services [http://www.vhi.org/health_care_prices.asp](http://www.vhi.org/health_care_prices.asp)
- ACOs drove the stakeholder interest in price transparency
- Virginia Health Information hosts a voluntary APCD
  - 9 participating insurers
Breast Biopsy (2012)

What is a breast biopsy?

A lump in the breast can be found during a self-exam, an exam by the doctor or on a mammogram image. A breast biopsy is performed to determine whether a lump is cancer or caused by something else. The doctor will remove a small amount of breast tissue from the lump. The tissue is sent to a lab and tested for signs of cancer. In this kind of breast biopsy, the doctor uses ultrasound or some other kind of imaging system to help guide the small needle to the right place, so a small amount of the tissue can be collected. The doctor usually has test results in a few days.

More on this health care service  |  Watch on YouTube  |  PRINT

Click on column title to sort

Average Allowed Amounts for possible services associated with this procedure
Your care may not require all possible services for Breast Biopsy

<table>
<thead>
<tr>
<th>Locations</th>
<th>Possible Total ▼</th>
<th>Facility</th>
<th>Surgeon</th>
<th>Radiologist</th>
<th>Anesthesiologist</th>
<th>Physician</th>
<th>Other Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office</td>
<td>$1,512</td>
<td></td>
<td>$778</td>
<td>$734</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>$3,864</td>
<td>$3,241</td>
<td>$333</td>
<td>$290</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

◆ - Too few health insurance carriers reported information to calculate
Independent Price Transparency Tools

- Healthcare Blue Book
- MyHealthCareOptions
- Clear Health Costs
- FairHealth
- MDSave

Advantages:
- Available to everyone, including uninsured
- Patients may trust independent sources more than health plans

Disadvantages:
- Often reflect only one aspect of price (e.g. charge amount)
- Impossible to personalize to patient
Value Proposition for Price Transparency:

- Economic benefit across stakeholders
- Engages consumers
- Informs employers (sponsoring health plans)
- Supports researchers and policymakers
Policy Objective

*Promote a consumer-driven health care system*
Connect consumers to meaningful information on health care prices and develop resources to help consumers engage in health care purchasing decisions
The Consumer

- Any individual seeking or utilizing a health care service
- Privately insured or uninsured
- Motivated to seek high-value care
  - High deductible plan, with or without an HSA
  - Not in a health emergency; able to plan, not emotionally conflicted
- Responsible for some or all costs
  - Insured (100% before deductible; coinsurance % after deductible)
  - Uninsured (100%)
Vocabulary

• Terms we may use
  ○ **Billed charge** – the amount providers bill for a service
  ○ **Contracted amount** – the amount a provider accepts as payment in full from a payer with which they have a contract
  ○ **Allowed amount** – the amount a provider bases payment on
  ○ **Price** – the total amount owed
  ○ **Price discrimination** – an economics term that describes the practice of charging different groups of people different prices for the same service
  ○ **Cost** – the consumer’s cost sharing responsibility
TDI’s SB 1731 Data Call

• Companies subject to reporting:
  - Companies offering PPOs, HMOs, and government employee plans sponsored by ERS, TRS, UT, and A&M – 21 entities reported in 2013
  - Companies with fewer than 10,000 covered lives may assert an exemption

• Reporting period:
  - Claims data from January 1 to June 30 must be submitted by September 1, annually

• Geographic regions:
  - Companies aggregate claims data across zip codes grouped into 11 Health and Human Services regions

• Scope of services for which claims data is collected:
  - 345 CPT® codes
  - 62 DRG codes
TDI’s SB 1731 Data Call

For a given code in a given region, companies report:
- Number of claims
- Total billed amount across all claims
- Total paid amount across all claims
- Total contracted/allowed amount across all claims

TDI aggregates across all companies and computes:
- Average billed amount
- Average paid amount
- Average contracted/allowed amount
# TDI's SB 1731 Data Call

## Search Results

**Service Category:** Professional Services - Radiology  
**Region:** Central Texas | Region 7

Viewing In-Network Rates | View Out-of-Network Rates

All specified rates below are averaged

### In-Network Rates

<table>
<thead>
<tr>
<th>CPT or MS-DRG Code and Description</th>
<th>Key</th>
<th>Billed Charge</th>
<th>Contracted Rate</th>
<th>Amount Paid to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>70450 - CT scan head or brain</td>
<td>R</td>
<td>$1,416.18</td>
<td>$583.03</td>
<td>$359.19</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>$1,971.12</td>
<td>$831.84</td>
<td>$566.53</td>
</tr>
<tr>
<td>70450 *26 - CT scan head or brain - professional component</td>
<td>R</td>
<td>$182.15</td>
<td>$67.02</td>
<td>$40.17</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>$188.22</td>
<td>$74.93</td>
<td>$48.36</td>
</tr>
<tr>
<td>70460 - CT scan head or brain with contrast</td>
<td>R</td>
<td>$757.00</td>
<td>$271.13</td>
<td>$226.25</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>$985.17</td>
<td>$429.93</td>
<td>$252.43</td>
</tr>
<tr>
<td>70460 *26 - CT scan head or brain with contrast - professional component</td>
<td>R</td>
<td>$235.52</td>
<td>$94.43</td>
<td>$47.83</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>$252.83</td>
<td>$109.78</td>
<td>$57.05</td>
</tr>
</tbody>
</table>
TDI’s SB 1731 Data Call

- TDI evaluates data for outliers and sends outlier summary reports to each issuer for review
- Issuers have three weeks to review outliers and three more weeks to make changes; TDI grants extensions as needed
- Most issuers do not make any changes to data following the outlier review – on average only one issuer submits revised data
  - With the exception of negative values, TDI does not exclude outlier data confirmed by companies
Challenges

- Data collection process, prescribed in rules at 28 Texas Administrative Code §§21.4501-21.4507
  - Rules include by reference data collection form and instructions
- Collecting data at an aggregate level produces only one data point per issuer, limiting our ability to evaluate whether data is reliable
- Collecting only six months of data limits the number of claims that are included in the data issuers report
- Collecting at the regional level limits ability to reflect market-specific rates, since some regions include multiple metropolitan areas with different health care markets
UT Audit Process

All TDI Codes
- Reviewed for codes requiring units and DRG reliability, excluded HMO data

Usable Codes
- Computed mean and median of TDI codes and compared to commercial and Medicare

Codes within Benchmark Range
- Removed codes that failed to fall within lower and upper quartiles

Modifiers and Facility Outpatient
- Removed facility outpatient codes due to revenue code issue
### UT Audit Findings

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Codes</th>
<th>Analysis</th>
<th>Final Result Falling in Benchmark Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Services – General</td>
<td>63</td>
<td>33 Usable, 30 Need Units of Service</td>
<td>6  (10%)</td>
</tr>
<tr>
<td>Prof Services – Pathology</td>
<td>29</td>
<td>16 Usable, 13 Need Units of Service</td>
<td>4  (14%)</td>
</tr>
<tr>
<td>Prof Services – Anesthesiology</td>
<td>20</td>
<td>Need Units of Service</td>
<td>0</td>
</tr>
<tr>
<td>Prof Services – Radiology</td>
<td>183</td>
<td>Usable</td>
<td>88  (48%)</td>
</tr>
<tr>
<td>Prof Services – Neonate CC/ Newborn</td>
<td>11</td>
<td>Need Units of Service</td>
<td>0</td>
</tr>
<tr>
<td>Prof Services – OP Claims</td>
<td>32</td>
<td>31 Usable, 1 Needs Units of Service</td>
<td>29  (91%)</td>
</tr>
<tr>
<td>Institutional – OP Claims</td>
<td>39</td>
<td>Need Revenue Codes</td>
<td>23 but 0 are useful</td>
</tr>
<tr>
<td>Institutional – IP Claims</td>
<td>62</td>
<td>DRG data Not Usable</td>
<td>0</td>
</tr>
</tbody>
</table>
Summary of Data Collection Issues

- Units of service not currently collected
- Code modifiers not sufficient
- Claims reported by DRG are not aggregated consistently (institutional inpatient)
- Revenue codes are not collected (needed for institutional outpatient claims)
- HMO data may reflect capitated payment methods
- Scope of billing codes not driven by shoppable treatment events relevant to target audience
Units of Service

- Multiple issuers have advised that we should be collecting this
- Units of service are required for certain CPT® codes
  - Units of service represent a count per code such as the minutes of anesthesiology, or number of allergy injections
- Without collecting units of service, the calculated average cost represents an unknown number of units
- We are not able to show the cost for a single unit
- Currently, cost data for services that need units of service is not very meaningful to consumers, and may be misleading
CPT® Code Modifiers

- Many procedures are billed with a modifier, which provides:
  - more information about the service being performed,
  - the provider performing the service, or
  - the environment in which the service is being performed

- We do not collect all possible modifiers, nor do we collect modifiers for all codes

- Billing codes with modifiers are associated with different levels of payment

- The full cost of a treatment event may be represented by the sum of billing codes with different modifiers along with any additional billing codes
Diagnosis-related group (DRG) is a system used in hospitals to categorize services according to a patient’s primary diagnosis.

TDI currently uses 62 DRG codes to collect inpatient hospital reimbursement rate data.

This data is not reliable because not all commercial payers apply DRGs or pay by DRG.

We didn’t recognize the need for providing detailed instructions in this area; for now, this data is not available to consumers.

- In order to provide inpatient data to consumers in the future, we must develop a methodology that produces a consistent bundle of costs associated with an inpatient treatment event.
Single Billed Services

- We currently collect and report data for a single line item, represented by a billing code.
- A single billing code rarely represents the full scope of items a consumer will be billed for after seeking care.
  - For example, in an office visit, a consumer may be billed for E&M and any procedures performed during the visit.
- In order to present data on the costs a consumer is likely to experience, it would be necessary to present data on the collection of services a consumer is likely to receive during a treatment event.
  - This would require revising the scope of billing codes we currently collect and establishing a methodology for grouping these codes together.
Example: Limitation of Single Code

- CPT 90746: Hepatitis B Immunization

Treatment event would usually involve
  - 90746 Immunization
  - G0010 or 90471 Administration of Vaccine
  - 99395 Evaluation and Management

- Only 90746 is available or useable in TDI data
- Full event cannot be priced
Institutional Outpatient

- TDI currently collects institutional outpatient claims by CPT® code
  - Example below illustrates why single CPT® code doesn’t capture all costs
- Facility bills have procedure code on same line as revenue code
- Procedure code may appear more than once on bill lines linked with revenue codes
  - 29880 – knee surgery (on bill for both operating room and med/surg supply categories)

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Procedure Modifiers</th>
<th>DOS From</th>
<th>Charged Amount</th>
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<tbody>
<tr>
<td></td>
<td>&lt;0250&gt; General</td>
<td>&lt;.999997&gt; _Not Available</td>
<td></td>
<td>11/24/2010</td>
<td>$175</td>
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<td></td>
<td>&lt;0270&gt; General</td>
<td>&lt;.999997&gt; _Not Available</td>
<td></td>
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<td>$464</td>
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<tr>
<td></td>
<td>&lt;0271&gt; Non-Sterile Supply</td>
<td>&lt;.999997&gt; _Not Available</td>
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<td>11/24/2010</td>
<td>$13</td>
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<td></td>
<td>&lt;0360&gt; General</td>
<td>&lt;20610&gt; Arthrocentesis Aspir/Injection Major Jt/Bursa</td>
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<td>11/24/2010</td>
<td>$1</td>
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<td></td>
<td>&lt;0370&gt; General</td>
<td>&lt;29880&gt; Arthrs Knee w/Menisectomy MedLat w/Shaving</td>
<td>RT</td>
<td>11/24/2010</td>
<td>$6,000</td>
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<td></td>
<td>&lt;0710&gt; General</td>
<td>&lt;.999997&gt; _Not Available</td>
<td></td>
<td>11/24/2010</td>
<td>$3,100</td>
</tr>
</tbody>
</table>

- 250=Pharmacy, 270=MedSurg supplies, 271= Non Sterile Supplies, 360= Operating Room, 370= Anesthesia, 710= Recovery Room
Billing Codes Collected

- The set of billing codes that TDI currently collects was the product of several advisory committee meetings and stakeholder input.

- These codes represent high volume services:
  - They are not necessarily targeted to our identified consumer:
    - Most inpatient codes are driven by Medicare volume.
    - Many codes are not shoppable.
    - We did not focus codes on services for which consumer are price-sensitive or that are known to vary widely in cost.

- The scope of codes does not include all complementary services needed to develop treatment events.
Recommendations

- Update data collection form to include key missing fields
- Reconsider the regional grouping system
- Revise data reporting period to yield a full year of claims data (rather than six months)
- Consider using multiple years of data to compute rolling 2-year average
- Consider changes to data analysis, audit, or presentation methods to improve quality of information
Recommendations

- Revise instructions for grouping inpatient services by DRG
  - Consider transitioning from DRG to ICD procedure groupings
  - Work with insurers to ensure our instructions produce a uniform reporting methodology
- Reconsider scope of codes to focus on shoppable procedures and services
  - Look at best practices from payers and other states
- Develop treatment events to provide more context for information at the individual billing code level
  - Give consumers a complete picture of the costs they can expect to face
Next Steps

• UT is researching best practices for:
  ○ Selecting treatment events most useful, relevant, shoppable
  ○ Grouping billing codes into treatment events that represent a typical consumer experience

• Consider modifications to the data collection form based on analysis and stakeholder input

• TDI will work with stakeholders independently to solicit your thoughts and get your input on some technical issues

• Subscribe to TDI’s eNews to stay up to date with our next steps: www.tdi.texas.gov/alert/emailnews.html
  ○ Consumer Health eNews Update
  ○ Life, Accident, and Health eNews Update
Future Efforts

- What can we do to improve information for consumers?
- What changes do you think we need to make to meet our project goal?
  - What changes can we make to reduce the burden to issuers?
  - What changes should we make to ensure this data collection produces data that is accurate?
  - What changes should we make to ensure this data collection produces information that is relevant and meaningful to consumers?
  - What best practices can we apply to our effort?
Thank You!

Questions? Comments? Want to discuss further?

Get in touch:

Rachel.Bowden@tdi.texas.gov
512-305-7323