CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

Texas CHC Coalition
Meeting Minutes

June 16, 2017

Present:	Anne Dunkelberg, Center for Public Policy Priorities Helen Kent Davis, Texas Medical Association Adriana Kohler, Texans Care for Children 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 Kylie Northam, Methodist Healthcare Ministries Hana Bakkar, National Association of Social Workers—TX Deborah Rosales-Elkins, NAMI-TX Tonia Wu, Children's Defense Fund – TX Paige Marsala, HHSC – Ombudsman Deborah De La Cruz, HHSC- Ombudsman Joel Schwartz, HHSC Ombudsman Erika Ramirez, HHSC Gina Carter, HHSC
On the phone:	Paul Townsend, Children's Hospital Association of Texas Sister J.T. Dwyer, Daughters of Charity Betsey Coates, Maximus Erica Laredo, Texas Children's Health Plan Laura Guerra Cardus, Children's Defense Fund-Texas Alice Bufkin, Healthy Futures of Texas Melissa McChesney, Center for Public Policy Priorities
Chair:	Anne Dunkelberg, Center for Public Policy Priorities
Minutes Scribe:	Kamia Rathore, Center for Public Policy Priorities
Next meeting:	July 21, 2017

I. State Legislative Session Recap *(Multiple Speakers)*

Legislative overview

- **Anne:** This would be a good time to look and reflect on our 2017 Coalition agenda, celebrate legislative victories, talk about vetoed bills, the special session, and any other challenges ahead. Some legislative victories this session are centered around the post-partum depression work the maternal and child health work group did. I cannot say enough good things about the MCH work group – it is a really valuable, talented team.
- **Clayton**: Absolutely. One of the largest victories of this session was the postpartum screening bill that was signed. It brought a lot of groups together, including mental health, child, and health care advocates. This is a new avenue for moms to access mental health care services, even if this bill just covers screenings. Even if moms fall into a coverage gap of sorts, they can still get started on the road through a screening covered by the child's insurance—and we already know that a mom is more likely to show up for to a child's doctor visit than her own, which makes this a good avenue to reach out to these moms.
- **Anne**: We did a great job keeping tabs on Medicaid budget and organizing testimony around appropriations and financing hearings. Some high level points about the final budget: there was no full reversal of therapy cuts and only 25 percent of the cuts were reversed; language in the house version of supplemental appropriations taking away the HHSC directive to reduce rates also did not make it into the final supplemental bill.
- **Clayton**: We might ask someone from Medicaid Managed Care to give a presentation on network adequacy of pediatric care; we've heard concerns from providers about this.
- **Anne**: On the work for continuous coverage encompassed by HB 1408, it is an open question of what we'll do in the next session. We should evaluate what administrative progress and partnerships we can work on during the interim to get the expertise and commitment to this issue on our side now. Some other agenda priorities also included expanding accessibility of CHIP Perinatal, but we didn't have much traction on the items that dealt with this, so we will have to re-evaluate for the next session.
- **Alice:** Yesterday, the Governor vetoed a bill that would have extended the Women's Health Advisory Committee, but there is a possibility of extending the authorization of the maternal mortality task force because it has been included in the special session call. The veto is rather disappointing: given that the state is in the process of applying for an 1115 waiver for its family planning program, having an advisory committee to get stakeholder input on women's health is now especially important. Depending on how broad the Governor's call is on maternal mortality, it may be possible to push for preventive care and connect how women's health affects mortality and morbidity. We know that maternal mortality and morbidity increase with incidence of pre-pregnancy obesity and smoking; if you want to affect mortality, you have to intervene far in advance. One task ahead of us is educating about the overlap between the two issues and connect WHAC's work to the maternal mortality taskforce. We need also need to be connecting how Healthy Texas Women and Medicaid interact, making and stressing those links.

State budget

- **Anne:** There is lower funding in this state budget for Medicaid compared to the last biennium, which includes the supplemental plus the appropriations bill. The biggest actual cut is in Rider 34 which includes $350 million in General Revenue savings; Rider 158 also includes a reduction in the risk factor formula by half percentage point; and the budget was built in with a caseload increase for 2018 but not 2019, with no cost inflation growth for either year. In most years, we would have better

numbers for what this means for the potential shortfall we're looking at, but we do not have LBB estimates for what inflation or caseload growth might be. This is also the first time we had a chamber suggest not even including caseload growth in the base budget. The low end estimate of what the supplemental might look like is 1 billion while the high end could be 2 billion.

- **Clayton**: It's concerning that caseload growth being left out is the new precedent for legislative budgets.
- **Anne**: The budget was around three billion down when it went to conference, but this is not as big as the worst shortfall we've seen, which was five billion in 2011. It is concerning that there's a belief you can have infinite reductions to Medicaid and continue to add cost-containment riders each session.
- **Clayton**: One thing to strategize about is how to begin messaging against these repeated cuts— it's overwhelming because there's no decision point to concentrate public advocacy efforts. There's one hearing, but all 500 areas of the budget are together, so it becomes difficult to convey the reality of what's happening.

II. Federal Updates *(Multiple Speakers)*

- **Anne:** The CBO score for the House bill estimates 23 million more uninsured and 14 mill fewer on Medicaid. CBO only produces national estimates, but there are estimates of coverage losses by state from Kaiser and RWJ Foundations. Texas is projected to lose a billion and half dollars every year in the first 10 years, starting in 2020. We know about the outcry and the damage done from the state therapy cuts that came out under 200 million dollars a year—this is one way to contextualize what a cut as large as $1.5 billion a year would mean for our state's health care system.
- No estimates for coverage losses by state in Senate bills.
- **Helen**: The CMS actuary report operates under the assumption that states wouldn't go through with cuts. The disparity between the numbers from the CMS and CBO does confuse messaging.
- **Anne**: I'm not seeing as much attention being paid to the CMS actuary report compared to the CBO score. There is also nothing in our Texas legislature experiences that suggests that the state would not go through with cuts.

CHIP reauthorization

- **Anne:** CHIP has not really been in the national conversation, but we've unfortunately had our own Senator Cornyn suggest that CHIP could be used a potential bargaining tool in the repeal debate. The most specific proposal about CHIP that we've seen has been President Trump's budget proposal. That budget assumes the House bill's cuts to Medicaid and then incorporates additional cuts to Medicaid and CHIP. There is some debate over the degree of overlap between the House cuts and the President's proposal.
- The Trump budget proposes to only extend CHIP funding for two years and cut the CHIP allotment by 21% by eliminating Maintenance of Effort requirements that currently prevent states from cutting eligibility in CHIP and Medicaid. It would get rid of the current 23 point matching rate bump and make states who choose to cover children at higher incomes go back to only covering children under 250 percent of the federal poverty level. States could undo the stair-step correction between Medicaid and CHIP under the ACA if they choose, as well.

Senate Health Care Bill

- **Anne:** As with the House bill, there are grievances about the secrecy of the process of the Senate bill. From a messaging standpoint, it will likely involve differentiating it from the House bill but also making clear that going from an $800 billion cut to $400 or $600 billion is still a cut. The Senate bill may not have as drastic changes as the House bill (*editor's note: Senate bills turned out to cut Medicaid more deeply than House*), but it will not mitigate the damage proposed by the House. There is a rumored change in the per capita formula in the Senate bill compared to the House—the bill may propose lowering the cap if a state's spending is less than the cap. A state might make certain cuts to stay under the calculated per capita cap; if they 'over-do' the cuts, then the cap would go down, forcing more state cuts in response. This could set up a cycle of increasingly deeper cuts in a system worse than the House's per capita system. The bill wouldn't allow insurance companies to directly charge individuals with pre-existing conditions more, but it would gut Essential Health Benefits, allowing insurance companies to sell insurance that doesn't cover enough or becomes too expensive. Senate plan will also likely include an opioid treatment fund—but this is a small fund that doesn't begin to offset the huge losses from cutting Medicaid and removing the expansion option from the ACA. The biggest piece of progress in opioid recovery and treatment has been comprehensive coverage through Medicaid. On the marketplace side—the House's model of premium assistance is so radically different from the ACA, and we don't yet know what the Senate's model might look like. The House didn't set premium assistance on a sliding scale based on income or tied to geography, and it also allows older individuals to be charged five times more than younger individuals.

III. OTA Meeting

Updates from the Office of the Ombudsman

Office of the Ombudsman (Rick Castillo, Deborah De La Cruz HHSC)

- *See slides below*
- **Deborah:** For the third quarter of this fiscal year, which ran from March through May there was a slight increase in overall contacts. There is a slight increase in CHIP contacts. The spike in CHIP Perinatal contacts at the end of the quarter may be due to client notices being sent out at this time, with clients calling to ask about the status of their application. There's a decrease in SNAP contacts and TANF contacts.
- **Rick:** STAR contacts have increased from the last quarter, as with STAR Plus. The spike in STAR Plus dual demonstration could be from more people knowing that the program exists and is in place.

Foster Care Ombudsman update

- **Deborah:** 30 percent of contacts were from foster care youth this quarter. The rest are usually from families, physicians, and others who we redirect to the right resource. This is an increase the foster youth contact percent from last quarter.

Managed care assistance team

- **Rick:** We're continuing our outreach on home visiting program, and we are working to create a webinar for nurses in the home-visiting program to educate about the role of the Office of the Ombudsman.

Updates from the Division of Access and Eligibility Services *(Erika Ramirez, Gina Carter, HHSC)*

- *See handout below*
- **Erika:** I'll respond to the questions sent over about the Raymond data, provide some updates, then walk through the handout on Periodic Income Checks.
- February 2014 – July 2015 was selected as the period of time for the Raymond data request because this was the time segment with the most complete data available. The letter also refers to a deeper analysis of churn for the child population during that time period to be completed later. We had follow-up conversations with the offices because it was readily-available data and would require a significant investment of staff resources. We are not currently working that data piece.
- **Melissa:** Can you give us a sense of what pieces would have been a significant endeavor?
- **Erika:** With the data request made by Uresti's office on PIC, we were able to parse out what we could provide. The Raymond data request was an overall request for churn data, PIC data and it is difficult to do a deep dive because we don't capture things at that level.
- **Melissa:** We would like to get a full sense of what children are going through to identify the holes and gaps where kids are falling through. Health plans and health clinics are seeing children staying on Medicaid for shorter times compared to before the ACA. We do have high-level evidence that supports what we're hearing anecdotally, but we would like full data to know about where eligible children are slipping through and churning out. The Uresti document has more details but what we don't have includes data on the number of those who don't make it through administrative renewal for procedural reasons—what are the reasons? Of those losing coverage because of checks, why is that? Is because people are over-income or are they churning out because they aren't providing the requested verification in time?
- **Erika:** Before I hand it off to Gina, just some updates about other requests first. The OTA asked for an update on loading CHIP and CHIP Perinatal into TMHP. This is not a current project and there are no immediate plans to pursue this project.
- **Melissa**: This may have been caught in transition of leadership at HHSC and it may be worth reassessing this priority in context of it being a long-standing request.
- **Erika**: And as a general update, chipmedicaid.org is going away and will be redirected to yourtexasbenefits.com. We will send an update to stakeholders like the coalition to help get that information out.

Outreach and Technical Assistance

- **Gina:** I'll focus on the specific blocked data from the Periodic Income Check handout. The period analyzed was chosen to see what time frame we were able to pull data for the quickest. The request was made during session and the more data pulled, the more time the request takes.

- We have to take a deeper dive into the actual cases to see which individuals were denied or which continued to remain eligible. As you point out, 0.66 percent of households were contacted based on PICs. It will take more time to look at those cases.
- The third question sent over by the group was about unaligned siblings and other related children on Medicaid and CHIP. Some of those households may never be aligned because the children are not related to each other. Siblings are aligned, but cousins are generally not aligned because we don't look at caregivers to determine eligibility for the child.
- **Anne**: Can they request alignment?
- **Gina:** There are constraints in statute that limit us, but to degree that we can align households, we do. We're trying to look into the cases of siblings who aren't aligned because based on the rules and processes we have in place, we shouldn't be seeing a high number of unaligned cases. We're looking into the specifics to see what the issue is with these unaligned cases.
- **Anne**: Can we request updates on how HHSC ends up addressing that unaligned sibling number?
- **Gina:** Sure, but it will be a slow process. Our staff has to read those individual cases and analyze them, but we will keep you updated.
- The fourth question sent over asked for an analysis on PICs for non-SSI related children. We are trying to parse this out and look at reasons for denial. We will continue to work on that 0.66 percent of cases identified as being contacted based on PICs, though we could see a challenge with parsing denials.
- **Anne**: We'll also continue to work with health plans, FQHCs to start record keeping on cases so that we can take those to HHSC as well.
- **Anne**: According to the data request, less than one percent of cases are contacted based on PICs, but 70 percent are contacted for administrative renewal. What's different in these processes that leads to this gap?
- **Gina**: Until we can parse this out and see what is not the population for Medicaid caretaker, aged, blind, &disabled, it's hard to say it is or isn't the same.
- **Anne**: Which point in time is administrative renewal for a child on Medicaid?
- **Gina:** The ninth month.
- **Anne**: What are you looking at during renewal that's not being looked at during PIC?
- **Gina**: It might information that's not financial. A residential move, perhaps. It's hard to compare these two numbers because the Medicaid children population is still included with other population numbers for the administrative renewal number.
- **Anne**: Thanks again for coming today to talk about this, it's an important priority of the Coalition. There's no other state doing anything like Texas' Periodic Income Check process. It seems like it's creating problems; it's not coming from a best practice elsewhere; it costs money; and it doesn't come from a legislative directive. That's why we continue to work on it and we're looking forward to constructively moving this conversation forward.

Clayton Travis from Texas Pediatric Society will chair the July 21th meeting, which is a regular 2-hour meeting.

CHILDREN'S HEALTH COVERAGE COALITION
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Budget:

1. Ensure adequate funding for Medicaid and CHIP and prevent reduction in critical health services or payments that will adversely affect children's and mothers' access to care.

SB1

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Children's Health Insurance Program (CHIP)

The budget for the 2018-2019 biennium allocates **$2 billion in All Funds** (including $153 million General Revenue) for the Children's Health Insurance Program (CHIP). This $0.18 billion higher than the amount allocated in the 2016-2017 budget.

SB1 covers the Legislative Budget Board (LBB) estimate for CHIP caseload growth for 2018-2019, but not cost growth per CHIP participant.

Medicaid

The budget for the 2018-2019 biennium allocates **$62.4 billion in All Funds** (including $26.3 General Revenue) for Medicaid total program funding. Funding for Medicaid client services is **$57.4 billion All Funds** over the biennium. This is lower than the amount ultimately allocated for the current 2016-2017 budget (that is, the 2015 budget bill plus the 2017 supplemental appropriation). Specifically, this is a biennial reduction $1.9 billion All Funds ($0.4 billion GR) for Medicaid program ($1.3 billion All Funds reduction for Medicaid client services).

SB1 covers what LBB estimates for Medicaid caseload growth for 2018, but NOT projected caseload growth for 2019. SB1 also does NOT fund projected cost growth per Medicaid participant for 2018 or 2019.

The funding levels above include a few things.

- **Funding includes amounts to restore about 25 percent of pediatric therapy rate cuts mandated in the 2016–17 biennium** and to phase in reductions associated with reimbursement policy for therapy assistants. The House version of SB 1 included a 75 percent restoration of the therapy rates, and the House version of HB 2 the supplemental bill included funds for 2017 restoration and a repeal of the directive for HHSC to move ahead seeking additional cuts. None of these positive proposals survived.
- **Funding for 2018–19 biennium assume $1.0 billion All Funds ($0.4 billion GR) in cost containment for Medicaid client services**. This includes amounts from reducing risk margin for Medicaid managed care and cost containment rider. Specifically, Rider #34 requires HHSC to reduce Medicaid spending by $830 million All Funds ($350 GR) through specific initiatives; and

> Rider #158 requires savings of $182.6 million All Funds ($76.3 million GR) from less generous formula used to set Medicaid managed care premium rates (i.e. reduces risk margin in managed care premiums).

From Anne Dunkelberg (Center for Public Policy Priorities), below:

> This Medicaid "IOU" is not as big as the 2011 session's IOU, which was nearly $5 billion GR when they passed their budget. As noted above, there is no recent official public LBB scoring of the value of the unfunded Medicaid cost inflation for 2018-2019. But based on HHSC's Exceptional Item requests, it is expected to fall between $1 billion and $1.5 billion GR. And, program reductions or efficiencies mandated in the riders described above assume another $426 million GR can be squeezed out of the already-lean program.
>
> **Lawmakers should expect to fill at least a $1.2 billion GR Medicaid hole in the 2019 session, and possibly closer to $2 billion if the costs run high and cost containment wish-lists cannot yield the required savings.**

Outreach, Enrollment, and Eligibility Systems:

2. Modernize and streamline eligibility and enrollment for children and pregnant women to remove unnecessary procedures, which contribute to unnecessary gaps in health coverage.

a. Streamline renewal processes for families by enabling those with multiple children enrolled in Medicaid or CHIP to renew coverage for each child on the same date every year. This creates a more uniform process for the state and families.

HB 3151 (Rep. Sheffield) Relating to demonstration projects to coordinate eligibility renewal and eligibility recertification for certain children in the Medicaid and child health plan programs

PASSED HOUSE, DID NOT RECEIVE SENATE HEARING

- Bill would have created a pilot program to align eligibility dates for families with multiple children enrolled in Medicaid and CHIP, enabling families to enroll all of their children in coverage on one date annually. As part of the pilot, the number of income checks per child in Texas Medicaid would have been reduced from five to two per year.

Additional background on the bill:

> **Medicaid and CHIP enrollees are certified as eligible every 12 months**. In addition, the Health and Human Services Commission (HHSC) performs electronic income checks at initial enrollment, and then **again at months 5, 6, 7 and 8**, and of course again at the 12-month renewal point. Parents must submit proof of income if their income level is not found "reasonably compatible" with electronic sources.

Families with more than one child enrolled in Medicaid are required to undergo multiple periodic electronic income checks (**total of 5 per year per child**). When children in the same family have different renewal date timelines, families with a change in income or a new job must undergo overlapping income verification checks month after month to keep their coverage.

HHSC adopted these new eligibility and renewal *procedures in 2014 without legislative or state statute guidance*. The new administrative policies have had unintended consequences, by interrupting continuity of care, and creating new hassles for parents, health providers, and health plans, which lead to increased healthcare costs for the state.

HB 3151 would have established a pilot to develop new processes to align the eligibility dates for families with multiple children, ***enabling parents to enroll all of their children into Medicaid and/or CHIP on one date annually.***

b. Modify Texas' continuous eligibility period for children's Medicaid, which is currently 6 months, to align with the 12-month Medicaid certification period – similar to what Texas has done for CHIP.

HB 1408 (Rep. Cortez) Relating to the period of continuous eligibility for the medical assistance program

HEARING HELD IN HOUSE HUMAN SERVICES COMMITTEE; LEFT PENDING IN COMMITTEE

- Would have provided 12-month continuous eligibility for children enrolled in Medicaid to reduce gaps in kids' coverage and align with Texas CHIP and 18 other state Medicaid programs
- Bill was supported by Medicaid managed care health plans, physicians who see Medicaid patients, and the families whose children rely on the program.
- By ensuring children maintain continuous Medicaid coverage in a given year, this bill would have improved health outcomes and continuity of care for kids; reduced administrative costs to the state, health plans, and Medicaid providers; and facilitated better tracking of quality-based value initiatives.

Access to Quality Care:

3. Improve maternal and child health by supporting policies and practices that will improve access to care before, during, and after pregnancy.

a. Ensure continued funding for the successful administration of Texas' state-funded women's health care programs – Healthy Texas Women and Family Planning Program.

The budget appropriates level funding over the previous biennium's appropriations for the state's women's health programs (Healthy Texas Women, the Family Planning Program, and Breast and Cervical Cancer Services). The budget does not delineate how much of the Women's Health Program strategy

funding is appropriated for each individual program. The budget contains language in a rider that assumes Texas will receive an 1115 waiver in fiscal year 2019 for the Healthy Texas Women program.

From the Texas Women's Healthcare Coalition, below:

> Texas Health and Human Services (HHS) has announced its intent to apply to the Centers for Medicare and Medicaid Services (CMS) for a new waiver under Section 1115 of the Social Security Act for the Healthy Texas Women program.
>
> You can find the waiver application and opportunities for public comment here.
>
> September 1, 2018 is the proposed effective date for a five-year waiver program ending August 31, 2023. If approved, the 1115 Waiver would allow Texas to receive federal matching funds to support the Healthy Texas Women program. An 1115 Waiver could have a significant impact on the funding, services, and structure of the state's women's health programs.

Prior to 2013, Texas' women's health program was financed at the standard 90:10 federal matching rate under the 1115 Medicaid waiver, but Texas chose to forfeit federal funding and fully fund the program with state dollars because federal policy prohibited Texas' exclusion of Planned Parenthood as a provider in 2013. The new waiver proposal would also exclude Planned Parenthood, and it is unclear at this time whether this waiver will be granted or how current eligibility and benefits may be impacted if federal funding is received. If a waiver is granted, it may also be legally challenged under the provider choice provision of federal law that has previously prevented states from restricting Medicaid beneficiaries' free choice in family planning providers. More information on this evolving issue can be found here and HHSC's public comment period ends June 12, 2017.

b. Make policy changes to allow more new mothers to receive screening for perinatal depression (also called postpartum depression) and substance abuse disorders and provide access to treatment for those in need.

First, Texas should enact new Medicaid policy to allow pediatricians, family physicians and other EPSDT providers to screen mothers for perinatal depression during the child's Medicaid or CHIP well-child visit.

Second, eliminate current coding and procedural issues that impede physicians and other providers from conducting perinatal depression screening and counseling for adult women enrolled in Medicaid or Healthy Texas Women.

HB 2466 (Rep. Davis) Relating to coverage for certain services related to maternal depression under the Medicaid and child health plan programs

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- Adds a benefit to Children's Medicaid and CHIP that allows mothers to receive one postpartum depression screening during their baby's well-check visit up to one year after the child's birth – with the screening covered by their child's Medicaid or CHIP coverage.
- Improves prenatal care and pregnancy health by adding two questions to the Medicaid for Pregnant Women application. First question asks pregnant women their preferred method of contact (e.g. text, telephone, email) so Medicaid plans can share information on prenatal care, well-child visits, and immunizations. Second questions asks if this is the first pregnancy so that women may be referred to Nurse Family Partnership program, which is available for first-time moms.
- Directs the state to apply to federal grant funds available under the 21st Century Cures Act to improve postpartum depression screening and treatment services in the state.

c. Direct HHSC to evaluate options for streamlining enrollment in women's health programs to promote continuous care following a pregnancy. This includes a streamlined enrollment and referral process between CHIP perinatal and the state's Family Planning Program.

CHIP Perinatal services cover the unborn children of women who do not qualify for Medicaid on the basis of income and/or immigration status. As of July 2016, women exiting Medicaid for Pregnant Women are automatically enrolled in Healthy Texas Women, one of Texas' women's health programs. A similarly streamlined process for CHIP Perinatal and the Family Planning Program would promote continuity of care.

- During budget conference process, proposed rider was removed that would have directed state to identify opportunities for outreach on Family Planning Program for women in CHIP Perinatal.
- Rider added into state budget that could help streamline enrollment of young adults into women's health programs. **Rider #209** directs HHSC to submit a report by July 2018 on the cost-effectiveness and projected savings of automatically enrolling into the Healthy Texas Women Program those female clients who become ineligible for CHIP or Children's Medicaid Program due to their age.

d. Amend HHSC policy to allow women to dually enroll in CHIP perinatal program and other private individual health coverage. Current state rules do not allow women to dually enroll in CHIP perinatal program and other private health insurance.

Lawfully present immigrant women eligible for CHIP perinatal may also be eligible to enroll in other private health insurance, which provides full medical coverage for additional medical needs unrelated to the pregnancy, but may have significantly higher deductibles and co-payments. While enabling women to dually enroll in private coverage and CHIP perinatal would improve continuity of care before, during, and after pregnancy and keep state health care costs down, the Coalition determined that a favorable

legislative environment did not exist in which to advocate for this priority. CHIP Perinatal outreach and enrollment continues to be a priority of the Children's Health Coverage Coalition, which will continue to discuss pursuing these initiatives during the interim.

4. Support legislation to create comprehensive coverage for Texas' low-income adults, improve maternal health, and enhance the financial security for parents striving to do the best job of raising their children and providing for their families.

Comprehensive coverage:

HB 3634 (Rep. Bonnen) Relating to the amendment of the Texas Health Care Transformation and Quality Improvement Program waiver

HAD HOUSE HEARING; LEFT PENDING IN HOUSE COMMITTEE

Several CHC Coalition members testified against HB 3634 about how the suggested changes to the Medicaid 1115 waiver would undermine coverage for kids and pregnant women.

- The bill would have repealed existing Texas laws that establish parameters for Texas' Medicaid 1115 waiver and replaced that language with a directive for HHSC to seek an amendment to the current waiver that follows a list of 12 requirements.
- Requirements included reversing changes to Medicaid eligibility that were part of the ACA. This would have included re-imposing the asset/resource limits, re-imposing "stair-step" income limits for children, and dismantling the current Medicaid-CHIP MAGI method
- Another of the 12 requirements was to mandate a 6-month certification period for all Medicaid enrollees. Currently, pregnant women are certified until 60 days postpartum and newborns are guaranteed a full year of coverage at birth. The bill also would have required all Medicaid enrollees to pay copayments.

Improving maternal and child health:

SB 1929 (Sen. Kolkhorst) Relating to maternal mortality and morbidity and pregnancy related deaths, including postpartum depression

PASSED SENATE AND HOUSE FLOOR; NO AGREEMENT REACHED ON AMENDMENTS IN CONFERENCE

SB 1929 and amendments did not pass due to an end-of-session standoff about expiration (or sunset) of several state boards, including the Texas Medical Board, which are set to expire in September 2017. However, several elements of SB 1929 were incorporated into budget riders (see below).Also, Governor Abbott has called for a special session to begin on July 18, 2017, with one of the 19 items on the special session agenda being a call to address Texas' high maternal mortality rate.

SB 1929, as passed in the Senate, would have:

- Extended authorization of the Texas Maternal Mortality and Morbidity Task Force until September 2023 and directs Task Force to study and review rates and disparities in pregnancy-related deaths and severe morbidity, in addition to the trends in morbidity the Task Force is already reviewing; and
- Directed the Task Force to evaluate options for reducing maternal mortality, focusing on the most prevalent causes of maternal mortality, and to evaluate options for treating postpartum depression among low-income women.
- Directed the state to apply for a federal grant program to address postpartum depression, using the findings of the Task Force when determining how to spending the grant funds.

The House amendments that were added would have:

- Required reporting the use of postpartum depression services in order to identify the ability for providers to meet mental health needs.
- Directed the Task Force to study and review conditions and factors that most disproportionately affect the most at-risk populations as determined by the Task Force; review best practices in other states; and compare the rates of maternal mortality and morbidity among women of different socioeconomic statuses.

Elements of SB 1929 that *made it into budget riders* include:

- **Rider #193** & HB 2466 directing the state to seek funding under the 21st Century Cures Act to improve screening and treatment of postpartum depression.
- **Rider #216** directing the Office for Minority Health Statistics (formerly Center for Disparities and Disproportionality, CEDD) "in collaboration with" the Maternal Mortality Task Force to study and review trends, rates, or disparities in pregnancy-related deaths and evaluate options for reducing maternal mortality (focusing on the most prevalent causes identified in the Task Force) and options for treating postpartum depression in economically-disadvantaged women.

SB 1599 (Sen. Miles) Relating to maternal mortality reporting and investigation information

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- Establish guidelines and best practices for reporting pregnancy-related death

Some budget riders adopted as part of SB 1 seek to improve maternal and child health. For example:

- **Rider 212 – Texas Medicaid Pre-term Births and Low Birthweight Births** – HHSC shall study and report on opportunities for cost savings to Texas Medicaid program from increasing minimum legal age to access tobacco and electronic nicotine from 18 to 21. Report must include estimates

related to prevention of preterm births and low birth weight attributable to smoking and the cost of treating low birth weight and preterm birth. Report due August 2018.

- **Rider 183- Increased access to community mental health services**. - $27 million GR and $3 million Federal funds each FY for purpose of eliminating waiting lists for community mental health services for adults and children, increasing capacity to avoid future waitlists, addressing population growth in LMHA service areas, and increasing equity in funding allocations to LMHAs.
- **Rider 172**- **Medicaid Services Capacity for High-Needs Children in Foster Care**. $2 million GR in FY 2018 for HHSC and DFPS to implement statewide grant program to increase access to TCM and rehabilitative services for high-needs children in foster care system.
- **Rider 164**- **Maternal and Neonatal Health** – HHSC shall identify opportunities for decreasing neonatal intensive care unit costs in Medicaid and CHIP through better care coordination and utilization of services provided by Better Birth Outcomes initiatives. HHSC shall identify strategies to increase prevention of NAS and reduce maternal mortality, focusing on top causes of maternal death identified by Maternal Mortality Task Force. HHSC shall provide report by December 2018.
- **Rider 195- Prioritization of Behavioral Health Treatment for Pregnant Women**- Out of funds in Strategy D.2.1 through D.2.5 Community Mental Health Services, Commission shall seek to educate and inform the public and behavioral health service providers that pregnant women and women with dependent children are a priority population for services funded through Substance Abuse Prevention and Treatment Block Grant.

Early Childhood Intervention:

HB 3930 Relating to health benefit plan coverage for early childhood intervention services

HAD HOUSE HEARING; LEFT PENDING IN HOUSE COMMITTEE

- Would require most private insurance companies to cover specific Early Childhood Intervention (ECI) services, such as speech therapy and specialized skills training when authorized by a child's Individual Family Services Plan (IFSP)

From Disability Rights Texas, Texans Care for Children, Texas Pediatric Society, and others, below:

This important program for Texas families faces significant pressures, including:

- **Underfunding.** Texas children of all incomes are eligible for ECI based on medical diagnoses or severity of developmental delays. Unlike other states, Texas does not require private insurance companies to cover most ECI services. Consequently, Texas disproportionately relies on State General Revenue and local funds to cover costs of services for Texas children, including those with private insurance.

- **Increasing population.** As the Texas population grows, the ECI program serves an increasing number of children. On average, the program served approximately 1,200 more children per month in FY 2015 than in FY 2012, for a total of **50,634** children receiving comprehensive services in FY 2015.
- **Decreasing provider base.** ECI providers are terminating contracts at an alarming rate due to underfunding and other financial pressures, leaving many families without reliable access to these services By requiring private insurance companies to cover ECI services under certain circumstances, Texas would join other states, establish equity between private insurance companies and Medicaid Managed Care Organizations, and take an important step toward fiscal stability for an important early intervention program for Texas children.

HB 3967 (Rep. Walle) Relating to the establishment of a task force to study the financing options for early childhood intervention services

DID NOT RECEIVE HEARING FROM HOUSE COMMITTEE

- Would create a task force to evaluate and make recommendations on the feasibility of requiring private insurance plans to cover ECI services and include ECI providers in their networks
- Task force would consist of representatives from ECI providers, ECI advocacy groups, HHSC, Texas Department of Insurance, and private insurance plans

Preventative care:

HB 1600 (Rep. S. Thompson) Relating to certain mental health screening under the Texas Health Steps program

SIGNED BY THE GOVERNOR

- Allows payment for one mental health screening at each Medicaid Texas Health Steps visit of children between the ages of 12 and 18.
- Current Medicaid policy requires at least one mental health screening between the ages of 12 and 18. HB 1600 allows for additional screenings to be reimbursed if the medical professional chooses to do so.

Notes for 6/15/2017 CHC meeting

Sen. Lisa Murkowski (R-AK)

“I want greater access and lower costs. So far, I'm not seeing that happen.”

Medicaid in Texas' 2018-2019 Budget

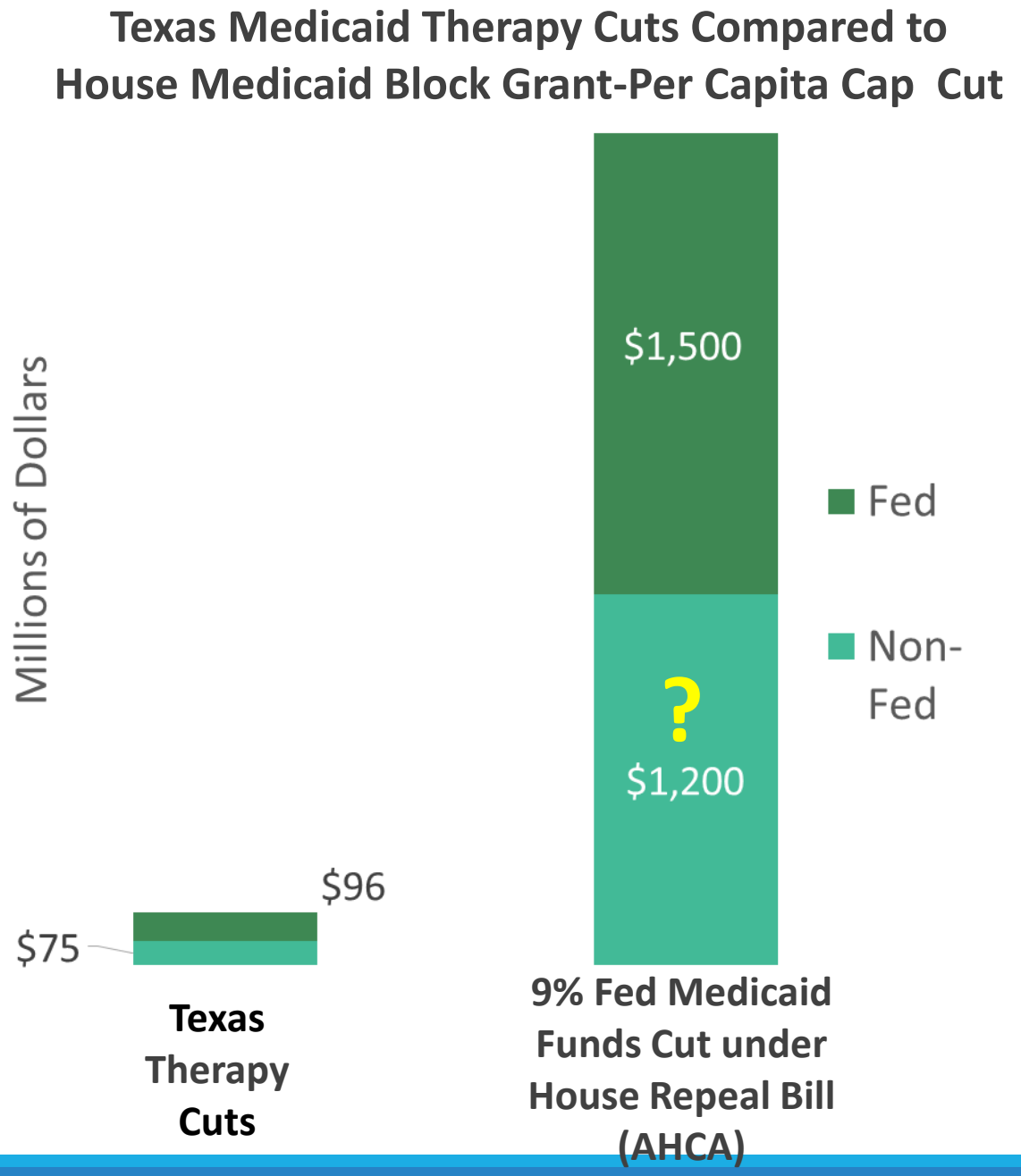
- Total funding for Medicaid in 2018-2019 is $62.4 billion All Funds ($26.3 billion non-federal).
- This is lower than current 2016-2017 budget (includes supplemental appropriation to finish out 2017).
- Largest Medicaid budget cut directive (HHSC) Rider #34 Cost Containment, requires HHSC to cut Medicaid spending $830 million All Funds ($350 million General Revenue).
- Also, HHSC Rider #158 requires savings from a less generous formula used to set Medicaid Managed Care premium rates: $182.6 million All Funds ($76.3 million GR).
- Caseload growth for Medicaid funded for 2018, but NOT for 2019; also unfunded for cost growth per Medicaid participant for 2018 or 2019. Combined, this underfunding totals at least $1.5 billion GR.
- SB 1 only restores 25% of Medicaid pediatric therapy rate cuts mandated in the 2016-2017 budget.
- Funds 735 Promoting Independence waiver "slots", and another 276 for children in Child Protective Services custody who need long-term services and supports.
- RESULT: at least a $1 billion GR Medicaid hole must be filled in the 2019 session -- possibly closer to $2 billion if the costs run high, and cost containment wish-lists cannot yield the required savings.

CBO Score:"AHCA" Repeal/Replace Bill, Medicaid

- The CBO's report shows:
  - 23 million more uninsured Americans by 2026, compared to current law.
    - 14 million more uninsured in 2018
  - By 2026 uninsured rate (under 65) grows from 10% percent today (where it is projected to remain if the ACA stays in place) to 18%.
  - People with lower incomes, ages 50-64, and rural residents hardest hit.
    - Funding that supports coverage for these groups today will be redirected primarily to large tax cuts that benefit wealthy households, as well as to corporations.
- Cuts Medicaid spending $834 billion/10 years; Texas share estimated at $15 billion/10 years
- 14 million fewer people have Medicaid coverage nationwide by 2026, compared to current law.

Damaging Texas Medicaid Therapy Cuts Dwarfed by US House Medicaid Cut

- Legislature's Medicaid Therapy rate cuts passed 2015 were **$171 million All Funds** ($75 million GR) per year, just 0.4% (less than one-half of one percent) of total All Funds Texas Medicaid funding for 2016.
- Compare: Projected $15 billion Texas loss of federal Medicaid funding over 10 years under House AHCA, or average $1.5 billion loss per year.
- Would Texas replace that, or even spend the $1.2 billion in state dollars that would have matched it?
- Imagine the cuts the Texas Legislature will have to decide on, the harm done, and the public outcry.
- Effect of AHCA: Massive Medicaid cuts, that shift costs to the state and local level.



CHIP (funding expires 9/30/2017)

President Trump Budget proposal:

- Includes all AHCA Medicaid cuts (i.e, $834 billion/10 years)
- PLUS specifies $616 billion in additional Medicaid and CHIP cuts
  - May be some technical overlap; estimated at $1.3 trillion when adjusted to remove any duplication (http://www.cbpp.org/blog/trump-budget-cuts-medicaid-even-more-than-house-health-bill-showing-danger-of-per-capita-cap)

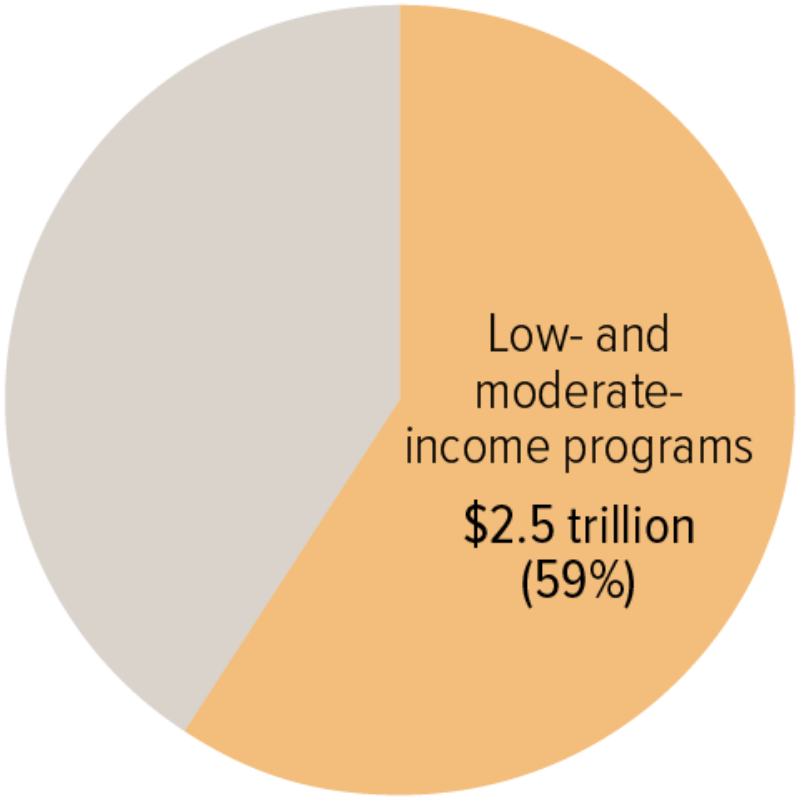
- Proposes only a 2-year CHIP extension
- CUTS CHIP allotments $5.8 billion, 21% cut, through these changes:
- Eliminates Maintenance of Effort for children (states could reduce eligibility)
- Eliminates the current 23-point matching rate "bump" (Texas at 92%)
- Eliminate Enhanced match for any kids over 250% FPL (24 states!)
- Re-establish stair-step allowed (move kids back to CHIP from Medicaid)
- See "Say Ahhh! Blog at ccf.Georgetown.edu; Voices for Kids Blog (First Focus)

Senate Secret Bill?

- **Senate version of Per Capita Cap:** "reset" proposal under consideration could mean that if a state's actual per-beneficiary spending for a population group falls below the per capita cap amount that would otherwise apply to that population, the cap amount for that group would be recalculated (REDUCED) based on what was actually spent. That, in turn, would give the state less overall Medicaid funding (A LOWER cap) than under the House bill's per capita cap.
- **Illustration:** If a state takes steps to cut spending and keep it 2 percent below the cap level for children. Under the reported rebasing approach, within a few years, the state's per capita cap amount for children would be **reduced by another 2 percent**, relative to what the cap would otherwise have been under the House bill formula. **If the state again cuts its spending further to stay below the new, lower cap, the per capita amount will later be reduced by 4 percent,** compared to the House bill's already highly inadequate cap levels, and so on. **The state will be caught in a cycle of increasingly severe cuts.**
- Senators Dean Heller, Rob Portman, Shelley Moore Capito, and others are supporting a phasedown of Medicaid expansion funding, with funding cuts still beginning in 2020.
- Eliminating House's option to not allow higher premiums for EHBs (that is, pricing based on health status/history, which ACA prohibits), will be meaningless if insurers simply use elimination of essential health benefits to screen out the same consumers.

Three-Fifths of Cuts in Trump Budget Come From Low- and Moderate-Income Programs

Total cuts, 2018-2027



Source: CBPP based on Office of Management and Budget and Congressional Budget Office

- $4.3 trillion in non-defense cuts through 2027.
- $2.5 trillion in cuts to programs assisting low- and
- moderate-income people = 59% of the total non-defense cuts
  - these programs = just 29% of non-defense spending, just 24% of total program spending.
- $1.9 trillion in health care cuts, vast majority to Medicaid
- and the rest to subsidies for health insurance.
  - Reduce federal Medicaid spending by $1.6 trillion from 2018 through 2027,
  - cutting Medicaid by nearly half (47% percent)
- $400 billion in cuts to discretionary programs for low- and moderate-income people. Includes LIHEAP, job training, housing vouchers
  - Overall cuts 41% by 2027 (relative to today's levels), after adjusting for inflation.
- **$193 billion in SNAP cuts.**
  - Cuts federal SNAP funding by more than 25% through eligibility and benefit cuts, and a massive cost shift to states
  - Requires states to pay for 25% percent of SNAP by 2023, $116 billion over 10 years, and allow states to cut SNAP benefits to reduce the new state costs.

TABLE 1

Trump Plan Gets 59 Percent of Non-Defense Cuts from Low- and Moderate-Income Programs

Program/Proposal	Ten-year cuts[1] (in billions of dollars)
Affordable Care Act (ACA) repeal	-$1,250.0
Additional Medicaid cut	-610.0
Supplemental Nutrition Assistance Program (SNAP)	-193.2
Temporary Assistance for Needy Families (TANF)	-21.8
Eliminate the Social Services Block Grant (SSBG) and shift some of its expenditures to Foster Care and Permanency	-16.5
Supplemental Security Income (SSI)	-9.0
Child Tax Credit (CTC) and Earned Income Tax Credit (EITC)[2]	-28.0
Other mandatory	-6.8
Estimated cut in discretionary low-income programs	-400.5
Eliminate subsidized student loans[3]	-38.9
Total low-income cuts[3]	**-$2.5 trillion**
As a share of total non-defense programmatic cuts	59%

[1] Net impact on spending, including small increases for some programs and excluding effects on tax receipts.
[2] The total CTC and EITC cut equals $40 billion, consisting of $28 billion in outlay reductions and $12.5 billion in tax increases.
[3] Total low-income cuts do not reflect the elimination of subsidized student loans. Unlike the other programs in this table, the overall student loan program is not targeted on low- and moderate-income families by CBPP's long-standing definition.

Source: CBPP based on Office of Management and Budget and Congressional Budget Office

— An “opioid fund” that restores only a small fraction of the massive Medicaid cuts and does not require insurers to cover related physical and mental health services.

— A “delay” of the end date for Medicaid expansion, probably beyond each of the senators’ re-election dates, but which would still end the expansion to people slightly above the poverty line and cause 50 million people to be without insurance by 2026.

— A “facelift” meant to improve the House bill for people with pre-existing conditions, but with loopholes that lead to the same result. For example, insurers couldn’t deny coverage to people with cancer, but they could refuse to cover cancer treatment.

— A small “topping up” of tax credits for older people who will pay much more for care under the House bill, but there will still be an “age tax,” which causes premiums to skyrocket for people in their 50s and 60s.

— “State buyoffs” that give something to one state paid for by all taxpayers.

Senators will claim that these deals have fixed the House bill’s problems. But the truth is that in a bill with more than $1.1 trillion in cuts to care for kids, seniors, small business owners and low-income people, they are essentially meaningless.

Figure 1. Medicaid and CHIP serve the United States' most vulnerable children.

A large share of at-risk children rely on public coverage, as reflected by the percentage of United States children in each group below that depend on Medicaid and CHIP for health care they need to thrive:

79% Children living in or near poverty.

45% **Infants, toddlers, and pre-schoolers** during the early years that are key to their healthy development and school readiness.

43% **Children with disabilities or other special health care needs** such as juvenile diabetes, congenital heart conditions, or asthma.

100% **Children in foster care** who face poverty, family dysfunction, neglect, and abuse that result in high rates of chronic health, emotional, and developmental problems.

48% **Newborns in families** to assure a healthy delivery and strong start during their critical first year of life.

Cutting Medicaid Funds to Texas through Block Grants or Per Capita Caps: Threat to Reverse Progress in Covering Children

Figure 6. States with the Greatest Decline in the Rate of Uninsured Children in Small Towns and Rural Areas, 2008-2009 and 2014-2015

State	Uninsured children, 2008-2009 (percent)	Uninsured children, 2014-2015 (percent)	Decline in uninsured (percentage points)
Nevada	21%	7%	-14%
Oregon	14%	4%	-10%
South Carolina	11%	3%	-8%
New Mexico	14%	5%	-8%
Colorado	15%	7%	-8%
Florida	16%	9%	-7%
Mississippi	11%	4%	-7%
Montana	15%	8%	-7%
Texas	18%	11%	-7%
Alaska	16%	9%	-6%

Note: Differences may not sum due to rounding.

https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf

Texas Schools depend More on Medicaid for Special Education support than any other State

In 2015, Medicaid paid for nearly $4 billion in school-based health care services, including both special education and EPSDT services provided outside of special education. Texas schools received $444 million, $250 million of it federal.

- For students with disabilities, schools provide medical services necessary for them to get an education as part of their special education plans, and Medicaid pays for these services for eligible children.
- Medicaid's role in schools goes beyond special education: it also pays for health services all children need, such as vision and dental screenings, when they are provided in schools to Medicaid-eligible children.
- Medicaid helps schools by reducing their special education and other health care-related costs, freeing up funding in state and school budgets to help advance other education initiatives.

http://www.cbpp.org/research/health/medicaid-helps-schools-help-children

60 year-old Dallas county resident, $30,000 annual income ; now pays $2,480 or 8% of her income.

Loses 1/3 of ACA tax credit: drop from about $6,000 today under the ACA to a flat $4,000 under the House repeal bill.

Rural neighbors take a bigger hit: Same 60-year-old living in Cleburne, Bowie or Wichita Falls, where insurance prices are higher, would lose 2/3 or more of her subsidy

County	Credit ACA	Credit House Bill	Loss
Bexar (San Antonio)	$5,840	$4,000	-$1,840 (32%)
Guadalupe (Seguin)	$12,150	$4,000	-$8,150 (67%)
Dallas	$6,000	$4,000	-$2,000 (33%)
Wichita Falls	$15,300	$4,000	-$11,300 (74%)
Montague (Nocona)	$11,280	$4,000	-$7,280 (65%)
Travis (Austin)	$6,730	$4,000	-$2,730 (41%)
Brazos (College Station)	$11,870	$4,000	-$7,870 (66%)
Tom Green (San Angelo)	$14,390	$4,000	-$10,390 (72%)

From: cc-imp-forum@googlegroups.com [mailto:cc-imp-forum@googlegroups.com] **On Behalf Of** Kyle Stock
Sent: Thursday, June 15, 2017 12:07 PM
To: Kyle Stock <KMStock@communitycatalyst.org>
Subject: Federal Activity Update

Dear Partners,

We have heard from all of you that periodic updates on activity at the federal level is helpful to your work. In response to this feedback, we will be sending updates as needed on the Community Catalyst google group.

What's Happened So Far?

- In early January, Congress passed a budget resolution with instructions to develop the language for a budget reconciliation package.
- The House Ways & Means and Energy & Commerce committees were tasked with drafting the actual language in the budget reconciliation package.
- In early March, both committees voted to pass their pieces of the reconciliation language and sent them to the Budget Committee. The Budget Committee also passed the legislation and sent it to the House Rules Committee.
- On the morning of March 24th, the House Rules committee voted to pass the bill.
- That afternoon, the Speaker of the House pulled the legislation from the floor of the House and announced that there would not be a vote on the bill. House leadership returned the legislation to the House Rules Committee.
- On May 4th, the House passed the American Health Care Act ("AHCA").
- On May 24th, the Congressional Budget Office released a revised score on the AHCA which found that 23 million people would lose coverage and Medicaid funding would decrease by $834 billion. CBO also determined that the AHCA would save $119 billion.
- Last week, the Senate Republican Caucus met to discuss proposals for repealing the Affordable Care Act. Also, the Senate Budget Committee announced that the House bill complies with the reconciliation process.
- On June 7th, the House transmitted the AHCA to the Senate.

Although not much has "happened" since in terms of process, many questions are swirling around. Here are our best answers:

When might we see a vote?
Unclear, but likely in the coming weeks. Senate Majority Leader Mitch McConnell continues to state publicly that he intends to hold a vote prior to the Fourth of July Recess. However, other Senate Republican leaders suggest that the timeline may stretch into July. For planning purposes, it is safer to assume that the vote will occur in June unless we get confirmed information otherwise.

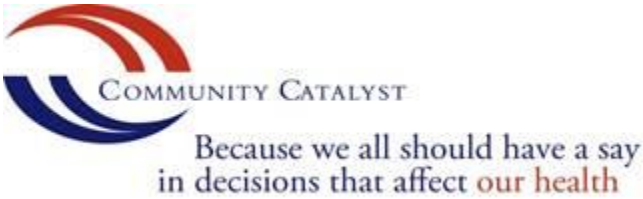
When will we see the text of the Senate version of the AHCA?
Unclear. Normally, we would expect to see bill language prior to a vote. We may see leaked bill language in the days prior to a vote. It is also possible that we will not see language until the voting process has already begun in the Senate. The Senate Majority Leader could bring the House version of the AHCA to the floor, proceed through the 20 hours of debate, and then substitute the Senate version during vote-o-rama (the rapid series of votes in the Senate on amendments to the legislation.)

When might we see a CBO score for the Senate version of the bill?
Unclear. Senate Republican leadership has been sending proposed provisions to the Congressional Budget Office. Since Senate Republican leadership continues to debate what to include in the bill, it is unlikely that CBO has the entire legislative package. Once the Senate finalizes its version of the bill, CBO can complete its analysis. Even then, we may not see a CBO score until the day before or the day of a Senate floor vote.

What might the CBO score tell us?
Unclear. CBO is not required to do a detailed report (e.g. coverage impact) to meet the requirements of the reconciliation process. The score we get prior to the vote might only be a few pages with a chart showing the legislation's impact on revenues and expenditures. In order for the Senate to vote, their version of the bill will need to save 1 billion from topics within the jurisdiction of the Senate Finance Committee and another 1 billion from the jurisdiction of the Health Education Labor & Pensions Committee. The total savings will also need to match the $119 billion saved under the House version. Even this limited information might not be available until very shortly before the vote.

Best,

Kyle Marie Stock, J.D. │ Senior Policy Analyst
Community Catalyst │ ONE FEDERAL STREET │Boston, MA 02110
617-275-2838 │ kmstock@communitycatalyst.org
twitter.com/healthpolicyhub │ communitycatalyst.org/blog
Pronouns: She, Her, Hers



HHS Office of the Ombudsman Update

Presented to
CHC Coalition
June 16, 2017

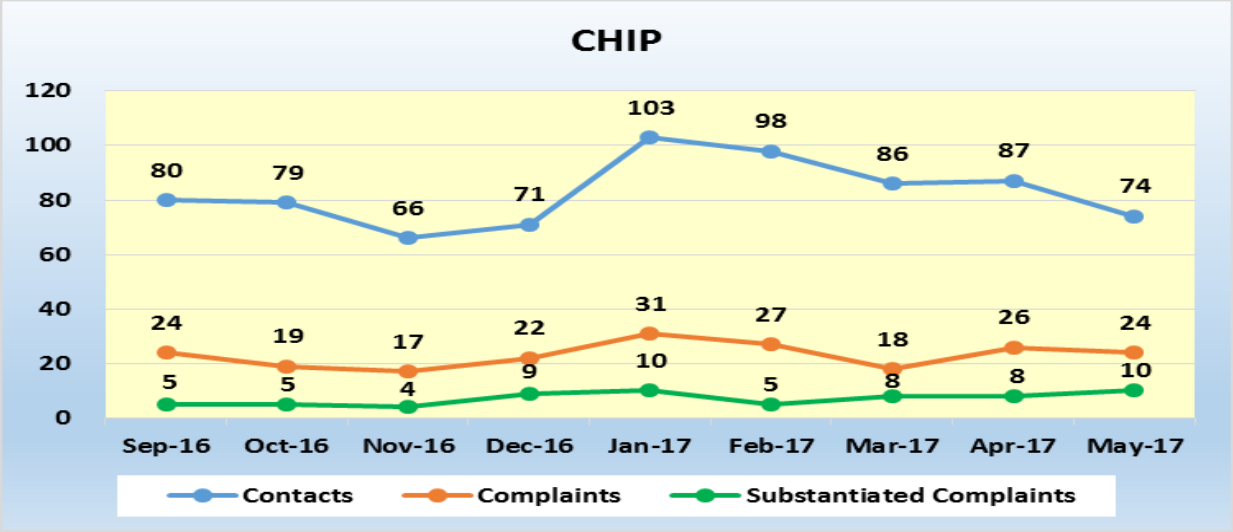
TEXAS
Health and Human Services

Total Ombudsman Contacts for 3rd Quarter FY 2017

- Complaints – 12,248
- Inquiries – 62,923

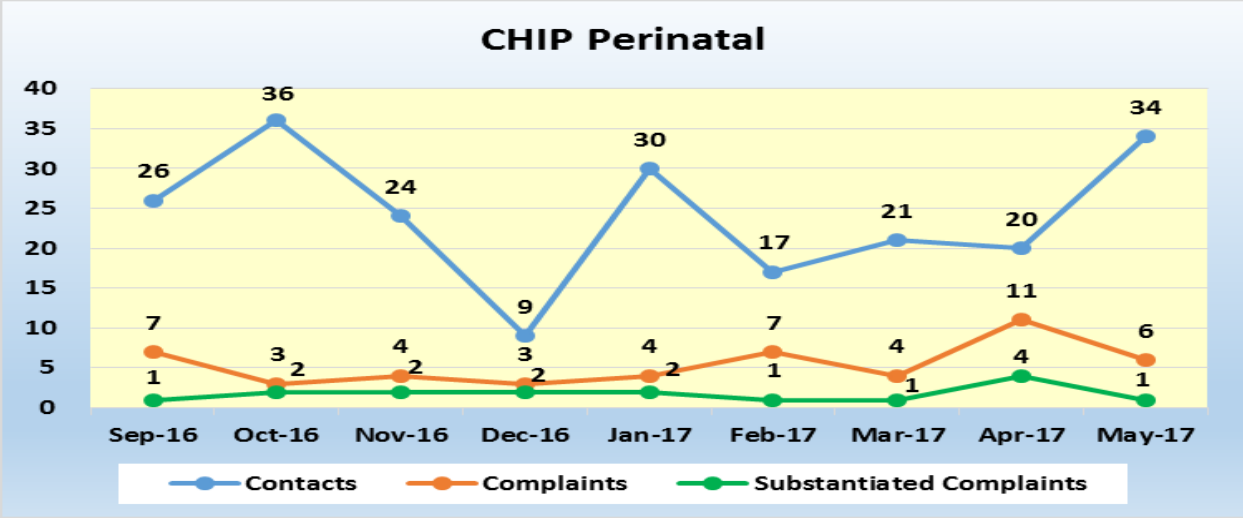
TEXAS Health and Human Services

Contact Volumes by Program Type
3rd Quarter FY 2017



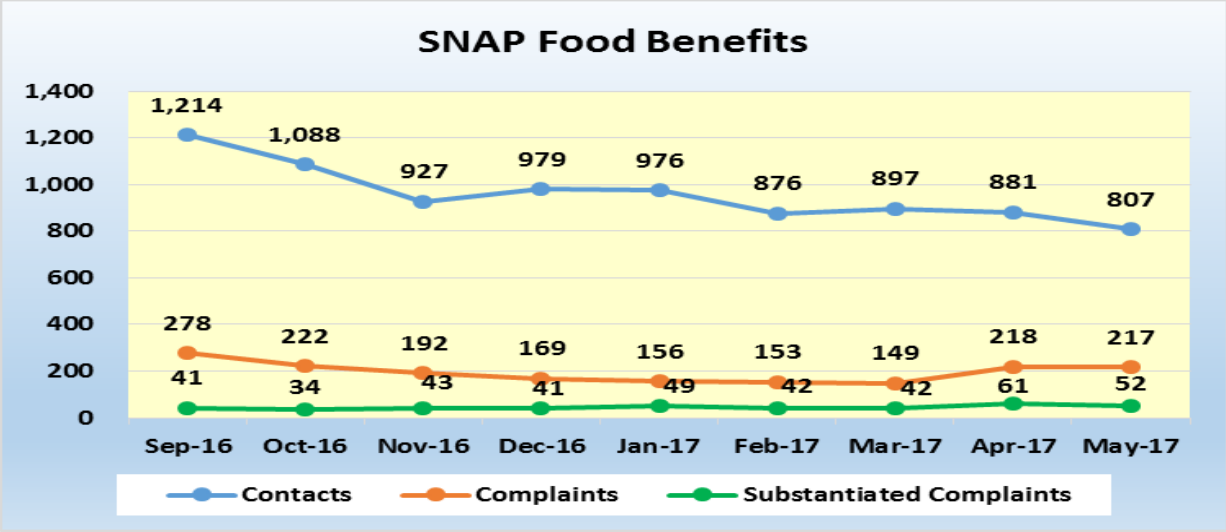
TEXAS Health and Human Services

Contact Volumes by Program Type
3rd Quarter FY 2017



TEXAS Health and Human Services

Contact Volumes by Program Type
3rd Quarter FY 2017



TEXAS Health and Human Services

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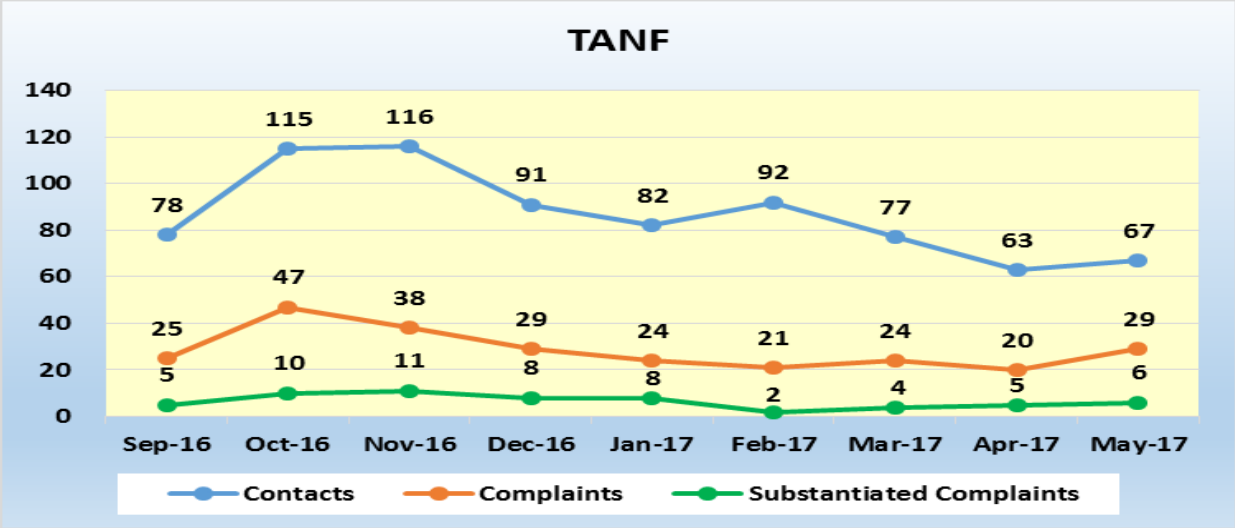

TEXAS Health and Human Services

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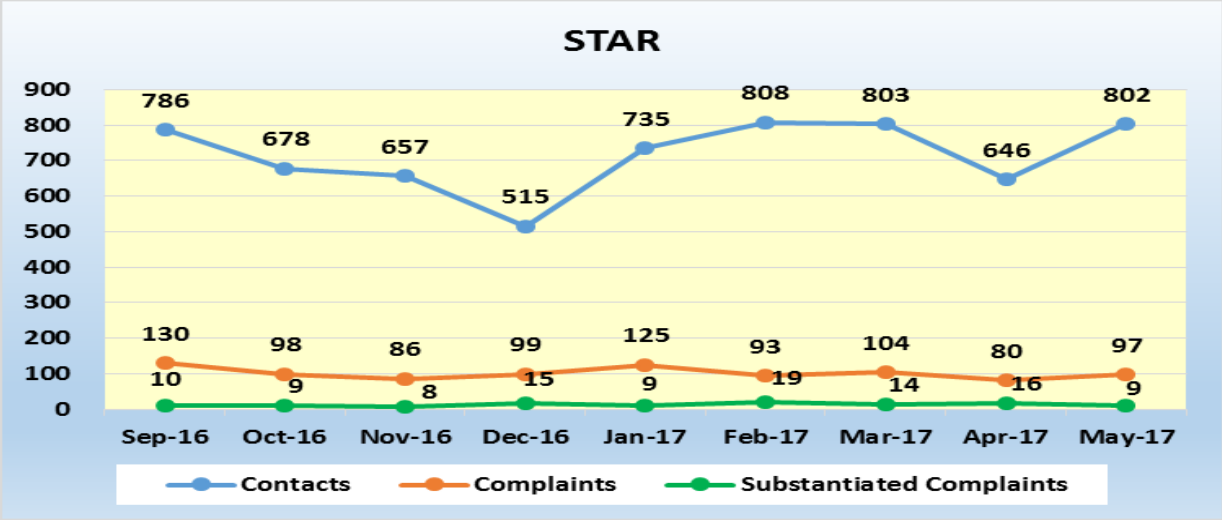

TEXAS Health and Human Services

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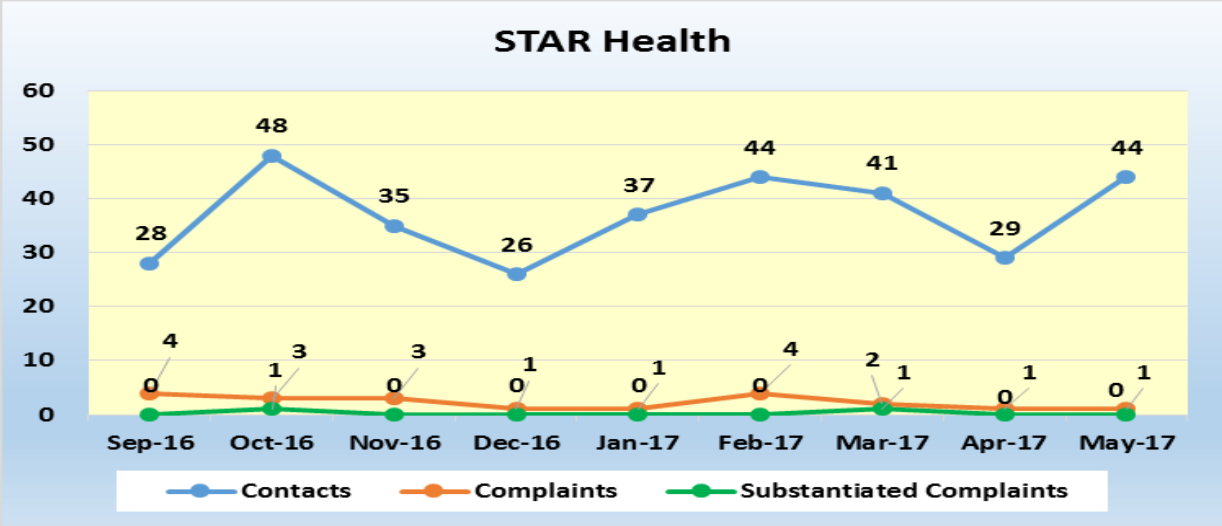

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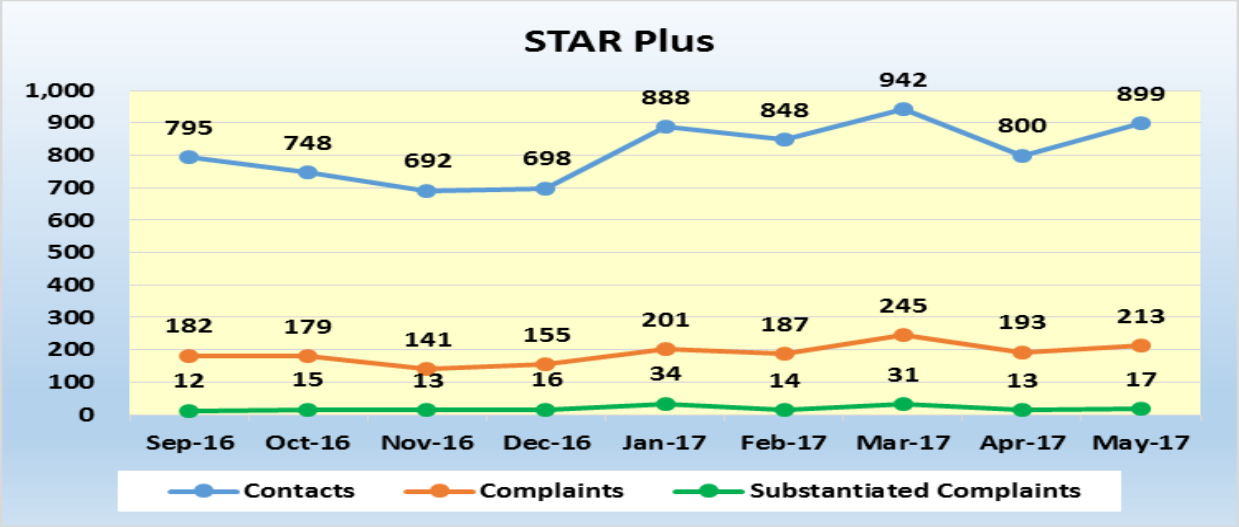

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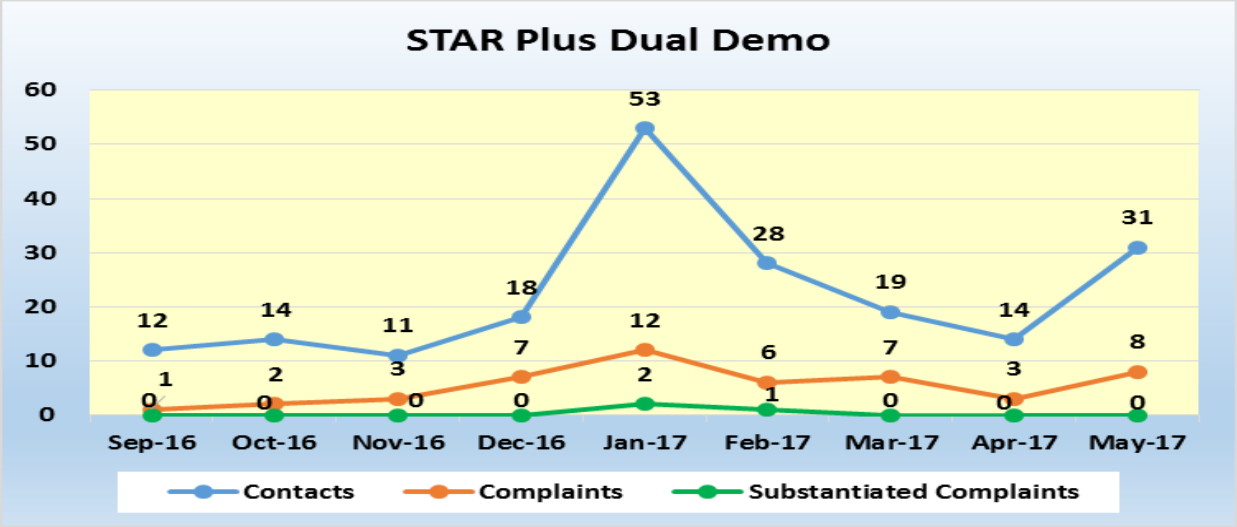

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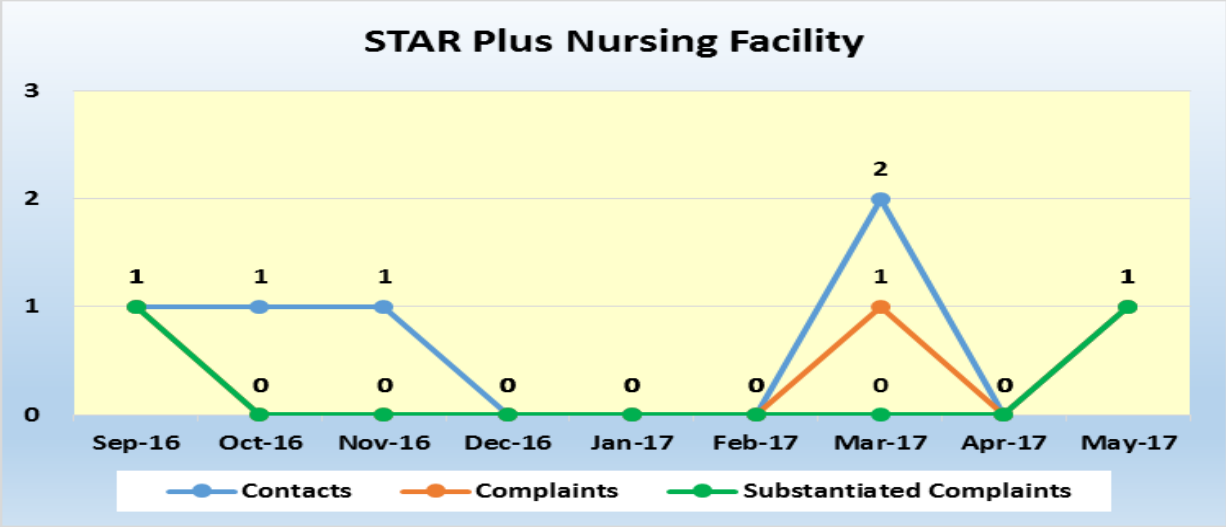

TEXAS Health and Human Services

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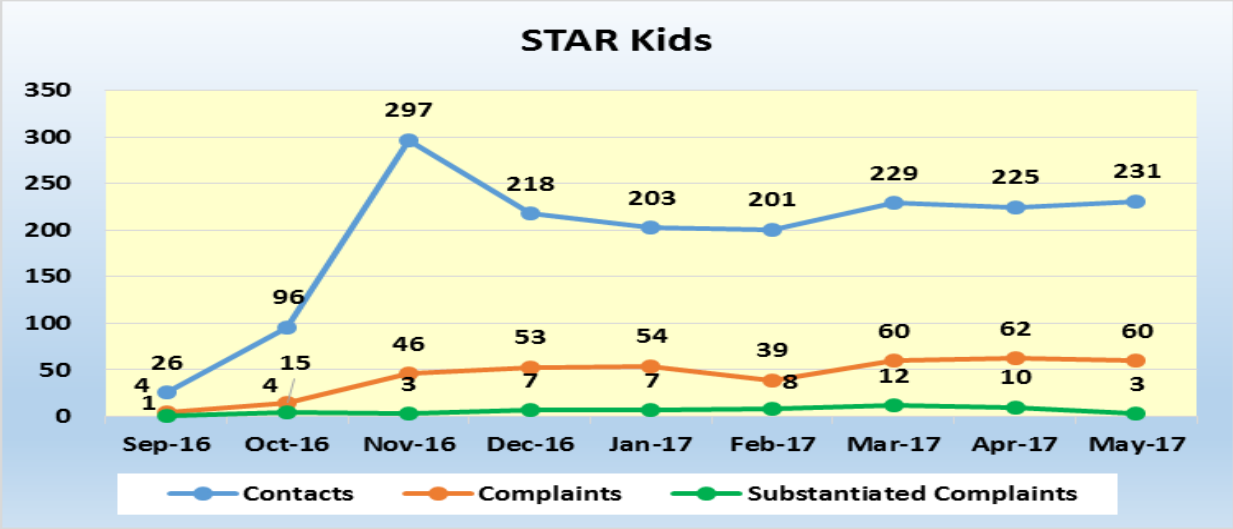
3rd Quarter FY 2017



TEXAS Health and Human Services

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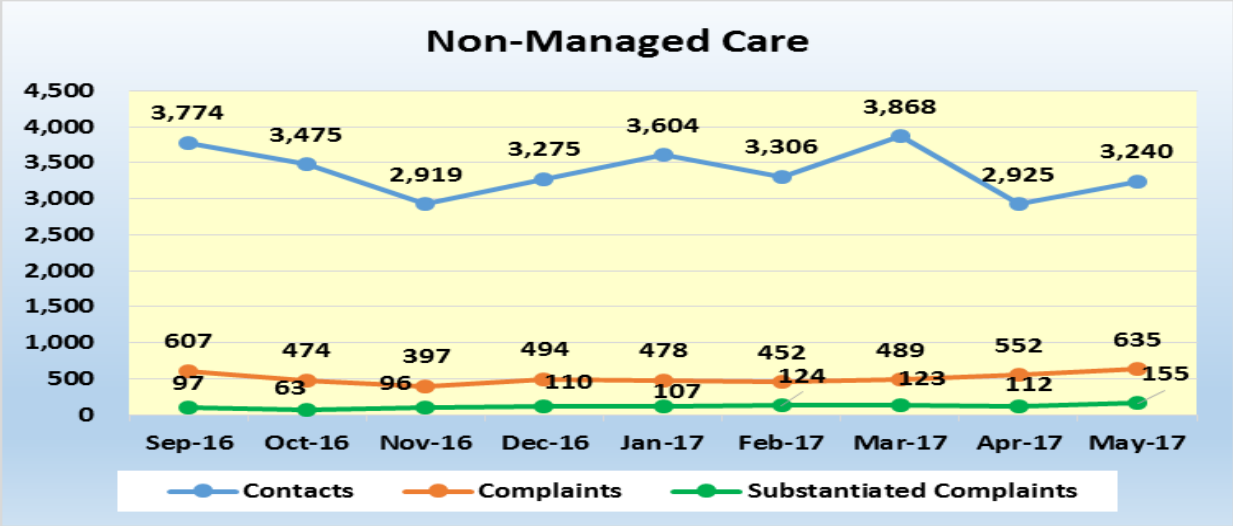

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type 3rd Quarter FY 2017

TEXAS
Health and Human Services

Top Three Reasons for Contact by Program Type
3rd Quarter FY 2017

CHIP	CHIP - Perinatal
Application Case/Denied	Application Not Completed
Check Status	Check Status
Contact Info Request	Client Billing
SNAP	**TANF**
Application/Case Denied	Application Case/Denied
Check Status	Check Status
Benefit Amount	Contact Info Request

TEXAS Health and Human Services

Top Three Reasons for Contact by Program Type
3rd 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	Access to Prescriptions
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
3rd Quarter FY 2017

STAR Plus DD	STAR Kids
Billing Inquiry	Access to Prescriptions
Access to Long Term Care	Access to PCP/Change PCP
Verify Health Coverage	Verify Health Coverage
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
3rd Quarter FY 2017

Contact Volume FCO Program 3rd Quarter FY 2017	
Foster Care Youth	149 (30%)
Total Contacts	494

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 – Home Visiting Program
- Managed Care Support Network
- Additional Assistance for Dual Eligibles
- Education for clients new to Medicaid

TEXAS 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 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

Periodic Income Check (PIC)

A PIC is an automated process used to determine whether there has been a change in an individual's household income that could potentially make them ineligible for Medicaid or the Children's Health Insurance Program (CHIP).

For children on Medicaid, PICs are processed in months five through eight of the certification period. The first month a child's eligibility could be impacted due to new income is the 7th month since the first six months of the certification period are continuous eligibility.

For the CHIP program, and income check is administered in month six of the certification period for households with income above 185 percent of the federal poverty level, as required by state statute[1].

For adults eligible under the Medicaid for Parents and Caretaker Relatives program, PICs are processed in months three through eight of the certification period.

December 2016 through March 2017 PIC

Total Avg. Monthly PICs	PIC Passed	PIC indicated the individual may be over income
	HHSC did not contact the household	HHSC contacted the household for income verification
844,236	99.34 percent	0.66 percent*

* Given the low number of individuals who are contacted during the PIC, HHSC does not have this data by outcome at this time.

Note: The **PIC indicated the individual may be over income** column includes individuals who were:

- Denied for:
  - Failure to provide the requested information, or
  - Being over the income; or
- Continued to remain eligible.

Children's Medicaid and CHIP Renewal Alignment

Currently, individuals who apply for children's health coverage on the same application have the same renewal dates when the children are eligible for the same program. In addition, when possible, HHSC aligns the renewals for siblings who are added after the initial certification and eligible to receive the same type program (Medicaid/CHIP). In general, HHSC adds a new child to a case without requiring a new application when the child's sibling are receiving services.

However, there are times when renewal due dates for children on the same case will not be aligned such as:

- When a household requests Medicaid or CHIP for a new child that is not a sibling (e.g. niece, nephew, etc.), a new application is required since the information needed to determine

the other related child's eligibility is different than what would be needed when the children are siblings.
    - The new child will receive a certification period that does not align with the certification period of the other related children in the household.
- For deemed newborn's[1], the newborn's certification period will not end with their sibling's certification period.
    - Since these newborns were born to mothers who received Medicaid for their labor and delivery, the newborn is continuously eligible from birth through the month of their first birthday.
- For siblings in the same household, renewals will not align if one child is receiving Medicaid and the other CHIP.
    - Medicaid eligibility usually beings the first day of the application month.
    - CHIP eligibility is prospective and is usually effective the month after the month in which the individual is required to pay an enrollment fee.

All Renewals due March 2017

	Renewal Due Dates Aligned	**Renewal Due Dates Unaligned**	
		Siblings	Other Related Children
Medicaid	72 percent	16 percent	12 percent
CHIP	80 percent	13 percent	7 percent

Administrative Renewals for Children

As federally required for the Modified Adjusted Gross Income (MAGI) programs[2], HHSC gathers information from a household's existing case and from electronic data sources to determine whether the household remains potentially eligible for Medical Programs without requesting information from the household through an administrative renewal process.

The administrative renewal process attempts to verify income by determining whether the household's income information is reasonably compatible with income information available through electronic data sources.

If the household's income can be verified using electronic data sources and the income is reasonably compatible, no additional information is needed from the household. The household is sent a notice informing them of their continued eligibility and is not required to send anything back to HHSC unless there is a change in the information.

If the household's income cannot be verified electronically, is over the income limit, or is not reasonably compatible, the household is sent a notice informing them that they must return a signed renewal application along with any required verifications.

[1] 42 Code of Federal Regulations §435.117
[2] 42 Code of Federal Regulations §435.916(a)

The chart below provides for the average monthly number of households that go through the administrative renewal process without requesting additional information and the number that must provide additional information.

November 2016 through March 2017 Administrative Renewals

Avg. Households Due a Renewal	Nothing Needed from Household	Information was requested from Household
170,827	30 percent	70 percent

In addition to the MAGI programs, the 70 percent also includes Medicaid for the Elderly and People with Disabilities programs which require additional asset verification processes and the Medicaid for Parents and Caretaker Relatives program which requires an interview prior to recertification. To gain efficiencies, and as allowed federally, HHSC chose to perform administrative renewals for these programs to verify income using electronic data sources.