Children's Health Coverage Coalition and OTA Meeting Agenda
Friday, August 21st, 2020
11:00 A.M. – 1:00 P.M.

Meeting Location: Zoom Meeting
Access Meeting Recording: https://app.box.com/s/8jvjg5vn1nvl7fpy21muxke195iwn1ty

Meeting Chair: Christina Hoppe- Children's Hospital Association of Texas

11:00 A.M. – 11:10 A.M.	**Welcome & Introductions**
11:10 P.M. – 11:15 A.M.	**Update on Public Charge (**Anne Dunkelberg)
11:15 A.M. – 11:30 A.M.	**Federal update on COVID-19** (Christina Hoppe – CHAT, Katie Mitten – TCFC) o Discuss Senate's response to the HEROES Act – Christina Hoppe o Action item from TCFC around FMAP/MOE Push – Katie Mitten
11:30 A.M. – 11:50 A.M.	**COVID-19 Policy Update** (Christina Hoppe – CHAT, Melissa McChesney – Every Texan, Clayton Travis – TPS) o Medicaid and Telehealth Flexibilities. Governor Abbott, HHSC Extend Flexibilities For Medicaid, CHIP Providers During COVID-19 Response, Christina Hoppe o Discuss Medicaid Renewals, Melissa McChesney o Discuss CHIP Renewals, Melissa McChesney o Back to school amidst COVID-19, Clayton Travis. • Video presentation
11:50 A.M. – 12:10 P.M.	**Update on Southern Solidarity Action for Coverage Expansion** (Laura Guerra-Cardus – CDF, Cindy Ji – CDF) o Discuss coordinated action across all non-expansion states

CHILDREN'S HEALTH COVERAGE COALITION

FORMERLY THE CHIP COALITION

12:10 P.M. – 12:30 P.M.	**Review fiscal notes for 12 month continuous eligibility in Medicaid** (Anne Dunkelberg – Every Texan) o Review policy differences between terminating income checks and providing continuous eligibility. o Discuss strategies for next session on 6 months v. 12 months
12:30 P.M. – 12:55 P.M.	**Legislative Priorities Discussion** (Katie Mitten- TCFC, Laura Guerra-Cardus CDF) o ECI Advocacy Coalition, Katie Mitten o Prioritize and narrow ideas from CHCC Legislative Document o Discuss possible next steps
12:55 P.M. – 1:00 P.M.	**Announcements**

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Friday, August 21st, 2020
11:00 A.M. – 1:00 P.M.

On Video Conference Line

Christina Hoppe – CHAT
Anne Dunkelberg – Every Texan
Clayton Travis – TPS
Connie Jimenez – Maximus
Patrick Bresette – CDF Tx
Melissa McChesney – Every Texan
Alison Mohr Boleware – NASW/Tx
Katie Mitten – TCFC
Nancy Walker – TCFC
Cindy Ji – CDF Tx
Erika Loredo – Center for Children and Women, HTx
Michelle Tijerina – Central Texas
Sonia Lara – TACHC
Celia Kaye – League of Women Voters of Tx
Alissa Sughrue – NAMI Tx
Darryl Galman – People's Community Clinic
Denise Gomez – Chindren's Health
Michelle Romero – TMA
Christina L – YI
Helen Kent Davis – TMA
Reid Martens – Methodist Health Ministries

Meeting Chair: Christina Hoppe – Children's Hospital Association of Texas
Meeting Scribe: Maria Elena Garcia, Every Texan

I. **Welcome & Introductions**
II. **Update on Public Charge** (Anne Dunkelberg)
    a. Anne: For a brief period of time the public charge rule was on hold. Around a week ago a judge stated that it was only off in New York, CT, and other northern states. It is not on hold here for us in TX or most of the country at this point. There are still ongoing challenges to the rule. We had some circuit courts rule that it is unlawful and another circuit upheld it. It is now headed to the supreme court. Unfortunately this freeze on public charge is ongoing.
    b. Christina: We were hoping it was going to be good news. Any idea on time line for the next step on the 3 panel of judges?
    c. Anne: It just states that at some point. Courts are all backed up since some froze things for a while and they are hoping to work out with online and remote work. Any questions?
III. **Federal update on COVID-19** (Christina Hoppe – CHAT, Katie Mitten – TCFC)
    a. Discuss Senate's response to the HEROES Act – Christina Hoppe

i. Christina: Similar to Anne's update we didn't know exactly how this update was going to be. Over a month ago the Senate sent their response to the Heroes Act. There are big points of difference. One is the total funding: the House version was $3 trillion and Senate is $1 trillion. House also included the continuation of $600 and Senate didn't. Senate included some business liability protections and in the House version it included some worker protection and standards about safe workplaces. House gave $1 trillion for state and local governments and Senate didn't. Both proposals still had that payment for families at certain income levels. In terms of provider relief funding House had $100 billion (to offset covid-19 related costs), Senate had $25 billion. They are far away from each other and there is some intense negotiation which is probably on pause. House has been discussing postal service.
ii. For next step: Maybe around Labor Day they could pick back on this. They are continuing resolutions that need to be passed by sept 30. I personally think there will be a COVID-19 relief package but there is still a big difference between Senate and House. Anyone has any questions?
iii. Anne: One of the things that we were encouraging is to make sure to understand that if Texas doesn't get more FMAP money, and if we don't get some meaningful extension for unemployment benefits, it will determine budget cuts in 2021 when the legislature comes in. We need to push this to local and state governments. If we don't get that funding, it could cut to K-12 education. When they give us Medicaid relief, it prevents cuts from other parts of the budget. We have to be weighing in and remind them the importance of what they are doing to our state budget.
iv. Christina: State and local funds are extremely important. There is some flexibility as to how we can use these funds so that they can fill in missing pieces.

b. Action item from TCFC around FMAP/MOE Push – Katie Mitten
i. Katie: I just put in the chat a link to our action statement to send a letter to senate for FMAP push. Make sure to share it with your network. Make sure to leave the FMAP language in there. When I talk to state representatives, I also bring this up and make sure they understand the connection and hold them accountable to secure our budget.

c. Any comments?

IV. **COVID-19 Policy Update** (Christina Hoppe – CHAT, Melissa McChesney – Every Texan, Clayton Travis – TPS)

a. Medicaid and Telehealth Flexibilities. Governor Abbott, HHSC Extend Flexibilities For Medicaid, CHIP Providers During COVID-19 Response, Christina Hoppe
i. The first update is that the governor of Texas extended the Medicaid and Telehealth flexibilities. Extension goes to oct 23rd. Maximizing telehealth and telemedicine.

b. Discuss Medicaid Renewals, Melissa McChesney
   i. Under the ACA, Medicaid agencies are required to increase renewals. Their process is not historically successful. They relaxed a lot of constrains for the big batch. Only about 25,000 received renewal documents. We are pleased with the decision and outcome. We are in conversations with HHSC pushing to improve the renewal process. We are already hearing about a lot of confusion as to when to renew. Many clients didn't understand the process. There is a lot of work to be done to improve the communications. We want the administrative renewal process to work better, because we've seen that it can be done and it reduces administrative burden to client and state and that way they can focus on applications. If you return your renewal package, you will get a 12 month certification if you're eligible. If you are not eligible you will still continue as long as the public health emergency is in place. After public health emergency, they will be given the opportunity to show further documentation. Obviously ineligible people (those who aged out) are the ones who are an exception to this. Right now they are looking at a December denial. All of this could get pushed as the Public Health Emergency is extended. They will get a denial letter and in the denial letter there will be an application to see if they are eligible for another reason. Women on pregnancy Medicaid could get rolled over to HTW.
   ii. Patrick: Is there anything to say about what made the initial administrative renewal so easy?
   iii. Melissa: The biggest thing that HHSC has pointed to is a restriction on the age of the data. Now we only use the quarterly wage data for income. There is no time limitation for income. If their income was eligible at any point, then they could get it. What we are recommending is that they relax the 60 day time frame moving forward. TWC data: you have to submit your quarterly earnings and it takes 30 days for the information to get to you, then you only have 30 days to use it. The time restriction is what we are looking at. The memo (pg. X) has additional recommendations. At this point we are prioritizing getting them to move on the restriction of the age of the data.
   iv. Christina: do you have a sense of how old the data is that HHSC is using?
   v. Melissa: We are providing a rec.

c. Discuss CHIP Renewals, Melissa McChesney
   i. Melissa: There has not been a decision made on September renewals. As of now, August extensions were made until September. If my child's renewal was due in April, I would receive a package from April-August. If they returned at least one of those packages, then HHSC will start processing them. If they don't respond at all, they will get them monthly. HHSC is only requesting extensions 30 days at a time.
   ii. Christina: do you have any info about what the other states are requesting?

iii. Melissa: We have communicated with national partners, but their info isn't as detailed. When Harvey happened we extended 6 months and this is also an emergency that should be treated similar. We didn't get that level of detail.
iv. Anne: we can put it out to other states. And ask for some examples even if we don't have 50 state data. I wanted to mention two hopeful notes:
    1. Health plans are exited to be able to resolve this confusing. HHSC understands that this is confusing and while we still have challenges,
    2. They did acknowledge about the less than ideal situation on the monthly renewal packages being sent out to families.

d. Back to school amidst COVID-19, Clayton Travis
    i. There is a presentation that our president sent out.
    ii. In essence, TPS put out a statement before school started highlighting the key points for in-person instruction when possible and safe. The media took the narrative that pediatricians wanted in person no matter what. There are many reasons why children should be going back to school. Schools offer safety net services: food, vaccines, counseling, emotional well being etc.. Pediatricians are reporting that kids are experiencing higher levels of depression and social anxiety because of quarantine. While we have trade-offs, there are some negative ramifications. Distance learning is not equitable. Many parts of states don't have access to fast internet that is required for virtual learning. Parents work outside of home and can't monitor their process. We need to keep in mind that it isn't an equitable arrangement for all families. We are making the point to minimize risk to students and asking ISDs to have solutions to minimize the spread. Guidance from Public Health departments is key and is best to advice school districts. When students go back to school, we put together some recs as to what it should look like:
        1. 2021 Public Health guidance from TEA
        2. They have been relying on this doc and it keeps improving
    iii. Health screening and special circumstances for children with co-morbidities (and staff), protocols for quarantine. Test to come back? Health and hygiene.
    iv. Biggest documents are the CDC back to school planning and APA's return to school document. If you have any questions there is good info there.
    v. There is no safe way to do back to school during the pandemic, or take care of kids. Most recommendations are about minimizing risk on both sides (infection control and effects of pandemic on social, emotional well-being).
    vi. We need to see robust funding for schools. We sent a letter to Texas congressional delegation. For schools to follow this guidelines, they need sufficient resources.

vii. TMA also has some school reopening sources. We also have some resources for school nurses, it is a clinical algorithm tree and it helps them determine and give recommendations. Any questions?

viii. Patrick: IS TEA doing anything about how to assists schools that don't have any healthcare professionals?

ix. Clayton: Right, not all schools have them. It has been a priority of us to ensure school nurses are represented on campus going forward for infection control and overall health. TEA has not given any guidance of hiring school nurses. There is an interim guidance submission request and there are specific question in the request form that asks about school nurses. Do they have the necessary equipment to keep schools safe? If this group wants to support that effort it would be appropriate and helpful.

x. Anne: Did you share all those links with us?

xi. Clayton: Yes, I will.

V. **Update on Southern Solidarity Action for Coverage Expansion** (Laura Guerra-Cardus – CDF, Cindy Ji – CDF)

a. Discuss coordinated action across all non-expansion states

i. Cindy: As you all know, Southerners for Medicaid expansion is a multi-state coalition of states coming together to honor people in the coverage gap. I want to emphasize that to underscore this message we will send out a sign-on for partners to sign on this message. SickOfItTX is doing work on this action. We want people to get in on this. We will send out something hopefully next week.

ii. Leading up to the vigil on October 1st, there will be a story-teller spotlight in Texas to identify their stories in the coverage gap. If you know anyone in the coverage gap, send them my way.

iii. We want people to safely participate in this pandemic for October 1st. We are hoping to finalize something this week to put out a visual display. The idea is to have a candle light animation representing the scope and scale of people in the coverage gap. We will have a message along the lines of "everyone's light can go out if we don't fix it". The projection is easy to set-up and we will make sure people in our team can help out. We would like to buy up billboards in strategic places, which will be aligned with gatekeeper legislators. Our team is working in identifying prominent places to share those projections.

iv. We will ask people to sign petitions, do click to tweet, take pictures with visuals. We will like to do a follow-up organizing activity: phone banking etc. We will also invite everyone to participate in a virtual event hosted by North Carolina. We will send out more info on this next week and share a more detailed ask. From partners we will be asking for support in identifying stories. Any and all coverage gap stories are welcomed. We want to bring in media and we will love support identifying reports who will be interested in sharing these events.

v. Patrick: I wanted to echo my excitement about the projection idea. We are trying to find a way to have a media worthy event so that the visual itself can live on. The image could be a powerful thing to have its own momentum.
vi. Cindy: We have been working on producing many video stories that support our legislative priorities. This week we published Melissa's about having Medicaid as a safety ladder, not only a safety net. If you could all share it, we will be grateful.

VI. **Review fiscal notes for 12 month continuous eligibility in Medicaid** (Anne Dunkelberg – Every Texan)
a. Review policy differences between terminating income checks and providing continuous eligibility.
b. Anne: It was part of our understanding that we needed to know about the fiscal notes. Some offices on the Senate side stated they didn't understand the notes and were skeptic about them, which might've been the reason why they killed the whole bill to fix the periodic income check problem. We are going to look at some pages out of the memo.
i. All of this was in the context of our coalition's mutual concern in decline in enrollment and the corresponding increase in uninsurance in Texas. Eligibility for kids flattened out in 2014 which was when they took away continuous eligibility and started periodic income checks. We had a decline in children's coverage.
ii. We have a short table on where we've been in continuous eligibility. (pg 5) when we created CHIP in the 1999 session and did it with continuous eligibility. Then in 2001 we got a reform in children's Medicaid to apply by mail instead of needing to go in person twice a year. They had to renew more often but at least obtained continuous eligibility without having to go to the welfare office. In 2003, there was a big push by conservative legislation to cut back social services programs. Children's Medicaid had 6 months of continuous eligibility from January 2002-2014, when the policy we were dealing with started, which flattened the enrollment. Since then, we had bills filed almost every session to try to get us to 12 months. And even without any lobbying we had the second 6 months administratively taken away. You can see in this document that there were bills filed throughout the years. The biennial GR estimate was catching the eye of fiscally conservative leaders that were skeptic of anything that might increase enrollment. It kept decreasing. $6 million for a program that covers 3 million children is microscopic for 12 months. The 2007 bill was filed during the early stages of a major collapse of eligibility processes, failed privatization attempts. It was way before ACA. The rules now are different. ACA also increased metric for CHIP, the state would have to pay far less for moving children from Medicaid to CHIP. Because of changes and the atmosphere of the welcome mat effect we had a substantial reduction in uninsured children in TX between 2013-2016.

ACA got rid of the asset test and also brought attention to a program that families and kids could be eligible for. Early models were assuming a big surge of eligibility that has already happened and is not part of the fiscal note.

iii. In 2019, it was the first time that HHSC did any impact analysis of the impact of their eligibility services. Dr. Sheffild asked to obtained data, except we didn't get any results until Feb. By the time they started doing fiscal notes they did the internal analysis. Then realized the offset costs they had to take into account.

iv. We do have an understanding of why the fiscal notes have come down and part of our discussion is that we all need to have a set of talking points in order to understand and help others understand.

c. Discuss strategies for next session on 6 months v. 12 months

i. Should we try to promote 6 or 12 months? My suggestion was to have a version of what a 6 month piece would look like. None of the ones who got rid of 6 months continuous eligibility are in the picture. There is not a lot of institutional memory or investment in this decision. The governor's office is looked up to for approval. Even if federal law requires states to do administrative renewals, they did not believe that the data for administrative renewal at the 6 month point was sufficient to meet the concept to trigger another 6 month continuous eligibility. That was based on internal beliefs and not specifics.

ii. My recommendation is whatever we put forward is to take us back to the policy that allowed growth for children's coverage. If we went back to consecutive 6 month segments, that would put us back on track for enrollment growth in children's Medicaid but we still need to attend to how we do administrative checking of earned income. Which can be a factor that undermines our ability to cover kids.

iii. Anne: we need to decide how to juggle supporting 12 month and 6 month. WE need to get to that decision eventually

iv. Nancy: without having that decision it is difficult to make the context that we are making and now is the time to have conversations with the legislative offices and we need to be clear about our ask.

v. Patrick: Anne's point is important about how some are going to file 12 month. The strategic question is who is going to work it and give them everything they need to support them. Intellectually, 12 month is the best practice and equitable. We also need to have a strategic conversation of a clean back-up. Best case scenario is we would have multiple bills and have a public conversation with legislature: here is best practice and here is what we have now. We need to be clear to support both and hold a high ground on what we think is best practice.

vi. Anne: an appeal of weighing out how to get back to 6 month continuous eligibility is that the majority of legislators didn't know it went away. We can get away with saying 12 month is gold standard or at least get back to

where we were on 2014. Some are not going to know this problem happened at all.

vii. Helen: We need to start where we really want, which is 12 months. Aim high and recognizing we probably won't get it given the budget environment, but also educate.

viii. Anne: We may have to package that together: this is gold standard, this is what kids have, and the problem is we don't even have 6 months anymore. We have to make it clear that there is a connection and then make it work.

ix. Nancy: I agree about making it the gold standard. The reality is, this session is going to do much less (with regards to time, actually coming together, lesser workload). We need to keep that in mind and there is power in a unified voice and standing behind the gold standard.

x. Rosie: It comes down to governor and he can veto a bill. We have to work on a veto-proof bill. We need to reeducate this legislature and we have to give the facts about the safety net we can offer to children is this time. I do think we need to be careful on how if we can't get 12 months we want 6.

VII. **Legislative Priorities Discussion** (Katie Mitten- TCFC, Laura Guerra-Cardus CDF)

a. ECI Advocacy Coalition, Katie Mitten

i. We have 5 big priories: two of them involve the budget.

1. First it is increase funding for Early Childhood Intervention (ECI)
2. Increase funding for caseload growth
3. Insuring that all TDI-regulated private health insurance plans reimburse ECI
4. Improving partnerships between childcare providers and ECI programs. This is a refuel from last session. The goal is to ensure childcare providers are educated on ECI. And clarify that childcare settings are required to offer ECI provider services.
5. Eliminating inaccurate mid-year removals for eligible kids. We will follow the lead of this group. The ECI coalition would like to support efforts.

b. Prioritize and narrow ideas from CHCC Legislative Document

i. Patrick: Can you all pull that up if you have the chance. We have the core mission and purpose. We all know budget is going to be a big deal and it is important to emphasize that FMAP is important. I will do a quick scan and open up the conversation. With the pandemic and successful use of telehealth tools we are trying to figure out a way to keep some of those best tools in place. Stacking could be best practice to work on those Medicaid renewals. There is a section on outreach and enrollment. The state is completely devested in direct funding for community outreach and enrollment. If we really want to reach families and kids and particularly those losing insurance, we should be doing a better job in targeting those activities in a community level; we have a new initiative in East Texas and The Valley. How do we get public health systems to include and identify

critical children? Finally, how to get the Medicaid program to be where it needs to be. It is important to highlight the health equity challenges.

c. Discuss possible next steps
    i. It is important to note that even while we nail the details on this, chambers and other partners are developing their agendas. Even if it takes us a while to nail this down, we could share these with them in order for us to be cohesive. Any questions or feedback?
    ii. Alison: I appreciate the inclusion of telehealth and telemedicine. The more people echoing that in different areas will be more helpful.
    iii. Patrick: Absolutely, it helped us get services to a child who had severe dermatological issues when the nearest dermatologist was far away.
    iv. Katie: Connect telehealth to a conversation on broadband.
    v. Melissa: Making sure that a cut to eligibility work is a cut to access. It was a problem before COVID-19, and is now an even bigger problem.
    vi. Patrick: There is an affinity group of texas rural funders and they are focusing on broadband as a topic. They are funding research and surveys to identify the problems. We will have interesting data to point on the extreme challenges across all kinds of systems.
        1. Feel free to send more feedback. We appreciate anybody's input.

A. Any announcements? Send Adriana a big congrats.

a. Anne: we will emphasize more e-mails on state of enrollment conference. Thanks
b. Patrick: I will be taking a lot of issues to an audience in August 31st.

B. Meeting adjourned 1:01

Administrative Renewals during PHE (debrief after meeting with HHSC on 8/20/2020)

Key Takeaways

- HHSC has stated that the improvements to the administrative renewal process were a one-time change and were only applied to the large batch renewals for clients whose Medicaid was extended in March through August. **HHSC will use the old, less effective policy for all administrative renewals ongoing.** In fact, they have already processed September administrative renewals using the more restrictive policy.
- This means that Texas' administrative renewal rate could likely plunge back to the single digits in September and thereafter. **Instead of having 97% of clients pass the administrative renewal, 90% or more could fail and be sent renewal packets.**
- Given this, almost all of the recommendations from the original memo are still valid.*
- According to HHSC, the high success rate of the administrative renewals in the Mar-Aug batch was primarily due to the removal of the system requirement that had prohibited earned income data that is more than 60 days old to be used. (We recommended this be relaxed in the original memo).
- While we don't feel it is necessary to remove the age restriction on income data entirely, as was done for the Mar-Aug batch, HHSC should relax the restriction considerably.
- TWC Quarterly Wage Data is currently the only electronic data source used by the administrative renewal process for *earned* income. Under the current system design, HHSC will be unable to verify earned income using TWC in *at least* 8 months out of the year, because the TWC data will be over 60 days old in those months. This means most people with earned income will fail the administrative renewal process in these months. (See detailed explanation below.)
- **Top Recommendation:** HHSC should allow the use of TWC quarterly wage data from the two quarters prior to the current quarter.
    - Example: If HHSC is processing an administrative renewal in September (which falls in Q3) the system should consider TWC wage data from Q2 and Q1 valid.

More Detail

TWC Wage Data and the 60-day restriction

- HHSC has stated that the most impactful change they made to the administrative renewal process for the March-August batch of renewals was that they eliminated the constraint on age of the income verification. Prior policy required that the electronic data must be no more than 60 days old.

- This "policy" is simply part of the system's HHSC-generated design. It is not required by CMS and is not documented in the State Plan, the Texas Administrative Code, or the Texas Works Handbook.

- TWC Quarterly Wage Data is the only electronic data source used by the administrative renewal process for *earned* income. HHSC stopped using paycheck data from the Equifax Work Number system (also known as TALX) in October 2019.

- This system design does not align with current policy for the use of TWC Quarterly Wage data by an eligibility worker when they manually process an application or renewal. Under current policy the worker is able to use wage data from the most recent quarter available, regardless of whether it is over 60 days old.

- Under the current system design for the administrative renewals HHSC will be unable to verify earned income using TWC in *at least* 8 months out of the year. Example using Quarter 2:
    - Q2 ends Jun 30, employers have until July 31 to submit wage reports.
    - At best HHSC has access to this data the first week of August.
    - Any renewals processed in August could make use of the Wage data.
    - Any admin renewals processed in September and October will not be able to use TWC wage data. This means most people with earned income will fail the administrative renewal process in these months. (The only exception would be if a person recently verified their income, for example during their SNAP renewal. HHSC would have to confirm this functionality)
    - New wage data for Q3 will be available at the earliest in the first week of November.

- Months were TWC wage data would be useable given the 60-day constraint:
    - ~~January~~
    - February - Can use Q4
    - ~~March~~
    - ~~April~~
    - May - Can use Q1
    - ~~June~~
    - ~~July~~
    - August - Can use Q2

- ~~Sept~~
- ~~October~~
- November - Can use Q3
- ~~December~~

New Hire Report

- As recommended by the earlier memo, for the Mar - Aug batch HHSC removed the system functionality which considers New Hire report data. They stated that they incorporate that data monthly through a different process and felt that it was redundant to consider again at renewal. Unfortunately, they plan to revert to old policy for all administrative renewals ongoing starting in September, and the New Hire Report will be used again. Therefore our original recommendation from the memo is still valid.

The process for manual renewals during the PHE

- No clients will be denied during the PHE, as required by the FFCRA.
- Clients who do not respond to the renewal packet will be given an additional opportunity to submit their renewal packet or needed verification prior to being denied at the end of the PHE.
- Clients who return their renewal packet and verification and are determined ineligible will be given the opportunity to submit updated information prior to being denied at the end of the PHE.
- HHSC will follow federal regulations and allow clients to return renewal information up to 90 days after termination without requiring a new application.
- Clients who are “obvious denials” (such as 19 year olds who aged out) will be automatically denied at the end of the PHE. But they will still be sent an application with their denial that they can return if they feel they are still eligible for Medicaid.
- Given the system changes, HHSC is uncertain whether renewal packets sent during the PHE will be pre-populated as is required by federal regulation.
- * There is one recommendation from the memo that HHSC will implement. HHSC has stated that they sent the entire renewal packet to clients processed in the Mar-Aug batch, as we recommended. HHSC plans to continue this for all renewals during the PHE.

EVERY TEXAN

Formerly Center for Public Policy Priorities

TO: **Executive Commissioner, Cecile Young**
Chief Program & Services Officer, Michelle Alletto
Acting Chief Operating Officer/Chief Policy and Regulatory Officer, Victoria Ford
Texas Health and Human Services

COPY: Stephanie Stephens, Wayne Salter, Suling Homsy, Michael Ghasemi, Allison Morris, Hilary Davis, Bill D'Aiuto

FROM: Anne Dunkelberg, Melissa McChesney – Every Texan (formerly Center for Public Policy Priorities)

Re: **Improving Renewals to Reduce Disenrollment of Eligible clients when HHSC begins Administrative Renewal Reviews: 8/2020 or at the End of the Public Health Emergency**

Background

Since 2014, federal rules have required state Medicaid agencies to first attempt to renew Medicaid eligibility using available electronic data before requiring the client to provide updated information. HHSC has stated in a recent policy bulletin, that it plans to resume administrative renewals in August 2020 for individuals whose coverage has been extended during the current public health emergency. We urge the agency to make prompt improvements to the administrative renewal process before it attempts to utilize it for clients whose coverage has been extended as required by the FFCRA.

Currently, Texas' policies and systems for performing administrative renewals for MAGI-based eligibility groups have a very low success rate in achieving renewals compared to other states. According to a 50-state survey from the Kaiser Family Foundation, **Texas is one of only eight states with an administrative renewal rate of less than 25%.** It is our understanding that Texas' success rate is actually significantly below 25% and is one of the lowest in the country.

Percentage of Renewals that are Automated (Completed without Enrollee Action)[2]				
<25%	25%-50%	50%-75%	75%-90%	≥90%
8	13	13	9	0

HHSC should consider prioritizing options to improve the administrative renewal process so that it can be utilized to more effectively renew coverage for eligible clients after HHSC resumes administrative renewal reviews in August as proposed, and at the end of the COVID-19 public health emergency.

Recommendations to improve administrative renewals:

- **Use self-attestation for non-financial eligibility criteria to the extent possible; specifically residency.** If the client has not reported a change in their residency, they should not be required to reverify with paper documentation that they still live in Texas. This is already done by HHSC for children's Medicaid and should be extended to more eligibility groups. This is a low-risk

policy solution because the state will act on returned mail, in the event the renewal packet is returned as undeliverable.

- **HHSC should evaluate their reasonable compatibility process to identify its impact on the state's low administrative renewal success rates.** Possible areas for improvement:
    - The process for determining whether the client's statement of income is considered reasonably compatible with electronic data is problematic. According to the original bulletin, one scenario where a client's statement of income may be determined not reasonably compatible with electronic data is if the, "Applicant or client has provided more income sources than are available from electronic data." However, if both the client's statement of income (at renewal this is what is included in the TIERS system) and electronic data on income show the client's income to be below the income limit, the income should be considered verified as required by federal regulation (42 CFR § 435.952(c)(1)). This system logic appears to violate this regulation.
    - Reinstate the use of the Work Number System data (ended by HHSC October 2019). This was the most detailed data available to verify income electronically without reaching out to the client.
    - Evaluate current constraints on the use of data from the quarterly wage reports from TWC to identify areas for improvement. Are there any constraints on the use of data based on its age? For example, if the agency only uses electronic data no more than 60 days old, this may prevent the agency from using TWC data much of the time. This data is only gathered quarterly and it may take TWC months or weeks to make new quarterly data available to HHSC.

- In addition to reviewing renewal policy, HHSC should do a thorough evaluation of the system design documents to identify rules and logic that may be creating unnecessary barriers to successful administrative renewals. Examples include:
    - The process for evaluating a new hire report is problematic. According to the original bulletin posted on administrative renewals, the system will request paper verification from a client due to a New Hire report unless the employer name and start date in the report match exactly with the employer name and date included in TIERS. Exact matches of employer names could be fraught with errors. Misspellings or uses of parent company names could easily cause a mismatch.

When the administrative renewal fails:

- **In recognition of barriers to internet access that may be heightened in the COVID-19 crisis, send the paper renewal packet to all clients.** Currently for all Medicaid programs with the exception of Medicaid for the Elderly or People with Disabilities (MEPD), full *paper* renewal packets are not sent to the client. In order to submit the renewal, the client must sign into their YourTexasBenefits.com account and submit an online renewal or print the paper renewal from

their account. This creates an unnecessary barrier to renewal for those without access to a computer, internet, or printer. This issue is further exacerbated by the pandemic as many clients may have reduced or no access to community computers and printers at the local library, community-based social service organization, or schools.

- Improvements to the automated administrative renewal process should be the top priority. This will reduce administrative burden on both clients and HHSC eligibility workers. In addition, we urge the state to evaluate a sample of cases to identify instances where the administrative renewal was unsuccessful and yet the client is likely eligible. The agency should continue to improve this process and to identify additional system barriers.

Questions on Texas Works COVID Policy Updates #12 published July 20, 2020

- Has HHSC made any updates or improvements to the previous administrative renewal process in anticipation of processing renewals beginning on August 8, 2020?
- For those individuals whose coverage HHSC is unable to renew:
    - Will those individuals' coverage be automatically terminated at the end of the public health emergency?
    - Will they be offered any additional opportunities to provide verification of their eligibility *without having to provide a new application*?
    - Will they receive any reminders of the need to return the renewal and required verification?
- If a household returns the renewal and any required verification will HHSC process the renewal and, if eligible, will these clients be given a new 12 month certification period?

Additional Resources

- Improving SNAP and Medicaid Access: Medicaid Renewals - Center on Budget and Policy Priorities

Thanks for your attention to these pressing issues. We appreciate the wide range of issues HHSC is managing in the COVID-19 crisis, and hope that attention to these policies that risk termination of eligible Texans at a time of great need can also be elevated and addressed soon. We would welcome an opportunity to discuss them further with HHSC staff. You may reach us at dunkelberg@everytexan.org and mcchesney@everytexan.org, or via telephone at the numbers below.

Sincerely,

Anne Dunkelberg
Associate Director
C 512-627-5528

Melissa McChesney
Senior Policy Analyst
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September 27, 2019

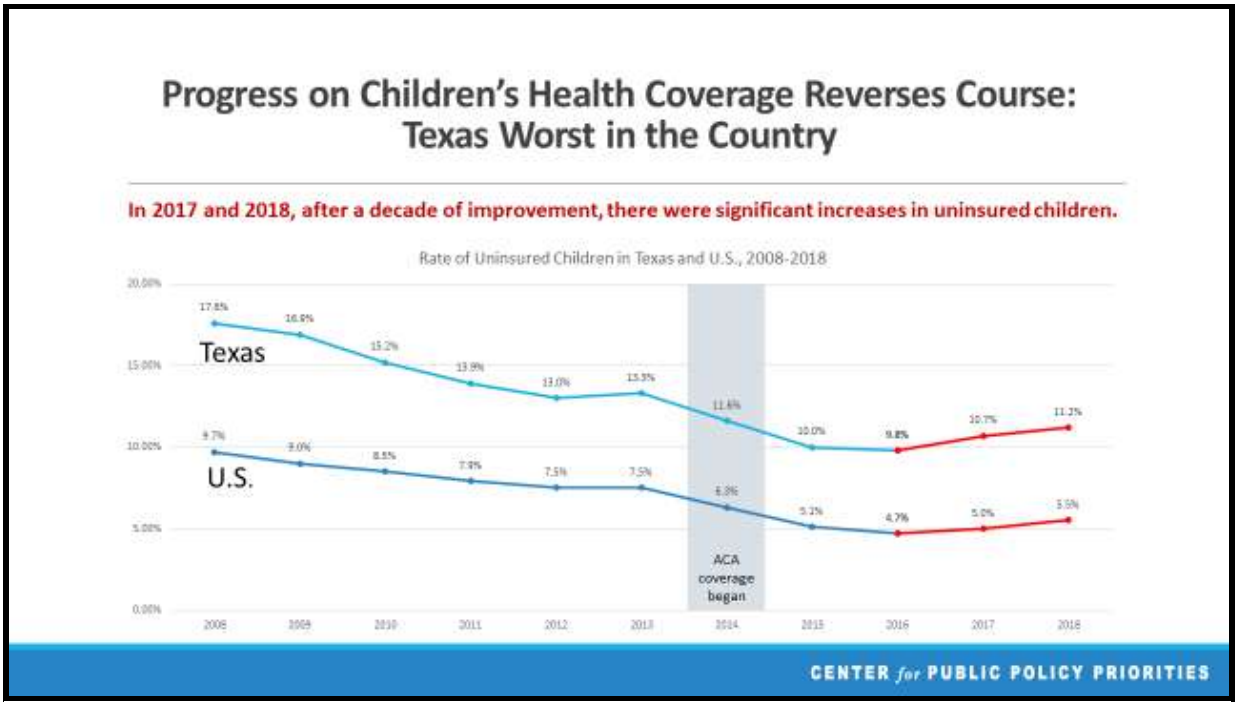
Memo for Texas HHSC Staff Discussion with Children's Health Coverage Coalition members

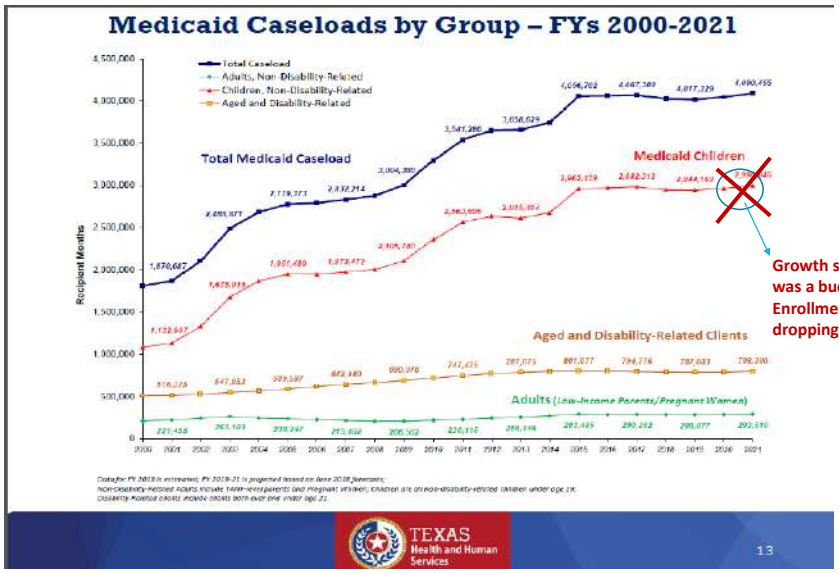
I. Continuous Eligibility Policy Timeline

II. Continuous Eligibility Bills and Fiscal Notes Timeline

III. Texas Statutes and Administrative Code

IV. Appendix





Steady Children's Medicaid Growth from 2000-2014, stopped in tracks with 2014 HHSC Policy Changes

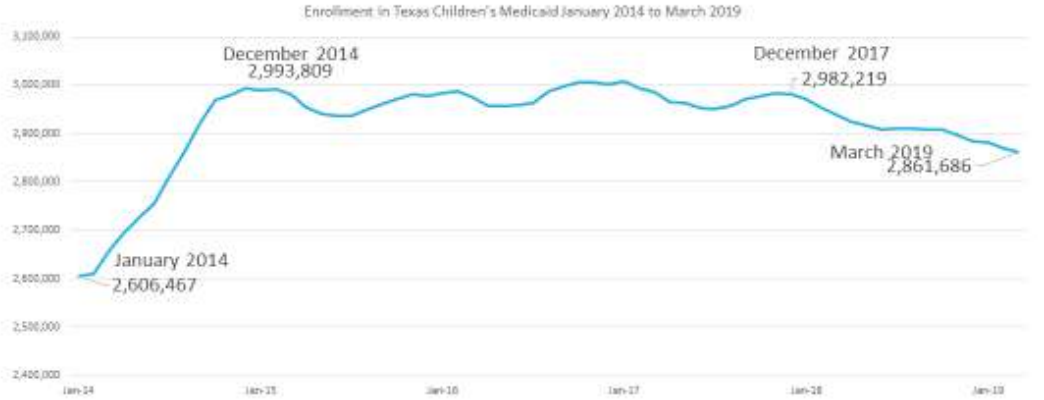
Growth shown here in 20-21 was a budget projection. Enrollment is actually dropping.

6

This HHSC graphic shows <u>historical</u> child Medicaid enrollment through 2019, but for 2020-2021 shows <u>projected</u> caseload as assumed in the House and Senate budgets. **HHSC Children's Medicaid enrollment data as reported to CMS actually shows child caseload <u>decline</u> in 2018.**

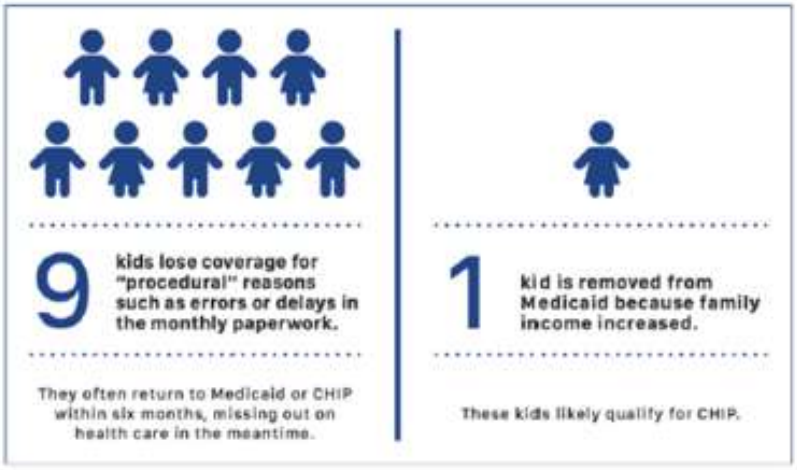
Children's Medicaid Enrollment Stalls, Drops

2014 - Present



8

For every 10 Texas kids who lose Medicaid coverage due to monthly income checks...



4,200 kids lose Medicaid each month because parent's response not received within 10 days

About 50,000 per year

fewer than 400/month actually found to be over income

2019 bill to end this problematic policy died in the Texas Senate.

9

I. Texas Medicaid-CHIP History with Continuous Eligibility for Children

When the Legislature created CHIP in 1999, all CHIP children had 12-month Continuous Eligibility (*and mail-in application and renewal*)

- **At that same time, children on Medicaid were eligible only month to month, and all application and renewal (twice a year) was done in person at a DHS office (which could take more than a day when lines were long).**
    - Parents of kids on Medicaid were obligated to report any income increase that would put a child over the income limit within 10 days, on penalty of fraud charges.
    - Small temporary income increases (like a month with 5 payday Fridays) knocked kids off Medicaid routinely.
    - Average child only got 4 months of coverage at a stretch; only 20% of kids got 12 months of Medicaid.[i]

CHIP's family-friendly policy was so successful that the 2001 Legislature adopted 6-month Continuous Eligibility (and mail-in application and renewal) for Medicaid children as well. (SB 43 by Zaffirini, which proposed phasing up to 12-month CE for children in 2003)

In the 2003 budget crunch, the Legislature cut CHIP Continuous Eligibility from 12 months to 6 months (along with several other policy changes to CHIP, in HB 2292 by Wohlgemuth)

- Section 2.101. The final HB 2292 bill also postponed 12-month continuous coverage in Children's Medicaid to September 2005, (as provided for in SB 1522 by Zaffirini and HB 728 by Delisi). By holding continuous eligibility at the current level of 6 months until 2005, the next legislature can determine whether or not to phase in 12-month coverage.

By January 2005, CHIP rolls had dropped over 175,000 since 9/2003 (35% decline).

- 2005 legislation froze both CHIP and children's Medicaid at 6 months CE. **SB 1863**
    - SECTION 3.01. Amends Section 62.102, Health and Safety Code, as follows: Sec. 62.102. CONTINUOUS COVERAGE. Requires the Health and Human Services Commission (HHSC) to provide that an individual who is determined to be eligible for coverage under the child health plan remains eligible for those benefits until the earlier of the end of a six-month, rather than 12 month, period following the date of the eligibility determination or the individual's 19th birthday. Deletes existing text from Subsection (b) relating to periods of continuous eligibility.
    - SECTION 3.02. Amends Section 32.0261, Human Resources Code, to require the rules [adopted by HHSC] to provide that the child remains eligible for medical assistance without addition review by HHSC or an agency operating part of the medical assistance program and regardless of changes in the child's resources or income until the earlier of the end of a six-month, rather than 12-month, period following the date of the eligibility determination or the individual's 19th birthday.
    - Medicaid provisions duplicated in SB 1188: SECTION 23. CONTINUOUS ELIGIBILITY.
- Legislators restored CHIP vision & dental, adopted new premiums, authorized prenatal care, and appropriated funds to allow enrollment growth.
- But, enrollment still continued to drop due to poor outreach, complex procedural changes, 6-month coverage (down from 12) and failure of the new CHIP enrollment contractor. By January 2007, CHIP rolls had dropped over 185,000 (37%).

In 2007, the Legislature <u>restored</u> 12-month Continuous Eligibility for CHIP, but left children's Medicaid with consecutive segments of 6-month Continuous Eligibility.

- House Bill 109 was projected to restore an estimated 127,000 Texas children to the CHIP rolls:
  - Restores outreach through community-based organizations
  - Deducts child care expenses when calculating income. .
  - Doubles the asset test limit from $5,000 to $10,000. The first vehicle allowance has been increased from $15,000 to $18,000. The second vehicle allowance has been increased from $4,650 to $7,500.
  - 12 months eligibility. Families will fill out one paper application a year.
    - Children above 185% of the federal poverty line ($38,203 a year for a family of four) would have their income (not assets) reviewed after six months by the Texas Health and Human Services Commission (HHSC). The state would use third-party computer databases to see if the family's income exceeded the CHIP limit of 200% of the federal poverty line ($41,300 a year for a family of four in 2007). If HHSC determines that the family has exceeded the CHIP limit, they must contact the family and give them an opportunity to correct information if necessary. **HHSC must also notify parents at least 30 days prior to the end of coverage.** The income checks will be phased in over time, and will be fully implemented by September, 2008.
  - Waives the 90 day waiting period for uninsured children. Only children who drop private health insurance (and do not qualify for an exception) will have to wait 90 days to enter the CHIP program. This restores the waiting period to the original 1999 Texas CHIP law.

In 2014, HHSC, as an internal agency policy without a statutory directive, made changes to the policy, process, and rules, which:

- Eliminated the second 6-month segment of Continuous Eligibility each year for children on Medicaid,
- Returned children's Medicaid coverage back to the pre-2002 month-to-month coverage policy for the second half of each year, and
- Introduced a new system of "Periodic Income Checks" (PICs) that check a child's family income at months 5, 6, 7, and 8 (and a full renewal packet comes in month 10).

Today, CHIP children have 12 months of Continuous Eligibility, and Medicaid-enrolled children have 6 months CE followed by 6 months on month-to-month coverage.

II. Continuous Eligibility Bills Filed and Fiscal Notes

Bills with Fiscal Notes	Biennial GR estimate	Estimated Enrollment Change	FTE and Admin Savings
80th, 2007: SB 266 Zaffirini	$281 million; ($198.6/yr GR subsequent)	267,002 in 2009 and subsequent	242 FTE reduction 2009 and beyond; ($6 million GR savings for biennium)
82nd, 2011 filed amendments to SB 1	$296 million	N/A (not fiscal note, only rider text)	N/A
83rd, 2013: HB 2070, Cortez	$37.6 million; ($76.7/yr million GR subsequent)	83,448 in FY 2016 and subsequent	126.0 in fiscal year 2016 and beyond; ($3.2 million GR savings for biennium)
85th, 2017: HB 1408 by Cortez, Lozano	$64.3 million; ($67 to $72 million GR/yr subsequent)	58,015 in FY 2019; 73,880 by fiscal year 2022	**No offset of reduced FTEs and admin costs is included**; increase in premium tax $2.1 million FY 2019, $4.0 million 2020; $2.8 million 2021, $2.8 million 2022
86TH, 2019: HB 342 Cortez | Rose | Davis, Sarah | Bernal | Sheffield	$5.8 million; ($6.4 to $7.5 million GR/yr subsequent).	6,053 in FY 2021; 7,148 by fiscal year 2024	**No offset of reduced FTEs and admin costs is included**; increase in premium tax $0.1 million 2021, $0.5 million 2022, $0.3 million 2023, 0.3 million 2024.
86th, 2019, CSHB 342	No Significant fiscal impact		

Context for FN changes over time

- 2007 bill came during early stages of the collapse of eligibility processes under the Accenture privatization.
- 2007 bill pre-dated ACA changes which had a substantial impact:
    - The ACA eliminated resource tests that were implicated as a major source of procedural denials of eligible children.
    - The ACA increased Texas' match rate for CHIP, so that moving kids from Medicaid to CHIP became even more fiscally beneficial to the state.
- Texas' percentage of uninsured children was cut in half between 2008 and 2016. The drop from 2013 to 2016 was especially large.
- The 2013 and 2017 FNs are methodologically different; some of the lower costs and caseload estimate for the 2017 bill may reflect awareness of the steep reduction in uninsured kids since 2013.
- The 2019 FNs were the first that are based on actual HHSC analysis of the impact of the 2014 elimination of Continuous Eligibility for Medicaid children in the second six months of each year. *(HHSC did no detailed analysis of the policy's impact before the 2018 request from the CHCC and Representative Sheffield.)* HHSC analysts now needed to take into account the current disenrollment of eligible children, and the retroactive costs of re-enrolling them.
- Implementing one Periodic Income Check at the six month mark—restoring the 2002-2014 6 month CE policy—of course should have a lower fiscal note than the one given to the introduced version of HB

342, which asked for 12 months of Continuous Eligibility. In the Committee Substitute fewer children will be able to retain their Medicaid coverage and this should therefore produce a lower fiscal note.

- HHSC's actual historical average length of enrollment (i.e., for children who are not disenrolled as the result of Periodic Income Checks) should be the basis for comparison with estimated new costs resulting either 12-month CE or restoration of the 2002-2014 6 month CE policy. *(Not all children remain enrolled for a full year; some move out of state, obtain other insurance, or age out of Medicaid. As a result, it would overstate the fiscal impact if the fiscal note assumed every child would remain enrolled for a full 12 months.)*
- Fiscal note should "back out" average months of retroactive eligibility that are extended to disenrolled children (that result from a PIC-related disenrollment), and not count those toward "new" costs of the bill.
- If HHSC retroactively re-enrolls a child granted retroactive eligibility in the managed care plan, but also covers any fee-for-service (FFS) costs paid to providers, any FFS costs should be subtracted from the fiscal impact estimate as those costs were no longer be incurred.
- The 2019 session formal budget processes assumed a small growth trend in children's Medicaid, but the program data both online on HHSC website and the data reported to CMS both show a downward trend. This apparently significant drop has offset the cost of 12-month continuous eligibility for kids.
- Kids ages 6 to 18 years and with family incomes 100%-138% FPL will continue to get the applicable higher CHIP match, so the fiscal note should take into account the lower costs per child in GR to provide 12-mo CE for that age group.
- ~~Per our previous HHSC briefings, TALX (aka Equifax) is the only database used for the PICs for which there is a volume-related cost. We were told that the way it is priced may not be a straightforward charge per person/per income check, but that HHSC will try to estimate savings from eliminating at least 3 checks per child per year; i.e., in the checks in months 5, 7, and 8.~~ **HHSC discontinued the use of TALX/the Work Number in October 2019, which saved money but left the Medicaid eligibility system with only TWC quarterly wage reports to refer to for income checks.**

Detailed Timeline of Continuous Eligibility for Children Legislation

80th, 2007: SB 266 Zaffirini

- Never heard but scheduled for hearing;
- https://capitol.texas.gov/tlodocs/80R/fiscalnotes/html/SB00266I.htm
- Estimated Two-year Net Impact to General Revenue Related Funds for SB266, As Introduced: a negative impact of ($281,332,093) through the biennium ending August 31, 2009.
- Establishing 12 months continuous eligibility would result in an additional 116,774 average monthly recipient months in fiscal year 2008 and 267,002 in fiscal year 2009 and subsequent years.
- There would be a net savings in administrative expenditures of $8.3 million All Funds (including $4.1 million in General Revenue Funds) in fiscal year 2008 and $3.8 million All Funds (including $1.9 million in General Revenue Funds) in fiscal year 2009 forward. This includes one-time costs for system changes and policy implementation, additional cost for enrollment broker services, savings in eligibility determination, and FTE reductions. Savings from FTE reductions total $12.1 million All Funds each fiscal year from reduction of 242.0 FTEs.
- Technology costs included above total $0.2 million All Funds, including $0.1 million in General Revenue Funds, in fiscal year 2008 for one-time costs associated with system changes.

81st, 2009: SB 23 Zaffirini

Never set for hearing, no Fiscal Note

82nd, 2011: SB 33 Zaffirini

- Never set for hearing, no Fiscal Note
- Companions filed: HB 58 by Martinez, "Mando"; HB 1598 by Marquez; SB 610 by : Rodriguez
- Rep. Coleman amendments #245 and #56 to SB 1, requested $296 million GR for 12-month CE
    - Excerpt: as follows: ____. 12 MONTH CHILDREN'S MEDICAID CONTINUOUS ELIGIBILITY, MEDICALLY NEEDY PROGRAM AND TUITION MITIGATION. Out of funds appropriated above in Goal B. Medicaid, for the fiscal biennium beginning September 1, 2009, the Commission shall allocate the following amounts contingent upon the enactment of legislation or the adoption of agency rules: (1) $296,000,000 for the purpose of providing 12 months of continuous Medicaid coverage for children; and

83rd, 2013: HB 2070, Cortez

- Heard in Human Services; https://capitol.texas.gov/tlodocs/83R/fiscalnotes/html/HB02070I.htm Estimated Two-year Net Impact to General Revenue Related Funds for HB 2070, As Introduced: a negative impact of ($37,595,440) through the biennium ending August 31, 2015; $76.7 million GR for subsequent years.
- **The increase to average monthly children's caseloads** is estimated to be 41,725 in fiscal year 2015 and 83,448 in fiscal year 2016 and subsequent fiscal years.
- There would be a **net reduction to administrative expenditures** related to 12 months continuous eligibility for children, primarily associated with a reduced need for eligibility determination staff related to less frequent renewals for children. **The net reduction to full-time equivalents is estimated to be 94.0 in fiscal year 2015 and 126.0 in fiscal year 2016 and beyond**. The net savings for administrative costs is estimated to be $3.2 million in All Funds (including $1.6 million in General Revenue Funds) in fiscal year 2015; and $3.3 million in All Funds (including $1.6 million in General Revenue Funds) beginning in fiscal year 2016.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	$0
2015	($37,595,440)
2016	($76,704,630)
2017	($76,704,630)
2018	($76,704,630)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *GR Match For Medicaid* 758	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	$0	$0	0.0
2015	($37,595,440)	($52,951,915)	(94.0)
2016	($76,704,630)	($107,266,915)	(126.0)
2017	($76,704,630)	($107,266,915)	(126.0)
2018	($76,704,630)	($107,266,915)	(126.0)

- **Technology:** There would be a one-time cost in fiscal year 2015 of $75,650 in All Funds, including $37,825 in General Revenue Funds, for modifications to the Texas Integrated Eligibility Redesign System (TIERS).

84th, 2015: SB 1127 Zaffirini, Rodriguez

- Never set for hearing, no Fiscal Note

85th, 2017: HB 1408 by Cortez; Lozano; SB 53 Zaffirini;

- HB 1408 in Human Services; https://capitol.texas.gov/tlodocs/85R/fiscalnotes/html/HB01408I.htm
- Estimated Two-year Net Impact to General Revenue Related Funds for HB1408, As Introduced: a negative impact of ($64,264,178) through the biennium ending August 31, 2019.
- The increase to average monthly children's caseload is estimated to be 8,988 in fiscal year 2018, 58,015 in fiscal year 2019, increasing in each subsequent year to 73,880 by fiscal year 2022.

- NOTE: UNLIKE ALL PREVIOUS FISCAL NOTES, NO OFFSET OF REDUCED FTES AND ADMIN COSTS IS INCLUDED.
- The increases in client services payments through managed care are assumed to result in **an increase to insurance premium tax revenue,** estimated as 1.75 percent of the increased managed care expenditures. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $2.1 million in fiscal year 2019, $4.0 million in fiscal year 2020, $2.8 million in fiscal year 2021, and $2.8 million in fiscal year 2022. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.
- Technology: According to the Health and Human Services Commission, there would be a one-time cost in fiscal year 2018 of $506,000 in All Funds, including $253,000 in General Revenue Funds, for modifications to the Texas Integrated Eligibility Redesign System (TIERS).

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2018	($9,202,368)
2019	($55,061,810)
2020	($67,322,523)
2021	($70,852,275)
2022	($71,860,964)

86TH, 2019: HB 342 Cortez | Rose | Davis, Sarah | Bernal | Sheffield

Coauthors: Anchia | Bucy | Calanni | Dominguez | Farrar | Fierro | González, Jessica | Goodwin | Guerra | Guillen | Hinojosa | Howard | Israel | Lambert | Lopez | Lozano | Martinez | Minjarez | Morales | Muñoz, Jr. | Ortega | Perez | Ramos | Reynolds | Sherman, Sr. | Stephenson | Turner, John | White | Wu

Also HB 829 Rose; SB 637 Zaffirini

- HS; Filed version FN https://capitol.texas.gov/tlodocs/86R/fiscalnotes/html/HB00342I.htm
- Estimated Two-year Net Impact to General Revenue Related Funds for HB 342, As Introduced: a negative impact of ($5,834,549) through the biennium ending August 31, 2021; annual GR amount $6.4-$7.5 million per year through 2024.
- The increase to average monthly children's caseload is estimated to be 6,053 in fiscal year 2021, increasing in each subsequent year to 7,148 in fiscal year 2024.
- NOTE: UNLIKE PREVIOUS FISCAL NOTES, NO OFFSET OF REDUCED FTES AND ADMIN COSTS IS INCLUDED.
- According to the Health and Human Services Commission (HHSC), system changes and modification of rules would occur in fiscal year 2020 at a cost of $0.5 million in All Funds, including $0.2 million in General Revenue.
- The increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $0.1 million in fiscal year 2021, $0.5 million in fiscal year 2022, $0.3 million in fiscal year 2023, and $0.3 million in fiscal year 2024. Pursuant to Section 227.001(b), Insurance Code, 25 percent of

the revenue is assumed to be deposited to the credit of the Foundation School Fund.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	($164,522)
2021	($5,670,027)
2022	($6,401,543)
2023	($7,113,149)
2024	($7,515,219)

86th, 2019: CSHB 342 Cortez et. al.

- https://capitol.texas.gov/tlodocs/86R/fiscalnotes/html/HB00342H.htm
- No significant fiscal implication to the State is anticipated.
- The bill would authorize HHSC to perform an income check during the sixth month following the date on which a child's eligibility for medical assistance is certified or recertified and requires HHSC to continue to provide medical assistance to a child whose household income is found to exceed the maximum income for eligibility for a period of not less than 30 days, in order to provide the child's parent or guardian with a period of 30 days to provide documentation demonstrating that the child's household income does not exceed the maximum income for eligibility.
- The bill would require HHSC to automatically enroll a child in the Children's Health Insurance Program (CHIP) whose household income is found during the income check to exceed the maximum income for eligibility for the medical assistance program but is eligible for CHIP.
- Based on the LBB's analysis of the Health and Human Services Commission (HHSC), duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

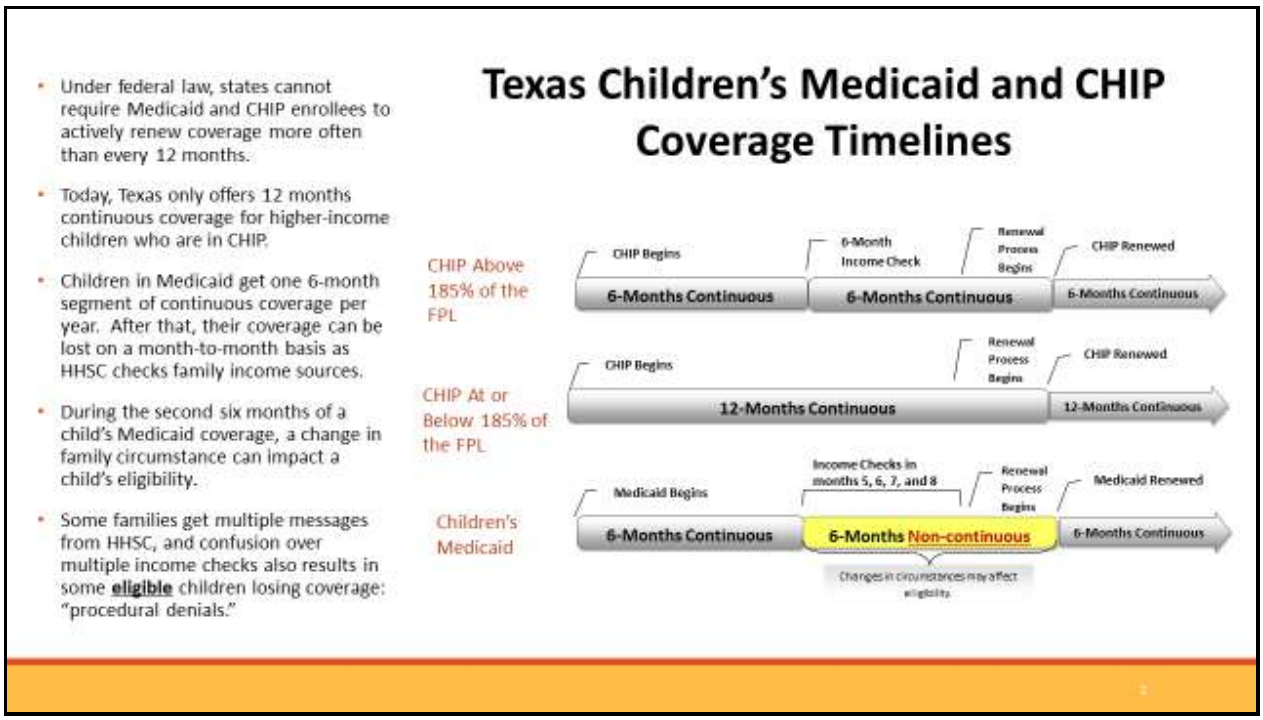
III. Texas Statute and Administrative Code

- **Texas state law** continues to call for 6-month Continuous Eligibility for Medicaid kids, though we have not provided that since 2014 (Section 32.0261, Human Resources Code).
- **The Texas Administrative Code** now includes contradictory sections: one calling for 6-month Continuous Eligibility for children, and another establishing the month-to-month coverage with the PICs.
- **The Human Resources Code** also directs HHSC to ensure that "that documentation and verification procedures used in determining and certifying the eligibility" be no more stringent than those used for CHIP.
    - Human Resources Code CH 32 §32.026(d)

      (d) In adopting rules under this section, the executive commissioner shall ensure, to the extent allowed by federal law, that documentation and verification procedures used in determining and certifying the eligibility and need for medical assistance of a child under 19 years of age, including the documentation and verification procedures used to evaluate the assets and resources of the child, the child's parents, or the child's other caretaker for that purpose, if applicable, **are the same as the documentation and verification procedures used to determine and certify a child's eligibility for coverage under Chapter 62, Health and Safety Code,** except that the documentation and verification procedures adopted in accordance with this subsection **may not be more stringent than the documentation and verification procedures existing on January 1, 2001, for determination and certification of a child's eligibility for coverage under Chapter 62, Health and Safety Code.**

IV. Appendix: Graphics and related resources

Comparing the current children's Medicaid, CHIP under 185% FPL, and CHIP above 185% FPL processes.



4) The Uninsured Rate for Texas kids increased from 2016 to 2017, after years of steady improvement.

- 835,000 Texas children were uninsured in 2017 per the Census, and
- about 462,000 of them are below 200% of the federal poverty income (the upper limit for CHIP).
    - **Reducing that number to eliminate any undocumented children, the estimate is that at minimum, 350,000 uninsured Texas kids could be getting Medicaid or CHIP—but are not enrolled.**

Critiques from stakeholders on problems with the PIC system include:

- **Late notices: families often get their notices shortly before, or even after the deadline: families are left with nowhere near 10 days to respond.** (It's not even clear that letters are mailed promptly, much less on the day the system generates the letter)
- **Families are burdened with "proving" they are no longer employed at previous jobs that show up in outdated databases.** (HHSC only reaches out when it appears a child's family is "over income", and showing multiple jobs would make the agency check for over income)
- **Families are frequently confused between data they have already provided, versus a new query from the agency.**

HHSC provided a partial response in February 2019 to an October 2018 data request from Representative (Dr.) Sheffield looking to into the results of these PICs for children.

- Dr. Sheffield requested the data because the Children's Health Coverage Coalition's Open Records request came back with a price estimate of over $5,000.
- The reason for the proposed $5,000 charge is that the agency had not previously analyzed data on the system since it was put in place in 2014. (The agency does not charge for data it has already analyzed.)

Key findings in data provided to Representative Sheffield

Number of Children Contacted for more information as a result of PIC *(Average monthly)*	Of those contacted as a result of PIC, number of children who remain eligible *(Average monthly)*	Of those contacted as a result of PIC, number of children denied *(Average monthly)*	Of those cut off Medicaid, number of children denied due to excess income *(Average monthly)*	**Of those cut off Medicaid, number of children kicked off because of procedural reasons** *(Average monthly)*
6,471	**1,932**	**4,539**	**372**	**4,162**
	30%	**70%**	**8%**	**92%**

Source: HHSC Data on Periodic Income Checks and Children's Medicaid, pg. 2, dated February 23, 2019

- One Texas Medicaid health plan analyzed their child Medicaid enrollment data, and reported that fewer than half of their enrollees got a full 12 months of coverage. The health plans also report that the current system and gaps in coverage undermine progress on quality measures for value-based care that improve outcomes and reduce costs over time. Many of these measures can ONLY be achieved with 12-month coverage.

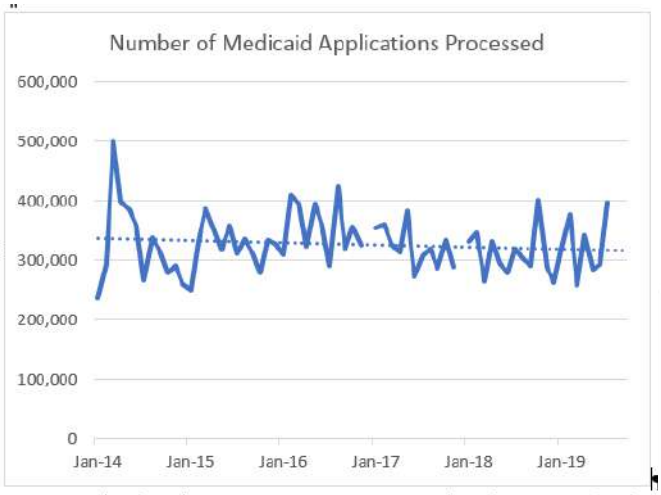


Figure 5, Medicaid Timeliness reports 2014-2019: CPPP analysis of Texas HHSC data last

HHSC Data Show Renewals may be a Weak Link

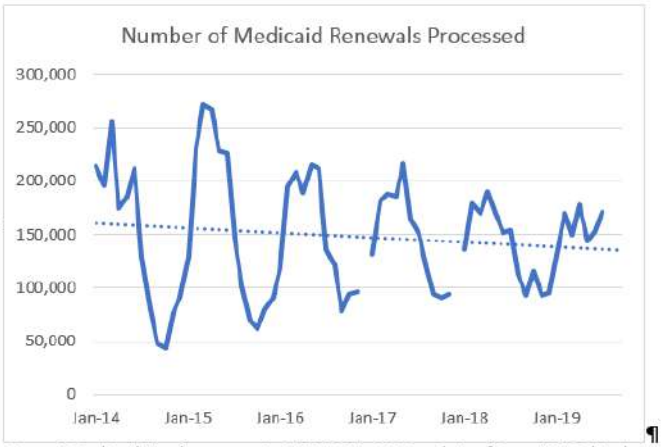


Figure 6, Medicaid Timeliness reports 2014-2019: CPPP analysis of Texas HHSC data last accessed Au

[i] Child Friendly? How Texas' Policy Choices Affect Whether Children Get Enrolled and Stay Enrolled in Medicaid and CHIP >>