CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

Texas CHC Coalition
Meeting Minutes

April 21, 2017

Present:	Diane Rhodes, Texas Dental Association Helen Kent Davis, Texas Medical Association Adriana Kohler, Texans Care for Children Alice Bufkin, Healthy Futures of Texas Leah Gonzales, Healthy Futures of Texas Clayton Travis, Texas Pediatric Society Shannon Lucas, March of Dimes Mary Allen, Texas Association of Community Health Centers RexAnn Shotwell, Texas Association of Community Health Centers Christina Phamvu, Methodist Healthcare Ministries Whitney Miller, Methodist Healthcare Ministries Angela Aguirre, Seton OB Navigation Diana Diaz, Seton OB Navigation Anne Dunkelberg, Center for Public Policy Priorities Melissa McChesney, Center for Public Policy Priorities Kelly Dees, Texas Pediatric Society Rona Statman, Everychild Elizabeth Tucker, Everychild Nakia Winfield, NASW-Tx Paige Marsala, HHSC – OO Deborah De La Cruz, HHSC- OO Joel Schwartz, Texas Attorney General Ombudsman
On the phone:	Paul Townsend, Children's Hospital Association of Texas Sister J.T. Dwyer, Daughters of Charity Betsey Coates, Maximus
Chair:	Diane Rhode, Texas Dental Association
Minutes Scribe:	Kamia Rathore, Center for Public Policy Priorities
Next meeting:	May 19, 2017

I. Discussion of Budget Items *(Multiple Speakers)*

- **Diane:** For dental, we're looking at a two percent cut for Medicaid reimbursement rates.
- **Anne:** What does that look like in the budget?

- **Diane:** It's in the EPSDT Dental line item, the dollar amount has been reduced for both the Senate and House version. The state sets the floor for dental reimbursement rates—if the state adjusts the floor by two percent, then the managed care plans adjust their reimbursement of providers by two percent.
- **Helen:** Did this come out of the interim recommendations for four percent reductions?
- **Diane**: Yes, that's my understanding. Are physicians facing this as well?
- **Helen:** Not any targeted cuts for physicians in the budget, but we're worried about the contract containment rider in the House. It's worded as a one percent reduction to the health plans, so we're concerned it's a back door cut to provider rates. Plans are also alarmed by the expectation that they can absorb the cuts.
- **Anne:** I've written a couple of blog posts about the budget and so has Eva De Luna Castro, our budget analyst, with an overview. Both chambers seriously underfund Medicaid— the good news is that the House is using the Rainy Day Fund to avoid bigger cuts and has passed a supplemental bill to fill a shortfall in this year's 2017 budget. The bad news on the House side is that they have a rider that would take 1 billion dollars in state funds for Medicaid, but they have said their intention is not to cut benefits**,** services, or rates. Caseload growth is also fully funded for both years in the House.
- The Senate side has not funded the 2017 shortfall. They have not yet passed their Supplemental budget. They also fund caseload growth for one year and hold it flat for next year. There's also a cost-containment rider that's much higher than the House included as well.
- Both chambers are betting on being able to kicks the can down the road for a giant supplemental bill. We also have to be aware of several revenue cuts that are proposed, including the franchise tax, which is the only business tax in Texas. If abolished, it would be a seven billion dollar revenue loss for the biennium.
- **Helen**: In the Senate, there's also a reduction of health plan risk margins by half a percent point. We're also looking at a rider proposal for statewide procurement that would make all plans procurement; we've been pushing back against this in favor of a regional approach. Our concern is that local plans will be particularly affected, and procurement pushes more risk on the plans assuming they can absorb it even if they're on the edge. Other states like Maryland and Connecticut have tried statewide procurement and it did not work. It puts community-based plans at a disadvantage and the worry is that they will significantly cut back on benefits or leave the area altogether.

II. Updates on State Legislation *(Multiple Speakers)*

Early Childhood Intervention (Adriana Kohler, Texans Care for Children)

- **Adriana:** There's a coalition of ECI folks who are focusing on the budget, which doesn't include an exceptional item for caseload growth. We're drafting a letter to the budget conferees on the stability of the ECI program. ECI is now down to 43 providers, with East Texas hit especially hard.
- There are two related bills we're supporting. HB 3930 would require private insurance plans to cover ECI. Because all other insurance plans are billed first before the state, this bill would increase funding stability. HB 3967 focuses on creating a task force to look at the feasibility of requiring insurance plans to cover ECI. These come out of LBB recommendations to use private insurance to fund larger portions of the program.

Maternal and Child Health (Multiple speakers)

*Streamlining eligibility renewal (*Mary Allen and RexAnn Shotwell, Texans Association of Community Health Centers)

- **Mary**: The Medicaid streamlining bill had a hearing last week. Overall, it was very positive. There were several questions about how the demonstration project would work and clarifications about whether more individuals would gain eligibility.
- **RexAnn**: The streamlining process aligns Medicaid-eligible children in the same household, allowing them to recertify at the same time. It would cut back periodic income checks on children to two times a year. I testified about working with eligibility workers who enroll these children and parents do come to the health centers confused about the multiple checks. If a household has more than three children, they're getting at least 15 income checks through the year. The parent has to provide proof of income every time, but its easy to miss the 10-day deadline and lose coverage. Then they get back on coverage later because they're still eligible. These gaps impact plans as well, as children bounce from fee-for-service to managed care. As Mary was saying, the message was well received, there were just concerns about the financial impact to the budget.

Women's health (Alice Bufkin, Healthy Futures of Texas)

- **Alice**: Healthy Texas Women, the state's women's health program, used to receive funding at a 9:1 federal funds matching rate. After the state drastically cut funding to planned parenthood, the federal government decreased its matching rate for the HTW program. The state feels that it may successfully re-secure that former 9:1 matching rate and the Senate accounts for this assumption in its version of the budget. However, there are a few concerns about unintended consequences. There is no guarantee that the state will receive this higher match rate; it could receive a rate that *is* higher, but not the same 9:1 rate; or it could receive the funding later than expected.
- The original family planning waiver is cost neutral, but the HTW program has some current services that it is unclear whether they could be covered if state funding is decreased.
- Automatic enrollment from Medicaid to HTW has gone well and is something we'd like to see continue. Several house riders improve data collection on the HTW programs and add outreach for CHIP-Perinatal and emergency Medicaid.
- HB 1161 would allow women to receive multiple months of coverage for prescription contraception. Often, women get a one month or a three-month plan, and this bill would prevent gaps in use.

Vaccine exemptions

- **Clayton:** There's a particularly worrying anti-vaccine bill up for hearing that would create the most lenient exemption process for vaccines in the country. Currently for an exemption, a parent would have contact DSHS for a specific form, fill it out and get it notarized before giving it to the school—so there are some barriers, and you don't have so-called exemptions of convenience. This bill would repeal that process, put the form up online and in all schools, and just allow parents to turn it in. There's a different, good bill related to vaccines – SB 2249 – that would require reporting of exemption levels by

school campuses rather than ISD. Exemptions cluster in certain communities and herd immunity is compromised in certain areas, which is why we're pressing on bill 2249.

III. Discussion of Periodic Income Checks (*Multiple speakers)*

- **Anne:** The ACA required that all children and families did not have to recertify more than once a year, although this is not a requirement for continuous eligibility. Texas has not had month to month eligibility for children on Medicaid since 2002, when six-month coverage was established with the hope of eventually scaling up to 12 months of continuous eligibility. 2003 cuts to Medicaid and CHIP removed the 12-month phase-in and CHIP's period of continuous eligibility was cut back from 12 to 6 months. When the ACA requirement was established, there was no discussion of the implications for Texas. The state decided a third party database was not adequate to certify establishment, so income checks were used. Income is checked upon entering Medicaid, then followed by a six-month period of continuous eligibility. Income is checked during month 5, then against during month 6, 7, 8, and 12. The checks make use of a quarterly job database, but by design, this means information is at least a quarter behind. We've been trying to get data on the effect of periodic income checks for over a year and half and this is an issue that circles back to HB 3151.
- Regardless of whether HB 3151 passes, there's still interest on moving on data collection. Families, health plans, and providers are all complaining—the current system has negative implications not only for access to care, but fiscal and recordkeeping concerns that have costs attached as well. The "wishlist" of items for an 1115 waiver also included continuous eligibility.
- Even though this is procedural, this is still an incredibly important issue. Procedural things make a large difference. We know from previous data that enrollment drastically declines when a second check is added. We didn't know in advance the negative affect periodic income checks would have, but it has gotten to the point where everyone has noticed it.
- **Melissa**: This also ties into one of the issues the OTA group focuses on. We have been talking about the additional problems a fifth check population on SSI faces. It requires a system fix, but the update to TIERS has still not been built. It's on the priority list to fix for this year, but that may change depending on the demands of the legislative session and interim.

IV. OTA Meeting

Updates from the Office of the Ombudsman

Office of the Ombudsman (Paige Marsala, Deborah De La Cruz HHSC)

- *See slides below*
- **Paige: Joel Schwartz, Ombudsman for AG**
- **Paige:** We received 9,000 complaints for the fiscal year. There's an increase in contact volume during January and February, likely due to holiday hourly increases and individuals exceeding income limits. CHIP perinatal contacts spike in November, although these were largely just inquiries. The peak for

SNAP contacts was in September, when the cost of living adjustment when up and the standard utility allowance went down.

- The January spike in contact volume for the dual demonstration program is due to yearly passive enrollment. In the six counties where the demonstration is being carried out, eligible individuals are passively enrolled. We receive calls from clients calling because they're in a new plan, they want de-enroll, or they want to change within the demonstration.
- For STAR Kids, contact spiked in November with the rollout of the program and there was a slight increase in March due to assessment results being released. Some clients were unhappy with results and some had concerns about losing eligibility for MDCP or decreases in the number of approved hours.
- **Elizabeth:** Kids shouldn't be dropping off of MDCP, though—their assessment results should be valid for longer. The population on MDCP who had an ICP assessment between August last year and April this year have that result cloned for 12 months, so they shouldn't lose eligibility. May is when new medical necessity assessments begin. There's also an issue with there being over 160,000 individuals in STAR Kids and less than half have been assessed.
- **Paige:** I will follow-up on that. We have found some reluctance for parents to go through assessments and difficulties trying to get a hold of parents. There may be communication strategies we can try, such as plans clearly identifying in calls and reaching out with texts.
- Going on, non managed care contacts are all conglomerated, but we do want to break it down further eventually. There are a lot of small programs that make up this category, so it's hard to analyze. We're working to disaggregate it.

Foster Care Ombudsman update

- **Deborah:** We've had 384 contacts, about 20% of which were from foster care youth. The contact reasons for those youth often include needing supplies like clothing, hygiene products. The majority of the calls are coming in from foster care parents. We try to educate them that they should be going to DFPS. If they need further assistance, we transfer them out to the appropriate line. We continue outreach from the ombudsman to foster care youth, making them aware that we're here, distributing handouts with their rights and our numbers. They can call in the evening and leave a voice message, and our ombudsman will reach out in the morning.
- **Elizabeth:** What's the age of the youth who are calling? Is there a certain cut off?
- **Deborah**: The majority of youth calling are between 15 and 17, and there's no minimum age. But if they're above 17, they are an adult. Foster care youth who have aged out reach out to the general ombudsman line at that point.

Managed care assistance team

- **Paige:** Our Managed Care Support Network had a meeting in early April. All the different areas shared what bills they're tracking, and we will meet in June to discuss what bills have passed and discuss any changes required for implementing. We'll also be moving to quarterly meetings.
- **Elizabeth**: Are there any ideas you have for outreach? How we can help and get clients to you?

- **Paige:** It used to be a little easier, when Medicaid was on paper forms and we could put physical reminders with every thing sent out. We are on every client notice, but those are eligibility notices. We are trying to get the Managed Care Assistance Team's contact information on all of the member handbooks. We also want it on all the action letters when something has been denied or reduced.

Recent Changes to Refugee Access to Benefits and Health Coverage *(Melissa Helber, Refugee Services of Texas)*

- *See slides below*
- **Melissa M:** HHSC's AES was not able to join us this month, but Refugee Services of Texas is presenting to us today. We've had some contact on these issues, as the refugee program in Texas has changed recently in how it is administered and Melissa is here to talk about some of that.
- **Melissa H**: I'll talk about the transition, my role, what the role of the regional designee is, and what this means for Medicaid, CHIP, and the Refugee Medical Assistance Program.
- The Office of Refugee Resettlement announced that beginning on February 1st, Texas would no longer oversee the state-funded refugee contracts. That federal funding still goes to Texas, but when a state does not want to oversee that, a non-profit organization or private organization is appointed to handle services. Because Texas is so large, a regional approach was chosen. There are four offices covering four regions.
- Office of Refugee Resettlement is separate from the Department of State that handles refugee resettlement. ORR covers social services, Refugee Medical Assistance, cash assistance, ESL, and so on. When the announcement was made, there was confusion over whether any new refugees would be able to come to Texas or be eligible for any services, which is not what was announced. We have attempted to do as much training as possible with eligibility workers to emphasize that nothing has changed in terms of refugee eligibility for services—just the way that services are provided.
- Refugee Medical Assistance was separate from Medicaid but it was run through the program because the state used to administer RMA. It was time-limited to eight months, and typically children would just go onto Children's Medicaid because they were eligible while parents would go on RMA.
- The agency that is facilitating RMA currently is USCRI, and they are using a different health care plan. There have been challenges with providers not knowing who the plan is, but a lot of outreach is happening. The refugee resettlement programs determine eligibility for RMA and they handle the application process, while refugee families still have to submit applications for Medicaid, CHIP, and SNAP.
- **Melissa M:** One issue we've seen is that applications for Medicaid and CHIP are now getting routed to local eligibility offices instead of a centralized team that used to only process applications from refugees. The local eligibility offices are likely seeing these applications for the first time and there's a learning curve to let eligibility workers know that refugees are still eligible. This is probably where the issue is coming from—they've heard that the state isn't providing Refugee Medical Assistance, but that doesn't mean there is no medical assistance being provided to refugees.
- I think, as with all eligibility issues, we have to collect case stories for the agency to continually emphasize the need for high quality training. We'd like to have a conversation with the agency and determine if the issue is systemic.

Administrative Changes to the Health Reform: Marketplace Rules and Executive Orders *(Melissa McChesney, CPPP)*

- *See slides below*
- **Melissa M:** We're continuing to keep an eye on the executive branch's ability to impact health care. There are a few major ways the Administration could make drastic changes: *House v Price* could impact the individual market and deals with subsidies that help individuals under 250 percent of the federal poverty level with out of pocket costs. The House sued because the money going to plans was never appropriated. The House won in lower courts and it has not yet reached the Supreme Court. If the Trump administration chooses to stop fighting the lawsuit, it would leave the lower court ruling in place and the subsidies would go away. There is a simple fix to the uncertainty this is causing insurers and individuals who have plans through the marketplace: the House can choose to appropriate the money. If subsidies are stopped, insurance plans are still required to offer robust plans under law and would likely pull out of the market.
- Moving on to Martketplace rules, there were several changes finalized after a short comment period. To go through the high-level changes, debt from previous years' premiums and whether an individual can pay back old debts can be a condition of enrollment. There is now a shorter enrollment period, cut in half from last year's, which may impact the risk pool because younger, healthier individuals are less likely to enroll. SEP enrollment is the largest section in the rules changes. This is the enrollment outside the open enrollment period. If an individual has a life-changing event, they have the opportunity to enroll in the marketplace but it is made considerably more difficult under these rules. Insurance companies have argued that users are using SEP enrollment to their advantage, but there's been no data for this claim.
- Verification for a life-changing event qualifying an individual for SEP enrollment could be shown after enrollment, but under the new rules verification is required before enrollment. There are also metal-level switching regulations that reduce an individual's ability to enroll in a different metal level plan during SEP. Additionally, the rules for continuous coverage and SEP enrollment have changed. Previously if you had gotten married and that allowed you to use SEP enrollment, only one spouse had to show prior coverage. Now, both have to have prior coverage. For individuals enrolling due to a permanent move, proof of prior coverage also must be provided.
- This next change will highly impact low-income households. Metal levels have a percentage they must cover in actuarial value—60, 70, 80. The margin or error allowed on the percentage has changed from plus or minus two percent to plus two percent or minus four. Essentially, plans get less coverage and because subsidies are based on the second lowest plan, this ends up devaluing the subsidies for more robust plans.
- Lastly, prior to the rules changing, health plans were required to contract with 30 percent of Essential Community Providers in a network. This has been reduced to 20 percent, which has the potential to reduce access and create narrower networks.

- **Melissa M:** I also wanted to cover Executive Orders on immigration, as we've been getting a lot of questions on this issue recently. One has been signed and the other is a leaked draft.
- The interior enforcement order has been signed, and it has been the catalyst for the spike in recent deportation numbers. We've heard reports of people taking kids out of school, not taking kids to the doctor's office, just generally hiding. This also impacts access to public benefits, and often there are citizen children born here eligible for benefits who have non-citizen parents. There is one portion of the order that addresses public benefits that indicates that one of the things that can make an individual a candidate for deportation is abusing public benefits. The advice advocates are providing to immigrant families with citizen children in public programs is that if they are eligible and the application has truthful information, they are legally allowed to stay enrolled in Medicaid. It's difficult, because you can give what's in writing but there is a level of fear in these communities.
- There is also a leaked order regarding changes to public charges that has *not been signed*. Currently, applying for a green card may be affected by status as 'public charge' impacted by use of TANF and LTSS. The leaked order has language indicating that public charge status would be impacted by use of any public benefit—potentially even including free lunch programs at school. It's fairly broad and there are a lot of areas that are unclear with this potential order. It's important to emphasize that this order *has not been signed or formally proposed.*

Kit AbneySpelce from the Central Health will chair the May 19th meeting, which is a regular 2-hour meeting.

Charles Smith
Executive Commissioner
Texas Health and Human Services Commission

cc: Gary Jessee
Deputy Executive Commissioner for the Medical and Social Services Division
Texas Health and Human Services Commission

cc: Lisa Carruth
Chief Financial Officer
Texas Health and Human Services Commission

January 20, 2017

Dear Commissioner Smith:

I am writing to request some information necessary to evaluate a legislative initiative I have under consideration. I am interested in ensuring kids in Texas have access to health coverage and health care they need. To inform our legislative effort, streamline our eligibility system, create the most prudent fiscal policy, and provide the most accurate data, we request the following information from the commission:

- The number of member months, by month, of children enrolled in CHIP and Medicaid for each of the preceding 18 months.
- An analysis of enrollment data for children in Medicaid or CHIP for the same time period, showing the number and percent of total enrolled children who experienced gaps in coverage following their initial enrollment, and were eventually re-enrolled.
    - In particular, we seek the best available measure of 'churning', whereby children remain eligible for Medicaid or CHIP coverage, do not complete necessary renewal process, and then are re-enrolled in a Medicaid or CHIP plan several months later.
- Analysis of the same or a similar period showing the reasons for denial related to children's loss of coverage, distinguishing which were related to a determination of ineligibility based on income or age, and which were related to failure to respond timely or complete renewal procedures, or to failure to provide needed information.
- Identify or distinguish the number of children experiencing a gap in coverage related to an intermediate income check rather than the annual renewal process.
- Estimate the all funds and state funding required to process Medicaid and CHIP re-enrollment applications.
- Estimate the net costs or reduction in these costs if all children in a Medicaid or CHIP household were renewed simultaneously.

I would greatly appreciate your feedback by February 13, 2017. If you have any questions or need further information, please contact me directly. Thank you for the opportunity to work closely with HHSC to make a real difference in the health outcomes of Texas families.

Respectfully,

Richard Peña Raymond
Chair, Human Services Committee
Texas House of Representatives

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

February 14, 2017

The Honorable Richard Peña Raymond, Chairman
House Committee on Human Services
State Capitol Extension, Room E2.152
Austin, Texas 78701

Dear Chairman Raymond:

Thank you for your letter dated January 20, 2017, in reference to the data inquiry on access to health coverage and health care for children in Texas. The Health and Human Services Commission (HHSC) continues to conduct the data analysis on your request for the number of children enrolled in Medicaid and CHIP (by month for the preceding 18 months), to include children experiencing gaps in coverage (for periodic income checks and renewals), and the fiscal analysis for processing Medicaid and CHIP re-enrollment applications. HHSC anticipates having that analysis to you by February 24, 2017.

HHSC will be using the data from February 2014 through July 2015 for the pending analysis on the number of enrolled children per month for an 18 month period. Below are the total number of children enrolled by month in Medicaid and CHIP for that time period.

	Medicaid Children*	**Traditional CHIP**
February 2014	2,579,771	560,961
March 2014	2,629,451	529,495
April 2014	2,664,434	495,187
May 2014	2,696,782	485,124
June 2014	2,726,398	465,587
July 2014	2,780,312	431,877
August 2014	2,833,262	405,654
September 2014	2,889,363	378,439
October 2014	2,938,450	358,881
November 2014	2,947,862	344,479
December 2014	2,962,822	335,120
January 2015	2,957,981	328,842
February 2015	2,960,617	324,225
March 2015	2,951,576	332,087

	Medicaid Children*	Traditional CHIP
April 2015	2,924,731	332,749
May 2015	2,909,263	329,804
June 2015	2,906,291	333,451
July 2015	2,906,618	337,342

* Only full benefit clients and does not include disabled or STAR Health clients
Traditional CHIP counts exclude perinatal clients

While the agency continues working on the requested data, HHSC does have the data you requested about denials for children renewing Medicaid and CHIP coverage. The analysis of denials for children in Medicaid and CHIP is separated into two categories: denials for failure to comply with procedures, which includes clients failing to provide missing information, documentation, or renewal forms; or denials for failure to meet eligibility criteria. In federal fiscal year 2016, denials for children were as follows:

- Medicaid
  - 61,139 (4.3 percent of children up for renewal) were denied for failure to comply with procedures; and
  - 111,474 (7.8 percent of children up for renewal) were denied for failure to meet eligibility criteria.

- CHIP
  - 8,763 (2.6 percent of children up for renewal) were denied for failure to comply with procedures; and
  - 27,449 (8 percent of children up for renewal) were denied for failure to meet eligibility criteria.

In regard to the request for an estimate on the net costs or cost reduction if all children in Medicaid and CHIP households were renewed simultaneously, HHSC does not have a cost estimate readily available. Producing an analysis would be a substantial project. Under federal requirements, HHSC must renew Medicaid and CHIP eligibility at least every twelve months and cannot renew earlier than twelve months.

In addition, HHSC has an integrated eligibility system for clients receiving cash, food, and health care benefits. Therefore, these limitations have prevented HHSC from achieving certification period alignment for Medicaid and CHIP. However, HHSC does take every opportunity when it is possible to align renewals and align children's certification periods when adding a child to the household for Medicaid and CHIP.

Please let me know if you have any questions or need additional information. Valerie Eubert, Medical and Social Services Division, serves as the lead staff on this matter and she can be reached by telephone at (512) 487-3309 or by email at Valerie.Eubert@hhsc.state.tx.us.

Sincerely,

Charles Smith

2017

January	February	March	April	May	June	July	August	September	October	November	December
Child 1 reenrolls				Child 1 income check	Child 1 income check	Child 1 income check	Child 1 income check	Child 1 Automated Renewal w/ income check			Child 1 renewal app. due if not automatically renewed
	Child 2 renewal app. due if not automatically renewed	Child 2 reenrolls				Child 2 income check	Child 2 income check	Child 2 income check	Child 2 income check	Child 2 Automated Renewal w/ income check	
Child 3 income check	Child 1 Automated Renewal w/ income check			Child 3 renewal app. due if not automatically renewed	Child 3 reenrolls				Child 3 income check	Child 3 income check	Child 3 income check

HHS Office of the Ombudsman Update

Presented to
CHC Coalition
April 21, 2017

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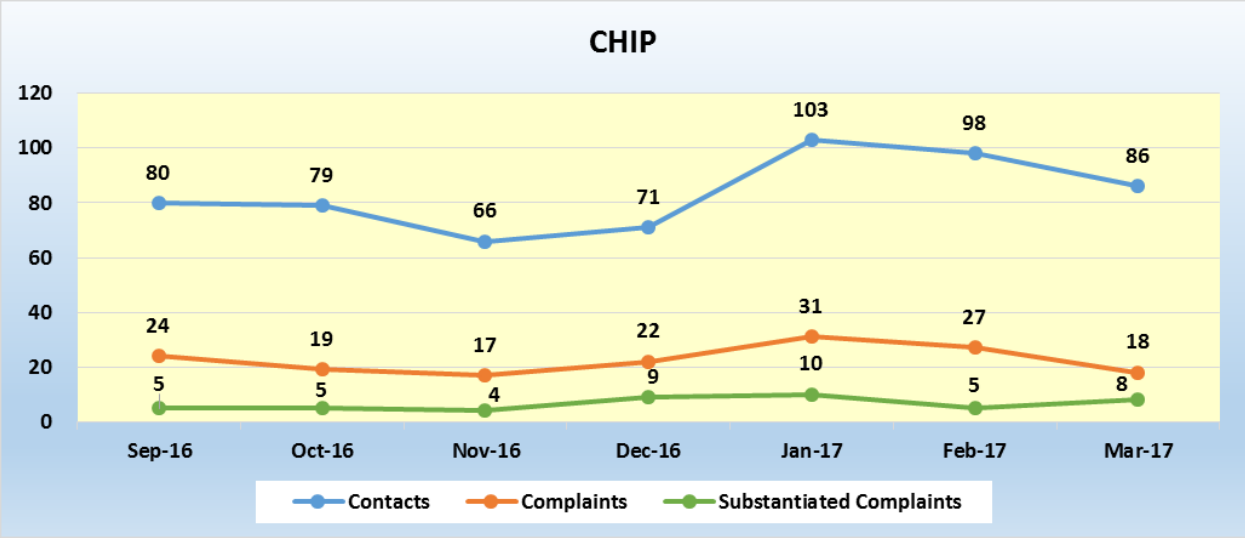
Health and Human Services

Total Ombudsman Contacts for September 2016 - March 2017

- Complaints – 9,191
- Inquiries –51,070

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2016 – March 2017



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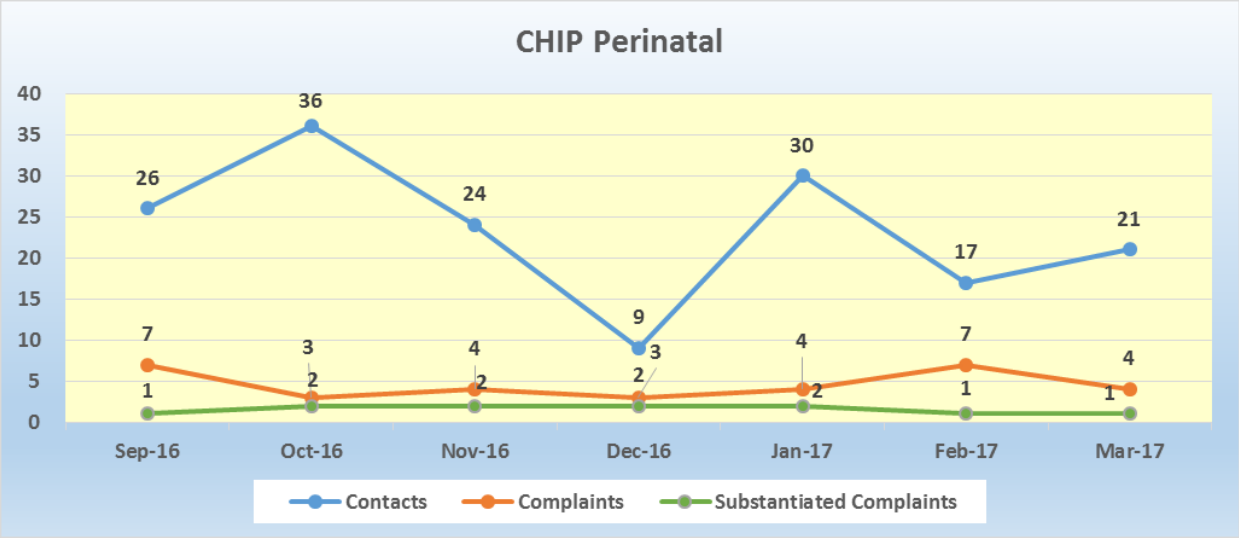
September 2016 – March 2017



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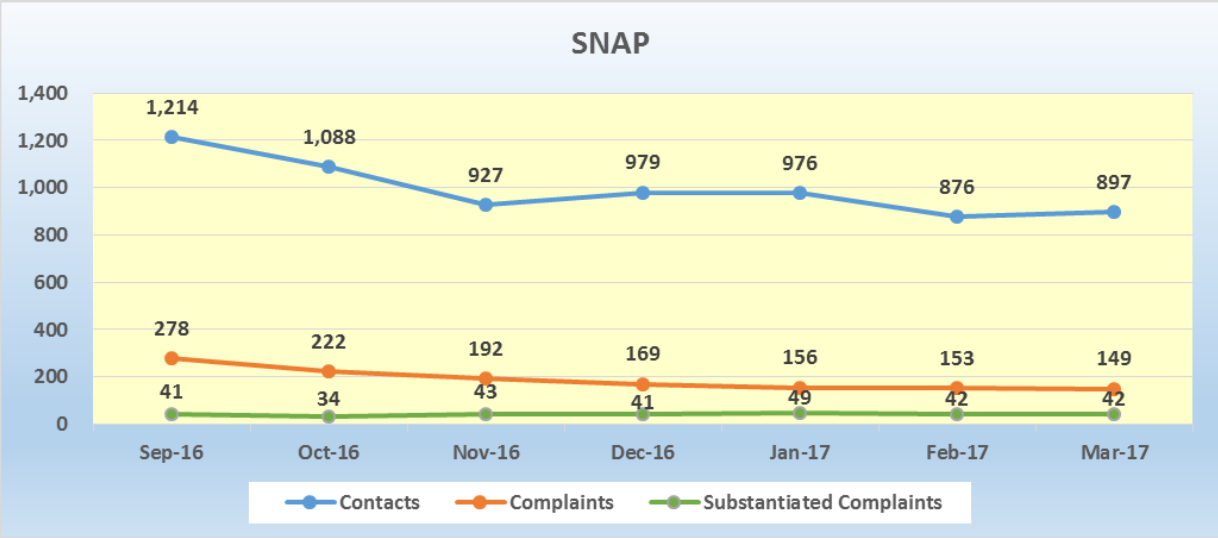

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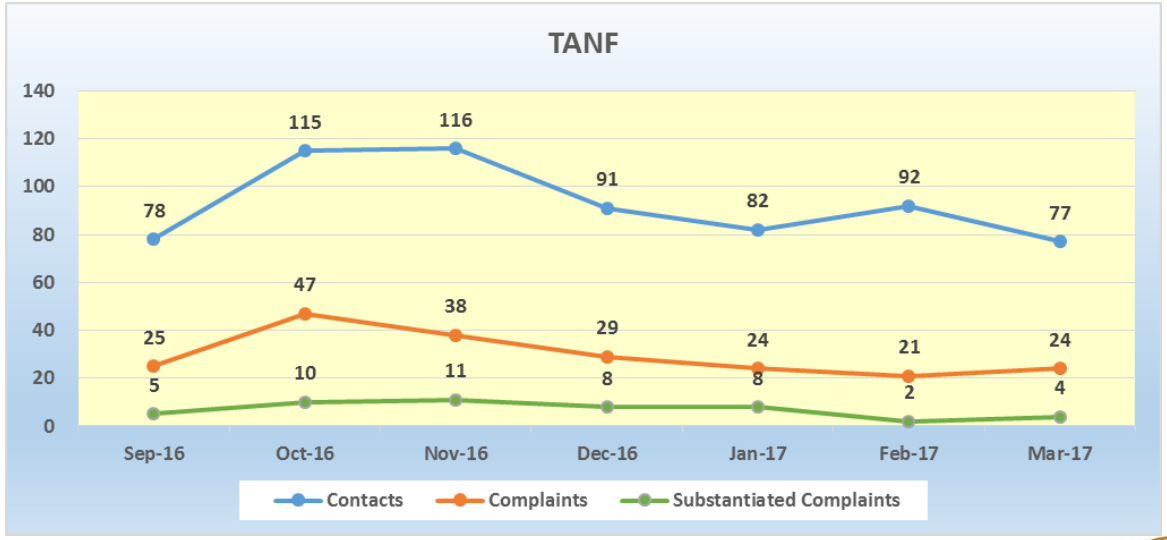

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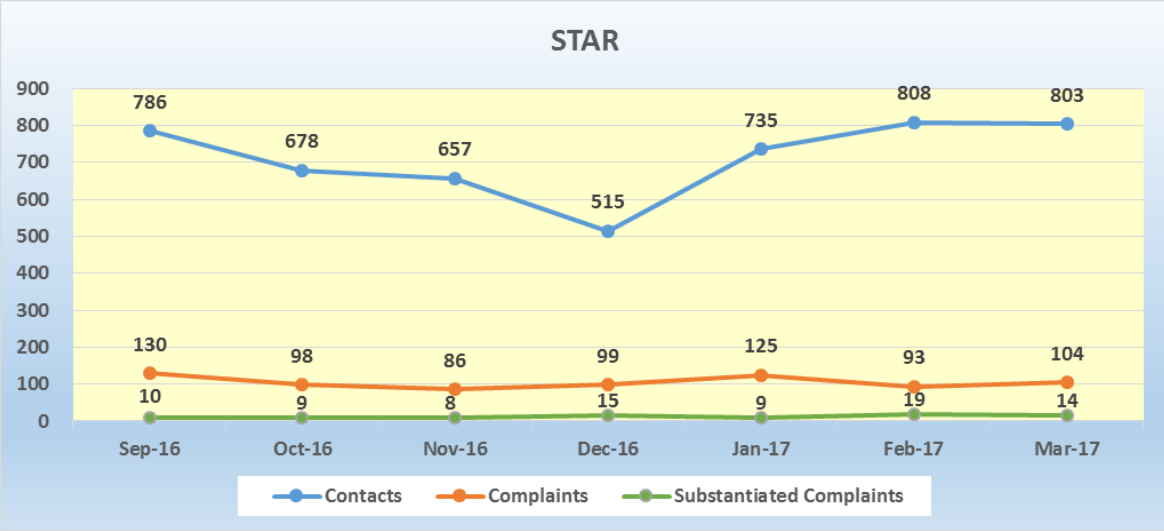

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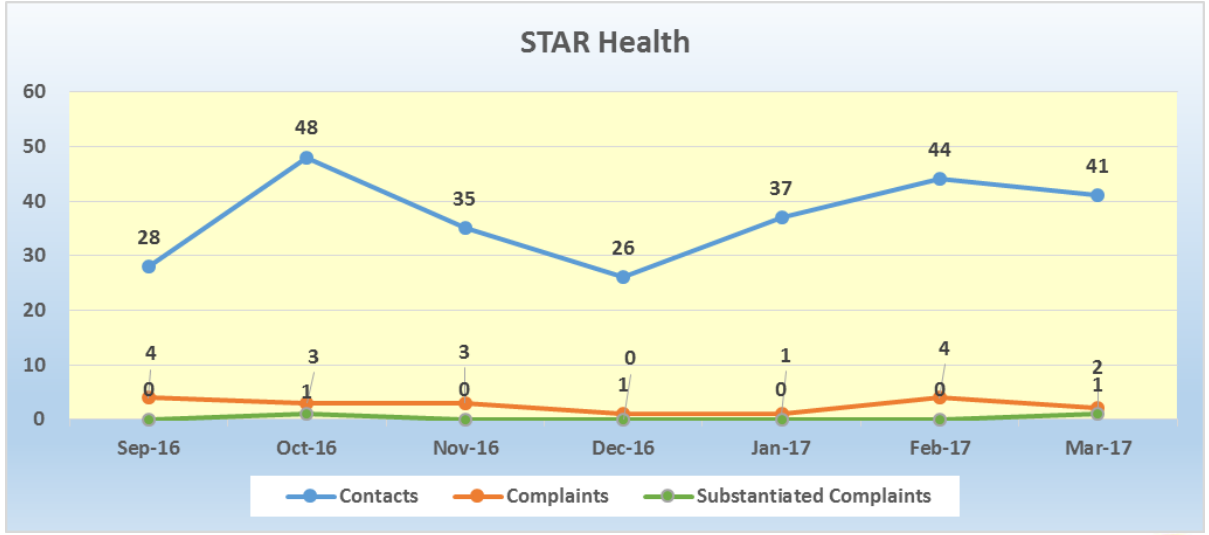

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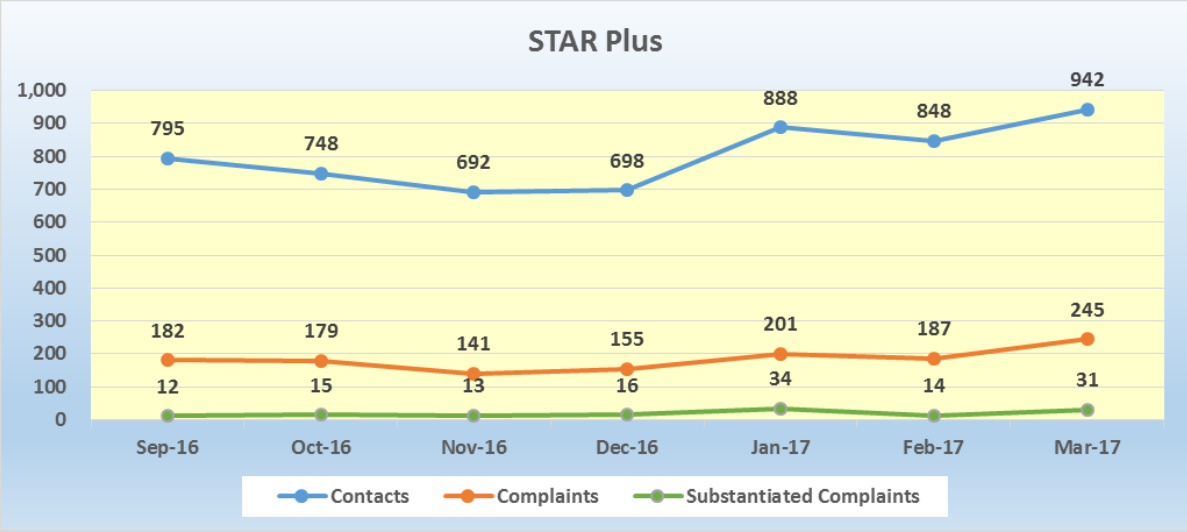

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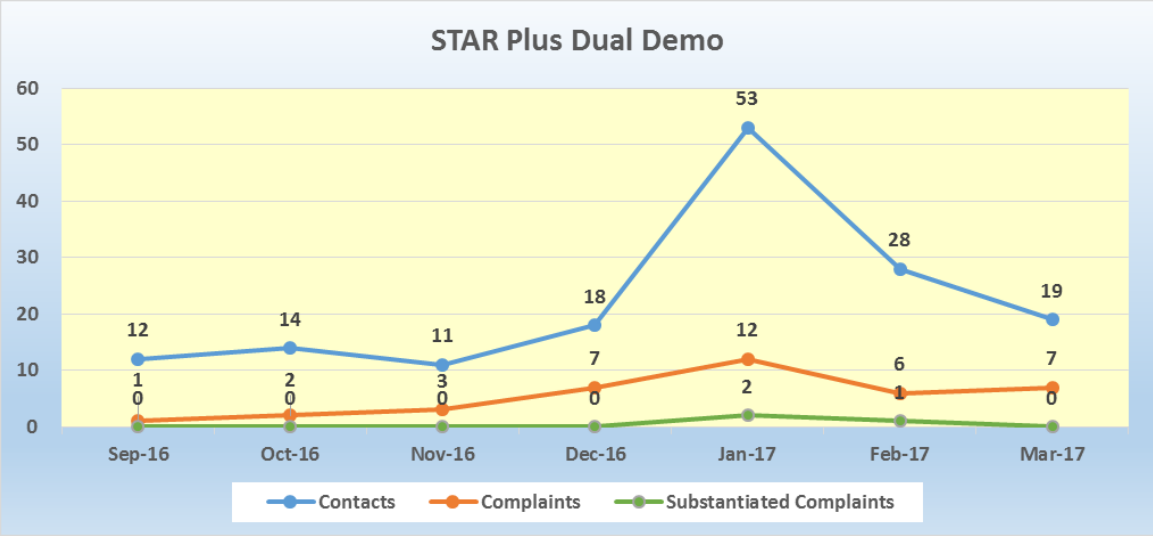

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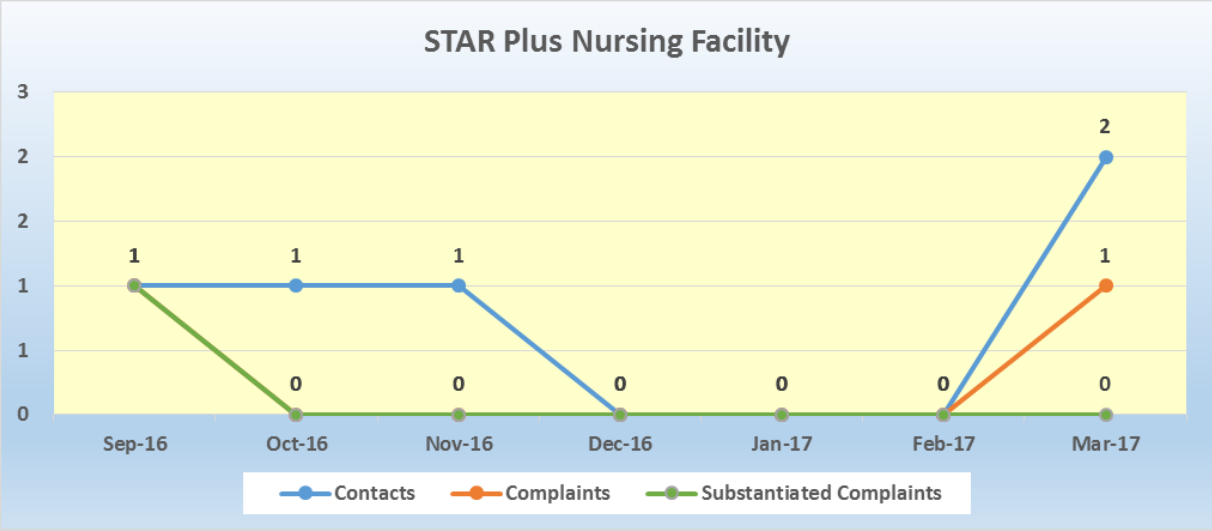

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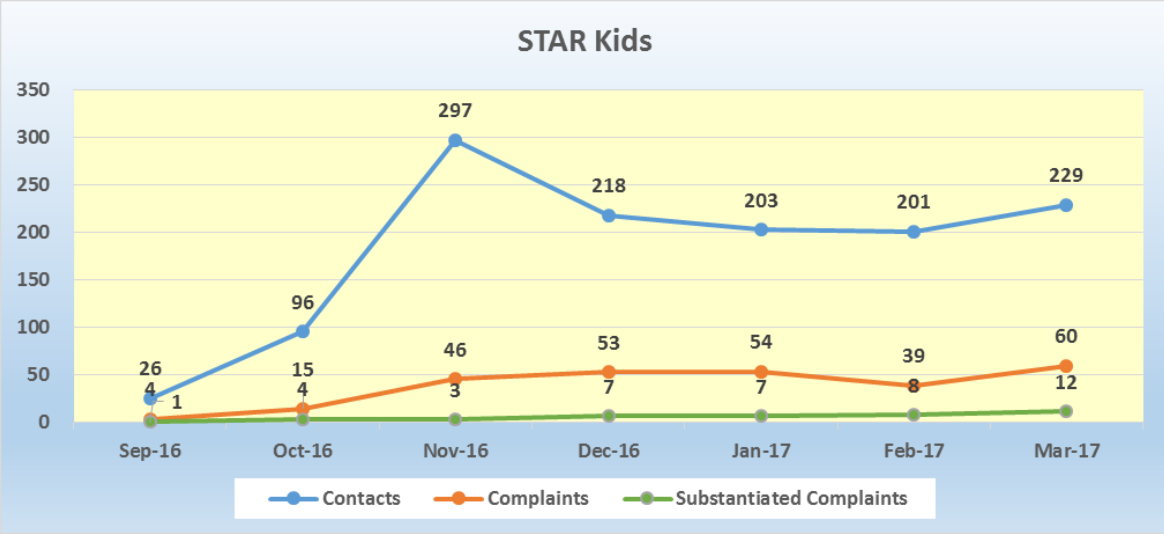
Contact Volumes by Program Type
September 2016 – March 2017



TEXAS
Health and Human
Services

Contact Volumes by Program Type
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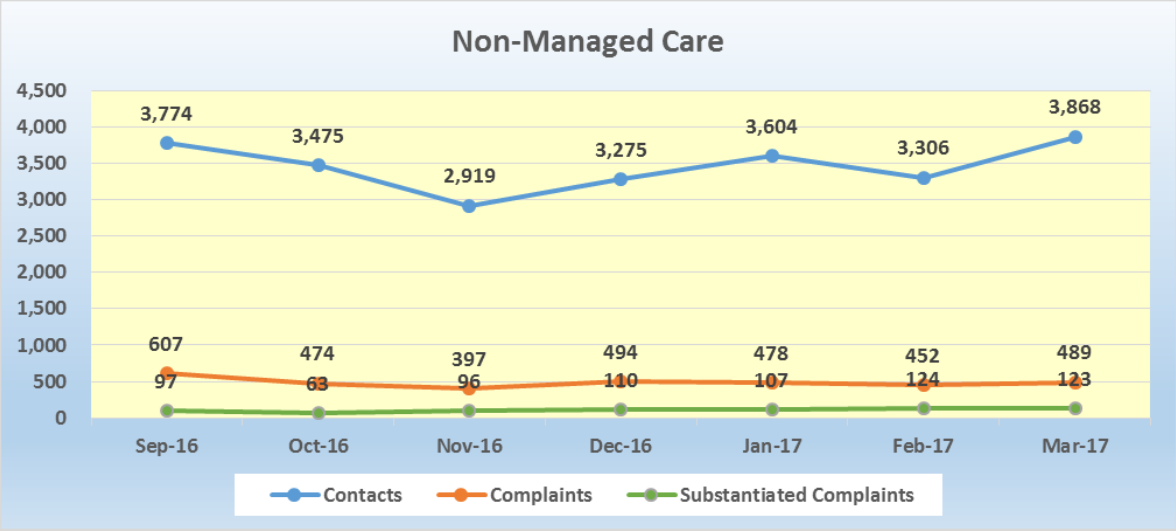

TEXAS
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Top Three Reasons for Contact by Program Type 2nd Quarter FY 2017

TEXAS
Health and Human Services

Top Three Reasons for Contact by Program Type
2nd Quarter FY 2017

CHIP	CHIP - Perinatal
Application Case/Denied	Application Not Completed
Explanation of Benefits/Policy	Client Billing
Contact Info Request	Application/Case Denied
SNAP	**TANF**
Check Status	Application Case/Denied
Application/Case Denied	Check Status
Contact Info Request	Application Not Completed

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type
2nd Quarter FY 2017

STAR	STAR Health
Access to Prescriptions	Access to PCP/Change PCP
Access to PCP/Change PCP	Verify Health Coverage
Verify Health Coverage	Change Plan-Provider (PCP, Facility, DME)
STAR Plus	
Access to Prescriptions	
Verify Health Coverage	
Access to Long Term Care	

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type
2nd Quarter FY 2017

STAR Plus DD	STAR Kids
Change Plan-Provider (PCP, Facility, DME)	Access to Prescriptions
Access to Long Term Care	Access to PCP/Change PCP
Verify Health Coverage	Change Plan-Provider (PCP, Facility, DME)
Non Managed Care	
Verify Health Coverage	
Access to Prescriptions	
Application/Case Denied	

TEXAS Health and Human Services

FOSTER CARE OMBUDSMAN

TEXAS
Health and Human
Services

Contact Volume FCO Program
September 2016 – March 2017

Contact Volume FCO Program September 2016 – March 2017	
Foster Care Youth	106 (28%)
Total Contacts	384

Information Shared

- Preparation for Adult Living (PAL)
- Court Appointed Special Advocates (CASA)
- Department of Family Protective Services (DFPS)

TEXAS Health and Human Services

Ombudsman Managed Care Assistance Team

UPDATE

- Outreach
- Managed Care Support Network
- Medicare Training

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Health and Human Services

Contact us

Phone (Toll-free)

Main Line: 877-787-8999
Managed Care Help: 866-566-8989
Foster Care Help: 844-286-0769
Relay Texas: 7-1-1

Online

hhs.texas.gov/ombudsman

Fax (Toll-free)

888-780-8099

Mail

HHS Ombudsman
P. O. Box 13247
Austin, Texas 78711-3247

TEXAS
Health and Human Services

Texas Refugee Medical Assistance: Frequently Asked Questions

Roles & Responsibilities

1. **I heard that refugee health is changing in Texas. What will be different?**

   Most things will stay the same. Refugees will continue to receive eight months of health insurance at no cost to them. The major change is that the Texas Health and Human Services commission will no longer administer the Refugee Medical Assistance (RMA) or former foster care Medicaid programs. The U.S. Committee for Refugees and Immigrants (USCRI) will administer these programs instead beginning February 1, 2017.

2. **Will USCRI administer any other programs in Texas?**

   Yes, USCRI will also administer the Refugee Medical Screening program. USCRI will coordinate with local health departments and hospitals to ensure that refugees receive medical screening within 30 to 90 days.

3. **Am I still supposed to help refugees apply for health insurance?**

   Yes, the local resettlement agency is still responsible for assisting refugees with cash and medical assistance applications, as appropriate, within seven working days of arrival.

4. **Do I still use the Texas Integrated Enrollment Redesign System (TIERS) to help refugees apply for health insurance?**

   Yes, but only if the refugee is applying for health insurance through the Medicaid program. If the refugee is applying for RMA, you should use eRED. eRED is USCRI's electronic RMA Eligibility Determination system.

5. **Is USCRI responsible for processing Medicaid applications too?**

   No, the Texas Health and Human Services Commission will continue to administer the Medicaid program. Keep in mind that starting February 1, 2017, applications for Medicaid and other benefit programs (e.g., SNAP, TANF) will no longer be processed by the Centralized Benefit Services office in Austin. Instead, all applications will be routed to the nearest Health and Human Services Commission local assistance office for processing based on the refugee's zip code.

Texas Refugee Medical Assistance: Frequently Asked Questions

Eligibility

6. Have the eligibility rules for RMA changed?

Yes, the start date for counting eight months of RMA eligibility is different. In the past, the start date was calculated based on the refugee's month of arrival. Beginning February 1, 2017 you should count a refugee's date of arrival to the U.S. as the first day of RMA eligibility. For example, a refugee who arrives on February 28, 2017 would be eligible for health insurance through October 28, 2017.

7. Are some refugees still eligible for Medicaid?

Yes, if a refugee falls into any one of the following categories, that person may be eligible for Medicaid: (a) a child; (b) an adult who cares for a child in his or her home; (c) pregnant; (d) 65 years old or older; or (e) has a disability. Those individuals should apply for Medicaid. Please visit the Texas Health and Human Services website for more information: https://hhs.texas.gov/services/health/medicaid-chip.

Refugees who do not fall into one of the categories listed above can be presumed categorically ineligible for Medicaid. You should help them apply for RMA right away, without first applying for Medicaid.

eRED

8. I am not familiar with eRED? How do I access and use that system?

USCRI will assign each case manager with a unique username and password. USCRI will also train case managers on how to use eRED. The trainings will be scheduled for the week of January 23 in four cities: Amarillo, Austin, Dallas and Houston.

9. I know I am supposed to use eRED to determine RMA eligibility. But how does it work?

eRED is a very simple, web-based software that guides case managers through a series of questions to help determine initial eligibility. The questions ask about a refugee's biographical data, immigration status and documentation, income and resources and other basic information. At the end, case managers can mark the application as either "Eligible" or "Ineligible". Once the case manager submits the

application, eRED automatically sends it to USCRI for review. USCRI's Regional Refugee Health Officer (RRHO) will conduct quality assurance checks and approve or disapprove the application. If the application is approved, eRED will create an eligibility letter and send it to the case manager through the software.

In some cases, the RRHO may send the application back to the case manager through eRED and ask for more information. This process will take the place of the Centralized Benefit Services that the Texas Health and Human Services Commission used to review RMA applications prior to February 1, 2017.

10. What else does eRED do?

eRED also stores client data, sends alerts or notifications and generates reports. You can use eRED to generate reports about how many RMA applications are pending, how many were approved, and how many terminations are coming up within a specified time-period. eRED can also generate reports on how many days lapsed between the refugee's arrival date and the RMA application date.

Health Insurance

11. What type of health insurance will refugees have?

Refugees will have insurance through a private health insurance plan. USCRI is working with a partner called Unified Administrators. Once enrolled, refugees will receive a health insurance card and a directory of healthcare providers who accept that insurance.

12. Will refugees still get the same level of covered health benefits?

Yes, refugees will receive the same level of covered health benefits as before. These health benefits will also mirror covered health benefits under the Medicaid program in Texas.

13. What happens to refugees who are already receiving RMA health insurance through the state of Texas?

The Texas Health and Human Services Commission will stop providing health or "medical" benefits through the RMA program as of January 31, 2017. But that does not mean refugees will lose their health benefits. The Texas Health and Human Services Commission is providing USCRI (through the federal Office of

Refugee Resettlement) with current enrollment data so USCRI can automatically transfer refugees' health benefits to the private health insurance plan. That way, refugees will not need to re-apply for RMA and there will be no interruption to their health insurance coverage.

14. How will newly arriving refugees enroll in health insurance?

There are two ways to enroll in RMA health insurance. Once a refugee has an approved RMA application, the case manager can use the Unified Administrators' online portal to enroll refugees one-by-one. USCRI can also generate an "Enrollment Ready" report using eRED and send it to Unified Administrators to enroll many refugees at one time.

Communication

15. How will refugees know about these changes?

The Texas Health and Human Services Commission will send a RMA termination notice to refugees in mid-January. Around the same time, USCRI will also send a letter to refugees. USCRI's letter will describe its role in the transition and explain that refugees' health insurance benefits will not be interrupted. Attached are samples of the notice from the Texas Health and Human Services Commission and the letter from USCRI.

16. Who should I contact if I have more questions?

It is a good idea to share your questions with your supervisor. Your agency may also want to contact the Regional Replacement Designee assigned to your local area. If you still have questions, you can send them to refugeehealth@uscritx.org.

For urgent questions about health insurance or medical claims, you can contact USCRI's hotline by calling 844-294-9622. Starting February 1, 2017 someone will be available to answer the hotline from 8:00 am to 8:00 pm central time. This hotline is reserved for local resettlement agencies in Texas only.

REFUGEE SERVICES OF TEXAS
Open Hearts. Fresh Starts.

THE REFUGEE JOURNEY

Flee country of origin to a relatively safe neighboring country or refugee camp.

UNHCR
The UN Refugee Agency

Apply as a refugee and the UNHCR determines the best durable solution for each refugee family, then submit referrals to the U.S. or other eligible countries for potential resettlement.

Wait for application to be processed and for referrals to be submitted. The average wait time is seven years.

Refugee families undergo RSC Africa Interviews/USCIS Interviews to demonstrate the applicant qualifies as a refugee. Extensive background checks are conducted.

Applications are approved or denied and refugee families must complete medical examinations.

Referrals are approved for resettlement. Refugees receive cultural orientation and language training based on their resettlement location.

Approved families then travel to the United States and are greeted by the local RST office. In the United States they will find a job, learn English, and integrate into the local community.

Refugee Security Screening Process

REFUGEE SERVICES OF TEXAS
Open Hearts. Fresh Starts.

1 Refugee Status

Individuals register with The UN High Commissioner for Refugees (UNHCR) and their biodata is collected to determine if they qualify as a refugee under international law.

2 U.S. Referral

Refugees are then referred to any of the twenty- eight resettlement countries, they do not get to choose. Refugees that meet one of the criteria for resettlement in the U.S. is referred to the U.S. Refugee Admissions Program (USARP) by the UNHCR.

3 Data Collection

Resettlement Support Center (RSC) contracted by the U.S. Department of State (DOS) conducts a preparatory interview in addition to gathering personal data and background information of refugees for the U.S. Citizenship and Immigration Services (USCIS) in-person interview.

4 Security Checks

The State Department checks all refugee names provided by the RSC through a standard CLASS (Consular Lookout and Support System) name check that contains watch-list information.

5 Additional Data Review

Certain refugees undergo Security Advisory Opinion (SAO) that require a positive SAO clearance from several U.S. law enforcement and intelligence agencies in order to continue the resettlement process.

6 Inter-Agency Check

Refugees that meet the minimum age requirement undergo an Inter-Agency Check (IAC) conducted by the National Counter-terrorism Center (NCTC).

IAC's are considered a "recurrent vetting" process; this means the USCIS will be notified of any new derogatory information up until refugee's travel to the United States.

7 Syria Enhanced Review

Syrian refugees undergo review by a Refugee Affairs Division officer at USCIS headquarters. If certain criteria is met, the case is referred to the Fraud Detection and National Security Review (FDNS) where a report is compiled based on open-source and classified research.

8 USCIS Interview

All refugee applicants over the age of fourteen are interviewed by a USCIS officer. Each interview are face-to-face and detailed. Based on the interview the DHS officer will determine if the individual qualifies as a refugee and is admissible under U.S. law. Fingerprints and photos are gathered at this stage also.

9 Approval

If individuals qualify as a refugee and meet other U.S. admission crieteria, the USCIS will conditionally approve the refugee's application and submit it to the U.S. Department of State for final processing.

Conditional approvals become final when the results of all security checks are received and cleared.

10 Fingerprints & Pictures

Fingerprints and photos collected are checked by the FBI's Next Generation Identification System, the U.S. Department of Homeland Security's Automated Biometric Identification System (ABIS), and the U.S. Department of Defense's ABIS.

11 Medical Screening

All refugee applicants with conditional approval undergo medical screenings. Screenings are conducted by the International Organization for Migration or by U.S. Embassy designated physicians and ensures refugees have no communicable diseases.

12 Sponsor Agency

All refugees are assigned to Voluntary Agencies in the U.S. that then place refugees with local partner agencies.

Lutheran Immigration and Refugee Service

CWS

episcopal MIGRATION MINISTRIES

13 Cultural Orientation

Refugees are offered cultural orientation when waiting for final processing. These orientations provide additional information about the U.S. to prepare them for their journey and initial resettlement.

14 U.S. Admission

Once at one of the five U.S. airports designated as ports of entry for refugee admission, the Customs and Border Protection (CBP) reviews arriving refugee information and conduct additional security checks with the National Targeting Center Passenger Program and Transportation Security Administrations secure Flight Program. This ensures that arriving refugees are the same individuals that were screened and approved for admission into the U.S.

Additional Resources

U.S. Citizenship and Immigration Services
https://www.uscis.gov/refugeescreening

Human Rights First
http://www.humanrightsfirst.org/resource/refugee-resettlement-security-screening-information

U.S. Department of State
https://www.state.gov/j/prm/ra/admissions/

Contact Us

Fort Worth Office

4200 South Freeway
Suite 320
Fort Worth, TX 76115
(817) 413-3772
fortworth@rstx.org
www.rstx.org

The information on this document was gathered from the USCRI and Refugee Council USA.

Administrative Impacts to Health Care Access

MARKETPLACE RULE CHANGES & EXECUTIVE ORDER ON IMMIGRATION

House v. Price

"I suppose I'll be the one
to mention the elephant in the room."

Marketplace Rules

- Debt from previous years
- Shorter enrollment period
- SEP enrollment
  - Verification
  - Metal level switching
  - Continuous Coverage
- Changes to metal levels, and lowering value of APTCs
- Reduces access to Essential Community Providers

Executive Order on Interior Enforcement

- Executive order on "interior enforcement" (force behind increased deportations)
  - Identifies as a priority for removal people who "have abused any program related to receipt of public benefits."
  - "Q&A" posted on its website, under question 18, "What threshold of abuse of a public benefit program will render someone removable?," DHS says, "Those who have *knowingly defrauded* the government or a public benefit system will be priority enforcement targets" (emphasis added).

DRAFT Executive Order on "Public Charge"

- Currently, the federal government looks at use of cash benefits (like Temporary Assistance for Needy Families) when it's making "public charge" decisions, but not in-kind benefits like Medicaid and the Children's Health Insurance Program.
- This executive action, IF SIGNED, would ask the Department of Homeland Security to issue a rule saying that an immigrant can't be admitted to the US if he's likely to get any benefit "determined in any way on the basis of income, resources, or financial need."
- Furthermore, people who use any of those benefits and are in the US on visas would be subject to deportation.
- This is a leaked draft and not currently in place. Immigrants (and their children) who eligible for benefits should continue to use those benefits.