Children's Health Coverage Coalition Meeting Agenda
Friday, November 15th, 2019
11:00 A.M. – 1:00 P.M.

Present:

Adriana Kohler, TCFC
Clayton Travis, TPS
Laura Guerra-Cardus, CDF
Dee Budgewater, HHSC
Erica Ramirez, TWHC

On Conference Line:

Melissa McChesney, CPPP
Peggy Dulage, Maximus
Christina Long, Young Invincibles
Celia Kay, League of Women Voters-TX
Lauren Rangel, Easter Seals Central Texas
Nataly Sauceda, United Way-TX

Meeting Chair: Helen Kent Davis, TMA
Meeting Scribe: Amanda Pouncy, CPPP

I. Introductions (Helen Kent Davis, 5 minutes) – [Meeting began at 11:05 AM]

II. HHS Blueprint (Dee Budgewater)

[Slides 1-2]
Over the next year, we are going to be rolling out a series of 7 goals and that is what will be discussed today.

[Slide 3]
We know that LARCs are the most effective form of birth control but we also have greater disparities in certain areas of the state which we intend to address. We are going to be exploring a partnership with TDCJ in order to enroll them in family planning and women's health programs. We will be working with providers to decrease the cost of these initiatives as well.

Helen Kent Davis
I think there are a lot of barriers to care on the physician's side and it would be helpful to discuss that further.

Dee Budgewater
We would be happy to meet with you and hear from you especially at this early point in implementation. We really want feedback and think it's important to receive that from stakeholders who are boots on the ground. We know what we want to focus on and we know what the goals are but we are still developing

how we are going to get there. For that reason, it's important that we work closely with stakeholders right now.

[Slide 4]
This goal was identified as a way to improve birth outcomes given that earlier access to prenatal care results in better birth outcomes. We see the greatest disparities in the panhandle and west Texas in this area. We are conducting studies to determine how to accomplish this. We are seeking to improve enrollment of those who are eligible for Medicaid but do not enroll. We are targeting areas across the state to determine how best to do this.

Remember that we are just getting out of the gate on this business plan and we didn't release this until last month. Because we are still very early on and in the planning phase, it is hard to give any of the details. As we continue to develop this we will be able to share more about how this will be implemented.

[Slide 5]
Based on the numbers from our pilot, we saw a great deal of improvement in birth outcomes and want to replicate that in four other sites.

[Slide 6]
We know that breastfeeding initiating across the state is much lower African American
Quality improvement initiatives, education and training initiatives will be provided as well as outreach and support for Texas Ten Step Programs. We recognize that a major issue is getting employers on board for breastfeeding and DSHS will be working with Texas breastfeeding worksites to improve this as well.

[Slide 7]
Again we see disparities for Hispanic and African American women in this area. We will be partnering with two providers to increase screening in the under insured and uninsured. We will be partnering with a mobile unit to help improve screening especially in rural areas. Community partnerships will be heavily utilized to accomplish this goal.

[Slide 8]
An increase to 70% was chosen because the last data showed the state at 64% in 2017.

Clayton Travis
I work very closely with physicians so anyway that we can do to coordinate at TPS we will be happy to do.

Laura Guerra-Cardus
How can we get suggestions to you?

Dee Budgewater

You can send them directly to me. I will take them and get them to where they need to be. The WIC team works directly with me on this so I can be that point of contact.

Adriana Kohler
It might be important to also consider how these kids are being affected because of paperwork and policy. For example, with continuous enrollment a lot of these kids are getting kicked off of the program. We also need to be thinking about how the chilling effect is effecting children's enrollment.

[Slide 9]
This goal was chosen because we understand that health care is even more important for those children with chronic asthma, and there are a lot of barriers to care with this population.

Helen Kent Davis
We would love to have you back early next year to hear more.

Dee Budgewater
Absolutely. I will definitely come back. This is a great time to hear from our stakeholders and we would really love to hear more from you. In the meantime, please send me anything that you would like for us to know and I will make sure it gets to the right department if I am not the person who handles that.

III. HHSC Legislative Appropriations Request Recommendations (Adriana Kohler)

You might remember if you joined last month's meeting that we asked for ideas for recommendations for LAR. Input from stakeholders are due by next Friday, November 22nd. What is in your inbox is a very rough draft which I am going to go through very quickly.

[See item 1 on draft]
The first one is around Medicaid and CHIP enrollment. The goal here is to ask for sufficient funding to increase enrollment. You will see on page 2 that Anne and Melissa looked at past spending to get an idea of what the range is for spending in the past. The question for you all is do we want a specific dollar amount ask?

Melissa, the chart that you have on page two, is that referring to the past state budget?

Melissa McChesney
Yes, the real issue is that we don't have dollar amounts that are any newer than this. These are the old numbers and what we used to spend. The issue is that I think we are not spending any of this anymore. It's not that we aren't doing any outreach but there isn't a line item anymore.

Laura Guerra-Cardus
I don't have the answer, but maybe we could say, "We recommend that you spend at least this

amount which was used in the past." Or we might just pick a state that makes sense and say this is how much they spend. I think looking at another state that does well on enrolling children.

Melissa McChesney
Unfortunately, we did try to do that and because that isn't being tracked anymore it's hard to find. I'm not saying it can't be done, and I encourage you to try, but we do have a November 22nd deadline so I'm not sure if it will come before that.

Helen Kent Davis
Maybe we should recommend a range because we are a large, diverse state and focus on telling them that we have to spend money to reach these hard to reach populations.

Laura Guerra-Cardus
And if we do it that way we can do it and use "restore" instead of spend.

[See item 2]

Helen Kent Davis
I think we should ask for 12 months CE. I don't think we should just start with "we want to eliminate the red tape".

Laura Guerra-Cardus
What is the opportunity for negotiation on this?

Helen Kent Davis
At the HHSC meeting yesterday, they didn't say a lot. They said that they will take in all of the LAR recommendations, then present a summary of them at the HHSC Council meeting in February. Next summer they will have their LAR hearing. So, we are looking at the next session before they get to this, and I think that we should make the fiscal note ask to accomplish that.

Melissa McChesney
This looks like it's good how it's written unless people have specific concerns about it. It does say "demonstrate … 12 months".

Adriana Kohler
Right. I think maybe in the title we say "Funding changes needed to ensure 12 months continuous enrollment"

Laura Guerra-Cardus
So yeah, I think the answer is to remove the reference to the committee substitute and just list out the improvement. I can send to Anne what I have in that.

[See item 3]

Adriana Kohler
On this one, this is a policy change but it is tech changes as well, meaning HHSC probably needs to request funding to make those changes.

Laura Guerra-Cardus
This is a big item on the wish list for folks who work in this area because it will be such a huge improvement for them.

[See item 4]

Adriana Kohler
This one is a two part ask and I want to make sure this is okay with everyone. The first part is a Medicaid ask and the second part is a request for more funding to support it. I don't know if this is muddying the water. I don't know if this should just be postpartum or coverage for women before and after pregnancy.

Helen Kent Davis
For TMA and the specialty societies, we have been looking at this as coverage for women both before and after pregnancy because of it effects health outcomes. OBs will tell you that if someone comes into their practice who is an unmanaged diabetic from day one that is an unhealthy diabetic vs if someone comes in and has been seeing an endocrinologist when they need to and is managing their diabetes their pregnancy is far better.

Adriana Kohler
We do have an opportunity to expand the ask.

Melissa McChesney
My concern with this is how do we advocate for implementation? Will it be framed as being discriminatory towards men?

Adriana Kohler
What if we make this a comprehensive health care for women ask?

Laura Guerra-Cardus
I think we should be thinking that way going into the next legislative session, but I'm not sure if it makes sense here because it is such a big budget ask? I feel like it might be reasonable to give them something that feels within reach. It can still be ambitious. So, to ask for expansion for women over age 18-40 who are reproductive age that lose coverage.

I don't think this is discriminatory to men. Women carry the children and as a result they have unique and complex health needs. We should be asking for funding to support that.

Erica Ramirez
I'm just curious are we only giving recommendations for programs that already exist? Or is this also an opportunity to propose new things? Can these programs even exist without a direct ask?

Helen Kent Davis
This is a budget document as well as a policy one so it certainly an opportunity to express a top priority for this next legislative session. These are all big asks and that shouldn't be something we shy away from.

Adriana Kohler
I'm a little concerned because I am not hearing a consensus here on what direction we should be going here. We only have a week to get this done so I really want to make sure that we are on the same page.

It sounds like we are leaning towards something more comprehensive. Would you be okay with us asking for comprehensive coverage for all?

Helen Kent Davis
That is what we will be doing at TMA. The physicians want to be united in that.

Nataly
Is there anything being done around auto-enrollment for those who age out?

Erica
That is something that we are working on at TWHC and we have some language around that which I can share.

Adriana Kohler
I think that we have past legislative documents where we asked for comprehensive care for women that we can pull from as well.

Melissa McChesney
Yes, I looked and we do have some legislative documents with language that we can pull from.

[See item 5]

Clayton Travis
The ECI program directors are meeting today and I want to get their opinion on what they think, their ask, and I will update CHCC next week.

IV. 1115 Waiver and DSRIP Updates (Helen Kent Davis)

Since we don't have a lot of time today, I will not say much about this and we will dive into it more next month. Please reference the slides which came from the hearing.

Just a couple of days ago, CMS issued new Medicaid fiscal accountability rules which everyone is trying to digest. According to recent comments from Seema Verma, the agency's administrator, CMS will be looking at "shady" financial arrangements states use to pay for hospital supplemental funding.

We'll talk more about this next meeting after we get feedback on these proposed rules.

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V. #SickofitTX Block Walk Report & Next Steps (Laura Guerra-Cardus)

[Refer to slides]

This is the same PowerPoint from before the block walks but I have updated this with some new information to share to help boost the message that the next session needs to be about coverage and access.

[Slide 11]

We ended up having 8 block walks across the state.

[Slide 14]

We saw a great turn out and are so excited to have had anywhere from 22-33 people at every block walk. What makes us even more excited is that many of the hosts and participants are committed to continuing to do this.

We had a VAN that we could use, but when people aren't in VAN we made a google doc. That google doc is going to continue to be used so that people can capture and generate a health care conversation anywhere and everywhere.

[Slide 15]

One of the things that really stood out is that even those people who have health care understood that many of their neighbors did not, and they were concerned about it.

The importance of stories for driving health care change is stories, and those stories can then be used to create action. So this person who is saying that the ER is asking for a down payment, we have their contact information and we can investigate that.

[Slide 16]

This is something we are committed to continuing to do. There are links here that will be useful and you are welcome to visit our website and

VI. Public Charge/Chilling Effect Update (Melissa McChesney)

Since we did touch on it last meeting, I am going to give an update of what has happened since October. The public charge rule was supposed to go into effect on October 15th but five injunctions have gone into effect—three of those are national. This is good, but unfortunately, we are still seeing the effects of this rule even without it going into effect.

It's important that we continue to share correct information with people are affected by this rule. We have update our website with some new information around how to do that which you can find on the landing page of www.cppp.org. Please reference this when seeking language around this.

On October 4th, the administration put out a proclamation basically saying if you want to come into the country using a visa you have to be able to show that in the first 30 days you'll be able to get coverage. The way that they define that is that they excluded any market coverage using

subsidies or Medicaid coverage. Otherwise you have to show that you can cover any medical cost on your own. There is a temporary restraining order on this but it is not permanent and will only last for 30 days. We are hopeful that the courts will analyze this and continue to block it. This could increase the use of short term health plans which is something that people can obtain but it is not comprehensive.

VII. Strategies to Improve Outreach & Enrollment for Medicaid & Chip Eligible Children (Open discussion facilitated by Helen Kent Davis)

In the HHSC meeting this week to discuss the Coalition's questions pertaining to the fiscal note for HB342 and the committee substitute, the commissioner asked that key stakeholders share recommendations on how to reach those children who have not previously been on Medicaid or CHIP but who are eligible to enroll. We offered that we would brainstorm here and discuss ways to reach these families. Public charge is obviously an issue, but we want to also think of other barriers that might come up with this population. We don't have to do an extremely detailed list right now, but it might be helpful to get a conference call together right after Thanksgiving to discuss and brainstorm how to do this.

Laura Guerra-Cardus
I can put together a list of folks who might be interested in discussing this further outside of CHCC and we can put them together with who is interested here.

Melissa McChesney
I will volunteer to put together national research on best practices for how to reach the eligible uninsured. That way we have a starting point for what we might pitch.

Erica Ramirez
It might be helpful to also connect those who work very closely with the community like community health workers.

Adriana Kohler
I also know of childcare folks who say that not being able to get immunizations is a major barrier to childcare and they are interested in improving that. I can give you a list of names there.

Nataly
I also feel like there are opportunities to leverage the 211 line and use that as a way to provide resources and ask other questions to help get those folks connected to childcare, immunizations, care, etc.

Helen Kent Davis
Okay so we will continue to think about ideas here and then gather on a call in early December. We will send more information out about that soon.

VIII. [Meeting adjourned at 1:11 pm]

TEXAS
Health and Human Services

Blueprint for Healthy Texas: Women and Children

Dee Budgewater

Deputy Executive Commissioner for Health, Developmental, and Independence Services

Initiative 8: Improve Health for Women, Mothers and Children

- Improving the health of women, mothers and children is critical to the future of Texas.
- Over the next year, HHS will pursue seven overarching goals in support of this initiative.

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Health and Human Services

Goal 1: Increase LARC Utilization

- Increase accessibility to long-acting reversible contraception (LARC) through outreach, enhanced partnerships and reduced administrative burdens.
- These efforts will result in a 10 percent increase in LARC use in FY 2020. This is an increase from:
  - 55,346 clients in FY 2018 to 60,881 clients in FY 2020 for the Medicaid and Healthy Texas Women programs
  - 8,128 clients in FY 2018 to 8,941 in FY 2020 in the Family Planning Program.

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Health and Human Services

Goal 2: Increase the Rate of Women Accessing Prenatal Care

- Evaluate pay-for-quality strategies and implement best practices to increase recommended prenatal visits received by women enrolled in Medicaid in selected sites.
- We expect these efforts to result in an increase of 10 percent.
- This is an increase from 68,538 visits in FY 2018 to a target of 75,392 visits in FY 2020.

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Goal 3: Increase Pregnancy Medical Home Sites

In FY 2020, evaluate, select and begin implementing four additional pregnancy medical home sites, increasing the total number of these sites to five in Texas Medicaid.

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Goal 4: Address Breastfeeding Barriers and Disparities

Address disparities in and barriers to breastfeeding by increasing breastfeeding initiation from 78.6 percent to 80.6 percent among black, non-Hispanic infants enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children, also known as WIC.

TEXAS
Health and Human Services

Goal 5: Implement Pilot Initiatives to Establish Baselines for Future Efforts to Address Disparities in Breast Cancer Mortality Rates

- Implement pilot initiatives in the Breast and Cervical Cancer Services program using evidence-based interventions and mobile mammography.
- These will establish baselines and best practices for developing future initiatives to address disparities.

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Health and Human Services

Goal 6: Increase the Rate of Children Getting Well-Child Visits

- Evaluate and implement best practices to increase the number of children under 15 months in Medicaid receiving the recommended number of well-child visits.
- We expect these efforts to result in an increase to 70 percent from 64 percent in FY 2017.

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Health and Human Services

Goal 7: Improve Health Outcomes for Children with Chronic Asthma

- Enhance review of managed care organization reporting for people with special health care needs to reduce the number of children with chronic asthma visiting an emergency department (ED) more than once.
- We expect these efforts to result in a reduction of 15 percent.
- This is a decrease from 5,016 children with multiple ED visits in FY 2018 to a target of 4,264 children in FY 2020.

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Thank you

To read the full plan, please visit:
hhs.texas.gov/business-plan

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Input on Texas Health and Human Services Commission Legislative Appropriations Request – FY 2022-2023

Thank you for the opportunity to provide input into the development of the Fiscal Year 2022-2023 Legislative Appropriations Request (LAR) for the Health and Human Services Commission (HHSC). The Children's Health Coverage Coalition, formerly Texas CHIP Coalition, is comprised of state and local organizations that support adequate state funding and program improvements for the Children's Health Insurance Program (CHIP) and Children's Medicaid. The Coalition engages in public education and advocacy, working closely with state agencies and the Texas legislature on behalf of children and their families.

As HHSC prepares its FY 2022-2023 Legislative Appropriations Request, the Children's Health Coverage Coalition (CHCC) makes the following recommendations for inclusion in Texas HHSC's Legislative Appropriations Request for 2022-2023 funding:

1. Outreach and Enrollment Funding

(Draft from Anne D.)

The CHCC has been in ongoing communications with Texas HHSC leadership and staff regarding our concern about the growing percentage and numbers of uninsured Texas children (as reported by the U.S. Census findings for 2017 and 2018), and the related decline in Texas children's Medicaid and CHIP enrollment in 2018 and 2019. As one promising tool to address this problem for our state, we strongly urge the Commissioner and HHSC to **renew a dedicated focus on marketing, outreach, and enrollment assistance.** Texas broke national records enrolling children in the new CHIP program in 2000 and 2001, and a strong intentional plan for marketing, outreach, and enrollment assistance was a significant part of that success. As the spreadsheet below illustrates, the first CHIP biennium was the high-water mark for outreach and marketing funding. Funds were available in the 2000's for community-based outreach and enrollment assisters, prior to the conversion to the contemporary un-funded Community Partners Program. The CHCC hopes that this recommended renewed budget investment will be paired with programmatic adjustments to create robust coordination across all the different types of outreach and enrollment assisters in Texas today—those directly employed by HHSC, as well as all others helping with applications for Medicaid, CHIP and the individual marketplace—which we will continue to discuss with HHSC.

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We hope the agency will request an amount that reflects this serious need, taking into account the historical funding in 2000-2001, population growth, and inflation. Texas' child population has increased from 5.9 million to 7.8 million from 2000 to 2018. DO WE WANT TO MAKE A SPECIFIC DOLLAR ASK? (we researched: there are no benchmarks for best spending practices, or even any national sources for what states spend on outreach enrollment and marketing)

	FY 00-01 9/1/99 - 8/31/01	FY 02-03 9/1/01 - 8/31/03	FY 04 9/1/03 - 8/31/04	FY 05 9/1/04 - 04/30/05	FY 06 9/1/05 - 8/31/06	FY 07 9/1/06 - 8/31/07	FY 08 Actuals*	FY 08 Budget**	FY 2009 Budget**
Marketing contract	$ 8,673,178	$ 3,786,221	$ 32,466	$ 218,074	$ 1,422,244	$ 1,734,961	$ 1,015,238	$ 2,000,000	$ 2,000,000
Community-based organization contracts	$ 6,650,388	$ 6,067,655	$ 2,500,000	$ 1,584,847	$ 4,697,797	$ 4,273,951	$ 3,395,944	$ 3,900,000	$ 3,900,000
Total TexCare Outreach Budget	$ 15,323,566	$ 9,853,876	$ 2,532,466	$ 1,802,921	$ 6,120,041	$ 6,008,912	$ 4,411,182	$ 5,900,000	$ 5,900,000

*Paid as of 10/17/2008

** The CBO contracts are at $3.5 million for FY 2008 and FY 2009. The additional $400k budgeted is a set aside in case additional funding is needed for outreach efforts. Funding not used in Fy 2008 may be carried forward to FY 2009.

2. **<u>Funding to make changes need to reduce red tape and ensure more continuous enrollment for kids in Medicaid</u>**

(Draft from Anne D)

The CHCC appreciates our ongoing conversations with HHSC regarding the impact of the current children's Medicaid eligibility rules and processes, implemented in 2014, which do not provide continuous eligibility during the second 6 months of each child's year of Texas Medicaid enrollment. HHSC Data provided to the Coalition via Representative Sheffield's 2018 request and HHSC's fiscal note analyses for the HB 342 and CSHB 342 demonstrate that implementing 12 month continuous coverage for children's Medicaid (filed version HB 342) and adopting processes targeted to dramatically reduce procedural denials (as in CSHB 342, e.g., give families more time to respond to request for information) will have a very minimal impact on the Medicaid budget. The positive impact when children's continuity of access to health care is improved will be of great value to the state of Texas. **The CHCC recommends that HHSC request these funds for 2022-2023, as another component of the agency's broader goal of reversing the growing child uninsured rate and the decline in children's Medicaid and CHIP enrollment.**

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3. **<u>Funding for any tech changes needed so CHIPRA grantees and CPP participants can see if a person's application actually led to enrollment. Since grantees are judges on that metric, they need to see if kid got enrolled in HHSC system.</u>**

(Draft from Patrick B.)
HHSC should make changes to the public benefit application forms and processes (Medicaid, CHIP, TANF, SNAP, etc.) so that assister organizations (e.g. Community Partner organizations and CHIPRA Connecting Kids to Coverage grantees) can more easily track the outcomes of client applications. For example, with client approval, an assister should be able to log into the Your Texas Benefits website and/or App and view the status of applications of the clients they have assisted. This will have direct client benefit in that it will allow assisters to troubleshoot any issues that might need to be addressed so that eligible clients can be successfully enrolled in programs and get the services and supports they need. Additionally, the Centers for Medicare and Medicaid Services (CMS) requires CHIPRA grantees to provide accurate data on the numbers of clients successfully enrolled in CHIP or Children's Medicaid. The current system design makes this data difficult to obtain. More direct access to the online system on behalf of clients would provide a significant improvement to federally required data reporting.

4. **<u>Enhance maternal and newborn health by requesting sufficient funding to ensure new mothers have primary, preventive, and specialty care for 12 months postpartum.</u>**

Healthy pregnancies and births are not just about prenatal care. Primary and specialty care in the months after a baby's birth are critical to manage pregnancy complications and treat health conditions like high blood pressure and diabetes that could harm a future pregnancy. Postpartum care is also vital to screen for behavioral health conditions such as postpartum depression, which affects 1 in 7 new moms and can arise up to a year after birth of a baby. If untreated, postpartum depression can have devastating effects on a mom and a baby's health, safety, and brain development.

Lawmakers and HHSC have adopted important initiatives to increase maternal health safety in hospitals, and we appreciate HHSC's initial efforts to develop a limited postpartum benefit package pursuant to SB 750. Yet there is still room for improvement. Texas has the nation's highest uninsured rate for children and for adults – and the problem is getting worse. About 17.7 percent of Texans did not have health insurance in 2018, which is more than twice as high

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as the national uninsured rate of 8.5 percent.[1] The challenge does not just affect certain regions of the state. From Longview to McAllen to Amarillo, every one of the 25 largest metro areas in Texas has a much worse uninsured rate than the national average.[2] Lack of comprehensive insurance significantly limits access to primary, behavioral, and specialty care needed to manage health conditions that could harm a mother and her baby.

Maternal deaths and severe pregnancy complications remain a significant concern in Texas. The Texas Maternal Mortality and Morbidity Review Committee found that almost 400 Texas mothers lost their lives during and after pregnancy between 2012 and 2015 – with the majority of maternal deaths between occurring more than 60 days postpartum. The Review Committee's number one recommendation for combating maternal mortality is to increase access to health services before and during the year after pregnancy to improve the health of women and enable effective care transitions. Specifically, the Review Committee recommends extending health coverage to Texas mothers for a full year.

Moreover, Texas' federal Delivery System Reform Incentive Payment Program (DSRIP) funding for innovative local health programs is already declining and will expire in October 2021. DSRIP has been incredibly valuable for maternal health safety, newborn health, and access to care in DSRIP-participating hospitals and health systems – and we appreciate HHSC's efforts to prioritize maternal and newborn health in the DSRIP Transition Plan. As DSRIP funding expires, it is more important than ever for HHSC to request sufficient funding to ensure new mothers have primary, preventive, and specialty care for 12 months postpartum.

We ask HHSC to consider the following:

- Request sufficient funding to ensure new mothers have primary, preventive, and specialty care for 12 months postpartum. Comprehensive postpartum coverage is key to sustaining the progress made on maternal and newborn health through DSRIP projects.
- As HHSC identifies a limited postpartum benefit package to add to Healthy Texas Women as part of SB 750, the agency should incorporate into its LAR request a projection of the true costs of postpartum services. The $15 million the Legislature appropriated this biennium for SB 750's limited postpartum package may not cover the array of postpartum services that new mothers need to avoid complications and stay healthy. An enhanced postpartum benefit should not jeopardize or dip into funding for family planning and preventive services in HTW. Rather, HHSC should seek funding that sufficiently covers the postpartum benefit package without coming at the expense of family planning or the women Texas is able to serve through HTW.

[1] https://covertexasnow.org/posts/2019/10/7/from-longview-to-mcallen-to-amarillo-top-25-tx-metro-areas-have-worse-uninsured-rate-than-us
[2] https://covertexasnow.org/posts/2019/10/7/from-longview-to-mcallen-to-amarillo-top-25-tx-metro-areas-have-worse-uninsured-rate-than-us

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5. **Early Childhood Intervention Funding**

ECI funding (we may not have set $ but we ask for full funding to support projected caseload growth and costs.) – Clayton

Medicaid Supplemental and Directed Payment Programs and 1115 Waiver Update

Charles Greenberg
Director, Hospital Finance and Waiver Programs

Andy Vasquez
Deputy Associate Commissioner, Quality and Program Improvement

November 12, 2019

TEXAS
Health and Human Services

Supplemental & Directed Payment Program Funding

TEXAS Health and Human Services

Approximately $11 Billion (All Funds) in Fiscal Year (FY) 2020

- Supplemental payments to providers are separate from claims payments
- Directed payments allow Medicaid MCOs to make payments to providers at the specific direction of HHSC
- Local government funding is used as the source of the non-federal share of funding
- Local taxes and Local Provider Participation Funds are methods used to transfer local funds to HHSC

Supplemental & Directed Payment Programs

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Supplemental Payments

- Uncompensated Care (UC)*
- Graduate Medical Education (GME)
- Disproportionate Share Hospital Program (DSH)
- Delivery System Reform Incentive Payments (DSRIP)*

Directed Payments

- Uniform Hospital Rate Increase Program (UHRIP)
- Quality Improvement Payment Program (QIPP)
- Network Access Improvement Program (NAIP)

*1115 Waiver Programs

Disproportionate Share Hospital (DSH) Payments

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- Medicaid supplemental payment to qualifying hospitals that serve large numbers of Medicaid and uninsured individuals
- Affordable Care Act (ACA) reduces DSH payments to states
- Reduced DSH payments delayed until at least November 21, 2019
- Congress temporarily stopped the first of what will add up to $44 billion in cuts through federal FY 2025

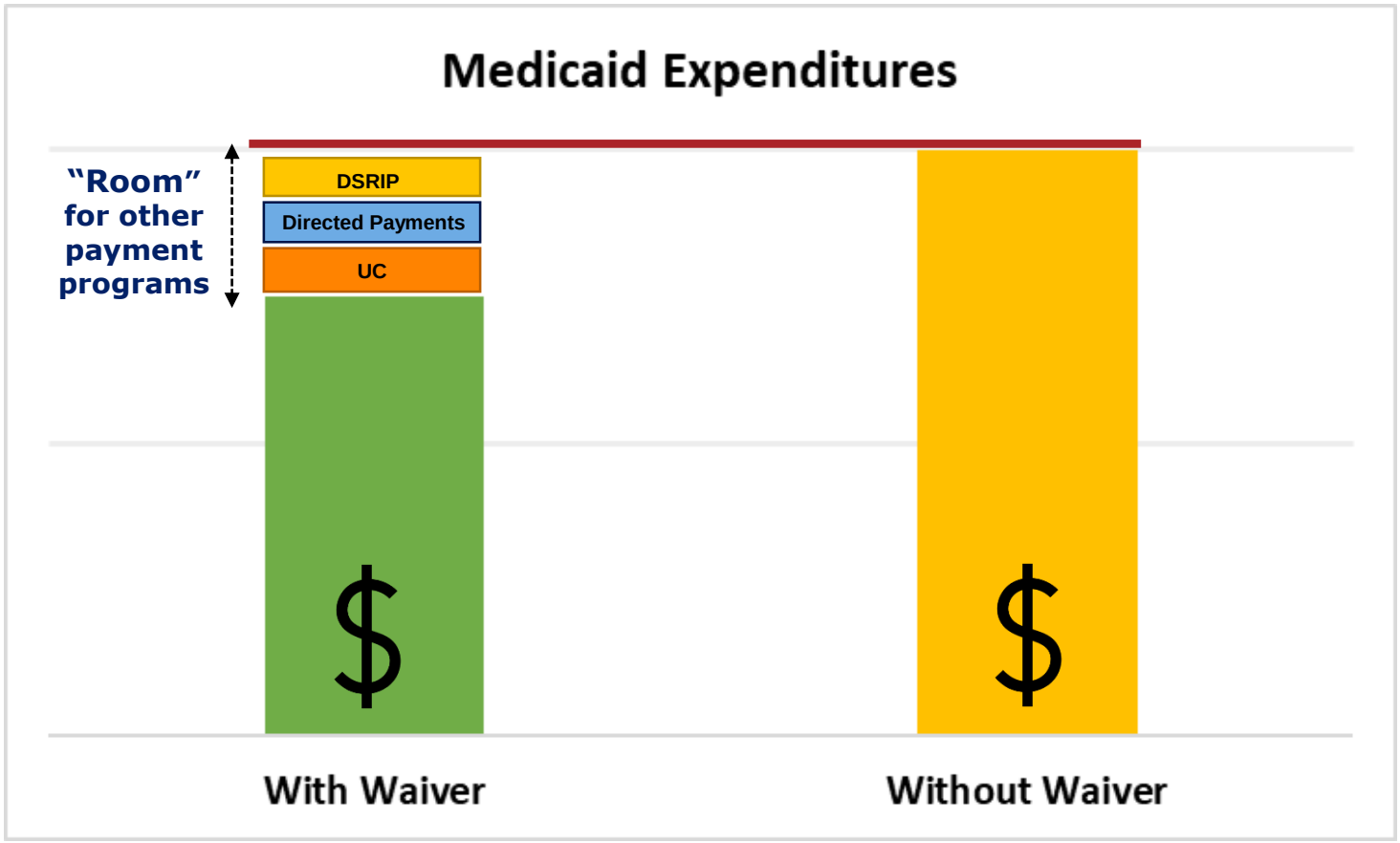
Medicaid 1115 Demonstration Waiver

- Allows states to operate programs that test policy innovations likely to further the objectives of the Medicaid program
- Must be budget neutral to federal government
- Five year extension of the Medicaid waiver approved through Sept. 30, 2022
- Allowed roll out of Medicaid managed care across the state
- Supports funding for hospitals and for local entities to access additional federal match funds for:
  - Uncompensated Care
  - Delivery System Reform Incentive Payments

Budget Neutrality

- 1115 Waivers must be budget neutral to the federal government
- Federal Medicaid spending for a state cannot exceed what would have been spent without the waiver
- Budget Neutrality is a long-standing policy of Centers for Medicare and Medicaid Services (CMS)
- States and the federal government negotiate budget neutrality terms
- Budget neutrality is not based in statute, nor federal regulations

Budget Neutrality



Budget Neutrality Methodology Changes

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Future 1115 Waiver Renewals

- CMS will rebase Without Waiver (WOW) cost baselines for all renewals starting in January 2021
- Limit unused savings rollover to most recent 5-year period
- Ongoing discussions with CMS are needed for guidance to determine budget neutrality flexibility

Local Provider Participation Fund (LPPF)

- Optional method of finance for local governments to generate and collect local funding for Texas Medicaid supplemental and directed payment programs
- Local jurisdictions operating an LPPF assess mandatory payments on nonpublic hospitals based on their annual net patient revenue
- LPPF governmental body determines the assessment rate annually, which is applied to the net patient revenue from all paying hospitals in district, county, or municipality
- Currently 26 LPPFs operating

1115 Waiver Programs: Uncompensated Care (UC) Pool

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UC participants:

- Are paid twice per year for charity care costs provided to the uninsured
- Submit cost information to HHSC to receive a UC payment
- Eligible providers include: hospitals (public & private), ambulance (public), physician groups, dental (public)

Status of UC Pool:

- UC Pool size is $3.87 billion for state FY 2020-2021
- More than 300 Texas hospitals participate
- As of October 2019, payments to providers are based on amount of charity care provided for the uninsured
- Payments used to be based on the amount of a provider's Medicaid shortfall and unreimbursed costs treating uninsured

Delivery System Reform Incentive Payment (DSRIP) Overview

DSRIP Program

- Provides incentive payments to participating providers to improve health outcomes
- 300 participating providers across the state, including:
  - Hospitals
  - Community Mental Health Centers (CMHC)
  - Physician Practices associated with Academic Health Science Centers (AHSC)
  - Local Health Departments (LHD)

DSRIP Overview

DSRIP 2.0 (Oct. 2017 – Sep. 2021)

Participating providers earn incentive payments by:

- Improving performance on select health outcome measures
- Reporting on population health measures and number of individuals served

Common quality measures:

- Chronic disease management
- Primary care and prevention
- Patient navigation, care transitions, and emergency department diversion
- Improved maternal care and safety

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DSRIP Common Core Activities

- Care Management, including disease self-management education
- Screening and follow-up services
- Manage individuals at risk for complications, co-morbidities, use of emergency room
- Services to address social drivers of health
- Expanded practice access (e.g., increased hours, telemedicine)
- Vaccinations for target populations
- Enhanced coordination between primary care, urgent care, & emergency departments
- Navigation services
- Certified Community Behavioral Health Clinic care model

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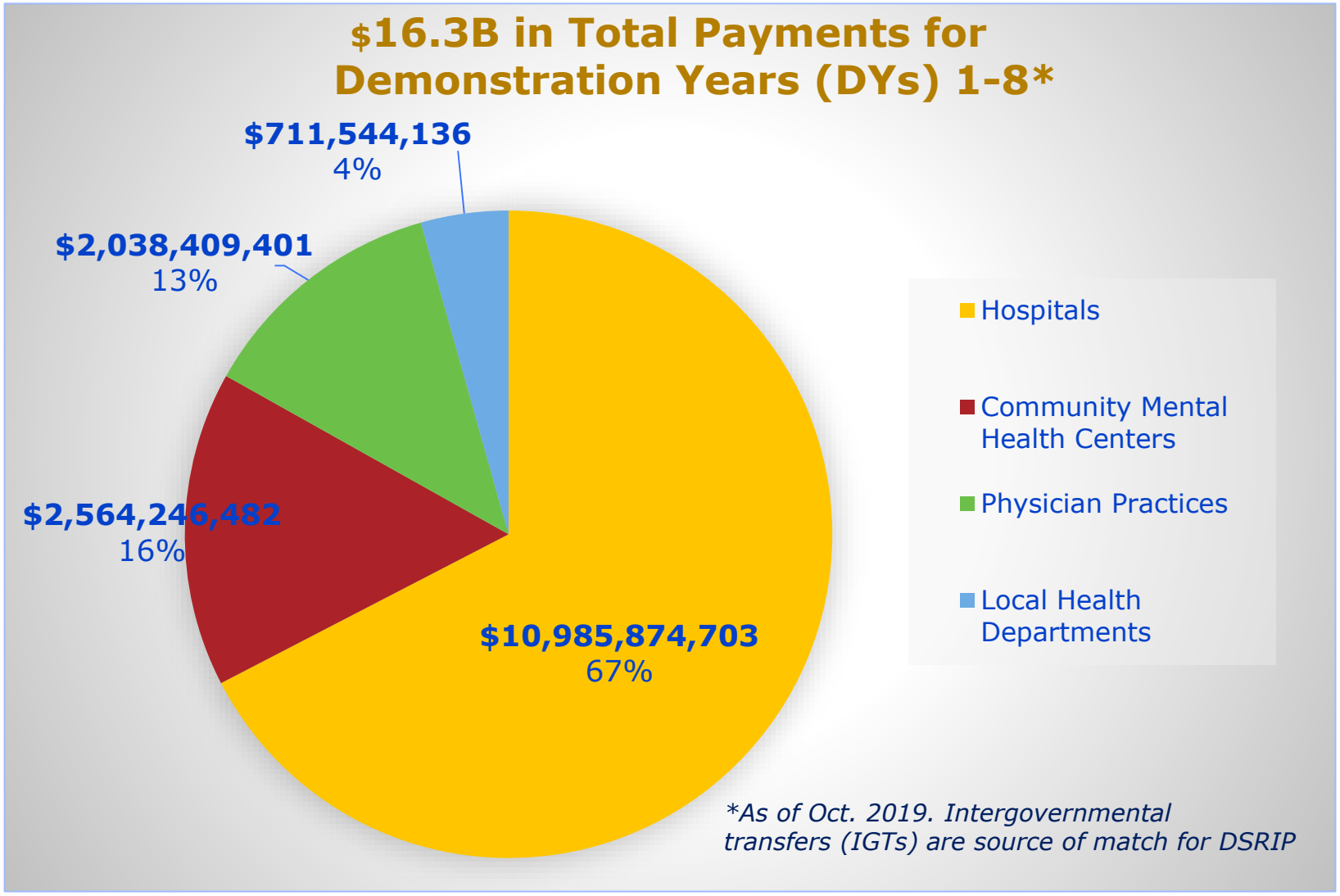
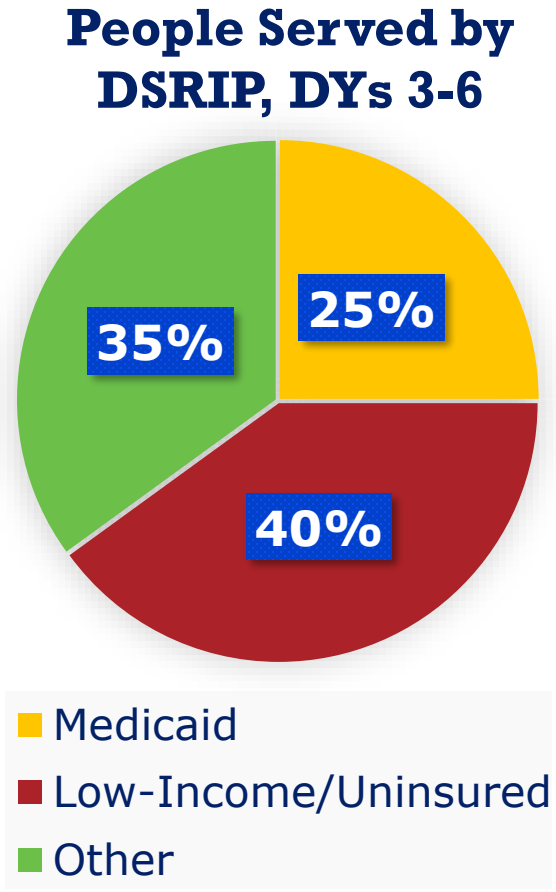
DSRIP Payments by Provider Type



People Served by DSRIP

DSRIP projects served 11.7 million people and provided 29.4 million encounters (DYs 3-6)*

**Figures may be duplicated across projects*



DSRIP Transition

- Waiver Special Terms and Conditions (STCs) required Texas to submit a DSRIP Transition Plan (STC 37)
- Waiver renewal approval letter from CMS specifies:

> *"Texas' DSRIP program will transition to a more strategic systemic effort focusing on health system performance measurement and improvement that achieves sustainable and effective delivery system reform."*

- HHSC submitted draft plan to CMS on Sep. 30, 2019 and must obtain CMS approval of final plan by Mar. 31, 2020

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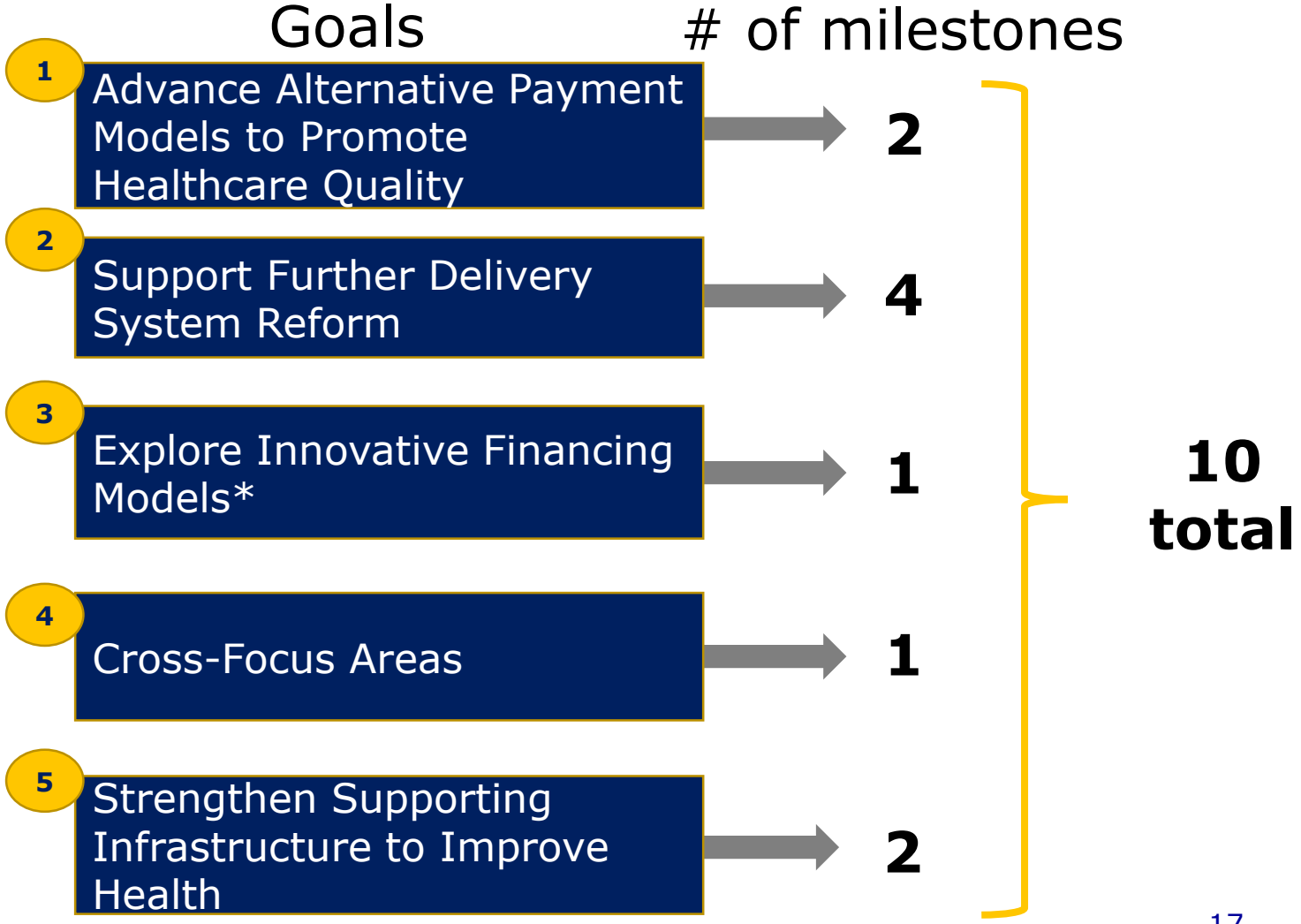
Draft DSRIP Transition Plan Goals



* *Incentivize MCOs to enter into quality-based alternative payment models.*

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Draft Transition Plan Milestones

2021 Texas Legislative Session

DY 11 (Oct. 2021 – Sept. 2022)

September 2020

- Update the Texas Value-Based Purchasing Roadmap to address strategies to sustain key DSRIP initiative areas
- Identify and submit to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11 of current Waiver period

December 2020

- Update the Texas Medicaid quality strategy to address program and stakeholder goals
- Review DSRIP activities as possible Medicaid state plan benefits and policy changes, and submit to CMS review results or approval requests, as necessary
- Assess the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps
- Conduct a preliminary analysis of DY 7-8 DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement

March 2021

- Assess Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identify potential opportunities to strengthen or align incentives
- Complete an assessment of which social factors are correlated with Texas Medicaid health outcomes
- Identify options for the Regional Healthcare Partnership structure post-DSRIP

September 2021

- Identify and submit to CMS any additional proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period

Ongoing, Active Stakeholder Engagement

Key Focus Areas for Post-DSRIP Efforts

- Sustain access to critical health care services
- Behavioral health
- Primary care
- Patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization
- Chronic care management
- Health promotion and disease prevention
- Maternal health and birth outcomes, including in rural areas of the state
- Pediatric care
- Rural health care
- Integration of public health with Medicaid
- Telemedicine and telehealth
- Social drivers of health

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Partner Engagement

Aug. 2019	• Comments submitted on draft DSRIP transition plan • Comments resulted in changes to draft plan and are informing milestone plans
Sep.-Oct. 2019	• Work sessions held with providers, associations, and representatives • Identified shared and unique considerations, priorities, and opportunities
Dec. 2019	• HHSC develops partner engagement plan to help achieve DSRIP transition plan milestones

Next Steps for HHSC

- Create detailed plan for completing each milestone in transition plan
- Develop partner engagement plan
- Collect data and analyze options for sustaining delivery system reforms
- Refine parameters with CMS
- Identify opportunities to promote collaboration between MCOs and providers

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Appendix

Local Provider Participation Funds (LPPF)

	Jurisdiction	Enacted Bill	Session	Year
1	Cameron County	SB 1623	83R	2013
2	Hidalgo County	SB 1623	83R	
3	Webb County	SB 1623	83R	
4	City of Beaumont	SB 1387	84R	2015
5	Bell County	HB 2913	84R	
6	Bowie County	SB 1587	84R	
7	Brazos County	HB 3185	84R	
8	**Cherokee County (Deactivated)**	**SB 1587**	**84R**	
9	Gregg County	SB 1587	84R	
10	Hays County	HB 3175	84R	
11	McLennan County	HB 2809	84R	
12	City of Amarillo Hospital District	SB 2117	85R	2017
13	Angelina County	HB 2995	85R	
14	Dallas County	HB 4300	85R	
15	Grayson County	HB 2062	85R	
16	Smith County	HB 2995	85R	
17	Tarrant County	SB 1462	85R	
18	Tom Green County	HB 3398	85R	
19	Williamson County	HB 3954	85R	
20	Lubbock County Hospital	SB 2448	86R	2019
21	**Statewide**	**HB 4289**	**86R**	
22	Ellis County	HB 4548	86R	
23	Bexar County Hospital District	SB 1545	86R	
24	Harris County Hospital District	HB 3459	86R	
25	Wichita County	SB 2286	86R	
26	Travis County	SB 1350	86R	
27	Taylor County	HB 1142	86R	
28	**Nueces County Hospital District (Not established)**	**SB 2315**	**86R**	
29	El Paso County Hospital District	SB 1751	86R	

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Total DSRIP Payments

Demonstration Year (DY)	Payments to Date*
DY1 (October 2011 - September 2012)	$ 0.48
DY2 (October 2012 - September 2013)	$ 1.93
DY3 (October 2013 - September 2014)	$ 2.54
DY4 (October 2014 - September 2015)	$ 2.68
DY5 (October 2015 - September 2016)	$ 2.84
DY6 (October 2016 - September 2017)	$ 2.87
DY7 (October 2017 - September 2018)	$ 2.70†
DY8 (October 2018 - September 2019)	$ 0.31†
TOTAL	**$ 16.35**

**All payments shown in billions and as of Oct. 2019*

† *Final incentive payments for a DY occur 1.5 years after the DY (final DY7 payment is July 2020, DY8 is July 2021)*

1115 Waiver Extension

- Dec. 2017 - CMS granted a five-year extension of Texas' Healthcare Transformation 1115 waiver.
  - Includes a four-year extension of DSRIP with funding phase-down
- Oct. 2019 - Waiver Special Terms and Conditions (STCs) required Texas to submit a DSRIP Transition Plan (STC 37)
- Oct. 2021 - DSRIP pool ends

1115 Waiver Extension

DSRIP Pool Under Extension

Demonstration Year (DY)	Pool Amount* (All Funds)
DY7 (10/1/17 – 9/30/18)	$3.10
DY8 (10/1/18 – 9/30/19)	$3.10
DY9 (10/1/19 – 9/30/20)	$2.91
DY10 (10/1/20 – 9/30/21)	$2.49
DY11 (10/1/21 – 9/30/22)	$0

**All amounts shown in billions*

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BE PART OF THE Rx FOR TX

SickOfItTX.com

The New York Times

Medicaid Covers a Million Fewer Children. Baby Elijah Was One of Them.

HOUSTON — The baby's lips were turning blue from lack of oxygen in the blood when his mother, Kristin Johnson, rushed him to an emergency room here last month. Only after he was admitted to intensive care with a respiratory virus did Ms. Johnson learn that he had been dropped from Medicaid coverage.

The 9-month-old, Elijah, had joined a growing number of children around the country with no health insurance, a trend that new Census Bureau data suggests is most pronounced in Texas and a handful of other states. Two of Elijah's older siblings lost Medicaid coverage two years ago for reasons Ms. Johnson never understood, and she got so stymied trying to prove their eligibility that she gave up.

"I've been on this emotional roller coaster," Ms. Johnson, 34, said of Elijah's loss of coverage, an error that happened apparently because she didn't respond quickly enough to a letter asking for new proof of income. "It's been a very scary month."

Instead of checking eligibility once a year, as many states do, Texas enrolls children for six months and then checks databases for four consecutive months to ensure family income is still low enough to qualify. If the databases show the income has gone over the limit, families are notified by mail and have 10 days to prove otherwise or lose Medicaid.

The Dallas Morning News

Texas moms are still dying. When will this state get serious about helping them?

Texas lawmakers talked a good game about addressing the disturbingly high number of women who die each year in this state from pregnancy-related complications.But after two years of acknowledging that the state has to do more to prevent dozens of deaths annually, we’re stunned that our representatives closed this legislative session without taking meaningful action to keep more moms alive.

They Want to Address Mental Health? Reduce the Uninsured Rate!

Stop attacking the ACA — and reduce the TX uninsured rate!

State Leaders Try again to Take Health Care away from Texans

Poll after poll shows Texans want lawmakers to focus on improving access to health care.

Texas Kids' Uninsured Rate Still Highest in Nation & Getting Worse, According to US Census

Health coverage should be a top priority for the next legislative session.

From Longview to McAllen to Amarillo, Top 25 TX Metro Areas Have Worse Uninsured Rate Than US

The Legislature must reduce the uninsured rate.

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Campaign Launch

#SICKOFITTX

- The **non-partisan** grassroots campaign for healthcare **to raise the profile of access issues in local communities across Texas**.
- Access issues have caused devastating consequences throughout our system.
- **The only way we are going to get the Texas legislature to start prioritizing access to healthcare for Texans is with people power.**
- We don't all need to agree on the specific policy solution, but we do all need to **speak with one voice that 2021 needs to be the session for healthcare coverage & access.**

Endorsing Partners

Houston March On Women

easterseals

American Federation of Labor and Congress of Industrial Organizations — Texas AFL-CIO

Free Our People ADAPT

Texas Alliance for Retired Americans

children's defense fund texas

TOP Texas Organizing Project

Proyecto Azteca — Building a better world.

Personal Attendant Coalition of Texas

Texas Impact

Center for Public Policy Priorities

Jolt Action

NAMI Texas — National Alliance on Mental Illness

equal voice for America's Families — Rio Grande Valley Network: 10,000 Families

NASW Texas Chapter — National Association of Social Workers

Indivisible Austin

Young Invincibles

CTD Coalition of Texans with Disabilities

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- Website launched on September 18.
- Over 66 local leaders - Healthcare Activist Leadership Network - who want to help lead the campaign in over 30 communities across Texas
- 13 local FB pages and 8,500 email recipients not counting partners lists
- Coverage on KUT, Texas Standard and Spectrum
- Seven Block Walk events across the state

Why Now?

- More competitive general elections are making an impact on the Texas political and policy landscape.
- Widespread upset that bi-partisan bills to help children and mothers access healthcare failed to pass last session.
- 1115 Waiver ending and Texas must figure out financing and healthcare delivery systems before 2022
- Grassroots organizing takes time, if we want to see progress in the next 2-4 years, organizing work must start now.

Block Walks for Health Care

AUSTIN

DATE: SATURDAY, NOVEMBER 9TH
TIME: 9:00 AM – 1:00 PM
LOCAL HOSTS: SHANE JOHNSON, TRISH CONTRERAS, AND TONY WEBER

HOUSTON

DATE: SUNDAY, NOVEMBER 10TH
TIME: 2:00 PM – 6:00 PM
LOCAL HOST: TIFFANY HOGUE

DALLAS

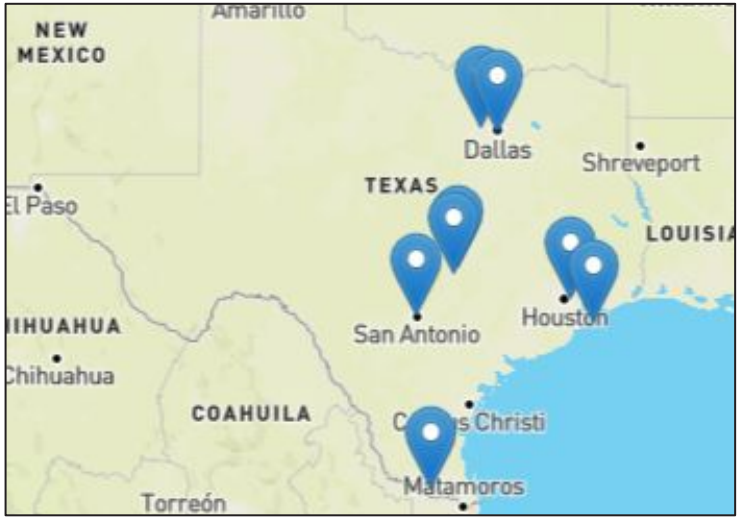
DATE: SUNDAY, NOVEMBER 10TH
TIME: 2:00 PM – 6:00 PM
LOCAL HOST: TERESA COX

SAN ANTONIO

DATE: SUNDAY, NOVEMBER 10TH
TIME: 2:00 PM – 6:00 PM
LOCAL HOST: SOFIA SEPULVEDA

MEETING POINTS ARE TBD. KEEP AN EYE OUT FOR UPDATES FROM LOCAL HOSTS!

Block Walks for Health Care



Austin, Dallas, Ellis, Galveston, Ft. Worth, Houston, McAllen and San Antonio!

BLOCK WALK QUESTIONS

1) Coverage questions: Are you insured? Are your children insured? What do you do when you get sick?
2) Access questions: Are you worried about your healthcare coverage, including protections for pre-existing conditions?
3) Motivation: How does that make you feel?
4) Voting: Do you plan to vote? Are you registered to vote? Do you need to update your info? Fill out commit to vote card.
5) Join us: Do you want to stay connected to our campaign to improve healthcare coverage and access for Texans?

Why Block Walks?

- Shows organizing strength
- Story Collection
- Voter registration
- Increase commitment of local advocates
- Invites others to join the movement

Block Walk Outcomes!

- 77 Block Walkers
- 1,466 door attempts
- 619 conversations
- 149 commit to vote cards
- 26 new voters
- 13 community leaders identified

STORIES

We spoke to a San Antonio **family of immigrants who can't get healthcare.** The wife is always sick and they live in constant fear. The husband works in construction, but now makes too much to be on the Travis indigent program. They **don't qualify for ACA because they don't have the right immigrant status.**

In McAllen we learned that people will **only go to the emergency room**, because they don't have healthcare. The ER will ask them for a downpayment, and **if they can't pay they are turned away.**

A woman in Houston told us **healthcare makes her feel 'secure.'** Her older sister who is in her 80's and has early onset dementia, **can't get on Medicaid**, and can't get the care she needs. It's a real struggle for her family to figure out what to do.

A man we met in McAllen used to go to the indigent clinic, but can no longer go because he doesn't have a current ID. He **can't renew his ID because he owes child support.** He has resorted to either **self-medicating** with street drugs, or buying insulin from time to time on the street.

Call To Action

1. Survey Your Community or Block Walk!
2. Join the movement and get others to do the same!
3. Tell us why you are sick of it through a video or picture post on Facebook.

#SICKOFITTX

- Sign up at www.sickofittx.com
- Like www.facebook.com/SickofitTX/
- Join regional FB groups: https://www.facebook.com/pg/SickofitTX/groups
- Follow @SickofitTX

Thank you!

Laura Guerra-Cardus
lguerracar@childrensdefense.org