Texas CHIP Coalition Minutes
Friday, September 18, 2009 - 11:00-1:00 p.m.
May Owen Conference Room, 10th Floor
Texas Medical Association

Attendees: Kit Abney-Spelce, *Insure-a-kid;* Jennifer Banda, *Texas Hospital Association;* Katie Coburn, *Texas Association of Community Health Centers;* Kevin Denmark, *Maximus;* Anne Dunkelberg, *Center for Public Policy Priorities;* Kathy Eckstein, *CHAT;* Shannon Foster, *Seton Health Plan;* Kay Gharemani, *Health & Human Services Commission;* Laura Guerra-Cardus, *Children's Defense Fund*; Jan Hudson, *Seton Helath Plan;* Lynne Hudson, *C-NAP;* Helen Kent-Davis, *Texas Medical Association;* Sonia Lara, *Texas Association of Community Health Centers;* Alison Little, *Texans Care for Children;* John Pellman, *Health & Human Services Commission;* Gina Perez, *Health & Human Services Commission;* Michelle Romero, *Texas Medical Association;* Melissa Shannon, *Center for Public Policy Priorities;* Emily Shelton, *Texas Impact;* Rexann Shotwell, *Insure-a-kid.*

Via conference call: Sister JT Dwyer, *Seton Family of Hospitals*; Julia Easley, *Tarrant County CHIP Coalition.*

Budgetary Update on Legal Immigrant Residents

Ms Perez informed the group that in February CMS issued new guidelines based on CHIPRA that allow Texas to eliminate the five-year waiting period for all legal resident children and pregnant women who are currently eligible for CHIP or Medicaid. The state has provided this care through CHIP, but with state dollars, but the budgetary shift will occur on May 1, 2010. The children currently enrolled in CHIP will remain in the program until the individual's renewal application is due. If the child is actually eligible for Medicaid they will be transitioned into the program.

Newborns and CHIPRA (see http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009%20schip%20reauth/smd083109b.pdf)

Ms Perez explained additional CMS guidance on the CHIPRA provision requiring improved automatic coverage for new infants born to teen mothers who are currently enrolled in CHIP. Currently Texas newborns to CHIP teen mothers have the same renewal date as the teen mother, depending on the program – the CMS rule change makes the infants automatically eligible for either CHIP or Medicaid (depending on family income) without any application, and their renewal date will come after at the infant's first birthday.

The CMS guidance also includes provisions that will help infants who do not stay with the mother, as the infant remains enrolled even if placed with another family member or in foster care. Every newborn must be issued a unique identifier, while still allowing for the mother's ID number to be used for billing until the state issues the child's own number.

Automatic ("deemed") coverage also applies to newborns of undocumented mothers, as well as legal permanent residents (who are also excluded from Texas Medicaid under current state

policy). Delivery of babies born to these Medicaid-ineligible mothers is covered under so-called "emergency Medicaid." CHIPRA and this guidance clarify that these newborns are also Medicaid eligible without application and do not renew until their first birthday.

Finally, CHIPRA eliminates any requirement for citizenship documentation for children born to a mother enrolled in CHIP, Medicaid, or CHIP perinatal, or who qualifies for Emergency Medicaid coverage of delivery.

Texas CHIP Perinatal

Texas continues to operate our CHIP perinatal program to provide prenatal care, labor, delivery, and postpartum care, as well as full CHIP benefits for the newborn until 12 months from the date when the mother enrolled in prenatal care. However, CMS wants the newborns under 185% FPL to be enrolled in Medicaid , not CHIP, following the birth if that's the program that they're income-eligible for. (The BBA of 1997 that created CHIP forbids enrolling kids in CHIP who qualify for Medicaid). Some members raised concerns regarding the long-term viability of the CHIP perinate program.

Ms Perez and Ms Gharemani noted that one issue with the perinatal program was that CMS wanted the agency to pay global prenatal care and delivery fees to doctors. Under the global fee method, a single payment is made for prenatal care, labor, delivery, and postpartum care per patient. This is problematic for health plans because this population group is more likely to see a number of different doctors.

However, research since the September meeting has indicated that the real do-or-die issue for both CMS and Texas HHSC is the question of enrolling perinate program newborns in Medicaid (and thus drawing a lower match rate for those months – that is, lower after the current higher federal stimulus package Medicaid matching rates expire). HHSC staff believe that legislative budget decisionmakers will not allow them to continue the program if they no longer can claim the higher CHIP match rate for the newborns.

CHIPRA Guidance on Medicaid Managed Care Protections to some CHIP Programs

(see http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009%20schip%20reauth/sho083109a.pdf)

Ms Gharemani opened up the discussion about CMS's state official letter for CHIPRA, which requires states to maintain the same managed care provisions outlined in Medicaid for the CHIP program. She noted that this change will not dramatically affect how the program works because these aspects were managed by the same staff. The CMS guidance calls for clients enrolled in CHIP to be able to change their enrollment into another health plan within 90 days of their enrollment, after which the recipient is locked in to the program until annual renewal. Previously enrollees were locked in throughout the duration of their enrollment. However, in

Medicaid recipients have the option to change the plan options every month. This provision will be implemented from October 1st.

Ms Gharemani noted that the CMS guidance will also require that at least two health plans exist in a particular area. Starting September 2010 the choice in plans will be (EPO) Superior and Molina. For the CHIP program, an applicant will have a choice in all areas of the state, whereas for Medicaid the second option will only be available in urban areas.

She informed the group that CMS guidance also includes new protections to expand coverage of dental services necessary to improve oral health. Under CHIPRA all states must offer dental, the managed care provision will apply to dental health plans too.

National Health Reform Update

Ms Dunkelberg began the discussion on national health reform with a break-down of the initial version of the Senate Finance bill. The cost estimate of the Senate Finance bill is at $856 billion, although the CBO estimates the costs at $774 billion over 10 years - $82 billion lower than Baucus' calculations.

Ms Dunkelberg outlined major differences between the Senate Finance proposal and the House bills. She addressed many of the concerns highlighted by the advocacy community – namely those related the gaps caused by an individual mandate that requires families to purchase coverage, but subsidies targets fail to make insurance affordable enough for families to purchase. Those 300-400 percent FPL may be expected to spend as much as 12 percent of annual household income on premiums alone. Many advocates are contest that this does not adequately tackle the problems of the uninsured. The House bill does a far better job at reducing the number of uninsured.

Ms Dunkelberg also explained that the Senate Finance version lacks an employer 'pay or play' provision, but rather imposes a small penalty on employers that have workers receiving subsidies. Many are concerned with a potential disincentive to hire low-income workers, or worse motivate businesses to lay-off workers that cannot get coverage through another family member. The proposed legislation does include a stipulation to tax more generous health plans. This raises concerns for families that have high costs plans but not necessarily receiving generous benefits. Also, unions are opposed to this provision because they have recognized rising health care costs and focused their attention on preserving these benefits rather than pay increases.

Further, the Senate Finance bill does not include a public option, and instead proposes state-level coops. There are many concerns that the state-based approach will not work as well, with one concern being that congress and state legislatures may not adequately fund or implement these provisions. Ms Dunkelberg warns that federal standards will have to be rigorous if access is to be equitable across the U.S..

Ms Dunkelberg did suggest that the Medicaid expansion component of the proposal is more generous than early summer drafts of the Senate finance proposal. The Finance formula would change over the years of the bill, but state share would never exceed 10% of the expansion costs.

The House Energy and Commerce version covers expansion costs in full for 2 years, then requires a 10% state share in the subsequent years. Requiring states to contribute to the Medicaid expansion efforts has major implications for state budgets, though the net gain in federal funding to Texas will be many times larger than the cost to the budget.

Finish Line Update

Dr. Guerra-Cardus provided an update on national health reform from the children's perspective. Her assessment was that the House bill is more comprehensive and included stronger protections to ensure affordabililty. Dr. Guerra-Cardus highlighted particular differences in the House and Senate Finance bills, noting the Senate focuses its efforts for children on providing wrap around services, which is complicated to deliver and monitor to ensure that children do not fall through the cracks. (Note: A late amendment to Senate Finance bill changed this; see http://theccfblog.org/2009/10/adopted-rockefeller-amendment-in-senate-health-reform-measure-maintains-chip-and-medicaid-for-childr.html).

Outreach & Technical Advice Update

Ms Abney-Spelce provided the Coalition with a draft version of a resource provides helpful information to assist outreach workers to help eligible applicants for CHIP and Medicaid collect all of the appropriate documentation and information necessary to complete a successful enrollment application on the first attempt. Ms Abney-Spelce was very clear that this tool is intended to assist outreach workers in completing the application with service users, rather than a tool for applicants to complete the application on their own, and asked that Coalition members did not distribute the document widely to avoid confusion.

Ms Abney-Spelce reminded the group that the resource was a work in progress. She noted that the OTA workgroup will continue to refine the document through discussions with commission staff so that to make it the most a reliable document to assist outreach workers. Ms Abney-Spelce requested that Coalition members look over the document and send comments.

Interim Charges

The group wanted to discuss issues that might be outlined in the interim. The deadline for interim studies is approaching. Some of the topics that may be addressed include an analysis of staffing levels at HHSC, the eligibility system and other concerns related to public benefits. Ms Dunkelberg noted that HHSC has already submitted a request to LBB for more staff, and presidential change makes it possible to improve the system in Texas. The new appointment of Commissioner Suehs and a class action lawsuit (*Note: Lawsuit now dismissed*) regarding delays in enrollment in public programs will draw greater attention on the eligibility system.

Achievements & Items for Follow-Up

Ms Lara informed the group of a major breakthrough experienced by the Texas Association of Community Health Centers. Within the last month the organization's Medicaid portability project had two claims paid by Texas to the Michigan system for children of migrant workers who are eligible for Medicaid, but often are thrown out of the system because their regular change in circumstances. The successful collection of these funds presents an opportunity to ensure continuation of care for a vulnerable population.

Ms Little committed to providing an update on the outcomes from the CHIP Vision meeting held in August. She will distribute a rough draft plan that will outline the Coalitions major priorities and incorporate suggestions addressed in this process. She asked for members to weigh in with additional input once the plans are more firm.

With no other agenda items the CHIP Coalition meeting adjourned at 12:56 p.m.