Texas CHIP Coalition
Meeting Minutes

February 21, 2014

Present:	Anne Dunkelberg, CPPP Helen Kent Davis, TMA Shelby Massey, TACHC Catherine Samuel, CDF Sr. JT Dwyer, Seton Sonia Boyd, BCBS TX Stacey Pogue, CPPP Gwendolyn Cubit, Office of Rep. Naishtat Clayton Travis, TCFC Lauren Dimitry, TCFC Kathy Eckstein, CHAT Laura Guerra-Cardus, CDF Kit Abney Spelce, insure-a-kid Ashlee Mooneyham, CommUnity Care Jenny Rocha, CommUnity Care Megan Randall, CPPP Stacy Wilson, THA King Hillier, Harris Health System Maria Serafine, Lone Star Circle of Care Alice Bufkin, TCFC
Conference Line:	Rose Marie Linan, HHSC Courtney Watson, CDF Melody Chatelle, United Ways Greg Hansch, NAMI TX Becky Huerta, Central Health RexAnn Shotwell, TACHC Betsy Coats, Maximus Veronica, Houston Children's Health Plan
Chair:	Laura Guerra-Cardus, Texas Associate Director, CDF
Minutes Scribe:	Megan Randall, CPPP
Next meeting:	March 21, 2014

I. Discussion: 2015 CHIP Coalition Legislative Agenda

See 2013 CHIP Coalition Legislative Agenda attached.

LGuerra-Cardus

- Looking at the 2013 CHIP Coalition Legislative Agenda, let's talk about each of the major headings. The first heading is "Preserve Comprehensive Coverage Under Medicaid and CHIP." Last session there was talk about block granting and we wanted language that supported improvements to the system but that was firm in opposing anything that looked

like a block grant or reduced access to care. My experience is that we typically have to defend Medicaid and CHIP in most sessions. Do we think that this item should remain?

SrJTDwyer

- We should keep it.

ADunkelberg

- I agree that whether or not we move into a more robust discussion about a Texas Solution or Medicaid expansion that there is a lot of pressure to roll back EPSTD, medical transportation, etc. and while there may be things we are willing to negotiate on, that those are still issues and this heading is a great header for capturing those things.

LGuerra-Cardus

- We need to think through potential conversations in the air that may affect children currently enrolled in Medicaid and CHIP and make clear what is not acceptable to us.

KEckstein:

- The scope of the principles document has historically been legislative, but this group does interact with federal entities. Should it be a broader principles document, including things like reauthorizing CHIP?

ADunkelberg

- I think it is a good idea to identify items specifically for the TX legislature, but if there is an interest in developing some items that are more federal, that is a great idea.

LGuerra-Cardus

- If the federal agenda items are things that we will use and publicize at the national level then, yes, that is a great idea. Reauthorization of CHIP will be a big issue in 2015.

SrJTDwyer

- Isn't it only the funding piece that we need to reauthorize? CHIP under the ACA was reauthorized until 2019, but was only funded until 2015.

ADunkelberg

- People will probably still refer to it as "CHIP reauthorization," more broadly, but that is technically correct.

LGuerra-Cardus

- Let's keep this section, then, to protect Medicaid and CHIP, looking at it under the lens of block granting but also from the perspective of other things possibly under negotiation, and we may also be including something on CHIP funding authorization.

KHillier

- CHIPRA was reauthorized under the ACA, but my understanding is you do actually have to reauthorize the act.

LGuerra-Cardus

- We will research the technicalities of this, but we know something needs to happen in 2015 to keep CHIP.

HKentDavis

- There is also a question in 2015 regarding parents and pregnant women, whether we will be dealing with any potential maintenance of effort issues

ADunkelberg

- It won't technically be a "maintenance of effort" issue since the ACA doesn't expand maintenance of efforts to adults past 2014, but we might expect to see some rollbacks in eligibility. There was maintenance of effort requirement for adult Medicaid coverage until January 1, 2014. We can't go below 138% of poverty for pregnant women, and the piece of our maternity coverage that is optional is for women between 133% and 185% FPL.

So, now that maintenance of effort is no longer in effect for adults, you could theoretically see a roll back for pregnant women.

- Children are protected under maintenance of effort requirements until 2019.

CTravis

- The first paragraph under the first heading in our legislative agenda only speaks to maintaining children's coverage. We could include a reference to coverage for pregnant women. But other than that, I don't see much that needs to be changed.

LGuerra-Cardus

- Also, the new rules that HHSC has released for Medicaid and their interpretation of 6-month continuous eligibility should probably be addressed somewhere. We might have to take a proactive stance on this issue.

ADunkelberg

- I agree that it has to fall into at least one of our categories, to the extent these problems persist into session.

LGuerra-Cardus

- There is also an eligibility system header where that issue might fit well.

KEckstein

- What about continuous eligibility? It doesn't seem like we mentioned it anywhere on the 2013 agenda and it seems like this could be a big push for us next session. Also, at the federal level, we have people supporting continuous eligibility. Additionally, yesterday, at the quality-based payment advisory committee, they said they will recommend 12-month continuous eligibility for children and women, and for pregnant women will recommend 6-month postpartum instead of the current 60 days. At the national level, you have Joe Barton supporting 12-months continuous eligibility as legislation.

KHillier

- Rockefeller has filed legislation in the Senate, also.
- Medicaid health plans have some great data showing how it does save money. This is one of the reasons why Barton signed on to it. We have an opportunity to show how it makes sense.

ADunkelberg

- That may also be helpful in rolling back these rules for kids regarding 6-month continuous eligibility. There is a question about where these issues would go in our 2015 agenda.

LGuerra-Cardus

- They might belong under "Improve and Modernize the Medicaid and CHIP Eligibility System." The principles that we are bringing up are important pieces, and exactly where they go is not the most important at this point. Continuous eligibility is a legislative agenda item we have wanted for a very long time and have had on our agenda most years.
- Is it possible that the price tag on 12 month Medicaid continuous eligibility is smaller with the ACA because of kids already getting enrolled?

ADunkelberg

- Our HHSC contacts have commented on that. A significant welcome mat effect would reduce it, but that does not mean that the official fiscal note will be lower.

LGuerra-Cardus

- Let's jump to the page 3 header, "Continue to Improve and Modernize the Medicaid and CHIP Eligibility System."

- What we might incorporate here is the transfer of information issues from HHSC to the Marketplace. There are a lot of glitches. Would it make since to make a section that speaks to eligibility systems across the Marketplace, Medicaid and CHIP?

ADunkelberg

- I think we can wordsmith this header so that our system of eligibility, enrollment and outreach encompasses both HHSC and its interaction with the Marketplace.

SWilson

- I agree.

SrJTDwyer

- It's good for us to put ideas out there right now. Let's get it on the table, and then later we can figure out if there is a part of this that is actually a state item that we can work on.

LGuerra-Cardus

- Yes, it is perhaps fair to only include items that HHSC actually has some control of, although if this agenda evolves to become a federal comment, as well, there might be other things we can include. So, we can include 12-month continuous eligibility in Medicaid, any others?

MSerafine

- From a providers' perspective, to verify eligibility for our clients, it would be great if the CHIP verification piece was TMHP so that you could go to one place to verify eligibility for benefits. Some of the websites are not very friendly, and it is very hard to verify that the clients are actually active on CHIP or CHIP perinate. Now that CHIP is in TIERS, why not roll it into TMHP?

SWilson

- Also, presumptive eligibility for hospitals in Medicaid.

ADunkelberg

- Any other lingering pieces of the recent HHSC rules may go here, as well. For example, asset information, and the state's rejecting the option to offer Medicaid to former foster care youth from out of state. Should this be part of the agenda?

CTravis

- Yes. I am not sure where it fits, either, but we will be following up with more information and advocacy on that during session. We don't know how many kids fall into this category.

GCubit

- In the Marketplace, when you put in a person's info to see eligibility for Medicaid/CHIP, how and why is it that the Marketplace is sending children not eligible over to HHSC?

ADunkelberg

- The federal Marketplace is supposed to be programmed with each state's Medicaid rules. It is, but that does not mean there aren't glitches and errors. It is supposed to be working, but we have heard complaints from people on the ground that cases which are clearly ineligible are being sent to HHSC.

KAbneySpelce

- It may be an issue of the Marketplace making determinations based on annual income, whereas Medicaid does point-in-time.

MSerafine

- The Marketplace is also using 2014 FPL levels for Medicaid eligibility. HHSC has said they will start to use new 2014 FPL levels March 1st, but the Marketplace has already started using these levels for Marketplace Medicaid/CHIP determinations.

II. HHSC ACA Implementation Update

See the attached presentation slides for more information.

SStephens

- Still receiving individuals from the Marketplace who are not eligible.
- Over-income is the biggest reason. These eligibility discrepancies refer to account transfers that we receive from the Marketplace and then run through our rules. So, we take their self-reported income, we input it into our system and it doesn't pass our rules. The Marketplace is sending us cases sequentially, so we are currently getting transfers from October. The Marketplace is not correcting files retroactively, just correcting prospectively. They have acknowledged that there were some defects around income and how they were doing income early on. We don't know what is causing the discrepancy.

SMassey

- How do people find out if they've been denied?

SStephens

- When we deny them, we will tell them they are denied. The Marketplace has recently put into place some solutions so that if someone has a denial s/he can use that denial and go through the Marketplace.

LGuerra-Cardus

- It is disheartening to know that, despite the no wrong door policy, this concept that the system will find the right place for you isn't actually what some families are experiencing. In the future, would there be a way to electronically transfer them back to the Marketplace?

SStephens

- When we deny someone, we do send them to the Marketplace electronically. We are sending them a denial notice, and then sending their account back to the Marketplace. We don't know what the Marketplace is doing with it once they get it. We are also receiving some cases which the Marketplace found ineligible and we took a look to confirm. Most of these cases are actually ineligible.

SrJTDwyer

- How many transfers have you received from the Marketplace?

SStephens

- It has been start and stop. We have received smaller groups since the initial transfer. We are supposed to be receiving them in a steady stream right now, but have only received a couple thousand over the last week. The most important thing to note is that CMS has 114,000 applications in the queue for us right now. As of this week, we are supposed to be in full production but everything changes on a day-to-day basis. It appears they are finding problems and trying to stop and fix them.

KAbneySpelce

- We need to watch, with this error rate, whether these children are going to be able to go back into the Marketplace by March 31st, if they've been sent to you guys and been denied. Is that considered a qualifying event?

SStephens

- We have a weekly call with CMS, and we asked them what their thinking on this date was, and they will have updates on this soon hopefully. Clients who are not eligible for Medicaid or CHIP will receive a notice that their info has been sent to the Marketplace. Notices are U.S. mail at this point.

KAbneySpelce

- Of the 79,000 you've transferred to the Marketplace, do you have a breakdown of how many are kids, adults, etc.?

SStephens

- I haven't seen that many stats on what we've been sending. I can follow up on this.

KitAbneySpelce

- Will you send someone to the Marketplace who is in the Medicaid expansion population, even if they are under 100% FPL and won't be eligible for subsidies?

VEubert

- If you are determined ineligible for *eligibility* reasons (including if you are denied because of income eligibility), then we send you to the Marketplace. If we deny based on a procedural reason, we won't send you to the Marketplace (you might get back to us later with the required information, etc.).
- When people are denied in the Marketplace, what they have told people is that you can go to apply directly with HHSC. Some people are in the Marketplace queue and are coming directly to us as well.

CoalitionMember

- Do we know how many people are duplicated in the process? How many of the 79,000 you sent to the Marketplace may be in the 114,000 that they are referring back to you?

SStephens

- We can't say it is NOT happening. There has been direction for people to apply in both doors, so it is possible there is some duplication.

LGuerra-Cardus

- For those of you who talk to CMS about this, maybe see if a data screening can be done. If you could identify folks in both sections, another more efficient process could be developed because they are at high risk of getting confusing communication.

SStephens

- Information on the new proposed rules. Rules restore assets test and continue them where we are allowed.
- Federal regulations outlined exemptions to the CHIP waiting period. These rules align our current exceptions with federal requirements.
- For the emergency rule, we had the option to cover foster care kids from out of state, but we took the option to only cover kids from Texas and aligned remaining policy with our existing programs for foster care kids. Current enrollees will be grandfathered and will continue to be eligible until they age out. We are currently developing a permanent rule.

CTravis

- Do we know how many of these kids would be grandfathered?

SStephens

- We have an estimate of how many people in the past came into our programs from out of state. Estimated four people per month coming into programs out of state.

CTravis

- What is the cost per enrollee?

SStephens

- I do not have this information with me. The direction we received was not to implement optional Medicaid programs, and that was the approach taken with the new former foster care youth.
- Regarding the transition from CHIP to Medicaid, effective January 1, the income limit for Medicaid was increased to 133%. If you are a new applicant, that new limit will apply. For current enrollees, we will transition you at renewal. CMS required a transition plan,

which we have submitted. We also submitted 2 notices to CMS: one saying there was a change and that one could apply to Medicaid if desired, and also a notice to providers. At this point, have not received approval for those notices or transition plan.

- Regarding hospital presumptive eligibility, CMS indicated that states must submit their state plan amendment by March 31, 2014. We plan to submit by this federal deadline.
- The soonest we can implement system changes is December of 2014, due to other ACA requirements that have really taken most of our system hours. CMS has mentioned implementing a manual process. I don't see how that is an option because we have to have a program in the system to put these individuals in and trigger payments to hospitals. But this is maybe something that CMS is discussing with us.

KAbneySpelce

- If the build is in December, 2014, do we go live January 1?

SStephens

- There will likely be a January effective date.

KEckstein

- Is there an opportunity for stakeholder input on the plan amendment?

SStephens

- The SPA is just a template at this point, and it is going through the internal review process right now, and then it will go to stakeholders, etc.

KEckstein

- So any policy decisions would not be in the SPA?

SStephens

- We will have standards in the SPA. There is also an option around requiring attestation for citizenship/immigration status/residency. We would expect this to be policy.

LGuerra-Cardus

- Regarding the asset question, for folks to whom you are still asking the question but for whom it is optional, if that question is left blank, is that application being denied or marked incomplete?

KAbneySpelce

- At our Central Texas Rack meeting, Jim Birds at HHSC they said that they might be pended. And then I looked it up, and we were told here that they would not be pended.

SStephens

- I can take this back, but the direction has been not to pend.

ADunkelberg

- Two days ago when we had our conference call, we were told then that there has not been a formal response to the SPA with the attached applications. My guess is that we will eventually see those applications rejected. It is a confusing interim time, however.

LGuerra-Cardus

- I will find where I saw this information about pending applications and send it to you.

SStephens

- I will send an e-mail today on that.

III. Tricia Brooks, Center for Children and Families, Georgetown University: CHIP Waiting Periods and CHIP/Medicaid Premium Administration

See the attached presentation slides for more information.

Waiting Periods

TBrooks

- It is important to know that waiting periods are not required nor are they encouraged. They are a fall-back policy to guard against crowd-out or substitution. The target audience for CHIP is uninsured children. This is why we ended up with states that have separate CHIP programs with waiting periods.
- We have gone from about 38 states that have waiting periods to now only 21. Definitely movement in the right direction. There are also exceptions to waiting periods.

ADunkelberg

- There are new state proposed rules to bring us into compliance with the federal requirements on exceptions to waiting periods. The ones Tricia has listed here are those under federal law and requirements, as opposed to what is already in TX law.

TBrooks

- Does Texas have any other exceptions?

ADunkelberg

- Texas adopted the same list of exceptions that were in Maine's law back in 1999.

TBrooks

- There are three reasons to eliminate waiting periods.
- The first is that they lead to gaps in coverage, delays in seeking care, and unmet healthcare needs. They can be particularly harmful for very young children.
- Second, there is no conclusive evidence that crowd-out is a problem.
- The third reason is that they are administratively burdensome and costly for the state. You have to take a harder look at the application if someone indicates they've been insured, and you must set up system so that you can track them. Administratively, it means that multiple agencies have to handle these cases.

Premium Administration

TBrooks

- CMS has defined premiums as anything required up front to enroll in coverage. For the number of states that charge either monthly, quarterly, or annual premiums, now that stair-step kids are moving to Medicaid, those kids won't be required to pay premiums.
- We will still have premiums for kids below 150% FPL. This is an area where Medicaid and CHIP don't line up. Medicaid prohibits charging kids, but CHIP never did. One of the things that the MACPAC is recommending is that CMS comes back and indicates that you should align Medicaid and CHIP for kids so that you wouldn't be charging premiums for kids below 150%. This is a good idea. As CHIP goes up the income scale, there are more states that collect monthly premiums or annual enrollment fees.
- In terms of lockouts, the state cannot require that any outstanding premiums be paid before a child can re-enroll. CHIP must give at least a 30 day grace period. This would apply at renewal for Texas. The other thing to keep in mind if your state thinks it wants to charge premiums is that the cost of collecting premiums can exceed the revenue it generates.
- In the Marketplace, CHIP premiums are not counted toward a family's expected premium contribution. So, families are paying an additional cost and this is another reason why some say that CHIP kids should just go into a QHP with their parents. I would suggest that it is not just a matter of premium stacking, however, but that it is important to look at the total cost-sharing a child would encounter in a QHP.
- I took a look at CHIP copayments and took a family earning 175% FPL and looked at the lowest-cost silver plans. The costs may add up in a QHP Marketplace plan. One of the considerations looking forward to CHIP reauthorization is whether kids be going in with their parents into QHPs, and cost-sharing is one of the things we will take a hard look at

ACA Technical Challenges

TBrooks

- One thing to look out for at the federal level is the way Medicaid income should be calculated through MAGI. The rules are not being consistently applied in states.
- Some known problem areas: self-employment, farm income (because prior to this time, states generally were not allowing full deduction of depreciation and now that is allowed), some states at the case worker level are counting child support received (which is not countable any more). We are also hearing that even though you do not count a child's income, sometimes states are continuing to count social security or survivor benefits.
- There have been some issues for kids on the cusp of CHIP eligibility that not even CMS has fully defined. There have also been extremely significant challenges for immigrants and mixed-status families.
- I did hear the prior conversation about what we do about this as open enrollment comes to a close. We had a call with CMS on Wednesday and they are still saying we will do everything we can to make sure folks get enrolled by March 15th but it is hard to imagine that this will happen in the next three weeks given the back logs.
- Lots of groups at the national level are advocating for either special enrollment periods or an extension of open enrollment. It is not fair to be locked out of coverage or penalized because of technical difficulties.
- One comment about the ineligible kids that HHSC has received from the Marketplace is that we know that in early weeks in the first two months there were a number of eligibility errors programmed into the FFM that have subsequently been fixed. My suspicion is that states will find a lot more errors in early files.

CHIP Reauthorization

TBrooks

- CHIP was strengthened and reauthorized for 5 years in 2009. That funding was a bit retroactive, and would have expired in 2013, but the ACA extended it through December of 2015. Folks are already starting to talk about reauthorizing CHIP. Congress rarely acts well in advance, however. At the time of the last reauthorization, CHIP had already expired and had temporary extensions twice before it was reauthorized. Don't expect a serious consideration until sometime in 2015. The other thing is that the ACA actually increases the CHIP match by 23% stating in 2016 and this is significantly increasing the cost of reauthorization.
- Question of should kids be with parents in the Marketplace? Are kids going to be well-served going into qualify health plan? Key Issues are:
- Cost-sharing
- Benefits (even though EHB includes pediatric services, there can be limits on care that won't serve kids with special health care needs well). We are doing a study with NASHP in April that will take a hard look at CHIP benefit packages and we would say that Medicaid is the gold standard according to the American Academy of Pediatrics. EHB will probably be less comprehensive than CHIP. For example, we know that habilitative services in QHPs are not robust enough for kids with special health care needs. There are also issues around dental coverage because plans are not required to provide dental coverage. There are separate cost-sharing maximums, etc. for dental plans in the Marketplace and APTCs generally won't be enough to cover the cost of standalone dental plans. EHB includes dental, but individual QHPs are not required to provide dental. This is made up through standalone dental plans.

- The Family Glitch. The affordability of job-based insurance is assessed using the cost of insuring only one worker relative to the household income. This is a battle we fought at the federal level, and it came from a congressional joint taxation committee and the administration has said that it will take a statutory change to fix. Another reason why CHIP is so important.

KEckstein

- For Medicaid Managed Care, the protections for network adequacy are better than QHPs. Would you say that the CHIP network adequacy protections are another positive for CHIP vs. a QHP?

TBrook

- I am putting it on my list of reasons we should be keeping CHIP. When CHIP was reauthorized, the Medicaid Managed Care protections were applied to CHIP and think this is true across the board. There is a draft issuer letter that CMS put out that would affect QHPs in 2015 and they are starting to address some network adequacy issues. Not final yet, but they do discuss some access standards, travel time, etc.

SrJTDwyer

- Have a question about child support. We learned from our state HHSC that the child support that you can disregard and that you don't have to report is *only* child support that formally comes through the Attorney General's Office.

TBrooks

- There should be a consistent application of MAGI across the board. If you receive child support, it is NOT taxable income and it is not countable income for MAGI-based Medicaid. If you are paying out child support, it previously was a deduction from income, but we no longer have any itemized deductions or disregards and only have the 5% standard disregard. Child support does not count as income either for Medicaid or premium tax credits.

ADunkelberg

- But the distinction we thought we were understanding is that it had to be a formal child support order going through the Texas Attorney General to be considered child support.

TBRooks

- I would be shocked if you find out there is some kind of distinction. I have never heard any distinction between how it is or isn't collected and when you look at training and rules around MAGI-based income, it is not taxable income.

KAbneySpelce

- The state thinks it would be counted as cash support, as a cash gift.

TBrooks

- If they are saying it is a gift, that is also non-countable income. The only option I am aware of for counting income differently for Medicaid is they can (state option) include cash support. They could be categorizing it as cash support, and that would be allowable if they have elected to include cash support.

LGuerra-Cardus

- If you have any more questions, e-mail them to me or Tricia
- Also, a few final announcements: MHM is thinking about calling a meeting for those organizations doing research or collecting data on coverage expansion issues, so if your group is making plans in that area, please email me.
- Also, Clayton Travis is facilitating the next CHIP Coalition meeting. If you have agenda items let us know.

Texas CHIP Coalition
2013 Legislative Principles & Agenda

Preserve Comprehensive Coverage under Medicaid and CHIP

Some contemporary state and federal proposals could re-structure Medicaid and CHIP in ways that could reduce access to quality care for the over 3 million Texas children who rely on the programs today to stay healthy.

Our coalition *supports* reforms to our public health insurance programs that:

- reduce the rate of health care spending growth while raising standards for quality of care, promoting evidence-based cost-effective care, and improving outcomes; and
- re-direct financial incentives away from rewarding either the over-or under-provision of care.

We *oppose* re-structuring and deficit reduction methods that:

- reduce children's access to comprehensive medically necessary care;
- reduce children's eligibility for affordable comprehensive coverage;
- make children's coverage unaffordable through cost-sharing obligations that are excessive relative to family income;
- eliminate the current federal funding partnership that guarantees that Texas can depend on increased federal funding to reflect both population and inflation growth, and in response to higher needs in times of economic downturns and major disasters.

Reverse Damaging Cuts to Texas' Critical Public Health Safety Net and Infrastructure

The 82nd legislature's budget for 2012-2013 cut Health and Human Services spending by $10 billion, from $65.5 billion in 2010-2011 to $55.4 billion for 2012-2013. Medicaid for 2012-2013 was budgeted at 21% below 2010-2011, with roughly $2 billion in total spending reductions, plus nearly $5 billion more in a funding shortfall "IOU." The $2 billion encompasses a wide range of service and benefit reductions, cuts to Medicaid and CHIP provider payments, and managed care-related spending reductions. These reductions touch all Medicaid enrollees: children, expectant mothers, Texans with disabilities, and seniors in nursing homes and in the community. The Medicaid funding IOU is reflected in HHSC's updated 2013 supplemental appropriations estimate for Medicaid of $4.7 billion: $3.7 billion GR at HHSC and another near $1 billion at DADS. State leaders have pledged to fund this "IOU" when they return in January 2013.

Our Coalition advocates that the Legislature:

- Honor its pledge to fully fund and cover the Medicaid shortfall "IOU" in 2013.
- Carefully consider all benefit, policy changes, and provider rate cuts enacted in 2011 and/or adopted through rules, and reverse those that have reduced access to medically necessary care from health care

providers, medical, dental and vision services, services and supports needed to stay in the community, diagnostic testing, and key medical supplies.

- Fully vet and evaluate proposed reforms and cost saving measures for their true impact, both fiscal and human. If cost savings assumed for policy changes in the 2012-2013 budget cycle are not fully realized, they should not be converted to even deeper cuts to safety net programs, decreasing the overall health of children and families, and ultimately costing more for Texas.

Reducing funding for safety net programs decreases the overall health of children and families and is ultimately more costly to the state. Deeper cuts in 2013 would further cripple an already devastated public health safety net. Reduced access to healthcare providers will only result in less preventive treatment and higher medical bills paid for by Texas tax payers at the local level.

Bolster the Texas Health Care Workforce

Texas has a large and growing population, but there are too few physicians, nurses, and health care professionals to meet Texans' health care needs. There is a shortage of every kind of health professional in Texas except licensed vocational nurses. Texas today has the second-worst primary care provider supply in the U.S., and our mental health provider shortage is the deepest of any category of care.

Exacerbating the problem, fewer physicians are now accepting Medicaid. Inadequate Medicaid payment rates, aggravated by growing program complexity are key reasons Medicaid physician participation is dropping. According to TMA's 2012 physician survey, only 31% of physicians accept new Medicaid patients, an 11 point drop from 2010 and 36 points below the 67% accepting new Medicaid in 2000. The survey shows that beyond just limiting their Medicaid participation, more physicians are declining to accept any Medicaid at all, a very worrisome trend.

Additionally, Texas Medicaid has not made regular inflation updates to physician and other health professional fees for 20 years, and in that time rates have been cut more often than increased. Texas Medicaid fees for physicians average about 73% of Medicare rates, which in turn are below commercial payment rates. These rates are set entirely by the Texas Legislature; federal Medicaid law does not set any minimum standards for state Medicaid program rates except in a very few cases.

Fortunately, as a result of the Affordable Care Act, Medicaid payment rates for primary care physician services will increase to Medicare parity for two years (2013 and 2014) with full federal funding. However, the ACA does not extend the more competitive payment rates to other Medicaid services, or to other Medicaid and CHIP physician and health professional types. Whether the enhanced federal funding for primary care will extend beyond 2014 cannot be predicted.

Access to providers is a serious problem today, and as more Texans gain coverage from private or public insurance, even more clinicians and technicians will be needed. Texas must reinvest and expand resources to build provider capacity so that both existing and future Medicaid and CHIP enrollees and privately-insured Texans alike will be able to obtain the health care services they need. The coalition supports investments to expand Texas' health care workforce. Given the time it takes to train new doctors, dentists, nurses, pharmacists, mental health professionals, and others in the health care workforce, Texas must take meaningful steps to expand its efforts to train and recruit more health care professionals during the 83rd legislative session.

Our Coalition advocates that:

- Texas increase to parity with Medicare all Medicaid and CHIP professional and provider payments, in addition to the set of primary care provider services that will be raised in 2013 and 2014 under the federal health system reform law.

- The legislature reverse cuts to all health care provider education and training programs enacted in 2011, and invest in expanded training and residency capacity to put our state on track for improved access to care for all Texans. Specifically restore funding for:
    - the physician loan repayment program to encourage more physicians to practice in medically underserved areas;
    - the Texas dental loan repayment program; and
    - the Children's Medicaid loan repayment program, which provided loan repayments to primary and specialty care physicians and dentists accepting Medicaid.
- Texas invest in research to identify and promote innovations in training primary care residents to encourage more medical students to choose primary care.
- The Legislature establish and implement a plan to increase residency slots to match the number of incoming medical students, as the Texas Higher Education Coordinating Board has recommended, so that we may retain here in Texas more of the doctors we have invested in and trained.
- Program planning and investment to train and keep an adequate health workforce covers the full spectrum of clinicians, technicians, and para-professionals needed to provide access to care.
- Texas streamline the Medicaid administrative processes to entice more providers to stay in Medicaid; for example, adopting a simplified HMO credentialing process and implementing standardized prior authorization mechanisms.
- Medicaid-CHIP program integrity policies and practices be carefully analyzed to ensure a proper balance between due diligence and administrative burdens, for both providers and clients.

Reduce Health Care Costs by Supporting Practices that Improve the Quality of Care for Children, Mothers and Newborns

The Coalition supports policies and programs to increase quality of care for children, mothers and newborns. These include policies to reduce pre-term births; to support healthy birth spacing; to improve maternal access to smoking cessation and substance abuse services; to broaden adoption of innovative programs and practices that improve the effectiveness of prenatal care; and to support breast feeding, all of which will improve health outcomes and reduce future taxpayer costs.

Our Coalition supports:

- Access to affordable basic and preventive health care for low-income uninsured Texas women.
- Policies that promote early entry into prenatal care.
- Policies that promote on-going preventive care for women and children, like chronic disease management and annual screenings.
- Development of a Maternal Mortality Review Program and ongoing support for Fetal, Infant and Child Mortality Review Programs.
- Policies that ensure continued access to critical neonatal services.
- NICU policies and procedures that promote AAP levels of care.
- Maternity services that reflect best practices identified in current, peer-reviewed obstetrical literature.

Continue to Improve and Modernize the Medicaid and CHIP Eligibility System

Since 2010, HHSC has made impressive strides in processing Medicaid and CHIP applications promptly and correctly. After several years of sub-standard performance, the eligibility system's accuracy, speed, and

customer service have all improved and Texas now meets or exceeds federal standards. HHSC has made these system improvements while rolling out the new TIERS eligibility computer system across the state and developing new online tools including a self-service portal.

Medicaid and CHIP rolls continue to grow in Texas. The economic downturn continues to lead more families—many for the first time—to seek coverage for their children in Medicaid and CHIP. In 2014, health reform offers Texas the opportunity to open the Medicaid rolls to more than a million currently-uninsured U.S. citizen adults, and our state systems must be fully interoperable with the new health insurance Exchange. Texas must be prepared with a fully modernized and streamlined eligibility system that provides good, speedy, and accurate customer service for more Texans, while minimizing the number of public employees needed to get the job done.

To further improve the current system and prepare to meet Texas' future needs, the Coalition supports*:*

- Giving top priority to identifying and eliminating all system barriers that delay access to newborn care or prenatal care. The HHSC should ensure that eligible newborns are enrolled in Medicaid no later than 15 days after proper documentation of delivery is received. The agency should also prioritize streamlining processes for submitting documentation, to reduce burdens on both families and providers;
- Full implementation of online self-service applications and renewals for Medicaid and CHIP, online access to case information, ability for families to update and request information and submit documents online, and the ability to contact families via email or text when they need to take actions;
- Continuing to identify and remove unnecessary or redundant policies and procedures, and adopt new processes that improve productivity and/or accountability to facilitate streamlined systems;
- Ensuring that the HHSC eligibility system is fully interoperable with the Health Insurance Exchange and able to provide "No Wrong Door" access for Texans; and
- Giving HHSC the resources and support needed to ensure a robust and diverse network of community partners to maximize the benefit of the new web portal and increase efficiency and access in the public benefits enrollment process.

Seek New Revenue Sources to Fill Budget Gaps instead of Slashing Health Care Programs for Children and other Vulnerable Texans.

The Coalition supports addressing the revenue deficit projected by state officials to result in a recurring shortfall of at least $10 billion every legislative session. The Coalition also supports using existing and new sources of revenue to ensure all eligible Texas children receive the quality health care they need.

In order to restore and protect health coverage for Texas children and families through Medicaid and CHIP, provider payment rates, and other vital public health and preventive health services, the state must utilize existing state resources, including the Rainy Day Fund, and look to increasing our resources, particularly by discouraging unhealthy behaviors related to the use of tobacco, alcohol, and sugary beverages.

Improve the Health and Well-Being of Texas Children by Maximizing Opportunities to Connect Entire Families with Affordable Health Care.

Expanded coverage opportunities in 2014 can help connect more of Texas' 1.2 million uninsured children with medical homes, and improve children's well-being. When private coverage becomes available through the health insurance Exchange, families with incomes just over the CHIP limits will have guaranteed access to comprehensive coverage at affordable prices not affected by their health status or history, that will include

sliding-scale help with premiums and out-of-pocket costs. Children's coverage will include dental and vision benefits.

Today, while 2.6 million Texas children benefit from Medicaid, only about 225,000 of their parents qualify for care. Studies suggest that if Texas accepts the opportunity to cover adult US citizens to 133% of the FPL in Medicaid, the children already enrolled in Medicaid will be more likely to get care, and a higher percentage of the uninsured children eligible for Medicaid will be signed up. Roughly half of Texas uninsured children and teens—about 600,000—are estimated to be eligible for Medicaid or CHIP but not enrolled today according to U.S. Census data.

Research has shown these important benefits for children when low-income parents also get coverage[1]:

- ***When parents are covered, more eligible children enroll.*** Low-income families with uninsured parents are three times as likely to have eligible but uninsured children as families with parents covered by private insurance or Medicaid.
- ***Children whose parents are enrolled are more likely to stay enrolled.*** Studies have found that children are less likely to experience breaks in their own Medicaid and CHIP coverage and remain insured when their parents are also enrolled.
- ***Children whose parents are covered get more preventive care and other health care services.*** Studies have found that insured children whose parents are also insured are more likely to receive check-ups and other care, compared to insured children whose parents are uninsured.
- ***Parents' health can affect children's health and well-being.*** The Institute of Medicine reports that a parent's untreated poor physical or mental health can contribute to a stressful family environment that may impair the health or well-being of a child. Beyond that, uninsured parents who can't get routine and ongoing care may be unable to work, or may end up with big medical bills even when they do get care. In either case, the financial consequences have a big impact on children—even when the children themselves have coverage.

Our state should take maximum advantage of the options offered under the ACA to improve coverage, access to preventive care, and child and family well-being.

Our Coalition advocates for:

- A thorough and thoughtful analysis and statewide dialogue on the costs and benefits of accepting the ACA's Medicaid coverage opportunity.
- Careful consideration of the positive impact on child and family well-being if the low-income parents of children in Texas Medicaid could also access care.
- Assessment of the economic impacts for state and local government budgets, including offsets to current local and state health, mental health, and criminal justice costs.
- Analysis of new opportunities to allow families to enroll in the same private health plan through the health insurance Exchange in 2014, such as consideration of the Basic Health Plan option to create "CHIP for parents" in Texas (this option is available only to states that accept the Medicaid expansion).

1. Georgetown University Health Policy Institute Center for Children and Families, *Expanding Coverage for Parents Helps Children: Children's Groups Have a Key Role in Urging States to Move Forward and Expand Medicaid*; July 2012, http://ccf.georgetown.edu/wp-content/uploads/2012/07/Expanding-Coverage-for-Parents.pdf

Sign-On Form for Support of Texas CHIP Coalition Position
83rd (2013) Texas Legislative Session

TEXAS CHIP COALITION

for healthy babies and children

http://www.texaschip.org

***RETURN THIS FORM BY EMAIL*: denton@cppp.org**

*(If you **cannot** reply by email, please fax or mail to:*
BY FAX: (512) 320-0227

QUESTIONS? Phone (512) 320-0222 X102, Anne Dunkelberg, or Laura Guerra-Cardus at 713-419-8422 (c)

Our organization wishes to be listed as a member of the Texas CHIP Coalition and in support of the Coalition's position for the upcoming 83nd legislative session.

Name of Organization:_____

Is your organization (check one): Statewide:_____ Local/Regional _____

Contact Person (authorized to sign off for your organization): _____

Email: _____

Address: _____

Phone_____ Fax: _____

Please complete all items above!

Even if your group has signed on with the CHIP Coalition in previous legislative sessions, we must receive this new form in order to list your organization for the upcoming session.

Texas CHIP Coalition 2013 Legislative Principles and Agenda: Supporting Organizations

Statewide

American Congress of Obstetricians and Gynecologists District XI

Amerigroup

Catholic Health Association of Texas

Center for Public Policy Priorities

Children's Defense Fund – Texas

Children's Hospital Association of Texas

Coalition for Nurses in Advanced Practice

Disability Rights Texas

La Fe Policy Research and Education Center

League of Women Voters of Texas

March of Dimes

National Association of Social Workers Texas Chapter

National Council of Jewish Women Texas

Teaching Hospitals of Texas

Texans Care for Children

Texas Academy of Family Physicians

Texas AFL-CIO

Texas American Federation of Teachers

Texas Association of Community Action Agencies, Inc.

Texas Association of Community Health Centers

Texas Dental Association

Texas Hospital Association

Texas Impact

Texas Network of Youth Services

Texas Nurses Association

Texas Pediatric Society

United Ways of Texas

Regional/Local

Austin Area

insure-a-kid

Seton Healthcare Family

Corpus Christi Area

Driscoll Health Plan

Harris County

Harris Health System

Houston Area

Texas Children's Health Plan

Texas Children's Hospital

Texas Children's Pediatrics

San Antonio Area

Ability Pediatric Therapy

Community First Health Plans

Methodist Healthcare Ministries

San Antonio Nonprofit Council

TEXAS
Health and Human
Services Commission

Status of Federally-Required Medicaid and CHIP Eligibility Changes

February 21, 2013

Status of Account Transfers

Account Transfers from the Marketplace to HHSC (Inbound)

- Between January 17 and February 19, HHSC received close to 6,500 unduplicated transfers.
- Twenty specialized staff have been processing account transfers from the Marketplace.
- Account transfers will soon be processed by staff statewide.
- We've processed files for 5,247 individuals received from the federal Marketplace. Of those:
  - 1,571 were referrals for long-term care services.
  - 2,710 were individuals the Marketplace said should qualify for Medicaid or CHIP. Of those:
    - 956 already had coverage or a pending application with the state.
    - 623 were approved for coverage.
    - 662 didn't qualify for coverage.
    - 332 are still open while we try to get more information from the family or a policy question answered.
    - 90 didn’t return additional information the state needed to complete the case.
    - 47 withdrew the applications.
  - 966 were cases that the Marketplace found weren't eligible for Medicaid but asked the state to also look at the case:
    - 22 were approved for Medicaid or CHIP coverage.
    - We agreed with 870 of the denials.
    - We're requesting more information in 29 cases.
    - 42 were current clients.
    - 3 didn’t return additional information the state needed to complete the case.
- CMS indicates that there are 114,320 applications that are in the queue to be transferred to HHSC.

Status of Account Transfers

Account Transfers from HHSC to the Marketplace (Outbound)

- Between January 5 and February 17, HHSC transferred 79,192 cases to the Marketplace. Transfers occur daily.
- Clients who are not eligible for Medicaid or CHIP will receive a notice that their information has been sent to the Marketplace.

New Proposed Rules

- Proposed rules relating to Medicaid, CHIP, and Refugee Medical Assistance eligibility were published in the February 14, 2014 issue of the *Texas Register*.
- The proposed rules:
  - Modify the income eligibility definitions for Medicaid and CHIP to align with the terms used in policy documents by OSS eligibility field staff (bulletins, handbook).
  - Restore assets tests for the Medically Needy and the Refugee Medical Assistance programs.
  - Modify the CHIP waiting period exemptions to align with federal rules.
  - Allow a Medicaid recipient denied at renewal for failure to provide information 90 days (instead of 30 days) to submit the requested information.
  - Allow each CHIP member to select a Managed Care Organization for health and dental coverage based on the service area where they live.
- Written comments on the proposed rules may be submitted to Amanda Austin at Amanda.Austin@hhsc.state.tx.us by March 16, 2014. A public hearing is scheduled for March 5, 2014.

Emergency Rule

- On January 17, 2014, an emergency rule was published in the *Texas Register* to limit eligibility for Medicaid for Transitioning Foster Care Youth to youth who aged out of foster care in Texas, rather than in any state. The rule also "grandfathers" eligibility for current clients in this program who are from out of state. The effective date of this rule is January 1, 2014, until May 1, 2014.
- HHSC is currently developing a permanent rule.

Transition from CHIP to Medicaid

- Effective January 1, 2014, HHSC is enrolling eligible new applicants ages 6 to 18 with income up to 133 percent of the federal poverty level (FPL) in Medicaid. Eligible children with income between 100 and 133 percent of FPL currently enrolled in CHIP will be transitioned to Medicaid at renewal. CMS requires approval of states' transition plans.
  - On November 29, 2013, HHSC submitted to CMS a proposed transition plan and justification for transitioning children from CHIP to Medicaid at renewal.
  - On December 8, 2013, HHSC submitted to CMS a notice that informs clients that their children may be eligible for Medicaid if they choose to apply, but no action is needed if they would like to remain on CHIP until renewal.
  - On January 8, 2014, HHSC submitted to CMS a notice to provide partners additional information about the transition.
  - The transition plan and notices are pending federal approval. HHSC has not received an official response from CMS.

Hospital Presumptive Eligibility

- CMS has indicated that states must submit state plan amendments (SPAs) for hospital presumptive eligibility (PE) by March 31, 2014.
- HHSC is currently working on the SPA for hospital PE and will submit it by the federal deadline.
- Systems changes for hospital PE are being planned for December 2014.
  - It was not feasible to implement systems changes sooner due to the scope of other federally-required eligibility changes.
  - CMS has suggested implementing a manual process for determining hospital PE. This is not a feasible option because systems changes are required to provide payment for services.

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

CHIP Topics in Texas: Waiting Periods Premium Administration CHIP Reauthorization and More

Tricia Brooks
Texas CHIP Coalition
February 21, 2014

Does making kids wait for coverage make sense in a post-health reform world?

Why do states have waiting periods?

- Not required (or encouraged) at federal level (even in 1997) but was fallback policy for states to guard against crowd-out or substitution of private insurance
- Unlike Medicaid where children can have other insurance, only “uninsured” children are eligible for CHIP

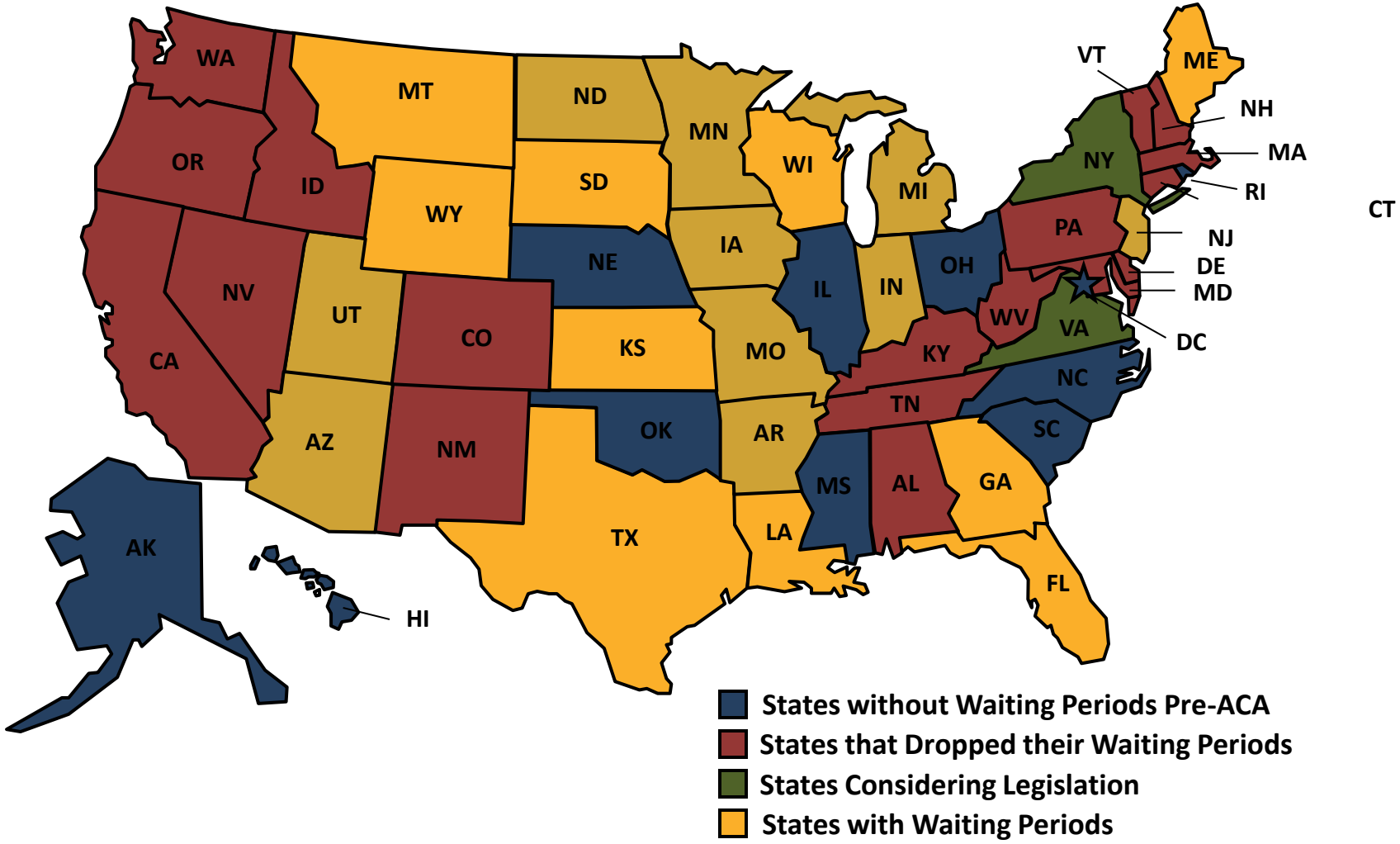
How does the ACA affect waiting periods?

- Guidance explicitly says that states may drop their waiting periods

  "Some states have already eliminated their CHIP waiting periods and we encourage other states to consider taking this step. Nothing in this final rule precludes a state from doing so." (preamble to regulations finalized July 2013)

- Going forward…
  - States are only required to monitor substitution
  - No state may have a waiting period > 90 days
  - States must implement specific good cause exemptions
  - States must track denied applicants and initiate enrollment at end of waiting period

Status of Waiting Periods (1/1/14)



SOURCES: State decisions on the Medicaid expansion as of October 21, 2013. Based on data from the Centers for Medicare and Medicaid, Kaiser Family Foundation and state legislative scan by Georgetown CCF.

Texas CHIP Waiting Period

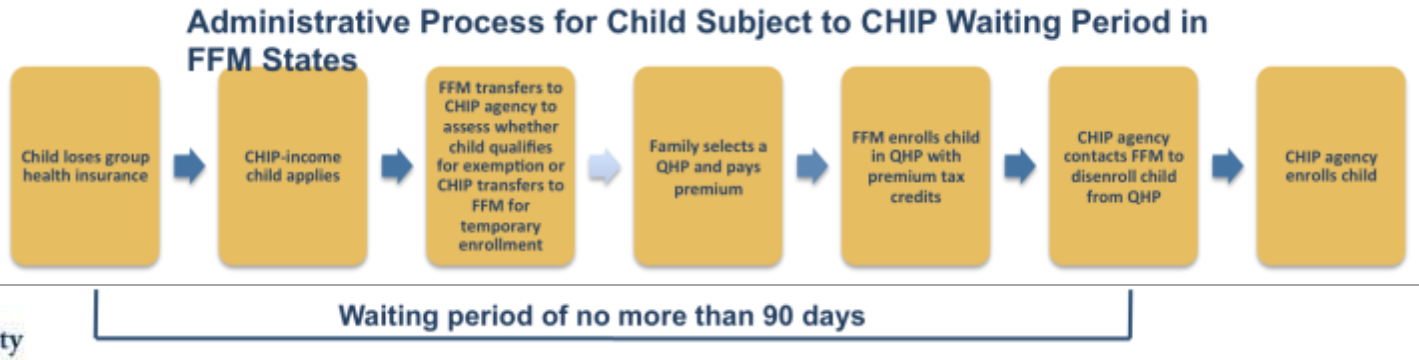
- Children applying for CHIP:
  - must be uninsured

    AND
  - cannot have been covered by group health insurance in the past 3 months

- Required exceptions:
  - Cost of coverage for child >5% family income
  - Cost of coverage for family >9.5% income
  - Parent lost job
  - Child has special health care needs
  - Divorce or death of parent
  - Employer drops coverage
- State may apply other exceptions as well.

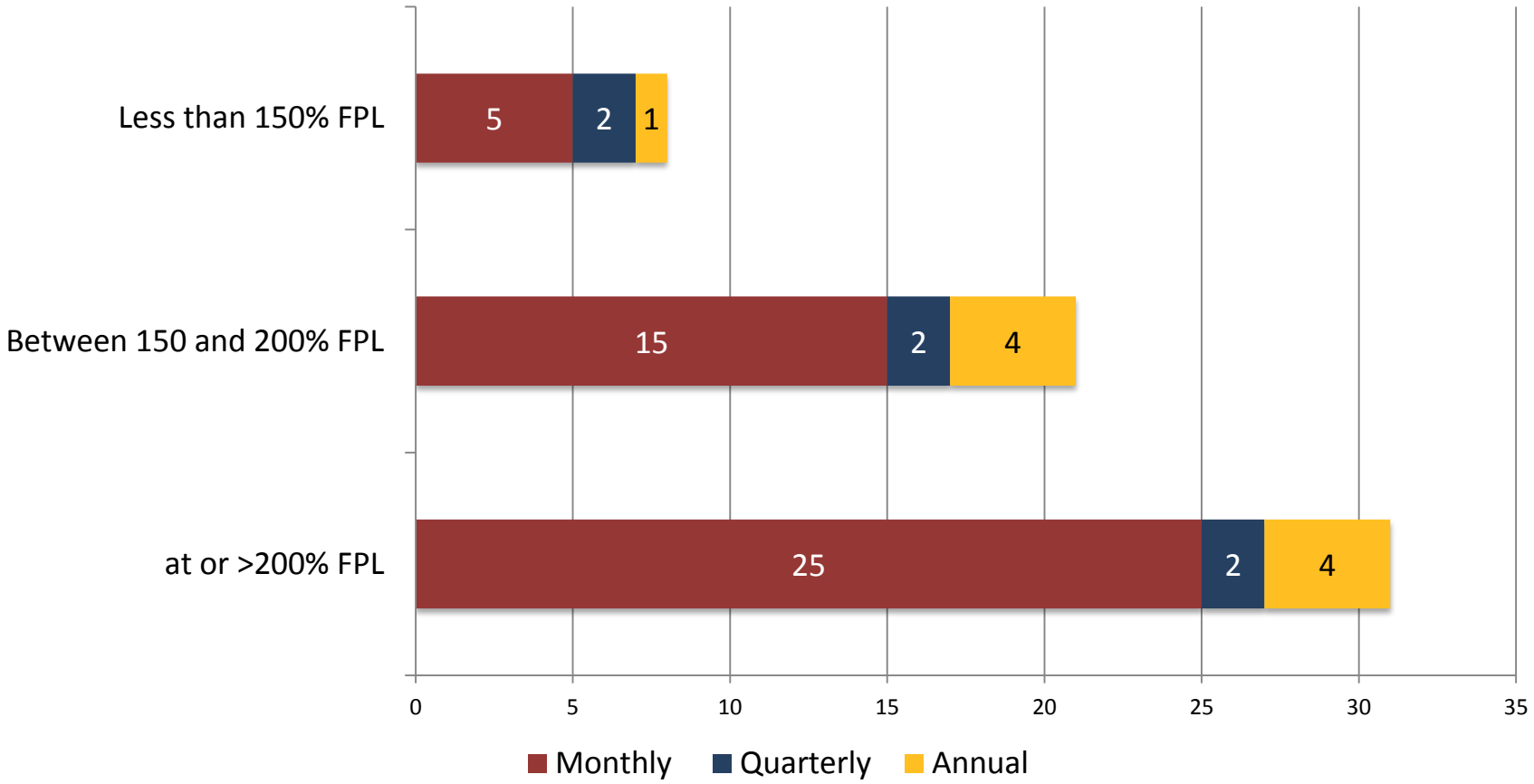
Three Reasons to Eliminate Waiting Period

1) Gaps in coverage lead to delays in seeking care and unmet health care needs, which can be harmful
2) No conclusive evidence that crowd-out is a problem (research has been mixed!)
3) Administrative burden will be costly and inefficient
   - Many children will qualify for exemption
   - State must set up system to track and enroll
   - Children will be bounced between FFM and CHIP



Administering Premiums and Cost-Sharing with Care

States Requiring Payments for Kids' Coverage



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Source: Annual 50-State Survey of Medicaid/CHIP by the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured

Rules for Children's Premiums

- No premiums in Medicaid under 150% FPL without waiver
- Total premiums and cost-sharing cannot exceed 5% of family income
- Children can not be locked out of coverage for nonpayment for more than 90 days
- Repayment of outstanding premium or fee cannot be a condition for re-enrollment, but can require a new application
- CHIP must give at least 30 day grace period for payment

Cost of Collecting Premiums Can Exceed Premium Revenue

- Most states contract with third-party administrators to collect premiums

Virginia charged premiums of $15 per child per month on families with income between 150% and 200% FPL. The state permanently eliminated the premiums when nearly 4,000 children were at risk of losing coverage for nonpayment of premium and a study indicated that the state was spending $1.39 in administrative costs to collect every dollar in premiums.

Source: Virginia Department of Medical Assistance Services memo (May15, 2002)

Premium Stacking

- CHIP premiums are *not* counted toward family's expected premium contribution when purchasing a qualified health plan (QHP) in the marketplace

CHIP Premiums/Fees

Expected family premium contribution = 2% - 9.5% of annual household income based on second lowest cost Silver plan.

Actual premium depends on plan selection (lower if lower cost plan is selected, and vice versa).

However, cost-sharing for children in QHP will likely be higher

	CHIP	Travis County Plans in FFM for Family at 175% FPL with Cost-Sharing Reductions	
		Lowest Silver	2nd Lowest Silver
Individual Deductible	$0	$900	$1,500
Prescription Deductible	$0	$500	$0
Primary Care Visit	$20-$25	$25	$30
Specialist Visit	$20-$25	$35	$50
Emergency Room Visit	$0	20% after deductible	$500
Non-Emergency E.R. Visit	$75	20% after deductible	$500
Generic Drug	$10	$17	No Charge
Brand Drug	$35	50% after deductible	$50
Inpatient Hospital	$75-$125	20% after deductible	$250 per stay

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CENTER FOR CHILDREN AND FAMILIES

Sources: Annual 50-State Survey of Medicaid/CHIP by the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured; www.healthcare.gov

Technical Challenges in FFM

Getting Better but…

- People are getting enrolled after a very rocky start
- Coordination of referrals between state Medicaid/CHIP and FFM continues to be problem
  - In many states, people are being told to reapply directly to Medicaid/CHIP
- Glitch with some children on cusp of CHIP eligibility potentially erroneously assessed
  - New fix that allows applicant to say they have been denied
  - But what about people who didn't get denial?
- Significant challenges for immigrants and mixed-status families
- Will there be special considerations beyond open enrollment?

What's on the horizon for CHIP?

CHIP Reauthorization

- CHIP was strengthened and reauthorized for 5 years in 2009
- Would have expired last September but the ACA extended funding through Sept 2015
- Congress generally acts at the last minute; unlikely to take up before 2015
- ACA bumps up CHIP match by 23 percentage points in 2016; significantly increasing the cost of reauthorization

Key question will be *"Should kids be with their parents in QHPs in the marketplace?"*

More importantly, *"What is our vision for children's health coverage going forward?*

Key Issues to Assess How Well the Marketplace is Serving Children

Cost-Sharing

- Family premiums for QHP are same whether children are enrolled or not
- Out-of-pocket cost-sharing for families will likely be higher
- Research clearly shows that cost-sharing inhibits timely access to care, particularly in low-income families

Benefits

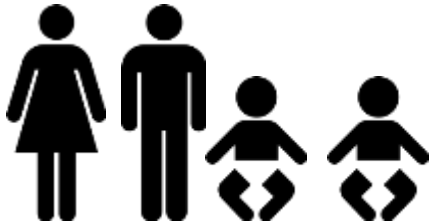
- CHIP benefits designed specifically to meet the needs of children
- While the Essential Health Benefit Package must include pediatric services, there may be limits on care
- Habilitative services in particular need to be evaluated

QHP Dental Coverage

- Essential Health Benefits are supposed to include dental for children
- Plans are not required to provide dental
- Stand-alone dental plans have separate cost-sharing maximum
- Generally, PTC will not help cover cost of stand-alone dental plan

The Family Glitch: Access to PTCs does not consider the cost of employer coverage for full family

Subsidies are NOT available for a family with an ESI coverage offer



IF

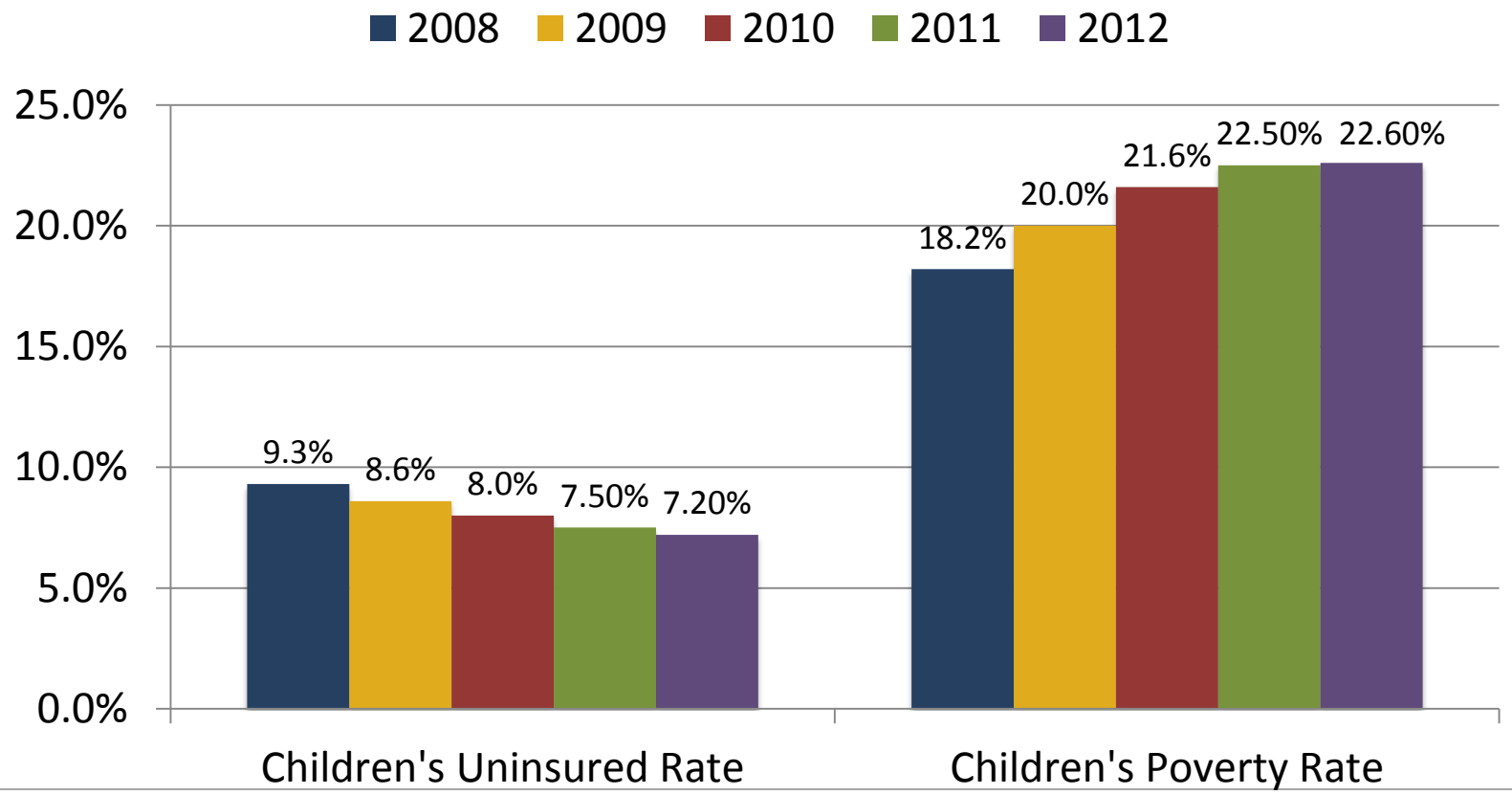
Premium cost for:
Self-only

$< 9.5\%$

Income of:
Household

Family members (not employee) are exempt from penalty if ESI family cost > 8% of household income

Even as more children have slipped into poverty, coverage rates have improved.



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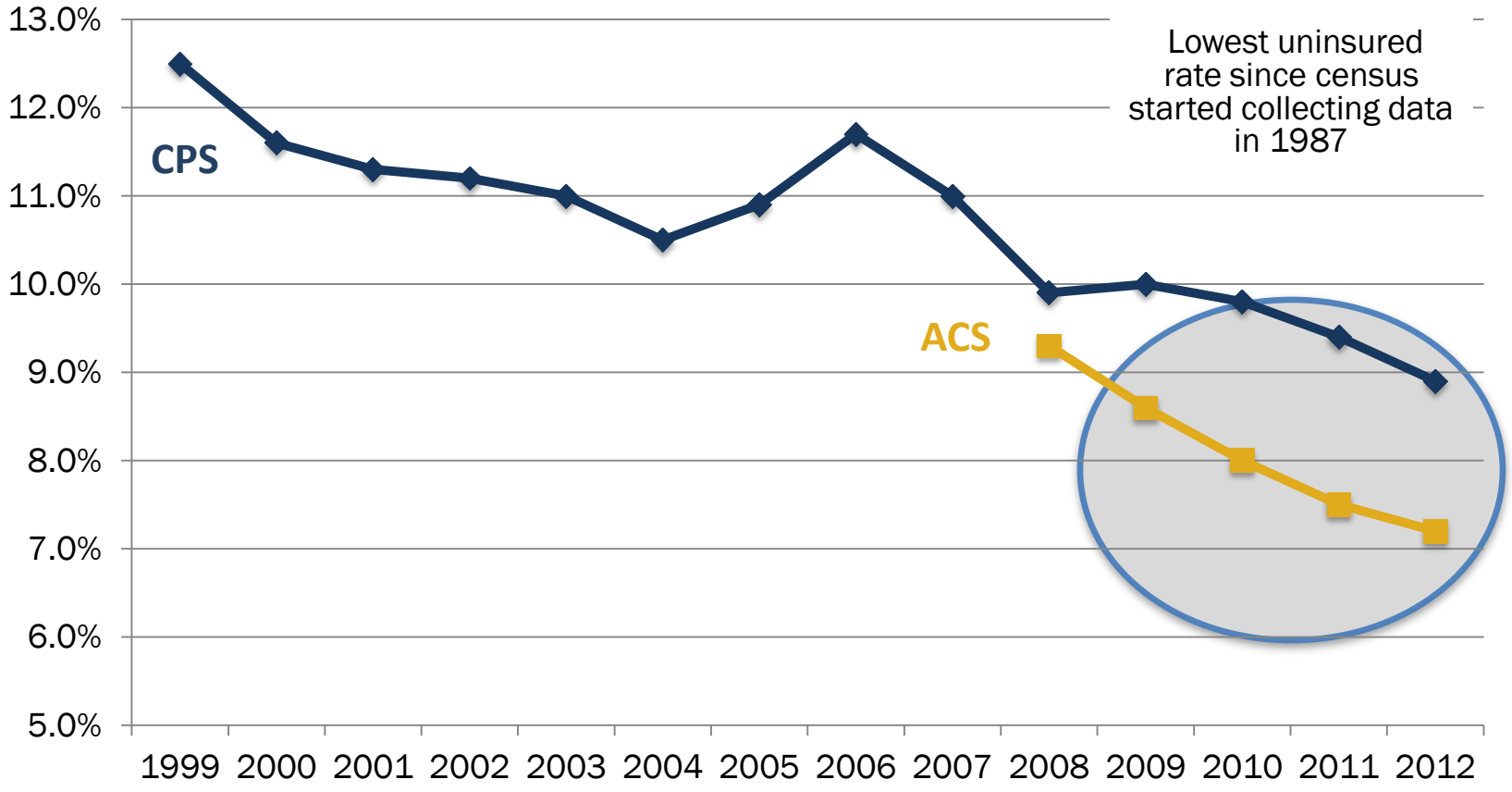
Source: American Community Survey, 2008 - 2011

Unprecedented results in covering children



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Source: U.S. Census Bureau, Current Population Survey (CPS), Annual Social and Economic Supplement; American Community Survey (ACS)

Resources

Annual and Interim 50-state Survey on Medicaid/CHIP

http://ccf.georgetown.edu/wp-content/uploads/2013/01/Getting-Into-Gear-for-2014.pdf

http://ccf.georgetown.edu/wp-content/uploads/2013/11/Getting-into-Gear-for-2014-SHIFTING-NEW-MEDICAID-ELIGIBILITY.pdf

CHIP Waiting Period Brief

http://ccf.georgetown.edu/wp-content/uploads/2013/12/Making-Kids-Wait-for-Coverage-Makes-No-Sense-in-a-Reformed-Health-System.pdf

Premium Administration Brief

http://ccf.georgetown.edu/wp-content/uploads/2013/12/Handle-with-Care-How-Premiums-Are-Administered.pdf

Georgetown Health Policy Institute Center for Children and Families

Tricia Brooks

Research Associate Professor – GU Health Policy Institute

Senior Fellow – GU Center for Children and Families

pab62@georgetown.edu

Our Website: http://ccf.georgetown.edu/

Our child health policy blog: Say Ahhh!

http://ccf.georgetown.edu/blog/