



Proposed Changes for Healthy Texas Women Waiver Implementation:
Solutions to Reduce Impact on Women's Health and Cost Savings
March 2021



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A. Executive Summary - Intended Termination of Crucial Policies and Proposed Solutions

In January 2020, Texas received approval from federal Centers for Medicare and Medicaid Services (CMS) to implement the 1115 Healthy Texas Women (HTW) Demonstration Waiver. The waiver allows Texas to receive federal Medicaid funds for HTW. The Texas Health and Human Services Commission (HHSC) received approval for its waiver implementation plan on January 4, 2021.

Through its HTW waiver implementation plan, HHSC intends to terminate three crucial policies:

- (1) Auto-enrollment of new mothers from Pregnant Women's Medicaid into HTW;
- (2) Adjunctive eligibility for women applying for HTW that are already enrolled in WIC, have a child in Medicaid, or in a household that receives SNAP or TANF; and
- (3) Simplified HTW Application Form (Form H1867).

Together, the above policies promote continuity of care for eligible women, improve access to women's health and family planning services, and positively impact the wellbeing of families. Eliminating them not only will erode Texas's progress to improve postpartum care and women's health outcomes, but also reduce the future cost savings of HTW. Gaps in coverage mean women may not obtain contraceptive and other services, resulting in an increase in the number of unintended Medicaid births later.

Notably, Texas must maintain budget neutrality as part of this 1115 waiver, meaning that the demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration. HTW is expected to achieve this goal by increasing access to women's health and family planning services, which in turn will reduce the number of unintended pregnancies, improve birth spacing, and reduce the number of premature deliveries and low-birth weight infants funded through Medicaid. Eliminating the above three policies could drastically decrease enrollment in HTW and access to women's preventive care -- which presents a serious risk to Texas's ability to achieve the budget neutrality expenditure targets included in the Standard Terms and Conditions of the approved waiver and ensure continued federal funding.¹

¹ If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. If at the end of the demonstration



Ultimately, success of the HTW waiver hinges on maintaining stable HTW enrollment and ensuring access to women's health care in order to achieve projected savings.

We understand that HHSC must make certain eligibility changes to meet federal waiver requirements, such as converting HTW's Federal Poverty Level threshold to a MAGI equivalent. There are clear policy steps Texas can -- and should -- take under the HTW waiver to ease the transition of new mothers from Medicaid to HTW, maintain continuity of care, maximize state cost savings, and minimize burdens on women, health clinics, and the state. **Below is a summary of potential solutions, which are also discussed in more detail in section G.**

Steps to make the transition from Medicaid for Pregnant Women to HTW more efficient:

1. HHSC should take steps to comply with the December 2020 Centers for Medicare and Medicaid Services (CMS) guidance that seeks to increase efficiencies in enrollment processes. Specifically, three key steps are needed to comply with federal guidance:
 - a. Provide a 12-month eligibility period to pregnant women who enroll in Medicaid for Pregnant Women, starting in the month of application;
 - b. Make transitions more efficient by treating the end of pregnancy and aging out of Children's Medicaid as a change in circumstance (rather than requiring a burdensome renewal). Under the CMS guidance, states may not require a full renewal or require a woman to reverify income at the end of the 60-day postpartum period unless the agency has information that her income has changed and that she would be ineligible for other programs;
 - c. Provide clients 30 days to submit verification information when HHSC is acting on changes in circumstance, including two scenarios: the end of pregnancy and aging out of Children's Medicaid. HHSC's current policy of 10 days for clients to provide verification of a change in circumstance does not align with CMS' expectation of 30 days. A reasonable time frame is especially important for a mother with a newborn who may need to verify a change or submit information at the end of the 60-day postpartum period.
2. Improve the administrative renewal process to ensure fewer women churn off of coverage at renewal. This will also help the recently launched HTW Plus program as established by Senate Bill 750 (86th legislative session) improve continuity of care for new mothers, thus contributing to better postpartum health outcomes. We recommend the improvements outlined and shared with HHSC by Every Texan in a [separate memo](#).

approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. See Special Terms and Conditions 50-53. Centers for Medicare and Medicaid Services. [Healthy Texas Women Approved Application](#). January 2020.

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3. HHSC should consider post-enrollment verification for women transitioning from Medicaid for Pregnant Women to Healthy Texas Women. Post-enrollment verification would not require a waiver from CMS and is already used for pregnant female applicants to Texas Medicaid for Pregnant Women.
4. HHSC should use self-attestation as verification for certain eligibility criteria – such as self-attestation of residency – in order to enable a better transition for new moms. Medicaid and CHIP regulations allow for the use of self-attestation as verification for all eligibility criteria except income, citizenship/immigration status, and SSNs. This does not require a waiver from CMS.

To continue Texas' progress in enrolling new eligible clients in HTW:

5. HHSC could request a waiver to continue adjunctive eligibility. CMS has allowed adjunctive eligibility for certain MAGI-based eligibility groups, such as express lane eligibility for children's Medicaid when they are enrolled in SNAP or WIC.

B. Current Auto-enrollment Policy

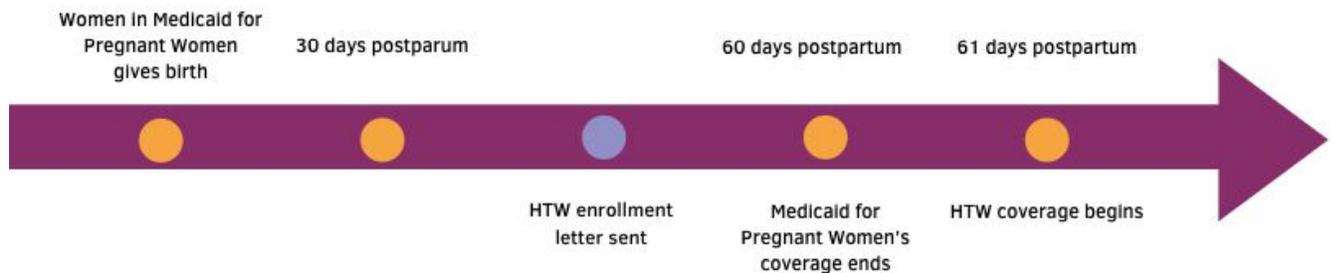
Since 2016, new mothers have automatically transitioned into HTW when coverage under the Medicaid for Pregnant Women program ends -- a policy that ensures continuity of care and improves health outcomes.

To increase enrollment in HTW and achieve program goals, HHSC implemented auto-enrollment from Pregnant Women's Medicaid into HTW when rolling out the 2016 iteration of the women's health program. When coverage under the Medicaid for Pregnant Women program ends, new mothers are automatically transitioned to the HTW program. While HTW's benefits are significantly more limited than Medicaid's, it covers family planning, preventive and basic primary care, which postpartum mothers need to stay healthy.

The current auto-enrollment policy does not require new mothers to submit another application or documentation during the process. Over 80,000 new mothers were auto-enrolled into HTW in fiscal year 2019.

Healthy Texas Women Auto-enrollment

CURRENT AUTO-ENROLLMENT PROCESS



Steps in the current process include:

- Women enrolled in Medicaid for Pregnant Women have coverage during pregnancy and 60 days after childbirth.
- About one month before Medicaid for Pregnant Women eligibility ends, HHSC determines if mom is eligible for other programs, starting with Medicaid, then CHIP, and lastly HTW. To determine Medicaid eligibility, HHSC requests verification of income or other eligibility criteria, which the new mom must submit within 10 days.
- New mothers ages 18-44 who are either: 1) determined ineligible for Medicaid/CHIP; or 2) do not submit requested verification needed for Medicaid/CHIP, are automatically enrolled into HTW. **HHSC does not request, and new moms do not have to send, income or any other verification prior to HTW auto-enrollment.**
- HHSC notifies the new mom about the automatic program transition and mails her an HTW *Your Texas Benefits* ID card. Her HTW coverage begins at 61 days postpartum, right as her Medicaid for Pregnant Women's coverage ends.

Lawmakers and HHSC have long-recognized the positive impacts of auto-enrollment.

HHSC stated in its 2018 report:

“With the launch of HTW in July 2016, HHSC began automatically enrolling eligible Medicaid for Pregnant Women clients into HTW upon conclusion of Medicaid coverage, if they were determined ineligible under another Medicaid category. Increased

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coordination among women’s health services has promoted a continuity of care and enabled some women to stay with their same doctor as they transition from Medicaid for Pregnant Women to HTW, resulting in positive health outcomes for Texas women.”²

HHSC reinforced the importance of this policy in its May 2020 Women’s Health Program Report:

“HHSC also automatically enrolls eligible women receiving Medicaid for Pregnant Women services into HTW upon conclusion of their Medicaid coverage. Increased coordination among women’s health services, including Medicaid, has promoted continuity of care. Automatic enrollment reduces the burden of re-enrollment for services and facilitates women’s access to postpartum care, with the goal of better health outcomes for both the mother and child.”³

Auto-enrollment has improved client enrollment in HTW.

The most recent data from HHSC show that HTW enrollment increased by 219 percent since the program’s launch in 2016, which included the auto-enrollment policy. Monthly client enrollment in July 2016 was 93,020 compared to August 2019 when monthly client enrollment increased to 296,959 clients enrolled. HHSC specifically stated that “[t]he increase in client enrollment is partly due to automatic enrollment into HTW from Medicaid for Pregnant Women. During fiscal year 2019, a total of 83,805 women auto-enrolled into HTW from Medicaid for Pregnant Women.”⁴

Women’s Health/TWHP/HTW	FY 2016	FY 2017	FY 2018	FY2019
Monthly Avg. Clients Enrolled	78,977	167,178	244,158	279,671
Clients Served	54,756	122,406	172,023	191,278
State Cost Savings	Not Available	\$63.1 million	\$87.9 million	\$96.8 million
Women Auto-enrolled	Not Available	38,959	Not Available	83,805

**All data pulled from HHSC reports or presentations*

² Texas Health and Human Services. [Auto-enrollment in the Healthy Texas Women Program](#). July 2018.

³ Texas Health and Human Services. [Women’s Health Programs Report Fiscal Year 2019](#). May 2020.

⁴ Texas Health and Human Services. [Women’s Health Programs Report Fiscal Year 2019](#). May 2020.

C. Proposed New Policy to Transition New Mothers to HTW

With the HTW waiver implementation, HHSC is proposing to eliminate auto-enrollment and replace it with its flawed “administrative renewal” process detailed below which will reduce projected cost savings, and add significant red tape for mothers, health care providers, and the state agency.

- Women enrolled in Medicaid for Pregnant Women have coverage during pregnancy and 60 days after childbirth.
- About one month before Medicaid for Pregnant Women eligibility ends, HHSC checks whether the new mom is eligible for any other program, starting with Medicaid, then CHIP, and lastly HTW.
- To determine eligibility, HHSC generally needs to request verification of income and other eligibility criteria, such as proof of residency and proof of citizenship. HHSC is required to use electronic data first, however, most new moms will be required to submit some amount of verification documents, such as pay stubs. Verification must be received within 10 calendar days of the request.
- HTW enrollment is not automatic. A new mom will only be transitioned into HTW if she submits within a 10-day window (or the agency has ready access to) verification of all required eligibility criteria (such as current income information, citizenship/immigration status, and proof of residency).
- New moms who do not submit requested information within the short timeframe provided will be denied HTW. They will not be enrolled in any program.
- Further exacerbating the challenge, in the event a woman is not enrolled in HTW because requested information was not received, the new mother will have to initiate and complete the full YourTexasBenefits application to enroll in HTW. She will no longer have the option to complete the simplified, one-page HTW Application Form (Form H1867), which is currently being used -- and HHSC plans to discontinue.

The administrative renewal process outlined above is how renewals are done across MAGI Medicaid programs. However, Texas’s current system of administrative renewal is not effective. According to HHSC, fewer than 9% of Medicaid and CHIP clients have their coverage automatically renewed by HHSC at the end of their certification period.

D. Adjunctive Eligibility: Current Policy and Proposed Change

Since the beginning of HTW and its predecessor programs in 2007, HHSC has used **adjunctive eligibility** to accurately confirm whether a woman is income eligible for the program while minimizing burdens on women, clinics, and agency employees. If at application or renewal a woman is enrolled in the Women's Infants and Children's Program (WIC), has a child enrolled in Medicaid, or is in a household that receives SNAP or TANF, she is not required to prove her income again for HTW. CMS has long allowed adjunctive eligibility for certain eligibility groups. For example, CMS allows what is known as "express lane eligibility" for Children's Medicaid. Express lane eligibility allows the state to identify, enroll, and recertify children by relying on eligibility information from other programs, like SNAP or WIC. CMS has also allowed adjunctive eligibility for certain adult eligibility groups through time-limited waivers.

Although HHSC's HTW 1115 women's health waiver application included the continued utilization of adjunctive eligibility⁵, HHSC recently has stated that it intends to **eliminate adjunctive eligibility** - an **unexpected departure from historical program norms**. The removal of adjunctive eligibility will certainly lead to a decrease in HTW enrollment, compromise women's access to timely, preventive health care and increase administrative costs to the agency, women, and health care providers.

E. Simplified HTW Application: Current Policy and Proposed Change

HHSC currently uses a **simplified, one-page Healthy Texas Women Application Form** (Form H1867) to determine eligibility. CMS has allowed the use of simplified application forms for a number of family planning demonstrations, including Texas's previous family planning demonstration.

HHSC's HTW website includes both the one-page application for download and a one-screen online application that can be electronically completed and submitted for processing. The simplified application also is readily available in clinics, community organizations, and Women, Infants, and Children (WIC) and HHSC offices. The availability of the simplified HTW application,

⁵ Texas Health and Human Services. [Healthy Texas Women Section 1115 Demonstration Waiver Application](#). June 2017.

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including the online application that launched in 2013, has allowed women to easily apply for HTW benefits on the same day they visit a clinic for services.

HHSC will discontinue the simplified, one-page application and require women to complete the Texas Works Application for Assistance (Form H1010) or Form 1205. This departure from previous program policy will lead to increased burdens on women and clinics -- and likely will result in decreased HTW enrollment.

F. Reductions in HTW Enrollment and Cost Savings

Eliminating **auto-enrollment**, **adjunctive eligibility**, and/or the **simplified application** constructs barriers to HTW and disincentivizes women from seeking services, as well as disincentivizing providers to engage in application assistance. A short one-page application form allows providers and clinic staff to help women apply for HTW in the clinic quickly and easily instead of having to put in the time to go through the 32-page single streamlined application (H1010). Given the fact that many women, if applying only for services for themselves, will most likely not be eligible for any other programs on the single streamlined application, the short one-page HTW application promotes efficiency. Adjunctive eligibility further streamlines the process because if she is on WIC or SNAP providers know she will be approved and can provide same day services.

Constructing barriers and disrupting the efficiency these current policies promote will result in fewer women served, potentially increasing unintended pregnancies -- thereby increasing Medicaid costs to the state. Medicaid pays for more than half of Texas births, costing \$3.5 billion in 2016 for birth and delivery-related services for mothers and infants in the first year of life.

Furthermore, studies clearly show a link between adverse birth outcomes and lack of timely family planning services. When women are able to plan and space their pregnancies, babies have less risk of prematurity and low birth weight, and mothers experience healthier outcomes too.⁶ Healthy pregnancies lower costs by reducing expensive neonatal intensive care stays for babies and preventing maternal health complications. For example, in fiscal year 2015, the

⁶ Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. [Birthspacing and risk of adverse perinatal outcomes: a meta-analysis](#). JAMA 2006; 295(15): 1809-1823



average cost to cover a full-term newborn's first year of life under Medicaid was \$572, while the average cost for a pre-term, low birth weight newborn's first year of life was \$109,220.⁷

In the most recent women's health programs report released in May, HHSC estimated that services provided by HTW in 2019 will save the state \$96.8 million in General Revenue.⁸ HTW is still a relatively new program, operating in its current iteration for just four years. The state has seen a steady growth in the clients enrolled and served through the program. A growing client base and committed investment in the program has resulted in increased cost savings for the state. It is in the state's best fiscal interest to keep enrollment in HTW high. Eliminating policies that streamline the enrollment and eligibility processes -- especially when a mother has a 1-month old newborn -- would undermine the goal of healthier moms and state cost savings.

G. Proposed Solutions

To ease the transition between Medicaid for Pregnant Women and HTW as well as minimize the added burden on mothers, health centers, and the agency, we recommend the following solutions which are in prioritized order:

1. Compliance with Federal Guidance

We recommend HHSC review the [Centers for Medicare and Medicaid Services \(CMS\) guidance](#) issued on December 4, 2020 and identify and prioritize any needed changes to current eligibility processes related to pregnant women. Based on our understanding of the guidance, we recommend the following updates to current HHSC policy and process to align with the CMS guidance:

- I. Provide clients determined eligible for Medicaid for pregnant women a 12-month eligibility period

Under current HHSC policy, pregnant women are not provided a 12-month eligibility period as required. Instead, women are given an eligibility period starting the month of application and extending two months beyond their anticipated due date. This does not align with this new guidance from CMS, and it also creates a barrier for pregnant women enrolling in Medicaid and accessing on-time prenatal care. In order to create this eligibility period in TIERS, HHSC

⁷ Delgado, E., French, L. [Presentation to the House Committee on Public Health: Better Birth Outcomes. Texas Health and Human Services System](#). May 19, 2016

⁸ Texas Health and Human Services. [Women's Health Programs Report Fiscal Year 2019](#). May 2020.

requires women to report an estimated due date on their application. We have consistently heard reports from enrollment assisters, clinics, and other providers that this requirement creates an unnecessary hurdle and delays enrollment. Women often do not know, and are unable to estimate their due date without having seen a doctor and many women struggle to see a doctor if they are not yet enrolled in Medicaid. HHSC should update policy to align with CMS' guidance and provide 12 months of coverage to pregnant women starting in the month of application. This would remove the need for an estimated due date from clients on the application, eliminate this known barrier to timely enrollment and access to care. This change is also needed in order to execute the additional changes listed below.

II. Streamline transitions between eligibility groups by treating the end of pregnancy and aging out of children's Medicaid as changes in circumstance

According to the CMS guidance, the end of pregnancy should be considered a "change in circumstance" not a renewal. When acting on the end of pregnancy and treating it as a change in circumstance, HHSC is required to assess eligibility for all other Medicaid programs, including Medicaid for Parents and Caretakers and HTW. Medicaid agencies are allowed to process a full renewal when acting on changes in circumstance if they have all needed information but they cannot require a full renewal before their 12 -month eligibility ends.

CMS guidance makes it clear that the same requirements apply to children aging out of children's Medicaid or CHIP at age 19. HHSC must assess eligibility for other Medicaid programs such as HTW and transition clients as applicable.

Taken in whole, this guidance prevents HHSC from processing a full renewal at the end of a women's postpartum period and when a child ages out of Medicaid or CHIP. When assessing eligibility during a change in circumstance such as end of pregnancy and age, the agency cannot require women to verify additional information not pertinent to the change. This means HHSC cannot require a woman to reverify her income at the end of her postpartum period unless the agency has information that her income has changed and that she would be ineligible for other programs. We believe aligning with this guidance will streamline these transitions to HTW and reduce the negative impact likely to result from the elimination of auto-enrollment.

III. Provide clients 30 days to submit verification when the agency is acting on changes in circumstance

In Appendix A item 4.b. of the guidance CMS states that a “reasonable” amount of time for a client to provide verification requested by the state when acting on a change is 30 days. Current HHSC policy only provides clients 10 days to provide verification of a change in circumstance. Stakeholders consistently receive reports that this timeframe is far too short and clients are routinely denied for failure to provide verification timely. HHSC should update policy to align with CMS’ expectation and allow clients 30 days to provide verification of a change. This is especially important for women who may need to verify a change at the end of their postpartum period, specifically if the agency has identified a change in income and needs additional information from the client.

2. Improve the Administrative Renewal Process

Federal rules and regulations allow states to implement administrative renewals such that eligible families can be enrolled in Medicaid and other programs without HHSC staff intervention. However, Texas’ current system of administrative renewal is not effective. According to HHSC, fewer than 9% of Medicaid and CHIP clients have their coverage automatically renewed by HHSC at the end of their certification period. This low rate of administrative renewals means HHSC staff must spend time processing the applications manually. Improving the administrative renewal process will ensure fewer women churn off of coverage at renewal. This will also help the recently launched HTW Plus program as established by Senate Bill 750 (86th legislative session) improve continuity of care for new mothers, thus contributing to better postpartum health outcomes. We recommend the improvements outlined and shared with HHSC in a [separate memo](#) by Every Texan.

3. Post enrollment verification

Post-enrollment verification allows a better transition for new moms, who could submit pay stubs or other required paperwork during a temporary period (90-day window) after she is enrolled. Post-enrollment verification is already used in Texas Medicaid for Pregnant Women and does not require a waiver from CMS.



4. Self-attestation as verification

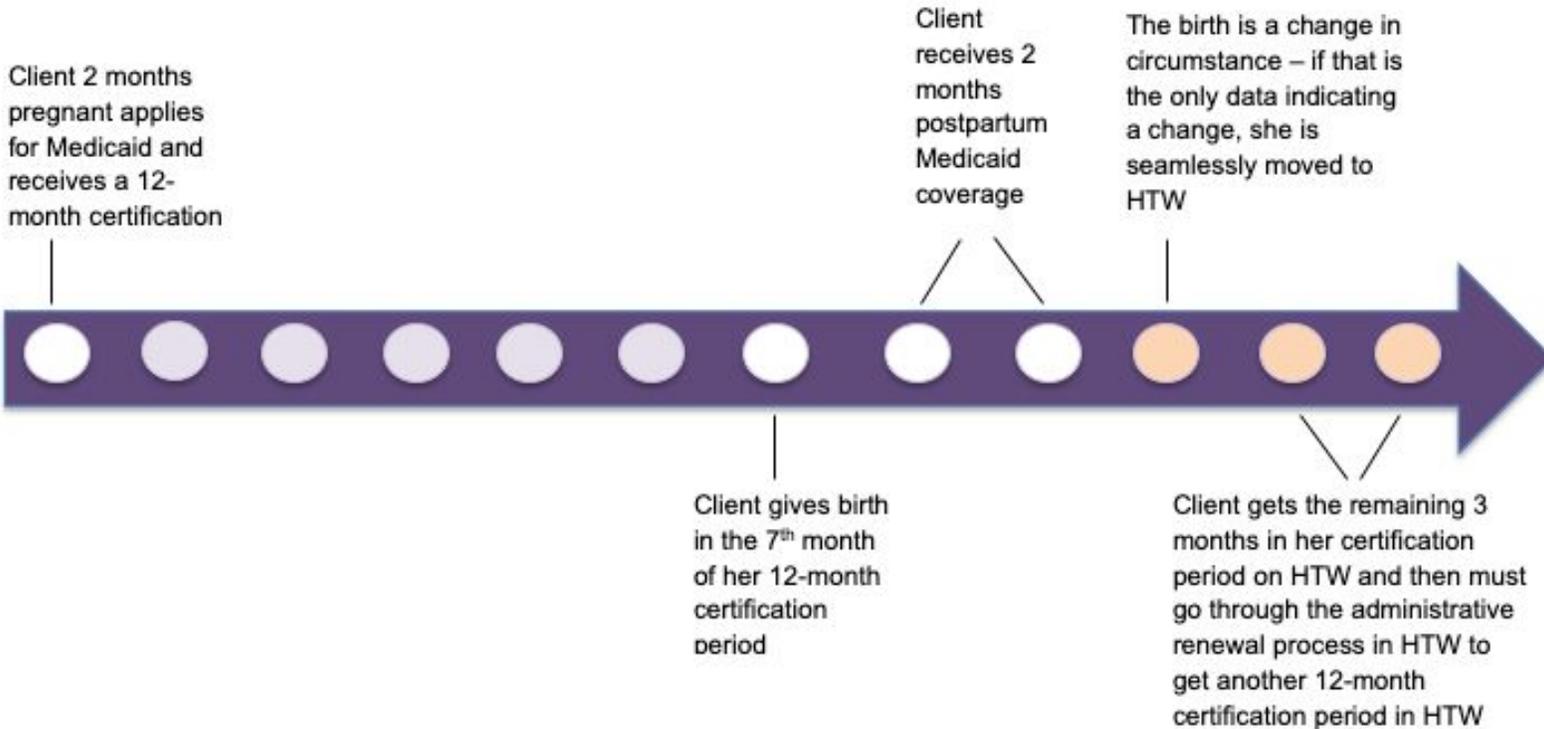
The use of self-attestation as verification for certain eligibility criteria would allow a better transition for new moms. Medicaid and CHIP regulations allow for the use of self-attestation as verification for all eligibility criteria except income, citizenship/immigration status, and SSNs. This does not require a waiver from CMS. As an example, self-attestation of residency is already used at renewal for Texas Medicaid for Children and CHIP.

5. Request a waiver to continue adjunctive eligibility

CMS has allowed adjunctive eligibility for certain MAGI-based eligibility groups. For example, CMS allows express lane eligibility for children's Medicaid when they are enrolled in SNAP or WIC. CMS has also allowed adjunctive eligibility for certain adult, MAGI-based eligibility groups, through time-limited waivers. HHSC would need to request a waiver from CMS to continue adjunctive eligibility.

Solutions Diagram

1. Compliance with Federal Guidance



2- 4: Improve administrative renewals; Post-enrollment verification; and Self-attestation as verification

These recommendations will streamline the renewal process for women to get an additional 12 months of HTW coverage postpartum and promote continuity of care and improve health outcomes for new moms.