Texas CHIP Coalition
Meeting Minutes

September 18, 2015

Present:

Anne Dunkelberg, Center for Public Policy Priorities
Jaye Wilcox, Texas Impact
Colleen Mckinney, Social workers
Caitlin Perdue, Clarity Child Guidance Center
Tina Mendiola, St. David's (South Austin Med Center)
Maureen Milligan, Teaching Hospitals of Texas
Mariah Ramon, Teaching Hospitals of Texas
Jennifer Banda, THA
Kathy Eckstein, CHAT
Marcus Denton, HHSC
Brian Dees, HHSC
Sandra
Marisa Luera, HHSC
Shannon Lucas March of Dimes
Clayton Travis, Texas Pediatric Society
Helen Kent Davis, Texas Medical Association
Alice Bufkin, Texans Care for Children

On the phone: Erica Loredo, Texas Children's Health Plan (Women's and Health)
Veronica Reyes, Texas Children's Health Plan
Donna D., Driscoll Health plan
Juanita Davis, Community Care
Angelica Davila, Community Care
Sonia Lara, TACHC
Elaine Goodman, Cook Children's
Dr. Emily Becker, HHSC
Laura Guerra-Cardus, Children's Defense Fund –TX

Chair: Miryam Bujanda, Methodist Healthcare Ministries (MHM)
Minutes Scribe: Julia Von Alexander, Center for Public Policy Priorities
Next meeting: October 16, 2015

I. Update & Discussion: Sunset Implementation
Anne Dunkelberg, CPPP (updates from Joey Reed)

- These updates are attached and were provided by Joey Reed. The last time he gave an update in person was July and he is willing to come if we have specific questions.
- Helen: Women's health programs have moved from DSHS to HHSC and advisory committee meets next week. The chair of that advisory committee is Paula Turicchi.

- To follow up – are draft HHSC organizational charts available?
- Specific request for Joey- when does mental health services move? All other questions are around the advisory committee revision.

HHS Advisory Committees

- Emily Becker- this recommendation was made by sunset commission, and decided by Legislature, and the agency must execute what is legislated. She is not sure what will replace the quality based payments advisory committee.
- Clayton: on advisory committee transition plan chart, the committee consolidations aren't detailed, what are those committees being consolidated into?
- Helen has sent a request from TMA asking HHSC for more details on Medicaid quality based payment advisory committee (consolidated) TX institute for healthcare quality/efficiency, traumatic brain injury committee (expanded). This message ended up going to the director of change management (Chris Adams). The response she received was that HHSC has not decided what those consolidations will look like. The advisory committees highlighted for consolidation were committees that could merge with another. So the public is welcome to comment on which advisory committees should be put together.
- The Medicaid and CHIP Regional Advisory Committees (RACs) are recommended for deletion. Reach out to people that participate in RAC meetings? Provider enrollment RACs only are the only opportunity for conversation. But it is hard to get to physicians, especially since RACs are regional and rural providers can't go. HHSC started statewide stakeholder webinars that cover RAC information and would be helpful for providers (quarterly). Helen: But RACs are often focused specific issues for their region (i.e. perinatal health in Central Texas). Without RACs, you lose this opportunity to bring together providers who may be sentinels for HHSC.
- Overall shared concern- that we need more information in order to comment. Anne to tell HHSC that the matrix provided does not provide not enough info to allow folks to make fully-informed comments. Looking for more input. If you object to something being abolished comment! Comments are due 9/25.

II. Update from Medicaid/CHIP Division

Updates on Free Care policy changes

Tamela Griffin

- CMS letter of December 2014, communicates to schools, health departments & other public providers that struggle with free care (find it **here**). Previously if health services offered for free, school couldn't bill Medicaid. This made it difficult for schools and other public agencies that are not designed to run an administrative machine and bill.
- Modified the policy so public entities may provide a service without a fee to non-Medicaid-eligible persons, and still bill Medicaid for a fee.
- Question: How does the rule relate to the School Health and Related Services SHARS program? Will there be changes to that program? Clarification- doesn't apply to schools using Medicaid for special services (SHARS), because they are not charging families for these services. SHARS was the only way to get federal money for schools before. MAC mechanism-administrative match rate through the state

for other promotion activities through the school. Over 700 out of 1000 (ISDs) in the SHARS program and most also do MAC. Still need to be a Medicaid provider, and need to retain a structure to charge appropriate 3rd parties. One barrier has been removed, but schools still need to be able to participate as a Medicaid provider (need a NPI). Schools that were MAC providers are Medicaid providers. Tamela will get information from rate analysis and to provide the group. Many CMS audits. ISD can either become a Medicaid provider through SHARS and if not SHARS, through the MAC.

- 80-85 school based health clinics (different from SHARS provider) and some are hospitals that are providing school based services. How are schools enrolled? No other mechanism to be service provider unless have contracts with Medicaid/CHIP HMOs
- Care coordination/outreach- outreach will always stay administrative. Coordination could be billed, and it is often most efficient to draw medical funds for that. Going to MAC because can capture activities for the all work that they do (i.e. outreach). Switch to a service basis for higher admin match?
- New change in policy is recent- may be hearing more about best practices.
- DSHS has distributed info and questions from schools that aren't currently participating have mostly been from a school nurse perspective, but there is no way to draw funds if not Medicaid provider. A short description of MAC is attached and more information is **here**.
- Laura: School district enrolled as a Medicaid provider can start billing Medicaid for any free care? No, would need to build a function like a Medicaid provider. SHARS program participating in MAC- must determine if have distinct Medicaid services that are outside of that and then enroll as Medicaid provider type for those services. Who is the contact for school districts to find out if they can take advantage of it? Tamela Griffin. Multi-tiered process so need lots of detail about the situation.
- HHSC is doing targeted research to find how we work on helping schools enroll in Medicaid.
- What are people's specific goals for what they want to happen?

Updates on Implementation of SB760

(Marisa Luera, HHSC per Debbie Weems notes)

- SB 760- includes 3 parts a network adequacy piece, abuse, neglect & exploitation, and consumer protection.
- HHSC is finalizing process for stakeholder input, should be out soon. Establishing workgroups and plan to implement by Sept 1 2016.
- They are also currently analyzing existing network adequacy standards and comparing those to other states. Expedited credentialing has been discussed. Will present rule changes to MCAC in Feb. 2016 Changes will be incorporated into uniform Medicaid contract.
- Anne: HHSC Medicaid Managed Care, please coordinate with TDI on House Bill 1624. Pay attention to standards and what we are doing to monitor it. Make sure to leverage best practices across the board: that is, Medicaid and commercial market should have equally strong consumer protections.

Updates on Therapy rates and policy changes

(Tamela Griffin/Sheri Waldi, HHSC)

HHSC Rider 50 directed Commission to achieve a $50 million savings through rate changes & $25 million through policy changes. Withdrew first proposal, and put out new rate changes- which is why there was a second hearing held 9/18/15. The new rate changes no longer use commercial rates as a comparison but

compare to other Medicaid programs. HHSC will submit state plan next week (after public hearing today). They have also posted changes to medical policy, accepted public comments, and had a hearing on that.

- Sherry: high level changes. Meet with medical necessity directors. Medical necessity required. Provider groups that had participated in previous therapy reviews- were a part of workgroups. The rider asked them to consolidate care categories- acute and chronic component initially, but will probably have adult and child categories to decrease confusion. Working on streamlining. Policies posted through 9/11, many comments and public testimony. Next steps: go through comments and addressing those issues.
- Clayton: Medical policy website- Can HHSC send a confirmation email when one submits comments? Response to comments received will be on the same website. Useful because we can direct other stakeholders there. The HHSC medical policy website is here: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml.
- Sherry: timeline- trying to get something out by the end of the month or early October.
- Proposed changes: Rider 50 requires- clarify policy language (i.e. co-therapy- 2 therapist from different disciplines treating at same time. Clarified definition, documentation/billing requirements.). Much positive feedback on this.
    - 3 provider types- Independent, home and CORF -- Comprehensive Outpatient Rehabilitation Facility/ORF Outpatient Rehabilitation Facility
    - Clarify who can participate (intern, students, aids, technicians, etc).Basically, who can bill vs. who can provide the services. Added language on supervisory requirements. Why isn't this counted as rate reduction? Because rate remains the same for the provider. Also, because rider laid out very specific goals. Using it as a tracking mechanism which OIG suggested, so they can know who provides the treatment. Concerns that assistants are used to often. Previously there was a lack of clarity in policy allowing students to participate, so clarified it.
    - Consolidation of 3 policies (traditional, CCP, home health)- children's (acute and chronic) and adults (acute). Was confusing to have 3 policies, so consolidating it into one. Describes how to deliver the services. Interpretation that no chronic therapy for adults? Medicaid limits adult benefit in a way that isn't allowed under federal Medicaid law for children. Maureen M.- old approach can have similar service under the 3- different rates under them, so easier to now have 1 rate structure.
    - Requiring primary care to refer before initial evaluation for therapy- new draft says may require prior authorization. To have an evaluation, managed care plans require prior authorization. Fee-for-service don't require prior authorization. TX Medicaid doesn't require prior authorization for fee for service, but may require for treatment but not initial evaluation. Health steps screening process- now just must certify that has been done in the last year.
    - Are MCOs really required to pass thru rate cuts or to follow policy changes? Not necessarily. Depends on the contract, generally have different policies and are more restrictive. The most medically complex kids aren't in MCOs yet, but will be. State is setting base medical policy- managed care contract can use their own path to prior authorization. Helpful to address concerns after policy change. Acknowledging that plans may use prior authorization but aren't required to.
    - Draft- exemption for ECI providers- just for medical policy not rate changes
    - Most cost-effective setting: National correct coding initiative being evaluated (want to comply) and are working to implement those changes.

Related comments (not part of HHSC presentation)

- Group discussion: Budget process- rushed and without much scrutiny (legislature). Many of the ruling party in the house have put out letters saying don't want to do such a large rate cut. Clayton: Budget process (rider language) was too directive and should have given more leeway to HHSC. So in the future all of us should try to follow the budget- CHIP coalition should raise alarm of future cuts at current hearings. Need to say you can't keep doing cost containment riders for Medicaid because it isn't bloated. Formal and strong message.
- Potential for interim study on cost containment. Let's look for real solutions instead of just rate cuts, and HHSC needs some discretion. Decisions made too hastily. Tax cuts paid for with therapy for kids with disabilities-article in Texas Monthly. It has been difficult to speak on the revenue side as a coalition, so need an answer to legislators wanting to cut taxes. THA- have considerably decreased amount/person on Medicaid since 2001. How can we be smarter about educating Texans and lawmakers on this? Clayton-health plan partners, saved money with Medicaid program with streamlining. Very efficient- managed care. Maureen- revenue from the premium tax is/has been a selling point for Medicaid Managed Care expansion,; but that doesn't help pay providers. Kathy- Medicaid transportation issues- if rate cuts/policy side restrict access to in-home therapy services, then there will be a corresponding increase in demand for medical transportation services- has this been costed out?- Will discuss this at a future meeting..
- CHIP Coalition needs to address and be proactive on Medicaid and advocacy. Messaging: cuts have taken place (under efficiency lens) for last three sessions. Tx has lower dollar expended /recipient since 2011. Ideas on entities and outreach discussed.

STAR Kids Development process

(Brian Dees)

- No too many updates. Agency changed procurement rules as a part of the general overhaul. Used to announce tentative awards, now don't do that. Announcements to come soon.
- Gearing up for outreach portion of roll out. Working on syllabus to educate MCO's. Will describe services, what expect from the program, etc.
- Regional based outreach to providers/stakeholders. 1st round- 2-3 months after contracts assigned and 2nd round 2-3 months before live.
- STAR kids advisory committee- how do we increase participation (especially working families)? Trying to do on weekends, during lunch hours.
- Working on screening/assessment instrument- comprehensive MCOs will administer the instrument (working with A&M School of Public Health). Working with some families to check the instrument.
- Anne- Most kids are on SSI, so what is the difference with new assessment from disability assessment? Answer: State agency (DDS workers now at DARS) performs the disability assessment, but the STAR kids assessment is a differently focused comprehensive functional needs assessment that anticipates the needs for therapy/behavioral health. - Assessment for STAR Kids will show needs in this moment in this time. Trying to find what services/treatments kids need right now.

Clayton-children with both mental health & developmental delays will end up in STAR kids. How will STAR kids coordinate for these kids with dual diagnosis? Don't reach (qualify for) SSI's level of disability- so where are they? Keeping data on kids with dual diagnosis? Will care coordinators know exactly what they need to get them? Eligibility- SSI kids and SSI related kids (many sub categories) and IDD waivers. If not in one of those categories will use a MCO. Kids on IDD waiver waitlist would be on Medicaid STAR until moved off the waitlist into STAR kids.

- Health plans should be sensitive to dual diagnoses and will provide appropriate referrals. HHSC is going to educate them to make sure they are up to speed. Expectations in contract that health plans go out and find providers that understand population's needs? Network adequacy requirements and significant traditional provider requirements. Health plans must offer contracts to providers for 3 years, and make appropriate arrangements to make sure clients' needs are met (including out-of-network providers). HHSC has continuity of care provisions- depends on type of care (acute vs chronic) and MCO is required to continue providing services for 90 days to 120 days to out of network so provider has time to get contract into place. Workforce difficulties- for these types of providers.
- Helen- on provider side, with managed care expansions. Training is done at times when providers can't go. If want to reach physicians and their staff (to talk about protections, contractual obligations, STAR kids), use webinars during lunch/evening, not seminars during working hours. Health plans must be communicating about what services they offer to physicians. Families also need similar additional outreach.

No news on 1115, so this agenda item was not discussed.

Update on Maternal/Child Health Working group

(Shannon Lucas /Alice Bufkin)

- Copy of the charge is attached.
- Requesting a continuation of what they were doing during the session- importance of postpartum care for women (up to 18 months). Believe there will be a cost-savings with keeping women in care.
- Several legislatures have also requested it. Hopefully, one of the LBBs will study during the interim. House deadline-still trickling in. Clayton to send list of interim studies.
- Texans Care for Children- copies of their interim study recommendations (will send out to listserv).

Update on EHB

Stacey Pogue, CPPP

- Different buckets of coverage, things missing previously are required. But in practice states pick or default to a benchmark plan (if don't choose). In Texas we default to a 2014 grandfathered plan that doesn't meet ACA standards. That benchmark includes what all plans must require. Texas defaulted to the largest small employer product (Blue Cross Blue Shield) similar to the one last time. One difference per TDI is that it covers for autistic kids for longer- to age 9 or 10. Comment period until 9/30, CPPP starting to put comments to talk about all of the holes because it doesn't comply with ACA/mental health parity. Need to tell the federal government that we expect them to make sure those are filled before they approve this benchmark and to make sure all 2017 plans actually cover all required things. Texas is one of only 5 states that is not enforcing the EHB itself. No reason to believe health plans aren't paying attention to the EHB benchmark plan, nor to worry the feds won't enforce it.

National partners think it is a good idea for us to document those gaps. Gaps are in the proposed new one which is grandfathered. Question is who fills them? Asking CMS to fill gaps before put out benchmark plan. However, CMS will tell insurance plans individually to comply with all of the laws. Most states had to supplement children's vision and dental and Texas took that from FEHB.

- Clayton- physicians would like to say they support filling holes.
- Deadline 9/30. CPPP will send this out to sign-on with a short turn-around.

Announcements

- Jennifer: New campaign from THA (attached document). Hospitals working on enrollment during enrollment period. Have materials for hospitals to use. Much research on effective outreach. Lots of confusion in Texas-people don't realize that we implemented ACA. Messaging on affordability and then about fines and time schedule. If can promote website (www.insurehealthTX.org) that would be great! People will get a text reminder for enrollment, if they sign up here. Also let Jennifer know if there is any enrollment activity you want to promote.

WHAT IS MEDICAID ADMINISTRATIVE CLAIMING?

The Medicaid Administrative Claiming (MAC) program provides Texas School Districts, including public charter schools, the opportunity to obtain reimbursement for certain costs related to administrative activities that support the Medicaid program. In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under the Texas Medicaid State Plan, and must adhere to applicable requirements as defined in State and Federal law.

School districts can be reimbursed for certain medical and health-related activities such as outreach services delivered to students within the district, regardless of whether the student is Medicaid eligible or not, and without any impact on other similar services the student may receive outside the district. Outreach services may be provided to a student or their family and may include activities such as coordinating, referring, or assisting the student/family in accessing needed medical/health or mental care services.

Revenue generated from MAC claims is dedicated to the provision of health services and may be used to enhance, improve and/or expand the level and quality of health/medical services provided to all students within the district.

WHAT TYPE OF ACTIVITY IS CONSIDERED "OUTREACH/CASE MANAGEMENT"?

A variety of personnel in local districts currently provide many health-related activities on behalf of their students. These include medical services such as physical therapy, occupational therapy, mental health services, and transportation services. Most schools conduct health screenings for all their students in such areas as vision and hearing. Many school districts employ school nurses to assist with the administration of medications and to assist students who become ill or injured. Some schools operate school-based clinics that provide direct medical services. More and more schools are engaged in Medicaid outreach activities to inform students and their families about the availability of Medicaid and the State Children's Health Insurance Program (CHIP) and to assist them in applying for these programs.

For example, student assistance programs may provide comprehensive case management programs for high-risk students. Special education programs perform routine case management and case coordination functions for special education students and coordinate the delivery of related services. Administrators often coordinate and/or become involved in community groups or councils and work to identify gaps or improve the delivery of health-related services to their students.

In addition, front line staff often perform a range of case management and case coordination functions to insure that students with health-related needs access care in a timely and appropriate manner. District personnel may be asked to provide families with health-related information about their child's growth and development or what to expect in caring for a student with disabilities or students with developmental delays. School staff in the elementary schools may identify health concerns and provide outreach and information to the family as well as referring them to Medicaid or other federal and state programs to help ensure the child obtains health care. As part of the ongoing case management function performed in the schools, staff may assist families in arranging transportation to take a child to a medical appointment. Staff who maintain the school's health clinic/office may discover that families of sick children do not have health insurance. Referrals are made to Medicaid when it is suspected that a family may be eligible for services. Other staff, especially those in special education, may facilitate Supplemental Security Income (SSI) applications for special needs students.

Speech, occupational and physical therapists may provide information to parents and other staff about specific health conditions or services to help such conditions. School staff may provide information to students and their parents about the risk of drug and alcohol usage and the signs of abuse or dependency.

School nurses, along with special education personnel, and even office staff are often the first to identify suspected health problems in children and to refer them for diagnosis, treatment of follow-up health, mental health, or substance abuse services. When ongoing health services are necessary and need to be provided in the school setting, school staff is in a position to assist children in appropriately following their health care plans. School nurses may monitor and provide training to aides who perform health procedures.

School psychologists or counselors commonly do crisis intervention in schools. They may perform case management activities with families to ensure the child's access to mental health or substance abuse treatment services. School staff may be required to assist an injured child in getting immediate medical attention.

HOW DOES THE DISTRICT OBTAIN REIMBURSEMENT?

Prior to submission and reimbursement of any claims made, participating Districts/Programs seeking to submit MAC claims for reimbursement must first enter into a contractual agreement with Health and Human Services Commission and participate in the Random Moment Time Study (RMTS).

To determine allowable Medicaid administrative costs within a local education agency, a quarterly RMTS will be conducted. The RMTS process starts with the school districts identifying staff that perform Medicaid allowable activity. Participating staff are then added to a participant list. The participant list is used to randomly select staff to participate in a RMTS. The RMTS measures the amount of time spent on eligible and reimbursable activity for MAC and direct medical services. Once the time study is completed and the results are compiled, they are used to calculate the MAC quarterly claim.

HOW IS THE REIMBURSEMENT DETERMINED?

School districts identify staff that perform Medicaid allowable administrative activities for some part of their work day. These staff will then be eligible to participate in the state-wide RMTS and the results will be used in the calculation of the MAC claim.

A claim will be constructed based on the following:

- The percent of allowable time based on the state wide RMTS results.
- The percent of children in the district who are Medicaid eligible.
- The indirect cost rate received from the Texas Education Agency.
- The quarterly costs of staff in the district who are listed on the participant list.

For additional information regarding the Medicaid Administrative Claiming (MAC) Project, please send your inquiry to MAC@hhsc.state.tx.us.

For information regarding the Random Moment Time Study (RMTS), please send your inquiry to TimeStudy@hhsc.state.tx.us. Additional information regarding RMTS can be found at the following website link:
http://www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/TS/SharsTimeStudy.html.

Texas CHIP Coalition Maternal & Infant Health Workgroup
Recommended Topic for Senate Health & Human Services Committee Interim Studies

Identify strategies to improve birth outcomes and reduce state costs by providing greater continuity of care for mothers after delivery.

Background:

Currently, women who deliver through Medicaid receive postpartum services for only 60 days after delivery, while women delivering through CHIP Perinate receive only two postpartum visits. Yet the need for basic health services, interconception care, and screening and treatment for chronic diseases and postpartum depression extends well beyond these eligibility periods. Particularly for women who are at risk of preterm delivery, the interconception period is a critical window for lowering maternal health risks, reducing the likelihood of subsequent preterm and low birthweight deliveries, and reducing costs for the state by improving birth outcomes. Texas can improve continuity of care for women through a number of strategies, including extending the length of Medicaid postpartum eligibility or expanding benefits available within existing women's preventive health care programs. Other states, including Louisiana and Georgia, have successfully implemented policies to increase access to postpartum and interconception care, and may serve as models for Texas.

The Texas CHIP Coalition specifically recommends that the Committee consider studying the following items:

Improve birth outcomes and reduce state costs by identifying strategies to provide greater continuity of care for mothers after delivery, including:

- Examining options for reducing Texas' rate of low birth weight and premature babies, and concomitant reductions in Medicaid costs, by establishing an interconception care program for women losing Medicaid maternity or CHIP Perinatal coverage.
- Examining adequacy and availability of mental health treatment services for low-income pregnant and postpartum women seeking care for maternal or postpartum depression
- Working with Medicaid and CHIP Managed Care Organizations to:
    - Provide patient education and information about postpartum health risks prior to delivery; and
    - Identify MCO best practices related to postpartum care.

THA CAMPAIGN OVERVIEW

What Is Insure Health. Insure Texas.?

Insure Health. Insure Texas. is a new campaign spearheaded by the Texas Hospital Association and implemented by our member hospitals with the goal of increasing the number of eligible but currently uninsured Texans in the federal health insurance marketplace.

INSURE HEALTH
INSURE TEXAS
www.InsureHealthTx.org

What are the goals?

Insure Health. Insure Texas. has the primary goal of compelling currently uninsured Texans to enroll in comprehensive health insurance through the federal health insurance marketplace once open enrollment begins on Nov. 1.

Secondary goals are to engage THA member hospitals in the common goal of reducing the number of uninsured in Texas and to begin laying the groundwork for improving health insurance literacy.

Who Is Involved?

To succeed, Insure Health. Insure Texas. needs the commitment and involvement of Texas hospital leadership, boards of trustees and communications/marketing staff.

What Is the Campaign Message?

Insure Health. Insure Texas. was developed using the most current research on what makes consumers enroll in the marketplace ... or not.

- The research clearly indicates that the decision to enroll is not a political or moral decision; rather it is a personal, financial decision.
- The politics surrounding Obamacare particularly in Texas have fostered confusion, uncertainty and apathy on the part of consumers rather than clear understanding of the availability of coverage and the affordability enhancements.

First and foremost, Insure Health. Insure Texas is promoting the message that available coverage is affordable.

Secondarily, the campaign is promoting the messages that there is a financial cost associated with not enrolling in the form of a penalty and that the timeframe for purchasing coverage is limited.

How Does It Work?

THA is developing tools and resources outlined below that member hospitals can use in their entirety or select from depending on their budget and resource capacity. The intent is to give hospitals all of the creative and technical resources so that they can promote health insurance enrollment in their communities easily and efficiently.

For the campaign to succeed, hospitals will need to implement these available resources.

What Are the Available Tools and Resources?

1. Consumer-focused microsite -- InsureHealthTx.org
   - Simple, clear and focused site that gives consumers the tools and information they need to make the financial decision to purchase coverage through the marketplace and how to use their insurance once purchased.
2. Digital ads
3. Print ads
4. Radio ads
5. TV ads