House Appropriations

Medicaid

February 15, 2023

ADVOCACY UPDATE
TAHP

Roll Call

Chair: Bonnen, Greg - Present
Vice-Chair: González, Mary - Present
Bell, Cecil Jr. - Present
Bonnen, Greg - Present
Bryant, John - Present
Gervin-Hawkins, Barbara - Present
Howard, Donna - Present
Johnson, Jarvis - Present
Martinez, Armando - Present
Martinez Fischer, Trey - Present
Morrison, Geanie W. - Present
Ortega, Lina - Present
Rose, Toni - Present
Wu, Gene - Present
Allison, Steve - Present
DeAyala, Mano - Present
Gates, Gary - Present
Isaac, Carrie - Present
Jetton, Jacey - Present
Orr, Angelia - Present
Spiller, David - Present
Stucky, Lynn - Present
Tepper, Carl - Present
Thimesch, Kronda - Present
Thompson, Ed - Present
Toth, Steve - Present
VanDeaver, Gary - Present
Walle, Armando - Present

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Resources

- Public hearing notice
- Video of hearing
  - Part 1
  - Part 2
- Presentation materials
  - HHSC presentation on Medicaid and Chip
  - HHSC presentation on Mental Health Services

Invited testimony

Overview of the Texas Medicaid Program

Claire Stieg, LBB, Budget Analyst (Part 1, 0:02:19)
97% of Medicaid recipients receive care through MCO's.

Waivers are another way that states can provide services in home and community based settings.

Primary budget drivers of Medicaid expenditures are caseload changers; result of policy, population growth, etc.

Reduction tied to the end of continuous coverage.

Projected decline in funds related to the end of enhanced matching.

Each state has a different FMAP.

6.2% increase of FMAP for public health emergencies if states maintained continuous coverage. This increase will be phased out through 2023.

Other services matched at a different rate.

76.9 billion, the vast majority at HHSC for Medicaid services

Does not include supplemental.

Toth: Cost-growth (page 9) rate change and acuity.
Stieg: Utilization is highest with continuous coverage.
Toth: Asks about illegal immigration and if that is driving the cost of Medicaid. Is the Fed paying the fair share?

Rose: Base bill adds funding to behavioral health. In my county we need step-down beds. Can this be used for that?
Stieg: I think there is a presentation on behavioral health that can outline it.

Stucky: Asks about where Texas sits compared to the other states in FMAP and expected contribution.

Stephanie Stephens, HHSC, State Medicaid Director (Part 1, 0:16:35)
Texas serves about 5.8 million through Medicaid, that is significant growth from PHE. Medicaid serves a broad swath of people and CHIP is children only, those at a higher level of income. Medicaid is an entitlement program and CHIP is not. Individuals must meet both income levels and eligibility in the population category. Texas Medicaid income levels in general align with federal requirements. The small number of those in fee for service are either in enrollment for managed care or a program not in managed care. We are continuing to move services to managed care. Focused on shifting from fee for service to value-based payments..

Molly Lester, HHSC, Deputy Chief Program and Services Officer (Part 1, 0:23:20)
On continuous coverage.

March 2020 allowed states to receive enhanced matches based on continuous eligibility. For the last 3 years, everyone on Medicaid stayed.

In December, continuous eligibility was no longer tied to the declared public emergency. States can start disenrolling April 1. We must do a full redetermination, 30 days notice

required, must pursue updated contact information including following up on returned mail.

About 2.7 of 5.9 million estimated to have been covered because of continuous eligibility. Top goal is maintaining coverage for those still eligible while balancing eligibility staff.

The unwinding process begins in April. Then normal time frames.

We are notifying members this is coming and asking them to update contact information. This includes texting those who have opted in. This weekend we are going to determine the redetermination population and put in cohorts.

In March we start with the first cohort. Start receiving packets in April. They have 30 days to respond. June 1 would be the first day to remove. March of 2024 the last to establish a redetermination.

The unwinding plan is currently 20 pages long. Added 1,000 eligibility workers, increased salaries, added 400 staff to 2-11 call center. Increased efficiency to electronic data sources, simplified some processes, worked with stakeholders including the Case Affiliate Assistance program. Last weekend started a password reset that doesn't require a 2-11 reset.

Ambassador program working with stakeholders. Now in the second phase of communications which includes more direct outreach and social media, etc.

Working with CMS to meet new requirements and guidance. There is a cross-functional agency group.

Wu: During the time expanded enrollment, was HHSC able to improve health results.
Stephens: The primary data we have is utilization. We have measures, but the lag is about 1-2 years.
Wu: Can you see that people are going to their GP more, regular screenings, etc.
Stephens: The public health emergency makes it tricky because everyone used less services during that time.

Wu: During normal eligibility you have to provide information, right?
Stephens: Correct. For example undocumented immigrants don't qualify for Medicaid, only emergency Medicaid

Walle: In the past HHSC provided good utilization rate data. Do you have the breakdown of the use by elderly, children, disabled.
Stephens: The majority are children. 4.2 million of the 5.8 (not counting children in the disability group). 392,000 Texans are aged or disabled.
Walle: There is a difference in how you pay for each subgroup
Stephens: The population is about 60-70 percent but are about 30 percent of the cost and the inverse is true
Walle: How do you get on Medicaid? Income levels?
Stephens: When you look at those charts, it's based on federal income poverty levels.

Walle: Clarifies that undocumented citizens only would qualify for emergency services.
Walle: On the winddown, we already had a lot of vacancies of staff, when you added these 400, does that take you to the level of staff that you need?
Lester: Our exceptional FTEs we asked for an additional 642 to support the unwinding ($143 million all funds).
Walle: Asked about eligibility at the time of sign up.
Lester: Clarified that everyone should have been eligible at the time of enrollment.

Walle: What was the impact of women receiving Medicaid extension related to the 6-months extension?
Lester: Because we don't currently have federal approval for 6-months, once we begin redeterminations those women will go back to 2-months postpartum. The earliest women who are past postpartum coverage would lose Medicaid is June. Those eligible will be transferred to healthy Texas Women.

Walle: What kind of services are available under HTW?
Stephens: General women's services, screenings, and there is health HTW Plus that includes services related to maternal mortality. We do monitor the availability of providers. Network adequacy standards are part of the waiver.

Walle: Do we need to pass another bill to get the 6-months coverage?
Stephens: With the waiver amendment, they do not have to respond.
Walle: What is the cost of the extension to 12 months for pregnant mothers?
Stephens: For 12 months (these are estimates for upcoming biennium) our estimate for 2024 would be 240 million in all-funds. About 90 million in GR. For the second year in the biennium, estimate is 310 million all-funds, 110 GR.

Toth: The Texas AG won a billion dollar settlement from Xerox now we have another contract with them. What do we do now to prevent problems?
Stephens: Our oversight of contracts has evolved. We now have 3 vendors, we have a governance structure including an executive group with LBB and DIR and other partners outside of the agency, key performance measures with penalties and liquidated damages if needed.
Toth: Is there a plan to bring the state auditors?
Stephens: Not that I know of, we have internal auditors at HHSC.
Toth: Forensic auditing is different from contract audits. What's going on in the field?
Stephens: We have performance metrics, require them to take action and impose damages

Spiller: You say 50% of Texas children are on Medicaid or CHIP. Do you have that breakdown?
Stephens: Right now the CHIP is 81,000 and Medicaid is 4.2 million, but this number is skewed because of continuous eligibility.
Spiller: How does coverage differ?
Stehens: CHIP is modeled on an employer-style coverage and Medicaid has requirements but the coverage is similar.

Howard: On postpartum coverage, in your three cohorts, those who are in the eligible 3-6 postpartum period, they will be in the last cohort.
Lester: Yes, there may be some in the first cohort but generally yes in the later cohort.
Howard: Without CMS approval, is there an option to fund with state dollars.
Lester: Yes, if we received that direction and funding we could start in March.
Howard: If we expedite it through emergency designation, we could start in March.

Lester: Yes, if we had the authority and funding by March. There are currently provisions that keep us from spending GR when there is federal funding. Legislation would be needed. This would require emergency legislation which would require the Governor's designation.
Howard: What is the time frame you would need to implement 12-month?
Lester: About 8 months, assuming the CMS model.
Howard: That means we would still have people that are disenrolled even if we passed it.
Lester: Yes.
Howard: So despite what the House did, because of what the Senate passed, there will still be people who drop off despite our desire to cover. I hope we get that emergency designation sooner rather than later.

Stucky: Is that additional staffing enough for redetermination? What's that process?
Lester: If we aren't able to verify electronically, we send out notices. They are staggered by the cohorts and initial renewal dates, but there will be an initial wave.
Stucky: Is the 1,000 additional you asked for enough?
Lester: We only anticipate the 642 through the unwinding but the 1,000 are filing pre existing vacancies.

Thimesch: The 642 would be temporary?
Lester: Yes, after unwinding we don't anticipate needing that on an ongoing basis.
Thimesch: The 1000, planning on keeping moving forward?
Lester: That will balance out with what is needed at the time with caseload.

Walle: What's the normal wait time for 2-11
Lester: 10 minutes.
Walle: Increase in wait times?
Lester: Did have a spike in wait times- had to do largely with SNAP applications.

Behavioral and Mental Health

Michelle Alletto, HHSC, Chief Program and Services Officer (Part 1, 1:07:55)
More than 8 billion dollars for mental health in 22-23 biennium.

2.3 billion in Medicaid and CHIP program.

Behavioral health covers mental health and substance use disorder funding.

Prevention and early intervention; programs important for children and adults mental health needs before they become more complex. Example; mental health first aid training.

Community based mental health services; case management, etc. LMHA's provide services to those with complex health needs.

Diversion services are geared towards adults and children that may have been in mental health institutions. Example; yes waiver program.

Crisis services can be short stays, or residential (longer) programs.

Inpatient psychiatric services are the most intensive; 343 private psychiatric beds, 20 are forensic. 215 community mental health beds. 2911 funded state hospital beds. Not all beds are online, largely because of staffing.

Hospital step-down program helps people go from inpatient to joining the community.

We have waiting lists and gaps including services for children. Our mental health partners have faced challenges.

Workforce is the biggest challenge. HB 1 funding has the tremendous opportunity to help our resources.

Jetton: Medicaid MCO's providing alternative behavioral services, in lieu of state services?
Ryan Van Ramshort: SB 1177 directed the agency to pursue an in lieu of services option to allow Medicaid Managed Care to cover certain additional services that we view as building out the continuum of care.

We let MCO's cover three of these services; partial hospitalization, intensive outpatient services, and coordinated specialty care. We had a contract starting at beginning of last year to MCO's. We are expecting plans to send operational plans to us 60 days before they plan to go live.

Jetton: Once those are received, is that when you figure out reimbursement rates, etc?
Van Ramshort: This middle is an in lieu of model, so there wouldn't be any separate type of rate changes.
Jetton: Obstacles?
Van Ramshort: Workforce comes to mind.
Jetton: Do we know how many beds are sitting there offline because workforce challenges?
Alletto: About 700.
Jetton: Once we get full capacity, do we know if this amount of beds is adequate?
Alletto: We don't think those numbers are optimal. Also have options to contract out in the community while waiting for hospitals to be built.

Rose: Local mental health authorities- haven't received additional funding. Did you all request any relief?
Alletto: We offered capacity building to LMHA's in a variety of ways. Covid relief funds and also through a novel PH provider charity program. LMHA's can request for uncompensated care costs to be covered.
Rose: Letter from Dallas county. What did that say?
Alletto: Concern for people in Dallas county jails waiting competency care; costs, workforce, etc.
Rose: People have been waiting over 900 days; expresses the inhumanity of this. Confirms the county is suing the state. The state needs to address this.

Bell: Discusses construction costs for forensic offices.

Walle: Uvalde; what specifically is HHSC doing?
Alletto: Disaster response counseling. Stay on the ground. Provide additional dollars so the local authorities could staff up. Budget execution order- 675,000 for multisystemic therapy.

Recess until final adjournment.

Continued discussions of Uvalde and competency care/bed availability for those incarcerated.

(Part 2, 0:53:32)
Johnson: How many vacant positions do state hospitals have? Is it a money thing?
Scott Schalchlin: 1800. I think people left for various reasons, including money (to make more in the private sector) and then competition increased everywhere. I think money is the main factor.
Johnson: Have you looked at how Medicare and Medicaid would impact this?
Alletto: We have not looked at these numbers to see how that would fix our waitlist in particular.
Schalchlin: Most would not be eligible.
Alletto: 60% of those in our hospital would not be forensic.

Wu: Is it that there are more mental health issues, or there's better diagnosing?
Sonja Gaines: All of the above.

Thimesch would like to see how many children are on waiting lists for hospitals.

Rose: Brought up the letter from Dallas County about the large number of inmates waiting on assessment. It cost Dallas County more than $500,000 to confine those that should be in state care.

The 1115 waiver should be what happens after DSRIP. The money now is what happens after DSRIP.

Trey: A part of the 1115 waiver negotiation, we wanted to do what we could to stabilize the LMHAs. It's a $500 million pool. If you look at the new money for directed payment programs, that more than makes up for DSRIP. $583 million compared to $400 million.

Rose: I'm concerned about the workforce.

Alletto: It does apply in that LMHA could apply to compensation rates.

Martinez-Fischer: Concerned about jail standards because too many inmates are waiting. What do we need to pay people to get the capacity we need? What efforts are we making?

Gervin Hawkins asked about short and long term strategies to address the backup of incarcerated individuals waiting, along with the 1800 bed vacancies.

Dr. Andy Keller, Meadows Mental Health Policy Institute (Part 2, 1:49:30)
Cannot have a state agency do everything, though believe they are doing everything they can.

Discusses LMHA's rate adjustment. Dollars never meant to be there to react to the workforce.

Need to have an "all of the above" approach to the workforce.

Innovative partnerships with local hospital systems; zero beds offline in hospital partnership systems.

Expanding diversion programs would be very impactful.

Recommend that lege fully funds consortium.

Rose: Do you feel like we have enough in this budget to fix the workforce shortage?
Keller: No, I do not.

Dr. David Lakey, Texas Child Mental Health Care Consortium (Part 2, 2:08:35)
Working across higher education to meet the mental health needs of our kids.

Five programs (equipping providers with tools, a learning health network, parental consent).

Budget: Last biennium 124 million dollars were invested. ARPA added more. All of our universities requested things and the committee put in what we needed.

If we can get the supplemental bill to carry dollars we haven't spent yet, that would be big.

Youth Aware of Mental Health program set up in schools. Increased child adolescent fellows training in Texas. 30.1 million dollars in CPWE- program where we put residents to train in LMHA's, and they will be more likely to work there after residency.