Children's Health Coverage Coalition
December Meeting Minutes
December 17, 2017

Present:

Laura Guerra-Cardus, Children's Defense Fund
Anne Dunkelberg, Center for Public Policy Priorities
Greg Hansch, NAMI Texas
Stacy Wilson, Texas Hospital Association
Clayton Travis, Texas Pediatric Society
Mimi Garcia, TACHC
Melissa McChesney, CPPP
Will Francis, NASW Texas
Rachel Cooper, CPPP
Kristina Happen
Leila Rice

Invited Guests:

Erika Ramirez, HHSC
Paige Marsala, HHSC
Deborah De La Cruz, HHSC
Stephanie Muth, HHSC
Gina Carter, HHSC

On Conference Line:

Diane Rhodes, Texas Dental Association
Kate, Community Health Plans
Leah Gonzales, Healthy Futures of Texas
Celia Kaye, League of Women Voters
Christine Yanas, Methodist Healthcare Ministries
Betsey Coates, Maximus Outreach
Kay Ghahremani, Texas Association of Community-Based Health Plans
Mikayla

Chair: Laura Guerra-Cardus, Children's Defense Fund
Meeting Scribe: Jessica Giles, Children's Defense Fund/CHC Coalition
Next Meeting: January 19, 2018

1. Introductions, Announcements, and Meeting Chairs

Laura Guerra-Cardus

- 2018 Meeting Chairs:

Friday, Jan 19.- **THA, Rm. 701**: Mimi, TACHC
Friday, Feb. 16- TMA, Thompson Auditorium: Diane Rhodes, Texas Dental Association
Friday, March 23- TMA, Thompson Auditorium: Greg Hansch, NAMI
Friday, April 20- TMA, Thompson Auditorium: Helen Kent Davis, Texas Medical Association
Friday, May 18-TMA, Thompson Auditorium: Stacy Wilson
Friday, June 15- TMA, Thompson Auditorium: Clayton Travis

Clayton Travis:

- CHCC will be redoing website and making several changes so it can serve its purpose better. The site will be rebranded, with text and content. CHAT has helped fund these changes.

2. Interim Charges (11:15 a.m. — 11:40 a.m.)

Laura Guerra-Cardus:

- See attached document for suggested coalition priorities for interim charges. Adirana Kohler developed first draft. If a specific interim charge stands out as needing to be our priority document, let us know. You can look through and reach out to me or Adriana. The charges are grouped around Medicaid and CHIP, Maternal Health and Birth Outcomes, and ECI. Are there other categories that should be prioritized?

Clayton Travis:

- CHCC should come up with a quick-glance guide that elevates our clear ask and message for each interim charge with easy talking/messaging points that can streamline our messaging. This guide will need to be a consensus-document and CHC Coalition members will need to contribute.

Laura Guerra-Cardus:

- Quick Glance Guide Workgroups
    - Medicaid and CHIP: Anne, Clayton, Laura, Mimi, Kay, Helen, Adriana
    - Maternal Health and Birth Outcomes: add Healthy Minds Coalition
    - ECI: ECI advocacy coalition has already come up with the asks that this coalition can support.
- Meetings with Committee Staff:

    - To be on planning chain: Anne Dunkelberg, Greg Hansch (Medicaid/CHIP), Mimi Garcia, Stacy Wilson (Medicaid/CHIP), Adriana, Clayton, Helen, Laura, Kay, Leah
- For HB2644 about screening for Postpartum depression during a child's well child visit- comments are due on Tuesday, Dec. 19. Adriana will be developing a template for non-experts who want to contribute in some way. Biggest issue is that only 1 screening over a 12 month period will be covered, which is inadequate and not in accordance of with AAP. Questions include- What do referrals look like? Is the system set up to receive women on the referral end? Recommendation for Texas Health Steps providers for handling these referrals. What about existing resource guides? More needs to be done to provide physicians regional-based resources for where to refer to. We're also interested in the screening tools being proposed and how they can be most effective
- Clayton points out that women are often on coverage for the first 60 days after birth, so they are likely to get the first two AAP recommended screenings at their OB GYN visit. HB2644 adds a third screening for the year. At least women can get three of the four AAP recommended screenings in the first 6 months.
- Maternal and child health issues on March 22: Substance Abuse and recovery for pregnant and postpartum women.

3. Cost Containment Rider Report (11:40 a.m. — 12:05 p.m.)

Clayton Travis:

- [see attached report]
- This is a report required from Rider 34. It requires a set dollar amount for HHSC to go out and find within the Medicaid budget. This report is all of HHSC, not just Medicaid this year.
- Risk-Margin reduction. MCOs are not happy with this. Update on where projections are on how much money will be saved. Will create about 74 million dollars in saving. Other areas for funds: Fraud, waste, and abuse.

- Section 5: implementing fee for service. Star kids managed care. Gross-claimed cost will be down by 7%. Making sure that children and clients are receiving services that they need. Prior authorizing to get a total decrease in the gross claims
- Item 6: Change for preferred to non-preferred antipsychotics
- Item 18: Only one initiative that found savings. Implementing Reinstating previous hospitals eligibility criteria for higher medicaid reimbursement
- Reviewing it: nothing is egregious. Similar changes would likely happen regardless of this rider. Not necessary that there be a set dollar amount. Movement towards getting rid of this rider. Should be approached by value-based and quality changes, rather than legislative process. It's a philosophical difference.

Kay Ghahremani:

- This rider has been in place for several sessions. HHSC has taken it very seriously because they're high dollar items. There's a lot of pressure on the agency to come up with these savings. It's not a good way to do this, because it forces managed care companies to do things that they don't' want to do and takes away flexibility.

Anne Dunkelberg:

- Made some good steps this year in educating lawmakers about actual health costs. May be a good idea to have a working group about taking that to the next level and increasing shared truth telling about Medicaid.

Clayton Travis:

- We need to paint a better picture about how it isn't appropriate for Medicaid to have multiple masters.
- Dell Med/Episcopal Health Foundation Project with HHSC: Went really well, talked MCO initiatives, HHSC moving MCO's toward value-based. Biggest takeaway was a coalescing that it's hard to do good work in Medicaid program with legislature stepping in and attempting to do cost constraints.

Clayton Travis on Medicaid Managed Care Updates:

- Texas Conservative Coalition Research Institute Paper- Had some good content. In the recommendations area, there are spots where the coalition is likely to disagree.

- Medicaid Managed Care is working. We're finding quality, reducing costs, etc. Certainly concerns from provider and consumer advocate, but the overall message is that Medicaid is a good thing.
- Consolidated Credential Verification Organization Notification- can submit to a hub for credentialing through one health plan. Submit information once from the hub and MCO's pull from the hub.

4.Federal Updates (12:05 p.m. — 12:15 p.m.)

Anne Dunkelberg on CHIP:

- Need to fix payers in CHIP bill. Continuing to complain to congress. Object to prioritizing tax bill.

Mimi Garcia:

- Sounds like there's active conversation with LBB, HHSC, and members of legislature about a possible program for keeping kids from falling off. Backfilled by federal funds. Legislature and LBB are actively paying attention, engaging, but unsure what they are actually doing.

Laura Guerra-Cardus:

- What was included in the continuing resolution. New formula for distributing redistribution funds. How it is actually done is still up in the air. How they come up with the formula will determine how it affects states. No matter how you dice it, it's clear that there is not enough redistribution funding to take care of all the state's needs to keep from running out by february.

Mimi Garcia on Health Center Funding:

- Health center funding and CHIP are riding together

Laura Guerra-Cardus:

- Tax bill seems to be changing all the time. No compromise has been reached yet. No additional changes are allowed after noon on Dec. 15, so no more final deals to get legislatures on board. Still somewhat unknown because the language will not be available until 5 p.m. Assumption is that the child tax credits went up. Unknown: Rubio, Lee,

Collins, Flake, Corker. McCain and Cochran have health issues. House will probably vote next Tuesday. Senate will go to action Tuesday evening.

5. Open Enrollment Update: (12:13 p.m. – 12:20 p.m.)

Melissa McChesney:

- Enthusiasm for signing up is there, but now we're out of time. We may see additional numbers come out after today, but they won't include auto-enrollees. It will be the first time that auto-enrollee enrollment will happen after enrollment ends. There is concern about what will happen to those waiting in-line at midnight. Some have urged agency to follow through with the process.
- [See attached document]. Fact sheet about special enrollment period for large chunk of Texas. 60% of Texas's population is in an area affected by Harvey. If they call the call center between 16th to the 31st, they get a special enrollment period. Enrollment can only been done by call center. Statement of affected by Harvey is all that is required, no proof needed. Dallas, Travis, Tarrant, Bexar county are all included. Most of our metropolitan areas are included. It's much more arduous to do it after Dec. 15. If they lived in the county during that period, they can get special enrollment. There are also areas outside of Texas that are covered. Press release from Cover Texas Now is going to press tomorrow.

6. CHIP Update from HHSC (12:20 p.m. – 12:35 p.m.)

Stephanie Muth:

- Notification from CMS about our redistribution amount has changed slightly from previous estimates. We now have enough funding ensured to get through February. HHSC is currently working on what the exacts dates for letters will be and are hoping for reauthorization, which HHSC is confident will happen. Notices will be sent out in January for February. There is still nothing that will get Texas through March. Received confirmation of redistribution funds during this week and do not need the physical money yet. CMS is still in the process of closing books for some states and there is a congressional proposal for prioritizing funding. Still plenty of redistribution funds to get us through February, but none for any further.

Laura Guerra-Cardus:

- Have there been any conversations between HHSC and LBB about contingency plans?

Stephanie Muth:

- We did meet with LBB, but we don't think we will need to exercise any options for the month of February. Anything beyond that, we'll need official guidance and those conversations are between LBB and leadership.

Laura Guerra-Cardus:

- In terms of Harvey impact on CHIP, some of our health plans partners mentioned that rolls have increased and attribute it to extended renewal period. Any insight on cost of Harvey on CHIP?

Stephanie Muth:

- HHSC believes that the reason for the bump is the enrollment period, but have not seen cost estimates yet..

7. Texas Healthcare Learning Collaborative Website (12: 35 p.m. — 12:45 p.m.)

Mimi Garcia:

- Creation of a new website Texas Healthcare Learning Collaborative, which is a joint project between Texas HHSC and Institute for Child Health Policy. The website features performance data by MCO's broken down by different regions and shows all of the plans. The website has a private side and public side. On the backend, there's more granular data. MCOs have log-in and providers may be able to access this information as well. States without managed care models have much greater compulsory power and insight. There's a lot of holes, so it's interesting.

8. Eligibility and Enrollment Portion (12:45 p.m. – 1:25 p.m.)

Gina Carter:

- Next February, we can have a training.

Melissa McChesney:

- There are multiple directions any application can go if an individual came forward to get a determination for medicaid. Is there any way to get denials specifically on immigration status? Many are likely to get a denial for not having a dependent or income, not for immigration status purposes.

Gina Carter:

- The individual can use the pre-screener. The pre-screener will always take them to the rapid router, asking some basic questions. If you don't have a yourtexasbenefits account, it will take you to the rapid router. The router doesn't ask about immigration status and cannot make a determination based off of status.

Melissa McChesney:

- People are not eligible for a multiple reason, and are getting denied for reasons other than immigration status. This is happening in other states as well.

Gina Carter:

- Lack of eligibility has nothing to do with an individual's alien status if they're not under a specific category. The router tells you the things that you're not eligible for.

Melissa McChesney:

- There's a large number of uninsured eligible for marketplace. ⅜ immigrants below the poverty line. Those immigrants are not being properly assessed for their tax credits.

Gina Carter on Child-only TANF:

- Child-only TANF is an actual program. In the system, it wasn't an easy thing for a staff person to do. If they do mark that they want to apply for a family, they do it for the entire household. If they're ineligible, now it will automatically look at child individually.
- They're working on the coding right now to make the change by this month. Should be made in the early part of January.

Rachel Cooper:

- CPPP received a call from a caregiver who had been told that she didn't qualify. Using the child-only kinship care language, she went back and the worker told her not to apply. Worker had to go back to the supervisor and the caller was told that she had to find the birth certificate for the child and proof that she's related to the child. CPS approved her of the caregiver and the relationship. Shouldn't that be sufficient?

Gina Carter:

- HHSC is not sure how CPS verifies a relative. If CPS has something that properly verifies a relationship, then it probably should be sufficient, but unsure if they have the same process as HHSC.

Rachel Cooper:

- There are ¼ million children in Texas who are potentially eligible for TANF, many of which are getting Medicaid. Many are being deferred before they even apply or are being denied.

Gina Carter:

- These people should be getting sent over to Ombudsman if this is what is happening. Anyone should be able to apply, get the notice, and appeal if necessary. There is a brochure that talks about all the benefits that they can get as grandparents, what they can do, and where they can get the services.

9. Office of the Ombudsman Update (1:25 p.m. — 2:00 p.m.)

Paige Marsala:

- [Powerpoint attached]
- 21,000 Ombudsman calls. Complaints were 34%. A lot was due to Harvey, as well as the rollout of adoption assistance and medicaid for breast and cervical cancer.
- Slide 4: started to get more contacts because of CHIP.
- CHIP Perinatal: Increase in November. There was also an increase in CHIP-Perinatal with uncertainty about the future of CHIP, which seems to show that they know they're on a CHIP program.
- Slide 6: Can see Harvey response. Most people have resettled by November and numbers have dropped off.

Deborah De La Cruz:

- Lone Star card issue were primarily related to Harvey and being new to the program. Some people got issued regular SNAP.

Paige Marsala:

- Slide 7: Increase in October. There was a change in income and how it was being applied. Ombudsman was able to determine that there was a spike in the Houston area.

Deborah De La Cruz on Foster Care Ombudsman:

- Only 36% were from actual foster care youth, which is what Ombudsman is used for. Not getting access to their own possessions is one of the rights. Hope to expand our Ombudsman staff so that we can do more outreach. Want to go into schools.

Paige Marsala:

- Last slide is not updated. In the past quarter, we were able to audit claims into Ombudsman series. Advocates are now referred to as Ombudsman 2. Complaint resolution specialists are now Ombudsman 3. Email box and online submission form that will be deployed in January. Approved to hire another Ombudsman 4: Team Lead. Will give more assistance in pulling reports and analyzing data.

Next Meeting: January 17, 2018

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

Relevant 2017-2018 Interim Charges

Interim Charges broken into the following categories:

- Health coverage, Health Access, and Medicaid Managed Care
- Women's Health and Birth Outcomes
- Early Childhood Intervention (ECI)
- Trauma and Children's Mental Health
- Substance Use and Addiction
- Foster Care
- Health Insurance Markets
- Telehealth and Rural Health
- Tax Reform, Revenue, and Rainy Day Fund

Health Coverage, Health Access & Medicaid Managed Care

House Committee on Appropriations

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

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

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

a. All activities and expenditures related to Hurricane Harvey;
b. Any lapses in funding at the Department of Family and Protective Services (DFPS) or the Health and Human Services Commission (HHSC) f**or prevention and early intervention, and/or behavioral health services;**
c. Implementation of therapy rate increases and policy changes at HHSC;
d. Ongoing impact of critical-needs funding at DFPS;
e. Medicaid cost-containment efforts;
f. Implementation of a capitated correctional managed healthcare rate;
g. [non-relevant charges deleted]

House Committee on Human Services

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

6. Monitor the HHSC's implementation of **Rider 219** in Article II of the General Appropriations Act related to **prescription drug benefit administration in Medicaid.** Analyze the role of pharmacy benefit managers in Texas Medicaid.

House Public Health

8. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature. In conducting this oversight, the Committee will also specifically closely **monitor the implementation of H.B. 10 (85R), H.B. 13 (85R), and S.B. 292 (85R).**

Senate Finance Committee

Monitoring: Monitor the implementation of the following funding initiatives:

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

Article IX, Sec. 10.06. Analysis of Certain Healthcare Data.

(a) Out of funds appropriated elsewhere in this Act, the Health and Human Services Commission shall coordinate with the Department of State Health Services, the Employees Retirement System of Texas, the Texas Department of Criminal Justice, and the Teacher Retirement System to develop recommendations and a comprehensive plan for an integrated health care information system that can be used to compare data related to the healthcare systems funded by appropriations made to these agencies. The integrated system should allow the state to collect and analyze data on utilization, cost, reimbursement rates, and quality in order to identify improvements for efficiency and quality that can be implemented within each healthcare system. In the development of recommendations and comprehensive plan, the agencies shall consider differences in population, acuity, and other necessary factors between systems, potential for expansion of existing healthcare data integration initiatives, the use of existing health claims data sources, and the collection of new inpatient and outpatient claims data.

(b) The agencies shall meet at least bi-monthly to develop these recommendations and shall consult with the Department of Information Resources and the Legislative Budget Board. The agencies shall submit a report to the Legislative Budget Board and the Governor no later than May 1, 2018 that includes the cost of the recommendations and comprehensive plan as well as any necessary statutory changes and potential impacts to data governance planning at each agency.

Sec. 10.07. Cross-agency Collaboration on Value-based Payment Strategies.

The Health and Human Services Commission, the Employees Retirement System of Texas, and the Teacher Retirement System shall collaborate on the development and implementation of potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives. To the extent possible, these agencies shall work toward similar outcome measures.

Senate Health and Human Services Committee

Medicaid Managed Care Quality and Compliance: Review the Health and Human Services Commission's efforts to **improve quality and efficiency in the Medicaid program**, **including pay-for-quality initiatives in Medicaid managed care**. **Compare alternative payment models and value-based payment arrangements with providers in Medicaid managed care**, the Employees Retirement System, and the Teachers Retirement System, and identify areas for cross-collaboration and coordination among these entities. Evaluate the commission's efforts to ensure Medicaid managed care organizations' compliance with contractual obligations and the use of incentives and sanctions to enforce compliance. Assess the commission's progress in implementing competitive bidding practices for Medicaid managed care contracts and other initiatives to ensure the best value for taxpayer dollars used in Medicaid managed care contracts.

Women's Health & Birth Outcomes

House Committee on Public Health

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

Senate Health and Human Services

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

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

ECI

House Committee on Appropriations

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

Trauma and Child Mental Health

House Public Health

3. Study and make recommendations to **improve services available for identifying and treating children with mental illness, including the application of trauma- and grief-informed practices.** Identify strategies to assist in understanding the impact and recognizing the signs of trauma in children and **providing school-based or community-based mental health services** to children who need them. Analyze the role of the Texas Education Agency and of the regional Education Service Centers regarding mental health. In addition, review programs that treat early psychosis among youth and young adults.

Substance Use and Addiction

- See Foster care section; Joint Public Health and House Human charge around children involved in CPS with mental health or SUD and children in CPS as a result of parental substance use

House Select Committee on Opioids and Substance Abuse

1. Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.

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

3. Review policies and guidelines used by state agencies to monitor for and **prevent abuse of prescription drugs** in state-funded or state-administered programs. Include in this review policies implemented by the Texas Medicaid Program, the Division of Workers' Compensation of the Texas Department of Insurance, the Teacher Retirement System, and the Employee Retirement System. Make recommendations regarding best practices.

4. Monitor and evaluate the implementation of legislation passed by the 85th Legislature regarding the **Prescription Monitoring Program**. In addition, review the prescribing of addictive drugs by physicians and other health care providers within various geographic regions of this state. **Determine the role of health care professionals in preventing overutilization and diversion of addictive prescriptions**. Provide recommendations that will improve efforts to prevent overutilization and diversion of addictive prescriptions.

5. Identify how opioids have impacted the normal scope of work for law enforcement, first responders, and hospital emergency department personnel.

6. **Examine the impact of substance abuse and substance use disorders on Texans who are involved** in **the adult or juvenile criminal justice system and/or the Child Protective Services system. Identify barriers to treatment and the availability of treatment in various areas of the state.** Recommend solutions to improve state and local policy, including **alternatives to justice system involvement**, and ways to increase access to effective treatment and recovery options.

8. Identify the specialty courts in Texas that specialize in substance use disorders. Determine the effectiveness of these courts and consider solutions to increase the number of courts in Texas.

Senate Health and Human Services Committee

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

Foster Care

House Committee on Human Services

4. Review the **availability of prevention and early intervention programs** and determine their effectiveness in reducing maltreatment of children. In addition, review services available to children emancipating out of foster care, as well as services available to families post-adoption. Determine if current services are adequately providing for children's needs and meeting the objectives of the programs. While reviewing possible system improvements for children, follow the work of the Supreme Court of Texas Children's Commissions' Statewide Collaborative of Trauma-Informed Care to determine how trauma-informed care impacts outcomes for children.

5. **Analyze the prevalence of children involved with Child Protective Services (CPS) who have a mental illness and/or a substance use disorder. In addition, analyze the prevalence of children involved with CPS due to their guardian's substance abuse or because of an untreated mental illness.** Identify methods to strengthen CPS processes and services, including efforts for family preservation; increasing the number of appropriate placements designed for children with high needs; and **ensuring Texas Medicaid is providing access to appropriate and effective behavioral health services.** ***(Joint charge with the House Committee on Public Health)***

7. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature. In conducting this oversight, the committee will also closely monitor the implementation of H.B. 4 (85R), H.B. 5 (85R), H.B. 7 (85R), and S.B. 11 (85R).

Senate Committee on Health & Human Services

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

- Initiatives intended to improve child safety, Child Protective Services workforce retention, and development of **additional capacity in the foster care system**. Make additional recommendations to ensure children with **high levels of medical or mental health needs receive timely access to services in the least restrictive setting;**
- [non-relevant monitoring charges deleted]

Health Insurance Markets

House Committee on Insurance

4. Assess the status of the health insurance market in Texas and opportunities to improve this market through waivers of federal law or other mechanisms. Monitor any changes in federal law that may affect these options. (Hearing Dec. 6th)

5. Evaluate recent efforts by the Legislature and the Texas Department of Insurance to minimize instances of surprise medical billing and to ensure the adequacy of health insurance networks. Identify instances in which surprise billing most often occurs and ways to decrease its frequency through enhanced transparency or other methods. (Hearing Dec. 6th)

6. Examine the impacts of changes in prescription drug coverage and drug formularies on patients, particularly those with chronic conditions. (Hearing Dec. 6th)

7. Evaluate recent efforts in Texas and in other states to enhance transparency regarding the practices of pharmacy benefit managers. (Hearing Dec. 6th)

Senate Committee on Business & Commerce

- Health Insurance Market Stability: Study the factors affecting health insurance markets in Texas, particularly the individual market, including federal and state law. Make recommendations that would result in increased stability in the markets and enhance value and affordability for individual consumers and businesses. Examine what steps the state needs to take to allow out-of-state health insurance sales. In developing its recommendations, the committee should consider the flexibility afforded to states by 1332 "state innovation" waivers, which allow states to modify or eliminate tax penalties associated with individual and employer coverage mandates; modify requirements for benefits and subsidies; and find alternative ways to provide benefit plan choices, determine eligibility for subsidies, and enroll consumers.

Telehealth & Rural Health

House Public Health

5. Review opportunities to improve population health and health care delivery in rural and urban medically underserved areas. Identify potential opportunities to improve access to care, including the role of telemedicine. In the review, identify the challenges facing rural hospitals and the impact of rural hospital closures.

House Committee on Juvenile Justice & Family Issues

3. Evaluate the use of telemedicine to improve behavioral health services in the juvenile justice system.

Tax, Revenue, and Rainy Day Fund

House Committee on Ways & Means

2. Review the property tax system and identify improvements relating to:
    a. Transparency and communications with taxpayers;
    b. The tax-rate-setting process;
    c. The training and expertise required of appraisal review board members;
    d. Appraisal review board composition, structure, and process; and
    e. Appeals of appraisal review board orders.

3. Review the franchise tax and identify any changes that would improve the state's business climate.

Senate Finance Committee

*Economic Stabilization Fund***:** Examine options to increase investment earnings of the Economic Stabilization Fund in a manner that minimizes overall risk to the fund balance. Investment options should ensure the liquidity of a sufficient portion of the balance so that the legislature has the resources necessary to address the needs of the state, including natural disasters. Evaluate how the Economic Stabilization Fund constitutional limit is calculated; consider alternative methods to calculate the limit, and alternative uses for funds above the limit.

Senate Select Committee on Property Tax Reform

Tax Rate and Appraisal Reform: Evaluate the effective tax rate and rollback tax rate calculations and identify modifications that would yield a rollback process that is meaningful for local governments and for citizens. Evaluate whether the current rollback election trigger serves modern objectives. Evaluate the operations of appraisal review boards (ARBs), specifically the training and expertise of members concerning appraisal standards and law, ethics, and meeting procedures. Determine whether ARB operations are sufficiently independent of central appraisal districts and taxing units and whether ARBs and/or chief appraisers should be elected.

Property Tax Data: Evaluate whether existing libraries of property tax data and collection methods are adequate for studying local property tax outcomes and identifying drivers of growing property tax levies. Determine the scope of existing data, where it is stored, and how it is made available to the public. Determine whether existing, available data is adequate for the needs of the legislature and the public. Review existing procedures for the collection and verification of data. Receive recommendations from the comptroller regarding the collection, verification, and publication of property tax data.

Lowering Property Tax Burden: Study the feasibility of replacing the property tax with sales tax or other consumption tax revenue, with emphasis on school maintenance and operations tax. Evaluate whether some local property taxes lend themselves to a swap more than others. Quantify the short-term and long-term economic effects of a tax swap. Identify a target property tax rate and evaluate how to reach that target with a consumption tax swap.

CHC Coalition

Potential Interim Charge Priorities

(A) Medicaid and CHIP (e.g. cost containment, value-based payment)

- House Approps - CHIP reauth, Medicaid block grant interim charge (#11 on Approps committee charge list)
- House Approps - Medicaid cost containment and therapy rate cuts (#18 on committee charge list)
- House Human Services - history of Medicaid managed care (and streamlining renewals where possible) (#2 on committee charge list)
- Senate Finance - Medicaid and value-based payments (monitoring charge)
- Senate HHS - Medicaid managed care and value-based payment charge

(B) Maternal Health and Birth Outcomes

- Senate HHS - monitoring charge - SB 19 maternal mortality
- Senate HHS - adequacy of substance use services for pregnant and postpartum women
- House Public Health - women's health; maternal mortality; birth outcomes

(C) ECI (ECI Advocacy Coalition to lead)

- House Approps - ECI charge
- House Select Committee on Substance Use - role of SUD in pregnant women, parents, and youth

This doesn't include private insurance interim charges, not does it include foster youth and health access charges. Does CHCC prioritize this during the interim or leave to individual organizations?

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Charles Smith
Executive Commissioner

December 1, 2017

Mr. John Colyandro
Policy Director
Office of the Governor
1100 San Jacinto, 4th Floor
Austin, Texas 78701

Ms. Sarah Hicks
Budget Director
Office of the Governor
1100 San Jacinto, 4th Floor
Austin, Texas 78701

Ms. Ursula Parks
Director
Legislative Budget Board
1501 North Congress Avenue, 5th Floor
Austin, Texas 78701

Re: Rider 34 Medicaid Cost Containment Initiatives for Fiscal Years 2018-19 (HHSC-2017-A-491)

Dear Mr. Colyandro, Ms. Hicks, and Ms. Parks:

In accordance with the requirement of the General Appropriations Act for the 2018-19 biennium (Senate Bill 1, Regular Session, 2017) the Health and Human Services Commission (HHSC) submits the Medicaid cost containment plan required by HHSC Rider 34. Based on current implementation plans and updated savings estimates, $281.3 million in general revenue of the $350 million target savings is currently estimated. The table below recaps items included in the rider and currently identified savings for this biennium. A more detailed breakout of initiatives is provided in Attachment A.

In addition to the items included in Rider 34, it is also important to note other Medicaid/Children's Health Insurance Program cost containment efforts, such as the risk margin adjustment being implemented this biennium through HHSC Rider 158, yielding an estimated $74 million in general revenue savings.

Rider 34 Medicaid Cost Containment Initiatives - General Revenue (GR) $ in Millions Estimated as of November 30, 2017		
Item	Description	Estimated GR Savings
1	Continue strengthening and expanding prior authorization and utilization reviews	TBD
2	Incentivize appropriate neonatal intensive care unit utilization and coding	TBD
3	Pursuant to Human Resources Code §§32.064 and 32.0641, maximize co-payments in Medicaid programs	TBD
4	Increase fraud, waste and abuse prevention, detection, and collections.	$ 20.0
5	Implement fee-for-service payment changes and managed care premium adjustments that incentive the most appropriate and effective use of services	$ 103.1
6	Increase efficiencies in the Vendor Drug Program: implementing changes to the preferred drug list and coverage options for specific drug classes	$ 35.5
7	Increase third party recoupments	$ 23.0
8	Implement pilot program on motor vehicle subrogation	$ 1.5
9	Achieve efficiencies in the printing and distribution of Medicaid ID cards	$ 1.5
10	Implement facility cost savings	$ 4.5
11	Recoup administrative costs for programs HHSC administers for other entities, such as the School Health and Related Services Program (SHARS) (Non-GR impact is $6 million)	$ -
12	Seek flexibility from the federal government to improve the efficiency of the Medicaid program	TBD
13	Improve prior authorization and utilization review for non-emergent air ambulance services.	$ -
14	Evaluate reimbursement for dual eligible	TBD
15	Review utilization and appropriateness of rates for durable medical equipment	TBD
16	Enforce Limitations on recipient disenrollment from managed care plans pursuant to Govt Code § 533.0076	$ -
17	Identify and execute savings by conducting audit of managed care premiums, fostering collaboration on Medicaid/CHIP data analysis, evaluating trend factor identification methodologies, using a competitive procurement process with price as one component evaluation, ensuring new expansions of managed care are cost-effective and performing cost benefit analysis of contracted human resource functions.	$ -
18	Implement additional initiatives and programmatic efficiencies identified by HHSC.	$ 92.2
	Total Cost Containment Rider 34, estimated as of November 30, 2017	$ 281.3
	Other Significant Cost Savings in the FY 2018-19 Biennium: GR $ in millions	
Rider 158	Medicaid and CHIP Capitation Risk Margin Adjustment	$ 74.0
	Savings estimated from both Rider 34 Cost Containment and Rider 158 Risk Margin Adjustment*	$ 355.3
	* GR Savings in Client Services (Includes Cost Containment in Rider 34 and Risk Margin Adjustment (Rider 158)	$ 346.5
	* GR Savings in Non-Client Services (Includes Cost Containment in Rider 34 and Risk Margin Adjustment (Rider 158)	$ 8.8

For each initiative included in the rider, the attachment provides a description, the status of implementation, and a comparison of the current savings estimate to the original targets assumed in the rider. Additionally, an explanation is provided for any items which are not being pursued.

Cost containment initiatives and savings estimates provided in this plan will be further developed and updated throughout the biennium. HHSC will continue to explore avenues to meet the target savings and will continue to pursue new opportunities for Medicaid cost containment savings. In addition, HHSC will proceed with routine processes, such as the Biennial Calendar Fee Review, to address the appropriateness of provider rates.

The Commission respectfully requests approval by the Legislative Budget Board, per the provisions of the rider, and notes that the plan shall be considered approved unless the LBB issues a written disapproval within 15 business days (December 22, 2017).

Please let me know if you have any questions or need additional information. Ms. Greta Rymal, Deputy Executive Commissioner for Financial Services, serves as the lead on this matter and she can be reached by telephone at (512) 424-6919 or by email at Greta.Rymal@hhsc.state.tx.us.

Sincerely,

Charles Smith

Attachment

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
1	**Continue strengthening and expanding prior authorization and utilization reviews**	TBD	TBD	9/30/2016	Cost savings for this initiative in the current biennium are either being determined or have already been included in forecasts, and thus do not represent newsavings.
	HHSC Managed Care Utilization Review's ongoing activities include Long Term Services and Supports (LTSS) Utilization Review and Acute Care Utilization Review (ACUR), both Legislatively-mandated functions. The agency also conducts Fee-For-Service (FFS) Utilization Review on certain Medicaid programs still in FFS. -**LTSS Utilization Review** investigates STAR+PLUS (Managed Care Organization) MCO procedures for determining the appropriateness of enrollment in the Home and Community Based Services (HCBS) program, including specifed review elements according to Government Code 533.00281 . Findings of contract non-compliance are subject to liquidated damages, corrective action plans, or recoupment ofcapitation. Fiscal year 2015 review recoupments of $207,566, were received in fiscal year 2016. These fiscal year 2015 recoupments were for STAR+PLUS HCBS members who were inappropriately in the HCBS risk group. At the time ofthis report, eligible recoupments for fiscal year 2017 reviews are not yet determined for STAR+PLUS HCBS due to encounter data lag; however ensuring appropriateness of STAR+PLUS HCBS services enables the State to get expected value on MCO capitation payments. Fiscal year 2017 reviews of STAR+PLUS HCBS anticipate liquidated damages, and propose coordinating corrective action plans to address contract non-compliance. The proposed liquidated damages are based on findings as of Quarter 3 of fiscal year 2017, and must follow internal liquidated damages process, as follows: Failure to provide an administrative service; failure to provide a covered service; and timeliness ofassessments. Going forward, for future reviews, LTSS UR will be dividing the review sample by segments for purposes of assigning, completing, and evaluating findings, providing regular feedback to MCOs, and pursuing any actionable items more frequently than once a year. The annual reporting will continue per the requirement in Government Code 533.00281(b). Expansion of the LTSS UR function was in the planning stages to reviewSTAR Kids MCOs' service provision of LTSS. Existing LTSS staff are part of the Priority Project on Prior Authorization and Impact to Access to Care, reviewing prior authorization practices of Private Duty Nursing, as part of the Medicaid and CHIP Services (MCS) operational reviews. - **ACUR** is directed in the Government Code, 531.076 (b), to monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services while safeguarding access to care by ensuring that Medicaid MCOs are not underutilizing acute care services bydenying necessary services. An ACUR pilot reviewwas conducted in August 2017. During FY 2018, the ACUR unit is part ofthe MCS Managed Care Compliance and Operations operational reviews. However, due to the ACUR function being new, and in the early stages of fact finding, there are no reported savings thus far. - **Fee-for-Service Utilization Review** The IDD Waivers/Community Services/Hospice UR section came to HHSC through Tansformation in September 2016, and conducts various types of reviews on waivers serving individuals with intellectual and developmental disabilities (IDD) to ensure compliance with CMS Performance Measures, plus other functions to ensure appropriate payment and utilization of services. Types of reviews include: Concurrent (pre-authorization) desk reviews for IDD waivers; Concurrent (post-authorization) face-to-face utilization reviews of IDD waiver services and State Plan CommunityAttendant Services; Level ofNeed desk reviews for provider payment for services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs); and Retrospective desk reviews of payment eligibility for providers in Medicaid Hospice. This FFS UR function revealed prevented costs of $9,488,173 in fiscal year 2016. Estimated prevented costs for the current biennium total $10.6 general revenue and $25.3 all funds, and have been incorporated in previous expenditure estimates.				

(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
2	**Incentivize appropriate neonatal intensive care unit utilization and coding**	TBD	TBD	9/1/2018	Once HHSC is able to identify the extent to which misalignment existed between prior and newly developed designated care levels, it may be possible to estimate cost savings for one component of this initiative.
	The Perinatal Advisory Council recommended criteria for neonatal levels of care designations to DSHS, which has adopted rules for neonatal care. As part of the designation process, a third party is now conducting site surveys to verify newborn care levels for all hospitals with newborn care units. A hospital is not required to have a neonatal level of care designation as a condition of reimbursement for neonatal services through the Medicaid program before September 1, 2018. This requirement should ensure better alignment between patient needs and capabilities of newborn care units, which should result in better newborn care. While new care designations will likely produce quality improvements and cost savings due to better alignment between the newborn needs and hospital capacity through a more rigorous designation process with externally verified standards of care across all hospitals for newborn levels of care, cost savings cannot be quantifed at this time due to the following unknowns: • Hospital accountability through more standardized and improved care; • Extent of misalignment between what hospitals now report as their newborn care levels and their future designated levels under the new structure; • Extent of quality improvements and cost savings resulting from the new designation process, and whether that will result in re-negotiations between MCOs and hospitals.				
3	**Pursuant to Human Resources Code §§32.064 and 32.0641, maximize co-payments in Medicaid programs**	TBD	TBD	n/a	HHSC will review copay options in a subsequent Medicaid waiver. See also Item 12.
	Based on federal restrictions contained in the Social Security Act and implementing regulations, HHSC estimates less than ten percent of the Texas Medicaid population could be required to pay co-pays for non-emergent use of the emergency department. This includes parents transitioning from Temporary Assistance to Needy Families (TANF) above 100% of the Federal Poverty Level (FPL), adults enrolled in 1915(c) waivers in managed care above 100% of FPL, and infants and children enrolled in 1915(c) waivers, through age 18, above 133% of FPL. Federal law requires that states track all cost sharing to ensure that it does not exceed five percent of family income. The current federal limitations on populations to whom cost-sharing could apply in Texas combined with the administrative costs associated with instituting co-pays prevent any potential cost savings. For clients with incomes up to 150% of the federal poverty limit, copays for non-emergent care provided in an emergency department (ED) cannot exceed $8. In addition, the state (not the recipient) must track the cost-sharing incurred by clients to ensure it does not exceed 5 percent of family income. Hospitals would have to follow requirements that prior to collecting cost sharing for non-emergency use of an emergency department, the hospital must assess the client, locate an alternative provider, and provide the client with a referral to that provider. Other states that HHSC staff have consulted in the past indicated that non-emergent ED co-payments did not promote client accountability because the hospitals chose to waive the co-pays. The hospitals indicated their administrative costs to comply with federal referral requirements exceeded the nominal co-pay amount they could collect. Other states implementing co-pays for non-emergent Medicaid visits to the ED report that administrative costs to comply with such federal regulations exceed nominal co-pays collected. Federal officials have indicated an interest in providing states with more flexibility in implementing Medicaid cost-sharing. HHSC staff will continue to explore this as an option.				

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
4	**Increase fraud, waste and abuse prevention, detection, and collections.**	$ 20.0	$ 52.1	various	Appeal and recoupment processes take several months. All estimates are preliminary
4.1	***MCO Recoveries: Allow IG to Keep Recoveries from Provider Overpayments in Medicaid Managed Care***	*$ 9.9*	*$ 23.1*	*9/1/2017*	*IG has provided guidance to MCOs that all referrals sent on 9/1/2017 and forward will be subject to the new law.*
	Texas Government Code 531.13 allows the state to retain fraud, waste and abuse recoveries it recoups from provider overpayments in Medicaid managed care according to which party is responsible for the recovery. If an MCO is responsible for the recovery, the MCO keeps half of the overpayment and the other half is an offset to the future state Medicaid payments. If an MCO and the Inspector General work together to obtain the recovery, the MCO keeps half of the overpayment and the other half is an offset to the future state Medicaid payments. If the Inspector General is responsible in obtaining the recovery, the entire overpayments are an offset to the future state Medicaid payments. There is currently no mechanism for processing MCO recoveries as there are Fee-For-Service (FFS) recoveries. Recoveries due to the state are refunded to the Health and Human Services Commission as an offset to the future state Medicaid payments. This could result in this item being classifed as a cost savings and not revenue for reporting purposes, however the IG intends to classify these as recoveries, as fee-for-service recoveries are currently counted. The IG assumes that 1/3 of cases in Fiscal Years 2018-2019 will be processed completely by the MCO, 1/3 will be processed by the IG, and 1/3 will be processed together.				
4.2	***Increase Investigative Recoveries through Theory of Constraints***	*$ 1.3*	*$ 6.6*	*5/1/2006*	
	Theory of Constraints (TOC) is a methodology to identify and reduce production constraints to improve overall system performance, increasing efficiencies and the quality, quantity and timeliness of IG work products. It is anticipated that this will increase recoveries by at least 10 percent. Recoveries come from Supplemental Nutrition Assistance Program (SNAP) Collections. SNAP recoveries are allowed to be kept at the state when there is recipient error or fraud uncovered and collected by the Inspector General. The adjusted amount of All Funds collections for these items was $32.4 million in Fiscal Year 2016. TOC has helped to increase overpayment dollars via the creation of a 23 person intake team to screen over 12,000 complaints received by General investigations each month, freeing up both our field and claims investigators to focus on investigating valid referrals. Since then, we have seen a state average increase of 25 percent in overpayment dollars identified.				
4.3	***Increase RAC Audit Scenarios***	*$ 1.0*	*$ 2.3*	*9/1/2017*	
	IG manages the recovery audit contractor (RAC) contract, which, under Centers for Medicare and Medicaid Services (CMS) requirements must be maintained to identify and reduce improper Medicaid payments. Item 4.3 will increase the scenarios that the IG requires the RAC contractor to use and thereby increase recoveries. A RAC audit reviews Medicaid paid claims to determine if services were provided in accordance with federal and state laws, rules, and regulations. The RAC employs data mining algorithms to develop various reviews, which are referred to as scenarios, to target a specific type of Medicaid provider or medical procedure to identify potential improper payments. For the past two years, the RAC has focused newborn up-coding reviews and inpatient hospital short stay scenario reviews, resulting in collections over that period, net of the RAC's fee of approximately 8.75 percent of dollars collected, of about $ 10,714,661 per year. Additional scenarios may include Diagnoses Related Group (DRG) validation and Herceptin multi-use vial wastage reviews. RAC efforts are focused on Fee-For-Service overpayments. Because 93 percent of Medicaid is now under managed care, potential overpayments in fee-for-service has been reduced. However, fee-for-service overpayments occur at a rate and frequency sufficient to sustain and increase the amount of collections the RAC is able to achieve. Note that the rate of collections paid to the contractor may vary in the future.				
4.4	***Increase Provider Audits***	*$ 0.8*	*$ 1.7*	*9/1/2017*	

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	The IG will increase the number and types of provider audits it performs to include Vendor Drug Program Inventory, Durable Medical Equipment Title XIX, Durable Medical Equipment Inventory, Speech Therapy providers, and Home and Community-based Services providers. This expansion will increase collections from fee for service overpayments.				
4.5	***Front End Error Rates***	*$ 5.1*	*$ 11.9*	*3/1/2018*	
	In FY 2017, using existing claim selection Utilization Review criteria for fee for service Medicaid inpatient hospital services and hospital review history, claims were selected for a pilot review. The pilot reviewed the FFS inpatient claims and the hospitals' claims submitted to four managed care organizations (MCOs). The review validated medical necessity, coding and DRG classification, and quality of care. MCOs manage inpatient hospital utilization through a prior authorization process. It is anticipated that prior authorization for inpatient care will reduce the number of medical necessity denials that are typically found in retrospective reviews in the FFS payment model. The pilot results identified a decrease in errors for managed care delivered services. The estimated error rate for inpatient hospital stays paid by MCOs was 9% compared to approximately 18% for FFS. Pilot results demonstrate that FFS claim selection criteria could be applied to MCO submitted claims to identify accuracy or errors in billing. Utilization review is developing these criteria for managed care reviews and revising its laptop application to support the review of both FFS and MCO submissions. Utilization review will yield inpatient hospital cost avoidance obtained through oversight and sampling of MCO paid admissions that evaluate medical necessity appropriateness of diagnosis and procedure coding, and quality of care. Additional cost avoidance in both payment models is expected to continue with greater payment specificity achieved in ICD-10 diagnosis and procedure coding and All Patient Refined DRGs (APR-DRG).				
4.6	***Durable Medical Equipment Analytics Project***	*$ 1.2*	*$ 2.8*	*9/1/2017*	
	Medicaid Provider Integrity (MPI) typically investigates DME cases after receiving a referral but has recently become more proactive in identifying trends through data analytics. Data mining identifies DME providers that consistently bill the maximum allowed amount for incontinence supplies. Based on those results, MPI can self-generate investigations which are expected to yield increased recoveries. When a provider is identified, IG initiates an investigation. If it results in an affirmative finding, the IG begins recoupment of funds from the provider. In FFS this is done through TMHP. This initiative will yield additional cost savings not recorded here resulting fom behavior change in providers. The IG is currently working on methodology to quantify this cost savings.				
4.7	***Food and Nutrition Services Disqualified Vendors***	*$ 0.4*	*$ 2.1*	*9/1/2017*	
	Food and Nutrition Services (FNS) uses data analysis and investigations to identify Electronic Benefit Transfer (EBT) vendors that have engaged in trafficking of benefits and disqualifies these vendors. Then FNS sends an individual disqualification packet to the Investigations Division, which identifies recipients suspected of trafficking with the EBT vendors on which FNS took action. Investigators then have clients sign payment agreements, making one-time payments or establish payment plans. Payment amounts are entered in Automated System of the Office of the Inspector General (ASOIG). The Accounts Receivable Tracking System (ARTS) is then responsible for collect payments from clients. FNS conducts investigations of authorized retailers trafficking in SNAP benefits resulting in the permanent disqualification of the retailers and also conducts data analytics of beneficiaries shopping in the related authorized retailers resulting in numerous beneficiaries being identified as trafficking in SNAP benefits. IG HHSC then pursues criminal prosecution or administrative disqualification hearings and recoupment of benefits of/from these beneficiaries. Identification of each vendor yields the identification of approximately 20 trafficker recipients, and recoupments fom each trafficker average $3500.				

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
4.8	***Cooperative Disability Investigations Program (CDI)***	*$ 0.3*	*$ 1.5*	*Early 2018*	*The cost savings from past task force operations in Dallas with SSA OIG show savings in Non-SSA programs (SNAP, Medicaid, TANF) for Federal FY15 as $11,324,546.*
	IG will partner with Social Security Administration OIG to obtain evidence of material fact sufficient to resolve questions of fraud in Social Security Administration (SSA) disability programs and SNAP/Medicaid/TANF recipient fraud. This is a task force approach utilizing two (2) IG-HHSC peace officers and one (1) analyst housed with SSA - OIG special agents in Dallas, TX. The results of these investigations will be presented to federal and state prosecutors for criminal action. Those other recipient matters not rising to a criminal matter will be presented for Administrative Disqualification Hearings at HHSC. Matters could also be handled administratively(SNAP; TANF) through state channels. The State DDS also can make timely and accurate disability determinations. Federal Funding is available to pay for 100 percent of the FTE salaries through reimbursement. The task force is scheduled to begin by early 2018 and is headquartered in Dallas, Texas. The CDI task force mission is accomplished through combined skills and specialized knowledge of the SSA-OIG; State Disability Determination Services (DDS); and State enforcement personnel (IG-HHSC) combatting disability fraud along with SNAP and TANF fraud in the respective area. The Dallas Task Force was last active during FY 15 and showed SSA savings of $45,125,804 and Non-SSA savings (SNAP; TANF; WIC; etc.) of $7,258,740.				
5	**Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services**	$ 103.1	$ 247.2		
5.1	***Medical Transportation***	*$ 1.1*	*$ 2.5*	*9/1/2017*	*Applies to demand response services only.*
	One Managed Transportation Organization (MTO), Logisticare, added several new demand response providers in the Regions 7, 8 and 11 in the Fall of 2016 resulting in a reduction to their demand response operating claims cost. The base period demand response claims cost for these regions were assumed to be the same as the demand response claims cost experience for the September 2016 through December 2016 period. As a result, this MTO's FY 2018 capitation rates have been adjusted to refect the savings.				
5.2	***Clinician Administered Drugs***	*$4.4*	*$ 10.9*	*9/1/2017*	*Applies to STAR, STAR+Plus, STAR Health, CHIP and CHIP Perinatal*
	Invalid clinician administered drugs (CAD) have been removed fom the FY 2018 capitation rate development. HHSC has provided guidance to the MCOs which specifies the reporting requirements for a CAD to be considered a valid claim. Those claims not meeting these requirements are assumed to be invalid and have been removed from the FY2018 Medicaid and CHIP rating analysis. Any savings is limited to FY2018 because some of these invalid claims are due to coding issues by the MCOs that is assumed to be corrected for the FY2019 rating cycle, at this time. This issue will be reviewed again, prior to developing the FY 2019 capitation rates.				
5.3	***STAR Kids Managed Care Capitation Rates***	*$53.9*	*$125.1*	*9/1/2017*	*FY 2018 savings are for the increase in the managed care savings factor from 3.9% in FY 2017 to 7.5%; For FY 2019 from 7.5% to 8.4%.*

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	The STAR Kids rating analysis includes an explicit assumption regarding the anticipated reduction in medical claims cost resulting from the implementation of managed care. In deriving the managed care efficiency factor, we relied upon experience from previous STAR and STAR+PLUS expansions. Based on this analysis it is assumed that the FY 2018 gross claims cost will be reduced by 7.5% due to the transition of clients from the FFS program to managed care under the STAR Kids program. No additional savings are assumed for those clients previously enrolled in managed care. This is an increase from the 3.9% managed care savings assumed in the FY2017 STAR Kids capitation rates. The increased managed care savings are assumed to occur as the prior authorization requirements placed on the managed care organizations are phased out.				
5.4	***Reflect acute care imaging rate reductions implemented mid-fiscal year 2017.***	*$ 19.5*	*$ 44.6*	*2/1/2017*	
	These fees cover hospital and acute care settings. Medicaid fees for general hospital imaging services (performed mostly in outpatient and emergency departments) are based on a percentage of the Medicare fee schedule for similar services with fees capped at 125 percent of the Medicaid acute care fee for the same service provided to an adult in a physician's office. Rule amendments were necessary to reflect declines in benchmark (Medicare) rates without unintentionally negatively impacting rural hospitals.				
5.5	***Reflect habilitation service rates in Texas Home Living and Home and Community Based Services implemented in late fiscal year 2017.***	*$ 24.2*	*$ 64.1*	*7/1/2017*	
	The base rate for these services was reduced from $22.41 to $17.73, moving rates closer to reimbursement levels for Community Living Assistance and Support Services (CLASS).				
6	**Increase efficiencies in the Vendor Drug Program: Implementing changes to the preferred drug list and coverage options for specific drug classes**	$35.5	$85.3	prior to 8/1/18	Actuaries will provide updated savings amounts. Figures here are preliminary targets. An external review of the protected drug classes is under development. The target date for implementation of new drug classes is July 2019.
	Rudd & Wisdom published a report entitled "State of Texas Vendor Drug Program: Formulary Control State Vs. MCO" in January 2017 that identified opportunities for savings through reevaluating and changing the preferred drug list (PDL) status in certain therapeutic drug classes. Drug classes with the most opportunity for savings include antibiotics, antihistamines, antivirals, glucocorticoid inhalers, pediatric vitamins and minerals, and antipsychotics. In coordination with Rudd & Wisdom, the vendor drug contractor, VDP staff, financial services staff, and HHSC actuaries, VDP is pursuing the following changes in accordance with the report: change from preferred to non-preferred status for a specific antibiotic formulation, create a new preferred drug list for the antihistamines and pediatric vitamin drug classes, change from preferred to non-preferred for an antiviral, change from preferred to non-preferred for an antihistamine, and change from preferred to non-preferred for several antipsychotics. Staff are meeting with the Preferred Drug List vendor to explore other potential cost containment options. Additionally, staff have developed a project plan with a goal to implement all changes prior to 8/1/18. Separately, HHSC will review protected drug classes to determine if the classes, which were implemented in 2004, are still appropriate.				
7	**Increase third party recoupments**	$ 23.0	$ 53.4	Various	
7.1	***MCO Encounter Recovery***	*$ 14.4*	*$ 33.4*	*5/1/2016*	*MCO encounter recovery is currently underway*
	This initiative is a redesign of the encounter recovery program resulting in more efficient and timely recoveries from a responsible third party payer. MCO's have 120 days from the date of adjudication of the claim that is subject to Third Party Recoupments, to attempt recovery. If the MCO is unsuccessful, HHSC has the right to attempt recovery from the responsible third party payor. This program has been redesigned and was recently implemented. MCS staff are monitoring the recoveries. $10.5 million has been recovered for FYs 16 and 17 through this initiative. The Third Party Recovery team monitors the billing and collections.				

Attachment A
Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
7.2	***Commercial Provider Claims***	*$ 6.0*	*$ 14.0*	*2/23/2016*	*Commercial Provider Claims is currently underway.*
	This project takes denied claims fom a commercial insurance carrier that have been identifed and rebills these claims to the responsible payer. HHSC is working on a special project with the commercial carrier noted above to rebill denied provider claims to the commercial carrier. $26 million has been recoveredof FYs 16 and 17 through this initiative. The Third Party Recovery team monitors billing and collections.				
7.3	***Behavioral Health Claim Edits***	*$ 2.6*	*$ 6.0*	*5/1/2017*	*Behavioral Health Claim Edit is currently underway.*
	This initiative adds a CMS approved edit to the claims system that allows cost avoidance on behavioral health claims that should be paid bya third party. The implementation of this new edit will now allow HHSC to cost avoid on behavioral health claims that should be paid bya third party. Cost savings data on this initiative is not yet available, but based on actual claims of $3 million annually in which other insurance should have paid, it is assumed this amount could be saved annually				
8	**Implement pilot program on motor vehicle subrogation**	$ 1.5	$ 3.3	1/1/2018	Estimate assumes $2 million all funds annually based on achieving at least 20% ofthe current tort collections that average $10 million annually
	MCS is implementing an initiative to obtain services that access motor vehiclé and other casualtyclaims data and matches the data with Medicaid paid claims to identify first and third party payors, which should result in greater cost recovery for the State. Currently, the Claims Administrator processes motor vehicle casualty claims by waiting on the Medicaid beneficiary or their legal counsel to contact the Claims Administrator. This pilot will be structured to have our EligibilityFile sent directly to a national data warehouse (Insurance Services Organization) where multi-state casualtyclaims are recorded. Ifa match is made, then the system notifies the responsible casualtyinsurance carrier of the State's lien and attempts to intercept payments before they are made to the claimant. MCS staf believe this will result in higher reimbursement for casualty claims. HHSC is in the process ofentering into an Interstate Compact agreement with Rhode Island for electronic data matching services that will use the Texas Medicaid eligibility file and the national casualtyclaims data warehouse (Insurance Services Organization) to match against Texas Medicaid paid claims data, to initiate this pilot project.				
9	**Achieve efficiencies in the printing and distribution of Medicaid ID cards**	$ 1.5	$ 3.0	11/1/2016	Currently exceeding target for estimated annual card decrease.
	As part of the Medicaid Eligibilityand Health Information Services (MEHIS) contract, the Medicaid ID cards are produced and distributed. MEHIS staffand the contractor supporting the system identified and revised an automated process with the Medicaid ID team which eliminated the re-issuance ofMedicaid ID cards for clients that would move between STAR to Fee-for-Service (FFS). This change was implemented in late October 2016 and was to assist in eliminating the need to print 100K –125K cards per month, resulting in a savings of approximately 1.5 M cards per year. The current card production rate is $0.406 and the postage rate is $0.42.The MEHIS team is working with the Healthy Texas Women Program to identify where there may be potential costs savings in issuing Medical ID cards.				
10	**Implement facility cost savings**	$ 4.5	$ 4.5	various	
10.1	***Implement facility cost savings by reducing leased space or decommissioning buildings***	*$ 0.5*	*$ 0.5*	*TBD but before 5/31/2019*	*FY 19 estimated savings are based on three months of rent (3 X $67,700).*

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Rider 34 Cost Containment Initiatives FY 2018-19 Biennium
(Dollars in Millions), Estimated as of November 30, 2017

Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	Currently the HHS Print Shop operations reside in leased space. The Austin Technology Blvd facility is comprised of 73,000 square feet of production and office space at an annual cost of $812,402. The state-owned warehouse located also in Austin on North Loop is rent-fee and has adequate space to support current warehouse operations as well as the HHS Print Shop operations. The Technology Blvd lease expires March 31, 2019. A request to renewwas not submitted. Relocating the HHS Print Shop to state-owned space will reduce HHSC lease footprint by 73,000 square feet while saving HHSC more than $800K in annual lease cost. The relocation is currently in the planning stages. The move is expected to be completed no later than May 31, 2019. A short lease extension was granted for one year with no increase in the lease amount.				
10.2	***Implement facility cost savings by reducing energy expense for HHS facilities in deregulated markets***	*$ 4.0*	*$ 4.0*	*8/1/2017*	*Energy costs under new contract will not increase throughout FY 2019.*
	The Health and Human Services Commission (HHSC) contracts with a single supplier of electricity for all HHS state hospitals, state supported living centers, and regional field offices outside of regulated areas. The previous contract expired on July 31, 2017, with no renewal options. The new electricity supply contract was awarded through a competitive bid process with an effective date of August 1, 2017 and run through December 31, 2019. The new contract is expected to cost approximately $6 million annually. The previous contract cost approximately $8 million annually. This savings is due to decreased energycosts over the past four years.				
11	**Recoup administrative costs for programs HHSC administers for other entities, such as the School Health and Related Services Program (SHARS)**	$ -	$ 6.0	12/1/2018	Revenues will not be achieved until FY 2019.
	SHARS allows school districts, including public charter schools, to obtain Medicaid reimbursementfor certain health-related services provided to students in special education under the Individuals with Disabilities Education Act (IDEA). SHARS services include audiology counseling, nursing, occupational therapy, physical therapy, physician services, personal care services, psychological services, speech therapy, and specialized transportation. HHSC must ensure repayment of Centers for Medicare & Medicaid Services (CMS) disallowance related to Medicaid overpayments. SHARS provider compliance monitoring is necessary to ensure that Medicaid payments are appropriate and to reduce any financial liability related to Medicaid SHARS overpayments. HHSC and TEA operate the SHARS benefit under a Memorandum of Understanding (MOU) which states that TEA has primary responsibility for SHARS compliance monitoring. Given findings of recent federal audits and associated financial liability, HHSC has concerns regarding SHARS provider compliance monitoring and proposed an option that would reduce financial liability to HHSC by improving quality and consistency of audits and monitoring, and generate additional funding to offset existing HHSC administrative costs. The Texas Administrative Code (TAC) allowing for this administration fee was approved for adoption on November 7, 2017.				
12	**Seek flexibility from the federal government to improve the efficiency of the Medicaid program**	TBD	TBD	n/a	Additional flexibilities will be pursued once the current 1115 waiver is renewed.
	The current administration, and federal Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) officials, have signaled a willingness to assist state Medicaid programs in their requests for greater flexibility in Medicaid program operations. This could include flexibility in eligibility, benefits, cost sharing requirements, work requirements, and innovative program elements that encourage personal responsibilityfor health care. Absent significant reform from Congress, the state can seek modifications to certain federal requirements through Section 1115 Demonstration waiver authority. The current Section 1115 waiver expires December 31, 2017. Until extended or renewed, no amendments to the waiver involving program flexibility can be introduced.				

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
13	**Improve prior authorization and utilization review for non-emergent air ambulance services.**	$ -	$ -	n/a	Assessment did not reveal savings.
	Medical Benefits staff worked together with the Office of Medical Director to assess air ambulance utilization data received from Center for Analytics and Decision Support (CADS). The overall data (FFS and MCO combined) did not show a significant increase in non-emergency air ambulance services from FY 2011-2015. The data indicate that from FY 2011-2015, non-emergency air ambulance transportation costs (which are currently < 10% of the total costs) have actually decreased by 16%, and any increase in costs is attributed to emergency air ambulance services, which increased to 10%. Further, between FY 2011-2015, the Medicaid population increased by 10%, and the total costs for air ambulance services increased by 8%, which does not demonstrate an increased utilization in air ambulance transportation services. HHSC may recommend the following language be incorporated into the Medicaid Ambulance Services policy to strengthen the prior authorization and/or utilization review criteria for non-emergency air ambulance services: • All facility-to-facility transports not meeting the criteria for emergency air ambulance transports are considered non-emergency conditions and will require prior authorization. • Medically necessary non-emergency air transports should consider all of the following criteria: o The patient requires services that are unavailable at the originating facility; and o The receiving hospital is the nearest one with the required capabilities; and o Explanation as to why alternate means of transports (e.g., Ground ambulance transport, commercial air transport) are unacceptable or contraindicated due to the client's medical or mental health condition. If another mode of transportation could be used safely and effectively, then air transport is not medically necessary. o Ground ambulance transport is precluded due to adverse weather and/or road conditions (flooding, ice or snow). • If an alternate method of ambulance transportation is clinically appropriate and more cost effective, HHSC reserves the right to adjust the amount of eligible expenses. As we determine to be appropriate, the coverage determination is based on the client's medical/mental condition, and geographic location. • Non-emergency air ambulance transportation services provided primarily for the convenience of the patient, the patient's family/caregivers or physician, or the transferring facility, including situations where long distances exist between the transferring and receiving facilities, are considered not medically necessary. • Transportation out of state may be considered when no comparable services are available in Texas and the risk to the patient's health is grave.				
14	**Evaluate reimbursement for dual eligible**	TBD	TBD	TBD	The initiative is undergoing further analysis to determine if savings exceed automation implementation costs, how reduced provider payments would be distributed among provider types and whether access to services would be affected. Following the analysis, implementation, if warranted, would be subject to submittal of a State Plan Amendment and CMS approval.
	This proposal seeks to limit the state's payment of the Part B deductible for qualified dual eligible members for any service not otherwise exempted. The exemptions have either been protected by statute since 2012 (ambulance), or the services address specific health care issue of a small number of Medicaid clients. The proposal is not expected to result in a decrease in services, but would result in lower net physician payments for some services. While the responsibility of payment for the deductible would shift to the client, it is generally assumed providers would absorb the impact of non-payment from the client. Savings will be based on the full dual and partial dual populations in all programs (including FFS). The full dual refers to full benefit dual eligible Medicaid clients, partial refers to our partial benefit Qualified Medicare Beneficiary (QMB) clients for which we only pay Medicare premiums, copays, deductibles, and coinsurance. The estimated number of impacted clients (full and partial duals) is 542,000 in FY 18; 555,000 in FY 19. Savings will be generated as a result of reduced liability for Part B deductible payments for non-exempt services.				
15	**Review utilization and appropriateness of rates for durable medical equipment**	TBD	TBD	Various	Rates for subgroups of DME items will be reviewed throughout the course of the Biennial Calendar Fee Review process, with the next review scheduled for February, 2018.

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	When Congress enacted the 21st Century Cures Act, the Medicaid program anticipated limitations would be provided for federal Medicaid reimbursement for durable medical equipment (DME), prosthetics, orthotics and supplies efective January 1, 2018. The limitations would have applied competitivelybid prices for Medicare as an upper limit for Medicaid payments. Further clarification from CMS is that Texas Medicaid will only consider fee-for-services (FFS) expenditures when reporting compliance with this provision. For the procedure codes required to be reported annually to CMS, the Texas aggregate expenditures is estimated to be $100,000 less than the Medicare expenditures, therefor no adjustment to our reimbursement rates is required from this Act. Focus will now return to the regular review process of DME rates, which occurs periodically throughout the course of the agency's Biennial Calendar Fee Review. Subgroups of DME items are reviewed, with the next subgroup(s) scheduled in February, 2018.				
16	**Enforce Limitations on recipient disenrollment from managed care plans pursuant to Govt Code § 533.0076**	$ -	$ -	n/a	This initiative would incur costs to implement, and is not expected to yield savings. Item not being pursued.
	Gov't Code § 533.0076 directs HHSC to implement a lock-in process for Medicaid managed care members to prevent members from frequently changing health plans. Federal regulations define the extent to which states can limit member disenrollment from Medicaid managed care organizations (MCOs). Under the most stringent application offederally permissible lock-in provisions, clients still must be afforded significant flexibility to change plans. Anytime a client is newly enrolled with a plan, including if the client has just switched from another plan, the client has 90 days to change that plan without cause before being locked in. Clients must have the opportunityto change plans at least every12 months. Government Code §533.0076 grants even more flexibility to change plans than what federal regulation would permit – it permits one additional opportunityper year to change plans without cause in addition to the opportunities alreadyafforded under federal law. The average monthly rate of plan changes among all STAR and STAR+PLUS clients during the six months from September 2015 to February 2016 was 0.33 percent, after eliminating clients who had to change plans because theymoved to a different service delivery area or who changed programs (e.g., from STAR to STAR+PLUS). This rate would decline further if the analysis also excluded clients who were changing plans during federally permissible timeframes (i.e., the first 90 days of enrollment or after 12 months).				
17	**Identify and execute savings by:**	TBD	TBD	various	Items 17 i-iv and 17 vi are underway, although not complete. No savings are estimated currently, however 17 ii will lead to improved identification of anomalies which may yield cost savings.
i	***Conducting an independent audit of Medicaid managed care premiums using a separate external actuarial firm every two years. The audit shall review HHSC's contracted actuarial services to ensure premiums are actuarially sound and are providing the greatest value for the state. Based on the audit findings, adjust Medicaid Managed care premiums. This audit shall begin with the Medicaid Managed care premiums for fiscal year 2018.***	*$ -*	*$ -*		*In progress*
	Conducting an independent audit of Medicaid managed care premiums using a separate external actuarial firm every two years. The audit shall review HHSC's contracted actuarial services to ensure premiums are actuariallysound and are providing the greatest value for the state. Based on the audit findings, adjust Medicaid Managed care premiums. This audit shall begin with the Medicaid Managed care premiums for fiscal year 2018.				

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
ii	***Ensuring collaboration between the Medicaid and CHIP data analytics unit and the HHSC actuarial staff to investigate and analyze any anomalies in the expenditure data used to set rates and ensure the expenditure data being used to set rates is sound. Additionally, any anomalies identified related to service utilization, providers, payment methodologies, and compliance with the requirements in Medicaid and CHIP shall be reported to the Office of Inspector General for further review;***	$ -	$ -	*9/1/2017*	
	A workgroup has been formed and has held three meetings during Fall 2017. The workgroup is developing a formal process for collaboration and anomaly identification. A project charter is being developed.				
iii	***Evaluating the methodology used to develop trend factors and other growth assumptions, including ensuring the methodology properly accounts for growth that could be considered one-time rather than on-going;***	$ -	$ -		*In progress*
	HHSC utilizes a CMS-approved methodology to develop assumptions for future trends in determining the Medicaid and CHIP managed care capitation rates. The trend assumptions are derived using standard actuarial practices and based on actual experience from the Medicaid and CHIP programs. All trends are adjusted to remove distortions or known events that have materially impacted historical costs and are not expected to be ongoing. Special care is used to exclude from the trend analysis those extraordinary one-time occurrences that have a significant impact on cost. Examples of such adjustments include: H1N1, Makena and other similar events. Additionally the Medicaid and CHIP programs have numerous provider reimbursement and policy changes each year, such as hospital reimbursement increases and attendant wage increases. These changes drive up (or down) cost, which in turn drives up (or down) the experience trend. Actuarial Analysis attempts to normalize these results by removing the impact from these changes to ensure that the one-time nature of these changes is not assumed to be ongoing. 42 CFR 438.5(d) states the following: "Trend. Each trend must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend must be developed primarily from actual experience of the Medicaid population or from a similar population." The Actuarial Standards Board's Actuarial Standard of Practice No. 49 includes the following: "The actuary should include appropriate adjustments for trend and may consider a number of elements in establishing trends in utilization, unit costs, or in total."				
iv	***Using a competitive procurement process with price as one component of the procurement evaluation;***	$ -	$ -		*In progress*

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	Using a competitive procurement process with price as one component of the procurement evaluation; HHSC is required to procure goods and services that provides the best value to the agency in accordance with §2155.144 of the Texas Government Code. Components of price, such as acquisition price, costs of employee training associated with the acquisition, long-term costs to the agency of acquiring particular goods and services, and installation costs, are among the express factors HHSC may, and routinely does, consider. However, in accordance with §2155.144, HHSC is obligated to consider all factors when determining best value. Therefore, price is not dispositive. Change to this stipulation would require change to statutory authority. HHSC must, except when provided for by law or in Chapter 391 of the Texas Administrative Code, utilize a competitive procurement method as the primary method of purchasing goods or services. The procurements that are exempt from competitive purchasing are sole source, proprietary purchases, emergency purchases, preferred supplier purchases, enrollment contracts, intergovernmental transfer, and those under $5000. Changes to these stipulations would require change to HHSC rules. Staf has conferred with Legal Services and this provision does not overrule, overturn or act as a waiver of other statutory requirements for purchasing such as Comptroller of Public Accounts purchasing requirements. In accordance with TAC §391.207(c), for procurements that are not exempt from competitive procurement methods, HHSC must include consideration of cost as a factor, unless not required by law or if not feasible. At this time, HHSC is continuing to assess the feasibility of including a cost component in managed care procurements. HHSC sets capitation rates for mature managed care programs based on managed care paid expenses, reported to HHSC and validated by various sources to be accurate and reliable. Currently HHSC has sufficient data to determine which existing, contracted MCOs are achieving the lowest cost. This information was shared with the Senate Finance Healthcare Costs workgroup during the 85th legislative session, for the STAR Program. HHSC could explore termination of contracts with high-cost MCOs, but doing so presents significant risks, challenges, and could have adverse impacts on service delivery. Managed Care products are already in place for FY 2018. Two product lines are currently being procured for operational dates in FY 2019. While HHSC will explore consideration of price as a specific component in managed care procurements, savings cannot be determined at this time.				
v	***Ensuring all programs are meeting cost effectiveness requirements in Texas Gov't Code § 533.0025;***	$ -	$ -	*n/a*	HHSC received guidance from LBB staff that this analysis is to be applied to any new managed care expansions.
	For any new managed care expansion, HHSC will ensure that cost effectiveness requirements are met.				
vi	***Conducting a cost-benefit analysis of contracted services for the provision of agency-related human resources functions. The analysis shall identify any additional operational efficiencies that could result in savings.***	$ -	$ -	*9/1/2017*	*In progress*
	Key staff working in Financial Services and System Support Services are undertaking a cost benefit analysis to determine if contracted services are cost efective. The study will determine the projected costs over a 5 year period related to Human Resource contractor and contract management state staf as well as the estimated number of the FTEs/support and costs that would be needed to bring all current contract human resource functions "in house". Subject matter experts across the agency are working together to complete the study by February 2018, including IT, Payroll and Financial Services, Budget, Accounting, Human Resources, and System Budget and Fiscal Policy. This will be followed by an analysis of any feasible carve outs of components of the current contract which will be completed in Summer 2018. Transition costs will be included over the 5 year timeframes for both internal and external entities.				
18	**Implement additional initiatives and programmatic efficiencies identified by HHSC.**	$ 92.2	$ 214.3		Items to be included as identifed and developed.

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
18.1	***Contractor to State Staff Conversions Cost Avoidance***	*$ 2.8*	*$ 7.3*	*9/1/2017*	*Continued conversions are in progress.*
	Historically, HHS Information Technology has used staff augmentation contractors to obtain advanced technical skill sets that may only be needed for the duration of specific projects and to supplement its state staf workforce in times of high demand for services. While staff augmentation is a viable strategy, HHS Information Technology wants to ensure continued development and maintenance of a qualified state employee workforce that can meet its long-term business needs and perform its core competencies. To achieve this cost avoidance goal, HHS Information Technology regularly evaluates its staf augmentation contractor positions for possible conversion to state staf positions. Since Spring 2017, HHS Information Technology has converted 114 contractors to state positions. These cost avoidance efforts were critical to address the reduced 2018-2019 appropriations.				
18.2	***Review policies for assignment of appropriate Resource Utilization Groups (RUGs)***	*TBD*	*TBD*	*TBD*	
	Staff will review policies to determine if revisions result in appropriate but less costly RUG assignments, which may reduce expenditures for nursing facilities.				
18.3	***Reinstate previous hospital eligibility criteria for higher Medicaid reimbursement.***	*$ 89.4*	*$ 206.98*		
	During the 2016-17 biennium, nine hospitals began billing Texas Medicaid at higher reimbursement levels for inpatient and outpatient services previously intended for rural hospitals only. These hospitals received Medicare designation as a Rural Referral Center, Sole Community Hospital or Critical Access Hospital that were not consistent with Texas legislative appropriation levels. HHSC strengthened it's rules to be consistent with Rider 37 of the 2018-19 General Appropriations Act in order to avoid additional costs.				
Total Cost Containment Rider 34, estimated as of November 30, 2017		**$ 281.3**	**$ 669.1**		
	Other Significant Cost Savings in the FY 2018-19 Biennium				
Rider 158	**Medicaid and CHIP Capitation Risk Margin Adjustment**	$ 74.0	$ 197.0	9/1/2017	Reduce risk margin from 2.0 percent to 1.5 percent or 1.75 percent, depending on the program

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Item	Item Description	Estimated Savings-GR	Estimated Savings-AF	Effective Date	Comments
	In accordance with Rider 158, HHS has reduced the risk margin provision included in the Medicaid and CHIP managed care capitation rates from 2.0 percent to 1.5 percent in the STAR, STAR Health, CHIP, Medicaid Dental, and Medical Transportation programs; and, from 2.0 percent to 1.75 percent in the STAR+PLUS (including Dual Demo) and STAR Kids programs. CMS requires that Medicaid and CHIP managed care capitation rates be certified as actuarially sound. Actuarial soundness requires that a risk margin be included in rate development. The level of risk margin is determined based on all financial risk mechanisms in the contract with the managed care organization, and risk inherent in the programs covered. It is common for actuaries to use margins in multiple components of rate setting; however, the rates that HHSC sets do not include any additional margins for risk. Risk margin provides protection against insolvency for managed care organizations, funds needed for statutory capital requirements, and to make investments in infastructure. Reducing the risk margin may make program participation less attractive for certain managed care organizations. CMS does not specify required risk margin levels. Only that the margin be reasonable and appropriate for the risks under consideration. Estimates above include the reduction state premium tax revenue, and the impact to the ACA Health Insurance Provider's fee in FY2019. Reducing the risk margin will offset experience rebate savings. Since the savings are determined as a percent of capitation, any changes to the capitation rates (e.g. other cost containment initiatives) will impact this estimate.				
	Savings estimated from both Rider 34 Cost Containment and Rider 158 Risk Margin Adjustment*				**$355.3**
	* Cost Containment Savings in Client Services	$ 346.5	$ 638.3		Includes Cost Containment in Rider 34 and Risk Margin Adjustment (Rider 158)
	* Cost Containment Savings in Non-Client Services	$ 8.8	$ 20.8		Includes Cost Containment in Rider 34 and Risk Margin Adjustment (Rider 158)

Rider 34: Medicaid Funding Reduction and Cost Containment.
a. The Health and Human Services Commission (HHSC) shall develop and implement cost containment initiatives to achieve savings throughout the health and human services system.

These initiatives shall include the following, if HHSC determines them to be cost-effective:

(1) Continue strengthening and expanding prior authorization and utilization reviews;

(2) Incentivize appropriate neonatal intensive care unit utilization and coding;

(3) Pursuant to Human Resources Code §§32.064 and 32.0641, maximize co-payments in Medicaid programs;

(4) Increase fraud, waste, and abuse prevention, detection, and collections;

(5) Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services;

(6) Increase efficiencies in the vendor drug program;

(7) Increase third party recoupments;

(8) Implement a pilot program on motor vehicle subrogation;

(9) Achieve efficiencies in the printing and distribution of Medicaid identification cards;

(10) Implement facility cost savings by reducing leased space or decommissioning buildings;

(11) Recoup administrative costs for programs HHSC administers for other entities, such as the School Health and Related Services Program (SHARS);

(12) Seek flexibility from the federal government to improve the efficiency of the Medicaid program;

(13) Improve prior authorization and utilization review for non-emergent air ambulance services;

(14) Evaluate reimbursement for dual eligibles;

(15) Review utilization and evaluate appropriateness of rates for durable medical equipment;

(16) Enforce the limitations on recipient disenrollment from managed care plans pursuant to Government Code, § 533.0076;

(17) Identify and execute savings by:

(i) Conducting an independent audit of Medicaid managed care premiums using a separate external actuarial firm every two years. The audit shall review HHSC's contracted actuarial services to ensure premiums are actuarially sound and are providing the greatest value for the state. Based on the audit findings, adjust Medicaid managed care premiums. This audit shall begin with the Medicaid managed care premiums for fiscal year 2018;

(ii) Ensuring collaboration between the Medicaid and CHIP data analytics unit and the HHSC actuarial staff to investigate and analyze any anomalies in the expenditure data used to set rates and to ensure the expenditure data being used to set rates is sound.

Additionally, any anomalies identified related to service utilization, providers, payment methodologies, and compliance with the requirements in Medicaid and CHIP shall be reported to the Office of the Inspector General for further review;

(iii) Evaluating the methodology used to develop trend factors and other growth assumptions, including ensuring the methodology properly accounts for growth that could be considered one-time rather than ongoing;

(iv) Using a competitive procurement process with price as one component of the procurement evaluation;

(v) Ensuring all programs are meeting cost effectiveness requirements in the Texas Government Code, including the requirements established in Texas Government Code 533.0025; and

(vi) Conducting a cost-benefit analysis of contracted services for the provision of agency-related human resource functions. The analysis shall identify any additional operational efficiencies that could result in savings;

(18) Implement additional initiatives and programmatic efficiencies identified by HHSC.

b. HHSC shall provide a plan to the Legislative Budget Board to implement cost containment initiatives by December 1, 2017. For initiatives determined not to be cost effective, the agency shall submit the analysis underlying that determination with the plan. The plan shall be considered approved unless the Legislative Budget Board issues a written disapproval within 15 business days.

HHSC shall achieve savings of at least $350,000,000 in General Revenue Funds and $480,000,000 in Federal Funds for the 2018-19 biennium through the initiatives identified above.

Rider 158: Managed Care Risk Margin.
Included in appropriations above in Goal A, Medicaid Client Services, is a reduction of $37,568,472 in General Revenue Funds and $52,308,256 in Federal Funds in fiscal year 2018 and $38,742,976 in General Revenue Funds and $53,943,566 in Federal Funds in fiscal year 2019, a biennial total of $76,311,448 in General Revenue Funds and $106,251,822 in Federal Funds as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent for STAR and STAR Health and from 2.0 percent to 1.75 percent for STAR+PLUS and STAR Kids.

Included in appropriations above in Goal C, CHIP Client Services, is a reduction of $373,514 in General Revenue Funds and $5,039,737 in Federal Funds in fiscal year 2018 and $392,166 in General Revenue Funds and $5,291,400 in Federal Funds in fiscal year 2019, a biennial total of $765,680 in General Revenue Funds and $10,331,137 in Federal Funds, as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent.

Special Enrollment Access Extended until December 31, 2017
For Areas Affected by Hurricane Harvey

The U.S. Dept. of Health and Human Services released guidance outlining a new special enrollment period (SEP) for people affected by the 2017 hurricanes, including hurricane Harvey. This new guidance will provide individuals who were impacted by Harvey additional time to enroll or change their ACA coverage for 2018. This guidance only applies to coverage purchased in the Health Insurance Marketplaces created by the ACA.

What does this mean for 2018 coverage?

The open enrollment period for individuals to enroll in coverage for 2018 began on November 1, 2017 and ends December 15, 2017. **BUT people who either currently reside in a disaster-affected area, or did when Harvey hit, will have until December 31, 2017 to enroll in 2018 coverage.**

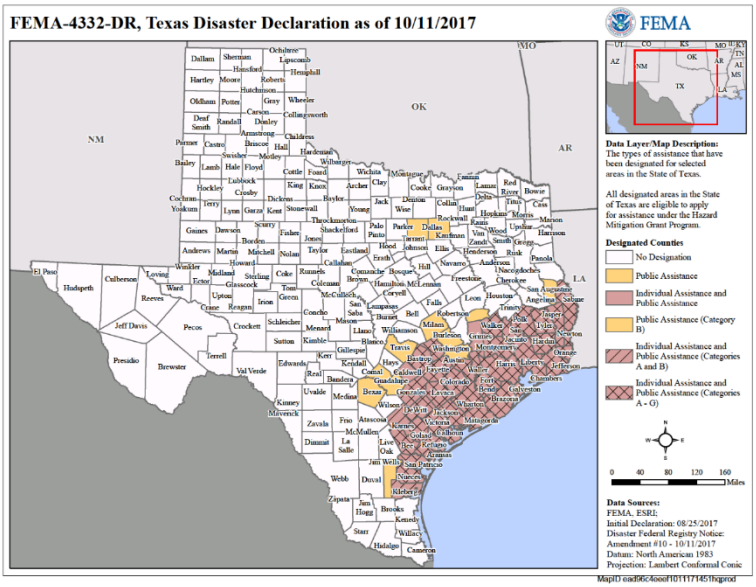
There has been some confusion between the hurricane SEP for 2017 coverage and the hurricane SEP which extends access to enrollment for 2018 coverage until December 31, 2017. For information about how to access health coverage which would be effective in the remainder of 2017, please read additional information on our blog.

Who is eligible for this extra time to enroll?

The guidance makes this SEP available to individuals who "reside, or resided at the time of the hurricane, in any of the counties declared as meeting the level of 'individual assistance' or 'public assistance' by FEMA." **If you currently live in a county that is considered affected by the hurricane or you lived in that county at the time of the hurricane (August 23, 2017 - September 15, 2017) then you are eligible to enroll in 2018 coverage until December 31st, 2017.**

Which Texas counties are included?

According to FEMA's website this includes the following Texas counties:
Aransas, Austin*, Bastrop, Bee, Bexar*, Brazoria, Burleson*, Caldwell, Calhoun, Chambers, Colorado, Comal*, Dallas*, DeWitt, Fayette, Fort Bend, Galveston, Goliad, Gonzales, Grimes*, Guadalupe*, Hardin, Harris, Jackson, Jasper, Jefferson, Jim Wells*, Karnes, Kleberg, Lavaca, Lee, Liberty, Madison*, Matagorda, Milam*, Montgomery, Newton, Nueces, Orange, Polk, Refugio, Sabine, San Augustine*, San Jacinto, San Patricio, Travis*, Tarrant*, Tyler, Victoria, Washington*, Walker, Waller, and Wharton.



Prepared by Center for Public Policy Priorities and reviewed for accuracy by federal CCIIO. For more information contact McChesney@cppp.org.

*These counties were designated as eligible for "public assistance" only but are still considered "affected" and therefore people in these counties are eligible for the extension.

Do I have to provide documentation that I was affected by the hurricane, such as documents from FEMA?

Anyone who lives in a county considered "affected" by the hurricane (or who lived in the county at the time of the hurricane) is eligible for the extension and must only attest to living in those areas and to not being able to complete enrollment due to the hurricane. No further documentation will be needed.

What if I lived in Florida during Irma or Puerto Rico during Maria but I have now moved to Texas?

Anyone who attests to moving from an area affected by a hurricane-related weather event in 2017 (and who lived in that area during the disaster) will be eligible for the extra time to enroll in coverage through December 31, 2017.

How can a person enroll using the SEP which extends enrollment access for 2018 coverage?

To access this additional time to enroll in coverage for 2018, a person must call the Marketplace Call Center and request the special enrollment period. However, the consumer can complete the application online – either alone or with in-person assistance – prior to calling the Marketplace Call Center. If the consumer's application is already complete at the time he or she is requesting the extension, the consumer should provide the application number to the Marketplace Call Center. The applicant must tell the Call Center Representative that he or she was affected by the hurricane and requires more time to complete 2018 enrollment. People may contact the Marketplace Call Center at 1-800-318-2596 or TTY at 1-855-889-4325 to request enrollment using this SEP after December 15, 2017. The call center is open 24 hours a day, seven days a week.

Navigators and Certified Application Counselors (CACs) may use the special helpline set up just for assisters:

- Assister line for Navigators: 1-855-868-4678
- Assister line for CACs: 1-855-879-2683

Here's how the process would work:

1) A person submits an application for 2018 coverage via Healthcare.gov. In most cases (unless they were found eligible for some other special enrollment period), they would then receive an eligibility determination notice that would say they are ineligible to enroll in coverage because the open enrollment period for 2018 ended on December 15th, 2017.

2) They can then call the Marketplace call center and request the special enrollment period which extends the open enrollment for people in areas impacted by Harvey. (This request must be submitted by the deadline of December 31, 2017). The applicant must tell the Call Center Representative that he or she was affected by the hurricane and requires more time to complete 2018 enrollment.

3) This request will then be forwarded to the Marketplace for review/approval.

4) Once the Marketplace has approved the enrollment extension and set the appropriate effective date, the consumer will be alerted via letter and will be able to go back to Healthcare.gov and select a plan.

What can I do if I am having trouble accessing the special enrollment period?

If you have questions or are having trouble using the enrollment extension then email Melissa McChesney at mcchesney@cppp.org.

HHS Office of the Ombudsman Update

Presented to
CHC Coalition
December 15, 2017

TEXAS
Health and Human Services

Total Ombudsman Contacts for 1st Quarter FY 2018

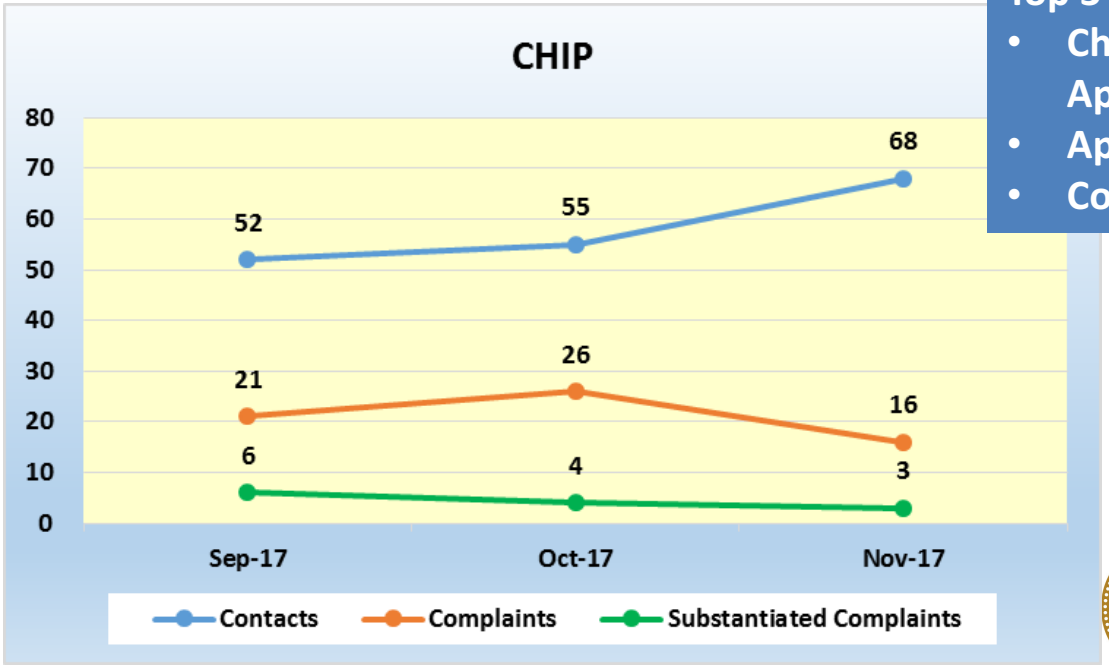
- Complaints – 7,165
- Inquiries – 13,903

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type 1st Quarter FY 2018

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

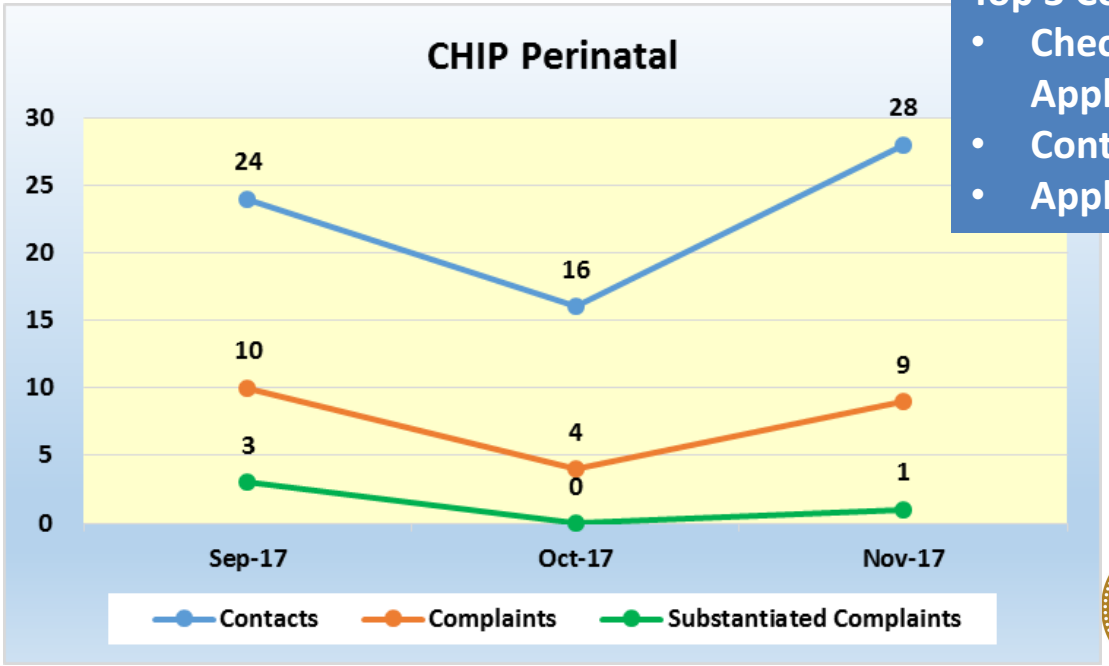


Top 3 Contacts – CHIP

- Check status of Application/Case
- Application/Case Denied
- Contact Info Request

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

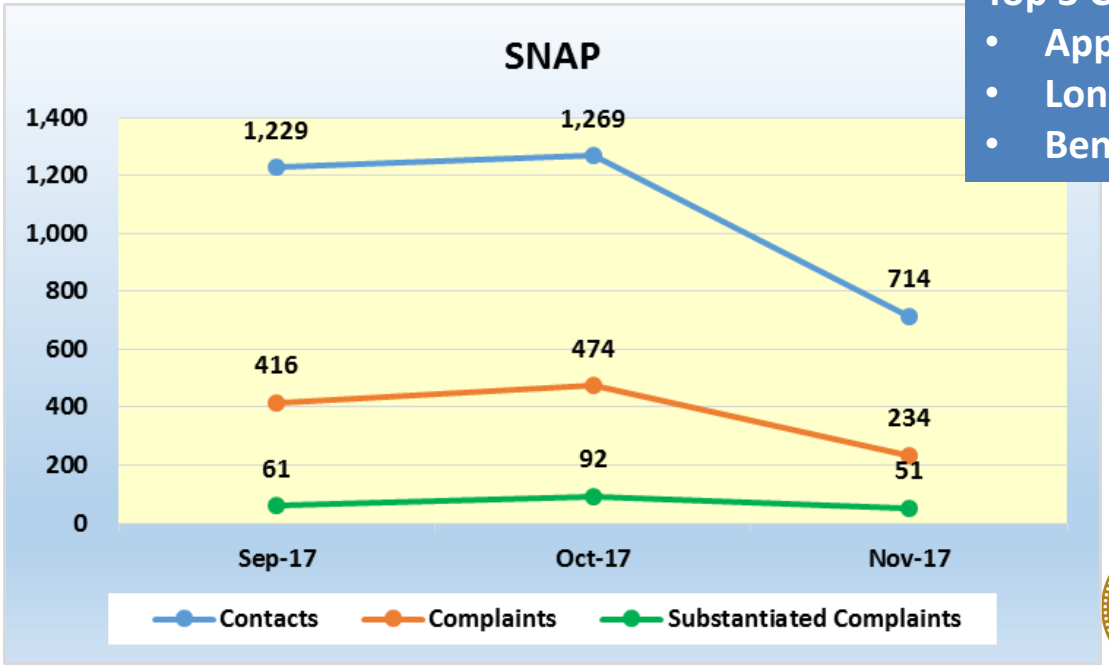


Top 3 Contacts – CHIP - P

- Check status of Application/Case
- Contact Info Request
- Application/Case Denied

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

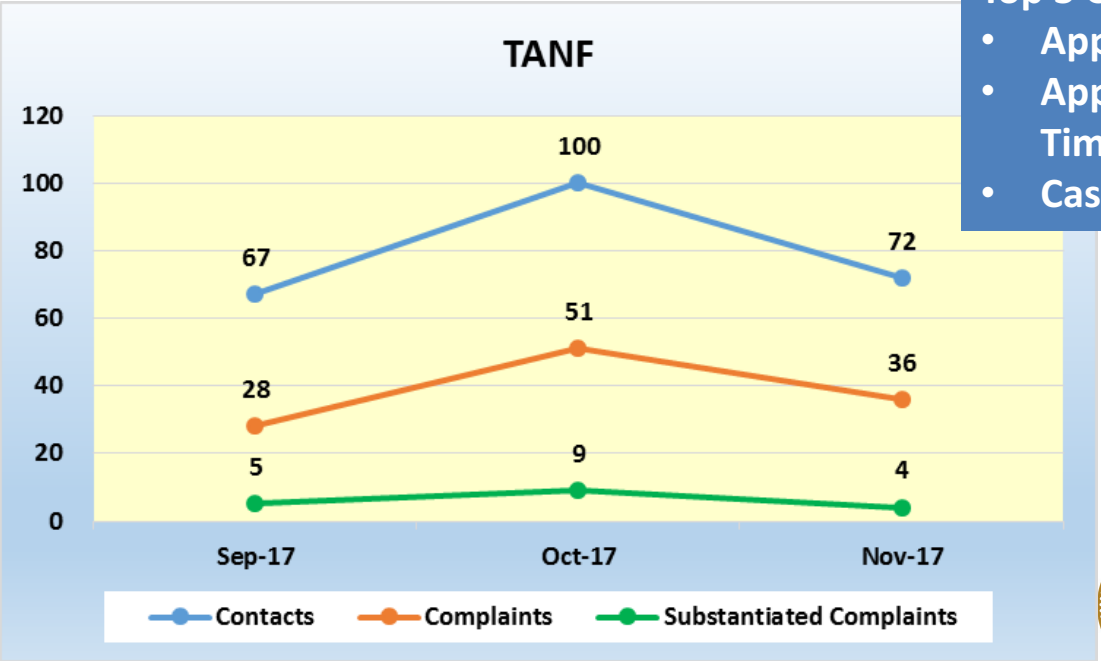


Top 3 Contacts – SNAP

- Application/Case Denied
- Lone Star Card Issue
- Benefit Amount

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

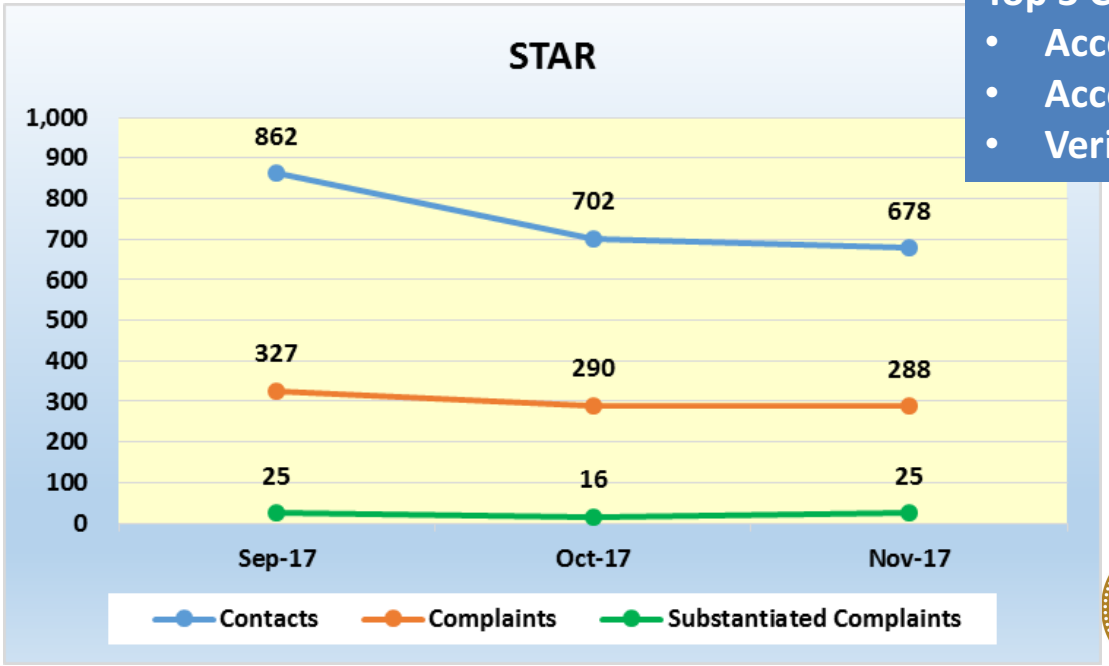


Top 3 Contacts – TANF

- Application/Case Denied
- Application Not Completed Timely
- Case Information Error

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

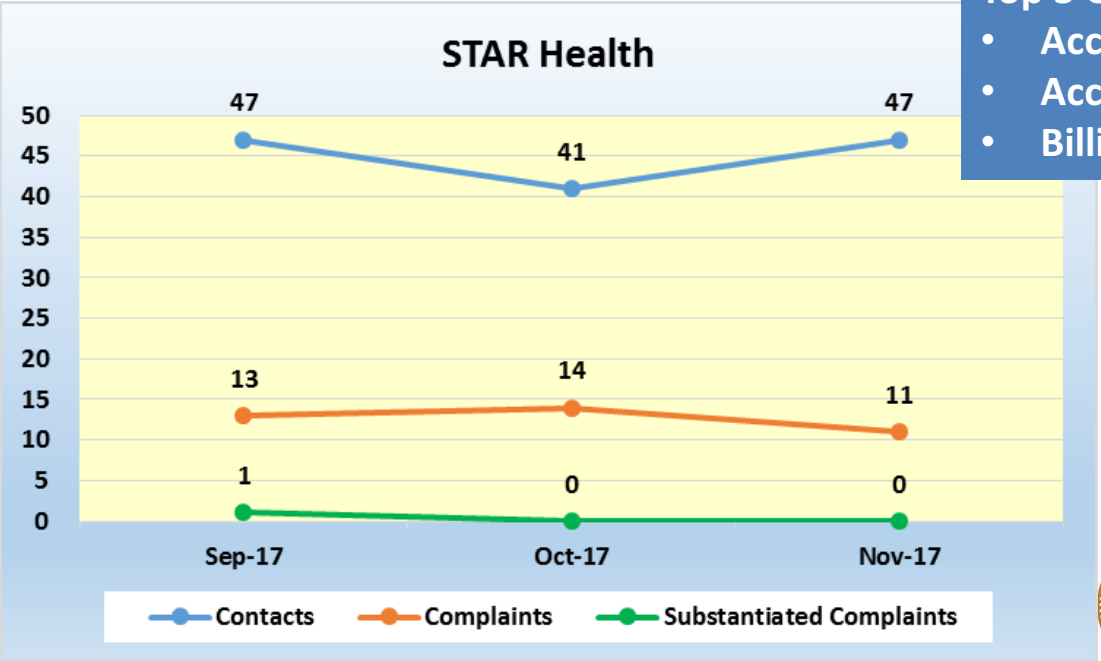


Top 3 Contacts – STAR

- Access to Prescriptions
- Access to PCP/Change PCP
- Verify Health Coverage

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

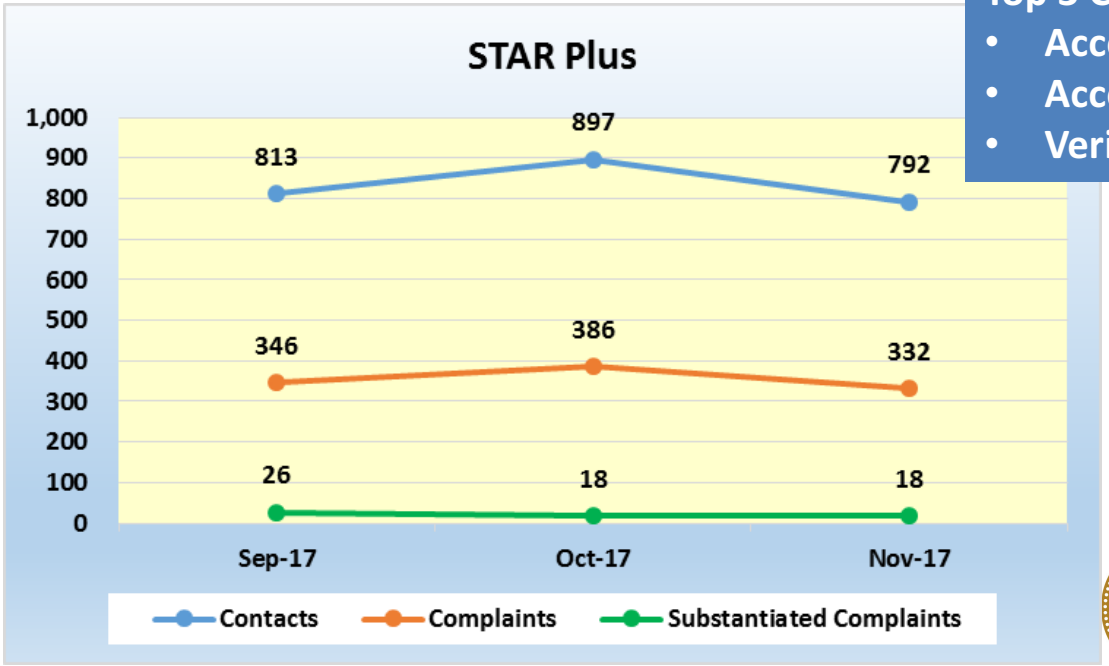


Top 3 Contacts – STAR Health

- Access to PCP/Change PCP
- Access to Specialist
- Billing Problems

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

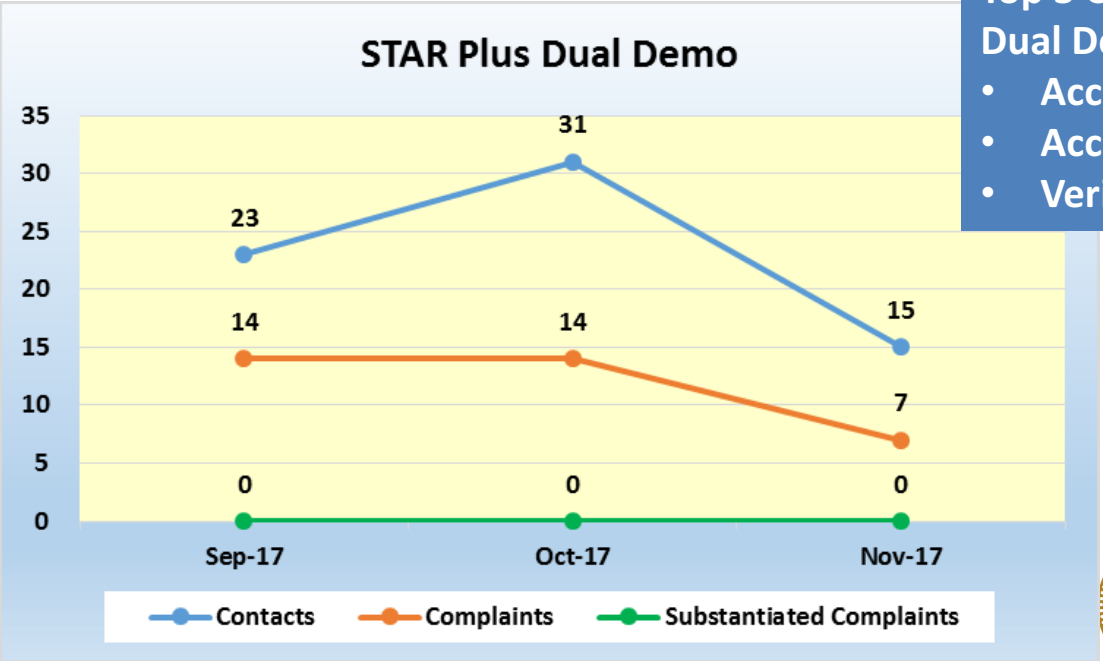


Top 3 Contacts – STAR Plus

- Access to Long Term Care
- Access to Prescriptions
- Verify Health Coverage

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018

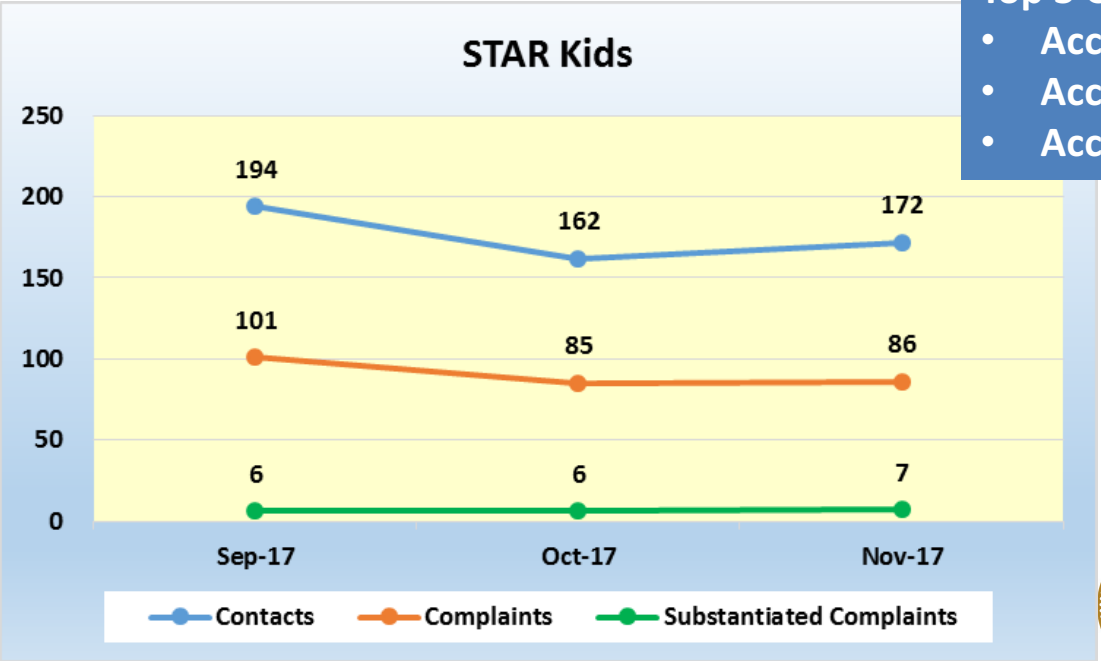


Top 3 Contacts – STAR Plus Dual Demo

- Access to Long Term Care
- Access to Prescriptions
- Verify Health Coverage

TEXAS Health and Human Services

Contact Volumes by Program Type
1st Quarter FY 2018



Top 3 Contacts – STAR Kids

- Access to Prescriptions
- Access to Long Term Care
- Access to PCP/Change PCP

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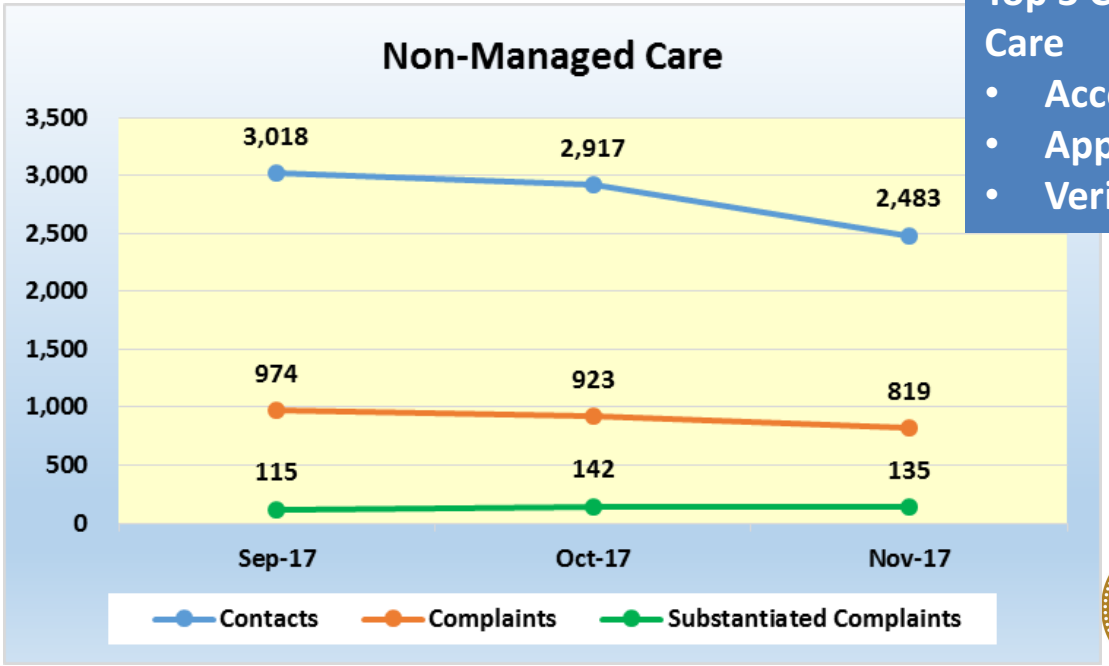
Contact Volumes by Program Type
1st Quarter FY 2018



Top 3 Contacts – Non Managed Care

- Access to Prescriptions
- Application/Case Denied
- Verify Health Coverage

TEXAS Health and Human Services

FOSTER CARE OMBUDSMAN

TEXAS
Health and Human
Services

Foster Care Ombudsman Program
1st Quarter FY 2018

Contact Volume 1st Quarter FY 2018	
Foster Care Youth	54 (36%)
Total Contacts	151

Top Three Reasons for Contact 1st Quarter FY 2018
Rights of Children and Youth in Foster Care
Caseworker not responding to phone calls
Placement Issue

Information Shared

- Preparation for Adult Living (PAL)
- Court Appointed Special Advocates (CASA)
- Department of Family Protective Services (DFPS)

TEXAS Health and Human Services

Ombudsman Managed Care Assistance Team

UPDATE

- Outreach – Home Visiting Program
- Managed Care Support Network
- Additional Assistance for Dual Eligibles
- Education for clients new to Medicaid

TEXAS Health and Human Services

Contact us

Phone (Toll-free)

Main Line: 877-787-8999
Managed Care Help: 866-566-8989
Foster Care Help: 844-286-0769
Relay Texas: 7-1-1

Online

hhs.texas.gov/ombudsman

Fax (Toll-free)

888-780-8099

Mail

HHS Ombudsman
P. O. Box 13247
Austin, Texas 78711-3247

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Health and Human Services