kaiser commission on medicaid and the uninsured

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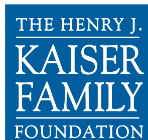
*Prepared by*
Anne Dunkelberg
Center for Public Policy Priorities




February 2003

# kaiser commission on medicaid and the uninsured

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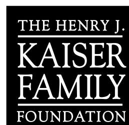


February 2003

## Executive Summary

In 2002, Texas implemented a number of changes to its Medicaid program designed to make it simpler and easier for families to apply for coverage on their children's behalf, as well as to renew their children's coverage after they are successfully enrolled. The changes have resulted in dramatic increases in Medicaid enrollment among eligible children -- between September 2001 and September 2002, an additional 350,000 children secured Medicaid coverage, an increase of 30 percent. Despite the early and dramatic success of the state's simplification efforts, it is not clear that the progress will continue. The state currently is implementing a new requirement under which parents will not be able to use the state's new, simplified mail-in renewal process unless the state has documented that their children are current with all recommended check-ups. The requirement presents a number of challenges for the Medicaid program and could make it more difficult for many families to keep their eligible children enrolled in coverage. In addition, the very success of the state's simplification efforts will likely tempt Texas lawmakers, facing inadequate revenues to support state services in 2004 and 2005, to re-impose procedural barriers to child Medicaid participation as a means of reducing Medicaid spending.

### Texas's Medicaid Simplification Law

Prior to Texas' implementation of SCHIP in 2000, about 600,000 of the estimated 1.4 million uninsured children in the state – close to half -- were believed to be in families income-eligible for Medicaid. When it first implemented SCHIP, the state opted to make it easy for families to enroll their children in coverage by allowing them to mail-in application and renewal forms, allowing self-declaration of assets, streamlining documentation requirements, and offering 12 months of continuous eligibility. In contrast, the families with children eligible for Medicaid enjoyed none of these simplifications. The barriers generated by the far more onerous Medicaid enrollment process were starkly apparent. In the first 10 months of SCHIP operations, 97,512 children applying for SCHIP were referred to Medicaid because their family income fell below the SCHIP eligibility level. Of these, only 24,299 (26%) successfully navigated the Medicaid application process and were enrolled in Medicaid.

In 2001, Texas lawmakers concluded that children's Medicaid application and renewal processes should be reformed to match the SCHIP model, and adopted legislation which made the enrollment procedures nearly identical (Medicaid eligibility was set at 6 months, rather than 12). While they streamlined enrollment procedures on the one hand, the lawmakers also added two new requirements to Medicaid that increased the chances families would find it difficult to renew their children's coverage. As a condition of using the mail-in renewal process in Medicaid, parents must attend an orientation session and they must keep their children up to date on recommended check-ups. Parents failing to meet these standards can be required to go to the welfare office for a face-to-face interview to renew their children's coverage. In comparison, the parents of children on SCHIP are not required to attend an orientation session or demonstrate they have kept their children up-to-date with check ups as a condition of being allowed to use a mail-in renewal form.

## The Effects of Texas's Simplification Efforts

After the implementation of Texas's Medicaid simplification law, the number of children enrolled in Medicaid surged upward. By September 2002, enrollment had jumped 30 percent over the prior year's level and the number of children with Medicaid coverage had reached more than 1.5 million children. Over this same period, the number of adults on Medicaid (who did not enjoy the same simplifications) increased only 6%, suggesting that it was primarily the simplifications that generated the enrollment increases among children rather than economic conditions that also would have driven enrollment increases among adults.

The enrollment among children has increased in large part because of significant improvements in the rate at which families' successfully complete the initial application process under the simplified policies. In the 16-month period prior to implementation, the average monthly approval rate for applications was 57.5%. After implementation of the state's simplification law, the application approval rate increased to 70.1%. Since simplification, the state also has experienced an increase in the rate at which families successfully complete the process for renewing their children's coverage. The renewal rate increased from 73 percent in the four-month period preceding implementation of simplification to 78 percent in the first nine months following simplification.

## The Effects of the New Orientation and Check-Up Requirements

To date, the requirement that parents of newly-enrolled Medicaid children attend a "health care orientation" (HCO) session or lose the opportunity to renew their children's coverage using a mail-in form does not appear to have adversely affected renewal rates. The HCO informs parents of the value of check-ups for children, as well as of the benefits of establishing a stable relationship with a primary care provider and using that provider (rather than the emergency room) to secure care. The HCO has been delivered to 75 percent or more of parents within 60 days of enrollment, and to 84 percent within 120 days.

In contrast, the requirement that parents assure their children are current with their check-ups as a condition of using the mail-in renewal process could pose more challenges. (The series of check-ups are known in Texas as the "Texas Health Steps" or "THSteps" check ups, and they are determined by the Medicaid EPSDT requirement for children.) Although it is not possible to provide data on the effect of the requirement because it is only now being implemented, it appears likely that the state will find it difficult to monitor the extent to which parents have complied with the requirement. In the latest evaluation of Texas Medicaid Managed Care data, only 49% of well-child check-ups found in children's medical records were correctly entered in their HMOs' computer files. Fee-for-service Medicaid data also historically have been dated and incomplete. In addition, chronic shortages of providers willing to conduct THSteps check-ups in many areas of the state may make it difficult for even the most willing parents to comply with the requirement; a recent survey by the Texas Medical Association shows that only 49 percent of Texas physicians are accepting new Medicaid patients, down from 66.8 percent two years ago.

## Conclusion

Texas' simplification efforts in Medicaid have been a major success in removing barriers to participation, as evidenced by a 30 percent increase in children's Medicaid enrollment from

September 2001 to 2002. The next six to nine months will reveal how well the Medicaid program's procedures for implementing the new EPSDT requirement can compensate for the shortcomings of data systems and provider networks.

However, the greatest challenge to the success of eligibility simplification is the state's looming revenue shortfall. Texas lawmakers are likely to consider reversals or even outright repeal of children's eligibility simplification as they attempt to write a budget within projected revenues. To keep the promise of the 2001 eligibility simplification legislation will undoubtedly require the identification of additional revenues. The 2003 Legislative session will thus put to the test Texans' commitment to child health care access.

## Introduction

With less than a full year of experience under Texas' new simplified Medicaid eligibility processes for children, the program reports resounding success, with more than 350,000 additional children enrolled between September 2001 and September 2002. However, the continued success of this effort is in question because of two imminent hurdles.

First, a new policy requiring that parents keep their children up to date with check-ups as a condition of using the simple, mail-in process is beginning to be applied. Because data system capacity limits the state's ability to track check-ups, and a shortage of willing providers limits parents' ability to access the check-ups, concern has been high that the new requirement, reasonable though it seems on the surface, could create a substantial new barrier, replacing those newly eliminated through the streamlining of eligibility processes. It is not yet known whether this requirement will have the effect of substantially reducing children's Medicaid renewal rates.

Second, Texas like all states is experiencing significantly reduced revenue collections. This is expected to result in a shortfall of at least $5 billion between state government current service needs and available funds for the state's next two-year budget (2004-2005). In their search for a balanced state budget, lawmakers will likely be tempted to reverse some or all of the reforms they have just instituted, despite or because of the very magnitude of their success.

**In This Report.** This brief report describes the initial success of Texas' new law in removing barriers to children's Medicaid participation, and the state's performance to date in delivering a new "health care orientation." Also described are the systems that have been developed to track the new requirement for parents that their children be current with EPSDT check-ups as a condition of accessing mail-in re-certification. So far, the one-time health care orientation requirement does not appear to be impeding significant numbers of children from accessing the mail-in option, but the EPSDT mandate presents a much more complex challenge. This analysis describes the major positive impact to date of Texas' new law on children's Medicaid participation, and provides the baseline information needed to observe and interpret how the next phase of implementation, the EPSDT mandate, will enhance or undermine the goal of broader coverage of Medicaid-eligible children in Texas.

## Background: Children's Medicaid Eligibility Before Simplification

When Texas first enrolled children in SCHIP in May 2000, about 600,000 of the 1.4 million uninsured Texas children were in families with incomes at or below the federal poverty income line ($18,100 annual income for a family of 4 in 2002), and another nearly 500,000 uninsured children fell in the SCHIP eligibility range (below 200% of poverty). Since federal law prohibits states from enrolling children who are eligible for Medicaid in SCHIP, Texas could not look forward to real progress in reducing the ranks of uninsured children without dramatically improving Medicaid enrollment of children in its least-prosperous families.

Though Texas SCHIP enrollment practices made participation easy for higher-income parents, prior to children's simplification Texas Medicaid imposed dramatically more burdensome requirements on poorer parents. This "rationing by inconvenience" — making the process difficult simply to keep state spending down — was imposed on parents who are more likely to have a hard time getting off work to go to a welfare office, who lose income when they do, and

who are likely to face greater transportation barriers as well. Major differences in SCHIP and child Medicaid requirements included:

**Mode of Application.** SCHIP applicants enrolled entirely by mail; parents of Medicaid applicants had to complete an in-person interview at a DHS office.

**Period of Eligibility.** SCHIP eligibility is for 12 full months, regardless of any change in family income. Parents of children in Medicaid had to report income changes within 10 days; and if income was too high the child lost eligibility in the following month.

**Re-certification.** CHIP parents must update eligibility information by mail annually. Medicaid parents had to re-visit the DHS office every 6 months, even if they had no income changes.[A]

**Assets Test.** Texas CHIP eligibility is not affected by non-income assets a family may have. For Texas Children's Medicaid, a family could not have more than $2,000 in assets such as money in the bank, savings, land, automobiles, pension benefits, etc. A family home and one automobile were exempted from this limit for children. Fair market value in excess of $4,650 of any car not exempted counted toward the family's $2,000 limit.

**Proof, Verification, Documentation.** Parents applying for CHIP must mail in proof of income, child care expenses or child support paid to another household (if they want those costs deducted from income), and copies of the child's immigration documents for a legal immigrant child. Parents applying for Texas Children's Medicaid had to provide all of the above, plus: birth certificates or school records; proof of assets, residence, past employment history; and other insurance, if a child had other health insurance.

Focus group research with Texas parents of Medicaid-eligible children confirmed what national researchers had reported: that "stigma" attached to Medicaid is not universal or clear-cut. Parents with Medicaid experience expressed approval for the program, along with strong expressions of gratitude for the benefits it provides their children. Roughly half the parents participating in the focus groups labeled Medicaid as "health insurance" or "help with medical expense for low-income families." However, most parents also reported negative experiences with the Medicaid eligibility process. Complaints included waits of many hours at the DHS office (despite having an assigned appointment time), inconsistent information and documentation requirements, perceived rude treatment by front-line staff; documents lost by DHS staff, and intrusive questions about sexual activity (related to medical support enforcement). Parents reported offices not equipped to accommodate children, and a lack access to food or drink while waiting. Leaving the waiting area to use the restroom, change a diaper, or quiet a fussy child could result in losing their appointment. While some parents interviewed regarded Medicaid as "part of welfare" and had some reservations about enrolling their children, it appeared that actual experiences of difficulty and perceived indignity of the eligibility process were the greatest disincentives to participation.[1]

Texas' early experience with SCHIP outreach demonstrated the barriers presented by the Medicaid requirements. When parents submitted mail-in applications to SCHIP for children who appeared to Medicaid-eligible, those applications were "referred" to DHS. As of February 2001, only 24,299 (26%) of the 97,512 children whose referrals to TDHS had been completed have been enrolled in Medicaid. Another 56,553 (58%) had been denied for procedural reasons —

[A] Many families receiving Food Stamps benefits as well were required to return to DHS every 3 months.

missed appointments, incomplete information, or "other" reasons. Because the Medicaid application process was not completed, these children could not enroll in either Medicaid or CHIP. Presented with this evidence of the contrast between SCHIP and Medicaid policies, Texas lawmakers concluded that children's Medicaid eligibility processes should be reformed to match the SCHIP model.

## Eligibility Simplification Law Adopted

In May 2001, the Texas Legislature passed legislation designed to make children's Medicaid eligibility procedures simpler and more like the processes in place for the state's separate SCHIP program.[2] The new law included several core elements:

- A single consolidated application and parallel procedures for children's Medicaid and SCHIP, including simple documentation requirements;
- Mail-in application and re-certification for children's Medicaid (i.e., without a face-to-face interview);
- a simplified, self-declared assets test for children's Medicaid, with no additional documents or proof required (i.e., the same treatment of assets used in the state's SCHIP program); and
- phased in continuous eligibility for children under age 19, with 6 months continuous eligibility implemented by February 2002. Transition to 12 months continuous eligibility was authorized to begin as early as September 2002 and no later than June 2003, a schedule which makes it possible for the Texas Legislature to pre-empt the transition to 12 months coverage during its 2003 session. Texas Medicaid has held continuous eligibility at the 6-month level thus far.

In addition, to reduce gaps in coverage when children lose Medicaid due to increased income, "aging out" of a Medicaid category, or failure to respond to a first notice to re-certify, several directives for the Texas Department of Human Services (DHS) were added to improve transitions from Medicaid to SCHIP.

Provisions of the law apply only to Medicaid applicants and enrollees under age 19; simplification is not extended to any adult coverage groups. Children eligible for Medicaid automatically due to SSI receipt are not included in the simplified processes.

**Compromise Adds New Requirements for Parents.**[A] Though the record votes do not reveal it, this legislation was controversial, and resisted by Legislators who wanted to avoid the immediate increased cost of covering more children as well as those motivated by a generic opposition to entitlement programs. In a move to gain conservative support for the bill, House leaders accepted two amendments offered by conservative legislators. Both amendments added new requirements for parents in conjunction with the enrollment and re-certification processes for children's Medicaid — requirements that do not apply to parents enrolling their children in SCHIP. First, parents of newly-enrolled children are required to participate in a one-time, newly-created "health care orientation." The second amendment also directed the Medicaid program to adopt rules to ensure that children on Texas Medicaid "comply with the regimen of

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[A] Many children enrolled in Medicaid live with caretakers other than parents; for simplicity, this report uses the term "parent" to include both parents and other caretakers.

care prescribed by Texas Health Steps" (Texas Medicaid's Early and Periodic Screening, Diagnosis and Treatment program, EPSDT).

Although the statutory language does not mandate or specify a penalty for parents who fail to comply with these requirements, the state's Medicaid program has adopted rules which require parents who do not meet the new requirements to go to a Texas Department of Human Services (DHS) eligibility office to renew the child's coverage. In other words, the rules make access to simplified child Medicaid eligibility processes contingent on parents accessing (1) the one-time orientation, and (2) the full schedule of check-ups recommended by the Texas Health Steps. Neither requirement is applied to parents of children enrolled in SCHIP.

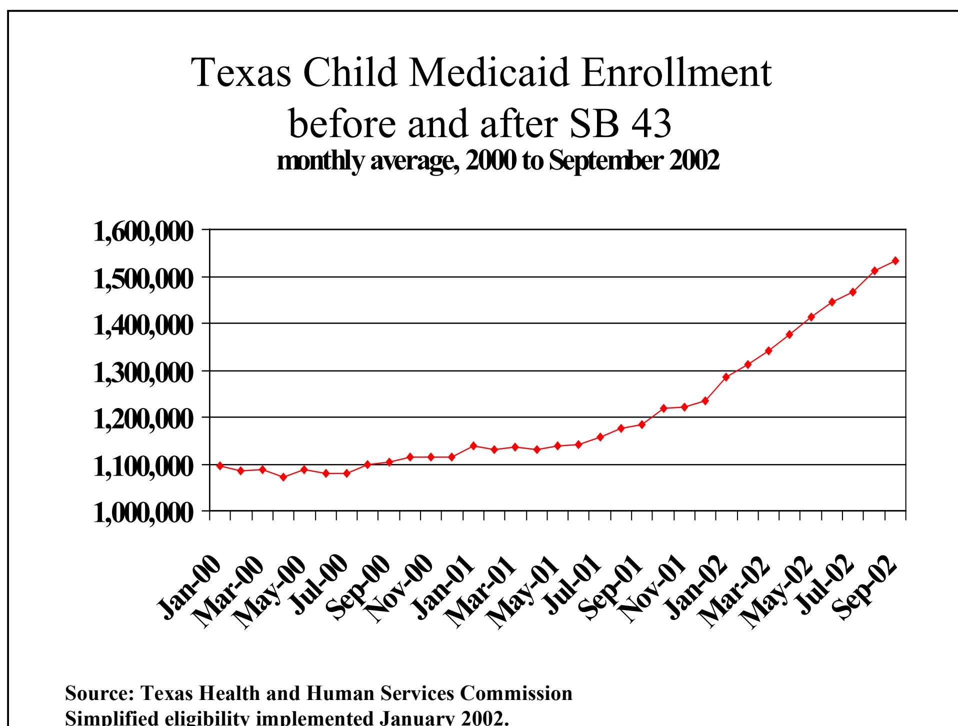
## Children's Medicaid Enrollment Trends in Texas

Texas has, among the states, had for more than a decade one of the highest percentages of children (and residents overall) who lack health insurance. Prior to SCHIP implementation, analysis of Census data suggested that uninsured Texas children were more concentrated at low incomes than the national average. Children at Medicaid income levels (at or near poverty income), but not enrolled, accounted for more than 42% of uninsured children in 2000. As described below, eligibility simplification has dramatically reduced the number of Medicaid eligible, not enrolled uninsured children. By mirroring SCHIP enrollment and renewal policies, Texas Medicaid has demonstrated that effective outreach and reasonable enrollment procedures can overcome years of low child Medicaid participation.

**Decline Linked to Welfare Reform.** As in many states, Texas Medicaid rolls declined precipitously from 1996 through late 1999. Monthly total caseloads dropped 15% from January 1996 to December 1999, a drop of 317,680 which included 208,518 children. Expansion of coverage to teenagers below poverty under the option created by the Balanced Budget Act of 1997 (and associated outreach), which began in July 1998, offset enrollment losses somewhat to prevent an even steeper decline. First-ever efforts at outreach and informing of Medicaid clients[3] (and eligibility workers) about the de-linking of Medicaid and TANF in fall 1999 contributed to the first signs of reversal of the decline. Outreach efforts related to SCHIP implementation followed shortly beginning in March 2000, and this new application pathway also added to caseload growth.

**SCHIP Outreach Impact.** Parents of children referred to Medicaid via Texas' SCHIP application process before children's Medicaid simplification (referred to from this point as "eligibility simplification") were required to complete a face-to-face interview requiring extensive additional documentation at a DHS eligibility office. This unpopular and time-consuming requirement resulted in 58% of applicants referred to Medicaid not completing the enrollment process, leaving their children ineligible for either Medicaid or SCHIP.[4] Despite this high attrition rate, Medicaid enrollment grew by over 91,000 children between December 1999 and September 2001, about half of whom applied through the SCHIP "TexCare Partnership" process. As of September 2001, monthly average child Medicaid caseload had climbed to 1,184,053, but remained below the 1996 level.

**Eligibility Simplification Implemented.** Most of the Medicaid simplification bill's provisions took effect in January 2002. While child Medicaid enrollment had begun a slow climb as early as December 1999, enrollment growth since eligibility simplification has been explosive. The September 2002 monthly average of 1,534,589 is over 350,000 more children above the September 2001 figure — a 29.6% increase.[A] At these enrollment levels, Texas' children's Medicaid simplification has not only fully reversed the dramatic loss of coverage by children who left TANF cash assistance (but who, under law, should have received ongoing Medicaid coverage), but also reached an all-time high. Of course, some of this growth is related to the downturn in the economy. Growth in adult Medicaid enrollment (which has not been simplified) over the same September-to-September period was over 44,395 (about 6%), suggesting that the impact of economic conditions is modest in comparison to the impact of simplification.[5]



Source: Texas Health and Human Services Commission
Simplified eligibility implemented January 2002.

**SCHIP Enrollment Moderates.** In contrast to the child Medicaid enrollment trend, Texas SCHIP enrollment has for the first time since its May 2000 inception shown signs of slowing; enrollment as of November 1, 2002 at 503,748 children is about 25,500 fewer than in May 2002. This due in some part to the impact of continuous eligibility in child Medicaid under eligibility

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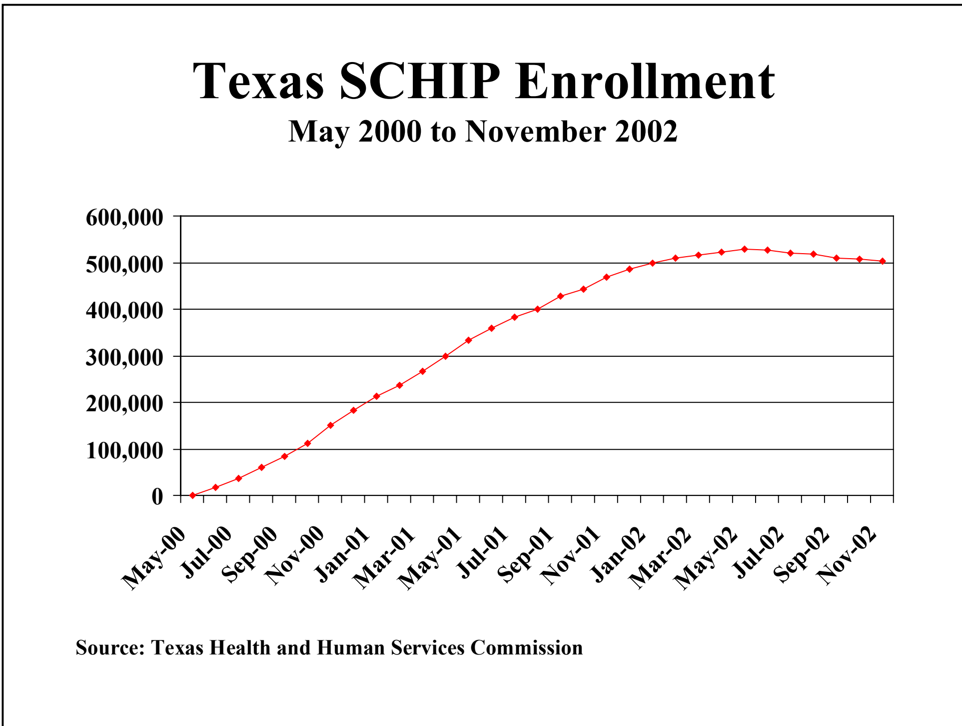
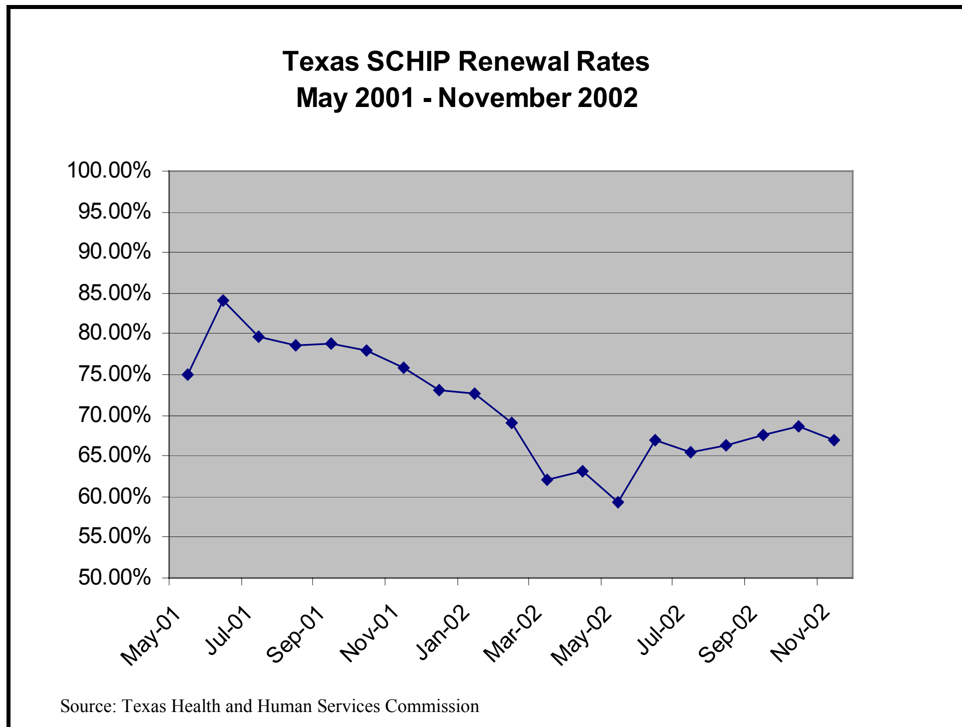
[A] Technical Notes: The enrollment surge resulting from the January 2002 implementation of eligibility simplification affects enrollment statistics back to October 2001 due to "3 months prior" coverage under Medicaid. Texas Department of Human Services eligibility system experts note that September monthly enrollment figures are always lower than average, due to an earlier "cut-off" date (to process annual changes to Food Stamp and TANF standards) for processing applications and re-certifications. Using September as a point of comparison does not distort the overall trend; August 2001 to September 2002 growth was almost 360,000 children for a 31% increase. Totals do not include children in SSI, or persons under age 19 covered as TANF caretakers or as pregnant women; eligibility simplification is not applied to these eligibility groups. Addition of these children and youth for September 2002 would add approximately 70,700 for a revised September 2002 total of 1,605,295.

simplification (children are no longer subject to month-to-month loss of Medicaid coverage due to minor income fluctuations, resulting in a transition to SCHIP), and may also reflect more family incomes dropping below the Medicaid threshold with the continued sluggish economy. Another contributing factor is that the new requirement in the joint Medicaid-SCHIP application of a social security number for all applicant children (previously optional when the application was for SCHIP only) allows the state to avoid enrolling children in SCHIP who are already enrolled in Medicaid. However, the strongest factor behind the recent enrollment decline is probably lower SCHIP renewal rates, which averaged 77% from May 2001 to January 2002, but dropped to 66% from January to November 2002. The state's current data reporting systems unfortunately do not capture what proportion of these children are departing CHIP due to reduced income and are enrolled subsequently in Medicaid, or the proportion leaving CHIP due to excess income.






**Impact on Total Numbers of Uninsured Children.** The latest U.S. Census three-year average estimate (1999-2001) finds Texas in a statistical dead heat with New Mexico for the highest uninsured rate in the U.S., with 23.0% of all Texans uninsured (25.9% of Texans under age 65). Despite the disappointing evidence that the overall number of uninsured Texans grew by about 500,000 between 1999 and 2001, there was one important area where insurance coverage improved. According to the same Census Current Population Survey (CPS) reports, the increase in the number and percentage of uninsured Texans was due entirely to increases in the number of adults without coverage, and Texas had an overall decrease in children without health insurance.

The Census data indicate that the number of children who were covered by Medicaid or SCHIP grew by 341,000 from 2000 to 2001. The number of low-income children (with incomes below 200 percent of the poverty line, or about $30,000 for a family of three) who were uninsured fell by about 83,000, but uninsured children above 200% of poverty grew by about 6,600, for a net reduction of about 77,000 children.[6]

The Census data do not appear to have fully captured the impact of Texas Medicaid and SCHIP enrollment on insurance status in 2001. Census experts say that people typically underreport their participation in SCHIP and Medicaid when they answer Census surveys, and Census data and administrative data about enrollment in SCHIP and Medicaid typically do not match. While the Census data show the number of children covered by Medicaid and SCHIP grew by 341,000 from 2000 to 2001, both CMS administrative data (unduplicated counts) and Texas HHSC administrative Medicaid and SCHIP data (monthly averages) show that child public program participation actually grew by more than 371,000. Thus, child Medicaid and SCHIP coverage appears to have grown by over 30,000 more than is shown in the Census data, and the number of uninsured low-income children may have actually fallen by as much as 107,000 in 2001, which

would increase the evidence that these programs were lowering uninsured rates among Texas children.

The number of uninsured low-income Texas children would have dropped even further, except that about 157,000 low-income children lost private health insurance coverage during the same time period. The Census data show that the number of low-income children who had employer-sponsored coverage fell by 129,500 and the number with other private insurance fell by about 27,800. This drop-off in private health insurance coverage for children parallels other trends showing that the number of adults who had private health insurance in Texas and in the rest of the nation dropped sharply in 2001, yet it is notable that the drop was far lower than that experienced by Texas adults.

Beyond limitations of the CPS, these newest Census numbers (2001) are not recent enough to capture the impact of children's Medicaid eligibility simplification and continued growth in SCHIP in 2002, after the time period CPS examined in the recent statistics. Texas' SCHIP program grew by more than 17,000 from December 2001 to November 2002, and child Medicaid increased by 300,000 from December 2001 to September 2002. However, it is impossible to estimate the current number of remaining uninsured children, since loss of employer-sponsored coverage due to job loss and high health insurance premium increases is likely to have once again offset some of the gains in covering children through SCHIP and Medicaid.

## Rulemaking and Eligibility Simplification

The agency with primary responsibility for Medicaid in Texas is the Health and Human Services Commission (HHSC), which is the "single state agency" for Medicaid and directly administers much of the program operations. Eligibility staffing and computer systems reside with the Texas Department of Human Services (DHS), and Texas Health Steps (THSteps, Texas' EPSDT program) operations are located at the Texas Department of Health (TDH). Policy development, coordination and related rulemaking are the responsibility of HHSC.

When rule promulgation related to eligibility simplification began in 2001, HHSC proposed to make access to mail-in renewal of children's coverage contingent on completion of the new health care orientation (HCO), and on children being current with EPSDT-recommended check-ups. A broad coalition of child health advocates disagreed with the agency decision because the enacting law did not mandate a penalty for parents who fail to comply with these requirements; the law says only that parents must receive an orientation and that their children must be up-to-date with their check-ups. However, key legislators indicated to HHSC that they did not oppose limiting access to mail-in renewal for parents who do not meet these standards, as long as the standards were applied in a highly flexible manner that did not penalize parents who cannot comply with the requirements due to shortcomings of the Texas Medicaid system.

The resulting final rules did make access to the simplified renewal contingent on the 2 new requirements. Medicaid program operating procedures for enforcing the new requirements generally are designed to "work around" the numerous system weaknesses that could prevent parents from meeting the standards. However, as this report illustrates, systems for data collection and reporting related to tracking the delivery of the HCO, "compliance" with EPSDT-recommended check-ups, and how often parents are denied access to the mail-in process are in

various stages of development. Some information is readily available, while other data systems are still being created.

## Initial Application Approval

The first indication of improved ease of application for children's Medicaid is reflected in significantly higher approval rates for initial applications under the new mail-in policy, with its simpler documentation requirements. Texas Department of Human Services (DHS) data show a substantial increase in average approval rates for children's Medicaid applications since the January 2002 launch of eligibility simplification. In the 16-month period prior to implementation, the average monthly approval rate was 57.5%. From January to September 2002, the average approval rate increased to 70.1%. (Source data provided in Appendix 1.)

## Health Care Orientation

During rulemaking, advocates were concerned about the speed with which HHSC and TDH would have establish a system to deliver the HCO. The health care orientation did not exist, no network was in place to deliver the orientation, and no funds had been appropriated to pay for new state staff or for community based organizations (CBOs) to deliver the orientation. Agency staff at HHSC, TDH and DHS responded by developing operating procedures intended to compensate for system shortcomings, and to ensure that parents are not penalized unfairly.[7]

**HCO Options.** Generally, the HCO requirement is a one-time requirement.[A] Only parents or guardians whose children are newly Medicaid certified after January 1, 2002, are subject to the HCO requirement. Parents (or caretakers) may meet the HCO requirement in one of several ways:

- attend an in-person HCO provided by THSteps or volunteer CBO in a group setting, or in a one-on-one session in an office or the caretaker's home;
- accompany the child to a THSteps medical check-up or a medical visit for any reason;[B]
- receive the HCO over the phone from THSteps staff and concurrently in the mail as an insert in the DHS notification of certification letter; or
- receive the HCO in a DHS office from a DHS eligibility caseworker at a face-to-face renewal visit.[C]

**Delivering the HCO.** Because Texas' EPSDT program already had systems in place charged with establishing regular contacts with the parent or caretaker of every child enrolled in Texas Medicaid, program officials chose to use this network as the basis for delivering HCOs at implementation. Texas' EPSDT program (operated by the Texas Department of Health, TDH)

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[A] Families with prior Medicaid coverage, but with gaps in service greater than two years will need to meet the HCO requirement.

[B] The authors of the statutory requirement for the HCO specified that an EPSDT medical visit could substitute for the one-time HCO, on the assumption that health care providers will perform an equivalent function to the HCO. This is separate and apart from the ongoing requirement for children to be current on their EPSDT check-ups.

[C] Although DHS rules and HHSC web site information suggest DHS workers may deliver the HCO when a family is initially applying for coverage, this is not currently the case.

currently contracts with a private vendor to provide THSteps outreach and informing activities in much of the state, while TDH regional staff perform these THSteps functions in 3 regions of the state.[8] Because the contractor covers most of the state's major urban centers, 78% of the HCO "demand" since implementation of eligibility simplification has occurred within the contractor's service area. About 50% of the contract staff are bilingual Spanish-speaking, and most other non-English languages are accommodated via telephone translation. The program staff report they are accessing translation services for about 30 different languages every month.

THSteps officials have released statistics describing the first 6 months of HCO delivery. From February to July 2002, 88% of HCOs were delivered by telephone, and the remaining 12% were delivered in some kind of in-person setting, including group presentations (about 50% of these in-person HCOs have been provided via home visits). Some basic HCO delivery statistics are provided in Table 1.

**Table 1: Health Care Orientation Delivery Method Report, February-July 2002**

| Certification Month | Total HCOs provided | Number by Telephone | Percent by Telephone | In Person* | Percent In Person |
|---|---|---|---|---|---|
| **February** | 7,151 | 6,197 | 87% | 954 | 13% |
| **March** | 9,232 | 8,269 | 90% | 963 | 10% |
| **April** | 13,771 | 12267 | 89% | 1,504 | 11% |
| **May** | 22,517 | 20,006 | 89% | 2,511 | 11% |
| **June** | 14,410 | 12,453 | 88% | 1,687 | 12% |
| **July** | 13,272 | 11,684 | 88% | 1,588 | 12% |
| **Totals, YTD** | **80,083** | **70,876** | **88%** | **9,207** | **12%** |

**In person includes home visits, office visits, group presentations, and CBO-delivered HCOs.*
*Source: Texas Department of Health*

In the process of implementing the new HCO, THSteps staff report that they have had to confront anew a long-standing problem afflicting EPSDT outreach efforts: the significant number of Medicaid applicants who do not have a telephone available to them, and the small but persistent number of applicants whose mailing addresses prove to be incorrect. In order to minimize the number of clients missed because the family moved to a new home shortly after application, THSteps staff began attempting immediate contacts, rather than mailing letters to parents; still, a significant number of parents could not be contacted with the information in the Medicaid system.

THSteps contract staff estimate that 35-40% of parents are reached through initial phone calls. The remainder require some additional follow-up, ranging from research to obtain a correct phone number or address, to home visits by field-based outreach workers. Parents not contacted by centralized staff after 3 weeks are referred to local field staff, who attempt to make phone or home visit contact for another 5 weeks. At 45 days, parents not contacted are placed on a high priority list for intense efforts to make contact, and at 50 days those remaining are mailed a letter requesting that they contact THSteps. If a parent cannot be reached within 60 days, the focus for

contact shifts to reaching the parent via the renewal process, described below. This system is resulting in successful contacts with 75% or more of "HCO candidates" (parents of newly-enrolled children) within 60 days of the child's Medicaid enrollment. By 120 days, TDH reports that the HCO completion rate increases to 84%. THSteps conveys information on HCOs delivered to the DHS system at weekly intervals.

The question of why so many parents cannot be contacted is of interest, since a correct mailing address is necessary in order for the parent to receive the monthly Medicaid ID letter, without which a child cannot access Medicaid health care. Of the parents not reached in a recent month, THSteps staff reported only 4% had supplied addresses that appeared to be nonexistent. In 36% of cases not reached, workers had made 2 to 4 home visits and found no one at home. 20% had moved, and 11% had provided insufficient information to physically locate the home, such as a post office box, or failure to include an apartment number. Safety issues for field workers attempting home visits, plus a growing number of locked apartment complexes to which the field workers cannot gain access are also factors hampering attempts to reach parents.

**Tracking Compliance with the HCO Requirement** According to rule, if a parent does not fulfill the HCO requirement, he may be required to renew the child's Medicaid in a face-to-face interview at a DHS office, rather than by mail. For this reason, oversight and tracking of compliance with the HCO requirement is linked to the 6-month child Medicaid renewal process. Procedures to track HCO delivery at the 6-month renewal point must accommodate logistical challenges of communicating information between the separate computer systems serving the TDH THSteps program and the DHS eligibility operations (which combine Medicaid, TANF, and Food Stamp eligibility and utilization history). Additionally, DHS is in the process of replacing its 30 year old mainframe system. This transition requires that the old and new systems run simultaneously over a 20-month period. During this transition period, very few changes can be made to either system, complicating the Medicaid program's ability to fine-tune any eligibility system processes.

Medicaid renewal packets are mailed at the beginning of the 4th month of a child's 6-month eligibility period. (Table 2 includes early data on the proportion of cases showing completed HCOs in DHS files at the point when renewal packets are mailed.) This timing is needed both to meet the monthly "cut-off" dates demanded by the old mainframe system, and to facilitate completion of the renewal process by the middle of the 5th month to allow sufficient time to "deem" (or automatically enroll) a child to SCHIP if he is no longer eligible for Medicaid due to income or assets. (More on efforts to eliminate gaps in coverage when children move from Medicaid to SCHIP is provided later in this report.) If the renewal form has not been received at beginning of the 5th month, a reminder is be mailed, stressing the importance of keeping Medicaid coverage, and the availability of CHIP for families whose incomes may have increased.

Table 2:
**Health Care Orientations (HC0s) Completed Prior to Renewal Mailings**

| New Caretaker Month | Total New HCOs Needed | HCOs Completed | Percent | HCOs Not Completed | Percent |
|---|---|---|---|---|---|
| March 2002 | 17,869 | 12,755 | 71.4% | 5,114 | 28.6% |
| April 2002 | 14,569 | 10,588 | 72.7% | 3,981 | 27.3% |
| May 2002 | 16,832 | 12,626 | 75.0% | 4,206 | 25.0% |

Notes:
1. "HCOs Completed" means DHS's data system shows the HCO was complete prior to start of the renewal period (4th month of 6th month eligibility period).
2. A "Caretaker" is an individual who is responsible for the care of Medicaid-enrolled children.
3. "New Caretaker Month" means the month in which the child was first certified for Medicaid and the need for an HCO for the caretaker was identified.

*Source: Texas Health and Human Services Commission, www.hhsc.state.tx.us*

When a parent returns the completed renewal packet to DHS, agency workers check to see if their system indicates that the parent has received the HCO. If the system does not include a record of an HCO, DHS attempts a telephone contact with the parent, offering an opportunity for the parent to self-declare that an HCO (or THSteps visit) has either been received or scheduled. Parents not reached by phone are sent a letter asking the same questions.[A] Parents thus have another opportunity to telephone THSteps, receive the HCO, return the form indicating the completion or scheduling of the HCO, and complete the child's renewal by mail. If the parent responds (by phone or mail) that they have not done either, DHS staff schedule a face-to-face appointment to deliver the HCO. This appointment is generally at a DHS office, though in some regions where processing of the children's renewals is centralized, other arrangements are made. Once the parent receives the HCO, the child's renewal can be processed.

**Content and Efficacy of the HCO.** In creating the HCO, the intent of legislators was to ensure that parents of newly-enrolled children would be informed about the value of check-ups for children, the benefits of establishing a stable relationship with a primary care provider and using that provider for sick care, and the reasons why seeking care for childhood illnesses in the Emergency Room is undesirable. In developing the HCO content, THSteps staff also incorporated the key elements of EPSDT informing; that is, what benefits Medicaid covers for children, including check-ups, immunizations, dental, vision and hearing services, prescriptions, and transportation. Families are offered assistance in locating a primary care provider, and negotiating health plan and provider selection in managed care. Parents are told what forms to expect in the mail, and informed that providers should not send them bills for Medicaid services. Information about WIC and SCHIP is also included. HCO are delivered in English, Spanish, and Vietnamese; clients speaking other languages or with hearing impairments are accommodated

[A] Currently, this letter (DHS form 1024) does not include the THSteps telephone number, though a variety of other materials mailed to the parent do include that information. DHS indicates the number is likely to be added when the form is revised.

through telephone translation services. Importantly, the HCO also now explains the renewal process, including what parents must do in order to renew children's coverage by mail.

As explained previously, the great majority of HCOs are being delivered by THSteps staff, with a smaller number being performed by DHS eligibility staff. While a role for community-based organizations (CBOs) in delivering the HCO in included in the Medicaid program eligibility simplification operating guidelines, thus far the role of CBOs has been quite limited. However, a nonprofit organization has recently completed a video production of the HCO in cooperation with Medicaid officials which they hope will help increase the number of orientations delivered by CBOs.[9] THSteps staff and DHS offices are also planning on using the video.

**Renewal Experience Overall**

Because the HCO requirement is applied at the first 6-month renewal point following a parent's first "simplified" application (i.e., first data were available after June 2002), relatively few months of data are available so far. As noted earlier, data systems for eligibility simplification operations and tracking are still evolving. Data available thus far do not include an accurate count of the number of child Medicaid cases not renewed due to failure to receive the HCO. Informally, state staff say high rates of HCO completion are achieved after the fourth month point in time captured in the table above; they credit ongoing work by THSteps staff and collaboration between DHS staff and THSteps to help parents complete the requirement. "Very few" denials, they say, have resulted from parents failing to access the "last-chance" face-to-face HCO offered by the DHS worker. DHS is attempting to capture an accurate count of such denials, but initial attempts to do so yielded inaccurate results, as workers misunderstood reporting codes and used them for a variety of other purposes. The agency hopes to produce consistent and reliable reports on the impact of the HCO on denials in the near future.

Generally, DHS renewal statistics for children's Medicaid indicate a significant improvement in renewal (re-certification) rates since the implementation of eligibility simplification. The average renewal rate was 73% from September 2000 through December 2001, and for the first 9 months of eligibility simplification has increased to 78%. Aside from this overall rate, other notable changes are a reduction in cases denied for failure to return requested information, which dropped from 12.8% to 1.7% over the same period. (Source data provided in Appendix 2.)

Preliminary data for October 2002 indicate that fewer than 7% of denials of children's Medicaid at renewal in that month were for excess income or assets, and only 0.1% of denials were for failure to attend a face-to-face HCO. The primary reason for non-renewals was failure to return the renewal forms at all, which accounted for 85% of case closures. The system is now designed to close the case automatically if renewal is not entered before the end of the 6$^{th}$ month. Some are terminated due to the parents' failure to return renewal forms, while others are actually simply processed late by DHS, after the automatic closure has been triggered. DHS officials indicate that an as-yet-unknown portion of these cases actually are reactivated in the following month without any interruption in the child's coverage. In these cases, the child's renewal — whether mailed late by the parent or processed late by DHS — shows up as a new application in the 7$^{th}$ month. The agency continues to work to refine data collection and reporting, within the constraints and demands imposed by the transition from an aging system to a new one.

## Medicaid to CHIP Transitions

**New Requirements in the Law.** To reduce gaps in coverage when children lose Medicaid due to increased income, "aging out" of a Medicaid category, or failure to respond to a first notice to re-certify, several directives for the DHS were included in the eligibility simplification legislation. One reason these transitions call for special attention is that while Texas Medicaid can pay bills retroactively for up to 3 months prior to the date a person applies, Texas CHIP currently has no such provision. As a result, if a child leaving Medicaid is not promptly enrolled in CHIP, a period of a month or two with no coverage can result. For a child with special health needs or chronic illness, this can mean unmet medical needs — or expensive medical bills his parents cannot afford to pay.

To address this problem, the bill directed DHS to adopt procedures to help families with children leaving Medicaid to make the transition to CHIP with no interruption in coverage. DHS must promptly transmit information to the SCHIP enrollment contractor about children leaving Medicaid due to income or resources. The agency was also directed to make special follow-up contacts with families whose children face Medicaid termination or denial for procedural reasons, like failure to keep an appointment or failure to provide information. These communications must inform parents of the need to re-certify, and that their children are likely to qualify for CHIP if the family income is now too high for Medicaid.

**Procedures**. As noted, Medicaid renewal packets are mailed at the beginning of the 4th month of a child's 6-month eligibility period. The renewal packet advises the family to return the form within seven days. Reminders about the importance of keeping Medicaid coverage and the availability of CHIP are mailed to families at beginning of 5th month if renewal form hasn't been received. If a family completes the renewal process by the middle of the 5th month, there is sufficient time to "deem" (or automatically enroll) in CHIP a child who is no longer eligible for Medicaid due to income or assets. Eligibility for Medicaid continues through the end of the 6th month. The family receives an SCHIP enrollment packet as soon as the deeming process occurs. If the parent returns the enrollment packet to SCHIP by the middle of the 6th month, enrollment in CHIP is effective the first of the 7th month, with no gap in health coverage.

If there is a delay in CHIP enrollment due to DHS or SCHIP contractor error (e.g., delays in processing the returned renewal form, or in mailing the SCHIP enrollment packet), Medicaid eligibility may be extended for one or two additional months to allow the family time to complete the process and still retain coverage. If the family is responsible for the delay, no action is taken to extend coverage until the child's SCHIP coverage becomes effective. Thus, the new policy can help parents who are vigilant and prompt to avoid interruptions in coverage. DHS has not yet produced statistics on what proportion of children deemed to SCHIP now make the transition without a gap in coverage.

## Next Phase: The Texas Health Steps Requirement

The previous discussion indicates that so far, the HCO requirement is not significantly impeding the success of eligibility simplification. However, the second new parental requirement will present greater challenges both for parents and for Medicaid program operations. State Medicaid eligibility staff will now begin to monitor whether children using simplified enrollment procedures are current with their Texas Health Steps (THSteps: EPSDT) check-ups at the point

when a child is due for his second renewal under eligibility simplification; (i.e., at 12 months). Serious data system limitations, as well as chronic shortages of providers willing to provide THSteps check-ups in many areas of the state must be overcome for this process to work properly.

**The Check-up Schedule.** The new requirement is linked to the medical check-up schedule, and not to the dental standards which are also a part of EPSDT and THSteps. EPSDT screening services (check-ups) must include a comprehensive physical exam, American Academy of Pediatrics (AAP) recommended immunizations, and vision, hearing, and dental exams. The recommended schedule for well-child medical exams in Texas Health Steps is based on the American Academy of Pediatrics' standard for well-child check-ups (referred to as the AAP periodicity schedule). The AAP schedule is the federal Medicaid minimum standard; states can do more, but not less. In 2001 Texas raised the bar a bit higher than AAP by recommending a check-up every year for children 10-20; the AAP standard is every other year.

Texas' standard is as follows:

- Birth to age one: 6 check-ups (at delivery, by 2 weeks, and at or by 2, 4, 6, and 9 months)
- Age one to two: check-ups at 12, 15, 18 and 24 months
- Ages two to 5: once per year
- Ages 6, 8, and 10 get check-ups (age 7 and 9 do not)
- Ages 11-20, every year.

Again, there is no parallel mandate for parents of children enrolled in Texas' SCHIP program to meet this standard.

**Information System Challenges.** The data systems needed to allow tracking of Texas Health Steps check-ups on a child-by-child basis did not exist prior to eligibility simplification, in part because federal reporting standards for EPSDT do not require this level of accuracy; the CMS "Participant Ratio" reporting requirement only assesses the ratio of enrolled children to the total number of check-ups delivered. However, Texas has since 1995 imposed financial sanctions on cash assistance recipients whose children fall behind in their THSteps check-ups.[A] Because of this policy, THSteps and DHS had experience prior to eligibility simplification with the challenges entailed in tracking THSteps check-ups for individual children. In response to multiple factors that added up to an inadequate record of check-ups being contained in the state's Medicaid data systems, the two agencies had to develop systems of manual case-by-case investigation to ensure that TANF families were not improperly sanctioned. However, TANF children represent only a small fraction of child Medicaid enrollment (less than 17% of the total); the prospect of extending this level of oversight to nearly all children on Medicaid has made it necessary for Texas Medicaid officials to dedicate new resources to resolution of some long-standing data problems.

The multiple computer systems that must interface in Texas Medicaid compound the challenge. In the latest published evaluation of Texas Medicaid Managed Care data, only 49% of well-child check-ups found in children's medical records were correctly entered in the HMOs' computer ("encounter data") files (i.e., had the correct patient, doctor, date, and the service provided). In

[A] This policy was part of Texas' AFDC waiver, which pre-dated the 1996 welfare law, the Personal Responsibility and Work Opportunity Reconciliation Act.

fee-for-service Medicaid, the data also has historically been dated and incomplete. Pediatric providers have complained that their Medicaid clients often receive letters telling them that they are behind on check-ups, even though the doctor has recently provided and billed for the service. Doctors do not have to bill for Medicaid check-ups for 95 days, so data on check-ups can lag far behind utilization. In the recent past, claims that contained a mistake or were appealed were not ever incorporated into the main DHS computer system. And, all this information has to be aggregated in the same antiquated mainframe system previously described. Thus, when eligibility simplification legislation was enacted into law in 2001, it was beyond the capacity of Texas Medicaid computerized information systems to account for services delivered in an accurate and timely way.

**Improvements Planned.** Texas Medicaid has been striving to improve all these data problems since 1993, the year when Medicaid Managed Care was first piloted, and also when the Texas first became involved in a federal class action lawsuit alleging that the Medicaid program was not complying with federal EPSDT laws, which entitle children to check-ups and related follow-up care. Despite continued pressure and good faith efforts to improve (and some significant progress as a result of those efforts), a great deal of work remains to be done.

A "Process Improvement Plan" initiative for THSteps was undertaken in 2002, which has identified a wide range of needed improvements, many of which would directly help ease the process of confirming THSteps check-up delivery. A number of system changes have already been implemented, including the elimination of rigid computer time frames for processing check-ups claims for infants (who require 9 exams from birth to age 2), and correcting the failure of erroneous or appealed claims to make their way into the database. Other changes are on a longer time line (i.e., a year or more required for completion). The broadest long-term goal is improving the collection of fee-for-service claims and HMO encounter data. This is necessary to allow THSteps to generate accurate and complete EPSDT participation reports (CMS-416, formerly HCFA-416) to CMS. It is also a necessary step to improve the timeliness and accuracy of THSteps utilization information in Medicaid computer systems, thereby improving the timeliness of outreach and overdue notices sent to parents. Presumably, many of these improvements are dependent on the successful replacement of the DHS mainframe Medicaid information system, which is scheduled to complete phase-in by August 2004.

**How the Requirement Will be Monitored.** To recap, Texas Medicaid is charged with verifying that a child has received his check-ups as a condition of simplified renewal of eligibility, but the state knows that its computer systems simply cannot yet provide that information reliably. As such, the program has developed operating procedures for the time being which are intended to make up for the lack of data.

Mirroring the current THSteps sanction process for TANF families, the new eligibility simplification process will be applied to children starting at age 2; the state believes that children under age 2 (or more accurately, their parents) typically have "high compliance." Children age 2 and older (exception: ages 7 and 9) will be required to have received an annual THSteps medical check-up visit.

THSteps outreach activities throughout the child's enrollment period support parents in arranging for check-ups. Parents are informed about the THSteps requirement both in the verbal HCO and in written materials provided at the child's initial certification for Medicaid. In addition, THSteps outreach workers encourage parents at that time to schedule a medical check-

up visit for the child or children, and offer to assist them as needed. Parents have for a number of years received reminders of due and overdue check-ups both on the child's monthly Medicaid identification letter and as separate mailings. Also, THSteps prior to eligibility simplification had a goal of making one telephone or face to face contact per child every 6 months (combining calls for families with more than one child where possible). When workers fail to make a direct phone or home contact, they mail a letter or leave a letter at the home while attempting a home visit.

As explained earlier, the child's THSteps status is not a barrier to renewal at the initial 6-month renewal (only the HCO is monitored). The 12-month renewal packet is mailed to parents in the tenth month after initial enrollment. As with the HCO, if no medical check-up is indicated in the DHS computer when the renewal forms are returned by the family, the family is to be contacted and given the opportunity to self-declare that the child either has had the check-up, is currently scheduled for a check-up, or the parent has good cause for not completing the medical check-up.

Good cause exceptions already established as part of the THSteps sanction policy for TANF families are to be applied to the new eligibility simplification requirement. These include:

- **Medical.** A medical provider may decide that for medical reasons a check-up is not required (e.g., a child is under active treatment for acute or chronic illness; or a recently enrolled child provides the doctor's documentation of recent medical check-up; or other physician discretion).
- **Religion.** The family has a religious belief that does not allow the child to have a medical check-up.
- **No medical provider or transportation.** There is no medical provider or transportation available within the family's geographic area. In practice, there is a "good cause" exemption from the sanction if the provider is booking appointments more than 60 days from request.

If the parent indicates that the child has had or is scheduled for the check-up, or has a good cause reason, the DHS worker enters that information into the DHS eligibility system, and the family can renew Medicaid eligibility by mail. DHS will verify the THSteps medical check-up visit at a later date, through the claims processing system. If the child is overdue for the medical check-up, the parent does not report the child having received or scheduled a check-up, and no good cause exception is claimed, the parent will be required to renew Medicaid coverage in person at a DHS office.

**Provider Availability.** Both parents and doctors face barriers to Texas Health Steps participation. A recent physician survey conducted by the Texas Medical Association shows that only 49 percent of Texas physicians are accepting new Medicaid patients, down from 66.8 percent two years ago. Medicaid provider shortages are a problem in many (perhaps most) parts of Texas. Access to appointments at times that are accessible for working poor parents, especially those with transportation barriers, is also limited. THSteps outreach staff, who help parents locate and schedule THSteps check-ups and other services, acknowledge that provider availability is a major issue. Doctors complain of a variety of administrative problems, ranging from what they have to do to enroll as a Texas Health Steps provider, to how they can bill for their services. Many of these issues are being addressed — some quickly, others slowly — by the THSteps Process Improvement initiative described above, but the process is too new to have yet reversed physician perceptions of the program. Also, $31 million state dollars — 62% of funds allocated for Medicaid physician fee increases — in 2002-2003 went to increasing the THSteps check-up fee from $49 to $70. This combination of administrative and financial

improvements is likely to improve physician participation over time, but in the meanwhile implementation of eligibility simplification's THSteps requirement must contend with bottlenecks in the accessibility of check-ups.

**TANF and THSteps Sanctions.** Can the outcome of the new parental requirement be predicted from experience with the TANF sanction? Texas families on TANF are subject to having their TANF cash assistance grants reduced if their children are behind on check-ups or immunizations; for example, a family of 3 receiving the maximum monthly grant of $213 would have that grant cut by $25 if they were out of compliance with THSteps alone. Sanctions are applied at the time a family reports for a combined TANF-Medicaid re-certification process (every 6 months). A range of 150-350 families are sanctioned each month for THSteps. About 6,300 TANF households had THSteps sanctions in place in August 2002. This is 5.1% of all TANF households, but more than one-third of households may not currently be subject to this sanction, so the effective proportion of families subject to sanctions is closer to 14%. The larger population of families with children eligible for Medicaid should not be expected to behave just like TANF families, however. The latter are surviving on less than $395 per month for a working mother with 2 children ($275 if the mother is not working), while the upper limits for child Medicaid coverage are $1,665 per month for young children, and $1,252 per month for ages 6 and older (both for families of 3). Though their incomes are also quite low, the non-TANF families on average may be better able to meet the THSteps requirement.

**THSteps Historical Data.** In 1990 federal Medicaid policy established a goal of having each state improve EPSDT participation to the point where 80% of children who are due to have one or more check-ups in a given year (which by THSteps standards means all children except 7 and 9-year-olds), would receive at least one exam. This is the federally-defined EPSDT "Participant Ratio." It is important to note that the Participant Ratio does not capture the percent of children (i.e., those under age 2) who have gotten all the exams which are recommended, but only assesses whether those children got at least one exam. The formula for the state Participant Ratios result in a number that is larger than a simple percentage, because the formula reduces the targeted number of check-ups to reflect the extent to which children are enrolled in Medicaid for only a part of the year. For example, if the average coverage period per child is only eight months out of a year, the target number of check-ups per child would be reduced to eight-tenths of a check-up. As a result, a state with eligibility policies that result in children churning on and off the Medicaid rolls could deliver fewer check-ups, but still have a better Participant Ratio than a state with continuous eligibility. For 1998, the latest year for which comparative national statistics are available, only 9 states reported meeting or exceeding the 80% goal. Twenty-three states reported Participant Ratios of 50% or less.

| Texas EPSDT Statistics | |
|---|---|
| Fiscal year | Participant Ratio |
| 1991 | .18 |
| 1992 | .25 |
| 1993 | .29 |
| 1994 | .35 |
| 1995 | .43 |
| 1996 | .51 |
| 1997 | .55 |
| 1998 | .66 |
| 1999* | .62 |
| 2000 | .63 |
| 2001 | .52 |
| *new methodology began | |
| Source: HCFA/CMS 416 reports | |

Recent Texas Health Steps statistics on check-up achievement for all children on Texas Medicaid do not in themselves paint a hopeful picture of the prospects for eligibility simplification; however, it is impossible to know to what extent these unimpressive statistics are due to inadequate data collection and reporting, rather than actual low check-up utilization. Texas' Participant Ratios for Texas Health Steps medical check-ups have improved annually from 1991-1998. However, the 1999 to 2001 ratios have showed a drop from the 1998 level (.66). According to the Texas Department of Health's analysis, about 4% of the overall 9% decline from 1998 to 1999 was due to the changes in federal methodology for EPSDT reporting. The rest of the drop is thought to be the result of an actual decline combined with unreliable Medicaid Managed Care check-up data. With so little certainty attached to the available statistics, it is difficult to guess which will be the greater challenge to THSteps and DHS in implementing the eligibility simplification requirement: overcoming the lack of reliable utilization information, or increasing the number of children who receive an annual check-up.

## Conclusion

Texas' new simplified enrollment and renewal processes for children's Medicaid have shown unqualified success in removing barriers to participation, as evidenced by a 30% increase in enrollment from September 2001 to 2002. Other key indicators of success include higher application approval and renewal rates, and reduced rates of procedural denials for incomplete information. Program staff appear to be reaching the great majority of parents with the new Health Care Orientation, and HCO delivery thus far does not appears to be a barrier to the simplified renewal process. The application of a new requirement that all children be current with their EPSDT check-ups as a condition of accessing simplified renewal processes at the 12-month period presents considerably greater challenges, however. Collecting and communicating timely information on check-ups received will be difficult, and limited availability of providers must also be overcome. The next six to nine months will reveal how well the Medicaid program's procedures for implementing this requirement can compensate for the shortcomings of the systems and provider networks.

Without a doubt, however, the greater challenge to the success of eligibility simplification is the state's looming revenue shortfall. Texas lawmakers are likely to consider reversals or even outright repeal of children's eligibility simplification as they attempt to write a budget within projected revenues. Keeping the promise of the 2001 eligibility simplification legislation will undoubtedly require the identification of additional revenues. The 2003 Legislative session will thus put to the test Texans' commitment to child health care access.

Appendix 1:

**Children's Medicaid Application Data**

| | Applications Approved | Simultaneous Approved and Denied* | Applications Denied | Total Applications Processed | Application Approval Rate |
|---|---|---|---|---|---|
| Sep-00 | 38,571 | 1,864 | 30,315 | 70,750 | 57.2% |
| Oct-00 | 51,492 | 2,497 | 41,268 | 95,257 | 56.7% |
| Nov-00 | 41,843 | 1,832 | 33,970 | 77,645 | 56.2% |
| Dec-00 | 39,568 | 1,790 | 29,665 | 71,023 | 58.2% |
| Jan-01 | 41,972 | 1,921 | 33,479 | 77,372 | 56.7% |
| Feb-01 | 42,806 | 2,247 | 30,982 | 76,035 | 59.3% |
| Mar-01 | 49,097 | 2,596 | 39,395 | 91,088 | 56.8% |
| Apr-01 | 39,829 | 1,812 | 31,394 | 73,035 | 57.0% |
| May-01 | 46,244 | 2,057 | 36,853 | 85,154 | 56.7% |
| Jun-01 | 39,315 | 1,762 | 31,598 | 72,675 | 56.5% |
| Jul-01 | 41,219 | 1,847 | 32,132 | 75,198 | 57.3% |
| Aug-01 | 46,561 | 2,028 | 35,667 | 84,256 | 57.7% |
| Sep-01 | 36,001 | 1,555 | 28,123 | 65,679 | 57.2% |
| Oct-01 | 58,479 | 2,535 | 43,603 | 104,617 | 58.3% |
| Nov-01 | 50,050 | 2,082 | 35,854 | 87,986 | 59.3% |
| Dec-01 | 40,571 | 1,649 | 28,453 | 70,673 | 59.7% |
| **Average, 9/00-12/01** | | | | | **57.5%** |
| Jan-02 | 67,766 | 2,428 | 34,021 | 104,215 | 67.4% |
| Feb-02 | 62,278 | 2,225 | 24,833 | 89,336 | 72.2% |
| Mar-02 | 66,098 | 2,135 | 28,081 | 96,314 | 70.8% |
| Apr-02 | 63,983 | 2,010 | 26,217 | 92,210 | 71.6% |
| May-02 | 55,330 | 1,740 | 23,475 | 80,545 | 70.9% |
| Jun-02 | 50,347 | 1,679 | 21,898 | 73,924 | 70.4% |
| Jul-02 | 62,929 | 1,782 | 28,346 | 93,057 | 69.5% |
| Aug-02 | 62,518 | 1,691 | 27,900 | 92,109 | 69.7% |
| Sep-02 | 46,872 | 1,167 | 22,257 | 70,296 | 68.3% |
| **Average, 1/02-9/02** | | | | | **70.1%** |

Texas Dept. of Human Services
Family Support Services
Programs Budget and Statistics
October 15, 2002
* Denotes cases in which eligibility was approved for a finite period (e.g. a single month), and thus an “end date” is also entered.

Appendix 2:

| Texas Child Medicaid Renewals, 2000-2002 | | | | |
|---|---|---|---|---|
| | **Total Reviews Sustained** | **Total Reviews Denied** | **Total Reviews** | **Total Review Approval Rate *** |
| Sep-00 | 99,572 | 38,350 | 137,922 | 72.2% |
| Oct-00 | 122,818 | 44,811 | 167,629 | 73.3% |
| Nov-00 | 97,874 | 35,294 | 133,168 | 73.5% |
| Dec-00 | 92,418 | 30,953 | 123,371 | 74.9% |
| Jan-01 | 106,351 | 39,870 | 146,221 | 72.7% |
| Feb-01 | 115,704 | 38,931 | 154,635 | 74.8% |
| Mar-01 | 128,433 | 46,075 | 174,508 | 73.6% |
| Apr-01 | 105,342 | 37,957 | 143,299 | 73.5% |
| May-01 | 119,159 | 42,337 | 161,496 | 73.8% |
| Jun-01 | 100,184 | 36,143 | 136,327 | 73.5% |
| Jul-01 | 108,087 | 39,191 | 147,278 | 73.4% |
| Aug-01 | 115,153 | 43,969 | 159,122 | 72.4% |
| Sep-01 | 88,234 | 33,003 | 121,237 | 72.8% |
| Oct-01 | 134,530 | 47,051 | 181,581 | 74.1% |
| Nov-01 | 112,092 | 40,445 | 152,537 | 73.5% |
| Dec-01 | 95,342 | 34,956 | 130,298 | 73.2% |
| Jan-02 | 140,894 | 37,853 | 178,747 | 78.8% |
| Feb-02 | 118,725 | 36,523 | 155,248 | 76.5% |
| Mar-02 | 145,127 | 40,772 | 185,899 | 78.1% |
| Apr-02 | 128,055 | 35,535 | 163,590 | 78.3% |
| May-02 | 126,598 | 31,812 | 158,410 | 79.9% |
| Jun-02 | 100,829 | 28,948 | 129,777 | 77.7% |
| Jul-02 | 138,660 | 23,418 | 162,078 | 85.6% |
| Aug-02 | 125,349 | 42,048 | 167,397 | 74.9% |
| Sep-02 | 98,412 | 46,798 | 145,210 | 67.8% |

Source: Texas Department of Human Services
Note: The month of September has an early cutoff (the 13th). Renewals processed in the remaining 2 weeks of the month will appear as approved applications instead of renewals. Thus, the renewal rate in September 2002 (or any month with an early cutoff) will appear to be lower than it actually is.

**Notes:**

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[1] 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.

[2] SB 43, 77th Texas Legislature.

[3] HB 820, 76th Texas Legislature, mandated new outreach and informing of Medicaid clients. Outreach was also extended to families that had left AFDC and TANF since 1995.

[4] Texas Health and Human Services Commission; www.hhsc.state.tx.us.

[5] Texas Health and Human Services Commission, unpublished enrollment data.

[6] These estimates are based on analysis of unpublished data from the Census Bureau, released in November 2002, by Leighton Ku and Matthew Broaddus of the Center on Budget and Policy Priorities, Washington, D.C.

[7] A description of HCO procedures can be viewed at http://www.hhsc.state.tx.us/chip/SB43/SB43_Simplification_Intro.html

[8] The EPSDT contractor is Maximus. TDH staff perform these functions in Regions 10 (El Paso and far west), 11 (Rio Grande Valley), 4 (Northeast corner) and the northern part of region 5 (just south of 4).

[9] The Texas Association of Community Health Centers, the grantee for the Robert Wood Johnson Foundation's Covering Kids and Families initiative in Texas, produced this video.

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