Texas CHIP Coalition
Meeting Minutes

June 20, 2014

Present:	Lauren Dimitry, TCFC Clayton Travis, TCFC Kathy Eckstein, CHAT Jessica Boston, Office of Rep. Naishtat Stacey Pogue, CPPP Sister JT Dwyer, Seton Reema Aleem, CDF Laura Guerra-Cardus, CDF Kathryn Hendrix, HHSC Valerie Eubert, HHSC Dorothy Mandell, DSHS Rick Allgeyer, HHSC Kathleen Davis, IAF Texas Stacy Warren, TMA
Conference Line:	Shannon Lucas, March of Dimes Bob Reid, Parkland Beth Keating, Parkland Gracie Escobar, Parkland Rose Marie Linan, HHSC Betsy Coats, Maximus Miryam Bujanda, MHM Kit Abney Spelce, Seton
Chair:	Anne Dunkelberg, Associate Director, Center for Public Policy Priorities
Minutes Scribe:	Megan Randall, Center for Public Policy Priorities
Next meeting:	July 18, 2014

I. ACA Implementation Update: Valerie Eubert, Manager, Policy Strategy, Analysis, and Development, Office of Social Services, HHSC

See the attached presentation slides for more information.

VEubert

- Account transfers: 215,000 unduplicated transfers from the Marketplace. From HHSC to the Marketplace (those ineligible for Medicaid or CHIP), we sent 452,000 cases. We are sending transfers on a daily basis.
- Of account transfers received, 66% are MAGI referrals which the Marketplace assessed as potentially eligible. 8% are those individuals who requested a full determination. 26% are non-MAGI referrals who may qualify based on age, blind, or disabled status.
- Only 18% of transfers received are being approved. Last month, it was 17%. It has gone up ever so slightly. 4% have withdrawn applications. This is consistent since we started to receive referrals. Anyone can contact HHSC to withdraw an application at any time.
- Of the approved applications, 90% are for children's programs.

ADunkelberg

- The main thing we are curious about is, within the MAGI referral population, how many applicants, denials, and approvals are adults, specifically.
- What we really want to know is why they are sending you so many ineligible people, and what type of cases are they?

VEubert

- We have a meeting with staff-level folks at CMS monthly. We have conversations, and they note that they are doing their best to follow what is in the state eligibility tool.
- One of the challenges we are facing internally is that we are getting a lot of different requests for data and we want to ensure we have accurate counts.

LGuerra-Cardus

- In addition to a breakdown of adults and kids, are most of the denials on the upper edge of the income eligibility spectrum? Or were they more low-income people that are being denied because of the Coverage Gap?

RAllgeyer

- We are having issues with the denial code information. We get lots of requests for info about why people are being denied. As we are digging into the data, we are finding tons of issues with it. There are almost 700 different denial codes that workers can use. There is a cluster of codes that workers use a lot, but unfortunately the ones they use don't mean anything. For example, there is an eligibility code saying "eligibility denied." That is the most used code we have. Almost every case gets this denial code. It provides a quick way of counting.
- One issue is whether workers are using the codes correctly, and we don't know.
- A second issue is, when decisions are made about which codes to add, where are those decisions being made? It is unclear to us how those codes are being populated.
- We have been trying to work on one project dealing with enterprise-wide policies and procedures for data management. These issues are going to be a top priority because this data is messy and, when we try to look at it, it doesn't make sense. We can't see just a simple trend line. When we moved cases into TIERS, things changed, and we don't understand why.
- When we look at things like income, we are struggling to make sure we understand what is going on. We are lacking data right now, but we are aware of it and are working on it.

ADunkelberg

- The split among denied MAGI cases between adults and kids is important because that would give a heads up as to why there are so many denied cases. We understand that the data challenge is more complicated because of coding issues, but figuring out how old people are would be a start.

RAlgeyer

- In our data, we don't know who was a Marketplace referral. We are going to have to take some interim steps to figure that out.

CTravis

- I didn't realize this data problem was so extensive. I would love to get updates on the denial code issues and why kids are getting dis-enrolled suddenly.

VEubert

- Applications: We submitted an appeal in March. For the single streamlined app, HHSC will be removing all of the asset questions from the application, removing the detailed absent parent questions from the 1205, continuing to ask whether an absent parent exists for individuals applying, and requiring parent caretaker groups to provide absent parent information prior to eligibility determination (through the interview process).

- Based on our conversation with CMS, these changes will make the applications approvable. We are still working out the timeline. For the integrated application, we are working through the same process for how we can make the changes there.

SisterJTDwyer

- What is the timeline?

VEubert

- Phased approach. It is likely that the paper applications may be as early as this summer and the online apps through YTB and associated platforms before the end of the calendar year.

SisterJTDwyer

- Is HHSC still receiving a significant percentage of the older version of 1010s or 1014s?

VEuebert

- We are receiving some. We don't know what the percentage is. I can see if I can find out.

SisterJTDwyer

- I have been in contact with a number of small groups who do applications assistance who are not present here and were shocked when told that the 1014 had gone away. They use paper apps. What I am getting at is whether there is a need to improve communication when you can get the 1205 and integrated app out again. If it isn't a large percentage, it might not be important (there is no way in a state as large as Texas you can get it perfect), but if it is a significant percentage then it may need to be looked at.

VEuebert

- We have an approved MAGI conversion plan. There are some outstanding questions on the non-MAGI conversion plan, and there is also requested analysis on some information that is still pending from HHSC.
- Administrative Renewals: Changes for the renewal process. We will provide clients with a pre-populated renewal form, and if clients are determined eligible, we let them know administratively vs requiring them to take action. The groups on the slide are those subject to administrative renewal. Includes Medicaid programs for elderly and those with disabilities. These are the groups that will be moving forward.
- All clients will receive a renewal cover letter letting them know the outcome of their eligibility determination. We will ask them to look over the form for accuracy. Action is only required if something on the form is incorrect.
- For a scenario in which additional information must be provided, they will receive a cover letter outlining that info that we need from them.
- The form will be a prepopulated form in YTB. It can be printed, etc. People can also call 2-1-1 if they would like a copy of pre-populated form or they can come into their local office. Staff will be trained to help renew through the lobby computer.

SisterJTDwyer

- How will they know the form is accurate if they are not receiving a copy? Why aren't you mailing it? This is very inconvenient.

VEubert

- 1) There is an initiative currently underway to reach out to the elderly and disabled to ensure that they understand the process and how to access their form, and 2) about 65% of actions today are occurring through YTB.com. The vision is to leverage the functionality of YTB.com.

SisterJTDwyer

- Accessing online might not be realistic for a large population affected by Medicaid.

CoalitionMember:

- Not providing the form in the mailing encourages the applicant not to check it.

ADunkelberg

- I would hypothesize that excluding the form in the mailing doesn't support program integrity. We may be able to advocate to ask to have it mailed to applicants.
- You might give some thought to giving this coalition a 72 hour opportunity to comment on the draft of the letter. Just to see if we can offer you any friendly suggestions. We would love to have that opportunity.

LGuerra-Cardus

- My gut feeling is that most families, even if receiving a cover letter, won't follow up to check. Having a copy of the form included with the letter may be more of an interest to the agency to make sure it is making the right eligibility determination. Are there repercussions to the family for not having caught a mistake?

VEubert

- Families are required to ensure that the information is accurate at redetermination.

LGuerra-Cardus

- Is there a penalty?

VEubert

- If the information is inaccurate when eligibility was re-determined it may or may not be able to be pursued through program integrity. It is only considered something that could be pursued if the intent was to defraud the state of Texas. If something has just changed in 2 -3 months and it was unintentionally left off, that is not considered by the inspector general as intent to defraud.
- The correspondence we provide always says that folks have 10 days to respond. Federally, people always have 30 days. However, if someone is going to call, we have found that when you give folks a shorter deadline you get action more quickly. We don't want to run into a place where we have issues with gaps of coverage.

KAbneySpelce

- What happens during the month-to-month review following the 6 month period of continuous eligibility?

VEubert

- This process here is only for folks coming up for renewal. Once you get to the ninth month in coverage, that is when those background periodic income checks will stop.

KAbneySpelce

- If they verify current eligibility during the month-to-month periodic checks, does that give them another 12 months or keep them in the current eligibility period?

VEubert

- They remain in the current eligibility period. This administrative renewal process will be kicked off at the ninth month for everyone.

SisterJTDwyer

- What kind of allowance is the state making for seasonally fluctuating incomes?

VEubert

- We don't have access to self-employment income electronically, so we won't check that electronically. No available information means you pass the process for the periodic checks. So, in October also as part of this release that goes live, we'll begin triggering that process in the background.
- Only if the electronic income data puts them over the limit will we be reaching out. They do have to respond to that request in order to maintain eligibility. We will let them know that we have information that might put them over and request verification from them.
- I can confirm whether we provide specific information to the client about which information puts them over.

- We use quarterly wage data and it is possible that in last quarter something has changed and we would want to know. TALX data is real-time as of when the request is called in, but employers report at different frequencies.

ADunkelberg

- How to resolve past additional sources of income that are not current is a challenge. There is tension between confusing people and providing enough information.

VEubert

- We will be monitoring this process to see how many folks are being kicked out for verification of income and what types of programs/populations, etc.
- The last periodic income check occurs in the eighth month. For the adult population, period income checks occur during months 3 – 8, for children's Medicaid months 6 – 8, and for CHIP children at 185 just at the 6-month mark.

II. Performance Indicators and Marketplace Impact: Rick Allgeyer, HHSC

See the attached handouts for more information.

RAllgeyer

- The feds have been trying to collect real-time Medicaid enrollment for states since the Marketplace opened. We are going from being three years behind to trying to have it in real time.
- There are lots of seasonality issues. When you look at the data, you will see some jumps that happen at key dates. The call center volume goes up high in October and January.
- None of our systems in our shop include any of these items, so we had to rely almost entirely on ad-hoc reports from our shop to get this data for us.
- For the Marketplace to bring in 40,000 per month is such a small amount that we typically wouldn't notice it. The number of people we approve through the Marketplace is small, from a statistical perspective.
- We have seen some constant growth in non-MAGI eligibility groups (e.g. SSI). Also seeing it take off in other populations, like pregnant women. But it has nothing to do with the ACA. It is related to other things that happened a while back from other programs, namely women's health cuts we assume are showing up in pregnant women umbers.

CTravis:

- Because Texas has such a high number of eligible unenrolled children, I was hoping we would see more of a spike.

RAllgeyer

- We are not seeing this. We are seeing an impact of CHIP moving over to TIERS.
- When we were working on LAR and our estimates, we did assume we would see a couple hundred thousand kids that we didn't see. When we modeled, we didn't know how the process would work. The big influx into the program was postponed until March. When we are doing these models, there is a big time lag between when we do stuff and how stuff actually gets implemented. Part of what is going on here.
- Bottom line from this report is that we don't see anything jumping out at us, and we haven't seen a huge influx in workload, caseload, etc.

ADunkelberg

- One of the things missing in terms of data, in the format we used to get, is the breakout of kids with disabilities. It would be really great to start posting that.

RAllgeyer

- This data does not include kids with disabilities. We will pass that request along.

III. Maternal and Child Health Trends in Texas: Dr. Dorothy Mandell, Medical Research Specialist, Office of Program Decision Support, Family and Community Health Services, DSHS

See the attached presentation slides for more information.

DMandell

- One of the first things that I present on is infant mortality rates for the US and Texas. Our infant mortality rate really shows how healthy our community is. It is the tip of the iceberg of overall health and wellbeing. In Texas, we are actually doing quite well. We have one of the lower infant mortality rates in the nation. We are meeting the Healthy People 2020 goal and have been since 2011.
- One of the big problems is disparities by race/ethnicity and region. The biggest racial disparity is within black and African American communities.
- When we look at our big communities, MSAs, what we also see is some pretty stark regional differences. The Panhandle and Longview have the two highest infant mortality rates in the state. Above 9.1.
- Also take note of Laredo and the Valley, and communities dominated by Hispanic population. 90% of babies born in Texas are born to Hispanic women. The infant mortality rate is creeping up in these regions for a population that currently has low infant mortality rates.
- San Antonio, for example. The infant mortality rate for Hispanics here is larger than it is for African Americans in the San Antonio region.
- It is very concerning for populations that typically have such good birth outcomes to have their rate creeping up.
- The Panhandle and Longview region has the highest maternal smoking rate in the state. Amarillo infant mortality is concentrated in the older age range. If we could affect the smoking rate in the Panhandle that area would be much better.

SisterJTDwyer

- What's going on in Midland and Odessa?

DMandell

- Their rate crept up this year as well. My office is in charge of doing statewide needs assessment and we are starting up the focus and listening groups to get a better sense of what is happening.

RAllgeyer

- We looked at employment data in the mining extraction industry and we saw two parts of the state that took off, and that is the Odessa Midland area.

DMandell

- From a maternal and child health perspective, it is important to note when there is the presence of migration or where there tend to be unstable families – whether the family stays somewhere else, or whether it is an entire family migrating.
- Killeen and Temple. We have also decided to start pulling specific statistics about Killeen. Looking in particular for issues related to stress and other aspects. Also some issues with the military hospital and what may be going on in the military hospital.
- Pre-term births. Prematurity is the leading cause of infant death. Affecting pre-term birth and low birth rate is important. Our preterm birthrate is not great. It is higher than the national average. While we have seen decreases, we are nowhere near meeting the Healthy People 2020 goal.

- There are major racial and ethnic differences in preterm births, as well as geographic disparities. East Texas and South Texas experience problems with preterm births. The Hispanic community is the only racial/ethnic group that has not seen a reduction since 2009. Our black communities have seen a reduction, as have white.
- When you look at El Paso and big players where the Hispanic population lives, El Paso, Laredo, Brownsville, you see a very high rate of preterm birth. Also going up through Houston and East Texas.
- 75% of all metro-dwelling African Americans live in DFW or Houston. But DFW is not seeing the preterm birth problem that Houston is.
- What causes preterm birth? Evidence shows that women with poor oral health during pregnancy are more likely to have a preterm birth. Bacterial infection from periodontal disease will actually cross the placenta. Trying to provide oral health services to women. Also, behavioral health – birth spacing and inter-pregnancy intervals. Substance abuse and smoking during pregnancy as well. Substance use will also be a big issue for us as an agency going forward because of increased opiate use. Neonatal abstinence syndrome. Also, pre-pregnancy weight: obesity is the indicator. Wrapped up in diabetes and hypertension, but also an independent contribution.
- Fetal deaths: Defined by risk that led to death.
- Maternal health period of risk. Percent of mothers with late prenatal care is one of the worst indicators for the Healthy People 2020 goal.
- What predicts whether a woman received care on time is whether she was on Medicaid and whether she had an unintended pregnancy.
- Preconception and inter-conception health are important.
- Diabetes is concentrated in the Hispanic population, hypertension in the African American population.
- We are setting up a lot of surveillance to review maternal deaths. Maternal death among the African American community is extremely high. The worst part about it is that it isn't going down, it is going up. It is an imperative within the task force to focus on this. Something may be happening at the delivery point.
- What are the community-based relationships and risk-clustering we are seeing? One of the things is that, within communities, we see significant clustering of women not receiving prenatal care, with high rates of severe morbidity and obesity.
- Pre-pregnancy health. Someday Starts Now focuses on pre-pregnancy health. Geared toward the African American community. There is a website that has a lot of toolkits that providers can use to help women with their pre-pregnancy health. www.somedaystartsnow.org.
- Access to dental care – Title V and safety net programs have started to provide dental care to pregnant women.

ADunkelberg

- What do you mean by "safety net"?

DMandell

- DSHS Expanded Primary Health Care Program provides dental to pregnant women. Pregnancies that are planned are healthy pregnancies. Access to family planning, choices etc. planning pregnancies will result in women seeking out prenatal care on time.
- Timely prenatal care. Under presumptive eligibility. Pilot work in Houston on prenatal care eligibility, as well.
- DSHS doing abstinence from substance use. Smoking cessation benefits are part of Medicaid benefits.

- When it comes to smoking, it is primarily a white woman's problem. Less than 2% of Hispanic women in this state have any smoking at all, and almost none are third trimester. Even African American women have low smoking rate in third trimester.
- Pregnant women are most susceptible to change. Pregnancy is a good time to pursue smoking cessation because they're ready to change.
- Family support during pregnancy. Family community health services are building more fatherhood-related programs, and focusing on the health of father with regard to chronic disease issues is important. All of our data is about mom, but dad's health is important as well.
- Chronic disease management. Healthy weight during pregnancy.

SisterJTDwyer

- How big a factor is oral health?

DMandell:

- Women who did not receive a check-up during pregnancy are more likely to have a low birthrate, even controlling for many other factors.

CoalitionMember:

- A lot of managed care organizations offer dental as part of Medicaid. From a cost-perspective, it is important to give that dental care to keep the baby from the NICU.

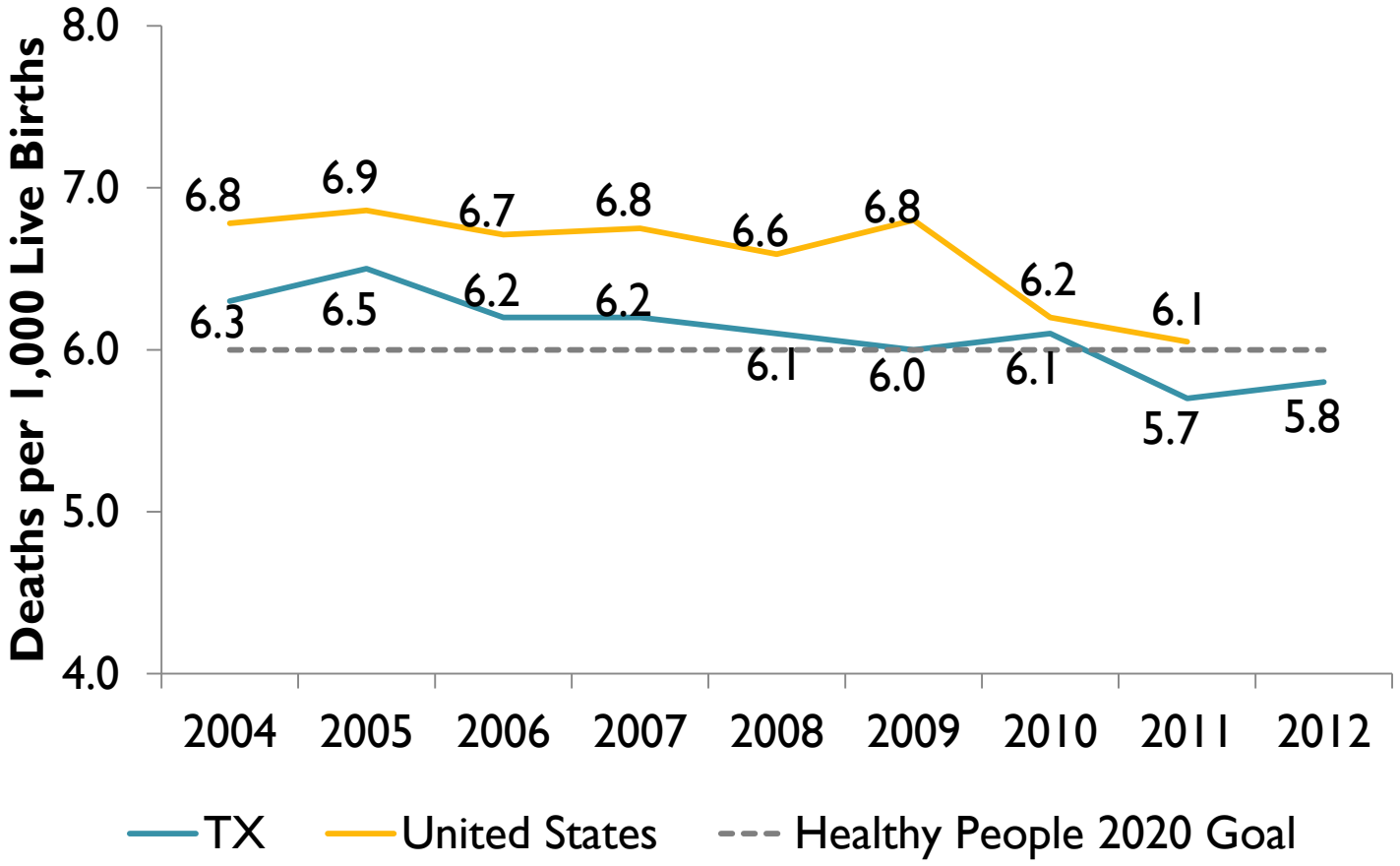
DMandell

- We are starting some specific surveillance looking at birth outcomes and the relationship to oral health. A lot of dentists are uncomfortable treating pregnant women because they don't know what they should/shouldn't do. Dental community has some issues with this. Systems issues and access issues.
- Peer educator training. Training people in colleges to train peers on good pre-pregnancy health and this is part of the Healthy Texas Babies initiative.
- Want to break up obesity issue and chronic disease issues: magnified with women who are older. Chronic disease issues may or may not be issues for the younger population. Right now, we are trying to understand whether chronic disease is an issue for younger populations because one issue with teen pregnancy is actually being underweight.

Maternal and Child Health Trends in Texas

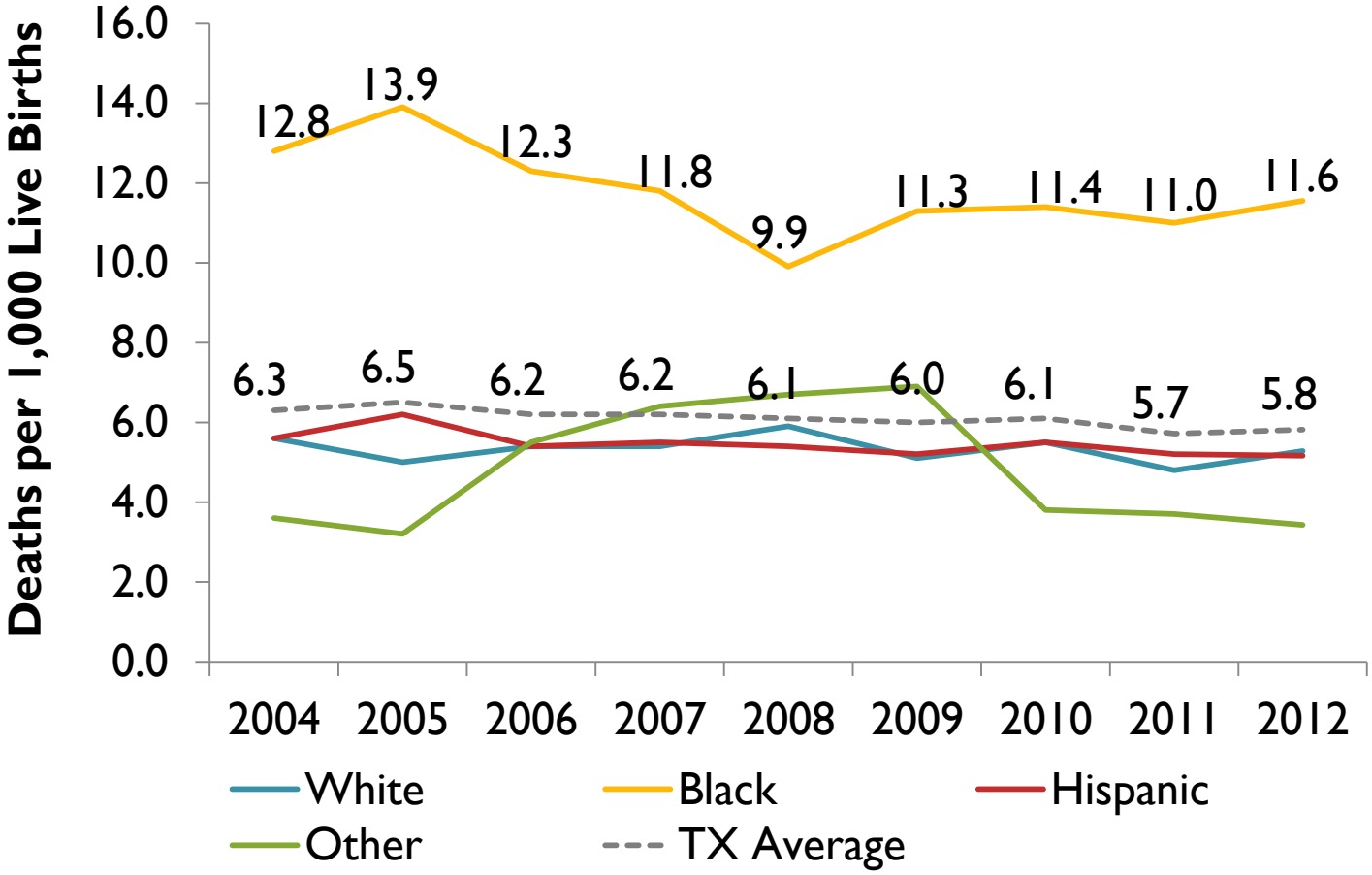
Dorothy J. Mandell, Phd
Office of Program Decision Support
Family and Community Health Services

Infant Mortality Rates for the United States & Texas



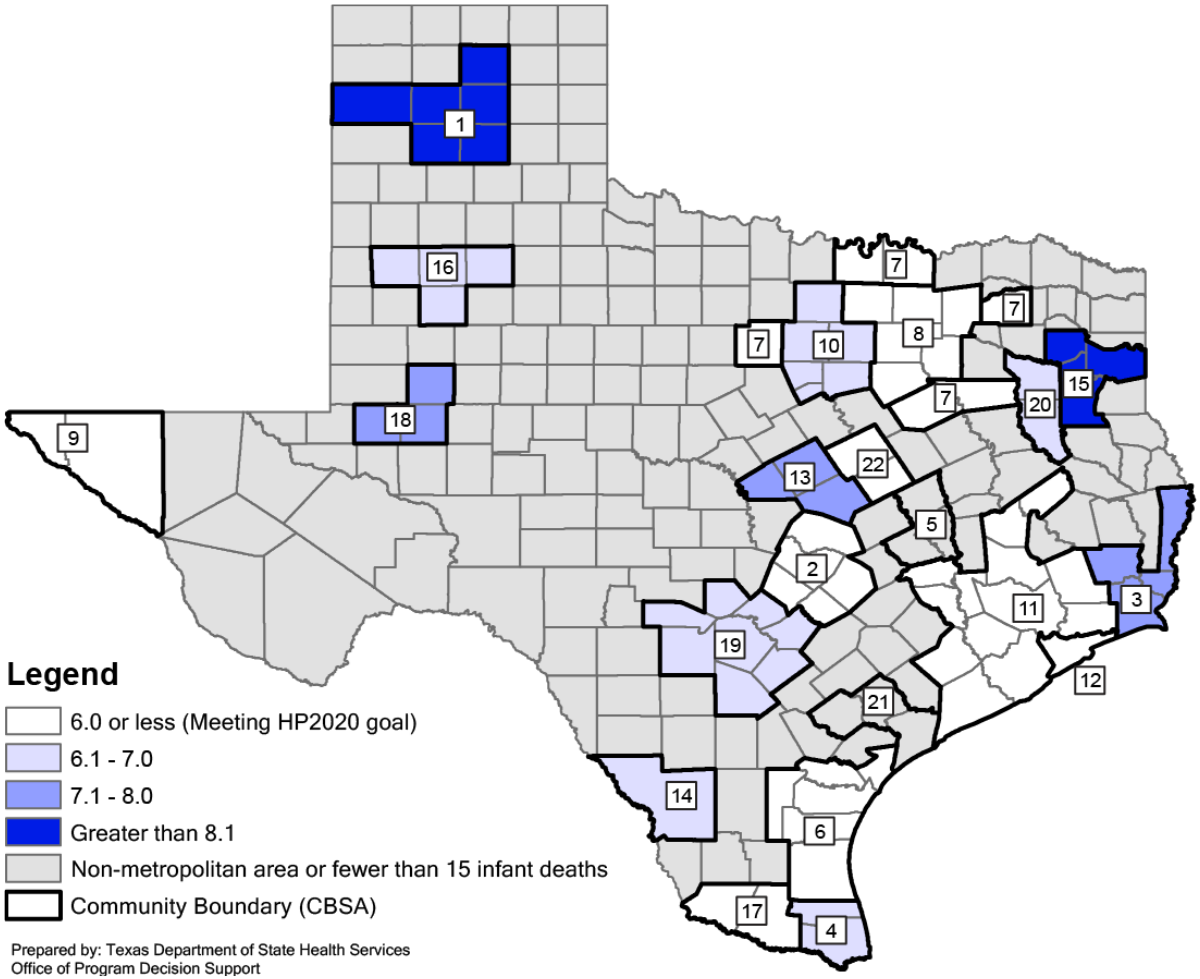
Texas data from Death Vital Records, DSHS, Center for Health Statistics
U.S. data from National Center for Health Statistics Vital Records Report, Deaths
Prepared by FCHS, Office of Program Decision Support

Infant Mortality Rate by Race / Ethnicity (2004 – 2012)



Texas data from Death Vital Records, DSHS, Center for Health Statistics
Prepared by FCHS, Office of Program Decision Support

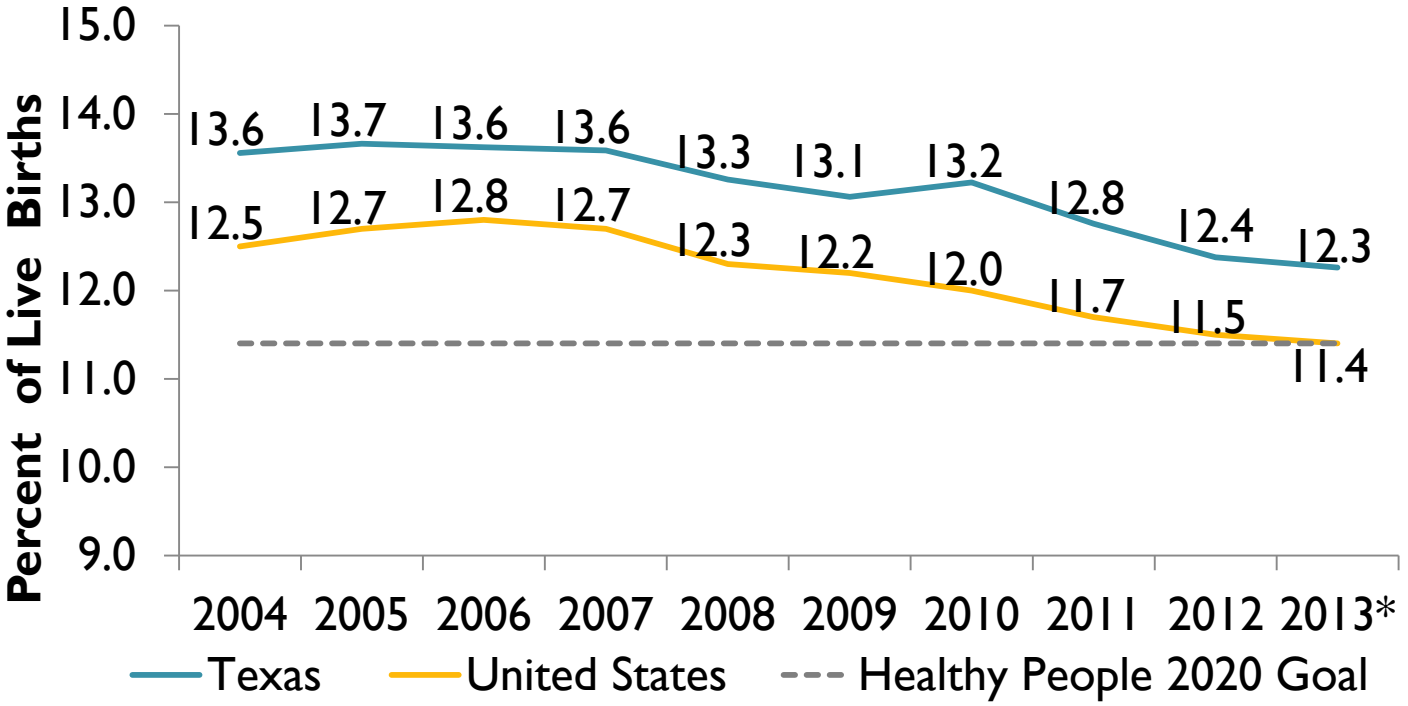
Infant Mortality Rate by Community, 2012



1 = Amarillo-Borger
2 = Austin-Round Rock
3 = Beaumont-Port Arthur
4 = Brownsvile-Harlingen-Raymondville
5 = College Station-Bryan
6 = Corpus Christi-Kingsville-Alice
7 = Dallas-Fort Worth outlying
8 = Dallas-Plano
9 = El Paso
10 = Fort Worth-Arlington
11 = Houston-The Woodlands
12 = Galveston
13 = Killeen-Temple
14 = Laredo
15 = Longview-Marshall
16 = Lubbock-Levelland
17 = McAllen-Edinburg
18 = Midland-Odessa
19 = San Antonio-New Braunfels
20 = Tyler-Jacksonville
21 = Victoria-Port Lavaca
22 = Waco

Percent of Infants Born Preterm

(United States and Texas 2004 – 2013)



The rate of preterm births has declined about 6% since 2009

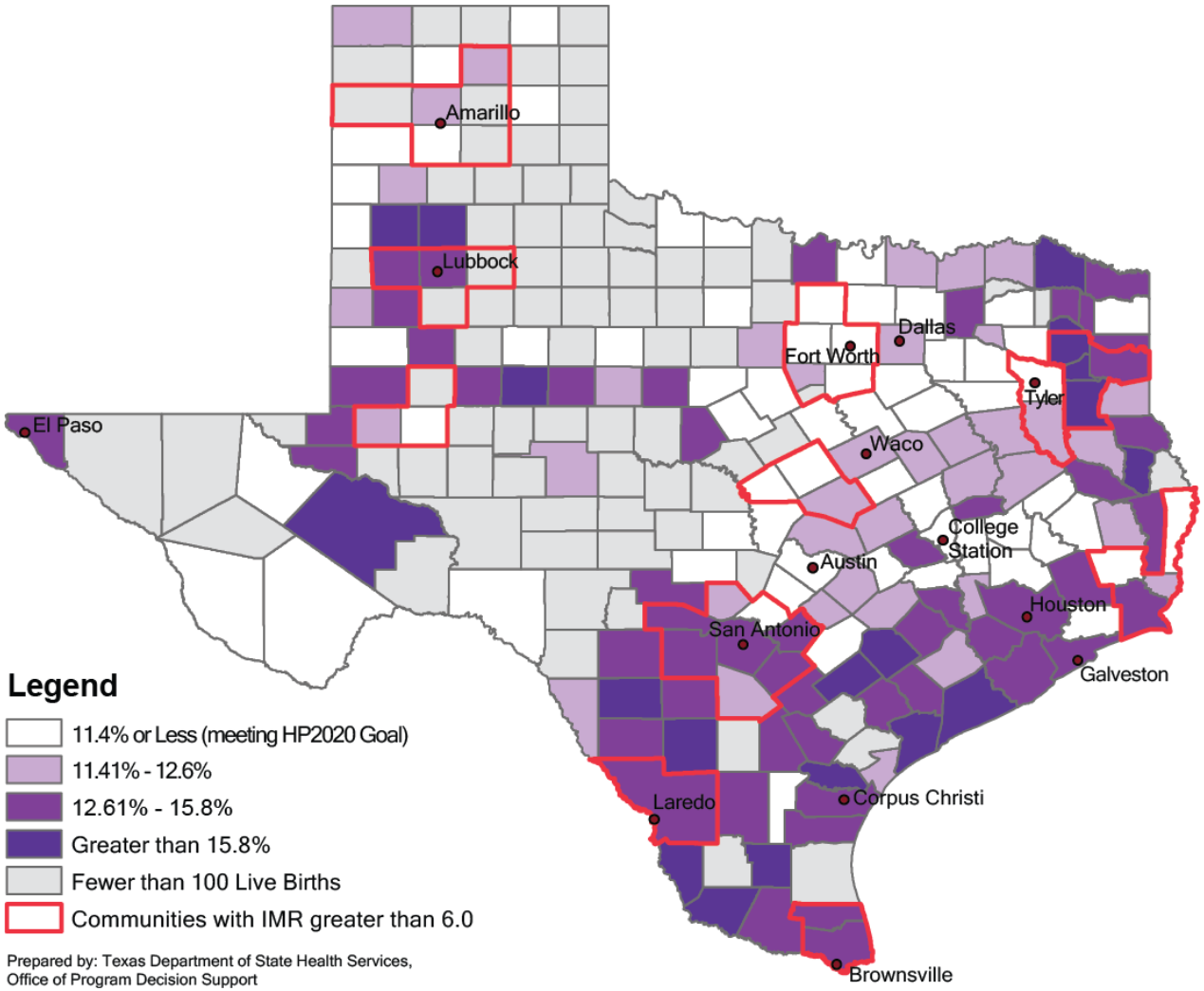
The decline is mainly among infants born between 34 and 36 weeks gestation

*2013 data are provisional and subject to change.

Texas data from Birth Vital Records, U.S. data from National Center for Health Statistics Vital Records Report

Prepared by FCHS, Office of Program Decision Support

Percent Preterm Birth by County, 2012



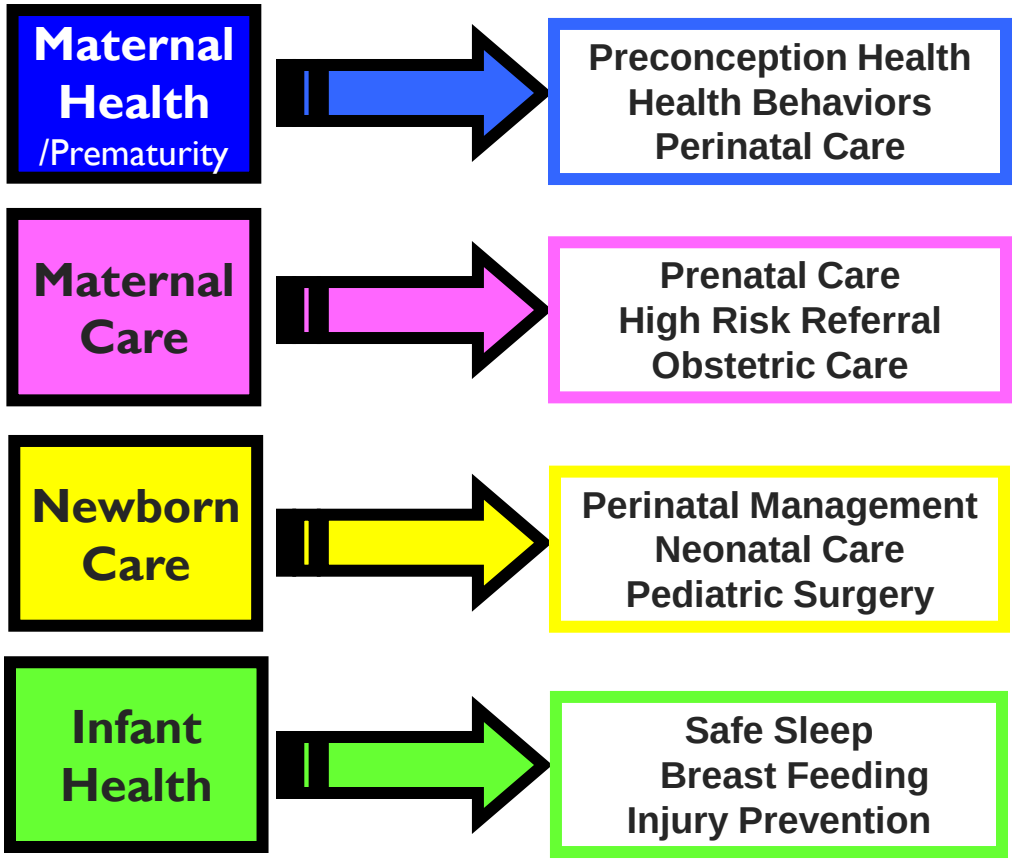
(non-exhaustive) Causes of Preterm Birth

- Genetic
  - Previous preterm birth
- Environmental
  - Viral and bacterial infections
  - Poor oral health
- Behavioral factors
  - Birth spacing
  - Substance Use/Smoking
  - Pre-pregnancy weight
  - Chronic disease management
- Social
  - Stress
  - Late prenatal care

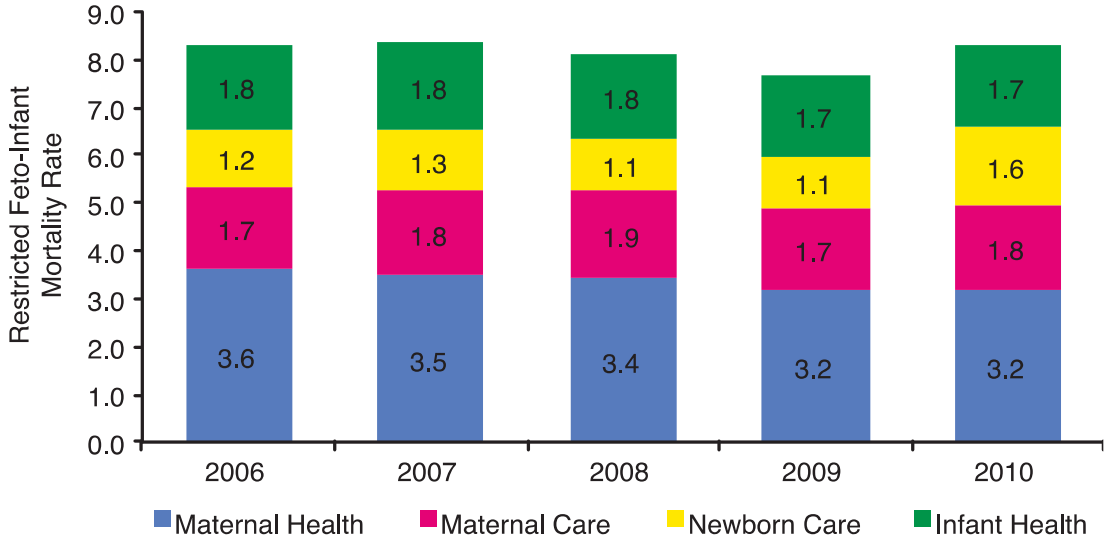
Understanding Infant Mortality: Periods of Risk

Definitions of the Four Perinatal Periods of Risk from the Restricted Feto-Infant Mortality Rate

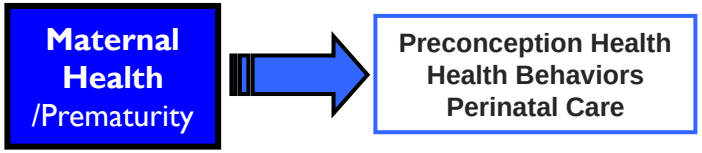
Maternal Health	Delivery weight less than 1500 grams
Maternal Care	Delivery weight greater than 1500 grams Fetal Deaths
Newborn Care	Delivery weight greater than 1500 grams Death within 28 days of birth
Infant Health	Delivery weight greater than 1500 grams Death after 28 days of birth



Texas, Feto-Infant Mortality Rate 2006-2010

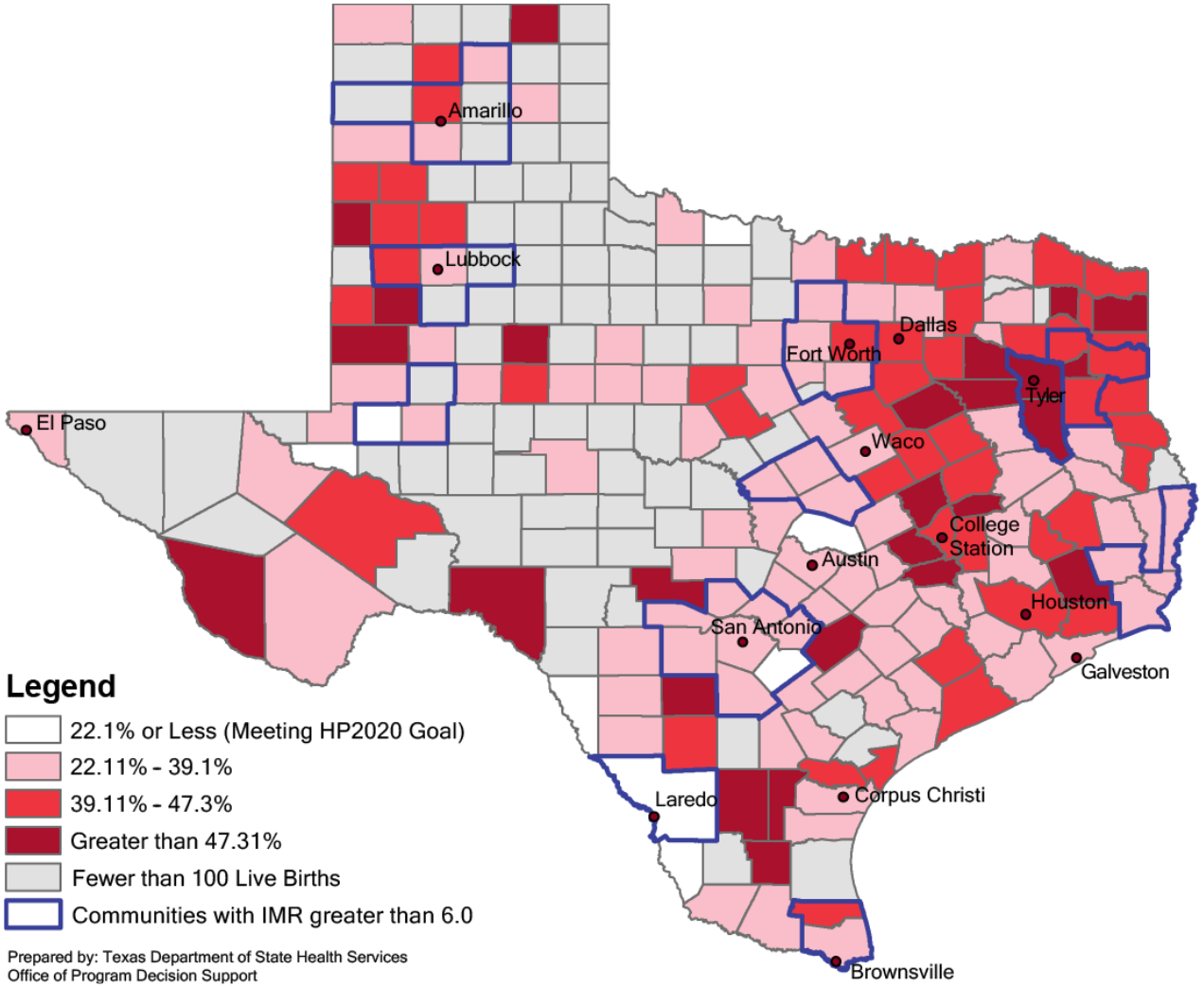


Texas data from Birth, Death, and Fetal Death Vital Records, DSHS, Center for Health Statistics
Prepared by: Texas Department of State Health Services, FCHS/OPDS, October 2013



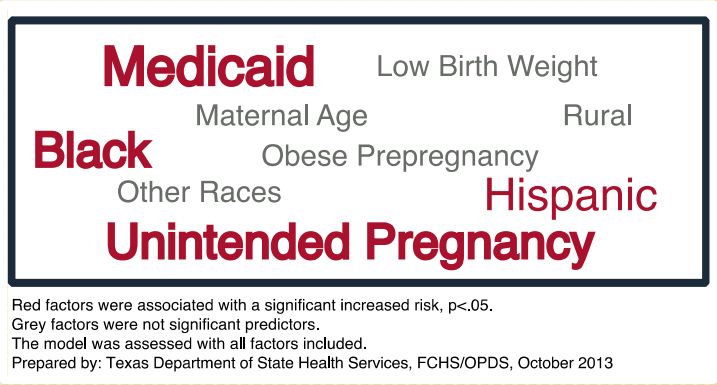
Percent of Mothers with Late or No Entry into Prenatal Care, 2012

Maternal Health /Prematurity → Preconception Health, Health Behaviors, Perinatal Care



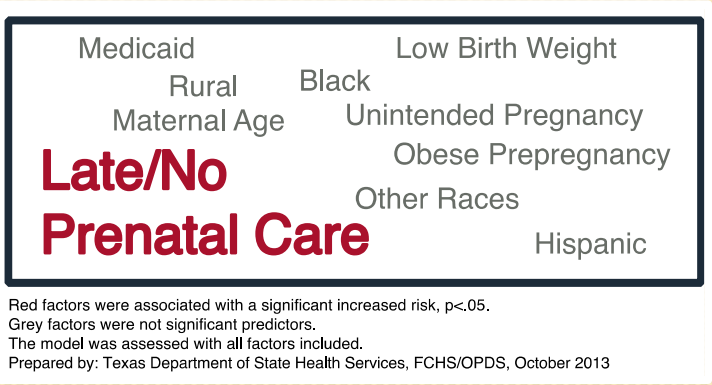
Factors Predicting Prenatal & Postpartum Care, PRAMS 2011

Prenatal Care



Red factors were associated with a significant increased risk, p<.05.
Grey factors were not significant predictors.
The model was assessed with all factors included.
Prepared by: Texas Department of State Health Services, FCHS/OPDS, October 2013

Postpartum Care



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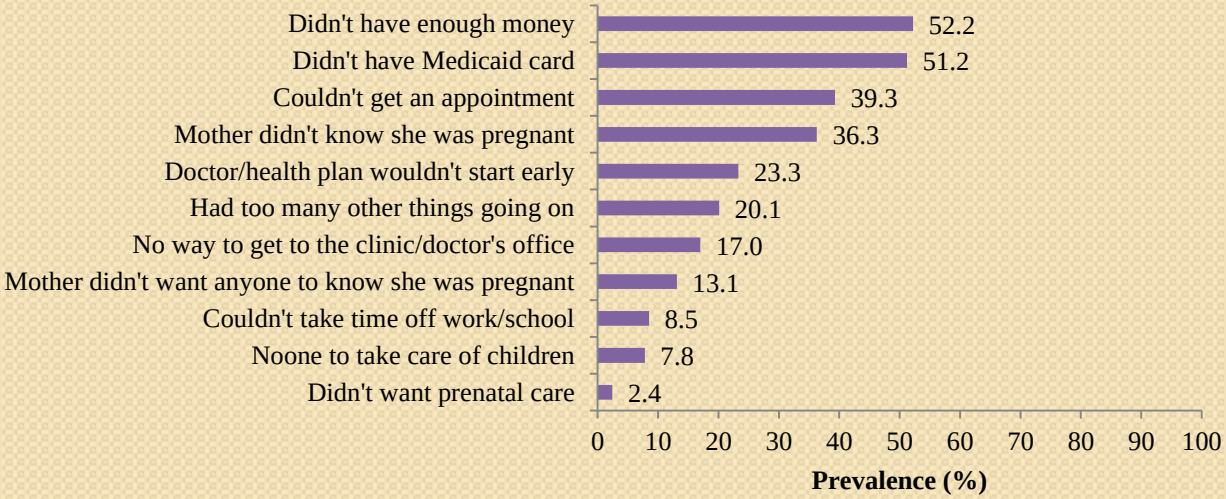
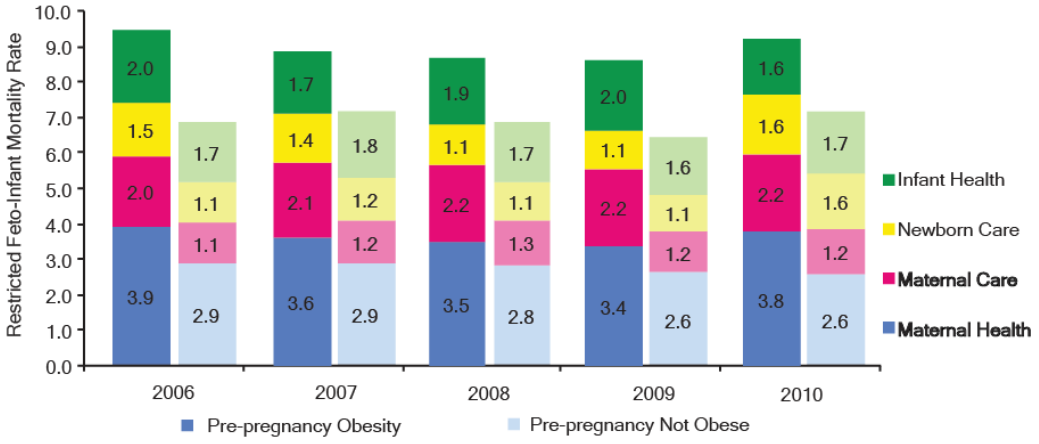


Chronic Disease: Obesity

Maternal Health /Prematurity → **Preconception Health, Health Behaviors, Perinatal Care**

Restricted Feto-Infant Mortality Rate for Women with Pre-pregnancy Obesity and Those Without, 2006-2010 Deliveries



Texas data from Birth, Death, and Fetal Death Vital Records, DSHS, Center for Health Statistics
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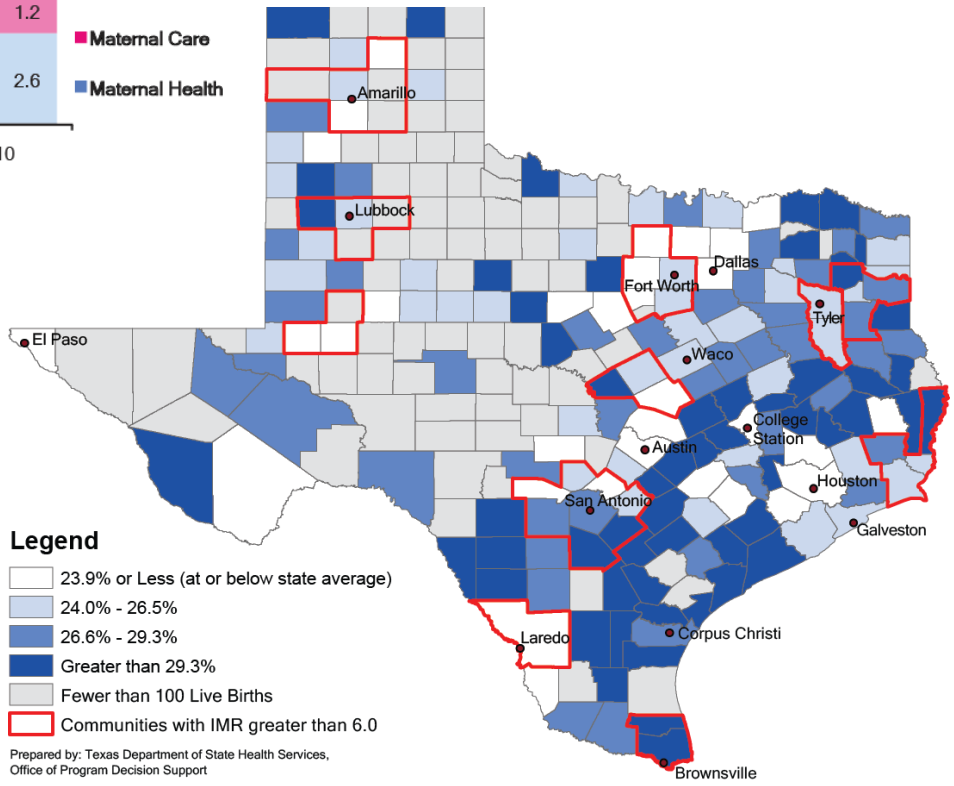
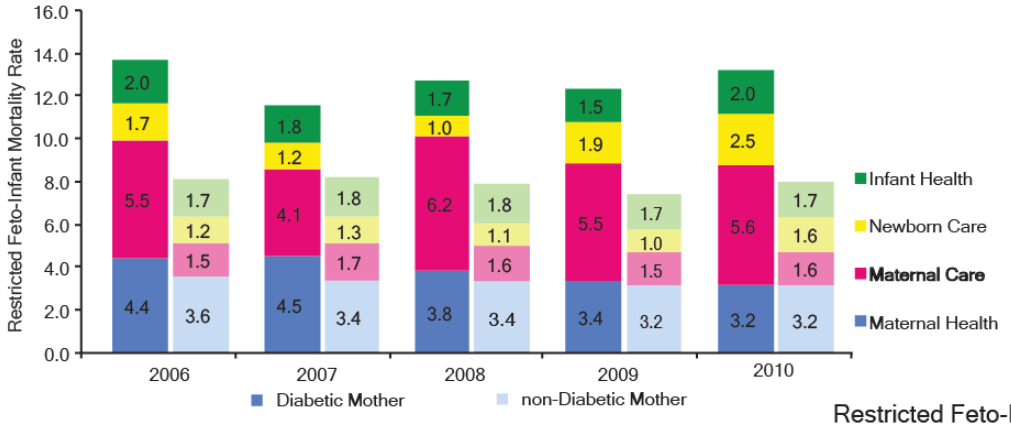


Chronic Disease: Diabetes & Hypertension

Maternal Health /Prematurity → Preconception Health, Health Behaviors, Perinatal Care

Maternal Care → Prenatal Care, High Risk Referral, Obstetric Care

Restricted Feto-Infant Mortality Rate for Diabetic and non-Diabetic Mothers, 2006-2010 Deliveries



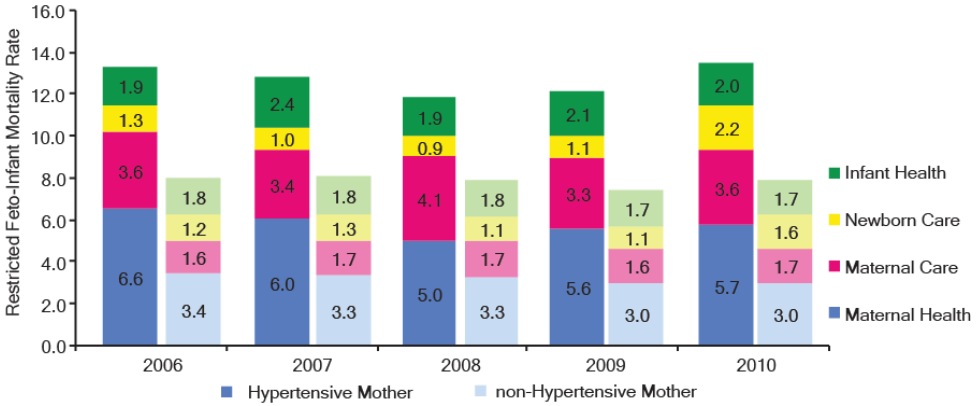
Texas data from Birth, Death, and Fetal Death Vital Records, DSHS, Center for Health Statistics
Prepared by: Texas Department of State Health Services, FCHS/OPDS, October 2013

Hypertension is not just a risk for the baby

Hypertension/eclampsia a top three diagnosis of severe maternal morbidity

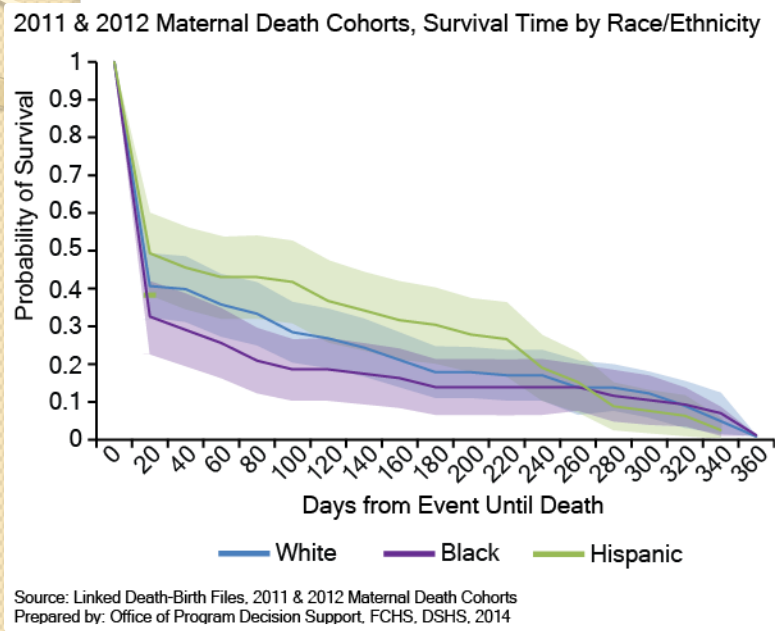
It is the second leading cause of *maternal death* for women in Texas, especially among Black mothers

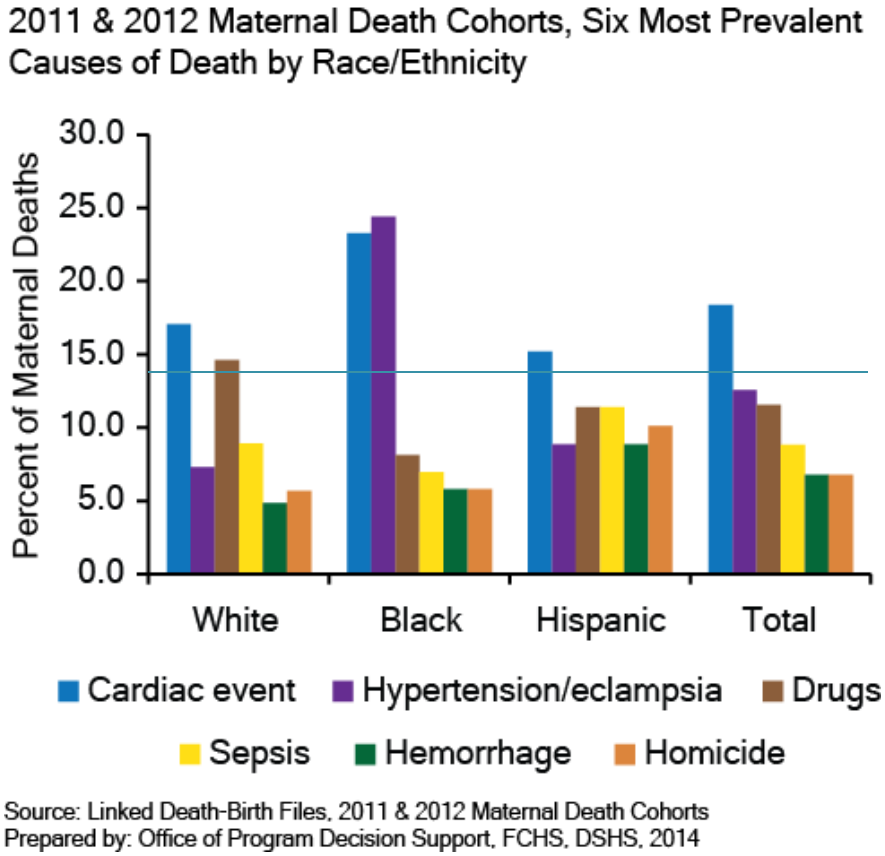
Restricted Feto-Infant Mortality Rate for Hypertensive and non-Hypertensive Mothers, 2006-2010 Deliveries



Texas data from Birth, Death, and Fetal Death Vital Records, DSHS, Center for Health Statistics
Prepared by: Texas Department of State Health Services, FCHS/OPDS, October 2013

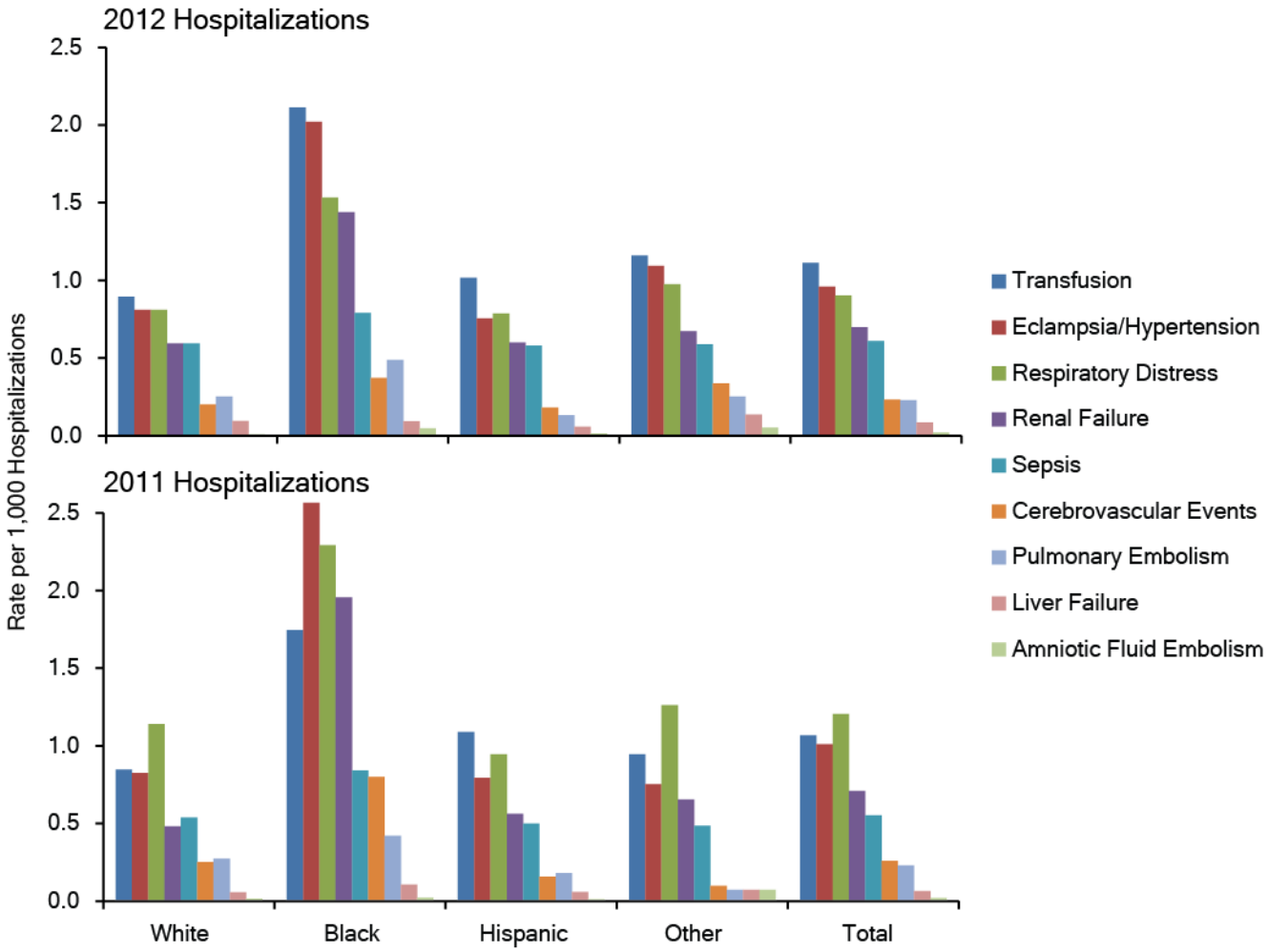
Racial/Ethnic Differences in 2011 & 2012 Maternal Death Cohorts





2011 & 2012 Severe Morbidity

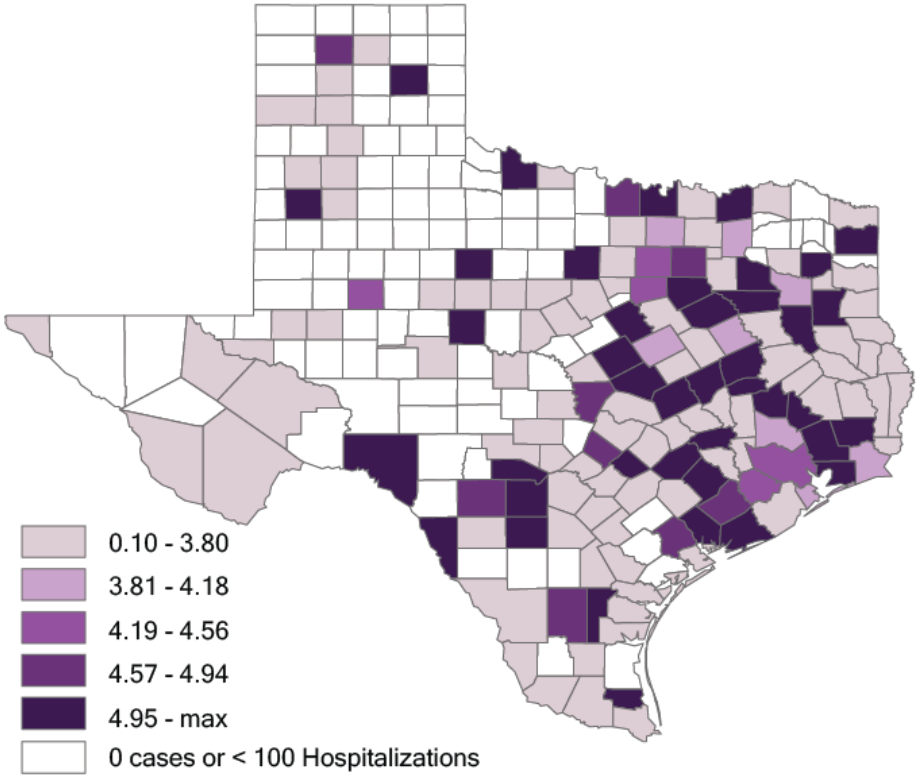
2011 & 2012, Rates* of Different Severe Morbidity Diagnoses by Race/Ethnicity



*Rates are not mutually exclusive as the majority of women have more than one diagnosis
Source: Texas Hospital Discharge Public Use Data:
Risk of Mortality High & Extreme for Identified Deliveries
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014

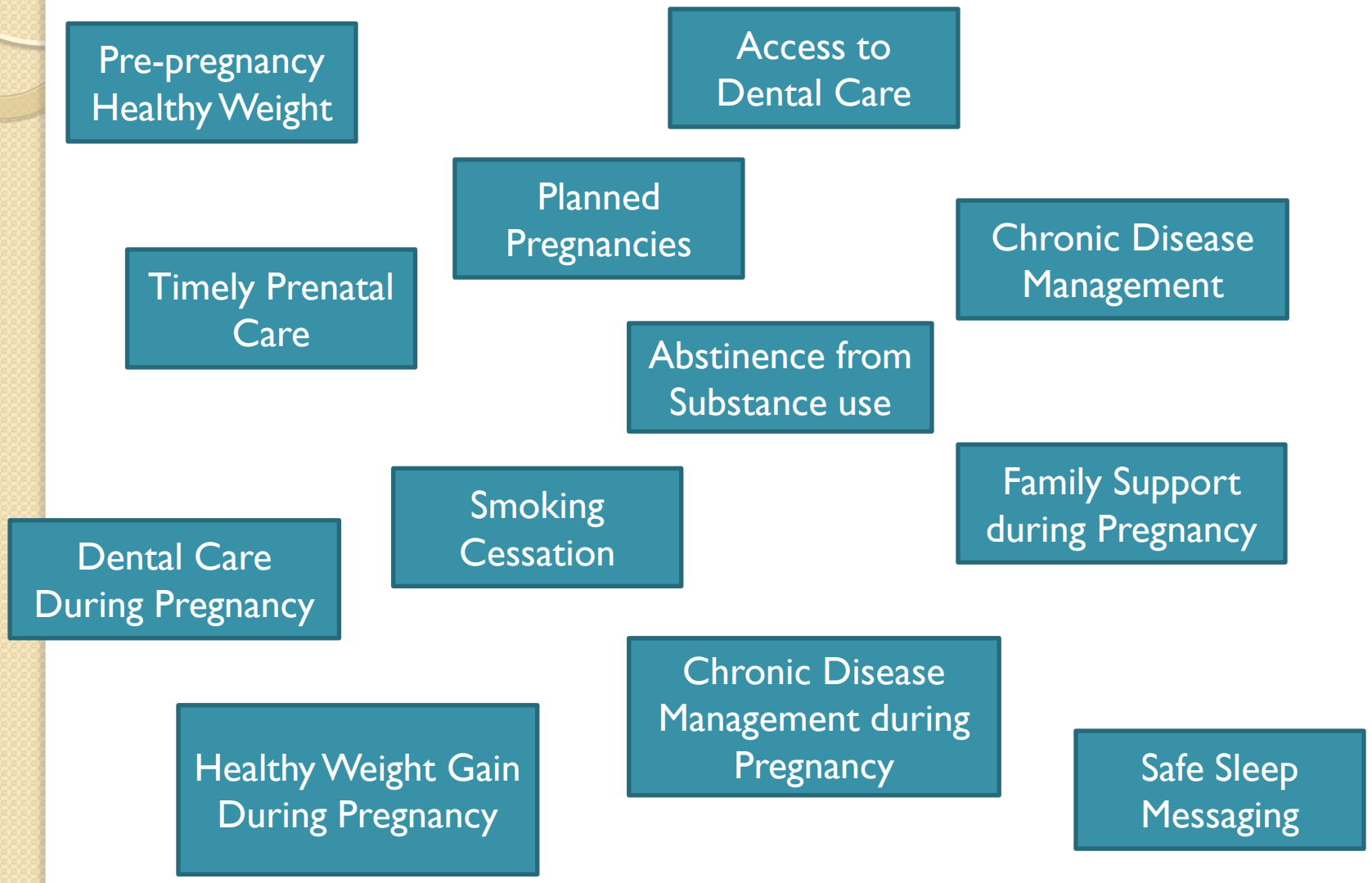
2011 County-Level Risks for Severe Maternal Morbidity

- No Significant Relations:
  - Low birth weight
  - Preterm birth
- Significant Relations:
  - Prenatal Care
  - Obesity



Source: Texas Hospital Discharge Public Use Data:
Risk of Mortality High & Extreme for Identified Deliveries
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014

Strategies to reduce infant mortality?



TEXAS
Health and Human
Services Commission

Status of Federally-Required Medicaid and CHIP Eligibility Changes

June 20, 2014

Status of Account Transfers

Account Transfers from the Marketplace to HHSC (Inbound)

- The federal Marketplace began sending applications to HHSC on January 17, 2014. HHSC currently receives applications weekly from the Marketplace and processes them as they are received. As of June 13, 2014:
  - HHSC has received 215,432 unduplicated transfers from the Marketplace.
  - HHSC has processed approximately 213,000 applications, of which, approximately 208,000 were completed and approximately 5,000 were in progress.

Account Transfers from HHSC to the Marketplace (Outbound)

- Between January 5, 2014 and June 13, 2014, HHSC transferred 452,575 cases to the Marketplace. Transfers occur daily.

Note: Each account transfer may contain multiple individuals.

Types of Account Transfers

- The following data are based on outcomes for 261,202 individuals.

- *MAGI Referrals* - 66 percent of applicants received from the Marketplace
  - The Marketplace assesses applicants' potential eligibility for Medicaid and CHIP programs that use modified adjusted gross income (MAGI) rules. If an applicant is assessed as potentially eligible, the Marketplace transfers the individual's information to HHSC. HHSC then performs the final eligibility determination.

- *Full Determination Referrals* - 8 percent of applicants received from the Marketplace
  - All applicants are provided the opportunity to request that the Marketplace send their information to HHSC for a "full determination" even if the Marketplace has assessed the applicant as potentially ineligible for MAGI-based Medicaid or CHIP.

- *Non-MAGI Referrals* - 26 percent of applicants received from the Marketplace
  - The Marketplace also transfers applicants assessed as potentially eligible for Medicaid due to age, blindness, or disability. These individuals are sent an application for Medicaid for the Elderly and People with Disabilities (MEPD).

Account Transfer Outcomes

- Of the applicants received via an account transfer:
  - HHSC denied 78 percent based on Texas eligibility rules.
    - Approximately 58 percent of all denials are for applicants whom the Marketplace assessed as potentially eligible (MAGI referrals). The difference between the Marketplace's assessment and HHSC's determination may be due to federal systems issues and differences in data sources used for verification (e.g., annual IRS tax return vs. current income verification).
    - Approximately 33 percent of all denials are for applicants whom the Marketplace assessed as potentially eligible for MEPD (non-MAGI referrals).
    - Approximately 9 percent of all denials are for applicants who were determined ineligible by the Marketplace but requested a full determination from HHSC (full determination referrals).
  - HHSC approved 18 percent.
  - 4 percent withdrew their application.

Account Transfer Outcomes: Approvals

- As of June 13, 2014, approximately 46,604 individuals referred from the Marketplace have been approved for Medicaid or CHIP (18%). The table below shows approvals by program. The majority of approvals have been for children's programs (90%).

Individuals Transferred from the Marketplace to HHSC

(As of June 13, 2014)

Type of Assistance	Approved	Percent of Approved
CHIP	12,571	27%
CHIP Perinatal	151	0.3%
Transitional Medicaid	55	0.1%
Parent and Caretaker Relative Medicaid	3,564	8%
Pregnant Women Medicaid	1,086	2%
Children's Medicaid (Under 1)	534	1%
Children's Medicaid (6-18)	22,149	48%
Children's Medicaid (1-5)	6,494	14%
Total	**46,604**	

Application SPAs Update

- States are federally-required to have an approved streamlined application for health care, including Medicaid, CHIP, and the Marketplace.
- On December 31, 2013, HHSC submitted to the Centers for Medicare and Medicaid Services (CMS) state plan amendments (SPAs) for the alternative single, streamlined application for health care.
- On March 31, 2014, CMS denied the SPAs due to the assets and absent parent questions on the application.
- On May 30, 2014, HHSC submitted a request for CMS to reconsider denial of the SPAs for the Texas alternative single, streamlined application.
- HHSC will make the following changes to the streamlined application:
  - Remove all assets questions.
  - Remove detailed absent parent questions. HHSC will continue to ask whether an absent parent exists, and will require parents and caretakers (formerly known as TANF-level Medicaid) to provide absent parent information prior to an eligibility determination.
- Based on conversations with CMS, HHSC understands that CMS will approve these changes to the streamlined application. HHSC will be working with CMS to determine the timeline for the changes.
- HHSC is working on how to incorporate these changes on the integrated application.

TEXAS Health and Human Services Commission

Conversion Plans

- On May 28, 2013, HHSC submitted to CMS the Texas MAGI Conversion Plan. The plan indicates Texas opted to use the Standardized MAGI Methodology with Survey of Income and Program Population (SIPP) data, and did not opt to adjust the SIPP data for time-limited disregards.

- On August 8, 2013, CMS approved HHSC's MAGI Conversion Plan.

- On August 9, 2013, HHSC submitted to CMS the Texas Non-MAGI Conversion Plan. The Non-MAGI Conversion Plan is in progress.

Administrative Renewals

Background

- Effective January 1, 2014, the Affordable Care Act (ACA):
  - Requires HHSC to use electronic data to the greatest extent possible before requesting information or verification from the client for all Medicaid and CHIP redeterminations
  - Requires clients to be provided a pre-populated renewal form
  - Requires clients that are determined ineligible based on electronic data to be provided an opportunity to provide updated information
  - Prohibits HHSC from requiring in-person interviews

- HHSC programs subject to administrative renewals:
  - Children's Medicaid and CHIP
  - Medicaid for Parents and Caretakers
  - Medicaid for the Elderly and People with Disabilities (MEPD)
  - Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)

Administrative Renewals: Eligibility

- The automated administrative renewal process:
  - Uses existing system data and electronic data source (ELDS)
  - Results in two eligibility outcomes:

1. **Eligible –** Sufficient information available to determine client potentially eligible
   - Client not required to return a signed renewal form or verifications

2. **Information Needed –** Insufficient information available to determine potential eligibility
   - Client required to return signed renewal forms and verification of missing information

Administrative Renewals: Client Renewal Process

1

All clients will receive a renewal cover letter notifying them of their eligibility outcome

2

Eligible

- Client asked to check over pre-populated form for accuracy
- Action only needed if information is incorrect (must report changes)

2

Information Needed

- Request for information form sent with cover letter
- Includes all required verifications to complete the renewal

3

All clients provided three ways fill out or check their pre-populated renewal form

1) Your Texas Benefits .com

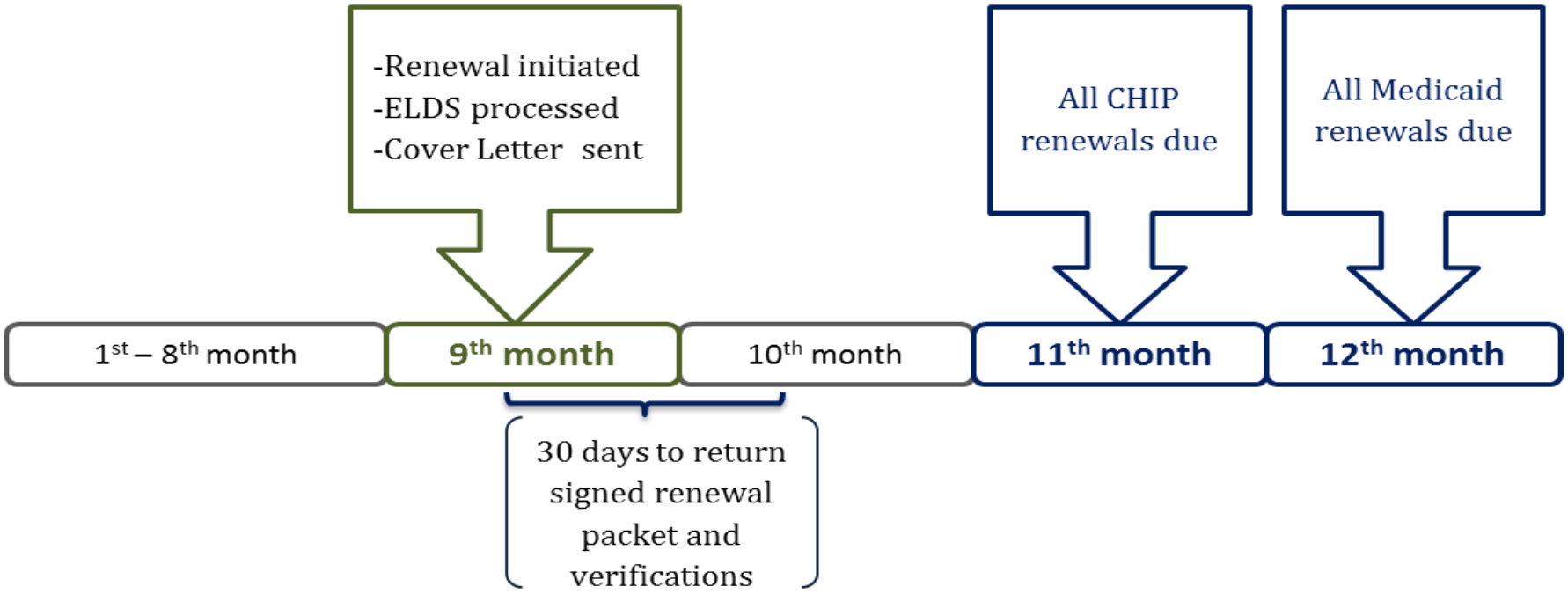
2) 2·1·1 TEXAS Connecting People and Services — **Option 2** *(to request paper packet mailing)*

3) **Local HHSC Office** *(To obtain paper packet or help on YTB.com)*

Administrative Renewals: Renewal Cover Letter Sample Text

Eligibility Outcome	Text
Eligible	"You need to check your renewal form. Look it over and make sure the facts we have about you are correct. To find out how, see below -- "How to fill out or check your renewal form." • **If some of the facts about you <u>are not correct</u>**: You must update your renewal form. • **If all the facts we have about you <u>are correct</u>**: You need to only check your renewal form -- you don't need to send it back to us.
Information Needed	"We need more facts from you before we can renew your health-care benefits."

Administrative Renewals: Timeline



- The system will initiate the administrative renewal, check ELDS, determine eligibility outcome, and send the Cover Letter (and Request for Information Form if needed) in the 9th month of eligibility.

- Timelines are defined to ensure administrative renewals can be processed timely to prevent gaps in coverage.

Administrative Renewals: Implementation Timeline

2014				2015
September	October	November	December	January
Renewal cover letters sent out: - FFCC (first FFCC renewals)	Renewal cover letters sent out : - Children's Medicaid and CHIP - Medicaid for Parents and Caretakers - MEPD - MTFCY		Renewals due: - FFCC	Renewals due: - Children's Medicaid and CHIP - Medicaid for Parents and Caretakers - MEPD - MTFCY

Periodic Income Checks

- In October 2014, HHSC's eligibility system will begin triggering periodic income checks to determine if there is an indication of a change in income from electronic data sources.
- Consistent with current policy, a periodic income check is not attempted when:
  - A renewal, change, or periodic income check is being processed
  - All client provided income verification is less than 60 days old
- Clients are contacted when electronic data indicates that a change has occurred in the client's income.
- Clients are provided the opportunity to verify information HHSC receives from electronic data sources prior to impacting eligibility.