Children's Health Coverage Coalition Meeting Agenda

Friday, June 16th, 2023

11:00 A.M. - 12:40 P.M. CST

Meeting Location: Zoom Meeting

Meeting Chair: Stacey Pogue from Every Texan

CHCC Agenda

11:00 A.M. - 11:05 A.M.	Welcome & Introductions
11:05 A.M. - 12:05 P.M.	Legislative and Budget Session Recap • Led by Texas Medical Association (Helen Kent Davis), Texans Care for Children (Diana Forester), Every Texan (Anne Dunkelberg), Children's Hospital Association of Texas (Christina Hoppe), Texas Women's Healthcare Coalition (Rachel Wolleben), Hogg Foundation of Mental Health (Alison Bohr Boleware)
12:05 P.M. - 12:20 P.M.	Top Issues in CMS Rules • Anne Dunkelberg (Every Texan) and Helen Kent Davis (Texas Medical Association)
12:20 P.M - 12:40 P.M	Medicaid Unwinding Issues and Outcomes • Stacey Pogue (Every Texan) and Adrienne Lloyd (Children's Defense Fund)

CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

Children's Health Coverage Coalition Meeting

Friday, June 16th, 2023

11:00 A.M. - 12:40 P.M.

Meeting Attendees:

Betsy Coats
Stacey Pogue
Helen Kent Davis
Adrienne Lloyd
Allison McHorse
Alec Mendoza
Alison Mohr Boleware
Anne Dunkelberg
Shelby Tracy
Karla Martinez
Michelle Tij
Sonia Lara
Linda Litzinger
Naomi Cruz
Andrew Smith
Stephanie Mace
Iris Sanez
Christina Hoppe
Lyssette Galvan
Daniela De Luna
Rachel Wolleben

Meeting Chair: Stacey Pogue – Every Texan
Meeting Scribe: Isabel Agbassi - Every Texan

CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

CHCC AGENDA

I. **Legislative and Budget Session Recap**

- **Helen Kent Davis:** HB 1575 is a bill that codifies the program that works with case management for pregnant women and children under the administration of Medicaid MCOs. It establishes a standardized screening process for non-medical drivers of health and passed. Women who are enrolled in Medicaid managed care and are pregnant are being screened for non medical drivers of health. Those who are deemed high-risk based on the screening are referred to additional services. Women can decline screening since it is voluntary. The information is collectively part of their medical record and can be used to help provide, arrange, or get referrals to needed services. Informed consent is key. In the past, case management programs were managed by mainly nurses or social workers, but the bill expands the ability for community health workers and doulas who go through state established training to also be case managers.
- HB 3286 passed by Representative Klick alongside HB 1283 by Oliverson passed. Oliverson's bill establishes Texas Medicaid for the next decade and will retain a stateward Medicaid preferred drug list. Without the passage of the bill, each Medicaid managed care plan would be assumed management of the formulary and preferred drug lists which raised concerns by physicians, pharmacists, and patient advocacy groups of the segmentation and how it can lead to administrative hurdles. There is one statewide formulary which has all FDA-approved drugs with some exceptions established by Congress or regulatory processes and those on the formulary with state additions. Then there's also the preferred drug list where drugs are determined by the state to be preferred or not preferred based on clinical efficacy, safety, and cost. The state also determines this based on a drug utilization review board which consists of physicians and pharmacists. What can happen now is a physician can prescribe, let's say, an antibiotic. They prescribe it. It's preferred. That will be part of the effort to include all the NDC codes to decrease delays in patient care and ensure continuity of care.
- (HB 24) It did not pass despite a really concerted effort at the end to get something added to the budget when the bill didn't pass. It was a bill by Representative Oliverson, regarding statutory protection for health plans affiliated with teaching hospitals. It means that health plans affiliated with those teaching hospitals and hospital districts are qualified if they meet the state standards to be an HMO as well as federal standards and they submit a bid. There is a from Dr. Oliverson and others about giving preferential treatment. However, they have to meet all state and federal standards to be a Medicaid health plan. Community based health plans have boards that are affiliated with their local physicians and business entities and so forth.
- **Allison McHorse:** HB 44 (Disenrolling Medicaid providers who have policies for clinics to dismiss patients who are not caught up on routine childhood immunizations) passed. With some additional language added, you cannot dismiss a patient solely based on vaccination status allowing some leeway to providers. There could be a federal waiver around this policy given public health protocols.

    - **Linda Litzinger:** We have a lot of families dually enrolled in private insurance and Medicaid. Does this mean they will lose it from having insurers and doctors take care of immunizations?
        - **AM:** This would disenroll the Medicaid provider (like pediatricians), not the patient.
- **Alison Mohr Boleware:** (SB 26) This mostly focuses on local mental health authorities and auditing and reporting requirements related to those entities. Part of the bill is creating a new grant program. It is creating a Child and Family Innovative Grant Program, and it does have $15 million per biennium in the budget for it. It's important that the program is a matching grant program, and it is supposed to be for community based initiatives that promote identification of mental health issues and improve access to early intervention and treatment just for children and families. It has to be either evidence based or otherwise demonstrate positive outcomes. Those outcomes can include improved relationship skills, improved self esteem, reduced involvement in the juvenile justice system, participation in the relinquishment diversion program which already exists with HHSC to help kids that are in crisis, etc. It can include training and services. It is broad for what the services and supports are for community based initiatives, agencies that provide services to children and families, and individuals who work with children or caregivers of children. The allowed entities are broad here on who can apply for the funds: hospital, a psychiatric hospital, a hospital district, a local mental health authority, a childcare facility, a county or municipality, or a nonprofit organization. It's $15 million in the budget as of right now. The bill hasn't been signed yet.
- In the budget, there was actually an increase in this year's budget from last session's budget for community mental health services. So those provided at local mental health authorities, an increase of $33 million to a total of $221,000,000. There is new funding for creating youth mobile crisis outreach teams. It's $7 million per fiscal year to create these mobile crisis outreach teams. Three of them are going to be dedicated to foster youth. There were three funding allocations under the programs for high risk youth. Category one is funding $15 million per fiscal year for multisystemic therapy, which is a specific type of therapy to help youth in crisis. Coordinated Specialty Care got $2.1 million per fiscal year. That's also a specific type of therapy for youth. And then Uvalde received $5 million in fiscal year 25 to start and operate a new behavioral health campus. The Child Mental Health Care Consortium, which was created in the 2019 session, got almost double the original amount that was included in last session's budget. So this session, it was an increase of $162,000,000 to now a total of $280,000,000.
- **Alec Mendoza:** HB 12 (Extends Medicaid coverage for 12 months after pregnancy) passed. It applies to all pregnancies and is not contingent upon an outcome. HHSC is developing an implementation timeline which should be submitted by the end of the year to start in 2024. This is a testament to everyone's work that has spanned the past 3 sessions. HB 465 (Pilot program to provide Medicaid coverage of doula services) didn't get a hearing but got passed the House. HB 852 (Composition of Texas Maternal Mortality and Morbidity Review Committee with addition of members based on 2022 report recommendation) had language around advocate members removed

and changed the community member language to be changed to individuals with health data experience. It was signed by the governor on the 12th of the month. HB 113 (Use of Community Health Workers in Medicaid Managed Care) would allow Medicaid MCOs to report community health workers as administrative cost instead of quality cost to allow more funds towards community health workers. It was signed by the governor on the 13th. SB 24 (codifies HOA and renaming to Thriving Texas Families program) moves Prevention and Early Intervention Program to HHSC.

- **Rachel Wolleben:** (HB 916) This would require that health benefit plans allow women to pick up a 12 month supply of birth control in one pharmacy visit if they choose. It pertains to only plans that already offer birth control coverage and includes private plans, Medicaid, etc. It passed and was signed by the governor on the 10th. It should go in effect September 1st, 2023, and it applies to only health benefit plans that are issued or renewed on or after January 1st, 2024.
- Big budget year for women's health programs in the form of $447 million in the biennium which is an increase from $94 million from the previous biennium. All the riders, including the family planning program, Healthy Texas Women Enrollment Support, and women's preventative health mobile units, were adopted.
- **Helen Kent Davis:** In addition to the ones that were mentioned by Rachel, the legislature, for the first time in about two decades, passed a Medicaid physician payment increase. They increased rates for children's services for children ages zero to 20 by 6%, and they also increased funding by 6% for what is styled in the writer as women's health and birth related surgeries.The rate increase related to children's services does also include a requirement. Also related to maternal health, rural hospitals have really struggled to maintain maternity services. There's been a writer in the budget for the last several years that provides an add on payment for every delivery at a rural hospital that was $500. That now has tripled to $1,500. The goal is to keep rural hospitals able to provide those services. They also adopted a Senate $50 million grant for rural hospitals that does three things: a) help stabilize rural hospitals b) help them transition to new alternative payment models to help them be more competitive in the market c) improvements related to maternal health.
- **Christina Hoppe:** The Pediatric Behavioral Health Strategic Plan was funded, and HHSC has had pre-planning meetings to get scope. In the workforce, there was increased support for nurses and physicians. The Children's Hospital Mental Health grant program didn't pass despite getting voted out of committee and making it through the House. Because of those efforts, there's now $15.8 million dedicated to Supplemental for Children's Hospital for inpatient mental health beds.
- **Anne Dunkelberg:** There was a rate increase for community attendance, not dependent on waivers. It was increased to $10/hour instead of $15/hour, still an improvement from $8/hour.

II. Top Issues in CMS Rules

[SEE ATTACHED SLIDES]

III. Medicaid Unwinding Issues and Outcomes

[SEE ATTACHED SLIDES]

EVERY TEXAN

CHCC, June 16, 2023

Federal Medicaid proposed rules for Access and Medicaid Managed Care

Anne Dunkelberg
Senior Fellow
dunkelberg@EveryTexan.org

“Medicaid Program: Ensuring Access to Medicaid Services” and “Medicaid Program: Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality.”

- **Comments are due by 4:00 pm Central 7/3/2023**
- https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance
- https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services

Proposed Rules contain Strong Pro-Consumer Content, plus stricter enforcement of provider tax rules (issue for Texas)

- Every Texan waiting for and **will share next week** Template comments from national health care advocates (Georgetown University CCF, Center on Budget and Policy, and National Health Law Program)

- **IMPORTANT:** Even if your organization wants to oppose the proposed stricter provider tax rules and/or defend Texas' current LPPF structure, PLEASE be sure to weigh in in support of pro-consumer proposed rules!

Top Pro-Medicaid enrollee Provisions in proposed rules (1)

Includes strong Medicaid beneficiary support/protection provisions, promotes adequate payments. Many parallel provisions between FFS and MMC rules

- Annual payment analysis for network adequacy (also publish FFS rates)
- Quality ratings for plans - new fed floor min standards apply, even if states use their own system
- MCACs must include 25% beneficiaries or family members and a separate "BAG" group of same. Better public info on both MAC and BAG.
- Texas Medicaid Managed Care does not require a "Medical Loss Ratio."
  - For States that DO, the MLR must be 85% or higher.
    - (In contrast, all Medicare Advantage plans and Marketplace QHPs are subject to MLR requirements).
  - Texas' "experience rebate" formula more complex, allows more profit
  - Proposed rule aligns Medicaid definition of QIA with Marketplace, limiting ability to sneak admin costs into medical category.

Top Pro-Medicaid enrollee Provisions in proposed rules (2)

- New fed standards for appointment wait times are a floor (states can do more, but not less) – but 4 years to implement…..
  - Routine primary care appointments (children and adults), obstetrics and gynecological appointments, state's standard could not exceed 15 business days from the date of request.
  - Routine outpatient mental health and substance use disorder services appointments (children and adults): wait times could not exceed 10 business days.
  - An appointment availability rate of 90 percent or more would be considered compliance
  - Independent secret shopper tests annually to show compliance
- Require annual enrollee satisfaction survey for each health plan.
- Annual rate review to compare plans' rates to Medicare
- Requires states to implement remedy plans for MCOs out of compliance

Top Pro-Medicaid enrollee Provisions in proposed rules (3)

- **Home and Community-Based Services:**
  - define direct care workers,
  - state discloses the average hourly payment rates for all direct care workers; # claims paid; # services rendered.
  - “interested parties” advisory/consult group to Medicaid agency on current and proposed direct care rates.
  - waiting list reporting
  - **Require minimum of 80% of HCBS spend to be on direct care!**

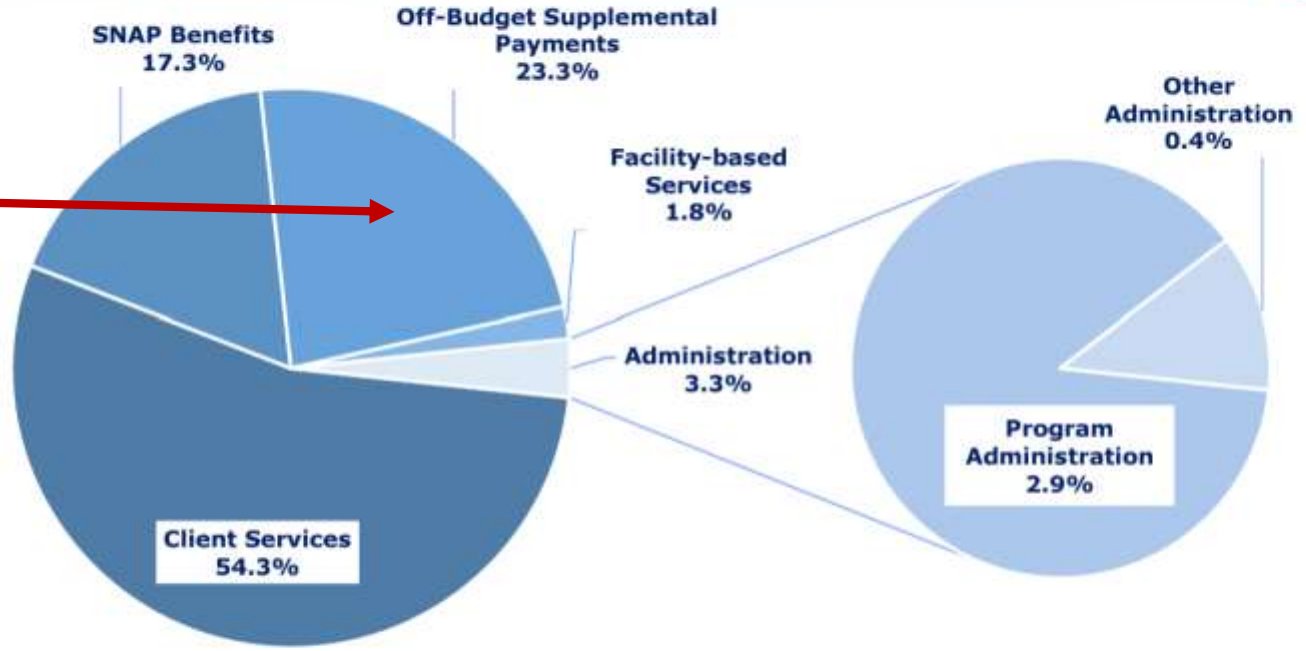
Controversial for Texas: State Directed Payments

- Texas Medicaid relies heavily on "State Directed Payments," which use local/regional provider taxes ("LPPFs) to draw federal match to make combined Medicaid provider payments closer to cost/Medicare/average commercial rates
- States must report all SDP $$$ to CMS. MCOs must report what they spend and receive in SDPs.
  - Current regs do not require states or MCOs to provide CMS with the actual amounts spent on SDPs. The proposed rule would require that MCOs include SDPs in MLR. States would have to report to CMS for each MCO.
- Comply with sources of non-fed share laws in order to get SDP approval
- Every SDP payment recipient (provider) must attest not involved in hold harmless
- States must report an MLR for each MMC plan
- No more provider incentives that are not earned (must be performance-based)
- Aggregate (base payment + SDP) can't exceed "average commercial rate"
- Evaluations to CMS @ 3 years if SDP total exceeds 1.5% of all capitations

Off-budget SDPs a growing part of Texas Medicaid Spending

Agency Overview

TEXAS Health and Human Services



Health and Human Services Commission – Percentages of Estimated Total Available Funds (2022-23 Biennium)

Does not include Interagency Contract Funds in Goal K, Office of Inspector General ($10.6 million), and Goal L, System Oversight and Program Support ($294.0 million). The Direct Administration category includes Access and Eligibility Services and Regulatory Oversight. SNAP benefits and Off-Budget Supplemental Payments are 2022-23 estimates.

In Lieu of Services (ILOS)

- ILOS: Option states can employ in Medicaid managed care to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing instability and nutrition insecurity, through the use of a service or setting that is provided to an enrollee in lieu of a service or setting (ILOS) covered under the state plan.
  - This flexibility can be really effective in BH and LTSS
- Proposed rule: Rights of Medicaid enrollees to NOT accept ILOS if they prefer an entitlement service
- Require states to define ILOS, MCOs to report % of spending on ILOS
- State can terminate an ILOS (why?)
- ILOS costs Not to Exceed 5% of total capitation payments; documentation and reporting are increased if exceed 1.5% of capitations.

Important for Texas Advocates to Support Pro-Enrollee proposed rule provisions, because strong SDP opposition expected.

Opposition that is expected:

- Requirements that would strongly enforce 30+ year prohibition in fed Medicaid law of hold harmless/quid pro quo in Medicaid provider taxes.
- Standards for Medicaid Managed Care network adequacy could be opposed by some MMC plans, especially for-profit plans.
- Some **states** may oppose the payment adequacy rules, because they carry costs.

children's defense fund texas

Initial Unwinding Renewal Data

Initial Unwinding

Of 18 states that have reported data, 31% lost coverage and about 24% were still being processed

Over 1 million Americans have lost Medicaid in unwind so far

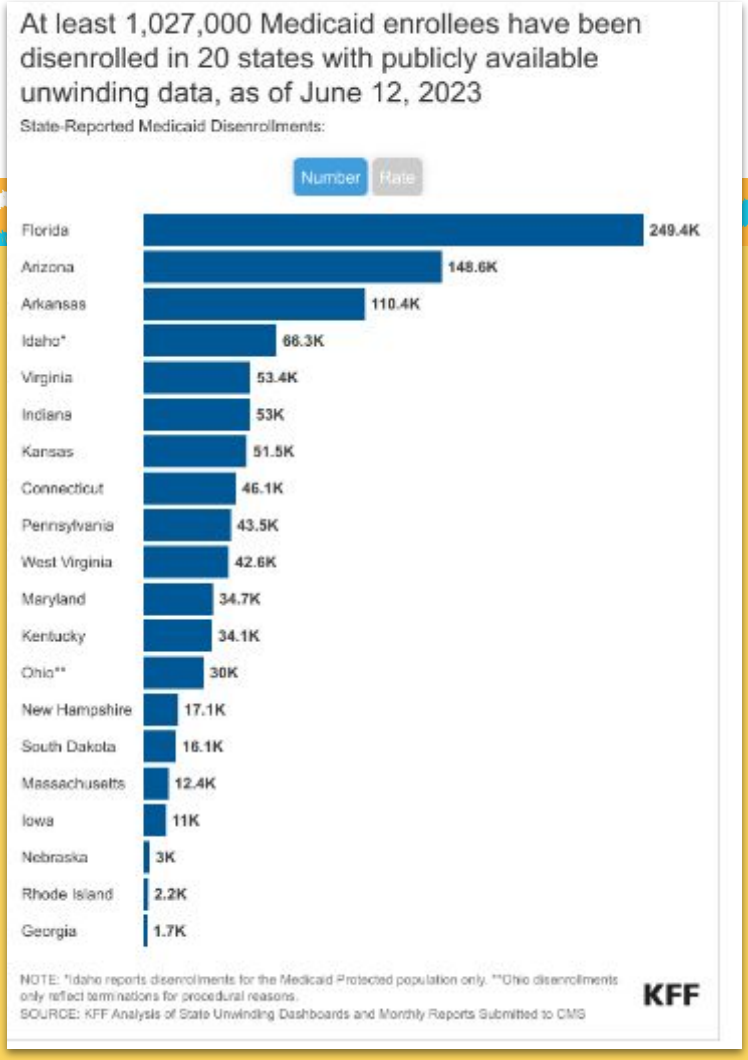
Renewal Data

Of those that lost coverage, 4 in 5 were dropped for procedural reasons

Children and people of color are most likely to lose coverage in general + due to procedural reasons

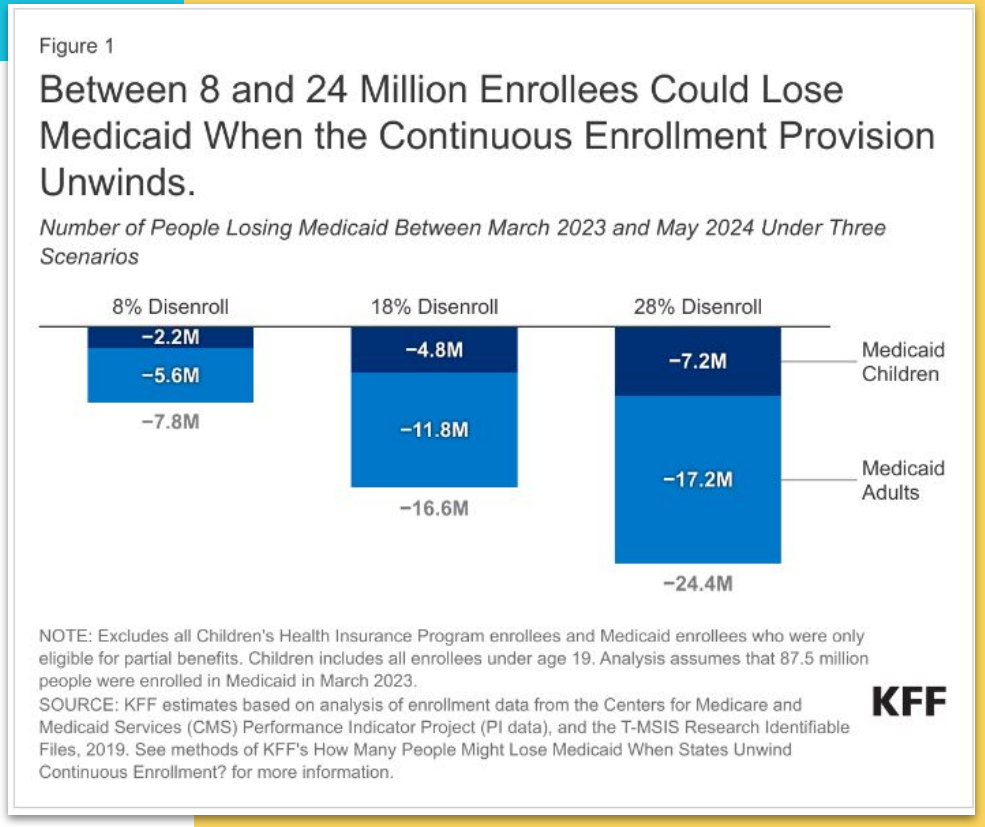
Initial State Renewal Data Reflect Advocate Fears

- **Arkansas**: In Arkansas, 142k lost coverage in first two months
  - **3-4k newborns, 22-24k children each month; 80% procedural reasons**
- **Florida:** in first month, 250k lost Medicaid (54% termination rate; **82%** of those for procedural reasons
- **Indiana**: 53,000 Medicaid members dropped in first month, 1/3 were kids; 90% procedural reasons
- **Utah:** Majority of members lost coverage, **90%** procedural reasons



Foreshadowing predictions

- Recent CBO estimate predicts **nationwide, child Medicaid enrollment will decline by 4.7 million** over the next three years
- HHS 45% of people who lose coverage will remain eligible
    - Worse for children: ASPE projects **3 out of every 4** children who are disenrolled from Medicaid will actually remain eligible



Calls to slow down, strengthen state plans

- Xavier Becerra, secretary of DHHS, sent a letter to state governors June 12th
- Wyoming is not dropping members for incomplete paperwork until July or August; Oregon won't start terminations until October
- State advocates (AR, Florida) letters asking for pause

Reality for Texas, Non Expansion States

- As a non-expansion state, the vast majority of Texas Medicaid members who lose coverage will be **children parents, young adults, and new mothers**
    - KFF report estimates between **500k-700k+ Texas children could will lose their Medicaid during the unwind**

Texas Unwinding Updates

Every Texan

Texas Unwinding Timeline

	April 8	May 13	June 10	July	Aug	Sept	Oct - March
Renewals initiated in month	1 million	226K	260K	1.3 million	1.3 million	1 million	170K – 280K
	Cohort 1			Cohort 2	Special populations	Cohort 3	

Data from HHSC Unwinding reports to CMS, June-March numbers are HHSC estimates

Initial Texas Unwinding Data

- Texas is not scheduled to start reporting unwinding renewal outcome data to CMS until August 8.
- HHSC has shared unwinding reports to CMS within a day or two
- HHSC verbally shared initial and incomplete response rates for renewals sent in April :
  - From 4/8 to 5/3: 21.7% of renewal packets were returned (due date was 5/15; this is not final data)

Several Unwinding Issues Reported

- **Notices**
  - Renewal packets or termination notices not received
  - Multiple notices/packets received, some with conflicting information
- **Verification**
  - Clients asked for information on items not required for Medicaid renewal. Clients not sent forms needed for renewal (Medicaid for Breast and Cervical Cancer).
  - Verification already submitted requested again
- **2-1-1**
  - Frequent disconnections
  - Long hold times for Spanish-language line
  - Conflicting information w/ YTB or notices
- **Delays**
  - Submitted renewals are taking more than 2 months for HHSC to process. Clients getting coverage extension notices
- **Your Texas Benefit**
  - Often offline for maintenance. Glitches/errors
  - Cannot renew/submit needed verification in reconsideration period

Next Steps

Goal: ensure HHSC has the flexibility, resources, and direction to address unwinding issues and maintain coverage of eligible individuals

- Collect and report issues. Share information on issues. Meetings every other week.
- Consider joint advocacy on new CMS flexibilities and other key recommendations
- Consider strategies to raise awareness of outcome data in August and stories of Texans.