Texas CHIP Coalition/OTA Meeting
Meeting Minutes

November 15, 2013

Present:
Anne Dunkelberg, CPPP
Aaron Herrera, Hunger Free Texans and Houston Food Bank
Clayton Travis, TCFC
Tierra Thomas, Sendero
Rita Hanson-Bohl, Sendero
Sr. JT Dwyer, Seton
Kit Abney Spelce, insure-a-kid
Tara Ray, UT Austin
Warren Cooper, TMA
Laura Blanke, TPS
Megan Randall, CPPP
Kathleen Davis, TX IAF Network
Helen Kent Davis, TMA
Lauren Dimitry, TCFC
Simone Nichols-Segers, NMSS
Ashlee Mooneyham, CommUnityCare
Sarah Ortiz, CommUnityCare
Debra Diaz-Lara, TDI
Doug Danzeiser, TDI
Laura Guerra-Cardus, CDF
RexAnne Shotwell, TACHC
Elizabeth LaMair, HHSC
Jessica Boston, Office of Rep. Naishtat
Trey Berndt, AARP
Stacey Pogue, CPPP
Summer Stringer, Texas Food Bank Network
Katy, Texas Food Bank Network
Kathy Eckstein, CHAT
Jeanie Donovan, CPPP
Maria Serafine, Lone Star Circle of Care
Jennifer Banda, THA

Conference Line:
Parkland Hospital
Deborah Ellison
Molina Healthcare
Vicki Perkins, Children's Hospital in San Antonio
Robin Chandler, Disability Rights Texas
Diane Rhodes, TDA
Betsy Coats, Maximus
Miryam Bujanda, MHM
Stacy Wilson, THA
John Berta, THA

Chair: Kathy Eckstein, Director of Public Policy, CHAT
Minutes Scribe: Megan Randall, CPPP

Next meeting: December 13, 2013

CHIP PORTION OF MEETING

I. Presentation on Network Adequacy and Balance Billing: Debra Diaz-Lara and Doug Danzeiser, Texas Department of Insurance

Network Adequacy

DDiaz-Lara

- We have the same network standards for HMO, PPO, and EPO.
- We are looking for sufficient primary care providers and specialists with admitting privileges 24/7. General psychiatric care 24/7 as well.
- For a limited network, or "narrow network," we can approve them but that network still has to meet all the same adequacy standards. Have to provide all services and have the same mileage/range. Urgent care within 24 hours. Routine care within 3 weeks and 2 weeks for behavioral health. Also look for preventive care within 2 months for children, 3 months for adults, and 4 months for dental services.
- Rule is 28 T.A.C. 11.1607. This is the HMO rule. Will be the same for PPO and EPO.
- Radius is 30 miles from everywhere in entire service area for a non-rural area. Radius is 60 miles for rural. 75 mile radius for specialty care/hospitals.
- For HMOs, if a plan cannot meet these requirements, must submit an access plan. Have to explain why they haven't contracted in that area, and give maps about who is and isn't available. Have to show a plan as to how to provide services to people in this area.
- PPO and EPO have to meet same standards (freedom of choice, availability of providers) but if they don't have an adequate network, they have to submit both an access plan as well as a request for a waiver to be able to market in that area. We want to see why they are not contracted with providers. The general answer tends to be that providers won't contract with them. All of the most recent waiver requests, however, said that there were no providers available in these areas. If there are no providers available, we can understand that, but we also double check to see if they have any of that type of provider.
- Every April, the plans have to show us they have an adequate network, or have to file a waiver request with an access plan. Starting next April, will start this on a routine basis.

TBerndt

- Texas is one of the most heavily urbanized states in the country. Have you reevaluated the 75 mile specialty care radius to see whether this is an appropriate urban standard?

DDiaz-Lara

- We have looked, but also need to balance this with where providers are and their availability. If we change the standard, then those in the south, west, and east Texas regions may not be able to meet a new standard.

TBerndt

- Medicare Advantage standards are adjusted based on size, and calculate an average plan size based on the counties, metropolitan size, rural vs. urban, etc. We think the 75 mile standard, both in the commercial world and also Medicaid, is outdated.
- Once you approve network, do you spot check to see if it is a valid network? Problem in Medicaid is that the network described in book is no longer a real network. Not taking new members.

DDiaz-Lara

- We do spot checks, call providers, and monitor complaint ratios. We go in if we are hearing complaints about it.
- We do Medicaid and CHIP plan review just like any commercial plans. Only exception, by rule, is for CHIP perinatal program.
- Plans have to submit provider list, where they are, whether accepting new patients or not. Will usually accept this at face value, unless we see an issue. Sometimes you can say that the network won't be adequate by looking at it, and then we verify. Otherwise, we assume it is correct unless we get a complaint. HMOs reviewed every three years by exam. PPOs are in same rotation. We can do a desk review at any time if we need to.

KAbneySpelce

- Is there a formula for each county, have to have X percentage taking new patients?

DDiaz-Lara

- Don't have a formula. Plans have to tell us how many members they expect to have. If we see a large jump in enrollment, we want them to be able to handle that load of patients and can make sure they can do this.

KEckstein

- State requirements for inclusion of essential community providers?

DDiaz-Lara

- TDI does not have these. If it is a requirement in CHIP or Medicaid plans, we'll look to see who those providers are and make sure they are included.

KEckstein

- Are access plans available to the public?

DDiaz-Lara

- Available as open records request. Exam docs not available.

KEckstein

- Are there state requirements for making provider directories available?

DDiaz-Lara

- Yes. Have to give a hardcopy, and have to have available online, and must update quarterly.

HKentDavis

- Will the April reports differentiate between broader and narrow networks? How will this be broken down for plans in the Marketplace vs. outside the Marketplace?

DDiaz-Lara

- Each plan has to be licensed through the department (inside and outside of Marketplace). Each statewide and each narrow network will have to have that report.

HKentDavis

- Any potential that TDI would make these available to the public, rather than through open records?

DDiaz-Lara

- Can't answer that here but can take it back and ask.

Payments and Balance Billing

DDanzeiser

- Payment issues come up with out of network services. Approach TDI has taken is we are not setting payment standards for insurers or consumers who voluntarily go out of network.
- We are setting reimbursement standards for consumers who are forced to go out of network either because of emergency or an inadequate network. In these cases, the carrier is supposed to go ahead and pay the claim at the usual and customary rate.

- There are standards about how they come up with this rate, and they have to tell consumers about the source of the data, how it is used, and what reductions they make. If the consumer does get a balance bill and pays it, then the insurer has to credit it to their deductible and out of pocket maximum.
- In terms of transparency, there are different things that insurers have to disclose to consumers. In provider directories, they have to identify hospitals that will assist patients in getting care from network providers. Hospital gets a gold star if they help you find an anesthesiologist in network. Information that will guide consumers to facilities where they will not get balance billed. Also have to disclose which facilities have a whole provider class (for example, anesthesiologists) in which none of their providers are contracted. Carriers have to notify through their website when there is a substantial decrease in in-network providers. Additionally, carriers have to be notified when a referral is made for surgery.

ADunkelberg

- What is the effective date of rules?

DDanzeiser

- Became effective in July and will roll-out as plans renew after July.

TBerndt

- Complaints from some AARP members who go into network hospital, where none of the emergency services or anesthesiologists are in network. When you say you are informing consumers, are they getting informed about it up front in consumer materials? Sophisticated issue for people to understand.

DDanzeiser

- What you've mentioned is a classic example of the problem that these rules are supposed to solve, and it is one important part in assessing the adequacy of the network.
- If there is a service area, we require that there is at least one hospital that has a variety of contracted providers there. There might be hospitals where they don't have everyone contracted, but they need to have a place where they can be confident that everyone will be contracted. Also, when you look at your directory, you'll be able to look and see the number of out of network claims, etc.
- We don't dictate exact language. But do have to disclose the percentage of out-of-network claims.
- Also, what this rule does is, in an emergency, the carrier has to bump the reimbursement rate up at least to the usual and customary rate.

KDavis

- Can TDI at least try to ensure that insurers have to provide this information in plain language and make it easily findable?

DDanzeiser

- Rule requires carriers to provide a bill of rights. This is a list of essential things we thought consumers needed to know. We also do review actual policy docs and have some standards for readability, so we would review them to make sure they aren't too complex.

HKentDavis

- How is "emergency" defined? At what point does it cease being an emergency? If someone comes into the ER, and then gets admitted, for example.

DDiaz-Lara

- Emergency applies up to point of stabilization. Until stabilization, they have to be covered and provided care at the usual and customary rate. Once stable, the carrier can arrange to have someone moved.

HKentDavis

- Patients won't necessarily understand that once they've been admitted, that they might be cared for by people out of network. Confusing during middle of crisis. Needs to be explained very carefully by carrier and in bill of rights.

DDiaz-Lara

- This is also why we want plans to identify facilities with out of network claims. So, hopefully, people will look at these stats previously before they have to make the claim.

TBerndt

- To clarify, is there no protection, other than arbitration, for the consumer in an emergency situation being balance billed?

DDanzeiser

- This rule makes it so that the insurer has to pay the usual and customary rate in an emergency situation. We think we will see a dramatic decrease in complaints.

RChandler

- Problem is that no incentive for radiologists and anesthesiologists to join a network. What's changed?

DDanzeiser

- New statutes required TDI to do network adequacy rules and now, for the first time on the PPO side, TDI has to ensure that all carriers have adequate networks. In past did not have that authority. TDI has to enforce mileage, access requirements, etc. So, if a carrier doesn't have radiology in that area, then their network will be inadequate. Might be possible that they can't get providers, and then will come to TDI and tell them no one will negotiate.

SPogue

- Seen drop in number of complaints or reports for mediation?

DDanzeiser

- Mediation statute is four or five years old, and we have never had a claim actually go to mediation. No one wants to do this with facility-based providers.

DDiaz-Lara

- Total number of complaints has been on steady downward trend. These rules, which are new, will have a significant impact on that.

II. Federal QHP Network Adequacy Requirements: Warren Cooper, Texas Medical Association

Please see presentation slides at the end of this document for more detailed information.

WCooper

- Federal requirements offer little specific guidance, and allow states to create own their standards. All ACA plans in Texas are under the requirements of TDI.
- Federal standards say that insurers must include essential community providers.
- QHPs also required to maintain network sufficient in number and types of providers, including mental health. No unreasonable delays.
- Info must be provided to prospective enrollees on network availability
  TDI does not have provider ratios. But they do require the mileage ratios.

KEckstein

- Federal regulation for essential community providers is very loose and can be satisfied in several different ways. Bottom line is that there are exceptions, narrative justification. Not a strong requirement.

WCooper

- Not required to contract if won't accept general rate.

TBerndt

- Plans have to have an actual percentage enrolled, or just an attempt?

KEckstein

- I believe it is just an attempt. Can write narrative justification.

WCooper

- TDI does not enforce it, and I don't know of any federal enforcement mechanism.

III. Network Adequacy Requirements for Medicaid: Elizabeth LaMair, Health and Human Services Commission

Please see presentation slides at the end of this document for more detailed information.

ELaMair

- As of March 2013, STAR is state-wide.
- STAR Plus as of March is in most of major metro areas, and in Medicaid rural service areas STAR Plus does not currently operate. Will expand to these areas as of Sep 2014.
- Laws and regulations focus on providing sufficient access and meeting needs in service area.
- State law also has standards for out of network utilization in Medicaid. Requires HHSC to set benchmark standards and to set reimbursement rates.

CTravis

- Explain 90% standard [see presentation slides] and what happens to 10% of kids who don't have access.

ELaMair

- 90% based on federal requirements. Acknowledges that it would be extremely difficult, especially in rural areas, to meet the100% standard. Most of our MCOs are coming closer to the 100% mark. Some areas, generally rural and for specialty types, where MCOs have some challenges.

ADunkelberg

- How do you measure that?

ELaMair

- MCOs submit reports on their mapping results. Our strategic decision support also does their own analysis based on provider files. We look at self-report data. Focus on PCPs and on provider types that are commonly accessed. Can also monitor member complaints.
- Do have a Medicaid transportation program that can come and help people if they need to travel a long distance.

SrJTDwyer

- Have heard from newly enrolled Medicaid people that they are told a doctor is a Medicaid doctor, and then told when they call that the doctor is not taking new patients.

HKentDavis

- Doctors are complaining about inadequate networks. They call plan and say, I have a kid who needs this service, and then they can't find someone in that specialty. Plan cannot help find a specialty service. Doctors' point is that they are left liable caring for a child they are not qualified to take care of. Several doctors just said that they refer people to the emergency services in Dallas.

ELaMair

- We encourage providers to come to us with type of issue.

ADunkelberg

- When we hear complaints about ER use by Medicaid recipients, and we know that one of the reasons that Medicaid and commercial people get sent to ER is because they can't get access to specialty care quickly, we can't complain about Medicaid patients going to ER.

TBerndt

- There is a fundamental weakness in this directory method. Don't use a statistical methodology to sample "realness" of network. I think some of the networks are a little bogus. Want to use statistical methodology to test those networks. We've been told they do a telephone spot check. As big as Medicaid managed care is now, there has to be a more sophisticated methodology.
- When managed care started, TDI standards were adopted as sort of a convenience. It is way past time to review that. Need to look at a much more sophisticated methodology with Medicare Advantage standards. Set provider ratios, set time and distance requirements. It is just a much more sophisticated methodology.

ELaMair

- Will take concerns back to leadership.
- We did borrow heavily from Medicare Part D standards. Divided into rural, suburban and rural.
- Seeing good program averages for main dentists. Seeing some problems with specialty.

HKentDavis

- If a provider is located in a community and could be in Medicaid, but isn't, does HHSC do any proactive outreach to providers to encourage joining managed care network?

ELaMair

- I am not the best person to speak for agency on recruitment efforts.
- Our MCOs and DMOs are measuring provider enrollment and are going to licensing boards, etc.

ADunkelberg

- Don't understand relevance of out of network ER visits.

ELaMair

- Ideally, all visits would be in-network. Putting threshold on how much out-of-network as an indicator of network adequacy.

HKentDavis

- Had a problem where health plans were not contracting with hospitals. Had out of network and had payment issues with hospitals.

ADunkelberg

- How recent are these thresholds?

HKentDavis

- Been around for at least 5 years.

ELaMair

- If an MCO is having difficulty meeting these standards, they can get special exception from the commission. If you are interested in seeing what MCO has to demonstrate, info is available on website..

KEckstein

- Have a question from Sue Milam. Dramatic reductions in social workers participating in Medicaid. Any requirements relating to social workers?

ELaMair

- Assuming would fall under 75 mile requirement for specialists. We would monitor complaints and appeals.

KEckstein

- In review, does HHSC really look at all types of providers?

ELaMair

- Focus on types of providers seen most frequently by members. If it doesn't fall under geo mapping categories, then will monitor complaints.

IV. Medicaid Coverage Gap Activities: Laura Guerra-Cardus, Children's Defense Fund

LGuerra-Cardus

- A lot of this planning happens in CTN.
- We've been talking about how, as people are enrolled in the Marketplace, people will find that they are in the coverage gap. Want to make sure that people understand this was a state decision. It is an important opportunity for us to connect with individuals and engage them in advocacy efforts to change policy.
- One tool is a mobile friendly website called texasleftmeout.org, available in English and Spanish. People who are working with that population can consider using it as a resource.
- People really want something like this because they have hard conversations with people who don't understand why they can't get help. Will be reaching out to navigators and CACs who work with these populations
- If you are a group working with this population and want to find out about options, e-mail me or one of our team members (Stacey Pogue) and we can work with you. Also, if you have any connections, or if there is a network that you know of, please let us know.
- Press event 12 months before next session. Doing something so that is a year long building momentum for coverage expansion.

V. Navigator Rulemaking Update: Stacey Pogue, Center for Public Policy Priorities

SPogue

- TDI just sent an outline during this meeting of how they plan to move forward.
- Process outlined in SB 1795 is that if TDI identifies deficiencies in federal standards, they need to notify feds. This outline serves as notice to federal gov't, saying that either federal or state rules should do X. Don't know whether CCIIO or CMS will do anything. Not rulemaking yet, just beginning of conversation about what could be in rule.
- Definition of navigators. Proposing to regulate at the state level anyone who helps you complete a Marketplace application for assistance. Exclusion to that definition includes anyone regulated under separate authority, such as CACs, or other non-Exchange programs. Definition will be regulating navigators, and anyone who hangs out a sign for enrollment assistance who is operating under no other authority.
- Comments due by close of business next week. Informal communication. Also are suggesting:
    - Registration with TDI
    - Posting a surety bond. Form of insurance for if consumer files complaints.
    - Finger printing and background checks. Navigators have to pay for that.
    - Regulated entities cannot charge consumers.
    - Requirements for training, HIPAA and Texas-specific Medicaid training
- Will have formal rulemaking process in the future. Will work on informal comments to this that we can share with folks.

VI. Marketplace Eligibility Check-in

MSerafine

- We have seen significant improvement in website, have been able to enroll people. Seems to be working quite a bit better.
- Have screen shots of process start-to-finish. Can share.

COMBINED CHIP/OTA PORTION OF MEETING

VII. ACA Implementation Update: Valerie Eubert and Gina Perez, Health and Human Services Commission

Please see presentation slides at the end of this document for more detailed information.

VEubert

- ACA implementation rules out for comment until 17th.
- Lots of questions about collecting of assets information. State leadership gave direction to collect asset information. Wanted to clarify some key points.
- We will request information on application about assets, but will not pend anyone that does not provide that information and we will continue to process that application even if it does not have that information. Will be using it solely for analysis purposes. Have been directed to provide that information on assets.
- Also, we will be accepting all three applications.
- For the certification period, we have proposed 6 months of continuous coverage and the second 6months of non-continuous eligibility. Don't believe that we have state statutory authority to do two consecutive periods of 6 months continuous coverage.
- At end of first six-month continuous coverage period, we will not be actively reaching out to clients unless our data sources give us information that would impact their eligibility.
- We will do periodic information checks in the second period of six-month non-continuous eligibility. We will be stopping periodic information checks once we begin the renewal process.

ADunkelberg

- How does state statute not give you the authority to have two periods of 6-month continuous eligibility? What is the rationale? I don't see how this complies with state law.

VEubert

- This is because we are not doing a full re-determination at 6- months (only looking at income), as dictated under new federal law and regulation.

ADunkelberg

- Sen. Zaffirini's Office is concerned about the compliance issue.

VEubert

- When in a non-continuous system we will be checking behind the scenes on electronic data.

SrJTDwyer

- I am troubled because people have very erratic incomes. So, if you recheck them in one of their flush periods, will you throw them off the program?

VEubert

- We are just required to follow-up. We will provide an opportunity for them to verify. And if no data available, no follow -up is required. Only if we have something to show that their income has changed.

CTravis

- What are the data sources?

VEubert

- RSDI info (disability), access to TALX. Quarterly wage data through workforce commission. Have real-time interface with those. We would only reach out if information is available.

ADunkeberg

- This is because of disconnect between federal and state law.

VEubert

- Currently working on the renewal process. If you can conduct the renewal process with the info available, then we would just send them a renewal packet saying they have been renewed. Long-term individuals won't have to come back in and reapply. Won't happen in January.

GPerez

- Other issues that came up in the rules. If foster children aged out from another state to Texas, we will not cover them. Federal option to cover.

KEckstein

- Not covered by maintenance of effort requirements?

GPerez

- Direction is not to cover it.
- Maintenance would apply to kids 18 – 21. 22 if in college. Typically children are 18 and under. Maintenance of effort is for children.

CTravis

- To clarify, 22 – 26 would not be covered.

GPerez

- Not covered under maintenance of effort.

CTravis

- Timeline on maintenance of effort?

GPerez

- Don't' have one yet.

ADunkeberg

- And there is nothing on the application saying that the asset questions are optional?

VEubert

- No

ADunkeberg

- Would be interested in updates on the challenges between communication between Marketplace and state.

VEubert

- Currently, HHSC has begun testing with the Marketplace. Having regular conversations with CMS. Still trying to work out those technical issues. As those account transfers begin to come through the system, they will send them through at one time. We are accepting determinations under MAGI rules for individuals who come in from Oct 1 – Dec 31. Haven't been given further information about dates that this transfer will occur.
- The plan has been that effective Jan 1 we will transfer to Marketplace.

MSerafine

- What does this referral look like for consumers? What do we tell them?

VEubert

- We can follow up and get back to you.

KAbneySpelce

- At one point, we got estimated numbers that Marketplace folks said that we had X number in the queue. Have you gotten any other numbers? Also, currently HHSC asks whether you plan to reside in Texas and this is not a question asked on the Marketplace application. Will this pend applications?

VEubert

- For pending information on intent to reside, currently we will request that information based on state policy guidance and current process. We are going to make an assessment in first month or so, and if that is the only reason we are pending applications coming through the Marketplace, then we will look to change it.

KAbneySpelce

- Will we be tracking this for a specific period of time?

VEubert

- Haven't put a timeline yet.

KAbneySpelce

- But all files will be pended, and you will have to go get the information?

VEubert

- Yes.
- Latest numbers are 20,000 individuals. Caveat is that they may not be Medicaid or CHIP eligible, that they don't have a process to verify whether or not they are currently covered. Also have no way of knowing which individuals in a household are eligible.

KAbneySpelce

- How are things going with moving into TIERS and disenrollment of pregnant women?

GPerez

- Have reopened CHIP into TIERS command center so that staff have a global contact if there is an issue. Any issues that come in with regard to CHIP into TIERS.
- Now we have a process to update the pregnancy due date for women. But women need to call and have it updated.

KAbneySpelce

- Challenges of CHIP perinate mom in calling 2-1-1 and not getting through prompts because you don't have Social Security, case number, etc. Something to look at.

SRJTDwyer

- And it wasn't that way before CHIP went into TIERS. Now they have to press a lot of options.

KAbneySpelce

- Any statewide system for providers to check CHIP eligibility?

MSerafine

- We have a statewide for Medicaid, but can't see CHIP on our portal when we do eligibility checks.

GPerez

- We will find out.

Parkland

- Also want to raise the issue that the initial application for CHIP perinate services is taking a little bit longer.

Network Adequacy Standards for Qualified Health Plans (QHP)

Texas Medical Association

Physicians Caring for Texans

An issuer must ensure that all QHPs meet the following standards:

- Includes essential community providers
- Maintains network that is sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay
- Information must be provided to enrollees and prospective enrollees on network availability
- Access to Provider Directory

Essential Community Providers

Definition: Providers that serve predominantly low-income, medically underserved individuals, including:

- those eligible for access to the 340B Drug Pricing Program
- Providers described in Section 1927 (c)(1)(D)(IV) of the Social Security Act
- Issuers not required to contract with ECPs if ECP refuses to accept the generally applicable rate of issuer.

What is Not Required

- Minimum Enrollee/Provider Ratios
- Minimum Travel Time/Distance
- Minimum Wait Times

TEXAS
Health and Human
Services Commission

Medicaid and CHIP
Network Adequacy Requirements

Elizabeth LaMair

Director, Contract Compliance & Support

Medicaid/CHIP Division – Program Operations

November 15, 2013

TEXAS Health and Human Services Commission

Topics

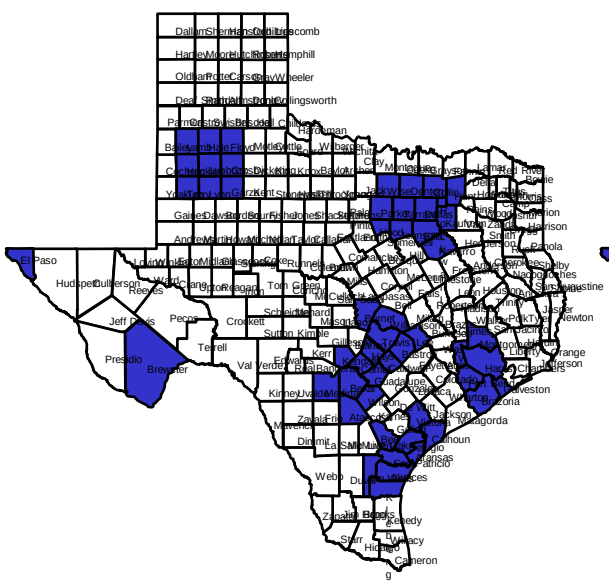
- Overview of Medicaid and Children's Health Insurance Program (CHIP) MCOs in Texas
  - Operational Authority
  - Medicaid Expansions/Maps
  - MCOs by Service Area
- Network Access Requirements & Standards
  - Federal & State Laws & Regulations
  - 1115 Waiver's Reporting Requirements
  - Managed Care Contract Requirements
- Balance Billing

TEXAS Health and Human Services Commission

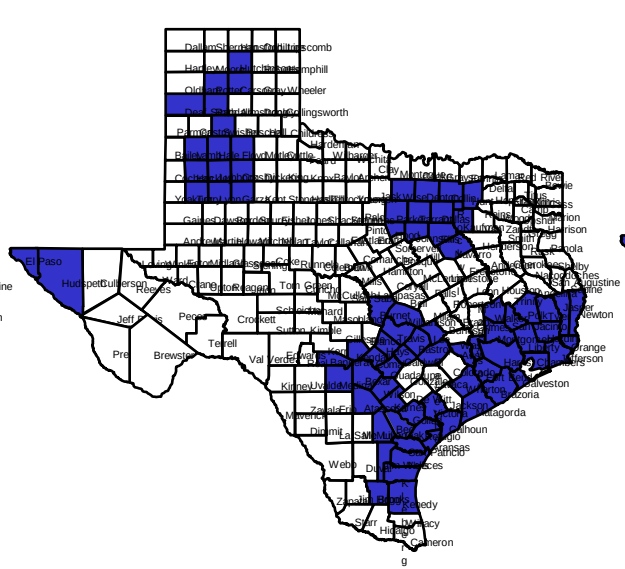
Operational Authority

- STAR, STAR+PLUS and Children's Medicaid Dental Programs -- Texas Healthcare Transformation and Quality Improvement Program Waiver (1115 Waiver)
- STAR Health – Medicaid State Plan
- CHIP – CHIP State Plan

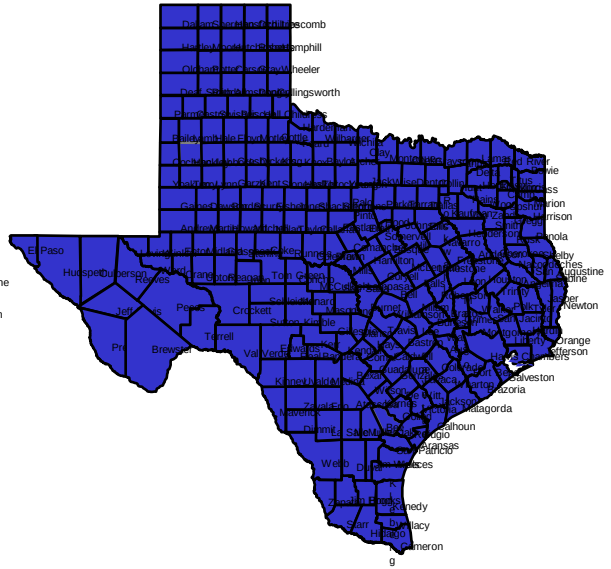
Overview : STAR Expansion



February 2011

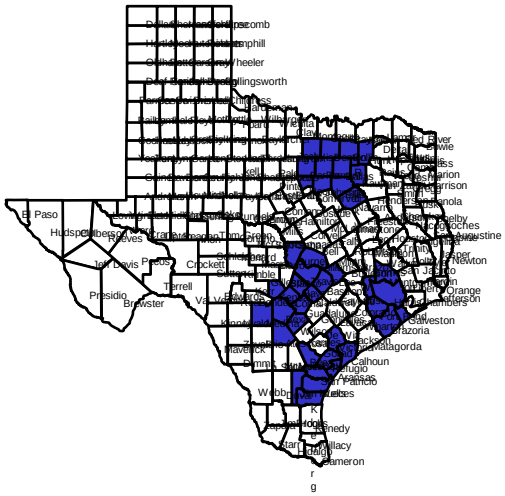


September 2011



March 2012

Overview : STAR+PLUS Expansion



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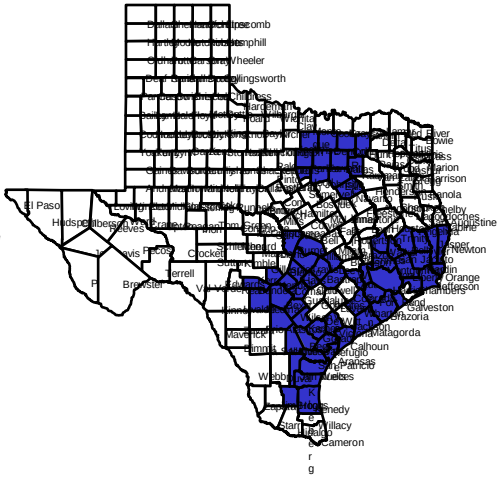

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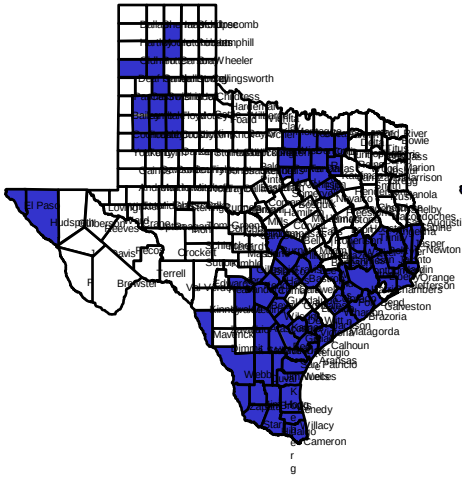
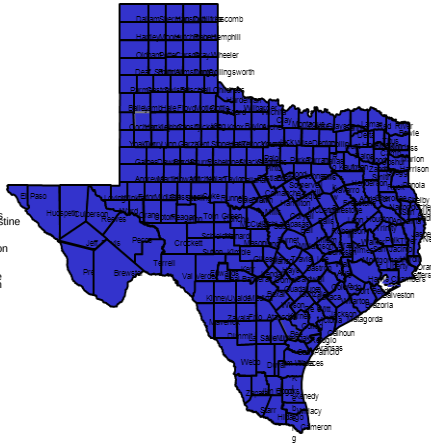


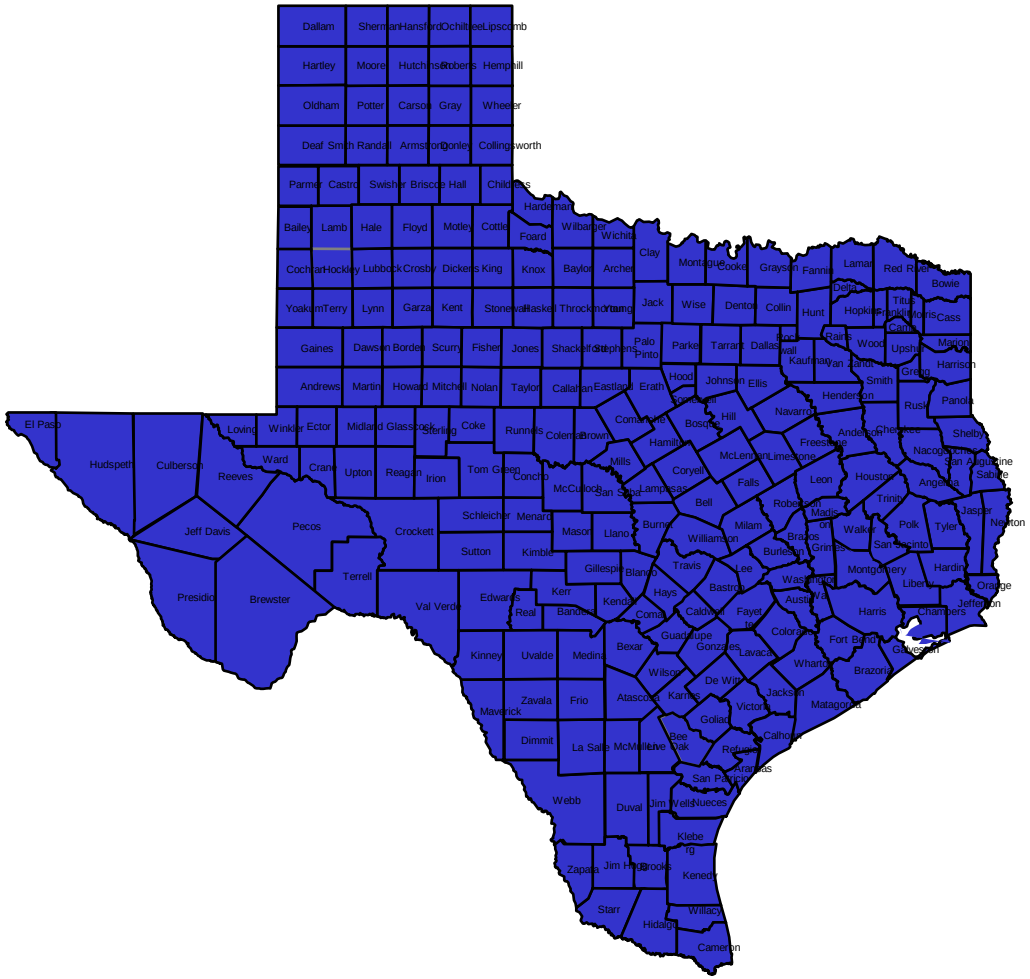
March 2012



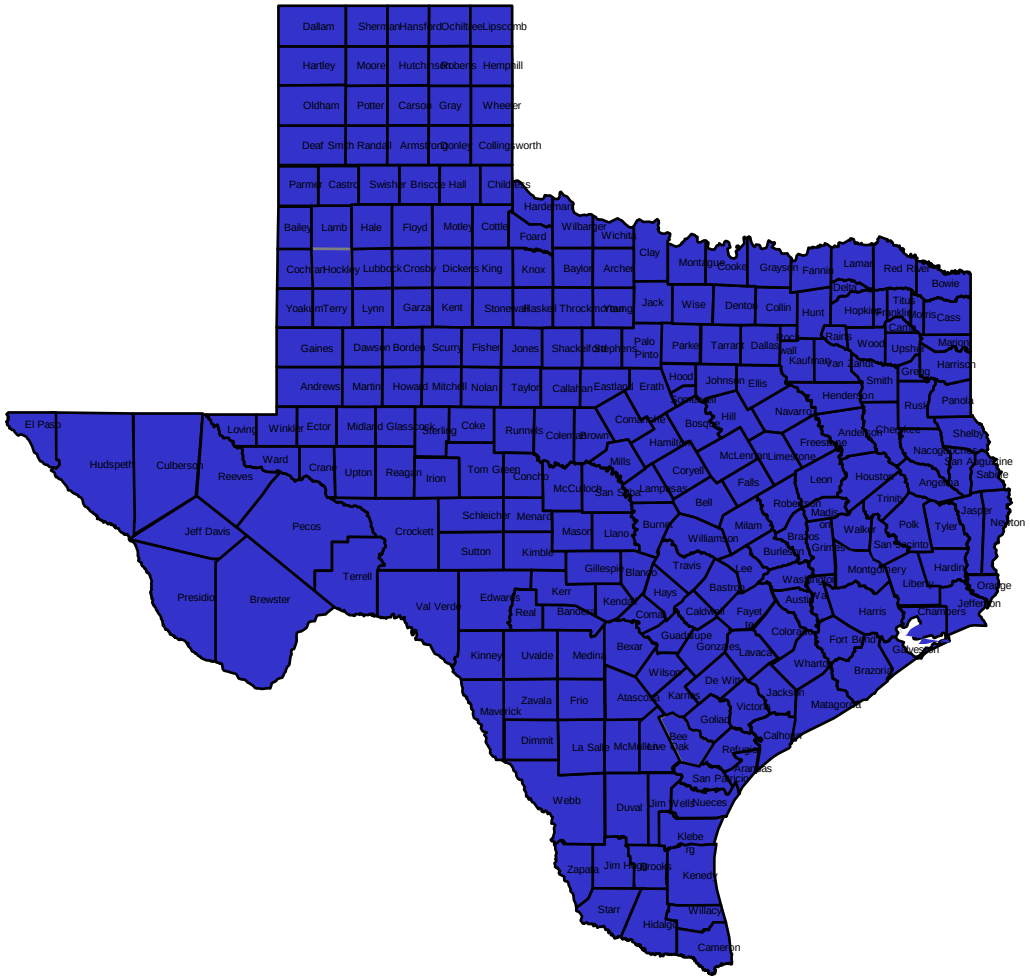
September 2014

Overview : Medicaid Dental Services

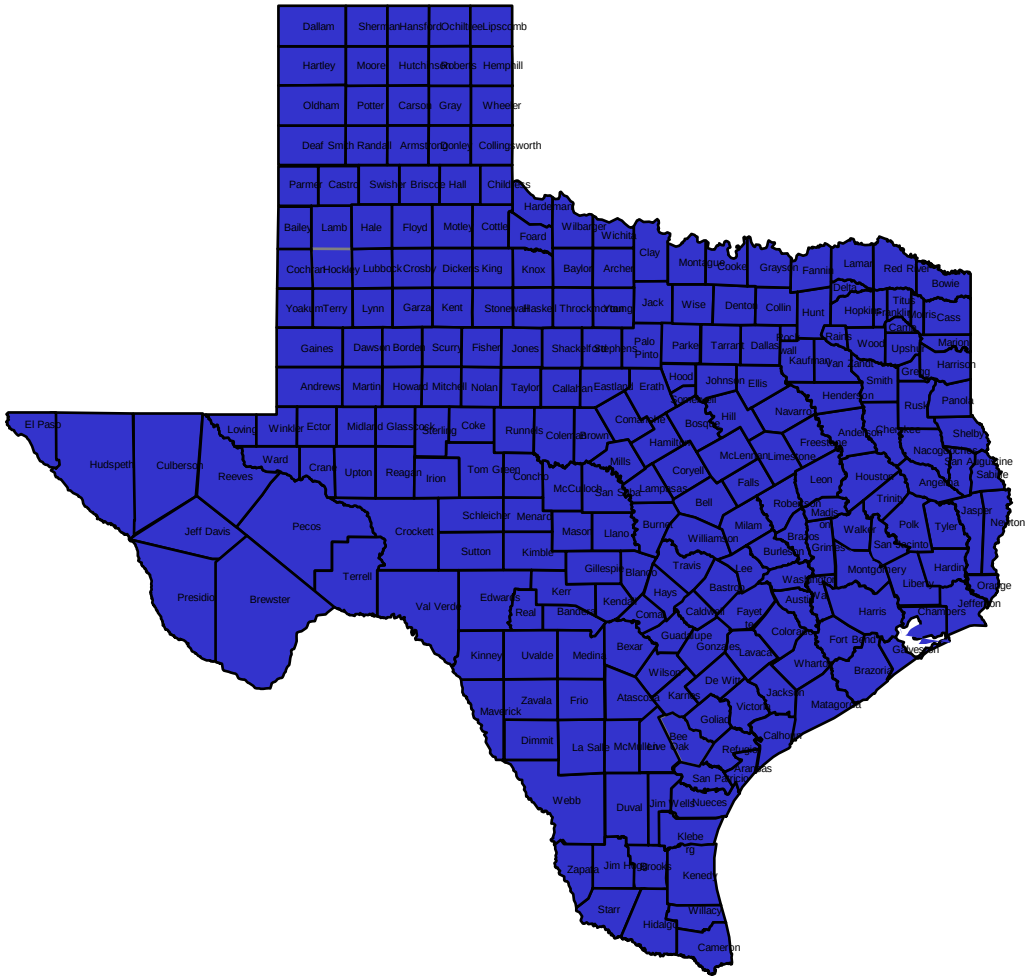
March 2012



Overview : STAR Health



Overview : CHIP & CHIP Dental Services



TEXAS Health and Human Services Commission

Overview : MCOs by Service Area

Service Area	STAR	STAR+PLUS	CHIP
Bexar	Aetna Better Health Amerigroup Texas Community First Health Plans Superior HealthPlan	Amerigroup Texas Molina Healthcare of Texas Superior HealthPlan	Aetna Better Health Amerigroup Texas Community First Health Plans Superior HealthPlan
Dallas	Amerigroup Texas Molina Healthcare of Texas Parkland Comm. Health Plan	Molina Healthcare of Texas Superior HealthPlan	Amerigroup Texas Molina Healthcare of Texas Parkland Comm. Health Plan
El Paso	El Paso First Health Plan Molina Healthcare of Texas Superior HealthPlan	Amerigroup Texas Molina Healthcare of Texas	El Paso First CHIP Superior HealthPlan
Harris	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan	Amerigroup Texas Molina Healthcare of Texas UnitedHealthcare Community Plan	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan
Hidalgo	Driscoll Children's Health Plan Molina Healthcare of Texas Superior HealthPlan Network UnitedHealthcare Community Plan	HealthSpring Life & Health Ins. Co. Molina Healthcare of Texas Superior HealthPlan	*** Part of the CHIP Rural Service Area** Molina Healthcare of Texas Superior HealthPlan
Jefferson	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan	Amerigroup Texas Molina Healthcare of Texas UnitedHealthcare Community Plan	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan
Lubbock	Amerigroup Texas FirstCare HealthPlans Superior HealthPlan	Amerigroup Texas Superior HealthPlan	FirstCare HealthPlans Superior HealthPlan
RSA Central	Amerigroup Ins. Co. Scott & White Health Plan Superior HealthPlan Network	***Effective 9/1/14** Superior HealthPlan UnitedHealthcare Community Plan	*** Part of the CHIP Rural Service Area** Molina Healthcare of Texas Superior HealthPlan
RSA Northeast	Amerigroup Ins. Co. Superior HealthPlan Network	***Effective 9/1/14** Cigna-HealthSpring UnitedHealthcare Community Plan	
RSA West	Amerigroup Ins. Co. FirstCare HealthPlans Superior HealthPlan Network	***Effective 9/1/14** Amerigroup Ins. Co. Superior HealthPlan	
Nueces	CHRISTUS Health Plan Driscoll Children's Health Plan Superior HealthPlan	Superior HealthPlan UnitedHealthcare Community Plan	CHRISTUS Health Plan Driscoll Children's Health Plan Superior HealthPlan
Tarrant	Aetna Better Health Amerigroup Texas Cook Children's Health Plan	Amerigroup Texas HealthSpring Life & Health Ins.	Aetna Better Health Amerigroup Texas Cook Children's Health Plan
Travis	Health Care Services Corp./BCBS Sendero Health Plans Seton Health Plan Superior HealthPlan	Amerigroup Texas UnitedHealthcare Community Plan	Health Care Services Corp./BCBS Sendero Health Plans Seton Health Plan Superior HealthPlan

Overview : MCOs Operating Statewide Programs

- Medicaid and CHIP Children's Dental Programs
  - Denta Quest USA Insurance Company, Inc.
  - MCNA Insurance Company
- STAR Health Program
  - Superior HealthPlan Network

Network Access : Federal & State Laws & Regulations

- In Medicaid, MCOs must:
  - Have sufficient capacity to serve the expected enrollment
    - SSA §1932(b)(5) ; Texas Government Code §533.005
  - Meet service area needs with geographic distribution of preventative, primary care, and specialty service providers
    - 42 C.F.R. §438.207; Texas Government Code §533.005
  - Establish and maintain networks providing access to all services covered under the state contract by looking at the geographic location of providers and Medicaid enrollees and the physical accessibility of the location for Medicaid enrollees with disabilities; and
    - 42 C.F.R. §438.206
  - Submit out-of-network (OON) utilization reports . HHSC is required to set benchmarks for OON utilization and establish standards for reasonable reimbursement rates.
    - Texas Government Code §533.007

Network Access : Federal & State Laws & Regulations

- CHIP:
  - CHIP State Plan must include methods to provide access to covered services, including emergency services
    - SSA §2102(a)(7); 42 C.F.R. §457.495
  - HHSC's CHIP contracts require MCOs to pay for OON covered services at "usual and customary rates" as defined by the Texas Department of Insurance (TDI)
    - 28 T.A.C. §11.506

- Federal regulations do not specify "time and distance standards" for measuring provider access
  - The MCO contracts with the state, or the state laws governing the operation of MCOs, establish these standards
  - HHSC established these standards in 1 T.A.C. §§353.411 (Medicaid) and 353.601 (CHIP)
  - Medicaid and CHIP MCOs also must comply with TDI's licensing standards

1115 Waiver's Network Adequacy Reporting Requirements

- For the STAR, STAR+PLUS and Children's Medicaid Dental Services programs
  - HHSC must submit reports documenting network adequacy during readiness review, quarterly, annually, and if significant changes in an MCO's operations "affect adequate capacity and services" (see the 1115 Waiver's Special Terms and Conditions 22, 24(e), 39(a & c), 40(b))

- The 1115 Waiver is available on HHSC's website at: http://www.hhsc.state.tx.us/1115-docs/TX-STCs_final_clean_9_6_13.pdf

Network Access MCO Contracts : Distance Requirements for Health Plans

- Health Care Services:
  - Plans must provide access to network health care providers within the following distances, measured from a member's place of residence:
    - 30 miles - 90% must have access to one open panel PCP and acute care hospital
    - 75 miles - 90% must have access to one specialist and specialty hospital
  - Additional *Frew* requirement for Medicaid:
    - 30 miles - 90% of child members must have access to at least two PCPs

Network Access MCO Contracts : Distance Requirements for Health Plans

- Pharmacy Services:
  - Plans must provide access to network pharmacies within the following distances, measured from the member's place of residence:
    - STAR Medicaid Rural Service Area:
      - 2 miles - 75% must have access to one network pharmacy (urban counties)
      - 5 miles - 55% must have access to one network pharmacy (suburban counties)
      - 15 miles - 90% must have access to one network pharmacy (rural counties)
      - 75 miles - 90% must have access to one 24-hour pharmacy (urban, suburban, and rural counties)
    - All other Programs and Service Areas:
      - 2 miles - 80% must have access to one network pharmacy (urban counties)
      - 5 miles - 75% must have access to one network pharmacy (suburban counties)
      - 15 miles - 90% must have access to one network pharmacy (rural counties)
      - 75 miles - 90% must have access to one 24-hour pharmacy (urban, suburban, and rural counties)

Network Access MCO Contracts: Distance Requirements for Dental Plans

- Dental plans must provide access to network dental providers within the following distances, measured from the member's place of residence:
  - 30 miles – 95% must have access to two open practice main dentists (urban areas)
  - 75 miles – 95% must have access to two open practice main dentists (rural areas)
  - 75 miles – 90% must have access to one specialist (urban and rural)

Network Access MCO Contracts: Medicaid Out-of-Network Utilization Thresholds

- HHSC monitors health and dental plan use of out-of-network facilities and providers
- In each service area, out-of-network use should not exceed the following thresholds each quarter:
  - 15% of inpatient hospital admissions (health plans);
  - 20% of emergency room visits (health plans); and
  - 20% of all other services (health and dental plans).
- A plan can request special consideration when it exceeds the utilization threshold if efforts to contract with an out-of-network provider are demonstrated
  - If the State grants special consideration, it removes the non-contracted provider from the plan's compliance calculations
- Sources: Tex. Gov.'t Code §533.005(a)(11); 1 T.A.C. §353.4(e)(2)

Network Access MCO Contracts: Wait Times for Appointments

- Medicaid and CHIP health plans must meet the following standards:
  - Provide upon member presentation at the service delivery site
    - Emergency Services
  - Provide within 24 hours
    - Urgent Care, Including Urgent Specialty Care
  - Provide within 14 days
    - Routine Primary Care
    - Initial Outpatient Behavioral Health Visits
    - Prenatal Care
      - except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within 5 days, or immediately, if an emergency exists
  - PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than 30 days
  - Preventive Health Services for adults must be offered within 90 days

Network Access MCO Contracts: Wait Times for Appointments

- Preventive Health Services for Children, including Well-child Checkups, are be offered to CHIP members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid MCOs utilize the Texas Health Steps periodicity schedule
  - New member birth through age 20
    - Overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members
  - The Texas Health Steps annual medical checkup for an existing member age 36 months and older is due on the child's birthday
  - The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday

Network Access MCO Contracts: Wait Times for Appointments

- Medicaid and CHIP dental plans must meet the following standards:
  - Provided within 24 hours
    - Urgent Care, Including Urgent Specialty Care
  - Provided within 14 days
    - Therapeutic and Diagnostic Care
  - Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the member's medical condition, but no later than 30 days
  - Non-urgent Specialty Care must be provided within 60 days of authorization
  - Preventive Dental Services for Children should be offered to CHIP members in accordance with American Academy of Pediatric Dentistry (AAPD) periodicity schedule, and to Medicaid members in accordance with the Texas Health Steps periodicity schedule

Network Access MCO Contracts: Other Requirements

- Network summaries that track:
  - PCP, Main Dentist, specialist, pharmacy, and total provider counts
  - Open panel PCPs and Main Dentists
  - Members per PCP and Main Dentist
- Complaints and appeals reports
- Member and provider hotline reports

TEXAS Health and Human Services Commission

Balance Billing in Medicaid

- SSA §1128B(d)(1)
  - Felony violation/up to $25,000 fine if a provider knowingly and willfully charges money or other consideration … at a rate in excess of the rate permitted under a Medicaid MCO contract
- 42 C.F.R. §447.15
  - State agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency (or MCO) plus any deductible, coinsurance or copayment
- 1 T.A.C. § 354.1005
  - Prohibits balance billing in Texas Medicaid

Balance Billing in CHIP

- 2013 Guidance from the CMS:
  - " Balance billing by medical providers imposes cost sharing on beneficiaries, and if that cost sharing exceeds the limits set forth in §2103(e) of the SSA and 42 C.F.R. Part 457, Subpart E, then the state is out of compliance with the requirements of CHIP. To come into compliance, the state would either need to enact state laws/regulations/contracts to preclude medical providers from balance billing (requiring them to accept CHIP payment and any permissible cost sharing as payment in full, like Medicaid), or the state would need to pay the providers their full charges. However, until this dispute over state law/contract is resolved, it is clear that making the beneficiaries liable would violate the federal CHIP requirements."
- 1 T.A.C. §370.453
  - Prohibits balance billing in CHIP
  - Requires eligible providers to agree that payment received for covered services will be payment in full
    - Eligible providers include network providers and OON providers who agree with CHIP MCOs to see CHIP members for an agreed-upon rate

Contact Information

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TEXAS
Health and Human
Services Commission

CHIP Coalition/OTA Meeting

November 15, 2013

Rules and Application Update

Rules

- The last day to submit public comments on HHSC proposed rules is November 17.
- HHSC has received comments on:
  - Assets
  - Applications
  - Certification periods for children's Medicaid
  - Former foster care children
- HHSC is reviewing comments and will respond as part of the rules process.

Application

- HHSC is finalizing the state plan amendments for the applications, and will submit them to the Centers for Medicare and Medicaid Services (CMS) shortly.

Hospital Presumptive Eligibility

- HHSC continues to research and develop options for policy and business processes for hospital presumptive eligibility.
  - Visited Scott & White Healthcare and will be visiting a smaller hospital.
  - Developing frequently asked questions with the Texas Hospital Association (THA).
  - Will participate on a second conference call with THA in December.
- HHSC also continues to work on determining the implementation timeline for hospital presumptive eligibility.