Texas CHIP Coalition
Meeting Minutes

November 14, 2014

Present:	Anne Dunkelberg, CPPP Nikki Metzgar, CPPP Kathy Eckstein, CHAT Maria Serafine, Lonestar Circle of Care Clayton Travis, Texas Pediatric Society Laura Guerra-Cardus, CDF Helen Kent Davis, TMA Grace Chimene, League of Women Voters Alice Bufkin, TCFC Sister JT Dwyer, Daughters of Charity Susanna Alcina, NASW/TX Shannon Lucas, March of Dimes Gwen Spain, HHSC Miryam Bujanda, Methodist Healthcare Ministries Kit Abney Spelce, Insure-a-kid Roxanne Shotwell Rachel Cooper, CPPP Alison Sinister
Conference Line:	Beth? Escobar from Parkland Martha Roscoe from Lone Star legal aid Veronica from Texas Children's Robin Chandler, Disability Rights Texas Nicole Love and Renee from TLRA Maria Norma Martinez Claudia Lindenberg, Central Health Stacy Wilson, THA Michelle Tijina from Central Health Frieda Wingate Smith, Legal Aid of Northwest Texas Betsy Coates, Texas Health Steps and STAR
Chair:	Kathy Eckstein, CHAT
Minutes Scribe:	Nikki Metzgar, Center for Public Policy Priorities
Next meeting:	December 12, 2014

I. Update from Medicaid Managed Care Consumer Protection Workgroup
Clayton Travis, Texas Pediatric Society

- The Medicaid Managed Care Consumer Protection Workgroup started 9 months to a year ago with two major goals:
    1. To fix upstream problems that consumers have been facing, including issues with utilization management and being denied; consumers struggling to understand the process for appealing a denial; and competing interests when it comes to service

coordination standards and network adequacy. All revolve around contract oversight and enforcement on behalf of the state. Consumer advocates feel that if we could force those contracts a little more, we could see outcomes improve.
2. Taking a look at downstream capacity of the ombudsman program so when consumers do experience problems or are being denied care, they can go to the program to field their questions about the processes of appeal and representing them through the appeal.

- There are 38,000 patients per staff person in the ombudsman program. If people knew about the program, ombudsmen would be overrun pretty quickly. In addition to appropriate staffing ratios, they would need to understand all the new programs coming online. We would like to see more independence with the ombudsman program. It's currently embedded in HHSC, which is good because it provides more direct link to HHSC staff but it also presents a potential conflict of interest.
- Financing is an issue; we would like to see the ombudsman program wrapped into renewal of 1115 waiver or MCOs providing some of the financing because they will also see better outcomes.
- Finally, we will be pushing better network adequacy standards, which we have discussed before. Recommendations will go to the commissioner about an improved ombudsman program and improved network adequacy standards. Hopefully, we'll see more interest in both of those items through the sunset hearing process.
- Gwen Spain from HHSC attended the meeting to offer any information about the ombudsman process the Coalition needs and to extend an ear for any suggestions for improvement that would not require legislative action. For example, HHSC is making updates to contract language to improve website requirements and provider directories.
- If interested in joining the workgroup, contact Clayton Travis.
- Another concern on the provider side: doctors don't know where to go to get patients care. The provider rep often doesn't return calls or it takes weeks, and doctors just give up and call TMA to escalate the problem to someone at the health plan. Single case agreements are not an efficient process. There needs to be a way to expedite requests to the health plan; information on how to file a complaint is so buried, doctors do not know there is a care coordinator. This is a problem when providers and patients don't know how to make the system work because it's too complicated. It needs to be streamlined and plans need to promote to providers and patients how to get the help you need.

II. Strategy Session: Advancing CHIP Priorities
Kathy Eckstein, CHAT

- Based on what's in the LAR, the number of children in CHIP is projected to grow by quite a bit by 2017. That means we are making strides in reducing the population of children that are eligible but not enrolled. Part of the environment we're going to be facing is that people are not happy about that growth in the Medicaid caseload.
- Anne Dunkelberg: We had to put in some numbers for a grant report recently, and the combined number for Medicaid CHIP enrollment has increased. If you look at the average gains, it's 25,000 kids a month. It makes you wonder how much additional welcome mat effect will actually be available by the next biennium. We may have some work to do on the accuracy of these projections.

- KE: Some legislators are attributing the increased enrollment as an effect of Obamacare and are concerned about the dollars that are going to have to be dedicated to HHSC instead of education. HHSC presents this as an ACA impact.
- KE: If we actually want to start working on legislation, I went back and looked at the last three sessions to see what had been filed in regards to Medicaid eligibility. Everything had been filed by Democrats, so that is who we are working with.
- Eliminating the CHIP waiting period: What does the statute actually say? There are a lot of exceptions to it in law and the time period itself is in statute so it would take legislation to get rid of it. There are only 10 states that have a waiting period for CHIP; 18 dropped the waiting period since the ACA. What is the cost for administering the waiting period?
- Whether or not eliminate waiting periods, under the ACA the CHIP matching rate is supposed to bump up so in Texas it would be in the neighborhood of 95% match rate. When entities like LBB do a cost estimate, they go by what's in the law. I think it would be useful to see what the cost would be if that match didn't take effect. I'm still confused about the status of our existing CHIP policy; waiting period has to be 90 days since the last time the patient had health insurance.
- Valerie Eubert, HHSC: All the federal exceptions were implemented on June 1, 2014 and they're a lot more broad than what was previously in place. If you're losing Medicaid for any reason in Texas, you're not subject to the waiting period; if your family lost insurance because of death, divorce, etc. you are not subject to it.
- Clayton Travis: How many kids are actually subject to the waiting period? A waiting period is set up to discourage people from signing up for CHIP if they could be signing up for employer sponsored insurance.

III. Joint CHIP Coalition/Outreach and Technical Assistance

Valerie Eubert, Claire Middleton, Stephanie Muth, HHSC

- Claire Middleton: An update on presumptive eligibility: We are still ticking along with implementation we have the website deployment on November 21. We're presenting HHSC TX administrative code rules for presumptive eligibility to the HHSC Council on November 21.
- There were 44 responses to initial survey of interest, which represented more than 100 hospitals through system responses. There are 600 eligible hospitals.
- Some hospitals have concerns over the standards they will need to meet to participate and may be waiting to see what the standards are before committing. The MOU will include proposed standards. Others are concerned about being able to use outstation workers to make determinations.
- HHSC is finalizing the role of outstation workers since not all hospitals have them.
- Valerie Eubert, HHSC: Status update on account transfers: HHSC received just over 239,000 unduplicated transfers from the Marketplace. Transfers occur on a daily basis, so when people are determined ineligible year-round. they are sent back to the Marketplace
- Since May we've only received about 34,000 transfers from the Marketplace to HHSC. This may increase when we move into open enrollment.
- After referral to HHSC, about 78% of the cases remain denied, but 40% of those are the folks the Marketplace said didn't look like qualified. At a high level, we know they're not meeting our income standards. 60% are MAGI related and 40% are either the non-MAGI or full determination. As we get more account transfers with open enrollment, we might see a change.

- CMS has identified defects that they know about and we can share those reports. Those are ones that they have fixed; they have acknowledged there are others but it's hard to know what they are specifically.
- What happens to women who are enrolled in the Marketplace and deliver babies that are referred to Medicaid but thanks to backlog are discharged without knowing whether they have coverage? What is the best door to send them so they get a faster determination? How do you make the transfer between QHP to Medicaid for pregnant women then go back to their QHP?
    - HHSC will discuss this on their next call with CMS, but initial response is that HHSC is the fastest door.
- Update on business process design: On average it takes 20 days to make a determination; a lot of that time is dead time because the missing information hasn't been filled out by staff because they are busy doing interviews. On average, we're being contacted by the applicant 3 to 5 times. We want to be more efficient and deliver the decision more quickly. Different offices in different locations have different business processes; now we are looking for consistency so that if someone picked up work from another office, you wouldn't need to start over. We're looking at leveraging technology now that we can work cases anywhere in the state. Pilot is 35 local offices and to date we've implemented in 11 offices. We've seen a sharp drop in days it takes for determination and overtime but after some time people revert back to the old ways. We've seen improvements to determination days across programs; triaging applications based on complexity of programs (TANF is most complex). We're trying to take away artificial barriers between programs so if someone is enrolled in many programs, one caseworker works all those applications unless someone else picks it up because the first worker couldn't finish.
- Two weeks ago HHSC launched a mobile app. It's designed to work in conjunction with the computer and the Your Texas Benefits.com account. We're going to release new functionality in several phases. The first phase is available to download right now; you can upload documents that you need to provide us and it will immediately be available to the worker. We are looking at being able to request Medicaid card replacement through the app and making basic info changes. Research shows more people have smartphones than access to a computer.