Children's Health Coverage Coalition and OTA Meeting Agenda
Friday, February 15th, 2019
11:00 A.M. – 2:00 P.M.

Present:

Betsy Coats, Maximus
Audrey Spanko, National Association – Social Workers, TX Chapter
Lorena Vela-Parker, Health and Human Services Commission
Laura Guerra-Cardus, Children's Defense Fund
Christina Phamvu, Methodist Healthcare Ministries
Denbigh Shelton, Health and Human Services Commission
Clayton Travis, Texas Pediatric Society
Suling Homsy, Health and Human Services Commission
Anne Dunkelberg, Center for Public Policy Priorities
Helen Kent Davis, Texas Medical Association
Paige Marsala, Health and Human Services Commission, Ombudsman
Kate Hendrix, Texas Hospital Association
Janie Contreras, Health and Human Services Commission
Gina Carter, Health and Human Services Commission
Adriana Kohler, Texans Care for Children

On Conference Line:

Melissa McChesney, Center for Public Policy Priorities
Tricia Brooks, Georgetown University Health Policy Institute, Center for Children and Families

Meeting Chair: Diane Rhodes, Texas Dental Association

Meeting Scribe: Arinda Rodriguez, Center for Public Policy Priorities

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

I. Introductions (Diane Rhodes, 5 minutes)

II. HHSC Plan Monitoring (Lorena Vela-Parker, 30 minutes)

[Lorena Vela-Parker]

I work under the Managed Care Compliance & Operations (MCCO) division. We oversee the contracts between HHSC and MCOs. I will go ahead and provide a high level overview of what MCCO works on, and then I'll go ahead and talk about each department within our division.

We are very focused on MCOs. The MCCO manages the day-to-day operations of health plans, including STAR, STAR+PLUS, STAR Kids, STAR Health, Children's Medicaid Dental Services, Dual Demonstration Project, CHIP, CHIP dental services.

We also manage the day-to-day operations of the Medical Transportation Program.

The MCCO does contract oversight and verifies that MCOs are compliant with our contracts and manuals. We collect data to identify trends, including complaints. We evaluate operational performance measures; including operational onsite visits. We recommend remedies of corrective action and/or liquidated damages. We serve as a point of contact and act as liaisons between the health plans and HHSC in areas as needed. We implement contract changes and manual changes. We receive, manage, and respond to complaints, inquiries and disenrollment requests. We also review and approve MCOs member outreach materials and assist with and escalate access to care and legislative issues.

There are different teams under the MCCO:

- Ops Readiness Team
    - The Ops/Readiness team does readiness review for HHSC roll out programs (ex. STAR Kids).
    - They also coordinate Operational Onsite Reviews
        - Our department is required to go to each of the plans and look at their operations. We'll look at their staff, their systems, and see if there are any findings. If found in non-compliance, HHSC steps in.
    - We also perform targeted reviews
        - If we determine that there is a trend then we may go out to the plan and look at that specific area.
    - We've been doing this for a year and a half and will start a new cycle in Sept. 2019.
    - We're going once a month with the plans
- Health Plan team's responsibilities include:
    - Data collection and analysis of MCO performance through quarterly data. MCOs are to submit specific deliverables such as hotline information, complaints information, member appeals information, claims information, networks information, and agency complaints.

    - We then determine their compliance. The maximum amount of time that they can have members on hold is 2 min, so if they are not compliant, MCCO comes in and asks MCOs to liquidate the damage.
    - We also track and trend our own complaints submitted to MCCO.
    - The Health Plan teams also act as liaisons by responding to inquiries and providing performance guidance, they recommend and monitor remedies, including CAPs and liquidated damages, and assist with complaints.
- Research and Resolution team
    - Our Research and Resolution team receives, manages, and responds to complaints, inquiries, and disenrollment requests sent to MCCO in regards to MCO/DMO.
    - They assist with escalated access to care, legislative, and routine issues.
- Marketing team
    - Our marketing team ensures that the MCOs are in compliance with our marketing and procedures. They also review and approve those materials, investigate reports of alleged marketing violations and train and certify staff from each MCO and DMO as trainers on the Marketing and Member Materials Policy.

<u>Questions:</u>

[Diane Rhodes]

Are the CAPs available to look at?

[Lorena Vela-Parker]

Yes, there's a website, I can word it and email it to you all. We have all the CAPs and liquidated damages.

[Clayton Travis]

Corrective action plans, do they say what the infraction is?

[Lorena Vela-Parker]

It should indicate what it is.

[Clayton Travis]

Last year was the 1st time they were enforced, and this year is the first year that liquidated damages will be assessed. In their description of infractions, are they specific to say, for example, how many neurologists they are missing?

[Lorena Vela-Parker]

It doesn't go into that level of detail.

[Clayton Travis]

19 out 20 managed care plans have some sanctions on network adequacy, but if it only says that they have a corrective action plan it is not very helpful. More details would help us in our legislative work.

[Anne Dunkelberg]

What level of information are the plans reporting? I think they have monthly deliverables, but you guys do a quarterly report. What level of reporting do they submit regarding their hotline services for example?

[Lorena Vela-Parker]

On their hotlines it's just basic call time info, but if you call the call center and it is determined that it's a complaint, it'll go to complaints, not to hotline. We are working on our complaints reporting. So we can synthesize the data.

[Anne Dunkelberg]

It's important to look at everything that is making people call, in order to create a record.

[Lorena Vela-Parker]

As far as the complaints reporting, it's getting more detailed.

[Laura Guerra-Cardus]

Y'all capture the data, but do you all, if you notice a lot of complaints in one area, do you guys take action on that? Is it through a corrective action plan?

[Lorena Vela-Parker]

Yes, we reach out to the plan and inquire on what is causing the trend.

[Laura Guerra-Cardus]

Are corrective action plans always done when there is noncompliance with the contract?

[Lorena Vela-Parker] We have to look at what the noncompliance is.

[Anne Dunkelberg]

Quarterly reports go to who?

[Lorena Vela-Parker]

They go to us, and we will go and do our recommendation.

[Anne Dunkelberg]

Are they kept internal, the reports?

[Lorena Vela-Parker]

Our reports on CAPs are the result of these internal reports, so those stay internal.

[Laura Guerra-Cardus]

Medicaid has the EPSDT requirements, I imagine it's in the contract between HSSC. And the health plans, what requirements are there for the plans? How are denials for services for kids dealt with under that context?

[Lorena Vela Parker]

If a member gets a denial, they can appeal it. If it is not resolved, it should be submitted as a complaint. And you also have the right to a fair hearing.

[Laura Guerra-Cardus]

Even for fair hearing, a medical person is not making the call in determining these denials. The states' responsible for complying with EDT.

[Anne Dunkelberg]

This issue is not unique to Texas. There is no clarity in law that helps to decide what medical necessity is.

[Denbigh Shelton]

CADS tracks fair hearings and the results of fair hearings. We can get you in touch with them.

[Clayton Travis]

On the MCO sanctions webpage, I assume that the caps reflected in corrective action plans are reflected in these liquidated damages?

[Lorena Vela-Parker]

No. Members are very important to us, so we do liquidated damages (LD) if it was an issue of access to care. It depends on the issue.

[Clayton Travis]

So there are two punishments for the problem, one more severe than the other.

[Lorena Vela-Parker]

Well we can do an LD and a CAP together, but it just varies.

[Clayton Travis]

The level of detail that we were talking about in these CAPs would be helpful since the information available doesn't help us portray issues to decision makers.

[Lorena Vela-Parker]

Some of them do have specifics on the CAPs.

[Clayton Travis]

I assume you give more detail to the plans to fix the problems and to justify the liquidated damages?

[Lorena Vela-Parker]

Yes, I'll bring that back to the agency and emphasize that you guys are interested in more detail, especially on network adequacy.

[Clayton Travis]

This is good data, what you have on the CAPs, but it's hard to do anything with it, I'm wondering if your analysis is published?

[Lorena Vela-Parker]

The way we can go about that is through open requests. I will get back to you about posting all documentation on the CAPs.

[Laura Guerra-Cardus]

On the corrective action, I imagine that you go back at a certain time and assess the success of health plans. I'm wondering if those reports also exist? What's done with it, if they didn't fully accomplish it?

[Lorena Vela-Parker]

It can, but there's no reporting on the website on how they're doing on their corrective action plan.

[Laura Guerra-Cardus]

Do you do it?

[Lorena Vela-Parker]

That's what happens in our operational reviews and that's how we know what we need to follow up on, and then we can do targeted review to see if they did what they said they would do.

[Laura Guerra-Cardus]

If those reports can be made accessible without open request it would help greatly.

III. Quality and Performance Improvement Efforts (40 minutes)

[Tricia Brooks]

[Refer to PowerPoint]

Today we will be talking about the framework that is established in federal regulation in regard to quality.

[Slide 2: Medicaid and Quality Oversight]

In the three blue pockets are the major components of the Federal Medicaid Managed Care Quality Requirements.

[Slide 3: State Managed Care Quality Strategy]

[Slide 4: Strategy must reflect state's goals and objectives and how the state will:]

These are the minimum requirements of the strategy.

Addressing health disparities is an area of growing interest and probably one where we haven't seen disaggregated data that will help us understand how the states are doing.

Special attention needs to be given to clients with special needs.

[Refer to link of the brief done by the Georgetown University Health Policy Institute: Center for children and families]

[Slide 5: Quality assessment & performance improvement program (QAPI)]

They have to identify mechanisms where they identify under- and over- utilization.

[Slide 6: Performance Improvement Projects (PIPs)]

They need to use objective quality indicators as baseline.

Interventions should be implemented to at least test if they will improve service.

When I say sustain improvement, it's a little bit of rub. For example, someone with extensive disabilities, we might not see a huge improvement in their functional ability, but ongoing services helps them maintain the quality of life they already have. It should also focus on clinical and nonclinical areas.

[Slide 7: Performance measures]

If the plans are relied on to calculate their own measures, there can inconsistencies from plan to plan. It's really important that those calculations are double checked for validity if they are creating their own measures.

Ideally, the state should be sending in their data, and have those measures calculated at the federal level so we can ensure that we have uniform data.

[Slide 8: QAPI Program Review]

You may get mixed results if you rely on the plan to evaluate the impact and effectiveness of its own QAPI.

[Slide 9: External Quality Review: A Key Quality Tool]

A rewrite to the Medicaid managed care.

Some of the regulations are new or have been refreshed since most states operated under a manage care framework.

States can contract with various EQROs, but they have to meet federal standards.

There are lots of issues around data transparency and comprehensiveness.

The rules and EQRs are intended to hold managed care organizations accountable.

[Slide 10: EQR Activities]

The slide is divided by what is mandatory by law and what is optional.

Validation of network adequacy every 12 months is new. They are now asking for specific network adequacy strengths. They're not as strong in the pediatric side, but they are better than they were.

Question: [Clayton Travis]

You mentioned that the validation of network adequacy, is new. What network adequacy criteria are they charged with reviewing? Is it just federal or looking at states only?

[Tricia Brooks]

The state is required to define network adequacy standards, and in the regulations there's a required process, that's not on one of the briefs I did, but in our website we have a webinar that was recorded a couple years ago about network adequacy and what is and isn't required. I'm not sure about the timeline, but I believe that has already passed, so the state should have already engaged in a process for defining the network adequacy standards, I can connect with Laura on that so you can look at that.

[Denbigh Shelton]

There are protocols for each of these activity, they have not put out a protocol for this new EQR activity. As of now, this requirement is not clearly defined, but we are using our EQRO to assess appointment standards and wait times. We're assuming we'll meet part of this requirement, new standards are being set as a result of the rule, but again the protocol hasn't been released yet by CMS. We may be fulfilling some of this requirements, but we won't really know until we have more details.

[Slide 11: Direct testing of network adequacy]

Based on our interpretation of the law, direct testing wasn't clearly mandated. You can do a desk review of the plan's policy, but from a report from HHS, you cannot adequately test network adequacy. It's a best practice, but we haven't received weigh in that will make it mandatory.

Administrative data leads to almost all performance measures, so if that administration data is not good, then you are not going to get good information that is based on that. So EQRO can go in an validate that information.

You can look at Ohio, where they rate their plans and provide information to their public. They are good example of how that happens. We have a star rating system in Texas that's not very good.

[Slide 12: EQR results]

Once we make recommendations, the next time around, we want to ask if they have paid attention to those recommendations.

States can review the report but not make substantive revisions.

In Medicaid Managed Care, you see these reports 3 to 4 years after the fact, but now we have a deadline for them to be posted.

[Slide 13: Federal financial participation (FMAP)]

Previously this match was applied to other types of MCC arrangements that were not comprehensive, but unfortunately the rule was reinterpreted and allows us to apply as it pertains to managed care organization.

[Slide 14: Creative ways to use EQR Financial incentives]

When thinking about testing a new measure, if it impacts quality, there's an option to try to get EQRO funding for this study.

[Slide 15: Additional Resources]

The information below can help educate stakeholders who feel they aren't expert enough, these resources can help.

In reality, it's only been a couple of decades that we've been serious about this work on quality assessment and EQRs.

Questions:

I suggest that you do a search for pediatrics, child, pregnant, maternal in your EQRO. I did look at your EQRO with Adriana, and its 540 pages and you open it up, if you do those searches for those key words you can hone in and find what you're looking forward.

We have to stop filling up the pipeline with children who come out the other end and have chronic health conditions. We need to invest more on children' health outcomes so they don't end up being one of those high costs individuals.

[Denbigh Shelton]

[Slide 3: Quality Measures]

We're looking at it with the STAR kids program. We are looking at how we can use those indicators to supplement the quality indicators we currently have. This is a long-term goal since it's conducted every other year. They're sampling strategy is different. Also, we do use dental quality alliance measures to evaluate the dental plans.

[Slide 4: Quality Initiative]

Plans are required to do 2 PIPs annually. The MCO report card is a quality assessment system. It's very difficult to get stakeholder feedback on these things, because it's complicated, and you can't show list of indicators without any background. Reading quality reading systems, CMS was supposed to come out with a proposal for states to use but we can use an alternative.

Performance indicator dashboards are a list of quality measures by program. For MCOs performing below these indicators, we will use corrective action plans.

For network adequacy and appointment availability, EQROs do the secret shopper study.

Under the QAPIs, MCOs are required to report to us annually and our EQRO also reviews

Administrative interviews are the annual external reviews.

The quality strategy is online and available to the public, it has been and is still under CMS review for under several months.

[Slide 5: Resources]

The HHSC Quality Webpage is where out EQRO annual report lives, where our strategies can be found, and where you can look at detailed studies on topics of our choosing.

We are currently looking at STAR Kids implementation. We've been rolling STAR Kids into all of our quality initiatives. We are having our EQRO do an implementation study of STAR Kids (pre, post interviews) interviewing caregivers. As we finalize them they will be posted.

The THLC portal is where we publish the data on all of our quality measures. You can look at results by year, by MCO, etc. Data can be stratified by age, race and ethnicity, clinical.

[Clayton Travis]

It's a great portal. We made recommendations, and y'all responded within a month. It's been extremely helpful.

[Diane Rhodes]

We've had a real good response and have been able to work with the agency. It has been very helpful in terms of providing education to dentists on population health.

[Clayton Travis]

I haven't reviewed the report cards recently, and they look much different, and better. One of the big concerns I had last time, is that at first they had a 3 star system and now they're 5, and it shows some stratification among plans.

[Denbigh Shelton]

We switched to 5 star to give that nuance. They are some survey measures and HEDIS measures also.

[Clayton Travis]

I feel much comfortable handing this to a beneficiary, thank you.

Is there no report card on STAR Kids?

[Denbigh Shelton]

Those are coming in on March.

[Anne Dunkelberg]

It's good to have the STAR Kids in their own bucket.

[Denbigh Shelton]

Evaluating quality for healthy kids vs. kids with chronic conditions should be different, we do struggle with that.

[Laura Guerra-Cardus]

With the EQRO results, is that then built into performance improvement plans, or continued oversight?

[Denbigh Shelton]

Yea, so we take the report, it always includes the recommendations, and look at those recommendations and at ways that we can implement them. We think about what are the state and agency priorities and try to align those.

[Laura Guerra-Cardus]

For the child core measures that Texas does a great job of tracking (about 26), are those over time? You can see indicators that we do better than in other states, are those used when you all are thinking about what to include in PIPs, or the goals for the state, or EQRO?

[Denbigh Shelton]

That's new, you're taking about the state card from CMS that compares states. We will be looking at that more. What we do right now, it's mostly related to the HEDIS measures, HEDIS provides national performance percentiles, and that's what we use for measuring ourselves. That's how we assess how improvement is going.

[Adriana Kohler]

How do you decide what the EQRO should look at and how do stakeholders get involved?

[Denbigh Shelton]

Usually internally, we look at where we need more information to prioritize. This year we are focusing on network adequacy since it's a critical topic. We really only have a quality measure for maternal health and that's from the HEDIS, we didn't feel that was sufficient, and we are looking at using aim-outcome measures. It depends on the areas we are working on, but we are definitely open to input on that. We don't have a formal process for us, it's more like the issues coming our way, but we are open to input on that. You can contact me to further talk about this. We don't have a formal mechanism for that.

[Laura Guerra-Cardus]

We may want to start inviting you here once a year.

[Denbigh Shelton]

I'd be happy to come back, we do periodically attend events. We would welcome that direct feedback on quality.

[Helen Kent Davis]

TMA's winter conference was in January, we got a request that HHSC is asking for feedback. It seemed like this feedback request was sent off to Medical directors, but not to other organizations. To the extent that you are soliciting feedback from health plans, it would be helpful to send that to other stakeholders. We had like 3 days to review and we didn't meet the deadline. The document that was send around didn't have much information on how they arrived to that conclusion. A rationale would have been very helpful to provide feedback.

[Denbigh Shelton]

We did reach out to TMA, THA, and TPS. I agree we didn't give much time, it was 2 weeks though. Oftentimes our processes consume a long time and we may have to rush things. It could be that our system for soliciting feedback is not good. And I agree there was insufficient context for people to really provide input.

IV. Legislative Check-In (Clayton Travis, 10 min)

[Clayton Travis]

Remember to go to Thursday meetings at the capital that Adriana hosts if you want to be on the loop of our legislative agenda and priorities.

There are several bills on the works for autoenrollment, like SB 189. In the House it's probably going to be Rep. Davis who leads this, but it hasn't been confirmed.

Women's health coverage is also a priority; ideally continuous coverage for women, that's more realistic.

We are keeping a close eye on Medicaid managed care bills.

TMA had a conversation with Rep. Frank on MMC and he wants to be a leader on the issue and streamline the process. Representatives Frank and Kolkhorst will spearhead these efforts, Klick and Davis have also shown interest.

V. Debrief On January CHCC Lege Briefing (Laura Guerra-Cardus, 5 minutes)

[Laura Guerra-Cardus]

Quick report on attendance for our briefing. About 130 people attended, including legislative staff and advocates and stakeholders. 45 unique democrat 16 unique republicans were present. In total, we had 61 legislative offices present. If interested, email Laura to inquire on the list of who participated.

CHILDREN'S HEALTH COVERAGE COALITION
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OTA

I. Texas Uninsured Rate and Medicaid Enrollment Discussion (Melissa McChesney)

[Melissa McChesney]

The 2017 census data shows that Texas has the worst uninsured rate in the country. The rate got worse in 2017, even though it was getting better with the ACA.

Part of our priorities is improving our insured rates by improving enrollment rates in the Medicaid and CHIP programs. But we know that the anti-immigrant rhetoric coming from federal leaders has caused a chilling effect within our immigrant communities and we've heard reports of people pulling themselves out of these programs. The conversation isn't just about enrollment it's also about today's context and how that has affected our rate today.

[Refer to PowerPoint]

[Slide 1: Progress on Children's Health Coverage Reverses Course: Texas Worst in the Country]

This is Texas' uninsured rate from the census through 2017. It's always a little bit behind on insurance rates in comparison to the U.S.

We did some improvements as of 2014. We saw more significant decreases in uninsured rates post ACA, but between 2016-2017 we saw an increase, and it was the first time in a long time that we saw this increase.

[Slide 2: ~40% of uninsured kids in Texas are eligible for Medicaid or CHIP]

Not every child who is uninsured is eligible for Medicaid or chip, but 40% are. This is a very conservative estimate, so the number of eligible unenrolled kids may be higher.

If there is a child who is lawfully present, almost all types of legal forms of documentation that are not temporary can make them eligible. It is not just citizen children who are eligible for CHIP and Medicaid now.

[Laura Guerra-Cardus]

We used to have a talking point regarding this. Even if you removed all children estimated to be undocumented, Texas still had the higher rates of uninsured children.

[Anne Dunkelberg]

Yes, even without the immigrant kids out of the equation, we still have very high rates of uninsured kiddos.

[Meeting attendee]

350,000 is a conservative estimate, did you make a range?

[Anne Dunkelberg]

We use migration policy institute data sets, I can follow up with you on this.

[Slide 3: CMS Enrollment Data, Dec 2017 – October 2018]

They had being using an older data point for the 2017 number, and in Jan. 2017, TGET updated what they were reporting to CMS from some beneficiary that hadn't received full benefits. This reporting change was an indicator of the 3% drop.

There were higher enrollment rates in summer months, and then they dropped in the fall months. It seems like the uninsured rate is not going to get better in the 2018 census when we see it this year.

[Slide 4: CMS data on incoming application and new determinations in Texas]

Application data does not include renewals. The number of applications has stayed relatively steady, but we're not seeing a huge increase or decrease in the number of applications.

[Slide 5: HHSC Data, Dec 2017 – October 2018]

Data is from the same time period that we looked at. Former foster care youth is not reported online but they report to HHS since they receive benefits.

[Slide 6: Main takeaways – HHSC data]

There was also some postponement of renewals due to Harvey related issues, and that could impact attrition rates for Medicaid and CHIP, because Harvey hit a very populous part of the state. These are general trends. There is also some prenatal data, but nothing that you can look month after month that helps identify trends.

[Slide 7: HHSC – Entire Medicaid Caseload: Monthly Enrollment Jan 2014 – Oct 2018]

We've had an increase in caseload in 2017, it does look like the enrollment stayed flat, but if you look at the 2016 time period, you see a decline in enrollment post 2016.

[Slide 8: HHSC – Entire Medicaid Caseload: Average Monthly Enrollment for 2014 – 2018]

For this graph I took each calendar year and averaged the monthly enrollment number.

You can see a nice upward trend up until 2016, since then the average enrollment has gone down, that's everybody including adults.

[Slide 9: Children's Medicaid Monthly Enrollment Jan 2014 – Oct 2018]

[Slide 10: Children's Medicaid by Year: Average Monthly Enrollment for 2014 - 2018]

You can see a sharp decline that came from the ACA. In Texas those individuals were renewed on the new program.

[Slide 11: HHSC – Regular CHIP: Monthly Enrollment Jan 2014 - Oct 2018]

CHIP has also seen a decline like the other groups in 2018.

[Slide 12: HHSC – Regular CHIP: Average Monthly Enrollment Jan 2014 - Oct 2018]

Enrollment changed throughout the year, but in general there is a downward trend on the number of pregnant women.

For the adult population, and pregnant women in particular, some of these women may have been receiving insurance through ACA's marketplace. Some of the downward trend could be due to them going into the ACA marketplace

[Slide 16: HHSC – Parents and Caretakers: Average Monthly Enrollment for 2014 - 2018]

There were changes in the income requirements, and a lot of variables changed during that time. But there are some uptakes to that 140 line. It does drop a little in the 2018 time period though.

[Slide 18: HHSC Disability – Related: Monthly Enrollment Jan 2014 – Oct 2018]

We have an action item and I will follow up with our national partners to check if there's a national trend.

It is rather difficult to get disability related Medicaid for those who became newly eligible for the ACA marketplace through premium subsidies. There may be some people who chose that route to get insurance, instead of jumping the administrative loops of getting disability Medicaid. We plan to follow up with our national partners on this. You can see it is a downward trend.

[Slide 19: HHSC Data on Applications and Renewals: Monthly 2014 - 2018]

These numbers come from two cells in spreadsheets over the course of Jan 2014 to Jan 2019. You'll see a few gaps, that means the spreadsheet was missing. Updates on HHSC's website were also reflective of some of the missing data.

Clearly, there are fewer renewals year over year, starting in 2016 – 2018. Those mountain peaks represent a new cycle of applications with the peak being in the spring and summer months. Those are getting small, and we are seeing fewer and fewer renewals getting processed.

We have a bill around 12 month continuous coverage addressing this. While the data doesn't confirm, it is interesting to see renewal trends.

A few of the things we said to Gina and Diana was to start a conversation around these trends. What's the agency's perspective on the drop of the insured rate? What can we do better to keep them from decreasing?

[Gina Carter]

I don't have anything further than what you provided. From the agency's perspective, we don't know if the fear is a reason people are disenrolling.

Did y'all see any other states and see if they are seeing a decline in their caseloads? Since we are assuming it's the rhetoric. We haven't seen a policy change.

[Laura Guerra-Cardus]

Only one state showed improvement I think, while 8 states were significantly statistically lower.

[Melissa McChesney]

There seems to be a national trend.

[Anne Dunkelberg]

I don't know how our -3 percentage compares to the nation.

[Laura Guerra-Cardus]

Texas was one of the fastest states whose uninsured rate increased.

[Anne Dunkelberg]

Who did you ask about the chilling effect on immigrant communities?

[Gina Carter]

Rep. Meza

[Anne Dunkelberg]

I don't know how Texas' chilling effects compares to other states, we probably don't even have the ability to go into other states' data and try to identify the US citizen children who have a non-US citizen in their household. But, 26% of children in Texas have a non-citizen member in their household, so we will be seeing a chilling effect here in Texas.

Yes we haven't seen a policy change, but the public charge rule has been out there for over a year, so anybody you talk to that is a health provider will tell you that they've had people disenroll.

We feel it's important to start a conversation about the chilling effect issue and hope that we can look at the agency playing a role and being part of the education process about what the rules are that are applicable. We've already started to come up with the materials for these families. We just wanted to make sure we are having this conversation.

[Laura Guerra- Cardus]

For our coalition, the renewal data is concerning and makes me concerned that the chilling effect is playing a role in this. It's important for our collation to work on those concepts.

[Anne Dunkelberg]

We don't expect miracles on this, but we want to start the conversation.

[Gina Carter]

I got the message and will take it back to the agency.

[Melissa McChesney]

I do think for me, when pulling the renewal data, it was especially surprising to see the decrease in our enrollment. With our renewals really dropping, I'd love to, in the future, get your thought on why that trend has started.

[Gina Carter]

Did you include data from the MEPD programs on your chart? Only all Texas works programs?

[Melissa McChesney] The data does not include MEPD because the data online excludes those populations. If people have additional questions I'd be happy to follow up via email.

II. Office of Ombudsman Update (Paige Marsala)

[Paige Marsala]

[Refer to Slide 2]

There were 65,000 total contacts per months in this fiscal year.

[Refer to Slide 4]

There was an interesting increase in Oct. – Nov. and the usual dip during the holidays that then comes back to life in January. We looked specifically if there was any out of the normal increases in contacts for any specific reason for the October numbers, and didn't necessarily find anything out of the norm.

Application/Case denied was top reason for contact during those months. A lot of the complaints about application/case denied were due to private insured and failures for consumers to pay enrollment fee.

[Refer to Slide 5]

[Refer to Slide 6]

You have your typical holiday decrease that goes back in January. This could be due to cost of living increase.

[Refer to Slide 7]

[Refer to Slide 8]

You have a holiday decrease that jumps back up on January. We did some further digging to see why it was higher in Jan, but there wasn't any kind of trend.

[Refer to Slide 9]

You can also see the holiday dip.

[Refer to Slide 10]

You can see the holiday dip and coming back up in January.

[Refer to Slide 11]

Same holiday dip pattern.

[Refer to Slide 12]

[Refer to Slide 14]

Clarisse couldn't be here, but if you have questions email me and I'll go ahead and follow up with her.

[Refer to Slide 15]

[Refer to Slide 16]

We've been working on a quarterly published report that is going to come out around March. It's going to be for the first quarter of 2019 (Sept – Nov). We're going to get feedback from Medicaid Services. It will be a 30 page report that includes top complaints, inquiry reasons, by service areas, by managed care delivery model, as well as trends, and recommendations we have for preventing those barriers.

The trends that are to be highlighted include:

- Access to prescription (top reason for complaints)
    - When client goes to pharmacy to run a prescription, the individual is not showing active with the health plan, which has to do with their daily files. Health plans don't always upload daily files the same day. They are required to report monthly within the end of the month. We'll have recommendations for plans to upload daily files daily.
        - [Anne Dunkelberg]
          It's doable,

        - [Laura Guerra-Cardus]
          It's doable but not in the contracts.
    - When clients have other health insurance plans coming up in their health insurance it prevents them from having access to prescription
        - There's nothing wrong with the interfaces, the problem is that the information is being added to their care. We will be providing recommendations to doing a better job to communicate with clients.
- Legislative Bills: Many are related to Medicaid. Our senior policy analyst is on top of this. We've been tracking:
    - Sarah Davis' Bill: Bill that moves ECI kids into STAR Kids or STAR Health. It suggests to have an ombudsman for the ECI children and Ombudsman for the providers of ECI services.
    - We are also closely watching one of the agency's exceptional items: Fair hearings appeal process. IRO (independent review) could be an opportunity to have medical professionals provide input. Fair hearing will still be an option though.
    - Also tracking a bill that would allow health plans to have their own drug formularies.
    - Also tracking a bill to give parents access to opt out of STAR Health if they care for children with disabilities
    - Also tracking a bill on preventative services for adults with disabilities.

[Anne Dunkelberg]

During a meeting yesterday, we we're talking to a legislator about Medicaid managed care legislation. I think you would benefit from having someone explain to them how the ombudsman division works. They had a notion that there were a lot of ombudsman out there, but I know that ombudsman are all together. Do you have access to more granularity, when it says access to health services and support?

[Paige Marsala]

We have the ability to dig through and read summaries. We're looking at that because I know that it is vague. We have more than 30 complaint codes, and it's a tricky game. You want to be as granulate as you can but you don't want to overwhelm.

[Anne Dunkelberg]

It's important to figure whether the problem is that "I can't get my wheelchair replaced" vs. "there's not assistance available".

[Paige Marsala]

I'll let the coalition know when the quarterly report is posted.

[Meeting adjourned at 2:00 pm]

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Tracking Quality of Medicaid Managed Care

Texas Children's Health Coverage Coalition

February 15, 2019

Tricia Brooks

Medicaid and Quality Oversight

State Managed Care Quality Strategy

- A written quality strategy for assessing and improving the quality of managed care
- Provides comprehensive details about the state's MC programs and its oversight and quality assurance
- Must be reviewed and updated after significant changes (and no less than every 3 years)
- Review process includes public comments and feedback from CMS
  - State responsiveness to EQR recommendations
  - Evaluation of effectiveness of prior quality strategy

Strategy must reflect state's goals and objectives and how the state will:

- Measure and improve quality
- Define network adequacy
- Arrange for independent EQR review
- Address health disparities
- Ensure quality through transitions
- Identify individuals with special health care needs or who need LTSS
- Impose sanctions on MCOs that violate federal law
- Define significant change that requires that the strategy be updated
- More (see page 7 of the brief linked below)

Review strategy, write comments, and recommend performance measures, PIPs, EQR review activities, and better disparities reporting to be required in all state managed care contracts.

Quality Assessment & Performance Improvement Program (QAPI)

- State contracts must require managed care plans to establish an ongoing comprehensive QAPI
- Basic Elements of QAPI:
  - Performance Improvement Projects (detail next slide)
  - Collection and submission of performance data
  - Mechanisms to:
    - Detect both underutilization and overutilization
    - Assess quality/appropriateness of care specially for individuals with special health care needs, individuals receiving LTSS, including home/community-based waivers

Performance Improvement Projects (PIPs)

- Use objective quality indicators
- Implement interventions to achieve improvement in access to services and quality of care
- Evaluate the effectiveness of interventions based on the quality indicators
- Include activities to increase/sustain improvements in health outcomes and enrollee satisfaction
- Focus on clinical and non-clinical areas
- At least annual reporting

Performance Measures

- State must identify the standard performance measures to be reported annually
- Not limited to the Child Core or Adult Core Sets of Quality Indicators but allows for state to state comparison

Options for Reporting

- Plan calculates and reports based on standard measures
- Plan submits data for state to calculate the measures
- Combination of these

QAPI Program Review

- State must review the impact and effectiveness of each plan's QAPI program at least annually
- Review must include the plan's performance on required measures, outcomes and trended results of PIPs, and community integration for LTSS
- States may require a plan to evaluate the impact and effectiveness of its own QAPI

External Quality Review: A Key Quality Tool

- Long standing requirement
- State is required to competitively contract with EQRO(s) that meet federal standards
- Activities must follow detailed federal protocols
- Has not always lived up to potential; but stronger with new rules
  - Improve data transparency and timeliness
  - Hold MC plans accountable to performance expectations
  - Provide states with financial incentives to innovate quality activities

EQR Activities

Mandatory Activities	Optional Activities
• Validation of PIPs • Validation of required performance measures • Review of compliance with managed care and QAPI standards every 3 years • Validation of network adequacy every 12 months	• Validation of encounter data • Administration or validation of consumer/provider surveys • Calculation of additional performance measures • Conduct additional PIPs • Conduct special studies • Assist with QRS

Encourage the state to adopt optional activities to ensure that quality review is comprehensive and conducted independently.

Direct Testing of Network Adequacy

- Active evaluation of plan compliance, such as conducting a secret shopper survey as opposed to a desk review of a plan's policies and provider directories
- Not mandated but best practice

Urge the state to use EQR for direct testing to validate network adequacy.

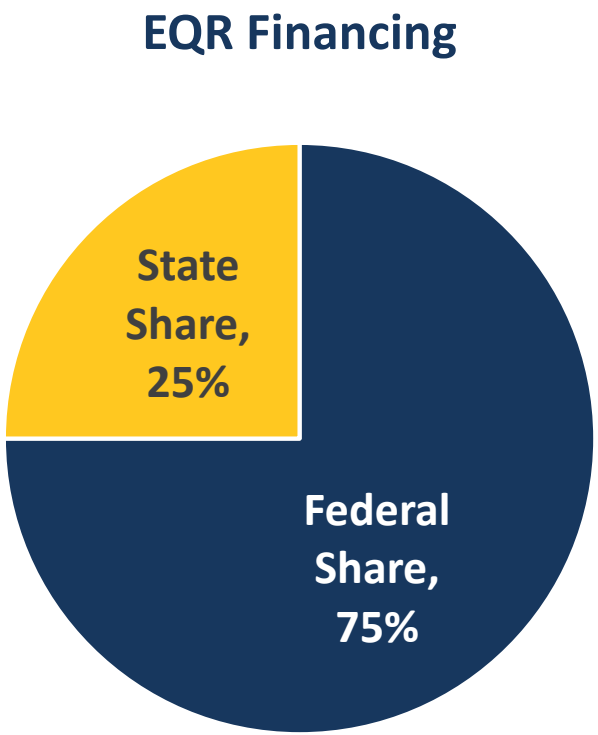
*HHS OIG, *State Standards for Access to Care in Medicaid Managed Care*, 15-16 (Sept. 2014).

EQR Results

- EQR reports can provide valuable data about plan performance
  - Including implementation of prior recommendations
- States must contract with EQRO to produce the annual report
- States cannot substantively revise the content without evidence of error or omission
- Reports must be:
  - Filed by April 30 of each year
  - Posted on the state website
  - Provided in paper or alternative formats upon request

Federal Financial Participation (FMAP)

- Previously, an enhanced federal match of 75% was allowed for all EQR activities conducted by EQROs
- The new rule reinterprets the law and only permits the enhanced match as it applies to EQR activities associated with MCOs



Creative Ways to Use EQR Financial Incentives

- Test a new measure or a consumer survey
- Direct testing of encounter data
- Stratification of quality data to examine health disparities
- Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

Additional Resources

- For a primer on the basics, background and status of quality measurement and improvement in Medicaid and CHIP, see Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders.
- CCF and NHeLP's brief: Medicaid/CHIP Managed Care Regulations: Assuring Quality
- For more information on Medicaid MC EQR, see NHeLP's External Quality Review: An Overview.

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Quality and Performance Improvement Efforts

Children's Health Coverage Coalition
February 15, 2019

External Quality Review

Federal regulations require external quality review of state Medicaid managed care programs

- Validation of MCOs' performance improvement projects,
- Validation of performance measures, and
- Determination of MCOs' compliance with certain federal Medicaid managed care regulations.
- Validation of MCO and dental maintenance organization (DMO) network adequacy

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Quality Measures

Used to track and monitor program and health plan performance

- Healthcare Effectiveness Data and Information Set (HEDIS)
- 3M Potentially Preventable Events (PPEs)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) member surveys
- Agency for Healthcare Research and Quality (AHRQ) - Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs)
- National Core Indicators-Aging and Disabilities (NCI-AD) Survey

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Quality Initiatives

Assessing and improving managed care quality

- Medical and Dental Pay-for-Quality (P4Q)
- Performance Improvement Projects (PIPs)
- MCO Report Cards
- Performance Indicator Dashboards
- Network Adequacy and Appointment Availability
- Quality Assessment and Performance Improvement Programs (QAPIs)
- Administrative Interviews
- CMS Core Measure Reporting

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Health and Human Services

Resources

Where you can find additional information

Texas Healthcare Learning Collaborative Portal:

https://thlcportal.com

HHS Quality Webpage:

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement

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Services

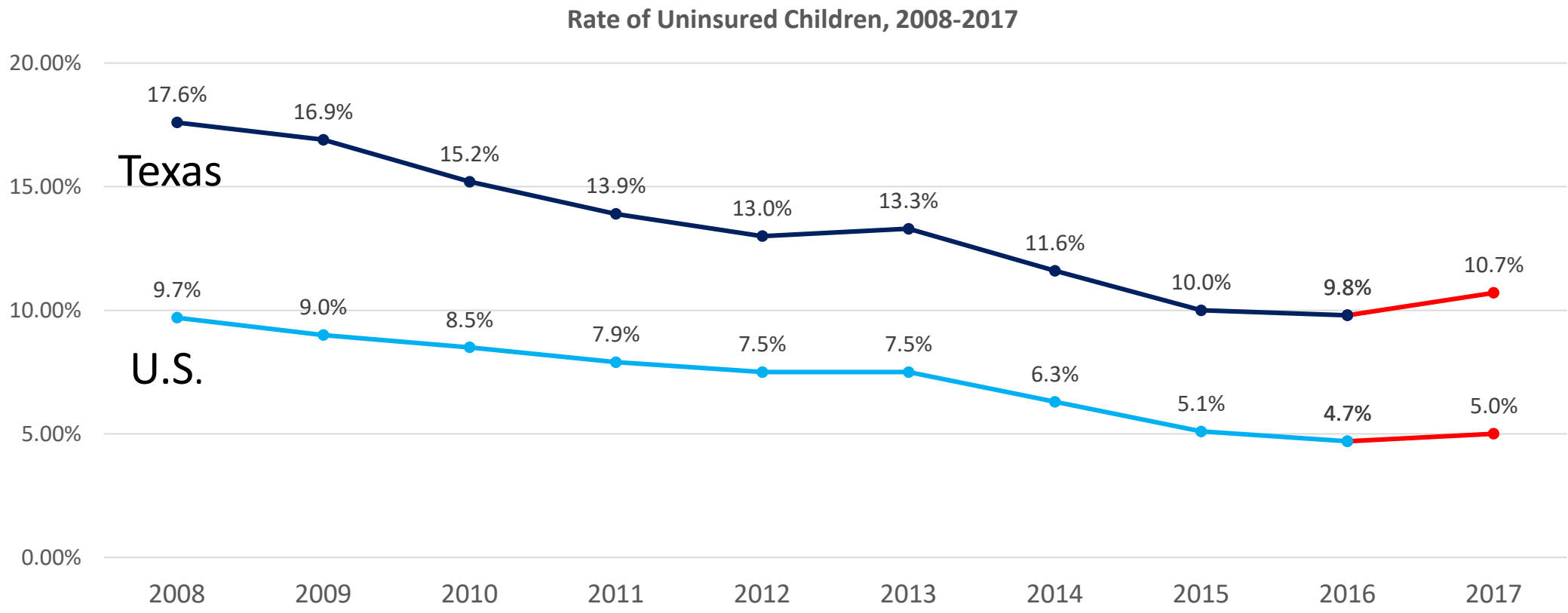
Thank you

Denbigh Shelton

Denbigh.Shelton@hhsc.state.tx.us

Progress on Children's Health Coverage Reverses Course: Texas Worst in the Country

In 2017, for the first time since ACA was implemented, there was a significant increase in uninsured children.



~40% of uninsured kids in Texas are Eligible for Medicaid or CHIP

According to the US Census, in 2017 roughly 462,000 of our 835,000 uninsured kids are below 200% federal poverty income.

When we reduce that number to remove any immigrant children who are not eligible for Medicaid or CHIP, **an estimated 350,000 Texas kids are eligible but are not enrolled.**

Sources:

- https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html ; Table HI-10
- Number and Percent of Children Under 19 Below 200% of Poverty by Health Insurance Coverage and State: 2017
- https://www.migrationpolicy.org/data/state-profiles/state/demographics/TX
- https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/TX

CMS Enrollment Data
Dec 2017 – Oct 2018

All

State	State Expanded Medicaid	Total Medicaid and CHIP Enrollment, December 2017 (Preliminary)*	Total Medicaid and CHIP Enrollment, October 2018 (Preliminary)	% Change December 2017 to October 2018	Number Difference December 2017 to October 2018
Texas	N	4,446,935	4,333,994	**-3%**	**-112,941**

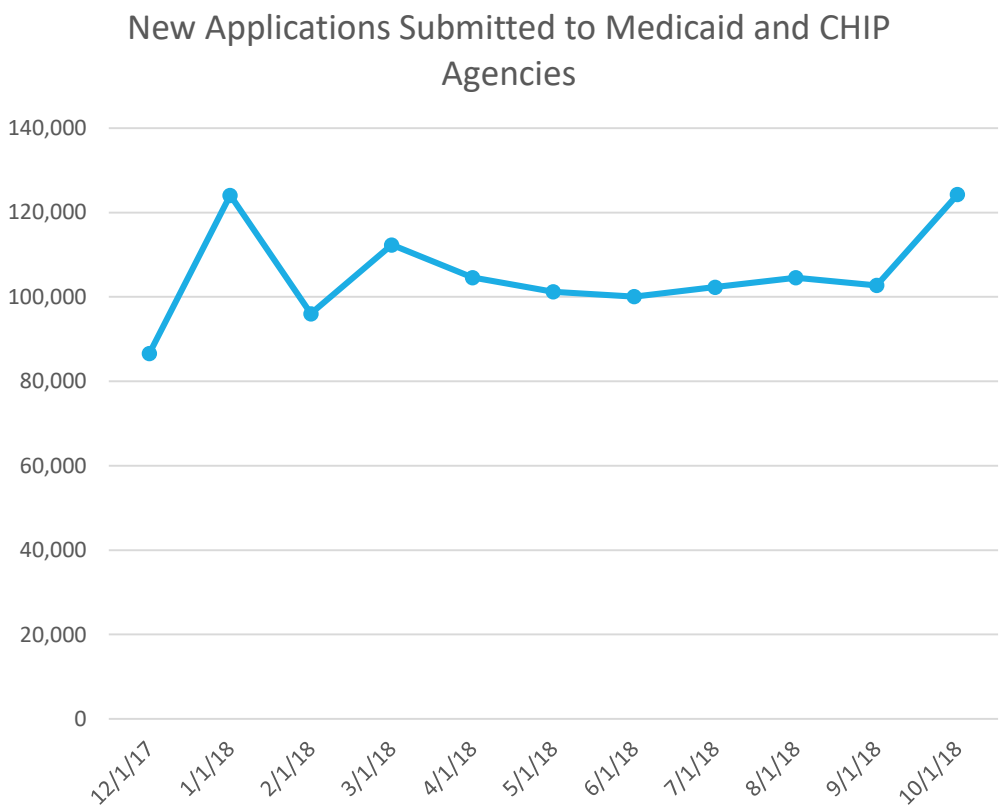
Children

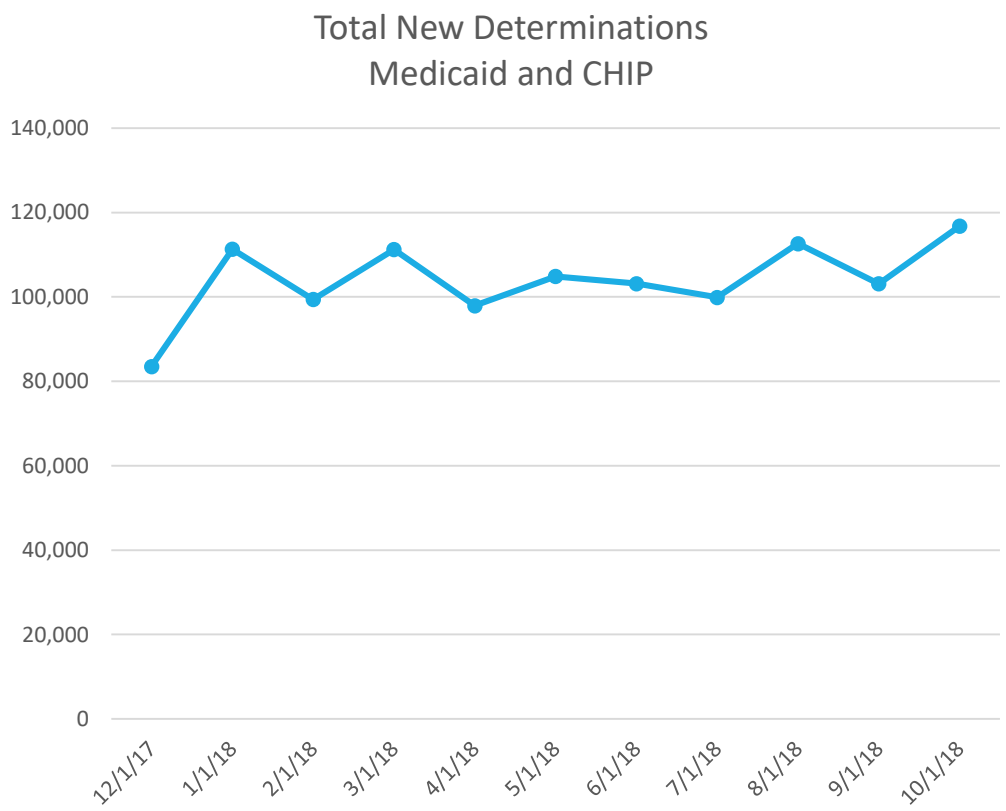
State	State Expanded Medicaid	Medicaid and CHIP Child Enrollment, December 2017 (Preliminary)	Medicaid and CHIP Child Enrollment, October 2018 (Preliminary)	% Change December 2017 to October 2018	Number Difference December 2017 to October 2018
Texas	N	3,529,641	3,422,390	**-3%**	**-107,251**

Texas' Enrollment in Medicaid and CHIP dropped for children and in the general population in 2018.

CMS Data on Incoming Application and New Determinations in Texas

(All ages. This should not include renewals.)





Based on this data, decline in enrollment would seem to be a result of fewer renewals not a reduction in applications.

HHSC Data
Dec 2017 – Oct 2018

All

Month	All Medicaid and CHIP Caseload	Change from Previous Month
Oct-18	4,376,573	5,723
Sep-18	4,370,851	(4,472)
Aug-18	4,375,322	(495)
Jul-18	4,375,817	413
Jun-18	4,375,404	(21,681)
May-18	4,397,086	(14,321)
Apr-18	4,411,407	(18,974)
Mar-18	4,430,381	(17,537)
Feb-18	4,447,918	(22,485)
Jan-18	4,470,403	(9,554)
Dec-17	4,479,957	

Overall
(103,384)
a decrease of 2.38%

Kids

Total CMA & CHIP	Change from Previous Month
3,306,443	5,442
3,301,001	-2,741
3,303,741	882
3,302,860	-3,022
3,305,882	-18,694
3,324,576	-13,396
3,337,972	-20,389
3,358,361	-14,105
3,372,466	-18,176
3,390,642	-13,979
3,404,621	

Overall
(98,178)
decrease of 2.88%

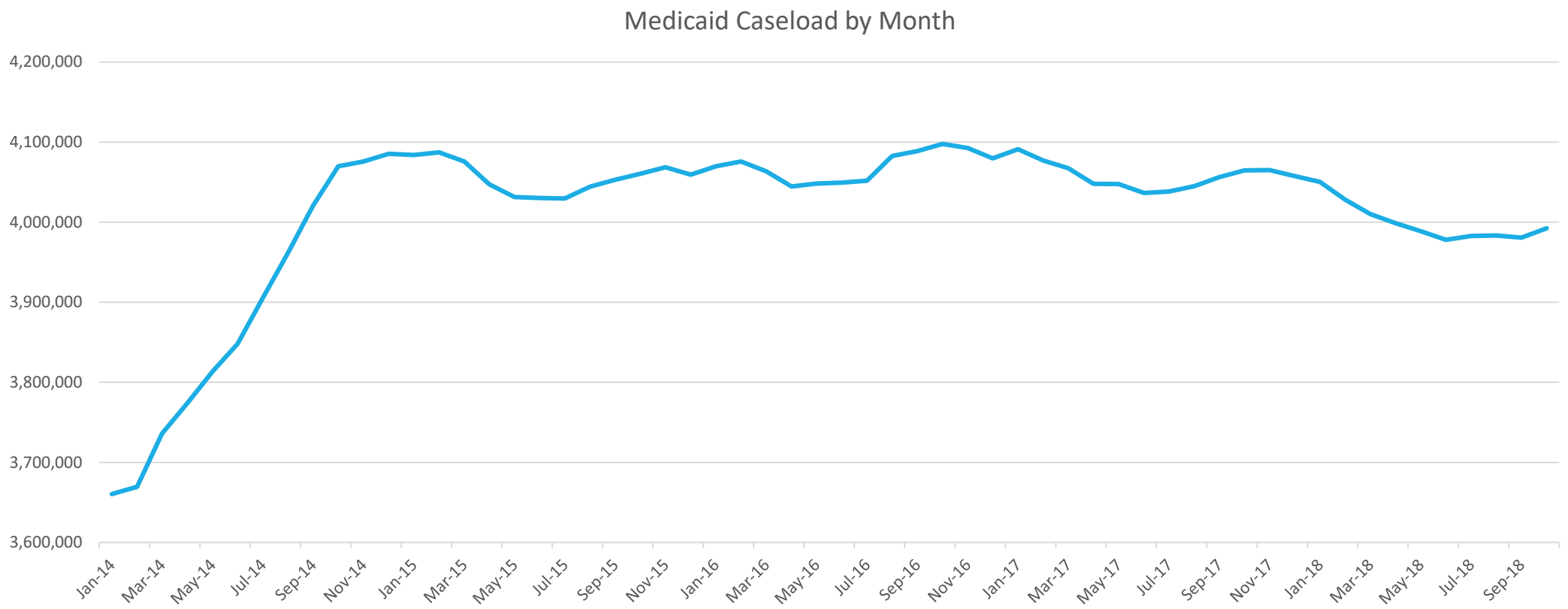
- While the enrollment data reported by CMS is not apples to apples with this data the numbers are close and the decline trend tracks with both data sets.
- HHSC data used for this presentation is available at: https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics

Main Takeaways – HHSC Data

1. Overall Medicaid caseload increased in 2014 due to ACA but has trended downward in recent years.
2. Due to income standard changes from the ACA **that shifted kids from CHIP to Medicaid,** CHIP enrollment dropped significantly in 2014 and has trended upward since.
   - Note: Postponement of renewals by HHSC in late 2017 (amid the federal CHIP funding fight) could mask any enrollment decline from 2017-2018.
3. Aged and Medicare-Related enrollment goes up and down throughout each year but overall does not seem to be trending downward.
4. Former foster-care youth and CHIP-P are not included in posted data.

HHSC – Entire Medicaid Caseload

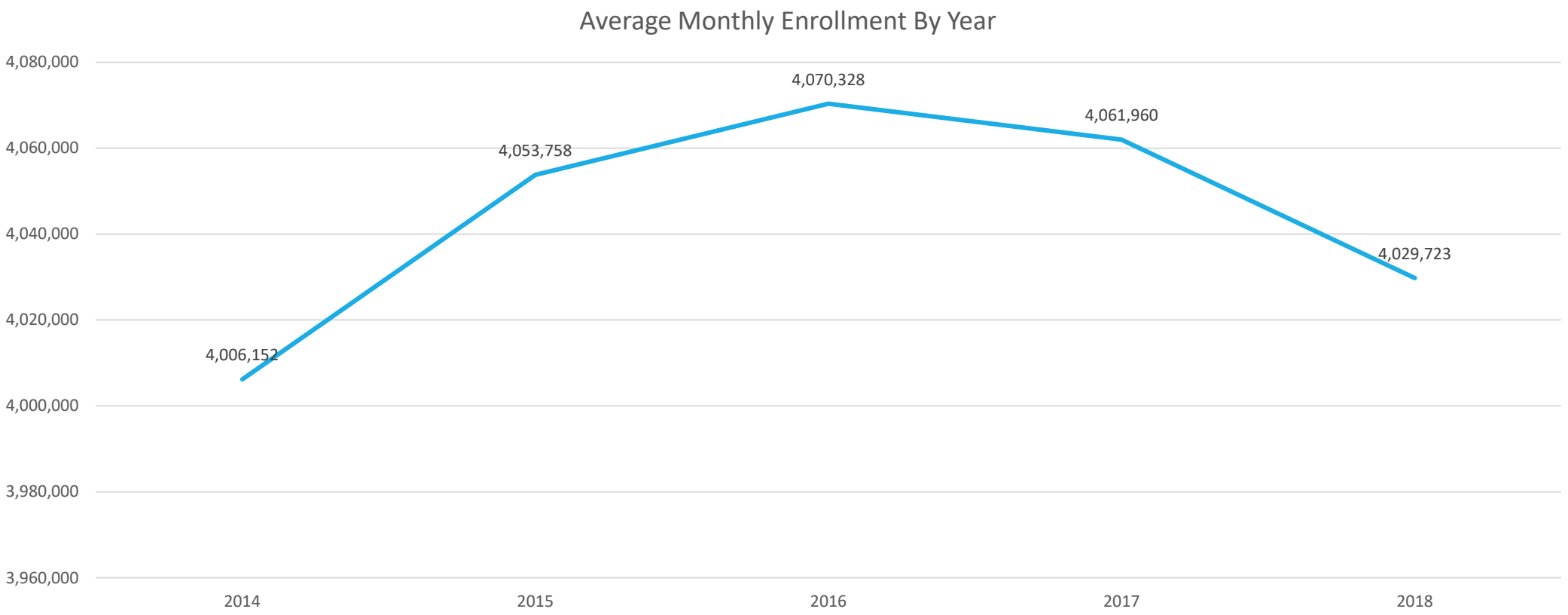
Monthly Enrollment Jan 2014 – Oct 2018



Overall Medicaid caseload increased in 2014 due to ACA but has trended downward in recent years.

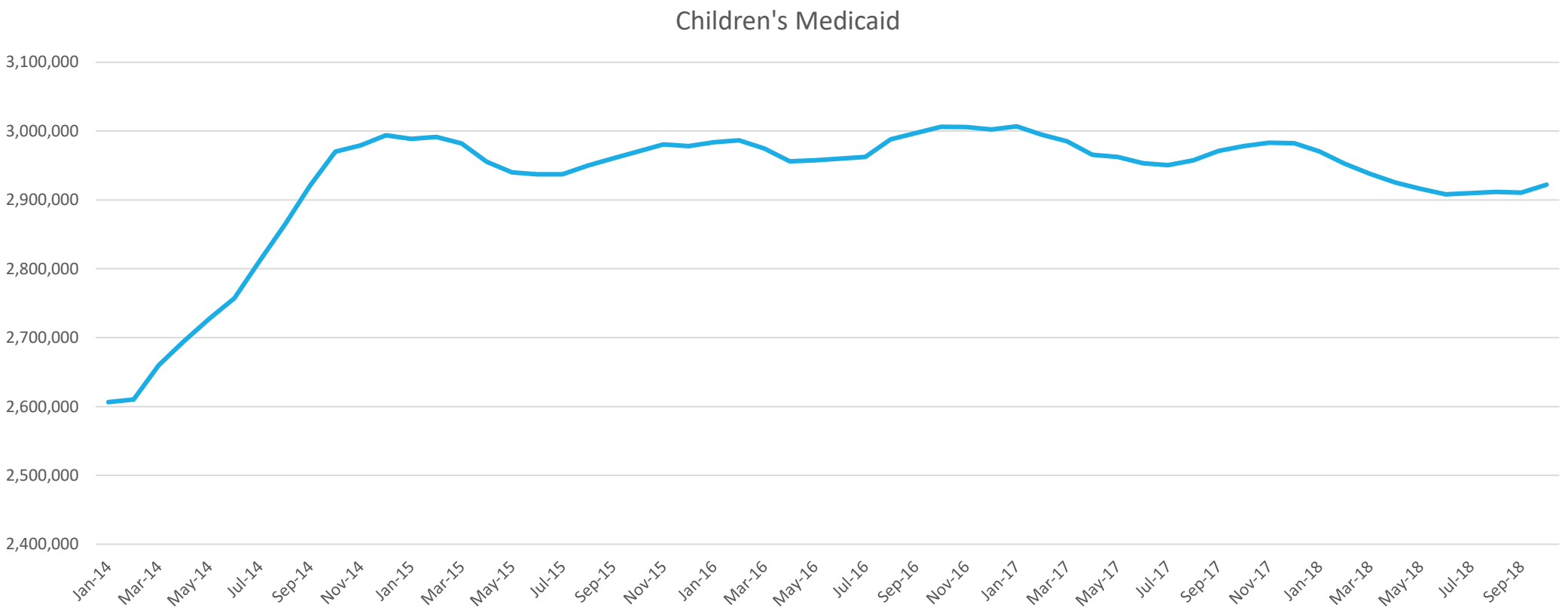
HHSC – Entire Medicaid Caseload

Average Monthly Enrollment for 2014 – 2018



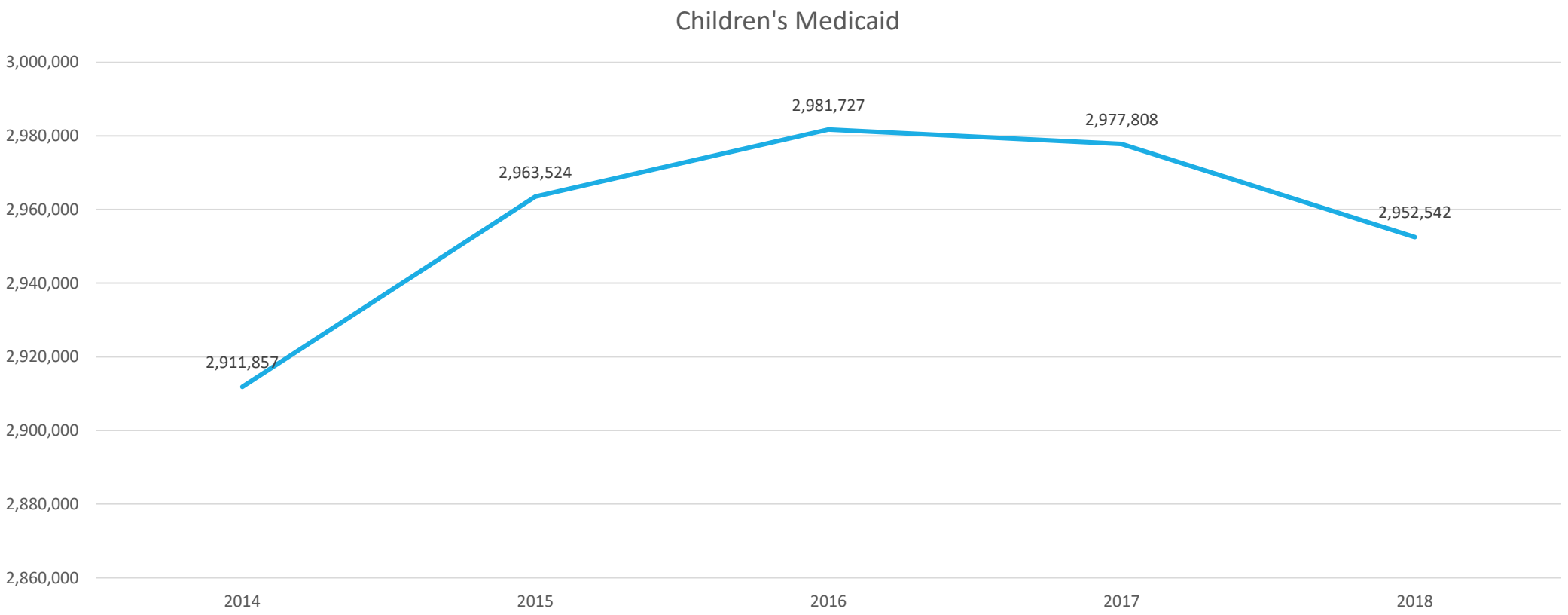
HHSC – Children's Medicaid

Monthly Enrollment Jan 2014 – Oct 2018



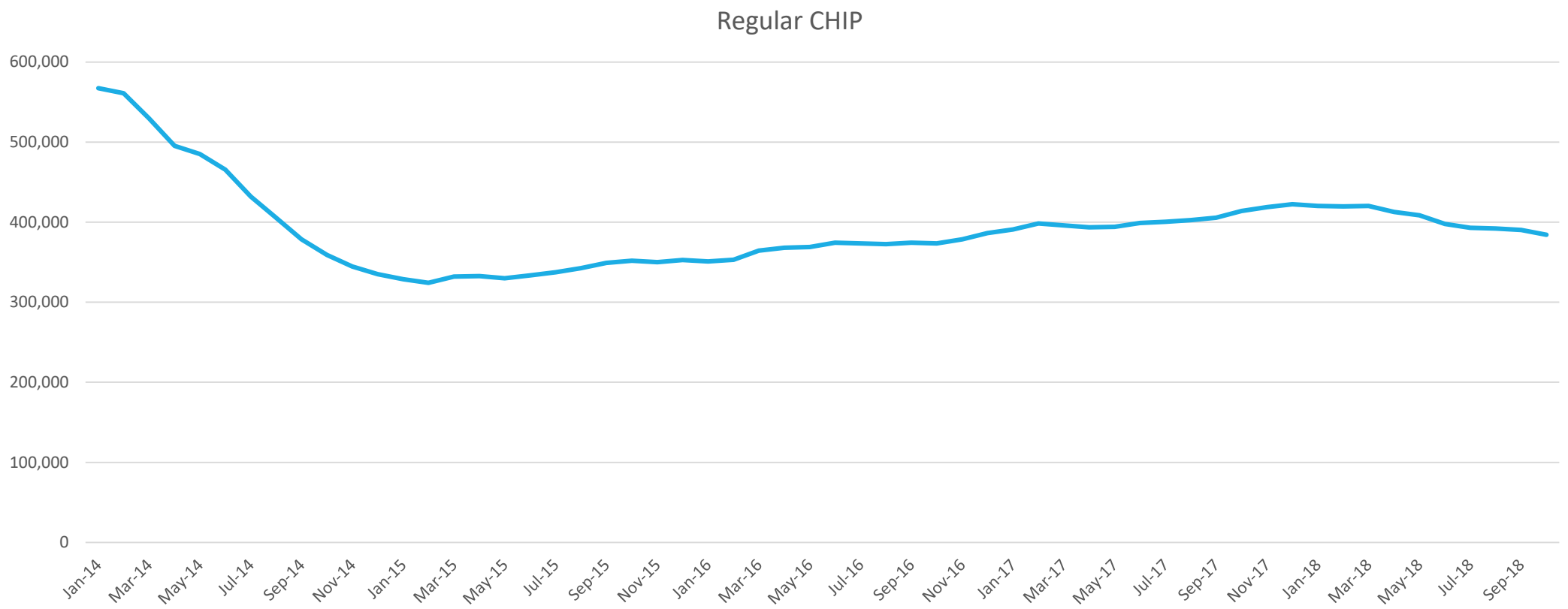
HHSC – Children's Medicaid by Year

Average Monthly Enrollment for 2014 – 2018



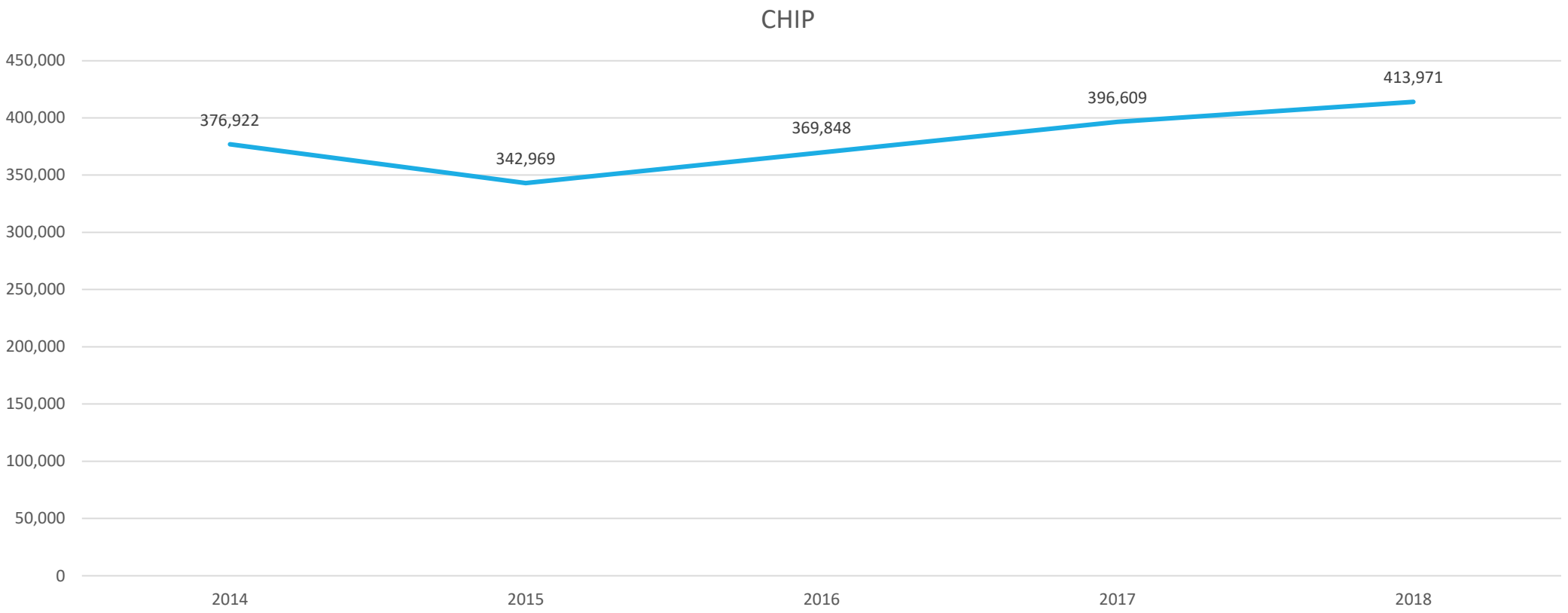
HHSC – Regular CHIP

Monthly Enrollment Jan 2014 – Oct 2018



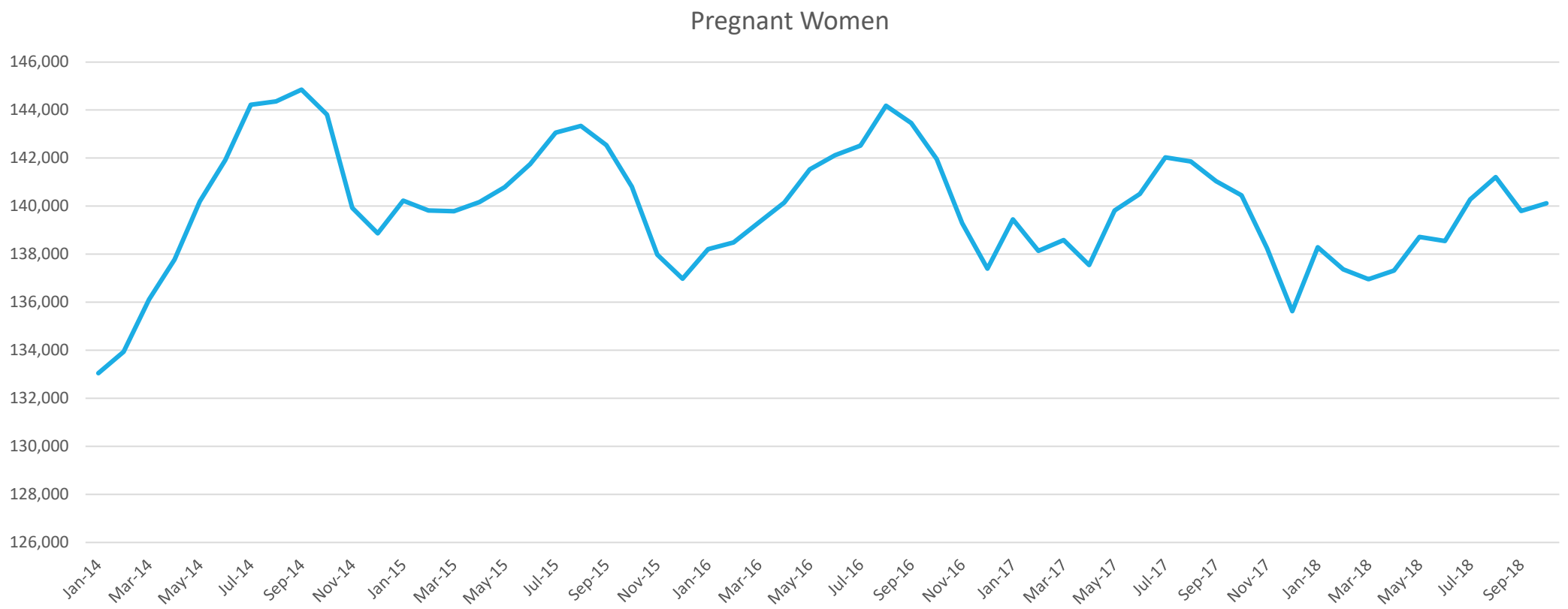
HHSC – Regular CHIP

Average Monthly Enrollment for 2014 – 2018



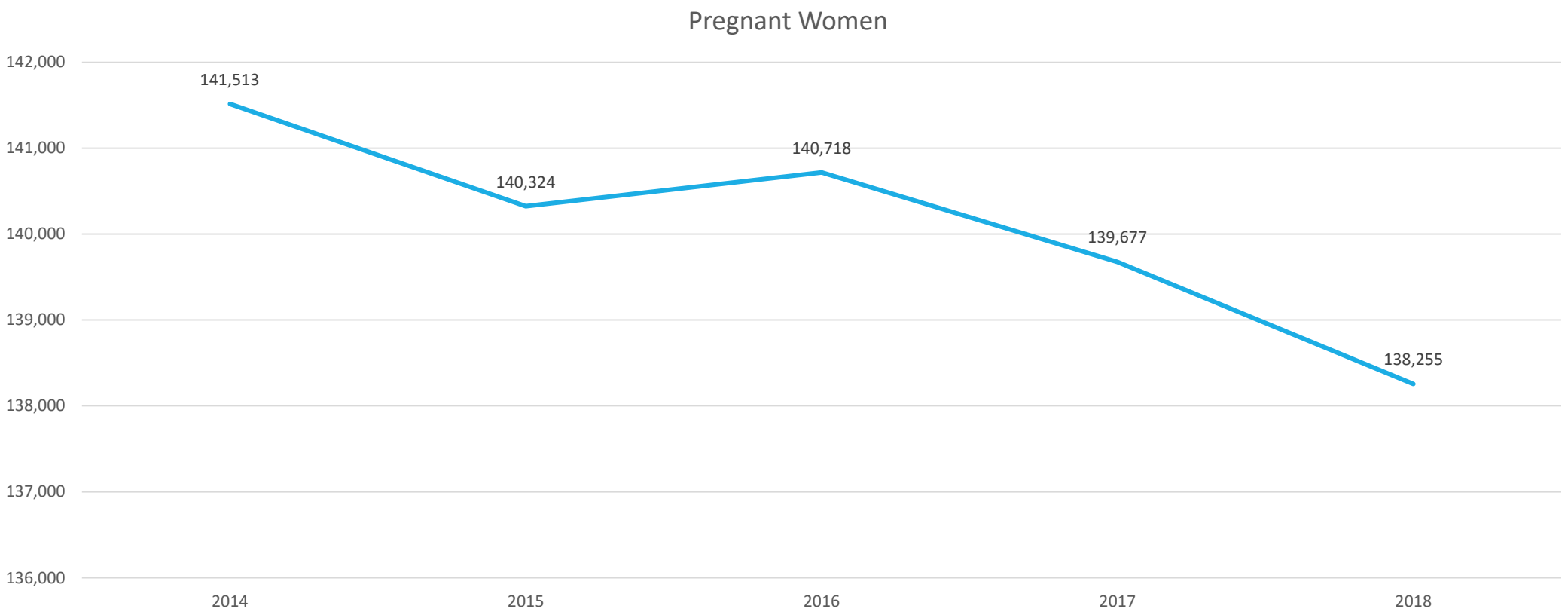
HHSC – Pregnant Women

Monthly Enrollment Jan 2014 – Oct 2018



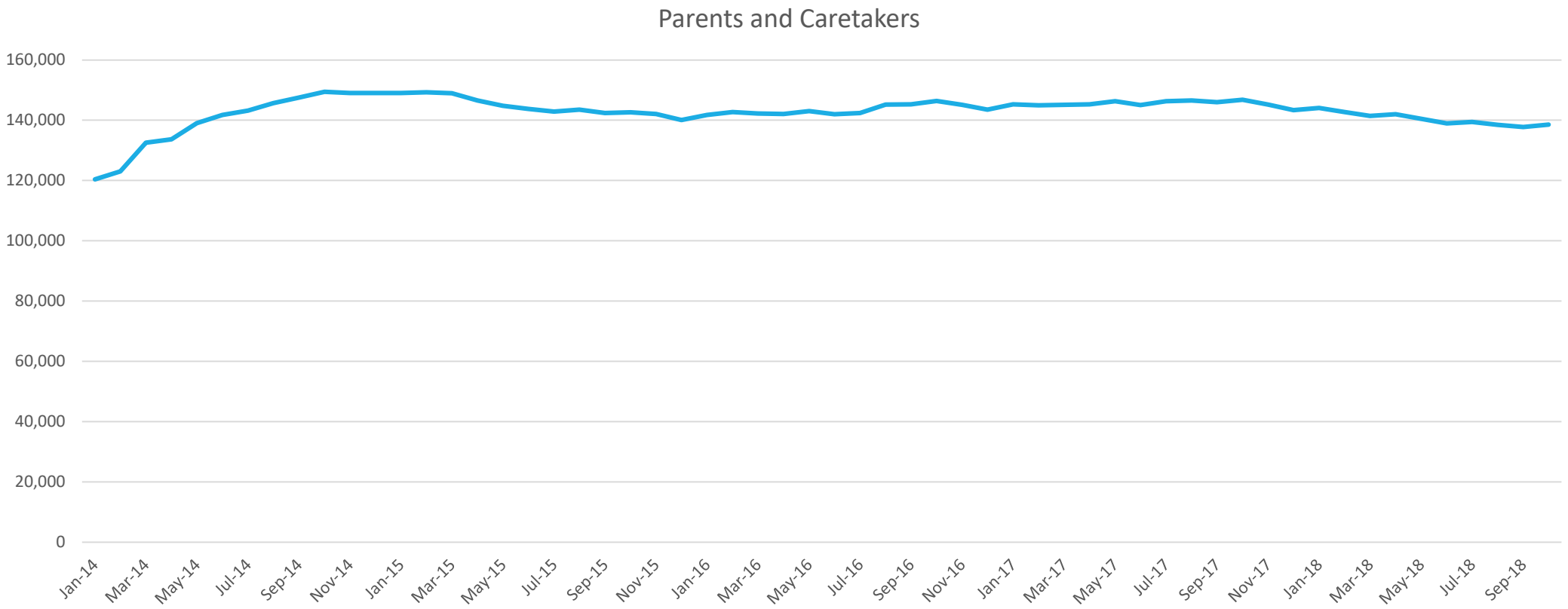
HHSC – Pregnant Women

Average Monthly Enrollment for 2014 – 2018



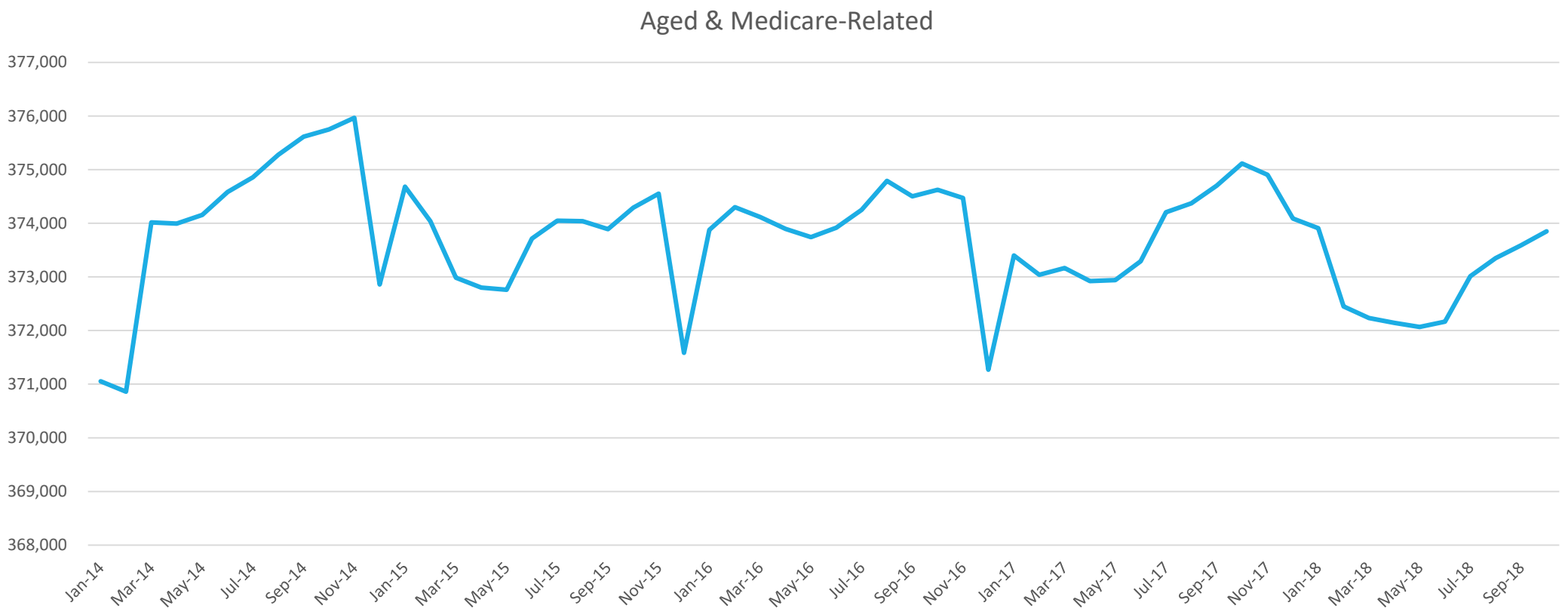
HHSC – Parents and Caretakers

Monthly Enrollment Jan 2014 – Oct 2018



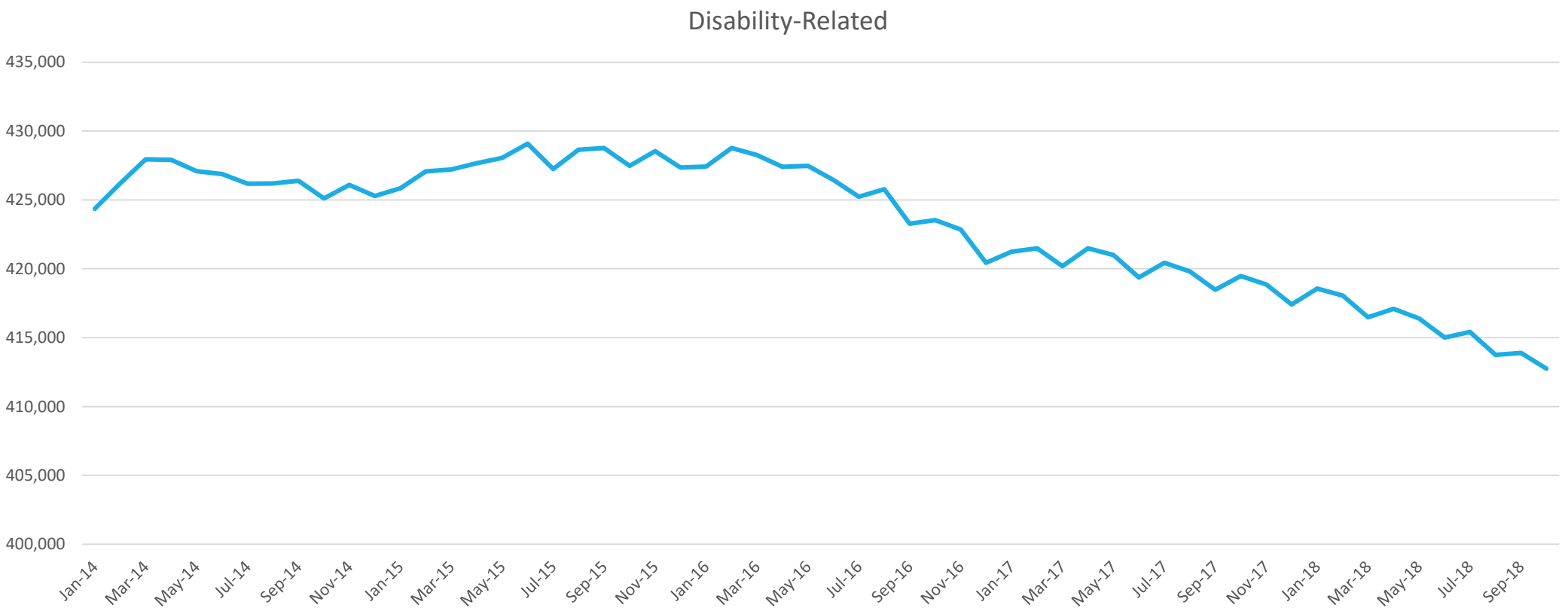
HHSC – Aged & Medicare-Related

Monthly Enrollment Jan 2014 – Oct 2018



HHSC – Disability-Related

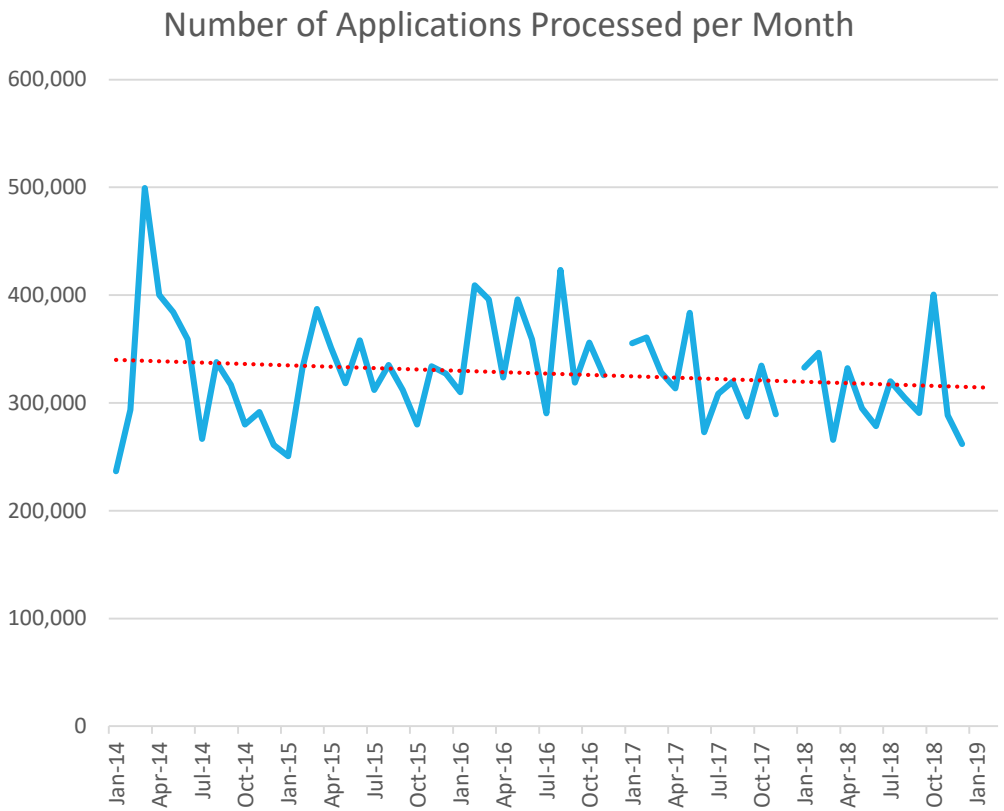
Monthly Enrollment Jan 2014 – Oct 2018

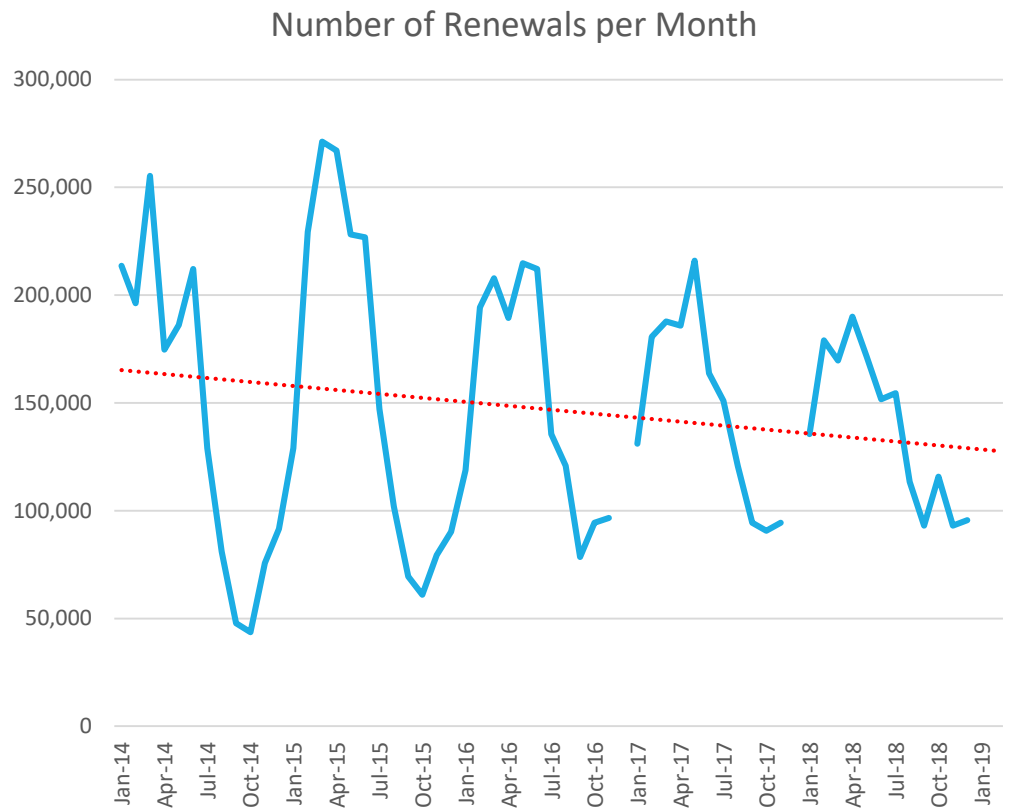


HHSC Data on Applications and Renewals*

Monthly 2014 – 2018

*Includes all programs except for MEPD.





The decline in enrollment would appear to be driven by a reduction in renewals as opposed to applications.

HHS Office of the Ombudsman Update

Presented to
CHC Coalition
February 15, 2019

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Total Ombudsman Contacts for September 2018 – January 2019

- Complaints – 10,207
- Inquiries – 21,906

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Contact Volumes and Top Three Reasons for Contact by Program Type September 2018 – January 2019

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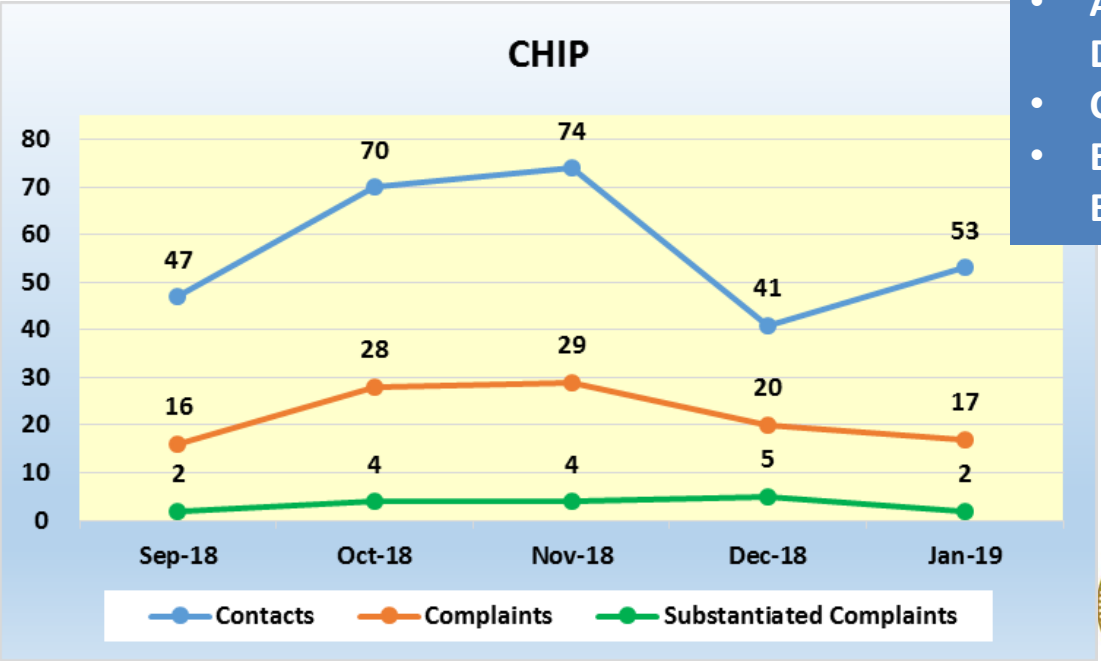
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – CHIP

- Application/Case Denied
- Check Status
- Explanation of Benefits/Policy

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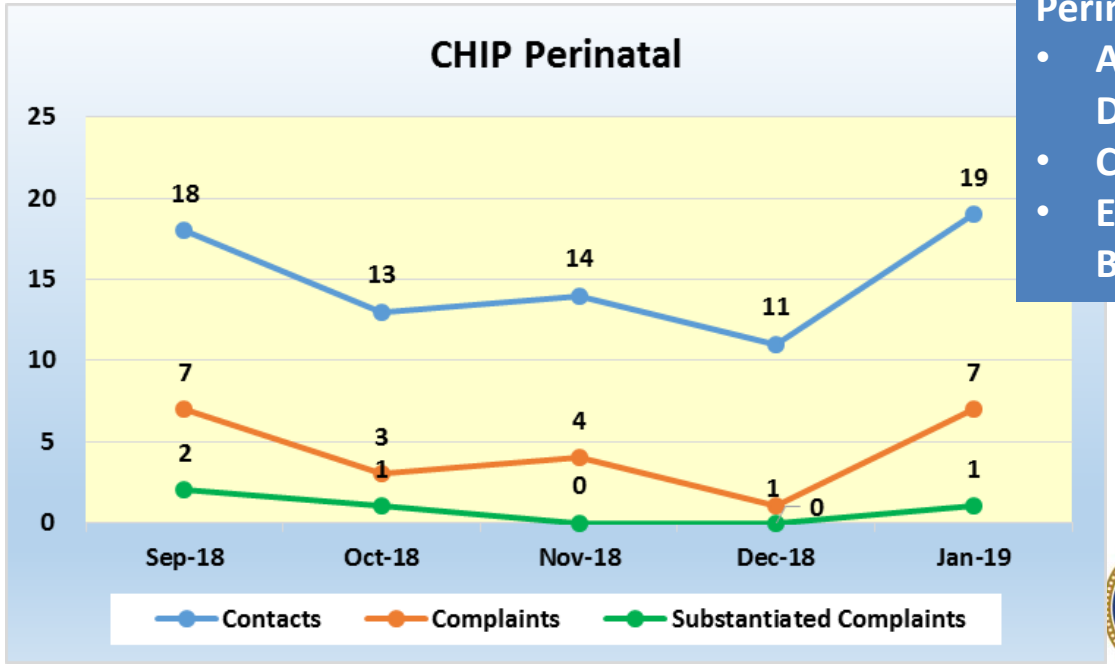
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – CHIP - Perinatal

- Application/Case Denied
- Check Status
- Explanation of Benefits/Policy

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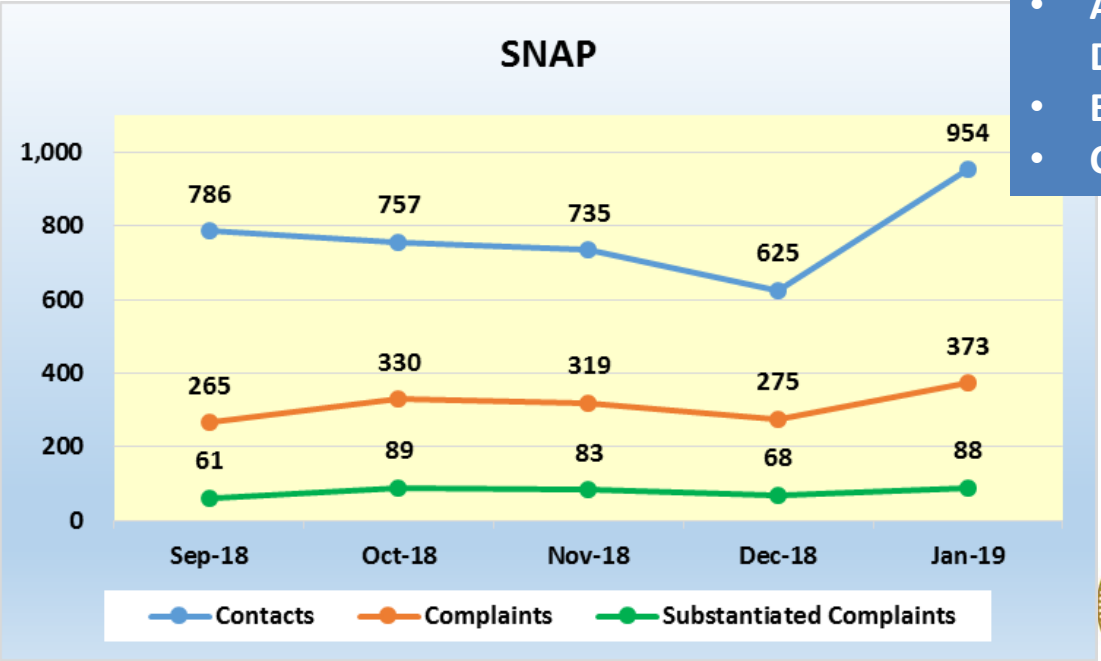
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – SNAP

- Application/Case Denied
- Benefit Amount
- Check Status

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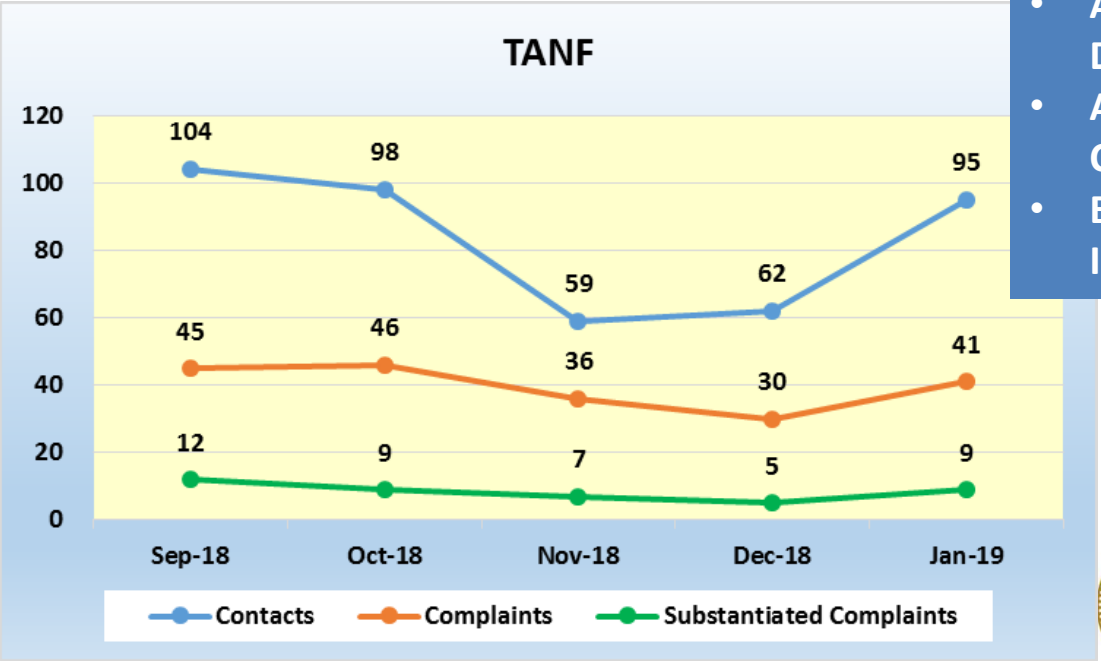
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – TANF

- Application/Case Denied
- Application Not Completed
- Benefits Not Issued/Not Received

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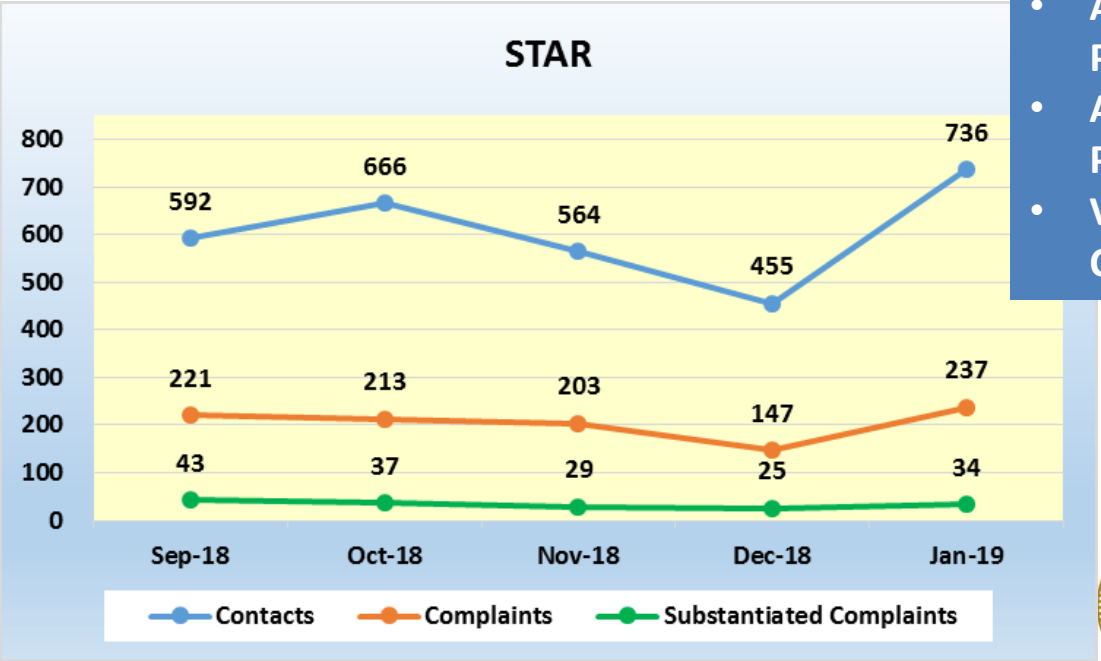
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – STAR

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

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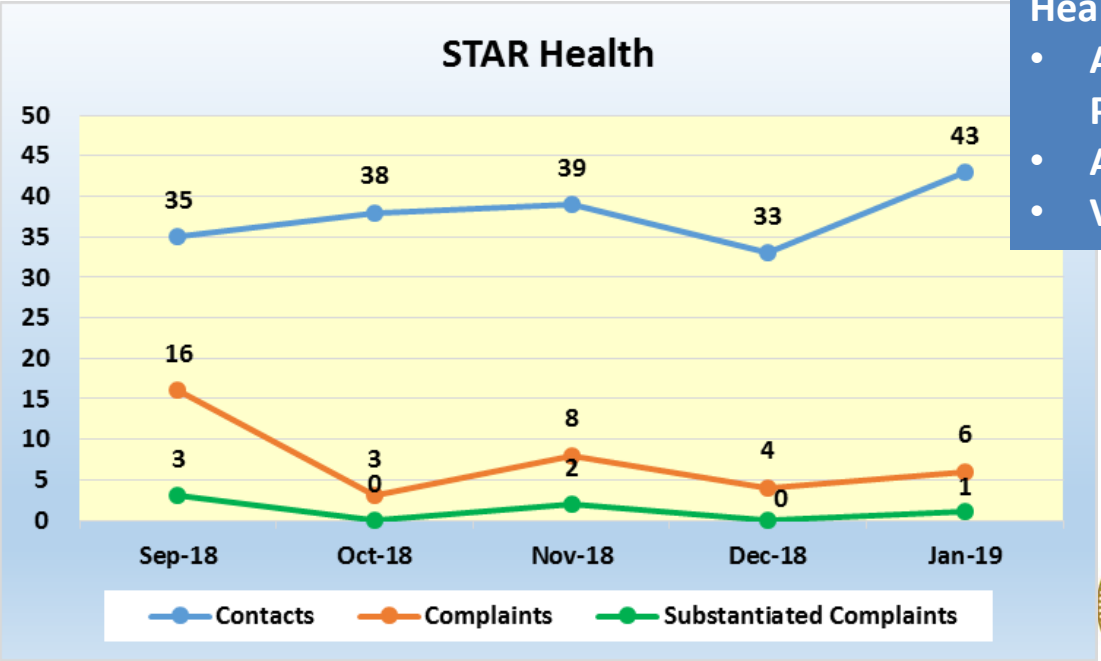
Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – STAR Health

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

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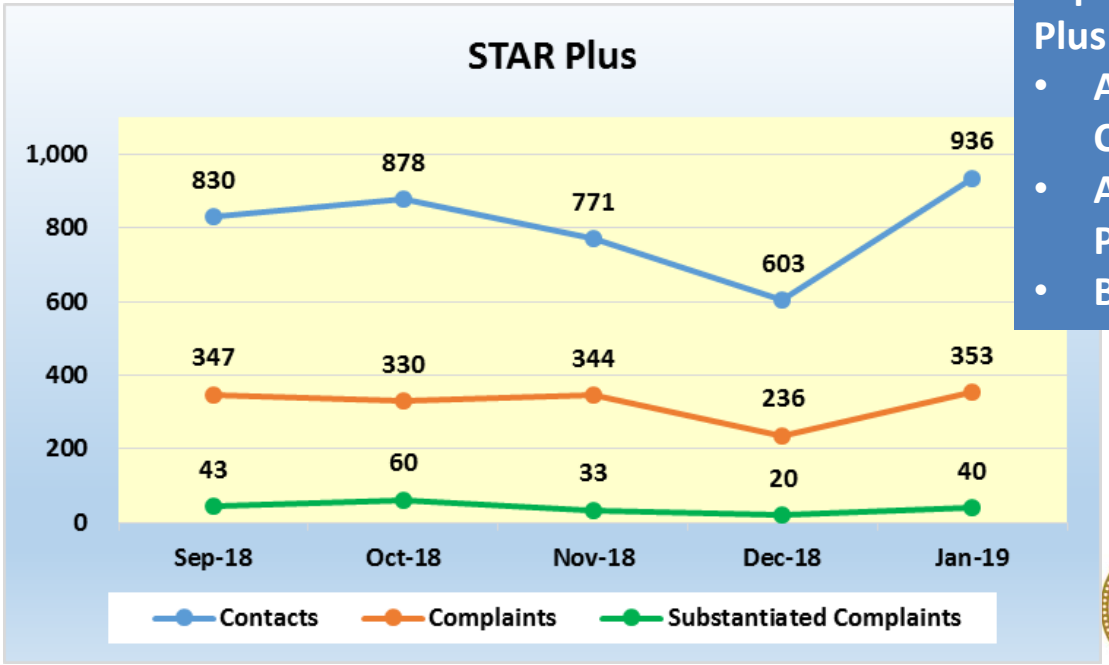
Contact Volumes by Program Type Sept. 2018 – Jan. 2019



Top 3 Contacts – STAR Plus

- Access to Long Term Care
- Access to Prescriptions
- Billing Issues

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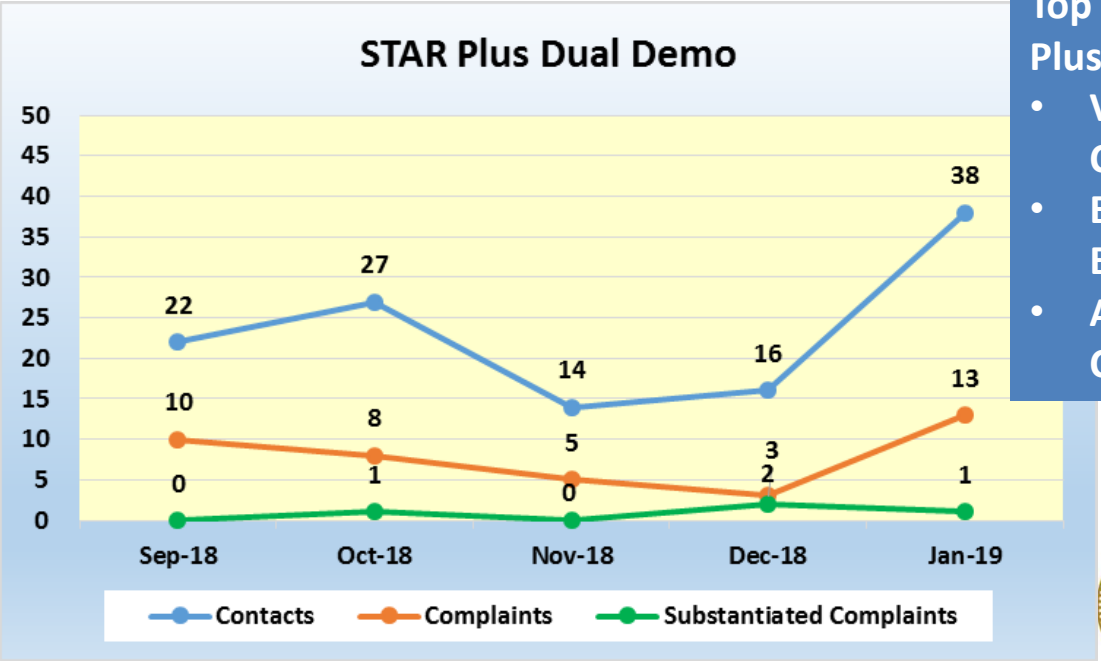
Contact Volumes by Program Type Sept. 2018 – Jan. 2019



Top 3 Contacts – STAR Plus Dual Demo

- Verify Health Coverage
- Explanation of Benefits/Policy
- Access to Long Term Care

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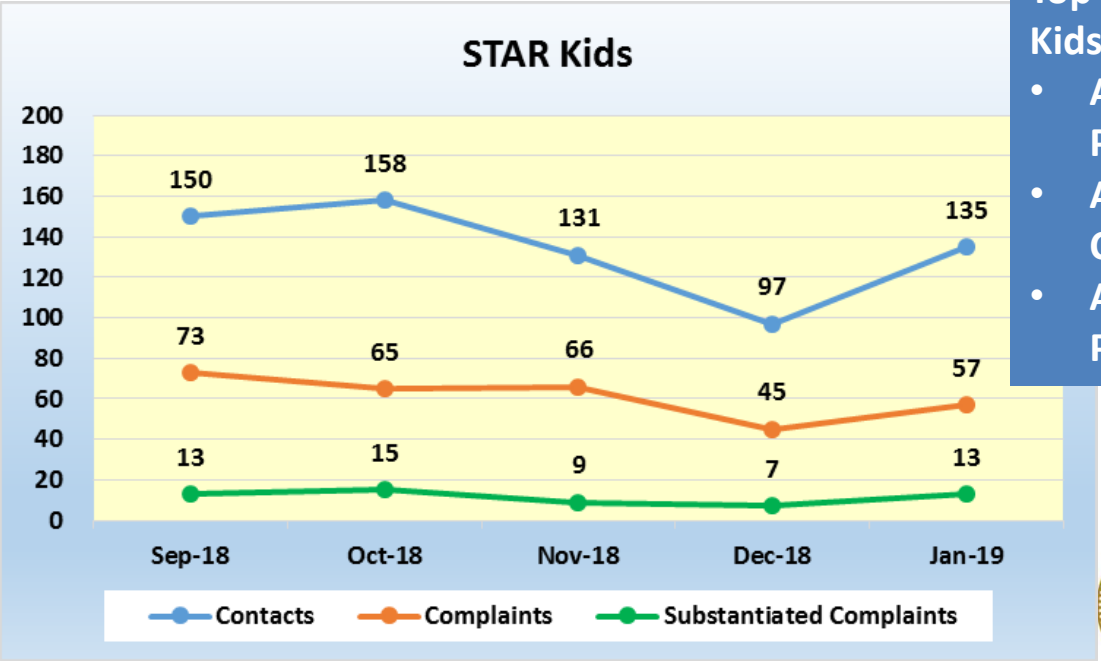
Contact Volumes by Program Type Sept. 2018 – Jan. 2019

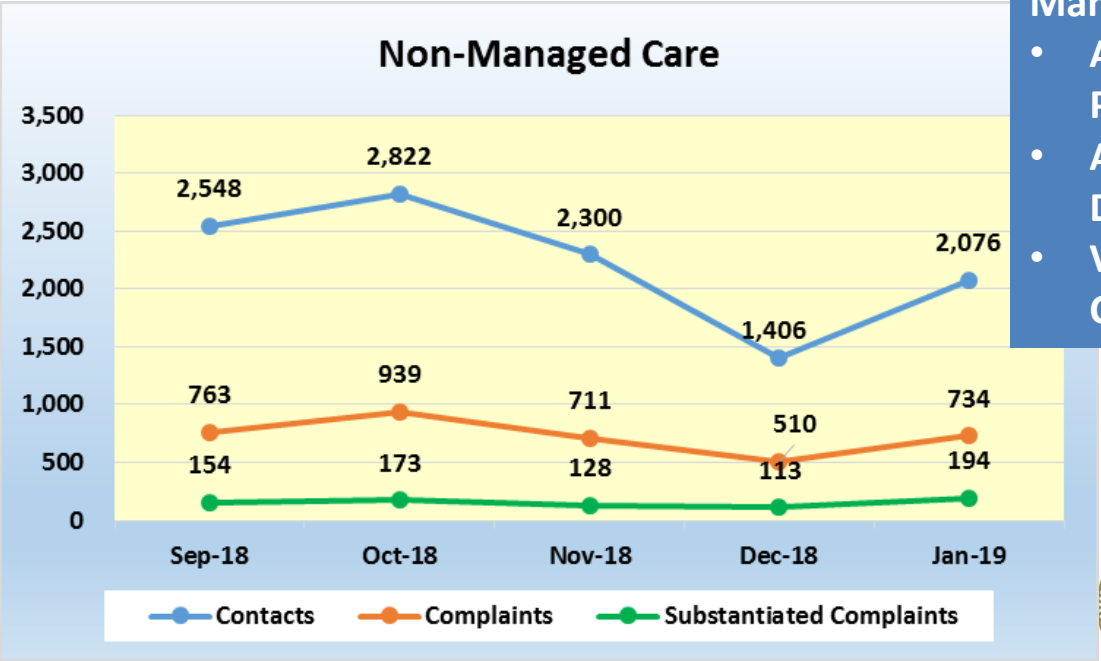


Top 3 Contacts – STAR Kids

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

TEXAS Health and Human Services

Contact Volumes by Program Type
Sept. 2018 – Jan. 2019



Top 3 Contacts – Non Managed Care

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

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FOSTER CARE OMBUDSMAN

TEXAS
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Services

Foster Care Ombudsman Program
Sept. 2018 – Jan. 2019

Contact Volume Sept. 2018 – Jan. 2019	
Foster Care Youth	81 (23%)
Total Contacts	346

Top Three Reasons for Contact Sept. 2018 – Jan. 2019
Rights of Children and Youth in Foster Care
Primary Caseworker Responsibilities
Other/NA

Information Shared

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

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Ombudsman Managed Care Assistance Team

UPDATE

- Problem Trends
- Bills
- Quarterly Published Report

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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