



Health Care Coverage and Access for Children in Low-Income Families: Stakeholder Perspectives from Texas

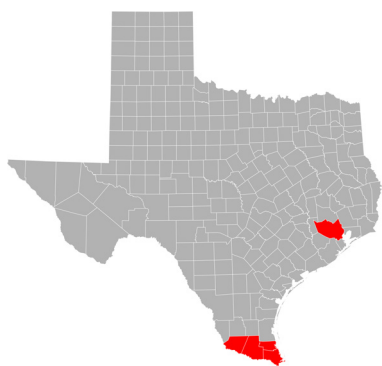
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State Statistics

- With a population of 26.95 million, Texas is the second most populous state in the country.
- 26 percent of Texas residents are under age 18.
- The population of Texas is 75 percent white, 12 percent black, 4 percent Asian, 0.5 percent American Indian or Alaska Native, and 8 percent other; 39 percent of Texans are Latino or Hispanic.
- The governor and most state representatives and senators are Republican.

Sources: U.S. Census Bureau (2014a); National Conference of State Legislatures (2014); National Governors Association (2015).



Map of Texas, with Harris County (middle right) and the Rio Grande Valley (bottom right) shaded red.

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Policy Research

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Executive Summary

An important question to ask about any health care system is how well it serves children in low-income families. In Texas, the question raises optimism as well as serious concerns. On one hand, the proportion of eligible Texas children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) has increased from 75 percent in 2008 to 84 percent in 2013. The passage of the Affordable Care Act (ACA) in 2010 and the reauthorization of CHIP in 2015 helped to protect these gains. But significant uncertainties persist. Texas has not expanded Medicaid as envisioned by the ACA; the introduction of the federal health insurance Marketplace was highly contentious in the state; and the U.S. Congress has funded CHIP only until 2017. Moreover, there is concern in Texas that access to high quality health care services for low-income children is not keeping pace with access to insurance.

Purpose. This issue brief was prepared as part of a small-scale qualitative study funded by the David and Lucile Packard Foundation to convey recent positive developments, remaining unmet needs, and emerging issues in children's health care coverage and delivery, from the perspective of knowledgeable stakeholders. Companion issue briefs on children's health in California and Colorado and a cross-state analysis will be available in early 2016.

Methods. The brief draws information from telephone interviews with 19 respondents in summer 2015. Respondents represented the Texas Health and Human Services Commission, health care providers and professional associations, Medicaid and CHIP managed care plans, county indigent-care plans, community-based organizations, advocacy organizations, and a health foundation. To capture some of the variation in insurance access and care delivery across the state, the interviews focused on three areas: (1) the state as a whole; (2) Harris County, the largely urban county that includes Houston and is home to the greatest share of children (18 percent) who are enrolled in Medicaid or CHIP; and (3) the Rio Grande Valley, a region along the U.S.-Mexico border.

Key findings. When asked about health insurance coverage, interview respondents described a few positive developments in insurance eligibility expansion, outreach, and enrollment simplification, nearly all of which stemmed from ACA mandates. Respondents cited more barriers to coverage than facilitators, however. When asked about access to care, respondents said rural primary care and statewide specialty care shortages are problematic for children. They thought recent state laws to improve provider directories and promote mental health services could benefit low-income children. In general, some respondents worried that low-income families that encounter dysfunction in Children's Medicaid may not be motivated to retain coverage later. Looking ahead, respondents will pay attention to Texas's prospects for Medicaid expansion, the renewal of its federal Healthcare Transformation waiver, and the implementation of mandatory managed care for children with disabilities.

Implications for advocates, decision makers, and funders. Respondents identified two avenues for making the health care system in Texas work better for low-income children that may be of interest to stakeholders. First, they observed that Texas children would benefit more from family-friendly approaches to coverage and care than from strictly child-focused ones. Second, they said long-term efforts are needed to improve voter participation civic engagement, so that low-income residents eventually have a stronger hand in shaping a health care system that works better for them.

I. Access to Health Insurance Coverage

In what ways has it become easier for low-income families in Texas to obtain health insurance for their children in the past few years?

As of 2014, more children from low- and moderate-income families in Texas have a pathway to affordable health insurance coverage. Because of ACA rules, families with children who do not qualify for Children’s Medicaid (as Texas calls its program) or CHIP may be able to cover them affordably through the federally facilitated Marketplace that now operates in Texas, especially if they qualify for premium tax credits. Families qualify for tax credits if they have income within a certain range and do not have access to affordable coverage through an eligible employee-sponsored plan, among other criteria.

Families generally have better access to information about pathways to coverage, how to apply, and how to use coverage than they did just a few years ago. Although respondents were pleased that the Marketplace gives Texans a new pathway to coverage, they noted that the existence of pathways does not necessarily mean they are easy to find or navigate. However, many respondents were impressed by the number and types of organizations that now lead or participate in outreach and enrollment activities for Children’s Medicaid, CHIP, and the Marketplace. They said advocacy organizations, community health centers, faith-based organizations, and social services providers were most active in outreach and enrollment.

“Of those potentially eligible, we do think the percentage of children that have actually enrolled has gone up, and some of that is due to the outreach for families around the Affordable Care Act.”

—State-level respondent

Respondents also praised the quality and completeness of information available to families from these sources. For example, during the ACA’s first open-enrollment period, organizations worked hard to dispel public confusion about whether Texas was expanding adult Medicaid, establishing a Marketplace, neither, or both. The Children’s Defense Fund-Texas (CDF-Texas) and others also educate parents about important post-enrollment steps that may not be obvious to them. These steps include choosing a health plan, dental plan, primary care physician, and dentist. CDF-Texas also counsels parents about the importance of children’s preventive care services and helps them become more savvy about interacting with health plans’ member services departments.

Respondents regretted to note that urban communities in Texas are richer in outreach resources than rural communities. In addition to having less funding for outreach, rural communities have less infrastructure to support common, broad-based outreach activities. For example, they have fewer grocery stores to host enrollment fairs in their parking lots, and fewer billboards and buses for advertisements or public service announcements.

In an exception to this characterization, CDF-Texas reported good success with the targeted outreach and enrollment activities that it conducts in rural and urban school districts. CDF-Texas partners with two Houston school districts to identify uninsured children and follow up with their parents to discuss their eligibility for Children's Medicaid, CHIP, or Marketplace coverage, or to refer them to a county indigent care program. In the Rio Grande Valley, CDF-Texas reaches out to large groups of school district employees (cafeteria staff, janitorial workers, and bus drivers) whose children attend school in the same district. The message to these parents is that coverage may be more attainable than they realize. With enrollment assistance, many parents reportedly obtain subsidized Marketplace coverage for themselves and Children's Medicaid or CHIP for their children.

Texas has introduced simplifications that should help families with Medicaid- or CHIP-eligible children to enroll their children and keep them enrolled. Respondents mentioned the following enrollment simplifications from the last year or two: (1) families can apply online for CHIP and Children's Medicaid, submit documents via smartphone, and opt for paperless program accounts; (2) families reapply for Children's Medicaid once a year instead of twice (although the state uses third-party data to verify eligibility periodically during the second half of the enrollment year); (3) Medicaid eligibility no longer involves an asset test; and (4) children on Medicaid who enter juvenile corrective and detention facilities will soon have their Medicaid suspended (rather than terminated) and automatically reinstated within two days after their release. In addition, beginning in April 2016, new mothers will be automatically enrolled in the state-funded Women's Health Program when their 60-day postpartum Medicaid coverage expires. The program provides family planning and well-woman services.

Respondents perceive the move to a 12-month reapplication cycle and the availability of online applications as the more important of these changes for children's coverage. A respondent with access to state enrollment and retention data said that the state's monthly caseload projections are higher than they used to be, and that children are keeping Medicaid coverage longer than they used to. The switch to the 12-month reapplication cycle appeared to drive both changes. The same respondent said the number of families using the online application increases monthly. Another respondent did not disagree, but noted that online applications are not uniformly popular. When she helps families in the Rio Grande Valley apply for Children's Medicaid, they commonly request a paper application. Not computer literate themselves, her clients feel more comfortable seeing their information recorded on paper. With the online system, clients ask, "What are you doing with my information?"

What key factors are driving these changes?

Nearly every positive change respondents mentioned is attributable to the ACA. The law established the federally facilitated Marketplace for states that chose not to build their own systems. It made federal matching funds and grants available for outreach and enrollment activities and for the modernization of states' eligibility and enrollment systems. Finally, the law prevents states from requiring families to reapply for Medicaid or CHIP more than once per year and from using assets as an eligibility criterion. The two improvements mentioned by respondents that were not driven by the ACA are the reinstatement of Medicaid enrollment within 48 hours after release from a juvenile detention or correctional facility, which is pending federal approval, and auto-enrollment into the Women's Health Program.

Because of their grounding in the ACA, most of the positive changes respondents described are expected to continue for at least the next several years, though some will then expire. For example, under maintenance of eligibility (MOE) provisions of the ACA, states cannot receive federal Medicaid and CHIP funds if they impose eligibility and enrollment requirements that are more restrictive than those that were in place when the ACA was enacted on March 23, 2010. The MOE provisions that affect children expire in 2019 (Henry J. Kaiser Family Foundation 2012).

Children's Well-Being

- 25 percent of children in Texas live in poverty.
- 48 percent of children in Texas (3.4 million) were enrolled in Medicaid or CHIP in 2014.
- Medicaid/CHIP participation among eligible Texas children increased from 75 percent in 2008 to 84 percent in 2013.
- Texas's Medicaid program covers infants up to 198 percent of the federal poverty level (FPL), 1- to 5-year-olds up to 144 percent FPL, and 6- to 18-year-olds up to 133 percent FPL. Its separate CHIP program covers children up to 201 percent FPL.

Sources: CMS (2015b); U.S. Census Bureau (2014b); Henry J. Kaiser Family Foundation (2012); Kenney et al. (2012); Urban Institute (2015).

Health Care

- 11 percent of children and 26 percent of working-age adults in Texas lacked health insurance in 2014.
- Texas has not expanded Medicaid as envisioned by the ACA. It uses the federally facilitated health insurance Marketplace.
- Most Medicaid services in Texas and all CHIP services are delivered through managed care.

Sources: U.S. Census Bureau (2014c); CMS (2015b); Texas Health and Human Services Commission (2015).

Funding to Texas organizations that provide navigation services to people when they are shopping for and enrolling in Marketplace plans also will be stable for the next few years. Many of the Texas organizations that received federal Navigator grants in 2013 and 2014 also received them for a three-year period starting in 2015 (Centers for Medicare & Medicaid Services 2015a). Likewise, several community-based organizations in Texas received outreach and enrollment grants in each of three funding cycles through the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) and the ACA. The 2015 CHIPRA will make a total of \$40 million available to states for outreach and enrollment in fiscal years 2016 and 2017 (Burak 2015).

In what ways has it remained difficult for low-income families to obtain coverage for their children? What factors are at work?

Families still face many barriers to obtaining coverage in Texas, stemming from adverse policies, administrative processes, and federal eligibility rules. An underlying barrier that respondents cited, however, is a belief held by state lawmakers and the governor that government should keep social programs small. Manifested as opposition to Medicaid and the ACA, the belief makes the work of children's health stakeholders a "pretty big battle." Respondents noted that, even with data that show well-controlled expenditures for Children's Medicaid and potential economic benefits from adult Medicaid expansion, the political opposition to date has been insurmountable.

Adverse policies

CHIP waiting period. Nearly every respondent lamented that Texas has not eliminated its requirement that children be uninsured for 90 days before enrolling in CHIP (with some exceptions). This is problematic for children who need immediate health care; in addition, respondents worried that a delay of 90 days before families can take their children to a provider diminishes the value of CHIP and may make families less likely to apply for or renew coverage.

Hospital presumptive eligibility standards. Several respondents noted that Texas is implementing the ACA hospital presumptive eligibility (PE) provisions with accuracy and timeliness requirements that are so stringent, they deter hospitals from participating. Participating hospitals can make PE determinations to (1) grant temporary Medicaid coverage to patients who appear eligible, and (2) claim reimbursement for the services hospitals provide. According to Texas's PE standards, 95 percent of hospital PE determinations must be followed by regular Medicaid applications within one working day, and 97 percent of PE determinations must be re-determined as eligible through a regular application (Texas Health and Human Services Commission 2015a). Respondents said these were unreasonable standards and more strict than those of most other states.

Residency of former foster care children. A few respondents mentioned the state's implementation of an ACA provision that is meant to allow former foster care children to maintain Children's Medicaid coverage until age 26 if they had coverage at 18. Adhering to very specific language in the law rather than the spirit of the law, Texas will only cover those youth who were Medicaid-covered at age 18 *and lived in Texas at that time*. Respondents perceived Texas's decision to not cover residents who lived in another state when they aged out of foster care as harsh treatment of a small but especially vulnerable group.

Administrative processes

States and the federal government faced great challenges when they were building eligibility and enrollment systems to accommodate the ACA's eligibility expansions and modifications. Respondents described Texas (which used the federal Marketplace) as being in a state of "mass confusion" before and for a while after the first ACA open-enrollment period, in 2013. Health plans and families felt the brunt of the

confusion as the state reportedly issued tens of thousands of retroactive eligibility decisions. Some proportion of these decisions involved Texas's "stair-step" children—the 6- to 18-year-olds affected by the ACA requirement that states transition children from CHIP to Medicaid if their household incomes were up to 133 percent of the federal poverty level (FPL). Health plan respondents said the state sent potentially confusing notices about eligibility changes to stair-step families without informing the health plans of the notices. The practice made it difficult for health plans and families to communicate clearly with each other. Although respondents could not precisely recall all the factors that contributed to the administrative confusion during the first open-enrollment period or who was at fault, they said some problems have subsided and probably were no worse than many states experienced.

Of continuing concern to children's health stakeholders are persistent administrative problems that they say should be avoidable. For example, a health plan respondent described a Children's Medicaid renewal determination that took two months to process. Countless calls by the health plan and physicians to the state at last revealed that a missing page from the child's faxed application caused the delay. Meanwhile, the applicant's severe asthma went unmanaged and resulted in multiple emergency department visits each week, the child and his family suffered unnecessarily, and the state's uncompensated care pool covered thousands of dollars of expenses. According to the respondent, such cases happen "all the time" in the Texas Children's Medicaid program.

Federal eligibility rules

Children of immigrants. According to the U.S. Office of Immigration Statistics, Texas has about 1.48 million unauthorized residents. By federal law, none of these residents are eligible for health insurance coverage through Medicaid, CHIP, or the Marketplace. But many Texas families have mixed immigration status and include children who are citizens and are eligible for Children's Medicaid or CHIP. Respondents said confusion about eligibility rules and fear of deportation keeps many of these families from obtaining Medicaid or CHIP coverage for their eligible children.

"Family glitch" children. Respondents hear from enrollment counselors that many Texas families cannot afford coverage because they are affected by the ACA's so-called "family glitch." Under the ACA, residents shopping for Marketplace coverage are not eligible for premium tax credits if they have access to affordable employee-sponsored coverage. The glitch in this standard is that affordability is based on the cost of individual coverage, even for employees shopping for family coverage. The glitch affects relatively few children in the many states that provide CHIP coverage for children with household incomes well above 200 percent of the FPL. Texas, however, provides CHIP coverage for children up to 201 percent of the FPL; those with household incomes between 201 and 400 percent of the FPL are affected by the glitch and, thus, may not be eligible for premium tax credits.

II. Access to Health Care Services

In what ways has it become easier for low-income families in Texas to get health care services for their children in the past few years?

Families may soon benefit from better provider directories. After Texas families enroll their children in Children's Medicaid, CHIP, or Marketplace coverage and choose health and dental plans, they use the plans' directories to choose a primary care physician and a dentist. Many respondents said this process is marred in Texas by the poor quality of the provider directories. Directories commonly include out-of-date contact information for providers, list providers who no longer participate in Children's Medicaid or CHIP, or list providers who are not accepting new Medicaid or CHIP patients. Respondents worry about the hassle families experience in finding

providers. If the hassle is not an isolated experience but follows, say, a trying enrollment experience, then families may perceive health insurance as having little value. Eventually, they may not renew their child's coverage or obtain coverage for additional children as their families grow.

As of 2016, Marketplace health plans in Texas will be more accountable for “actually having the provider networks they say they do,” according to one respondent. Plans also will have to update provider directories monthly, make them available online and searchable without requiring members to enter a username and password, and indicate whether providers are accepting new patients. Similarly, Medicaid managed care plans will be held to higher standards for the accuracy of provider directories and giving more assistance to members who need help locating providers. Respondents were cautiously optimistic that the changes will make it easier for families to access health care beginning in 2016.

Some children will have better access to behavioral health services. Recent changes in Texas include making mental health first-aid training available to school district employees and school resource officers (when introduced, in 2013, such training was available only to educators). In addition, Texas has changed its policies so that Children's Medicaid enrollees can be screened for autism and mental health issues at the frequency and with the screening instruments recommended by the American Academy of Pediatrics. Finally, Texas will establish limited peer support services provided as part of the Medicaid mental health rehabilitation benefit for children with serious emotional disturbances.

What key factors are driving these changes?

The new provider directory standards result from federal requirements and bills signed by Governor Abbott in 2015. Respondents were pleased with these new policies, but noted that their potential to benefit low-income families depends on whether state agencies enforce the policies, seek stakeholder input, and impose allowable financial penalties for noncompliant health plans.

The autism and mental health screening guidelines reflect revisions to the state's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Because the changes not only allow more frequent screening but also allow providers to bill Medicaid for the screenings they administer and document, respondents were hopeful that more children actually will be screened.

The use of peer support will occur through a Medicaid home- and community-based services waiver program. A respondent familiar with relevant Texas pilot projects did not know whether to be heartened or wary about the inclusion of peer specialists in Medicaid. On the one hand, she has been highly impressed by the added dimension of experience and compassion that peer specialists can share with others and believes peer specialists could expand families' access to mental health services by helping to alleviate severe mental health workforce shortages in the state. On the other hand, she worries that the state legislature, in a perpetual drive to reduce Children's Medicaid spending, views peer specialists not as adding value to existing service providers, but as a lower-cost substitute for those providers. The respondent said the state legislature has lately shown similar enthusiasm for providing mental health care via telemedicine, which she also worries will be substitutive rather than additive.

In what ways has it remained difficult for low-income families to get health care services for their children? What factors are at work?

Accessing health care services, especially in rural areas, is a longstanding problem in Texas for many families with children in Medicaid or CHIP. Texas has state-of-the-art children's hospitals and many pediatricians, but they are concentrated in the state's large cities. For enrollees in Children's Medicaid or CHIP, accessing care can be difficult even in

cities because not enough providers participate in and/or accept new patients from those programs. In Texas's rural areas, access problems arise from outright shortages of health care providers.

Low Medicaid participation among urban providers. Participating in Children's Medicaid may be a relatively unattractive option for health providers in some urban areas of Texas; they stand to make more money with less hassle from other payers. Providers who participate in Children's Medicaid face complex state participation requirements, lengthy credentialing processes for managed care plans, low reimbursement rates, and onerous preauthorization requirements, among other rules. (Although respondents said access to care could be difficult in both Children's Medicaid and CHIP, their comments about barriers to provider participation pertained to Children's Medicaid.)

Respondents do not believe the state will act to improve this situation in the foreseeable future. Some noted that more providers participated in Children's Medicaid and CHIP and accepted new patients from these programs while ACA provisions requiring parity in Medicare and Medicaid reimbursement rates for selected primary care services were in effect. Because the state legislature recently voted to discontinue parity in payment, Medicaid participation is reportedly reverting to earlier levels. On a positive note, the Texas Association of Health Plans intends to adopt a common credentialing process for all managed care plans in order to make credentialing less of a burden for providers and encourage them to participate. In addition, some Children's Medicaid managed care plans are supplementing Medicaid reimbursement rates with performance-based incentive payments so that primary care doctors do not "lose money every time they see a Medicaid child," a respondent explained.

Primary care shortages and hospital closures in rural areas. In contrast to Texas's cities, primary care physicians and other providers are in short supply in the Rio Grande Valley and other rural areas. In the four Rio Grande Valley counties, the ratio of population to primary care physicians ranges from 2,109:1 (Cameron County) to 4,710:1 (Starr County). By contrast, the ratio in Harris County, which includes Houston, is 1,739:1 (University of Wisconsin Population Health Institute 2015). Although their numbers are few, most Rio Grande Valley providers participate in Children's Medicaid and CHIP because those are predominant forms of insurance in the low-income region.

"There are just many, many barriers that still exist for families to apply, keep the coverage, and utilize it."

– Rio Grande Valley respondent

Given current Children's Medicaid reimbursement rates, however, primary care providers must see a large volume of patients to earn a living and run their practices. A few respondents described some primary care providers in the Rio Grande Valley who see 50 to 60 patients per day or who double- and triple-book appointment times. These respondents are concerned that high-volume practices do not provide high quality, comprehensive care. They also fear that families who spend hours in a waiting room and mere minutes in a consulting room will not be motivated to maintain Medicaid coverage.

In the last two years, 10 hospitals have closed in rural Texas. A respondent who is monitoring the closures worries about their effects on low-income families because the nearest alternative could be a great distance away. Respondents noted that rural hospitals have long faced myriad financial challenges. They speculate that Texas's decision not to expand Medicaid likely was the tipping point causing closures. That is, Texas hospitals now receive lower federal payments for serving the uninsured, but the lower

Harris County Context

- Harris County, which includes Houston, has 4.4 million residents. It is the third most populous county in the United States and one of the most racially and ethnically diverse.
- 26 percent of children in Harris County live in poverty.
- 14 percent of children in Harris County lacked health insurance in 2013.

Sources: U.S. Census Bureau (2014a, 2014b, and 2013b).

Rio Grande Valley Context

- Cameron, Hidalgo, Starr, and Willacy counties make up the Rio Grande Valley and have a combined population of 1.3 million. More than 85 percent of residents in each county are Latino or Hispanic.
- 47 to 50 percent of children in the Rio Grande Valley live in poverty, depending on the county.
- 14 to 19 percent of children in the Rio Grande Valley lacked health insurance in 2013, depending on the county.

Sources: U.S. Census Bureau (2014a, 2014b, 2013a, 2013b, 2013c).

payments are not offset by a larger base of insured patients, as Medicaid expansion would help ensure.

Lack of specialists statewide. Respondents uniformly noted that low-income families throughout Texas have difficulty accessing specialty care and pediatric subspecialty care. They said the state's shortage of child psychiatrists is especially severe. The upshot, respondents explained, is that already-burdened primary care providers "bear the brunt" of the shortages themselves.

"Sometimes I'm afraid the families don't get the greatest care because these [pediatric subspecialists] are rushed and, you know, they don't spend the time that sometimes the kids' problems really need."

– Rio Grande Valley respondent

Again, respondents were not optimistic that state lawmakers would act to alleviate the shortages. Respondents suggested that higher Medicaid reimbursement rates, student loan forgiveness for physicians, and more residency placements for recent medical school graduates could attract more specialists to Texas. One respondent explained, however, that Texas once had a very generous loan forgiveness program through Medicaid that was meant to entice primary care physicians and pediatric specialists to "stay in Texas and establish their practices in underserved areas." The program existed for three years until lawmakers defunded it.

III. Emerging Issues and Opportunities

What issues will children's health stakeholders in Texas keep their eyes on during the next year or two, and why?

Texas's prospects for Medicaid expansion, the renewal of its 1115 waiver, and the introduction of mandatory managed care for children with special health care needs were cited by many respondents as key issues to watch in the next two years.

- **Medicaid expansion prospects.** Respondents are proud of the number and range of stakeholders, including provider organizations, community- and faith-based organizations, advocacy organizations of many types, independent economic analysts and demographers, and 26 chambers of commerce, that have actively supported Medicaid expansion during more than two years of intensive debate. Obviously, these supporters view Medicaid expansion very differently than the Texas governor and legislature, who have vehemently opposed expansion and the whole of the ACA. Advocates plan to continue to rally supporters and proactively argue for Medicaid expansion in Texas. They worry, however, that some supporters, seeing no sign that elected officials will change their mind or compromise, will move on to other, more tractable issues. A couple of respondents predicted that Texas eventually will expand Medicaid as a result of a looming "financial crisis in the hospital system."

"After a couple of years of fighting over new formulas for how to divide up a shrinking pot [of uncompensated care payments], hospitals will realize there is no way out except to push for coverage expansion. So we will get there."

– Harris County respondent

- **1115 waiver renewal.** Texas's federally approved Healthcare Transformation Waiver expires in September 2016. The waiver has enabled a wide range of health care quality improvement projects that the state hopes to continue upon renewal. But

respondents are anxious about the state's waiver negotiations with CMS. Specifically, they fear that CMS will reduce Texas's Uncompensated Care funding pool to reimburse hospitals for care to the uninsured, as the agency recently did with Florida, thus jeopardizing hospitals' financial health.

- **Mandatory managed care for children with disabilities.** Texas children who are eligible for Supplemental Security Income because of severe disabilities will be enrolled in Medicaid managed care beginning in 2016. Participating managed care plans will provide nearly all community-based services, long-term supports, and medical services. If managed care improves upon the traditional fee-for-service model, then children will have better coordinated care and participating primary care practices will be more fairly compensated for the time and case management services these children require. Respondents were reserving judgement about whether or not managed care would deliver on this promise.

What opportunities might advocates, decision makers, and funders choose to consider?

To make the health care system in Texas work better for low-income children in the years ahead, respondents recommend strategies to promote (1) family-friendly approaches to coverage and care, and (2) civic engagement.

- **Covering and caring for families.** Finding ways to improve coverage and care for low-income families—children and parents alike—was an underlying theme in many interviews. Until the ACA's passage in 2010, uninsured rates fell more quickly for children than for adults in the United States, thanks partly to child-focused federal and state policies and the efforts of advocates to ensure their implementation. Respondents appreciated the importance of these efforts but some noted that, going forward, Texas children would benefit more from family-friendly approaches to coverage and care than from child-focused ones.

"Children are part of families," one respondent explained; it is to their detriment when a family's access to insurance or decent health care is fragmented. In separate interviews, respondents described (1) insured children facing financial insecurity because their parents or other immediate family members are uninsured, (2) insured children continuing to visit hospital emergency departments inappropriately because their uninsured parents are accustomed to seeking their own care there, and (3) families never connecting with a primary care practice because they find retail-based health care clinics to be more convenient. Helping children by helping families will not be easy in Texas, especially if the state does not expand Medicaid, but it is a paramount goal among the state's children's health stakeholders.

- **Increasing civic engagement among low-income families.** Respondents who reflected on Texas's past, present, and future described a course of deepening conservatism in state politics leading to policies that undermine the health care system's ability to serve low-income families; as a result, some families may simply accept a system they believe will never improve. Reversing course in Texas, respondents said, will require greater voter participation in low-income communities. Voter-participation rates in Texas are among the lowest in the country. One respondent explained, "If we were to focus on getting people to come out and vote to elect people to office who accurately represent the community, in the next five or ten years the positive outcomes would go beyond coverage expansion, and I think we would be seeing a lot of better policies across issues affecting children and families." Of course, a substantial proportion of parents in Texas who rely on Medicaid, CHIP or the safety net for their children's health care are not eligible voters because they are not citizens. Thus, strategies in addition to get-out-the-vote are needed to get immigrants "engaged and advocating for their own needs and wants." Respondents described many efforts to help low-income families navigate Texas's complex health care system in recent years. Their next challenge may be empowering low-income families to actually change the system.

IV. Conclusion

Using data from interviews with children's health stakeholders, this issue brief has characterized the recent experiences of low-income families in Texas as they seek health care coverage and care for their children. In general in the past couple of years, getting and keeping children's coverage seems to be somewhat easier for low-income families throughout Texas, but many potential improvements remain. The experience of finding and seeing children's health care providers seems not to have changed much—this process has been and remains difficult for low-income families. Meanwhile, the health policy debate in Texas is both highly polarized and highly visible. Stakeholders believe engaging low-income families in the debate may be a key to long-term systemic improvements.

References

- Burak, Elizabeth Wright. "Medicare Access and CHIP Reauthorization Act of 2015: Summary of Key Provisions Impacting Children." Center for Children and Families. Washington, DC: Georgetown University, May 2015. Available at <http://ccf.georgetown.edu/wp-content/uploads/2015/05/MACRA-Kids-Brief.pdf>. Accessed October 19, 2015.
- Centers for Medicare & Medicaid Services. "CMS Awards \$67 Million in Affordable Care Act Funding to Help Consumers Sign Up for Affordable Health Insurance Marketplace Coverage in 2016." Press release. September 2, 2015a. Available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-02.html>. Accessed October 19, 2015
- Centers for Medicare & Medicaid Services. "State Medicaid & CHIP Profiles." 2015b. Available at <http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html>. Accessed October 19, 2015.
- Henry J. Kaiser Family Foundation. "Understanding the Medicaid and CHIP Maintenance of Eligibility Requirements." May 2012. Available at <http://kff.org/health-reform/fact-sheet/understanding-the-medicaid-and-chip-maintenance-of/>. Accessed October 19, 2015.
- Kenney, Genevieve M., Victoria Lynch, Michael Huntress, Jennifer M. Haley, Nathaniel Anderson. "Medicaid/CHIP Participation Among Children and Parents." Timely Analysis of Health Policy Issues series, December 2012. Available at <http://www.urban.org/research/publication/medicaidchip-participation-among-children-and-parents>. Accessed October 6, 2015.
- National Conference of State Legislatures. "2014 State and Legislative Partisan Composition, as of November 19, 2014." 2014. Available at http://www.ncsl.org/Portals/1/Documents/Elections/Legis_Control_2014_Nov19_10am.pdf. Accessed October 19, 2015.
- National Governors Association. "Governors Roster 2015." 2015. Available at <http://www.nga.org/files/live/sites/NGA/files/pdf/GOVLIST.PDF>. Accessed October 19, 2015
- Texas Health and Human Services Commission. "Presumptive Eligibility: Sample Memorandum of Understanding." 2015a. Available at https://www.texaspresumptiveeligibility.com/APP/UI/MOUQH_Static.aspx. Accessed October 27, 2015.
- Texas Health and Human Services Commission. "Texas Medicaid and CHIP: Managed Care Medical and Dental Plans." 2015b. Available at <http://www.hhsc.state.tx.us/medicaid/managed-care/plans.shtml>. Accessed October 19, 2015.

The Urban Institute. "Medicaid and CHIP Participation Rates." InsureKidsNow.gov, April 2015. Available at <http://www.insurekidsnow.gov/professionals/reports/index.html>. Accessed October 1, 2015.

U.S. Census Bureau. "1-Year American Community Survey." Table DP05. 2014a. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "1-Year American Community Survey." Table DP03. 2014b. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "1-Year American Community Survey." Table S2701. 2014c. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "5-Year American Community Survey." Table DP05. 2013a. http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "1-Year American Community Survey." Table DP03. 2013b. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "1-Year American Community Survey." Table S2701. 2013c. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

U.S. Census Bureau. "3-Year American Community Survey." Table S2701. 2010. Available at http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed October 19, 2015.

University of Wisconsin Population Health Institute. "County Health Rankings & Roadmaps 2015." Available at www.countyhealthrankings.org. Accessed October 19, 2015.

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