SUBJECT: Simplifying Medicaid enrollment for children

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Coleman, Capelo, Glaze, Longoria, Maxey, Uresti

2 nays — Delisi, Wohlgemuth

SENATE VOTE: On final passage, April 18 — voice vote (Staples recorded nay)

WITNESSES: For — James Donovan, Jr., Americaid; Anne Dunkelberg, Center for Public Policy Priorities; Lisa McGiffert, Consumers Union; *Registered but did not testify:* Tom Banning, Texas Academy of Family Physicians; Jose Camacho, Texas Association of Community Health Centers; Melody Chatelle, United Ways of Texas; Chuck Cliett, Community First Health Plans; Richard Daley, Texas Catholic Conference; Helen Kent Davis, Texas Medical Association; Wanda Douglas, Texas Nurses Association; DeAnn Friedholm, March of Dimes, Texas Chapter; Leslie Hernandez, National Association of Social Workers; Patricia Kolodzey, Texas Hospital Association; Kevin Perryman, Texas Medical Association, Texas Pediatric Society and Texas Academy of Family Physicians; Candie Phipps, Texas Pediatric Society; Therese Ruffing, Texas Association of Public and Not for Profit Hospitals; Leah Rummel, Texas Association of Health Plans; Linda Rushing, Texas Conference of Catholic Health Facilities; Marc Samuels, Texas Academy of Internal Medicine; Sam Stone, Texas Academy of Physician Assistants

Against — None

BACKGROUND: Medicaid is a state-federal health-benefit program for the poor and uninsured, for which Texas now pays 39.8 cents and the federal government pays 60.2 cents of every dollar spent on services. Medicaid is an entitlement program, which means that federal law requires states to provide medically necessary care to all eligible people who seek Medicaid services, and the state may not cap enrollment.

To enroll in Medicaid, a person must fill out an application, attend an hour-long interview, and demonstrate income below certain levels as well as cash

assets and car values. Recipients must reapply for benefits at least every six months, unless on a fixed income. The original purposes of these features were to narrow program eligibility or to make eligibility conform to the former cash-assistance program, Aid to Families with Dependent Children (AFDC), and to prevent fraud.

The Children's Health Insurance Program (CHIP) provides comprehensive health-benefit coverage to children in families who earn up to 200 percent of the federal poverty level, or about $2,842 per month for a family of four. The state pays 25 percent of the costs and the federal government pays 75 percent. CHIP outreach efforts target uninsured low-income and working families in the same communities in which Medicaid-eligible families reside. Under federal law, CHIP cannot provide benefits to someone eligible for Medicaid, so families responding to the CHIP outreach efforts must be screened for Medicaid eligibility as well.

The Medicaid program uses several criteria for determining eligibility, based on a person's income, family size, age, marital status, disability status, pregnancy status, financial assets, and sometimes the amount of medical bills a family already has paid. In general, asset limits are $2,000 for families who apply for Medicaid. While one vehicle is not counted, the value of a second vehicle over $4,650 does count against the cash asset limit. CHIP eligibility is based on income and family size alone.

For additional background information, see "Streamlining Access to Medicaid Coverage," House Research Organization *Interim News* Number 76-5, May 19, 2000.

DIGEST:

CSSB 43 would direct the Texas Department of Human Services (DHS) to develop forms and procedures for Medicaid applications for children under age 19 that are similar to those used to apply for CHIP, including a mail-in option. DHS would have to ensure that the documentation and verification processes, including those used to evaluate assets and resources, were the same as those for CHIP, but not more stringent than CHIP processes in place on January 1, 2001.

The bill would allow recertification of a child's eligibility and need for medical assistance by telephone or mail, rather than in person. DHS also

would have to adopt rules to provide continuous eligibility for 12 months or until the child's 19th birthday, whichever came first.

DHS would have to seek any necessary federal waivers or authorizations needed to implement the bill's provisions and could delay implementation until the federal waivers or authorization was granted.

The bill would take effect January 1, 2002. The Health and Human Services Commission (HHSC) and DHS would have to adopt the necessary rules by February 1, 2002, and the rules would have to provide continuous eligibility for a child whose eligibility was determined on or after the effective date of the rules.

SUPPORTERS SAY:

Texas' current application process for Medicaid prevents too many eligible people from receiving coverage. In keeping eligible people off the Medicaid rolls to minimize state expenditures, the state actually increases costs to hospitals and local taxpayers, who end up providing health care for indigent people as part of local charity-care obligations.

Streamlining the Medicaid application process would help the state achieve its goal of reducing the number of uninsured children. Texas now has about 1.4 million uninsured children, almost half of whom are eligible for Medicaid but not enrolled. The state should take steps to ensure that as many Medicaid-eligible children as possible are enrolled. CSSB 43's provisions are similar to procedures and rules that already have proven successful for CHIP.

Application process. The Medicaid application process should be similar to the CHIP process in the type of information needed to ensure that families who respond to the outreach efforts obtain the health coverage to which they are entitled. To receive CHIP benefits, a family need only complete a two-page application form and affirm that the information is accurate. However, if the family is suspected of being Medicaid-eligible, it must go through another screening process that can require many forms, signatures from neighbors, landlords, and employers, and a face-to-face interview, and can take weeks to complete.

To complicate matters, because Medicaid eligibility primarily depends on age, income, and assets, many families may have one or more children eligible for CHIP and other children eligible for Medicaid. This situation not only requires families to go through two application processes, it also splits children within the same family among different physicians and other health-care providers. Because the only federally required Medicaid documentation is a Social Security number and a declaration of immigration status or citizenship, the state could make the Medicaid application form similar to that for CHIP and still comply with federal regulations.

Face-to-face interview. The state should eliminate the face-to-face interview requirement and allow applications to be mailed in. DHS originally instituted this interview to help speed the processing and verification of the combined application for Medicaid, cash assistance, and food stamps, but federal law does not require the interview for Medicaid, and other states accept mail-in Medicaid applications for children. Follow-up verification can be performed over the telephone or through third-party information systems.

The face-to-face interview is an enormous barrier to obtaining medical coverage for children with working parents. DHS will not allow people to schedule interviews around their work schedule, but rather assigns them a time. Most parents with children on Medicaid are working low-paying hourly jobs with little flexibility. The interview requirement forces them to sacrifice some earnings by taking time off work and possibly putting their jobs in jeopardy. While the interview is an opportunity for the eligibility specialist to resolve unclear or incomplete information in the application and to inform recipients of their rights and responsibilities associated with receiving Medicaid, these functions could be performed adequately over the telephone.

The face-to-face interview is not a significant antifraud provision. It is designed to resolve inconsistencies in the application, not to discover them. The discovery of inconsistencies that may point to fraud is accomplished by other techniques that DHS performs before the eligibility determination.

Asset test. The assets test is not required by federal law but is a state holdover from earlier Medicaid and AFDC requirements, and Texas is one of only 10 states that still use such a test. Most states have dropped the test because the effort to verify assets is costly and rarely uncovers families who

hold sizeable assets but are masquerading as impoverished. At most, a working family may be saving to buy a house and may have several hundred dollars over the $2,000 limit. Or the family may own two cars so that the parent and teenager can drive to work and to school separately, and the second car may be worth more than the limit of $4,650.

The state should encourage families to save some money to become increasingly self-sufficient. The best way for families to move off public assistance, including medical assistance, is by saving enough money to weather emergencies. The $2,000 asset limit is too low to allow families to graduate to higher levels of self-sufficiency with any degree of security. The use of the fair market value of the car, rather than the family's equity in it, also works against families trying to buy reliable transportation, an important part of long-term sufficiency.

Continuous eligibility. Children enrolled in Medicaid should have 12 months of continuous eligibility. Medicaid recipients now must certify their eligibility for the program every six months. This also is a holdover requirement of AFDC, but federal Medicaid requirements now call for a recertification at least every 12 months.

One year of continuous eligibility for Medicaid is important to reduce the application hassles encountered by working families and to give patients a "medical home" for preventive care, one of the main benefits of the Medicaid managed-care system that the state has struggled to implement over the past few years. Six-month recertification requires families repeatedly to complete the two-page application form and other attachments and to visit a DHS office for an interview. As a result, families often let coverage lapse until a child falls ill again, or they reenroll as necessary but end up in another plan with a different provider. Such situations hinder physicians from practicing good primary and preventive care, which usually requires a longer-term physician-patient relationship.

Eligible children are enrolled in CHIP for one year, regardless of a family's change in income. Working families whose income may fluctuate slightly above or below the income standards may switch between CHIP and Medicaid. Texas' Medicaid program requires families to report changes in income within 10 days, and a family's coverage is cut off the next month

even if a parent earns one dollar more than the income limit. The family then could apply for CHIP coverage for a year, but if its income fell again, the child would have to be reenrolled in Medicaid. Continuous eligibility would help provide continuous coverage for a child through a single health-care provider, despite the modestly fluctuating income levels of the child's family.

Families with children in both CHIP and Medicaid now must contend with two or more enrollment schedules and processes. Every six months they must recertify their children's eligibility for Medicaid or enroll children who have "aged out" of the Medicaid program into CHIP, and once a year they must reenroll children already in CHIP.

Cost. These changes would cost the state money, but they might not be as expensive as the bill's fiscal note suggests. The fiscal note estimates a cost of $324.5 million in fiscal 2002-03; however, the cost of each change was estimated separately, and projected enrollment increases and medical costs were added together rather than taking into account the combined effect of all changes. The projected number of people who would enroll in Medicaid for the first time double-counts children who would enroll newly because of either of these changes. Also, the projections do not take into account savings to local governments and hospitals that provide indigent and charity care to eligible patients not enrolled in Medicaid.

OPPONENTS SAY:

The Medicaid program is sufficiently different from CHIP to require different application processes and requirements. CHIP essentially is subsidized private insurance, not a state program. Medicaid, however, is funded and administered by the state and is unlike private insurance in that it includes unlimited health benefits without financial participation. Medicaid should not be made to look like CHIP because it is not like CHIP.

The state should not aspire to enroll as many children as possible in Medicaid, but rather should create policies that allow children to be enrolled in CHIP. The CHIP program is superior to Medicaid in a number of ways, including cost sharing, which allows families to participate in their children's health care, and inclusion of private organizations, which makes it similar to the health-care coverage that self-sufficient families have, as opposed to those on public assistance.

The current application process actually puts more children in CHIP, which is a better program. Because children who are eligible for Medicaid are, by law, ineligible for CHIP, the current Medicaid rules make more children eligible for CHIP. The key benefit of enrolling children in CHIP versus Medicaid is the copayment, which allows parents to participate in their child's health care and disassociates them from "welfare." Also, expanding Medicaid enrollment over CHIP would not maximize the federal funds the state receives for insuring children. CHIP has a better match rate of three-to-one for federal funds, versus two-to-one for Medicaid.

Application process. It would be a disservice to Texas' low-income families to make the application form for Medicaid a bare-bones form like that used for CHIP. When families apply for CHIP, the state presumes that they do not need additional assistance such as cash assistance or food stamps. This works for CHIP because the income requirements usually indicate that the families would not be eligible for other services. That is not the case for Medicaid, however. Often families that are eligible for Medicaid also may be eligible for other forms of public assistance. If the Medicaid form did not collect information to make those determinations, these families might not be screened for eligibility for other services. If they were, they would have to fill out many additional forms to apply anyway.

Another key function that the application serves is determining outstanding medical bills at the time of application. Unlike CHIP, Medicaid will pay some levels of outstanding medical bills. Because many families wait to apply for assistance until a child is sick and they are in a dire financial situation due to medical bills, it is important for the application to collect the information DHS needs to determine what outstanding medical bills exist and if they are eligible for payment.

Face-to-face interview. The state should not remove this important antifraud measure. Over the phone, interviewers could not detect nuances or facial expressions that may be clues to fraud. An interviewer could not even verify the interviewee's identity. Medicaid is a valuable benefit because there is no dollar limit for health-care benefits. The potential for fraud is great, and the state must verify that recipients are eligible to receive benefits. The state should ensure that its Medicaid dollars are going to those who need it.

The benefits of the face-to-face interview are most evident in determining initial eligibility. The state could retain it for the initial application but then allow recertification by phone or by mail. This would provide some of the flexibility that opponents of the interview desire, while preserving the antifraud protection it provides.

The face-to-face interview may be a burden to some working families. In those cases, it should be waived to encourage people to work. However, families with no earned income are the most likely to need multiple services and should have enough time to come into a DHS office, so they should not be exempt from the interview. The office visit may be the only contact those people have with DHS and may be their only opportunity for exposure to information about job training, child care, and other assistance the state can provide.

Asset test. The asset test for Medicaid should remain in place because it helps children become eligible for CHIP. Medicaid was intended to provide health benefits only for the neediest families. Those with some resources should be encouraged to participate in graduated self-sufficiency through programs like CHIP. If a family has more than $2,000 in assets, the sliding-scale fee of less than $15 per month for CHIP is appropriate. However, if a child is eligible for Medicaid, then CHIP eligibility is denied. Removing the asset test would force children into Medicaid when their families could afford CHIP.

Continuous eligibility. The current eligibility requirements ensure that the state spends scarce Medicaid resources on clients only as long as they need care. Longer periods of continuous eligibility would increase state Medicaid costs by keeping children on the Medicaid rolls longer, even if they did not need or seek medical care, because managed-care organizations receive a set monthly amount per enrollee regardless of care provided.

The state should not prevent families from switching between CHIP and Medicaid as their financial situations change. As families graduate to a higher level of income, they should not be locked into more months of Medicaid than they need. The state also should not pay for more months of Medicaid versus moving children over to CHIP. Because the federal

government pays 75 percent of CHIP costs, it is more cost-effective for the state to enroll children in CHIP than in Medicaid whenever possible.

Continuous eligibility should be available only for recipients who would benefit from it. Many families in Medicaid managed care do not receive the continuous care they need because they change physicians or plans. The state should make continuous eligibility contingent on certain health milestones, such as an annual checkup or use of a primary-care physician. This would help break the cycle of emergency room use and would encourage people to develop relationships with primary-care physicians. Continuous eligibility also could be contingent on income, which would capture the benefits for people who cannot take time off work to come in and be recertified, but also would ensure that people who do not work are exposed to the assistance that DHS can provide.

Cost. The changes proposed by CSSB 43 would be expensive, perhaps even more so than expected. The cost projections may be too low because they do not take into account a possible increase in fraud as a result of these measures, as well as the less favorable match rate for Medicaid versus CHIP. If these changes were implemented, the state could receive a larger than expected Medicaid bill in two years.

These changes would increase Medicaid caseloads, a course that should be approached with great caution in an environment of rising costs and usage. Medicaid caseloads were higher than expected in fiscal 2000-01, in part because of legislation to keep eligible people in Medicaid. Because of this, the state had to spend $600 million more than appropriated for Medicaid. Given that costs are projected to continue to rise in the coming biennium, the state should be cautious about expanding eligibility for Medicaid services.

The bill should direct DHS to seek a waiver to allow the state to use copayments for Medicaid recipients who would take advantage of a simplified application process and who had income. Uses for Medicaid funds generally are determined by federal and state regulations, but the federal government has created ways for states to try alternative programs. To do this, a state must apply for a waiver or must propose a demonstration project. Texas should apply for a waiver to allow copayments, which would make Medicaid more like CHIP and would offset part of the state’s cost.

This waiver, coupled with cost sharing, should be incorporated into plans for Medicaid simplification.

OTHER OPPONENTS SAY:

CSSB 43 would create changes without regard to the long-term implications of expanding Medicaid eligibility. The fiscal note estimates that the cost of these changes would grow to $462 million in fiscal 2004-05. Some of the bill's provisions should be subject to availability of funds. For example, an earlier version of the bill would have established continuous eligibility for children under age five and expanded such eligibility for remaining children subject to availability of funds. This would ensure that the state could meet its financial and social obligations in a sustainable manner.

The state should reform Medicaid before expanding it. Reports of poor management of contracts, missed deliveries of technology improvements, possible fraud by pharmaceutical companies, and findings that children already in Medicaid may not be receiving adequate care should be addressed before the state makes major changes to the program.

NOTES:

The bill's fiscal note estimates that simplifying the Medicaid application process would cost the state $324.5 million in general revenue in fiscal 2002-03, assuming that the rules for continuous eligibility were adopted by February 1, 2002. Annual costs would reach $247 million by fiscal 2006.

Article 11 of the House-approved version of SB 1 by Ellis, the general appropriations bill for fiscal 2002-03, included a $347.8 million rider for the purposes of this program. Article 11 of the Senate version included a rider for $436.4 million.

The committee substitute would establish continuous eligibility for all children on Medicaid under age 19, while the Senate engrossed version of SB 43 would have established it for children under age five and would have expanded it for the remaining children subject to availability of funds.