CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

February CHC Coalition and OTA Meeting Minutes
Friday, February 16th 11 a.m. 2 p.m.

Attending:

Diane Rhodes, Texas Dental Association
Christina Phamvu, Methodist Healthcare Ministries
Rey De La Garza, Texas Nurse Practitioners
Greg Hansch, NAMI Texas
Adriana Kohler, Texans Care for Children
Alison Mohr Boleware, Texas Medical Association
Christina Hoppe, CHAT
RexAnn Shotwell, TACHC
Sonia Lara, TACHC
Courtney Weaver, TACHC
Kayla Sohns, TACHC
Julia O'Hanlon, CDF-TX
Aliyah Conley, CDF-TX
Laura Guerra-Cardus, CDF-TX
Anne Dunkelberg, CPPP
Jessica Giles, CPPP
Clayton Travis, Texas Pediatric Society
Kay Ghahremani, Texas Association of Community Based Health Plans
Rachel Cooper, CPPP

On-Conference Line:

Shannon Lucas, March of Dimes
Betsey Coates, Maximus
Melissa McChesney, CPPP
Elizabeth Tucker, Every Child Inc.
Sara Gonzales, Texas Hospital Association
Crystal Cortana, Children's Health

Invited Guests:
Gina Carter, HHSC
Erika Ramirez, HHSC
Dan Huggins, HHSC

Chair: Diane Rhode, TDA
Meeting Scribe: Jessica Giles, CPPP

1. Federal Updates

Anne Dunkelberg on CHIP:

- CHIP extended for 10 years. After 2 years, the match Texas has will go away and we'll go back to the historic CHIP match. There are some oddities in the bill language.

Laura Guerra-Cardus:

- There are CHIPRA Outreach grants that we know are going to continue, so that's exciting for community based items

Anne Dunkelberg:

- Quality measures for children are continuing, which is important for folks working on quality of care.

Courtney Weaver on Community Health Center Funding:

- [See Handout]
- Funding was renewed for 2 years and Community Health Centers got an additional $600 million over the next 2 years. There were 29 yes votes out of 36 for our delegation. $3.8b for FY18. $4b FY19. Still waiting on $1.5b and would have preferred if it were renewed for longer.

2. Substance Use Workgroup Overview

Adriana Kohler:

- During this interim, Senate and House have several charges related to substance use, some that are addressed in CHCC's Quick Glance Guide. This workgroup came out of the Healthy Minds Coalition to discuss legislative strategy. The group is coming up with position statements and recommendations for a variety of issues since substance use is very broad. This group addresses criminal justice, juvenile justice, youth prevention programs, and health. There could and should be a stronger presence from health stakeholders.
- Main Issues: (1) Access to a strong continuum of care for youth and adults; (2) prevention of substance abuse among youth and adults; (3) Provider education and training; (4) Criminal Justice reforms; (5) Keeping families together; (6) Data gaps and opportunities; (7) funding needs and opportunities; and (8) Co-occurring disorders. The goal is to put together a 1-pager for each of these main issues.
- Hearings have already been announced.

Greg Hansch:

- **The ask is do you want to be a part of this workgroup** and **do you have any policy recommendations that fall under these categories that this group should know about?**
- First meeting for the select committee will probably run through the six charges from the House Select Committee. May not have public testimony opportunities, so meetings with the members are very important.
- If you're interested in getting added to the list-- **reach out to Greg Hansch.** The next meeting is **March 7th.**

3. Interim Charges

Anne Dunkelberg:

- Thanks Clayton, Adriana, and Helen for all of the hard work on this document. Today, we are hoping to get a head count in the room regarding whether folks are comfortable with this. This is an internal document, so it's a way to identify common themes.
- **[see quick glance guide attachment]**

(A) Medicaid and CHIP Charges

Allison Mohr Boleware:

- For the Medicaid cost containment efforts, the work requirement conversation is starting to come up more. Schwertner is interested in a work requirement here in Texas. This would obviously affect caregivers of children, since only 7% of our adults on Medicaid are actually able-bodied.

Anne Dunkelberg:

- These charges were written before and the coalition's responses were written before this became a big issue, but we should add something here.
- Cover Texas Now has a strategy planning meeting about work requirements. We will circulate information about this meeting.

Work Requirement Meeting: February 22nd from 3:00 p.m. – 4:30 p.m. at CPPP

Kay Ghahremani:

- If you're on TANF, is there a work requirement already?

Anne Dunkelberg:

- Yes, but there are very few parents left on TANF, so it won't be a very big group. We'll add some language about work requirements. Additionally, will make edits to item #4.

Greg Hansch on House Committee on Human Services Item 2:

- #3 is an effort to carve in children's mental health services into the managed care system.

Kay Ghahremani on Senate Health and Human Committee:

- There are disincentives to do creative things, because if you save money, that money is taken. Sometimes, there is upfront capital to do incentive payments and other similar things. There are some issues with the ways that capitation is developed. There is a requirement that MCO's have to bid their administrative portion. What's happened in other states is that commercial companies come in, have lots of resources, they'll underbid, which knocks out other plans that have given more realistic costs and then the next year rates go up. There is concern that there are some companies that want to get in and they'll undercut knowing. There is an opportunity to comment on the Draft RFP. Comment period closes on March 1st.

Anne Dunkelberg:

- There is growing complexity of our method of financing Medicaid: local participation funding mechanisms, uniform hospital rate increase program. Need an understanding of what, if any, potentially problematic things will come out of that.

(B) Maternal Health and Birth Outcomes Charges

Anne Dunkelberg:

- Is March of Dimes looking at and continuing to see process barriers?

Shannon Lucas:

- We are still having trouble with getting women in and seen quickly enough to start 17p programs, as well as trouble with prior authorizations holding things up. 17p is a progesterone-based shot that women have to get weekly during the first few weeks of pregnancy and up until 24 weeks. It is indicated for a prior preterm birth and is shown to reduce complications. There's a tight window for getting on these shots and part of the trouble is getting women into the program early enough to see if it is something that benefits them. Some of it is community outreach and some is getting women to understand that they need to go as soon as they can.

Anne Dunkelberg:

- So there are three factors that we're concerned about: Go before you show because there are interventions you need quickly, eligibility process, and the track record of point of eligibility and getting women into their 1st appointment. Are there specific pieces? Do we need to be getting the state to put their efforts behind Go Before You Show?

Shannon Lucas:

- Healthy Texas Women population messaging of that effect would be helpful.

Anne Dunkelberg on Substance Abuse/Opioids:

- For a lot of uninsured women, going to these OB/GYN appointments may be their only medical appointment within a year.

Adriana Kohler:

- We provided background to the roundtable on maternal mortality. The National trend is 30% of child removals due to parental substance abuse. In Texas, it's about 60%. There are provider protocols, but CPS has discretion on whether to immediately remove a baby. Hospitals and providers have done a great job of implementing best practices, including rooming-in, breastfeeding, skin-to-skin care, low-lighting. These things reduce NAS, which reduces Medicaid costs. If a baby is removed from CPS immediately, there are none of those great effects. There is a disconnect between evidence-based practices and some of the on-the-ground practices by DFPS. It's case-by-case and subjective to what the provider and caseworkers want to do.

Kay Ghahremani:

- Women who are pregnant and taking MAT is the standard of care, but there is a problem of DFPS interpreting that as a mother abusing that as a substance.

A modestly edited final version of the Quick Glance Guide will be sent out shortly.

4. Fee Reviews and Rate Process

Dan Huggins:

- **[See PowerPoint]**
- There are two areas where we publish our notices: HHSC website and the Texas Register. We also publish the rate hearing methodologies. There is a distribution list where we publish rate hearing packets. Rate hearing packets come out about 5 days before the

hearing. The biennial fee review calendar goes through groupings on a quarterly event and the groupings cycle. There is a requirement to schedule a meeting with HHSC management to discuss all of the rate hearings that will happen. Groupings to see how it affects overall rate hearings and getting the right document out to the public. At rate hearings, comments are summarized and the recommendations are offered up based off of the testimonies. The rates set can only go higher than what was proposed at the rate hearing. The Biennial Calendar Fee Review isn't on a website, so there isn't a way to know what codes are coming up, but that information could be given to you if interested.

Anne Dunkelberg:

- In a world where 90+% of Medicaid payments are going through HMOs, can you explain how rate setting relates to HMOs using the rates?

Dan Huggins:

- I don't work in MCOs, but I've been told that MCOs review and look at our rate schedules-how that relates to actual contract and payment is completely out of my scope.

Clayton Travis:

- MCOs often report that they follow a fee schedule or use a percentile off of it. For your calculation of rates, does this factor in?

Dan Huggins:

- No. We don't have a managed care rate setting piece and they don't either.

Laura Guerra-Cardus:

- What are factors that go into determining a reimbursement rate?

Dan Huggins:

- The Federal government has a relative value unit of 3.76. Have a conversion factor based on dollars available to the program to spend. In our state plan, we have posted our conversion factors.

Anne Dunkelberg:

- How often do those change?

Dan Huggins:

- The last time I had to update them was about 4 years ago. The RVU goes up and down more than the conversion factors do. CMS updates RVU quarterly. Annually, CMS updates conversion factor for different provider types. Can also look at it in access to care, other 14 states (4 surrounding Texas, 10 most populous). Other insurance programs to see what they get to reimburse for that procedure code. Miscellaneous codes that are reimbursed on submitted invoices. Have to get all of those different comparables to make sure that rates make sense. Contentions to these numbers are where we need the input of the providers and professionals.

Adriana Kohler:

- For a new benefit that we will know be part of Managed care, do you still set the rates for fee-for-service? Ex: thinking of maternal depression screening

Dan Huggins:

- Yes, it'll be part of a rate hearing. New procedure codes that the federal government puts out. They're always doing something, so every quarter we'll have an update. Annually, they'll come out with some big changes.
- One takeaway- use my email, phone number. Your input is valuable and we need it. Your input is taken into consideration.

Clayton Travis:

- What is the logic behind a decrease in a rate?

Dan Huggins:

- RVU drop in CMS.

Anne Dunkelberg:

- RVU is zero sum. So if something deserves to be paid higher, something else has to go down.

Dan Huggins:

- CMS's population is much different than the concerned population that we have in Medicaid.

Diane Rhodes:

- Billing is very different for the dental side. 300+ codes they were very straightforward was based on this 14 state average and that was the main reason. Direction from executive leadership that we don't want to be paying more than any of these other states.
- Relationship between rate setting and DMOs- follow the rates set by the state, may go somewhat below it, but for the most part they're married with the state fee-for-service rates. Why it was so upsetting when the state tried to do it in this way because it will directly impact managed care rates. Last fee increase dental had was in '07 session.

5. Public Charge Proposed Rule

Melissa McChesney:

- The idea of a public charge is used to determine whether a particular individual who is seeking a green card will need to rely on public benefits. Historically, the benefits that were examined was very limited to cash assistance (TANF, SSI, or Medicaid in nursing homes). Public charge is NOT part of the naturalization process. It's part of getting a green card, not part of getting citizenship. These possible changes will simply continue to add to the confusion around the issue. There is a large number of benefits that could be included. The list includes Medicaid, CHIP, SNAP, WIC, Section 8 Housing, Head Start, and any of the subsidies that are provided through the health insurance marketplace under ACA. Dependent family members of a green card seeker and their use of these benefits could be used in determination.
- Who would be affected: **Not the citizenship path.** That's part of statute and cannot be changed through rulemaking. There are certain immigrants who aren't subject to a public charge test: humanitarians, refugees, asylum seekers, human trafficking. That's something that could be changed by rulemaking.

- Sense of a timeline: very subject to change, but they do expect that the rulemaking will go to the office of management and budget sometime before the end of March. Then it will be shared to affected agencies, feedback will be received, the proposed rule will be evaluated and then there will be a 30-60 day timeframe for public comment.
- [see handout for additional information]

Christina Hoppe:

- Is there any argument that these are inconsistent with the federal law?

Melissa McChesney:

- Historically, for public charge, a lot of guidance was all done in a sub-regulatory fashion and hasn't been spelled out specifically and scrutinized on a legal level because it was defined on a sub-regulatory fashion. Could be the potential for some lawsuits.

Anne Dunkelberg:

- There's not anything that is glaringly inconsistent. It is possible that one of the challenges will be on the premise that a person's ability to get a green card should not be affected by someone else's use of benefits if they are receiving them lawfully. Also the impact on the harm of a child because of their use of the benefits. There are principles around all US citizens being treated equally.
- We will send out to the listserv- the National Immigration Center—protecting immigrant families nationally. We would love to have more partners outside of their historical nucleus of immigrant rights activist groups.
- Timelines: 20 years later, you still have immigration attorneys that tell families not to use any public benefits and families who are afraid to do that. If you haven't spent time on any of those immigration issues, the amount of due process available to non-citizens is very little.
- 34% kids have one foreign born parent in Texas. 17% of Texas kids have two non-citizen parents.

Adriana Kohler:

- Some of the ECI providers have said that they're seeing more families not renew Medicaid coverage for kids, which is putting a strain on ECI providers who are obligated to serve kids under federal IDEA.

On Conference Line:

- We're already seeing this population not utilize our facilities at Harris Health. We're very concerned about this. Every time there is an immigration debate, we're working with our community to let them know that it is safe to go to our places, but people are scared. This is going to have a complete negative outcome on quality health measures and is driving people to emergency rooms. We're already seeing a reduction in our outpatient services.

6. OTA: Eligibility and Enrollment

Gina Carter:

- [See PowerPoint]

- We have to do a 6-month evaluation to FNS and migration of population is not something required in the report. Not uncommon that this happens whenever there is a disaster, but we don't have finite numbers

Melissa McChesney:

- Has there been any increase in regular SNAP because people signing up for D-SNAP and then registered for regular SNAP after? In general, when things like this do happen, you'll see an increase. We want to make sure that those folks are aware that regular SNAP is available and that they could be eligible.

Gina Carter:

- HHSC doesn't trend that out. A lot didn't know that SNAP existed or D-SNAP, because they never needed it. You receive a notice after D-SNAP runs out and contact information about other questions.

Melissa McChesney:

- TIERS changes have been made and we are all very happy about that

Gina Carter:

- [see PowerPoint]
- Payments depend on what the site is.
- If it's denial to excess income but the income falls within CHIP, then they'll cascade over to the CHIP program. If it's over, we'll refer them to the marketplace Electronic renewals.

Laura Guerra-Cardus:

- Do you know generally the percentage of renewals that go through without any additional input?

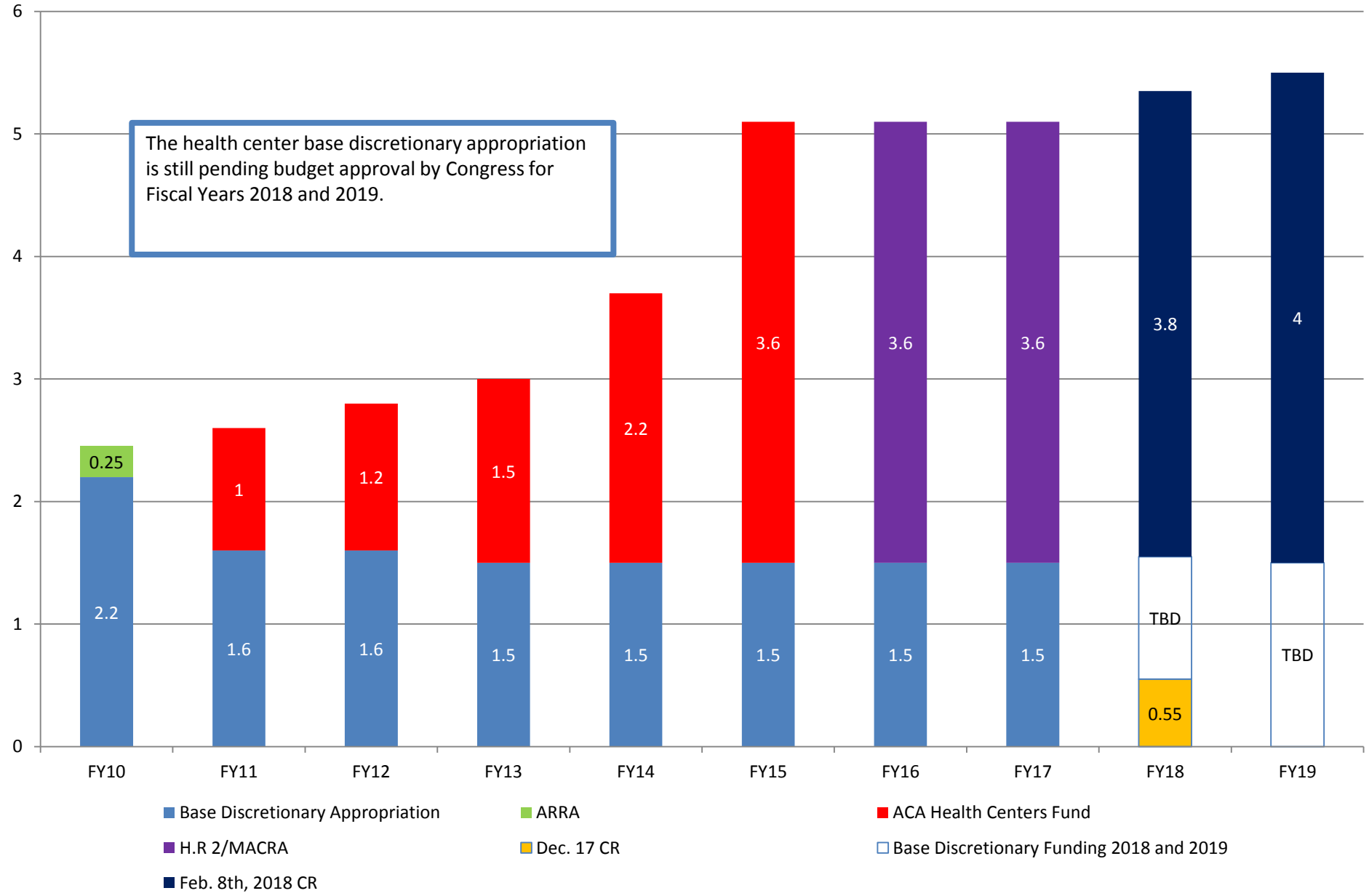
Gina Carter:

- HHSC did Nov 2016- March 2017. 171,000 that go through the process every month. 30% nothing needed, but we included the Medicaid population with disabilities.

Next Meeting: March 23, 2018

Federal Health Center Funding FY10-FY19

(Amounts in Billions)



CHILDREN'S HEALTH COVERAGE COALITION
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2018 "Quick Glance" Interim Charge Guide

(A) Medicaid and CHIP

House Committee on Appropriations

4. Monitor the ongoing implementation of S.B. 20 (84R), S.B. 533 (85R), and S.B. 255 (85R), as well as Article IX, Sections 7.04, 7.10, and 7.12 of the General Appropriations Act. Study the ***processes by which state agencies award, execute, manage, and monitor state contracts****, and make recommendations on whether any changes are necessary to safeguard the best interest of the public and state. Evaluate measures utilized to determine vendor performance, and make recommendations on how to improve vendor selection and performance. When reviewing the Health and Human Services Commission's (HHSC) managed care contracts, determine if HHSC has adequate data, staff, and processes to provide appropriately rigorous contract oversight, including but not limited to the use of outcome metrics. Consider whether HHSC properly enforces contractual sanctions when managed care organizations (MCOs) are out of compliance,* ***as well as how HHSC uses Medicaid participants' complaints regarding access to care to improve quality.***

Coalition positions:

1. Ensure a comprehensive review of the current Texas Medicaid Managed Care (TMMC) oversight standards of network adequacy and timeliness of care, including information regarding:
    a. How frequently HHSC verifies compliance and by what means,
    b. Breakdown of types and locations of providers serving Medicaid enrollees with behavioral health, long term services and supports, and medically fragile needs,
    c. Whether and how HHSC considers physician, provider and patient satisfaction in assessing HMO contractual compliance, and
    d. Detailed information on the subjects about which enrollees make inquiries or request help from MCOs but which HHSC may not ultimately categorize as complaints.
2. Review how HHSC handles complaints filed through the Office of the Ombudsman and whether those complaints are used to improve plan performance
3. Evaluate the status of implementation of the Behavioral Health Access to Care Ombudsman position created through HB 10 (85R).

11. ***Monitor Congressional action on federal healthcare reform and CHIP reauthorization.*** *Identify potential impacts of any proposed federal changes. Identify short- and long-term benefits and challenges related to converting Texas Medicaid funding to a block grant or per capita cap methodology. Determine how Texas should best prepare for federal changes, including statutory and regulatory revisions, as well as any new administrative functions that may be needed. Explore opportunities to increase the state's flexibility in administering its Medicaid program, including but not limited to the use of 1115 and 1332 waivers.*

Coalition positions:

1. The coalition opposes any capped funding arrangement that would result in reductions in eligibility, benefits and services for Texas' traditional Medicaid population locks in inadequate Medicaid physician and provider payments, or precludes the state from quickly and effectively responding to unanticipated higher health care costs stemming for natural disasters, innovations in medical care, or unanticipated health care emergencies.
    a. If Texas pursues a capped Medicaid funding proposal or if Congress enacts a capped funding formula, the legislature should clearly articulate how the state reduce Medicaid spending to stay within the new federal target, including whether it will reduce benefits, services, eligibility and/or provider payments.
    b. Alternative proposals must ensure access to pediatric-centered providers including children's hospitals, pediatricians and pediatric specialists.
2. Ensure that any analysis of Congressional proposals to cap federal Medicaid funding assesses:
    a. Both the near- and long-term aggregate and per-beneficiary reductions in funding,
    b. Exclusions of children from per-capita caps or using different inflation factors,
    c. The impact on health outcomes for Texas children and families, and
    d. The potential increase in uncompensated care for physicians and providers.

    Further, the coalition recommends that any analysis of a capped funding arrangement also compares Medicaid per-capita caps to Medicare and private market average per capita costs for comparable beneficiaries in Texas.
3. Ensure that if any new models of health care coverage pursued under a Medicaid 1115 waiver and/or Section 1332 waiver establish cost sharing requirements than they should be established on a sliding scale to ensure patients can obtain care timely without incurring medical debt.
4. Encourage the legislature to study and adopt new financing structures that can comply with federal Medicaid policy and aggregate the current patchwork of special funding and payment systems supporting hospital services (including trauma care) and Delivery System Reforms with the goal of providing financial resources to ensure that millions of working poor Texas adults can access affordable medical coverage.

18. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature. In conducting this oversight, the Committee will also specifically monitor:

- ***All activities and expenditures related to Hurricane Harvey;***
- *Any lapses in funding at the Department of Family and Protective Services (DFPS) or the Health and Human Services Commission (HHSC) f****or prevention and early intervention, and/or behavioral health services;***
- ***Implementation of therapy rate increases and policy changes at HHSC;***
- ***Medicaid cost-containment efforts***

Coalition positions:

1. The review of Medicaid-specific funding relief related to Hurricane Harvey should include inquiry into the adequacy of the response for non-hospital health care providers, and for non-urban Harvey-affected counties.
2. Review of any Medicaid cost-containment efforts should include analysis of the comparability of Medicaid payment rates for an affected service to those of Medicare, and whether proposed cost containment constraints on spending for a service may contribute to higher costs in hospitalization or long term services and supports.

3. Additional funding should be made available for conditions made worse by Hurricane Harvey such as behavioral health trauma and asthma.

House Committee on Human Services

2. Review the history and any future roll-out of Medicaid Managed Care in Texas. Determine the impact managed care has had on the quality and cost of care. In the review, determine: ***initiatives that managed care organizations (MCOs) have implemented to improve quality of care; whether access to care and network adequacy contractual requirements are sufficient; and whether MCOs have improved the coordination of care. Also determine provider and Medicaid participants' satisfaction within STAR, STAR Health, Star Kids, and STAR+Plus managed care programs****. In addition, review the Health and Human Services Commission's (HHSC) oversight of managed care organizations, and make recommendations for any needed improvement.*

Coalition positions:

1. Ensure a comprehensive review of the current Texas Medicaid Managed Care (TMMC) oversight standards of network adequacy and timeliness of care, including information regarding:
    a. How frequently HHSC verifies compliance and by what means,
    b. Breakdown of types and locations of providers serving Medicaid enrollees with behavioral health, long term services and supports, and medically fragile needs,
    c. Whether and how HHSC considers physician, provider and patient satisfaction in assessing HMO contractual compliance, and
    d. Detailed information on the subjects about which enrollees make inquiries or request help from MCOs but which HHSC may not ultimately categorize as complaints.
2. Ensure that a review results in the availability of a table or matrix from HHSC detailing the unique care coordination and case management features and standards of each category of TMMC. Testimony from beneficiaries and their caregivers should be sought to solicit independent perspectives on the adequacy of or gaps in care coordination. Further, what obligations, if any, do the TMMC care coordinators have to work with a patient's physician(s)? If any, how do care coordinators communicate with physicians?
3. Evaluate efforts to streamline credentialing requirements for providers seeking to offer targeted case management and rehabilitative services to children, adolescents, and their families. This analysis should include a review of changes in the number of providers offering these services, as the intent of SB 58 (83R) and SB 74 (85R) was, in part, to increase statewide capacity for targeted case management and rehabilitative services for high-needs children, adolescents, and their families.
4. Identify continued opportunities to reduce paperwork and red tape, including reductions in MCO prior authorization requirements, as a means to recruit and retain more participating Medicaid MCO physicians and providers.

Senate Health and Human Services Committee

Medicaid Managed Care Quality and Compliance: Review the Health and Human Services Commission's efforts to ***improve quality and efficiency in the Medicaid program****,* ***including pay-for-quality initiatives in Medicaid managed care****.* ***Compare alternative payment models and value-based payment arrangements with providers in Medicaid managed care****, the Employees Retirement System, and the Teachers Retirement System, and identify areas for cross-collaboration*

and coordination among these entities. Evaluate the commission's efforts to ensure Medicaid managed care organizations' compliance with contractual obligations and the use of incentives and sanctions to enforce compliance. Assess the commission's progress in implementing competitive bidding practices for Medicaid managed care contracts and other initiatives to ensure the best value for taxpayer dollars used in Medicaid managed care contracts.

Coalition positions:

1. Review in detail the rate-setting process for TMMC premiums, and analyze the relationship between allowable retained profits for MCOs and the adequacy of primary care physician, physician specialist and provider reimbursement rates. Identify aspects of the methodology which may provide financial disincentives for adoption of delivery system reforms and best practices broadly by all MCOs.
2. Examine strategies for improving efficiency in Medicaid/CHIP eligibility and renewal processes in order to decrease gaps in coverage, avoid related costs to managed care system, and promote quality-based value initiatives through managed care.
3. Examine how implementation of new value-based payment arrangements will impact solo and small provider practices and what resources the state and/or MCOs should provide to help these practices evolve to meet new quality and performance standards.
4. Explore how value-based payment models can incorporate evidence-based maternal health and safety bundles -- which are best practices and protocols for maternity care -- in order to reduce maternal mortality and improve infant health.
5. Review the role of evolving Local Provider Participation Funding (LPPF) mechanisms and Uniform Hospital Rate Increase Program (UHRIP) mechanisms in supplementing the adequacy of state-budget-funded MCO premiums. Explore how changing federal Medicaid policies regarding the sources of matching funds and the methods by which the gap between Texas Medicaid and Medicare rates can be financed may create incentives for adopting new uniform statewide funding approaches. Explore how Texas could comply with changing federal Medicaid policy regarding funding for Delivery System Reform Incentive Payment (DSRIP) projects, specifically the directive that the innovations be "built into" TMMC benefits and premiums, to allow Texas retain successful DSRIP innovation as well as the related federal funding.

Senate Finance Committee

Monitoring: Monitor the implementation of the following funding initiatives:

- *Health Care Costs Across State Agencies, Monitor coordination efforts among state agencies to **improve health care and reduce costs** pursuant to Article IX, Section 10.06 and Section 10.07*
- *Behavioral Health, Monitor the state's **progress in coordinating behavioral health services and expenditures** across state government, pursuant to Article IX section 10.04, including the impact of new local grant funding provided by the 85th Legislature.*

Coalition positions:

1. Examine the extent to which new local behavioral health grant funding serves children. Consider a requirement that a certain percentage of local behavioral health grant funding go towards early intervention and prevention.
2. To be comprehensive, the review should examine strategies for improving efficiency in Medicaid/CHIP eligibility and renewal processes for children in order to decrease gaps in coverage, avoid related costs to managed care system, and promote quality-based value initiatives through managed care.

(B) Maternal Health and Birth Outcomes

Senate Health and Human Services Committee

Monitoring Charge: Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:

- ***Initiatives to better understand the causes of maternal mortality and morbidity, including the impact of legislation passed during the first special session of the 85th Legislature. Recommend ways to improve health outcomes for pregnant women and methods to better collect data related to maternal mortality and morbidity;***

Coalition positions:

1. Enhance investments in critical programs aimed at improving maternal and infant health outcomes, including programs designed to reduce maternal mortality and morbidity. Among the areas the committee should explore include adequacy of funding for Medicaid, CHIP, women's health, mental health and substance use treatment and recovery programs. To maximize the return of Texans' federal tax dollars, prevent damaging cuts to the medical safety net programs, and reduce maternal mortality and morbidity, the Legislature should study and adopt new financing structures that aggregate the current patchwork of special programs and payment systems and ensure more Texans can access affordable medical coverage, including enhanced coverage for women before and following pregnancy in order to improve maternal health.
2. Expand the reach of current campaigns and initiatives to educate women about the importance of prenatal and postpartum care. Assess the extent to which the state can utilize multiple points of contact (including home visiting programs, community health workers, and health plans) to increase access to prenatal and postpartum Examine ways to utilize telehealth to improve prenatal and postnatal health and safety, including in rural areas and areas with transportation barriers; and specific strategies to reduce turnaround time for Medicaid/CHIP Perinatal applications and receipt of insurance cards.

Senate Health and Human Services Committee

*Substance Abuse/Opioids**: Review substance use prevention, intervention, and recovery programs** operated or funded by the state and make recommendations to enhance services, outreach, and agency coordination. **Examine the adequacy of substance use, services for pregnant and postpartum women enrolled in Medicaid or the Healthy Texas Women Program and recommend ways to improve substance use related health outcomes for these women and their newborns**. Examine the impact of recent legislative efforts to curb overprescribing and doctor shopping via the prescription monitoring program and recommend ways to expand on current efforts.*

Coalition positions:

1. Analyze the extent to which devising coverage options for low-income Texas adults could most effectively support optimal access to adequate substance use disorder treatment, mental health, and postpartum care while maximizing the return of federal tax dollars to Texas and reducing the shift of costs to local taxpayers.
2. Continue sustainable funding for health programs that prevent and treat substance use disorders, including but not limited to funding for Medicaid, CHIP, and substance use treatment

and recovery programs. This includes increasing state investments (state match) in treatment/recovery providers funded under Texas' Substance Abuse and Prevention Block Grant.
3. Continue robust funding for Texas' women's health programs, which may provide a woman her only source of medical care within a year and thus an opportunity to screen for opioid use or other behavioral health disorder.
4. Fully fund and expand successful, cost effective services aimed at reducing the incidence, severity, and costs associated with fetal alcohol spectrum disorder and neonatal abstinence syndrome, including but not limited to the Mommies Program and the Pregnant, Postpartum Intervention Program (PPI).
5. Examine opportunities to increase capacity among HHSC-funded substance use treatment providers; examining barriers to accessing Medication-Assisted Treatment (MAT) including provider shortages and transportation barriers, and assessing ways to expand the reach and capacity of female-specialized substance use treatment/recovery programs that keep parents and children together.
6. Review in detail DFPS policies for investigation and child removal as a result of parental substance use and compare with clinical best practices to support infant health and maternal outcomes for pregnant and postpartum women.

House Select Committee on Opioids and Substance Abuse

2. ***Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness.*** *In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served.* ***Consider whether the programs have the capacity to meet the needs of Texans****. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans.* ***Recommend strategies to increase the capacity to provide effective services.***

Coalition positions:

- *See Senate positions above*

House Committee on Public Health

1. Review state programs that provide women's health services and recommend solutions to increase access to effective and timely care. During the review, identify services provided in each program, the number of providers and clients participating in the programs, and the enrollment and transition process between programs. Monitor the work of the Maternal Mortality and Morbidity Task Force and recommend solutions to reduce maternal deaths and morbidity. ***In addition, review the correlation between pre-term and low birth weight births and the use of alcohol and tobacco.*** *Consider options to increase treatment options and deter usage of these substances.*

Coalition positions:

1. Continue robust funding for Texas' women's health programs, which further our state's efforts to improve maternal and child health and while also reducing Medicaid and public health costs. Healthy Texas Women and the Family Planning Program offer preventive care and health screenings that help improve pregnancy health, reduce risks of pre-term and low-birth weight births, and help women manage health conditions before they become pregnant. HTW and FPP providers may be the only provider a woman sees in a year for routine care, presenting a vital

opportunity to screen and refer women to additional behavioral health and substance use services.

2. If data indicates inadequate provider capacity or quality of care within the state's women's health programs, legislators should work with HHSC to address gaps in health coverage and to ensure that all providers offer services that meet quality family planning standards as recommended by the Centers for Disease Control and Prevention.
3. Increase awareness of and access to the state's women's health programs by utilizing multiple points of contact -- such as community health workers, health plans, or peer services.
4. Though women from Medicaid for Pregnant Women are auto-enrolled in Healthy Texas Women 60 days after delivery of a child, legislators should identify ways to ensure more women receive health services after being auto-enrolled into HTW, including more outreach to inform clients and health providers about this opportunity.
5. Study and adopt ways CHIP Perinatal health plans can connect women to Texas' Family Planning Program in their service area after the birth of their child.
6. Examine extent to which CHIP health plans can help connect youth who are aging out of CHIP coverage (e.g., turning age 19) with the state's women's health programs in order to support continuity of care.
7. Examine to enhance coverage options for low-income women as a means to improve access to primary care before, during, and after pregnancy, improve birth outcomes, and reduce maternal deaths and morbidity while maximizing the return of federal tax dollars to Texas and reducing the shift of costs to local taxpayers.

(C) Early Childhood Intervention

House Committee on Appropriations

10. Examine the Early Childhood Intervention Program (ECI) in Texas, including a review of historical funding levels, programmatic changes, challenges providers face within the program, and utilization trends. Evaluate ECI's impact on reducing the long-term costs of public education and health care. Identify solutions to strengthen the program.

Coalition positions:

1. Increase the per child allotment to ECI contracted entities to cover the actual (or closer to actual) costs of providing services to one child who qualifies for services
2. Highlight the lack of appropriations to fund Child Find efforts and caseload growth within ECI session after session. Possibly explore a policy mechanism to ensure future funding of Child Find efforts and caseload growth.
3. Mandate commercial insurance to cover services provided by the credentialed Early Intervention Specialists (EIS staff) for Specialized Skills Training (SST) to assist ECI contractors to increase revenues from third party sources and alleviate the need to use GR contract funds.
4. Further restore therapy rate reductions and/or hold ECI harmless from previous rate reductions due to the program's best practice status for children 0-3

House Select Committee on Opioids and Substance Abuse

1. Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas.

Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.

Coalition positions:

1. [*Also see section above on Maternal Health and Birth Outcomes*]
2. Highlight the impact of parental substance use on newborn children and the availability of ECI as resource for children with disabilities as a result.
3. Increase investment in ECI (see above ECI asks) to ensure access to services for all children who need them.
4. Evaluate insurance practices and coverage requirements regarding substance use treatment for children.

Biennial Calendar Fee Review

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Biennial Calendar Fee Review

- Critical Website Information
- Example Fee Review Topics
- Steps in Calendar Fee Review Process

Biennial Calendar Fee Review

Critical Website Information

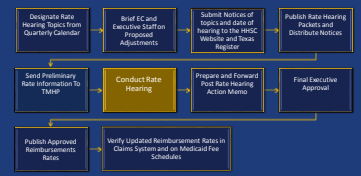
- **HHSC Main Website:** https://hhs.texas.gov/
- **HHSC Rate Analysis:** https://rad.hhs.texas.gov/
- **HHSC Meetings and Events:** https://hhs.texas.gov/about-hhs/communications-events/meetings-events
- **Texas Register:** http://www.sos.state.tx.us/texreg/index.shtml
- **Texas Medicaid Healthcare Partnership (TMHP):** http://www.tmhp.com/Pages/default.aspx
- **TMHP Provider Website:** http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx
- **TMHP Fee Schedules:** http://public.tmhp.com/FeeSchedules/Default.aspx

Biennial Calendar Fee Review

PRICING AND FISCAL IMPACT

Category of Codes	Category Description	Effective Date of Rate Change	Estimated # of Unique Procedure Codes	Estimated # of TOS Code Combinations
Blood Products	Blood Product Codes	10/1/2017	97	97
"A" Codes	DME	10/1/2017	199	199
Female Genital System Surgery	Surgical procedures associated with the Female Genital System	10/1/2017	483	894
Ears, Nose and Throat	Special procedures of the Ears, Nose and Throat, and Speech and Hearing Devices. Swallowing Evaluations	10/1/2017	123	123
Radiation Oncology	Radiology Guidance procedures	10/1/2017	146	263
Nuclear Medicine	Radiology-Nuclear Medicine	10/1/2017	473	815
Physician Administered Drugs	2nd Review SFY17	10/1/2017	532	577
Vaccines and Toxoids	2nd Review SFY17	10/1/2017	185	187
Physician Administered Oncology	2nd Review SFY17	10/1/2017	379	379
Dental Services	Dental Services procedures	10/1/2017	26	26
Home Health Agency Review	Home Health procedures including PDS and PDN (Exc legislative action (excluding Therapies)	10/1/2017	11	11
Renal Dialysis	Renal Dialysis procedures	1/1/2018	35	35
"H" Codes	Portable x-ray	1/1/2018	1	1
Diagnostic Radiology	Diagnostic Imaging	1/1/2018	430	1,245
"Q" Codes	Temporary Codes	1/1/2018	31	47
Musculoskeletal System-Surgery	Surgical procedures associated with the Musculoskeletal System	1/1/2018	1,695	5,825
Enteral Supplies ("B" codes)	Enteral and parenteral therapy	1/1/2018	62	62
Radiopharmaceuticals	A-Codes associated with Radiopharmaceuticals	1/1/2018	18	18

Biennial Calendar Fee Review



Thank you

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The Trump Administration's "Public Charge" Attack on Immigrant Families
INFORMATION ABOUT AN UPCOMING PROPOSED RULE

Last updated February 8, 2018

THE TRUMP ADMINISTRATION IS OPENING a new front in its assault on family-based immigration by making it harder for immigrants who might use essential public services to come to the United States and settle there permanently.

The Department of Homeland Security has informed the Office of Management and Budget (OMB) that it plans to propose regulations that discard longstanding policy about the meaning and application of the "public charge" provisions of immigration law.[1] Reuters reported on a leaked draft of the proposed regulations, and Vox published the draft on February 8, 2018.[2] Under the current definition, a public charge is a person who is primarily dependent on the government for subsistence. A person deemed likely to become a public charge can be denied admission to the U.S. or the ability to become a lawful permanent resident (LPR). In very rare circumstances a person who has become a public charge can be deported.

Based on the draft leaked to the media, the Notice of Proposed Rulemaking (NPRM) would greatly expand the benefits that could be considered in determining whether a person is likely to become a public charge. Immigrants' use of programs related to their health, well-being, and education — *or that of their family members, including U.S. citizen children* — could be weighed in deciding whether to deny entry to the country or lawful permanent residence.

Immigrant families already worry that using government programs will harm their immigration status or their future opportunities. Any policy forcing millions of families to choose between the denial of status and food or health care would exacerbate serious problems such as hunger, unmet health needs, child poverty, and homelessness, with lasting consequences for families' well-being and long-term success and community prosperity.

How soon could the regulation be issued?

Federal agencies are generally required to inform the OMB of any significant regulations they plan to release and to submit drafts of those proposed regulations for its review.[3] The OMB reviews the drafts for multiple factors, including their consistency with applicable law. Once the OMB review is complete, the agency shares the proposed regulation with the public by publishing an NPRM in the Federal Register, and the public is provided an opportunity to comment on the proposed rule.[4]

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[1] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=1615-AA22.

[2] https://www.reuters.com/article/us-usa-immigration-services-exclusive/exclusive-trump-administration-may-target-immigrants-who-use-food-aid-other-benefits-idUSKBN1FS2ZK; https://www.vox.com/2018/2/8/16993172/trump-regulation-immigrants-benefits-public-charge; https://cdn.vox-cdn.com/uploads/chorus_asset/file/10188201/DRAFT_NPRM_public_charge.0.pdf.

[3] https://www.reginfo.gov/public/jsp/Utilities/EO_12866.pdf.

[4] https://www.federalregister.gov/.

The U.S. Department of Homeland Security notice to OMB indicates that the NPRM will be published in July 2018. However, the NPRM could be published in the Federal Register much sooner than the published release date.

What's at risk?

Federal law allows immigration and consular authorities to deny admission to the United States or adjustment to LPR status to a person they deem likely to become a public charge. The law requires officials to look at multiple issues, including the intending immigrant's age, health, education, income, assets, skills, employment, family status, and allows consideration of other relevant factors. Current policy allows officials to consider only two types of public benefits in a public charge determination: cash assistance for income maintenance and institutionalization for long-term care at government expense.[5]

This policy has advanced the public interest in ensuring that everyone can receive essential services, such as health and nutrition benefits, without being considered a public charge on that basis. The proposed changes may cause immigrant families to forego needed health care or go hungry in an effort to keep their families together.

What would the proposed rule do?

Adoption of the draft proposed regulations would mark an unprecedented departure from the current, longstanding interpretation of the public charge rules. If the draft proposal were adopted, immigration and consular officials could consider whether individuals or any of their dependent family members, *including U.S. citizen children,* had received or *simply sought* virtually any public service. Benefits that could be considered in a public charge determination would include virtually any public service, such as Medicaid, CHIP, SNAP, WIC, Section 8 housing vouchers, the Low-Income Home Energy Assistance Program, Head Start and financial assistance provided through the health insurance marketplaces established under the Affordable Care Act.

The draft NPRM also lays out negative and positive factors to be "heavily weighted" in a public charge determination. Heavily weighted negative factors include receiving public benefits for a total of more than six months during the two years before seeking admission or LPR status.

Certain benefits would be exempt from consideration in the public charge determination, including "earned" benefits connected to work or military service, loans, and emergency and disaster assistance. Services that are available to communities rather to specific individuals are also exempt from consideration under the draft proposed rule.

The draft NPRM states that noncash benefits previously excluded from the public charge determination will be considered only if those benefits are received after the effective date of the final rule. In addition, the draft provides an option for certain individuals to post a bond or cash deposit against being considered a public charge, but this option is not available to anyone receiving a public benefit and it is not clear how it would work in practice.

Who would be affected?

The public charge policy primarily affects noncitizens who are applying for LPR status through family-based visa petitions. It is important to note that **some immigrants are not subject to the public charge rules**. These include refugees; asylees; survivors of

[5] https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet.

trafficking and other serious crimes; self-petitioners under the Violence Against Women Act; special immigrant juveniles; and certain people who have been paroled into the U.S.

Public charge is not a factor in naturalization applications — LPRs applying for citizenship do not undergo a public charge test. These exceptions are encoded in law and cannot be changed by executive or administrative action.

How should we talk about this?

Investing in nutrition, health care, and other essential needs keeps children learning, parents working, and families strong, and allows all of us to contribute fully to our communities. Policies such as those outlined in the draft proposed rule are intended to discourage hard-working people from immigrating and to deter immigrant families, most of which include U.S. citizen children, from seeking help when they need it.

Already, low-income children with foreign-born parents are less likely to receive SNAP or Medicaid than are children with U.S.-born parents. And one million Latino children, 95 percent of whom are U.S. citizens, are eligible for Medicaid or CHIP but not enrolled.

Immigrants have higher rates of employment than U.S.-born citizens but often work in jobs that pay them less than their U.S.-born counterparts. Billions in taxes paid by immigrant families help support all government programs. For all people working low-wage jobs, health and nutrition assistance helps them and their families stay healthy, thrive, and contribute to society.

What can we do to resist?

We suggest that you do what you can to educate policymakers, your state and local legislators, and local community leaders about the contributions immigrant families make to your state's economy and culture — about the critical role access to nutrition and health care play in promoting community health and strengthening local economies. They need to hear about the sweeping negative consequences of any effort to expand the grounds for determining that a noncitizen is or is likely to become a public charge.

The Protecting Immigrant Families Campaign, led by the National Immigration Law Center (NILC) and the Center for Law and Social Policy — and comprised of advocates for immigrant rights, health justice, children's rights, and anti-poverty, as well as health and human service providers and legal services attorneys — has organized to support immigrant communities and to fight against these proposed changes.

If and when an NPRM is released, we will immediately share action steps and talking points for advocates. To sign up for updates, visit http://bit.ly/PIFCampaign.

In the meantime, you are welcome to reach out to us directly if you have any questions. You can contact Jenny Rejeske at the National Immigration Law Center (rejeske@nilc.org) or Madison Hardee at the Center for Law and Social Policy (mhardee@clasp.org).

How can you learn more?

NILC's website has additional resources, including an overview of public charge and advice on talking about these issues with immigrant families.[6]

[6] www.nilc.org/wp-content/uploads/2015/12/public-charge-overview-2013-10-01.pdf; www.nilc.org/exec-orders-and-access-to-public-programs/.

Social Services Programs: Medicaid and CHIP

Medical and Social Services

Access and Eligibility Services

Agenda

- **Periodic Income Checks**
- **Administrative Renewals**

Periodic Income Checks

Periodic Income Check - Purpose

A Periodic Income Check (PIC) is the process used to determine whether electronic data indicates that there has been a change in the household's income that may potentially impact eligibility.

Periodic Income Check - Programs

PICs are performed for the following programs:

- Children's Medicaid,
- Parents and Caretaker Relatives Medicaid, and
- CHIP.

Periodic Income Check - Frequency

- Children's Medicaid
  - Months 5, 6, 7, and 8
  - The first time the result of an income check could impact eligibility is in the 7th month.
- Parent and Caretaker Relatives Medicaid
  - Months 3, 4, 5, 6, 7, and 8
  - The first time the result of an income check could impact eligibility is in the 4th month.
- CHIP households (who require an income check)
  - Month 5
  - The first time the result of an income check could impact eligibility is in the 7th month.

Periodic Income Check - Process

- The Texas Integrated Eligibility Redesign System (TIERS), HHSC's eligibility automation system, triggers the automated periodic income check process at the beginning of the applicable month.
- During the PIC process, TIERS compares a household's income information already existing in TIERS and any reported changes that have not yet been processed (often because they were reported during the continuous eligibility period of the certification) with electronic data income information.

Periodic Income Check – Data Sources

Electronic Data Sources (ELDS) used during a PIC include:

- Earned income from the Texas Workforce Commission (TWC) and The Work Number System (TALX)
- Retirement, Survivors and Disability Insurance (RSDI) income from the SSA
- Unemployment income from TWC
- Federal New Hire Report

When Periodic Income Check is Not Done

PICs are <u>not</u> performed in the following situations:

- When a renewal, change, or periodic income check is being processed;
- When income verification provide by the household is less than 60 days old;
- For children aging out of Medicaid or CHIP during the month of the periodic income check; and
- CHIP households with income below 185 percent FPL at the time of application or renewal.

Periodic Income Check – Outcomes

- The PIC process could result in the following outcomes:
  - Benefits sustained
  - Request for additional information
  - Denial due to excess income
- The entire process can be completed without staff action or requesting information from the household if there is no indication there has been a change in the household's income that makes them potentially ineligible for Medical Programs.

Periodic Income Check – Reasonable Compatibility

	Reasonable Compatibility Result	System Outcome
1.	FPL: Client Statement / Electronic Data	• The individual is not contacted and remains eligible
2.	FPL: Client Statement / No Electronic Data	• The individual is not contacted and remains eligible
3.	FPL: Electronic Data / Client Statement	• System will pend for required verification
4.	FPL: Client Statement / New Hire Report Exists	• System will pend for required verification
5.	FPL: Client Statement / Electronic Data	• Individual determined ineligible due to excess income
6.	FPL: Client Statement / Electronic Data	• Individual determined ineligible due to excess income

Periodic Income Check – Outcomes

Medicaid

- If eligibility is sustained, the individual continues receiving Medicaid.
- If eligibility is denied at PIC based on income and income is at or below the CHIP limit, the child is certified for CHIP beginning the month after the Medicaid denial.
- If eligibility is denied at PIC based on income and the income is above the CHIP limit, the child is referred to the Market Place.
- If eligibility is denied based on failure to provide information, the child is not referred to the Market Place.

CHIP

- If eligibility is sustained, the child continues to receive CHIP through the end of their 12-month certification period.
- If eligibility is denied based on income, the child is referred to the Market Place.
- If eligibility is denied based on failure to provide information, the child is not referred to the Market Place.

Administrative Renewals

Administrative Renewal Process

The automated renewal process runs the weekend before cutoff in the ninth month of the certification period for Medicaid programs and CHIP.

The process uses electronic data that automatically:
- Evaluates the verifications required for renewals;
- Determines the eligibility outcome; and
- Sends the appropriate renewal correspondence to the household.

Administrative Renewal Process

Automated Renewal Process: Verifications Required by Type Program for Renewals	
Parents and Caretaker Relatives Medicaid	• Residence • Income and Expenses • Immigration Status* • Domicile • Full-time School Attendance, when the only dependent child(ren) is age 18
Children's Medicaid CHIP	• Income and Expenses • Immigration Status*

*Immigration status is only verified during the automated renewal process if the individual's immigration document expires during the current certification period.

Administrative Renewal – Data Sources

Electronic Data Sources (ELDS) used during Administrative Renewals include:
- Earned income from the Texas Workforce Commission (TWC) and The Work Number System (TALX)
- Retirement, Survivors and Disability Insurance (RSDI) income from the SSA
- Unemployment income from TWC
- Federal New Hire Report
- USCIS SAVE

Administrative Renewal Outcomes

The Administrative Renewal could result in following outcomes:
- Eligibility potentially approved
- Additional information needed
- Eligibility terminated

Administrative Renewal – Reasonable Compatibility

	Reasonable Compatibility Result	System Outcome
1.	FPL — Client Statement — Electronic Data	• No additional verification is required from the individual
2.	FPL — Client Statement — No Electronic Data	• No additional verification is required from the individual
3.	FPL — Client Statement — Electronic Data	• System will pend for required verification
4.	FPL — Client Statement — New Hire Report Exists	• System will pend for required verification
5.	FPL — Client Statement — Electronic Data	• Individual determined ineligible due to excess income
6.	FPL — Client Statement — Electronic Data	• Individual determined ineligible due to excess income

Administrative Renewal Outcomes

Eligibility Potentially Approved

- All required eligibility information can be verified during the automated renewal process for the program.
- Households are provided with a pre-populated renewal form, H1206, Health Care Benefits Renewal, and a cover letter informing the household they must:
  - Review the information used to determine their eligibility; and
  - Return the Form H1206 *only* if the information on the renewal form is incorrect or there are changes to the individual's information.

Administrative Renewal Process

Additional Information Needed

- Additional information required to determine whether the individual remains eligible since:
  - Electronic data sources indicated there was a change in income that may result in ineligibility for Medical Program
  - Information was found on the New Hire Report which requires verification.
- Households are provided with a pre-populated renewal form, H1206, Health Care Benefits Renewal, and a cover letter informing the household they must:
  - Return the signed Form H1206, and
  - Provide all required verification(s) within 30 days.

Administrative Renewal Process

Eligibility Terminated

This outcome may be the result of two scenarios:

- The previous eligibility outcome was *Additional Information Needed* and eligibility was terminated because the individual:
  - Did not submit the required verifications within 30 days to verify that income is under the limit; or
  - Submitted verifications that showed that the income was over the limit.
- The individual reported a change in income that was over the income limit and eligibility was terminated before the automated renewal process was triggered.