CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

2017 LEGISLATIVE AGENDA
CHILDREN'S HEALTH COVERAGE COALITION

The Children's Health Coverage Coalition (formerly the Texas CHIP Coalition) is dedicated to ensuring the health and wellbeing of children and families in the state of Texas. The CHC Coalition engages in public education and advocacy, working closely with state agencies and the Texas Legislature on behalf of children and their families. We are dedicated to reducing the number of uninsured children in Texas and improving health outcomes for them and families. Achieving these goals will require investing sufficient resources into Medicaid and the Children's Health Insurance Program (CHIP), which together are essential to Texas' efforts to enhance the lives of Texas' low-income families. At the same time, we support prudent reforms that will enhance patients' access to timely services and quality of care, while also reducing Medicaid and CHIP costs.

During the 85th legislative session, the CHC coalition will support the following strategies and initiatives.

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.**

   The Medicaid and CHIP programs should be funded adequately, including caseload and cost growth. Medicaid and CHIP budget reductions jeopardize access to and the quality of care for children and pregnant women. Today, some provider types are paid rates that reflect only a portion of the costs of care. Texas needs to create a sustainable process in which provider payments increase each biennium to match the cost of delivering services and to ensure Medicaid managed care provider networks are adequate to meet the needs of enrollees.

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. Of the 682,000 uninsured Texas children in 2015, about 315,000 children are eligible for Medicaid or CHIP but not enrolled.[1] Efforts to streamline eligibility and enrollment will help**

enable uninsured children in Texas to get the health coverage they need to grow and thrive. In particular:

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.

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. Right now, with multiple income checks and the lack of continuous coverage, children in Medicaid continue to fall through the cracks and get disenrolled from insurance – even if they are still eligible. Twelve-month continuous eligibility promotes retention, reduces workload and administrative costs for the state, and prevents kids from cycling on and off of insurance during the year. Across the country, this approach is the recognized best practice and the single most effective step our state can take to reach the roughly 315,000 remaining uninsured children who are eligible for Medicaid or CHIP but not enrolled.[2]

<u>Access to Quality Care</u>:

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.** Preventive care and screenings before and between pregnancies help promote healthier pregnancies and reduce the risk of babies being born too early or too small.

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. Timely screening and treatment of perinatal depression is critical for both a mom's health and a child's development. Left

untreated, perinatal depression has adverse effects on a child's brain and language development, as well as academic achievement, and may increase the likelihood of developing behavioral problems, sleeping and eating difficulties, social disorders, and learning disabilities.[3] Untreated perinatal depression also increases health care costs. Untreated depression during pregnancy increases the risk of preterm birth,[4] which has substantial costs to Texas' Medicaid program.[5] Women facing perinatal depression are four times more likely to have emergency room visits and incur 90 percent higher health care costs compared to non-depressed women.[6] Earlier identification and treatment can divert women from costly emergency room care.

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. Primary care physicians frequently interact with mothers during a child's first year of life, thus providing greater opportunities to detect perinatal depression early.[7] Ten other states have clarified that Medicaid covers perinatal depression screening during pediatric or family medicine visits, under the child's Medicaid.[8]

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.

These two steps can improve the rate of early detection and treatment. However, limitations remain. The current Healthy Texas Women program does not provide comprehensive treatment or counseling for perinatal depression and substance abuse disorders. A limited benefit for perinatal depression is allowed – such as screening and a brief consultation with a primary care provider – but specialty care, including mental health counseling or substance abuse treatment, is not covered. Additional policy changes will be needed to ensure new mothers diagnosed with perinatal depression or substance use disorders are able to receive the recommended treatment they need.

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. Continuity of care after delivery of a child and between pregnancies improves health outcomes for moms and babies, prevents preterm birth, promotes better birth spacing, and reduces unintended pregnancies, in turn lowering the state's Medicaid costs.

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. CHIP perinatal is limited to pregnancy-related services for pregnant women who do not qualify for Medicaid. 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. Dual enrollment would enable women to get pregnancy-related services in CHIP perinatal program and other benefits through their private insurance, thereby reducing the likelihood of being otherwise uninsured.

   Enabling women to dually enroll in private coverage and CHIP perinatal would not only improve continuity of care before, during, and after pregnancy, it could increase state savings because private insurance must be the primary payer and the state CHIP perinatal program would be the payer of last resort.

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.

Parents' access to health care coverage not only benefits them, but also the entire family by promoting better health and financial security. An estimated 864,000 Texas adults have

income too low to qualify for health insurance subsidies and too high to qualify for Medicaid.[9] One out of three uninsured adults are parents of dependent children.[10]

Health insurance matters. Children are more likely to be insured – and stay enrolled in coverage – if their parents are insured.[11] Most children have the same health insurance status as their parents, and previous expansions in health insurance for adults have been connected to better insurance rates for children, increasing consistency of regular check-ups and preventive care.[12] An analysis of health literature by the Kaiser Family Foundation found that children who receive regular doctor visits and preventive medical and dental care perform better in school. Teens with regular access to care are less likely to drop out.

Health insurance coverage for adults has been shown to improve overall family economic security. Studies show that being insured through Medicaid reduced by more than 50 percent the chances of having to borrow money or skip paying other bills because of medical expenses. Texas' uninsured rate has dropped significantly over the past several years thanks to greater access to affordable health insurance. But more than 4.6 million Texans remain uninsured.[13]

Further, women's access to comprehensive health coverage before, during and after pregnancy is critical to babies' health. In fact, the lack of post-partum care in the year following birth is a critical contributor to Texas' alarming increase in pregnancy-related deaths and severe health complications.[14] More than 1.5 million Texas women of childbearing age between age 15 and 44 lack health insurance (27 percent).[15] More than half of births in Texas are covered by Medicaid,[16] but these women do not qualify for Medicaid before pregnancy to get preventive care and screenings that are crucial to ensure healthy pregnancies and prevent pre-term births. Also, Medicaid maternity coverage ends just two months after birth of a child, meaning new mothers with infants are becoming uninsured at a time when they are facing great risk of pregnancy-related deaths or complication. In fact, the 2016 DSHS Maternal Mortality and Morbidity Task Force found that 60 percent of maternal deaths occurred more than 42 days and up to a year after delivery of a child.[17] Increasing health insurance coverage is an essential step to improve birth outcomes and address Texas' alarming spike in pregnancy-related deaths and complications.

Further, as noted in the coalition's Access to Care recommendations above, treatment for perinatal depression is vital to the health of mothers and babies. Yet, when women lose Medicaid 60 days after birth of a child, coverage for perinatal depression is extremely limited. Women residing in urban counties with comprehensive indigent care programs may be able to access specialty care, but women living in rural and suburban counties are not as fortunate. Implementing comprehensive coverage would ensure access to the full array of perinatal depression treatment options and improve Texas' maternal and infant health outcomes.

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[1] Georgetown University Health Policy Institute, Center for Children and Families, "Children's Health Coverage Rate Now at Historic High of 95 Percent," (October 2016); and Georgetown University Center for Children and Families unpublished analysis of U.S. Census American Community Survey data for 2015.

[2] Ibid.

[3] See Center on the Developing Child at Harvard University. "Maternal Depression Can Undermine the Development of Young Children." Working Paper No. 8. (2009). M. England and L. Sim, eds., *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*. National Research Council and Institute of Medicine (NRC/IOM), Washington: National Academies Press. (2009). Available at http://www.ncbi.nlm.nih.gov/books/NBK215117/.

[4] Women with significant depressive symptoms were almost twice as likely to deliver a preterm baby compared to pregnant women with no symptoms of depression. Li, D. and Liu L. *Presence of depressive symptoms during early pregnancy and the risk of preterm delivery: a prospective cohort study*. Hum Reprod. 24(1):146-53 (Jan. 2009). Some studies have shown that depression during pregnancy may triple the possibility of early labor. Humenick SS, Howell OS. *Perinatal experiences: the association of stress, childbearing, breastfeeding, and early mothering.* J Perinat Educ. 12(3):16–41 (2003). *See also* Chung TK, et. al. *Antepartum depressive symptomatology is associated with adverse obstetric and neonatal outcomes.* Psychosom Med. 63(5):830–4 (2001)(finding that depression late in pregnancy has increased risk for epidural analgesia and increased likelihood of admission to neonatal care unit).

[5] During the first year of life, a healthy, full-term newborn birth costs Texas Medicaid about $572, while a newborn born preterm or with low birthweight complications costs $109,220 to the Medicaid program. Lesley French and Evelyn Delgado. "Presentation to the House Committee on Public Health: Better Birth Outcomes." Health and Human Services Commission and Department of State Health Services. May 19, 2016.

[6] Research found that women facing perinatal depression incurred 90 percent higher health services expenditures compared to non-depressed women, controlling for demographics, health status, and other characteristics. Dagher, Rada K.; McGovern, Patricia M.; Dowd, Bryan E.; Gjerdingen, Dwenda K. (2012) "Postpartum depression and health services expenditures among employed women". *Journal of Occupational & Environmental Medicine.* 54(2):210-215 (Feb. 2012).

[7] The American Academy of Pediatrics recommends screening for perinatal depression at well-child appointments up to 12 months of age. A 2004 study showed that screening at well-child appointments up to one year of life has led to significant increases in recognizing perinatal depression. Chaudron, L., Szilagyi, P. G., Kitzman, H. J., Wadkins, H., & Conwell, Y. "Detection of postpartum depressive symptoms by screening at well-child visits." *Pediatrics*, 113(3), 551-558 (2004).

[8] The ten other states are Colorado, Delaware, Illinois, Iowa, Nevada, North Dakota, South Carolina, Virginia, and Washington. The Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin in May 2016 stating that, since the maternal

depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit (Texas Health Steps). CMS Informational Bulletin. *Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children.* (May 2016). Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf. *See* Sheila Smith, National Center for Children in Poverty. *Using Medicaid to Help Young Children and Parents Access Mental Health Services: Results of a 50-State Survey* (Aug. 2016). Available at http://www.nccp.org/publications/pdf/text_1164.pdf.

[9] See Center for Public Policy Priorities' analysis of U.S. Census American Community Survey data for 2015. Available at http://bettertexasblog.org/2016/06/texas-medicaid-expansion-and-coverage-gap-estimates-need-some-updating/.

[10] See Kaiser Family Foundation. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." (October 2016). Available at http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[11] States that extended Medicaid coverage to more uninsured adults saw nearly double the rate of decline in uninsured children from 2013 to 2015 as compared to states that did not expand Medicaid. See J. Alker, A Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," Georgetown University, Center for Children and Families (October 2015). *Also see* Urban Institute. "Health Care Coverage, Access, and Affordability for Children and Parents: New Estimates from March 2016" (September 2016). Available at http://hrms.urban.org/briefs/health-care-coverage-access-affordability-children-parents-march-2016.html.

[12] Studies have found that insured children whose parents are also insured are more likely to receive check-ups and other care, compared to insured children whose parents are uninsured. *See* Center on Budget and Policy Priorities and Georgetown University Center for Children and Families. "Expanding Coverage for Parents Helps Children" (2012). Available at: http://ccf.georgetown.edu/wp-content/uploads/2012/07/Expanding-Coverage-for-Parents.pdf.

[13] While Texas' uninsured rate has fallen in recent years, Texas still has the highest percentage of people without health insurance in the country. Jessica C. Barnett and Marina S. Vornovitsky, U.S. Census, "Health Insurance Coverage in the United States: 2015 Current Population Reports" (September 2016). Available at: http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf.

[14] Texas Department of State Health Services, "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report," (July 2016), accessed at http://dshs.texas.gov/ConsumerandExternalAffairs/legislative/2016Reports/M3TFBiennialReport2016-7-15.pdf.

[15] Center for Public Policy Priorities and Kids Count. *State of Texas Kids 2016.* (May 2016). Available at http://forabettertexas.org/images/KC_2016_SOTCReport_web.pdf.

[16] David Lakey, MD, "Healthy Babies Initiatives," Presentation to Health Resources and Services Administration Infant Mortality Summit (Jan. 12, 2012). Available at http://mchb.hrsa.gov/infantmortalitysummit/presentations/lakey.ppt.

[17] Texas Department of State Health Services, "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report," (July 2016).