August Children's Health Coverage Coalition Agenda

Friday, August 19th, 2022

11:00 A.M. - 1:00 P.M. CST

Meeting Location: Zoom

Meeting Chair: Helen Kent Davis – Texas Medical Association

11:00 A.M. - 11:05 A.M.	Welcome & Introduction
11:05 A.M. - 11:15 A.M.	"Free Care" Medicaid in Schools • Adrienne Lloyd (Children's Defense Fund – TX) and Karla Martinez (Every Texan)
11:15 A.M. - 11:25 A.M.	Value Based Payment Improvement Advisory Committee (VBPQIAC) • Helen Kent Davis - Texas Medical Association
11:25 A.M. - 11:30 A.M.	Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program • Allison McHorse - Texas Pediatric Society
11:30 A.M. - 12:00 P.M.	Updates on Timeliness, Staffing, Office Closures, and PHE • Hillary Davis and Gina Carter - HHSC
12:00 P.M - 12:10 P.M	Optional Brain Break

12:10 P.M. - 12:45 P.M.	CHCC Legislative Priorities Discussion & Healthcare Reform Select Committee Updates • Anne Dunkelberg (Every Texan), Alec Mendoza & Diana Forester (Texans Care for Children), and Helen Kent Davis (Texas Medical Association)
12:45 P.M. - 1:00 P.M.	SDOH Comments • Allison McHorse – Texas Pediatric Society

Children's Health Coverage Coalition and Outreach, Eligibility and Technical Assistance Workgroup Meeting

Friday, August 19th 2022

11:00 A.M. - 1:00 P.M.

On Video Conference Call:

Anne Dunkelberg
Belina Olivo
Helen Kent Davis
Allison McHorse
Diana Forester
Adrienne Lloyd
Alec Mendoza
Shelby Tracy
Allison McHorse
Shari Waldie
Karla Martinez
Beth Olson
Preston Poole
Bryan Mares
Naomi Cruz
Petra Chilaka
Anna Stelter
Brittany McAllister
Denise Gomez
Jessica Boston
Michelle Romero
Stephanie Ma
Stacey Pogue

Meeting Chair: Helen Kent Davis – Texas Medical Association
Meeting Scribe: Isabel Agbassi - Every Texan

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

CHCC AGENDA

I. "Free Care" Medicaid in Schools

[See Slides]

Questions:

- **Anne Dunkelberg:** When you detail the June 25th legislation that was signed by Biden, the piece that I did not pick up was whether this is an option for states to participate in or whether it's going to be automatic. Are states going to have to take action to access?
    - **Adrienne Lloyd:** The option became available to states in that 2014 free care reversal. It's not going to be a mandate. The act that I referenced Biden signing in June is actually just providing more guidance and support and grant dollars. But states would still have to decide to make this move, and it could be through a state plan, amendment, legislation.
        - **Helen Kent Davis:** It does say it requires updates, outdated billing guidelines. I'm assuming that's a directive to CMS. If they participate.
            - **AL:** Yes
- **HKD:** Do we know if Texas legislators or HHSC has started looking at this?
    - **AL:** There was a bill introduced last session with the Texas School Nurse Association. Can share more about that later. But there has been interest, and HHSC was aware of it a long time ago. I'm not sure where the current staff is on it. I think it was kind of dropped because they determined that legislation would be needed for them to take action because of its budget implications.
        - **HKD:** We can talk about it more during legislative discussion.

II. Value-Based Payment Improvement Advisory Committee (VBCQIAC)

Helen Kent Davis: For context, it's a group of hospital administrators, policy staff, physicians, nurses, and a variety of others who work with agency to develop recommendations to improve healthcare quality and promote value based initiatives within the Medicaid program.One of the things they've been working on for a number of years and have had recommendations to the legislator about it is addressing nonmedical drivers of health, sometimes referred to as social determinants of health. At their last meeting on July 26, the committee adopted a report unanimously that gave guidance to HHSC about how to address non medical factors in lieu of services. So we do that now in mental health. It gives more flexibility to the health plan. For example, if we offer this benefit, which isn't really part of the state plan, and do this instead because it reduces costs, improves quality, improves access, HHSC will allow them to do it. It's a means to do things like how do you address food insecurity among families who need additional assistance, housing, and other types of these non medical factors? They are very focused in this work group around food as medicine or other initiatives around

preventing hunger and giving the legislature a roadmap to do that. There is broad support for doing this. I know this coalition has been supportive in the past.
Certainly my organization, the Pediatric Society, many others, are working on efforts to reduce food insecurity, but they're trying to find a way to bridge it in a way that will appeal to legislators. Some of you may recall that last legislative session, Dr. Oliverson had a bill on this, and it's my understanding he's still planning to move forward with some aspects of that relating to food insecurity and is working with legacy community health plans, community health plans, community health centers in Houston on an initiative. There is legislative support, and I can send the report to you. It's rather lengthy, and the committee did recommend that the full report be posted because it has a lot of great data, evidence from other states about how to do this in a way that would be cost effective and beneficial to Medicaid enrollees.

They do have other suggestions, including addressing housing, for example, housing insecurity, but I encourage everybody to take a look at it. And once HHSC officially adopts it, it will be available for you to review. I can send you the draft. I don't think anything will change, but if you're interested in hearing the discussion about it, the last meeting is posted, and we'll make sure it gets circulated to everybody through Isabel, if you're interested in going back and watching that part of the hearing. And they do a good job of bookmarking where things are in those committee hearings. So that's all unless you have questions about it. I do think the Center for Healthcare Strategies helped the committee write it. And some really thoughtful health researchers, in addition to a number of physicians, hospitals, community representatives, myself, were on the work group who put the proposal together. But it has been adopted, and I expect HHSC to have it posted by the end of August.

III. Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program

[Link to Program:
https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/comprehensive-health-homes-integrated-care-chic-kids-pilot-program]

Allison McHorse: I just wanted to share a little bit about a new pilot program through Starkids at HHSC. It's the Comprehensive Health Homes for Integrated Care Kids Pilot program. This is part of Senate Bill 1648 from last session, and it directed HHSC to implement a pilot program that is to help create specifically designed health homes for children with medically complex conditions. So the pilot program has encouraged MCOs. They'll be working with providers to develop projects to support better care coordination, caregiver assistance, all sorts of things to enhance, like a medical home, and create a system that adequately meets the unique needs of families with kids with medically complex conditions. We'll likely have some alternative payment models and things like that. We're very excited about the opportunity to explore different models for these kids. And it will be Star Kids providers, so it will be serving the Medicaid community. But also, it's not required to all be Star Kids participants. They just closed applications, so I'm waiting on an update from the Star Kids team about how many people they were able to get involved in the pilot program, but the pilot will run from December of this year through

December of next year, and then HHSC is hoping to then take some of the programs that worked and expand them and build on them. So hopefully we'll have more opportunities to explore improving the quality of care for these families.

- **HKD:** Will the pilot be in a specific community or is it going to be all over the state based on who submitted proposals?
    - **AM:** It will be all over the state, so any MCO and provider who partner together and come up with a program, they can implement that in their own community. Unfortunately, there wasn't extra money included for this program, so it's just going to have to be up to the MCO and providers to come up with that plan.
        - **HKD:** Excellent. Once we get more information, it would be great to have you back to tell us more about who submitted proposals and where they are and what they suggested.

III. Updates on Timeliness, Staffing, Office Closures, and PHE

[See attached document]

Gina Carter: We have answers to all the questions that we received, and we'll give those in writing as well, but just wanted to kind of go through the questions on what we've been doing for the PHE and the continuous Medicaid. We haven't received the 60 day notice, so all those around from the National Association of Medicaid Directors to everybody, their opinion is that we'll have it extended to January, but we haven't received anything that says otherwise.

HKD: Could you briefly describe the PHE implications and why it matters when it ends before going into questions? Some people on the call are new.

Gina Carter: I'm the Senior Policy Advisor to the Deputy Executive Commissioner of Access and Eligibility Services. Hillary Davis is on as well, and she is the Deputy Associate Commissioner for Program Policy and does all of the policy pieces for all the programs: Medicaid, CHIP, TANF, SNAP, and some others.

What the ending of continuous coverage does is because states who took the option to extend coverage as of the March 18 date received an increased match from the government for keeping those people on Medicaid even though they're no longer eligible. And so since that March 2020 date, anybody who was eligible as of that date, changes do not impact their eligibility, so they have been continuously receiving Medicaid. And so once the PHE or continuous coverage ends, we will then go with the Centers for Medicare and Medicaid Services. The guidance has required that the states perform a renewal on all the population of those receiving Medicaid and CHIP. We need to initiate those within twelve months and complete them by 14 months. Some of them may, when we send renewal packets, may not be submitting those right now because they are continuously eligible. Some of them have been submitting those renewal packets especially if they're receiving SNAP benefits, then we do those renewals. So it is a big endeavor to do. When we started March of 2020, we were at about 3.8 million people on Medicaid. As of

May 2022, we're at about 5.4 million people on Medicaid. And so a renewal will need to be done on all of them to ensure that they continue to be eligible under some group, or we deny them if they are not or they do not submit the renewal packet or information.

- **Denise Gomez:** I was on a Young Invincibles call yesterday, and they also mentioned that the deadline for the PHE was on Sunday. So the next time that this could potentially happen would be in January. I think everyone has been working with the Ambassador toolkits that the state has provided and what CMS has provided nationally as communication toolkits. Is there like an ideal timeline of when we should start spreading the message for families to do that? Should we continue doing that now up until January?
    - **GC:** I think what would be best is that as much as we can communicate to all about ensuring that the information we have is correct as far as our addresses and things like that. Any changes that they're required to report and to remind them that if they get anything from the agency that they should respond to those so that we can ensure that we are looking at it and we can determine if they continue to be eligible or not. I am a big advocate of over communicating just to ensure that they know that things are coming. We're looking at submitting or sending the renewal packets and information in a colored envelope so that they know that it's different. So I'm sure we'll get more out when we are definitive on those. A lot of states have been having paper shortages. And that'll be one of the things we talk about with the questions that you all provided to us about things we're looking at and keeping track of, so that we ensure that we're on top of those things as we move on and as we get any indication that the PHE will end.

Questions:

- **Decrecia Limbrick:** Decrecia from the Houston Health Department. Earlier, Gina, you mentioned you got it down, I think from 91 to 78 days in terms of touching a case. Curious as to what your goal is and what you see as an acceptable time frame to return or reply to an applicant. And I do have a second question once you answer that one.
    - **GC:** Before PHE, my recollection was ten lead days. I will jot that one down and get with our eligibility folks on what that is. Because of our challenges with retaining staff and such, we always strive to get to them as soon as possible. Now, what's realistic with the people that we have working is something different. So I will get back to you on what our expectation is and what our goal is and where we are so that we're ready for when the PHE ends. What is that time frame and what do we want it to be so that we're ready for when the PHE ends and being successful with that. So we'll definitely take that one back.
        - **DL:** And I have another question, and it's probably because we have many multi service centers that individuals look at as resource centers, so we may not be getting the comments from the job that you do well, rather the ones that people have concerned about. So one of the things we get a lot of questions about is how far down the list am I? I'm curious to know if there's any way that you all can create some kind of visual on your website that says, we're working on May 15 applications so that individuals have an idea of where you are in terms of your workload.

    - **GC:** We are working on those things to get the data and so that it is much more of a visual on the public website. There is technology now where you can hover over it and it'll tell you. It's going to tell you where we are from a standpoint of timeliness in total picture, not individual picture, but we are also looking at (I'm sure there's probably a better technical term) but I'm calling it the Pizza tracker. So, you know, I always get excited when I order Domino's or on Amazon and I look at it on my app. I'm like, oh, they're over here. We're working at doing that as well, so people can track where their application renewal is right, in the grand scheme of all of the things that need to happen.
- **Stacey Pogue:** Do you guys know if you're asking for SNAP renewal extension for September because you're expecting timeliness to get better than or is that decision still being made?
    - **Hillary Davis:** We have drafted the request for September through November. It's going through leadership approval right now. So if it does get submitted to FNS, we will definitely let y'all know. But we can only do them for three months at a time. We are in the process of routing everything and seeing if that's going to be something our leadership wants to submit again. But as soon as we get it submitted and approved, FNS usually turns them around pretty quickly. We'll let y'all know.

HKD: Big thanks to both of you, Gina and Hillary, for being on the call and for all the work you put into answering the questions. And we appreciate your dedication to making lives better for so many Texans and trying to improve the process. We always enjoy working with you. So thank you and I know we'll see you again soon.

IV. CHCC Legislative Priorities Discussion and Healthcare Reform Selection Committee Updates

Allison McHorse: We sent out the comments that TPS and TMA and some others were submitting on new Medicaid draft policy on social determinants of health screening in Texas Health Steps. So this actually went through the topic nomination process instead of a legislative avenue that we pursued. We submitted that topic nomination request in 2020. Finally got the draft policy this summer. And so what the policy does is it is an optional policy for physicians or other clinicians to screen for social determinants of health, or as we're trying to use now, non medical drivers of health during visits. The policy, the way it's written, says one screening per Medicaid member per year. In our comments, we suggested that they switch that to at each Texas Health steps while the child visits, just to make things easier and provide more consistency. But we're really excited about the policy. It's only for the screening and it's optional. So we also are trying to encourage HHSC through our comments to recognize that once a patient screens positive, then there are additional resources and actions needed to make sure that the patient is then connected to resources that they need and that referral happens, and then that also takes resources to make that happen. So hopefully that's taken into consideration when the rate is set. Our other main recommendation was to align the language with non medical drivers of health and then provide some more examples on services. The policy is really broad in that it says that any evidence based screening tool can be used. It's not prescriptive to one screening tool, and it's not prescriptive just to housing or food. It can be housing, food, transportation, utilities, etc. So hopefully this is a step in the direction towards covering and integrating non

medical drivers of health through the Medicaid system, like Helen mentioned earlier. Hopefully we get some traction on integrating them through in lieu of services as well.

- **HKD:** Probably the only thing I'd add is at least for those who aren't in the practicing community, there's a lot of support for doing this. But it's also really difficult to do, at least in a community based private practice, just different levels of resources and being able to interact with the health plans, the community resources. So that's one of the things that we're really trying to help emphasize, is it's not just paying for the screening, but you have to have assistance with coordination of services. But the first step is getting screening. There's lots of doctors who are excited about doing it, so that's a start.
- *Questions:*
    - **AD**: The topic nomination process she mentioned, is that's an internal HHSC process that they do with providers?
        - **AM:** So anyone is able to. There's a topic nomination form that you fill out for Texas Medicaid. It's not just open to providers. I think anyone can fill it out, and you have to go through and explain the benefit and provide the evidence for why it should be included. And then you submit that they take their time evaluating it and decide whether to accept it.
            - **HKD:** And this is mostly in the clinical kind of it goes to the office of the medical director and his team and they look at it, but it is open to anyone who wants to suggest a benefit. And we have been successful on this one and some other ones with other services like Nephrology, but often there's just new benefits that get approved or new services that HHSC hasn't quite caught up adding.

HKD: Anne, why don't you kick us off with what happened at the Healthcare Reform Committee?

- **AD:** I was only there for a portion of it. As you know, it was a two day hearing and those of us who participate in Cover Texas Now had a discussion of different folks talking about the different pieces they participated in. The section that Stacey and I got to present on was related to ways Texas could reduce the number of the uninsured.
    - **HKD:** Does everybody on the committee know or here in the group know about the House Select Committee on Health System Reform? Just want to make sure they understand what we're talking about.
        - **AD:** You can go to the TLS website. You can look at who's on that committee and you can also see what their charges are. But you have to go to the official House of Representatives website, to find the charges.
- **AD:** So there were lots of charges for this committee and they were not all being covered in this hearing. And those of us who were invited to give testimony got a fair amount of guidance from the staff about what they wanted to talk about. They specifically asked us to wait until another upcoming hearing to talk about our outreach concerns. So several of us may have mentioned our outreach concerns when we testified, but we were not given that hearing as the place to vet those things. One of the biggest single steps Texas could take to reduce the number of our uninsured, starting with the lowest income, would be

our Medicaid expansion for adults. There was a ton of interest in how House Bill 133 was going to be implemented. We were in the thick of the misinformation that the media had picked up that mistakenly said that CMS had turned down Texas waiver request for House Bill 133 implementation. There was a lot of interest in the question of whether we had so many more people on the Medicaid roles that it was actually outweighing the benefit of having a massive 6.2 percentage points added to our FMAP going back to March of 2020. And there's sort of a confusing distinction between the so called tipping point that they use, which is the point where the enrollment has gotten so high that it actually is starting to outweigh all of the additional billions of dollars that Texas has gotten in match rates. There is a distinction between that and whether or not it is more fiscally sound for Texas to stay committed to the continuous eligibility, because losing those 6.2 percentage points would be such a huge fiscal hit for the state.

- It's good to be reminded that we do have not only sort of standard conservative pushback suggesting that having a low income is a character flaw, but also some very strong ideology that we'll always have to deal with. We have to remember to keep all the folks who are closer to the middle informed with better information.
- **Alec Mendoza:** Our brief on Medicaid enrollment and getting eligible kids enrolled into healthcare coverage was what talked a lot about that in the hearing. One of the big things that we focused on was some of these bureaucratic barriers that we have seen that have kind of been there that prohibit families from enrolling in coverage. So we talked about 211 and your Texas benefits, and members of the committee seemed very receptive to those things and kind of realizing that maybe this is a problem that should be fixed. And it was good that we brought a lot of that stuff up because HHSC testified before Stacey, Anne, and I, and they didn't really seem to talk about some of those bureaucratic barriers. So I'm glad we were able to put it on their radar. And like I said, they seemed very receptive to it. And then we also talked about some different policies that we think could maybe help get eligible kids enrolled. One of them that we talked about today with Adrienne and Karla was Medicaid reimbursement in schools. And we have been trying to do follow up with some of the committee members like Anne and I can only speak to our panel and what we said.
- **Stacey Pogue:** One piece I covered that Alec didn't was just to point out to the committee that another important part of covering the Uninsured in Texas is making sure we have a strong pathway to coverage at healthcare.gov that it's working really well, that there's subsidies that made it much more affordable and drove a huge increase in our enrollment in the last two open enrollment cycles. And those were just extended in the Inflation Reduction Act. So that'll mean we have a really good platform from which to keep our record breaking enrollment in healthcare.gov. It doesn't carry the same weight for kids. There's about 200,000+ kids that's up through age 17 in the Texas marketplace, and about 420,000 if you go all the way to age 26. So because of Medicaid and CHIP eligibility, marketplace doesn't serve the same role right for kids. But we do have a lot of kids in the marketplace whose families do rely on those subsidies and enhanced subsidies to get coverage.
- **HKD:** For those interested, it was a 2 day hearing and it covered a wide variety of topics on healthcare transparency, pricing, accountability, coverage, access, and PBM pricing. You can go back and listen to it. Day two was more focused on all of the issues that affect this group, though the whole thing is quite interesting, but if you don't have 18 hours to spare, then definitely go back and listen and you can fast

forward. . Anticipating that we will have another hearing for this group later this fall, probably mid to late September, is kind of what we're hearing. So there will be an opportunity for a more detailed dive on PHE and the state staff, if you're interested in listening again on day two. Stephanie Stevens is a Medicaid director and Trey Wood, who's the CFO, and Michelle Aleto, who's a Deputy Associate Commissioner, I think is her title. But they all talked about the PHE and the numbers, and you can listen to their testimony again on day two, which was August 5. Any questions for anybody about the hearing?

- **AD:** I just want to point out that we made sure that we coordinated and talked about our testimony and that's part of the reason you got a pretty robust report back from HHSC today because we've had a lot of discussion at this hearing about backlogs and timeliness issue. It is important for us to talk to each other before these hearings and think about what messages we want to get across and which ones maybe need to be at least subtly repeated.

HKD: We do start the legislative session in January. And typically the coalition does put together a legislative agenda that addresses a wide range of issues affecting children and families.

So for those of you who might not be familiar, the agencies have directed the Legislative Budget Board to put together their Legislative Appropriations Request, or LAR for short. HHSC had solicited feedback on theirs in late 2021, which a year ago, the Department of State Health Services did have a process in July. It was early August on theirs, and it wasn't to propose their exceptional items. These are the things that they think need to be funded. But to solicit feedback from stakeholders. LDB will hear from the agencies within the next couple of months about what they think they need in terms of so that's another area that this group typically keeps an eye on because Medicaid and CHIP are funded by the state. And if we need, for example, to amplify a request to fix something to do with 211 or any of the eligibility pieces, the budget piece will be really important. And groups including this one can testify at the LBB hearings. Usually it's just staff, but nevertheless, it's an opportunity to again keep amplifying these messages.

Typically our legislative agenda is broken down into issues regarding coverage, access, benefits, kind of these broad categories like preventive care. We might have this one relating to technology. But within those broad categories, there are recommendations. So it's meant to give legislators a broad view of all the ways in which they can support not only children's health, but the health of families. We know that healthy families promote healthier children. So within those topics, we've always advocated for increasing health care coverage among children, whatever that means, in a different legislative session. It's been different, but maybe, Anne, since you have the deepest bench.

AD: The buckets from last year are maybe not appropriate anymore, but we always want to talk about coverage. So, that might be the place where we acknowledge our problems with not having done Medicaid expansion. So there would be a bucket for anything around the extended maternal coverage and where we are in that process. We'll have to draft it in a way that is flexible to be updated as developments roll out with that as we approach the session. Coverage expansion for all of the parents of our kids on Medicaid, as well as all the adults without dependent children at home, aka Medicaid expansion under the ACA. Then we'll have to have some kind of

placeholder for the budget right now. We have addressed barriers to enrollment and renewal related to the issues around timeliness.

Between midterm elections and just the fact that all of this stuff is in flux, we will have to write these up in a way that allows us to provide a general understanding of what the issue is, but then allows for flexibility to update them as we approach the session. There's issues around outreach in the public schools that have come up forever. There is a major issue about the need to get the state involved in updating our outreach and our materials and our training for eligibility workers on eligibility for lawfully present non Citizens, as well as training about the eligibility issues for mixed immigration status families. So we lost about 240,000 kids from the Medicaid and CHIP rolls between December of 2017 and February of 2020. And our working theory of that is that most of that is around the chilling effect of families under the Trump administration being afraid that if they enroll their US. Citizen kids, let alone their green card holding kids, would affect a non citizen parent's ability to either get a green card or naturalize. And that's more than a quarter of the children in the state of Texas. And then the clinical innovations.

HKD: Access is one certainly I'd be remiss as working for the Medical association. Access is a real big concern in terms of what we're hearing. We always hear it, but it gets worse. It seems like every year in terms of people being able to find a physician. Practices are full and when there's so much demand and Medicaid pays so little comparatively to other payers. So there's just reasons why people throw up their hands and decide not to participate. But access is a big one that of course we will push on to make sure we have sufficient payments to recruit primary care and specialists. Because at least for the anecdotal information, it's indicative of some pretty big problems with people getting into care. So that's another bucket that we typically talk about. There may be some new ones. I know some of our physicians are talking about whether we have enough resources or the right benefits. We'll have more of course, presumably with the decisions around Roe and SB 8. More women delivering babies who may need special needs services. And the hospice benefit is not that easy to access according to the pediatricians.

Brittany McAllister: Unfortunately, we're not immune to the nursing challenges going on right now. And so we're going to be asking for cost of living adjustments to our state funded contracts, which have been more or less flat for the past 15 years. And so we're going to be asking for that adjustment as our primary advocacy ask this year. Beyond that, our national office, some of you may know, has introduced a new home visiting model that is separate from Nurse Family Partnership called Child First.

Child First is a mental health home visiting model that utilizes Master's level licensed professionals alongside a bachelor's level care coordinator to stabilize a family, connect them to resources, and provide child parent psychotherapy to address problem behaviors in the child to address trauma that the parent or the caregiver as well as the child have faced or are facing. So this program does not yet exist in Texas but it exists in about five states. So we've been exploring mechanisms for funding this program. We're finding an absence of publicly funded services for the 0-3 population. This program serves prenatals to five, no matter how many children a family has. We are possibly pursuing a budget rider. We're just sort of still in flux on that. So I'd ask for a nursing partnership. But also the mental health focus would be another area where we need to provide more services to children. We did testify

at the Select Committee on Youth Health and Safety back in May. They did a panel of mental health supports for children across the lifespan from infancy to adolescents. And our program was highlighted there and we're still seeking that participation. So we'd suggest that as another agenda item and note that these home visitors are connecting families to services where they're eligible, helping get them enrolled, and being an additional advocate for them is another tie to sort of the goals of this coalition.

Children's Health Coverage Coalition (CHCC) August 2022 Questions

1. **Timeliness:**

   a) **HHSC data below shows SNAP timeliness, especially for renewals, is well below federal standards, which calls for 95% of applications to be processed within 30 days, and a corrective action plan if Application Processing Time (APT) drops below 90%. Because Medicaid timeliness is also below federal standards for processing within 45 days, we are interested in tracking solutions for both programs.**

   HHSC is able to track progress and/or volume of work by program, due date and workload type through the Eligibility Workload Management System (EWMS). HHSC has also built specialized reporting to aid in tracking the life cycle of Medicaid cases that are impacted by the PHE unwind, track the progress of renewals by program, and monitor the outcome of case actions for quality. HHSC utilizes this reporting and EWMS to shift resources to programs based on volume or priority and allows for assessing the success of workload initiatives.

   b) **In your last report to CHCC you let us know that HHSC was initiating another round of 3-month postponement of SNAP renewals, as well as waiving interviews, in order to improve SNAP timeliness from its recent slump. Please update our group on how this is helping, and on any additional measures HHSC is taking to improve performance across SNAP, Medicaid or both?**

   HHSC expects to see improvements to timeliness and a decrease in the number of days to initiate applications by September 2022. As previously mentioned, HHSC has implemented several workload and workforce initiatives in an effort to increase capacity and achieve efficiencies. For example, the days to initiate a SNAP application (lead days) have reduced from over 90 days at the end of June 2022 to 58 days as of September 13, 2022.

Timeliness Applications				
Calendar Year	**SNAP**	**TW Medicaid**	**TANF**	**MEPD**
2019	94.0%	98.4%	96.0%	95.7%
2020	91.6%	98.4%	90.8%	93.4%
2021	78.8%	96.0%	90.5%	91.1%
2022 (June)	73.9%	64.7%	80.7%	63.1%
2022 (July)	71.45%	61.61%	81.20%	51.21%

2022 (August)	56.87%	50.04%	60.31%	54.09%

2. Staffing: Eligibility and 2-1-1

a) Can you provide an update that includes the number of open (unfilled) eligibility system positions, as well as the number posted for hiring? We want to cite the most recent official agency numbers.

Houston Chronicle reported in January that "The agency cut the equivalent of just over 700 eligibility jobs last fiscal year, much of it through a hiring freeze; as of the fall, it was down by what would amount to about a thousand positions from the end of 2019 — a 15-percent cut for an agency that had roughly 7,000 eligibility workers in 2019."

In February 2022, HHSC had 4,046 filled eligibility advisor positions with a vacancy rate of 20.43%. As of September 8, 2022, HHSC has 4,505 filled eligibility advisor positions which equates to a 11.13% vacancy rate. HHSC is committed to increasing capacity and retaining our eligibility staff so that we can process eligibility as quickly as possible.

Effective August 1, 2022, HHSC has increased base salaries for clerks, eligibility advisors and supervisors. Frontline eligibility advisor classifications received 25 percent salary increase. This increase is expected to improve retention among current staff and strengthen recruitment efforts to further boost eligibility operations capacity.

b) We continue to hear reports of very poor response times (e.g., measurable in hours, not minutes) from HHSC's contracted 2-1-1 staff. Has HHSC asked the vendor for improvement or staffing increases?

In March 2022, HHSC approved a wage increase for 2-1-1 staff. HHSC continues to work with the 2-1-1 contractor to ensure there is sufficient capacity to meet the needs of callers. The number of agents taking calls from March 2022 to July 2022 has increased by 59.64%, from 612 agents taking calls to 977. While the ESS contractor has increased the number of agents taking calls, call volume for the ESS Call Center has also increased.

Month	Agents Taking Calls	Actual Net Staff Gain or Loss from previous month
April 2022	664	52
May 2022	754	90
June 2022	846	92
July 2022	977	131
August 2022	1,060	82
***September**	1,191	131

***Data is from September 1-13, 2022.

In addition to the retention and recruitment initiatives, the following strategies have been implemented to manage call volume and increase the center's capacity to handle the

additional projected end of PHE call volume, while stabilizing the center's performance overall:

- In November 2021, HHSC implemented a Courtesy Call Back feature. This feature provides an option for individuals calling during high wait times to exercise the option to virtually hold their place in line and be called back by the system when it is their turn. This helps reduce the number of repeat callers.

- HHSC implemented a virtual lobby in April 2022 to offset Medicaid calls in preparation for the end of continuous Medicaid coverage. The virtual lobby uses trained clerical staff versed in providing benefit information to help individuals seeking assistance and who have access to the eligibility system. Staff may assist with:
  - Answering questions regarding Your Texas Benefits website and the Your Texas Benefits Mobile Application;
  - Printing and reprinting forms – notices or blank forms;
  - Providing office location information;
  - Making transfers to the Flexible Appointment Line for households needing an interview;
  - Providing general program information; and
  - Escalating applications or renewals when requested.

- In May 2022, HHSC implemented the ability to route end of PHE calls to a specialized call queue. Individuals calling with specific questions regarding the end of PHE will be routed to either the Virtual Lobby or to specially trained call center agents. This will direct this traffic away from the regular call population, allowing for consistent messaging and tracking.

- Maximus and HHSC have been working together to implement changes to scripting and call handling instructions to address calls more quickly, enabling existing staff levels to manage more calls. Initiatives to decrease average handle time are ongoing.

- Since September 2021, Maximus has diverted additional staff to taking calls. This initiative is ongoing and evaluated based on staffing and call volumes.

- Since March 2020, Maximus has been asking existing call center staff to work overtime to add call taking capacity until staffing levels stabilize. This initiative is ongoing and evaluated based on staffing and call volumes.

- In February 2022, Maximus added additional trainers to accommodate training classes to support additional new hires. This initiative is ongoing and evaluated based on staffing levels.

- Interactive Voice Response (IVR) Redesign project is scheduled to begin late September 2022. While this is a long-term project, HHSC is working to increase the amount and the

reliability of information callers can obtain by self-service while in the IVR, reducing the need to speak with an agent.

Time Period	Call Volume - Offered to CCRs	Calls Handled	Average Speed to Answer (secs)	ASA in mm:hh:ss	Abandonment Rate (%) - CCR Calls
January 2022	655,133	438,808	1,607	00:26:47	25.69%
February 2022	607,491	437,032	1,764	00:29:24	27.33%
March 2022	736,839	524,482	1,838	00:30:38	28.05%
April 2022	654,242	480,606	1,629	00:27:09	25.72%
May 2022	796,529	554,511	1,866	00:31:06	29.46%
June 2022	927,765	630,917	1,932	00:32:12	28.57%
July 2022	852,195	588,762	1,970	00:32:50	30.39%
August 2022	798,796	709,914	520	00:08:40	10.70%
***September 2022**	273,661	249,288	416	00:06:56	8.48%

* Data is from September 1 - 13, 2022.

3. Office Closures

a) Please provide an update on HHSC eligibility office closures. We have heard that the Odessa office will be closed, and the HHSC website recently indicated Midland was temporarily closed. We would like a list of offices closed in 2021 and 2022.

The Odessa office was permanently closed on June 28, 2022. The Midland office was closed briefly due to weather damage, but it is now open. Telephone RD in Houston will temporarily close on August 1, 2022, for building repairs. The attachment includes the list of offices closures from 2021-2022.

City	Address	Zip Code	Phone	County	Move/Close Date	Comments
Austin	1601 Rutherford Ln	78754		Travis	5/17/2021	Open but no longer public facing.
Brownfield	101 N Ave D	79316	806-637-8576	Terry	7/30/2021	
Post	S US Hwy 84	79356	806-495-2881	Garza	7/30/2021	
Port Lavaca	436 Hwy 35 Bypass	77979	361-552-9702	Calhoun	4/11/2022	
Fredericksburg	1906 N Llano Hwy	78624	830-997-7546	Gillespie	4/11/2022	
Kirbyville	314 N Herndon	75956	409-423-4612	Jasper	4/15/2022	
Ennis	2707 N Kaufman St	75119	972-875-6571	Ellis	5/31/2022	
Odessa	3016 Kermit Hwy	79764	432-333-5141	Ector	6/28/2022	

b) HHSC web link on office closures is designed to help locate an individual office but doesn't provide information in a way that details the scope and locations statewide of office closures (https://www.hhs.texas.gov/about/contact-us/office-closures.

This weblink provides the most up-to-date temporary closures. To find an office, individuals may visit www.yourtexasbenefits.com/Screener/FindanOffice

4. **PHE update – If possible, we would like to see your latest projections of # of renewals processed and # of renewals still needing to be processed.**

   As of April 2022, the total estimated population whose Medicaid was extended due to the continuous coverage requirement is 2.7 million individuals.

   States are required to initiate a renewal for all enrolled in Medicaid and CHIP as of the end of the month prior to their unwinding period within the 12-month PHE unwind period, even for those who were renewed prior to the end of the PHE.