Texas CHIP Coalition
Meeting Minutes

July 18, 2014

Present:	Laura Guerra-Cardus, CDF Alice Bufkin, TCFC Lynn Phan, CDF Reema Ali, CDF RexAnn Shotwell, TACHC Stacey Pogue, CPPP Shelby Massey, TACHC Olga Rodriguez, TACHC Sister JT Dwyer, Daughters of Charity Carrie Kroll, THA Marian Williams, AACOG Lauren Dimitry, TCFC
Conference Line:	Diane Rhodes, TDA Lauren, Texas Children's Health Plan Ellen, Children at Risk Alina Batool, Community Health Choice Betsy Coats, Maximus Miryam Bujanda, MHM Gracie Escobar, Parkland Hospital Bob Reid, Parkland Hospital Chris Yanas, THOT
Chair:	Laura Guerra-Cardus, Texas Associate Director, Children's Defense Fund
Minutes Scribe:	Megan Randall, Center for Public Policy Priorities
Next meeting:	August 15, 2014

I. ACA Implementation Update: Valerie Eubert, Manager, Policy Strategy, Analysis, and Development, Office of Social Services, HHSC

VEubert

- Standard monthly update on account transfers. Updated figures.
- CMS hosted a webinar last week to talk about known defects in account transfers they are sending to states, and what may have caused the scenarios in which the Marketplace told an individual they may be eligible but the state determination says ineligible.
- We can forward the slide deck to the group. In non-expansion states, for example, we are seeing adults who reported their income as $0 but who actually *did* have income.
- There is also an issue of individuals living in the applicant's household who may not have a tax relationship to the applicant and so were not being counted by the Marketplace.
- Another potential issue is that when individuals skipped the Marketplace question about annual income, the Marketplace set that amount to $0, showing them as having no income.
- There were also a number of instances where they thought a child might be eligible for CHIP but they were actually currently enrolled in other health insurance coverage.

- CMS only listed items in the slide deck that they have worked to fix. They acknowledged that there are a host of other defects. They didn't identify them or give a timeline for fixing them.
- Applications and SPAs. When we spoke last, HHSC communicated that we are working with CMS on a timeline for making changes to make the HHSC applications to make them approvable.
- We are working to remove asset and detailed absent parent questions by the end of August. We will also remove asset questions from the online application by the end of August. Our goal for the whole set of changes is by the end of the calendar year. We will continue to ask whether an absent parent exists for the parent/caretaker Medicaid group. But the goal is to have them provide that information prior to eligibility determination during the interview process.
- Administrative renewals. The ACA requires that states move toward an administrative renewal process, using electronic data to the greatest extent possible before requesting information from the client during redetermination. We will make available a prepopulated renewal form, and for clients who are determined ineligible we make sure to provide them with an opportunity to give us updated information at their renewal.
- We have the same timeline we shared last month. At the beginning of September is when we have system functionality to move forward. The first group of letters for foster care youth will be sent out in September of this year. For other groups, the letters will be generated in October.
- Between now and October, we are working on a number of strategies to help clients transition to the new process. We have specific training for eligibility staff so that they understand the process and can communicate to clients. We are working on an FAQ for call center and ombudsman staff. We are making sure that they have information about the process. We will have Community Partner program briefings for groups that participate. They are working on a collaboration plan with stakeholders whom they are interacting with. We are also working on communications for provider groups serving Medicaid and CHIP clients. In addition to that, we are working on operational process changes.
- One change is adding a selection to 2-1-1 to request a paper renewal form. The plan currently is that individuals will not be provided with a paper pre-populated form, but they can request a paper copy via 2-1-1, or on ytb.com.
- Another change will be to the language in the renewal letter. It is a little bit different than the standard renewal. We are changing the verbiage on the envelope to let the client know that action is required of them.
- We are developing specific communications for elderly and disabled populations. We are working on communication before this process goes live and before the renewal letters will go live. Giving them information that the renewal process is changing, information on how to use ytb and how to designate an authorized representative to act on their behalf. The authorized representative can help them work through the renewal process.
- In addition to that, we are also working on communication that will be sent after the renewal is issued to them. When the renewal is sent, in the event that we don't hear back from them or they don't renew online, we will be working on a reminder notice. We are hoping that this may mitigate some issues. I think what is most important is that we are working on monitoring the process closely. We will be actively monitoring issues that come up, issues with certain populations, etc.

LGuerra-Cardus

- For the electronic pre-populated form, for a child on Medicaid, what happens at 6 months?

VEubert

- You are speaking about periodic income checks. Children have 6 months of continuous coverage. For the sixth, seventh, and eight month of coverage, the system will check administratively to see if there has been an increase in income that would make the child ineligible. If there is a change in income that would make them ineligible, then we would reach out to them asking for more information.
- In month 9 (September), we would initiate the administrative renewal process. The family will be sent a cover letter letting them know about their renewal status. There are two possible outcomes in this letter: 1) we have enough information to re-determine eligibility and the cover letter will say, "You have been determined eligible, please review your form and let us know if anything has changed," they will be informed that they can call to request a paper form, go into their local office to print one out, or access it via ytb.com.

LGuerra-Cardus:

- But if there are no changes to report, they do not have to report to you at all?

VEubert

- Correct. They will get a formal notice of eligibility in the 12th month of coverage saying, "Your eligibility has been renewed," etc.

LGuerra-Cardus

- And what if there IS a change found in the electronic system?

VEubert

- For the administrative renewal process, we will assess whether the change puts you over-income for the program, and only if the system finds you income-ineligible or if we can't access electronic information will we reach out to ask for more information.
- Importantly, for the periodic income checks, a lack of available electronic information will not trigger a request for information. But for administrative renewal, if there is no information available, then we would send a request.
- There are periodic income checks at 6 months for children in Medicaid, and these will occur in months 6, 7, and 8. For CHIP, they will only occur at 6 months for kids over 185% FPL, and for adults in parent/caretaker Medicaid checks will occur in months 3 – 8.
- At 6 months, for children's Medicaid, if there is no electronic information available, we will not request anything from the family.
- At the renewal point, we will provide a cover letter letting them know that we need information and the cover letter will include a request for missing information listing all the pieces we need to renew eligibility and the same information about how to renew via the pre-populated form.

LGuerra-Cardus

- So, all they need to do is provide the missing information or verify income?

VEubert

- We would still need a signed form from them and the missing information.
- They can print the form or provide an electronic signature on ytb.com, or request a form via 2-1-1, or their local office.

SisterJTDwyer

- Why can't you provide a simple form to people as they start this new process, asking them whether they would like to receive a paper copy of their renewal form? Accessing things via 2-1-1 is incredibly difficult and complex (too many sets of numbered options). Why can't we make it easy for people who want to have a paper form to check their stuff?

- I know we're trying to move people to electronic stuff, but a significant portion of Medicaid people won't have access to that type of thing or know how to use it.
- There are like seven steps on 2-1-1 that people have to go through and the questions are very complex. What do we do with people who have a limited education?

VEubert

- We have done an expansion of a lobby computer program in the last several months where additional computers have gone into lobbies. Do any of you have feedback on the experience for clients? We have been expanding training for lobby staff. It does require that someone be able to get into an office, but that is an additional thing we have worked on.

SisterJTDwyer

- Why can't we make a simple check-off form that initially asks the client, "Do you want to receive your information on paper, or electronically?" The most vulnerable are the ones that we need to have a special concern for and not make them go through twenty steps to get their form.

CHoppe

- Also, our Community Partners are increasing every week and we are trying to get more CPs, and that would be another place to access this renewal form.

RShotwell

- As organizations increase in the Community Partner program, the online applications have been increasing. Whether or not the applications are submitted from home or in a local office. If someone initially applied by paper, it does make sense that they should have a paper form mailed to them. If they started online, however, they may be more likely to complete the process online in the future.

MWilliams

- As a navigator, we are seeing individuals face-to-face. This is information we could give them as they sign up in the Marketplace. You may need to access 2-1-1, ytb.com, etc. but I don't know if this information is getting to the navigators to be able to give to consumers.

LGuerra-Cardus

- CPPP is spearheading a meeting on October 14 on healthcare coverage, both the enrollment and coverage gap pieces. If you all (HHSC) had a cheat-sheet that you wanted people to see, we would be happy to provide those resources to enrollment specialists at that point.

II. Discussion: 2015 CHIP Coalition Legislative Principles

LGuerra-Cardus

- You should have received one copy before edits were incorporated and another draft, distributed this morning, *after* incorporating everyone's edits. Will be going through every bullet point in the version that incorporates the edits.
- Now is the opportunity for anyone to make additional suggested edits. In the new *edited* draft, the order of the principles has been changed and some of the bullets are moved around. I went through each one and identified those that had disappeared from the 1st to the 2nd draft. We will review them at the end to see if we want to add them back. The easiest thing to do will be to read the new version and see if we are OK with it.
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Principle 1:

LGuerra-Cardus

- Comments on new title to Principle 1?
- On first item under Principle 1? It is the same language. No changes in this new draft.
- Second item, also no changes, regarding12-month continuous eligibility.
- Third item, on removing unnecessary policies/procedures. **We want to remove the reference to asset questions** since this has already been addressed by HHSC.

SisterJTDwyer

- It seems to me that, when we have bullet points under the principles they should only state what it is we want or don't want. We should not state *how* to do it or what to do, specifically. Those things belong in the longer explanatory document.
- For the third item, the language of "such as" makes it hard to follow. Put a period after grow and thrive.
- Also, for the longer explanatory document, there is some content that is included in the explanation but that is not mentioned in the bullet points and vice versa. Need to change this.
- Also, I think that 7 is the absolute top number of bullet points that we can tolerate under any principle. In some cases, items things could be merged.

LGuerra-Cardus

- In general, I think having a broad statement is the way to go but we want to make sure that it is clear. The purpose for the shorter principles document is the understanding that some people will never read the longer explanatory document. So, if this is the only thing that we are giving people to read, we want to communicate the specifics of what we are talking about.
- I feel that we are unhappy about unnecessary monthly reviews, *specifically*. We could even have bullet-point saying, on its own, unnecessary monthly reviews. We can certainly **add a reference to this bullet in the explanation**, and I would argue for keeping the wording of unnecessary monthly reviews somewhere in this shorter principles doc. Thoughts?

LDimitry

- Is this item a placeholder, or are there are specific policies that this encompasses?

LGuerra-Cardus

- Both. We want a bucket for opposing anything *like* that.

LDimitry

- I could actually see taking away the front part of the statement, and focusing on monthly reviews, but if there is a desire to have placeholder then we could leave it.

LGuerra-Cardus

- **We will make it clearer that we are *specifically* talking about monthly reviews and then add *additional* wording indicating that we would oppose additional items along those lines.**
- Item 4, foster care, there have been no change in language.
- Item 5, Community Partner program. No changes in new draft.
- **Take out "the" in front of HHSC.**
- Item 6, hospital presumptive eligibility. No changes.
- Item 7, HHSC consumer assistance and ombudsman. Wording is off here?
- **Substitute word "receiving" for "provided."**

LGuerra-Cardus

- Item 8, postpartum, question about whether we want to indicate support for 1 year of full coverage (versus the 60 days specified in the agenda currently).

LDimitry

- From a values standpoint, 1 year would not be out of line, but it might not be politically feasible.

ABufkin

- Also, keeping the language as is (at 60 days), doesn't prevent us from advocating for or support organizations that are advocating for one year.

SisterJTDwyer

- **We could include the one year idea in the longer explanatory information.**

LGuerra-Cardus

- If groups working on this have additional information or talking points on this issue that they would like to have incorporated into the explanatory document, please send to Megan (randall@cppp.org).

RShotwell

- It is referring to extending eligibility for the same program, right? Not transitioning to a different program, but within same program?

LGuerra-Cards

- For those who aren't familiar with this issue, **in the explanatory document let's make it clear that the request is for enhancing post-partum Medicaid eligibility for mothers so that people know we aren't talking about moving them to regular Medicaid.**

SisterJTDwyer

- Under old Principle 4, I had suggested merging bullet points 4, 8, and 9. All of these have to do best practices in maternity services.

LGuerra-Cardus

- Let's put pin in that and when we get to that section or other combined ones, we 'll see if it makes sense to move anything over.

MBujanda

- If you want to shorten these here, items 1, 5, and 7 address things within HHSC. Since three list HHSC, we could combine those.

SMassey

- Maybe combine 8 and 9, along those lines, as well.

LGuerra-Cardus

- We will put a pin in eight and nine and will discuss.
- Item 9

ABufkin

- The agency is looking to do auto-enrollment in other family planning programs, as well. Do we want a broader bullet point talking about auto-enrollment more generally?

SMassey

- Same comment.

LGuerra-Cardus

- **Alice, will you draft a bullet point along those lines?**

SisterJTDwyer

- Also, **can we can say women's preventive health programs?**

MBujanda

- Yes, staying with preventive component.

Principle 2 (former principle 1, to preserve comprehensive coverage)

LGuerra-Cardus

- Items 1 and 2 are new ways to talk about benefits and funding. Simpler language.
- Item 3 is the same.
- Item 4 is a new bullet point.

- Item 5 has a new header.
- **Take out "as a result of affordable care act," and put in background piece.**

SMassey
- **Principle 3, item 2 belongs under Principle 2.**
- **I can work on language so that the items are not contradicting one another.**

SisterJtDwyer
- I would like to see item 5 be item 1. It is an important issue.
- Also, do we want to address the administrative items in the original principles document (under the original principle 3) here? I merged those last two items under the original principle 3. Streamline Medicaid administrative processes to incentivize and ensure proper balance. If we are striving to strengthen provider participation, the hassle factor is one related item.

LGuerra-Cardus
- It makes sense to move the "hassle factor" item up to here. Principle 3, bullets 9 and 10.

SMassey
- I agree with that. All the other bullets are workforce-related, and these two are participation in Medicaid/CHIP.

LGuerra-Cardus
- So, **under the current Principle 2 (item on strengthen provider participation) we will move also streamlining the administrative process so doctors can more easily become Medicaid providers, and move analyze Medicaid and CHIP program integrity policies, etc. We can also possibly combine those two to make them shorter. Will make one sub-bullet point about administrative burden. CDF will do that one.**

Principle 3:

LGuerra-Cardus
- What do we think about the "reduce rate of healthcare spending growth" sentence? that was removed from this updated draft.
- **Incorporate it into the background piece.**

SisterJTDwyer
- It might make the document more appetizing if we had some reference to reducing health care costs and those ideas. But it is OK in the background doc rather than in the bullet points.

LGuerra-Cardus
- Next one that was left out: redirect financial incentives away from rewarding under or overprovision of care. **Put this in the background explanation.**
- Item 1: **Correct typo** ("need occurs need")
- Item 2: **We decided to move to Principle 2.**
- Item 3:

SisterJTDwyer
- I suggest we change the wording. I don't think we should tell them "how to do it."

LGuerra-Cardus
- I could go both ways, however our main rec was to use the vehicle of the tax.

LDimitry
- We do have other partners who would like to see us reference tax policies.

LGuerra-Cardus
- I want to check in with our main involved partners and make sure no one really wants this here.

- It seems we have **decided to move the tax concepts to the background document.**

Principle 4:

LGuerra-Cardus

- Item 1, additional language in red. Thoughts?

SMassey

- It seems like this is a more general version of more specific bullets that come later on.

LGuerra-Cardus

- I agree. Other bullets talk about increasing residency, etc. Maybe this bullet refers to training outside of medical schools or residency programs? Let's check with TAM to see if this can be removed.

SisterJTDwyer

- I suggested we keep the first bullet point and eliminate the four bullet points about all those detailed recommendations. This is the CHIP/Medicaid coalition and we need to be sure there are providers but I think it is the role of THOT, TMA, and THA to push these points. I'm not opposed to them, but I *am* opposed to having 10 bullets on workforce.

LGuerra-Cardus

- What if we **put more detailed bullet points into the background doc, and keep the general one?**

SMassey

- I agree. These are complicated things to explain, and if you are not in these groups, then it will be difficult.

LGuerra-Cardus

- Item 2:
- **Keep mental health one.**

SisterJTDwyer

- I wouldn't have it as number 2, but I would keep it. We want to push nurses. **I would push number 8 up to number 3 and would take out 4,5,6,7.**

LGuerra-Cardus

- Item 3
- Should we **say "increase?"** Or are the appropriate funds already there?

DRhodes

- I support a change to language to say increase since in 2013, dental didn't get any funding at all.

MBujanda

- Are we adding other professions to Item 1? There are other "non-clinical" providers in the healthcare workforce that can be included under number one.

LGuerra-Cardus

- If we are taking details away from this section and putting them into the background doc, then having physicians and residency capacity is important, and we should not dismantle that point any further.
- We can add one bullet point that is umbrella for all clinical/nonclinical types of providers, and then leave that one with training and residency issues, and then mental health.

MBujanda

- **Will draft an umbrella statement this is a bullet point.**

LGuerra-Cardus

- **It is numbers 1, 2, 3, currently and number 8 that are staying.**

Principle 5:

LGuerra-Cardus

- Has a new title
- Items 1 – 4, not new.

ABufkin

- **Might consolidate 3 and 5**, but keep items after colon. I can combine. **Also could combine 2 and 3.**

SisterJTDwyer

- I recommend combining 1 and 2.

CKroll

- But task forces have different functions. The first item is more of a making sure state has internal funding to support the work of review teams.

LGuerra-Cardus

- **For Item 7, can we rework the language to focus on quality?** Or maybe can just put under six without a separate bullet?

Principle 6

- Item 2: Just say "to close the coverage gap"

Decided Edits

Principle 1

Item 3:

- Remove reference to asset questions (since already addressed by HHSC)
- Reword sentence to focus specifically on monthly reviews, noting that the coalition would oppose other similar practices.
- In the background document, include some more detailed explanation in the narrative text (currently no mention of this bullet in the narrative text).

Item 5:

- Take out "the" in front of HHSC

Item 7:

- Substitute word "receiving" for "provided."

Item 8:

- Include reference to a full year of coverage as the ideal in the explanatory document. Leave as is in the shorter principles doc.
- In the explanatory doc, make it clear that the request is for enhancing post-partum Medicaid eligibility for mothers so that people know we aren't talking about moving them to regular Medicaid.

Item 9:

- ABufkin to draft broader bullet point talking about auto-enrollment more generally.
- Also, modify to refer to "women's preventive health programs" more broadly.

Principle 2

Item 5

- Take out "as a result of the Affordable Care Act"
- Move Principle 3, item 2 under Principle 2.
- SMassey will draft language so that the new bullet doesn't contradict Item 5.
- Create a sub-bullet combining items 9 and 10 in the former principle 3 (regarding administrative burden and provider participation) and move it into this section.

Principle 3

Items removed in updated draft

- Include “reduce rate of healthcare spending growth” statement in background document.
- Include “redirect financial incentives away from rewarding under or overprovision of care” in background document.

Item 1

- Correct typo (“need occurs need”)

Item 2

- Moved under Principle 2, SMassey will revamp.

Item 3

- Keep bullet but decided to move the tax concepts, specifically, to the background document.

Principle 4

Add Item

- Umbrella item referencing workforce development for all providers (clinical and nonclinical). MBujanda will draft.

Item 1

- Keep.

Item 2

- Keep.

Item 3

- Change “maintain” to “increase”

Items 4 through 7

- Move to background document

Item 8

- Keep, bump up to make it Item 3.

Principle 5

Items 2,3, and 5

- Conslidate. ABufkin will work on language.

Item 7

- Rework language to focus on quality. ABufkin will rework.

Principle 6

Item 2

- Just say “to close coverage gap.”

TEXAS
Health and Human
Services Commission

Status of Federally-Required Medicaid and CHIP Eligibility Changes

July 18, 2014

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 daily from the Marketplace and processes them as they are received. As of July 16, 2014:
  - HHSC has received 221,204 unduplicated transfers from the Marketplace.
  - HHSC has processed approximately 218,000 applications, of which, approximately 214,000 were completed and approximately 4,000 were in progress.

Account Transfers from HHSC to the Marketplace (Outbound)

- Between January 5, 2014 and July 16, 2014, HHSC transferred 523,332 cases to the Marketplace. Transfers occur daily.

Note: Each account transfer may contain multiple individuals.

Account Transfer Outcomes

- Of the applicants received via an account transfer:
  - HHSC denied 78 percent based on Texas eligibility rules.
  - HHSC approved 18 percent.
  - 4 percent withdrew their application.

- As of July 16, 2014, approximately 48,317 individuals referred from the Marketplace have been approved for Medicaid or CHIP. The majority of approvals have been for children's programs (89%).

Note: This data is based on outcomes for 269,571 individuals.

TEXAS Health and Human Services Commission

Application SPAs Update

- States are federally-required to have an approved streamlined application for health care, including Medicaid, CHIP, and the Marketplace.

- On December 31, 2013, HHSC submitted to the Centers for Medicare and Medicaid Services (CMS) state plan amendments (SPAs) for the alternative single, streamlined application for health care. CMS denied the SPAs on March 31, 2014.

- Since March 2014, HHSC and CMS have been in discussions regarding the application SPAs.

- HHSC is making the following changes to the applications:
  - By the end of August 2014, HHSC will remove assets and detailed absent parent questions from paper applications and will remove assets questions from the online streamlined application.
  - By the end of December 2014, HHSC will remove detailed absent parent questions from the online streamlined application.

- HHSC will continue to ask whether an absent parent exists, and will require parents and caretakers (formerly known as TANF-level Medicaid) to provide absent parent information prior to an eligibility determination.

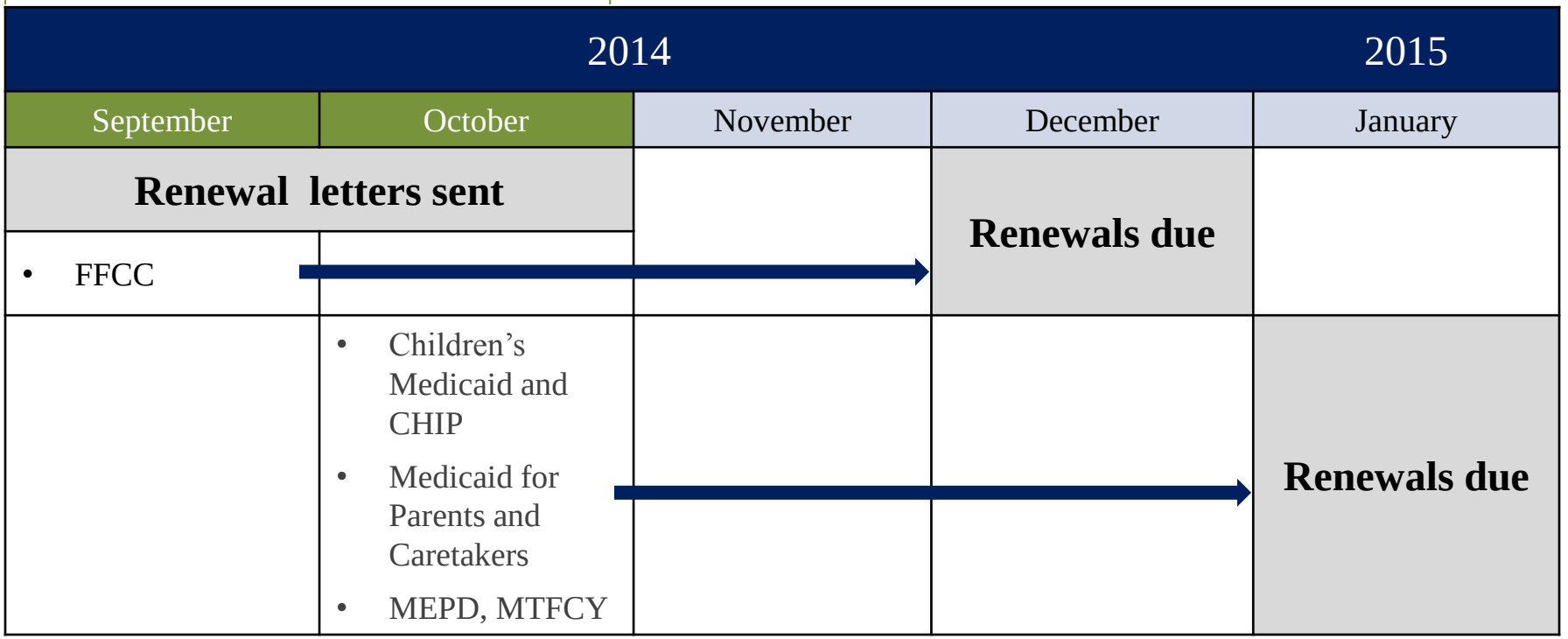
Administrative Renewals: Background

- **Effective January 1, 2014, the Affordable Care Act (ACA):**
  - Requires HHSC to use electronic data to the greatest extent possible before requesting information or verification from the client for all Medicaid and CHIP redeterminations
  - Requires clients to be provided a pre-populated renewal form
  - Requires clients who are determined ineligible based on electronic data to be provided an opportunity to update information
  - Prohibits HHSC from requiring in-person interviews

HHSC Programs Subject to Administrative Renewals			
Medicaid for Parents and Caretakers	Medicaid for the Elderly and People with Disabilities (MEPD)	Children's Medicaid and CHIP	Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)

New Renewal Process: Implementation Timeline

Former Foster Care Children (FFCC): First renewal letters sent in September
All other programs: First renewal letters sent in October



New Renewal Process: Transitioning Clients

Raise awareness with key client touchpoints

HHSC Staff

Call Center & Ombudsman

Community Partners

Various Stakeholders

*Planned operational changes**

2-1-1: IVR Selection to "Request a Paper Renewal Packet"

Stamp on the Renewal Letter Envelope

Additional MEPD Outreach

**Still in the process of being finalized*