Texas CHIP Coalition
Meeting Minutes

May 20, 2016

Present:	Clayton Travis, TPS Julia Von Alexander, CPPP Adriana Kohler, Texans Care for Children Leah Gonzalez, Healthy Futures Helen Kent Davis, TMA Jessica Cassidy, Texas Legal Services Marvin Okafor, Texas Legal Services Kathy Eckstein, CHAT Michelle Romero, TMA Colleen McKinney, NASW-TX Laura Guerra-Cardus, CDF-TX Mary Allen, TACHC Helen Davis Hunt, TMA
On the Phone:	Stacy Wilson, CHAT Jennifer Banda, THA Greg Hansch, NAMI Alanna Boulton, Central Health Johnna Carlton, Texas Children's Hospital Donna Deeb, Driscoll Health Plan Corpus Christi Betsy Coats, Maximus Sister J.T. Dwyer, Daughters of Charity Carrie Kroll, THA Shannon Lucas, March of Dimes
Chair:	Adriana Kohler, Texans Care for Children
Minutes Scribe:	Julia Von Alexander, Center for Public Policy Priorities
Next meeting:	June 17, 2016

I. Updates from Medicaid/CHIP Division

Eliminating the Waitlist for SSI kids in STAR Kids (Brian Dees, HHSC)

- Background: The CHIP coalition has asked if, similar to STAR PLUS, HHSC could eliminate the waitlist for kids on SSI that meet the medical necessity criteria to be moved on to MDCP. MDCP rolls into STAR Kids on Nov. 1st. The Children's Policy Council also requested this.
- 2 scenarios:
    - 1. Kids with SSI and already meet needs for nursing care (like STAR Plus rollover). Would be about 1100 kids/month. FY 18- 20 million. FY 19- 21 million, from GR: FY 18- 8.7 million and FY 19- 9.2 million
    - 2. Cost to provide MDCP whether the kid has SSI or not. This is about 2100 eligible kids/month. FY 18-113 million, FY19- 117 million. From GR: FY 18- 49 million, FY 19- 51

million. This second scenario is much larger because these kids don't currently have access to all of the Medicaid acute care services.

- Kathy E: Is HHSC going to request this? Brian- no LAR currently to his knowledge. Once in the Children's Policy Council's legislative report will get some traction. Agency will review legislative report.
- Clayton- Anyone put it in their LAR input? No, in part because had so many issues to submit in LAR.
- Every Child Inc. and Disability rights Texas led the charge. We might want to check in to see if they are making that ask.

Implementing Mental Health Parity in CHIP/Medicaid (Allen Pittman, HHSC)

- **See slides.**
- Parity refers to health insurance companies treating mental health equally to physical health services.
- Even if an individual with Medicaid managed care receives some services through Fee for Service (FFS), they are still protected. For those in Medicaid FFS in Texas, parity doesn't apply.
- Use CMS classifications to apply parity
- Clayton T.- additional classifications in the final rule? Are subclassifications are being compared to the subclassification? Allen- There are some subclassifications (will follow up with what they are). We do compare the subclassifications.
- Autonomy as a state to decide which services go in which classifications (must be similar to physical)
- 1. Substantially all- must apply to 2/3 of services on physical health side. 2. Predominant- least restrictive level on the physical health side. CMS outlined a very specific and rigid framework to determine parity compliance.
- The rule applies to Medicaid Managed Care and CHIP only. Is commercial very different? Allen- think is similar, but unsure. Will follow up.
- General types of limitations: treatment (quantitative treatment limits, non-quant) and financial requirements (see slide 8 for a detailed list). Includes prior authorizations and "First fail"
- MCOs use prior authorizations the most. "First fail" policies are not allowed, meaning MCOs can't say individuals must fail on one medication before using another.
- Stacy W.- Anecdotally we have heard that MCOs are saying clinically the treatment is different so doctors must call every day for a concurrent review. Seems to be a way of getting around parity requirement, which is concerning. Once rules in effect if they are still finding this happening who should they contact? Who is regulating it? Allen- Single state Medicaid authority. So HHSC would be the contact. Will look into further, since TDI has been doing parity for commercial plans for many years.
- Clayton T.- Network adequacy- same standards or generally an adequate network. Allen to follow up.
- SB760- new standards on net adequacy helpful to know if must be same standard.
- Can amend the state plan or modify MCO contracts. Will likely be modifying contracts because of short timeline. Due October 2017.
- Cost into MCOs capitation rate. Exceptional item? Need to do an analysis to determine potential cost.
- Clayton T.-In current contract, only 1 line. How much detail? Allen- Will have to standardize and have reporting requirements, e.g. What prior authorization for each type (mental vs. physical health)? Likely will be robust.
- Clayton- would love to see robustness in that section to demonstrate exactly what is needed.
- Clayton T.- Greg/Katharine/Allison→parity compliance leaders, focused on commercial insurance though. Updates on how to get engaged (next steps for Medicaid/CHIP).

- Greg H.- house select committee on mental health- hearing on insurance benefits next month (hopefully incudes Medicaid and CHIP). Conversation on mental health parity. Greg/workgroup-aren't pursing any particular reforms Medicaid/CHIP
- Tamela Griffin will likely be testifying at that committee. (similar presentation to Allen P.'s)
- Usually agencies can include related increases needed due to federal law in baseline implementation request.

Implementing the Medicaid and CHIP Managed Care Final Rule (Brian Dees, HHSC)

- Cross agency team working to analyze these. Very extensive rules.
- Some provisions effective this July. CMS has helpful fact sheets including an implementation calendar on their **website**.
- Timeline for provisions going into effect is from July 2016 – July 2018
- Modernizes Medicaid and CHIP Managed Care Rules (not updated since 2002). Since then the number of individuals in managed care has really increased. Very small FFS population in Texas. 4 million in managed care, 560,000 in FFS. Will be even less with STAR Kids implementation and carve-ins.
- Aims to strengthen and standardize the access to care provisions. States must develop time and distance standards for primary, specialty, hospital, behavioral, pediatric, etc. Most of these are already included in their contracts with MCOs.
- States must assess and certify managed care network access annually and when there are program design changes.
- 2013 CMS guidance on managed long term services and supports is more or less codified in these rules. So Texas is complying with a lot already.
- Modernizes member outreach- allows states to use electronic communications as long as members can always request paper copies without a charge. For example, provider directories. STAR Kids plans are struggling because it is hard to send out packets for large service area.
- Standards in the rule around care coordination, assessment and treatment plans for individuals with special health care needs. Extended to those needed long term services and supports. Already a part of STAR Kids, but this expanded the scope.
- Trying to standardize Marketplace/Medicaid Managed Care/CHIP
- External quality review for network adequacy- External Quality Review Organization (EQRO) (Texas uses external review entity through University of Florida) will now need to validate network adequacy annually. Medicaid and CHIP MCOs must provide performance information.
- Clayton T.-3 star report cards expanded? Brian D.- probably more robust, but need to get into the rules more. Clayton T.-What is network adequacy validation? Doing cold calling for STAR Kids, people contracted and taking new clients. Clayton T.- Where does the responsibility lie? No discussions on that yet.
- More robust websites for state Medicaid and MCOs. Will post information on their contracted MCOs, annual reports on managed care plans, enrollment, benefits covered, grievances and appeals, sanctions/corrective action, factors related to delivery, information for enrollees (provider directories, formularies, etc).
- Adriana K.-Timeline for info on website? Brian D.- unsure, will have a robust spreadsheet in 2 weeks with implementation deadlines.
- Kathy E.- thoughts on provisions by states directing spending by the MCOs- minimum or maximum that they can spend. Brian- can't comment yet.
- By July, will have analyzed and written an action plan so will have much more specifics for CHIP coalition. May be new regulations, but many things we are already doing. Need to figure out what new things are required.

- Clayton T.- is getting into this better for the Medicaid Managed Care Consumer Protection Working Group? They could report highlights to CHIP coalition. Adriana K.- agrees it might be better.

Updates relating to the Medicaid Equal Access Rule (written update from Carisa Magee)

- Written statement from Carisa Magee (provided in CHIP email and below)
- Access analysis for FFS. When states submit state plan amendments impacting rates, they must include the analysis (that includes stakeholder concerns). Gives advocates a way to provide input on access. HHSC is working to comply with the requirement and SB760. Some differences in methodologies.
- Clayton T.- Pam McDonald indicated it was for FFS. Doesn't seem to apply much to managed care.
- Kathy E.-Only helps to the extent that MCOs go by FFS rates to some extent. Clayton T.-Might hope for higher managed care rates.
- Another avenue to complain to federal agencies.

II. Update on Birth Certificate Denials (Anne Dunkelberg, CPPP)

- Background- lawsuit filed last June (Perales Cerna et al. vs DSHS). Root of issue is that some county local birth certificate registrars stopped accepting many different forms of foreign identification that had been accepted in the past. When an undocumented parents try to get a hard copy of their kids' birth certificate were/are being denied access to that.
    - When born in U.S. hospital, hospital does the following: 1. Birth put into TX vital statistics 2. Apply for SSN 3. Enrolls child in Medicaid. So getting Medicaid initially isn't the issue for most. But the family may need proof of the child's citizenship and that they are the child's parents for other reasons (e.g. crossing the border, daycare, etc.)
    - Last year, we reported on 4-5 issues affecting access to health care in TX for immigrants. At that meeting, CHIP coalition interested in making sure when those babies are at 1st birthday can renew Medicaid (not delayed or denied). TX vital statistics database is supposed to be first resort (shouldn't require a birth certificate). Still last Dec. some kids having issues renewing Medicaid or getting onto CHIP.
- Update- Jennifer Harbury confirmed that when they send the violation of the policies to TX Medicaid or Ombudsman they get a prompt resolution. One of most common situations where encounter barriers to Medicaid/CHIP renewal is when there was an error in official record entered at birth. 3 databases where could make mistakes, and when they don't match or are incorrect, parents have issues.
- Mary A.- they called their centers with a focus on the centers in the Valley. They haven't really seen any barriers to renewal at their health centers.
- Anne D.- Must send a clear message that can't help with bigger legal battle, but if disruption in Medicaid/CHIP we are happy to facilitate communication with HHSC. TACHC's centers not be best example, because they know the TX Medicaid program so well there.
- CHIP coalition can act as a resource to connect with the correcting policy. We have done so in the past when there have been disruptions of coverage by putting information on the website as well as a coalition member's contact information. Proposing to do that again.
- Clayton T.- willing to be a conduit for concerns? Anne-yes, the CHIP coalition website probably has an old offer to be a point of contact when people are having barriers. Anne to update and refresh it (specific to birth certificates). Will need to translate into Spanish. We can also distribute information to partners/stakeholders. Anne will reach out to HHSC to see who to send those complaints.
- Jessica C.- go through Jennifer H. or Marvin O. to request funding from the state bar's translation money.

III. Update from the Medicaid Managed Care Consumer Protection Working Group (MMCCPWG) (Clayton Travis, TPS & Adriana Kohler, Texans Care)

Comment Process for Contract Changes in Managed Care

- Clayton T.- provide stakeholder input in changes on managed care contract process.
- Right now just HHSC and MCOs, less access than before Medicaid managed care stakeholders could comment since things went through the rulemaking process.
- Rudy Villareal will take back to Medicaid/CHIP to see if this is a feasible resolution.
- For instance, parity rule- in contract making changes.
- **Email Clayton** if interested in joining/attending the MMCCPWG. Next meeting to include: an update on notice of action letters (HHSC ombudsman managed care), SB760 (what would we like to see in discussions, how you can weigh in, minimum standards from group), vendor drug program carve in, updates from Medicaid managed care plans (Rudy Villarreal).

Upcoming Hearing on SB760 on June 6th

- More of a forum than a hearing.
- SB 760 passed last session, heightened network adequacy standards. For provider directories and expedited clinicians (adding social workers besides physicians)
- June 6th at 1pm, public hearing room at HHSC
- Panel (some of our members are presenting). HHSC laying out high level recommendations on implementation, reforms, etc.
- All recommendations are initial and HHSC will be incorporating comments.
- Will include provider directories and websites listing someone to call if you can't find someone in network (with a timeframe). Ratios and changing the specialty distance w/in urban areas.
- Section for public comment as well.
- Recommendations for comments from Clayton T.: Basics need stricter network adequacy standards, need to be able to enforce them, based on geographic location.
- Kathy E-Contracts require quarterly reports including network adequacy- may want to ask HHSC to put them on the website too.

Open positions for HHSC advisory committees

- See openings here: **http://www.hhsc.state.tx.us/hhs-transformation/advisory-committees.shtml**
- Let us know if your group is involved/on an advisory committee so we can potentially use you as a conduit.
- Below are the advisory committees with applications still open:
    - DSHS: Healthcare Safety Advisory Committee; Sickle Cell Advisory Committee
    - HHSC: e-Health Advisory Committee; Policy Council for Children and Families

IV. Discussion on the Coalition Name Change (Adriana Kohler, Texans Care)

- Name that workgroup recommended: Children's Health Coverage Coalition
- Vote at this meeting and extend for a month for a vote through email.
- Vote taken- using Robert's rule. All in favor in the room.
- If you want to vote no, **email Julia**. If you would like, you can also provide any reasons in that email.
- Suggestion-if changing the name need a process to educate people on that new name.
- Rebranding campaign- in June. Will keep the kids on our logo. Increasing participation in briefings before and during session. Will also have a tagline (The CHIP coalition). Hopefully a press

conference/briefing to come soon. Will maintain the name change workgroup to become the rebranding workgroup.

- Laura G.- discussed at last meeting- rebranding would help to achieve goals like increasing presence. Leveraging the name change to become a more robust coalition.
- Join the workgroup! Clayton, Laura, Melissa, and communications are on it now. Reach out to them.

V. Discussion on Legislative Appropriations Request Hearing and Comments

- Written input to the HHSC LAR already due, but public hearing next Wed. Can still get involved.
- Many members have submitted comments and/or are attending the public hearing.
- Comment form was difficult. Any confirmation? No.
- What issues are groups raising?
    a. TPS, TMA and OB/GYNs comments for all HHS- payment rates and competitive payments for physicians, restoration of the cut for co-payment for dually eligible patients, women's health outreach campaign, and promotion of LARCs (workaround is cumbersome &need to update rates more frequently). DSHS-more tobacco prevention in youth, increasing vaccination rates in healthcare workers, more clinical/epidemiological expertise for Zika and other emerging infectious diseases, birth outcomes, addressing obesity, and child fatality review teams- more funding and training at local level. DARS- ECI (similar to ECI coalition) funded.
    b. Medicaid pays for LARCs immediately post-partum, or can wait and get through healthy Texas women's program or family planning. But issue is that payment rates are only updated every 2 years. Also, through VDP patients have to come back for the service, can't get at time of appointment. Been asking that they update payment process so that MDs can just stock them in their office. Specialty pharmacy process has helped, but still issues. Not best practice.
    c. Kathy E, CHAT- Outpatient services is the biggest gap, so requested fully funding it. Increasing outpatient rates, maintaining funding for safety net hospitals asked for GR (source of funding last year is trauma funds which is almost out), pilot telemedicine program (rural hospitals- allows to access specialty care). Also submitting to DFPS on medically complex kids in foster care, who end up staying at a children's hospital don't have a placement. Currently there is no money that would allow foster family to have a medically complex child in their home.
    d. Adriana K.-Texans Care commented on ECI (like ECI coalition's to DARS) on making sure kids can be referred; continued funding for healthy Texas women and family planning women; allowing children in CHIP to dually enroll in CHIP and Texas women's program to get contraceptive services.
    e. Colleen M. testifying on Wednesday increasing pay for social workers who bill Medicaid.
- DFPS- hearing on May 26th; DSHS- hearing in June.

VI. Interim Charges, Hearing Updates and Discussion

- Birth outcome (public health hearing)- good panel of experts. Women's Health Coalition doctor, DSHS commissioner and Lesley French, and Doctors Olie and Lakey spoke.
- Low birth rate babies, preterm birth. Agency presented lots on programs. (presentation **here**)
- Shannon L., March of Dimes- in the hearing, women off of Medicaid automatically enrolled in healthy Texas women. People asked about CHIP-P, but agency said you didn't direct us to set it up that way. Technical issue, that can fix if direct them to do so. May be something our coalition pushes during session. Let Adriana know if you are interested in this issue of automatic enrollment for CHIP-P.

- Helen K.- Cost issue with changing TIERS. May want to do a rider. Won't move unless is very clear that they have that authority. Same with CHIP-P providing LARCs. Want associations to work on it at national level. Letter/inquiries to CMS.
- Sarah Davis and others interested in increasing LARC usage, and smoking cessation among pregnant women, which has implications for low birth weight. Also treatment options for opioids use.
- Interest in replicating/integrating medical homes for pregnant women
- Sister J.T.- FPL for women's health? Is 200% for Healthy TX women and 150% for family planning
- Upcoming hearings? Select committee on mental health- June 2? Insurance hearing June 1

Laura Guerra-Cardus of CDF-TX will chair on June 17, which is a 90-minute meeting followed by Outreach and Eligibility Working Group meeting.

Written Statement on Medicaid Equal Access Rule (Carisa Magee, HHSC)

The Medicaid Equal Access Rule is intended to establish a data-driven process to comply with Social Security Act §1902(a)(30)(A), which requires Medicaid payments are sufficient to assure adequate beneficiary access to covered services. The rule applies to state plan services in the fee-for-service delivery model. State Medicaid programs must submit an Access Monitoring Review Plan (AMRP) by October 1, 2016, and every three years thereafter. The plan must analyze certain services for sufficient access under a state-established methodology and identify the method to monitor any rate reductions or restructuring for at least three years post-implementation.

When states submit state plan amendments impacting rates, they must include the AMRP related to the service, analysis of impact on access, and analysis of information and concerns shared by stakeholders. States must establish or maintain ongoing provider and beneficiary means for access to care input. States must establish corrective action plans to remediate identified access to care issues within 12 months.

HHSC currently is working to comply with the requirements of the Medicaid Equal Access rule. Staff on this initiative are working closely with staff working to comply with requirements of SB 760 designed to address access in Medicaid managed care to ensure that access reviews are streamlined and uniform to the extent possible and similar methodologies are followed when possible. Some differences in methodology will be inevitable given that the information gathered in provider data and claims data in fee-for-service and provider data and encounter data and in managed care differ.

Scenario 1: providing MDCP services to inidividuls on interest list who meet nursing facility level of care and have SSI

	Eligible per Month	Total Annual Cost AF	Total Annual Cost GR
FY2018	1,121	20,000,000	8,764,000
FY2019	1,164	21,000,000	9,202,200
Biennial		41,000,000	17,966,200

Scenario 2: providing MDCP services to inidividuls on interest list who meet nursing facility level of care, regardless of SSI

	Eligible per Month	Total Annual Cost AF	Total Annual Cost GR
FY2018	2,107	113,000,000	49,516,600
FY2019	2,188	117,000,000	51,269,400
Biennial		230,000,000	100,786,000

Note: analysis assumes a start date of September, 2017

HHSC System Forecasting, April 2016

TEXAS
Health and Human
Services Commission

Mental Health Parity in Texas Medicaid and CHIP

Allen Pittman
Behavioral Health Program Specialist
Medicaid CHIP Division
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Today's Presentation

- Legislative history and background
- Overview of mental health parity and its application to Texas Medicaid/CHIP
- Process for determining parity compliance
- Next steps at HHSC

Mental Health Parity Background and History

- 1996: Mental Health Parity Act of 1996 (MHPA)
  - Required certain commercial group health coverage have parity in aggregate lifetime and dollar limits
- 2008: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)
  - Added substance use disorder services and required parity in treatment/financial limitations
- 2013: Final mental health parity rules for commercial plans
  - Did not apply to Medicaid and CHIP
- 2016: Final mental health parity rules for Medicaid and CHIP managed care organizations (MCOs)

Mental Health Parity Overview

- Requires equal treatment of behavioral health conditions to physical health conditions
- Prevents MCOs from imposing less favorable benefit limitations to mental health and substance use disorder services compared to physical health services
- All people receiving any services through Texas Medicaid and CHIP MCOs are protected by mental health parity requirements, even if some services are provided in FFS
- Parity does not apply for Medicaid recipients receiving all services through fee-for-service

Process for Determining Parity Compliance

- Benefit Classifications
- Substantially All and Predominant
- Treatment Limitations

Benefit Classifications

- The State/MCOs determine which Medicaid services are included in each of the 4 classifications used in parity analysis:
  - Inpatient
  - Outpatient
  - Emergency Care
  - Prescription Drugs
- Limitations on behavioral health services in each classification can not be more restrictive than limitations on physical health services in the same classification
- When determining the classification, the MCO must apply "the same reasonable standards to medical/surgical benefits and to mental health or substance use disorder benefits"

Substantially All and Predominant

- Financial requirements and treatment limitations that are applicable to mental health or substance use benefits must be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits.
  - "Substantially All" – meets this standard if a level applies to at least two-thirds of all medical/surgical benefits in that classification. If a financial requirement/treatment limitation does not apply to two-thirds of medical/surgical benefits, it can not be imposed on MH/SUD benefits.
  - "Predominant level" – the level that applies to more than one-half of medical/surgical benefits in a given classification.

Types of Limitations

- Treatment Limitations
  - Quantitative Treatment Limitations: Limits on benefits based on the frequency of treatment
    - Number of visits
    - Days of coverage
    - Days in a waiting period, or
    - Other similar limits on the scope or duration of treatment
  - Non-Quantitative Treatment Limitations: No "hard limits" but limit the ability of a person receive a certain service or level of services
    - Prior Authorization Processes
    - Concurrent Review
    - "Fail First" Policies
- Financial Requirements
  - Deductibles
  - Co-payments
  - Co-insurance
  - Out of pocket maximums
  - Aggregate lifetime or annual dollar limits are not considered financial requirements are dealt with separately in the final rule

Parity Compliance

- For state plan MH/SUD services that are not in compliance with parity requirements, Texas has two options:
  - Amend the state plan to ensure the service package complies with parity rules
  - Modify relevant treatment limitations from Medicaid services provided by the MCOs. This does not require modifying state plan
- Required to make parity compliance documentation available to general public within 18 months of the rule's date of publication

Parity Compliance

- The rule does not include an increased cost exemption
- Final rule allows Texas to include costs of becoming compliant with MHPAEA in payments to MCOs

Implementation Timeline

- CMS will continue to issue technical guidance related to parity implementation in the coming months.
- Texas must be fully compliant with final Parity rules by October 2017
  - Must make documentation of compliance available to general public
  - September 2017 managed contracts must be amended
  - Stakeholder engagement

Questions Related to Mental Health Parity

- Allen Pittman, Behavioral Health Program Specialist
  - Allen.Pittman@hhsc.state.tx.us
  - 512-730-7438