House Select Committee on Health Care Reform

March 9, 2023

ADVOCACY UPDATE
TAHP

Roll Call

Sam Harless: Chair - Present
Donna Howard: Vice-Chair - Present
Eddie Morales - Present
Tom Oliverson - Present
Greg Bonnen - Present
Four Price - Present
John Bucy - Present
Toni Rose - Present
James Frank - Present
Armando Walle - Present
Stephanie Klick - Present

Resources

Hearing notice
Video of hearing
Presentation materials

- HHSC
- Texas Primary Care Consortium
- APCD

Invited Testimony

Texas Health and Human Services Commission

Wayne Salter (3:30)

5.5 million identified as uninsured in Texas. 1 million bc don't fall within 5 covered populations. 5.4 million are undocumented. 19% of 5.4 are ineligible for subsidies. 47% are eligible for subsidies but not Medicaid. 10% of 5.4 are Medicaid eligible but not enrolled.

Community partner program. Partner with us to provide application and renewal assistance. 604 Community partner organizations. 696 partner sites across the state.

Page 6. Outreach/partnerships: Healthy Kids Act, Case Affiliate Program, etc.

New administrative process; gained access to "Work Number" from Federal Data Hub. Periodic income checks. Improved 211 capacity and responsiveness. Implemented virtual lobby to assist individuals during peak call times. Courtsey callback feature.

Reduced time of hire to starting training by 50%. Job fairs. Other initiatives. 1000 eligibility staff increase since 2022.

Molly Lester (12:20)
April 1st disenrollment will begin. Enhanced FMAP will phase out over 2023. Recheck eligibility for everyone on Medicaid and CHIP- full redetermination while allowing members 30 days to respond to renewal info.

Estimated 2.7 million on caseload.

Stagger redeterminations. 3 cohorts for Contin. Cov. People not in Continuous Cov will have it based off of their normal renewal dates.

June 1st is the earliest effective date for anyone in the first cohort to be disenrolled.

Online password reset capability. Eligibility support contracter working with us to process materials. Ambassador program engages community partners.

Planning mode moving to implementation mode. Continue working with CMS, completing final checks, monthly reports, etc.

Salter (20:15)
Areas for additional support: exceptional item requests additional funding to hire 642 FTE's to meet workload demands.

Other initiatives: application tracker, automate account transfers, allow for e-signatures, 211 voice respondent improvements, prompts to encourage people to complete applications.

Frank: Around 4 million on Medicaid going into pandemic. Now 5.9. 2.7 million that are at risk for dropping off, can you give more detail on this?
Lester: We implemented a flag system, instead of denying them and moving them to Medicaid we flagged them as people that would have been denied in normal times. Over biennium we assume our caseload to realign with historical trends.
Frank: Insurance and health care are not the same thing. What percent of those folks received any sort of health care?
Lester: Don't have details but can get you some information on that.

Walle: Eligibility and enrollment piece. Has it consistently been 10% people you can't reach? Are these measures working?
Salter: Historically been between 10 and 13%.
Walle: Do you work with FQAC's?
Salter: We do, we take their lead. And see what works with their outreach efforts.
Walle: For someone doing outreach, what's their starting salary?
Salter: Varies, we don't know those numbers.
Walle: For those doing eligibility, what is the starting salary?
Salter: 32,000, and we just bumped this up.
Walle: What is the 642?
Salter: 642, those are the state staff and these people are required by federal law to do the final authorization.
Walle: Retention, are these measures keeping staff?
Salter: We've gone from 21% down to 6%, but we've retained 91% of those individuals. We lose about 1% a month which is far improvement.
Walle: On processing for Medicaid and SNAP, do we have timeframe/turnaround time info?
Salter: About 25 days from when they apply.

Harless: Average wait time for when they call into 211?

Salter: A little over 2 minutes until answer.

Rose: How are y'all making use of texting/reaching out to members?
Salter: We can follow up with more detailed info on this plan. But it is our intent to utilize it more.

Bucy: 21% vacancies to 5.9%, what exact number is this?
Salter: A little over 300 vacancies. We have about 140 that are currently going through the onboarding process.
Bucy: What is the backlog now? Is there gonna be a gap, because we don't have enough staff in the interim?
Salter: Technology is built in for this. If we're delayed in processing, they will bump ahead and continue coverage until we can get to it.
Bucy: Ok, so that won't happen if they can't get to it. What's the trigger for the callback feature?
Salter: 15 minute wait, then callbacks get offered. Not dependent on time of day.
Bucy: When do they get the callback?
Salter: The same day.

Howard: What happens if you don't get the exceptional item appropriated?
Salter: We would have to direct non eligibility staff to do this job. Would be more difficult.
Howard: Idea is to get back down to a more normal FTE level?
Salter: Correct.
Howard: Tier system, what is required cost wise to do the upgrades and make it compatible?
Lester: Can work and get more info about this to you all.
Howard: Three cohorts. 3 month postpartum would be in the third cohort so we dont drop them?
Lester: Yes ma'am.
Howard: What can we do to get 6 month postpartum, with state dollars?
Lester: Would need a bill that says statute doesn't apply.
Howard: State dollars need to allow 6 month postpartum. Legislative intent would be met?
Lester: Yes.

Howard: Outstationed eligibility staff, how many?
Salter: 429 staff supporting 1024 locations.
Howard: Do you still have remote staff? Outstationed eligibility staff?
Salter: We would need to get back to you with this data.

Howard: If they don't respond in the time frame of 30 days, what do we do?
Lester: Don't have enough info to make sure they're eligible. They would be denied. People that need this info, we're confident they will have multiple opportunities.
Howard: Important we reach those that have less/no access to technology.

Walle: Technology, exceptional items?
Lester: We have discussed ITE needs, can work with y'all longterm on these needs/

Price: Community partner program. Education, awareness, and enrollment, correct? Utilized for any assistance in unwinding?
Salter: Yes, we are working with community partners to educate them, on how to educate partners.
Price: Increasing the sites? Stat: 1 partner site for 2200 people in poverty?
Salter: That's the goal. We have to set reasonable expectations. Last two years stunted our ability to get out there and recruit.
Price: Want 3x the amount you have currently?
Salter: Longterm, I believe so.

Morales: 5.9 million Texans served. Has that been the highest in the last 10 years?
Lester: Yes.
Morales: 30 million?
Lester: Sounds right.
Morales: Can you provide demographic information?
Lester: Yes.
Morales: Can you break up by regions?
Lester: Yes, I can definitely work to get all this information to you.

Morales: My district being the largest district and very rural in nature. I've heard it can take my constituents months to get service. Any ideas on how to get more physicians to accept Medicaid?
Lester: I am sure our Medicaid and CHIP teams have thought about this. Can refer them to get this to y'all.
Morales: Would be good to get info on this and how proactive they're being.

Morales: Chat GPT, many possible uses. Challenging you in a positive way, can this be implemented?
Lester: Last three years allowed us to look at opportunities for efficiencies. Can't say I've had discussion about Chat GPT, but broadly yes we are looking at this.
Morales: Can you ask the agency specifically about this program?
Lester: Certainly.

Frank: Just a comment. From an expansion standpoint, 7000 more would be enrolled.

Texas Primary Care Consortium

Ankit Sanghavi (1:11:00)
We are a statewide collaborative initiative.

Highlights the uninsured rate in the state. 2021 data shows the 19-34 and 0-18 age groups have the largest concentrations. With Texas children, almost twice the uninsured rate compared to the rest of the nation. Men have a higher rate of uninsured compared to women. Slides share data points on race and ethnicity.

Education and insurance coverage have a positive correlation.

Insurance needs in Texas are highly concentrated in rural and border areas, in the immigrant population, and those with a lack of educational attainment or experiencing unemployment.

Nationally, key reasons for the uninsured: coverage not affordable (70%), not eligible (26%), don't need or want (23%), confusing (20%), lost job (3%).

Where do the uninsured in Texas receive care? Primarily, FQHC's. Emergency departments, rural health clinics, nonprofit health systems, etc.

Frank: Reason for being uninsured- not being affordable is the largest reason. Health care is expensive. What do you think your organization can do to address the cost?
Sanghavi: Primary care spending in the state is 5 to 7 percent of health care expenditure. Primary care has an impact on 90% of health outcomes. With access, we need to emphasize primary care centric solutions and designs. Increase investment in primary care, we will see that cost come down.
Frank: Totally agree but see that the insurance model favors specialization. I would like to talk more about primary care vs the uninsured.
Sanghavi: Totally. When it comes to the problem of access, I would love to see a systematic investment of primary care and moving to a holistic approach vs the current fee for service.

Bucy: Can you explain how primary care helps address access for the uninsured population or anyone who struggles with access?
Sanghavi: I will probably be redundant. For example with chronic diseases, prevention first approach is important, and with primary care we are able to do that proactively and avoid emergency rooms, etc.
Bucy: 5 to 7 percent of cost for health care is primary care, can you elaborate on what this says?
Sanghavi: Data points on page 6 and 7. The percentage of uninsured who do not have a usual source of primary care, it's significantly higher. It's an acute problem.
Bucy: Those who do have primary care versus those who don't.
Sanghavi: An example, I was a practicing dentist. Would see lots of tooth decay. Obesity is a big issue particularly among those without primary care, which is correlated to lack of coverage. Obesity correlated with tooth decay.

Howard: Not having insurance is a barrier to not having health care. Example; maternal and postpartum care. To decrease maternal mortality, an example is my goal is to extend health care coverage to 12 months postpartum.

Howard: Going back to your slides, looking at tax credit eligible uninsured. Significantly increased Texans who got on those health care subsidized plans since this 2021 data. 570,000 new was a 31% increase.
Sanghavi: I believe you are correct that there's a decrease with the tax credit eligible in the uninsured populations as well as decrease in the marketplace eligible.
Howard: Idea is we need to approach this with all the different barriers, other than sorts of Medicaid expansion.
Sanghavi: Right, we can build on past successes.
Howard: Rate reimbursement is a massive barrier of adequacy of providers. Multiple physicians where it's just not sustainable at the rates we are reimbursing. There are a lot of factors involved here.
Sanghavi: Agree with this, and find that it's a holistic thing. Yes it has to do with insurance, but also has to do with geographical challenges, etc. Speaks to network adequacy.

Frank: To clarify, I'm not anti-insurance. It's great. But if they have insurance and no access to care, that's not good. We need to make sure we are looking at the goal. Need to address the cost of access to care. But also, some just can't afford insurance.

Walle: Do you have data as far as how much we have been leaving on the table at a federal level?
Sanghavi: Yes, I can provide that info. General sense, it's in the billions. I can show what we have retrospectively lost and will lose. Nationally and statewide.

University of Texas Health Houston

Lee Spangler (1:51:50)
Largest repository of research data in the state. The APCD will collect historical Texas claims data from Texas payors beginning from at least January 1, 2019. Claims will be collected every month.

Total covered lives, about 18 million. 60% of all insured Texans.

We make sure that data is accurate and complete before being put into use. Have to evaluate and analyze the data. Charged with establishing an advisory group, reporting to the legislature, and maintaining a portal that aggregates reports.

Shows mockup of what utilization dashboard would look like. Breaks it up by Medicaid, Medicare, Commercial, and also Community Factors (non-claims/non-medical information that provides insight into other numbers. Example: prevalence of smoking in an area).

We are in Phase 1 of development. Done with the registration period. Phases:

1. Data submission
2. Data enhancement
3. Data marts- development and maintenance

Harless: When do you anticipate this portal being available?
Spangler: Late 2024.

Price: When this is all accessible, you will illustrate trends but not necessarily make recommendations?
Spangler: We would be required to make recommendations that run through an advisory group. This makes sure we are focusing on the right things.
Price: DSHS, have y'all considered gathering data and reporting on the lag that may exist when people are sending their stuff into the lab and then getting their results back?
Spangler: Frankly, no. We are a claims database so we only get information about when a claim comes in.

Frank: When it rolls out, will you be able to see what a procedure costs?
Spangler: We will be able to report in the aggregate. Trends in cost, we could determine what it would cost in a geozip. The aggregate, not provider level.
Frank: That data won't mean much if there's only one player in an area.
Spangler: No prohibition on statewide averages in the act so don't see why we would not provide statewide averages. Won't confine to a small window.
Frank: If we could use something at a consumer level, that is what would maybe actually make a difference. Thanks for your work.

Howard: Milestones and progress. January 2022, advisory group established. Who in general is on this? When do you all meet?

Spangler: Reps of hospitals, community plans, health plans, health economists, etc. Have met a few times virtually.
Howard: Immunizations track registry. Problems of interoperability with this and a lot of health systems.
Spangler: We get info when something is paid for. We are a way to fortify these registries. DSHS has reached out because they want us to help them I'm sure.
Howard: Is interoperability gonna be an issue?
Spangler: Don't have any idea of this, because we are truly a medical claims database. There should be no friction there.