Texas CHIP Coalition
Meeting Minutes

April 17, 2015

Present:	Kit Abney, Seton Patrick Bresette, Children's Defense Fund Anne Dunkelberg, Center for Public Policy Priorities Nikki Metzgar, Center for Public Policy Priorities Miryam Bujanda, Methodist Healthcare Ministries Sonia Lara, TACHC Sister J.T. Dwyer, Sisters of Charity Laura Guerra-Cardus, Children's Defense Fund-TX Melissa McChesney, Center for Public Policy Priorities Clayton Travis, Texas Pediatric Society Kathy Eckstein, CHAT Shannon Lucas, March of Dimes Alice Bufkin, Texans Care for Children Laura Dimitry, Texans Care for Children Sherry Vetter, Texas Children's Health Plans Helen Kent Davis, Texas Medical Association Karisna DeLaRosa, TPS
On the phone:	Marcus Denton, HHSC
Chair:	Miryam Bujanda, Methodist Healthcare Ministries
Minutes Scribe:	Nikki Metzgar, Center for Public Policy Priorities
Next meeting:	May 15, 2015

I. Group Discussion on House/Senate budget differences (see attached handout)
Kathy Eckstein, CHAT

- The handout compares Texas House-passed bill to Senate passed bill and what they added or deducted.
- On Medicaid cost growth, the Senate added $678 million of GR, and according to Dr. Schwertner, that is the full amount needed for cost growth. It's pretty different from the HHSC request for money
- Senate took away $373 million for cost containment, so net they really only added $300 million in GR, which is not a lot in a program this big. The specifics of cost containment measures:
  - Lower premiums, so the health plan association is in a state of alert
  - Reduce risk margin for the health plans, from 2% to 1.5%. There's a 2% margin that health plans have that allow for ups or downs in the payment that they get. It's difficult to make that cut across the board, because some hospitals—specifically, the non-profits—have lower margins than others. Texas Children's is working with House folks to make sure it doesn't get passed.
  - $200 million would be taken from therapies
  - 3rd party resource recovery: if someone on Medicaid has home owners insurance or auto insurance and has an accident, then state pursues those third party resources instead of Medicaid paying. Main concern is what is the impact on providers? A huge hassle for doctors and hospitals to deal with third parties.

- There's not money in either bill for disproportionate share funding.
- For children with special health care needs, the House added $5 million, the Senate didn't add any.
- $30 million more on the Senate than on the House for women's health
- If anyone wants to see the text of these riders, let Kathy Eckstein know.
- Art. XI has Hinojosa rider $50M for high volume hospitals to get funding.

II. Primary care funding increase

Helen Kent Davis, TMA

- $460 Million General Revenue (GR) in House bill, none in Senate. This is a huge priority for medicine to get this increase maintained for primary care physicians. Under the federal law, the bump would apply to pediatricians, family physicians, general internal and their subspecialties. The increase is only for primary care services, so the increase is not for every single service those physicians provide. It's basically if you come in for an office visit and the physician is providing cognitive services
- Supplemental payments expired December 31, 2014. The higher rates in HB1 would begin September 1, 2015. Between Jan 1, 2015-Aug 31, 2015, there will not be higher Medicaid payments for eligible PCPs and services.
- Texas did not extend this to OBGYNs.
- HHSC asked whether doctors would prefer the bump rolled into rates or as a supplemental payment. We asked for rolled into rates, unless it takes two more years. They told us it would be a year and a half. So we don't want that.
- They're making quarterly payments and they're retroactive. But it really takes longer than a quarter to process the payments. The implementation has been a complete nightmare, but since they have it more or less working, I would rather have that continue and the doctors just get paid than wait.
- Doctors receive a lump sum; it's not itemized based on the services they provide. So they just have to accept that they've gotten the right amount. So if they get audited, it's going to be a difficult. Also, if they are in a group of doctor's, the payments are not identified by doctor providing the services. We're going to run into problems, but $460 million in the budget is better than 0.
- Physician assistants and nurse practitioners are not part of the bump.
- Texas Children's gets a file from the state that basically lists the physician name and the dollar amount but nothing related to claims. So we can't even pass the money through our claims system. So it's been an administrative burden on us as well and we would prefer to see it in the rates as long as it gets established in a premium. The only way we could make that gap whole from January to August is if it's in the premium and it's not.
- A number of senators have said that they strongly oppose the funding increase. All hope for federal fix is over. The Medicare fix that occurred a few weeks ago on the national level does not help.

III. CHIP Legislation Update

Shannon Lucas, March of Dimes; Anne Dunkelberg, CPPP and others

- Status on post-partum depression bill: Governor Abbot made this one of his campaign priorities to increase screening and treatment of postpartum depression in women who are losing Medicaid and the CHIP perinatal population.
- Bills filed: HB3115, which has had a hearing, and another bill by senator Huffman, which hasn't had a hearing and was referred to Senate Health. Unless it got voted out today, the HB has not moved. It does have about a $5 million fiscal note. What we're hearing is they're going to try to roll this into the new consolidated Women's Health Program. In the Senate, they've taken all the family planning and expanded primary health care and put them into one strategy at HHSC. The thinking is that you can add mental health care screening and treatment, but we don't know what the benefit package would be

exactly. Women would need some kind of counseling, many women would need access to anti-depressants or outpatient/inpatient health services.

- They don't want to do presumptive eligibility. What happens when a woman loses pregnancy-related Medicaid and doesn't enroll in this program, and shows up at a clinic and a provider suspects she has depression, how does she get quickly enrolled to get screening? Who are the providers going to be? Just FQHCs? We don't know. There is an interest in funding it, so maybe the kinks just get worked out after session.
- On the Senate side, there's that additional $50 million for women's health services, and that is where the money would come from to pay for whatever this benefit package looks like. There's still going to be questions about the CHIP perinatal program because we understand that women who qualify would then be eligible for family planning services. Since CHIP perinatal benefits accrue to the baby, how would you attach mental health care services to the woman through this program? This population may just not be covered for this screening and treatment. But there may be more information in the next few days.
- We do have Senate and House versions of CHIP waiting period bills and Melissa McChesney (CPPP) has authored a brief on the CPPP website. I don't know if they're going to get hearings or not. Consumer support and managed care may have hit an unanticipated bump in that the author of that bill is the only 'no' vote on the budget in the Senate and it's possible that her bill will be targeted to not move forward. So we might have to find other legislative vehicles.
- There's also a House bill by Rep King that was referred to State Affairs for a hearing. It aims at putting undocumented children at the bottom of the waiting list for children with special healthcare needs program. It's against federal law to discriminate against them but the author thought it might be allowable to shuffle them constantly to the bottom of the list. It's pending in committee and CPPP registered opposition and reached out to Office of Civil Rights. Hopeful that the federal government would get enough involved in the conversation that the bill won't go anywhere. It's easy to go and explain the federal policy and that violation, but it's just an argument about doing the right thing.
- There are 2 immunization bills held up in calendars, so if you're supportive of that you may reach out to calendars members to see if we can get those moving.
- Given the CHIP Coalition's positions on healthcare workforce, there are a couple of good bills. SB18 by Nelson enhances graduate medical education (GME) funding and sets up a funding source for it. HB2434 Schwertner's Medicaid network adequacy bill has been voted out. We haven't seen who the sponsor is in the House. HB 2434 by Coleman on the loan repayment for mental health professionals.
- There are 3 telemedicine bills that were just passed out of public health committee. There was an expiration date in current law for tele-monitoring services and one of these bills would reboot that expiration date. Another is for school-based telemedicine for kids and another is developing a program for telemedicine for certain kids. HBs 2082, 1623 and HB 1878.

III. ACA update

Valerie Eubert, HHSC

- The 90 day period for returning information: Under the ACA, if you got your renewal and you haven't submitted the information needed, we reopen your renewal if you provide that information within 90 days. It used to be 60 days. The Coalition mentioned that clients are being asked to provide a new application instead of reopening the previous application. If you have specific case information, we'll be happy to look into that. We've been doing the outbound calling campaign for people who we haven't gotten the info from. In some cases, the client has put in the renewal but not the signature for the renewal. They're not taking that additional step to send in that paper signature or electronic signature. It could just be a need for training the state workers on how to reopen a case without a new application.

- Kit: In the outbound call, what percentage of individuals are you actually getting in contact with? We know phone calls can be challenging to clients. Valerie will take this question back to HHSC for an answer.
- 211 (option 2/Maximus) is currently telling folks to go to the office to get the 1087 form when they need the 1024 form. What can people do in the interim while you address this problem on a systems level?
- HHSC has had more than 20,000 individuals decide to go paperless since the option was opened. We're hoping this will be a good avenue for connecting with this population. Next month, individuals will be able to make that choice through the mobile app.
- Starting February with release 2 of the Your Texas Benefits (YTB) app, clients can create a YTB account on the mobile act without creating it first on the computer. You cannot submit a new application on the mobile app. You have to do a brand new application on the computer that you can check on the phone once you have your case number. HHSC is working on making that change long-term, although right now Flash products can't be carried on Apple phones.

- Presumptive eligibility for Medicaid:
  - 21 hospitals that have submitted notices of intent, 18 are fully approved and 3 are in progress. This accounts for approximately 66 locations statewide. None of the large hospitals have applied.
  - We have about 37 individuals certified statewide to do those determinations.
  - 41 presumptive eligibility determinations since February, don't know their outcomes at this moment.
- Community Partner Program (CPP) pdate: 1,181 community partners, so it's grown a little bit since the close of last calendar year. CPP would like to be added to a future OTA agenda to have feedback about providing the partners with reports on eligibility determinations. Partners want to be able to know if the person they assisted with an application actually ended up getting coverage.

IV. Health plan selection, cost containment and 1115 Waiver

Lori Van Hoos, Director of Policy Development for Medicaid and CHIP and Kay Ghahremani, HHSC

- We allow for individuals to select a health plan when they have been determined eligible. By federal law, a minimum of 2 plans/choices required for every program. For CHIP and STAAR we have 3 health plans. If we're going to roll out a new product in a new area, we spend months spreading the word. There's a month and a half delay before people can be in their managed care and in the meantime they're in fee-for-service. We're looking for options on how to close that gap.
  - It takes a long time making changes on Accenture system;have old architecture so it can take a while.
  - For Medicaid, people can change their health plan at any time. They're enrolled for a month in a health plan but then they can switch as much as they want.
  - For CHIP, kids are being defaulted to a health plan unless applicant identifies/lists the primary doctor with national provider ID number. Few applicants know the national provider ID number for their primary doctor. Coalition asked HHSC how this barrier could be removed.
  - For CHIP, once assigned a health plan, they have 3 months to switch and stay in the plan for the remainder of eligibility period. We don't see very much switching, a little over 1% a month.

- Medicaid Cost containment rider would require $373 million GR reduction over the next biennium, and we've already had to cut $400 million this biennium. We were scrambling for ideas and actually got direction for most of it. There are still some dollars that we don't have savings for.

  - We're looking at up to a $200 million dollar reduction in therapy rates; not a benefit cut, a rate cut. According to a Texas A&M study, Texas therapy rates were much higher than other states. So it's an area that every biennium the legislature says we're going to reduce. There were some complaints about the methodology of the study and how the rates were compared.

- Other cost containment areas include half a percent rate cut to the risk margin for the health plans ($75-85 million GR); studying prior authorization as another area; and subrogation/third party recovery (no dollar amount currently associated).
- Still $100 million short-- Kay is hopeful HHSC won't end up with this large a containment request. We've taken so many rate cuts over the past 2 bienniums that there is nothing outstanding in terms of providers being overpaid. Honestly, don't know what we would do. We have a new STAR plus utilization unit, and there's an expectation that as nurses go out and look at service coordination of star plus, perhaps there's something there.

- Changes to prior authorization processes: Our new medical director is thinking we might be making prior authorizations too much on the fee-for-service side. They need to explore more on health plans and prior authorization.
- Next year we're auto-enrolling Medicaid women into the Texas Women's Health program when they give birth. System change will take place April 2016. Legislature is looking at what TWHP will look like in the future.
  - We're pushing incentivizing postpartum Long-Acting Reversible Contraception (LARCs) with hospitals and FQHCs. Starting September 2015, there will be an add-on payment for these. Is there a way to look at them for CHIP perinatal population? It would need to be a wrap with DSHS.
  - Can you have TWHP and Medicaid or any other insurance at the same time? You can have TWHP and private insurance if it doesn't cover family planning, but you can't be on TWHP and Medicaid together.
- 1115 Waiver: Hopefully CMS will come down in the fall. We're going to have an easier time getting the DSRIP side of the waiver approved. Eventually the federal government doesn't want to be putting all this money into these initiatives, they want Medicaid to be paying for this through expansion. I think we're going to be able to convince them to let us do DSRIP for at least a few more years. We'll get something that is some version of what we have now, although they'll make some changes.
  - This was all set up presuming Medicaid expansion. Uncompensated care costs are not going down, so if the federal government doesn't continue to allow states to claim that, it is a real problem for hospitals. They want to see rates going up instead of these supplemental payments. Waiver renewal application is due September 30, 2015, with the hope to negotiate a renewal by Sept. 2016 and there is the expectation that there will be an extension to make time for the negotiation. Summer 2015 there will be a public input and work group process to determine what the renewal will look like.
  - If we expanded Medicaid, we would cover another million and a half people. In Texas, there would still be uninsured people and uncompensated care (undocumented persons, family glitch). The direction CMS is going in, they don't think they should be paying states for people that should be covered under expansion. We don't see this as an ongoing fund for shortfalls which should be built into the rates. They want reform baked into Medicaid managed care.
  - There are innovative healthcare ideas that can only be funded under DSRIP and Medicaid rules don't allow them. Is there an inventory of what those ideas are? HHSC hired someone to "marry" what's going on with managed care with what's going on with DSRIP. We need to allow health plans to count some things as medical expenditures v. administration expenditures.