Children's Health Coverage Coalition and OTA Meeting Agenda
Friday, February 21st, 2020
11:00 A.M. – 2:00 P.M.

Present:

Anne Dunkelberg, CPPP
Laura Guerra-Cardus, CDF
Adriana Kohler, Texans Care for Children
Sophie Jerwick, TMA
Sonia Lara, TACHC
Jana, TACHC
Christina Long, Young Invincibles
Melissa McChesney, CPPP
Alissa, NAMI TX

On Conference Line:

Betsy, Maximus
Nancy Walker, UT Health
Jenna Darling, Methodist Healthcare Ministries
Jennifer Banda, Texas Hospitals Association
Ashley, Children's Health
Nataly Sauceda, United Ways of Texas
Graciela Camarena, CDF
Michelle Tijarina, Central Health

Meeting Chair: Alison Mohr Boleware, NASW-TX
Meeting Scribe: Cindy Ji, Emily Wang, Zoe Marshall, CDF

I. Introductions (Alison Mohr Boleware) – [Meeting began at 11:04 AM]

II. HHSC Meeting Update – Public Charge & Eligible Unenrolled (Adriana Kohler, Texans Care for Children)

Last meeting: Melissa sent out draft memo on (1) helping eligible uninsured kids get enrolled and (2) ideas to help prevent the repercussions from public charge and ensure that families who are eligible can get enrolled. Memos are in your inbox.

Commissioner Philips met with members from our coalition. Ten HHSC staff were there, including Wayne (AES) and Hillary (AES).

Commissioner was interested in which local community groups, health settings, and organizations do help families get info on public charge. We offered some organizations at the meeting, but it's worth doing a follow up on this.

We also talked about updating the training for 211 staff so that they can also provide accurate information about public charge. Wayne from AES was receptive to this. He mentioned that they

can provide updated scripts and trainings. We also talked about having updated WIC flyers. We had an example of a flyer from Tyler, and the Commissioner was very interested in examples like this that work.

LGC: The high level thing that stood out to all of us was that, before this, staff in the agency had said that they didn't have a role in working on public charge—it was a federal issue. The fact that they coordinated this meeting and the Commissioner joined, they clearly communicated that this had changed. This is a big win. That said, we now have an outgoing Commissioner and medical director, but it's good we had this

MM: Wayne Solter was the one that oversees the 211 piece, so if he's on board, that's good for us moving forward. All the access and eligibility is under him

SG: What kinds of local organizations are they looking for?

AD: I think we need to figure out how to follow up on the different pieces. CDF and CPPP have been involved in outreach, so it's more about figuring out how to follow up at this point.

AK: The memo includes recommendations for how to get organizations to help with outreach and application assistance. We went through this thoroughly with HHSC. One of the biggest things: how to reach the hardest-to-reach.

Wayne mentioned that they recently met with TEA. This is good. AES is targeting school districts with high numbers of eligible but uninsured kids.

We talked about FQHCs, CHIP grantees, and State of Enrollment. A lot of different orgs are doing more trainings and engagement with their outreach and application assistance.

MM: We now do the State of Enrollment with TACHC, so that connection is there.

AD: We wanted to bring HHSC more into this process.

AK: Wayne wanted a list of both community-based organizations and FQHCs with application assistors that they wanted as community partners.

SL: We have a list. A lot of our CHCs receive funding from cities for assistors.

AD: The thing that we don't have is a list of the unaffiliated places...

MM: It does exist. CMS has this list and they update it regularly.

AK: They also want recommendations from managed care organizations on how they can help with marketing, education, and outreach. This is still TBD.

MM: (Recommendation 2, bullet 1, subbullet 2) HHSC has agreed to let all CHIPRA grantees level 3 access. This is something we've wanted for a long time. It's a nationally recognized practice. We're finally seeing movement on this, and this is a big help.

LGC: Is this a substantial step on their part? I ask because in the past we had contracts...

MM: Those are two separate asks. We'd asked for MOUs, and now they're working on getting the MOUs and level 3 access.

III. Finish Line Strategy Meeting Update on Legislative Priorities (Laura Guerra-Cardus, CDF

LGC sent links, which will be shared with everyone in the follow up to this meeting. CDF, Texans Care, and CPPP were funded under the Finish Line grant, which has now been moved under Episcopal Health (but the team still receives TA from the Finish Line network). The only way that work can happen is through our coalitions and partnerships. This funds the man hours needed to build thinking around the next legislative session and what we need to do in 2020 to prepare for it. Don't think of this as our work; think of it as *our* work.

Three policy priorities:

(1) Children's Health Coverage: 12 month continuous coverage for kids in Medicaid. This was changed to 6 months, and the final bill had no fiscal note. We are probably recommending 12 months continuous coverage as our starting point for the next session, which will probably have a fiscal note of about $5.7 mil.

(2) Funding for CHIP and Medicaid outreach. We used to have this, but this shifted to funding community partner organizations, and then that went away. We think it should be a big message to all our partners that the legislature needs to do something to address our child uninsured rate. That includes continuous coverage, and investment in outreach.

(3) Progress on coverage. We frame it broadly because that's what we identify as a win, whether it's children's coverage, maternal coverage, or taking advantage of a window of opportunity for expanding Medicaid. The big message there is that it's time for the legislature to do something on coverage. Last session was about education, and 2021 needs to be about coverage.

In terms of activities, (a) building support across our partners, media, and legislatures, and (b) building a cohort of legislative champions that should include R's filing bills on (1) and (2). This is the high level overview of our work.

I'm going to go over the tasks for this, and would love your feedback on it.

(a) Packaging our messaging. Three things are in the works: (i) a global document on high uninsured, (ii) another one-pager that frames the issue of continuous eligibility for kids on Medicaid but with different political language. The liberal framing is dominance vs. who gets taken advantage of, but the conservative framing is order and rules vs. mayhem. Melissa is working on this.

MM: A draft is going out for second-level review today.

LGC: The third is (iii) a document on outreach funding, both the history of funding in TX and what we'd like to see. We want to break down the data on uninsured by race, and we also want to challenge the myth that our uninsured rate is only due to public charge and undocumented people. We want to show that we have the highest uninsured rates across all categories.

We're also looking for polling. CPPP is doing an update on county stats—

AD: The model we have on the impact of Medicaid Expansion on counties is out of date, so I'm trying to update it. I'm trying to get someone else (not CPPP) to run the numbers. This should be done by summer.

LGC: Next task. We want to develop early relationships with legislators and their staff, so we want to divvy up the committees and representatives and see who in our coalition could meet with them.

AD: Just as a reminder, the campaign is c(3), so the activities are all things that c(3)s can do.

LGC: We also want to move as many partners as we can to high-action, high-alignment. We want to get outside of the providers and associations we already work with. That includes getting chambers to start adding coverage priorities to their agenda. I don't know what was there last session, but it's been tapering off. The metro chambers used to, several years ago, have 12 month continuous coverage language.

We also want partners who have good language on this. A hospital in MO or MS was able to find data on where funding for kids' care is coming from. It'd be great if we can get this data. So if we can get education partners, CHCs, and association of Health Plans on board.

Another strategy is about interim charges. Weneed to put pressure on the chairs to focus on the uninsured. But these aren't the same committees that would be working on coverage, so we want to identify what those would be, and meet with them to raise coverage as an issue.

Sick of it TX asks to partners right now is to get as many people as possible to ask candidates healthcare questions. We really believe that priorities for next session get set early, even before people are elected, and people are more receptive right now. We have a guide for questions to ask. We also have resources on how to get in front of your candidates, which include going to candidate forums, reaching out directly, and messaging them on social media (Facebook). We're also doing base building and story collection. We can also magnify your own stories

Does anyone have questions or feedback?

SG: TMA is figuring out how to talk about coverage, even though some legislators only want to focus on private insurance. Right now we're in the process of putting together our policies.

CL: YI has an event in the spring, and we have a session in Austin that will specifically be a storytelling session. One other quick note: we want to do some advocacy around the 10-year anniversary of the ACA.

AD: There are some folks in CTN who are also thinking about this. Start an e-mail with the listserv.

Office of Ombudsman Update (Paige Marsala, HHSC)

AD: We've heard that any expression of dissatisfaction is categorized as a complaint.

PM: Yes, that is how we define a complaint.

[Slide 3]

[Slide 4]

There were only 17 business days in Dec, which accounts for the jump.

MC: Is there any indication that the backlog in Medicaid and SNAP has increased the complaints?

PM: Let's get there when I get to SNAP.

[Slide 5]

Top reasons people were denied include people being over the income limit and people failing to submit their paperwork on time. We also had some people who failed to pay enrollment fees.

[Slide 6]

30% increase in complaints. I'm going to be focused on complaints. There was an increase in COLA, which can lead to an increase in the SNAP benefit amount. Melissa what was your question?

MC: We've been getting complaints from various parts of the state, so I was wondering if your office has been hearing about it.

PM: I don't have this on me, but I can give you the number of complaints from applications not completed in a timely manner.

For application/case denied, we saw most in failure to provide missing information, employment and training (ENT) sanctions.

AD: Food stamps has its own requirements for training.

PM: For application not completed, we saw a lot of people not turning their application for redetermination on time.

[Slide 7]

Application not completed: information was not being turned in timely.

[Slide 8]

92% increase in complaints from Dec to Jan were related to information being placed on their case that was inaccurate or outdated. Unable to access prescription services related to not showing "active." If someone recertifies for Medicaid within the month, the health plan doesn't have it within their contracts to upload daily files within one business day of receiving.

[Slide 9]

Verifying Health Coverage

Access to PCP:

The numbers are so low so there aren't really trends to talk about. But you can tell from the first two items that it's mostly issues you'd expect from kids who are moving to homes.

[Slide 10]

Access to Prescriptions: complaint being that there's other insurance on the Medicaid case that is outdated or erroneous

[Slide 11]

Increase by 13 complaints. There's really no trend. It varied for various reasons, with no trend identify.

AD: Are you seeing verify health coverage being higher than usual across these programs?

PM: That's always going to be up there, but I can look into it more. Do you want me to look at it for SNAP?

AD: Yes, SNAP is such a basic need. I don't know if it'll affect STAR Plus.

[Slide 12]

27% increase, but the numbers are so small.

[Slide 13]

96% increase in complaints for January. No trends identifiable, just more complaints for different reasons. The top 3 complaints were for accessing prescriptions (because there was other insurance in the case), and for

[Slide 14] Medicaid

Application/Case Denied: Application not completed on time, and case error.

Client Notice: I can't understand it

How to apply

48% increase in complaints.

AD: Is it that the agency did not process timely or the applicant did not submit information timely?

PM: Let me take that back and look at all the reasons for that.

[Slide 15] Behavioral Health

I asked each of these areas for more specific information on reasons for contact, but I didn't bring that, so I'll follow up. We have examples for other as well.

AMB: Is this a typical volume for substantiated?

PM: I can find out.

[Slide 18]

MM: Looking at the asterisk, is it that 83 complaints were substantiated, or a single kiddo had several complaints, and only some of them were substantiated?

PM: We do add all of them up...I can get some more information on these numbers.

[Slide 20] IDD

AD: I guess these don't have the component of resolution? Or substantiated?

PM: I will follow up.

[Slide 21]

Not really any problem trends, so I'll move to projects. We're trying to get people to move to contacting us online and not just through the phone. The majority of folks who get to our lines call the number on the backs of their Medicaid cards, so we're working with ____ to get those updated and include our online form.

We're also getting our complaint codes in line with MCOs so we're comparing apples to apples.

We're also working on improving customer service overall and trying to track whether people were helped, whether person on the line was showing empathy when they should be, etc. We have a survey now.

Questions?

RC: How normal are the spikes from Dec. to Jan.? Some of these increases seem to be increases even from October.

PM: That's usual. That's the ongoing trend. Exactly why, I'm not sure. I can only guess that it's due to the holidays. That's something I've noticed across all program areas.

IV. CMS Medicaid Expansion Block Grant Guidance (Anne Dunkelberg)

AD will go over Manatt consulting slidedeck.

[Slide 2]

Huge body of literature indicating that access to check-ups, etc have improved in expansion states. Contact Anne if you want this.

[Slide 4]

"Healthy Adult Opportunity " is misleading because many in non-expansion states can't access Medicaid unless they have serious conditions, mental illness, or until they're 12 months away from death.

Texas would be required to use Per Capita Cap for the first two years

Uncertainty about what base would be going into expansion

Texas would have to be cutting back on spending per capita under this model

[Slide 8]

Dark blue on slide 8 is what has already been available (CMS made it really hard to qualify under presumptive eligibility)

MM on aligning the renewal cycle with Marketplace: you can still apply anytime throughout the year but they can force you to reapply during marketplace enrollment so the idea is that you would go to the marketplace. Unclear why this is beneficial to the client because special enrollment exists

AD: Long-term care didn't have to be included automatically

Important to understand that -- you can't expand to less than 138% poverty and get match, can't have enrollment cap even though you'll have to be shrinking what you provide to people if , can't add asset test back in (part of ACA)

[Slide 9]

AS: Could a state siphon healthcare funds off to something else? Anne - I think they could - but we'd have to be saving a lot to do this (we're not);

MM: if you can't do those things under this waiver [see slide 11], the likelihood of seeing shared savings is pretty low

AD: You could constrain what an expansion population would cost you

OTA (Facilitated by Melissa McChesney

V. Office of the Ombudsman Update (Paige Marsala)

VI. Eligibility and Enrollment (Janie Contreras & Hilary Davis)
a. Backlog of applications

MM: Reports from CDF of delays in application processing for Medicaid/CHIP/etc. Are we still in a backlog?

HC: Get estimates every Friday. There was an increase in applications and a decrease in staff back in Dec/Nov. Supervisors implemented mandatory overtime.

AD: was it planned?

HD:No.

MM: was the increase in applications a normal trend you'd see in that time of year?

HD:Yes, going into the holidays. Numbers are within time frames now.

MM: SNAP below 30, Medicaid below 45?

HD: Yes.

MM: Do we know how long it takes in the 45 day mark?

HD: Looking at 25 days.

MM: Is this Medicaid/CHIP specific?

HD: No this is for all applications (did not break it down).

Rachel: Were there any policy changes making the applications take longer?

HD: No. No new policy changes impacting timeliness. Trying to move toward less verification.

Rachel: How long can you run on forced overtime?

HD: We've gotten everything back to a manageable caseload.

Rachel: Do you have the expected caseload and appropriate workforce so that this doesn't happen again?

HD: They're looking at training to make sure they are retaining staff. Last year there was a cut in funding. No SNAP bonus. 2018 FAR bill, they took it away.

MT on the phone: Does the backlog include TP40 and CHIP perinatal applications?

HD: Yes, but it's not broken down at that level. They're on time. They're still able to do expedited processing for pregnant women.

MM: On the CHIP perinatal, those that were not timely, since CHIP doesn't go retro, was affecting coverage not starting until later and wasn't going back to the application date.

HD: With these, they'd have to look on an individual basis.

MM: Theoretically it's possible the start date could end up being later.

HD: There's an expedited process for renewals to cover that gap in case they are the reason there's an error.

MM: But for new applications, they could end up delaying access?

HD: Yes.

GC: In doing follow up with many of the families assisted during December, showed that no application for renewal had been received in the last 45 days. Someone had verified that it was received, showed that it was just waiting in queue. They told her a date: February 16. They did escalate only at mom's request. Has caused a lot of stress on parents/time - only because mom was persistent, that it was escalated. There are still some apps that are out there that havent been finished?

HD: Speaking to renewals, they're prioritized based on when the due date is. If they know they don't have to work the ones due in Feb, they work the Dec/Jan ones first. This was just a side effect of the backlogs.

MT: If they're not registered for 211, the initial response is that they have no application.

AD: Is this a training issue for 211 that they don't know what to tell people?

HD: It's partially because of access - staff only has access to certain systems.

AD: Is there a technological fix?

MM: Is there a solution?

HD: We can look at 211 call scripts, what can we do during OE.

MM: If I started on YTB, 211 should be able to see it. If I faxed it in, is there a potential for a lag?

HD: Yes.

MM: Fax, mail, or marketplace - no clear link between the 211 system and these ways of applying.

Rachel: For all the cases that were submitted, but for backlog reasons they weren't gotten to, when you did get to them, were you still using the income info they submitted?

HD: Yes.

MM: We have seen cases where that's not true- could be a training issue.

HD: There are limitations in our system where it wants most recent within 60 days. Backlog hasn't really ever been this bad, but the economy is wonky, staff is not highest paid and leave. They're asking for more extra money and FTEs.

GC: As of now, we did comply with submitting the extra information that was requested and there has not been an end result as of today.

MM: There has not been a lot of coordination with assisters and the agency. Clients feel it helps them understand that it's in process and it's working, rather than the panic of "they lost my application." Are you communicating with the community partner program. If we know there's a backlog in place and we can give expectation to clients.

HD: It doesn't always get communicated outside of Access and Eligibility Services, so a lesson that there needs to not just be internal communication but also with community partners. Can expand information outside to community partners to make sure its being communicated appropriately without causing panic.

b. Issues with account transfers from Healthcare.gov

MM: Is there any system glitch where it's coming through wrong? There are some defaults: children's medicaid sometimes defaults to parent. They're looking on fixing that if it's just the child on there. For some reason, reading just as a one person household. Is there a way to do staff training? Staff just denied the parents and never processed the kid. Let staff know to look for birthdays for children under 19.

HD: The issue is with the automated system, but can work with staff to make sure they don't automatically deny parents.

Rachel: Reminds me of the TANF process.

HD: Staff is not allowed to do automatic denials, have to go through an entire process

MM: Will give update.

AD: Just to clarify, is it ever going to be possible to find out that your application that came over from the FFM is in the queue before it gets registered?

HD: Not at this point because it has to be in a system accessible to staff. We would have to make some sort of automation advancement.

AD: maybe argue for a training and marketing piece that says "if we're not seeing your application, it may be because…"

Melissa will send this info over to Foundation Communities.

c. HHSC response to public charge rule change

MM: Looking more toward the actual technical information in the application. What will you all do now that the rule is coming into effect?

HD: Waiting on direction from agency leaders for next steps. Already know to add SNAP, Medicaid; instructing people to talk to an agency with more expertise to help those whose immigration status may affect their application

MM: Something we would hope for as far as language: if there's an opportunity for input. Overlap between those affected by public charge and who can qualify for public assistance is so small.

HD: Is about 2000 SNAP recipients affected, and is those who aren't green card holders. The biggest differences will be seen with SNAP. For the most part, little overlap.

AD: Also judged on whether they're likely to receive benefits in the future

HD: Are basically going to say this might impact you and redirect them to resources who can help with immigration issues.

MM: Any training being done for staff?

HD: No training, but will put out a bulletin with information. Can work with 211 staff to make sure people are connected to resources and next steps.

Updates on things we're working on: one of focuses was alignment of kids' Medicaid - working on processes to align siblings and non-siblings in tiers by May. It's the policy in place for nonsiblings that needed to be addressed, so that is likely to be done by May.

JC: alignment with kids Medicaid certification (enhancements for siblings and non-siblings in the same household) in May 2020.

We can't align Medicaid and CHIP because CHIP is prospective. Implemented by July 11, 2020 (making all changes to exclude pre tax contributions - modifying applications at YTTB.com, looking at apps and forms in online app to make changes with the tax cuts and jobs act of 2018).

Alimony no longer considered income for divorces after Dec 21, 2018.

One major change: CMS finally approved the Medicaid 1115 waiver for Healthy Texas Women Program for 18-44 year olds. 15-17 year old kids are going to be moving to a different program.

Rachel: Curious about nonkinship families and Star Health Plans for those placed in a home

MM: What is the plan to communicate to outside stakeholders?

HD: Staff determines eligibility, other avenues in which we can communicate

MM: Not necessarily a new channel.

Rachel: Are you communicating to other groups like FPS that work with nonkinship families?

HD: Can see what's going

Rachel: Can use easy-to-understand language and can share with nonkinship families.

VII. [Meeting Adjourned at 1:51 PM]

TO: Courtney N. Phillips, Phd, Executive Commissioner
Texas Health and Human Services Commission

FROM: Texas Children's Health Coverage Coalition

RE: Decreasing the number of Texas children eligible for Medicaid or the Children's Health Insurance Program but not enrolled

DATE: January 17, 2020

Summary

An estimated 275,000 to 355,000 children in the state of Texas are eligible for Medicaid or the Children's Health Insurance Program (CHIP), but are uninsured. Consistent access to health care begins with adequate health insurance coverage. Health insurance for children is also linked in research to better health, educational, and economic outcomes well into adulthood. In order to reduce the number of uninsured children in Texas by reaching these "eligible but uninsured" children, the Children's Health Coverage Coalition has compiled the following list of recommendations for the Texas Health and Human Services Commission. The final recommendations are grouped into three categories, listed in order of priority:

1. Identify and enroll children already enrolled in other benefit programs such as SNAP or WIC, but not enrolled in Medicaid or CHIP.
2. Revitalize the state's marketing, outreach and application assistance efforts to connect more eligible children to health coverage.
3. Improve client-facing literature, including the integrated paper application and notices to applicants and enrollees.

Background

Texas has the highest uninsured rate in the nation for children, adults, and women of childbearing age — and it's getting worse. The uninsured rate for Texas children was 11.2 percent in 2018, an increase from 10.7 percent in 2017.[i] That rate is much worse than the national average of 5.5 percent. The recent decline in the number of Texas children enrolled in Medicaid/CHIP — dropping by nearly 209,000 kids from Dec. 2017 to Oct. 2019 — is a big reason why the uninsured rate for Texas children is getting worse[ii].

U.S. Census data show that about 478,000 of the uninsured Texas kids in 2018 (about 55 percent of all our uninsured kids) were in families below the income limit for Medicaid and CHIP (200 percent of the federal poverty income). There are an estimated 207,000 undocumented children under 19 in Texas[iii].

If we assume that 100% of all undocumented kids in Texas are both uninsured *and* under 200 percent of the federal poverty income FPL, Texas would have *at least* 275,000 uninsured kids who could be enrolled in Medicaid or CHIP (i.e., because they are US citizens or lawfully present immigrants, and below 200 percent of the federal poverty income). And since that assumption is so conservative, the number eligible for CHIP or Medicaid is almost certainly higher. The most recent national estimate of eligible but uninsured Texas children is from a May 2019 report from the Urban Institute, which estimated about 355,000 eligible but uninsured Texas children in 2016-2017[iv].

Recommendations

The Children's Health Coverage Coalition makes the following recommendations to HHSC (in order of priority) to reduce the number of children in Texas who are eligible for Medicaid or CHIP but not enrolled:

Recommendation #1 - Identify and enroll children already enrolled in other benefit programs such as SNAP or WIC but not enrolled in Medicaid or CHIP.

Research has shown that as many as 24.9 percent of children enrolled in SNAP nationwide are not enrolled in Medicaid[v]. Because of this, many states have successfully reduced the number of uninsured children by targeting outreach and enrollment efforts to children accessing other public benefit programs but not enrolled in Medicaid or CHIP. It is a state option in Medicaid to use "Express Lane Eligibility" (ELE) to enroll and renew Medicaid and CHIP coverage by simply confirming enrollment in SNAP along with other public benefit programs. Express Lane Eligibility has the added benefit of being cost effective because it reduces the administrative burden at application and renewal.

Several southern states have successfully implemented Express Lane Eligibility and have reduced their number of eligible but uninsured children. Louisiana, Georgia, Alabama, and South Carolina all use ELE, all but Georgia have child uninsured rates at or below the national average. Furthermore, a Congressionally-mandated evaluation of ELE showed significant administrative savings from the use of this policy[vi]. According to the report, Alabama, South Carolina, and Louisiana saw an average of more than $1 million per year in recurring net gains.

Recommendation #2 - Revitalize the state's outreach and application assistance efforts to connect more eligible children to health coverage.

- **Focus efforts and funding on community-based initiatives to enroll the most hard-to-reach populations.** Outreach efforts should seek to connect with community-level stakeholders to best reach historically uninsured children, including:
    - Increase outreach funding, with a portion of the funding allocated for community-based organizations (CBOs) to perform outreach and enrollment assistance activities at the community level.
    - Reinvigorate the Community Partners Program with increased agency staff support and increased case management capabilities. This could be achieved by expanding the Level III community partner designation to more partners.
    - Continue to increase the capacity of outstationed eligibility workers at FQHCs and hospitals.
    - Work with schools and CBOs to systematically identify uninsured children and connect them with outreach assistance. Encourage schools to distribute educational materials during the registration process and to consider asking a question about the insurance status of incoming students on registration forms to identify families who could be assisted with enrolling their uninsured children. Encourage the use of materials with a "sign and review" component to ensure parents receive information about healthcare coverage options for their children.
    - Work with businesses who don't traditionally offer health insurance, to reach working parents who may assume that their children don't qualify for Medicaid or CHIP.
    - Partner with churches and faith-based organizations, as they are often trusted messengers at the community level.

- **Identify potential outreach and enrollment opportunities with other state agencies.** For example, actively facilitate outreach and enrollment into Medicaid and CHIP for families receiving services through DFPS Prevention and Early Intervention programs, workforce services through TWC, and services at local public health departments in collaboration with DSHS. As an example, outreach and enrollment efforts could be achieved by ensuring community-based programs delivering PEI services to families with young children have educational materials on Medicaid and CHIP, importance of health coverage, and how to sign up. Additionally, to reach young children, HHSC could actively facilitate outreach and enrollment through partnership with Texas Head Start Collaboration Office, TWC, and local workforce boards that can disseminate information to child care providers across Texas.

- **Leverage 211 (both local/regional Information and Referral and HHSC Option 2) to reach unenrolled children.** Train staff to identify households that have children who may not be enrolled in coverage, and encourage them to apply and use the hold message to encourage enrollment. (See Attachment 1 for more details on this recommendation from CHCC member United Ways in Texas.)

- **Strengthen messaging for outreach to pregnant women for Medicaid and CHIP perinatal.** While this memo focuses on child enrollment, the CHCC is also interested in improved enrollment of pregnant women to increase on-time prenatal care in Texas and improved birth outcomes. We suggest stronger messaging on availability of Medicaid and CHIP perinatal, with an emphasis on the fact that these are available for free to low-income women without co-pays. The top reasons why women are late in seeking prenatal care is being uninsured and an inability to pay for care[vii].

Recommendation #3 - Improve client-facing literature including the integrated paper application.

- **Streamline the integrated application.** The Affordable Care Act required many changes to integrated application (the Form H1010). To meet implementation deadlines, these changes were done quickly and piecemeal. The result is the Form H1010 is longer than ever, making it difficult to understand and complete. Many of the hardest to reach populations in Texas prefer to use the paper form or are in rural areas without sufficient internet. We recommend a holistic evaluation of the paper application with input from community members through an advisory committee.

- **Implement consistent, accurate, and encouraging messaging on Medicaid and CHIP enrollment.** Current HHSC messaging on who qualifies for coverage is confusing and could lead to families assuming they are not eligible before they even apply. Current income limits published on HHSC website do not include the mandatory 5 percentage point income disregard for MAGI-based Medicaid and CHIP. We recommend creating a consistent messaging for all HHSC public-facing materials that focuses on the importance of health coverage, encourages enrollment, and uses the true income limits which include the mandatory 5 percentage point income disregard for MAGI-based income Medicaid and CHIP. This effort should also consider client messaging that clearly articulates terms of eligibility for non-citizens and their citizen family members. The current language on the Form H1010 regarding immigration status and public charge is clear and understandable but is hard to locate. Language like what is now included on the Form H1010 should be more prominent in public-facing outreach materials, given the climate of fear in accessing government services in the immigrant community.

- **Modernize the Medicaid Managed Care Organization contracts to allow for outreach to encourage child and maternal Medicaid enrollment via contemporary available technology such as social media.**

Additional Considerations

This is not meant to be a comprehensive list of potential actions the agency could take to address our state's high child uninsured rate. These recommendations focus on reaching and enrolling what we refer to as "eligible but uninsured" children. We believe that to see a significant increase in the number of children insured, the state of Texas must *also* address issues related to children churning on and off Medicaid, and families disenrolling from the program due to fear of immigration-related consequences for utilizing public benefits. These issues are top priorities for the Children's Health Coverage Coalition but are not specifically addressed in this memo.

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[i] U.S. Census Bureau, 2017 American Community Survey
[ii] https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics
[iii] CPPP analysis of Migration Policy Institute estimates:: https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/TX
[iv] https://www.urban.org/research/publication/improvements-uninsurance-and-medicaidchip-participation-among-children-and-parents-stalled-2017
[v] Urban Institute analysis of American Community Survey data.
[vi] https://www.mathematica.org/our-publications-and-findings/publications/chipra-mandated-evaluation-of-express-lane-eligibility-final-findings
[vii] 2011 Annual report: Texas Pregnancy risk assessment monitoring system.

Attachment 1 - United Ways in Texas' Recommendation to the Children's Health Coverage Coalition on Leveraging 211 for Outreach and Enrollment

HHSC should leverage the existing 211 platform for outreach purposes to ensure eligible, uninsured children enroll in Medicaid and CHIP. In Texas, 211 is a public-private partnership between the Texas Health and Human Services Commission (HHSC) and a network of 25 Area Information Centers (AICs), which are operated by many local United Ways in Texas. 211 is a connector for all Texans to critical community services including housing, food, mental health services, and financial assistance. As a trusted community resource, Texas 211 has been able to reach populations across the state and provide important information such as ACA open-enrollment period, locations of summer food programs sites, flu shot locations, and information and referral to available childcare programs. The 211 Referral Specialists working at the 25 AICs are trained and certified Community Resource Specialists and assist every caller in assessing their needs. Therefore, 211 is a system that can provide education and support to families with uninsured children who may be eligible to enroll in Medicaid or CHIP.

There are two ways this can be done: 1) through the 211 Referral Specialists staffed at AICs and 2) through the Benefits Specialists—who are Maximus employees and not housed at AICs. When callers dial 211, they are given the option to press 1 for resource referrals by trained Referral Specialists or to press 2 for Your Texas Benefits to apply for state benefits via the Benefits Specialists. Through both touchpoints, callers can be assessed by either call specialist—ex. does caller have children and are children eligible, uninsured—and subsequently referred to enrollment services. HHSC can support this need identification via these two routes, essentially allowing Texas 211s the flexibility to—at the bare minimum—ask callers specific probing questions to identify uninsured children who are eligible for Medicaid or CHIP. HHSC can assess wait-times for Option 2, given that it allows callers to immediately start the enrollment process for state benefits. If callers are disconnected or experience lengthy waiting times, Option 2 might be a barrier for families seeking to enroll their child in healthcare coverage. Moreover, for AICs with additional capacity, HHSC can allow for follow up calls with these families to ensure enrollment occurred and that the family was successfully connected to a healthcare provider.

HHSC can promote 211 through any issue related materials in order to 1) increase public awareness and education about 211 as a community resource and connection to benefits and 2) provide a central point of contact for families to call to get connected to enrollment and pediatric care services. Moreover, an active 211 marketing campaign that highlights child health insurance enrollment assistance can help reach a broader audience across the state—more so than issue-specific materials available at targeted sites (ex. community clinics, early childcare centers). We know that—for a variety of complex reasons—not all Texas families access child-specific services like childcare or healthcare. Therefore, enrollment outreach to Texas families must permeate into everyday settings, which can be accomplished via the marketing of a broad community resource like 211.

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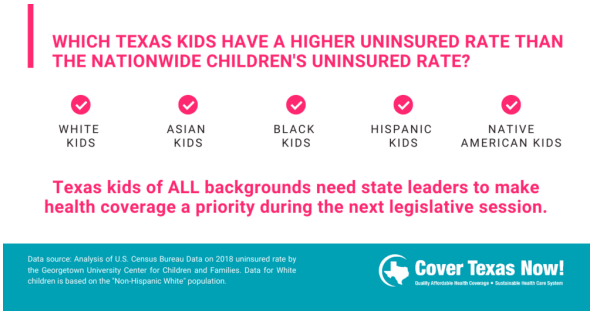
High TX Uninsured Rate Includes Texans Of All Backgrounds And Communities

December 6, 2019 · Cover Texas Now

As you've probably heard by now, Texas has the worst uninsured rate in the nation for children, women of childbearing age, and the overall population. And it's getting worse.

It's important to understand that the high uninsured rate is in large part a result of state policies, so it includes Texans of many different backgrounds and in many different communities. Consider:



- From Longview to McAllen to Amarillo and beyond, all of the state's top 25 metro areas have a worse uninsured rate than the nation as a whole.
- In Texas, the children's uninsured rates for White (non-Hispanic), Black, Hispanic, Asian, and Native American children are **all** higher than the national children's uninsured rate.
- The vast majority of uninsured Texans are U.S. citizens. If all non-citizens (both lawfully present and undocumented) were removed from the Texas uninsured data, the state's uninsured rate would be 12.6 percent, still much higher than the national average of 8.5 percent and still the largest number of uninsured in the U.S., according to analysis of U.S. Census Bureau data by the Center for Public Policy Priorities.

While the Legislature passed zero bills during the 2019 legislative session to reduce the uninsured rate, we are encouraged by the growing level of interest in addressing this problem during the next legislative session. For example, in announcing House and Senate interim charges, Lt. Governor Patrick and Speaker Bonnen recently directed legislative committees to study ways to reduce the uninsured rate. Fortunately, there are a number of policy solutions available to state leaders.

We look forward to working with legislators to make health coverage a priority during the next legislative session.

PREVIOUS

Report: Uninsured Rate for TX Kids Under Age 6 is a Big Problem

NEXT

Lege Leaders Call for Studying Ways to Reduce TX Uninsured Rate

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FIND OUR RESOURCES

MAJOR HEALTH COVERAGE POLICY AREAS

Affordable Care Act (ACA)

ACA Enrollment

Medicaid

Medicaid Expansion

Medicaid 1115 Waiver

Medicaid Block Grants

Private Coverage

HEALTH CHALLENGES AND POPULATIONS

Substance Use Disorders

Maternal Health

Mental Health

Children's Health

Immigrants' Health

Texas Uninsured

POLICY LEVEL

Federal policy

State policy

GET INVOLVED

Tools and Opportunities for Advocates

TO: Courtney N. Phillips, Phd, Executive Commissioner
Texas Health and Human Services Commission

COPY: Victoria Ford, Stephanie Muth, Suling Homsy, Michael Ghasemi, Allison Morris, Hilary Davis

FROM: Texas Children's Health Coverage Coalition

RE: Enrollment and retention of eligible children from mixed-status families in Texas Medicaid and CHIP: Recommendations, resources, and best practices to respond to the Public Charge "chilling effect"

DATE: January 22, 2020

Background: This memo relates to supporting:

- Medicaid and CHIP coverage of U.S. citizen children who have a non-citizen parent (U.S. Census estimates 26% of Texas children fit this description);
- children with a lawful immigration status who are themselves eligible for Medicaid or CHIP;
- pregnant women seeking Medicaid Maternity benefits (e.g., who may have an eligible immigration status such as refugee, or a non-citizen spouse); or
- pregnant non-citizens—with or without a lawful immigration status—seeking participation in the CHIP Perinatal program.

The number of Texas children enrolled in Medicaid/CHIP dropped by nearly 209,000 kids from Dec. 2017 to Oct. 2019, and is almost certainly a significant contributing factor to the 2 years of worsening uninsured rates for Texas children. Texas HHSC—supported by other health care stakeholders—has a unique capacity , and responsibility, to monitor the "chilling effect" of the federal policy changes and proposals that can create community concern and confusion, and then use its special expertise to inform the public as effectively as possible to help counter that trend.

Recommendations:

CHCC recognizes that Texas HHSC has over 20 years of strong policy and practice providing good information to Texas' mixed-immigration-status families about public benefits eligibility and the privacy of information related to benefits. Our recommendations focus first on capitalizing on that foundation.

Recommendation 1:

Analyze past data (e.g., back to 2016) and track future enrollment and renewal trends, with an emphasis on trends among children and pregnant women who are non-citizens or whose households include a non-citizen. To be most useful, the analysis should include data by race and geography as well.

Recommendation 2:

The most widely used HHSC application (Form H1010) includes good clear language on public charge. CHCC encourages HHSC to use this language to:

1. create new (additional) public-facing materials (examples are offered below); and
2. to more clearly highlight/elevate this language on both the paper H1010 form, and especially on the online YTB application.

Examples of HHSC's effective and accurate Form H1010 language:

Citizenship and Immigration Status

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps immigrants with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

Social Security Numbers

You only need to give the Social Security numbers (SSNs) for people who want benefits. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN can't get benefits. If you don't have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have an SSN and you don't. We will not give SSNs to the Bureau of Immigration and Customs Enforcement. We will use SSNs to check the amount of money you get (income), if you can get benefits, and the amount of benefits you can get. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)

Section V

Statement of Understanding

Read Section W before signing page 19.

All Benefit Programs

Facts HHSC Has About Me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping My Facts Private

HHSC will keep my facts private if they were collected:

- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

Recommendation 3: Updated Training for Eligibility Staff

CHCC recommends HHSC provide a special reminder bulletin to eligibility workers on related policies, including:

- Educating workers on the current federal public charge policy, and reiterate that it has not yet been changed. (We understand that HHSC is not planning to update eligibility-related document language to conform to the proposed new rule unless/until that new rule actually goes into effect.)
- Reminding eligibility workers that they may not require information that is not pertinent to an individual's eligibility, including immigration status or SSNs of non-applicant household members;
- Creating scripts for both 2-1-1 Option 2 staff and eligibility workers to address clients' who express concerns about applying. These could use current language from the Form H1010.
- Encouraging eligibility workers to point to the language on the application as a way to reassure clients.

Examples of Effective Client-Facing Materials from Other States

California: A good 2-page flyer that needs to be updated to reflect the injunction that has indefinitely suspended implementation of the new rule, and the landing page that explains the injunction and gives links to versions in four additional languages.

> https://www.chhs.ca.gov/wp-content/uploads/2019/09/CHHS-Public-Charge-Guide-FINAL-9.10.2019-Accessible-Version.pdf
>
> https://immigrantguide.ca.gov/en/publiccharge/

The California State Department of Social Services, which administers SNAP and TANF, has also contracted the National Immigration Law Center to provide training and resources to its eligibility workers, including consumer-facing materials in several "threshold" languages.

Illinois: The Illinois Department of Human Services has developed scripts for staff, along with client facing English and Spanish Fact sheets, and a statewide list of non-profit organizations that can help families with questions about the Public Charge policies: https://www.dhs.state.il.us/page.aspx?item=118786.

Washington: The state Department of Health provides a simple landing page on Public Charge, with an FAQ. Format: https://www.doh.wa.gov/CommunityandEnvironment/HealthEquity/PublicCharge

Oregon: The Oregon Health Authority hosts a Public Charge landing page with links to fact sheets in 9 languages. Other resources at the Oregon link include some very simple client-facing social media messaging cards on English and Spanish, as well as agency webinar materials. https://www.oregon.gov/OHA/ERD/Pages/public-charge.aspx

The NYC Mayor's Office of Immigrant Affairs, and NYC Public Health Care System:

The Office of Immigrant Affairs landing page offers public charge facts sheets in 15 languages, an FAQ, and guidance on where to get qualified legal assistance to answer individual clients and families' questions. https://www1.nyc.gov/site/immigrants/help/legal-services/public-charge.page. NYC Health + Hospitals hosts a Public Charge landing page with a similar range of languages and resources at https://www.nychealthandhospitals.org/immigrant/

Other Resources and Issues:

- **Use of CHIP funding for outreach and enrollment.** Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change; June 2019; https://cssp.org/resource/medicaid-blueprint/; see Appendix C: Table C-1, States' CHIP Spending Relative to the 10 Percent Limit on Non-Coverage Expenditures, Federal Fiscal Year 2017. This could be a resource for implementing the recommendations above.
- Our colleagues at Georgetown U Center for Children and Families tell us they are not aware of any data compilation/reporting that would identify what states are spending on Medicaid and CHIP outreach, enrollment assistance, and marketing.
- While CHCC is primarily focused on health coverage and care, we partner with hunger and social service advocates and application assisters who are similarly concerned about the chilling effect impact on SNAP, WIC, and school meals. We share a Texas WIC poster that seeks to reassure families, and welcome discussion of the input we have had from agencies that serve immigrant populations across this broader range of programs.

Memo compiled by CPPP and CDF, questions may be addressed to dunkelberg@cppp.org.

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A Brief Overview: TX Lege Must Reduce The Uninsured Rate

January 14, 2020 · Cover Texas Now

Texas has the highest uninsured rate in the nation for children, adults, and women of childbearing age — and it's getting worse.

DOWNLOAD A PRINTABLE PDF OF THIS BRIEF

- The uninsured rate for Texas children was 11.2 percent in 2018, an increase from 10.7 percent in 2017. [i] That rate is much worse than the national average of 5.5 percent. The recent decline in the number of Texas children enrolled in Medicaid/CHIP — dropping by nearly 209,000 kids from Dec. 2017 to Oct. 2019 — is a big reason why the uninsured rate for Texas children is getting worse.
- The uninsured rate for Texas adults and children combined was 17.7 percent in 2018, an increase from 17.3 percent in 2017. The Texas uninsured rate was more than twice as high as the national uninsured rate of 8.5 percent. Just over five million Texans were uninsured in 2018. The uninsured rate for Texas women of childbearing age was 25.5 percent in 2017, double the national average of 12.3.

Because the high uninsured rate is in large part a result of state policies, it includes Texans of many different backgrounds and in many different communities.

- From Longview to McAllen to Amarillo and beyond, all of the state's top 25 metro areas have a worse uninsured rate than the nation as a whole.

national average of 8.5 percent and still the largest number of uninsured in the U.S. [ii]

- In Texas, the children's uninsured rates for White (non-Hispanic), Black, Hispanic, Native American, and Asian children are all higher than the national uninsured rate for children.
- Other border states have much lower children's uninsured rates than the Texas rate of 11.2 percent: Arizona (8.4 percent), California (3.1 percent), and New Mexico (5.3 percent).

Many low-wage jobs do not offer health insurance, so Medicaid policy is a key part of the solution. Uninsured workers — with or without children — typically are NOT eligible for Medicaid under Texas policy, while uninsured children often ARE eligible for Medicaid/CHIP but encounter bureaucratic barriers.

- Many adults working as child care teachers, cashiers, home health aides, or in other low-wage jobs do NOT receive job-based insurance for themselves or their kids; do NOT earn enough to purchase private insurance; and do NOT qualify for Affordable Care Act (ACA) insurance subsidies designed for individuals above the poverty line. They typically do not qualify for Medicaid insurance, which Texas largely limits to kids, pregnant women, seniors, and people with severe disabilities. The ACA was intended to cover them through Medicaid expansion, but Texas has not accepted that funding.
- Of the state's 873,000 uninsured children, at least 275,000 — and likely more — are eligible for Medicaid or CHIP. [iii] That means that Texas could significantly reduce the rate of uninsured children by improving outreach and reducing red tape that removes eligible children from Medicaid.

The high uninsured rate has serious consequences. Research shows that when people have insurance, they are healthier and less likely to die prematurely.

- The high uninsured rate undermines Texas' efforts to address mental health, maternal and infant health, substance use disorders, and other challenges.
- There is a valuable patchwork of services for the uninsured, including community health centers, but it's often too little, too late. Many charity providers can't keep up with demand. Care is unavailable in many counties, especially rural ones. Many

- Uninsured individuals typically wait longer to seek medical care , leading to worse health outcomes and higher costs for families and taxpayers, and are less likely to see a health care professional.
- When children and others cycle on and off of insurance plans and bounce around to different care providers, they miss out on consistent care and regular checkups they need for healthy outcomes. This fragmented care also creates costly duplication of health care and avoidable administrative costs.

The 2019 Texas Legislature did NOT pass any bills to reduce the uninsured rate, but momentum is building to address health coverage in the 2021 session. The House and Senate both have interim charges directing committees to study ways to reduce the uninsured rate.

- In 2019, the postpartum maternal health coverage bill, HB 744, passed the House on a vote of 87-43 but did not come up in the Senate. A version of the children's health coverage bill passed the House as an amendment but did not come up in the Senate. The House voted down Medicaid expansion as a budget amendment on a vote of 66-80. The Legislature did pass bills to improve insurance for Texans who already have coverage.
- Kaiser Family Foundation-Episcopal Health Foundation polling in 2018 found that 87 percent of Texans believe that increasing access to health insurance is either a top priority or important and that 64 percent support Medicaid expansion, similar to other Texas polls.

Reducing the uninsured rate must be a priority for the 2021 legislative session, and we urge state leaders to describe their plans for addressing this challenge. Here are some ways that the Texas Legislature could reduce the uninsured rate in 2021.

- Restore the state's outreach and application assistance efforts to connect more eligible children to health coverage.
- Reduce red tape in children's Medicaid that leads to eligible kids cycling on and off of insurance.
- Extend Medicaid insurance to cover uninsured mothers for 12 months after childbirth, rather than the current 2 months.
- Expand health coverage as part of a renegotiation of the federal 1115 Medicaid Waiver.

[i] Unless otherwise noted, all uninsured data are from the U.S. Census Bureau.

[ii] Analysis by the Center for Public Policy Priorities (CPPP) using U.S. Census Bureau data.

[iii] Analysis by CPPP using data from the U.S. Census Bureau and the Migration Policy Institute.

PREVIOUS

Families Should Stay in Medicaid/CHIP After Court's Immigration Ruling

NEXT

TX Leaders a Step Closer to Taking our Health Care Protections

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FIND OUR RESOURCES

MAJOR HEALTH COVERAGE POLICY AREAS

Affordable Care Act (ACA)

ACA Enrollment

Medicaid

Medicaid Expansion

Medicaid 1115 Waiver

Medicaid Block Grants

Private Coverage

HEALTH CHALLENGES AND POPULATIONS

Substance Use Disorders

Maternal Health

Mental Health

Children's Health

Immigrants' Health

Texas Uninsured

POLICY LEVEL

Federal policy

State policy

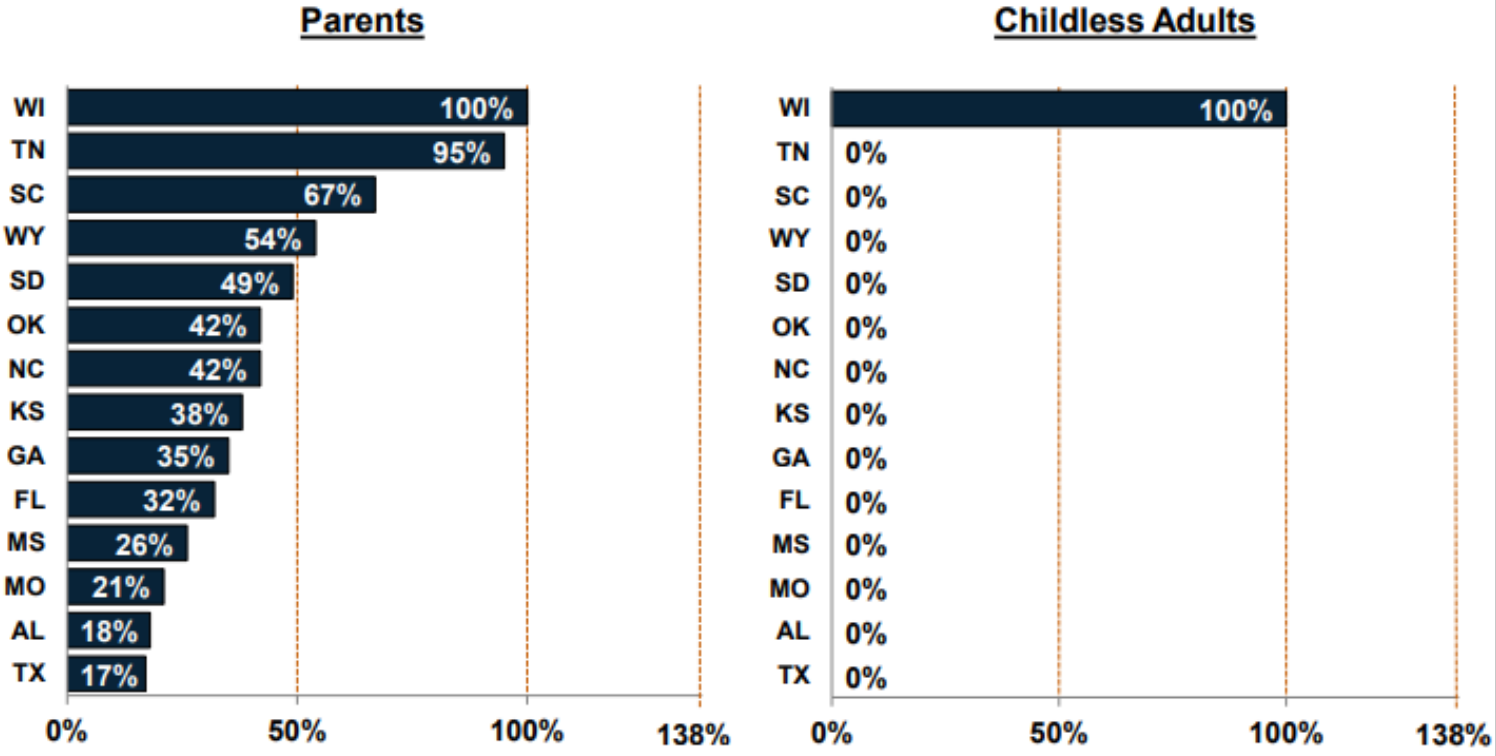
GET INVOLVED

Tools and Opportunities for Advocates

1

Figure 5

Medicaid Income Eligibility Limits for Adults in States that Have Not Adopted the Medicaid Expansion, January 2019



NOTES: Eligibility levels are based on 2019 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2019, the FPL was $21,330 for a family of three and $12,490 for an individual. Thresholds include the standard five percentage point of FPL disregard. OK provides more limited coverage to some childless adults under Section 1115 waiver authority

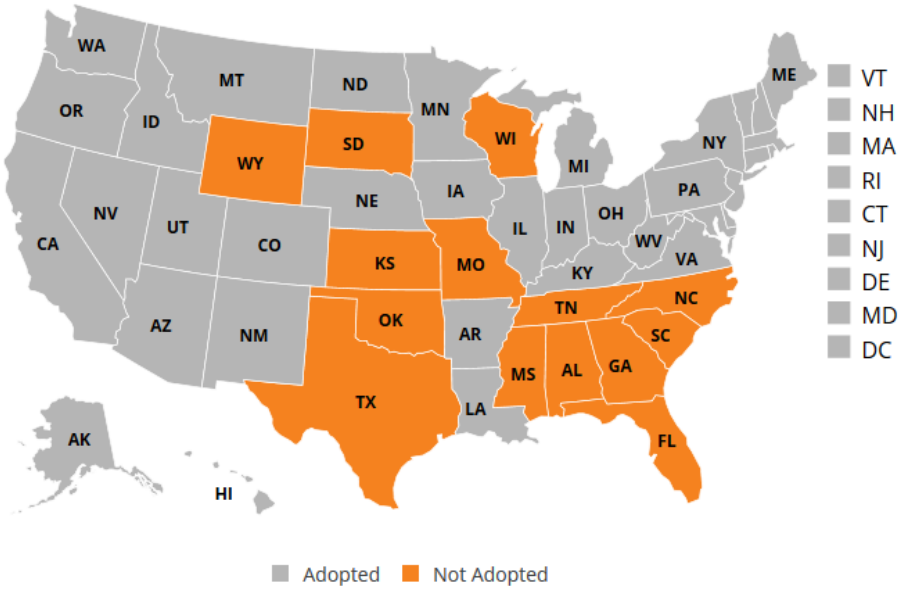
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

KFF

2

4.4 Million Uninsured Adults Could Get Coverage through Medicaid Expansion
1.5 million (31%) are Texans

14 States Have Not Adopted Expansion



Graphic: Kaiser Family Foundation

Studies find Medicaid expansion leads to Increases in:

- People getting regular check-ups
- Prescriptions filled for heart disease and diabetes
- Early-stage cancer diagnoses
- People getting surgical care consistent with clinical guidelines

Decreases in:

- People skipping medications due to cost
- One-year mortality among patients diagnosed with end-stage renal disease
- People screening positive for depression
- People without a personal physician or usual source of care

Source: Ghosh et al. 2019, Loehrer et al. 2018, Miller et al. 2019, Sommers et al. 2016, Soni et al. 2017, Swaminathan et al. 2018

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

https://www.cbpp.org/sites/default/files/atoms/files/10-2-18health.pdf

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A Review of the New Healthy Adult Opportunity Demonstration Guidance

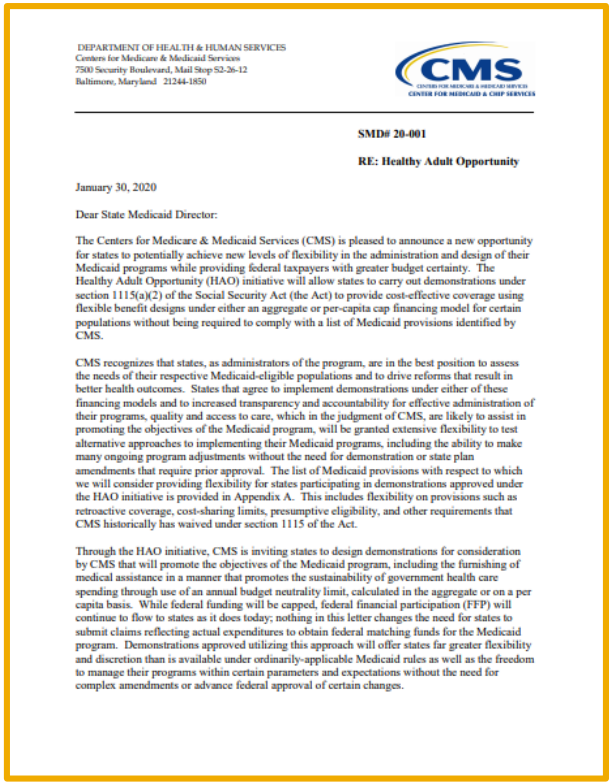
Allison Orris

Manatt Health

Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter (SMDL) available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.

Healthy Adult Opportunity Demonstration Guidance

On January 30th, CMS issued an SMDL and template inviting states to apply for Section 1115 "Healthy Adult Opportunity" demonstrations that would cap federal Medicaid funding for a portion of their Medicaid population.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 20-001

RE: Healthy Adult Opportunity

January 30, 2020

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new opportunity for states to potentially achieve new levels of flexibility in the administration and design of their Medicaid programs while providing federal taxpayers with greater budget certainty. The Healthy Adult Opportunity (HAO) initiative will allow states to carry out demonstrations under section 1115(a)(2) of the Social Security Act (the Act) to provide cost-effective coverage using flexible benefit designs under either an aggregate or per-capita cap financing model for certain populations without being required to comply with a list of Medicaid provisions identified by CMS.

CMS recognizes that states, as administrators of the program, are in the best position to assess the needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes. States that agree to implement demonstrations under either of these financing models and to increased transparency and accountability for effective administration of their programs, quality and access to care, which in the judgment of CMS, are likely to assist in promoting the objectives of the Medicaid program, will be granted extensive flexibility to test alternative approaches to implementing their Medicaid programs, including the ability to make many ongoing program adjustments without the need for demonstration or state plan amendments that require prior approval. The list of Medicaid provisions with respect to which we will consider providing flexibility for states participating in demonstrations approved under the HAO initiative is provided in Appendix A. This includes flexibility on provisions such as retroactive coverage, cost-sharing limits, presumptive eligibility, and other requirements that CMS historically has waived under section 1115 of the Act.

Through the HAO initiative, CMS is inviting states to design demonstrations for consideration by CMS that will promote the objectives of the Medicaid program, including the furnishing of medical assistance in a manner that promotes the sustainability of government health care spending through use of an annual budget neutrality limit, calculated in the aggregate or on a per capita basis. While federal funding will be capped, federal financial participation (FFP) will continue to flow to states as it does today; nothing in this letter changes the need for states to submit claims reflecting actual expenditures to obtain federal matching funds for the Medicaid program. Demonstrations approved utilizing this approach will offer states far greater flexibility and discretion than is available under ordinarily-applicable Medicaid rules as well as the freedom to manage their programs within certain parameters and expectations without the need for complex amendments or advance federal approval of certain changes.

Healthy Adult Opportunity Guidance 101:

Capped Funding. States agree to accept caps on their federal matching dollars in one of two forms: a per capita cap or an aggregate cap

Flexibility. In exchange for accepting a cap, states can get pre-approved authorization to constrain eligibility, impose premiums/cost sharing, and modify benefits

"Shared Savings". States could divert "unused" federal block grant funds to other purposes

Timeframe. Demonstrations are authorized for a five-year demonstration period

Some of the content included in this presentation was developed for the State Health & Value Strategies program, a grantee of the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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Demonstration Eligible Populations

The guidance targets the Affordable Care Act adult expansion group, but some other populations could be included.

Demonstration Eligible Populations:

Affordable Care Act adult expansion group

Optional populations of non-elderly, non-disabled adults (e.g., optional parents and pregnant women whose household income is above the federal mandatory threshold for these groups)

States may shift existing Medicaid populations (state plan or demonstration) to the capped funding demonstration, or use the demonstration to extend coverage to new populations

Ineligible Populations:

Children, elderly/disabled, and mandatory adults (e.g., mandatory parents and pregnant women)

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States May Choose a Per Capita Cap or Aggregate Cap

States covering new populations (e.g., a newly expanding state) must use a per capita cap for the first two years.

Cap Model	Base Payment	Trend Rate	Federal Matches Up to the Cap	States At Risk For
Per Capita Cap – Cap is set per person	Based on historical spending per enrollee	Cap grows each year by pre-set trend rate: the *lower* of state historical spending growth or the **medical CPI**	CMS matches state spending at applicable match rate but only up to the cap	Increases in health costs but not enrollment
Aggregate Cap (Block Grant) – Cap is set for all spending under the demonstration	Based on historical spending and enrollment (total costs)	Cap grows each year by pre-set trend rate: the *lower* of state historical spending growth or **medical CPI plus .5**	CMS matches state spending at applicable match rate but only up to the cap	Increases in health costs and enrollment

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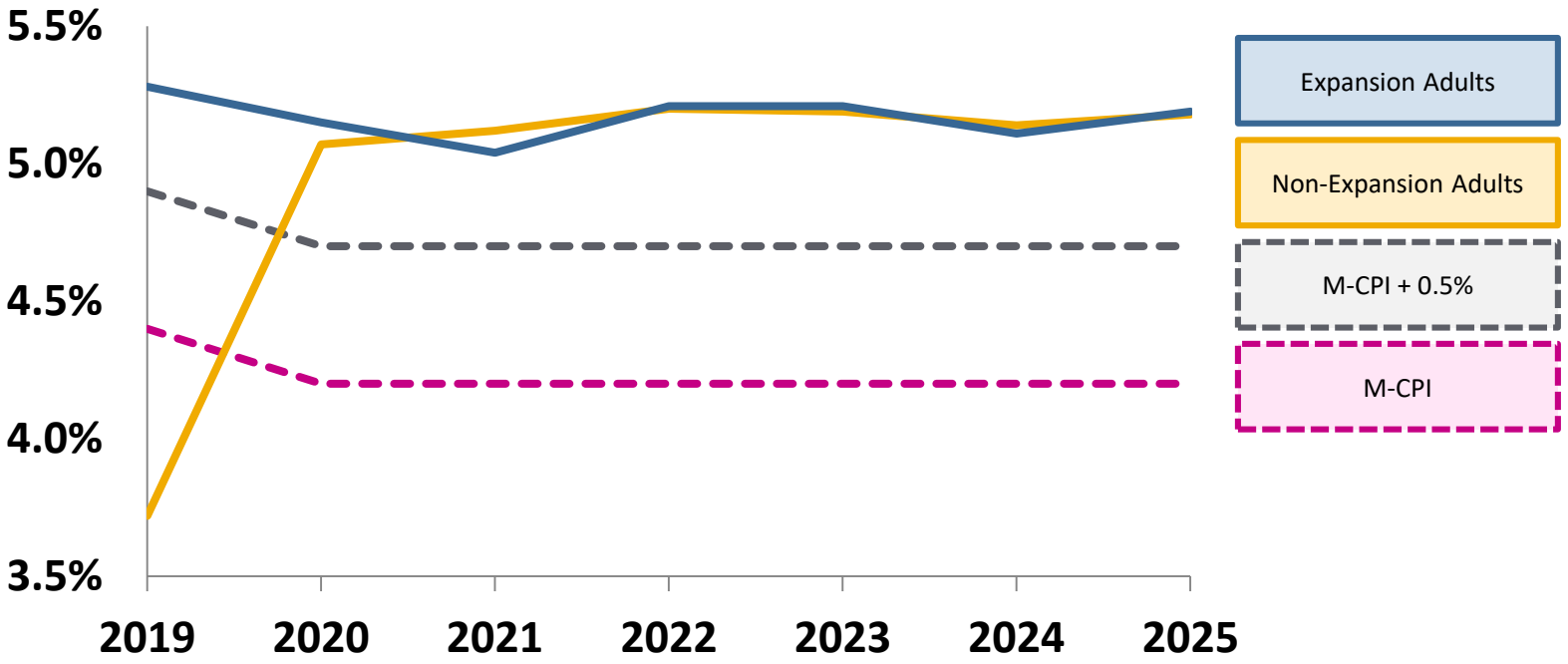
Capped Funding Demonstration Trend Rates

Medicaid expenditures are expected to grow more quickly than the allowable capped funding demonstration trend rates; over time, this will likely constrain state spending relative to current levels.

Projected Annual Per Enrollee Spending Growth Rates (2019 – 2025)



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Source: OACT 2017 Actuarial Report on the Financial Outlook for Medicaid.

“Program Flexibility” in Exchange for Capped Funding

In exchange for assuming additional financial risk, the guidance authorizes CMS to approve new “program flexibilities” for demonstration populations, many of which are currently available.

ELIGIBILITY & ENROLLMENT	Work requirements	■
	Prospective enrollment (i.e., delay before coverage becomes effective)	■
	Eliminate retroactive eligibility	■
	Eliminate hospital presumptive eligibility	☑
	Lock-out periods	■
	Health risk assessment	■
	Healthy behavior incentives	■
	Align renewal cycle with Marketplace (i.e., reduce first coverage period)	■
	Continuous eligibility up to 12 months	■
COVERED BENEFITS	Align benefits with Essential Health Benefits (EHB) (incl. mandatory plan and ABP) by eliminating:	
	Non-Emergency Medical Transportation (NEMT)	■
	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19 & 20 yo	■
	Long-term care	■
	Closed prescription drug formulary while retaining Medicaid Drug Rebate Program (MDRP) rebates	■
	Vary amount, duration, and scope of covered benefits	■
	Lifetime/annual treatment limits on non-EHB services	■
	Coverage of additional items and services beyond EHB standard	■

■ Approved under demonstrations without a cap (post ACA)

■ Approved/permitted under rules for ACA expansion population (except medically frail)

☑ Newly available under capped funding demonstration

"Program Flexibility" in Exchange for Capped Funding (Continued)

PREMIUMS & COST SHARING	Charge premiums at all income levels	■
	Impose cost sharing in excess of statutory limits	☑
DELIVERY SYSTEM & FEDERAL OVERSIGHT	Flexibility in delivery system	■
	Pre-approval of policies that may be implemented during demo	☑*
	Eliminate CMS pre-approval of managed care rates & retro adjustments, contract amendments, directed payments, provider payment methods	☑
	Depart from managed care rules on actuarial soundness, network adequacy	☑
	Depart from FFS access standards (rate setting, payment methods)	☑
	Reimburse Federally Qualified Health Centers (FQHCs) through value-based purchasing rather than enhanced FQHC rates	☑
FINANCING	Shared savings based on "unused" federal financial participation (FFP) under aggregate cap	☑
APPEALS	Modify fair hearing processes	☑

Unavailable under capped funding demonstration if state seeks 90% enhanced match rate:

- ✕ **Partial expansion**
- ✕ **Enrollment caps**
- ✕ **Asset tests**

■ Approved under demonstrations without a cap (post ACA)

■ Approved/permitted under rules for ACA expansion population (except medically frail)

☑ Newly available under capped funding demonstration

**Although CMS has previously pre-approved a range of premium levels in a post-ACA demonstration without a cap, this program flexibility is designated as "newly available" because, under a capped funding demonstration, CMS is open to pre-approving a much broader range of policies.*

"Shared Savings" May be Available to States That Opt for an Aggregate Cap

Provided states meet certain performance criteria, they could divert federal block grant funds; creates a strong incentive for states to spend well below the cap.

Drawing Down "Shared Savings"

A state may convert unused federal spending into a "shared savings" payment

- 25 – 50% of unused federal matching dollars can be drawn down as "shared savings," if state meets certain performance benchmarks
- States must draw down "shared savings" at the applicable matching rate by spending state funds; lower match rate than for the demonstration assuming the demonstration covers the expansion group
- States can divert the federal funds into state-funded health-related state programs
- Federal "shared savings" may not supplant existing federal funding, but can replace existing state spending on health programs as long as state match requirement is met, thereby freeing state dollars for other uses (e.g., roads and infrastructure)

Alternatively States Could Use Savings as a Cushion in Later Years

- A state that underspends in a given year may apply unused federal funds to offset overspending in any of the next three years

Some of the content included in this presentation was developed for the State Health & Value Strategies program, a grantee of the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Considerations for "Shared Savings"

While "shared savings" and the ability to divert federal dollars may sound initially appealing, a number of factors limit their appeal.

Looking Under the Hood

- ✕ To access any federal savings, **states must reduce their total Medicaid expenditures beyond what is required to simply live within the caps**
- ✕ States still must provide matching dollars to draw down "shared savings" **at the regular match rate, which is likely below the demonstration match rate** (if state is covering expansion group under the demonstration)
- ✕ Newly expanding states would **not be eligible for "shared savings" in in the first two years when they are under a per capita cap; other limitations may apply in later years** (e.g., data limitations; last year of demonstration)
- ✕ States must **establish a comprehensive set of baseline quality metrics for the demonstration population,** which may prove challenging in some states

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Capped Funding Demonstrations: The Potential Appeal vs. The Reality

Potential Appeal for Some States

✓ **Reduces Medicaid spending** on the demonstration population

The Reality for States

✕ **Cuts and level of risk grow over time**

✕ Because of the 90/10 match, **most of the reductions in spending for the expansion population accrue to the federal government**, not the state

State Share of the Reduction in Spending (10%)

Federal Share of the Reduction in Spending (90%)

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Capped Funding Demonstrations: The Potential Appeal vs. The Reality (Continued)

Potential Appeal for Some States	The Reality for States
✓ If a state spends well below the cap some of the Federal savings can be reinvested through the **"shared savings" option**	✕ It will be **hard to cut that deeply**; state match still required, time frame is limited particularly for newly expanding states, and data may be an issue
✓ In exchange for less federal funds, the federal government will **allow certain policy options/program changes**	✕ **Many of the policy options/program changes offered have been approved in other waivers** without caps on federal Medicaid funding ✕ Harm to coverage and access to care ✕ **Reductions in payments to plans/providers** may be unsustainable
✓ **Relaxed federal oversight** (e.g., prior approval from CMS not required for certain actions)	✕ **CMS will still monitor** and may require retrospective adjustments for states deemed out of compliance; guidance imposes **new monitoring and reporting obligations on states**
✓ More politically acceptable **pathway to expansion?**	✕ **Legal challenges** are highly likely, with associated costs and uncertainty

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Thank You

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About Manatt Health

Manatt Health integrates legal and consulting services to better meet the complex needs of clients across the health care system. Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions and lead health care into the future. For more information, visit https://www.manatt.com/Health.

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Appendix

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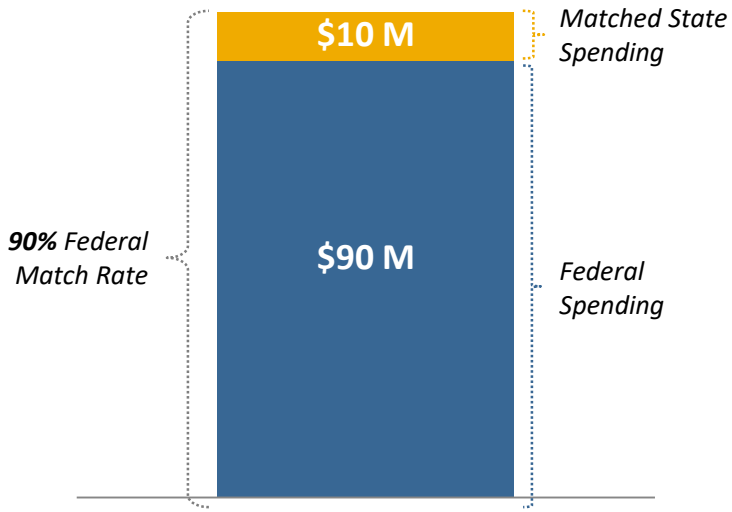
A Fundamental Change in Medicaid Financing

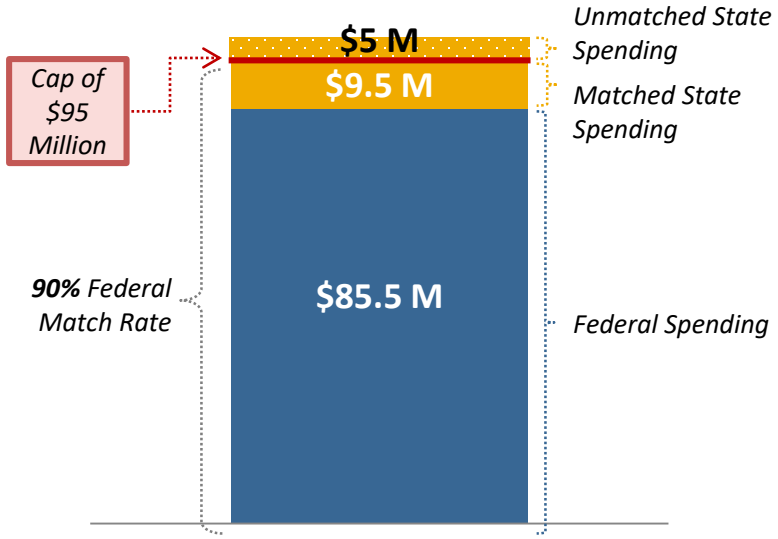
The federal government currently matches state expenditures without any cap. The new demonstration caps federal matching dollars.

Medicaid Spending Without a Cap – Year 1



Total Spending: $100 Million

Medicaid Spending With a Cap – Demonstration Year 1



Total Spending: $100 Million

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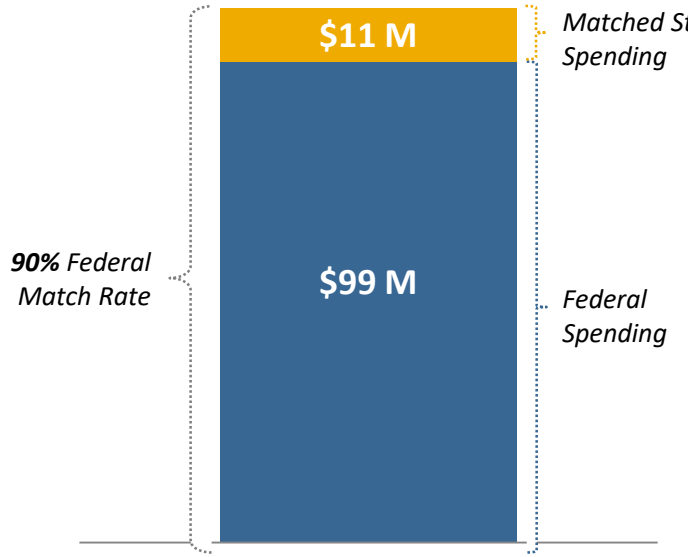
A Fundamental Change in Medicaid Financing (Continued)

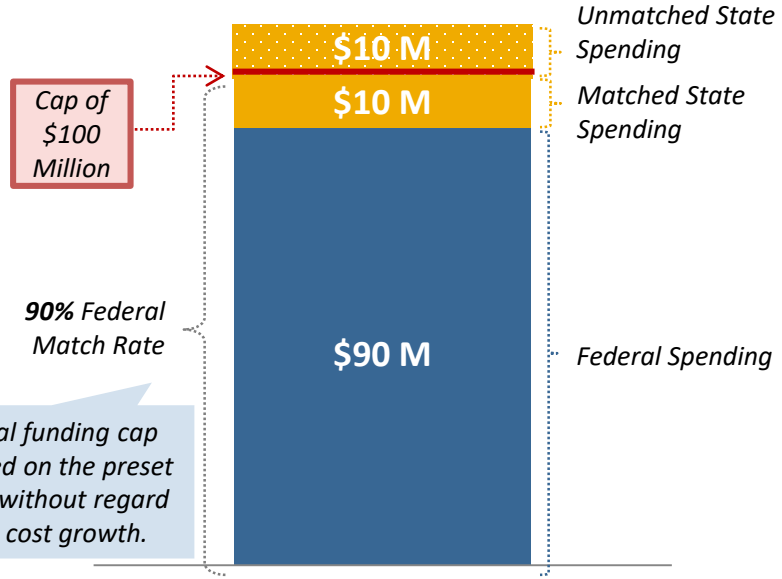
When Medicaid costs go up under current law, federal funding increases proportionately. Under the demonstration, the cap limits federal spending regardless of actual costs.

Medicaid Spending Without a Cap – Year 2



Total Spending: $110 Million

Medicaid Spending With a Cap – Demonstration Year 2



The federal funding cap grows based on the preset trend rate without regard to actual cost growth.

Total Spending: $110 Million

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Cover Texas Now!
Quality Affordable Health Coverage • Sustainable Health Care System

Families Should Stay In Medicaid/CHIP After Court's Immigration Ruling

January 28, 2020 · Cover Texas Now

We believe Texas children and pregnant women must be able to get the medical care they need to stay healthy.

So we are deeply concerned about the U.S. Supreme Court's ruling yesterday on a key Trump administration immigration policy. The Court determined that the new Public Charge rule for green card applicants can take effect as lower courts consider the legal challenges against it. We are very concerned that the ruling will scare families into pulling out of critical health care programs.

AS NEWS OF THE RULING SPREADS, WE NEED YOUR HELP REASSURING SCARED TEXAS FAMILIES THAT THEY SHOULD "KEEP CALM AND STAY ENROLLED."

Specifically:

- If families are going to apply for a green card (legal permanent residency) from INSIDE the United States, **it is SAFE to keep their children enrolled in programs like Medicaid, CHIP, housing assistance, and SNAP food stamps and SAFE for pregnant women to stay enrolled in CHIP-Perinatal and Medicaid.**
- If families are going to apply for a green card from OUTSIDE the United States, they should check with an attorney to see how the new rule might affect them.

The fact is, most immigrants in Texas are **not** eligible for public benefits, regardless of this new rule. **But there are many mixed status families with children who are U.S.**

SHARE THE MESSAGE ON TWITTER

SHARE THE MESSAGE ON FACEBOOK

Here's more information about who and what is covered by the new rule:

- When the new rule takes effect, it will penalize applicants for green cards if they themselves (not their children) have legally enrolled in a public assistance program.
- Because of program eligibility rules in Texas, only a very small number of legally-present immigrants without green cards can personally use SNAP food stamps or housing assistance and therefore be affected by the rule when they apply for a green card.
- The new rule does **NOT** penalize a green card applicant for using Children's Medicaid (up to age 21), CHIP, Medicaid for Pregnant Women, ACA subsidies, emergency medical care, WIC, or school breakfast or lunch.
- The new rule does **NOT** consider benefits used by the applicant's family members.
- For green card applicants applying within the U.S., there is **NO** benefit to a if their family members drop their Medicaid, SNAP, CHIP, ACA subsidies, school meals, or other important services.
- Those who already have their green cards are **NOT** affected by this rule when they apply to become a citizen.
- Refugees, asylees, and several other humanitarian immigration categories are also **NOT** included in the rule.
- Because undocumented immigrants are **NOT** eligible for Medicaid or SNAP, this new rule will **NOT** directly affect them.
- One of the big reasons that many organizations and elected officials oppose this rule is that it **WILL** make it much harder for immigrants to obtain a green card if their family income is low enough for children or a spouse to qualify for Medicaid

- To determine if the rule affects a family member who is currently applying for a green card or is legally present and plans to apply for a green card in the future, families should consult with a qualified immigration legal services provider. Texas has many reputable community organizations that can provide free or low-cost help.

Thank you for standing up for health care for Texas families!

READ MORE FROM THE CENTER FOR PUBLIC POLICY PRIORITES

PREVIOUS

TX Candidates Want Your Vote. Ask Them This First.

NEXT

A Brief Overview: TX Lege Must Reduce the Uninsured Rate

Cover Texas Now!
Quality Affordable Health Coverage • Sustainable Health Care System

FIND OUR RESOURCES

MAJOR HEALTH COVERAGE POLICY AREAS

Affordable Care Act (ACA)

ACA Enrollment

Medicaid

Medicaid Expansion

Medicaid 1115 Waiver

Medicaid Block Grants

Private Coverage

HEALTH CHALLENGES AND POPULATIONS

Substance Use Disorders

Maternal Health

Mental Health

Children's Health

Immigrants' Health

Texas Uninsured

POLICY LEVEL

Federal policy

State policy

GET INVOLVED

Tools and Opportunities for Advocates

Cover Texas Now!
Quality Affordable Health Coverage • Sustainable Health Care System

TX Candidates Want Your Vote. Ask Them This First.

February 20, 2020 · Cover Texas Now

With early voting already underway in Texas, candidates for the Texas Legislature, Congress, the White House, and other offices are frantically asking you for your vote.

They may be texting you, emailing you, inviting you to events, or knocking on your door.

But before you give the candidates an answer, they should give you some answers.

If you want to push them to make health care a priority, here are a few questions to ask Texas candidates:

- Texas leaders and the White House are pushing a Health Care Repeal Lawsuit that would end protections for pre-existing conditions and other health benefits.

  So, do you support the Health Care Repeal Lawsuit?

- Texas has the nation's worst uninsured rate. The high uninsured rate includes kids and adults of all backgrounds and communities.

  So, what is your plan to reduce the Texas uninsured rate?

So, do you support keeping eligible Texas kids enrolled in health coverage?

CHECK OUT OUR FULL VOTER GUIDE WITH CANDIDATE QUESTIONS

Thank you for asking candidates the hard questions on health care and putting this critical issue on the agenda!

NEXT

Families Should Stay in Medicaid/CHIP After Court's Immigration Ruling

FIND OUR RESOURCES

MAJOR HEALTH COVERAGE POLICY AREAS

Affordable Care Act (ACA)

ACA Enrollment

Medicaid

Medicaid Expansion

Medicaid 1115 Waiver

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Texas Uninsured

POLICY LEVEL

Federal policy

State policy

GET INVOLVED

Tools and Opportunities for Advocates

HHS Office of the Ombudsman Update

Presented to
CHC Coalition
February 21, 2020

TEXAS
Health and Human Services

Total Ombudsman Contacts for September 2019 – January 2020

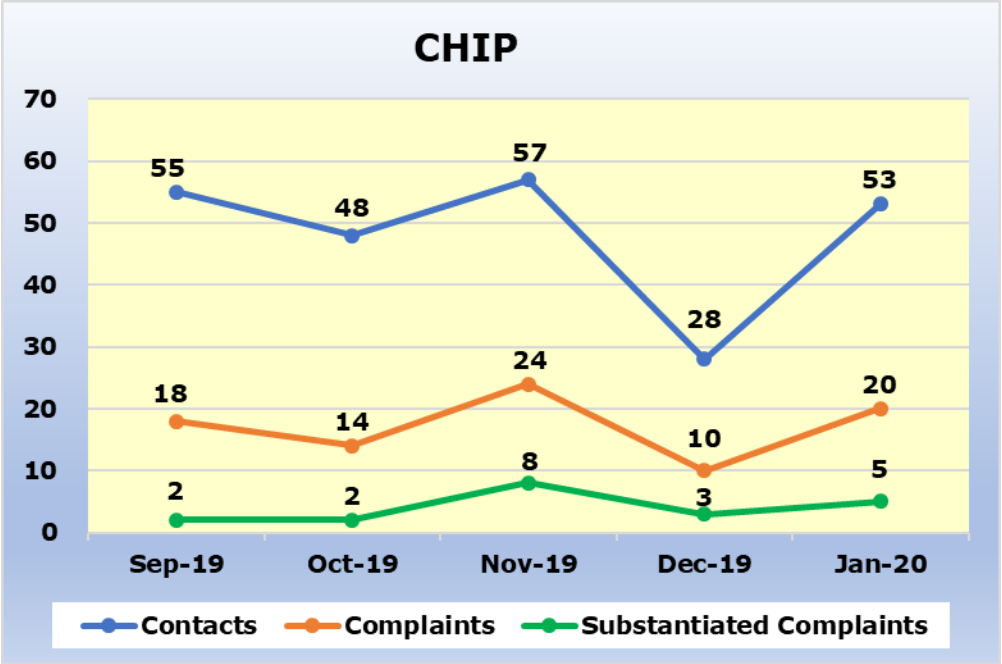
- Complaints – 10,429
- Inquiries – 23,729

TEXAS Health and Human Services

Contact Volumes and Top Three Reasons for Contact by Program Type September 2019 – January 2020

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

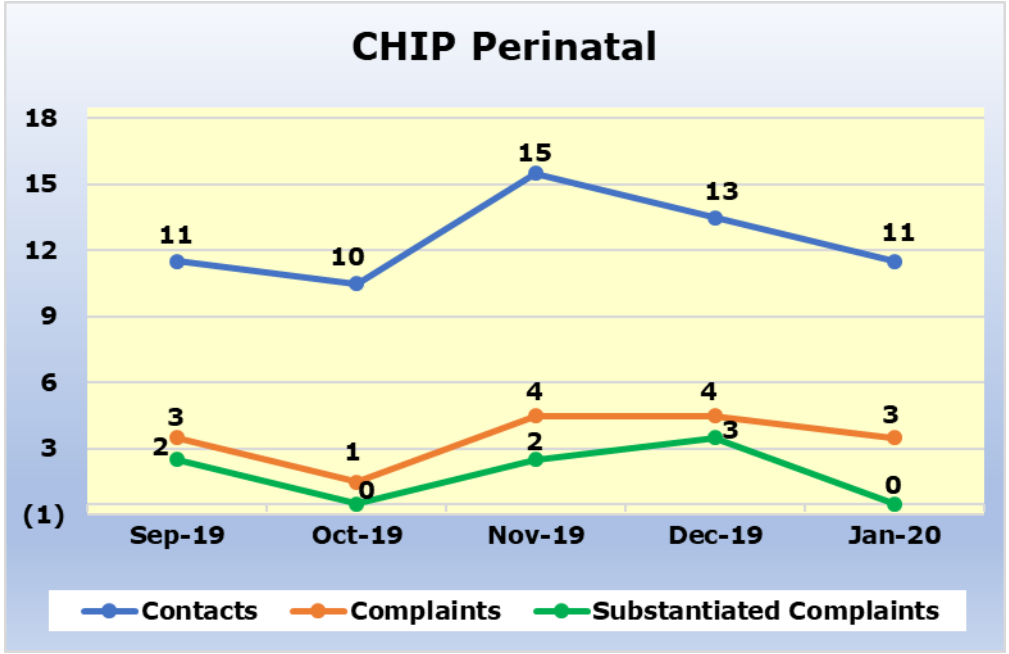


Top 3 Contacts – CHIP

- Application/Case Denied
- Check Status
- Other/NA

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

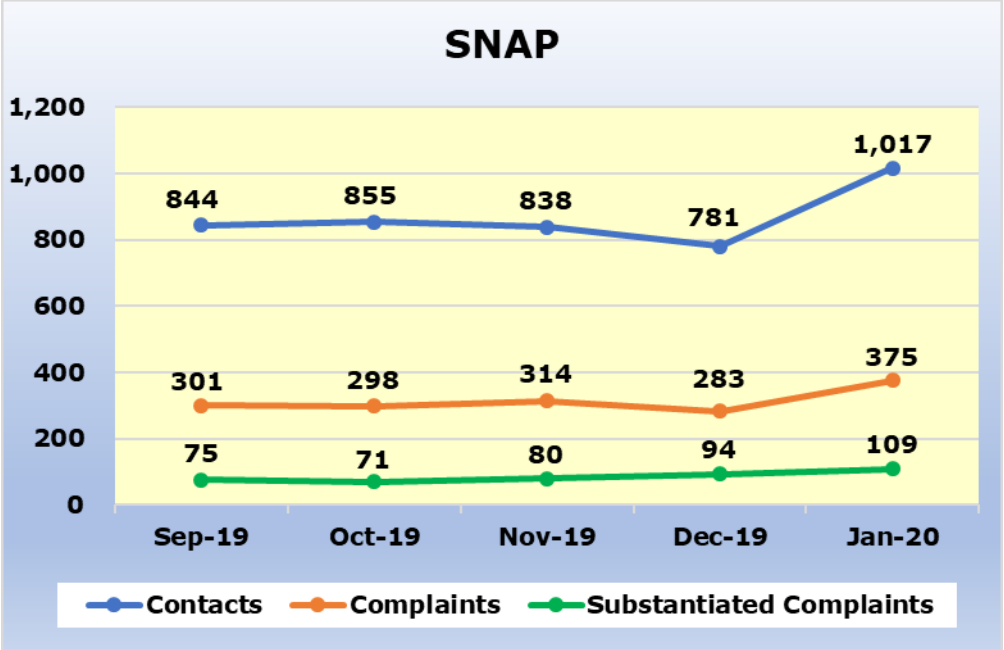


Top 3 Contacts – CHIP Perinatal

- Check Status
- Application/Case Denied
- Application Not Completed

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

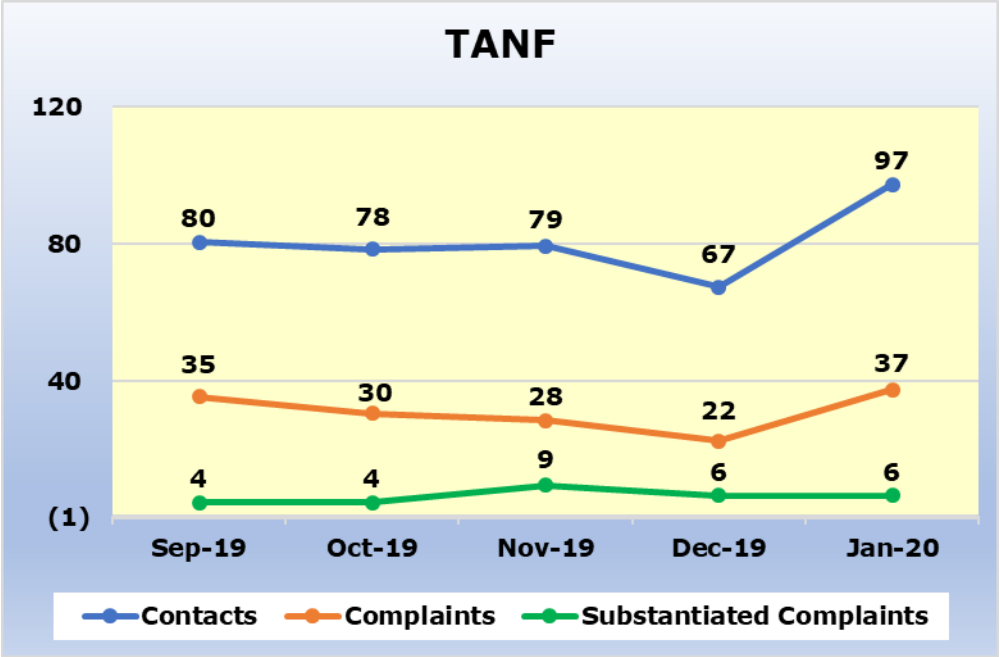


Top 3 Contacts – SNAP

- Application/Case Denied
- Benefit Amount
- Application Not Completed

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

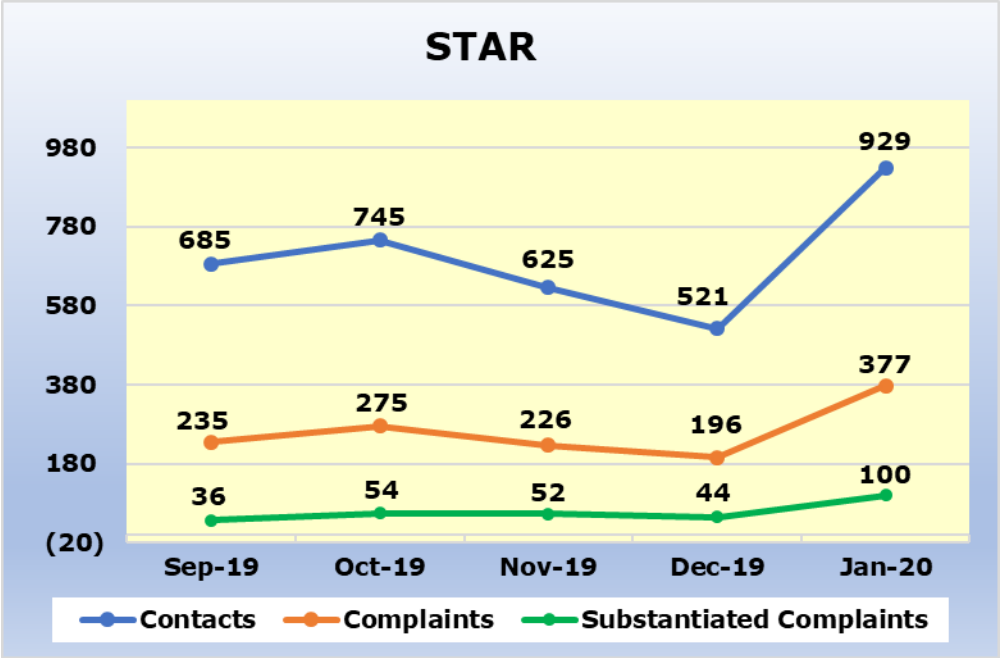


Top 3 Contacts – TANF

- Application/Case Denied
- Check Status
- Application Not Completed

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

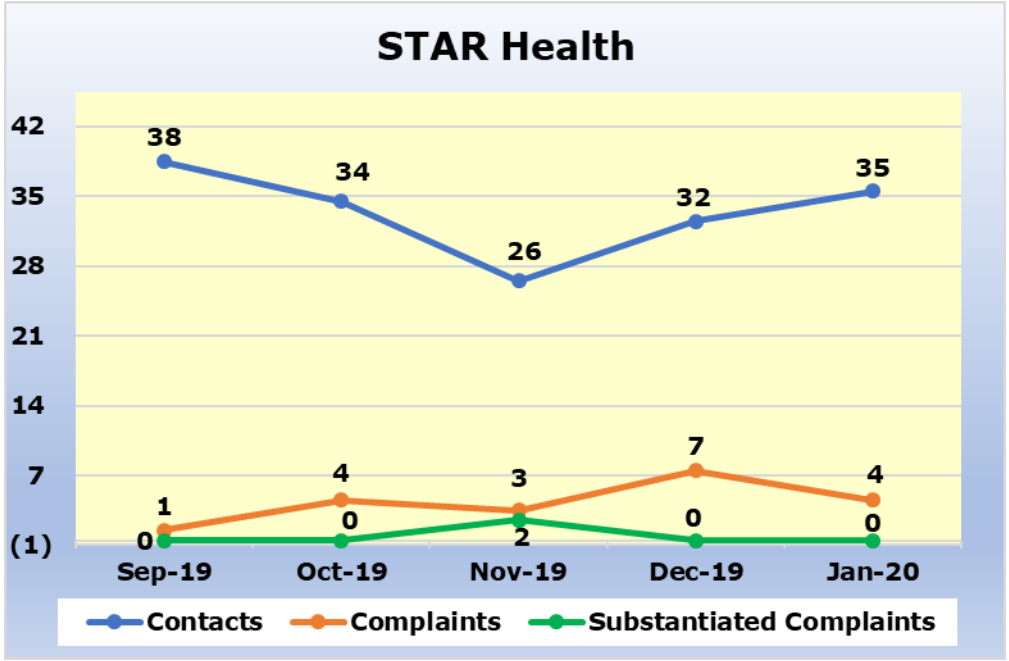


Top 3 Contacts – STAR

- Access to Prescriptions
- Verify Health Coverage
- Change Plan

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

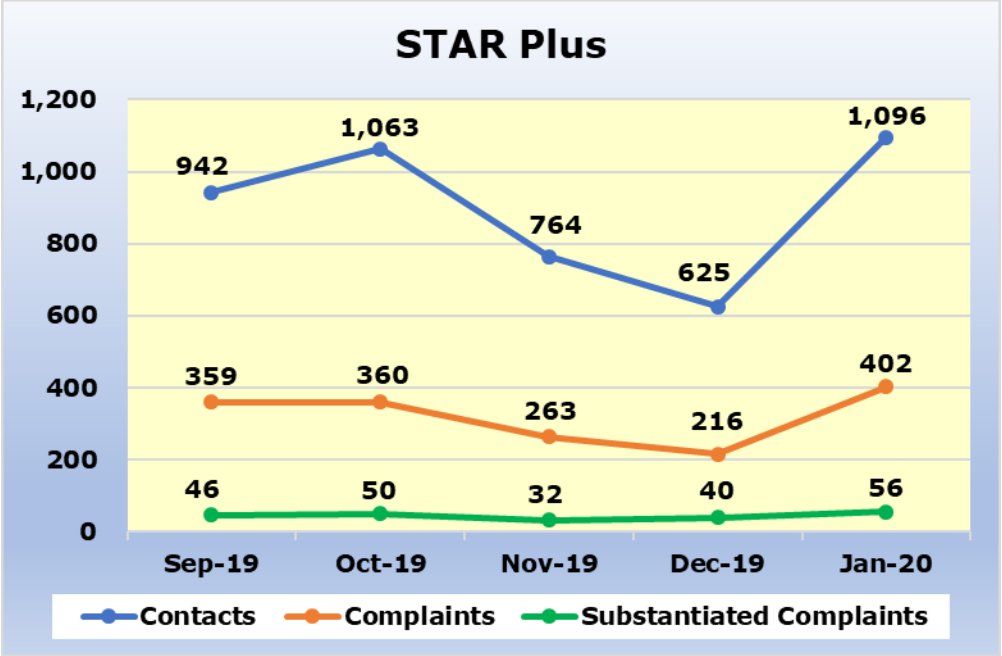


Top 3 Contacts – STAR Health

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

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

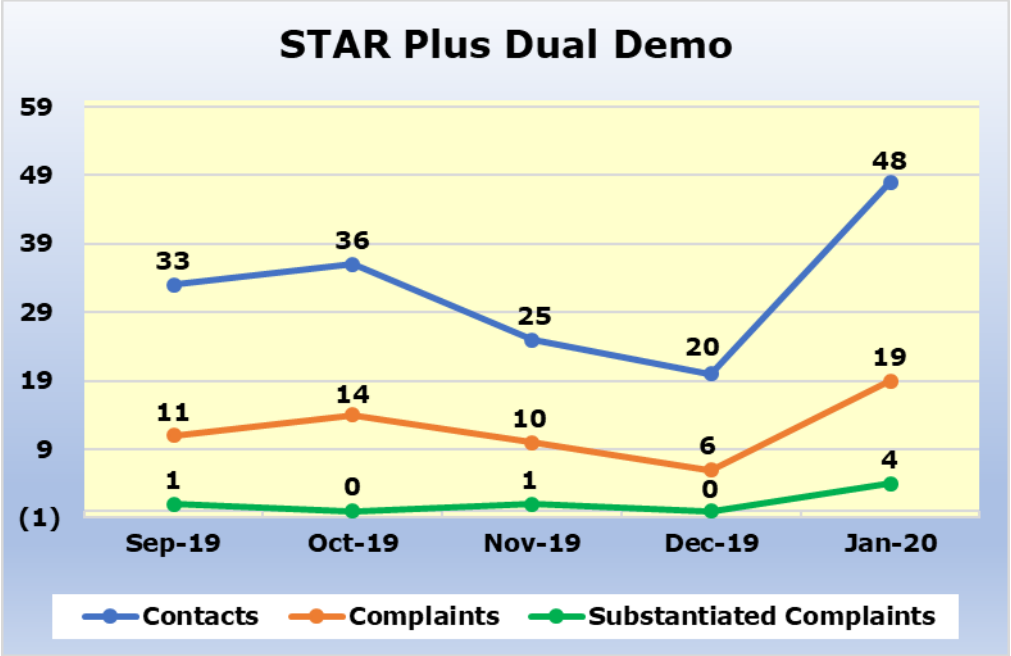


Top 3 Contacts – STAR Plus

- Verify Health Coverage
- Access to Prescriptions
- Access to DME

TEXAS Health and Human Services

Contact Volumes by Program Type September 2019 – January 2020

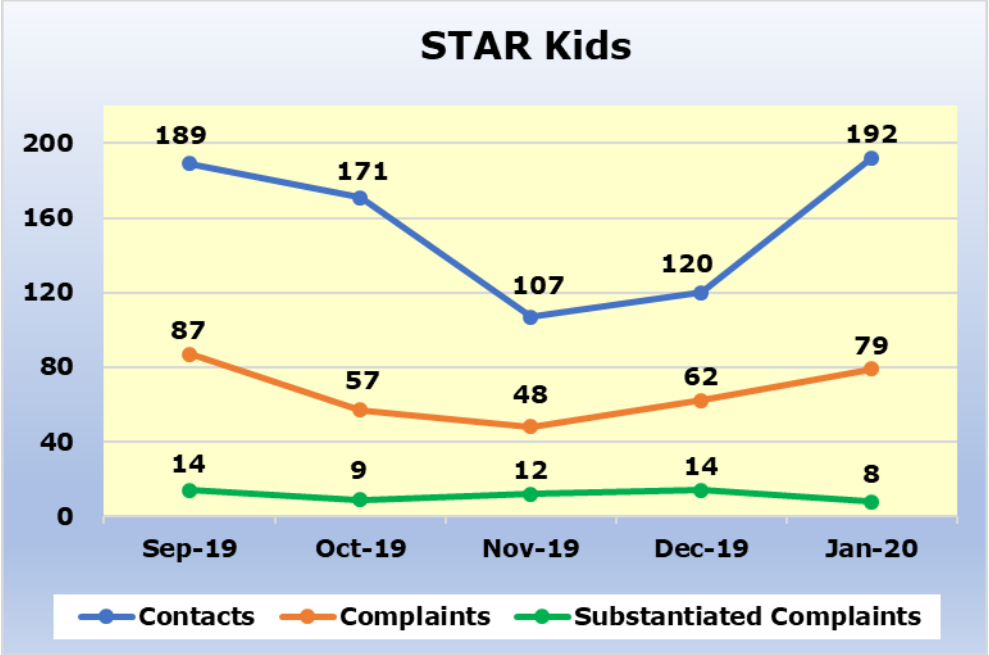


Top 3 Contacts – STAR Plus Dual Demo

- Verify Health Coverage
- Billing
- Access to DME

TEXAS Health and Human Services

Contact Volumes by Program Type September 2019 – January 2020

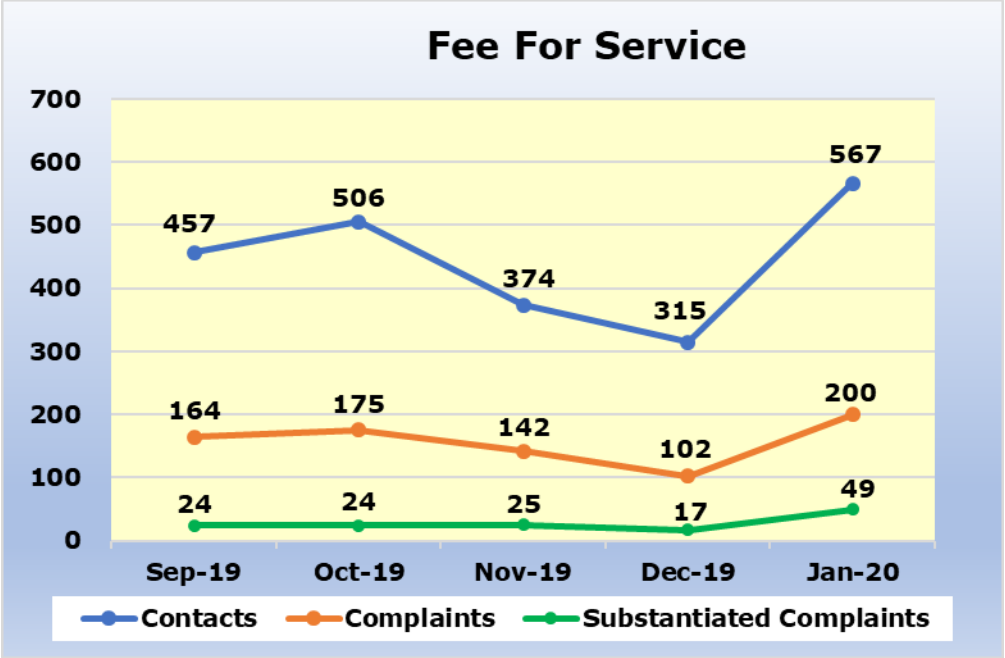


Top 3 Contacts – STAR Kids

- Access to Prescriptions
- Verify Health Coverage
- Change Plan

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020

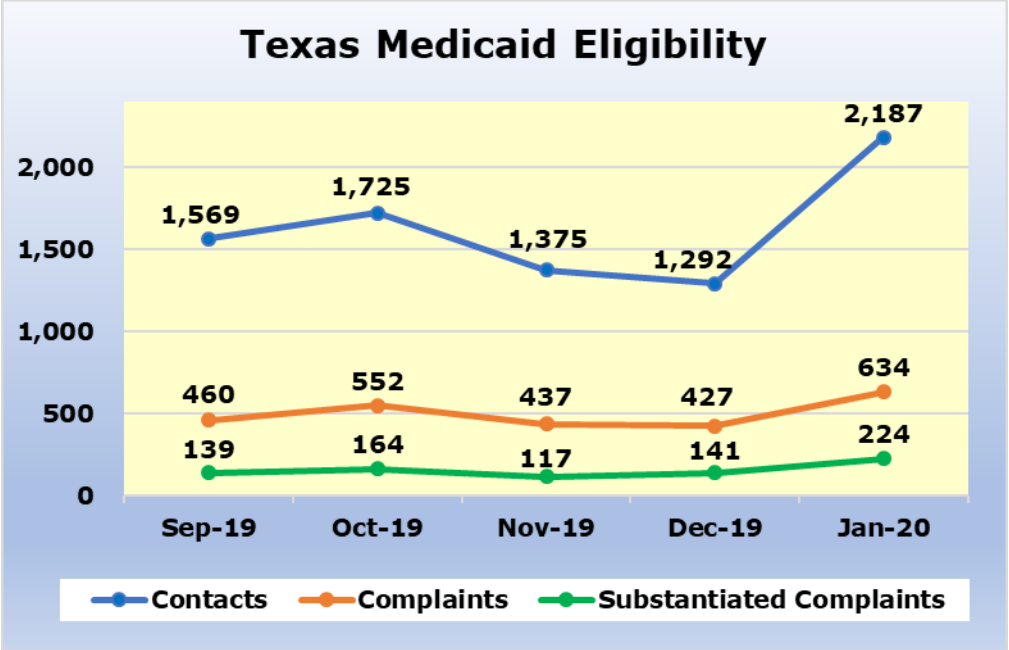


Top 3 Contacts – Fee for Service

- Access to Prescriptions
- Verify Health Coverage
- Enroll in Managed Care

TEXAS Health and Human Services

Contact Volumes by Program Type
September 2019 – January 2020



Top 3 Contacts – Texas Medicaid Eligibility

- Application/Case Denied
- Client Notice
- How To Apply

TEXAS Health and Human Services

OMBUDSMAN FOR BEHAVORIAL HEALTH

TEXAS
Health and Human Services

Ombudsman for Behavioral Health Program
September 2019 – January 2020

Contact Volume	
Complaints	119 (35%)
Substantiated Complaints	1 (1%)
Inquiries	221 (65)
Total Contacts	340
Top Three Reasons for Contact	
Referrals	
Other	
Injury/Abuse/Neglect	

Information Shared

TEXAS Health and Human Services

FOSTER CARE OMBUDSMAN

TEXAS
Health and Human
Services

Foster Care Ombudsman Program
September 2019 – January 2020

Contact Volume	
Foster Care Youth	106 (30%)
Total Foster Care Youth Complaints	83
Total Foster Care Youth Substantiated Complaints*	83
Total Contacts	354
Top Three Reasons for Contact	
Rights of Children and Youth in Foster Care	
Case Recording	
General Caseworker Duties	

*Foster Care Youth may have multiple complaint reasons for a single complaint contact which may possibly make the number of complaint contacts fewer than the number of complaint reasons.

TEXAS Health and Human Services

INDIVDUAL WITH INTELLECTUAL or DEVELOPMENTAL DISABILITIES OMBUDSMAN

TEXAS
Health and Human Services

Individual with Intellectual or Developmental Disabilities Ombudsman Program September 2019 – January 2020

Contact Volume	
Complaints	2,568 (81%)
Inquiries	601 (19%)
Total Contacts	3,169
Top Three Reasons for Contact	
Abuse/Neglect/Exploitation	
Rights	
Services	

Information Shared

TEXAS Health and Human Services

Ombudsman Managed Care Assistance Team

UPDATE

- Problem Trends
- Projects

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

Behavioral Health: 800-252-8154

IDD: 800-252-8154

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

The following are follow up items for Paige Marsala in the Office of the Ombudsman sent via email after the meeting.

1) Slide 9 – Top 3 Contacts for STAR Health – included Change Plan as the 3rd highest contact reason.
    a. After reviewing these assignments, all should have been coded as Access to PCP. These are being recoded. Since Access to PCP was the 2nd highest reason for STAR Health clients to contact OMCAT, the correct 3rd highest contact reason for the STAR Health program now becomes Access to Dental Services.
    b. Slide 18 – Foster Care Ombudsman – the following table was provided.

Contact Volume	
Foster Care Youth	106 (30%)
Total Foster Care Youth Complaints	83
Total Foster Care Youth Substantiated Complaints*	83
Total Contacts	354
Top Three Reasons for Contact	
Rights of Children and Youth in Foster Care	
Case Recording	
General Caseworker Duties	

The table shows that the FCO received a total of 354 contacts for the period of Sept. 2019 through January 2020. Of those 354, the table shows that 106 (30%) were from foster youth. What it does not show is that 248 (70%) were contacts from non-foster youth. Out of the 106 contacts received from youth, 83 of those contacts were coded as complaints. Here is where its now going to get a little tricky; one contact can contain several complaints. So even though the contact to the FCO is overall a complaint contact, there may be several different complaints the youth reports in that one contact. FCO tracks all of the individual complaints in each contact and determines if they are substantiated or not. Out of all of the individual complaints reported by youth, 83 of them were substantiated. The table does not show the total number of individual complaints that youth reported which originated from the 106 contacts reported as complaints. The number of individual complaints from foster youth is higher than 83 but only 83 were found to be substantiated. It is only a coincidence that the number of contacts coded overall as complaints is the same number of the number of substantiated individual complaints recorded.

Regarding the top 3 reasons for contact, below is more information on what those codes entail.

- Rights of Children and Youth in Foster Care can be any of the 45 Child's Rights that are being reported by the youth as being violated while in care.
- Case Recording issues involve Caseworkers not updating the IMPACT system timely to correspond with the information that is being reported to FCO during our investigation process.
- General Caseworker Duties complaints are when a child reports that they haven't been in contact with their worker within the allotted timeframe (e.g. the worker hasn't been out to youth in two months, by policy they are required to see their children monthly face to face or have had a caseworker in the region where the youth is residing to see the child in the month. Also, if the primary caseworker has not followed up with request from the youth in a timely manner.

2) Slide 16 – Ombudsman for Behavioral Health
   a. There was only one substantiated complaint out of 119 received from Sept. 2019 through Jan. 2020, - is this common?
      - Most commonly, state hospital calls are related to individuals being held in the hospital against their will. If the client is on a court order, his/her rights are not being violated as the court has issued an order forcing treatment. The second most common complaint from a state hospital is related to forced medication. Most commonly when the court issues an order for a client to receive treatment against his/her will, they also issue an order to force medication. The client does not agree with this decision, but the court order allows the hospital staff to force a patient/client to receive medication against his/her will. There are many things that patient's disagree with, but their rights were not necessarily violated. We do periodically determine that there are rights violations, but the hospitals and centers should be working with the campus located Rights Protection Officers to ensure that they are not violating the patient's rights when there are issues/concerns or problems. OBH is the last gate, not the first.
   b. Top 3 reasons for contact were Referrals, Other, and Injury/Abuse/Neglect. The following is an explanation of the types of calls that are coded as referrals or other.
      - Referrals most commonly refer to other agency that investigate an allegation that does not fall within OBH's purview. This would include HHS Provider Investigations (for a private psychiatric facility) and for a complaint of abuse and neglect inside a state hospital setting. We don't take these allegations, they are

referred to the appropriate entity that is responsible for investigating these complaints.

- Other is complaints regarding anything other than care received at a state hospital or community mental health center. If, for instance, a patient has a complaint about the court that sent them to the hospital, or their lawyer, or not receiving needed psychotropic medication in jail, or a delay in returning to jail from a state hospital. This office has no authority or jurisdiction over jails, decisions made by the court, or a lawyers failure to adequately represent their client. We would refer them to the Commission on Jail Standards, or Commission on Judicial Conduct or the State Bar. We get calls for all kinds of things, fishing license, and random things like this. This constitutes an "other" call.

3) Slide 20 – IDD Ombudsman – did they not have any substantiated complaints from Sept. 2019 through January 2020.
    a. The database for the IDD Ombudsman does not currently have a field to mark if a complaint was substantiated. A request has been put into IT to have this field added. The IDDO is waiting on that enhancement.
    b. Regarding the top 3 contacts of Abuse/Neglect/Exploitation, Rights, and Services, the following is an explanation of what those contacts include.
        - ANE: Intakes for these complaints are entered in IDDO HEART, but HHSC Provider Investigations (PI) conducts the investigations. If PI decides not to investigate because the allegation does not meet their definition of ANE, the complaint is referred back to IDDO for resolution.
        - Rights:
            - Provider does not allow an individual's family or dating partner to visit them
            - Provider restricts access to an individual's video games after behaviors but does not have a behavior plan authorizing the restriction
            - Provider refuses to hire service providers of the individual's choice
            - Individual has diabetes, so the provider never allows them to eat sweets
            - Local authority service coordinator tells an individual they cannot have a job because they have behaviors
            - Local authority service coordinator tells an individual they must live in a group home and cannot live in their own home
        - Services:

- Providers refusing to serve individuals due to diagnosis or behaviors – provider tells an individual they do not have residential services or provider tells individual they will no longer provide residential services because the individual has behaviors
- Delays of service – individual has not received a service in 3 months; individual has tooth pain for 2 weeks without being taken to the dentist
- Providers not providing services in accordance with TAC requirements – more than 4 people receiving residential services in one home; host home provider not promoting community inclusion
- Local authority service coordinator has not visited the individual in 5 months

4) Request to check across all programs to see if there was an increase in contacts related to checking the status of one's application/benefits/or health care coverage.
    a. After running reports across all programs, as well as each program individually, and averaging the number of contacts received per business day in those categories, the only trend identified was an increase across all programs in checking the status/coverage during the month of January 2020. However, keep in mind that contacts increased overall in January 2020, for most types of contacts.
5) The number of complaints received per day related to applications not being completed timely doubled between November 2019 and January 2020. In November 2019, the number of complaints received related to applications not being completed timely was 5 per day. By January that number doubled to 10 received per day. The substantiated number of complaints of applications not being completed timely doubled from around 2 per day in September to around 4 per day in January. The percentage of all complaints of applications not completed timely that were substantiated are as follows: September 34%, October 39%, November 45%, December 36%, and January 41%.