Children's Health Coverage Coalition Meeting Agenda
Friday, January 17th, 2020
11:00 A.M. – 1:00 P.M.

Present:

Adriana Kohler, TCFC
Helen Kent Davis, TMA
Laura Guerra-Cardus, CDF
Cindy Ji, CDF
Maureen Milligan, THOT
Kate Hendrix, THA
Sonia Lara, TACHC
Alissa Sughrue, NAMI-TX
Alison Mohr Boleware, NASW-TX
Amanda Gonzalez, MHM
Emily Wang, CDF
Stephany Ibarra, YI
Nancy Walker, Harris Health
Jenna Darling, MHM
Jana Eubank, TACHC
Sophie Jerwick, TMA

On Conference Line:

Melissa McChesney, CPPP
Peggy Gulledge, Maximus
Celia Kaye, League of Women Voters-TX
Lauren Rangel, Easter Seals Central Texas
Nataly Sauceda, United Way-TX

Meeting Chair: Anne Dunkelberg, CPPP
Meeting Scribe: Amanda Pouncy, CPPP

I. Introductions (Anne Dunkelberg) – [Meeting began at 11:05 AM]

II. 1115 Waiver and DSRIP Updates (Kate Hendrix, THA & Maureen Milligan, THOT), and MFAR (Medicaid Fiscal Accountability Regulation)

[Refer to handouts]

Maureen Milligan

(1) The important thing to think about as we go through these questions is where is the federal funding? Think about it this way, the states are the feds nieces and nephews and the funding needs to be separated out to them. That is the difference between these federal and state contributions.

(2) The first to think about is Medicaid services to Medicaid eligible. Those are your provider rates. These will be a very cut and dried situation where a patient goes to a doctor and gets medication and Medicaid pays out for that service.

Kate Hendrix

Base payments comprise about 40% of Medicaid payments to hospitals in Texas, so the bulk of Medicaid revenues are coming from outside of base payments. The non-base or supplemental payments are not just limited to the 1115 waiver, although that is a big chunk. The state is not putting out general revenue for those non-base programs. It is all coming from local government and other funders, liker LPPFs ("local provider participation funds").

Maureen Milligan

We talked about Medicaid base payments which are very clear. You break a leg and you go to the hospital it gets paid.

(3) DSH funds (disproportionate share hospital) are for those hospitals who are seeing a lot of uninsured or Medicaid (with its low payment rates) and need funds. The hospital districts end up paying for a lot of the non-federal share of this.

(4) In Texas, the legislature says that they are only going to pay the minimum amount they are required to pay. The feds are saying that they will only pay x maximum amount (referring to UPL, upper payment limit) and there now exists this issue of who is going to pay non-federal matching funds for the gap between the Texas rate and the federal UPL.

Kate Hendrix

(5) Refer to THA handout titled 1115 Waiver Is Critical for Texas' Health Care Safety Net

If you look at the bar chart at the bottom of this page, you will see the difference between the previous waiver and current waiver.

Maureen Milligan

The term "Medicaid shortfall" get used two different ways in Texas. At the legislature, they refer to a Medicaid shortfall when the Appropriations Act is not funded enough to cover a full 24 months of Medicaid, requiring a supplemental appropriations bill at the beginning of the next session. In the 1115 waiver and context of the federal Medicaid laws, the Medicaid Shortfall term is sometimes used to describe the gap between what a state Medicaid program would pay a hospital in the base payments, and the larger amount that Medicare would pay for the same services. Supplemental payments like DSH and 1115 waiver uncompensated care payments are

often designed to use local tax dollars and provider taxes to cover the non-federal share of paying hospitals the difference between the Texas Medicaid payments, and what Medicare would have paid (of course it's a little more complex than that).

(6) Can UC continue without a waiver? No. The feds are saying right now that we can continue to do this because of that waiver, so without it we will have no matching funds. The waiver allows us to make that deal.

Anne Dunkelberg

I am hoping that now you can give us some insight into the formal process that is happening regarding coverage and funding once DSRIP goes away.

Kate Hendrix

I would say that what is happening right now is fleshing out the formal transition. I think we are working on fleshing out and resubmitting the plan to CMS.

Anne Dunkelberg

Is this a plan that just shows how we get to 0 by the end of this year? Alternatively, is it a plan about what we want to do after this year?

Kate Hendrix

No, it is a plan for a plan for what we want to do after this. It is a plan to figure out what avenues we can take going forward without this funding. They are kind of in a peculiar situation. CMS is saying we need more substance in this plan and HHSC is saying well we are not in session so we cannot commit. One of the things that they are saying and encouraging HHSC on is how do we fold this in to the managed care system?

There is no shortage of ideas, it is just a matter of them figuring out what are we able to do?

Maureen Milligan

I think Kate also made an important point, which is that a lot of the matching funding is provider money. The HHSC cannot just go in and say okay we are going to use your money to do this.

Kate Hendrix

Right and there is no clear process right now for how to handle that. There are some ideas about how CMS changes will support this.

Recent CMS policy guidance on 1115 waiver Budget neutrality is all sub regulatory, so it is not in law. It is not in rule. It exists primarily in two public facing things. CMS put out a PowerPoint on a SODA call, a state technical assistance call, in September 2018, I believe.

https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf

Anne Dunkelberg

Where do the supplemental payments fit into the budget neutrality?

Kate Hendrix

Well that is the thing. We do not know. There are many things in that PowerPoint and related materials that we need more information on. There are people who are asking these questions and looking at HHSC for answers, but they are not obligated to respond when negotiations are still a few years out.

Anne Dunkelberg

On the other hand, there is still no limitation on the amount of funds that we could get from a Medicaid expansion. So, in some ways by doing a waiver we are limiting ourselves fiscally.

[Refer to THA Medicaid Fiscal Accountability Rule Could Upend Texas' Health Care Safety Net handout]

Maureen Milligan

In this we see that the feds are saying we don't like this and don't want to do this anymore which is, of course, a problem for us.

What CMS is doing in this role is saying we are going to change the definition and the type of funding that you can use.

So, everyone here knows that our hospital districts are using these tax funds, but few outside the hospital are aware that they are putting up the match for 60% of Medicaid hospital payments.

Maureen Milligan

Yes, it is pretty significant. Texas Medicaid is about 15% from state general revenue, 25% local, and the rest is federal funds. The other thing to add is that urban and rural areas are going to differ because of where they get their funds from; few non-urban counties have county tax funds to contribute, so the LPPFs have grown as a way for them to draw down the federal funds for supplemental payments.

Anne Dunkelberg

I think there are only 5 or 6 states that aren't relying on these types of funding. So, it isn't as if THA and THOT are the only ones who are going to be going up against this.

This makes us question what this administration wants. Why are we expanding these waivers and then cracking down on MFAR?

Helen Kent Davis

Many other state governments especially in the south are also pushing back on this. This is really an issue for those of us who do not have other means to cover the majority of our population. So there will certainly be some pushback, although this may still get adopted in some way.

Maureen Milligan

The other thing that we have happening is if they're saying that you can only use property taxes to pay for this (that is, patient revenues can't be used to draw matching funds, only local tax revenues) it puts pressure on the local government to raise property taxes.

If you all would like to draft letters to be sent about this please reach out to us to consult.

III. Memo to HHSC for uninsured/eligible/unenrolled (Open discussion, facilitated by Melissa McChesney, CPPP)

[Refer to Memo Draft]

One of the things that we have been encouraged to do is to provide input on how to reach those families with kids who are uninsured, eligible, and especially those who were never enrolled.

[Melissa McChesney]

Back in December those of us who were interested in drafting this memo got together and developed this draft.

The 275,000 eligible but unenrolled uninsured Texas children we have listed here is a very conservative number because we took the estimate of all undocumented children in the state and subtracted them from the US Census count of uninsured children with incomes below 200% FPL remove them. We know that is a very rough estimate.

I would love to hear feedback if anyone has some. The three big buckets that were identified: First, identify and enroll children that are already on a benefit program but not on Medicaid and CHIP. It has been estimated that there are around 25% that fall into this category. Some other states have a much lower uninsured rate for children by addressing this.

The second is to improve outreach and marketing, and the third is to improve the client-facing materials. Refer to the memo draft for more details on this. One of the things we really want to address is the accuracy of the materials and the overall tone that is being used. We want to tell people that having health coverage is a good thing.

We will be sharing this with the commissioner on Wednesday, so we have a quick turnaround but want to make sure we talked about it

IV. Discuss interim hearings, legislative intel, and any upcoming issues (Open discussion facilitated by Alison Mohr Boleware)

So, there is a workgroup within Cover Texas Now that is working on more details around this, but I'll start with what we have so far.

One of the issues we have been working on with the Senate HHS Committee is talking about workforce and children's health. We want to really talk about how we can address issues in rural issues from more than just a facilities standpoint—rates would be a great place to start. We need to address how the provider rates are affecting rural issues.

Nataly Sauceda

I think it might be helpful to mention transportation. If these facilities are being improved but people can't get to them you're still going to have a problem.

Alison Mohr Boleware

That is a good point. Under the monitoring for the Senate Committee there is a point about medical transportation.

Adriana Kohler

We don't know when medical transportation is going to go to hearing, but it is something that they are looking at right now. It isn't clear how they plan to address that, but it is something we should look into.

Alison Mohr Boleware

I was curious about the healthcare costs charges in the Senate HHS committee.

Anne Dunkelberg

Senate Business and Commerce also has a charge that makes reference to uninsured people in Texas.

Alison Mohr Boleware

I haven't talked to anyone on the committee, but does anyone know someone or have plans to go and talk about healthcare costs?

Anne Dunkelberg

Alison if you would feel comfortable you could certainly reach out in behalf of the coalition.

Alison Mohr Boleware

I will go ahead and reach out about next steps since it sounds like a lot of these are not going to be scheduled until after the primaries.

V. #SickOfItTX Story Campaign 2020 (Laura Guerra-Cardus, CDF/SOIT & Kristen Gunn, SOIT Digital Campaign Consultant)

[Refer to Slides]

Laura Guerra-Cardus

This is just an opportunity for everyone to get to know Kristen Gunn who works with Rouser and is our digital campaign consultant for #SickOfItTX.

Kristen Gunn

My background is in documentary, television, and advertising where I have created high impact, meaningful stories. In the past, I worked for an agency that focused on gathering data to determine why people click on what they click on online and what it means for us as producers. With that in mind, a large part of what I am doing right now is making a series of educated assumptions about what works with this audience and using that to determine how we move forward. Please reach out to me via my email at the end if you have feedback or ideas.

Main reasons people don't engage with things:

1) It's a bummer – It doesn't make people feel good. It's sad. Watching this is going to make me feel bad so I'm not going to click on it.

2) Will this actually do anything – People are skeptical that signing that petition or sharing that information will actually do something.

So, we are working along with CPPP (Mia Ibarra) to develop the kind of content that makes people change their minds about these points and click it anyway. One of the things that we have identified that works is aligning with folks who already have a power that they already bring within their community who we can get to share our branding and ideas. If anyone comes to mind that you think would fit into this area, please share that with me.

Second, there is a huge legislative piece to this. There is going to be a lot more data and analysis that goes into this but this will be the second part of our campaign.

[Refer to slide 4-5]

We really want to champion getting stories into our story collection to help support this. Traditionally, we talk to a family and we ask them for a picture of them or their face. But I want to share how that can be different.

Everyone is their own social media expert. When you think about things that you would pause to read, share, like, listen to, or share—what are those things? They need to have a certain level of quality, as in, they need to feel valuable to you.

We had a supermom who did not want her child's face shared on social media but she was chronically ill. So, the mother shared a photo of a full-body cast that she had to endure. That, as a mother or parent, will really pull people in and help them to understand your story.

There is a television production company that went out on the street in the UK and asked people what they think people in the US spend to have a baby. The people say, "oh I don't know.

Probably a lot but I spent $50 here." Then they tell them the absurdly high amount the people in the US spend on average and you see them react. That video was shared millions of times and people just went crazy about it. That is what we want to kind of recreate. We want for people across the state to be able to relate to each other because of these stories.

[Refer to Slide 6]

Sharing these stories can be as simple as writing one sentence or sharing a longer story. The big thing is that we get people sharing and using our hashtag. We want to organize these efforts across the state and in our local communities.

Please let me know if there is anything that you feel should change or be improved. I want to make sure that everyone feels like this is the right approach, because of it doesn't pass the test for you all it will not work out there.

VI. [Meeting Adjourned at 12:56 PM]

Texas Hospital Association

1115 Waiver Is Critical for Texas' Health Care Safety Net

Texas' current Medicaid 1115 Waiver and its funding, worth approximately $25 billion over five years, ***expires Sept. 30, 2022.*** Texas hospitals strongly support the waiver and its ability to protect the health care safety net and improve health care delivery and outcomes for Texans. Hospitals that serve vulnerable, uninsured individuals rely on the funding to maintain financial vitality and stability. Without it, critical health care access could be severely compromised.

The waiver has been key to successful health care delivery reform, with funding for Texas worth $64.6 billion through the life of the waiver. A "one-size fits all" approach doesn't work for a state as large and diverse as Texas, but the flexibility inherent in the waiver has afforded the state the authority to test innovative solutions to improve Medicaid service delivery and contain costs.

Critical Supplemental Medicaid Payments

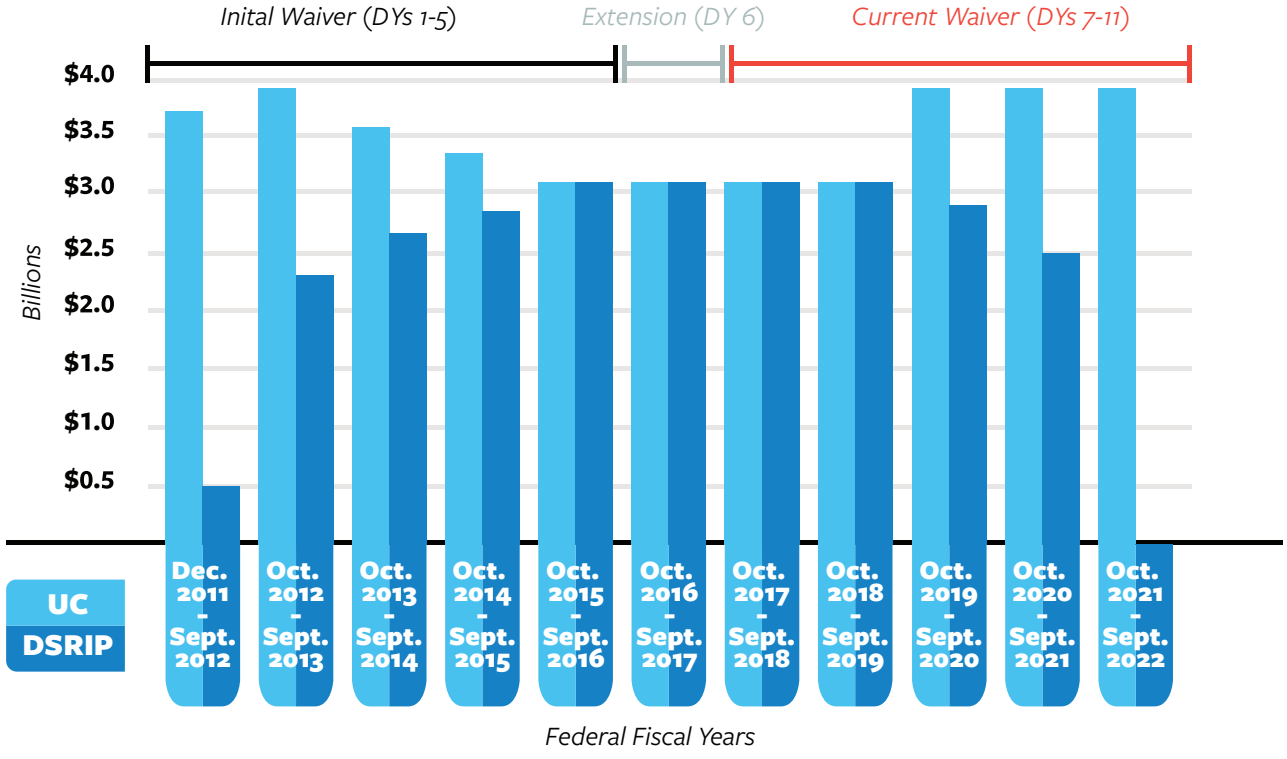
The waiver provides billions of dollars a year in supplemental payments to Texas hospitals and other health care providers through two pools of funding – **Uncompensated Care** and **Delivery System Reform Incentive Payment**. The current waiver requires changes for the funding pools and payments.

UC has provided nearly $27 billion since 2012 to help offset the costs of providing care for the uninsured. In October 2019, the methodologies to determine the size of the UC pool and calculate UC payments changed to be based on hospitals' uninsured charity care costs, as reported on the Centers for Medicare & Medicaid Services' Medicare Cost Report. Medicaid shortfall and bad debt costs are no longer considered for the calculation of payments.

DSRIP has provided approximately $20 billion since 2012 to incentivize hospitals and other providers to collaborate regionally to drive innovations in care delivery and infrastructure development that improve access to quality care. DSRIP funding began to wind down in October 2019. Funding will be eliminated entirely by October 2021.

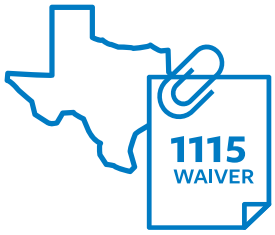
As with all Medicaid payments, a state contribution is required to draw down federal dollars. In Texas, the state share for supplemental Medicaid payments is generated by hospitals, either through public hospitals' tax revenue or local provider participation funds.

1115 Waiver Funding Pools: 2011 - 2022



Waiver Challenges Going Forward

DSRIP Transition: DSRIP has transformed health care delivery in Texas and improved outcomes for some of the state's most complex health care concerns. Patients served through DSRIP — 40% of whom are uninsured — are better able to manage their diabetes and control high blood pressure. DSRIP hospitals have reported increased access to primary and preventive care, increased emergency department diversion and enhanced behavioral health services.



As DSRIP funding phases out, a strong, clear transition is critical for the future of the health care safety net in Texas.

Texas hospitals' priorities for the DSRIP transition include:

- Ensuring access to care for the uninsured.
- Building DSRIP successes into existing Medicaid managed care structures.
- Preserving and maximizing federal payments for hospitals and other providers.
- Rewarding collaboration and partnerships among local providers.

Budget Neutrality: A long-standing requirement of 1115 waivers is that they must be "budget neutral" to the federal government. In other words, Texas can't spend more federal Medicaid dollars with the waiver than it would without the waiver. CMS is seeking to change the way it calculates budget neutrality for the next waiver renewal, which could potentially result in fewer dollars available for supplemental payments. THA continues to work with state officials to pinpoint specific impact these changes will have going forward.

WHAT'S THE BIG PICTURE?

Even with a waiver renewal through 2022, funding variables create a difficult and uncertain financial landscape for Texas hospitals.

This unpredictability threatens hospitals' ability to plan appropriately and, *if unresolved*, could **seriously impact the delivery of health care** throughout the state with the closure of hospitals — particularly in already hard-hit rural areas — and service reductions.

Additional information on the Medicaid 1115 Waiver is available from **www.tha.org/waiver**.

DSRIP allocation data from HHSC:

DSRIP payments through 10.2018

68% Hospital ($9,302,298,740)

16% Community Mental Health Ctr* ($2,174,9896,468)

12% Physician Practice ($1,666,437,364)

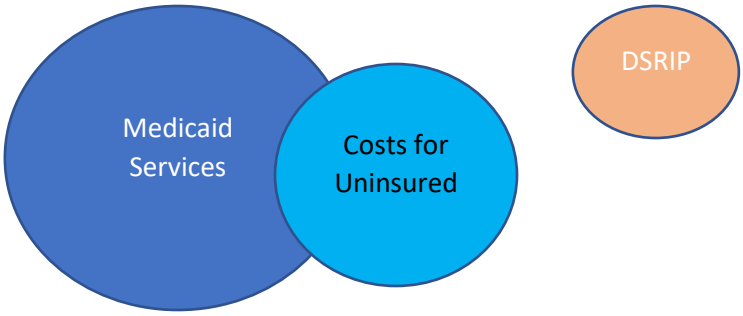
4% Local Health Dept ($597,372,615)

DSRIP DY 3 – 6 Patient Impact

25% Medicaid

35% Other

40% Low-Income/Uninsured



Think: "Federal Funding Authority:"

1. Federal and Bona Fide State Contributions.
2. For Medicaid Services (in the State Plan) provided to Medicaid eligible: Base Medicaid payments
3. DSH – to help hospitals that do a DISPROPORTIONATE SHARE of uninsured care and Medicaid (not directly tied to individual claims)
4. How much will we pay for in base Medicaid Payments – UPL
5. Regulatory Impacts: CMS – Can't have UPL if you are using HMOs to pay for services.
    a. Waiver – vehicle to authorize payments for:
        i. Uncompensated Care – defined as bad debt, Medicaid shortfall, and uninsured care
        ii. DSRIP – innovation, not tied to costs, and not included as a "Medicaid payment" when CMS considers the most it will pay in Medicaid.
6. Waiver Changes:
    a. UC: Change definition to charity care programs for the uninsured
    b. DSRIP – We don't like this anymore: put it into Medicaid HMO programs OR come up with a new innovative program.
7. MFAR: We don't like your state contributions….

Texas Hospital Association

Medicaid Fiscal Accountability Rule Could Upend Texas' Health Care Safety Net

The stability of Texas' health care safety net is in jeopardy as a proposed federal rule – the Medicaid Fiscal Accountability Rule – seeks to **severely limit states' ability to draw down critical federal Medicaid payments** that hospitals nationwide use to ensure access to essential care for Medicaid enrollees and the uninsured.

The rule, proposed by the Centers for Medicare & Medicaid Services in November 2019, **erodes states' flexibility and imposes new conditions on the methods states can use to finance the non-federal share of Medicaid payments,** which are required to draw down federal matching funds.

CMS should withdraw the rule and continue to work with states to identify acceptable methods of financing the non-federal share of Medicaid payments.

In a state that leads the nation in the number and percentage of uninsured individuals, the stakes for Texas are high.

5 MILLION

OR NEARLY

ONE IN SIX

TEXAS RESIDENTS (17.7%) HAVE NO FORM OF HEALTH CARE COVERAGE

ANOTHER MILLION

PEOPLE IN TEXAS ARE MEDICAID ENROLLEES

STATE AND FEDERAL LAW REQUIRE HOSPITALS TO

PROVIDE CARE

FOR ANYONE WHO SEEKS IT,

REGARDLESS OF THEIR

ABILITY TO PAY

TEXAS HOSPITALS' BASE MEDICAID PAYMENTS

DO NOT COVER

THE COSTS OF PROVIDING CARE

Supplemental Medicaid payments, which make up *two-thirds* of Texas hospitals' total Medicaid payments, are at risk.

These payments, totaling ***$11 billion in federal fiscal year 2020***, help Texas hospitals offset some of the costs of providing unreimbursed care for the uninsured and lower-than-cost Medicaid reimbursement.

The proposed rule, however, would restrict the ability to finance this contribution through intergovernmental transfers, health care-related assessments, such as local provider participation funds, and provider-based donations.

Texas, like other states, has worked closely with CMS over the years to identify acceptable methods of financing the non-federal share of Medicaid payments. Shifting rules at this stage ***undermines the stability and flexibility states need*** to sustain their Medicaid programs and ensure access to care for the growing number of Texans who depend on it.

Without existing supplemental Medicaid payments:

- The Texas Legislature would have to address a larger financial burden for Medicaid.
- Local taxes would increase.
- Fragile rural hospitals would shutter at an even higher rate.
- Essential service lines, including already hard-hit labor and delivery services, would be reduced.
- Access to specialized and lifesaving care for all Texans would suffer.

BIG PICTURE:

States need the flexibility to finance the non-federal share of supplemental Medicaid payments.

DRAFT

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:
    - Increased outreach funding, with a portion of the funding allocated for community-based organizations 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, workforce services through TWC, and services at local public health departments in collaboration with DSHS.

- **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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- Response to a political problem.
- Allows for broad public engagement, policy-maker accountability, issue campaigns around elections, taking the conversation to local communities.
- Builds long-term advocacy infrastructure for access issues.

STORIES

We spoke to a San Antonio family of immigrants who can't get healthcare. **The wife is always sick and they live in constant fear.** The husband works in construction, but now makes too much to be on the Bexar County indigent program.

In McAllen we learned that people will **only go to the emergency room**, because they don't have healthcare. The ER will ask them for a downpayment, and **if they can't pay they are turned away.** We are exploring where this happened.

A woman in Houston told us **healthcare makes her feel 'secure.'** Her older sister who is in her 80's and has dementia, **can't get on Medicaid**, and can't get the care she needs. The family is very worried about what they are going to do. We are following up to see if we can assist.

A man we met in McAllen used to go to the indigent clinic, but can no longer go because he doesn't have a current ID. He **can't renew his ID because he owes child support.** He has resorted to either **self-medicating** with street drugs, or buying insulin from time to time on the street. A current ID is not needed and follow up in progress.

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Thank you!

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