CHILD FRIENDLY?

How Texas' Policy Choices Affect Whether Children Get Enrolled and Stay Enrolled in Medicaid and CHIP

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CPPP
Center *for* Public Policy Priorities

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Introduction and Executive Summary

Texas Can Cut the Number of Uninsured Children in Half: Here's How!

Modern medicine has enabled us to improve the lives of all of our children, and limiting their access to health care unjustifiably denies them equal opportunity. Ethical considerations aside, our state and nation's future depends on having a well-educated and healthy workforce for continued prosperity. As a practical matter, all Texans will benefit from a strong public-private network of health coverage that leaves no child without care. Eliminating red tape barriers to health care for Texas children in favor of sound, competent policies and practices is both doable and affordable.

Children's Medicaid and CHIP have been resoundingly successful in Texas and across the nation, in providing low-income children with cost-effective access to the health care they need, and in reducing uninsured rates for children substantially. Voters overwhelmingly support CHIP and children's Medicaid. Still, despite the acknowledged need for access to comprehensive care for children, actions taken by Texas leaders have sometimes worked against full participation by eligible uninsured children in these children's coverage programs. In recent years, some policymakers have advocated higher levels of out-of-pocket family spending and more paperwork for parents of children seeking public health insurance to foster parental responsibility. Others advocated more frequent income checks and more extensive documentation to deter fraud—real or imagined. As the result of our policies and practices to date, there are today about 2.2 million children covered by the two programs, but an estimated 750,000-850,000 uninsured Texas children who could be enrolled in either Medicaid or CHIP, are not.

State requirements for enrollment significantly control what portion of potentially eligible kids actually enroll. Texas' ups and downs in children's Medicaid and CHIP enrollment are not because we don't know how to encourage high participation rates by truly eligible children; rather, they are a reflection of our state's ambivalence and constantly shifting attitudes about what priority children's health care should be given in the state budget.

This report details the recent history of Texas policies and practices related to eligibility and enrollment in children's Medicaid and CHIP. To the extent possible, we illustrate the history and consequences of policy changes using official state program data. We also summarize national and state research on the effects of eligibility and enrollment policies, and explain how Texas policies compare to those of other states. Finally, we suggest easy fixes that could reduce the number of uninsured children by 50%, and bring Texans' federal tax dollars back home to get the job done.

Key Findings:

- Several Texas policies are used by very few other states. Texas is one of only two states with a CHIP assets test and one of only five with a child Medicaid asset test.
- New 2007 policy changes bring Texas in line with some best practices. No other state had imposed an across-the-board delay in coverage like Texas' 90-day delay in CHIP enrollment; under HB 109 (80th Texas Legislature, see page 5) Texas returns to our original crowd-out prevention policy. And, most states with separate CHIP programs offer 12-month eligibility: 69%, or 25 out of 36 states—now 26, with Texas returning to 12 month coverage for most CHIP children.
- There is a large body of research and practical experience to guide states that are willing to aggressively pursue high participation rates among children eligible for CHIP or Medicaid, without sacrificing program accuracy and integrity.
- Texas can cut the number of uninsured children in half if we dramatically improve enrollment of currently qualified uninsured children in CHIP and children's Medicaid.

- Eligibility and enrollment policies and practices caused declines in children covered by CHIP and children's Medicaid that kept the combined number of low-income Texas children covered by CHIP and children's Medicaid below the number enrolled in September 2003 for four full years. As a result, our uninsured rate for children and teens jumped from 19% in 2005 to 22% in 2006. **Only as of September 2007 did the number of children covered finally exceed the September 2003 number.** All eyes are on the Texas Health and Human Services Commission's (HHSC) eligibility system and the implementation of HB 109, to see if sensible policies and competent performance can keep enrollment back on track.

- CHIP declines have been worst among rural Texas children, pre-school children, and kids in the lowest-income CHIP families.

- The single most significant policy change responsible for the decline in CHIP enrollment since 2003 was the shorter, six-month coverage period. This is because with twice as many children up for renewal each month, twice as many children were denied—but nothing was done to increase new enrollment. It was like opening a second drain in a bathtub that was slowly filling. Without turning up the water, the bathtub was bound to drain. Other policy changes added to this decline. The return to 12-month coverage initiated in September 2007 is expected to eventually restore growth in Texas CHIP enrollment.

- Multiple problems with the transition to a new CHIP contractor in 2006 caused processing errors and delays that further accelerated the ongoing CHIP decline. Though HHSC has terminated its contract with Accenture, the same subcontractor that was performing most of CHIP eligibility remains in charge of CHIP enrollment, and some HHSC procedures that exacerbated CHIP enrollment problems remain in place.

- The decline in children's Medicaid in 2006 was driven primarily by state eligibility staffing shortages. It was aggravated significantly by errors made by the CHIP contractor in processing renewals and incoming applications through that channel. If operating properly, both processes would normally result in thousands of children's Medicaid enrollments each month.

- Unresolved performance shortcomings with the TIERS eligibility computer system are contributing to serious delays and substandard processing times for children's Medicaid.

- The recent (July 2006) citizenship documentation requirement imposed on U.S. citizens is another factor decreasing enrollment of eligible uninsured children in Texas Medicaid.

Summary of Recommendations (*updated to reflect actions during and since the 2007 legislative session*):

1) Deliver on the Promise of Seamless Transitions between Medicaid and CHIP.

The 1999 enacting legislation for Texas CHIP and the 2001 children's Medicaid simplification legislation both included specific provisions requiring the state to go the extra mile to prevent gaps in coverage. New riders in the 2008-2009 state budget direct HHSC to eliminate these gaps. Still, community-based organizations (CBOs) and advocates report that these transitions remain a major weakness, with far too many eligible children experiencing gaps of several months when they are required to move from one program to the other. Though Texas lawmakers have established in law requirements for seamless transitions between CHIP and children's Medicaid, the reality still falls short of the law. Texas should rededicate efforts toward this goal, and identify and correct the current system inadequacies that have us far from compliance with our own chosen law and policy.

2) Make Reducing "Procedural Denials" to as Close to Zero as Possible the Goal of the CHIP and Children's Medicaid Eligibility System.

"Procedural" denials are cases denied or closed because of missing paperwork issues, or failure to return forms. **In these instances, HHSC never actually learns whether the child was eligible or not.** Two ways to cut the red tape are to (1) make application and renewal forms and instructions so simple and clear that very few missing information requests are needed, and to (2) make application and renewal assistance widely available.

In Louisiana, a state campaign to reduce procedural denials was able to cut children's Medicaid/CHIP cases closed for failure to return renewal forms from 17% to 2%; increase renewal rates to 92%; and reduce the rates of children experiencing gaps moving between Medicaid and CHIP from 18% to 6% over two years.

80th Session Update: The 80th Legislature took several steps to improve performance in the eligibility systems for Medicaid and CHIP. HB 3575 creates a Legislative Oversight committee for the HHSC eligibility system and sets goals to improve customer service, reduce processing time, and meet federal standards. Article IX of the budget includes riders 19.66 and 19.77 to improve the CHIP and children's Medicaid eligibility process and eliminate barriers, delays and wrongful denials. Two Article II budget riders (HHSC #54 and #68) provide authority for the agency to add staff if needed to meet federal performance standards. Like most 2007-enacted changes, these policies took legal effect in September 2007, and therefore have just begun to affect system performance and enrollment. ***The performance of the eligibility system should be closely monitored in 2008-2009 to make sure the system is performing efficiently to deliver maximum coverage to eligible children.***

3) Adopt 12-month Coverage for Children's Medicaid, and Carefully Monitor HB 109's *modified* 12-month CHIP Coverage for Children between 185-200% of the federal poverty level (FPL).

Annual renewal for children is clearly associated with better access to a consistent medical home. National research and Texas experience have proven that an annual renewal period reduces the number of eligible children left uninsured due to procedural denials. Annual renewal reduces administrative costs for the state's public-private eligibility system, and could provide badly needed relief for the private and public components of the system, which are both badly over-taxed.

HB 109 essentially cuts renewals in CHIP from over 630,000 a year (based on September 2007 enrollment) to 315,000. Taking the next step and cutting children's Medicaid renewals per year from 3.7 million a year to 1.85 million could provide an enormous reduction in workload, and may be the best hope for Texas to restore the Medicaid eligibility system to acceptable performance levels.

The provision of HB 109 which requires a 6-month income review for children in families with income from 185-200% FPL (about 8% of Texas CHIP children in December 2007), like the troubled Integrated Eligibility system, is a good concept in search of a workable process. Children's health advocates and policymakers should be prepared to closely monitor the development and implementation of this process in 2008-2009.

4) Abandon CHIP Policies That Are Not Working.

HB 109 improves Texas policy greatly by restoring the original CHIP 90-day crowd-out prevention policy, reforming the CHIP asset test, and restoring limited income deductions for child care expenses.

Unresolved is the 2003 elimination of CHIP **income deductions for child support paid out**, which has had unintended consequences. The original CHIP policy gave parents credit for all child support payments to another household (a positive incentive to make payments). But after the 2003 policy change, a child in a household making a support payment can be denied CHIP coverage based on income not really available for his support, while the recipient household also must report the very same income. The original deduction policy was successful, supported responsible parental behaviors, and should be restored.

5) Invest in a More Robust Statewide Outreach and Application Assistance Network.

Ongoing outreach and application assistance programs are a vital part of connecting children with a medical home and keeping them healthy. HHSC's recent contracts for children's insurance marketing and community-based organization (CBO) outreach are excellent first steps, but additional funding is badly needed. HHSC now expects those CBOs to serve not only the 2 million Texas children enrolled in Medicaid and CHIP, but also the other 2 million Texans who include aged and disabled Medicaid clients as well as families who need Food Stamps. And, **despite a workload that has more than doubled, the current 2008-2009 allocation for outreach and marketing ($3.8 million for the biennium) appears to be less than 40% of what Texas spent in 2002-2003.** Out-stationed eligibility workers need the flexibility to expand their role in

application and renewal assistance. Special resources should be targeted to remedy the much higher lost CHIP enrollment among rural Texas children and pre-school-aged children.

6) Insist on Adequate Staffing, Training, and Information Systems in the Eligibility System. Stop the addition of any more Medicaid or waiver clients into TIERS until the system can process eligibility in accordance with federal law timeliness standards.

Our public and private eligibility systems need to be adequately staffed, sufficiently trained, and equipped with reliable computer support. Over the last decade, Texas legislatures have not devoted attention to ensuring even minimally acceptable state staff-to-client ratios in the eligibility system. The state's own data show employees cut by more than half while caseloads grew, resulting in client loads per worker more than doubling, and with no compensating technical improvements in the system. Inadequate staffing levels are now preventing not only children, but also elderly and disabled adults, from getting the health care they need and for which they are eligible. Likewise, the legislature should ensure that the private components of Texas eligibility system are adequately staffed and trained, and that their computer systems deliver the outcomes that have been promised to the taxpayers.

Given the strong evidence that, whatever its promise for the future may be, the TIERS system (and staff tenure with that system) cannot currently support legal or acceptable Medicaid processing times, HHSC should halt the conversion of women's health waiver and related clients to TIERS, the addition of new geographical areas, and the conversion of CHIP to TIERS. The freeze should remain in place until solutions have been implemented that are proven to result in prompt TIERS eligibility processing.

7) **Implement Systems to Ensure that U.S. Citizens are Assisted in Documenting their Status, and that HHSC Policy is Accurately Followed by all State Eligibility Staff.** While Texas may have succeeded in avoiding the denial rates experienced in some states, the 35,000 reported denials in 13 months (with pregnant women, infants and children accounting for most denials) and the indications that Anglos and African American Texans have been disproportionately affected suggests strongly that U.S. citizens are being denied coverage for which they are actually eligible. Targeted, "plain-English" training should be delivered to all eligibility staff on this policy. This should be coupled with creation of a new system to assist citizens needing help acquiring an out-of-state birth record and, a mandatory referral to that assistance.

We Can Do This!

Texas has been a leader before in establishing model eligibility systems that helped low-income working Texans access the health care children need to become productive and successful adults. With all of our support, and with strong leadership committed to doing what's right for our kids, Texas can once again take an enormous step toward assuring that every Texas child has access to cost-effective health care.

HB 109, 80th Texas Legislature, in a Nutshell:

HB 109 by Representative Sylvester Turner (D-Houston) and Senator Kip Averitt (R-Waco) will restore an estimated 96,000 to 127,000 Texas children to the CHIP rolls by 2009 through the following measures:

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

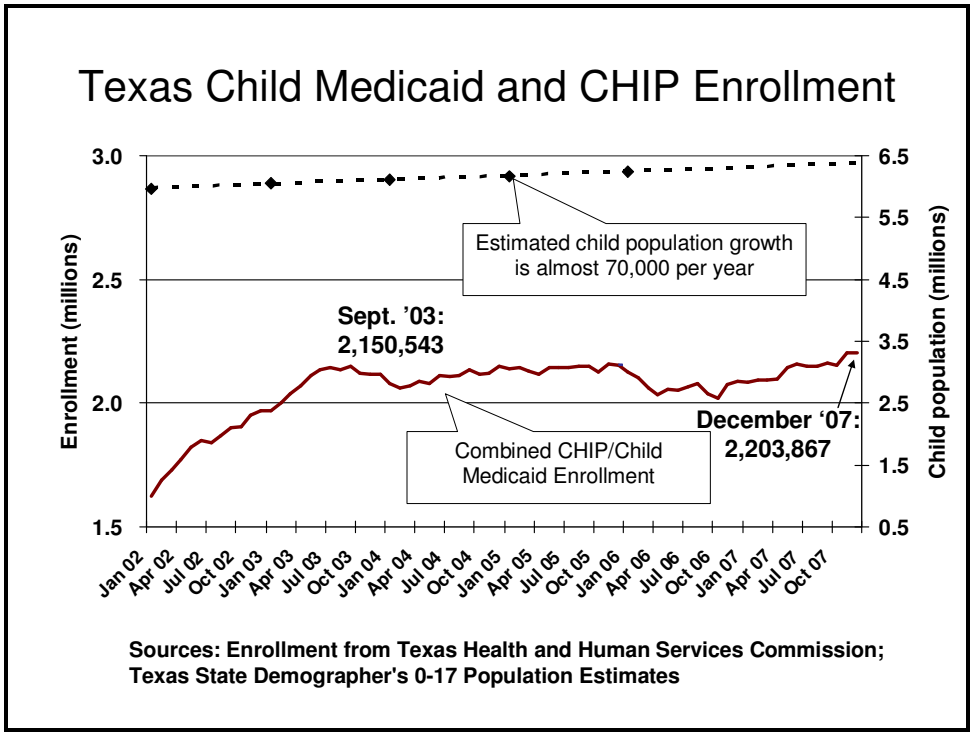
These provisions, except for the six-month electronic check for families earning more than 185% of the federal poverty line, took effect on September 1, 2007.

Focus on Uninsured Texas Kids:
Impact of CHIP and Streamlined Children's Medicaid

In 1997, when Congress created the CHIP Block Grant, the U.S. Census[1] estimated that:

- About 53% of Texas children had employer-sponsored health benefits.
- 25% of Texas children were uninsured (about 1.4 million children), and over three-quarters (76%) of these were in families at or below 200% of the FPL.
- There were about 5.95 million Texas children under age 19.

Since then, the creation of Texas CHIP, the streamlining of children's Medicaid enrollment and renewal (to make it more like CHIP), and simple population growth have resulted in the public coverage of about 1 million more Texas children.



Today, the U.S. Census estimates that:

- 49% of Texas children have employer-sponsored health benefits;
- 22% of Texas children under age 19 (1.5 million) are uninsured; and just over two-thirds (68%) are in families below 200% FPL.
    - 505,000 uninsured children live in families below the poverty line;
    - 510,000 uninsured children live in families between one and two times the poverty line;
    - 279,000 uninsured children live in families between two and three times the poverty line; and,
    - 208,000 uninsured children live in families above three times the poverty line.
- There are about 6.9 million Texas children under age 19.

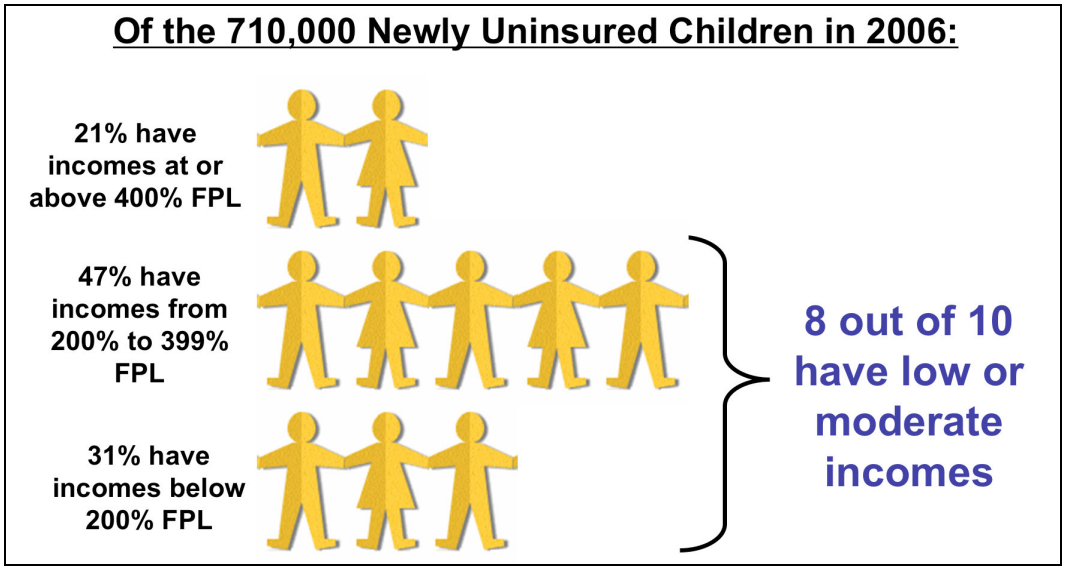
[1] Congressional Research Service report 97-310 EPW, "Health Insurance: Uninsured Children by State, 1994-1996"; U.S. Census Table HI-5, "Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1987 to 2005."

Other Medicaid and CHIP Facts:

- The decline in the uninsured rate among low-income (<200% FPL) American children since 1996 was due somewhat more to increased enrollment of Medicaid-eligible children than to CHIP enrollment, with 59% of the decline due to Medicaid coverage and the remainder to CHIP.[2]
- "Participation" in children's Medicaid (that is, the percentage of eligible children actually enrolled) is estimated at about 79% nationwide, but for CHIP is estimated at 63%. Both programs have improved those rates significantly in recent years.[3]
- When children's Medicaid and CHIP are combined, the national average participation rate is 74%, and Texas is scored at below 70%. HHSC estimates that before 2003 cuts, Texas CHIP participation never exceeded 85%. The highest recorded participation rate was Vermont's 92%, and no other state has a rate greater than 90%.[4] *(Note: For this reason, a 2007 federal CHIP rule requiring states to prove 95% or better participation in children's Medicaid and CHIP before they can offer coverage for children between 250-300% FPL is in effect a prohibition of coverage at those higher incomes.)*

Uninsured Children ABOVE 200% FPL

- The most recent Census uninsured data find that over two-thirds (68.7%) of the national increase in uninsured children from 2005 to 2006 was among children above 200% FPL. This underscores the need to seek solutions that will guarantee access to affordable coverage for every Texas child.



Source: Center for Children and Families, Georgetown University; from Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, "What Happened to the Insurance Coverage of Children and Adults in 2006?"

- Most uninsured children in moderate-income families above the Texas CHIP upper limit do not have access to coverage through an employer. A recent study found that only 8% of families with income between 200% and 400% FPL have declined an offer of employer-sponsored insurance, and another reported that about 80% of uninsured children between 200-300% FPL live in a family where their parent does not have access to an employer-based plan that covers children.[5]

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[2] "Medicaid at the Ten-year Anniversary of SCHIP: Looking Back and Moving Forward," *Health Affairs*, March/April 2007, p. 374.
[3] *Ibid.*
[4] "Moving Backward: New Federally Imposed Limits On States' Ability to Cover Children," Center for Children and Families, Georgetown University Health Policy Institute, August 2007.
[5] Center on Budget and Policy Priorities, November 5, 2007, "Martinez Bill Would Weaken Children's Health Coverage Bill;" Lisa Clemans-Cope, Bowen Garrett, and Catherine Hoffman, "Changes in Employees' Health Insurance Coverage, 2001-2005," Kaiser

- Given this limited access to group employer-sponsored coverage, most parents of uninsured children above the CHIP income limit today can only look to the individual health insurance market for care. Unfortunately, research also indicates that individual insurance is likely to be unaffordable and limited in scope—or denied altogether to children with medical conditions. One study found that families with incomes between 200-299% FPL who purchased insurance in the individual market spent 21% of their income on medical costs, including premiums and cost-sharing, despite the fact that only relatively healthy people were able to purchase the individual-market coverage at all.[6] Another study in California found that individual-market insurance paid just over half—55%—of beneficiaries' medical costs, well below the 83% of medical costs paid by policies in the small-employer group market.[7]

- Individual health insurance is especially problematic for children with chronic health conditions, because companies selling insurance in the individual market can vary premiums substantially based on a family member's health, charge very high amounts, refuse coverage for these children's medical conditions, or refuse to sell the insurance at all. A Commonwealth Fund survey found that one-third of persons in poor health who sought coverage in the individual market were either denied coverage or charged a higher premium for their pre-existing conditions.[8]

Some Good News

Since there are now nearly **a million more children** in Texas than in 1996, the percentage of uninsured Texas children has dropped significantly (by about 4%) even though the number remains close to 1.4 million. Moreover, the uninsured rate among Texas children below 200% of the FPL (i.e., the group potentially served by children's Medicaid and CHIP) has dropped from 35% to 31%. These gains are in spite of a recent deepening of Texas' child uninsured rates from 2004 to 2006 (the 2004-2005 uninsured rate was 20%, and for children below 200% of the FPL was 29%).

Of course, other states were also improving their rates of children's coverage during this period, so despite meaningful progress, Texas has not improved its ranking among the states on this issue.

We Can Cut the Number of Uninsured Texas Kids in Half

The same U.S. Census data put the number of uninsured Texas children in families below 200% of the FPL at about 1,015,000. Adjusting for undocumented children, most recently estimated at around 230,000,[9] at least 750,000 of the remaining children should be able to enroll in Medicaid or CHIP.[10] A recent HHSC report using a different model estimated as many as 850,000 eligible, but unenrolled, uninsured children. In other words, ***the number of uninsured Texans children could be reduced by at least one-half if the majority of eligible, but not enrolled, children were brought into Medicaid and CHIP.***

Commission on Medicaid and the Uninsured, October 2006; Linda Blumberg and Genevieve Kenney, "Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Expansion?," Urban Institute, October 2007.

[6] Linda J. Blumberg et al., "Setting a Standard of Affordability for Health Insurance Coverage," Health Affairs web exclusive, June 4, 2007.

[7] "Health Insurance: Can Californians Afford It?" California HealthCare Foundation, June 2007.

[8] CBPP, *Op. Cit.*, Collins *et al.*, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006.

[9] Pew Hispanic Center tabulations of Current Population Survey (CPS) data with immigration status assigned with methods, initially by Passel and Clark (1998); see also Passel, Van Hook, and Bean (2004, 2005). Average of 2003 and 2004 data.

[10] Texas CHIP is available to legal immigrant children, so undocumented children below 200% of the federal poverty line are the most significant identifiable groups of children who do not qualify for CHIP despite their family income.

The Big Picture:
How Eligibility Policy Affects Health Care for Eligible Kids

Policymakers can turn to a large body of research and experience about how Medicaid and CHIP eligibility rules and procedures affect children's enrollment in public insurance programs. In the interest of brevity, this report provides key findings only, with links to more detailed research for interested readers.

What Federal Law Requires for Children's Medicaid and CHIP Eligibility

Medicaid: Federal law and regulations have only minimal requirements for states related to children's Medicaid eligibility. (*See Appendix A for a more detailed description*.) The key requirements are:

- **A signed application**, including the applicant's attestation that the information is truthful (under penalty of perjury);
- **Social Security numbers** for applicant children (this cannot be required of non-applicants, such as parents);
- **Documentation**[11] **of immigration status** from "qualified aliens" (e.g., legal permanent resident immigrants) and verification of that status with federal immigration authorities (CIS);
- **Documentation of U.S. citizenship** for all other children; and
- **A system for income and eligibility verification;** states are *not* required to collect income documentation from applicants, but they must have some system of checks, such as random audits, or checks of third-party federal and state agency databases to verify income.

States are also required to meet several quality and performance standards: no delay in application; mandatory out-stationed workers in certain hospitals and clinics; eligibility decision within 45 days; notice of decision and reasons for denials; ready access to simple, understandable information on eligibility rules, rights, responsibilities; and appeal and fair hearing rights.

CHIP: Federal policy is even more flexible for separate CHIP programs like Texas. The only requirement from the list above that applies to CHIP is the provision of Social Security numbers.

What States are Allowed to Do for Children's Medicaid and CHIP Eligibility:

- **Mail, telephone, facsimile, and Internet:** There is no requirement for a face-to-face interview for either children's Medicaid or CHIP applications or renewals.

  What Other States Do: *Every state but Mississippi and Kentucky allows children to apply for Medicaid and CHIP by mail or telephone.*

- **Eliminate resource or asset limits in children's Medicaid and CHIP.** No asset limits are required in either children's Medicaid or CHIP.

  What Other States Do: *Texas is one of only four states (along with Hawaii, Montana, and Utah) with an asset test for children's Medicaid, and one of only two states (along with Oregon) with an asset test for CHIP. Moreover, Texas' asset tests for both Medicaid and CHIP are more restrictive than those of the small group of states who also use asset tests. Hawaii's $7,500 asset limit applies only to Medicaid children above 200% of the FPL, and Montana and South Carolina's assets limits for children's Medicaid are*

[11] It is worth noting the distinction between federal law requiring that Medicaid recipients be either U.S. citizens or lawful immigrants, and federal law directing specific documentation requirements for proving that status. While U.S. citizenship or legal immigration status has long been required for Medicaid, and the few legal immigrants who qualify in Texas have long had to provide their official immigration papers to enroll, only since July 2006 have U.S. citizens had to provide specific papers to prove their citizenship.

$15,000 and $30,000, respectively. Oregon's CHIP asset limit is $10,000. Texas children's Medicaid limits assets to $2,000, and as of September 2007 Texas CHIP sets the limit at $10,000.

- **Up to 12 months continuous eligibility.** States are not required to check income constantly (or monthly) and terminate children's eligibility immediately when family income increases. Federal law allows states to offer periods of guaranteed eligibility up to 12 months. Re-certification is required at least every 12 months, but does not have to be face-to-face.

  What Other States Do: *Seventeen states offer 12-month continuous coverage for children's Medicaid, and 25 states do so for CHIP.*[12] *Texas provides 6 months of continuous coverage in children's Medicaid, and as of September 2007 provides 12-month continuous coverage for most children in CHIP. Under HB 109, children with family incomes between 185-200% FPL, who make up less than 9% of Texas CHIP, will be subject to an electronic income check at six months once a system is established (to be implemented no later than September 2008) to perform those checks.* *(More information on page 5.)*

  Electronic verification, third-party verification, and self-declaration of eligibility information. States are not required to collect documentary proof of eligibility-related questions other than immigration/citizenship status, described above. States do not have to request hard-copy proof of income, age, residency, or resources. (In Medicaid, states *do* have to have a system for using other sources of information to verify income, as described above.)

  What Other States Do: *Thirteen states accept self-declaration of income for children's Medicaid, CHIP, or both: AL, AZ, AR, CT, GA, HI, ID, MD, MI, MT, OK, VT and WY. Texas requires documentation of income for both Medicaid and CHIP. By 2008, electronic verification is expected to be used in some cases to perform 6-month income reviews for CHIP children from 185-200% FPL.*

- **Joint application for children's Medicaid and CHIP.** Federal policy strongly encourages states with separate CHIP programs to use a single joint application for children's Medicaid and CHIP.

  What Other States Do: *Every state that operates a separate CHIP program except Montana, Nevada, and Utah uses a joint application for children's Medicaid and CHIP. Texas has used a true joint application since January 2002.*

- **Policies to discourage dropping private coverage (anti-"crowd-out").** Federal CHIP law directs states to design their programs in ways that will minimize insured parents dropping private coverage in favor of CHIP, but states are given complete flexibility in designing those incentives. **Texas' CHIP research has found extremely low levels of substitution of CHIP for private coverage.**[13] Most states have adopted the approach of requiring that children be uninsured for a specified period before they can be eligible for CHIP, except in situations such as a child's loss of Medicaid; loss of insurance due to parents' divorce, death, or job loss; and cases in which insurance costs exceed a high percentage of family income (e.g., in Texas costs exceeding 10% of family income are grounds for exception).

  What Other States Do: *Currently, 15 states have no waiting period for CHIP coverage. The remaining states are split evenly between those with waiting periods of 4 months or less, and those with a 6-month uninsured requirement. Before HB 109, Texas policy enacted in 2003 (HB 2292) did something altogether different: we were the only state in the U.S. to impose a waiting period after eligibility began, delaying coverage even for newborns and children who had never had insurance. As of September 2007, Texas CHIP returns to the same kind of requirement all other states use—that children be uninsured for at least 3 months prior to application for eligibility (with exceptions, as explained above).*

[12] 36 states including Texas operate separate CHIP programs, and the other 14 use their CHIP funds to expand children's Medicaid.
[13] Texas CHIP has had periodic studies of new enrollees performed by its independent evaluator, the Institute for Child Health Policy of the University of Florida; see Appendix A for references.

Enrollment Fees or Premiums:

Children's Medicaid and CHIP are subject to different federal standards for allowable out-of-pocket spending requirements. The primary focus below is on enrollment fees and premiums, because they affect whether children can enroll in CHIP and stay enrolled (in contrast, co-payments and the like affect access to care after a child is enrolled).

Children's Medicaid.[14] Cost sharing for Medicaid children was entirely prohibited before recent changes passed in the federal "Deficit Reduction Act" (DRA, signed February 8, 2006), and still must meet specific standards designed to prevent barriers to care.

Under federal law, no co-payments or coinsurance are allowed for preventive care (e.g., medical or dental check-ups, immunizations) for any child in Medicaid. Nearly all children in Texas Medicaid are still exempt from premiums (or enrollment fees), and from co-payments or coinsurance[15] for most medical care. The exceptions as they apply in Texas are:

- Newborns (under age 1) in families with incomes between 150% of the FPL and the upper limit of 185% of the FPL could technically be charged **premiums** (or enrollment fees) and denied coverage for non-payment.[16]

  However, this is a very small subset of the children enrolled in Texas Medicaid, and the costs of modifying Texas computers to identify them as a distinct group just to charge them would be considerable. Also, the state should avoid discouraging parents of newborns from accessing medical care.

- Newborns (under age 1) in families with incomes over 133% of the FPL but less than the upper limit of 185% of the FPL could technically be charged **co-payments or coinsurance**. But, the same problems explained in the bullet above apply here.

- Under new federal law, children up to 150% of the FPL may be charged **co-payments up to $3 for non-preferred prescription drugs** (but none are allowed for preferred drugs).[17] Moreover, children may be charged up to $6 for non-emergency use of the Emergency Room.[18]

- The DRA allows (but does not require) states to deny care or prescriptions to a Medicaid recipient who cannot make a co-payment **only if that person has an income above the FPL.** The law allows states to deny coverage to a person who cannot pay a premium (though again, premiums are infeasible in Texas Medicaid). ***Note:*** *the Tax Relief and Health Care Act of 2006 (TRHCA) clarified the exemption of below-poverty Medicaid enrollees from denial of care, and also that rules for "nominal" cost-sharing amounts still apply to those below-poverty clients. As a result, the vast majority of Texas Medicaid clients are subject to these protections.*

[14] Note: Medicaid has a different set of federal standards for "cost sharing" by adults.
[15] *Co-payments* are a flat amount paid, for example per visit or prescription; *coinsurance* is usually a percentage of a total bill that the patient must pay out of pocket (e.g., 10% of charges).
[16] If Texas applied either this premium option or the co-payment option in the previous bullet to those newborns, those costs could not exceed 5% of the families' monthly or quarterly income.
[17] No co-payment may be charged if the prescribing doctor says the non-preferred drug would be ineffective or have adverse effects.
[18] The $3 and $6 caps will per federal law be updated annually by the medical CPI, which means they will grow faster than Medicaid recipients' incomes, because the medical CPI is generally a larger percentage than the annual increase in the federal poverty guidelines used for Medicaid eligibility.

CHIP. Because CHIP was created to serve a higher-income population, federal rules allow more cost sharing than Medicaid, but families are also protected from high out-of-pocket costs, and no co-payments are allowed for preventive care.

- **Premiums** for children in families below 150% of the FPL cannot be higher than $19 per month.[19] For all families, including those above 150% of the FPL, premiums must be low enough to ensure that, combined with co-payments and any other out-of-pocket costs, families are not charged more than 5% of their income.

- **Co-payments and co-insurance** for CHIP children in families below FPL are limited to the same "nominal" amounts defined for adult Medicaid. Unlike children's Medicaid, CHIP kids can be charged for office visits or hospital stays. Like children's Medicaid, CHIP prohibits co-payments for well-child care and immunizations. Federal rules set different co-payment caps for children below poverty, between the poverty line and 150% of the FPL, and those above 150% of the FPL.

What Other States Do: *CHIP premium and enrollment fee structures are not easily ranked. Of the 36 states with separate CHIP programs, five charge no enrollment fee or premium at any income level (CT, MD, PA, WA, WV). Among the 31 states that do charge fees, Texas' current annual enrollment fees of $35 for families at 150-185% of the FPL and $50 for 185-200% of the FPL are at the lower end of the range (for detailed Texas CHIP cost sharing, see: http://www.chipmedicaid.com/english/cost.htm).*

National Research: Impact of Premiums and Enrollment Fees on Enrollment. A large body of research on medical co-payments and the poor has shown that co-payments reduce use of services, but that unfortunately low-income Americans are just as likely to forego critical medical care (e.g., blood pressure medications, diabetes treatments) due to costs as they are to pass up less urgent care.[20] Other studies have examined the actual impact over the last 6 years on poor and low-income families' enrollment when fees and premiums are increased in Medicaid and CHIP. Some key findings include:

- **For low-income uninsured populations, any amount of premium/enrollment fee will result in reduced enrollment.** For example, one study found that increasing from no premium to charging just 1% of family income reduced participation by eligible persons from 67% to 57%, and that participation dropped by another 10 percentage points for every additional 1% of income charged for the premium. Recently increased premiums in Maryland, Oregon, Rhode Island, and Vermont all resulted in significant declines in coverage. In Oregon, total premium revenues collected by the state actually dropped with the increased rates, because such a large percentage of participants dropped their coverage.

- **Enrollment drops the most sharply when premiums or enrollment fees are applied to below-poverty groups, but even populations above 150% of the FPL have shown high disenrollment rates** (e.g., 18-28% of enrollees left after the recent Rhode Island and Maryland premium increases).

- **Studies show that the majority of children terminated for non-payment of premiums re-qualify at a later date,** meaning non-payment by a parent often results in loss of coverage for income-eligible children. When Rhode Island began to charge CHIP premiums for the first time, 20% of those subject to premiums were disenrolled for non-payment. Follow-up studies showed that 49% who lost coverage were uninsured afterwards, and that eventually 60% were re-enrolled.

[19] The cap is lower for families with lower incomes, see 42 CFR §447.52; and §457.540.
[20] See Appendix A for links to research on this topic.

Research Round-Up: National Experts Identify State Policies That Encourage or Discourage Health Coverage of Children

A number of recent reports have examined states' experiences with enrollment and renewal practices, eligibility policies, program integrity measures, and outreach and marketing of children's Medicaid and CHIP. Key findings are summarized below.[21]

Centers for Medicare and Medicaid Services (CMS), *Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*. This 2001 report from federal Medicaid and CHIP authorities details the great flexibility states have to streamline eligibility processes and facilitate high participation rates.

1. **Application Options**. States may use online applications and electronic signatures. Other than citizenship or immigration documents, no specific documents are required for application and CMS says that *"states have found they can effectively preserve program integrity without requiring additional documentation from families."* In particular, self-declaration of income and resources, combined with third–party database verifications, random audits, and Medicaid Eligibility Quality Control (MEQC) pilots are promoted as a means to streamlining enrollment.

   Easy access to translation services and translated materials, along with out-stationed state workers and community-based application assistance, are recommended. States are encouraged to *"shorten and simplify the application"* by omitting all unnecessary questions, clearly designating optional items, and explaining the reasons for questions. Mail and telephone applications, as well as better community outreach and dissemination of information about qualifications for coverage, are encouraged.

2. **Renewal Policies.** CMS reminds states that they are **required** by federal law to use all available information to administratively determine if a child continues to be eligible for Medicaid; that is, states must retain a child on the rolls if they have access to information that verifies that the child is still eligible, regardless of whether the parents have returned a "renewal form" (this is called "*ex parte*" eligibility review). States are encouraged to consider simplifying renewal via pre-populated forms (what Texas has called "EZ renewal"), to accept income self-declaration with third-party verification, to allow out-stationed workers to perform renewals, and to incorporate the renewal date on Medicaid-ID cards so that clients are consistently reminded every month about how soon renewal will be required. Follow-up with families who fail to complete renewal is identified as a best practice.

3. **Program Integrity and Self-Monitoring**. States are encouraged to monitor correct application of policy in the field and to establish enrollment goals. MEQC pilots can be used to monitor not only "negative case actions" (checking whether denials were correct) but also to investigate "procedural denials" (children denied for failure to complete paperwork, not because they were actually determined ineligible) so that states can figure out how to minimize such denials.

National Academy for State Health Policy, *Seven Steps Toward State Success in Covering Children Continuously*. This 2006 brief looks at best practices from a decade of work with officials in state children's Medicaid and CHIP programs. The seven steps are:

1. **Keep enrollment and renewal simple**. Twelve-month continuous eligibility and "administrative renewal" processes are identified as the two most important and effective practices. Administrative renewal involves using all third-party information available to the Medicaid-CHIP agency to see if a child is still eligible, so that many families are not required to provide any new documents at renewal time. These practices also reduce state administrative costs, as seen in the cases of Louisiana and Illinois.
2. **Promote community-based enrollment efforts.** Outreach and enrollment assistance at the local level are strongly tied to enrollment and retention; once these programs are cut back, enrollment and renewal rates drop.

[21] Links to all the cited reports are in Appendix A.

3. **Use technology to coordinate programs and reduce administrative burdens**. Examples include online applications and electronic eligibility referrals of children eligible for school lunch and WIC programs.
4. **Change agency culture**. State Medicaid and CHIP officials report that eligibility staff benefit from "internal marketing," emphasizing connecting children with health care and minimizing procedural denials. Workers also need the training and tools to help them achieve these goals.
5. **Encourage leaders who can articulate a clear vision.** Governors or other state leaders who vocally champion the goal of maximizing enrollment of eligible children are associated with high participation rates.
6. **Engage partners** (in outreach and enrollment). Beyond state agencies and contractors, successful participation requires involvement of schools, businesses, community organizations, health providers and plans, and foundations.
7. **Market effectively.** Review of state practices finds that marketing via diverse media and targeting to language and population groups is important. Simple messages about covering children and focusing on the health care they need, particularly preventive care (i.e., not just promoting "insurance"), are often successful.

The Commonwealth Fund, by Georgetown University Health Policy Institute: ***Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies.*** This 2006 report reviews national and state studies, and analyzes interviews with state program officials and the experiences of **Louisiana, Rhode Island, Virginia, and Washington** in enrolling and retaining children in Medicaid and CHIP. Key findings include:

- Some "churning" on and off of Medicaid and CHIP is inevitable due to real family income changes. Even so, when state officials are committed to minimizing gaps in coverage, effective solutions can be applied to minimize the "procedural" disenrollment of children who remain income-eligible.
- Gaps in coverage for income-eligible children undermine disease management and case management, and drive up administrative costs for states and health plans.
- All four states reported that significant numbers of children (one-fifth to one-third) had gaps in their Medicaid-CHIP coverage over periods of a year or more, and that a high percentage of those children were subsequently re-enrolled. In other words, many children are experiencing gaps in coverage despite meeting all the criteria for eligibility as the result of "procedural denials."
- Longer eligibility periods and simplified "administrative renewal" practices are identified as the most effective tools to reduce gaps in coverage for eligible children.
- **In Louisiana, more than half of the children on Medicaid/CHIP are renewed internally via administrative renewal, and another 9% via telephone. Cases closed for failure to return renewal forms dropped from 17% to 2%, and renewal rates increased to 92%.**
- Louisiana reduced the share of children with gaps in Medicaid-CHIP coverage from 18% to 6% over 2 years, with a concentrated effort and policy changes. Louisiana tracks children's renewal rates by regions, and each region is charged with developing a localized plan for improving renewal rates. Special attention has been paid to ongoing consistent training for eligibility staff on current policy.

- Washington state's children's Medicaid-CHIP[22] experience since 2003 shares some similarities with Texas' CHIP policy changes in the same period. In 2003 Washington cut children's coverage in both CHIP and Medicaid back to 6-month renewals from 12 months, discontinued administrative and telephone renewals, and ended self-declaration of income. These policies resulted in a steady decline in children's enrollment until 2005, when the new governor restored 12-month coverage and enrollment began to grow again.

Kaiser Family Foundation, by The Children's Partnership, ***Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Unenrolled Children Get Health Insurance.*** This 2006 report reviews the techniques that states have developed over the last decade to increase the proportion of income-eligible children enrolled in Medicaid or CHIP. Many of the steps are similar to those identified by CMS and the other researchers cited above; some key findings and recommendations include:

- Every additional step added to the enrollment or renewal process requiring parents to return a form or document results in a significant loss of eligible children to procedural denial. Thus, states should attempt to make their processes clear and simple enough that follow-up steps are not needed.
- States should pursue and federal authorities should support the development of greater information-sharing capacity between public programs to reduce duplicative requirements and make greater use of administrative renewal processes possible.

2007 Reports on Children's Eligibility Policy Enrollment, Retention and Participation

The Kaiser Commission on Medicaid and the Uninsured and the Children's Partnership, ***Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices*** **(May 2007).** This report identifies promising technological practices across the country which can ease participation barriers, while preserving and strengthening both program integrity and personal privacy. Some key findings include:

- More and more states are performing **automatic electronic cross-checks** between Medicaid and CHIP programs and other programs with similar income and eligibility criteria (e.g., Food Stamps, school lunch) to allow electronic collection of renewal data and eliminate duplicative requests for income documentation from families.
- States are finding **low-cost solutions to allow incompatible and aging data systems to communicate** across programs and agencies. So-called "middleware" such as "enterprise service bus" utilities creates a communications bridge between otherwise incompatible databases and systems, for a fraction of the costs of fully integrating those systems.
- State agencies are building **privacy protections and security procedures** that ensure that enhanced data sharing across programs is authorized by clients, and not vulnerable to hacking. Approaches include routine inclusion of opt-in or opt-out client consent on applications, carefully controlled access to queries, and use of "pointers" and tiered servers to protect accumulated data from unauthorized access.
- States are also **building error protection protocols into third-party electronic verification processes, to ensure that such processes reduce paperwork for families without introducing new errors that deny eligible persons coverage.** Steps include applying "substantial match" protocols that reduce match failures caused by minor data entry errors and inconsistencies, running data matches against multiple databases, using the most complete information possible to run the match, and—importantly—establishing simple procedures for families to follow when an electronic match results in an erroneous coverage denial.

[22] Washington Medicaid covered children to 200% FPL prior to the creation of SCHIP by Congress; the state's separate CHIP program is for children from 200% to 250% FPL.

The Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents* (May 2007). This project conducted focus groups with parents with income at or below 300% of the federal poverty level in four cities (Chicago, Houston, Los Angeles, and Miami) in January and February 2007. Separate focus groups were held with parents of uninsured children (including several conducted in Spanish), and with parents of children who are enrolled in Medicaid or CHIP.

- Many parents of uninsured children still know little about children's Medicaid and CHIP. Many reported believing that children in working families do not qualify, and others simply assume incorrectly that they earn too much for their children to qualify.
- Parents with strong connections to the workforce who have never used any kind of public assistance are especially likely to be uninformed or misinformed about children's health programs.
- Parents who have been denied in the past—including those denied not due to ineligibility but because of closed enrollments or waiting lists—tended to assume their children remained ineligible.
- Parents who are exposed to outreach from a number of different sources are more aware of and have more accurate information about children's Medicaid and CHIP.
- Parents of pre-school children are less informed about children's Medicaid and CHIP, because they do not benefit from school-based or -linked outreach programs.
- Parents who have experienced streamlined applications and renewals appreciate those processes (Illinois' All Kids program was especially popular with focus group parents in this regard). Other parents reported complex and confusing documentation requirements.
- All parents agreed that that they were unwilling to mail original valuable identity documents (such as birth certificates and passports) to state programs.
- While Spanish-speaking parents reported that written application materials are usually available in Spanish, most reported difficulty accessing eligibility staff who spoke Spanish when they needed personal assistance.
- Parents in families with mixed immigration status (i.e., families that include either a legal or an undocumented immigrant) continue to express fears about enrolling eligible uninsured U.S. citizen children in children's Medicaid or CHIP, because they fear negative impacts on non-citizen family members.

Key Findings and Implications

Premiums will always result in no coverage for some children, and periods without coverage for others. In short, analysis of real programs shows that as premiums increase, enrollment declines, and this effect is highest among those who are poorest. Children themselves have no income and cannot control whether their parents can afford, or will pay for, coverage. This creates a special dilemma when making decisions about voluntary premiums and enrollment fees for coverage of children. **As a practical matter, as long as insuring children is optional some parents will allow their children to remain uninsured. In light of this, Texas must carefully consider and balance premium and enrollment fee policies for CHIP to minimize the loss of access to health care for children.**

Compulsory coverage is the only way to ensure all children are insured. Texas should also consider requiring health coverage of children, much as education of children is required. While parents have choices—public or private schools, or home schooling—simply not educating your children is not an option under the law. Of course, to make this policy possible, Texas would have to take steps to create guaranteed access to affordable health coverage for children at every income level. Such steps would include more

efficient enrollment and renewal processes for Medicaid and CHIP (since we would need to enroll at least 750,000 currently uninsured children eligible for, but not enrolled in Texas Medicaid or CHIP), plus a buy-in program of some kind for children in families above 200% of the FPL who make up one-third of our uninsured children. It would also require our state to address in some way the needs of the estimated 230,000-250,000 undocumented children who are ineligible for Medicaid or CHIP.

Simplicity Matters. In the current voluntary system, every step Texas can take to streamline processes and paperwork for eligible children can make a difference in reducing the uninsured rate for our children, reducing so-called "rationing by inconvenience." Accuracy and program integrity need not be sacrificed when hassles are reduced.

Leadership, Commitment to Coverage and Outreach Matter. As the NASHP and Commonwealth reports demonstrate, where state leaders and Medicaid officials make simple and efficient processing of eligibility a priority, both participation by eligible children and renewal rates can be quite high. Texans should demand an efficient eligibility system that is truly committed to maximizing enrollment of eligible children.

Background: A Brief History of Children's Medicaid and Texas CHIP Eligibility Policy

"B.C.": Before CHIP, No Outreach, Welfare Reform Losses. Before Texas implemented CHIP, Texas Medicaid did not reach out to let working poor parents know their children could qualify or encourage them to enroll their children. In fact, the implementation of welfare reforms in Texas led to a large decline (over 220,000 children from 1996 to 1999, a 17% decline) in Medicaid-covered children, largely because families leaving welfare did not realize their children still qualified for Medicaid.

Texas Medicaid processes did not guarantee that children leaving welfare would transition to Medicaid-only coverage, and as a result only about 1 in 5 children leaving welfare in Texas from 1995 to 1997 were automatically transitioned. In 1999, the 76th Texas Legislature both authorized the Texas CHIP program and also passed a state law requiring the Texas Department of Human Services (DHS), which then administered both cash assistance and Medicaid eligibility, to inform parents leaving welfare that their children could continue their Medicaid coverage.[23] These two steps began to pave the way for increased coverage of children.

2000: CHIP's Simplicity Highlights a Medicaid Mess. With CHIP implementation in May 2000 came Texas' first-ever efforts to attract low-income parents to apply for coverage through marketing, outreach, and application assistance. Federal law required that all CHIP applicants be "screened (for Medicaid eligibility) and enrolled (in Medicaid, if they were eligible)." These new efforts resulted in much higher application rates.

However, the children applying for CHIP who appeared Medicaid-eligible were not enrolled in Medicaid; they were simply sent a letter and told to make an appointment at a local DHS office. Not surprisingly, as of April 2001, DHS had processed more than 116,000 referrals from CHIP, but only 24% of those children had been enrolled in Medicaid. Some 58% of the children referred to Medicaid were denied for procedural reasons, like failure to appear for the assigned interview time, or failure to complete required documentation. As a result, they could not enroll in either Medicaid or CHIP.

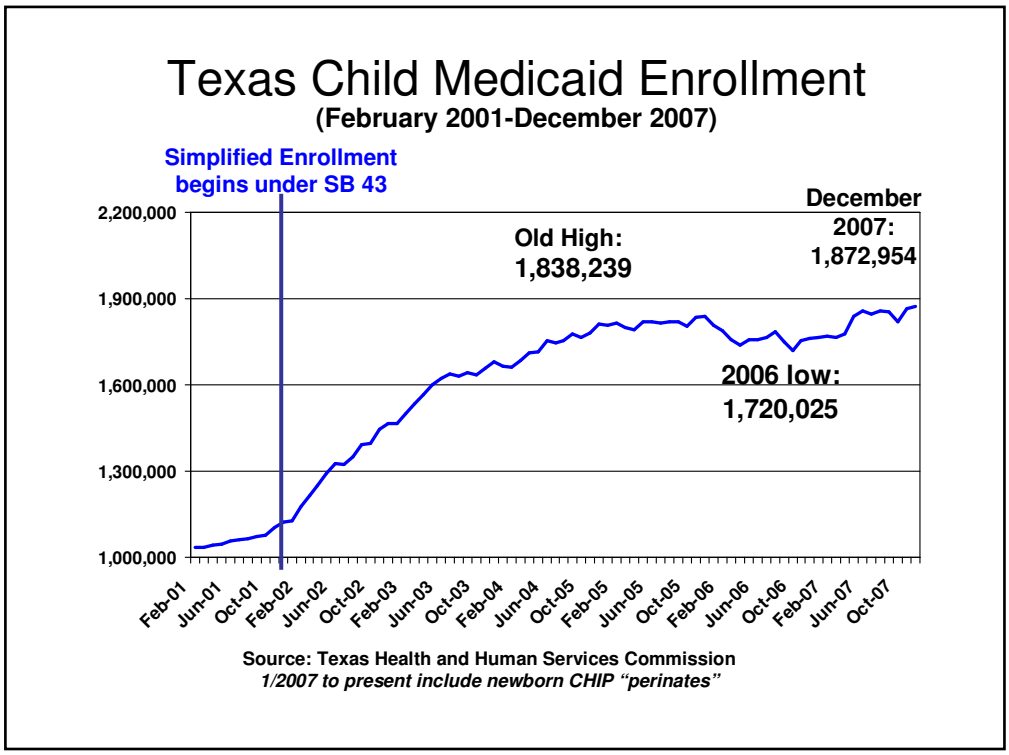
Interest in streamlining cumbersome eligibility processes attracted the attention of Medicaid officials as well as advocates. In 2000, DHS convened a workgroup of Medicaid staff, advocates and other stakeholders to review options within then-current Texas and federal law to simplify the application process. This project resulted in a more user-friendly combined application form for Texas Medicaid, Food Stamps and TANF[24], as well as the elimination of a number of obsolete documentation requirements not required by federal law and deemed by seasoned DHS eligibility staff to be duplicative and unnecessary. The new DHS policies took effect in January 2001.

2001: Streamlined Policies Adopted for Children's Medicaid. The stark contrast between the CHIP and children's Medicaid enrollment and renewal requirements convinced Texas lawmakers that the time had come to let working poor parents enroll and renew their children in Medicaid by mail, just as CHIP allowed. In 2001, the 77th Legislature passed legislation, S.B. 43, designed to make children's Medicaid processes more like CHIP's. Key changes for children's Medicaid included:

- Mandating a true joint application with CHIP;
- Using the same documentation and verification practices for income and assets as used in CHIP;
- Allowing application and renewal by mail; and
- Instituting 6 months of continuous eligibility. Children had been eligible month-to-month, and as a result, the average coverage period for children's Medicaid was only 4 months, with only 1 in 5 children covered for 12 consecutive months. As originally passed, coverage would have been extended to 12 months effective September 2003.

[23] SB 445 by Moncrief; HB 2082 by Naishtat.
[24] Temporary Assistance for Needy Families; the Texas application form is now known as the H 1010 form.

The new law took effect in January 2002, and the impact on enrollment was immediately evident. Children enrolled in Texas Medicaid grew by more than 345,000 (31%) in the first 12 months of the new law, application approval and renewal rates improved significantly, and denials for missing information plummeted.



Special Efforts for U.S. Citizen Children in Families that Include Immigrants. In the development of CHIP and improved children's Medicaid processes, state agencies involved in eligibility and program administration have paid special attention to meeting the informational needs of Texas families that include non-U.S. citizens. According to U.S. Census data, an astounding 23% of all Texas children live in "mixed-immigration families," in which one or more parent is a non-citizen (either a legal or undocumented immigrant) even though the vast majority of these children are themselves native-born U.S. citizens. Of Texas children below 200% of the FPL, more than one-third have a non-citizen parent. Disseminating accurate information about children's Medicaid and CHIP eligibility to these families is critical to reaching high participation levels in the two programs.

Since 2001, Texas Medicaid and CHIP have provided clear guidance and instructions to mixed-immigration families, consistent with federal law. Eligibility for these programs depends on each individual's immigration status, and is not affected by the status of family members (e.g., a U.S. citizen child can be eligible for Medicaid or CHIP even if he has a non-citizen parent). Federal policy also dictates that only persons applying for benefits for themselves have to provide a Social Security number (SSN); ineligible family members need not provide a SSN as long as they do not seek benefits for themselves). Federal policy also specifies that valid, non-fraudulent use of health benefits by an individual will not create immigration problems for that individual or for his relatives.

Texas Medicaid and CHIP's efficacy in providing policy information was matched with help from the non-profit sector. In particular, the Covering Kids and Families project[25] in Texas targeted a portion of its media

[25] Covering Kids & Families was a 50-state national initiative of the Robert Wood Johnson Foundation, which from 1997 to 2006 focused on reducing the number of eligible but uninsured children and adults through enrollment in Medicaid or the State Children's Health Insurance Program. In Texas, the project was sponsored by the Texas Association of Community Health Centers.

and community-based outreach resources to reaching mixed immigration families to inform them that their U.S. citizen children could safely participate in Medicaid and CHIP. This complementary effort contributed to Texas' early relative success in enrolling citizen children with immigrant parents.

June 2003: Texas Legislature Adopts Policy Changes Designed to Reduce CHIP Caseloads. Like many other states, Texas began its 2003 legislative session facing a budget shortfall of unprecedented magnitude. The alarming drop in state tax revenue contributed to an estimated shortfall of between $9.9 and $16 billion for the 2004-2005 biennium. However, unlike other states, Texas entered this fiscal crisis already near the bottom nationally in both revenue and spending. In 2002, Texas ranked 49th in state spending and state taxation per capita. The combination of these realities, a commitment to "no new taxes," and significant philosophical opposition to public health coverage for children, resulted in dramatic budget cuts affecting both CHIP and Medicaid.

The vehicle for budget cuts was HB 2292, a 310-page bill that also encompassed reorganization of Texas' health and human services agencies plus a wide variety of other policy changes. HB 2292 made a number of changes to CHIP, some of which were initially proposed by HHSC (agencies were directed to propose changes to achieve budget cuts), while others were proposed by state legislators. The changes adopted included:

- Coverage period reduced from 12 months to 6.
- Premiums and co-payments increased.
- New coverage delayed for 90 days.
- *Benefits eliminated: dental; vision (eyeglasses and exams); hospice; skilled nursing facilities; tobacco cessation; chiropractic services. Mental health coverage reduced to about half of the coverage provided in 2003.
- Income deductions eliminated (gross income determines eligibility).
- *Asset test (limit) added for those above 150% of the FPL (took effect August 2004).
- *Outreach and marketing reduced.

June 2003: Children's Medicaid Changes. Federal Medicaid laws protecting children's benefits and establishing Medicaid eligibility maintenance of effort requirements prevented any cuts to Medicaid eligibility or benefits for children. However, HB 2292 did modify two provisions of SB 43, the 2001 law that streamlined children's Medicaid processes. First, the bill postponed the scheduled implementation of 12-month Medicaid coverage for children until 2005, holding the coverage at 6 months. Second, the bill allowed (but did not require) HHSC to perform "third-party database" checks on asset information in child Medicaid applications and renewals. HHSC officials assured lawmakers that the policy change would not require additional documentation for parents.

August 2003: Children's Medicaid Changes Begin. DHS state workers began conducting the "data broker" checks authorized by HB 2292 for children's Medicaid applications and renewals in time to affect September 2003 enrollment. Almost immediately, problems arose because the asset information in the children's Medicaid files was often outdated, resulting in a high proportion of mismatches with the data broker information which then required further investigation. In an effort to comply with state law that requires that documentation and verification procedures used for children's Medicaid be no more stringent than those used by Texas CHIP,[26] DHS had used an "EZ renewal" process that asked parents to update any changed information rather than complete a new application. DHS officials recognized the problem, and believed that by returning to the old process of requiring all new information, including new documentation of income, the high rate of mismatched information would decrease.

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*Items marked with asterisk were proposed by the legislature, rather than HHSC.

[26] Human Resources Code Chapter 32 §32.026(d).

October 2003: Problems as EZ Renewal Ends for Children's Medicaid. In October 2003, DHS reinstituted a policy requiring full re-application and income documentation at renewal for children's Medicaid. While this policy change was not specifically called for in any 2003 law changes, state Medicaid officials concluded that a more rigorous review would be consistent with the intent of the 2003 laws. Technically, this violated the provisions of state law mentioned above (which was not amended by HB 2292) which directed that children's Medicaid income and asset documentation and verification processes could not be more restrictive than those used for CHIP.[27] Nevertheless, parents were once again required to complete the entire 4-page children's Medicaid-CHIP application at renewal and provide new income verification (pay stubs, etc.). Children renewing CHIP coverage continued the "EZ renewal" process, and the departure from state law went unchallenged.

Even with the more up-to-date information, the new data broker check process continued to create problems for children on Medicaid. The new checks and the increased paperwork had been implemented without building any additional time into the renewal process: no extra time for parents to complete the forms, and no extra time for state eligibility workers to process the information, perform data broker checks, and follow up on any inconsistencies resulting from the checks. Exacerbating the increased amount of work required per child were legislatively mandated eligibility staff cuts, which by fall of 2004 had reduced staff to 6,900, compared to 9,140 just 2 years earlier (a reduction of 24%), when both enrollment and work per child were substantially lower.

The final factor leading to a troublesome result was the fact that, in 2002, the Medicaid eligibility computer systems had been modified to **automatically close** a child's case after 6 months unless a renewal was input into the system by a certain deadline (before then, the opposite was true: an affirmative action was required to close a case). Each renewal took longer to process, fewer workers were available to process those renewals, and at the same time total workload increased because more children were enrolling. Episodes of automatic closure of Medicaid cases began to occur even though children's parents had returned all the required information "on time" simply because state staff could not process renewals quickly enough.

Significant numbers of children (estimated at 20,000-30,000 at the time) in the Houston and Dallas areas lost their coverage in error. Though most children later regained coverage, Medicaid Managed Care health plans reported that the problems were not fully resolved nor caseloads fully restored until May or June of 2004. To correct the problem, DHS officials reallocated staff resources and in some areas began using special centers for processing children's renewals. This eventually resolved the problem for a time. Despite these localized and temporary setbacks in 2004, children's enrollment in Texas Medicaid continued to grow slowly until state staffing shortages and flawed interactions with a new CHIP contractor late in 2005 and in 2006 spurred another round of accidental closures (described later in this report).

Fall 2003: CHIP Changes Begin and Enrollment Drops. The first policy change to affect CHIP enrollment was the **90-day delay** in effective coverage for newly eligible children, which was first applied to children found eligible in September 2003. Because this policy meant that very few new enrollees[28] were added to the program, enrollment began to drop in October 2003.

Next, the **elimination of income deductions** for child care and child support expenses was applied to all CHIP enrollees (not just new applicants) to affect November 2003 enrollment. This had the effect of "shifting" many children from one income category up to the next higher category, as income previously not counted was now reflected. Of course, this also "shifted" about 17,000 children out of CHIP coverage that month, as their newly counted income exceeded the 200% of the FPL upper limit.

Three other CHIP policy changes were implemented in September 2003 which combined to take a toll on enrollment. First, **premiums** were increased. The most dramatic change affected the roughly half of CHIP children who were in families from 100-150% of the FPL, whose premiums jumped from $15 per year to $15 per month.

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[27] *Op. Cit.*

[28] Certain children qualify for exceptions to the delay under state law, and are enrolled immediately.

At the same time, the **coverage period was reduced from 12 to 6 months**. This meant that twice as many children were renewing coverage every month, compared to the original CHIP policy. For example, under 12-month coverage, 1,000 children per month might be due for renewal, and on average 25% failed to renew, so that 750 per month would successfully renew. Upon switching to 6-month renewal, suddenly 2,000 children would be sent renewal forms each month. If the same percentage (25%) failed to renew, then only 1,500 of the 2,000 children would complete renewal and remain enrolled. Since no offsetting policy changes increased the number of new applicants coming into the program each month (and to the contrary, the increased premiums, reduced benefits, and 90-day delay actually reduced new enrollment), simple math made a significant enrollment decline inevitable.

The elimination of dental and vision benefits added to the impact of the other changes, since those services are needed on a regular basis by healthy children and entail significant costs for low-income families. Parents reported deciding to drop CHIP coverage in order to save the money they would have spent on premiums, and use it instead on dental exams and treatment.

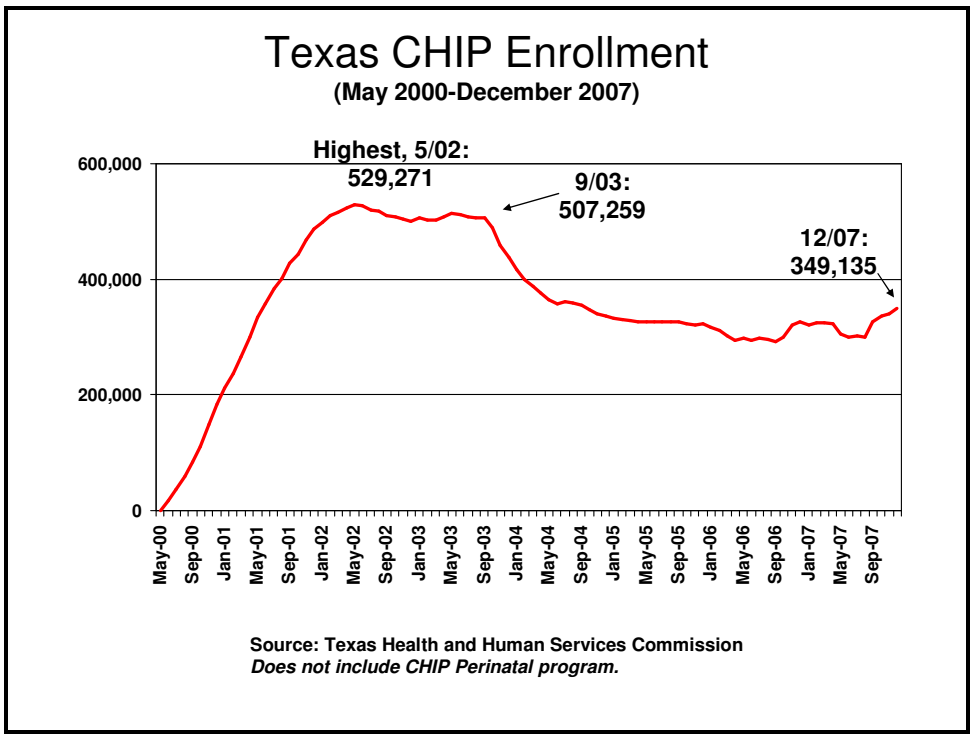
The combined impact of the policy changes was quickly apparent; from September 1, 2003, to January 1, 2004, enrollment dropped by nearly 91,000 children. Before September 2003, over 28,000 new children per month were added each month to CHIP, while about 21,800 per month left the program. More children were added each month than left, so the program rolls grew. After September 2003, the newly enrolled children each month dropped to fewer than 22,000 while children losing coverage each month increased to over 25,000—reversing the original CHIP trend, with more leaving each month than coming in—for a net decline.

2003-2004: Impact of Higher CHIP Premiums. As noted above, one factor affecting CHIP new enrollment and renewal rates was the imposition in September 2003 of higher premiums for most CHIP families. As noted previously, research shows that premiums are always associated with some degree of decreased participation. Until September 2003, Texas CHIP charged a single $15 annual enrollment fee for families from 100-150% of the FPL. Families below poverty had no enrollment fee (and remained exempt under the 2003 changes), and those above 150% of the FPL paid monthly premiums. The shift from $15 per year to $15 per month for the lower-income CHIP families called for a significant change in behavior and out-of-pocket spending: from $15 annually to $180 annually, an increase of $165. In contrast, the families above 150% were already in the habit of submitting a monthly premium, and their annual outlay increased by only $60-$84. When this sharp increase in outlay for the lower-income families was combined with the loss of coverage for dental care and vision care—two benefits which entail significant out-of-pocket costs for children even if they are in robust good health—the expected negative enrollment impact of higher premiums intensified, as many parents calculated that the $165 they would save on premiums might be just enough to cover the routine dental care their healthy kids required.

January & August 2004: Premium-Related CHIP Terminations Suspended. The rapid decline of CHIP caseloads in the first 3 months after September 2003 concerned both HHSC and the legislative leadership who had approved the cuts. In January 2004, with enrollment already down by over 91,000 and facing additional unprecedented disenrollment for non-payment of premiums, HHSC made an unannounced decision to suspend "mid-term" disenrollments for non-payment. In other words, children not up for renewal would not lose coverage solely for their parents' non-payment, at least until their next 6-month renewal was due. At that point, parents would have to complete the renewal forms and pay any back premiums in order for coverage to continue. In effect, this meant most children did not lose coverage until their renewal month. Children's health advocates were first informed of the working policy in March 2004.

Despite this change, monthly enrollment declines remained high. In June 2004, with enrollment already down more than 149,000 children, HHSC announced that another 130,000 children had been mailed notices of premiums arrears. Facing a potentially unacceptable level of disenrollment and concerned that some families continued to pay premiums while other did not, the Governor announced in August 2004 that he had directed HHSC to formally suspend the collection of premiums. Thus, no CHIP coverage was terminated specifically for non-payment of premiums after January 2004, although presumably many parents

decided not to renew between January and August because they understood that they would have to make monthly payments and eventually pay back premiums as a condition of coverage.

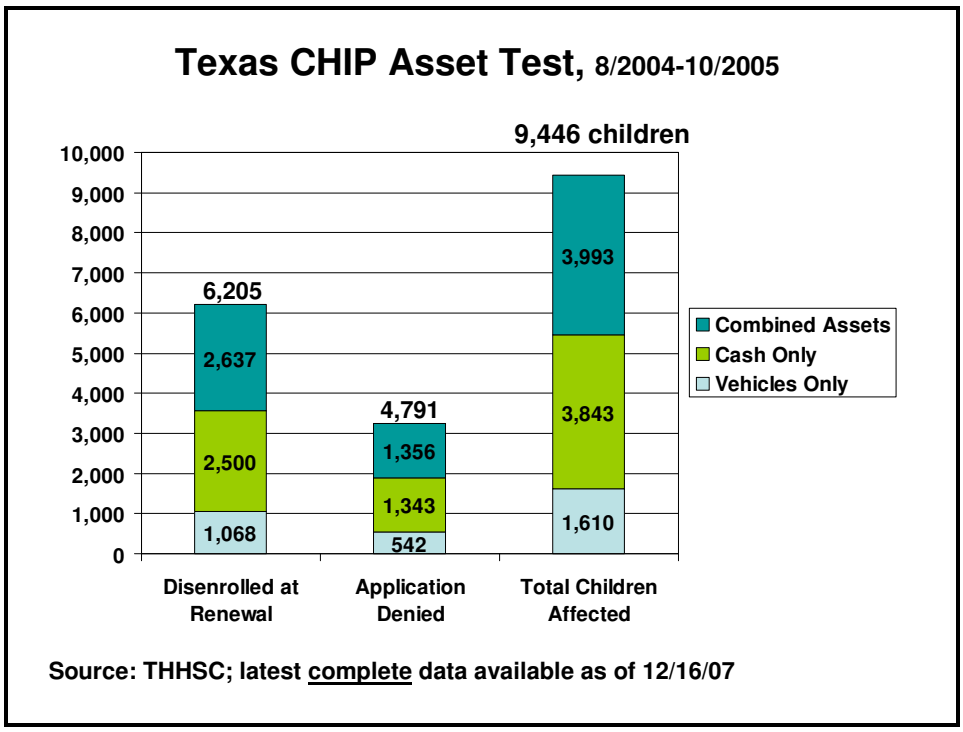


August 2004: New CHIP Asset Test Takes Effect. The addition of an asset test to Texas CHIP was, as previously indicated, not an HHSC initiative, but rather a proposal by the author of HB 2292. By August 2004, CHIP enrollment had dropped below 360,000, and it was clear that the rolls for the 2004-2005 budget period would be significantly lower than the targets in the 2-year state budget. Given that savings targets were already assured, children's advocates strongly urged that HHSC not implement an asset test at all, since the asset limit was permitted, but not required, by HB 2292.

Problems with Texas CHIP Assets Test. In addition, advocates were critical of the specific asset limit of $5,000 that HHSC proposed for children in families above 150% of the FPL, which was essentially a slightly modified version of the Texas Food Stamp asset limits. The Food Stamp policy is inappropriate for these families for several reasons. First, though the technical upper limit for Food Stamp participation is 130% of the FPL, the U.S. Department of Agriculture reports that 90% of Food Stamp recipients are below 100% of poverty. Thus, HHSC imposed a resource limit designed for below-poverty families on a population above 150% of poverty.

Second, the Food Stamp/CHIP asset limit policy exempts only $15,000 of the value of a family's first vehicle, and then counts any value in excess of $4,650 of additional vehicles toward the $5,000 total limit (which also includes any cash in checking or savings). A vehicle may only be exempted if it is actually used for a parent's job, like a vehicle used to transport the tools of the trade to each job site—just needing the vehicle to get to a job does not qualify for exemption. The policy contradicts the goals of building family self-sufficiency, prosperity, and reaching the middle class through asset development.

The Center for Public Policy Priorities strongly recommended in 2004 that HHSC not implement the optional asset test at all. But, if the agency chose to do so over the objections of advocates, CPPP recommended that the policy be revised to (1) at least double the allowed asset total to $10,000 to reflect the higher-income population to which it was applied, (2) exempt one vehicle entirely, and (3) exempt a second vehicle in two-parent families. These revisions were not adopted, however.



Also, under HHSC policy vehicle-value "assets" are counted based on the market value of a car, regardless of whether the parents actually have any equity in the vehicle (e.g., when parents are buying a car on credit). This means children can be denied CHIP for a car that is, by normal accounting standards, not an asset at all, but a pure liability (this policy remains unchanged in the revised 2007 policies described below).

Children Denied CHIP Due to Asset Test. Only a very limited amount of data on the CHIP asset test has been reported by HHSC due to systems problems related to the November 2005 transition from the original CHIP contractor to the current contractor. However, data on the impact of the first 15 months of the asset test (August 2004 to October 2005) are available. As the graphic above shows, over that period, 9,446 children were denied CHIP at application or renewal time due to the assets limit. Not surprisingly, the largest group of children (42%) was denied coverage due to a combination of cash and vehicle assets, followed closely by those disqualified due to cash savings alone (41%). Vehicle values contribute to 60% of total denials, but only 17% were due to vehicles alone. The asset test accounted for about 7% of all denials at renewal during this period. It is not known what proportion of total applications received the 4,791 denials comprised, since HHSC does not currently[29] report total application volume.

HHSC has also released just four months of more recent denial data, and hopes to eventually reconstruct the rest of the 2006 and 2007 data and resume regular reporting of asset denials. From November 2006 to February 2007 an average of 500-600 children per month were denied CHIP due to assets.

Unknowns Re: Asset Test. Another factor that cannot be assessed with the current data is the extent to which the "hassle factor" related to reporting assets added to these numbers. For example, application instructions do not make it clear that reporting the make, model, and year of a vehicle is not sufficient; parents must also provide the "style code" which can greatly affect the market value of a vehicle. As a result, large numbers of missing information requests were sent back to parents applying or renewing coverage. The extent to which more parents now fail to complete applications because of the asset questions is also unknown; HHSC's initial CHIP research revealed that parents perceived asset questions as far more intrusive

[29] HHSC has been asked to report both Medicaid and CHIP application processing volumes, and agency analysts have indicated that at some point these data will be regularly reported and posted to the HHSC web site.

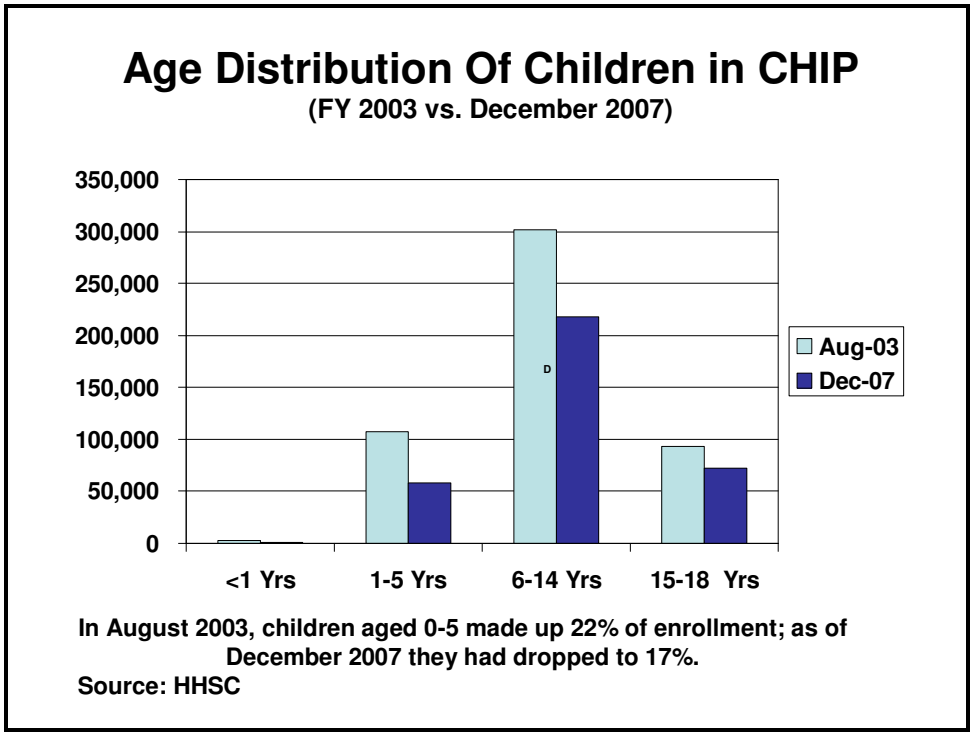
than those related to income, which they saw as fair and reasonable. Program statistics alone cannot capture the reasons why parents fail to complete an application, or respond to a request for additional information.

2007 Law Increases Asset Limits. As the summary on page 6 notes, HB 109 of the 80th Texas Legislature increased the asset limit for CHIP families above 150% FPL to $10,000, along with increased allowances for vehicle values within that cap. While reliable data on the effect on asset denials have not yet been released by HHSC, the agency reports that preliminary data suggest that asset denials have dropped quite substantially since implementation in September 2007.

2003-2006: Changes in Outreach, Application Assistance, and Marketing Policy and Spending. Much of Texas' early success in creating a robust CHIP program was due to the strong performance of community-based outreach and application assistance under contract with HHSC, coordinated with professional marketing of CHIP and children's Medicaid. In 2002-2003, community-based organization (CBO) outreach was funded at $6.1 million, and direct marketing at $3.8 million. In contrast, between September 2003 and May 2006, CHIP and children's Medicaid marketing and outreach were dramatically reduced. CBOs were no longer paid to assist new applicants (only renewals), and the marketing visibility of the program dwindled. Additionally, HHSC officials did not use their outreach resources to enlist CBOs, health plans, or public service advertisers to educate parents about the changes to CHIP in 2003 or in 2005, or to encourage parents to retain their children's coverage.

During this period, Texas' largest cities (Austin, Dallas, Houston, and San Antonio) were home to coalitions of groups whose missions and non-HHSC resources allowed them to continue strong local outreach and application assistance efforts. The impact of their efforts is reflected in some of the age and location trends discussed below.

CHIP Age Distribution Changes Since 2003: Fewer Pre-School Children Covered Today. HHSC data track the age distribution of Texas children enrolled in CHIP. Since the sweeping program changes of 2003, one notable impact has been a significant decline in the proportion of pre-school children enrolled. In August 2003 (the last month before the changes), 22% of children enrolled were under the age of 6. By December 2007, that age group had declined to just 17% of children, including just 824 infants under age one. The pre-school decline may be due in part to the fact that back-to-school enrollment efforts were such an important part of the surviving outreach during the period of outreach inactivity by the state. In addition, the loss of deductions for child care may have discouraged enrollment by parents of infants and toddlers. Of course, the 90-day delay in coverage also reduced infant enrollment, since parents who applied for their babies had to wait at least 3 months before coverage took effect. In September 2007, the 90-day delay was eliminated under HB 109. The graphic below illustrates the change in age distribution of CHIP children from August 2003 to December 2007.



Geographical Impact of CHIP Decline: Rural Texas Kids Hit Hardest. HHSC data comparing CHIP enrollment in September 2003 with December 2006 reveal a starkly larger average decline in CHIP in rural Texas. The largest cities have had much smaller proportional declines than Texas' smaller cities and rural areas. County-level declines are even more extreme, with 122 rural counties experiencing declines over 50%, and 48 of these losing 60% or more of CHIP enrollment (see Appendix C).

The lower impact in urban Texas is likely due in part to the strong outreach collaborations that persisted in the big cities during the period of little marketing and outreach from September 2003 to May 2006. To illustrate the impact of the different rates, had the rest of Texas experienced the lower level of decline seen in the big cities, about 20,000 more children would be enrolled in CHIP today.

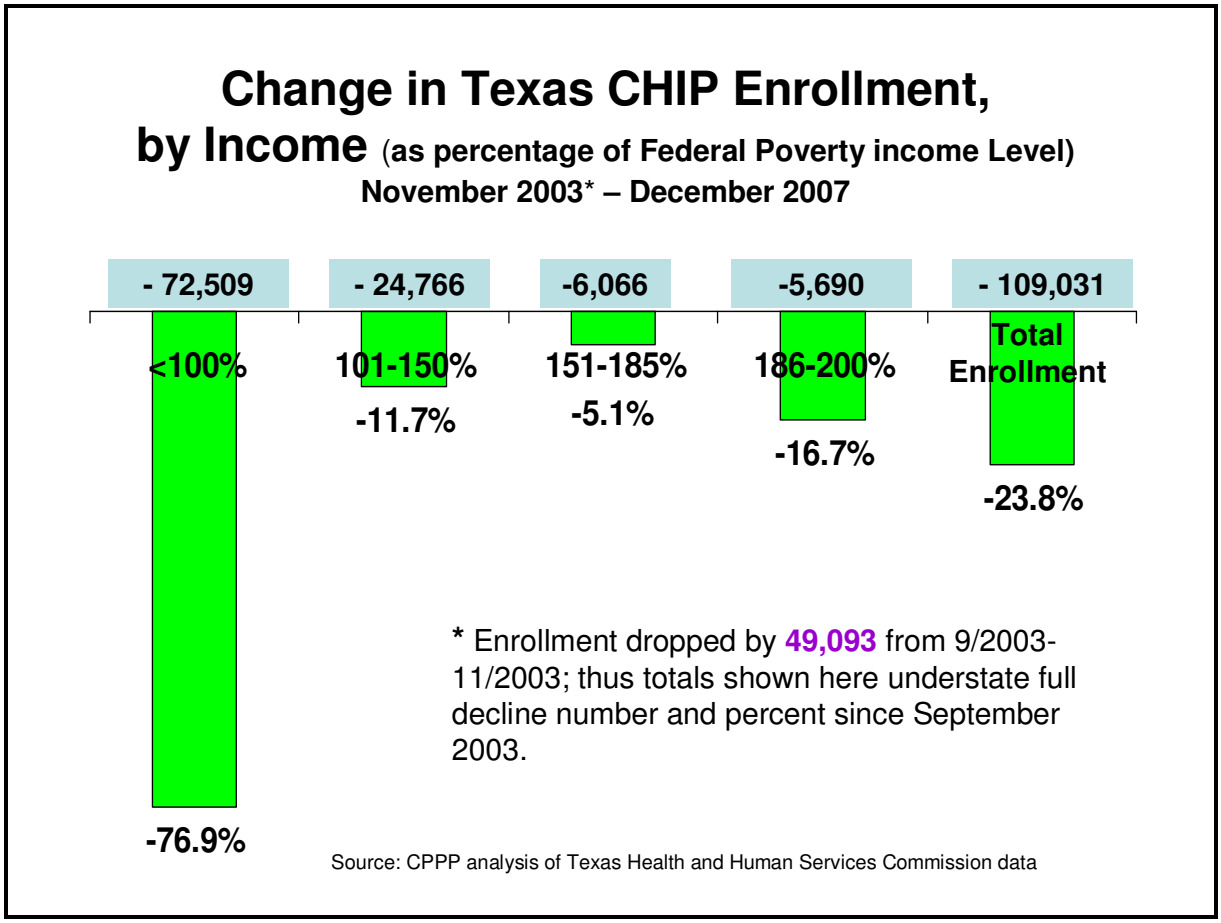
Texas CHIP Enrollment by Service Area, September 2003 and December 2006
Source: Texas Health and Human Services Commission

CHIP Service Area	Sept. 2003	Dec. 2006	Decline	% Decline
1 Amarillo-Lubbock	13,541	6,639	-6,902	**-51.0%**
2 Dallas-Fort Worth	100,654	73,745	-26,909	**-26.7%**
5 Austin	25,038	17,011	-8,027	**-32.1%**
6 Houston	137,639	93,219	-44,420	**-32.3%**
7 San Antonio	38,060	25,810	-12,250	**-32.2%**
8 Corpus Christi	18,332	10,349	-7,983	**-43.5%**
10 Laredo	10,080	5,869	-4,211	**-41.8%**
11 El Paso	22,216	13,842	-8,374	**-37.7%**
Total EPO[30]	141,699	79,747	-61,952	**-43.7%**
Statewide Total	**507,259**	**326,231**	**-181,028**	**-35.7%**

Update: As of December 2007, with 4 months of the initial impact of HB 109 having increased CHIP enrollment by nearly 49,000, the disparity between urban and rural Texas remains high, with Dallas-Fort

[30] Exclusive Provider Organization. All areas of Texas not served in one of the large areas listed above are served by the EPO. All EPO regions have had CHIP declines significantly worse than the state average. See HHSC web site for a map of service areas: http://www.hhsc.state.tx.us/chip/families/County_Map_090106.pdf .

Worth enrollment just 18% below the September 2003 benchmark, compared to 45.6% below in the Corpus Christi area, Amarillo-Lubbock at 42.5% below, and the rural EPO counties 42.4% below.

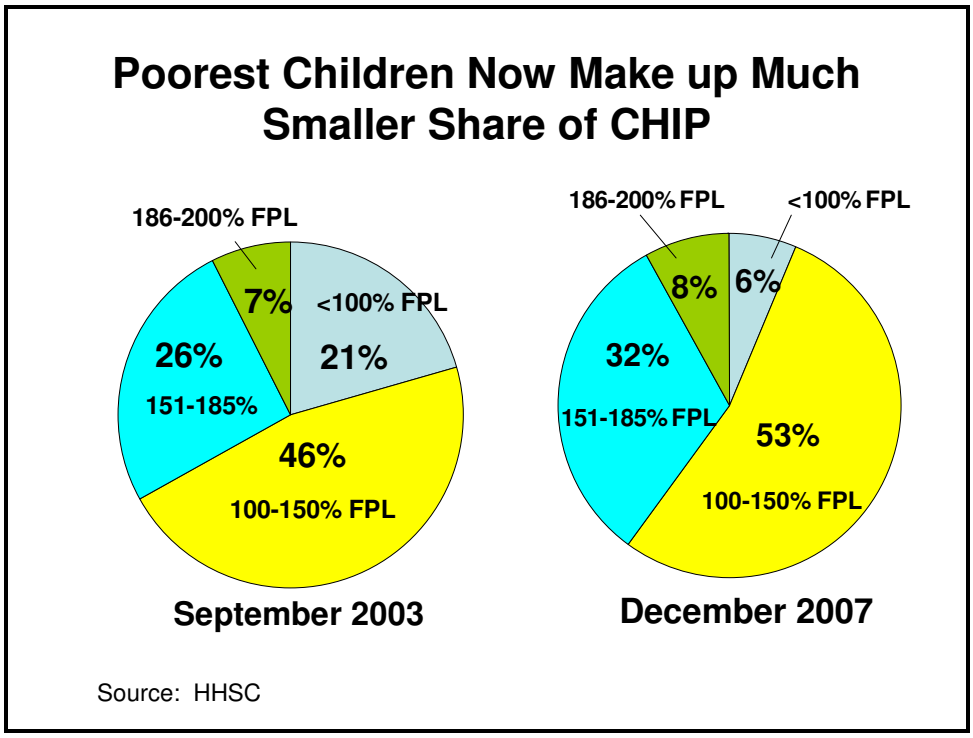


CHIP Income Distribution: Dramatic Drop Among Children with Lowest Family Incomes. The elimination of income disregards in CHIP was applied to all enrollees effective November 2003. This had the effect of "shifting" many children from one category to a higher category (and "shifted" about 17,000 children out of CHIP that month). For this reason, it is necessary to use November 2003 as a benchmark for comparing how the income distribution in CHIP has continued to change after that one-time shift. The change from November 2003 to the present is "real," that is, it resulted from factors other than the income disregard change.

State CHIP officials reported that renewal rates among the lowest-income CHIP families—those below 100% of the FPL—had always been lower than other CHIP families, and after the 2003 policy changes those rates dropped further. This was somewhat perplexing, since the below-poverty group was not subject to the increased premiums that challenged children in the 100-150% of the FPL family group. Increased co-payments and decreased benefits, coupled with the absence of an offsetting outreach message from the state, appear to have been especially disruptive for the lowest-income children.

As the graph above shows, all CHIP income groups have declined since November 2003, but the below-poverty group saw by far the largest decline (-72,509), a 76.9% drop within that category, and accounting for more than two-thirds of the total decline in CHIP. The decline within the 100-150% of the FPL group—where enrollment was and still is concentrated, and which appears to have grown the most in the first months of HB 109 implementation—is a lower percentage (11.7%), but accounts for 22.7% of the total drop in CHIP rolls. In contrast, the groups above 150% of the FPL have seen relatively low declines (5.1% and 16.7% respectively), and have accounted for less than 22% of the total drop in children covered. As a result,

the income mix in CHIP today looks quite different, as the graph below demonstrates, with just 6% of CHIP children below 100% of the federal poverty level today, compared to 21% in September 2003.



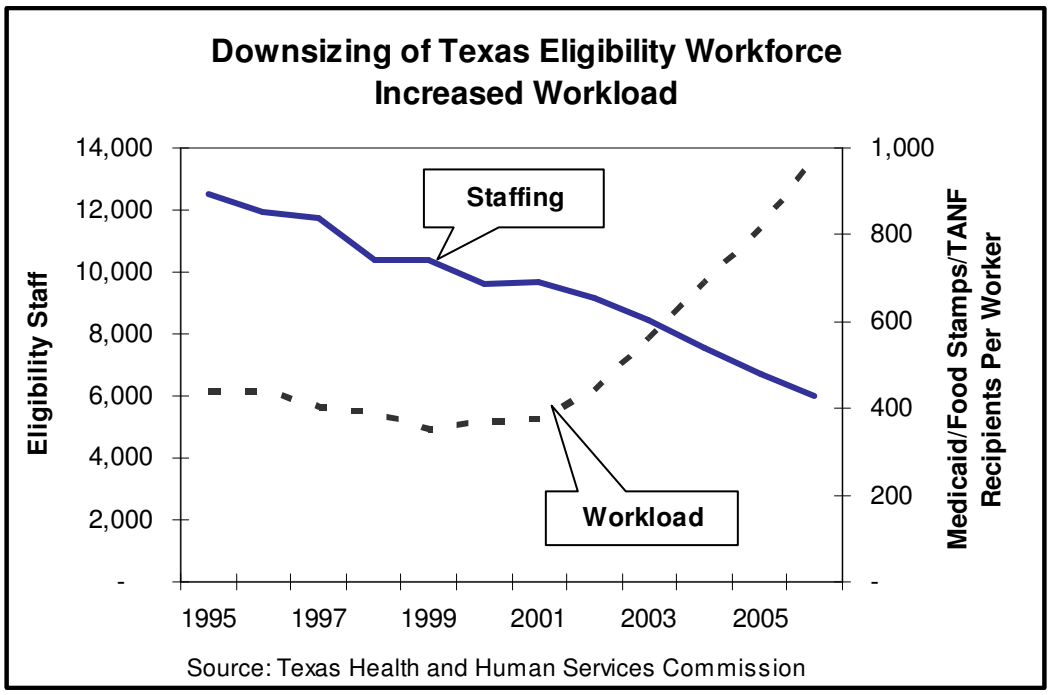
May 2005: Legislature Approves Funding Intended to Result in CHIP Growth. The 79th Texas Legislature passed a budget that included funds to allow the CHIP rolls to grow to at least 345,000 in 2006 and over 351,000 in 2007. They even added a provision directing HHSC to ask for more money if CHIP enrollment exceeded these targets, rather than capping the program or otherwise cutting back. Legislators approved a premium and enrollment fee policy that was more affordable than the one they adopted in 2003, and restored vision, dental, and mental health coverage back to pre-2003 levels. Children's Medicaid rolls were assumed to continue the same slow but uninterrupted growth they had experienced since 2000. Legislators went home in June 2005 assuming all was on track for at least a partial recovery of the CHIP program.

CHIP Rolls Decline Faster, Abrupt Children's Medicaid Decline Begins. Those expectations did not materialize. A look at children's Medicaid and CHIP monthly enrollment reveals an abrupt change in January 2006. Though CHIP rolls had declined every month since September 2003, in 2006 the rate of monthly decline more than tripled, compared to 2005. Children's Medicaid had grown steadily since 1999, though the initial rapid growth in 2002 and 2003 associated with the removal of red tape barriers had moderated to a slow steady growth more reflective of population growth. Medicaid had not experienced more than 2 consecutive months of declining child enrollment since the days of welfare reform, when parents leaving welfare were not told that their children could still receive Medicaid coverage. In 2006, children's Medicaid rolls declined for 7 out of 12 months.[31] Children covered in November 2006 were more than 82,000 below the December 2005 caseload, a decline of 4.5%.

What happened? Unfortunately, the answer is not a simple one. This report summarizes significant issues which have not only caused recent accelerated declines in CHIP, but also declines in children's Medicaid of a magnitude not seen since the wake of welfare reform a decade ago. In the interest of brevity, the key problems that have taken a toll on Texas CHIP and children's Medicaid in late 2005 and in 2006, in rough chronological order of their onset (many have not been fully resolved and persist to the present) include:

[31] See Appendix B.

- **June 2005:** Legislature approved new CHIP premiums and benefit restorations scheduled for January 2006, but no outreach or education for CHIP families was conducted by HHSC in advance, nor were CHIP health plans or contracted CBOs advised of plans or engaged in outreach.
- **Fall 2005:** State staffing shortages in HHSC eligibility offices hit critical levels, due to prior anticipation of Integrated Eligibility job losses and the October 2005 announcement of positions to be eliminated.
- **November 2005:** Transition from original private CHIP eligibility contractor to the new contractor that was in charge of the entire Integrated Eligibility project.
- **November 2005-January 2006:** HHSC imposed a range of CHIP policy and processing changes which complicated the contractor transition, materially changed the process for parents, but which were implemented without any prior outreach or education for CHIP families, and without advance consultation with CHIP health plans or contracted CBOs.
- **December 2005:** Operations by the new CHIP/Integrated Eligibility contractor were riddled with errors due to multiple problems and failures of various contractor computer systems, and heavy reliance on untrained entry-level private workers.
- **January 2006:** The same problems with the new contractor also created problems for Medicaid clients of all ages in Travis and Hays counties, where Integrated Eligibility is first piloted. These problems were compounded by continued problems with TIERS, the computer system the state has been developing for years to support Integrated Eligibility.



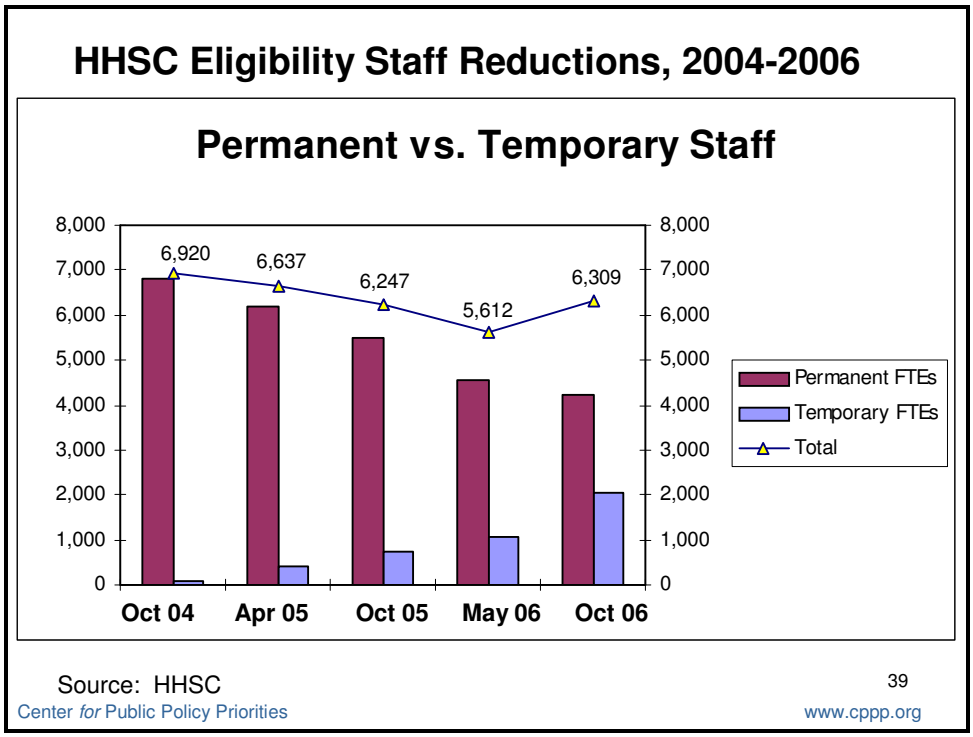
The multi-layered sources of these troubles meant that fixing the ongoing eligibility system woes will also require a multi-faceted approach. Readers may refer to Appendix A for links to more detailed analyses of these recent eligibility problems. Some additional detail is provided below on key issues that will require resolution if Texas Medicaid and CHIP eligibility systems are to regain competent and reliable functionality.

Inadequate Numbers of State Eligibility Staff. As described earlier (and shown in the graph above), the Texas Legislature has reduced eligibility staff repeatedly over the last decade, despite growing caseloads and without any major improvements in automation to reduce work for staff. As a result, by October 2004, staff had dropped to about 6,900, compared to almost 12,500 in 1995. At the same time, the number of clients per worker had grown from about 430 per worker in 1995 to over 800 per worker in 2005.[32]

[32] For detailed HHSC data, see http://www.hhsc.state.tx.us/news/presentations/IEE_HAC041706.pps .

When HHSC took over eligibility systems from their historical home at DHS, and career eligibility staff faced the conversion to a call center approach and likely privatization of major functions directed by HB 2292, staff levels were already perilously low. After HHSC's October 2005 announcement of which workers could eventually expect to lose their jobs, retirement incentives and the expectation of even more massive downsizing resulted in higher than expected worker attrition. From April 2005 to May 2006, staff dropped by more than 1,000 workers. By fall 2006, one-third of workers were temporary staff whose training and productivity could not match that of the tenured staff lost over the previous 2 years. Moreover, workload per worker in 2006 was still over 900 recipients per worker.

Out-stationed Workers in Health Care Facilities. The state eligibility staff counts reported here include "slots" for "out-stationed" eligibility workers (OEWs) who are required by federal law to be placed in certain hospitals (disproportionate share reimbursement, or "DSH" hospitals) as well as community health centers known as Federally Qualified Health Centers (FQHCs). Of 674 positions reported in December 2007, 106 are dedicated to nursing home eligibility, 32 are in FQHCs, and the remainder perform general Medicaid eligibility for hospitals. About 15% of the slots are vacant, so there may be only about 575 out-stationed workers at the present.



Texas is home to 55 FQHCs (and similar centers) that operate 306 different health care delivery sites. Currently, the state's 50% share of most Texas OEWs' salaries is paid by the hosting hospital or FQHC, but those facilities are allowed no voice in directing those workers' activities. Hospitals and Community Health Centers have advocated for a number of years for a change in this policy, and in particular, have requested that OEWs in their facilities be authorized to assist their patients with Medicaid renewals, not just new applications. Providers have reported that HHSC recently has required their OEWs to assist in processing backlogs of renewal forms from local HHSC offices, yet still has not authorized those workers to routinely assist their own patients with renewal processing.

Why Children's Medicaid Rolls Dropped. Medicaid rolls for children dropped as the result of several factors. First, inadequate state staffing levels produced long delays in processing new applications as well as renewals. This resulted in a recurrence of automated closures of cases, despite parents having returned all

required information. These problems persist, with state "timeliness" ratings well below the minimum standards required under federal law.[33]

Confusion over the transition to the new Integrated Eligibility system also resulted in some long delays in processing early in 2006, because HHSC had announced that the contractor would process all new children's Medicaid applications. Even though HHSC reversed that decision early in the year, for several months workers in some parts of the state continued to instruct parents to send their applications to the contractor, causing many to be delayed or even lost entirely.

Finally, even if Medicaid applications had not been misdirected to the contractor, the CHIP (and Integrated Eligibility) contractor would still have had a major impact on children's Medicaid enrollment because the contractor: 1) processes many new Medicaid applications and 2) is responsible for moving children from CHIP to Medicaid every month.

Since 2002, parents have been able to submit a mail-in application for either Children's Medicaid or CHIP to the CHIP contractor. If the child is eligible for Medicaid, the application is referred to a state worker for completion, and the child is supposed to be enrolled without delay and with only minimal additional steps for the parents. Since the creation of CHIP, there have been two ways for children to enter Texas Medicaid: through the HHSC state-operated eligibility system, or through the CHIP contractor's "joint application" process. Thus, the same problems that disrupted CHIP enrollment and renewals also disrupted those flows into children's Medicaid, as evidenced by the fact that the Medicaid decline did not begin until the transfer of the CHIP contract.

2005-2006 Changes in Texas Children's Medicaid Enrollment

	December 2005 enrollment	November 2006 enrollment	Change, Dec. 2005 to Nov. 2006	
State total	**1,838,239**	**1,755,715**	**-82,524**	**-4.5%**
Bexar	139,682	135,320	-4,362	-3.1%
Cameron	64,339	63,089	-1,250	-1.9%
Dallas	182,954	175,965	-6,989	-3.8%
El Paso	98,319	91,905	-6,414	-6.5%
Harris	316,896	296,459	-20,437	-6.4%
Hays	4,953	5,384	431	8.7%
Hidalgo	122,325	122,937	612	0.5%
Tarrant	97,908	93,467	-4,441	-4.5%
Travis	52,667	51,519	-1,148	-2.2%
Webb	36,473	33,893	-2,580	-7.1%

Source: HHSC

Special problems plagued Travis and Hays counties in the first 6 months of 2006, since the Integrated Eligibility contractor was in charge of both CHIP and Medicaid processing in those two counties alone. In May 2006, the children's Medicaid decline in the pilot counties was more than three to four times the statewide decline, and in response HHSC focused extra staff resources to correct the localized problems there. By November 2006, the decline in the Integrated Eligibility pilot counties was below the state average.

HHSC Imposes CHIP Policy Changes at Same Time as Contractor Transition. HHSC chose to make CHIP policy and processing changes in January 2006, which contributed to the accelerated CHIP decline in 2006. First, HHSC implemented the new enrollment fees without first doing outreach and education for parents, though the program had collected no fees since August 2004. Technical polices regarding how household members and income are counted were changed. Simultaneously, and also without prior outreach, HHSC eliminated "EZ renewal" for CHIP, just as it had done in October 2004 for children's Medicaid. HHSC also imposed third-party "data broker" checks on income and resource information, to verify the

[33] See HHSC web site: http://www.hhsc.state.tx.us/research/FMTtimeliness.html .

documentation provided by families, but did not build any additional time into the process for parents or for contractor staff.

Unlike the 2004 data broker implementation for children's Medicaid, the data broker checks were now being attempted by low-paid, untrained contractor staff who did not have an accurate grasp of CHIP or Medicaid eligibility policy. Between the contractor's technical problems and unqualified staff, the new policies—which might have been expected to create some delays simply because parents were not used to them—were also not applied accurately. HHSC's own independent evaluator found that CHIP parents reported dramatically higher rates of being asked for missing information than Medicaid parents. This was consistent with complaints that contractor staff were requesting information that was irrelevant to children's cases, as well as requesting the same information repeatedly even though parents had already submitted it. Advocates and legislators' offices have been inundated with requests for help from families whose children lost coverage even though the parents submitted—often multiple times—all the required information and their children were fully eligible for benefits.[34]

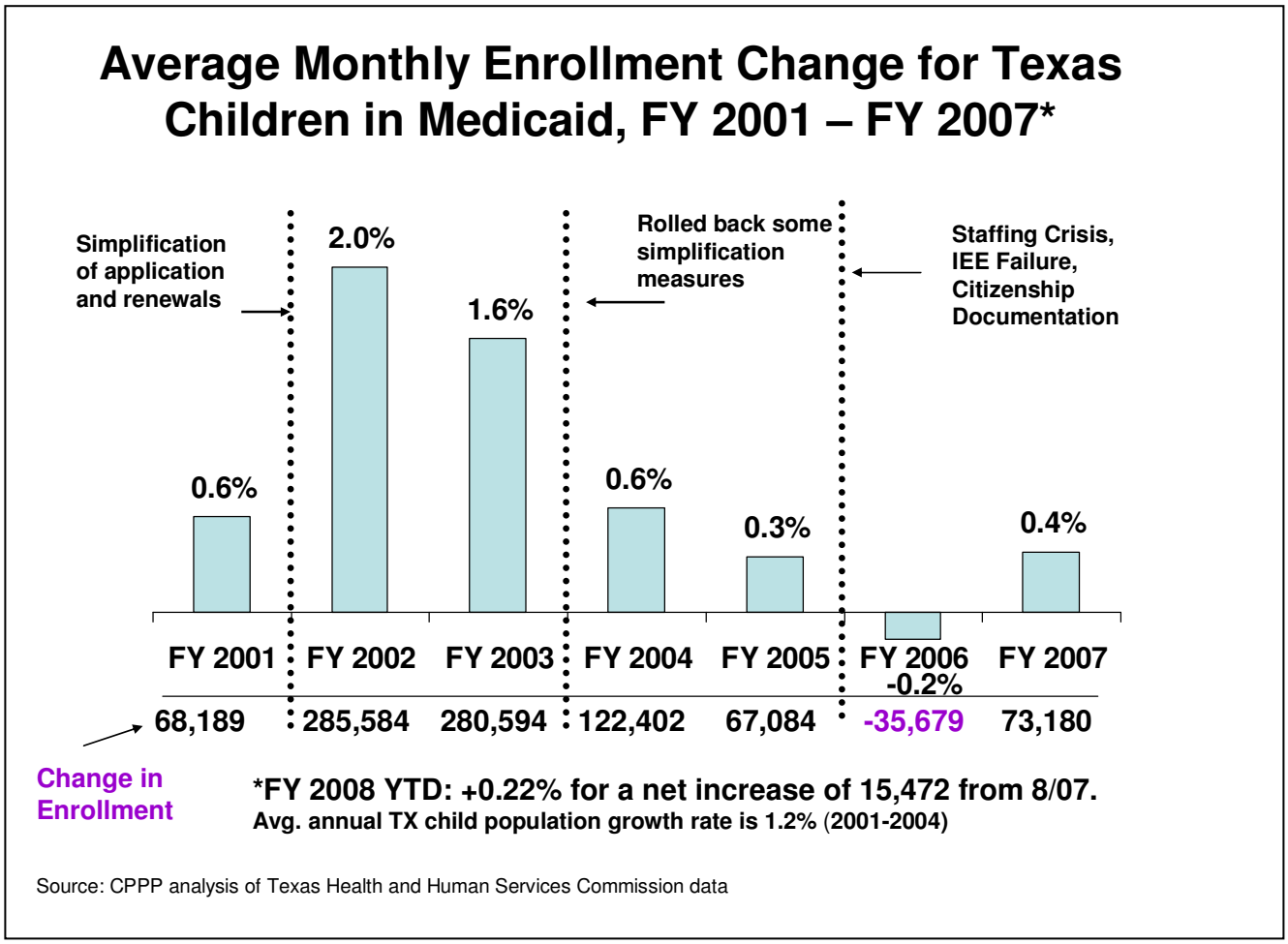
A special concern of advocates was that contractor staff were demanding information that would not affect a particular child's eligibility for Medicaid or CHIP and delaying eligibility because the irrelevant information had not been supplied. This occurred not only because the untrained staff did not understand the different program requirements, but also because the contractor and HHSC had agreed on this approach. Essentially, the unskilled workers were collecting all the information that could theoretically be needed for either Medicaid or CHIP (and in some cases even asking for Food Stamp requirements as well), rather than zeroing in only on the information necessary for each child's case. The latter approach had been the long-standing policy both for HHSC staff and for the former private CHIP contractor. This is probably the reason for the higher rates of missing information ICHP (Institute for Child Health Policy of the University of Florida, HHSC's independent evaluator) found among the CHIP children compared to Medicaid.

Did the CHIP Rolls Drop because the Children Moved to Medicaid? A frequent question since 2003 has been whether the CHIP declines were simply a reflection of family incomes dropping and children moving to Medicaid. However, both HHSC's enrollment data and repeated analyses by ICHP show that this is simply not true. First, Texas children's Medicaid enrollment growth rates dropped considerably since 2003; whereas if transfers to Medicaid from CHIP had increased, the child Medicaid growth rate would also have increased. Second, HHSC's own internal analysis of children leaving CHIP showed no increase (and possibly a decrease) in transfers to Medicaid in fiscal year 2004 when the CHIP cuts rolled out.

Additionally, ICHP's December 2004 report on children who left CHIP found that found 52% of kids leaving CHIP remained uninsured. Of the 47% who got coverage later, 31% went to Medicaid and only 11% got employer-sponsored insurance. New ICHP studies of children losing CHIP or children's Medicaid in 2006 found that ***only 28%*** of kids who lost CHIP (and 24% of kids losing Medicaid) had any kind of health coverage afterwards, and only 19% (i.e., about two-thirds of the 28%) moved to Medicaid.[35]

[34] See Appendix A, *In Harm's Way: True Stories of Uninsured Texas Children*, Houston, Texas, Children's Defense Fund Texas, March 2007, a report on Texas children's problems with the CHIP and children's Medicaid eligibility system.

[35] Institute for Child Health Policy of the University of Florida. http://www.hhsc.state.tx.us/chip/chip_pubs.asp .



2006 HHSC Actions to Improve Eligibility Performance. HHSC took several steps to address the problems with the public and private components of the eligibility system. As mentioned, state staffing levels, while quite low, by January 2007 were some 500 workers higher than at their May 2006 low. Roll-out of Integrated Eligibility was temporarily halted, and ultimately the state elected to terminate the contract. The state has once again allocated a modest amount of funds for CHIP and children's Medicaid marketing, and will pay CBOs to provide outreach and application assistance (though at far lower funding levels than in earlier years).

HHSC has clarified that when parents neglect to check a box on a form, in most cases the missing answer can be reported over the phone, rather than through a protracted sequence of mail requests for additional documents.[36] In May 2006, HHSC also initiated special policies designed to compensate to some degree for the unresolved problems in the contractor's CHIP processing, including extending the time for receiving and recording renewal forms and enrollment fees, accepting reporting of more missing information by phone, and accepting some data broker information in lieu of hard copy documents. In December 2006 HHSC announced a major scaling-back of its contract with the private company performing enrollment, and in March 2007, the agency announced termination of the contract, with CHIP duties to be assumed by a subcontractor.

July 2006: Congress Adds a New Challenge in Medicaid Citizenship Document Policy. The federal "DRA" budget bill approved early in 2006 imposed a new requirement that state Medicaid programs require more documents from U.S. citizens to prove their status (the limited number of legal immigrants who qualify for Medicaid already had to provide their immigration documents to enroll). Since relatively few Americans

[36] Such apparently "simple" fixes have required significant re-tooling for the contractor, since many contract employees were literally not empowered or equipped to make outgoing phone calls.

have a passport, most Medicaid enrollees must now provide a birth certificate along with identity documents to satisfy the new requirement. And, though most U.S. children have had a birth certificate issued in their name, children almost never possess any form of official identity document, either with or without a photograph. For children or adults born in another state, getting a birth certificate from their home state can be challenging, as prices range from $5-$23, and online services typically require a credit card for payment—something that most poor and low-income parents lack. Because of these red tape issues, state Medicaid directors and health care advocates alike anticipated that the new requirement could result in significant numbers of eligible U.S. citizens being denied Medicaid to which they were entitled.

Federal Medicaid rules for the new documentation requirement were (and remain) cumbersome and far more complex than the statute required. However, Texas HHSC's process directives to eligibility staff were designed to minimize hassle and delays in processing for clients. For example, the Texas policy emphasizes that the combined CHIP-children's Medicaid application doubles as a sworn affidavit of identity for the children applying, so that completing an extra form is not required. It also reminds staff that they should be checking the Texas Bureau of Vital Statistics database to verify birth certificates for Texas-born children who lack a hard copy. Texas policy also clarifies that enrollment of newborns (i.e., born in Texas hospitals) should not be delayed while the parents wait for a birth certificate to be issued. There are also provisions designed to prevent delays in enrolling pregnant women in prenatal care.

How Citizenship Document Requirement Affects U.S. Citizens. In a recent national survey of state Medicaid directors, most of these state officials identified the citizenship documentation requirement as the number one reason for recent declines in enrollment in their states. Almost 75% of states reported that the new requirements have slowed enrollment growth, and 45 states reported increased administrative costs due to the policy. States also said that the new requirements cause delays in applications and renewals, and that in most cases these delays are for U.S. citizens eligible for Medicaid.[37]

Several states have also reported that their new documentation requirement has primarily denied Medicaid to Anglo and African-American Medicaid clients and applicants. Alabama, Kansas, and Virginia have reported substantially higher impact on enrollment of these populations, while Hispanic enrollees experienced dramatically lower denial rates, and even positive enrollment growth while other ethnicities were seeing declines in caseload.[38] Interviews with families indicated that Hispanic parents, being more accustomed to having their citizenship questioned, were in the habit of keeping identity and birth certificate documents close at hand, while Anglo and African-American parents were not.

Texas Impact of Citizenship Documentation. The Texas HHSC approach was expected to reduce the impact of the DRA citizenship documentation provision on U.S. citizens, and there are some indications that in fact Texas Medicaid enrollment may have suffered less than some other states. Still, in the first 13 months since the requirement took effect in July 2006, over 35,000 Medicaid applications and renewals were denied because of the new policy, most of them children. For example, over 2,300 newborns were denied coverage which points strongly to incorrect denials, since infants born in Texas should all possess the documents needed to prove citizenship (i.e., proof of birth in a Texas hospital). Preliminary analysis of Texas Medicaid enrollment and denial data by ethnicity seem to reflect other states' findings that Hispanic enrollment has been much less affected by the requirement than have the Anglo and African-American groups.

The significant numbers of denials suggest that several factors are at work in denying U.S. citizens coverage. First, some eligibility workers are not applying the Texas policy correctly—a very real possibility given the limited time for training due to very low staffing levels, and the fact that so many workers are still either temporary or very newly trained. Training issues are such a concern that HHSC analysts believe that the denial rates reported are not fully reliable, as some workers have confused the code for citizenship

[37] *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007,* Kaiser Commission on Medicaid and the Uninsured, October 2007, http://www.kff.org/medicaid/7699.cfm

[38] *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants*; Center on Budget and Policy Priorities, July 10, 2007, http://www.cbpp.org/7-10-07health.htm .

documentation with the long-standing code for being an ineligible non-citizen. HHSC sent clarifying guidance to the eligibility field staff in February 2007 in an attempt to both improve assistance to clients and to improve accuracy of making and reporting eligibility decisions. The second factor appears to be that applicants born in other states are simply not getting the help they need to get copies of their birth certificates.

Denials of Texas Medicaid Applications and Renewals for Citizenship Documentation, August 2006 through August 2007

Eligibility Group	March 2006-August 2006		September 2006-February 2007		March 2007-August 2007		Total Denials, March 2006-August 2007	
	Applications	Renewal	Applications	Renewal	Applications	Renewal	Applications	Renewal
Pregnant Women	375 (1.6%)	11 (.0%)	1,559 (6.1%)	270 (.3%)	2,208 (7.8%)	260 (.3%)	4,142 (5.3%)	541 (.2%)
Child < age 1	112 (1.3%)	50 (.2%)	1,008 (7.8%)	231 (.7%)	739 (5.9%)	238 (.8%)	1,859 (5.5%)	519 (.5%)
Child 1-5	464 (1.0%)	114 (.1%)	4,882 (7.5%)	742 (.3%)	2,960 (5.1%)	844 (.4%)	8,306 (5.0%)	1,700 (.3%)
Child 6-18	634 (1.0%)	145 (.1%)	6,685 (7.1%)	691 (.3%)	4,601 (5.5%)	869 (.4%)	11,920 (4.9%)	1,705 (.3%)
Adults (TANF level)	409 (0.5%)	24 (.1%)	1,861 (2.3%)	69 (.3%)	2,071 (2.5%)	74 (.3%)	4,341 (1.8%)	167 (.2%)
Total Denials by Time Period	1,994 (0.9%)	344 (.1%)	15,995 (5.8%)	2,003 (.3%)	12,579 (4.8%)	2,285 (.4%)	**30,568** (4.0%)	**4,632** (.3%)

Source: CPPP analysis of Health and Human Services Commission data. (Percentages are of all denials in the time period.)

December 2006: As 80th Session began, Children's Medicaid and CHIP Not Out of the Woods. As the legislature convened in January 2007, the degree to which the problems that had driven down children's caseloads over the last 12 months were resolved was unclear.

There were hopeful signs in CHIP, which had 3 consecutive months of enrollment growth (in October, November and December 2006) for the first time since 2003. CHIP renewal rates from August 2004 to December 2005 averaged 81%, and while renewals were not clearly recovered, the program had reported renewal rates of 73% or higher since June 2006—after a 5-month run of rates below 57%. CHIP rolls were still 181,000 below the September 2003 benchmark, but had at least risen back to the levels of August and September 2005.

Children's Medicaid enrollment in November 2006 (Medicaid reports tend to lag behind CHIP) remained over 82,000 below December 2005, and the 3 months of declines in the last 6 months outnumbered the increases in the other 3 months. It was not possible to identify a clear trend at that time.

Discouragingly, families continued to report new examples of often outlandish problems with the eligibility systems. For example, in early 2007 the CHIP contractor had still not eliminated system problems that caused families to receive letters with current postage dates warning of CHIP terminations, but which made reference to documentation deadlines that were months in the past, and which called for documents already submitted and/or payments already submitted (and paid by checks which had long since cleared the bank). One of the most damning indicators is that many of these problems are reported by parents of children with special health care needs, who are highly motivated and practiced in carefully submitting all required documents by the proper deadlines, yet their children still lost coverage. In more than one case, children referred by advocates for assistance from HHSC officials to restore coverage due to contractor errors 6 months earlier found themselves once again erroneously terminated at their following 6-month renewal.[39]

[39] See Appendix A: *In Harm's Way: True Stories of Uninsured Texas Children*, Houston, Texas, Children's Defense Fund Texas, March 2007.

2007 Legislature responds to Medicaid and CHIP Woes. The 80th Legislature responded to the well-documented problems with Medicaid and CHIP eligibility in several ways. HB 3575 by Patrick Rose created a Legislative Oversight committee for the HHSC eligibility system and set goals to improve customer service, reduce processing time, and meet federal standards. In addition, Article IX of the 2008-2009 budget includes riders to improve the CHIP and children's Medicaid eligibility process and eliminate barriers, delays and wrongful denials. Two other budget riders (HHSC Sections 54 and 68) authorize HHSC to (1) add eligibility workers as needed to replace contracted workers and (2) increase staff by up to 10% to meet all federal performance standards (accuracy, timeliness).

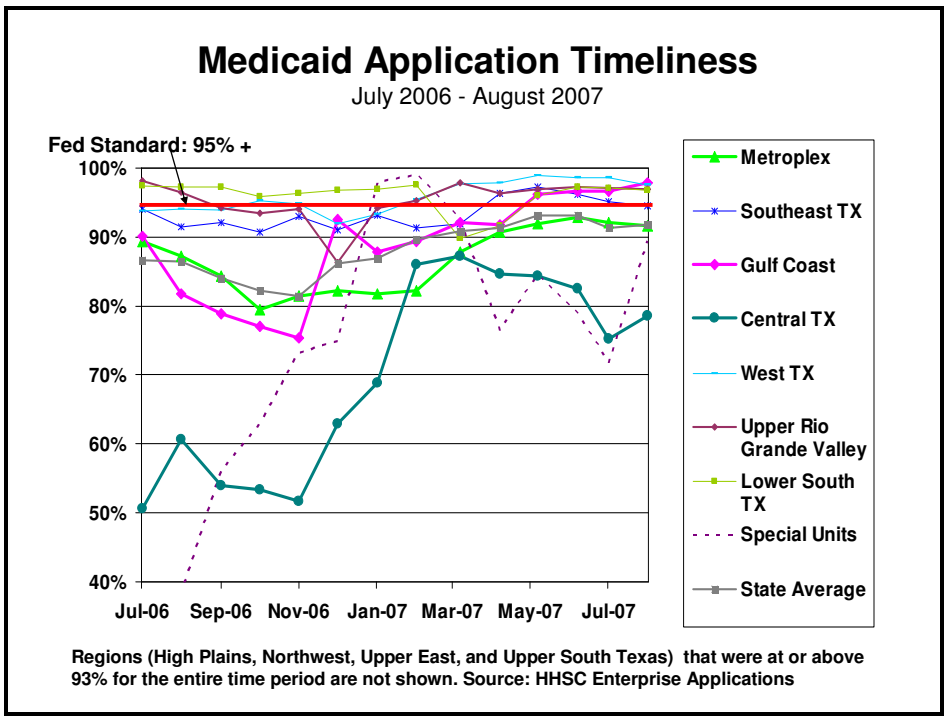
In another major step, the legislature adopted HB 109 by an overwhelming margin, designed to reverse or modify several of the 2003 CHIP policy changes which had caused the dramatic caseload declines that occurred even prior to the eligibility system crises of 2006. Key provisions of the bill (summarized on page 5) were restoring 12-month continuous coverage for CHIP children, eliminating a 90-day delay in all new coverage (in favor of the original crowd-out provisions enacted in 1999), increasing the asset limits for children above 150% FPL, and allowing some deductions for child care expenses.

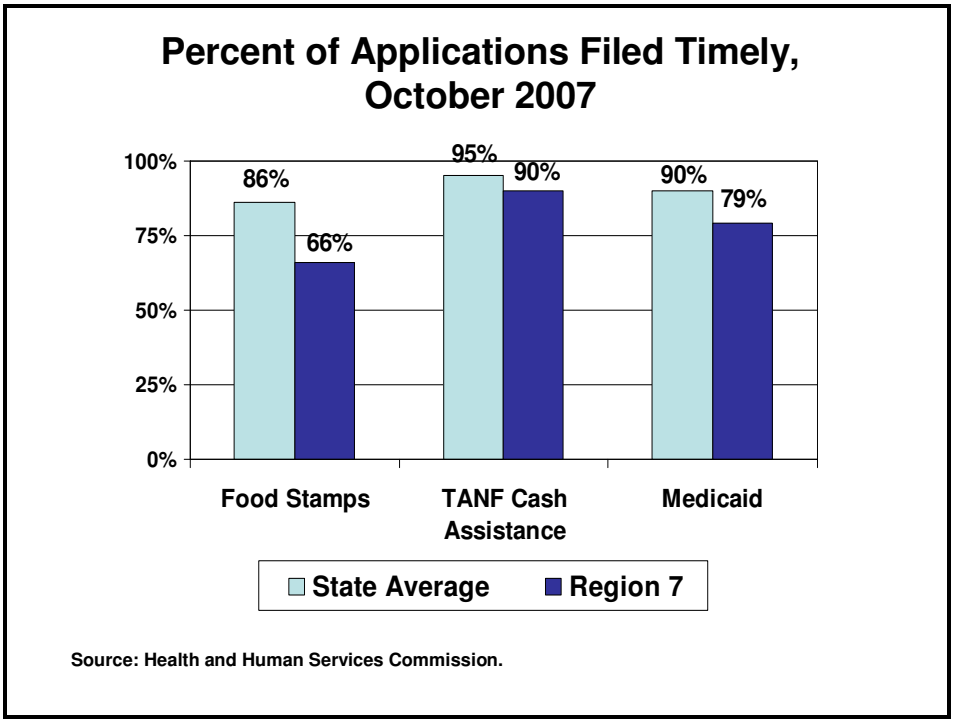
Fall 2007 Staffing Update. Since January 2006, HHSC has converted 2,000 temporary jobs to regular employment status. Still, by the end of fiscal year 2007 the number of total eligibility staff was only slightly higher (1.6%) than it was 2 years before, despite increased demands on the system, and poor performance measures indicating the clear need for more workers. In fiscal 2007, HHSC had a workforce of 6,454 eligibility staff (monthly average), a 7% increase over the fiscal 2006 low, but only a 2% increase over September 2005. HHSC efforts to recruit and retain staff have now brought workers back up from that low point, to 6,339 filled jobs in December 2007. The agency is budgeted to have over 7,100 eligibility workers in 2008. If it succeeds in filling these authorized positions, HHSC still projects a load of over 780 clients per eligibility worker in 2008. Experience and proficiency of workers also affects performance, and about a quarter of eligibility workers now have less than 2 years experience, compared to fewer than 4% in 2004 (when there were also more total workers).

State Auditor Finds TIERS Problems Add to Eligibility Performance Failures. In November 2007, the State Auditor's Office (SAO) released an audit of the TIERS computer system, assessing its problems and current capacity to support eligibility functions. On the positive side, SAO reported that individual case reviews showed that TIERS was processing benefits accurately. However, the auditors also said that TIERS needs significant additional processing capacity and storage to support a statewide rollout. SAO found that TIERS has a number of fundamental design flaws which make it cumbersome for workers to use, increase staffing requirements, slow processing times, and hinder data integrity.

Testing of TIERS has been almost entirely delegated to a contractor, and SAO recommended that HHSC instead perform its own TIERS system testing, so that the agency can ensure that the system is improving with each new "build" (system upgrade or modification). The SAO urged HHSC to improve oversight of TIERS development and implementation, and "take ownership of the change management process." The report observed that the agency had entrusted too much control to Accenture, limiting HHSC's ability to know what was going wrong.

The auditor's report pointed out that time to process applications and renewals ("timeliness") is poor and well below federal standards in the TIERS system, and recommended that HHSC implement internal benchmark and controls to ensure applications processed on time. SAO recommended that HHSC consider "streamlining" application processes (while maintaining program integrity) and suggested a goal of a 4-page application (in contrast to the current 11-page integrated application Form 1010) as an example. **Most critically, the auditor recommended no further TIERS rollout until issues identified by this audit have been fixed.**





"Timeliness" Problem Persists in TIERS. While poor timeliness performance in violation of federal law standards has improved since the worst points in the staffing crisis of 2006 (see graphic above), processing of Medicaid (and Food Stamp) cases in TIERS is still far below standards. This is most apparent in Region 7, where the Travis, Hays and Williamson county populations are all processed in the TIERS system (see graphic above). However, HHSC has acknowledged that the subset of clients across Texas whose cases are processed in TIERS show equally poor timeliness rates when analyzed separately from the SAVERR population.

TIERS Numbers Increasing Rapidly. Though only three counties are fully converted to TIERS, HHSC policies are expanding the number of cases in TIERS rapidly across the state. In addition to the three Region 7 counties, clients in TIERS include: all children in state foster care placements, all clients whose cases were

established in TIERS in Region 7 who later moved to another part of the state, all women enrolled in *or applying for* (i.e., even if denied waiver coverage) the Medicaid Women's Health waiver, and *all adults and children who are enrolled in Medicaid or Food Stamps in SAVERR who are in a household with that waiver enrollee*. Enrolling the last two groups in TIERS (women waiver clients and their family members) has dramatically accelerated the number of Texans across the state in TIERS, as there are nearly 75,000 women enrolled in the waiver as of December 2007. This is creating greater and greater need for TIERS-trained staff, and far more pressure on those staff already trained in the system.

Reports from HHSC eligibility staff dealing with TIERS across Texas echo the SAO findings. Senior staff expert in TIERS report that only after several years of experience are they able to process applications and renewals in an amount of time comparable to the old SAVERR system. While a new case might take 1.5 to 2 hours to complete in SAVERR, under TIERS a typical worker (i.e., one with less than several years of experience) will need 3 to 4 hours to complete the same task. TIERS workers across the state are working not only their local TIERS cases, but also work redistributed from Region 7 and other parts of the state. These workers are being assigned double and triple the normal number of clients to interview by telephone, and often must simply take notes from these interviews and work overtime after normal hours to enter the information in TIERS later, because the system works too slowly to allow them to enter in the short time they have to speak to the client. With only a small proportion of HHSC staff having significant experience with TIERS, and such a high proportion of staff who are novices, the prospects for improving current performance in order to meet federal timeliness standards (45 days to complete Medicaid, 30 days for Food Stamps) are poor unless or until improvements in the technology are made and more staff are available and trained.

November 2007: HHSC Steps to Address Children's Medicaid Backlog Crisis. As of December 2007, community groups assisting families with children's Medicaid and CHIP applications have observed some reduction in errors by the CHIP contractor. However, children's Medicaid cases continue to face serious processing delays, especially (but not exclusively) those in Region 7 and TIERS. Though HHSC has been trying to rebuild staffing in its Austin-based centralized processing unit for children's Medicaid and other units across the state, a significant proportion of cases are still delayed so long that they are not processed until more than 3 months after they are submitted. In such a case, the child has typically been without coverage for at least a month, often 2 or more months. When a worker approves the overdue case, policy demands that the child's coverage be "valid" back to the original date when they submitted their completed application or renewal forms. And, since the coverage period for children is just 6 months, this often means they are "certified" for coverage for 4 months in the past—months when they received no Medicaid ID and lacked access to a Medical Home—and for the current month and perhaps one more month. As a result, they are literally required to "renew" coverage immediately upon notice that the child's case was approved in order to maintain coverage. And, the same delays face those renewal forms once submitted.

Enough cases were caught in this vicious cycle that HHSC elected in November 2007 to create new policies that will provide an extended certification period to children whose cases have been delayed so long, to ensure that they will effectively receive 6 months of actual, future coverage—not theoretical coverage in the past. The policies also clarify that staff are not to re-request information that was submitted with the original application. They are to use this information even if it is now over the 30-day time period, e.g., if a family submits a paycheck stub that is 15 days old when they send in their application, but because of HHSC delays is 75 days old when processed, HHSC staff are directed to process this application using this pay check stub; they are not to request a newer paycheck stub. Staff are also to use third-party data whenever possible to allow them to approve a case without delay or missing information requests.

December 2007: Hopeful Trends, a Long Way to Go for Children's Medicaid and CHIP Rolls. As this report goes to press, enrollment trends for children's Medicaid and CHIP look better than they have since 2003, yet much progress will be needed to transcend the challenges presented by lingering CHIP contractor issues, state staffing levels, and TIERS. From the first implementation of HB 109 in September 2007 with the elimination of the 90-day delay, the more generous asset limit, and the modest child care deductions restored, CHIP enrollment grew by almost 49,000 children as of December.

Because of the way that the new 12-month coverage policy is being applied (children with new applications since August 2007 are enrolled for 12 months, while prior enrollees do not get a 12-month coverage period until their first renewal after August 2007), the enrollment growth seen since August is NOT due to 12-month coverage, but to the changes listed above. Texans should start to see the impact of the 12-month coverage in March 2008, the first month in which the pool of children renewing will be smaller due to 12-month coverage.

Yet to be implemented is the HB 109 provision for "administrative review" of income for children in families with income from 185-200% of the federal poverty level, scheduled to begin on January 31, 2008. HHSC will conduct a 6-month income review for these children (about 8% of CHIP children as of December 2007) using third-party databases wherever possible. One potential pitfall of this new provision could be the process for the segment of Texas working parents in employment situations (such as self-employment or contract labor) for which no wage records will appear in the usual databases searched by the state.[40] At this time it appears that they will be asked to provide new income documentation at 6 months.

HHSC plans to provide a 30-day advance notice of denial for parents to correct an over-200% FPL finding at the 6-month income check, or to seek other health insurance coverage before disenrollment. That time frame for all CHIP children facing denial (i.e. not just the 185-200% kids at 6-month review). Every child will now get a "renewal outcome letter," and for this reason, renewal packets will be mailed in month 9 of 12, rather than month 10 as was the case before CHIP eligibility was shortened to 6 months by HB 2292 in 2003. Families will also get two reminder notices after the renewal packet is mailed.

Meanwhile, children's Medicaid has experienced modest growth since August 2007, for a net increase of 15,472 children. This more modest increase for the much larger program is not unexpected, given the major backlogs in processing that trouble the program currently and the fact that unlike CHIP, no major eligibility policy changes favorable to increased enrollment are underway. Still, if the recent procedures described above can succeed in reducing delays and backlogs, it may be possible to begin in earnest to build enrollment at a more robust rate. Only with a major effort to reduce the estimated 750,000 to 850,000 uninsured children who qualify for Medicaid or CHIP but remain unenrolled can Texas move toward a goal of health coverage and a real medical home for every child.

[40] Texas Workforce Commission, TALX, and Unemployment Insurance.

Good News:

Texas REALLY CAN Cut the Number of Uninsured Children in Half

Operating an accurate and streamlined eligibility system is critical to achieving that goal for Texas.

Covering Texas children is good for families, businesses, and taxpayers alike. The next logical step for Texas—and an attainable goal—is to cut the number of uninsured children in half simply by reaching the uninsured kids who are eligible right now, but not insured. To make that happen, Texas needs to re-establish a well-functioning enrollment system.

Texas' CHIP and children's Medicaid program history and the experiences of other states have shown that we do not have to choose between program integrity and accuracy on the one hand; and enrollment and renewal practices that are simple, streamlined, and fair on the other hand. Here are concrete goals for restoring the credibility and competence of the eligibility system for children's Medicaid and CHIP.

1) **Deliver on the Promise of Seamless Transitions between Medicaid and CHIP.** The 1999 enacting legislation for Texas CHIP and the 2001 children's Medicaid simplification legislation both included specific provisions requiring the state to go the extra mile to prevent gaps in coverage. Still, CBOs and advocates report that these transitions remain a major weakness, with far too many eligible children experiencing gaps of several months when they are supposed to have been moved from one program to the other. In response, the 80th Texas Legislature added directives to the state budget, again spelling out their intent that transitions between Medicaid and CHIP be seamless. As the state law provisions below show, the legislature has spoken clearly on its intent that there should be no gaps in coverage moving between children's Medicaid and CHIP.

Human Resources Code (Children's Medicaid):

- Texas Medicaid must transmit eligibility information of children losing Medicaid coverage due to income or assets over to the CHIP program, and Medicaid must adopt procedures to allow these children leaving Medicaid to transition to CHIP "**with no interruption in coverage**" (§32.0262 (a)-(d)).
- Texas Medicaid must ensure that documentation and verification procedures used for children's Medicaid eligibility—specifically including the documentation and verification of assets and resources—are the same as those used for CHIP, and not more stringent than those CHIP used on January 1, 2001 (§32.026(d)).

Health and Safety Code (CHIP):

- The CHIP application form and procedures must be coordinated with children's Medicaid to ensure that there is a single consolidated application for both programs (§62.103(b)).
- CHIP application and renewal procedures must ensure that Medicaid-eligible children are **identified, referred, and assisted in enrolling in Medicaid**. Any child found to be referred to Medicaid in error (i.e., should have been enrolled in CHIP) must be enrolled in CHIP with **no further delay** (§62.104 (a)-(d)).
- CHIP application decisions must be made within 30 days (as contrasted with the 45 days allowed for Medicaid determinations) (§62.104 (f)).
- A child losing Medicaid coverage because of age, or increased income or assets, is not subject to a waiting period for CHIP coverage (§62.154(b)).

2008-2009 State Budget (Article IX):

Sec. 19.66. Medicaid Eligibility Determinations for Children, and Sec. 19.67. CHIP Eligibility Determinations for Children.

- The HHSC commissioner shall diminish errors which create barriers that wrongly deny or delay coverage for which a child is eligible, and ensure that children are screened simultaneously for eligibility for Medicaid and CHIP using a consolidated application; and that children identified as eligible for either program should be automatically enrolled without further application or qualification.

- HHSC shall ensure that systems that support the eligibility and enrollment process are performing properly and that applications and redeterminations for the children's Medicaid program are completed within state and federal standards.

  If a child becomes ineligible for either Medicaid or CHIP, HHSC shall determine whether the child is eligible for the other program based on the information currently available to the commission, and if the child is eligible, enroll the child in the other child health program without requiring further application or qualification (except for any enrollment fee that may be due), unless the child's parent objects to enrollment.

Despite all the attention lawmakers have given to establishing in Texas law the importance of seamless transitions between CHIP and children's Medicaid, the reality still falls short of the law. Texas should rededicate efforts toward this goal, and identify and correct the current system inadequacies that have us out of compliance with our own chosen law and policy.

2) **Make it the Goal of the CHIP and Children's Medicaid Eligibility System to:**
   - **Reduce "procedural denials" to as close to zero as possible, and**
   - **Reduce "missing information" requests to as close to zero as possible.**

"Procedural" denials are those cases denied or closed because of missing paperwork issues, or failure to return forms. In these instances, HHSC never actually learns whether the child was eligible or not. These denials are responsible for much of the higher rates of denial and case closure in 2006. Louisiana's CHIP and Medicaid Director has directed state eligibility staff that eliminating procedural denials should be their highest priority—no child should be denied coverage simply because the process was not completed. Louisiana officials report that eligibility staff now take great pride in achieving renewal rates in excess of 90%, and reducing procedural closures below 10%.

Two tricks to cutting the red tape include:

(1) Making application and renewal forms and instructions so simple and clear that very few missing information requests are needed, and

(2) Making application and renewal assistance widely available.

This will call for simple, easy-to-understand documentation requirements, as well as clear instructions about **exactly** what documentation is required to apply or renew. This is perfectly compatible with program integrity. Income documentation requirements can, and should, be clearly explained so that documents are submitted correctly the first time (of course, current contractor problems with lost documents and duplicate requests must be eliminated). This information must be widely available and well understood by CBOs, health plans, and contractor staff alike. If this job is done well, missing information requests will be minimized.

80th Session Update: The 80th Legislature took several steps to improve performance in the eligibility systems for Medicaid and CHIP. HB 3575 creates a Legislative Oversight committee for the HHSC eligibility system and sets goals to improve customer service, reduce processing time, and meet federal standards. Article IX of the budget includes riders 19.66 and 19.77 to improve the CHIP and children's Medicaid eligibility process and eliminate barriers, delays and wrongful denials. Two Article II budget riders (HHSC #54 and #68) provide authority for the agency to add staff if needed to meet federal performance standards. Like most 2007-enacted changes, these policies took legal effect in September 2007, and have only begun to have an effect on system performance and enrollment. ***The performance of the eligibility system should be closely monitored in 2008-2009 to make sure the system is performing efficiently to deliver maximum coverage to eligible children.***

3) Adopt 12-month Coverage for Children's Medicaid, and Carefully Monitor HB 109's *modified* 12-month CHIP Coverage for Children in Families With Incomes from 185-200% of FPL.

An annual renewal period for children is clearly associated with better access to a consistent medical home. National research and Texas experience have proven that it reduces the number of eligible children left uninsured due to procedural denials. Annual renewal reduces costs for the state's public-private eligibility system. And in the current case of serious performance failures in both the private and public systems, 12-month renewal could make an enormous reduction in workload that would provide enormous relief to the badly over-taxed eligibility system. Achieving "savings" by leaving eligible children uninsured should not be a public policy strategy.

HB 109 essentially cuts renewals in CHIP from over 630,000 a year (based on September 2007 enrollment) to 315,000. Taking the next step and cutting children's Medicaid renewals per year from 3.7 million a year to 1.85 million could provide an enormous reduction in workload, and may be the best hope for Texas to restore the Medicaid eligibility system to acceptable performance levels.

The provision of HB 109 which requires a 6-month income review for children in families with income from 185-200% FPL (about 8% of Texas CHIP children in December 2007), like the troubled Integrated Eligibility system, is a good concept in search of a workable process. Children's health advocates and policymakers should be prepared to closely monitor the development and implementation of this process in 2008-2009.

4) Abandon CHIP Policies that are Not Working.

HB 109 improves Texas policy greatly by restoring the original CHIP 90-day crowd-out prevention policy, reforming the CHIP asset test, and restoring limited income deductions for child care expenses.

Unresolved is the 2003 elimination of CHIP **income deductions for child support paid out**, which has had unintended consequences. The original CHIP policy gave parents credit for all child support payments to another household (a positive incentive to make payments). But after the 2003 policy change, a child in a household making a support payment can be denied CHIP coverage based on income not really available for his support, while the recipient household also must report the very same income. The original deduction policy was successful, supported responsible parental behaviors, and should be restored.

5) Invest in a Robust Statewide Outreach and Application Assistance Network.

Ongoing outreach and application assistance programs are a vital part of connecting children with a medical home and keeping them healthy. They are also an important tool in helping parents take responsibility for their children's health, because many need help understanding how to enroll their children and what their responsibilities are in effectively and appropriately using health care services. Providing this hands-on assistance is a principled approach to balancing parental responsibility with our obligation to protect children's health. HHSC's recent contracts for children's insurance marketing and community-based organization (CBO) outreach are excellent first steps.

However, additional funding for outreach and application assistance is badly needed. HHSC now expects those CBOs to serve not only the 2.1 million Texas children enrolled in Medicaid and CHIP and reach another 750,000-850,000 who could be enrolled, but also at least 2 million other Texans who include aged and disabled Medicaid clients as well as families who need Food Stamps. In 2002-2003, CBOs outreach for children only was funded at $6.1 million, and direct marketing at $3.8 million. But, despite a workload that has more than doubled, the current 2008-2009 allocation for outreach and marketing ($3.8 million for the biennium) appears to be less than 40% of what Texas spent in 2002-2003. If Texas is serious about reducing the number of eligible but unenrolled uninsured children, funding should be increased to at least match the earlier CHIP years, with additional funds allocated to serve the complex adult Medicaid and Food Stamp populations.

Outreach and assistance targeted to children's health care should invite partnerships with schools, businesses, churches, and other trusted community institutions willing to contribute to the effort to enroll eligible

children in health care. Special outreach attention should address the drop in pre-school children in CHIP, as well as the much steeper losses of coverage in rural Texas.

HHSC should also take a fresh look at the roles of out-stationed eligibility workers, in collaboration with the providers who pay for their work. Letting out-stationed workers assist with renewals is a logical extension of the community-based application assistance model, and providers should be able to negotiate with HHSC for different work rules for these critical on-site staff, when doing so would improve productivity and client access without compromising accuracy.

6) Insist on Adequate Staffing, Training, and Information Systems in the Eligibility System. Stop the addition of any more Medicaid or waiver clients into TIERS until the system can process eligibility in accordance with federal law timeliness standards.

Our public and private eligibility systems need to be adequately staffed, sufficiently trained, and equipped with reliable computer support. Outsourcing and privatizing public functions should never be used to escape accountability for the performance of those public functions.

Over the last decade, Texas legislatures have not devoted attention to ensuring minimally acceptable state staff-to-client ratios in the eligibility system. Elected officials have a long history of asking state agencies to do more with less, and never accepting "no" for an answer. In the case of Texas' public benefits eligibility system, this is one case where the cuts simply were taken too far. The state's own data show employees cut by more than half while caseloads grew, resulting in client loads per worker more than doubling, and with no compensating technical improvements in the system.

Inadequate staffing levels are now preventing not only children, but also elderly and disabled adults, from getting the health care they need and for which they are eligible. The eligibility system cannot function properly without greater numbers of staff and competent computer systems, as evidenced by our current failure to meet federal law timeliness standards in several urban areas, and for the clients who must rely on the TIERS system. State leaders should set a goal of restoring workers' caseloads comparable to or better than those in 2003, and to meet federal timeliness standards in every part of Texas and within the TIERS system. **HHSC should use the authority it was given by the 80th Legislature to add enough staff to achieve these workload and timeliness standards.**

Texas should ensure that the private components of Texas eligibility system are likewise adequately staffed and trained, and that their computer systems deliver the outcomes which have been promised to the taxpayers. According to the SAO, the total 1999-2010 cost of TIERS is projected at $575 million, of which HHSC has spent 61% to date. The size of this investment makes it unlikely that the state will abandon TIERS while there is any chance that it can be made to work. But, it is far from clear whether—or how quickly—solutions can be found to make TIERS workable.

There is strong evidence that, whatever its promise for the future may be, the TIERS system (and current staff tenure with that system) cannot currently support legal or acceptable Medicaid processing times. **HHSC should halt the conversion of women's health waiver and related clients to TIERS, the addition of new geographical areas, and the conversion of CHIP to TIERS. The freeze should remain in place until solutions have been implemented that are proven to result in prompt TIERS eligibility processing.**

7) **Implement Systems to Ensure that U.S. Citizens are Assisted in Documenting their Status, and that HHSC Policy is Accurately Followed by all State Eligibility Staff.** While Texas may have succeeded in avoiding the denial rates experienced in some states, the 35,000 reported denials in 13 months (with pregnant women, infants, and children accounting for most denials) and the indications that Anglos and African-American Texans have been disproportionately affected suggests strongly that U.S. citizens are being denied coverage for which they are actually eligible. Targeted, "plain-English" training should be delivered to all eligibility staff on this policy. This should be coupled with creation of a new system to assist citizens needing help acquiring an out-of-state birth record, and a mandatory referral to that assistance.

We Can Do This!

Texas has been a leader before in establishing model eligibility systems that helped low-income working Texans access the health care children need to become productive and successful adults. With all of our support, and with strong leadership committed to doing what's right for our kids, Texas can once again take an enormous step toward assuring that every Texas child has access to cost-effective health care.

Appendix A: Sources of Detailed Information and Research on Medicaid and CHIP Eligibility and Enrollment Practices

Texas CHIP New Enrollee and Disenrollment Reports: These reports provide information about previous insurance experience of CHIP children, as well as information about why children leave the program voluntarily or through denial of coverage. These periodic studies of new enrollees are performed by Texas HHSC's independent evaluator, the Institute for Child Health Policy of the University of Florida. http://www.hhsc.state.tx.us/chip/chip_pubs.asp.

50-State Updates on Eligibility Rules, Enrollment and Renewal Practices in State Medicaid and CHIP programs. These reports are produced by experts at the Center on Budget and Policy Priorities in Washington, and sponsored and distributed by the Kaiser Family Foundation. http://www.kff.org/medicaid/enrollment.cfm.

2006 Report (2007 may be posted by publication time): http://www.kff.org/medicaid/upload/7608.pdf.

Reports on Texas CHIP and Children's Medicaid Eligibility Policy:

In Harm's Way: True Stories of Uninsured Texas Children, Houston: Children's Defense Fund Texas, March 2007; http://www.cdftexas.org/attached/INHARM%27SWAY.pdf .

Texas Health Care: What Has Happened and What Work Remains, Austin: Center for Public Policy Priorities, June 2006; http://www.cppp.org/research.php?aid=535.

Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2004; http://www.kff.org/medicaid/kcmu072304pkg.cfm.

Simplified Eligibility for Children's Medicaid: A Status Report at Nine Months, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2003; http://www.cppp.org/policy/healthpolicy/kaiser.pdf.

Medicaid and State Budgets: A Case Study of Texas, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2002; http://www.kff.org/content/2002/20020322/4036.pdf.

Every Child Equal: What Texas Parents Want from Children's Medicaid, Austin: Center for Public Policy Priorities and Orchard Communications, co-author Cathy Schechter, September 2000; http://www.cppp.org/research.php?aid=59&cid=3&scid=4.

Effects of Premiums and Enrollment Fees:

The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings, Washington, DC: Center on Budget and Policy Priorities, July 2005; http://www.cbpp.org/5-31-05health2.htm.

Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2005; http://www.kff.org/medicaid/7322.cfm.

Research on State Policies that Encourage or Discourage Enrollment of Children:

Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies; The Commonwealth Fund, by Georgetown University Health Policy Institute: http://www.cmwf.org/publications/publications_show.htm?doc_id=376823.

Enrolling and Retaining Low-Income Families and Children in Health Care Coverage; Centers for Medicare and Medicaid Services (CMS), August 2001; http://www.cppp.org/research.php?aid=639.

Seven Steps Toward State Success in Covering Children Continuously; National Academy for State Health Policy, October 2006; http://www.nashp.org/Files/seven_steps.pdf.

Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Unenrolled Children Get Health Insurance; Kaiser Family Foundation, by The Children's Partnership, April 2006; http://www.kff.org/medicaid/7506.cfm.

Texas' Recent Eligibility System Changes:

Audit of HHSC's IE&E Contract with Accenture**;** October 25, 2006. State Comptroller of Public Accounts; http://www.cpa.state.tx.us/comptrol/letters/accenture/**.**

Updating and Outsourcing Enrollment Public Benefits: The Texas Experience**;** Austin: Center for Public Policy Priorities, November 2006; http://www.cppp.org/research.php?aid=582&cid=3&scid=7.

CPPP Legislative Letter on Integrated Eligibility and Enrollment, Austin: Center for Public Policy Priorities, July 2006; http://www.cppp.org/files/3/IErolloutletter.pdf.

Rocky Road for Children's Health Care**;** Austin: Center for Public Policy Priorities, June 2006; http://www.cppp.org/research.php?aid=534&cid=3&scid=7.

Texas CHIP Coalition's Letter to HHSC Commissioner Albert Hawkins; May 2006; http://www.cppp.org/files/3/TCC%20Ltr.pdf.

HHSC Awards Call Center Contract; Austin: Center for Public Policy Priorities, July 2005; http://www.cppp.org/research.php?aid=432&cid=3&scid=7.

State Moves Forward With Plan to Use Call Centers to Enroll People in Key Social Services: Radical Restructuring Would Lay Off More than 4,500 staff, Close 200 Local Offices; Austin: Center for Public Policy Priorities, April 2004; http://www.cppp.org/research.php?aid=44&cid=3&scid=7.

Appendix B: Texas Children's Medicaid and CHIP Enrollment History, May 2000-December 2007					
	Children's Medicaid*	Medicaid Change from previous month	CHIP	CHIP Change from previous month	Combined Coverage
May-00			30		
Jun-00	989,786		17,049	17,019	1,006,835
Jul-00	996,447	6,661	36,186	19,137	1,032,633
Aug-00	996,128	-319	59,870	23,684	1,055,998
Sep-00	976,000	-20,128	83,490	23,620	1,059,490
Oct-00	995,293	19,293	111,277	27,787	1,106,570
Nov-00	990,233	-5,060	149,887	38,610	1,140,120
Dec-00	1,011,740	21,507	183,553	33,666	1,195,293
Jan-01	1,021,870	10,130	212,066	28,513	1,233,936
Feb-01	1,033,094	11,224	236,419	24,353	1,269,513
Mar-01	1,035,450	2,356	265,658	29,239	1,301,108
Apr-01	1,041,222	5,772	299,682	34,024	1,340,904
May-01	1,045,810	4,588	333,877	34,195	1,379,687
Jun-01	1,056,353	10,543	358,162	24,285	1,414,515
Jul-01	1,061,653	5,300	383,482	25,320	1,445,135
Aug-01	1,064,317	2,664	400,385	16,903	1,464,702
Sep-01	1,073,836	9,519	428,890	28,505	1,502,726
Oct-01	1,077,424	3,588	443,317	14,427	1,520,741
Nov-01	1,102,971	25,547	468,380	25,063	1,571,351
Dec-01	1,121,610	18,639	486,391	18,011	1,608,001
Jan-02	1,127,858	6,248	498,328	11,937	1,626,186
Feb-02	1,178,595	50,737	510,303	11,975	1,688,898
Mar-02	1,215,325	36,730	516,516	6,213	1,731,841
Apr-02	1,249,460	34,135	523,570	7,054	1,773,030
May-02	1,290,748	41,288	529,271	5,701	1,820,019
Jun-02	1,325,237	34,489	526,499	-2,772	1,851,736
Jul-02	1,322,117	-3,120	519,981	-6,518	1,842,098
Aug-02	1,349,901	27,784	517,719	-2,262	1,867,620
Sep-02	1,391,592	41,691	510,278	-7,441	1,901,870
Oct-02	1,395,579	3,987	507,691	-2,587	1,903,270
Nov-02	1,445,750	50,171	503,748	-3,943	1,949,498
Dec-02	1,467,043	21,293	500,567	-3,181	1,967,610
Jan-03	1,465,593	-1,450	505,566	4,999	1,971,159
Feb-03	1,500,197	34,604	501,788	-3,778	2,001,985
Mar-03	1,533,021	32,824	503,344	1,556	2,036,365
Apr-03	1,564,140	31,119	508,176	4,832	2,072,316
May-03	1,598,662	34,522	513,715	5,539	2,112,377
Jun-03	1,621,482	22,820	512,986	-729	2,134,468
Jul-03	1,636,795	15,313	509,182	-3,804	2,145,977
Aug-03	1,630,495	-6,300	506,068	-3,114	2,136,563
Sep-03	1,643,284	12,789	507,259	1,191	2,150,543
Oct-03	1,633,488	-9,796	488,690	-18,569	2,122,178
Nov-03	1,659,184	25,696	458,166	-30,524	2,117,350
Dec-03	1,680,482	21,298	438,164	-20,002	2,118,646
Jan-04	1,665,023	-15,459	416,302	-21,862	2,081,325
Feb-04	1,663,118	-1,905	399,306	-16,996	2,062,424
Mar-04	1,682,806	19,688	388,281	-11,025	2,071,087
Apr-04	1,713,258	30,452	377,057	-11,224	2,090,315
May-04	1,714,696	1,438	365,731	-11,326	2,080,427
Jun-04	1,751,936	37,240	358,230	-7,501	2,110,166
Jul-04	1,745,637	-6,299	361,464	3,234	2,107,101
Aug-04	1,752,897	7,260	359,734	-1,730	2,112,631
Sep-04	1,778,603	25,706	355,528	-4,206	2,134,131
Oct-04	1,766,152	-12,451	348,145	-7,383	2,114,297
Nov-04	1,779,084	12,932	340,101	-8,044	2,119,185
Dec-04	1,812,086	33,002	335,751	-4,350	2,147,837
Jan-05	1,806,017	-6,069	332,055	-3,696	2,138,072
Feb-05	1,814,181	8,164	330,393	-1,662	2,144,574

	Children's Medicaid*	Medicaid Change from previous month	CHIP	CHIP Change from previous month	Combined Coverage
Mar-05	1,801,151	-13,030	328,350	-2,043	2,129,501
Apr-05	1,791,650	-9,501	326,836	-1,514	2,118,486
May-05	1,819,124	27,474	326,809	-27	2,145,933
Jun-05	1,819,625	501	326,473	-336	2,146,098
Jul-05	1,814,940	-4,685	327,267	794	2,142,207
Aug-05	1,819,981	5,041	326,770	-497	2,146,751
Sep-05	1,820,102	121	326,557	-213	2,146,659
Oct-05	1,803,679	-16,423	323,343	-3,214	2,127,022
Nov-05	1,836,291	32,612	321,562	-1,781	2,157,853
Dec-05	1,838,239	1,948	322,898	1,336	2,161,137
Jan-06	1,809,164	-29,075	317,408	-5,490	2,126,572
Feb-06	1,790,369	-18,795	310,981	-6,427	2,101,350
Mar-06	1,759,584	-30,785	302,020	-8,961	2,061,604
Apr-06	1,739,043	-20,541	294,189	-7,831	2,033,232
May-06	1,759,387	20,344	298,776	4,587	2,058,163
Jun-06	1,759,159	-228	293,342	-5,434	2,052,501
Jul-06	1,765,318	6,159	298,731	5,389	2,064,049
Aug-06	1,784,302	18,984	295,331	-3,400	2,079,633
Sep-06	1,748,695	-35,607	291,530	-3,801	2,040,225
Oct-06	1,720,025	-28,670	300,685	9,155	2,020,710
Nov-06	1,755,715	35,690	321,341	20,656	2,077,056
Dec-06	1,760,683	4,968	326,231	4,890	2,086,914
Jan-07	1,764,595	3,912	321,815	-4,416	2,086,410
Feb-07	1,769,254	4,659	325,479	3,664	2,094,733
Mar-07	1,766,948	-2,306	325,090	-389	2,092,038
Apr-07	1,776,591	9,643	323,069	-2,021	2,099,660
May-07	1,840,077	63,486	305,991	-17,078	2,146,068
Jun-07	1,859,342	19,265	300,798	-5,193	2,160,140
Jul-07	1,844,241	-15,101	302,386	1,588	2,146,627
Aug-07	1,857,482	13,241	300,262	-2,124	2,157,744
Sep-07	1,852,249	-5,233	327,379	27,117	2,179,628
Oct-07	1,819,378	-32,871	336,076	8,697	2,155,454
Nov-07	1,863,509	44,131	340,985	4,909	2,204,494
Dec-07	1,872,954**	9,445	349,135	8,150	2,222,089
Source: All data from Texas Health and Human Services Commission.					

* January 2007 forward includes CHIP Perinatal program newborns, most of whom would be enrolled as Medicaid newborns if the perinatal program did not exist.

** December 2007 preliminary.

Appendix C: Texas CHIP Changes by County

Source: Texas Health and Human Services Commission
Data analysis by Center for Public Policy Priorities, P. Fatehi

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Anderson	978	607	-371	-37.9%	548	-430	-44.0%
Andrews	572	241	-331	-57.9%	208	-364	-63.6%
Angelina	1,539	860	-679	-44.1%	761	-778	-50.6%
Aransas	551	251	-300	-54.4%	218	-333	-60.4%
Archer	150	55	-95	-63.3%	57	-93	-62.0%
Armstrong	60	21	-39	-65.0%	16	-44	-73.3%
Atascosa	1,189	620	-569	-47.9%	756	-433	-36.4%
Austin	577	336	-241	-41.8%	350	-227	-39.3%
Bailey	233	130	-103	-44.2%	164	-69	-29.6%
Bandera	437	198	-239	-54.7%	191	-246	-56.3%
Bastrop	1,668	887	-781	-46.8%	947	-721	-43.2%
Baylor	157	58	-99	-63.1%	56	-101	-64.3%
Bee	694	435	-259	-37.3%	442	-252	-36.3%
Bell	3,445	1,908	-1,537	-44.6%	2,119	-1,326	-38.5%
Bexar	31,075	22,516	-8,559	-27.5%	24,408	-6,667	-21.5%
Blanco	236	124	-112	-47.5%	101	-135	-57.2%
Borden	15	3	-12	-80.0%	6	-9	-60.0%
Bosque	538	248	-290	-53.9%	232	-306	-56.9%
Bowie	1,111	707	-404	-36.4%	710	-401	-36.1%
Brazoria	5,483	3,168	-2,315	-42.2%	3,528	-1,955	-35.7%
Brazos	2,062	1,270	-792	-38.4%	1,441	-621	-30.1%
Brewster	168	57	-111	-66.1%	86	-82	-48.8%
Briscoe	53	20	-33	-62.3%	14	-39	-73.6%
Brooks	267	132	-135	-50.6%	133	-134	-50.2%
Brown	768	354	-414	-53.9%	462	-306	-39.8%
Burleson	394	194	-200	-50.8%	180	-214	-54.3%
Burnet	1,063	662	-401	-37.7%	622	-441	-41.5%
Caldwell	1,014	594	-420	-41.4%	618	-396	-39.1%
Calhoun	561	254	-307	-54.7%	258	-303	-54.0%
Callahan	403	181	-222	-55.1%	203	-200	-49.6%
Cameron	13,505	8,128	-5,377	-39.8%	9,019	-4,486	-33.2%
Camp	357	225	-132	-37.0%	263	-94	-26.3%
Carson	114	34	-80	-70.2%	25	-89	-78.1%
Cass	751	390	-361	-48.1%	366	-385	-51.3%
Castro	266	143	-123	-46.2%	182	-84	-31.6%
Chambers	495	269	-226	-45.7%	278	-217	-43.8%
Cherokee	1,237	845	-392	-31.7%	925	-312	-25.2%
Childress	158	61	-97	-61.4%	72	-86	-54.4%
Clay	222	93	-129	-58.1%	87	-135	-60.8%
Cochran	121	46	-75	-62.0%	46	-75	-62.0%

County Name	September 2003 Enrollment	February 2003 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Coke	84	28	-56	-66.7%	25	-59	-70.2%
Coleman	262	119	-143	-54.6%	142	-120	-45.8%
Collin	4,626	3,999	-627	-13.6%	4,802	176	3.8%
Collingsworth	84	51	-33	-39.3%	65	-19	-22.6%
Colorado	600	270	-330	-55.0%	294	-306	-51.0%
Comal	1,524	965	-559	-36.7%	1,132	-392	-25.7%
Comanche	466	222	-244	-52.4%	269	-197	-42.3%
Concho	106	42	-64	-60.4%	46	-60	-56.6%
Cooke	631	442	-189	-30.0%	422	-209	-33.1%
Coryell	746	418	-328	-44.0%	426	-320	-42.9%
Cottle	46	36	-10	-21.7%	25	-21	-45.7%
Crane	161	31	-130	-80.7%	37	-124	-77.0%
Crockett	140	50	-90	-64.3%	45	-95	-67.9%
Crosby	243	124	-119	-49.0%	133	-110	-45.3%
Culberson	110	46	-64	-58.2%	57	-53	-48.2%
Dallam	249	120	-129	-51.8%	169	-80	-32.1%
Dallas	48,206	37,316	-10,890	-22.6%	40,207	-7,999	-16.6%
Dawson	394	195	-199	-50.5%	187	-207	-52.5%
Deaf Smith	611	287	-324	-53.0%	363	-248	-40.6%
Delta	127	64	-63	-49.6%	51	-76	-59.8%
Denton	5,633	3,843	-1,790	-31.8%	4,634	-999	-17.7%
DeWitt	414	262	-152	-36.7%	270	-144	-34.8%
Dickens	64	12	-52	-81.3%	26	-38	-59.4%
Dimmit	449	157	-292	-65.0%	197	-252	-56.1%
Donley	109	59	-50	-45.9%	56	-53	-48.6%
Duval	460	201	-259	-56.3%	171	-289	-62.8%
Eastland	706	326	-380	-53.8%	293	-413	-58.5%
Ector	3,956	1,721	-2,235	-56.5%	1,618	-2,338	-59.1%
Edwards	102	37	-65	-63.7%	35	-67	-65.7%
Ellis	2,177	1,598	-579	-26.6%	1,815	-362	-16.6%
El Paso	22,082	14,067	-8,015	-36.3%	15,518	-6,564	-29.7%
Erath	756	421	-335	-44.3%	544	-212	-28.0%
Falls	279	192	-87	-31.2%	174	-105	-37.6%
Fannin	656	348	-308	-47.0%	365	-291	-44.4%
Fayette	609	349	-260	-42.7%	322	-287	-47.1%
Fisher	142	34	-108	-76.1%	37	-105	-73.9%
Floyd	269	130	-139	-51.7%	141	-128	-47.6%
Foard	61	39	-22	-36.1%	33	-28	-45.9%
Fort Bend	7,577	5,840	-1,737	-22.9%	6,303	-1,274	-16.8%
Franklin	286	176	-110	-38.5%	150	-136	-47.6%
Freestone	322	170	-152	-47.2%	193	-129	-40.1%
Frio	602	286	-316	-52.5%	261	-341	-56.6%
Gaines	962	472	-490	-50.9%	407	-555	-57.7%
Galveston	4,436	2,922	-1,514	-34.1%	2,802	-1,634	-36.8%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Garza	183	85	-98	-53.6%	99	-84	-45.9%
Gillespie	696	353	-343	-49.3%	378	-318	-45.7%
Glasscock	50	25	-25	-50.0%	19	-31	-62.0%
Goliad	114	74	-40	-35.1%	61	-53	-46.5%
Gonzales	526	262	-264	-50.2%	260	-266	-50.6%
Gray	453	185	-268	-59.2%	229	-224	-49.4%
Grayson	2,045	1,193	-852	-41.7%	1,335	-710	-34.7%
Gregg	2,983	1,668	-1,315	-44.1%	1,747	-1,236	-41.4%
Grimes	478	249	-229	-47.9%	278	-200	-41.8%
Guadalupe	1,565	1,133	-432	-27.6%	1,237	-328	-21.0%
Hale	910	472	-438	-48.1%	575	-335	-36.8%
Hall	100	56	-44	-44.0%	55	-45	-45.0%
Hamilton	297	148	-149	-50.2%	126	-171	-57.6%
Hansford	190	71	-119	-62.6%	106	-84	-44.2%
Hardeman	109	42	-67	-61.5%	44	-65	-59.6%
Hardin	1,567	735	-832	-53.1%	812	-755	-48.2%
Harris	93,901	67,701	-26,200	-27.9%	71,496	-22,405	-23.9%
Harrison	1,243	719	-524	-42.2%	769	-474	-38.1%
Hartley	43	32	-11	-25.6%	41	-2	-4.7%
Haskell	213	103	-110	-51.6%	100	-113	-53.1%
Hays	2,209	1,480	-729	-33.0%	1,538	-671	-30.4%
Hemphill	90	40	-50	-55.6%	36	-54	-60.0%
Henderson	2,033	1,049	-984	-48.4%	1,099	-934	-45.9%
Hidalgo	28,834	16,237	-12,597	-43.7%	17,895	-10,939	-37.9%
Hill	944	559	-385	-40.8%	602	-342	-36.2%
Hockley	661	271	-390	-59.0%	310	-351	-53.1%
Hood	1,005	560	-445	-44.3%	622	-383	-38.1%
Hopkins	832	494	-338	-40.6%	519	-313	-37.6%
Houston	390	198	-192	-49.2%	227	-163	-41.8%
Howard	753	430	-323	-42.9%	391	-362	-48.1%
Hudspeth	134	59	-75	-56.0%	72	-62	-46.3%
Hunt	1,342	900	-442	-32.9%	970	-372	-27.7%
Hutchinson	587	268	-319	-54.3%	272	-315	-53.7%
Irion	64	1	-63	-98.4%	14	-50	-78.1%
Jack	270	104	-166	-61.5%	83	-187	-69.3%
Jackson	344	175	-169	-49.1%	179	-165	-48.0%
Jasper	1,005	412	-593	-59.0%	459	-546	-54.3%
Jeff Davis	26	19	-7	-26.9%	23	-3	-11.5%
Jefferson	5,134	2,854	-2,280	-44.4%	2,816	-2,318	-45.1%
Jim Hogg	224	84	-140	-62.5%	98	-126	-56.3%
Jim Wells	1,468	733	-735	-50.1%	724	-744	-50.7%
Johnson	3,065	1,812	-1,253	-40.9%	2,054	-1,011	-33.0%
Jones	533	202	-331	-62.1%	229	-304	-57.0%
Karnes	392	152	-240	-61.2%	163	-229	-58.4%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Kaufman	1,548	1,259	-289	-18.7%	1,466	-82	-5.3%
Kendall	517	227	-290	-56.1%	250	-267	-51.6%
Kenedy	19	17	-2	-10.5%	11	-8	-42.1%
Kent	34	3	-31	-91.2%	12	-22	-64.7%
Kerr	1,196	588	-608	-50.8%	653	-543	-45.4%
Kimble	146	81	-65	-44.5%	79	-67	-45.9%
King	9	2	-7	-77.8%	0	-9	-100.0%
Kinney	80	44	-36	-45.0%	51	-29	-36.3%
Kleberg	773	494	-279	-36.1%	447	-326	-42.2%
Knox	181	59	-122	-67.4%	52	-129	-71.3%
Lamar	1,011	649	-362	-35.8%	601	-410	-40.6%
Lamb	611	249	-362	-59.2%	306	-305	-49.9%
Lampasas	484	245	-239	-49.4%	231	-253	-52.3%
La Salle	177	63	-114	-64.4%	80	-97	-54.8%
Lavaca	590	261	-329	-55.8%	301	-289	-49.0%
Lee	463	243	-220	-47.5%	246	-217	-46.9%
Leon	466	179	-287	-61.6%	200	-266	-57.1%
Liberty	2,329	1,139	-1,190	-51.1%	1,184	-1,145	-49.2%
Limestone	481	258	-223	-46.4%	257	-224	-46.6%
Lipscomb	87	39	-48	-55.2%	47	-40	-46.0%
Live Oak	236	131	-105	-44.5%	134	-102	-43.2%
Llano	488	231	-257	-52.7%	194	-294	-60.2%
Loving	0	0	0	0	0	0	NA
Lubbock	4,718	2,479	-2,239	-47.5%	2,794	-1,924	-40.8%
Lynn	192	78	-114	-59.4%	89	-103	-53.6%
Madison	194	152	-42	-21.6%	122	-72	-37.1%
Marion	227	142	-85	-37.4%	108	-119	-52.4%
Martin	161	113	-48	-29.8%	84	-77	-47.8%
Mason	134	65	-69	-51.5%	68	-66	-49.3%
Matagorda	1,292	641	-651	-50.4%	561	-731	-56.6%
Maverick	2,346	1,485	-861	-36.7%	1,676	-670	-28.6%
McCulloch	357	167	-190	-53.2%	170	-187	-52.4%
McLennan	3,800	2,221	-1,579	-41.6%	2,103	-1,697	-44.7%
McMullen	11	15	4	36.4%	8	-3	-27.3%
Medina	948	520	-428	-45.1%	522	-426	-44.9%
Menard	84	45	-39	-46.4%	37	-47	-56.0%
Midland	3,318	1,456	-1,862	-56.1%	1,532	-1,786	-53.8%
Milam	551	320	-231	-41.9%	338	-213	-38.7%
Mills	81	53	-28	-34.6%	68	-13	-16.0%
Mitchell	225	88	-137	-60.9%	97	-128	-56.9%
Montague	605	258	-347	-57.4%	291	-314	-51.9%
Montgomery	6,391	3,915	-2,476	-38.7%	4,632	-1,759	-27.5%
Moore	366	173	-193	-52.7%	234	-132	-36.1%
Morris	312	193	-119	-38.1%	207	-105	-33.7%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Motley	47	13	-34	-72.3%	2	-45	-95.7%
Nacogdoches	894	555	-339	-37.9%	556	-338	-37.8%
Navarro	517	500	-17	-3.3%	540	23	4.4%
Newton	421	189	-232	-55.1%	165	-256	-60.8%
Nolan	548	228	-320	-58.4%	229	-319	-58.2%
Nueces	8,384	4,955	-3,429	-40.9%	4,751	-3,633	-43.3%
Ochiltree	245	103	-142	-58.0%	131	-114	-46.5%
Oldham	78	28	-50	-64.1%	36	-42	-53.8%
Orange	2,231	1,087	-1,144	-51.3%	1,061	-1,170	-52.4%
Palo Pinto	711	353	-358	-50.4%	374	-337	-47.4%
Panola	477	230	-247	-51.8%	262	-215	-45.1%
Parker	1,654	923	-731	-44.2%	997	-657	-39.7%
Parmer	308	176	-132	-42.9%	193	-115	-37.3%
Pecos	415	195	-220	-53.0%	153	-262	-63.1%
Polk	1,018	551	-467	-45.9%	598	-420	-41.3%
Potter	2,297	1,248	-1,049	-45.7%	1,512	-785	-34.2%
Presidio	213	96	-117	-54.9%	97	-116	-54.5%
Rains	315	163	-152	-48.3%	153	-162	-51.4%
Randall	1,525	711	-814	-53.4%	840	-685	-44.9%
Reagan	214	59	-155	-72.4%	67	-147	-68.7%
Real	105	40	-65	-61.9%	47	-58	-55.2%
Red River	352	157	-195	-55.4%	183	-169	-48.0%
Reeves	438	220	-218	-49.8%	196	-242	-55.3%
Refugio	208	140	-68	-32.7%	133	-75	-36.1%
Roberts	7	5	-2	-28.6%	5	-2	-28.6%
Robertson	363	148	-215	-59.2%	160	-203	-55.9%
Rockwall	696	536	-160	-23.0%	581	-115	-16.5%
Runnels	371	184	-187	-50.4%	150	-221	-59.6%
Rusk	976	631	-345	-35.3%	710	-266	-27.3%
Sabine	274	134	-140	-51.1%	111	-163	-59.5%
San Augustine	228	100	-128	-56.1%	98	-130	-57.0%
San Jacinto	463	315	-148	-32.0%	271	-192	-41.5%
San Patricio	2,316	1,248	-1,068	-46.1%	1,270	-1,046	-45.2%
San Saba	186	82	-104	-55.9%	91	-95	-51.1%
Schleicher	114	42	-72	-63.2%	42	-72	-63.2%
Scurry	493	151	-342	-69.4%	219	-274	-55.6%
Shackelford	121	56	-65	-53.7%	48	-73	-60.3%
Shelby	608	311	-297	-48.8%	374	-234	-38.5%
Sherman	74	21	-53	-71.6%	18	-56	-75.7%
Smith	4,571	2,755	-1,816	-39.7%	2,984	-1,587	-34.7%
Somervell	223	100	-123	-55.2%	123	-100	-44.8%
Starr	3,058	1,881	-1,177	-38.5%	1,596	-1,462	-47.8%
Stephens	347	188	-159	-45.8%	181	-166	-47.8%
Sterling	47	17	-30	-63.8%	12	-35	-74.5%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change	December 2007 Enrollment	Change from 9/03 to 12/07	% Change
Stonewall	47	21	-26	-55.3%	25	-22	-46.8%
Sutton	167	60	-107	-64.1%	49	-118	-70.7%
Swisher	230	133	-97	-42.2%	122	-108	-47.0%
Tarrant	28,962	20,481	-8,481	-29.3%	23,164	-5,798	-20.0%
Taylor	2,956	1,575	-1,381	-46.7%	1,784	-1,172	-39.6%
Terrell	13	6	-7	-53.8%	8	-5	-38.5%
Terry	390	170	-220	-56.4%	200	-190	-48.7%
Throckmorton	80	24	-56	-70.0%	20	-60	-75.0%
Titus	929	649	-280	-30.1%	632	-297	-32.0%
Tom Green	2,580	1,329	-1,251	-48.5%	1,452	-1,128	-43.7%
Travis	12,635	9,352	-3,283	-26.0%	9,340	-3,295	-26.1%
Trinity	283	164	-119	-42.0%	171	-112	-39.6%
Tyler	617	276	-341	-55.3%	299	-318	-51.5%
Upshur	1,016	530	-486	-47.8%	514	-502	-49.4%
Upton	110	44	-66	-60.0%	44	-66	-60.0%
Uvalde	782	525	-257	-32.9%	512	-270	-34.5%
Val Verde	1,107	715	-392	-35.4%	707	-400	-36.1%
Van Zandt	1,375	687	-688	-50.0%	806	-569	-41.4%
Victoria	2,349	1,055	-1,294	-55.1%	1,228	-1,121	-47.7%
Walker	595	411	-184	-30.9%	389	-206	-34.6%
Waller	914	597	-317	-34.7%	578	-336	-36.8%
Ward	362	132	-230	-63.5%	103	-259	-71.5%
Washington	453	306	-147	-32.5%	297	-156	-34.4%
Webb	8,903	5,094	-3,809	-42.8%	5,548	-3,355	-37.7%
Wharton	1,193	632	-561	-47.0%	626	-567	-47.5%
Wheeler	151	46	-105	-69.5%	41	-110	-72.8%
Wichita	1,813	872	-941	-51.9%	1,023	-790	-43.6%
Wilbarger	204	122	-82	-40.2%	138	-66	-32.4%
Willacy	811	439	-372	-45.9%	446	-365	-45.0%
Williamson	5,377	3,348	-2,029	-37.7%	3,654	-1,723	-32.0%
Wilson	805	490	-315	-39.1%	534	-271	-33.7%
Winkler	349	133	-216	-61.9%	121	-228	-65.3%
Wise	1,223	619	-604	-49.4%	672	-551	-45.1%
Wood	995	686	-309	-31.1%	674	-321	-32.3%
Yoakum	343	115	-228	-66.5%	133	-210	-61.2%
Young	552	193	-359	-65.0%	200	-352	-63.8%
Zapata	493	196	-297	-60.2%	264	-229	-46.5%
Zavala	488	176	-312	-63.9%	232	-256	-52.5%
Texas	**507,259**	**325,479**	**-181,780**	**-35.8%**	**349,135**	**-158,124**	**-31.2%**