Medicaid and CHIP Services

Stephanie Stephens, State Medicaid Director
**Impact Perspective**

19.5% of Texans covered

5.8 million Texans receiving services

51% of Texas births covered by Medicaid

50% of Texas children on Medicaid or CHIP

57% of nursing home residents covered by Medicaid

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**Medicaid is an entitlement program**

Federal funding is open ended to provide eligible services to eligible persons

**CHIP is not an entitlement program**

Federal funds are capped - when a state’s CHIP funds are spent, no more are available

*Note: Medicaid and CHIP caseload data is for November 2022 as of December 2022 and is not final. The Families First Coronavirus Response Act requirement to maintain eligibility for enhanced federal match has increased caseload.*
Who is Eligible for Medicaid?

**Federal law**
- Requires coverage of certain populations and services
- Gives flexibility for states to cover additional populations and services

### Financial Criteria
How the applicant’s income compares to the definition of the federal poverty level (FPL) for annual household incomes

### Non-Financial Criteria
- Age
- Residency
- Citizenship or alien status

### Eligible Population Categories
- Children and Youth
- Parents and Caretaker Relatives
- Women
- People Age 65 and Older
- Children and Adults with Disabilities
More information on eligibility criteria for Medicaid and CHIP can be found in Chapter 1 of the 14th edition Texas Medicaid and CHIP Reference Guide.
## Primary Medicaid and CHIP Services

<table>
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<tr>
<th>Services</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Acute Care Services</strong></td>
<td>Preventative care, diagnostics and medical treatments</td>
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<td><em>Examples: Physician, inpatient and outpatient hospital services, laboratory, x-ray services</em></td>
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<td><strong>Long-term Services and Supports</strong></td>
<td>Support with ongoing, daily activities for individuals with disabilities and older adults</td>
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<td><em>Examples: Community-based care, personal assistance with activities of daily living (cleaning, cooking), nursing facility services</em></td>
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<td><strong>Behavioral Health Services</strong></td>
<td>Screening and treatment for mental health conditions and substance use disorders (SUD)</td>
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<td><em>Examples: Inpatient psychiatric services, outpatient services such as counseling and psychotherapy, and crisis intervention services</em></td>
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<td><strong>Medical Transportation Services</strong></td>
<td>Non-emergency medical transportation (NEMT)</td>
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<tr>
<td><strong>Pharmacy Services</strong></td>
<td>Coverage for prescription drugs</td>
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Two Models for Service Delivery

1. Managed Care
   - 97% of clients
   - A managed care organization (MCO) is paid a capitated rate for each member enrolled
   - MCOs provide a medical home through a primary care physician (PCP) and referrals for specialty providers, when needed
   - MCOs negotiate rates with providers
   - MCOs may offer value-added services

2. Fee-for-Service (FFS)
   - 3% of clients
   - Clients go to any Medicaid provider
   - Providers submit claims directly to HHSC’s administrative services contractor for payment
   - Providers are paid per unit of service
   - Most FFS clients do not have access to service coordination

Managed Care Growth

Managed Care Programs

**STAR**
- **Children, pregnant women, and some families**: 75%
- **STAR Kids**: Children and youth with disabilities: 3%

**CHIP**
- Children and youth who don’t qualify for Medicaid due to family income: 5%

**STAR Health**
- Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care: 1%

**STAR+PLUS**
- Adults with a disability, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer: 12%

*Source: Texas Medicaid and CHIP Reference Guide, 14th Edition*

Dental for most children and young adults enrolled in Medicaid
Managed Care Service Areas

(Texas Health and Human Services)
Delivering Quality, Cost-Effective Services

**Access to services**
Network adequacy, appointment availability, member satisfaction

**Service delivery**
Acute care utilization reviews (UR), long-term services and supports URs, drug UR, electronic visit verification

**Quality of care**
Performance dashboard, value-based enrollment, improvement projects, pay-for-quality, alternative payment models, MCO report cards

**Financial**
Financial statistical reports (FSRs) validation, administrative expense and profit limits, independent auditing

**Operations**
Readiness reviews, biennial operational reviews, targeted reviews

Key Focus Areas

Texas Medicaid

Improvements focus on four major areas

1. Ensure members have timely access to the services they need
2. Encourage providers to participate in the Medicaid program
3. Incentivize value using innovation in the service delivery model
4. Strengthen partnerships through transparency and accountability

Ending Continuous Medicaid Coverage

Molly Lester
Deputy Chief Policy and Services Officer
March 2020: Congress passed the Families First Coronavirus Response Act, allowing states to receive enhanced federal match provided they maintained continuous coverage for most people enrolled in Medicaid until the end of the federal public health emergency.

December 2022: Congress passed the 2023 Consolidated Appropriations Act, which separated the continuous Medicaid coverage requirement from the federal public health emergency.

March 31, 2023: Continuous coverage requirement ends.

April 1, 2023: States may begin disenrolling members who are no longer eligible.

April 1 – December 31, 2023: Enhanced FMAP will be phased out.
Federal Guidance

States have 12 months to initiate redeterminations for everyone enrolled in Medicaid and CHIP

States must conduct a full redetermination following all federal regulations and allow members a minimum of 30 days to respond to renewal packets or requests for information

States must attempt to get updated contact information and may not disenroll members based on returned mail unless the state attempts to contact the member through multiple modalities (e.g., phone, text)
Plan to Unwind Continuous Medicaid Coverage

Unwinding continuous Medicaid coverage will be an immense undertaking for states.

• As of September 2022, **2.7 million members have extended Medicaid coverage** due to the continuous Medicaid coverage requirement

• States must renew everyone on Medicaid and CHIP within the 12-month unwinding period

• HHSC must complete the redetermination process for **more than 5.9 million members** by May 2024
Plan to Unwind Continuous Medicaid Coverage

Guiding principles for unwinding continuous Medicaid coverage include:

- Maintaining coverage for people who remain eligible.
- Prioritizing redeterminations for those most likely to no longer qualify for Medicaid.
- Ensuring a sustainable workload for our eligibility system and future renewal schedule.
HHSC will stagger Medicaid redeterminations over multiple months.

- Continuous coverage population will be distributed into **three cohorts**
- Redeterminations will be initiated for each cohort in consecutive months at the start of the unwinding period
- People enrolled in Medicaid and CHIP not included in the continuous coverage cohorts will have their eligibility redetermined based on their normal renewal dates
Timeline for Ending Continuous Medicaid Coverage

- **February 18, 2023**: Identify continuous coverage population and distribute into cohorts.
- **March 31, 2023**: End of continuous Medicaid coverage requirement.
- **June 1, 2023**: Earliest effective date for first cohort to be disenrolled.
- **March 2024**: Last month to initiate a redetermination for the unwinding.

- **January 28, 2023**: Members began receiving notice continuous coverage is ending.
- **March 2023**: Begin checking electronic data sources for members in first cohort.
- **April 2023**: Members in the first cohort receive renewal packets or requests for information, with 30 days to respond.
- **December 31, 2023**: Enhanced FMAP ends.
Addressing Workload/Workforce Issues

- Net increase of **1000 additional eligibility workers** since April 2022
- **Increased base salaries** for eligibility workers effective August 2022
- **Added more than 400 2-1-1 call center staff** since July 2022
- Gained access to additional data sources to update contact information and streamline eligibility processing
- Simplified onboarding and basic training processes to expedite new eligibility workers into production
- Implemented Case Assistance Affiliate program to allow Medicaid health plans to assist members with applications and renewals
- Implemented online password reset capability for YourTexasBenefits.com
- Engaged the Eligibility Support Services contractor to assist with processing applications and fair hearing packets
We developed a proactive multi-pronged communications campaign to help members, providers, health plans, and advocates prepare for the end of continuous coverage.

Second phase includes texts, notices, social media, earned media and paid outreach from HHSC to Medicaid members.
Current Priorities

- Continue working with CMS to keep aligned with the latest federal guidance and requirements
- Complete final checks to ensure systems and workforce are prepared
- Established a cross-functional agency command center to oversee implementation of the unwinding
- Develop monthly reports to monitor and track progress on unwinding efforts
- Continue engaging with contract partners and external stakeholders to build awareness for the unwinding plan and actions members will need to take