

# Texas CARTS FY2020 Report

## Basic State Information

### Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the [CARTS Help Desk](#).

1. State or territory name:

Texas

2.

Program type:

- Both Medicaid Expansion CHIP and Separate CHIP
- Medicaid Expansion CHIP only
- Separate CHIP only

3. CHIP program name(s):

N/A

Who should we contact if we have any questions about your report?

4. Contact name:

Michelle Erwin

5. Job title:

Medicaid and CHIP Services, Deputy Associate Commissioner, Office of Policy and Program

6. Email:

Policy\_and\_Program\_Deputy\_Associate\_Commissioner@hsc.state.tx.us

7. Full mailing address:

Include city, state, and zip code.

701 W. 51st Street Austin, TX 78751

8. Phone number:

(512) 431-8293

## PRA Disclosure Statement.

This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## **Program Fees and Policy Changes**

### **Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems**

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

Is the maximum premium a family would be charged each year tiered by FPL?

Yes

No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

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## **Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems**

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

Is the maximum premium a family would be charged each year tiered by FPL?

Yes

No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5.

Which delivery system(s) do you use?

Select all that apply.

- Managed Care
- Primary Care Case Management
- Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All CHIP services are delivered through managed care medical and dental plans.

## **Part 3: Medicaid Expansion CHIP Program and Policy Changes**

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

Yes

No

N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A



6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to the substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

Have you made any changes to the enrollment process for health plan selection?

Yes

No

N/A

11.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

12.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

13.

Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

Yes

No

N/A

14.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

15.

Have you made any changes to eligibility for "lawfully residing" children?

Yes

No

N/A

16.

Have you made changes to any other policy or program areas?

- Yes
- No
- N/A

## **Part 4: Separate CHIP Program and Policy Changes**

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

- Yes
- No
- N/A

2.

Have you made any changes to the eligibility redetermination process?

- Yes
- No
- N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

- Yes
- No
- N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

- Yes
- No
- N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A



9.

Have you made any changes to substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

Have you made any changes to an enrollment freeze and/or enrollment cap?

Yes

No

N/A

11.

Have you made any changes to the enrollment process for health plan selection?

Yes

No

N/A

12.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

13.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

14.

Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

Yes

No

N/A

15.

Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

16.

Have you made any changes to your Pregnant Women State Plan expansion?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

17.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

18.

Have you made any changes to eligibility for "lawfully residing" children?

Yes

No

N/A

19.

Have you made changes to any other policy or program areas?

- Yes
- No
- N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

Due to COVID-19, CHIP co-payments for office visits were waived for all CHIP members.

21.

Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- Yes
- No

## Enrollment and Uninsured Data

### Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the

CARTS data below to update.

<b>Program</b>	<b>Number of children enrolled in FFY 2019</b>	<b>Number of children enrolled in FFY 2020</b>	<b>Percent change</b>
Medicaid Expansion CHIP	346,371	313,959	-9.358%
Separate CHIP	733,942	591,510	-19.406%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

It is possible that COVID-19 has had a significant impact on enrollment in Texas CHIP. As required by H.R. 6201 to receive the increased federal match, HHSC is maintaining continuous Medicaid eligibility during the COVID-19 public health emergency (PHE). During the PHE, children who are no longer eligible because of increased household income are remaining enrolled in Medicaid instead of transitioning to CHIP. Additionally, because of changes in family income due to COVID-19, new applicants may meet Medicaid eligibility criteria instead of qualifying for CHIP.

## **Part 2: Number of Uninsured Children in Your State**

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	450,000	20,000	6%	0.3%
2016	436,000	16,000	5.7%	0.2%
2017	462,000	18,000	6%	0.2%
2018	478,000	20,000	6.2%	0.3%
2019	531,000	22,000	6.9%	0.3%

Percent change between 2018 and 2019
Not Available

2.

Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- Yes
- No

3.

Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

Yes

No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)



# Eligibility, Enrollment, and Operations

## Program Outreach

1.

Have you changed your outreach methods in the last federal fiscal year?

Yes

No

2.

Are you targeting specific populations in your outreach efforts?

For example: minorities, immigrants, or children living in rural areas.

Yes

No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

For outreach materials updated in FFY 2019, effectiveness was measured by the number of outreach materials ordered on the online platform by community organizations and other external stakeholders. These entities will share materials with the general public. The efficacy of the outreach materials is measured by the number of applications processed and hits to the website. Preliminary figures from January 2020 through June 2020 showed: b" Out of the 20,000 CHIP brochures, 473 remained. b" Out of 15,000 CHIP-Perinatal brochures, 8,358 remained. b" Out of 5,000 CHIP posters, 4,220 remained. b" Out of 15,000 CHIP income insert limit cards, 13,572 remained.

4. Is there anything else you'd like to add about your outreach efforts?

No

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

## Eligibility, Enrollment, and Operations

### Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded

insurance such as CHIP.

1.

Do you track the number of CHIP enrollees who have access to private insurance?

Yes

No

N/A

2.

Do you match prospective CHIP enrollees to a database that details private insurance status?

Yes

No

N/A

%

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

Yes. For question 3, because the HHSC eligibility system does not specify the type of third-party resource, Texas cannot provide an exact number of children screening with group health plan coverage. Instead, Texas has provided the total number of individuals screened who were found to have a third-party resource. In FFY 2020, out of 382,141 individuals screened for CHIP coverage, 723 individuals had a third-party resource.

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

# Eligibility, Enrollment, and Operations

## Renewal, Denials, and Retention

### Part 1: Eligibility Renewal and Retention

1.

Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

This question should only be answered in respect to Separate CHIP.

Yes

No

N/A

2.

In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

Yes

No

3.

Do you send renewal reminder notices to families?

Yes

No

4. What else have you done to simplify the eligibility renewal process for families?

N/A

5. Which retention strategies have you found to be most effective?

HHSC has not evaluated the effectiveness of these strategies.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

HHSC has not evaluated the effectiveness of these strategies.

7. Is there anything else you'd like to add that wasn't already covered?

No

## Part 2: CHIP Eligibility Denials (Not Redetermination)

1.

How many applicants were denied CHIP coverage in FFY 2020?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

121815

2.

How many applicants were denied CHIP coverage for procedural reasons?

For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

27569

3.

How many applicants were denied CHIP coverage for eligibility reasons?

For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

93968

3a.

How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

0

4.

How many applicants were denied CHIP coverage for other reasons?

278

5. Did you have any limitations in collecting this data?

No



Table: CHIP Eligibility Denials (Not Redetermination)

This table is auto-populated with the data you entered above.

Type	Number	Percent
Total denials	121815	100%
Denied for procedural reasons	27569	22.63%
Denied for eligibility reasons	93968	77.14%
Denials for other reasons	278	0.23%

### Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in CHIP in FFY 2020?

287778

2.

Of the eligible children, how many were then screened for redetermination?

239167

3.

How many children were retained in CHIP after redetermination?

185682

4.

How many children were disenrolled in CHIP after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

53485

**Computed:** 53485

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

9887

4b.

How many children were disenrolled for eligibility reasons?

This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

43580

4c.

How many children were disenrolled for other reasons?

18

5. Did you have any limitations in collecting this data?

The numbers are very different from prior years, as would be expected given the COVID-19 pandemic. HHSC believes that most of the difference can be explained due to policy changes HHSC made during COVID-19 and due to the impact of COVID-19 on incomes. A number of CHIP denials in the "Other" eligibility denial category may reflect children who may have moved into Medicaid programs, as there is no denial reason for that denial type. There are reduced counts of redeterminations due to the automatic extension of renewals, which are not captured in the worker-based dispositions that are the basis of HHSC's analysis. The files also will not capture the administrative renewals (another automated transaction).

Table: Redetermination in CHIP

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	239167	100%
Children retained after redetermination	185682	77.64%
Children disenrolled after redetermination	53485	22.36%

Table: Disenrollment in CHIP after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	53485	100%
Children disenrolled for procedural reasons	9887	18.49%
Children disenrolled for eligibility reasons	43580	81.48%
Children disenrolled for other reasons	18	0.3%

## Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in Medicaid in FFY 2020?

3278075

2.

Of the eligible children, how many were then screened for redetermination?

779790

3.

How many children were retained in Medicaid after redetermination?

670315

4.

How many children were disenrolled in Medicaid after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

109475

**Computed:** 109475

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

48411

4b.

How many children were disenrolled for eligibility reasons?

This could be due to an income that was too high and/or eligibility in CHIP instead.

57310

4c.

How many children were disenrolled for other reasons?

3754

5. Did you have any limitations in collecting this data?

The numbers are very different from prior years, as would be expected given the COVID-19 pandemic. HHSC believes that most of the difference can be explained due to policy changes HHSC made during COVID-19 and due to impact of COVID-19 on incomes. A number of CHIP denials in the "Other" eligibility denial category may reflect children who may have moved into Medicaid programs, as there is no denial reason for that denial type. There are reduced counts of redeterminations due to the automatic extension of renewals, which are not captured in the worker-based dispositions that are the basis of HHSC's analysis. The files also will not capture the administrative renewals (another automated transaction).

Table: Redetermination in Medicaid

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	779790	100%
Children retained after redetermination	670315	85.96%
Children disenrolled after redetermination	109475	14.04%



Table: Disenrollment in Medicaid after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	109475	100%
Children disenrolled for procedural reasons	48411	44.22%
Children disenrolled for eligibility reasons	57310	52.35%
Children disenrolled for other reasons	3754	3.43%

## Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

## Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

27

20274

30351

12530

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in CHIP six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

20

16058

25366

10636

5.

How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

0

174

195

71

6.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

7.

How many children were no longer enrolled in CHIP six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

8.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9. Is there anything else you'd like to add about your data?

During the public health emergency (PHE), Texas suspended periodic income checks for Medicaid and CHIP. Texas provided extensions for CHIP renewals from April 2020 - June 2021. Texas is maintaining continuous Medicaid eligibility until the end of the PHE. In October 2020, Texas updated TIERS functionality to automatically test a child enrolled in CHIP for Medicaid when HHSC receives information indicating they may be eligible for Medicaid. Previously, a household had to submit a new application to have a child enrolled in CHIP tested for Medicaid. CHIP can be terminated if the child: b" dies, b" is incarcerated, b" moves out of state, b" is determined eligible for Medicaid, or if the family withdraws the child from CHIP coverage. A child's CHIP coverage can be terminated if they were eligible for expedited CHIP enrollment and the household did not pay the enrollment fee within 90 days. b◇

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in CHIP 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in CHIP 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

15.

How many children were continuously enrolled in CHIP 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18.

How many children were no longer enrolled in CHIP 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16



19.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

20. Is there anything else you'd like to add about your data?

## Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

## Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

57966

60326

75282

34237

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in Medicaid six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

56987

58808

73490

33239

5.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

204

444

459

220

6.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

3

84

88

33

7.

How many children were no longer enrolled in Medicaid six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

775

1074

1333

778

8.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9

276

353

181

9. Is there anything else you'd like to add about your data?

During the public health emergency (PHE), Texas suspended periodic income checks for Medicaid and CHIP. Texas is maintaining continuous Medicaid eligibility until the end of the PHE. In October 2020, Texas updated TIERS functionality to automatically test a child enrolled in CHIP for Medicaid when HHSC receives information indicating they may be eligible for Medicaid. Previously, a household had to submit a new application to have a child enrolled in CHIP tested for Medicaid. Medicaid can be terminated if the child: b" dies, b" moves out of state, b" is determined eligible for CHIP, or if the family withdraws the child from Medicaid coverage.

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in Medicaid 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in Medicaid 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

15.

How many children were continuously enrolled in Medicaid 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16



18.

How many children were no longer enrolled in Medicaid 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

19.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

20. Is there anything else you'd like to add about your data?

## Eligibility, Enrollment, and Operations

### Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles,

coinsurance, and copayments.

1.

Does your state require cost sharing?

Yes

No

2.

Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- Families ("the shoebox method")
- Health plans
- States
- Third party administrator
- Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

The CHIP administrative services contractor confirms the notification from the family when the family is near their cap on out-of-pocket information. The CHIP administrative services contractor then notifies the member's health and dental plan who then issues a new membership card that indicates no cost-sharing is required through the end of that member's enrollment period. In addition to seeing the member's membership cards, providers can also access a toll-free line operated by the CHIP administrative services contractor that provides eligibility information.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

1

5.

Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

Yes

No

6.

Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

Yes

No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

HHSC has not evaluated the impact of waiving office visit co-payments during the COVID-19 pandemic on enrollment and utilization.

8. Is there anything else you'd like to add that wasn't already covered?

No

9.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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## **Eligibility, Enrollment, and Operations**

### **Employer Sponsored Insurance and Premium Assistance**

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1.

Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

Yes

No

# Eligibility, Enrollment, and Operations

## Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1.

Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

Yes

No

2.

Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

Yes

No

3.

Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

Yes

No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

Regarding prevention, HHSC Office of the Inspector General (OIG) has written policies and procedures pertaining to the placement of providers on prepayment review. Regarding investigations and referrals of fraud and abuse, HHSC-OIG follows statutory requirements in the Texas Government Code, rules published in the Texas Administrative Code and its own policies and procedures.

5.

Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

Yes

No

N/A

6.

How many eligibility denials have been appealed in a fair hearing in FFY 2020?

1998

7.

How many cases have been found in favor of the beneficiary in FFY 2020?

8.

How many cases related to provider credentialing were investigated in FFY 2020?

0

9.

How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?



10.

How many cases related to provider billing were investigated in FFY 2020?

1856

11.

How many cases were referred to appropriate law enforcement officials in FFY 2020?

522

12.

How many cases related to beneficiary eligibility were investigated in FFY 2020?

109

13.

How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

7

14.

Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- CHIP only
- Medicaid and CHIP combined

15.

Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- Yes
- No

16.

Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- Yes
- No

17. Is there anything else you'd like to add that wasn't already covered?

Regarding #6 and #7, the CHIP Request for Review (RFR) unit is a specialized group of HHSC staff administratively categorized the same as Medicaid fair hearings staff. RFR handles CHIP requests for review (CHIP appeals) and retroactive CHIP coverage requests. A request for review is any expression of dissatisfaction with an adverse action such as denial of eligibility, an untimely eligibility determination, termination of enrollment, or when CHIP and CHIP perinatal households do not agree with period of coverage. The data provided in question #6 are for all RFRs received by the RFR unit. Regarding #8 and #9, HHSC-Office of Inspector General does not investigate provider credentialing. Provider investigations are normally focused on how a provider bills Medicaid or CHIP for services provided (or not provided) to Medicaid or CHIP recipients or quality of care issues where physical harm or neglect may be an issue. Therefore, Texas does not have any numbers to provide for Question 8 and 9. Regarding #15, the numbers reported are solely based on investigative work performed by the State as we do not rely on contractors to perform the functions; however, the State contracts with managed care organizations and under those contracts the plans are required to conduct fraud, waste and abuse investigations. This work is done by the managed care organization's Special Investigations Units (SIU). Upon completion of an SIU investigation where fraud, waste, and abuse is suspected, the SIU must refer the case to the State. HHSC OIG does not provide an answer to #5 because it does not rely on contractors to perform the functions noted in the questions above. However, SIU work can be the basis or initiation of work that leads to the State's reporting results. The explanation provided under #6 explains oversight of the SIUs. One exception to the explanation for #5 is the collaboration and Joint Operating Agreement (JOA) that exists between HHSC-OIG and the CMS UPIC contractor (currently Qlarant). This project began in 2019 and involves the use of the contractor to perform investigations with the assistance and guidance of HHSC-OIG. CMS oversees the performance of the contractor. Question 16 continued: As mentioned above, in order to ensure integrity of CHIP services under the managed care arrangement, HHSC, by administrative rule, requires the managed care organizations and dental maintenance organizations to have SIUs to investigate allegations of fraud, waste and abuse. Each managed care organization and dental maintenance organization must have a fraud, waste, and abuse plan that outlines how it will identify potential provider and beneficiary fraud, waste and abuse as it relates to CHIP. These fraud, waste and abuse plans are submitted

annually to HHSC for review and approval. Additionally, the managed care organizations and dental maintenance organizations are required to refer any allegations of fraud, waste and abuse to HHSC-OIG for further investigation. Managed care organizations and dental maintenance organizations submit a monthly log of all investigative activity to HHSC-OIG and to the Attorney General's Medicaid Fraud Control Unit.

18.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

## Eligibility, Enrollment, and Operations

### Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups

Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-18 years) instead.

Yes

No

2.

How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages  
10-14

Ages  
15-18

25

26128

68460

109586

141333

91670

3.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages  
10-14

Ages  
15-18

2

12767

36969

63695

78106

45131

## Dental care service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
2	11757	32250	60694	75601	42836

## Dental care service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim. All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?

This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	292	6782	23837	27673	17806

#### Dental treatment service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6.

How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

13103

## Sealant codes and definitions

The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7.

Do you provide supplemental dental coverage?

Yes

No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

No

9.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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# Eligibility, Enrollment, and Operations

## CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1.

Did you collect the CAHPS survey?

Yes

No

## Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1.

Upload a summary report of your CAHPS survey results.

This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

2.

Which CHIP population did you survey?

- Medicaid Expansion CHIP
- Separate CHIP
- Both Separate CHIP and Medicaid Expansion CHIP
- Other

3.

Which version of the CAHPS survey did you use?

- CAHPS 5.0
- CAHPS 5.0H
- Other

4.

Which supplemental item sets did you include in your survey?

Select all that apply.

- None
- Children with Chronic Conditions
- Other

5.

Which administrative protocol did you use to administer the survey?

Select all that apply.

- NCQA HEDIS CAHPS 5.0H
- HRQ CAHPS
- Other

5a. Which administrative protocol did you use?

Generally, HHSC follows NCQA HEDIS specifications for CAHPS 5.0H, with a modification to the data collection protocol using Computer Assisted Telephone Interviews (CATI).

6. Is there anything else you'd like to add about your CAHPS survey results?

No

## **Part 3: You didn't collect the CAHPS survey**

### **Eligibility, Enrollment, and Operations**

#### **Health Services Initiative (HSI) Programs**

All states with approved HSI program(s) should complete this section. States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1.

Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?

Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

Yes

No

# **State Plan Goals and Objectives**

## **Part 1: Tell us about your goals and objectives**

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.

Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

The state compares annual data on the number of CHIP income-eligible children that participate in CHIP to the estimated number of CHIP income-eligible children that remain uninsured. The goal is to decrease the rate of low-income uninsured children by enrolling as many eligible children as possible.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Number of children enrolled in the program as of the last month of FFY 2020 (September 2020)

4.

Numerator (total number)

307372

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

The sum of the number of children enrolled and the number of low-income uninsured children likely to qualify for the program as of the last month of FFY 2020 (September of 2020).

6.

Denominator (total number)

410000

**Computed:** 74.97%



7.

What is the date range of your data?

**Start**

mm/yyyy

10 / 2019

**End**

mm/yyyy

09 / 2020

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

b"Maintenance of effort (MOE) policy in Medicaid is keeping clients/children enrolled in Medicaid. There are a large number of children that transfer from Medicaid to CHIP on a monthly basis under normal conditions and that is not occurring during the COVID-19 PHE. b"Due to changes in family income, a greater share of children may transfer from CHIP to Medicaid or may now be eligible and apply for Medicaid during the COVID-19 PHE.

10. What are you doing to continually make progress towards your goal?

We're conducting outreach activities, including distributing outreach materials to community organizations and other external stakeholders. These entities will share materials with the general public.

11. Anything else you'd like to tell us about this goal?

The data for each Objective was pulled from either the 2019 Quality of Care Tables, the 2019 Child Core Measure Survey, or the 2021 MCO Report Cards.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Provide Improved Health Outcomes for New CHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

4.

Numerator (total number)

28912

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

6.

Denominator (total number)

31136

**Computed:** 92.86%

7.

What is the date range of your data?

**Start**

mm/yyyy

03 / 2019

**End**

mm/yyyy

11 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

From the FFY 2019 report to FFY 2020 report, the percentage of CHIP enrollees with good access to urgent care has increased from 85.6 percent to 92.9 percent.



10. What are you doing to continually make progress towards your goal?

In addition to the quality improvement activities described below, HHSC uses the 3M potentially preventable emergency department visits (PPVs) as a quality measure to assess CHIP managed care organization performance for Pay-for-Quality (P4Q) and the Performance Indicator Dashboard. Lack of access to urgent care can be a factor in the use of emergency departments for care that could be provided in a nonemergency setting. There are four main quality improvement activities intended to improve results for this measure.

**Appointment Availability** The Appointment Availability Study is intended to improve member access to health care providers. The Texas Medicaid/CHIP program established a process for direct monitoring of a managed care organization's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. The Texas Uniform Managed Care Contract (UMCC) specifies that Medicaid and CHIP managed care organizations must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters. Access to urgent care is assessed through the Primary Care Provider (PCP) Appointment Availability study. The study looks to ensure that CHIP members receive an appointment within 24 hours. For 2020 study, 100 percent of the managed care organizations met the requirement for CHIP.

**Pay-for-Quality (P4Q)** The P4Q program applies to all CHIP managed care organizations. There are two types of measures in the P4Q program: At-Risk Measures and Bonus Pool Measures. Up to three percent of each managed care organization's capitation may be recouped and redistributed based on performance on At-Risk Measures. If any recouped funds remain after all distributions are made, the funds can be distributed based on managed care organization performance on Bonus Pool Measures. The CAHPS Access to Urgent Care measure is a Bonus Pool Measure for CHIP P4Q in 2018 and 2019.

**Performance Improvement Projects (PIPs)** There are currently 15 CHIP health plans and three dental plans in Texas. Typically, each health plan is required to complete two, two-year PIPs per program. The 2019 PIP goal for managed care organizations is

to reduce potentially preventable emergency department visits and inpatient stays among members with anxiety or depression through improved medication management among primary care providers and improved treatment for behavioral health conditions. These PIPs will be extended to a third year due to the impact of the COVID-19 pandemic.

Performance Indicator Dashboard The Performance Indicator Dashboards include a series of measures that identify key aspects of managed care organization healthcare quality performance. The dashboard is designed to provide a snapshot of managed care organization performance in CHIP. Additionally, managed care organizations are expected to maintain minimum standards of performance on two thirds of the measures. Managed care organizations with more than one third of measures falling below the minimum standard will be subject to corrective actions. The CHIP dashboard measures include the CAHPS access to urgent care measure.

11. Anything else you'd like to tell us about this goal?

Description of what is being measured: CAHPS Health Plan Survey 5.0H, Child Version - Question CAHPS 4 "In the last 6 months, when your child needed care right away, how often did you get care as soon as you needed?" The rate represents the percentage of caregivers who responded "usually" or "always". Rates are based on simple random sample of 411 collected for this year. Only weight corrections for potential non-response bias were necessary.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Provide Improved Health Outcomes for New CHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase the rate of follow-up after hospitalization for mental health disorders.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Outpatient visit or partial hospitalization within 30 days for members six years of age and older who were hospitalized for selected mental health disorders

4.

Numerator (total number)

714

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Members six years of age and older who were hospitalized for selected mental health disorders

6.

Denominator (total number)

1243

**Computed:** 57.44%

7.

What is the date range of your data?

**Start**

mm/yyyy

01 / 2019

**End**

mm/yyyy

12 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

From 2019 to 2020, the percentage of discharges for members six years of age and older who were hospitalized for selected mental health disorders and who had an outpatient visit or partial hospitalization follow-up visit with a mental health practitioner within 30 days increased from 54.5 to 57.4 percent.



10. What are you doing to continually make progress towards your goal?

There are three main quality improvement activities intended to improve results for this measure. Performance Indicator Dashboard The Performance Indicator Dashboards include a series of measures that identify key aspects of managed care organization healthcare quality performance. The dashboard is designed to provide a snapshot of managed care organization performance in CHIP. Additionally, managed care organizations are expected to maintain minimum standards of performance on two thirds of the measures. managed care organizations with more than one third of measures falling below the minimum standard will be subject to corrective actions. The CHIP dashboard measures include Follow-up After Hospitalization for Mental Illness (7 and 30 day). Performance Improvement Projects (PIPs) There are currently 15 CHIP health plans in Texas. Typically, each health plan is required to complete two, two-year PIPs per program. 2019 and 2020 PIPs will be extended to a third year due to the impact of the COVID-19 pandemic. The 2019 PIP goal for managed care organizations is to reduce potentially preventable emergency department visits and inpatient stays among members with anxiety or depression through improved medication management among primary care providers and improved treatment for behavioral health conditions. 2020 PIPs target improving the rate of follow-up care after admission for mental illness. Value Based Enrollment Value-based enrollment (VBE) incorporates member satisfaction related to use of preventive health. Experience of care measures include a rating on getting care when needed, rating of personal doctor or child's personal doctor, and health plan rating. Preventable emergency room and hospital admissions are also incorporated into VBE, which can be considered measures for the effectiveness and/or availability of routine preventive care.

11. Anything else you'd like to tell us about this goal?

The data for each Objective was pulled from either the 2019 Quality of Care Tables, the 2019 Child Core Measure Survey, or the 2021 MCO Report Cards.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

Provide Increased Preventive and Primary Health Care Services to new CHIP-Enrolled Texas Children.

1. Briefly describe your goal for this objective.

Increase the percentage of members ages 13-19 years old who received one or more well-care visits during the specified timeframe.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

**Start**

mm/yyyy

01 / 2019

**End**

mm/yyyy

12 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

From FFY 2019 report to FFY 2020 report, the rate of adolescent CHIP members who had an Adolescent Well-Care Preventive Visit has increased from 69.8 percent to 70.8 percent.

10. What are you doing to continually make progress towards your goal?

There are three main quality improvement activities intended to improve results for this measure: Appointment Availability The Appointment Availability Study is one of the quality improvement activities that involves the CHIP program and benefits CHIP enrollees. This quality initiative is intended to improve member access to health care providers. The Texas Medicaid/CHIP program established a process for direct monitoring of a managed care organization's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. The Primary Care Provider (PCP) Appointment Availability study assessed the wait times for preventative care for CHIP enrollees. For 2020, 97 percent of the managed care organizations met the requirement providing an appointment within 90 days to CHIP members for preventative care. Pay-for-Quality (P4Q) HEDIS Adolescent Well Care (AWC) is an At-Risk Measures for CHIP in P4Q for 2018 and 2019. Up to 0.75% of a managed care organization's capitation can be recouped if their performance declines significantly over the prior year, or if they are performing poorly compared to state and national benchmarks. Alternatively, a managed care organization can earn up to 0.75% above their capitation rate if they perform well on the AWC measure. Performance Indicator Dashboard The Performance Indicator Dashboards include a series of measures that identify key aspects of managed care organization healthcare quality performance. The dashboard is designed to provide a snapshot of managed care organization performance in CHIP. Additionally, managed care organizations are expected to maintain minimum standards of performance on two thirds of the measures. managed care organizations with more than one third of measures falling below the minimum standard will be subject to corrective actions. The CHIP dashboard measures include HEDIS Adolescent Well Care.

11. Anything else you'd like to tell us about this goal?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

Provide Increased Preventive and Primary Health Care Services to new CHIP-Enrolled Texas Children.



1. Briefly describe your goal for this objective.

Increase the percent of CHIP enrollees who have a usual source of care.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

4.

Numerator (total number)

111516

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

6.

Denominator (total number)

130579

**Computed:** 85.4%

7.

What is the date range of your data?

**Start**

mm/yyyy

03 / 2019

**End**

mm/yyyy

11 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

From FFY 2019 report to FFY 2020 report, the percent of CHIP enrollees who have a usual source of care has decreased from 91.8 percent to 85.8 percent.

10. What are you doing to continually make progress towards your goal?

Appointment Availability The Appointment Availability Study is a quality improvement activity that involves the CHIP program and benefits CHIP enrollees. This quality initiative is intended to improve member access to health care providers. The Texas Medicaid/CHIP program established a process for direct monitoring of a managed care organization's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. The Primary Care Provider (PCP) study seeks to ensure that routine care is provided within 14 days of an appointment request. For 2020 study, 100% of the managed care organizations met this requirement.

11. Anything else you'd like to tell us about this goal?

Description of what is being measured: CAHPS 5.0H The Consumer Assessment of Healthcare Providers and Systems (CAHPSB.) Health Plan Survey 5.0H question CAHPS 30: "A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?" The rate represents the percentage of caregivers who responded "Yes". Information for this goal is obtained from the Established Enrollee Survey. The Texas external quality review organization (EQRO) contractor, the Institute for Child Health Policy, University of Florida, administers telephone surveys to caregivers of children enrolled in CHIP, on a biennial basis.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

Provide Increased Preventive and Primary Health Care Services to new CHIP-Enrolled Texas Children.

1. Briefly describe your goal for this objective.

Increase the percentage of CHIP members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Numerators and denominators are not shown because the weighted state rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

**Start**

mm/yyyy

01 / 2019

**End**

mm/yyyy

12 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source



9. How did your progress towards your goal last year compare to your previous year's progress?

From FFY 2019 report to FFY 2020 report, the number of children 3 to 6 years of age in CHIP Preventive Care for Children who had a well-care visit decreased from 80.1 percent to 79.9 percent.

10. What are you doing to continually make progress towards your goal?

There are three main quality improvement activities intended to improve results for this measure: Appointment Availability The Appointment Availability Study is a quality improvement activity that involves the CHIP program and benefits CHIP enrollees. This quality initiative is intended to improve member access to health care providers. The Texas Medicaid/CHIP program established a process for direct monitoring of a managed care organization's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. Primary Care Provider (PCP) Appointment Availability study evaluated appointment wait times for preventive care for CHIP members. 97 percent of the managed care organizations met the 90-day appointment wait time requirement. The Performance Indicator Dashboards The Performance Indicator Dashboards include a series of measures that identify key aspects of managed care organization healthcare quality performance. The dashboard is designed to provide a snapshot of managed care organization performance in CHIP. Additionally, managed care organizations are expected to maintain minimum standards of performance on two thirds of the measures. Managed care organizations with more than one third of measures falling below the minimum standard will be subject to corrective actions. The CHIP dashboard measures include HEDIS Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.

11. Anything else you'd like to tell us about this goal?

Numerators and denominators are not shown because the Weighted State Rates are the sum of weighted managed care organization rates, accounting for proportional membership meeting denominator inclusion criteria. The denominator inclusion criteria are the HEDIS specifications for the denominator for that particular measure.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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**Do you have another in this list?**

Optional

**Do you have another objective in your State Plan?**

Optional

## Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

Texas uses managed care organization Report Cards to measure and report on access, quality and member outcomes for the CHIP population. Texas provides CHIP members managed care organization report cards, which provide information on access, experience, outcome and process measures related to the CHIP population. These report cards are available on HHSC's webpage and are included in enrollment packets to aid members in choosing a managed care organization. Each item on the report card is assigned between one and five stars. The report cards provide information on individual measures, composite scores of related items, and one overall score for each managed care organization. The report cards are separated by service delivery area, so members have information that is specific to them. These are completed on a calendar year basis. The most recent information available from the report cards uses calendar year 2018 administrative data and surveys fielded in 2019. The average overall rating for the CHIP managed care organizations was 3 out of 5 stars. "Children and teens get regular checkups" and "Parents give high ratings to the health plan" had the highest average ratings, 3.2 stars.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

HHSC does not plan to add new CHIP-specific strategies at this time.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

No

4.

Optional: Attach any additional documents here.

For example: studies, analyses, or any other documents that address your performance goals.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

## Program Financing

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

### Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 824,833,231

\$ 867,883,153

\$ 904,908,624

2.

How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 824,833,231

\$ 867,883,153

\$ 904,908,624

3.

How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 821,381,389

\$ 863,889,430

\$ 900,260,568

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

Type	FFY 2020	FFY 2021	FFY 2022
Managed Care	824833231	867883153	904908624
Fee for Service	Not Answered	Not Answered	Not Answered
Other benefit costs	821381389	863889430	900260568
Cost sharing payments from beneficiaries	3451842	867883153	904908624
Total benefit costs	1649666462	2599655736	2710077816

## Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

This includes wages, salaries, and other employee costs.

2020

2021

2022

\$ 25,426,810

\$ 297,330,275

\$ 25,192,377

2.

How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 10,673,707

\$ 12,480,222

\$ 10,575,296

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 14,239,939

\$ 21,427,120

\$ 19,481,020

4.

How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

5.

How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 277,172

\$ 324,083

\$ 274,616

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

7.

How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 3,985,574

\$ 4,660,129

\$ 3,948,828



Table 2: Administrative Costs

This table is auto-populated with the data you entered above.

Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

<b>Type</b>	<b>FFY 2020</b>	<b>FFY 2021</b>	<b>FFY 2022</b>
Personnel	25426810	297330275	25192377
General administration	10673707	12480222	10575296
Contractors and brokers	14239939	21427120	19481020
Claims processing	Not Answered	Not Answered	Not Answered
Outreach and marketing	277172	324083	274616
Health Services Initiatives (HSI)	Not Answered	Not Answered	Not Answered
Other administrative costs	3985574	4660129	3948828
Total administrative costs	54603202	336221829	59472137
10% administrative cap	182529197.56	95987714.44	100028952

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

<b>Type</b>	<b>FFY 2020</b>	<b>FFY 2021</b>	<b>FFY 2022</b>
Total program costs	1704269664	2935877565	2769549953
eFMAP	84.12	73.27	72.56
Federal share	1433631641.36	2151117491.88	2009585445.9
State share	270638022.64	784760073.12	759964507.1

8.

What were your state funding sources in FFY 2020?

Select all that apply.

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations
- Tobacco settlement
- Other

8a. What other type of funding did you receive?

CHIP Experience Rebates and Vendor Drug Rebates

9.

Did you experience a shortfall in federal CHIP funds this year?

Yes

No

### Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1.

How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022

363954

329703

344286

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

Round to the nearest whole number.

2020

2021

2022

\$ 165

\$ 180

\$ 185

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	363954	329703	344286
PMPM cost	165	180	185

## Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1.

How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022




2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020

2021

2022

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	Not Answered	Not Answered	Not Answered
PMPM cost	Not Answered	Not Answered	Not Answered

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

In federal fiscal year 2013 and forward, drug costs are included in the capitated costs through managed care rather than from fee for service. Funding for CHIP extended through Federal Fiscal Year 2023 via H.R. 3921, HEALTHY KIDS Act. Under the HEALTHY KIDS Act, the federal CHIP match rate was increased by 11.5 percentage points from October 1, 2019 through September 30, 2020. Texas has CHIP-related expenses for its claims administrator which performs some CHIP functions such as reporting enhancements. These are captured as contractor/ broker costs.

2.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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## Challenges and Accomplishments

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Texas CHIP remains subject to the maintenance of effort (MOE) requirements. Benefits and eligibility were maintained at the same level as the previous fiscal year.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

As with all programs, the COVID-19 public health emergency has had a significant impact on CHIP members and their families.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

In response to the COVID-19 public health emergency, the Texas CHIP program was able to waive CHIP outpatient office visit copayments to ensure quick access to COVID testing and treatment. CHIP also extended certification periods, which reduced an administrative step for families during the pandemic.. Both of these changes are temporary.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

In FFY 2020, in response to the COVID-19 public health emergency, the Texas CHIP program was able to waive CHIP outpatient office visit copayments to ensure quick access to COVID testing and treatment. CHIP also extended certification periods, which reduced an administrative step for families during the pandemic. Both of these changes are temporary.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)