Texas CHIP Coalition
Meeting Minutes

May 16, 2014

Present:	Lauren Dimitry, Texans Care for Children Alice Bufkin, Texans Care for Children Clayton Travis, Texans Care for Children Catherine Samuel, Children's Defense Fund Sister JT Dwyer, Seton Anne Dunkelberg, CPPP Megan Randall, CPPP Kathy Eckstein, Children's Hospital Association of Texas Dimitria Pope, HHSC Shannon Lucas, March of Dimes Sonia Boyd, Blue Cross Blue Shield Kit Abney Spelce, insure-a-kid Laura Blanke, Texas Pediatric Society Helen Kent Davis, TMA Stephanie Stephens, HHSC
Conference Line:	Gracie Escobar, Parkland Health and Hospital System Bethanne Keating, Parkland Health and Hospital System Bob Reid, Parkland Health and Hospital System Community Dental Care Micah Wright, Children's Medical Center of Dallas Covenant Children's Hospital in Lubbock Rose Marie Linan, HHSC NASW Texas Chapter Sierra Thomas, Sendero Health Plan Kiera Sammis, Children's Hospital of San Antonio Miryam Bujanda, Methodist Healthcare Ministries Adam Ibarras, Texas Children's Health Plan Robin Smith, Driscoll Children's Hospital Annette Frantz, Texas Breastfeeding Coalition Cynthia, Harris Health Summer Stringer, Texas Food Bank Network Christine Sinatra, Enroll America RexAnn Shotwell, TACHC
Chair:	Kathy Eckstein, Director of Public Policy, Children's Hospital Association of Texas
Minutes Scribe:	Megan Randall, Center for Public Policy Priorities
Next meeting:	June 20, 2014

I. Medical Transportation Program (MTP): Dimitria Pope, Director, Medical Transportation Program, HHSC

See the attached handouts for more information.

DPope:

- In August of this year, the new rules will be adopted. We want them adopted prior to implementation of the program on September 1. There will also be amendments to the state plan to address service delivery model issues. We have to submit a waiver application to CMS because of the type of service we are delivering.
- We provide demand response. A client calls in and requests a trip, if MTP-eligible. They also have to be Medicaid-eligible, or be a child with special health care needs. We also have a small population of indigent cancer patients to whom we provide services.
- In addition to the demand response, we also have mass transit. We provide bus tokens if they live within a quarter mile of a bus stop and are physically able to ride a bus. Most services are shared rides. However, if there are specific medical needs, we will accommodate on a case-by-case basis.
- If the client needs to travel a certain distance, we provide transportation through commercial airlines. We also have mileage reimbursement and individual transportation participants. These are individuals who transport clients from the residence to the health care appointment. In the past, it was reimbursed at 50 cents per mile but we just received approval to increase the reimbursement rate to 56 cents per mile.
- The last piece we provide is advanced funds. This is money that we provide to families who are financially unable to transport their child, or themselves, to a healthcare appointment.
- We used to contract with a provider for these services, but then we brought these activities in-house. We are now contracted with a US bank that provides a credit card to clients (for gas and oil purchases only). We also provide cash assistance to clients via Western Union. The amount we give is based on the hotel and if they need some other assistance for an attendant, we evaluate and provide those funds.
- Beginning September 1, these contractors/vendors/MTOs will be responsible for delivering the same quality of service that we have provided in-house. The way we will hold them accountable is to be sure that they submit policy and operation manuals. Clients will have even more avenues to voice issues or complaints. They can go to the MTO, to the office of the ombudsman, or to our administrative offices.

ADunkelberg:

- How will MTOs interact with managed care organizations?

DPope:

- I have reached out to say we need to include these health plans in this discussion so that they can understand what our policies are.

CTravis

- Is it the responsibility of the managed care plan to make the call to the MTO? Or is the onus on the client?

DPope:

- The client can make the call, or the case worker/case manager, or the health plan. There is communication, though not as much as I would like.

CoalitionMember:

- When clients call the 866 number, they are told they need to call their MCO for a letter of authorization. Will this still be the process for all these MTOs?

DPope:

- This is not the typical way. The only time we ask for preauthorization is if they are crossing into another region, or going out of state. Then we ask for a letter of

authorization. We collect all that info and send it to the office of the medical director and let them make that decision. We will take care of the transportation, if approved.

KEckstein:

- Is there a standard form, or do all MCO's have their own?

DPope:

- They all have their own.

KEckstein:

- The overlap on the map between MTOs and MCOs will be complicated because we will be dealing with multiple MTOs and MCOs. If there is any way that HHSC can go through these policies and push for standardization it would help.

SBoyd:

- We currently have a case where a member's appointment has been moved from July 2 to Monday. We only have so much time to put in letter of medical necessity and there is only so much time for them to get reimbursed.

DPope:

- We have worked a lot of last-minute cases. We handle them personally. Often we find that clients will change the appointment on a whim. Part of the educational piece is that, to the degree you can call and give us a date ahead of time, where we can accommodate you, we will. With advance funds, all we have to do is call to validate that the appointment does take place. The onus is on the client to bring documentation, but it doesn't mean we wouldn't give them the money up front. If you have the Medicaid number and the clients' name we will look that up specifically and tell you what the status is.

RSmith:

- When working with MTOs, it is important to understand that there is a huge initiative nationwide to try to get patients seen sooner, so we are working on getting them the 1st – 3rd appointment available, and this is all over the nation.

DPope:

- All our intake agents have to identify themselves by their first name and a four-digit ID. If you are having a problem, you can call me directly and identify the agent and I can go and listen to the recording. I also just had a meeting with all the respective vendors this week. Once the contracts are executed in June, I intend to bring the vendors back and at that point reinforce that we want them to not only deliver quality transportation services but really meet the needs of clients. That is why I created the Default Call Center. We have about 50 people staffed at the Default Call Center. We will schedule as needed, but it is the MTO's responsibility to schedule those trips. But if a client calls and wants to complain, they can come directly to the call center. All calls will come directly to me if the MTO is down.

CTravis:

- How many clients are served by the program?

DPope:

- We provide transportation services to 3 million unduplicated clients a year.

ADunkelberg:

- I'm sure you always have people along edges of regions who may go into other regions for services, where do they go?

DPope:

- We have identified several thousand clients who live on border zips. We would handle that. The originating region provides the service.
- We currently pay fee-for-service based on trips and number of people. In this new world, we will go to a capitated rate structure, and pay per member per month. We will calculate

a rate for a specific region, with the variable being the number of eligible clients (potential), and we are paying for that.

KEckstein:

- Are any services provided across MTO lines that the MTO is not responsible for?

DPope:

- They are paid per member per month, regardless of where the members have to go. Currently, they work as island entities. We want to alleviate that dynamic and remind them that there really isn't the same competition that existed before, and we need to keep the client's benefit first. Work out some type of arrangement with the receiving entity so that they can help you out.
- Current MTP program pays for services for a patient and a person or provider and we are now moving to a managed program paid per member per month.

SLucas

- Are pregnant women eligible for pre and postnatal appointments?

DPope:

- I don't know.

ADunkelberg

- My default sense would be yes, because they are a mandatory Medicaid service.

SLucas:

- Post-natal appointments have low attendance, and transportation is a big reason. Have to have a car seat, and if have multiple children, can't bring more than one child. So many women are not going for their post-partum appointment because of hurdles with transportation.

DPope:

- MTOs are not required to provide car seats, and policies regarding families with multiple children are left up to the discretion of MTOs.

SBoyd

- Have a case of a pregnant mom who has to have her baby in Houston. So, she was going to get mileage reimbursement, but would not be eligible for lodging until the baby was born.

DPope:

- Mileage reimbursement is typically only available for children with special health care needs under 20, so the adults are ineligible. We might be able to work something out for her in this situation. Call me directly and I can look into it.

HKentDavis:

- Moving forward, establishing standards regarding where women and neonates should be delivered when they are high risk will be a big issue. Doctors think they need to be in Houston, Dallas, etc. because they are higher risk. There are only a few hospitals in the state that would be at that level of designation. Something needs to be worked though with the Perinatal Advisory Council to make sure we have options.

SBoyd:

- Also, it is an issue with meals and lodging. They have to be in that area before the baby is born for these babies to be taken care of.

KEckstein:

- If a family wants to get their own reimbursement, they enroll as an individual transportation provider because the state is using a claims administrator. This is complicated, that families are treated like providers. Does this mean that the MTOs will now provide that service?

DPope:

- Correct. The individual transportation providers won't have to go through the claims process any longer. There was what appeared to be thousands of people with delayed reimbursement who had to submit documents repeatedly. TMHP lost them and so we pulled them out because we did not want them treated as providers. All individual transportation providers will have to do is provide a copy of a driver's license and vehicle insurance to be credentialed by the MTO. They can make the decision to approve them and validate that they went to the appointment.

SBoyd

- So the vehicle insurance doesn't have to be under the name of the person driving the vehicle? We get a lot of mileage reimbursement returned. Very frustrated with the system.

DPope:

- To the degree that we can address it, we can look at it specifically to make sure that all the facts are on the table.
- Whoever is driving the vehicle needs to make sure they have the correct and up-to-date insurance information.
- 512-706-4901, Dimitria.pope@hhsc.state.tx.us

KEckstein

- Implementation plan was for all of this is to turn over in July?

DPope:

- Yes. We will initiate contracts and get them executed during the first week in June. Those MTOs will be responsible for getting logistical and administrative systems set up. We are working now with two big pieces:our IT piece and telecom. Those are critical threads that will tie all these MTOs together. They have a deadline to get all their work completed by the 1st of July. During the latter part of July, MTOs will be expected to take calls from the 1st through 15th of August and schedule for trips for Sep 1.
- Each MTO will have a call center in addition to the default one.
- People won't have to memorize numbers, it will be the same number. So, they enter a zip code and it knows where to go. 1 MTO per region.

SisterJT:

- We are in the process of writing policies that will govern the operation of vendors. Are you considering designing a client satisfaction form? Participants in the program would be urged to fill it out. It would be a very simple form (e.g. did the ride arrive on time, etc.) so that we can get a handle on what vendors are doing and how they are performing. Second, in the present model, you record all the calls. Will this be a rule or policy for vendors?

DPope:

- Yes, we are going to be recording calls. Those calls will be maintained at our location. The client satisfaction survey component has already been done. This was part of the requirement of the RFP. The survey will not be uniform. They will have to contract with an independent company that does this, and then put a threshold on it. They have to have 95% satisfaction. If they fall below that, there are liquidated damages assessed.

SisterJT:

- What percentage return on the form is required?

DPope:

- Don't remember specifics, but do have some requirements.

SisterJT:

- The reading level of the form needs be appropriate, and easy to fill out.

II. HHSC ACA Implementation Update: Stephanie Stephens (HHSC)

See the attached presentation slides for more information.

SStephens:

- Receiving and sending account transfers. We have received 200,000 and have touched 199,000. We have transferred 391,000 to the Marketplace. At the last meeting, we gave you a breakout of different reasons we received transfers and what the ultimate eligibility decision was. From April to May that has stayed pretty steady. Not a lot of change. 65% are MAGI referrals, 8% are full determination requests, and 27% are non-MAGI referrals.
- We were also asked for some additional data on account transfers, and numbers for the denials. As of May 5, some of these data are not apples to apples and are from different points in time so they won't add to 100%. 99,000 denials for MAGI referrals.\
- At this point, we don't have a hierarchy of reasons for denials. The top reason is income. In our systems, cases get multiple denial reasons and we have to apply a hierarchy to them and are working on that.

ADunkelberg

- What we want to understand is what is driving so many of these referred cases being ineligible/denials. Why it is such a big number being referred and such a small determined eligible?

SStephens

- Top reason is over-income, but beyond that we are still drilling down.

ADunkelberg

- What is it that they are seeing that makes the Marketplace think they are under-income, and HHSC think they are over-income?

SStephens

- I have seen some data that they have sent showing that the income is just over our limit.

ADunkelberg

- Some of us as CACs saw that happen while assisting people, particularly early in the process.

SStephens

- I don't know how granular we can get. We don't have visibility into what the Marketplace is doing that is making them say the person is eligible when the income is over the limit.

CTravis:

- Is the income way over the limit, or just on the line?

SStephens

- The ones I saw weren't close. It wasn't a matter of a couple of dollars, it was that they were over the limit.
- The small amount of info we have from other states is that other states are reporting a similarly high percentage of denials. I do not believe it is unique to us. Other states are reporting high denial rates as well.

KAbney:

- Do you have a breakdown between adults and kids? Are a lot of these referrals adults?

SStephens

- We have data on approvals.90% of approvals are falling into the children's group. We haven't looked at specific data for denials by age.

KAbney:

- Since we didn't expand Medicaid, is the ACA still sending Medicaid-eligible adults to you?

SStephens:

- They have told us they are not sending us the expansion group. We know that we are getting people over income and households that don't have an eligible child, but we don't know that it is because they are sending us expansion people.

CTravis:

- We would get a lot more denials if they were sending the entire expansion population.

SisterJt:

- It is a tremendous waste of state and federal resources, having to look at cases multiple times.

SBoyd:

- I wish we could take these denials and have a human being analyze what is going on here. Is it because we use current income and they use projected yearly income, is that what is not understood by them?
- Is it that they don't understand that to get parent Medicaid you have to have a child? You can't just send an adult or married couple. What is it that the feds do not understand?

SStephens

- We have communicated to them that we are denying a high percentage. We have sent them specific cases and examples of people that we are denying that they said were eligible.

KAbneySpelce

- Is there a good dialogue?

SStephens

- We have routine contact with CMS. There is a lot going on and now that open enrollment is done we not sure how they are prioritizing things. We have strongly communicated that these people are not Medicaid-eligible. There has not been follow-up on where they are in the process of addressing this.

CTravis

- It sounds like it is a national problem.

ADunkelberg

- I think, like Stephanie said, that there is a lot of stuff on their plate right now. About once a month, we get to talk to CMS and CCIIO. This is the type of thing that I can raise with them.

KAbneySpelce

- When people apply through the Marketplace (with annual income), and this referral comes to you, do the workers go into state systems to look at current income? Are all of these people getting income verification letters? How many get denied because they don't follow through or provide information?

SStephens

- There will be both. It will be a mix. The data has all different kinds of cases from different time periods. There are data that include early system errors, data where we were processing things somewhat differently (i.e. just accepting income from CMS), and now we are applying normal verification requirements. We now have a mix of failure to provide information and denied because they are over income.
- But when we were just running straight cases through our rules, some of those were over-income, too. Some of these are a mix of different kinds of processing and different time periods.

KAbneySpelce:

- But going forward, you receive a referral from the Marketplace, you use your systems to verify current income, and if you can't verify you will pend and send a letter asking for

income verification. It may then get denied either because of failure to provide or because you review current income and make the eligibility determination.

ADunkelberg

- What is being denied because of missing information vs. over-income?

SStephens

- Let me go back and check.

ADunkelberg

- I had a discussion yesterday with the Deputy Commissioner who said most of the denials were for missing information. Procedural denial not the same as a determination of ineligibility.

SStephens

- Yes, but we can say that the highest reason for denial is over-income (not failure to provide).

KEckstein:

- Have you received any response from CMS about the SPA for presumptive eligibility?

SStephens

- We are having calls with CMS on each of those SPAs, but we haven't had it on the hospital piece yet.
- I don't know what conversations they are having with other states, but we know that other states have submitted similar standards and have not seen CMS give an official approval of those things. We have a call next week with CMS on the hospital presumptive eligibility SPA.

KEckstein:

- It would be good to get a picture of changes that have happened throughout the eligibility system. For example, hospitals don't know where out-stationed eligibility workers are in Texas.

SStephens

- I will follow up and see if I can get you a list. We will get you some answers to the questions you forwarded by end of day.

KEckstein:

- It would be great to know how many out-stationed eligibility workers there are, and what each hospitals' contribution is.

KAbneySpelce:

- Have you heard anything about the 1205? Any response on that?

SStephens

- We are in discussions with CMS.

ADunkelberg

- HHSC has 60 days to file an appeal, correct?

SStephens

- Yes, and we have not appealed yet. We are in discussions with CMS.
- The intention is to continue to use the application as is until those questions are resolved.

ADunkelberg

- Regarding continuous eligibility, it is very clear that there will be a requirement for monthly reporting at a highly granular level. Where does the agency see that process on its timeline? Would like to send those links to the list.

SStephens

- We should be able to get answers to those questions today.

KAbneySpelce:

- When Stephanie sends responses to some of the questions, one of the continued questions is whether there is movement to put CHIP verification into TMHP or its successor(so that there is one location for verification for all coverage).
- There were also concerns about CHIP perinate coverage.
- Also, there are lots of folks working in a hospital setting who are still using paper applications and we want to be sure we are filling them out correctly. It would be great to get a training, going through the paper application section by section, illustrating how to complete it correctly.

CTravis:

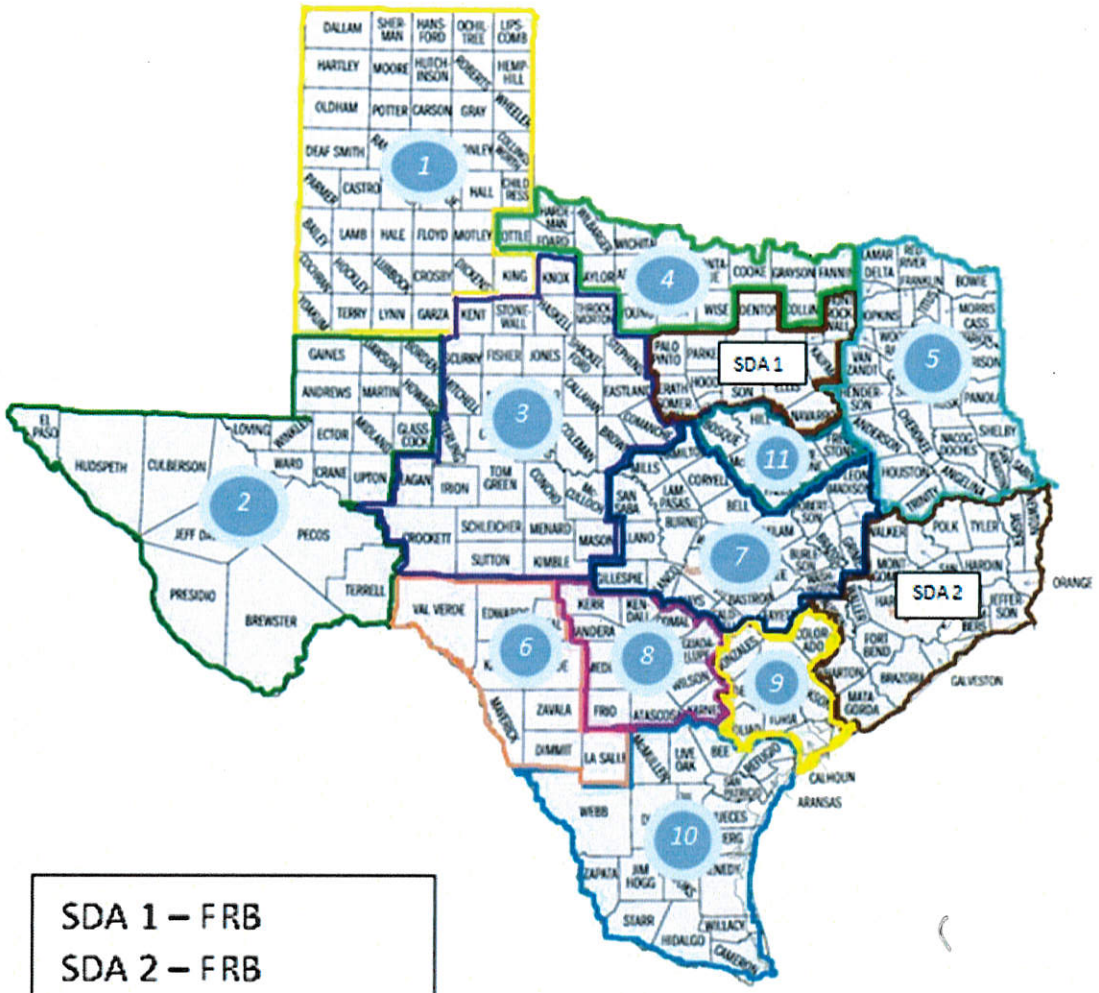
- Texans Care for Children distributed some comments on regulations around former foster care children, if you want to sign on, please do so by Wednesday of next week.

KEckstein:

- Also, it is the season for LAR input and the agencies right now are asking for stakeholder input.Today is the deadline for HHSC.

TEXAS
Health and Human
Services Commission

Proposed Regions: Option 3



MTO Region 1 – Panhandle
MTO Region 2 – West Texas
MTO Region 3 – Northwest Central
MTO Region 4 – North Texas
MTO Region 5 –East Texas
MTO Region 6 – Southwest Texas
MTO Region 7 – Central Texas
MTO Region 8 – South Central Texas
MTO Region 9 – Southeast Texas
MTO Region 10 – South Texas
MTO Region 11 – Northeast Central

SDA 1 – FRB
SDA 2 – FRB

MAY 22, 2014

MEDICAL TRANSPORTATION FORUM

10:00 AM - 12:00 PM

Sponsored by HHSC:
Medical Transportation Program (MTP)

The purpose of this forum is to gain an understanding of how medical transportation services can work together to improve services to all Texans.

RSVP to Alexis Vasquez:
Alexis.vasquez@hhsc.state.tx.us

PUTTING THE PIECES TOGETHER

Invitees:

Department of State Health Services (DSHS)

Full Risk Brokers

Medicaid CHIP Division

Medical Transportation Program (MTP)

Texas Ambulance Association (TAA)

Texas Medicaid & Healthcare Partnership (TMHP)

Regional Contracted Brokers

STEPHEN F. AUSTIN STATE OFFICE BUILDING

1700 North Congress Avenue, Room 170
Austin, TX 78701

TEXAS Health and Human Services Commission

TEXAS
Health and Human
Services Commission

Status of Federally-Required Medicaid and CHIP Eligibility Changes

May 16, 2014

TEXAS Health and Human Services Commission

Status of Account Transfers

Account Transfers from the Marketplace to HHSC (Inbound)

- The federal Marketplace began sending applications to HHSC on January 17, 2014. HHSC currently receives applications weekly from the Marketplace and processes them as they are received. As of May 13, 2014:
  - HHSC has received 208,278 unduplicated transfers from the Marketplace.
  - HHSC has processed 199,000 applications, of which, approximately 188,000 were completed and approximately 11,000 were in progress.

Account Transfers from HHSC to the Marketplace (Outbound)

- Between January 5, 2014 and May 13, 2014, HHSC transferred 391,549 cases to the Marketplace. Transfers occur daily.

Types of Account Transfers

- There has been a slight increase in the proportion of MAGI referrals received and a slight decrease in the proportion of Non-MAGI referrals received over the last month.

- *MAGI Referrals* - 65 percent of applicants received from the Marketplace
  - The Marketplace assesses applicants' potential eligibility for Medicaid and CHIP programs that use modified adjusted gross income (MAGI) rules. If an applicant is assessed as potentially eligible, the Marketplace transfers the individual's information to HHSC. HHSC then performs the final eligibility determination.

- *Full Determination Referrals* - 8 percent of applicants received from the Marketplace
  - All applicants are provided the opportunity to request that the Marketplace send their information to HHSC for a "full determination" even if the Marketplace has assessed the applicant as potentially ineligible for MAGI-based Medicaid or CHIP.

- *Non-MAGI Referrals* - 27 percent of applicants received from the Marketplace
  - The Marketplace also transfers applicants assessed as potentially eligible for Medicaid due to age, blindness, or disability. These individuals are sent an application for Medicaid for the Elderly and People with Disabilities (MEPD).

Account Transfer Outcomes

- Account transfer outcome data has generally remained stable over the last month. There has been a slight shift in the distribution of denials by referral type.

- Of the applicants received via an account transfer:
  - HHSC denied 79 percent based on Texas eligibility rules.
    - Approximately **57** percent of all denials are for applicants whom the Marketplace assessed as potentially eligible (MAGI referrals). The difference between the Marketplace's assessment and HHSC's determination may be due to federal systems issues and differences in data sources used for verification (e.g., annual IRS tax return vs. current income verification).
    - Approximately **43** percent of all denials are for applicants who were determined ineligible by the Marketplace but requested a full determination from HHSC (full determination referrals) and applicants whom the Marketplace assessed as potentially eligible for MEPD (non-MAGI referrals). Almost all full determination and non-MAGI referrals were denied.
  - HHSC approved 17 percent.
  - 4 percent withdrew their application.

Account Transfer Outcomes: Denials

Total Denials

As of May 5, 2014, of the sample cases processed, approximately 172,000 were denied. Of the denials approximately:

- 99,000 were "MAGI Referrals"
- 16,000 were "Full Determinations"
- 57,000 were "Non-MAGI Referrals“

Reasons for MAGI Denials

- At this time, HHSC does not have data that includes full details on denial reasons.
- The most common occurring denial reason is excess income.
- HHSC uses more current verification sources, whereas the Marketplace may use older verification such as IRS tax information.

Account Transfer Outcomes: Approvals

Individuals Transferred from the Marketplace to HHSC *(As of May 13, 2014)*		
Type of Assistance	**Approved**	**Percent of Approved**
CHIP	11,500	28%
CHIP Perinatal	100	0.3%
Transitional Medicaid	50	0.1%
Parent and Caretaker Relative Medicaid	3,200	8%
Pregnant Women Medicaid	900	2%
Children's Medicaid (Under 1)	400	1%
Children's Medicaid (6-18)	19,500	47%
Children's Medicaid (1-5)	5,700	14%
Total	**41,350**	