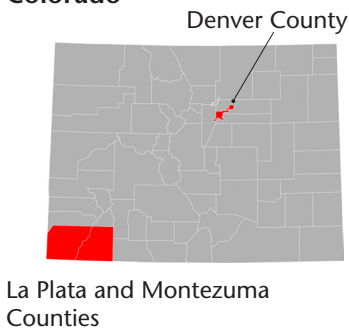


**Our study covered three states and focused on the areas shaded in red.**

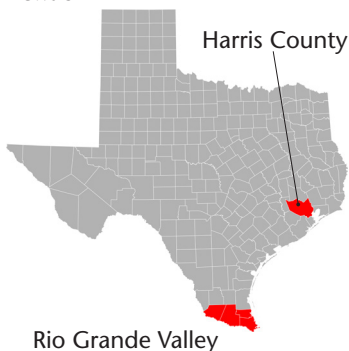
## California



## Colorado



## Texas



**MATHEMATICA**  
Policy Research

By Tricia Collins Higgins, Leslie Foster, Dana Petersen, and Rachel Miller

## Executive Summary

Recent national and state policy developments have created opportunities and uncertainties for low-income families seeking health coverage and care for their children. On one hand, the percentage of eligible children who participate in Medicaid or the Children's Health Insurance Program (CHIP) throughout the country increased from 81.7 percent in 2008 to 88.3 percent in 2013. The passage of the Affordable Care Act (ACA) in 2010 and the reauthorization of CHIP in 2015 helped protect these gains. On the other hand, uncertainties about political support for Medicaid expansion, future reauthorization and funding of CHIP, and whether all children in low-income families will have access to high quality health care services, persist in varying degrees throughout the country.

**Purpose.** Focusing on the diverse states of California, Colorado, and Texas, this issue brief was prepared as part of a small-scale qualitative study funded by the David and Lucile Packard Foundation and the Colorado Health Foundation to convey recent policy developments, remaining unmet needs, and emerging issues in children's health care coverage and delivery, from the perspective of knowledgeable stakeholders. Individual, in-depth issue briefs on children's health in the three states are available [here](#). This cross-state brief summarizes information presented in the individual state briefs and compares respondents' reports of low-income families' experiences obtaining coverage and care for their children. It also highlights emerging issues and opportunities to improve coverage and care in California, Colorado, and Texas.

**Methods.** This brief draws information from telephone interviews with 78 respondents (32 in California, 27 in Colorado, and 19 in Texas) conducted in summer 2015. Respondents represented state Medicaid and CHIP agencies, health care providers and professional associations, Medicaid and CHIP managed care plans, community-based organizations, county indigent care programs, advocacy organizations, and health foundations. To capture some of the variation in insurance access and care delivery within each state, we focused on (1) each state as a whole, (2) the county within each state with the greatest share of children enrolled in Medicaid or CHIP (Los Angeles County in California, Denver County in Colorado, and Harris County, which includes Houston, in Texas), and (3) a region with rural areas in each state (Monterey County in California, La Plata and Montezuma counties in Colorado, and the Rio Grande Valley in Texas).

**Key findings.** States' policy and programmatic decisions can powerfully shape children's coverage and access to health care in just a few years. The decisions by California and Colorado to expand Medicaid, along with other state policy decisions, have helped reduce the numbers of uninsured children in low-income families in the past two to three years. Although Medicaid expansion focused primarily on adults in these states, respondents noted that insured adults are more likely to enroll their children in coverage. Conversely, Texas's decision not to expand Medicaid, coupled with other state policies, has hindered the ability of low-income families to cover their uninsured children.

## State Context

### Population

- *California and Texas are the two most populous states in the nation, with populations of 38.8 million and 27 million, respectively. Colorado has a population of 5.4 million.*

### Race and Ethnicity

- *California is the most racially diverse state in our study: the population is 61 percent white, 6 percent black, 14 percent Asian, and 19 percent other.*
- *Texas's population is 75 percent white, 12 percent black, 4 percent Asian, and 9 percent other.*
- *Colorado's population is 84 percent white, 4 percent black, 3 percent Asian, and 9 percent other.*
- *39 percent of Californians and Texans are Hispanic or Latino, whereas 21 percent of Coloradans are Hispanic or Latino.*

Source: U.S. Census Bureau 2014a

Access to health care services for children in low-income families is less than optimal in all three states. California and Colorado respondents praised their states' strong networks of safety net and other providers, but expressed concerns about their capacity to deliver high quality care to the increasing numbers of children with Medicaid or CHIP coverage. Texas respondents said access to primary care is challenging across the state for uninsured children and those with Medicaid or CHIP because of provider shortages and low Medicaid participation. All three states face shortages of specialists who provide care to children in low-income families, particularly behavioral health specialists. Access to care tends to be more problematic in rural areas of California, Colorado, and Texas. Texas's Medicaid expansion decision, in particular, seems to have contributed to the recent closures of rural hospitals, which cared for many uninsured patients in the state.

**Implications for advocates, decision makers, and funders.** Respondents identified several ways to make health systems in California, Colorado, and Texas work better for children in low-income families. Policy recommendations included continuing to advocate for or support expanded Medicaid programs and CHIP funding and reauthorization. Texas respondents added that long-term efforts to promote civic engagement and improve voter participation among low-income residents will be critical to shifting the state's health care policies in the future. Respondents also provided several family-centered recommendations, such as strengthening targeted outreach to remaining uninsured children, particularly children of immigrants, and improving health literacy among families with children in Medicaid or CHIP. Finally, respondents proposed various methods to promote health workforce development and improve networks of primary and specialty care providers serving children in low-income families, such as loan forgiveness programs and increased Medicaid reimbursement rates.

## I. Access to Health Insurance Coverage

### Positive developments in California, Colorado, and Texas

*Low-income families have gained access to more pathways to coverage for children in the past two to three years.* In California, nearly all children in low-income families will soon be eligible for publically funded health insurance coverage. The state's eligibility requirements for Medicaid are very generous compared to those of most other states, and California further expanded its Medicaid program to include low-income adults as part of the ACA. California operates its own Insurance Marketplace, Covered California, which offers coverage to many families who do not qualify for Medicaid but who cannot afford coverage otherwise. In addition, through new state legislation, undocumented children will become eligible for full-scope Medicaid as soon as May 2016, and multiple local "gap" programs exist to cover health care costs for children who do not qualify for Medicaid and do not have access to other health insurance options.

Like California, Colorado opted to expand Medicaid under the ACA to include low-income adults and established a state-run Insurance Marketplace. Several key state policy developments in recent years have also contributed to increased access to coverage for children in low-income families: (1) removal of a three-month waiting period for CHIP coverage, (2) funding to implement Colorado's 2009 elimination of a five-year waiting period that prevented lawfully present immigrant children and pregnant women from enrolling in public health coverage programs, (3) implementation of a Medicaid and CHIP buy-in program for low-income children with disabilities, and (4) the passage of Hospital Provider Fee legislation in 2009, which authorizes the state's Department of Health Care Policy and Financing to collect a fee from hospital providers to increase Medicaid and Colorado Indigent Care Program payments to hospitals, fund hospital quality incentive payments, and expand health care coverage in Medicaid and CHIP programs.

Texas has not expanded Medicaid, but eligible Texas families have the new option of seeking coverage through the federally facilitated Marketplace.

*Families in all three states have better access to information about health coverage options and more access to enrollment assistance.* Respondents in California, Colorado, and Texas said increased funding for outreach and enrollment from the ACA, the 2015 Medicare Access and CHIP Reauthorization Act (MACRA), foundations, and some state and county sources has strengthened these activities in the past few years. Low-income families have been able to seek enrollment assistance in many places, including school-based health centers; federally qualified health centers and other community clinics; community-based, faith-based, and advocacy organizations; social service providers; and public health offices. Respondents observed that culturally and linguistically appropriate outreach to low-income families has increased.

In both California and Colorado, respondents described strong outreach and enrollment networks in urban and rural parts of the states. In Texas, respondents noted that urban areas had stronger networks than rural areas, which have less funding and infrastructure to support these activities.

*Enrollment and redetermination processes are simpler.* The ACA created a single, streamlined, online application for all subsidized medical coverage, including Medicaid, CHIP, and the Marketplace. The law also prevents states from requiring families to reapply for Medicaid or CHIP more than once per year and from using assets as an eligibility criterion. Stakeholders said these were important changes that helped drive coverage and retention gains in the three states.

State-level policy decisions and technological developments have also helped simplify enrollment and redetermination in California, Colorado, and Texas, most notably 12-month continuous eligibility. Continuous eligibility allows children to remain eligible for coverage regardless of changes in family income, which may improve continuity of care. California and Colorado provide 12-month continuous eligibility for children in Medicaid and CHIP; Texas provides the same for children in CHIP only. Both Colorado and Texas recently developed smartphone apps to support families with enrollment and redetermination processes.

### Remaining challenges

*To varying degrees across the states, families still face barriers to obtaining and maintaining coverage due to adverse policies, administrative processes, and federal eligibility rules.* Barriers to coverage exist in all three states for some common reasons and some divergent ones. These barriers are most pronounced in Texas, where state lawmakers and the governor want social programs to remain small, resulting in the state's decision not to expand Medicaid under the ACA or take steps that other states have taken to facilitate the enrollment of children in low-income families. In contrast, California has relatively generous Medicaid eligibility rules and state policies that aim to cover all low-income children—yet some low-income families still find it challenging to navigate the enrollment and retention process.

**Adverse policies.** In addition to opting not to expand Medicaid, Texas lawmakers have upheld the state's 90-day waiting period for CHIP; imposed stringent hospital presumptive eligibility standards that seem to deter hospitals from granting temporary Medicaid coverage to patients; and continued Medicaid coverage of former foster children *only* for those who turned 18 while living in Texas, as opposed to all former foster children up to age 26.

## State Context (cont'd)

### State Government

- *The California state government is mostly Democratic, whereas the Texas state government is mostly Republican. The Colorado state government is a mix of a Democratic governor and a divided legislature.*

Source: Henry J. Kaiser Family Foundation 2015a

### Medicaid Expansion and Insurance Marketplaces

- *California and Colorado both expanded their Medicaid programs as envisioned by the ACA and operate state-based Insurance Marketplaces. Texas did not expand its Medicaid program and uses the federally facilitated Insurance Marketplace.*

Source: Henry J. Kaiser Family Foundation 2015b

**Administrative processes.** County-level administration of Medicaid programs in California and Colorado presents challenges for some families, due to a lack of standard processes across counties. This issue is particularly problematic for families who move from county to county, such as agricultural workers and other low-income families whose employment and housing situations are unstable. In California, families who move to a new county risk losing coverage if they do not re-apply through their new county's system. In Colorado, families' information is not always transferred from county to county and caseworkers may have different processes for establishing and maintaining coverage.

California respondents added that, because of inconsistent staffing and training, families may receive different levels of support and different information depending on how they try to enroll in public coverage. For example, one respondent explained that if a mother applies for coverage for her child online, the child receives temporary eligibility while the application is being verified, but if the mother applies in person at a county office, the child does not receive temporary coverage. In addition, staff at certified enrollment entities may be better prepared than county staff to handle new income eligibility requirements. Finally, California respondents said redetermination processes pose challenges to families because they require parents to actively demonstrate their child's continued eligibility by responding to notices, affirming that their household size and income have not changed, and indicating that they want to continue coverage.

In Texas, although the state took advantage of the ACA's generous federal match for Medicaid and CHIP to make major eligibility system improvements, respondents said certain problems that should be avoidable remain. For example, they described lengthy Medicaid redetermination processes that can drag on because of a single, repeatedly overlooked detail.

**Federal eligibility rules.** Under federal law, undocumented immigrants are not eligible for coverage through Medicaid, CHIP, or the Marketplace. However, many immigrant families include children who are citizens and are eligible. Respondents in Colorado and Texas said that confusion among families with mixed immigration status and fear of deportation may prevent many from enrolling eligible children. Although California's upcoming implementation of legislation that provides state-funded coverage to undocumented children may help address this issue there, respondents said immigrant families' concerns may continue to hinder enrollment of eligible children.

In addition, many Texas families cannot afford coverage due to the "family glitch," which refers to the fact that under the ACA, employees seeking coverage through the Marketplace are not eligible for premium tax credits if they have access to affordable employer-sponsored coverage. The glitch is that the standard for affordability is based on individual coverage, rather than more expensive family coverage. This affects relatively few children in states with generous CHIP coverage, but Texas provides CHIP coverage for children only up to 201 percent of the federal poverty level (\$40,521 for a family of three). Those with household incomes between 201 and 400 percent of the federal poverty level are affected by the glitch and may not be eligible for premium tax credits. Colorado respondents noted more families in that state would also be affected by the glitch if Congress fails to fund CHIP past 2017.

## II. Access to Health Care Services

### Positive developments in California, Colorado, and Texas

*Strong provider participation in Medicaid and CHIP has improved access to health care services for many children in low-income families.* In all states, the ACA temporarily increased Medicaid reimbursement levels to match Medicare reimbursements during calendar years 2013 and 2014 as an incentive for more primary care providers to accept Medicaid patients, and respondents perceived positive effects of this parity on children's access to primary care. The Colorado legislature extended these higher Medicaid reimbursements for primary care providers through the 2016 fiscal year, although the governor's proposed budget for 2016–2017 would eliminate this policy. In California and Colorado, respondents said low-income families can seek care for their children in various places, including public hospitals, local health departments, community clinics, federally qualified health centers, rural health centers, and school-based health centers. In these states, safety net systems are strong, particularly in urban areas. California respondents said that the state's expansion of Medicaid managed care in 2012 to all 58 counties in the state has likely improved access to care for children living in rural and remote areas due to accountability standards for timeliness of care. In Colorado, respondents said the state's early efforts to establish medical homes for children enrolled in Medicaid and CHIP have contributed to the wide network of providers committed to serving these children.

“[The Medicaid rate increase] has been a huge incentive for other private practices to accept more Medicaid patients. After we work on...expanding coverage, we need to make sure that then reimbursement allows for providers to give access to care for those populations.”

– Colorado respondent

*Recent initiatives and policy developments may increase low-income children's access to some behavioral health services.* In Colorado, several recent initiatives have focused on integrating behavioral health and primary care, including the state's \$68 million State Innovation Models Initiative (SIM) grant from the Centers for Medicare & Medicaid Services (CMS). California and Texas have expanded the list or amounts of behavioral health services covered by their Medicaid programs. In California, expanded benefits will include services for children with mild-to-moderate mental, emotional, or behavioral issues and children with autism spectrum disorders. In Texas, mental health first-aid training will be available to school district employees and school resource officers. In addition, Texas children enrolled in Medicaid are now screened for autism and mental health issues at the frequency recommended by the American Academy of Pediatrics.

### Remaining challenges

*In rural areas, access to primary or specialty care is a longstanding problem for many families with children in Medicaid or CHIP.* Access to care in rural areas of all three states is more difficult due to fewer providers and longer travel distances to health care facilities. Particularly in Texas, families in rural areas are challenged by an outright shortage of providers and the fact that Medicaid and CHIP providers must run high-volume practices to stay afloat financially. In some urban areas of Texas, access problems stemmed from low rates of provider participation in Medicaid, which may be ascribed to complex state participation requirements, lengthy credentialing processes for individual managed care plans, low reimbursement rates, and onerous preauthorization

## Children's Health Coverage

### Medicaid/CHIP Eligibility

- California's Medicaid program covers children up to 261 percent of the federal poverty level (FPL). California does not have a separate CHIP program.
- Texas's Medicaid program covers infants up to 198 percent of 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.
- Colorado's Medicaid program covers children up to 142 percent of FPL. Its combination CHIP program covers children from 143 to 260 percent FPL.
- The FPL is \$20,160 for a family of three.

Source: CMS 2015

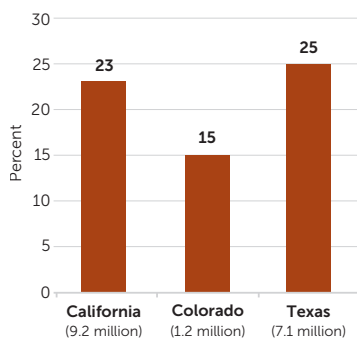
### Medicaid/CHIP Enrollment (2014)

- 43 percent of children in California (4.2 million)
- 42 percent of children in Texas (3.2 million)
- 35 percent of children in Colorado (475,900)

Source: Henry J. Kaiser Family Foundation 2015c



## Children Under Age 18 Living in Poverty, 2014



Source: U.S. Census Bureau, 2014b

requirements. Respondents added that, while more providers participated in Medicaid when the ACA provisions requiring parity in Medicaid and Medicare reimbursement for certain primary care services were temporarily in place, Texas did not extend this policy, and Medicaid participation has since reverted to previous low levels. In addition to the low rate of provider participation in Medicaid, respondents noted that 10 hospitals have closed in rural Texas in the past two years, likely due in part to the state's decision not to expand Medicaid. Texas hospitals now receive lower federal payments for serving the uninsured, but these lower payments are not offset by a larger base of insured patients, as Medicaid expansion would have helped to provide.

"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."

– Texas respondent

*Even in states with strong safety net systems, many primary care providers serving children in Medicaid and CHIP are reportedly near or at capacity.* In California, some children in low-income families face challenges finding primary care providers. As in Texas, many primary care providers in California choose not to participate in Medicaid due to low reimbursement rates and burdensome administrative requirements for participation. Also like Texas, California did not extend Medicaid-Medicare reimbursement parity. As a result, many families with children enrolled in Medicaid turn to safety net providers for primary care, and these providers report being overwhelmed. In Colorado, despite the state's decision to extend Medicaid-Medicare parity in reimbursements through 2016, providers are feeling stretched to capacity by the recent influx of Medicaid and CHIP patients. Respondents worry that if the state fails to extend increased Medicaid reimbursement rates past 2016, access to care for Colorado children with Medicaid or CHIP would worsen.

*Low-income families face challenges with access to pediatric specialty care, particularly for behavioral health issues and oral health care, and for children with special health care needs.* Respondents in California, Colorado, and Texas all expressed concern about low-income children's access to specialists:

- Access to basic behavioral health care—such as screening and short-term treatment—has improved somewhat (as discussed above), but access to more comprehensive and ongoing care is severely lacking. This is especially true in rural areas in all three states, where often there are few or no child psychiatrists.
- California and Colorado respondents said access to dental care remains challenging for many families, due to shortages of dentists serving children with Medicaid or CHIP and parental confusion or lack of awareness about which oral health services their plans cover. Texas respondents did not mention oral health access problems.
- Low-income children with special health care needs face barriers to accessing care in all three states. In California, children with the most complex needs qualify for the California Children's Services (CCS) program and receive high quality services through a certified provider network. However, children with less severe concerns who do not qualify for the CCS program face significant access issues. Many low-income Colorado families with children who have special needs struggle to connect to early intervention services, ongoing specialty care, and transitional care when children reach adulthood. This is particularly true in rural areas. Texas children experience similar challenges.

Respondents reported several strategies to address specialist shortages, such as using telehealth and flying specialists from urban to rural areas periodically to see patients. Longer-term strategies included higher Medicaid reimbursement rates, student loan forgiveness programs, and more residency placements for medical school graduates to attract more specialists to rural areas.

*Socioeconomic and health literacy barriers may prevent low-income families from accessing care.* Low-income families often face transportation issues (in both rural and urban areas), lack of time off from work to take children to appointments, and fears of potential co-pays or other costs associated with medical care. In addition, low-income families—particularly those who have insurance for the first time—may not know how to use their coverage and navigate the health care system to access appropriate services. Respondents in the three study states noted that increasing health literacy among low-income families and providing support to these families in the form of navigators, community health workers, or other support staff are vitally important to helping them use their coverage.

“Parents will deal with a broken bone. But really, for parents who are new to coverage, [to help] their kids access vision, dental, and behavioral health services...education needs to be done for the whole family about the value in seeking that care, so that they actually access the benefit.”

– California respondent

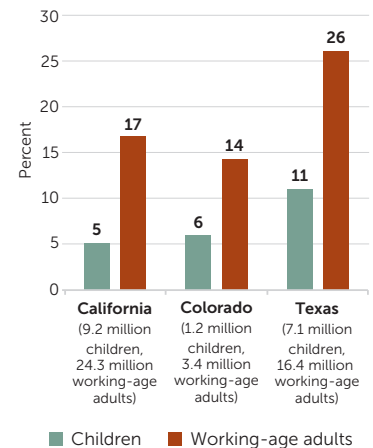
### III. Emerging Issues and Opportunities

#### Emerging issues

*Maintaining or increasing long-term funding and political support for Medicaid and CHIP is a concern for respondents in all three states.* In California, which has embraced Medicaid expansion with broad eligibility standards, respondents worried about maintaining the funding needed to support expanded coverage in the long term, as well as providing quality care for so many newly covered people. They were also concerned about whether Congress will reappropriate funding for CHIP in 2017 and the potential negative impacts of decreased federal funding on reimbursement rates and covered benefits. Colorado respondents feared that Medicaid’s rapid growth in the state may become politically contentious, and that the state-run Marketplace faces a challenging transition from a start-up to a sustainable entity. Colorado faces unique state constitutional budget constraints, particularly the Taxpayer Bill of Rights (TABOR), which shapes political debates about funding for public services. Moreover, as in California, there are concerns about how Colorado would cover children if funding for CHIP is not continued past 2017. Respondents in Texas viewed the state’s decision not to expand its Medicaid program as the main barrier to low-income families obtaining coverage for their children. Respondents noted that, even with data showing well-controlled expenditures for Medicaid and potential economic benefits from expanding the program to adults, political opposition to date has been insurmountable.

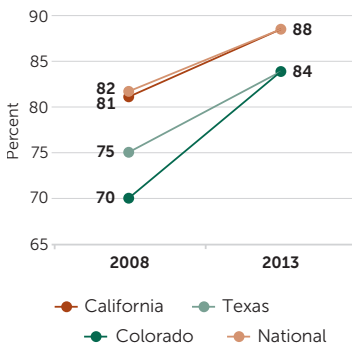
*Covering remaining uninsured children—particularly children in mixed-status or undocumented immigrant households—remains a concern for respondents in all three states.* Despite state legislation that will soon expand coverage to undocumented children, respondents in California are concerned about whether the state and the counties will

### Uninsured Children and Working-Age Adults, 2014



Source: U.S. Census Bureau, 2014c

## Medicaid or CHIP Participation Among Eligible Children, 2008-2013



Sources: Kenney et al. 2012; Urban Institute 2015

be able to enroll these children, due to fears related to other family members' immigration status, or to provide them with services if they enroll, due to an inadequate supply of providers who serve children with Medicaid. Although there is no state coverage for undocumented children in Colorado or Texas, respondents emphasized the importance of identifying and enrolling eligible children in families whose parents or other family members may be undocumented immigrants. Respondents in all three states said that significant and tailored outreach will be required to convince undocumented parents, who may be too fearful of the legal repercussions of identifying themselves to enrollment entities, to even consider enrolling their eligible children.

*Respondents in all three states will continue to monitor challenges faced by families who have children with complex health care needs.* California is redesigning its Medicaid carve-out program for children with special health care needs to integrate care for these children into Medicaid. Some respondents worry this will hinder continuity of care and decrease care quality, but others argue that a single system through which children can access all needed services will be easier for families to navigate than the current model in which children obtain services through multiple systems. In Texas, respondents hoped that the implementation of mandatory managed care for children with severe disabilities (beginning in 2016) will improve access to care. Managed care plans will provide nearly all community-based services, long-term supports, and medical services for these enrollees. Colorado respondents will continue to work on policy and programmatic strategies to address challenges with connecting children with special needs to early intervention services, ongoing specialty care, and transitioning to adulthood.

*Respondents also identified a number of state-specific emerging issues that they will watch in the next few years:*

- California respondents noted a need for improved quality monitoring of Medicaid managed care, especially for children, and increased efforts to publicly report and use data to drive quality improvement efforts. Although California law requires health plans to separately monitor timely access to care for their Medicaid and commercial members, respondents reported this requirement is rarely enforced. Respondents suggested encouraging the California Department of Health Care Services to invest in more robust data collection and to more carefully enforce its managed care contracts. Some also argued for the use of value-based purchasing, which would tie provider payments to health care outcomes.
- In addition to concerns that increased Medicaid reimbursements for primary care providers will end in 2016, Colorado respondents noted uncertainties about how children will be incorporated into the state's SIM Award from CMS. Some respondents are concerned that children's particular behavioral health needs may get "lost in the shuffle" of the larger delivery system issues the SIM aims to address. Respondents also stressed the importance of promoting prevention and other aspects of children's health as the state discusses payment reform and Medicaid delivery system reform.
- Texas respondents discussed the importance of the state's upcoming 1115 Health-care Transformation Waiver renewal, which will occur later this year. The waiver has helped to support a wide range of health care quality improvement projects that the state hopes to continue upon renewal. Respondents are anxious about the state's waiver negotiations with CMS; they worry 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 potentially negatively impacting hospitals' financial health.



## Opportunities for advocates, decision makers, and funders

*Respondents in California, Colorado, and Texas provided ideas on how to improve access to coverage and care in their respective states. Below are several common themes that emerged.*

**Policy opportunities.** Respondents in all three states described the need to advocate for new or continued support for expanded Medicaid programs and CHIP reauthorization. In California and Colorado, respondents recommended increasing stakeholder advocacy for funding and political support for Medicaid expansion. They also recommended including children's health stakeholders in policy planning and implementation so that the needs of children and families are not overshadowed by those of other target populations. In Texas, where political opposition to Medicaid expansion is significant, respondents stressed that long-term efforts are needed to improve voter participation and civic engagement among low-income residents. Texas respondents added that children would benefit more from family-friendly approaches to coverage and care than from strictly child-focused ones. They explained that families with coverage (as opposed to those with some uninsured members) tend to be more financially secure, more likely to have an appropriate source of usual care (as opposed to visiting hospital emergency departments because they are accustomed to seeking care there), and more likely to have a consistent, ongoing relationship with their providers.

**Outreach and educational opportunities.** Respondents from all three states stressed the importance of targeted outreach and enrollment assistance for hard-to-reach populations, particularly eligible children of immigrants (and in California, undocumented children who will soon qualify for coverage). Respondents also recommended improving health literacy among families with children enrolled in Medicaid and CHIP, especially regarding appropriate use of coverage and the importance of accessing regular preventive services.

**Provider and delivery system opportunities.** Respondents proposed various methods to promote workforce development and improve networks of primary and specialty care providers serving children in low-income families. These included student loan forgiveness programs and more residency placements for medical school graduates, particularly in rural areas. Respondents in all three states also supported advocacy for higher Medicaid reimbursement rates, which they linked to increased Medicaid participation among primary care providers. Respondents also mentioned increased use of telehealth and e-consults as potentially helpful workarounds to address delivery system shortcomings.

## IV. Conclusions

Using data from interviews with children's health stakeholders, we have characterized the recent experiences of low-income families in California, Colorado, and Texas, three states with very different political landscapes and approaches to coverage of and care for children. Our findings include many longstanding issues common across all states, such as the complexity of navigating Medicaid and CHIP enrollment and retention and how best to cover remaining uninsured children. However, states' policy and programmatic decisions related to the ACA, which introduced a mix of mandatory and voluntary provisions, provide an interesting glimpse into how state-level philosophies of government can powerfully shape children's coverage and access to health care over just a few years.

Contrasts across the three study states' experiences with coverage are clear. Respondents said that California's and Colorado's decisions to expand Medicaid, as well as numerous other state policy decisions, have helped reduce the numbers of uninsured children in low-income families in the past few years. Although Medicaid expansion focused primarily on adults in these states, respondents noted that insured adults are more likely to enroll their children in coverage. Conversely, Texas's decision not to expand Medicaid, coupled with other state policies, has hindered the ability of low-income families to cover their uninsured children. Texas's Medicaid expansion decision also seems to have contributed to the recent closures of rural hospitals, which cared for many uninsured patients in the state.

Access to health care services for children in low-income families is less than optimal in all three states. California and Colorado respondents praised their states' strong networks of safety net and other providers, but expressed concerns about their capacity to deliver high quality care to the increasing numbers of children with Medicaid or CHIP coverage. Texas respondents said access to primary care is challenging across the state for uninsured children and those with Medicaid or CHIP because of provider shortages and low Medicaid participation. All three states face shortages of specialists providing care to low-income children, particularly behavioral health specialists. Access to care tends to be more problematic in rural areas of California, Colorado, and Texas.

Looking ahead, respondents in the three states identified numerous ways to make their health systems work better for children in low-income families. Given California's soon-to-be universal coverage of children, respondents said they will focus on reaching the small group of eligible children who remain unenrolled, particularly undocumented immigrant children who will soon qualify for coverage; improving data collection and monitoring of Medicaid managed care plans; and increasing the pool of primary and specialty care providers who serve children in low-income families. Like California, Colorado will continue outreach efforts to enroll remaining uninsured children and to increase all low-income children's access to care; however, undocumented children in Colorado remain without options to enroll in public coverage. Colorado respondents also stressed the importance of including child health stakeholders in ongoing discussions of payment and Medicaid delivery system reform. In Texas, respondents focused on the state's political climate. Texas respondents felt that their ability to improve access to coverage and care for children in low-income families is hampered by low participation among low-income residents in the political process and the need for a major shift in social policy.

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State-specific briefs focusing on California, Colorado, and Texas are available [here](#). Foundation grantees and other children's stakeholders who made this work possible by participating in interviews and sharing their perspectives are listed in the individual briefs.

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