CHILD FRIENDLY?

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

Center for Public Policy Priorities

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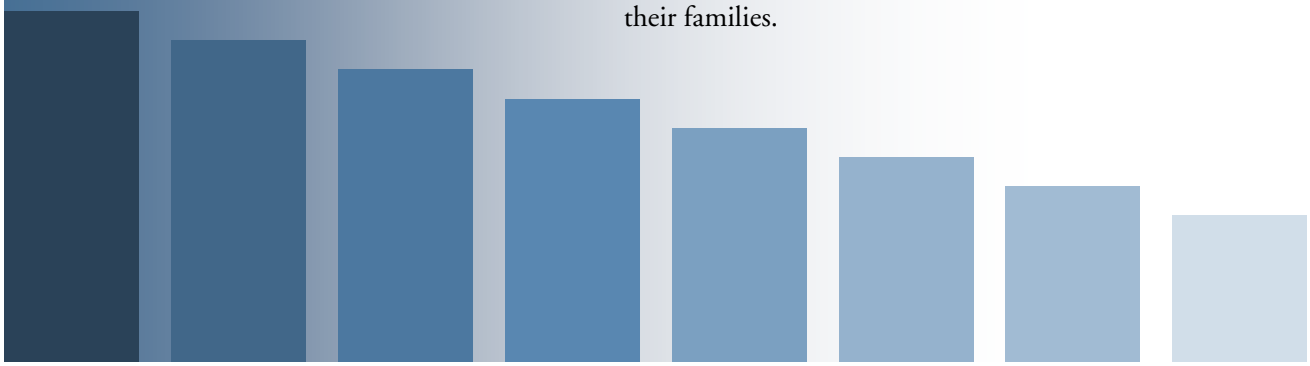

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CPPP is a nonpartisan, nonprofit research organization committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans.

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Introduction and Executive Summary

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.

Despite the acknowledged need for access to comprehensive care for children, support for children's Medicaid and the Children's Health Insurance Program (CHIP) in Texas has been inconsistent. 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.

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 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.

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.

Key Findings:

- Several Texas policies are used by 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. No other state has imposed an across-the-board delay in coverage like Texas' 90-day delay. Most states (69%, or 25 out of 36 states) with separate CHIP programs offer 12-month eligibility.
- There is a large body of research and practical experience that can guide states 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.
- Recent declines in children covered by CHIP and children's Medicaid have left the number of Texas children covered by CHIP and children's Medicaid more than 55,000 below the number enrolled in September 2003. 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 has been 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.
- Multiple problems with the transition to a new CHIP contractor in 2006 caused processing errors and delays that further accelerated the ongoing CHIP decline.
- The decline in children's Medicaid in 2006 was driven primarily by state eligibility staffing shortages. It was also aggravated significantly by errors made by the CHIP contractor in processing renewals and

incoming applications through that channel. Both would normally result in thousands of children's Medicaid enrollments each month.

Summary of Recommendations:

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 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 it the Goal of the CHIP and Children's Medicaid Eligibility System to Reduce "Procedural Denials" to as Close to Zero as Possible.

"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.

3) Adopt 12-Month Coverage for Children in Medicaid and CHIP.

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 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 a badly needed bail-out for the current state of serious performance failures in both the private and public systems. By cutting the number of children's renewals per year from 4 million to 2 million, 12-month renewal could provide an enormous reduction in workload that may be the only way Texas can restore the system to acceptable performance levels.

4) Abandon CHIP Policies That Are Not Working.

The original Texas CHIP 90-day crowd-out prevention policy was effective and fair, and should be restored. The current policy punishes newborns and children who have gone without insurance for years. Texas should drop the CHIP asset test, or at the very least, reform the policy to accommodate higher CHIP family incomes and to encourage appropriate asset development among low-income families. Finally, the elimination of CHIP **income deductions for child care and child support paid out** has had unintended consequences. The original CHIP policy gave parents credit for a portion of their child care expenses, and for all child support payments to another household (a positive incentive to make payments). The 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. HHSC's recent contracts for children's insurance marketing and community-based organization-based (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. Out-stationed state workers need the flexibility to expand their role in application and renewal assistance. Special resources are needed to remedy the higher lost CHIP enrollment among rural Texas children, and preschool-aged children.

6) Insist on Adequate Staffing, Training, and Information Systems in the Eligibility System.

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 adequate attention to ensuring minimally-acceptable state staff-to-client ratios in the eligibility system. The state's data show employees cut by more than half while caseloads grew, resulting in client loads per worker more than doubling, and with no compensating 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.

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.

The Big Picture: How Eligibility Policy Affects Enrollment by 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**[1] **of immigration status** from "qualified aliens" (e.g., legal permanent resident immigrants) and verification of that status with INS;
- **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; 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 five states (along with Hawaii, Idaho, 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 far 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*

[1] Note: 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.

children's Medicaid are $15,000 and $30,000, respectively. Oregon's CHIP asset limit is $10,000. In contrast, Texas children's Medicaid limits assets to $2,000, and Texas CHIP sets the limit at $5,000.

- **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[2]. Texas provides 6 months of continuous coverage in both children's Medicaid and CHIP.*

- **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.*

- **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.[3] 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.* ***Texas currently does something altogether different: We are the only state in the U.S. to impose a waiting period after eligibility begins.*** *Texas CHIP was implemented with 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). In 2003, the Legislature changed that policy to achieve savings, saying instead that every child found eligible for CHIP (and not subject to an exception) would experience a delay of 3 months before their coverage took effect. This means that even a child who has never been insured, or a newborn, will not get CHIP coverage until 3 months after being found eligible. In effect, Texas' policy since 2003 is* no *longer an "anti-crowd*

[2] 36 states including Texas operate separate CHIP programs, and the other 14 use their CHIP funds to expand children's Medicaid.

[3] 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 for references.

out policy," since it treats the child who has been uninsured for years exactly the same as the child with private coverage.

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.[4] Cost sharing for Medicaid children was entirely prohibited before recent changes passed in the DRA (signed 2/8/2006), and some details are still being clarified.

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[5] 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.[6]

  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).[7] Moreover, children may be charged up to $6 for non-emergency use of the Emergency Room.[8]

- 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 enrollees from denial of care, and 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.*

[4] Note: Medicaid has a different set of federal standards for "cost sharing" by adults.
[5] *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).
[6] 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.
[7] No co-payment may be charged if the prescribing doctor says the non-preferred drug would be ineffective or have adverse effects.
[8] 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.[9] 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 100% of the 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 fees for families 150% of the FPL and above are at the lower end of the range.*

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 (more "expendable") care.[10] 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. Recent increased premiums in Oregon, Rhode Island, Vermont, and Maryland 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 showed 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.

In short, when premiums increase, enrollment declines, and this effect is highest among those who are poorest. However, there is reason to be especially mindful of this reality when making decisions about premiums and enrollment fees for coverage of children. Children themselves have no income and cannot

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

control whether their parents can afford, or will pay for, coverage. **If our society values protecting children, regardless of the limitations or failings of their parents, then premium and enrollment fee policies for public programs must be carefully scrutinized to minimize the loss of access to health care for blameless children.**

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.[11]

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") self-declaration with third-party verification, allow out-stationed workers to perform renewals, and incorporating 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 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:

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

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.
3. **Use technology to coordinate programs and reduce administrative burdens**. Examples include online applications and electronic eligibility referrals of children eligible for 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, (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, where 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 <u>eligible</u> 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[12] 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 of 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.

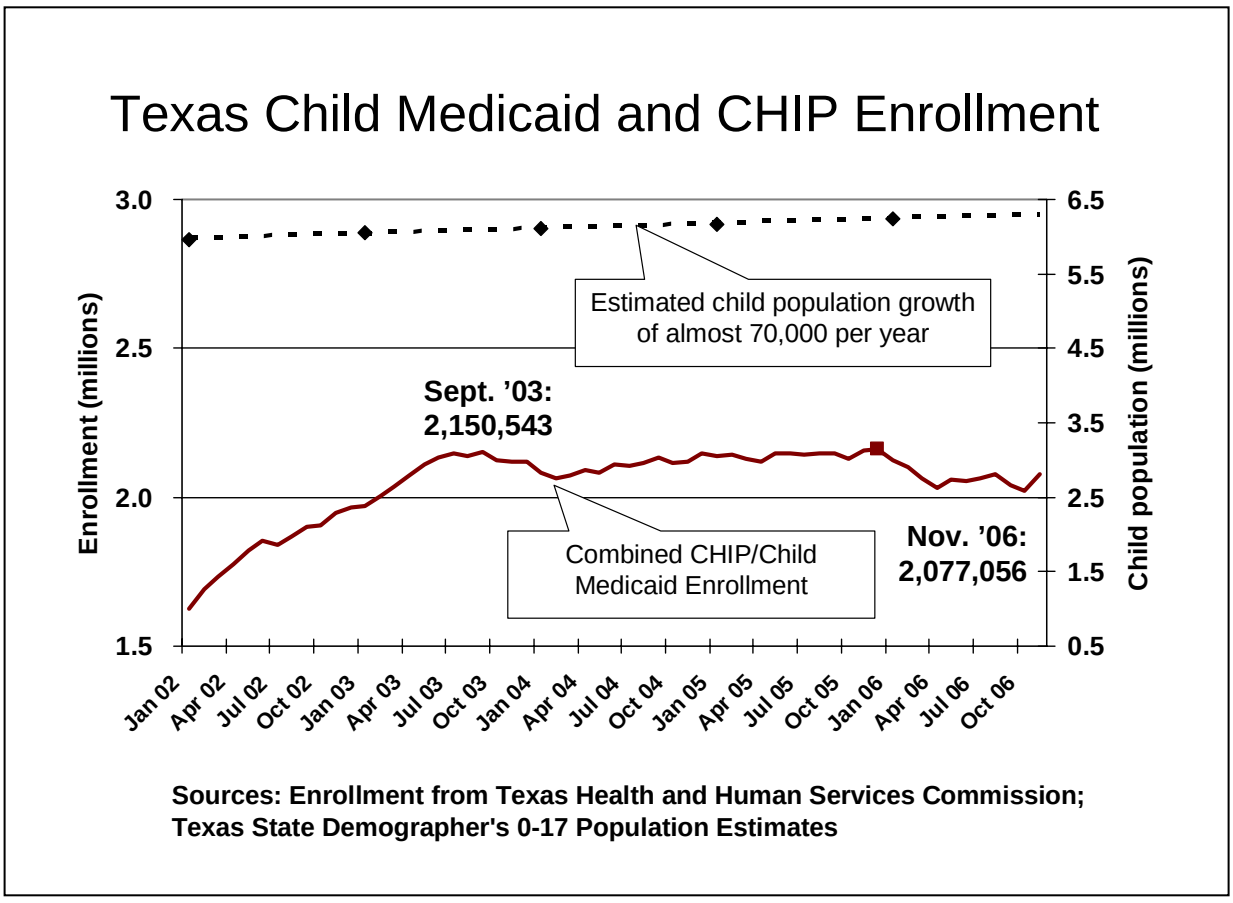
[12] Washington Medicaid covered children to 200% FPL prior to the creation of SCHIP by Congress; their separate CHIP program is for children 200-250%% FPL.

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[13] estimated that:

- About 53% of Texas children had employer-sponsored health benefits.
- 24%-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:

- 51% of Texas children have employer-sponsored health benefits;
- 20.4% of Texas children under age 19 (1.37 million) are uninsured; and just over two-thirds (68%) are in families below 200% FPL.
- There are about 6.6 million Texas children under age 19.

[13] 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".

Some Good News

Since there are now 638,000 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 29%. Of course, other states were also improving their rates of children's coverage, 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 919,000. Adjusting for undocumented children, estimated at around 230,000, most of the remaining 689,000 children should be able to enroll in Medicaid or CHIP. In other words, ***the number of uninsured Texans children could be reduced by one-half if the majority of eligible, but not enrolled, children were brought into Medicaid and CHIP.***

Background: A Brief History of Texas CHIP and Children's Medicaid 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 was automatically transitioned. In 1999, the 76th Texas Legislature both authorized the Texas CHIP program and also passed a state law requiring that the Texas Department of Human Services (DHS), which then administered both cash assistance and Medicaid eligibility, inform parents leaving welfare that their children could continue their Medicaid coverage.[14] 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[15], 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.

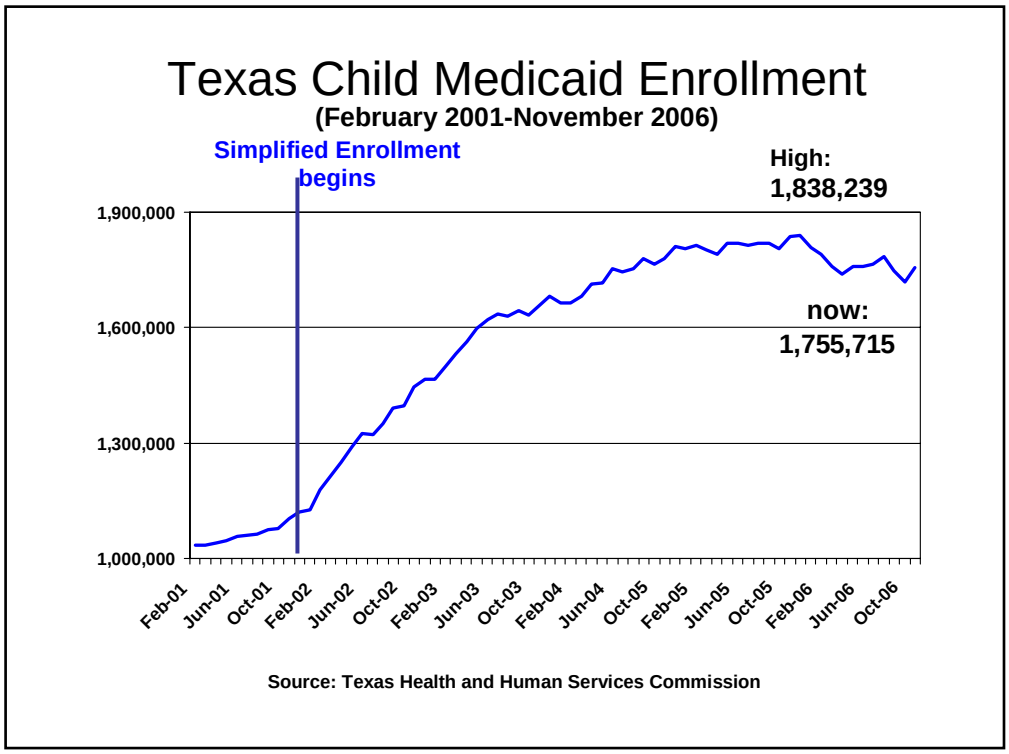
2001: Streamlined Policies Adopted for Children's Medicaid. This stark contrast between the CHIP and children's Medicaid enrollment and renewal requirements convinced Texas lawmakers that the time had come to let working poor parents enroll and renew their children in Medicaid by mail, just as CHIP allowed. In 2001, the 77th Legislature passed legislation 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

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

children covered for 12 consecutive months. As originally passed, coverage would have been extended to 12 months effective September 2003.

The new law first 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 non-citizen (either legal or undocumented) even though the vast majority of these children are themselves native-born U.S. citizens. When looking at children below 200% of the FPL, more than one-third of children 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 2 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 (i.e., ineligible family members need not provide 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[16] in Texas targeted a portion of its media 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 six.
- 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

[16] Covering Kids & Families was a 50-state national initiative of the Robert Wood Johnson Foundation (RWJF), which from 1997-2006 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

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

than those used by Texas CHIP,[17] 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.

October 2003: Problems as EZ Renewal Ends for Children's Medicaid. In October 2003, DHS reinstituted a policy requiring full re-application and incomer 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.[18] 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 could process the renewals, and more children enrolled. 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 20-30,000 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[19] 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 in CHIP 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

[17] Human Resources Code Chapter 32 § 32.026(d).
[18] Op. Cit.
[19] Certain children qualify for exceptions to the delay under state law, and are enrolled immediately.

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 took a combined toll on enrollment. First, **premiums** were increased effective September 2003. 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.

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 of parents (25%) failed to renew, then only 1,500 of the 2,000 children would complete renewal and remain enrolled. Since nothing happened to increase 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 makes 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 on dental exams and treatment.

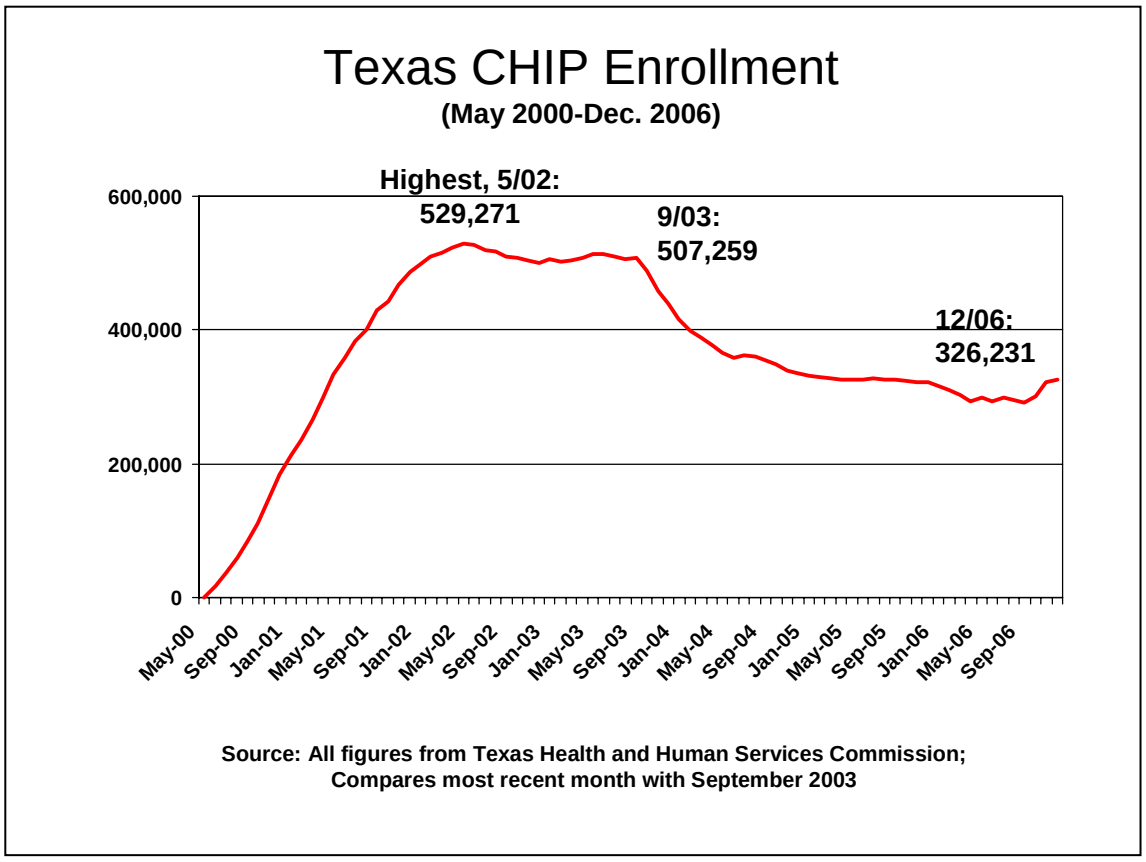
The combined impact of the policy changes was quickly apparent; from September 1, 2003, to January 1, 2004, enrollment dropped by nearly 91,000 children. Before September 2003, over 28,000 new children per month were added each month to CHIP, while about 21,800 per month left the program. More children were added each month than left, so the program rolls grew. After September 2003, the newly enrolled children each month have 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 downward 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, the agency 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 both complete the renewal forms any 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.



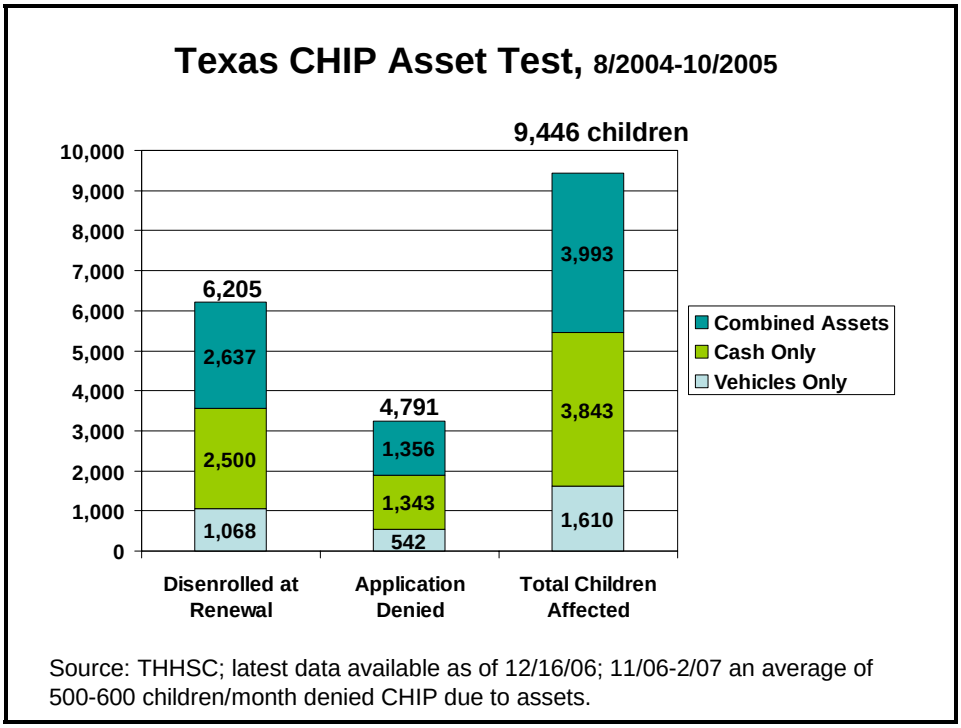
August 2004: New CHIP Asset Test Takes Effect. The addition of an asset test to Texas CHIP was, as previously indicated, not an HHSC initiative, but rather a proposal by the author of HB 2292. By August 2004, CHIP enrollment had dropped below 360,000, and it was clear that the rolls for the 2004-2005 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, 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 Stamps 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.

Secondly, 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, it was recommended that the policy be revised to (1) at least doubled 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.



Source: THHSC; latest data available as of 12/16/06; 11/06-2/07 an average of 500-600 children/month denied CHIP due to assets.

Also, 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.

Children Denied CHIP Due to Asset Test. A 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. HHSC has also released four months of the most recent denials, and hopes to eventually reconstruct the rest of the 2006 data. From November 2006 to February 2007 an average of 500-600 children per month were denied CHIP due to assets.

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[20] report total application volume.

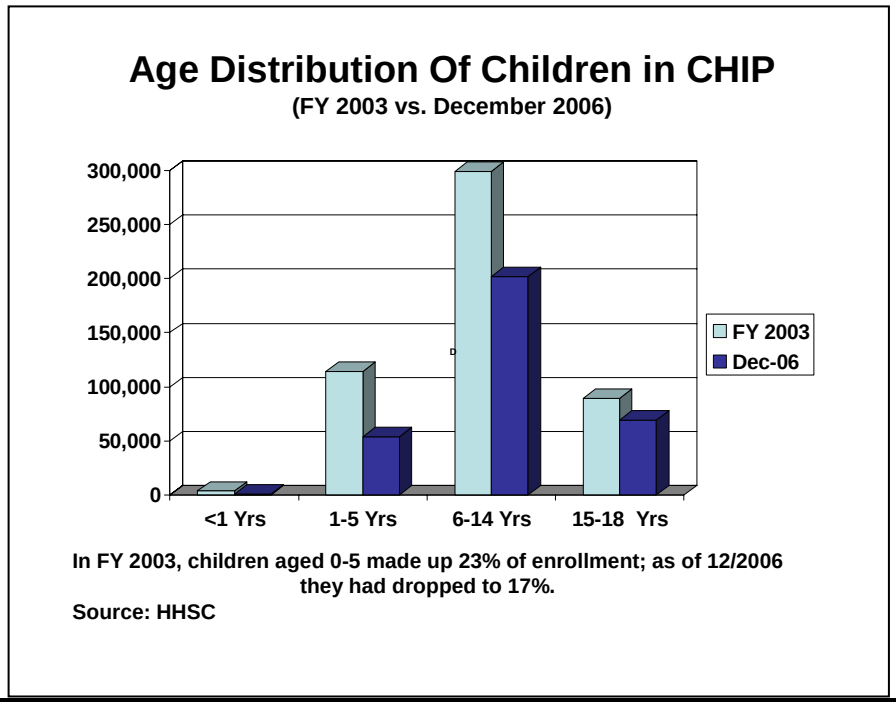
Unknowns Re: Asset Test. Another factor that cannot be assessed with the current data is the extent to which the "hassle factor" related to reporting assets added to these numbers. For example, until very recently, application instructions did not make it clear that reporting the make, model, and year of a vehicle was not sufficient; parents must also provide the "style code" which can greatly affect the market value of vehicle. As a result, large numbers of missing information requests were sent pack 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 than those related to income, which they saw as fair and reasonable. Program statistics alone cannot capture the reasons parents fail to complete an application, or respond to a request for additional information.

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 and advertising to educate parents about the changes to CHIP in 2003 or in 2005 or to encourage them to retain their children's coverage.

During this period, Texas' largest cities (Dallas, Houston, Austin, 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 FY 2003 (the last year before the changes), 23% of children enrolled were under the age of 6. As of December 2006, that age group had declined to just 17% of children, including fewer than 800 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 reduces infant enrollment, since parents who apply for their babies must wait at least 3 months before coverage takes effect.

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



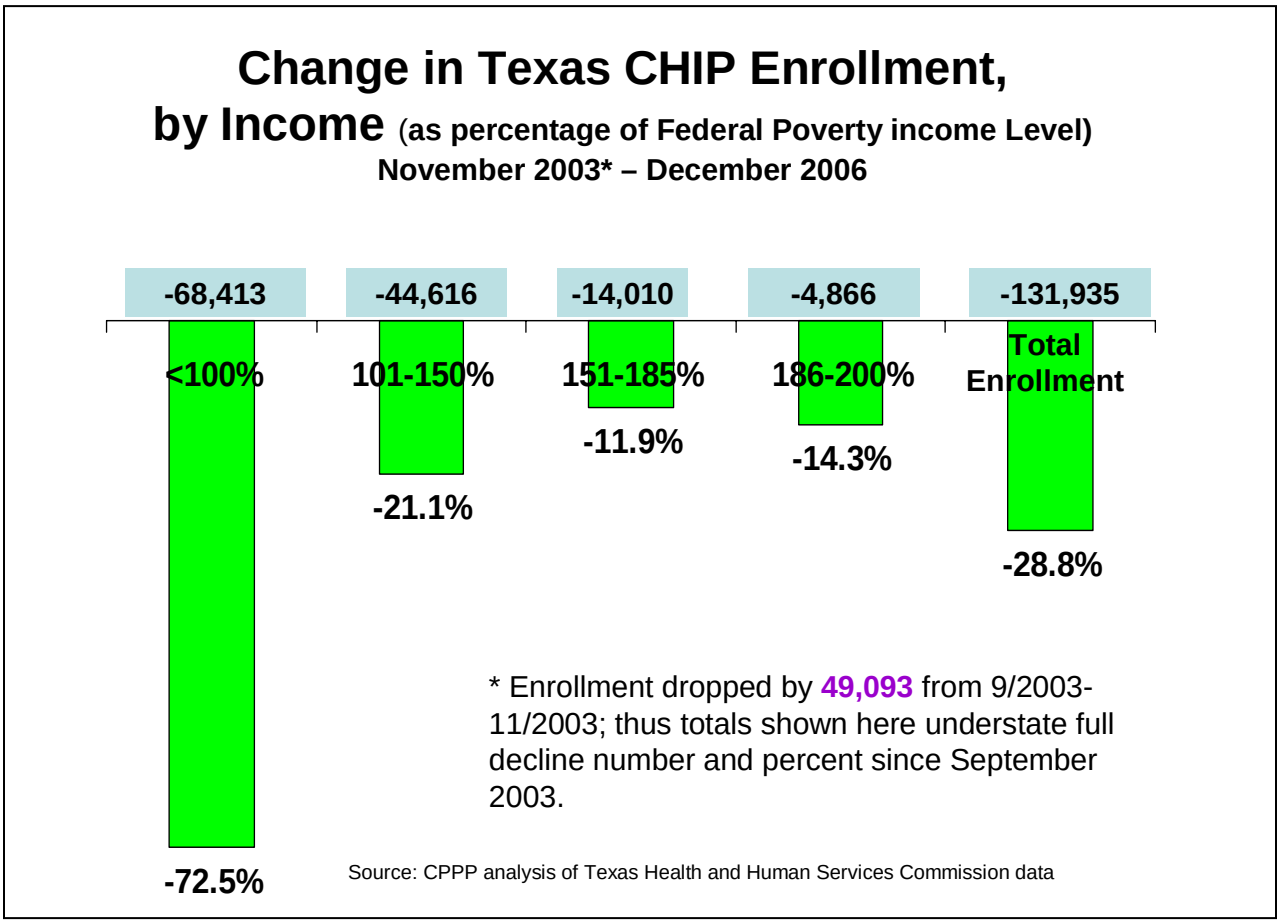
Texas CHIP Enrollment by Service Area, September 2003 and December 2006				
CHIP Service Area	**Sept. 2003**	**Dec. 2006**	**Decline**	**% Decline**
1 Amarillo/Lubbock	13,541	6,639	-6,902	**-51.0%**
2 Dallas-Fort Worth	100,654	73,745	-26,909	**-26.7%**
5 Austin	25,038	17,011	-8,027	**-32.1%**
6 Houston	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[21]	141,699	79,747	-61,952	**-43.7%**
Statewide Total	**507,259**	**326,231**	**-181,028**	**-35.7%**

Source: Texas Health and Human Services Commission

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 and 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.

[21] 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: Hhttp://www.hhsc.state.tx.us/chip/families/County_Map_090106.pdfH .

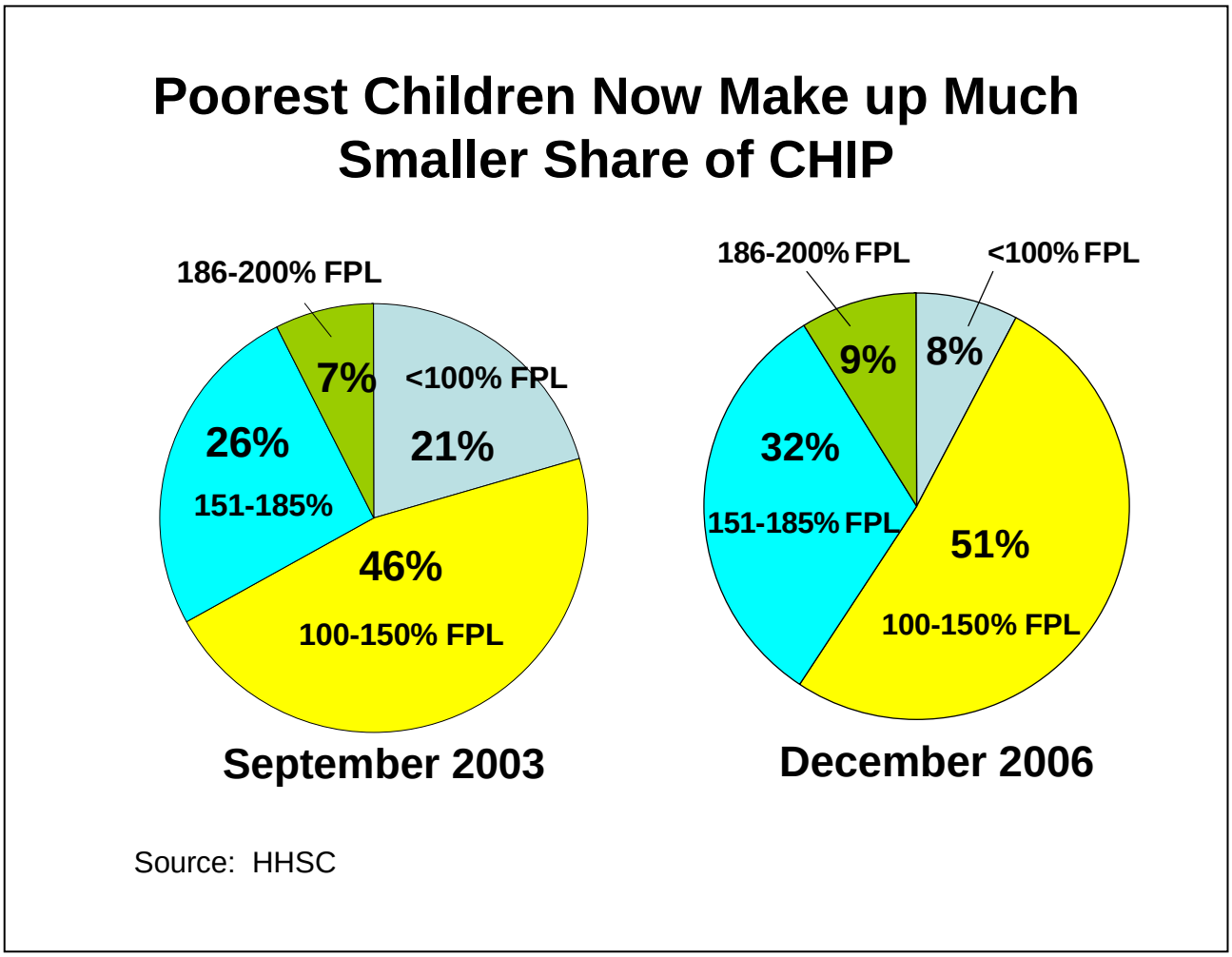


CHIP Income Distribution: Dramatic Drop Among Children with Lowest Family Incomes. The elimination of income disregards in CHIP was applied to all enrollees effective November 2003. This had the effect of "shifting" many children from one category to a higher category (and "shifted" about 17,000 children 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 other factors 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 (-68,413), a 73% drop within that category, and accounting for more than half the total decline in CHIP. The decline within the 100-150% of the FPL group—where enrollment was, and still is, concentrated—was a lower percentage (21%), but in numbers accounted for 34% of the total drop in CHIP rolls. In contrast, the groups above 150% of the FPL have seen relatively low declines (12% and 14% respectively), and have accounted for less than 15% 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 8% of CHIP children below 100% of the FPL 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 & 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 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 counts from HHSC 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 have declined for 7 out of 11 months.[22] Children covered in November 2006 remain more than 82,000 below the December 2005 caseload, a decline of 4.5%.

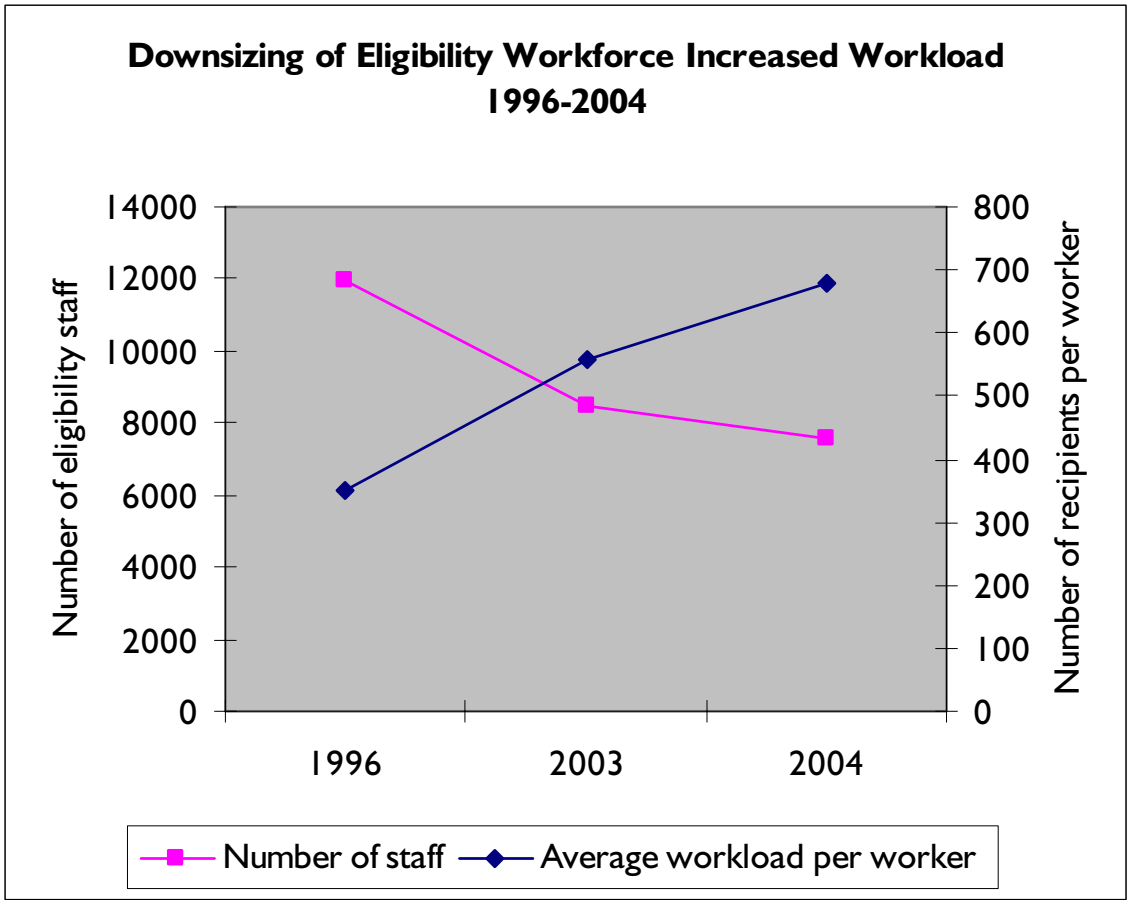
What Happened? Unfortunately, the answer is not a simple one. This report summarizes significant issues which have not only caused recent increased declines in CHIP, but also large declines in children's Medicaid not seen since the wake of welfare reform. In the interest of brevity, the key problems 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 (most have not been resolved and persist to the present) include:

- **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 suggests that fixing the current woes will also require a multi-faceted approach. Readers may refer to the appendix 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 below), 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 over 12,000 in 1995. At the same time, the number of clients per worker had grown from about 430 per worker in 1995 to between 700-800 per worker in 2004.[23]

[22] Most recent data available as of 12/18/2006.
[23] For detailed HHSC data, see http://www.hhsc.state.tx.us/news/presentations/IEE_HAC041706.pps .



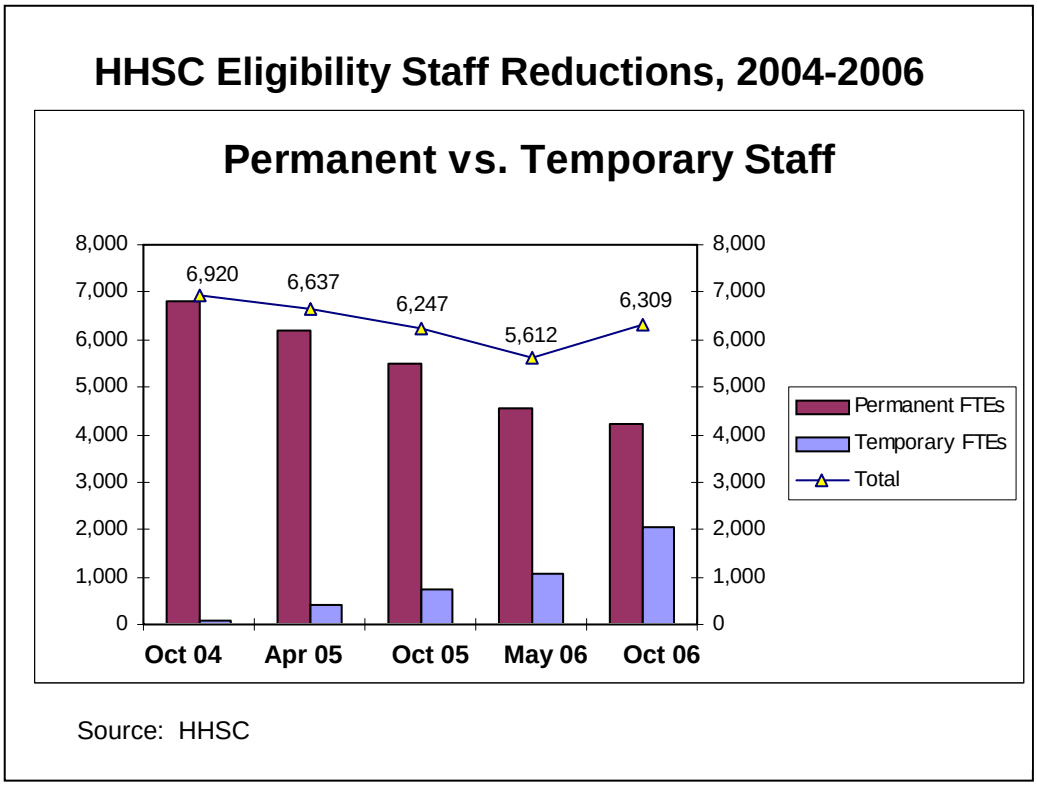
When HHSC took over eligibility systems from their historical home at DHS, and career eligibility staff faced the conversion to a call center approach and likely privatization of major functions directed by HB 2292, staff levels were already at perilously low levels. After HHSC's October 2005 announcement 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. HHSC efforts to recruit and retain staff have now brought workers back up from that low point (to about 6,300 in September 2006), but one-third of those workers are temporary staff whose training and productivity cannot match that of the tenured staff lost over the last 2 years. Moreover, workload per worker in 2006 is still over 900 recipients per worker.

The state eligibility staff counts reported here include 664 "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 these positions, 101 are dedicated to nursing home eligibility, 29 are in FQHCs, and the remainder perform general Medicaid eligibility for hospitals. About 20% of the slots are vacant, so there are around 560 OEWs working 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.[24]

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 it: 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.

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

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 2 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.

Recent Declines in Texas Children's Medicaid Enrollment				
	December 2005	November 2006	Decline, December to November	
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

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 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 created 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.[25]

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

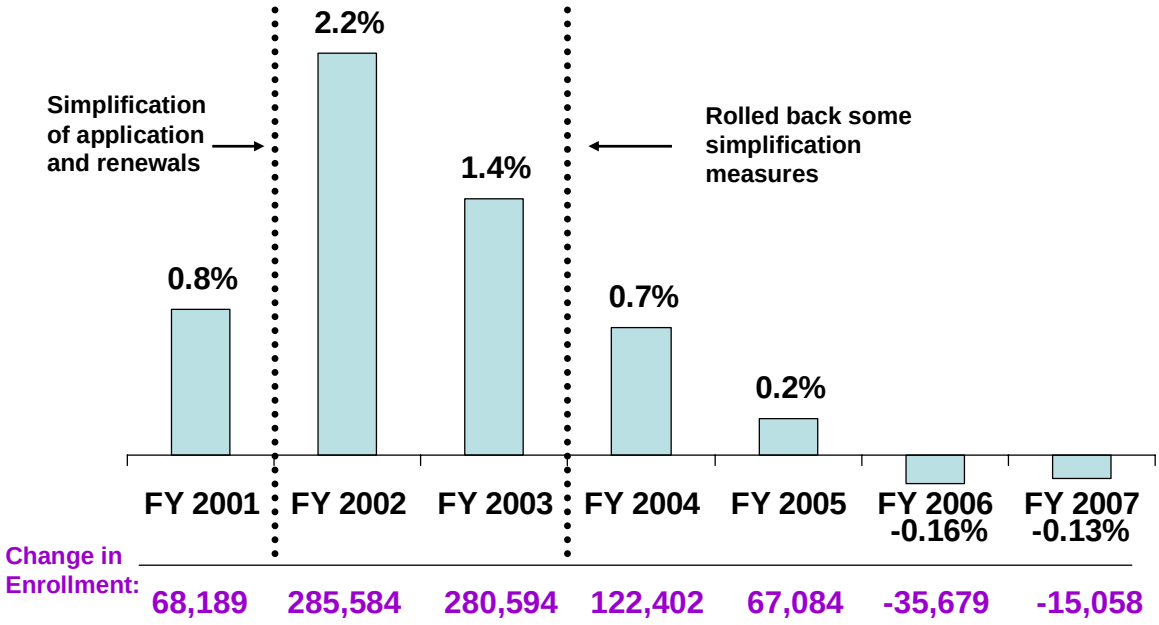
[25] A report compiling family stories of Texas children's problems with the CHIP and children's Medicaid eligibility system will be published by the Children's Defense Fund early in 2007.

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 FY 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.[26]

Average Monthly Enrollment Growth for Texas Children in Medicaid, FY 2001 – FY 2007*



***FY 2007 YTD through 2/07; Avg. annual TX child population growth rate 1.2% (2001-2004)** Source: CPPP analysis of Texas Health and Human Services Commission data

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HHSC Actions to Improve Eligibility Performance. HHSC has taken steps to address the problems with the public and private components of the eligibility system. As mentioned, state staffing levels, while quite low, are some 500 workers higher than at their May 2006 low. Roll-out of Integrated Eligibility has been temporarily halted, so it is possible that the contractor's computer, training, and business model shortcomings can be rectified before they affect not just CHIP but the 4 million Texans receiving Medicaid or Food Stamps. The state has once again allocated funds for CHIP and children's Medicaid marketing, and will pay CBOS to provide outreach and application assistance (though, thus far at 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.[27] In May 2006, HHSC also initiated special polices 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. As this report goes to press, it remains to be seen whether the new contract arrangement will result in significantly improved performance.

July 2007: Congress Adds a New Challenge in Medicaid Citizenship Document Policy. The federal "DRA" budget bill imposed a new requirement that state Medicaid programs demand more documents from U.S. citizens to prove their status (the limited number of immigrants who qualify for Medicaid already had to provide their immigration documents to enroll). Since relatively few Americans have a passport, most must provide a birth certificate along with identity documents to satisfy the new requirement. Texas HHSC has adopted procedures designed to minimize delays and maximize use of Texas' electronic Bureau of Vital Statistics databases, which, if used properly, should ease the paperwork hassle for Texas-born Medicaid clients.

Still, in the first 3 months since the requirement took effect in July 2006, nearly 3,800 new Medicaid applications were denied because of the new policy, most of them children. The relatively large numbers suggest that either 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 1/3 of workers are temporary) or that applicants born in other states are not getting the help they need to get copies of their birth certificates.

[27] 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.

Denials of New Texas Medicaid Applications for Citizenship Documentation, 8-06 through 10-06

	August	September	October	Row total
Pregnant Women	123	252	201	576
Child < age 1	20	92	88	200
Child 1-5	161	473	657	1,291
Child 6-18	94	370	571	1,035
Adults (TANF level)	147	262	256	665
Column total	545	1,449	1,773	**3,767**

Source: Texas Health and Human Services Commission

December 2006: Status of Children's Medicaid and CHIP: Hopeful Signs, but Not Out of the Woods. As this report goes to press, the degree to which the problems that have driven down children's caseloads over the last 12 months are resolved is unclear.

The most hopeful signs are 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 are not yet clearly recovered, the program has reported renewal rates of 73% or higher since June 2006—after a 5-month run of rates below 57%. CHIP rolls are still 181,000 below the September 2003 benchmark, but they have risen back to the levels of August and September 2005.

Children's Medicaid enrollment in November (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 is not possible to identify a clear trend at this time.

Discouragingly, families continue to report new examples of often outlandish problems with the eligibility systems. For example, the CHIP contractor has still not eliminated system problems that cause families to receive letters with current postage dates warning of CHIP terminations, but which make reference to documentation deadlines that are months in the past, and which call for documents already submitted and/or payments already submitted (and paid by checks which have 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 practiced in carefully submitting all required documents by the proper deadlines, yet their children still lose coverage. In more than one case, children assisted by HHSC officials in restoring coverage due to contractor errors 6 months ago have found themselves once again erroneously terminated at their next 6-month renewal.

Good News: Texas 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. As the regular session of 80th Texas legislature approaches, it is time to identify 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. As the Texas Human Resources and Health and Safety codes provisions below show, the legislature has spoken clearly on their 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)).

Despite 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 far from 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 a 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.

3) Adopt 12 month coverage for children in Medicaid and CHIP.

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 may be the only action Texas can take that is capable of restoring the system to acceptable performance levels, essentially cutting the number of children's renewals per year from 4 million to 2 million.

It might also save the state money. It has been suggested that the shorter 6-month period reduces state dollar costs by shifting kids more quickly from Medicaid to CHIP, with its higher federal match rate. However, HHSC data have consistently shown that the number of kids moving from CHIP to Medicaid each month is far higher than the number of children moving from Medicaid to CHIP, resulting in a net loss in state dollars. Achieving "savings" by leaving eligible children uninsured should not be a public policy strategy.

4) Abandon CHIP policies that are not working.

As explained in the report, the 2003 conversion of the CHIP 90-day crowd-out prevention policy into an across-the-board **90-day delay** had the effect of delaying health care for newborns, as well as children who have been uninsured for years, or their entire lives, instead of acting as a disincentive to dropping private coverage. No other state has ever had such a policy, and HHSC's independent evaluator for CHIP (ICHP) has reported that, under the original Texas policy, less than 1% of new CHIP enrollees dropped private coverage to enroll in CHIP. The original Texas CHIP policy was effective and fair, and should be restored.

Texas is one of only two states with a **CHIP asset test**, and the only other state uses a cash limit twice as high. In a rush to implement the unplanned provision, HHSC simply adopted the Food Stamp limits, designed for a population with half the income. Texas should drop the CHIP asset test, or at the very least, reform the policy to accommodate the higher incomes and to encourage appropriate asset development among low-income families.

Finally, the elimination of **income deductions for child care and child support paid out** has had perverse unintended consequences. Parents of the youngest children (infants, toddlers, and pre-school age), who face the highest child care costs are much more likely to have to choose between child care and health care than parents whose children are school aged. The current policy of child support payments means that 2 different households have to claim child support income: both the household of the parent who makes the payment, and the household that receives the payment. Texas children have denied CHIP as a result of this nonsensical policy. The original CHIP policy gave parents credit for a portion of their child care expenses, and all child support payments to another household (a positive incentive to make payments). The 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-based (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 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. In 2002-2003, CBOs outreach was funded at $6.1 million, and direct marketing at $3.8 million. Funding for FY 2007 and beyond should be increased to match the earlier years, and to add new capacity 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 use of out-stationed eligibility workers, in collaboration with the providers who pay for their work. Allowing OEWs to 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.

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 adequate attention to ensuring minimally-acceptable state staff-to-client ratios in the eligibility system. The state's data show employees cut by more than half while caseloads grew, resulting in client loads per worker more than doubling, and with no compensating improvements in the 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. 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 system cannot function properly with one-third of positions filled by temporary workers, as evidenced by our current failure to meet federal law timeliness standards in our largest urban areas. The Legislature should seek to restore workloads comparable to or better than those in 2003.

Outsourcing and privatizing public functions should never be used to escape accountability for the performance of those public functions. 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.

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.

Most recent: http://www.kff.org/medicaid/upload/7608.pdf.

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

Texas Health Care: What Has Happened and What Work Remains, Austin, Texas, 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: the 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: the 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: the 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, D.C.: 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, D.C.: 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:

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

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

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

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.*** 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.

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Appendix B: Texas Children's Medicaid and CHIP Enrollment History, May 2000-December 2006

	Children's Medicaid	Medicaid Change from prev. mo.	CHIP	CHIP Change from prev. mo.	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
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

	Children's Medicaid	Medicaid Change from prev. mo.	CHIP	CHIP Change from prev. mo.	Combined Coverage
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			326,231	4,890	

Source: All data from Texas Health and Human Services Commission.

Appendix C: Texas CHIP Enrollment Decline, September 2003 to February 2007

Source: Texas Health and Human Services Commission

Data analysis by Center for Public Policy Priorities, P. Fatehi

BY COUNTY ALPHA

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Anderson	978	607	-371	-37.9%
Andrews	572	241	-331	-57.9%
Angelina	1,539	860	-679	-44.1%
Aransas	551	251	-300	-54.4%
Archer	150	55	-95	-63.3%
Armstrong	60	21	-39	-65.0%
Atascosa	1,189	620	-569	-47.9%
Austin	577	336	-241	-41.8%
Bailey	233	130	-103	-44.2%
Bandera	437	198	-239	-54.7%
Bastrop	1,668	887	-781	-46.8%
Baylor	157	58	-99	-63.1%
Bee	694	435	-259	-37.3%
Bell	3,445	1,908	-1,537	-44.6%
Bexar	31,075	22,516	-8,559	-27.5%
Blanco	236	124	-112	-47.5%
Borden	15	3	-12	-80.0%
Bosque	538	248	-290	-53.9%
Bowie	1,111	707	-404	-36.4%
Brazoria	5,483	3,168	-2,315	-42.2%
Brazos	2,062	1,270	-792	-38.4%
Brewster	168	57	-111	-66.1%
Briscoe	53	20	-33	-62.3%
Brooks	267	132	-135	-50.6%
Brown	768	354	-414	-53.9%
Burleson	394	194	-200	-50.8%
Burnet	1,063	662	-401	-37.7%
Caldwell	1,014	594	-420	-41.4%
Calhoun	561	254	-307	-54.7%
Callahan	403	181	-222	-55.1%
Cameron	13,505	8,128	-5,377	-39.8%
Camp	357	225	-132	-37.0%
Carson	114	34	-80	-70.2%
Cass	751	390	-361	-48.1%
Castro	266	143	-123	-46.2%
Chambers	495	269	-226	-45.7%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Cherokee	1,237	845	-392	-31.7%
Childress	158	61	-97	-61.4%
Clay	222	93	-129	-58.1%
Cochran	121	46	-75	-62.0%
Coke	84	28	-56	-66.7%
Coleman	262	119	-143	-54.6%
Collin	4,626	3,999	-627	-13.6%
Collingsworth	84	51	-33	-39.3%
Colorado	600	270	-330	-55.0%
Comal	1,524	965	-559	-36.7%
Comanche	466	222	-244	-52.4%
Concho	106	42	-64	-60.4%
Cooke	631	442	-189	-30.0%
Coryell	746	418	-328	-44.0%
Cottle	46	36	-10	-21.7%
Crane	161	31	-130	-80.7%
Crockett	140	50	-90	-64.3%
Crosby	243	124	-119	-49.0%
Culberson	110	46	-64	-58.2%
Dallam	249	120	-129	-51.8%
Dallas	48,206	37,316	-10,890	-22.6%
Dawson	394	195	-199	-50.5%
De Witt	414	262	-152	-36.7%
Deaf Smith	611	287	-324	-53.0%
Delta	127	64	-63	-49.6%
Denton	5,633	3,843	-1,790	-31.8%
Dickens	64	12	-52	-81.3%
Dimmit	449	157	-292	-65.0%
Donley	109	59	-50	-45.9%
Duval	460	201	-259	-56.3%
Eastland	706	326	-380	-53.8%
Ector	3,956	1,721	-2,235	-56.5%
Edwards	102	37	-65	-63.7%
El Paso	22,082	14,067	-8,015	-36.3%
Ellis	2,177	1,598	-579	-26.6%
Erath	756	421	-335	-44.3%
Falls	279	192	-87	-31.2%
Fannin	656	348	-308	-47.0%
Fayette	609	349	-260	-42.7%
Fisher	142	34	-108	-76.1%
Floyd	269	130	-139	-51.7%
Foard	61	39	-22	-36.1%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Fort Bend	7,577	5,840	-1,737	-22.9%
Franklin	286	176	-110	-38.5%
Freestone	322	170	-152	-47.2%
Frio	602	286	-316	-52.5%
Gaines	962	472	-490	-50.9%
Galveston	4,436	2,922	-1,514	-34.1%
Garza	183	85	-98	-53.6%
Gillespie	696	353	-343	-49.3%
Glasscock	50	25	-25	-50.0%
Goliad	114	74	-40	-35.1%
Gonzales	526	262	-264	-50.2%
Gray	453	185	-268	-59.2%
Grayson	2,045	1,193	-852	-41.7%
Gregg	2,983	1,668	-1,315	-44.1%
Grimes	478	249	-229	-47.9%
Guadalupe	1,565	1,133	-432	-27.6%
Hale	910	472	-438	-48.1%
Hall	100	56	-44	-44.0%
Hamilton	297	148	-149	-50.2%
Hansford	190	71	-119	-62.6%
Hardeman	109	42	-67	-61.5%
Hardin	1,567	735	-832	-53.1%
Harris	93,901	67,701	-26,200	-27.9%
Harrison	1,243	719	-524	-42.2%
Hartley	43	32	-11	-25.6%
Haskell	213	103	-110	-51.6%
Hays	2,209	1,480	-729	-33.0%
Hemphill	90	40	-50	-55.6%
Henderson	2,033	1,049	-984	-48.4%
Hidalgo	28,834	16,237	-12,597	-43.7%
Hill	944	559	-385	-40.8%
Hockley	661	271	-390	-59.0%
Hood	1,005	560	-445	-44.3%
Hopkins	832	494	-338	-40.6%
Houston	390	198	-192	-49.2%
Howard	753	430	-323	-42.9%
Hudspeth	134	59	-75	-56.0%
Hunt	1,342	900	-442	-32.9%
Hutchinson	587	268	-319	-54.3%
Irion	64	1	-63	-98.4%
Jack	270	104	-166	-61.5%
Jackson	344	175	-169	-49.1%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Jasper	1,005	412	-593	-59.0%
Jeff Davis	26	19	-7	-26.9%
Jefferson	5,134	2,854	-2,280	-44.4%
Jim Hogg	224	84	-140	-62.5%
Jim Wells	1,468	733	-735	-50.1%
Johnson	3,065	1,812	-1,253	-40.9%
Jones	533	202	-331	-62.1%
Karnes	392	152	-240	-61.2%
Kaufman	1,548	1,259	-289	-18.7%
Kendall	517	227	-290	-56.1%
Kenedy	19	17	-2	-10.5%
Kent	34	3	-31	-91.2%
Kerr	1,196	588	-608	-50.8%
Kimble	146	81	-65	-44.5%
King	9	2	-7	-77.8%
Kinney	80	44	-36	-45.0%
Kleberg	773	494	-279	-36.1%
Knox	181	59	-122	-67.4%
La Salle	177	63	-114	-64.4%
Lamar	1,011	649	-362	-35.8%
Lamb	611	249	-362	-59.2%
Lampasas	484	245	-239	-49.4%
Lavaca	590	261	-329	-55.8%
Lee	463	243	-220	-47.5%
Leon	466	179	-287	-61.6%
Liberty	2,329	1,139	-1,190	-51.1%
Limestone	481	258	-223	-46.4%
Lipscomb	87	39	-48	-55.2%
Live Oak	236	131	-105	-44.5%
Llano	488	231	-257	-52.7%
Loving	0	0	0	0
Lubbock	4,718	2,479	-2,239	-47.5%
Lynn	192	78	-114	-59.4%
Madison	194	152	-42	-21.6%
Marion	227	142	-85	-37.4%
Martin	161	113	-48	-29.8%
Mason	134	65	-69	-51.5%
Matagorda	1,292	641	-651	-50.4%
Maverick	2,346	1,485	-861	-36.7%
McCulloch	357	167	-190	-53.2%
McLennan	3,800	2,221	-1,579	-41.6%
McMullen	11	15	4	36.4%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Medina	948	520	-428	-45.1%
Menard	84	45	-39	-46.4%
Midland	3,318	1,456	-1,862	-56.1%
Milam	551	320	-231	-41.9%
Mills	81	53	-28	-34.6%
Mitchell	225	88	-137	-60.9%
Montague	605	258	-347	-57.4%
Montgomery	6,391	3,915	-2,476	-38.7%
Moore	366	173	-193	-52.7%
Morris	312	193	-119	-38.1%
Motley	47	13	-34	-72.3%
Nacogdoches	894	555	-339	-37.9%
Navarro	517	500	-17	-3.3%
Newton	421	189	-232	-55.1%
Nolan	548	228	-320	-58.4%
Nueces	8,384	4,955	-3,429	-40.9%
Ochiltree	245	103	-142	-58.0%
Oldham	78	28	-50	-64.1%
Orange	2,231	1,087	-1,144	-51.3%
Palo Pinto	711	353	-358	-50.4%
Panola	477	230	-247	-51.8%
Parker	1,654	923	-731	-44.2%
Parmer	308	176	-132	-42.9%
Pecos	415	195	-220	-53.0%
Polk	1,018	551	-467	-45.9%
Potter	2,297	1,248	-1,049	-45.7%
Presidio	213	96	-117	-54.9%
Rains	315	163	-152	-48.3%
Randall	1,525	711	-814	-53.4%
Reagan	214	59	-155	-72.4%
Real	105	40	-65	-61.9%
Red River	352	157	-195	-55.4%
Reeves	438	220	-218	-49.8%
Refugio	208	140	-68	-32.7%
Roberts	7	5	-2	-28.6%
Robertson	363	148	-215	-59.2%
Rockwall	696	536	-160	-23.0%
Runnels	371	184	-187	-50.4%
Rusk	976	631	-345	-35.3%
Sabine	274	134	-140	-51.1%
San Augustine	228	100	-128	-56.1%
San Jacinto	463	315	-148	-32.0%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
San Patricio	2,316	1,248	-1,068	-46.1%
San Saba	186	82	-104	-55.9%
Schleicher	114	42	-72	-63.2%
Scurry	493	151	-342	-69.4%
Shackelford	121	56	-65	-53.7%
Shelby	608	311	-297	-48.8%
Sherman	74	21	-53	-71.6%
Smith	4,571	2,755	-1,816	-39.7%
Somervell	223	100	-123	-55.2%
Starr	3,058	1,881	-1,177	-38.5%
Stephens	347	188	-159	-45.8%
Sterling	47	17	-30	-63.8%
Stonewall	47	21	-26	-55.3%
Sutton	167	60	-107	-64.1%
Swisher	230	133	-97	-42.2%
Tarrant	28,962	20,481	-8,481	-29.3%
Taylor	2,956	1,575	-1,381	-46.7%
Terrell	13	6	-7	-53.8%
Terry	390	170	-220	-56.4%
Throckmorton	80	24	-56	-70.0%
Titus	929	649	-280	-30.1%
Tom Green	2,580	1,329	-1,251	-48.5%
Travis	12,635	9,352	-3,283	-26.0%
Trinity	283	164	-119	-42.0%
Tyler	617	276	-341	-55.3%
Upshur	1,016	530	-486	-47.8%
Upton	110	44	-66	-60.0%
Uvalde	782	525	-257	-32.9%
Val Verde	1,107	715	-392	-35.4%
Van Zandt	1,375	687	-688	-50.0%
Victoria	2,349	1,055	-1,294	-55.1%
Walker	595	411	-184	-30.9%
Waller	914	597	-317	-34.7%
Ward	362	132	-230	-63.5%
Washington	453	306	-147	-32.5%
Webb	8,903	5,094	-3,809	-42.8%
Wharton	1,193	632	-561	-47.0%
Wheeler	151	46	-105	-69.5%
Wichita	1,813	872	-941	-51.9%
Wilbarger	204	122	-82	-40.2%
Willacy	811	439	-372	-45.9%
Williamson	5,377	3,348	-2,029	-37.7%

County Name	September 2003 Enrollment	February 2007 Enrollment	Change from 9/03 to 2/07	% Change
Wilson	805	490	-315	-39.1%
Winkler	349	133	-216	-61.9%
Wise	1,223	619	-604	-49.4%
Wood	995	686	-309	-31.1%
Yoakum	343	115	-228	-66.5%
Young	552	193	-359	-65.0%
Zapata	493	196	-297	-60.2%
Zavala	488	176	-312	-63.9%
Texas	**507,259**	**325,479**	**-181,780**	**-35.8%**