**October Children's Health Coverage Coalition and OTA Meeting**
Friday, October 19th
11:00 a.m. – 2:00 p.m.

**Children's Health Coverage Coalition and OTA Meeting Minutes**
**Friday, October 19th, 2018 @ THA**

**Present**

Helen Kent Davis, TMA
Anne Dunkelberg, CPPP
Will Francis, NASW-TX
Christina Phamvu, MHM
Jennifer Banda, THA
Erika Ramirez, TWHC
Leah Gonzalez, TWHC
Adriana Kohler, TXFC
Mary Allen, TACHC
Clayton Travis, TPS
Nancy Walker, Harris Health

**On Conference Line:**

Melissa McChesney, CPPP
Betsy Coats, Maximus
Karen Cheng, Superior Health Plans
Celia Kaye, LWVT
Alissa Sughrue, NAMI-TX
Whitney Thurman, United Methodist Women
Valerie Houston, HHS – Access & Eligibility Services
Christina Hoppe, CHAT
Orlando Jones

Meeting Chair: Helen Kent Davis, TMA
Meeting Scribe: Arinda Rodriguez, CPPP

## 1. Introductions [5 minutes]

## 2. Public Charge [Anne Dunkelberg, CPPP, 15 minutes]

On October 10th, the proposed rule was officially published, last day to submit comments will be December 10th. So far there have been 15,000 comments submitted, which means that it may be likely that we meet 100,000 comments goal.

New stuff is being posted a lot on the national campaign side, but sometimes it's not easy to find what's new.

I'm getting opportunities to get into the weeds of this rule and I'm interested to hear from people if they want to have a side conversation about public charge where we get into the weeds of the rule and its changes.

I know there have been conversations about complicated formulas they are using to look at public benefits. They are also creating a bunch of new responsibilities for state agencies (HHSC) to be part of a system that will report back to Homeland Security on who has misused benefits. Please give me some feedback on whether you would like to engage in this side conversation to talk about getting into the weeds of content strategies.

Also, in regard to the commenting period on the Public Charge rule, long detailed organizational comments are encouraged. It's a good strategy to extend the review process and turn in long detailed comments that will actually be reviewed. I [Anne D] will provide tips on how to make these comments more effective.

One way that people could approach this is by pulling in data from your state on the impact of this rule.

Please be mindful that we need individual comments just as much as the organizational/institutional ones, and I encourage everyone here to submit one individual comment. There are various outlets through which you can submit a comment. There are the Protecting Immigrant Families (PIF) and the Texas Women Voters League platforms. However, PIF is pretty angry, and uses such language. I know that some organizations may not feel comfortable using PIF's portal and comment samples. The Texas Women Voters League created a portal like PIF, and might be an alternative resource you can use to submit comments.

**[Will Francis, NASW-TX]**

Also, make the comments as unique as possible, because the more unique, the more it makes the process about what the comments are saying.

If you can customize at least 30% of the content, that will trigger a thorough reading and avoid it being put in a mass email box that doesn't get as much attention.

**[Adriana Kohler, TCFC]**

At a recent webinar they encouraged groups to focus on the program rather than the rule. Are there any opportunities where organizations engage in comments pertaining to health and offer health-related templates for comments?

**[Anne Dunkelberg, CPPP]**:

I don't think you'll find one that's perfect for your needs, the only one that is health related that I've seen is on the PIF website, a health-focused mini comment, sort of like the generic one they have. I think the answer is yes.

**[Clayton Travis, TPS]**

Is anybody from the health plans who is on the line right now planning on sending anything?

**[Karen Cheng, Superior Health Plan]**

We have had discussions with our national folks, I expect that we may, but I won't know until next week.

### 3. Legislative Priorities Presentations from Other Coalitions

<u>The Coalition for Health Minds</u>

**[Will Francis, NASW-TX]**

[Refer to "86th Texas Legislature Priorities Draft Document"]

This week we had a coalition meeting where we talked about these ideas. We are still fine-tuning, but what you see here is the bulk of what our priorities are.

We want to make sure that people have access to stable housing, access to providers, and to the workforce. Our ultimate goal is to prevent the use of criminal justice system and psychiatric systems.

It's a really diverse group of stakeholders in this coalition, but the value is that the information sharing is a big piece of what we do, and we are able to partner up when there's an opportunity. These priorities are broad but because of the broad nature of this coalition.

[Refer to "86th Texas Legislature Priorities Draft Document"]

**[Adriana Kohler, TCFC]**

CPAP stands out, is that something that the healthy minds coalition engage on actively or in a supportive role?

**[Will Francis, NASW-TX]**

Yes, how we fund to give psychiatric services is a big one for TCHM.

Texas Women's Health Coalition

**[Erika Ramirez, TWHC]**

We are also in the process of finalizing priorities:

We shared our draft with our steering meeting, but haven't shared with our full coalition yet. When we do we will send it to Arinda for distribution to the CHCC.

Also, on October 30th TWHC will have a Webinar to talk about our legislative priorities.

Basically our priorities can be distributed into 5 buckets:

1. **Ensure funding for women's preventive healthcare, including contraception, can fully meet the growing need among low-income, uninsured women:** We will continue to protect funding for this program. We're also monitoring the 1114 Healthy Woman Waiver Response, not much has happened but that doesn't mean that it can't impact the budget. There is a place holder on that.
2. **Identify areas with a shortage of qualified family planning providers and develop strategies to increase provider participation in the state's women's health programs.**
    a. Looking into network adequacy for providers providing preventative care for women.
3. **Ensuring women have access to the full range of FDA-approved contraceptives of their choice, including the most effective forms of contraception – implants and intrauterine devices, as well as counseling and medically accurate information on the full range of FDA-approved contraceptives.**
    a. Looking into 12 month supply birth control
    b. Looking into increasing access to long-acting reversible contraceptives
4. **Increasing continuity of care for women by eliminating barriers to preventive healthcare access**
    a. Looking into auto-enrollment of women aging out of CHIP and Medicaid into the Texas Healthy Women program
    b. We are also advocating for awareness and information to improve autoenrollment, and work to ensure women receive effective referral services
5. **Maximizing the ability of women's healthcare safety net to reach more women and save Texas taxpayer dollars.**
    a. Extending Medicaid coverage for individuals on Pregnant Women's Medicaid for up to a year postpartum

**[Clayton Travis, TPS]**

What are the coalition's [TWHC] thoughts on CHIP and contraceptive coverage ?

**[Erika Ramirez, TWHC]**

We want to find a solution to that population, whether it is advocating for contraceptive coverage in CHIP or allowing clients to receive benefits from both CHIP and THW.

**[Anne Dunkelberg, CPPP]**

What is the bottom age for THW?

**[Erika Ramirez, TWHC]**

15

**[Clayton Travis, TPS]**

I haven't seen an active effort to strike the statute that states that contraceptive services can't be offered by CHIP. Does everyone think that it's really hard?

**[Erika Ramirez, TWHC]**

It's a policy issue, and requires policy change, and I don't see people interested in pursuing legislation to change this.

**[Melissa McChesney, CPPP]**

We had members of the legislature talking about how great it was that we lowered the age for women in THW, but that did not help because they still have to choose CHIP and THW, and it's misleading that people are glad that we lowered the age.

**[Helen Kent Davis, TMA]**

Also, if you try to change CHIP statute, they will be opening the statute, and that might have implications that may not be something people want to deal with. That may invite other things to get change, and that can be problematic for the CHIP program.

**[Clayton Travis, TPS]**

I just want to make sure that we've established that this is a concern, and that we don't just mention this issue and forget about it for another 10 years.

Child Protection Roundtable

**[Will Francis, NASW-TX]**

[Refer to PowerPoint, slide 21]
Invest in Community-based primary prevention programs

- It is positive that we use the language of prevention

The Family First Prevention Service Act is a big piece of legislation, but it means that we can move some funds towards preventive efforts. Looking into becoming more trauma-informed.

[Refer to PowerPoint, slides 25-26]
Strengthen CPS Capacity and Improve Child Well-being

- Looking into developing a statewide real time portal & advance data sharing that can enhance provider placement capacity & improve placement stability
- Invest in Supervised Independent Living (extended foster care)

**[Anne Dunkelberg, CPPP]**

Regarding the Family First Prevention Services Act, I believe there are things in exceptional items that won't be triggered from that act unless the legislature moves it into the budget. We got about 250,000 kids living with relatives in Texas compared to about 30,000 with formal placements, but have no services for these families in informal placements. Is the Child Protection Roundtable going to pursue this kinship issue on the Family First Prevention Services Act?

**[Will Francis, NASW-TX]**

We have to figure this out by 2021, Kinship Navigators are something we can look at this legislative session, but we won't know until later.

Cover Texas Now

**[Anne Dunkelberg, CPPP]**

We are closed to completion but not 100% done.
Our priorities can be divided into 3 big buckets

- 2 state policies
    1. Improve the health and well-being of Texans by ensuring access to affordable health care coverage
        - State-wide comprehensive coverage plan for low-income adults
        - Implement 12-month continuous coverage for children in Medicaid
        - Streamline renewal processes
        - Improve access to comprehensive and affordable private insurance

2. Ensure that health care coverage provides real value to Texans by strengthening consume protections
    - Protect Texas consumers form surprise medical bills
    - Ensure consumers can easily get accurate information about healthcare insurance networks and expected costs
    - Increase consumer protection for skimpy, short-term plans

- 1 federal agenda
    1. Oppose any federal effort to reduce health coverage access for all populations
        - Including efforts for ACA repeals
        - Opposing Public Charge Rule

Medicaid Managed Care Informal Working Group

**[Clayton Travis, TPS]**

The way we've been conceptualizing our work, is by creating buckets of things we want to continue educating ourselves on.

6 – 7 buckets that we want to continue pursuing

1. Care coordination: We'd like to see improvements, and streamline/definitions for care coordination, how to access care coordination.
2. Appeals and fair hearings: This concern specifically came out due to the Dallas Morning News series, is it fair for families? We would like to figure out better ways to improve that process for consumers and for the process to be more transparent and see ways that we can offer help. Texas RioGrande Legal Aid is an organization that offers services to help appeal decisions in the fair hearing process. They have a direct connection to HHSC Counsel
3. Provider Networks: We want to make sure that children have adequate access to providers. We are following the roll out of SB760, which outlines new standards for access to care and network adequacy standards. The rule regarding this bill is out for comments. This coalition and the working group will closely look at this bill. We are also looking at STAR Health and STAR kids, and looking into the unique issues of these populations. Ensure kids are getting their services.
4. Streamline of prior authorizations processes on MMC companies.
    a. Sunset processes
5. Clinical input on policy. We specifically mention Medicaid and HHSC policy, we want to ensure there is clinical guidance at the agency.
6. Transparency, coordination of complaints and queries. All complaints and queries that hit the agency are seen in a holistic process to look at patterns and trends.
7. General agency oversight functions, making sure those oversight functions are adequate, efficient, transparent.
    a. Contracting processes
    b. Audits

c. Corrective action plans

**[Anne Dunkelberg, CPPP]**

There is a subset of those components you just mentioned that are specifically articulated in the CTN agenda, which are:

- Transparency
- Network Adequacy
- Care coordination
- Fair hearings

**[Karen Cheng, Superior Health Plan]**

We would agree that the policy issues talked about are things that we do need to work on. There's should be a better process for fair hearings. We're looking at improvements in care coordination definitions. We look forward to continuing to have discussions with you all on it.

## 4. CHCC Legislative Priorities Discussion

**[Helen Kent Davis]**

[Refer to "Draft 2019 CHCC Policy Priorities and Areas of Support"]
We have our suggestions for policy priorities and the suggestions where we can offer support. Are there issues on this list that we can support but not invest too much time on?

[Refer to page 2 of "Draft 2019 CHCC Policy Priorities and Areas of Support"]
*Improved Continuity of Coverage:*

1. Modify Texas' continuous eligibility period for Children's Medicaid, which is currently 6 months, to align with the 12 month certification period (similar to what Texas has done for CHIP)

Traditionally a priority, but CTN can take the lead.

*Increase Access to Health Coverage*

1. Extend Medicaid coverage during pregnancy and 12 months postpartum. CHCC/TWHC priority.

There's been a lot of support for extending maternity health coverage because a doctor can't treat you for all your chronic diseases the day you find out you're pregnant.

**[Adriana Kohler, TCFC]**

We need to make sure we have a unified policy strategy.

**[Helen Kent Davis, TMA]**

Policy strategy is certainly an important conversation. Today is about figuring out who's taking the lead on some priorities.

**[Erika Ramirez, TWHC]**

We, as a coalition, may want to capitalize on the 12 month extended coverage for pregnant women.

**[Anne Dunkelberg, CPPP]**

I suggest the CHCC supports restoring continuous coverage for kids receiving 6 months coverage on how it was on 2014. There might be a place where we can have a list of additional issues that the coalition supports, and continue to keep the coalition informed in opportunities where we can provide support testimony.

[Refer to page 3 of "Draft 2019 CHCC Policy Priorities and Areas of Support"]
*Promote Innovative strategies that improve access to quality health care*

1. Create a Child Psychiatric Access Program (CPAP) to further enable primary care physicians to provide behavioral health services to children (CHCC/TCHM)

This is something we can certainly get behind, perhaps we could move it to the CHCC's priorities.

**[Christina Phamvu, MHM]**

Senator Nelson is going to carry this bill (CPAP) and will have a lot of talk at the capitol.

**Notes on changes for this document (Draft 2019 CHCC Policy….) can be send to Arinda**

[Refer to page 3 of "Draft 2019 CHCC Policy Priorities and Areas of Support"]
*Make Improvements to Medicaid Managed Care System*

1. Create an Independent Provider Health Plan Monitor to address issues between providers and plans (CHCC)

TCHM will definitely get behind this.

[Refer to page 3-4 of "Draft 2019 CHCC Policy Priorities and Areas of Support"]
*Improve Access to Family Planning and Contraceptive Care*
TWHC is the lead on all of these.

Texas Campaign is getting behind allowing minors who are parents to consent to contraception, we are thinking of letting them take charge of this.

**[Helen Kent Davis, TMA]**

I think access to contraception is not something that the CHCC should take the lead on.

Also, I think we should create a table with columns listing the priorities and have people vote and see who's in favor of what policies, see which ones the CHCC should stand behind.

**[Clayton Travis, TPS]**

Also, if your coalition wants to join this tobacco campaign let me know. The name of the full campaign is: Tobacco 21 Campaign. The coalition that helps the campaign is the Texas Public Health Coalition.

## 2. OTA

Office of Ombudsman Update

**[Paige Marsala, HHSC]**

[Refer to Slides]

4th Quarter FY 2018

**[Anne Dunkelberg, CPPP]**

Folks working on the Medicaid Managed Care working group would like to see the agency pull out all the different channels where inquiries and complaints come in through, and get more detail on them. It would be really important to track and share with the public what the inquiries are about. Is that something that could happen on behalf of the agency?

**[Paige Marsala, HHSC]**

Which part of it?

**[Anne Dunkelberg, CPPP]**

Data reporting. It would be helpful for us to have a sense of the types of things that people need help with.

**[Paige Marsala, HHSC]**

We currently run "agency monthly contact reports" that we submit to the executive commissioner every quarter. The type of process you are requesting is already happening in this report. It's more focused on the complaints, but the structure is already there if we would like to look into inquiries.

[Refer to Ombudsman PowerPoint]

*Contact Volumes by Program Type*

1. CHIP – P
An increase at 6%.
Analysis: No trends on this data.

2. SNAP
Didn't change much over the quarter.

3. TANF
Decreased over the quarter, which is interesting because it usually increases during the month of August.

4. STAR
13% increase from July to August.
Trend: increase in inquiries related to accessing prescriptions.

5. STAR Health
Went down a little bit.

6. STAR Plus
The increase is less than 5% and wasn't really worth looking into.

7. STAR Plus Dual Demo
Inquiries went down.

8. STAR Kids
Stayed about the same throughout the quarter.

Ombudsman will provide additional report on the non-managed care data.

<u>Foster Care Ombudsman</u>

[Refer to Ombudsman PowerPoint]

4th Quarter FY 2018

Kids are calling saying they want to be in different placements.

Good news: We recently hired additional staff to our department. With new staff we have plans to go to the RTC facilities and visit children in person and have face-to-face conversations.

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

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Managed Care Assistance Team Update

[Refer to Ombudsman PowerPoint ]

They've been meeting with an additional division in HHSC to offer better analysis of the trends we are seeing in both areas. Better alignment of those codes that will allows us better trend analysis

Our office is collaborating with DFPS to make sure that foster parents are aware of the MMC system that is available to help. They don't really know about us, and we are working with DFPS to make sure that they have us as a resource to assist them in the process of Medicaid managed care options.

**[Adriana Kohler, TCFC]**

With the new DFPS Medical director, how do you envision your role or engagement with him and that team?

**[Paige Marsala, HHSC]**

We just met with the medical director and Elizabeth Kroenke, who works closely with him. Right now we are just trying to get our foot on the door at DFPS. My goal is that we use all of the support that's already there within DFPS for kiddos on STAR health and foster parents, that we are working together when either of us receives complaints of kids on STAR health. We'll see how far we can get. There's nuances in trying to work that collaboration.

**Note: The Child Protection Roundtable has been in communication with HHSC Foster Care department.**

HHSC Data Request Update

**[Anne Dunkelberg, CPPP]**

As you know, the HHSC, without legislative direction, adopted some radical legislation regarding children eligibility where children went from having 6 month-to-6 month coverage, to 6 month coverage to month-by-month coverage, followed by periodic income checks to establish eligibility.

We turned in this data request on December 2017, and HHSC followed up saying we needed to request it as an Open Request, which led to them sending at $5K bill on this data request.

[Refer to Data Request Document]

In that Open Request, we asked for data from a time period of 12-18 months to allow an adequate sample size that could determine the causes of disenrollment for kids who are subject to the new children eligibility rules. We also clarified that we were only interested in the MAGI population.

HHSC tends to refer request to the open records division, and this trend has increased throughout the years.

Clayton inquired on whether Dr. Shaefield would be interested in submitting the request for us, but if they do not feel comfortable submitting it, I'll come back to this group to decide what we can do to cover the expenses and whether or not we should move forward with this.

I don't know that we will have realistic shot at legislation for the upcoming session, but this is an ignored issue that needs to be addressed. It'd be beneficial for the agency and legislation to look into.

**[Clayton Travis, TPS]**

My original intent was not to persuade the coalition to not follow through with is, but we acknowledge that it is strategically difficult.
We've always had six month to six month enrollment, and now we have six month to month-by - month. We could have a legislative ask where we go back to 6 month to 6 month, instead of 6 month to 1 month.

**[Melissa McChesney, CPPP]**

From their perspective, if we go back to 6 month to 6 month, they might shut us down because they will say, well it's federal law that they offer 12 months. We need to be careful about how we go about this ask.

**[Will Francis, NASW-TX]**

What was Nebraska like? Is the new commissioner someone we can consider an ally?

**[Anne Dunkelberg, CPPP]**

I have no idea, but we can find out easily on Kaiser. We can look into the Nebraska data. She very well could be an ally, but we don't know. We can get back to you on that.

**[Christina Hoppe, CHAT]**

HHSC has previously provided data on periodic income checks, the impact during that 6 months of non-continuous eligibility is really low, but when eligibility continues for 12 months, they're estimating there is a significant cost increase, and that needs to be an inconsistency of having the non-continuous period because there isn't a lot of impact during that period.

**[Clayton Travis, TPS]**

If we need money, we may look into our foundation partners. Secondly, looking into the November meeting, maybe the steering committee can look into bringing the HHSC commissioner for the meeting. If we want to look at a 12 month continuity legislative priority, we need to contact health plans and have conversations with them as well.

**[Anne Dunkelberg, CPPP]**

Adriana, did you check the Nebraska stuff?

**[Adriana Kohler, TCFC]**

They have a November ballot on expanding Medicaid, but they do not have 12 month coverage.

**[Melissa McChesney, CPPP]**

Open Enrollment does begin on November 1st, and we will make sure that there are outreach materials, so that we can do another outreach pitch for open enrollment. We have lost almost all our navigator funds, so we may be going against the current with this. We have an outreach eligibility enrollment working group working on these issues.

<u>State of Enrollment Conference Update</u>

**[Anne Dunkelberg, CPPP]**

This conference was already very well-planned by the folk at TACHC and Melissa. Due to the elimination of navigator funds we knew that it would be difficult for assisters to travel, but Melissa and folk at TACHC were able to find an incredible affordable location to do it.

Because of their fantastic work preparing for the conference, I was able to reach out and focus on doing outreach for donations. Community Health Choice, volunteered $5,000, El Paso Health $5,000, and FirstCare $5,000. Additionally, Superior Health Plan and St. David's Foundation each gave donations of $5,000.

As a result we had about $20,000+ funds for this conference. We were able to offer 24 travel scholarships. They were about 200 people that stayed for the whole thing and were engaged.

The people doing outreach enrollment are in a connected world to this conversation but not always with us in the room, but there is a natural partnership there.

We are also working with Young Invincibles. Nationally they are trying to pick up some of the roles that Enroll America engaged in.

We'll be trying to slowly increase the levels of communication and support for these professionals working on enrollment.

We do have a network that we want to figure out how to keep in communication and foster it.

**[Melissa McChesney, CPPP]**

We've been working with Young Invincibles for about a year. They have recently they hired a new Southern Regional Director, Fedora Galasso, who comes with great background into this space. She used to manage HHSC's Community Partner Program. So we're excited to have her on board.

**Meeting adjourned at 1:17 pm**

Texas Coalition for Healthy Minds

# 86th TEXAS LEGISLATURE PRIORITES
## *DRAFT DOCUMENT*
## OCTOBER 17, 2018

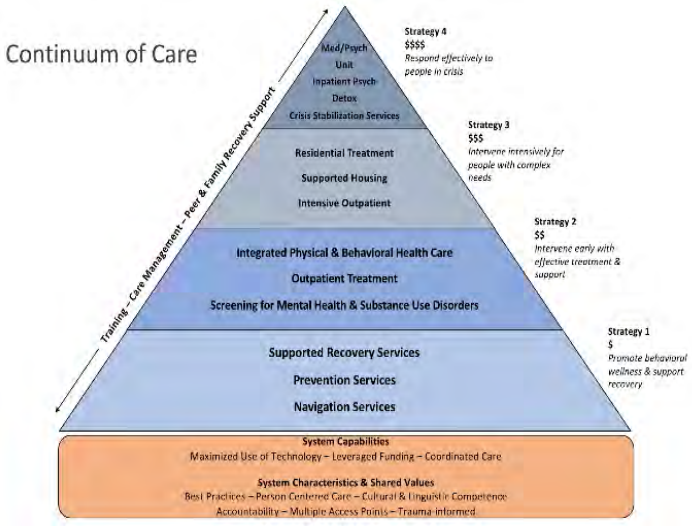


### 1. BUILD CAPACITY ACROSS THE CONTINUUM OF CARE FOR PEOPLE WITH MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

While smart investments have been made by the legislature, additional action is critical to ensure mental health and substance use disorder service capacity keeps pace with poverty and population growth. Essential mental health and substance use disorder services provide cost effective alternatives to hospital emergency rooms and the criminal justice system which represent much greater costs to tax payers.

A continuum of care – one that promotes prevention, treatment and recovery strategies – is critical to ensuring that people with mental health conditions and substance use disorders have ready access to cost effective community-based services, delivered at the right place and time.

Texas has some of the most severe workforce shortages in the country. The state should prioritize access to care, including an expansion of the workforce for the 21st century and beyond. Access to care depends upon it.




The basic necessity of a stable home can be hard to come by. The lack of safe, affordable housing often leads to homelessness, jails, shelters, and hospitalizations. It can also compromise a person's stability, basic well-being, and recovery. Texas should build upon existing supportive housing programs and identify programming that addresses specific gaps in the housing continuum.

- Comprehensive, community-based housing options
- Criminal justice pre-and-post-booking diversion
- Workforce development
- Peer services
- Inpatient, outpatient and crisis services

- Insurance coverage, including parity

**2. PREVENTION & INTERVENTION FOCUSING ON CHILDREN, YOUTH AND FAMILIES**

Trauma and chronic adversities during childhood are highly associated with the development of mental health disorders. Fifty percent of mental health conditions begin by 14 and 75% by 24, but these issues often go undetected and untreated until they reach a crisis point. The rate of attempted suicide among youth in Texas (one in eight) has increased in recent years and exceeds the national rate.

Children, youth, and families need access to effective mental health prevention, intervention, and support strategies across the different systems that serve them. Trauma-informed practices should be woven into all health, education, social service, and justice systems to help mitigate the negative effects linked to trauma and adverse childhood experiences.

Increasing access to mental health professionals in schools and/or the community can help in addressing mental health issues when students are young. Access to supportive services early in life helps children and youth build resiliency and cultivate mental well-being, helping avoid negative outcomes associated with untreated mental illness, such as academic challenges, substance abuse, self-harm, or involvement with the justice system.

Supporting children's mental health includes providing their families with services and supports, too. When a child experiences a serious emotional disturbance, families often need guidance, support, and education to help their children reach their treatment goals. Family support services keep children in their homes and in school – and out of institutionalized settings like hospitals, residential treatment, or justice facilities. This includes services that connect families with individuals and family members who have lived experience successfully navigating mental health systems. Mental illness and/or substance abuse within a household are included among the adverse childhood experiences shown to have short- and long-term impacts on a child's health, behavior, and ability to manage future stressors. Treatment of mental illness and/or substance abuse in family members is critical for both their and their children's health and well-being.



Some of the strategies being discussed among policymakers and advocates to address these issues include:

- Helping schools address students' mental health
- Addressing maternal mental health and mortality
- Increasing access to specialized treatment for early onset psychosis
- Strengthening and expanding youth suicide prevention
- Promoting trauma-informed care and practice across settings
- Increasing access to family peer support services

**3. INTEGRATION & SPECIAL POPULATIONS**

The mental health care system and the primary care system are historically separate from one another, causing certain health needs of individuals with mental illness to go unaddressed. The mental health care system and the primary care system should both be equipped to address health care needs across the spectrum. Texas should continue to invest in integrated behavioral health initiatives and continue to address the pervasive mental health workforce shortage in order to better serve the needs of people with mental health conditions.

People with mental illness may turn to substances (drugs) as a form of coping or self-medication. The consequences of substance abuse for people with mental illness can be extensive, devastating, and counterproductive to recovery. Texas should explore solutions to the challenges of substance abuse.

The mental health needs of individuals with intellectual and developmental disabilities (IDD) are frequently overlooked or ignored, in large part because disabilities often overshadow mental health conditions. Texas should explore solutions to better meet the mental health needs of people with intellectual and developmental disability across systems (schools, healthcare, juvenile and criminal justice, etc.)

Individuals with mental illness often find themselves involved in the criminal justice systems. Similarly, families struggling with mental health and substance use conditions who do not have access to adequate interventions often interface with our child welfare system. We can interrupt these cycles by providing linkages to treatment, streamlining access to care, and emphasizing safe and humane conditions. Texas should prioritize mental health within criminal justice and child welfare reform.

- Primary care
- Substance use disorders
- Intellectual and developmental disabilities
- Criminal/Juvenile justice
- Veterans
- Child welfare/CPS
- Parent and family support/peer services

# Child Protection Roundtable (CPRT)

LEGISLATIVE BRIEFING

JULY 2018

The Child Protection Roundtable

# Who We Are: CPRT

70+ member organizations statewide

Led by Steering Committee:

*TexProtects, Texans Care for Children, Texas CASA, Upbring, United Ways of Texas*

- Founded in 2008 as a means to empower the diverse leading voices of child protection across Texas to speak with unity, shared purpose & maximum impact
- Serves as a convener for organizations engaged in child welfare which share a child-centered common vision and seek to leverage data, resources and strategy to achieve more progress collectively than could be achieved individually

For more information visit the webpage: https://www.texprotects.org/roundtables/CPRT/

The Child Protection Roundtable

# Our Focus

The Child Protection Roundtable

# Agenda

I. Child Protective Services (CPS) Data Overview (2017 Update)

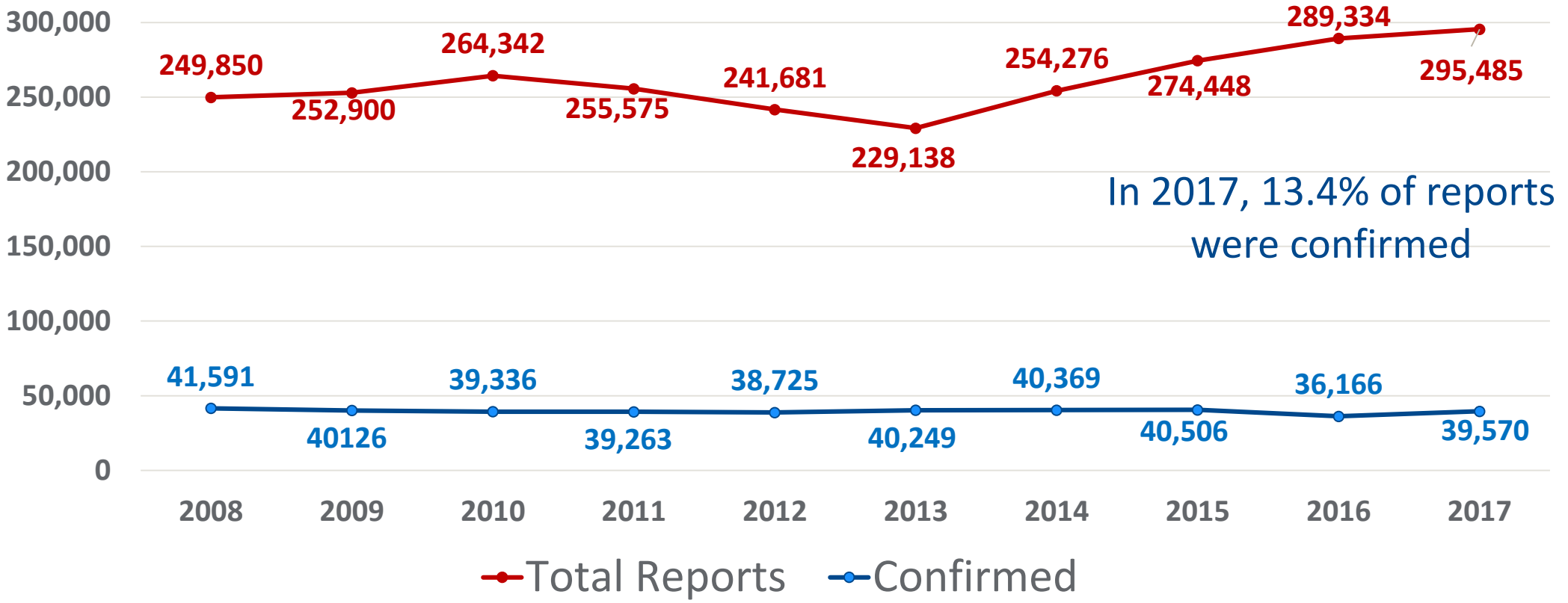
II. Update on Federal Legislation
   - Family First Prevention Services Act

III. CPRT Legislative Priorities

# Texas Child Welfare Landscape

The Child Protection Roundtable

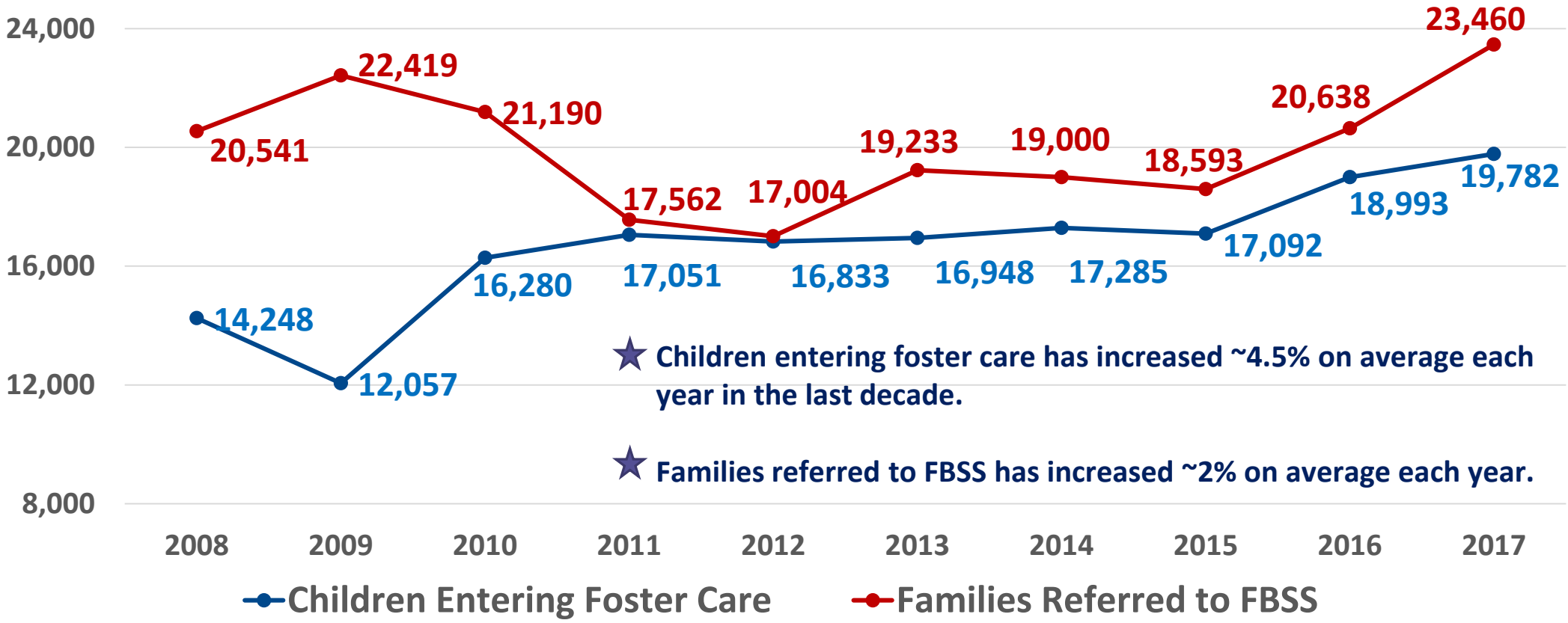
# Reports to CPS (2008-2017)




In 2017, 13.4% of reports were confirmed

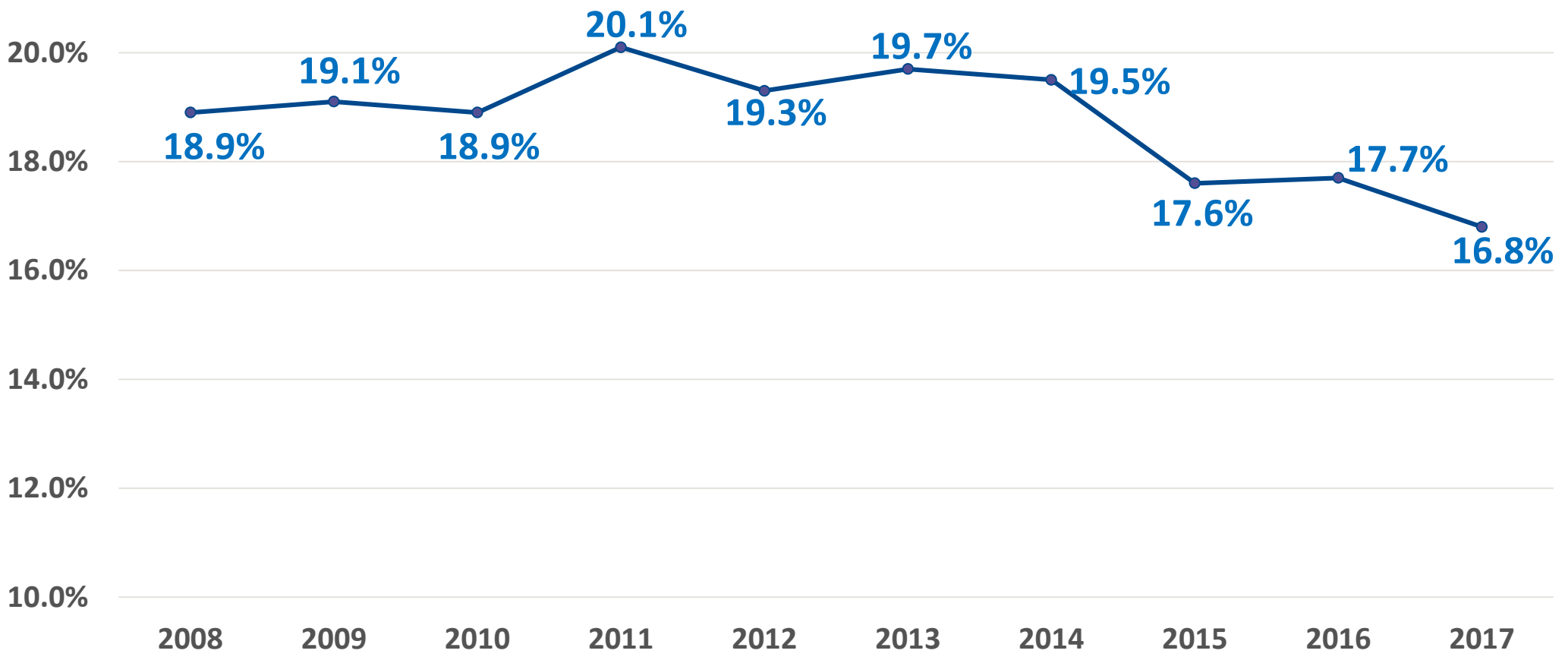
The Child Protection Roundtable

# Families in Need of Services (2008-2017)



The Child Protection Roundtable

# Recurrence within 5 Years of Services (2008-2017)



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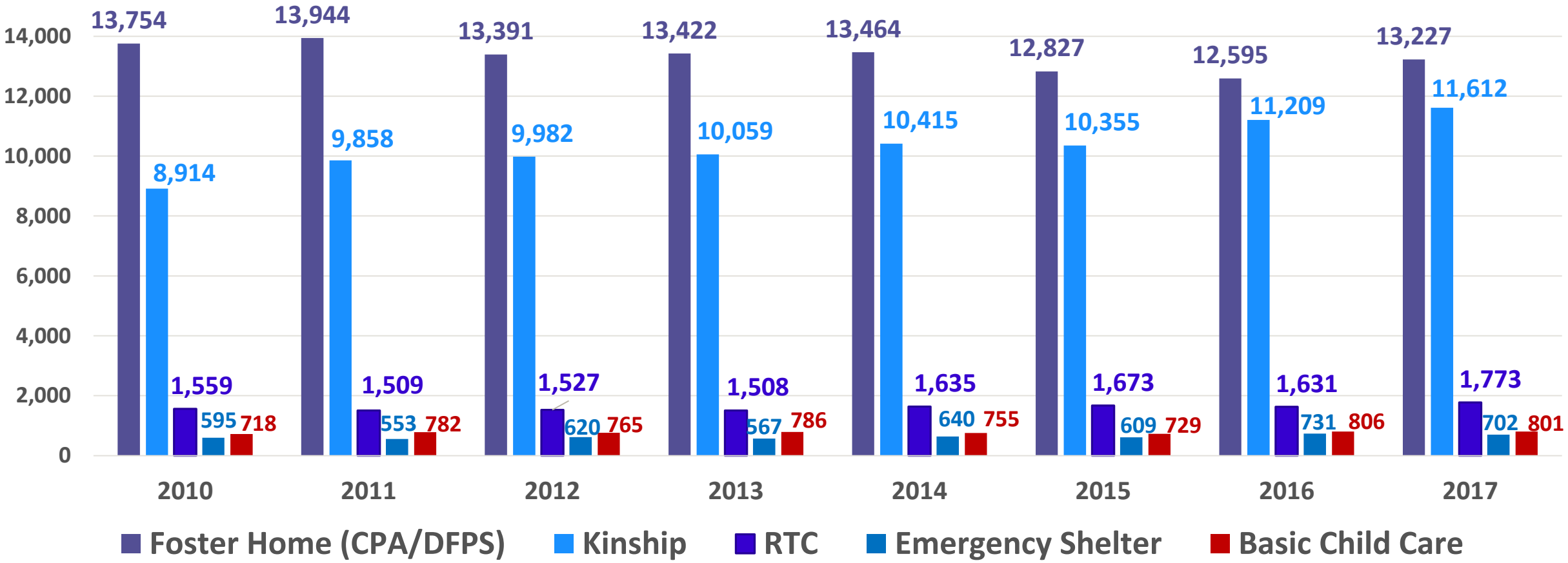
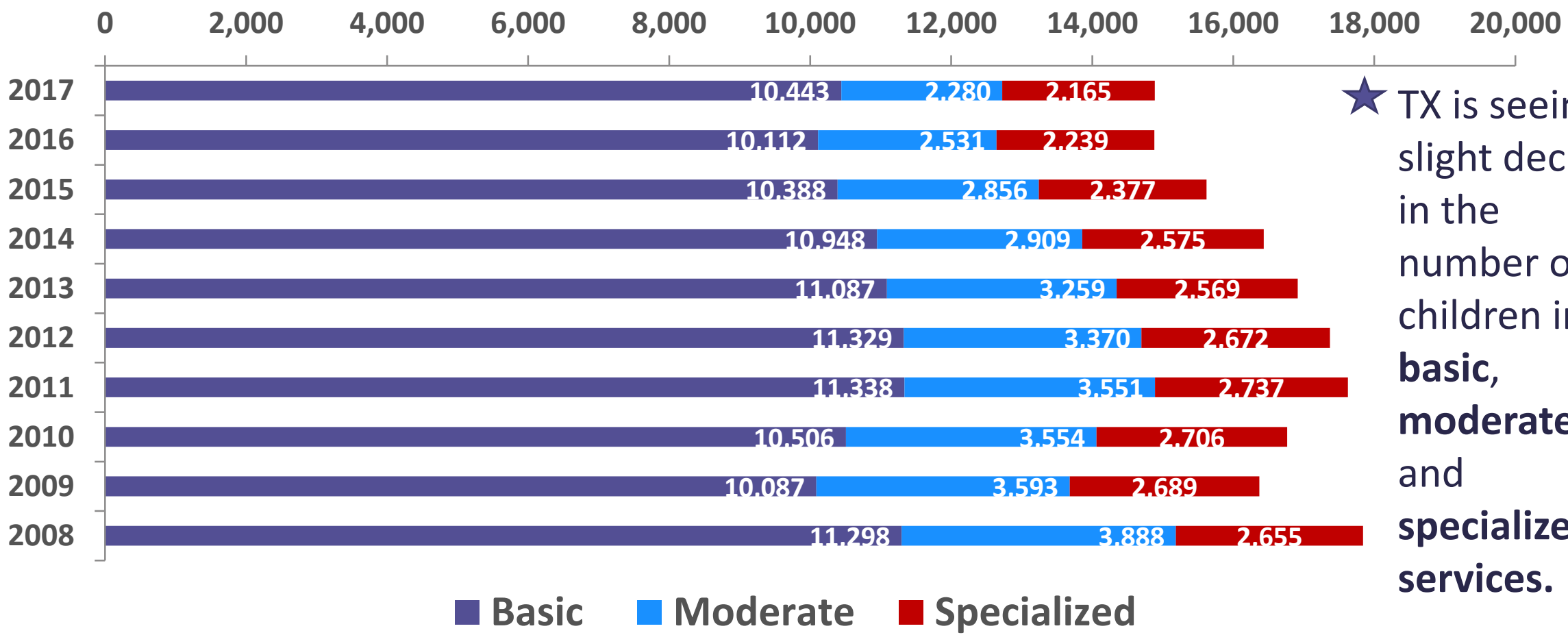
# Children in Substitute Care – Placements (2008-2017)



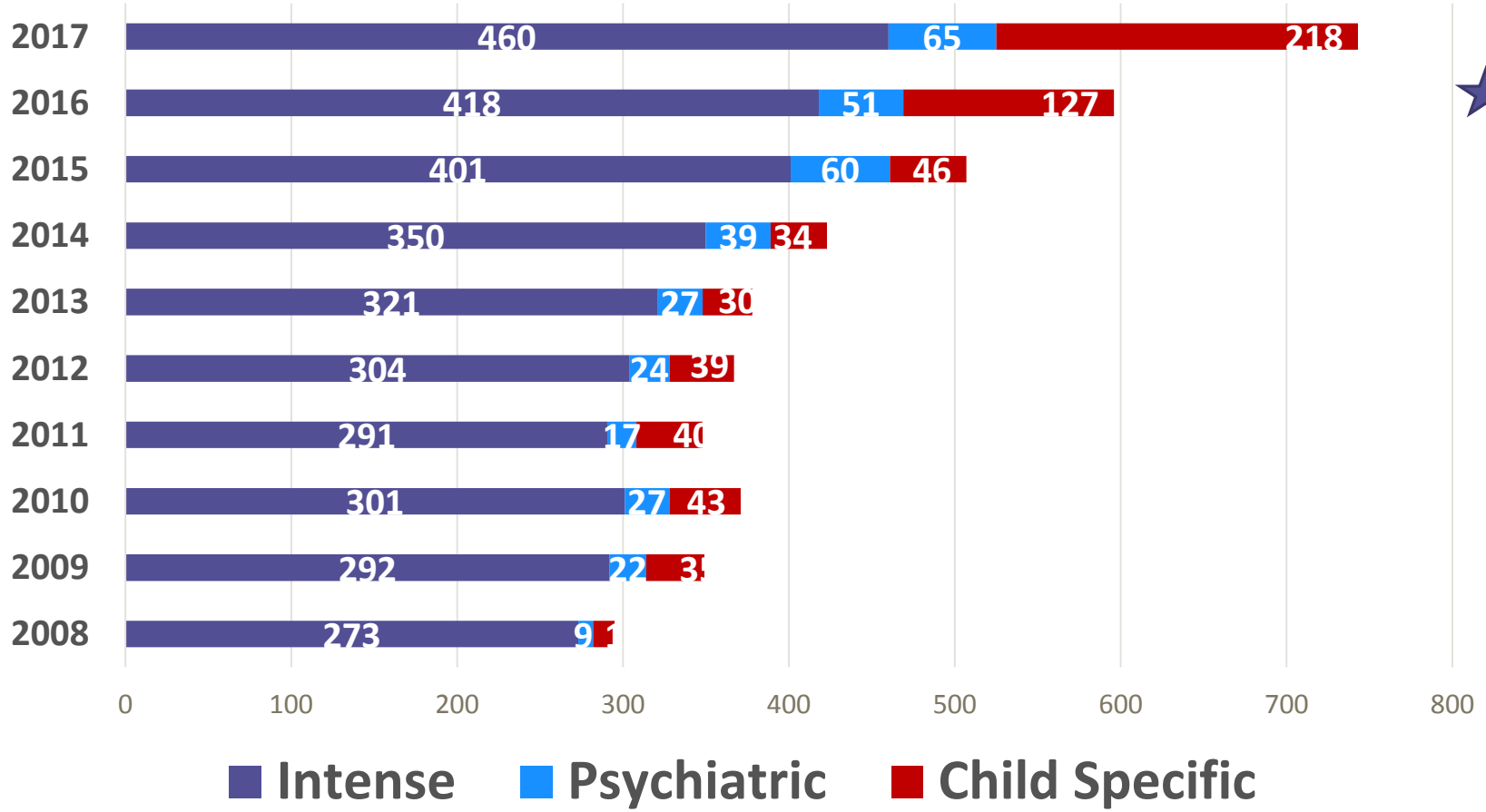
The Child Protection Roundtable

# Children in Care by Service Level (2008-2017)




★ TX is seeing a slight decline in the number of children in **basic**, **moderate** and **specialized services.**

# Children in Care by Service Level (2008-2017)




★ However, Texas saw increases in **intense** (6% growth), **psychiatric** (30% growth), and **child specific services** (51% growth)

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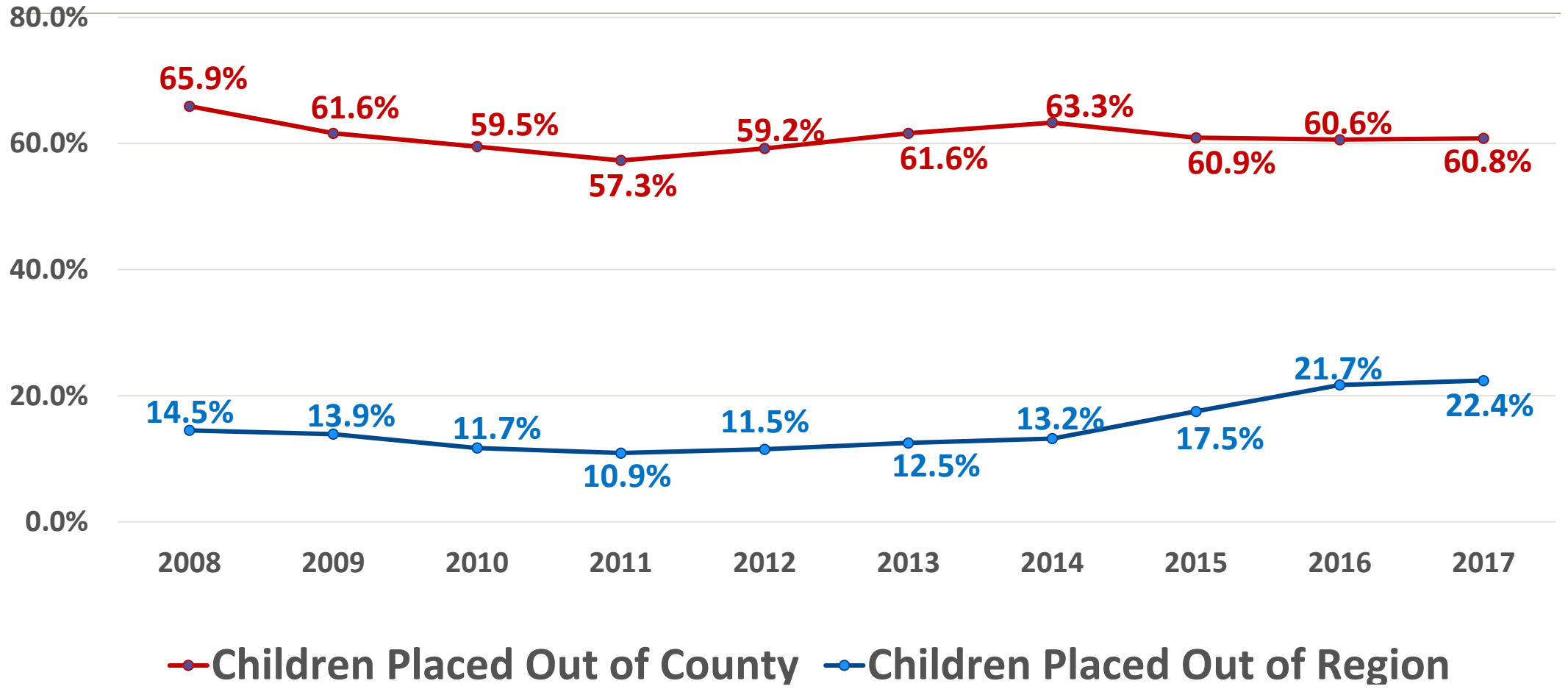
# Placement Proximity – Statewide (2008-2017)



# Family First Prevention Services Act

The Child Protection Roundtable

# Family First Prevention Services Act

- Authorized **February 9, 2018**

| *Family First Act is a significant victory for Texas families!* | | | | | |
|---|---|---|---|---|---|
| **Invests in prevention for children at risk of foster care** | **Supports kinship caregivers & provides targeted investments to keep children safe with families** | **Funds evidence-based services & substance use treatment** | **Ensures children in foster care are placed in least restrictive, most family-like setting** | **Promotes permanency families for children** | **Supports youth transitioning from foster care** |

The Child Protection Roundtable

# Family First Prevention Services Act

## Investing in Family Preservation and Services

- Federal Title IV-E funds include: **trauma-informed**, **evidence-based** prevention services for **eligible children** for up to 12 months (renewable).
- Implement **no later** than **October 1, 2019- October 1, 2021**

The Child Protection Roundtable

# Family First Prevention Services Act

## ELIGIBLE CHILDREN AND FAMILIES

- Candidates for foster care
- Their biological parents & kinship caregivers
- Pregnant and parenting foster youth

## EVIDENCE-BASED

- Promising
- Supported
- Well-supported 50%
- Training & Administrative costs

## TRAUMA-INFORMED

- Mental Health
- Substance use Prevention & Treatment
- In-home parent skill-based programs

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# Family First Prevention Services Act

## Investing in Family Preservation and Services

- Federal Title IV-E funds → **evidence-based kinship navigator programs**
- Link relative caregivers to services & supports
- **October 1, 2018**

The Child Protection Roundtable

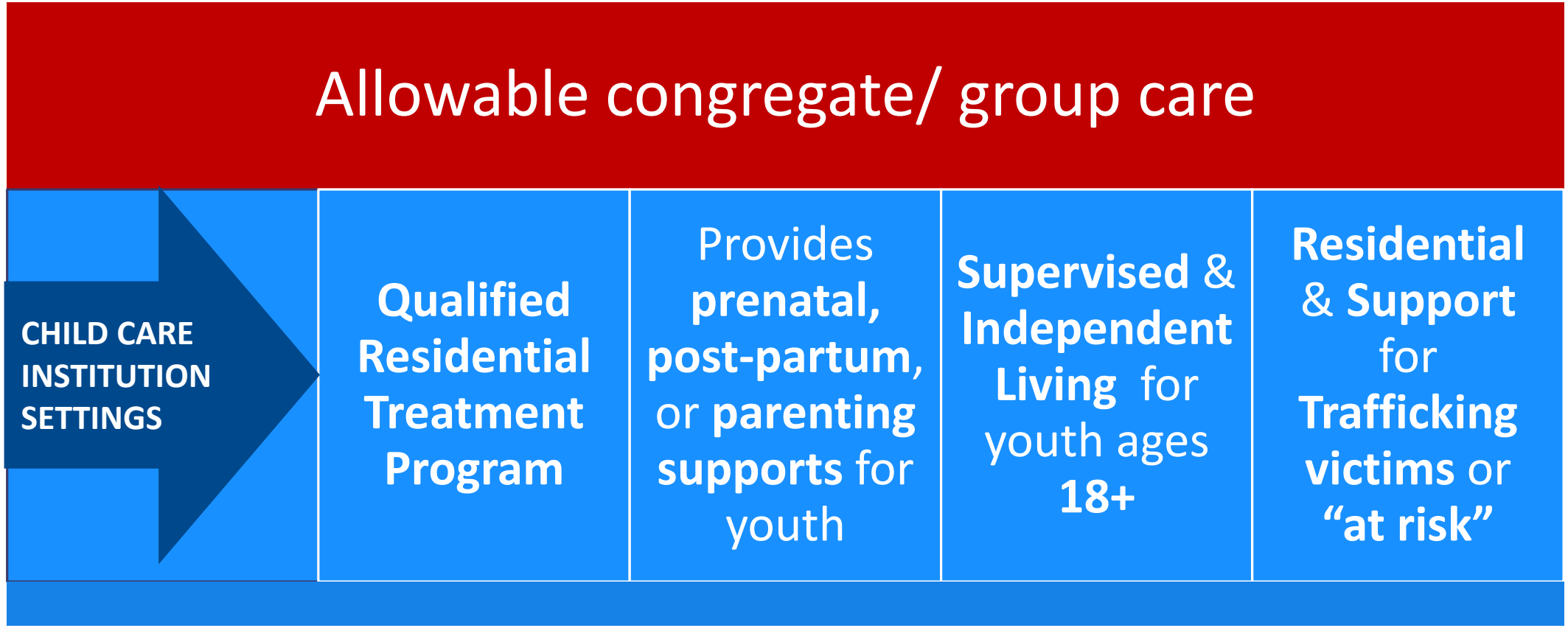
# Family First Prevention Services Act

## Ensuring children in foster care are placed in least restrictive, most family-like setting

- Restrictions federal Title IV-E funds → **congregate/group foster care**
- Implement **no later** than **October 1, 2019- October 1, 2021**
- Beginning 3rd week foster care, foster care payments in following settings:
  - Licensed foster **family home**, **6 or fewer** children
  - Licensed **child-care institution**, **no more** than **25** children in **certain** settings

The Child Protection Roundtable

# Family First Prevention Services Act



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# Family First Prevention Services Act

## A Qualified Residential Treatment Program (QRTP):

- **Trauma-informed** to address needs of children w/ emotional or behavioral disorders
- Registered/licensed nursing & clinical staff
- Outreach to family members, provides discharge planning & family-based care support for 6 months after discharge
- Licensed & nationally accredited or an accreditation approved by the Secretary of HHS.

# CPRT Priorities for the 86th Legislative Session

The Child Protection Roundtable

# 86th Legislative Session

## Invest in Community-Based Primary Prevention Programs

- **Strengthen children and families** with highest need & increase youth resiliency, which reduces need for costly down-stream state provided services:
  - Healthy Outcomes through Prevention and Early Support (HOPES)
  - Texas Home Visiting
  - Nurse-Family Partnership
  - Services to At-Risk Youth (STAR)
  - Helping through Intervention & Prevention (HIP)

The Child Protection Roundtable

# 86th Legislative Session

## Prevent Child Maltreatment and Preserve Families

- Invest across state agencies in continuum of services by **identifying state funds** & implementing strategic plan to **maximize federal funds**, including funds from FFPSA
- Better integrate and provide **trauma-informed and well-supported interventions** in the areas of:
  - Mental Health early intervention & treatment services;
  - Substance use prevention & treatment services; and
  - In-home parent “skill-based” programs, especially for pregnant & parenting foster youth, & children at risk for entering foster care

The Child Protection Roundtable

# 86th Legislative Session

## Strengthen CPS Capacity and Improve Child Well-Being

⓾ Invest additional state funding and maximize FFPSA funds for foster parent recruitment and retention to **increase capacity and quality of foster family homes**, including therapeutic foster care and foster family homes that serve special populations

The Child Protection Roundtable

# 86th Legislative Session

## Strengthen CPS Capacity and Improve Child Well-Being

⓾ Enhance provider **placement capacity** & improve placement **stability** by developing statewide, **real-time tracking** portal & advance **data sharing**

The Child Protection Roundtable

# 86th Legislative Session

## Strengthen CPS Capacity and Improve Child Well-Being

⑩ Invest in **Supervised Independent Living** (extended foster care) to expand capacity for young adults to live on their own while still receiving casework, education, & support services to help them become independent, self-sufficient, and successful.

# Contact us:

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***TexProtects***
(512) 913-4408
pamela@texprotects.org

The Child Protection Roundtable

**Kaitlyn Doerge**
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Kaitlyn.Doerge@txpeds.org

**Kate Murphy**
***Texans Care for Children***
(281) 433-3700
kmurphy@txchildren.org

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

# 2019 Policy Priorities

- **Budget**
    1. Ensure adequate funding for critical health programs aimed at improving maternal and children's health. This includes preventing reductions in critical health services or payments that would jeopardize access to and quality of care for children and mothers. Strong investment is needed in:
        - Medicaid, Children's Health Insurance Program, CHIP perinatal
        - Early Childhood Intervention (ECI)
        - DSHS programs and initiatives designed to improve maternal health

- **Improve Continuity of Coverage – prevent youth and adults from losing coverage and falling through the cracks**
    1. Establish auto-enrollment for 19-year-olds who age out of CHIP and Children's Medicaid to seamlessly access care via Healthy Texas Women program
    2. Establish streamlined transitions and renewal processes for Texas youth who age out of foster care and transition from STAR Health (age 18-21) to a STAR plan (age 21 – 26).

- **Increase Access to Health Coverage**
    1. Improve maternal and child health by creating a tailored coverage option for women to access to care before, during, and after pregnancy.

- **Make Improvements to Medicaid Managed Care System**
    1. Provide clear, easy-to use resources to Medicaid clients, families, and doctors on care coordination services provided in each STAR program.
    2. Enforce network adequacy standards and make Corrective Action Plans more transparent.
    3. Establish a repository at HHSC of Medicaid client inquiries, complaints, requests for appeals – including inquiries made to health plans, HHSC, ombudsman, and legislators – so HHSC can better track trends and emerging issues.

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

# 2019 Policy Areas of Support

*These items are areas of CHCC support, but have not been prioritized in 2019 or are being spearheaded by a partner coalition.*

Coalition Key:

- CHCC – Children's Health Coverage Coalition
- TWHC – Texas Women's Healthcare Coalition
- TCHM – Texas Coalition of Healthy Minds
- CPRT – Child Protection Roundtable
- TPHC – Texas Public Health Coalition
- CTN – Cover Texas Now

❖ **Budget**

1. Ensure adequate funding for critical health programs aimed at improving maternal and children's health. This includes preventing reductions in critical health services or payments that would jeopardize access to and quality of care for children and mothers. Strong investment is needed in:
    - Texas' women's health programs (TWHC)
    - Mental health and substance use treatment and recovery programs (TCHM)
    - Family Violence Program, HHSC Exceptional Item #34 (CHCC)
    - Behavioral Interventions for Children w/ASD, HHSC Exceptional Item #44 (CHCC)
    - Prevention and Early Intervention Services, DFPS Exceptional Item #8 (CPRT)
    - Services for Early Psychosis, HHSC Exceptional Item #19 (TCHM)

❖ **Improve Continuity of Coverage – prevent youth and adults from losing coverage and falling through the cracks**

1. Modify Texas' continuous eligibility period for Children's Medicaid, which is currently 6 months, to align with the 12-month certification period (CHCC)
2. Streamline renewal processes for families by enabling those with multiple kids enrolled in Medicaid or CHIP to renew coverage for each child on the same date every year (CHCC)
3. Direct HHSC to evaluate options for streamlining enrollment and referral process from CHIP perinatal to the state's Family Planning Program (CHCC)

❖ **Increase Access to Health Coverage**

1. Extend Medicaid coverage during pregnancy and 12 months postpartum (CHCC/TWHC)

2. 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 (CTN/CHCC)

❖ **Promote innovative strategies that improve access to quality health care**

➢ **Telehealth Strategies**

1. Create a Child Psychiatric Access Program (CPAP) to further enable primary care physicians to provide behavioral health services to children (CHCC/TCHM)
2. Fund exceptional item #49, Pediatric Telemedicine Grant Program for Rural Texas (CHCC)
3. Medicaid coverage for and promotion of virtual pregnancy medical homes (CHCC/TWHC)

➢ **Transportation Strategies**

4. Make improvements to non-emergency Medicaid transportation benefit so that pregnant women and new mothers can take their children with them and get to critical medical visits. Promote initiatives and partnerships with health plans so that Medicaid transportation options work more effectively for families (CHCC)

❖ **Improve Behavioral Health**

1. *See above under Telehealth*. Create a Child Psychiatric Access Program (CPAP) to further enable primary care physicians to provide behavioral health services to children (CHCC/TCHM)
2. Promote use of integrated care that combines medical and behavioral health by covering the Collaborative Care Model approach through Medicaid (TCHM)
3. Direct HHSC to promote best practices and training on screening and brief interventions around substance use issues, including giving health professionals materials on OSARS (Outreach, Screening, Assessment, and Referral entity) in their local area and materials on where to refer a person for substance use intervention or treatment (TCHM)

❖ **Make Improvements to Medicaid Managed Care System**

1. Create an Independent Provider Health Plan Monitor to address issues between providers and plans (CHCC)

❖ **Improve Access to Family Planning and Contraceptive Care**

*In addition to policy priorities listed above under Budget, Continuity of Care, and Access to Health Coverage:*

1. Improve access to contraception through CHIP –by covering through CHIP or allowing dual enrollment of clients in CHIP and HTW (TWHC)

2. Improve maternal health and birth outcomes by covering postpartum contraception through CHIP Perinatal (TWHC)
3. Allow minors who are parents to consent to contraception (TWHC)
4. Require Medicaid and private health plans to cover 12-month supply on contraception at one time (TWHC)

❖ **<u>Improve public health to reduce health care coverage costs</u>**

1. Raise the age of tobacco purchases to age 21 (TPHC)

# HHS Office of the Ombudsman Update

**Presented to**
**CHC Coalition**
**October 19, 2018**

TEXAS
Health and Human Services

# Total Ombudsman Contacts for 4th Quarter FY 2018

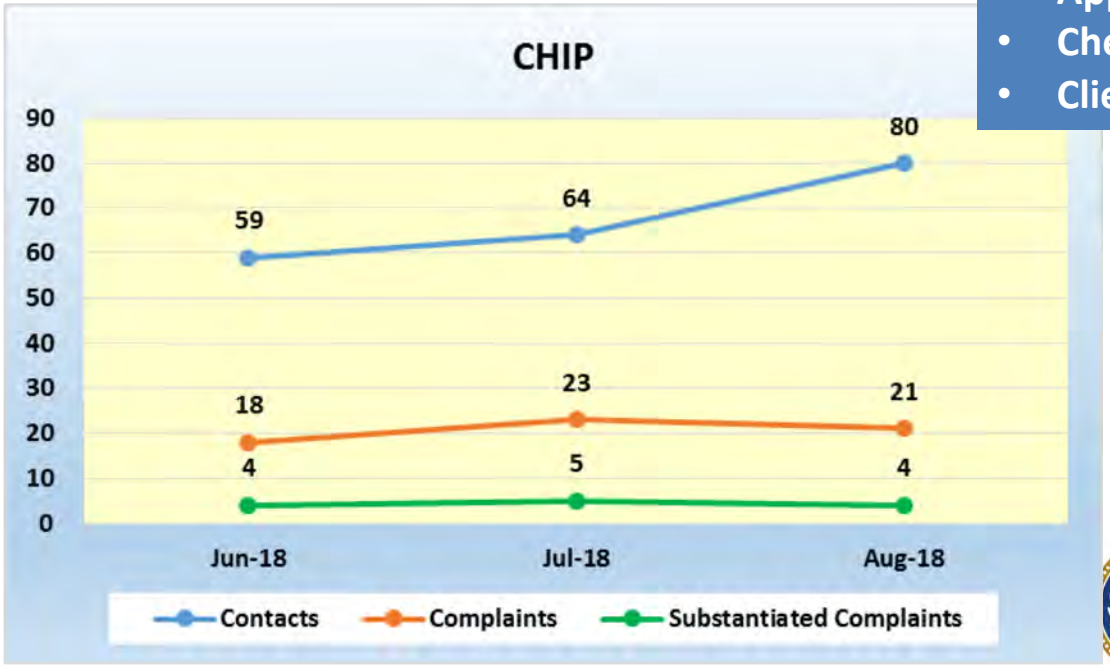
- Complaints – 6,610
- Inquiries – 15,158

TEXAS Health and Human Services

# Contact Volumes and Top Three Reasons for Contact by Program Type 4th Quarter FY 2018

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

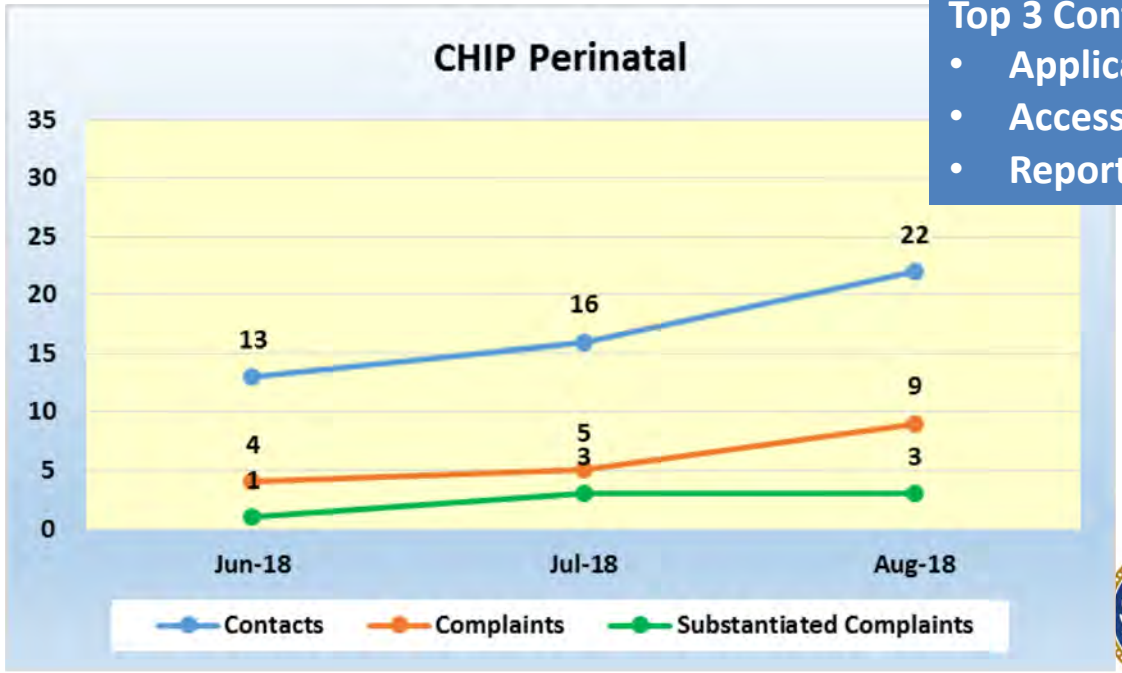



**Top 3 Contacts – CHIP**

- Application/Case Denied
- Check Status
- Client Notice

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

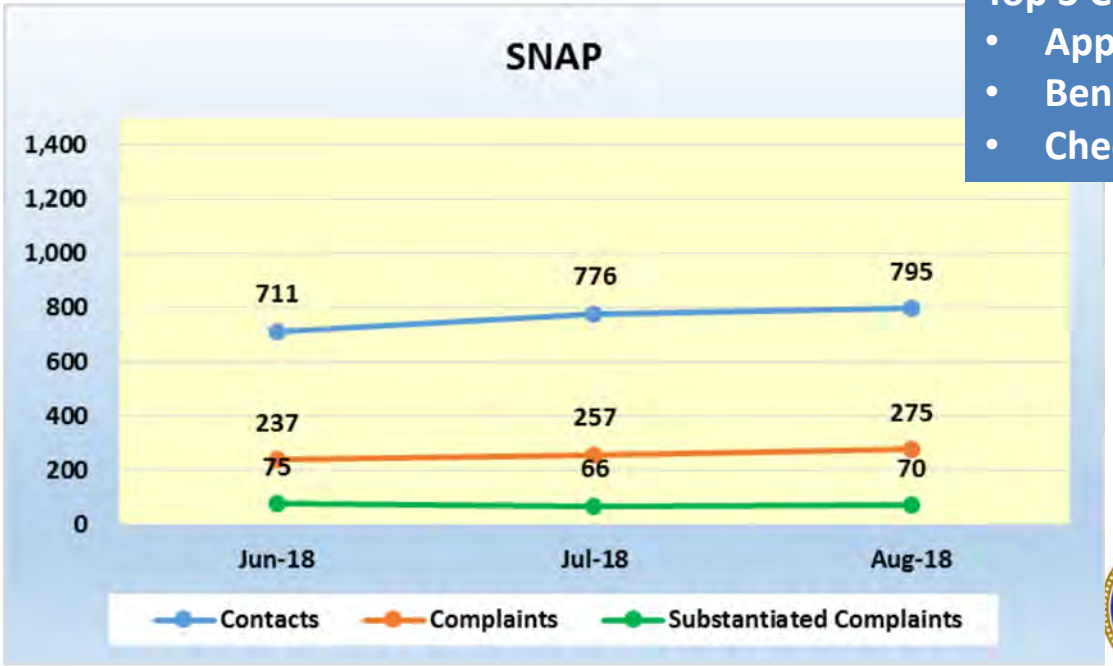



**Top 3 Contacts – CHIP - P**

- Application/Case Denied
- Access to Provider
- Reporting Change

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

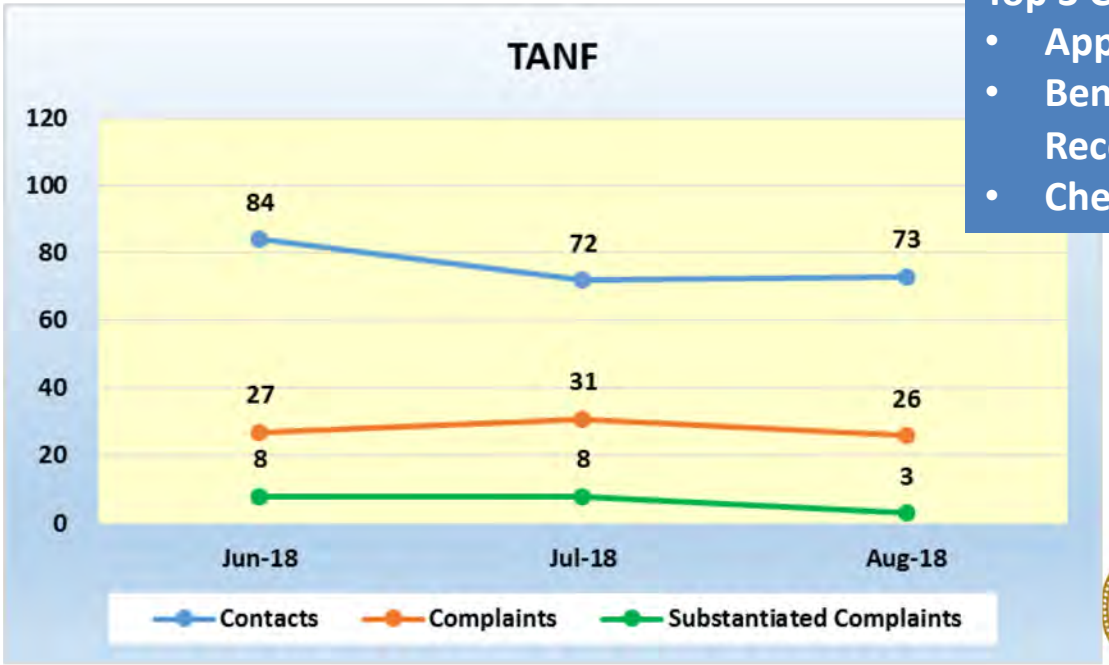



**Top 3 Contacts – SNAP**

- **Application/Case Denied**
- **Benefit Amount**
- **Check Status**

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

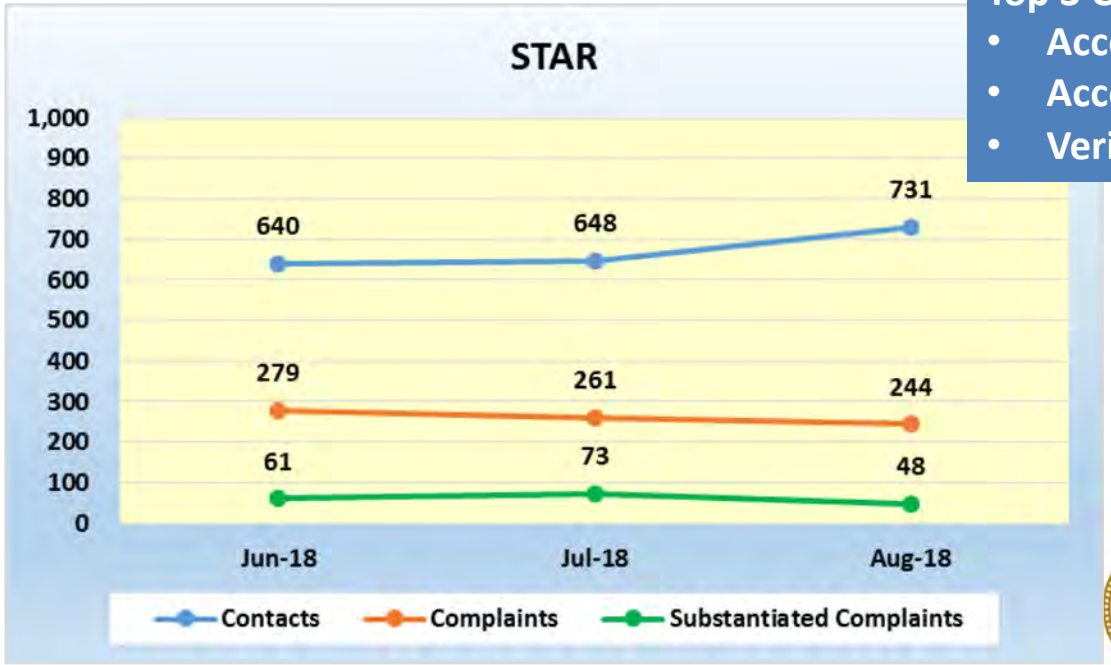



**Top 3 Contacts – TANF**

- **Application/Case Denied**
- **Benefits Not Issued/Not Received**
- **Check Status**

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

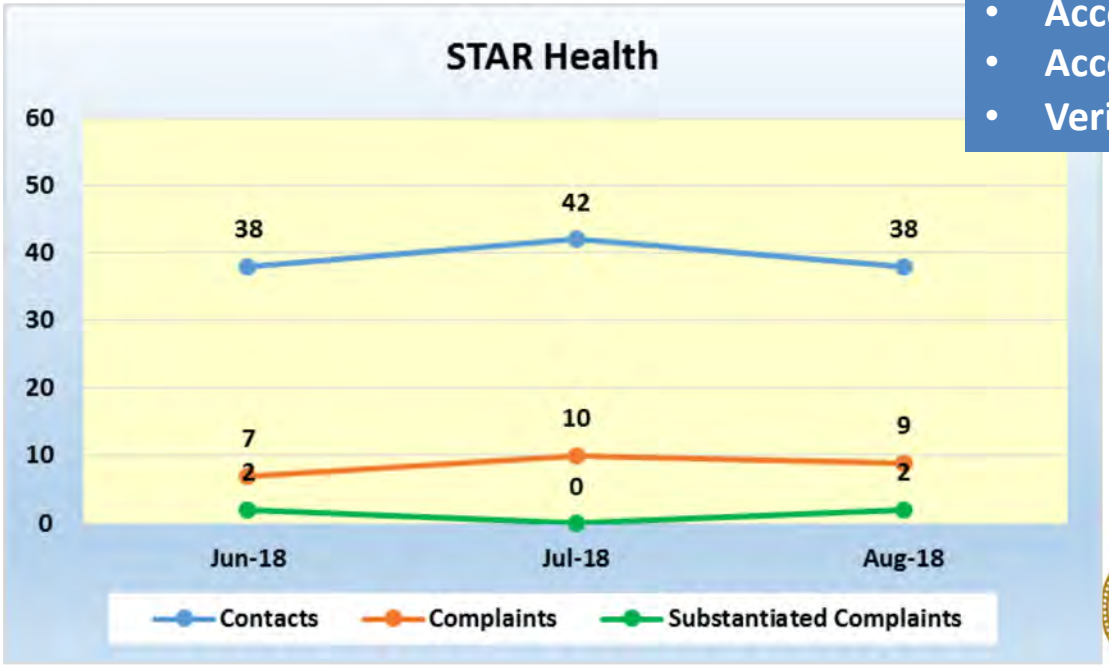



**Top 3 Contacts – STAR**

- Access to Prescriptions
- Access to PCP/Change PCP
- Verify Health Coverage

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

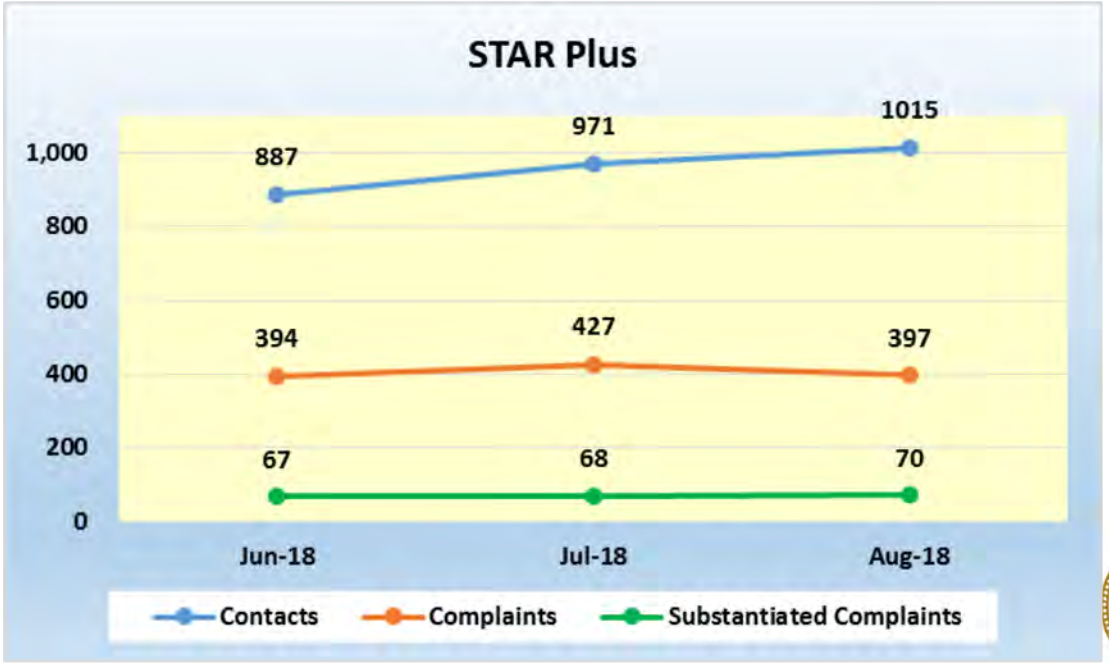



**Top 3 Contacts – STAR Health**

- Access to PCP/Change PCP
- Access to Specialist
- Verify Health Coverage

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

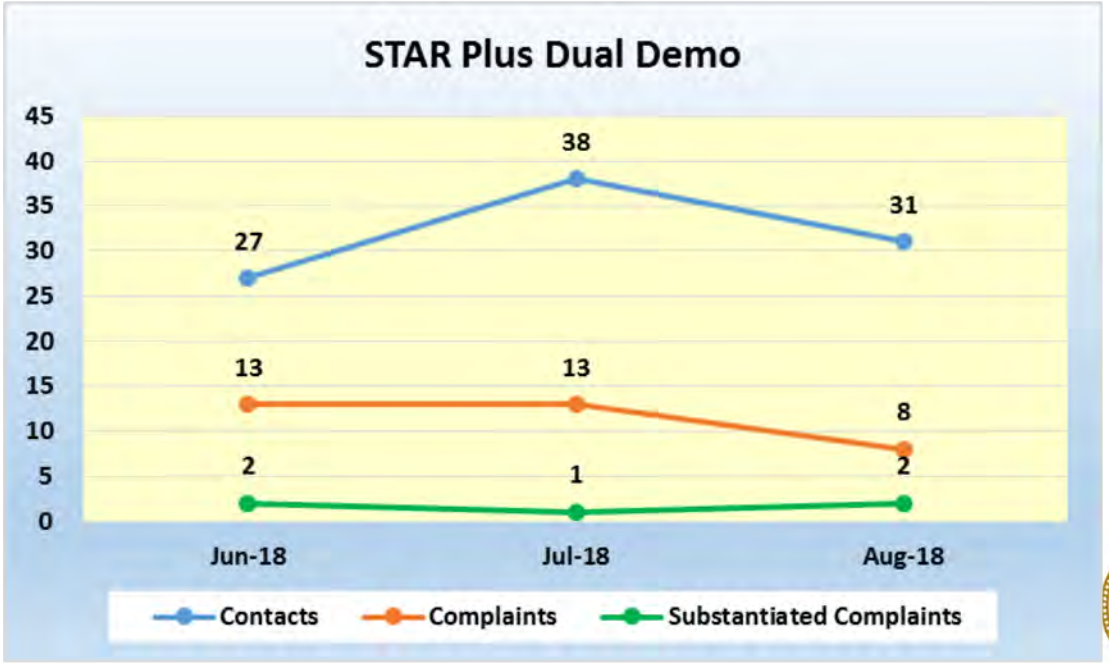



**Top 3 Contacts – STAR Plus**

- Access to Long Term Care
- Access to Prescriptions
- Verify Health Coverage

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

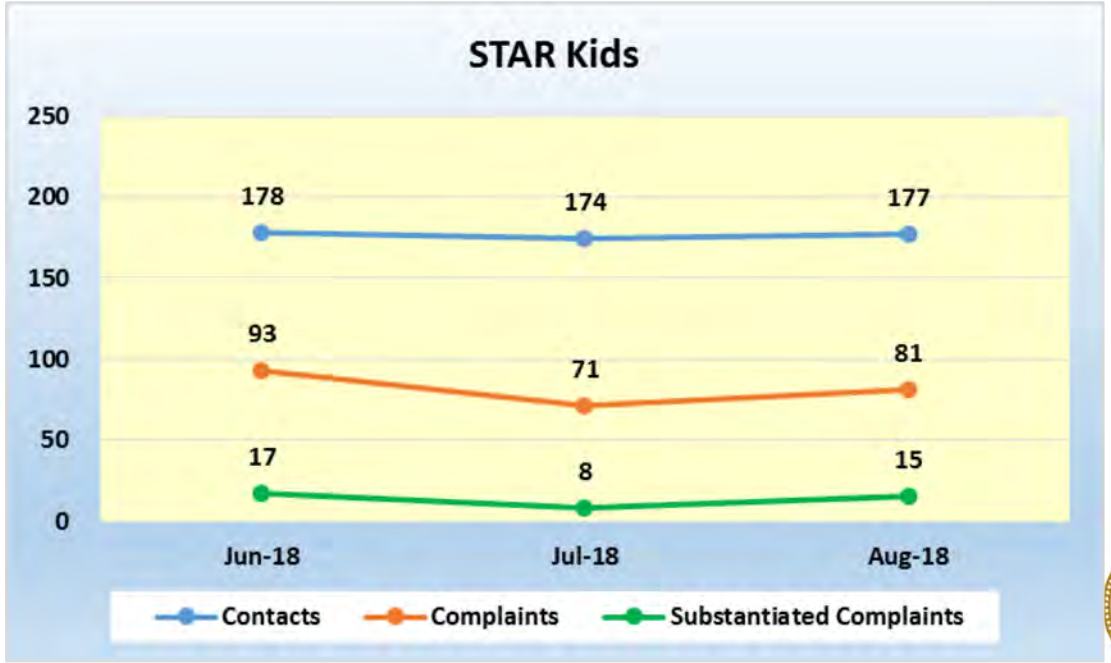



**Top 3 Contacts – STAR Plus Dual Demo**

- Access to Long Term Care
- Access to Specialist
- Explanation of Benefits/Policy

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018

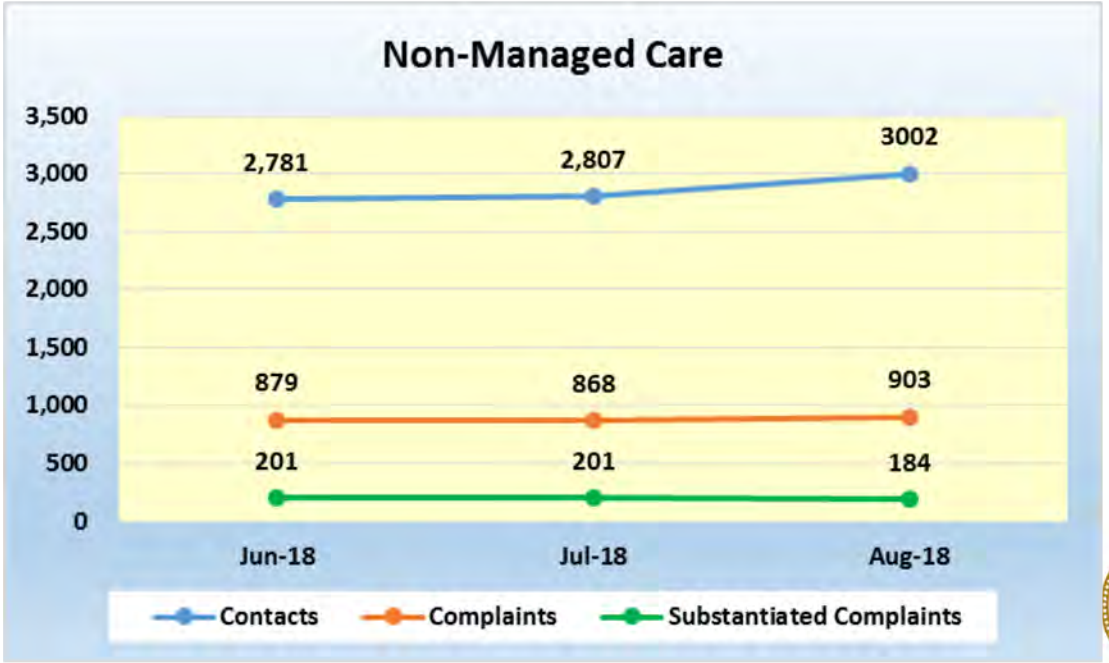



**Top 3 Contacts – STAR Kids**

- Access to Prescriptions
- Access to Provider
- Access to Care Coordination

TEXAS Health and Human Services

# Contact Volumes by Program Type
# 4th Quarter FY 2018




**Top 3 Contacts – Non Managed Care**

- Verify Health Coverage
- Application/Case Denied
- Access to Prescriptions

TEXAS Health and Human Services

# FOSTER CARE OMBUDSMAN

TEXAS
Health and Human
Services

# Foster Care Ombudsman Program
# 4th Quarter FY 2018

| Contact Volume 4th Quarter FY 2018 | |
|---|---|
| Foster Care Youth | 58 (33%) |
| Total Contacts | 175 |

| Top Three Reasons for Contact 4th Quarter FY 2018 |
|---|
| Rights of Children and Youth in Foster Care |
| Placement Issue |
| Primary Caseworker Responsbilities |

**Information Shared**

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

TEXAS Health and Human Services

# Ombudsman Managed Care Assistance Team

## UPDATE

- MCCO & OO alignment  of complaint codes and single point of entry for client Medicaid managed care complaints
- Collaboration with DFPS to outreach foster parents

TEXAS Health and Human Services

# Contact us

## Phone (Toll-free)

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

## Online

hhs.texas.gov/ombudsman

## Fax (Toll-free)

888-780-8099

## Mail

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

TEXAS Health and Human Services

**HHSC Open Records Coordinator**
**MC-1070**
**4900 N. Lamar Blvd.**
**Austin, Texas 78751-2316**
**Fax: 512-424-6586**
**Email: OpenRecordsRequest@hhsc.state.tx.us**

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

**Children's Health Coverage Coalition (former Texas CHIP Coalition)**
**Request for Information on Caseload Impact of Elimination of 6-Month Continuous Eligibility in second Six months of year, and Imposition of Periodic Income Checks (PICs) for Children under age 19 in Texas Medicaid**

The Children's Health Coverage (CHC) Coalition submits this Open Records request under the Texas Public Information Act. CHCC submitted this request to the HHSC Access and Eligibility Services division initially in December of 2017. In August of 2018, we were informed by agency staff that the 12/2017 request had not been filled and would need to be re-submitted as an Open Records request. We hereby make that request of HHSC.

The CHCC has been in active conversation for several years with HHSC regarding agency data and analysis of the impact of HHSC policy which eliminated the second 6-month segment of continuous Medicaid eligibility for Texas children, and re-instituted month-to-month eligibility with periodic third-party income checks during that period. Our inquiries began with the announcement of the policy in the summer of 2014, before the initiation of the change in children's Medicaid eligibility processes launched by HHSC in October 2014.

Here is the CHC Coalition's updated Open Records request from HHSC. As an appendix to this request, we provide a PDF re-cap summary of all the past major data requests and responses related to the 2014 policy changes, which have brought us to the current request.

**We want to work with HHSC to develop a data analysis that will provide a nuanced and complete picture of the separate and combined impacts of the current policies for children's Medicaid eligibility, PICs, and renewal.**

**Time frame requested:** A recent time period, preferably going back no further than 2016, that is long enough to allow the disaggregation of PIC-related eligibility denials by type (e.g., procedural denials versus those established to be over income). The period of analysis need not be a full 18 months, but it needs to be long enough to allow adequate sample size to determine the causes of disenrollment for children subject to the children's Medicaid MAGI procedures.

**Over this time period, we request the following data:**

- The total numbers renewed for Medicaid and CHIP (as in the CRaymond reply, but updated for the more recent time period), by program, and with breakout of procedural denials, versus failure to meet eligibility criteria.
- Quantitative detail on reasons for denial, disaggregated to show the relative frequency of different denial reasons, e.g. age, income, failure to respond timely or provide information

- Total numbers denied at the time of a 5,6,7, or 8-month PIC; with breakout of procedural denials and failure to meet eligibility criteria.
- An analysis of the # and % of Medicaid-enrolled children over the time period showing the # and % experiencing a gap of 1 month or more in coverage with subsequent re-enrollment. This should be done in a manner that identifies (does not leave out) those children whose re-enrollment may have triggered 3-month-prior retroactive Medicaid.
- Monthly # PICs, including the denominator of total Medicaid-enrolled children that month to clarify what % of enrolled kids have a PIC each month;
- #/% of the group examined who "passed" PIC and were not contacted; and #/% of those who were contacted (attempted),
    - as well as #/% of the contacted group who were denied versus continued eligible,
    - and of those denied at PIC, the #/% who were denied for procedural reason versus being over income.
- *Universe is MAGI children and newborns (no adults)*
- *All responses should be sure to provide both numerator and denominator, to allow for % frequencies to be calculated*
- *HHSC may wish to consider a separate parallel analysis for children on SSI or in special income group for LTSS, with input from other consumer advocates representing those children.*

Please understand, as always, that we are eager to work with your expert staff to modify the data request above for clarity, feasibility, and practicality. We request that HHSC staff consult with the Coalition members to clarify or modify any of the elements of this request as needed, rather than not fulfilling certain elements.

This completes the open records data request. We have appended as a separate PDF a listing of previous data requests and responses from HHSC related to this area of children's eligibility policy and practice, to inform the staff's analysis.

We look forward to answering any questions HHSC staff may have to help complete this data request. Please copy Anne Dunkelberg (dunkelberg@cppp.org ) and Mary Allen (mallen@tachc.org ) in your communications.

With sincere thanks,

**Anne Dunkelberg**
Associate Director
**Center for Public Policy Priorities**
7020 Easy Wind Dr., Suite 200 ● Austin, TX 78752
**T** 512 823-2864 *desk* | **C** 512-627-5528

**Copy:**
Cecile Erwin Young, Interim Executive Commissioner
Stephanie Muth, Deputy Executive Commissioner and Medicaid Director
Victoria Ford, Chief Policy Officer and interim Chief Operating Officer
Chief Program & Services Officer, Enrique Marquez
Deputy Executive Commissioner, Access and Eligibility Services, Wayne Salter

Background Information:

**Recapping Children's Health Coverage Coalition (former Texas CHIP Coalition) Requests for Information on Caseload Impact of Elimination of 6-Month Continuous Eligibility and Imposition of Periodic Income Checks (PICs) for Children under age 19 in Texas Medicaid**

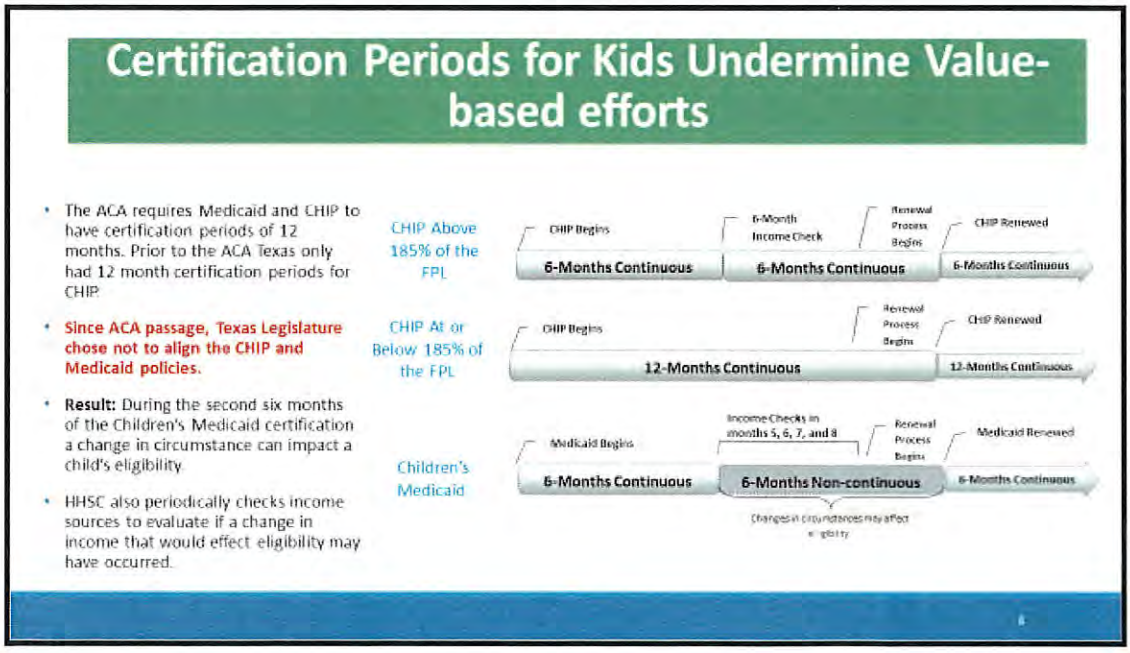
## Background, timeline/sequence of PIC-related data requests

(See: http://www.texaschip.org/pdf/CHIP-Coalition-Minutes_140718.pdf; http://www.texaschip.org/pdf/CHIP-Coalition-minutes-062014.pdf )

HHSC's policy eliminated the second six month segment of continuous eligibility, returning Texas kids to month-to-month coverage—which had been abolished in 2001 by the Texas legislature under SB 43—for the second six months of each year of their Medicaid coverage. As the graphic below shows, in that second six-month period, HHSC pays contractors to do four (4) database income checks. When added to the initial income check at initial enrollment, the checks at months 5, 6, 7 and 8 total five income checks per year per child, compared to two per year that were the policy under state law from January 2002 to October 2014.

Parents must submit proof of income if their income level is not found "reasonably compatible" with electronic sources. The combined effect of 4 scheduled income checks per year is that a child's coverage can too easily be interrupted if parents confuse the newest request from HHSC, with the last one they already responded to.

The current HHSC process was not established under Legislative directive, it was an internal administrative process developed by the agency. As such, most Legislators are unaware of the procedural problems that have resulted. However, physicians, health plans, application assisters, and families have all indicated problems resulting from unintended consequences of the process.



CHC Coalition members are interested in the aggregate impact of eligibility policies on enrollment and retention of eligible children, as well as in looking at the distinct impact of each of the moving parts of the overall process. The 2014 changes for children included increased use of administrative renewal at the 12-month point, elimination of hard-copy renewal packets in favor of online access, and the adoption of PICs at months 5, 6, 7 and 8. We are equally concerned about the drivers of enrollment loss at each of these points. Below is a recap of data we have received from HHSC to date, and updated requests.

Our CHC coalition members worked with Chairman Richard Raymond; Representative J.D. Sheffield, M.D.; Representative Phillip Cortez, Senator Judith Zaffirini, and Senator Carlos Uresti on legislation they filed in the 85th Legislature related to children's eligibility and enrollment policies. Through those processes, which began before the Legislative session, several data requests were made to HHSC, and some of the questions posed have been answered. Here is a listing of requests related to the new 2014 process and PICs, the HHSC replies, and remaining unanswered questions.

**1 20 2017 Letter to HHSC from Chairman Raymond**

Requested:

- Children's Medicaid and CHIP enrollment by month for the most recent 18-month period (i.e., last 6 months of 2015, all of 2016). *(Note: all data requested should provide both numerator and denominator, to allow for % frequencies to be calculated.)*
- Analysis of Medicaid-enrolled children over the time period showing the # and % experiencing a gap of 1 month or more in coverage with subsequent re-enrollment
- Quantitative detail on reasons for denial for those children experiencing gap in coverage, disaggregated to show the relative frequency of different denial reasons, e.g. age, income, failure to respond timely or provide information
- Quantitative detail on # children denied at 12-month admin renewal point, versus the # denied at the time of a 5,6,7, or 8-month PIC.
- HHSC budget/costs for Medicaid-CHIP enrollment, PICs, and renewal.

**2 14 2017 HHSC Reply to Chairman Raymond**

- Enrollment data and related stats provided are for 2/2014-7/2015 (not 7/2015-12/2916 as requested)
- HHSC states analysis of most recent 18 months is underway;
- Letter references the Raymond request for analysis of children with gaps in coverage, and for analysis that breaks out denials at renewal and at PICs;
- *HHSC states both of the above 2 bullets will be provided by 2/24/2017; however, this did not occur*.
- In FFY 2016, provides # and % of children denied at renewal (not as result of PICs) for failure to comply with procedures, and for failure to meet eligibility criteria; provided for both Medicaid and CHIP.

**4/7/2017 Agency Cost Estimate Filed Version HB 3151**

- This cost estimate looks only at the proposal to pilot-test alignment of eligibility periods for all children in a household, does not assume any change to PIC policy, no reduction in DataMart costs;

- Estimate assumes any eligibility policy change pursued via legislation will be assessed costs of TIERS updates in its fiscal note.

**HHSC Memo to Senator Uresti's staff 5/15/2017**

- Undated memo
- Page 1, December-March 2017 PIC stats:
  - *Mixed parents/caretaker data in with children's Medicaid; need data that eliminates adults.*
  - Provides avg. monthly # PICs, but not the denominator to clarify what % of enrolled kids have a PIC each month;
  - *Shows % of the group examined who "passed" PIC and were not contacted. But of those contacted, does not show breakout of number denied versus continued eligible, nor does it show which were denied for procedural reason versus being over income.* HHSC cited small (3 month) sample size for this lack of analysis. However, PICs have been done since 10/2014, so analysis of larger sample should be possible.
- Page 2, Administrative Renewals for Children. This includes a high-level description of how a question about income eligibility based on third-party data sources would be handled by HHSC, *but additional step-by-step and definitional detail is needed.*
  - *Example, "If the household's income cannot be verified electronically, is over the income limit, or is not reasonably compatible, the household is sent a notice..." A clear definition and examples of under what circumstances a child might NOT be over income but whose third-party information is deemed not reasonably compatible by HHSC.*
  - *We need an interactive training with HHSC staff in which they can answer questions, and describe the steps that are taken in months 5, 6, 7, and 8 when information is requested from a household. This will include understanding the timing of the requests and replies and eligibility terminations.*
  - *For example, if a family responds with documentation related to either an over-income or lack of reasonable compatibility issue noted in month #5, what happens if the same or similar info is encountered by the data broker in months 6, 7, and 8?*
  - *How are families contacted? We would like to see the text of the notices? Will notices in months 5 ,6, 7, and 8 to families include dates that make it clear that the notice is not the same as one from a previous month?*
- Page 3, Nov 2016-March 2017 Administrative renewals stats
  - The data provided include both parent-caretaker adults and MEPD enrollees; the CHC requests data for MAGI children (under 19) only.

**June 2 2017 Request from CHC for HHSC PIC briefing and data,:**

CHC requested for HHSC staff to attend June 2017 monthly meeting to answer questions about both the Raymond and the Uresti HHSC responses, particularly related to the PICs. This was provided by HHSC, notes are below from the meeting.

Also requested, staff able to answer questions regarding what assumptions were made when estimating the cost of providing continuous eligibility to all children in Medicaid. (Not provided by HHSC.)

**At June 16, 2017 CHC Coalition meeting (excerpt from minutes):**

- **Erika:** I'll respond to the questions sent over about the Raymond data, provide some updates, then walk through the (Uresti) handout on Periodic Income Checks.
- February 2014 – July 2015 was selected as the period of time for the Raymond data request because this was the time segment with the most complete data available. The letter also refers to a deeper analysis of churn for the child

population during that time period to be completed later. We had follow-up conversations with the offices because it was not readily-available data and would require a significant investment of staff resources. **We are not currently working that data piece.**

- **Melissa:** Can you give us a sense of what pieces would have been a significant endeavor?
- **Erika:** With the data request made by Uresti's office on PIC, we were able to parse out what we could provide. The Raymond data request was an overall request for churn data, PIC data and it is difficult to do a deep dive because we don't capture things at that level.
- **Melissa:** We would like to get a full sense of what children are going through to identify the holes and gaps where kids are falling through. Health plans and health clinics are seeing children staying on Medicaid for shorter times compared to before the ACA. We do have high-level evidence that supports what we're hearing anecdotally, but we would like full data to know about where eligible children are slipping through and churning out. The Uresti document has more details but what we don't have includes data on the number of those who don't make it through administrative renewal for procedural reasons—what are the reasons? Of those losing coverage because of checks, why is that? Is because people are over-income?

***Outreach and Technical Assistance***

- **Gina:** I'll focus on the specific blocked data from the Periodic Income Check handout. The period analyzed was chosen to see what time frame we were able to pull data for the quickest. The request was made during session and the more data pulled, the more time the request takes.
- We have to take a deeper dive into the actual cases to see which individuals were denied or which continued to remain eligible. As you point out, 0.66 percent of households were contacted based on PICs. It will take more time to look at those cases.
- The fourth question sent over asked for an analysis on PICs for non-SSI related children. We are trying to parse this out and look at reasons for denial. We will continue to work on that 0.66 percent of cases identified as being contacted based on PICs, though we could see a challenge with parsing denials.
- **Anne**: We'll also continue to work with health plans, FQHCs to start record keeping on cases so that we can take those to HHSC as well.
- **Anne**: According to the data request, less than one percent cases are contacted based on PICs, but 70 percent are contacted for administrative renewal. What's different in these processes that leads to this gap?
- **Gina**: Until we can parse this out and see what is not the population for Medicaid care-taker, aged, blind, &disabled, it's hard to say it is or isn't the same.
- **Anne**: Which point in time is administrative renewal for a child on Medicaid?
- **Gina:** The ninth month.
- **Anne**: What are you looking at during renewal that's not being looked at during PIC?
- **Gina**: It might information that's not financial. A residential move, perhaps. It's hard to compare these two numbers because the Medicaid children population is still included with other population numbers for the administrative renewal number.
- **Anne**: Thanks again for coming today to talk about this, it's an important priority of the Coalition. There's no other state doing anything like Texas' Periodic Income Check process. It seems like it's creating problems; it's not coming from a best practice elsewhere; it costs money; and it doesn't come from a legislative directive. That's why we continue to work on it and we're looking forward to constructively moving this conversation forward.

## HHSC information provided to CHC for August 2017 meeting (by email, 8/11/2017)

In preparation for attending the August CHC meeting, we wanted to share a chart that outlines the high level differences between Administrative Renewals and Periodic Income Checks. If there are any questions about the chart, Christina Hoppe will be able to speak to it at the August 18th meeting.

| | Administrative Renewal | Periodic Income Check |
|---|---|---|

| | | |
|---|---|---|
| **General Requirements** | For Children Medicaid and the Children's Health Insurance Program, an Administrative Renewal (AR) consist of reverification of certain eligibility criteria such as the household's income (i.e., current income and/or new or terminated income) and alien status, if expired, which is used to determine continued eligibility as required federally. | A Periodic Income Check (PIC) is an automated process used to determine whether there has been a change in an individual's household income that could potentially make them ineligible for Medicaid or CHIP. |
| **Federal Requirements** | HHSC complies with the requirement in 42 CFR 435.916 which requires the state renew an individual's status once every 12 months. | HHSC complies with the requirements in 42 CFR 435.952 and evaluates changes in income that may impact eligibility through the PIC process. |
| **Verification Requirements** | Verification is requested when a determination of continued eligibility cannot be made using electronic data or the electronic data indicates the individual is over income. | Income verification is only requested when electronic data indicates the individual may be over income. |
| | Verification is not requested when electronic data verifies an individual remains income eligible and meets other eligibility requirements. | Income verification is not requested when electronic data does not indicate the individual is over income. |

We are still working on the following items:

1. For the PIC data shared, determine if, and provide if available, of the 0.66 percent the number who were denied or remained eligible.
2. For the alignment data shared, provide for timely updates related to the agencies progress performing detailed case analysis, what is found, and what next steps are (i.e., training needs, system modifications, etc.).
    - CPPP agreed to share cases they come across experiencing alignment issues with AES.
3. For the Administrative Renewal data, provide data for only children; determine if, and provide if available, the number denied (and data related to reasons for denial) and the number of those who remained eligible

Charles Smith
Executive Commissioner
Texas Health and Human Services Commission

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

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

January 20, 2017

Dear Commissioner Smith:

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

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

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

Respectfully,

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

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

February 14, 2017

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

Dear Chairman Raymond:

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Charles Smith

**Agency Cost Estimate**
**Health and Human Services Commission (HHSC)**
**85th Legislative Session**

| | | | |
|---|---|---|---|
| **Bill:** | **HB3151** | **Version:** | **FIL** |
| **Author:** | **Sheffield** | **Date:** | **04/07/2017** |
| **Prepared by:** | **Doreen Streit** | **Phone No.:** | **512/424-6961** |

**Topic or Caption:** Relating to demonstration projects to coordinate eligibility renewal and eligibility recertification for certain children in the Medicaid and child health plan programs.

**Summary of Fiscal Implications:**

While implementation of this bill may result in costs to HHSC, a specific estimate cannot be provided at this time. HHSC does not have the information necessary to make appropriate assumptions to determine the overall fiscal impact.

Fiscal impact can only be estimated for implementation of system changes to the Texas Integrated Eligibility Redesign System (TIERS).

This estimate only assumes the impact for HHSC.

| Fiscal Year | Probable Cost to GR | Probable Cost to Federal Funds | Probable Savings to GR | Probable Savings to Federal Funds | Probable REVENUE Gain/(Loss) to _xxx__ | Change in FTEs |
|---|---|---|---|---|---|---|
| 2018 | 310,058 | 609,942 | 0 | 0 | 0 | 0.0 |
| 2019 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| 2020 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| 2021 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| 2022 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Total ALL YRS | 310,058 | 609,942 | 0 | 0 | 0 | |

| | | | |
|---|---|---|---|
| GR FY 18-19 | 310,058 | AF FY 18-19 | 920,000 |
| FTEs FY 18 | 0.0 | FTEs FY 19 | 0.0 |
| GR FY18-19w/out Fringe | 310,058 | AF FY18-19w/out Fringe | 920,000 |

| | | | |
|---|---|---|---|
| Net Impact GR FY 18-22 | 310,058 | Net Impact AF FY 18-22 | 920,000 |

## I. Bill Summary / Fiscal Analysis

SECTION 1. This section amends Subchapter C, Chapter 62, Health and Safety Code, by adding Sec. 62.1025, Eligibility Renewal Demonstration Project. This new section

provides that:
(a) HHSC shall establish a demonstration project through the child health plan program to allow the commission to simultaneously renew the eligibility of multiple children within the same household who are eligible for enrollment in the program.
(b) HHSC shall adopt rules necessary to determine the scope of, and eligibility for participating in, the demonstration project.
(c) HHSC shall operate the demonstration project under this section in conjunction with the demonstration project under Section 32.02614, Human Resources Code, if feasible.
(d) Not later than December 1, 2020, HHSC shall submit a report to the legislature regarding the commission's progress in establishing and operating the demonstration project and recommendations on continuing or expanding the demonstration project.
(e) This section expires September 1, 2021.

SECTION 2. This section amends Subchapter B, Chapter 32, Human Resources Code, by adding Sec. 32.02614, Eligibility Recertification Demonstration Project. This new section provides that:
(a) HHSC shall establish a demonstration project through the medical assistance program to allow the commission to simultaneously recertify the eligibility of multiple children within the same household who are eligible for medical assistance under this chapter.
(b) HHSC shall adopt rules necessary to determine the scope of, and eligibility for participating in, the demonstration project.
(c) HHSC shall operate the demonstration project under this section in conjunction with the demonstration project under Section 62.1025, Health and Safety Code, if feasible.
(d) Not later than December 1, 2020, the commission shall submit a report to the legislature regarding the commission's progress in establishing and operating the demonstration project and recommendations on continuing or expanding the demonstration project.
(e) This section expires September 1, 2021.

SECTION 3. Not later than September 1, 2018, the Health and Human Services Commission shall implement the eligibility renewal and eligibility recertification demonstration projects required by Section 62.1025, Health and Safety Code, as added by this Act, and Section 32.02614, Human Resources Code, as added by this Act.

SECTION 4. This section authorizes the agency to seek Federal approval to implement the provisions of the bill and delay implementation if necessary.

SECTION 5. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2017.

## II. Methodology/Assumptions

In past legislative sessions, HHSC established costs and FTE thresholds for consideration of no significant fiscal impact when preparing estimates. The flexibility to absorb any additional costs is eliminated with the appropriations bill as introduced.

Prior to commencing service delivery, HHSC must:

- Prepare a waiver and obtain federal approval
- Promulgate and adopt rules
- Carry out automation systems development or changes
- Hire and/or train staff and contractors on new or changed policies, procedures, and automation systems
- Conduct prior outreach or notification
- Implement modifications to the Texas Integrated Eligibility Redesign System (TIERS). Based on the development cycle of TIERS, additional modifications cannot be scheduled for implementation prior to August, 2018. The cumulative effect of implementing multiple bills enacted by the 85th Legislature could impact further scheduling.

Some of these implementation activities may be concurrent while some must be scheduled sequentially. These activities normally take 8-12 months. Actual timeframes may vary based on external factors, such as receiving federal approval.

Costs related to the adoption of the rules are immaterial and would be absorbed within existing resources.

SECTIONS 1 & 2

The bill requires HHSC to establish demonstration projects through the Children's Health Insurance Program and the medical assistance program to allow HHSC to simultaneously renew or recertify eligibility for multiple children residing in the same household under the same program.

Currently, in general, individuals who apply for Children's medical programs on the same application have the same renewal due dates when the children are eligible for the same program (i.e. both children are eligible for Medicaid or both children are eligible for CHIP). When possible, HHSC currently aligns the renewals for children. For example, when a child is added to the case during their sibling's certification period, the new child's renewal due dates are aligned with their siblings.

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

- When a household requests Medicaid or CHIP for a new child that is not a sibling, a new application is required. The new child receives a certification period that does not align with the certification period of the other children in the household.
- When a family has children certified for Medicaid, the renewal due dates may not align because the coverage started in different months. Medicaid coverage starts the month the application was submitted.
- When a family has children certified for Children's Medicaid and Medicaid for former foster care children, the renewal dates may not align as the eligibility for Medicaid for former foster care children begins the month after the youth transitions out of Foster Care Medicaid.
- When a family has children certified for Children's Medicaid based on the child's disability, the renewal dates may not align because a fixed certification period is not assigned to these types of medical assistance; the renewal date is set 12

months from the date the application or renewal is disposed.

Based on federal requirements, HHSC cannot delay a Medicaid or CHIP eligibility determination to align the renewal due dates and renewals for Medicaid and CHIP must occur once every 12 months and no more frequently.

Implementation of this bill requires HHSC to align certification periods in the demonstration project which would impact caseload and client services, eligibility policy, and operational procedures. However, due to the complexity of implementation, costs cannot be estimated at this time.

Not later than December 1, 2020, HHSC is to submit reports to the legislature detailing HHSC's progress in establishing and operating the demonstration projects and HHSC's recommendations on continuing or expanding the projects. HHSC assumes that any costs associated with preparing and submitting the reports would be immaterial and would be absorbed within existing resources.

While the procedural implementation, caseload, and client services are too complex to estimate their impact, the required TIERS modifications are not. The same TIERS modifications will be required for most scenarios of implementation. Please refer to the Technology Impact Section IV for details.

## III. Fiscal Impact

This bill is estimated to cost $310,058 in General Revenue and $920,000 in All Funds for the biennium. The estimated five year cost is $310,058 to General Revenue and $920,000 in All Funds.

## IV. Technology Impact

The total technology cost are estimated to be $920,000 in FY 2018, $0 in FY 2019, $0in FY 2020, $0 in FY 2021, and $0 in FY 2022.

Additional capital authority of $920,000 for the 2018-19 biennium would be required for the technology impact.

Application/System modifications to Texas Integrated Eligibility Redesign Systems (TIERS) are estimated at a one-time cost of $920,000 in FY 2018 (8,000 hours x $115 per hour). The modification to TIERS would include the following:

- Modify Eligibility Determination/Benefit Calculation (EDBC) logic to align the renewal due date during initial approval and renewals. Logic will be modified to identify and align renewal due dates for the household with children who are in Children's Health Insurance Program (CHIP), Children's Medical Assistance (CMA) or Former Foster Care Children (FFCC).
- Modify EDBC required verification rules for children Medicaid and CHIP Eligibility Determination Group (EDG) that are getting renewed early.

- Modify data collection to fetch EDGs of all children living in the same household during online renewal for a given case, when a renewal initiated by worker. An alert will be created for the worker to start renewal on related EDGs in the different case if any exists.
- Modify Medicaid Renewal process to identify related EDGs when an EDG is due for renewal and initiate the renewal process even if the renewal date is later than the current EDG's due date.
- Modify Scheduling, Correspondence and Alerts to accommodate the changes to renewal and alignment of due date for children in the same household.
- Scope includes testing with impacted trading partners like Texas Medicaid & Healthcare Partnership (TMHP), Enrollment Broker (EB), Medicaid Eligibility and Health Information Services (MEHIS) etc.
- Changes may be needed in reasonable compatibility and Electronic Data Sources (ELDS) functionality.
- Changes to Your Texas Benefits (YTB) is limited to Frequently Asked Question (FAQ) update.

**Assumption**

- DataMart impact not included in this estimate.
- New born (TP45), and Children's Health Insurance Program – Perinatal (CHIP-P) and Women's Health Program (WHP) not impacted.
- No functionality changes need to YTB/Mobile.
- No new Interface/ Web Service (WS) required.
- Hours provided in this High Level Estimate (HLE) will be converted to Sprints after epic deconstruction occurs for the intended scope.
- During the first time renewal and alignment process for a given case, there is no restriction on the number of months client gets certified. System can align with the earlier certification end date.
- Trading partners will accept certification periods aligned by TIERS.
- No change to Periodic Income Checks (PIC) process.
- Certification alignment is restricted to Children's Medicaid and adult or non-Medicaid EDG will continue to current determined certification end dates.

## V. Local Government

HHSC does not anticipate a fiscal impact to local government entities.

## Periodic Income Check (PIC)

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

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

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

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

**December 2016 through March 2017 PIC**

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

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

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

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

## Children's Medicaid and CHIP Renewal Alignment

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

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

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

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

**All Renewals due March 2017**

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

**Administrative Renewals for Children**

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

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

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

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

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

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

**November 2016 through March 2017 Administrative Renewals**

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

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