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**Congressionally
Mandated Evaluation
of the State Children's
Health Insurance
Program**

*Site Visit Report: The State of
Texas TexCare Partnership*

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I. PROGRAM OVERVIEW

Texas is one of the 19 SCHIP programs in the nation that combines a separate state plan with a Medicaid expansion. Branded the *TexCare Partnership*, the Medicaid component extended coverage to children between the ages 15 and 18 in families with income below 100 percent of poverty,¹ while the separate program covers children under age 19 living in families with incomes up to 200 percent of the federal poverty level. As detailed in Tables 1 and 2, Phase I of the program—the Medicaid expansion—was implemented in July 1998, while Phase II—the *TexCare Partnership*—was approved by the then-Health Care Financing Administration on November 8, 1999 and implemented in April 2000.

Although Texas' separate program was launched roughly two years after the majority of states had implemented their SCHIP initiatives, state officials used the extra time to carefully plan and design a program drawing on extensive public input and building on the lessons learned from other states. Described by state officials as “a program for Texans, designed by Texans,” the *TexCare Partnership* incorporates many components common in private insurance, including highly visible media and marketing materials, a simple enrollment process, service delivery through managed systems of care, and cost sharing, in the form of premiums, copayments, and deductibles. The program is administered by the Texas Health and Human Services Commission (HHSC), which also administers the Medicaid program.

¹As of October 1, 2002, Texas' program will become a “separate” state SCHIP program, as opposed to a “combination” program, as the federal mandate for phasing in poverty-level Title XIX coverage of children under age 19 born after September 30, 1983, will be complete. Thus, Texas' initial Title XXI plan to accelerate Medicaid coverage for children ages 15 to 19 living in families with incomes below poverty will be subsumed within Title XIX.

TABLE 1: SCHIP STATE PLAN AND AMENDMENTS

Document	Dates			Description
	Submitted	Approved	Effective	
Original Submission	4/1/98	6/15/98	7/1/98	As a “placeholder” plan, obtained federal matching funds for the expansion of Medicaid to children between the ages of 15 and 18 in families with incomes below 100 percent of the FPL, with all Medicaid policies to apply
Amendment 1	6/23/99	11/8/99	4/3/00	Applied for federal funds to implement a separate state program for children up to 200 percent FPL up to the age of 19

SOURCE: Centers for Medicare & Medicaid Services (CMS), *Texas Title XXI Program Fact Sheet*. CMS web site <http://www.hcfa.gov/init/chpfstx.htm>

NOTES: SCHIP=State Children’s Health Insurance Program. FPL=federal poverty level. NA=not applicable.

TABLE 2: MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS^a, EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL)

	Age (in Years)			
	Up to 1	1-5	6-15	16-18
Medicaid standards in effect 7/1/98	Up to 185%	Up to 133%	Up to 100%	Up to 18%
SCHIP Medicaid expansion	NA	NA	NA	18-100%
SCHIP separate child health program	185-200%	133-200%	100-200%	100-200%

SOURCES: Centers for Medicare & Medicaid Services (CMS), *Texas Title XXI Program Fact Sheet*. CMS web site <http://www.hcfa.gov/init/chpfstx.htm>

NOTES: SCHIP=State Children’s Health Insurance Program (Title XXI). NA=Not applicable.

^a Income standards are net of deductions

By September 2001, just 17 months since the program's start in April 2000, *TexCare* had enrolled 432,745 children, exceeding the state's self-imposed enrollment target of 428,000. Credited for this success is the simple enrollment processes and effective outreach campaigns. There are, however, current and impending problems regarding access to care.

This case study is based primarily on information gathered during a visit to Texas conducted in June 2001 as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. During the 5-day visit, 23 interviews were carried out with a broad range of key informants at the state and local level, including state program administrators, Governor's staff, state legislative staff, child advocates, managed care organizations, health care providers and provider association representatives, local social services staff, and staff of various community-based organizations involved in outreach and enrollment. (See Appendix A for a complete list of key informants.) In addition to our interviews in the state capitol of Austin, we gathered information about local implementation in three local areas—the urban cities of Dallas and San Antonio, and the smaller town of Waco. Dallas is a large city in the north/central part of the state accounting for 5.7 percent of the state's 208 million residents; 35 percent of the city's population is Hispanic. San Antonio is a city of similar size to Dallas located in the south/central portion of the state. Four hours from the border with Mexico, it has a very large Hispanic population—58 percent—many of whom are recent and/or undocumented immigrants. Finally, Waco, located between Austin and Dallas, a mid-sized town of approximately 114,000, represents 0.5 percent of the state's population, of which 24 percent are Hispanic.

II. BACKGROUND AND HISTORY OF SCHIP POLICY AND POLICY DEVELOPMENT

In June 1997, the Texas legislature, which meets biennially, adjourned for its customary two-year break. Two months later, President Clinton signed into law the Balanced Budget Act of 1997 which created SCHIP as Title XXI of the Social Security Act. Though Title XXI was a prominent, bipartisan piece of legislation garnering considerable national attention, Governor George W. Bush did not convene a special session of the state legislature to address SCHIP.² Rather, he instructed the state's Medicaid agency—the Health and Human Services Commission (HHSC)—to begin reviewing the state's options and planning for adoption of SCHIP at a later date. Consequently, two years would go by before the Texas legislature would meet to consider SCHIP, during which time some 1.5 million children in the state remained uninsured.³

While an insurance expansion was significantly delayed, the two-year period was used to great advantage and effect for development, advocacy and planning purposes. In the fall of 1997, HHSC formed an interagency task force to assess options for the design of the SCHIP program. At the same time, concerned advocates and provider associations resurrected the advocacy-based Maternal and Child Health Coalition, comprising providers, health plans, community groups and advocacy organizations, and renamed it the CHIP Coalition as a vehicle to advise and lobby the state legislature. As a means of ensuring Texas' access to the 1998 allotment of federal funds, HHSC submitted its initial state plan in the spring of that year proposing to accelerate poverty-level Medicaid coverage for children between the ages of 15 and

²Governors very rarely call special sessions of the legislature in Texas.

³Kaiser Family Foundation. State Health Facts Online. *Distribution of Children 18 and Under by Insurance Status, 1997-1999*.

18. This amendment was described by state officials as a “placeholder,” that would allow the state to continue planning the remainder of its more ambitious SCHIP initiative.

The interagency task force and CHIP Coalition had numerous program design decisions to make, but the two-year gap between the passing of the federal law and the next session of the state legislature placed the groups in a somewhat unique position. Namely, they had the advantage of being able to observe how other states designed and implemented their SCHIP programs, and could consider and evaluate factors that led to their successes and failures. Furthermore, the two years gave the interagency task force and CHIP Coalition time to gather extensive information and to create broad-based support for the initiative. Throughout this “consultative” process, the HHSC and the CHIP Coalition worked in partnership, attending each others’ meetings, seeking advice from one another, and planning joint forums. The success of this partnership critically affected the development of the program. There was also considerable public input, comprising both public hearings across the state and a series of 27 focus groups. The HHSC utilized the Internet, too, most notably to ask for feedback on draft Requests for Proposals for the outreach and health plan contracts. Through this process, the HHSC obtained “thousands of free hours of consultation” from vendors, providers, and managed care organizations hoping to contract with the state.

The deliberations of the groups were also affected by an important environmental factor—the recent creation of the Texas Healthy Kids Corporation (THKC), a public/private partnership modeled after Florida’s “Healthy Kids” program. In short, the interagency work group and the CHIP Coalition needed to consider the extent to which the program should serve as a base upon which to build Texas’ SCHIP program. Overseen by the Texas Healthy Kids Corporation, THKC was designed to supplement state funds with private financing to subsidize primary and preventive care for children aged between two and 17 with incomes up to 185 percent of poverty.

Begun in 1996, the program had enrolled approximately 15,000 children whose parents paid premiums of up to \$20 per month for coverage. The program was perceived by some as a successful private-public model; to others, however, it was viewed as deeply problematic, given its small size, its unstable funding base, and the very limited scope of its benefits. To its supporters, the Texas Healthy Kids Corporation appeared to be an ideal place to house SCHIP, a private solution to a public problem. To its detractors, notably the advocates and health plans, HHSC was viewed as a much stronger option given its years of experience running the much larger Medicaid program and its greater public accountability. Despite the state's inclination towards private options, the lack of capacity and limited track record of the Texas Healthy Kids Corporation swayed decision-makers to give administrative responsibility to the larger, more experienced HHSC.

By 1999, HHSC and the CHIP Coalition had prepared three alternative program designs to present to the returning legislature: one would create a separate program in the model of private insurance; the second would solely expand Medicaid; and the third would create a separate Medicaid “lookalike.” Though there was support for a Medicaid expansion from many members of the CHIP Coalition—some providers viewed it as administratively simpler, and advocacy groups preferred its entitlement protections—strong resistance from Governor Bush and the conservative legislature meant that, politically, the option was “dead on arrival.” According to these politicians, there was much to detract from the Medicaid option in Texas: as an entitlement, it represented budget uncertainty, especially in the light of the structural dip in the SCHIP allotment two years into the program. Medicaid was also a program perceived to be burdened by “stigma” associated with its complex application process and procedures. In contrast, the separate option was seen as an opportunity to create a program with an application process that was simple and straightforward, and one that was dissociated from the perception of

Medicaid as a “government handout” program, an association many feared would doom SCHIP to failure. A separate program also had the strong attraction of a budget that could be controlled by the state, and of a philosophy that complemented the “welfare reform” policies so popular in Texas. After considering its options, the legislature endorsed the plan to pursue the separate program in the model of private insurance, and HHSC was identified as the appropriate entity to administer the program.

One of the most visible legislative debates was over where the upper income eligibility threshold for the program would be set. Governor Bush and the Republican-controlled Senate supported 150 percent of poverty as a sensible opening eligibility level for SCHIP, one that would limit the state’s fiscal exposure while also minimizing the risk of “crowding out” employer-sponsored health insurance. However, many members of the Democratic-controlled House, as well as the CHIP Coalition, advocated a broader eligibility expansion to 200 percent of poverty. After heavy lobbying, 200 percent was written into the law, with the proviso that “crowd out”—a source of considerable anxiety amongst many members—would be addressed by the imposition of a 3-month waiting period during which children would have to be uninsured before being permitted to enroll in SCHIP.

The next step for the HHSC was finalizing its SCHIP plan amendment for Phase II of the program. Based on the extensive public input already gathered, and guided by its observations of successful strategies in other states, the agency began to formulate the many critical components of the program, including a multi-faceted marketing campaign, a community-based outreach effort to help find and enroll harder-to-reach children, a simplified enrollment process, a service delivery approach relying heavily on managed care organizations, and a cost sharing structure that would emulate private insurance. At the urging of the CHIP Coalition, the pediatric community, and state agency experts in behavioral health and community advocates,

the program was also designed to cover a broad set of benefits, using the State Employee Health Benefit Package as a base, but going beyond it to include an array of specialty and behavioral health services of particular importance to children with special health care needs.

Texas' SCHIP program—branded the *TexCare Partnership*—was finally implemented in April, 2000. The first enrollees began receiving care in May 2000, nearly three years after the federal SCHIP law passed. By September 2001, however, Texas had exceeded its enrollment target and become one of the three largest SCHIP programs in the nation.

III. OUTREACH

A. POLICY DEVELOPMENT

In devising its outreach strategy for SCHIP, HHSC made extensive use of public input and lessons learned from other states, a process that has continued throughout its evolution. As a result, decisions were made to create a strong brand identity for the SCHIP outreach campaign—the *TexCare Partnership*—and, similar to many other states, develop both a statewide marketing campaign and various community-based components.

For the statewide campaign, marketing began with a broad “call to action,” a \$2 million advertising effort featuring branded outreach materials and a centralized toll-free hotline. The objective was to establish a strong identity for the program and encourage families to call the hotline to request information or an application form. Six months after enrollment into *TexCare* began, the state revised its approach—consumer focus groups had made it clear that the public wanted more, and more detailed, information from the advertising. The state’s outreach budget was quadrupled to \$8 million and advertisements shifted away from their simple “call this number” message to more specific information about the pricing and benefits of the *TexCare* program.

Although the media campaign was implemented statewide, the size and diversity of Texas clearly necessitated a complementary campaign of “foot soldiers” at the local level. A budget of \$5 million—more than twice the amount for the initial statewide campaign—was allocated to develop a network of grass roots coalitions at the community level to conduct further outreach and to assist families with enrolling in the program. After an extensive procurement process, contracts were let to 50 community-based organizations who were given the broad charge of

developing locally-tailored campaigns, employing the state’s *TexCare Partnership* outreach materials, and referring families to the hotline number identified therein. After several promising months, HHSC decided to also strengthen this component of the overall strategy, increasing the CBOs’ budgets to \$7.5 million and permitting CBOs to develop their own outreach materials and hotlines to bolster those of the state.

It is worth noting that Texas’ outreach campaign was designed to be “generic,” with the aim of enrolling children in whatever health insurance program they qualified for—be it SCHIP, Medicaid, or THKC. The *TexCare Partnership* name was intended to be synonymous for all the programs, and the application form makes it clear that children may be enrolled in SCHIP, Medicaid, or THKC as a result of filing an application. At the same time, officials were reluctant to print “Medicaid” explicitly on the front of its printed outreach materials to avoid the possibility that Medicaid “stigma” might undermine the launch of SCHIP. It is also noteworthy that health plans were not incorporated in the state’s outreach strategy. Indeed, HHSC developed explicit rules limiting the extent to which plans could market themselves under SCHIP, in part because of existing restrictions on Medicaid health plan marketing and the need to ensure that both federal and state Medicaid marketing restrictions were not violated when conducting *TexCare* outreach.⁴

B. STATEWIDE/MEDIA EFFORTS

Branding and design have been of central importance in defining the message of the outreach campaign in Texas. Yellow in color, featuring the smiling faces of children of different

⁴According to state officials, however, the process of developing marketing guidelines for SCHIP health plans did create the opportunity for the state to relax some of the more stringent state requirements it imposed on Medicaid plans, as they strove for consistency across the two programs.

ages, ethnicities, and health care needs, and dominated by the *TexCare Partnership* logo, the design has been the unifying feature of the multiple visual aspects of the statewide campaign. The central message across the components of the campaign has been “easy to apply, fits your budget, choice of doctors, call the toll-free number now”. The individual components are summarized below.

- **Radio and television advertisements:** Television advertisements run every other week, at times and during programs considered optimal according to market research. Initially, advertisements were designed to simply establish the identity of *TexCare* and let it be known that there was a program of “affordable” health insurance for children. Subsequent generations of ads featured a traditional Hispanic rhyme, “Sana Sana,” used commonly by mothers for soothing sick children. Since January 2001, advertisements have become considerably more focused. On the advice of focus groups, ads now feature “price points” (ie, the exact cost of the program in premiums and copayments), details on benefits coverage, and the “spoken words” of parents who have had positive experiences with the program. A more recent initiative involves the radio broadcasting of “children’s health minutes,” which are a set of informative public services announcements on *TexCare*, the importance of health insurance coverage, preventive care, and other information on children’s health and safety.
- **Print media and materials:** HHSC has developed a full range of print materials that match the design and incorporate the messages of the radio and TV spots. These materials, which include billboards, posters, flyers, brochures and the like, are distributed to a broad range of audiences, including CBOs, provider site and clinics, children’s hospitals, and county agencies. Local departments of human services, for example, have *TexCare* materials available in their lobbies for families seeking cash assistance, Food Stamps, or Medicaid. The state Department of Motor Vehicles also includes *TexCare* flyers in its vehicle registration notices.
- **Toll-free hotline:** The toll-free hotline advertised on the materials used in the statewide campaign is administered by the HHSC’s administrative services vendor Birch and Davis. The hotline fields general inquiries about SCHIP and the application process and sends out application forms to families who request them. The telephone operators also assist callers with completing the applications, a process dealt with in more detail in the next section.
- **Telethons:** Birch and Davis has also been used to organize and host “telethons,” which are very visible events designed to raise the public’s awareness of *TexCare* and to generate calls to the outreach hotline. Broadcast on network affiliate stations in large media markets such as San Antonio and Austin, they often feature local politicians and celebrities, and have been very well received by the public, as evidenced by caller volume to the hotline.

C. COMMUNITY-BASED EFFORTS

To complement its state-based media campaign, HHSC intended from the outset to implement a large community-based outreach effort. Whereas media publicity was seen as a tool for branding *TexCare* and raising the public's awareness of the new program, more intensive local level efforts were seen as critical for building trust in the program at a community level, persuading families to apply for coverage, providing concrete assistance in completing application forms, and for reaching "hard to reach" groups, including ethnic minorities, Hispanic families, immigrant families and working poor families who might not have had prior experience with public programs. From the start, very large numbers of CBOs expressed interest in conducting SCHIP outreach. Because HHSC officials felt ill-equipped to judge the relative strengths and abilities of local organizations across the large state, the agency implemented a regional procurement process, using the government infrastructure in place in each of Texas' eight public health regions, to ensure that appropriate CBOs were identified. In each region, a team was formed to organize and administer the local procurement process, and to review and select winning proposals from among bidders.

The HHSC awarded contracts to 50 CBOs that included a broad range of groups, including community action agencies, county health departments, hospital partnerships, health provider groups, faith-based charities, and other grassroots organizations. These groups were charged with spreading the word about *TexCare* through locally-tailored strategies and were also asked to help families in their communities complete the *TexCare* application. To extend their efforts as far as possible, the CBOs have adopted a "train the trainer" model, providing training in SCHIP and application assistance, but no funds, to many local organizations that could then be enlisted in outreach and enrollment activities. Crucially, too, CBOs also received training and other forms of support from the administrative services vendor, Birch and Davis, and had opportunities

to work with the state's marketing contractor, Sherry Matthews Advertising, to tailor campaigns to local needs.

As a result of these partnerships, SCHIP has been institutionalized at the local community level; literally hundreds of CBOs across Texas have become involved with local outreach and application assistance, with the function efficiently managed through a relatively small number of regional contracts. The specific outreach strategies that CBOs have employed vary considerably, tailored as they are to their local communities. Broadly, however, we learned of five commonly used approaches:

- ***Local hotline:*** Usually funded and administered by the contracted CBO, local hotlines link families to CBO staff who can answer about SCHIP, in general, and receive assistance with the application process, more specifically.
- ***Broad community-wide education:*** CBOs have sought to raise awareness of the program by giving presentations, distributing outreach materials, broadcasting on the local media, placing posters in community settings, and printing announcements in community bulletins and newspapers.
- ***Forging partnerships with other organizations:*** CBO contractors have partnered with organizations such as hospitals, clinics, churches, landlords, schools, charitable organizations and employers on promotional activities such as staffing outreach at health clinics and WIC sites, working with schools to identify uninsured children and distributing flyers to participants in the school lunch program, and collaborating with community centers that organize ethnic-specific community events.
- ***Inreach:*** Each CBO and its coalition partners naturally come in contact with families with uninsured children in the course of their daily business. Inreach is promoted so that local staff will continuously promote *TexCare* to their clients, along with whatever else the organizations provide to client families. Furthermore, inreach was also described as CBOs ensuring that their own staff have health insurance for their children.

Some examples of the types of coalitions formed by outreach contractors, and the strategies they use, are detailed below.

- ***Children’s Medical Center (CMC), Dallas:*** The Children’s Medical Center in Dallas has the highest-volume pediatric ER in the nation, and treats many uninsured children. It made sense, therefore, for the center to get involved with outreach for *TexCare* given that it could both provide a valuable new source of revenue and reduce pressure on the ER by providing children with a “medical home.” Thus, though CMC was not awarded the outreach contract for Dallas—it went to the Community Council of Greater Dallas (CCGD), a traditional social services agency—it has worked closely with CCGD as part of the Dallas CHIP Coalition and has helped spearhead local outreach and training efforts. In October 2000, CMC did receive funding from a local foundation to employ outreach workers in five Dallas zip codes known for their low SCHIP enrollment rates. Reasoning that their time would best be spent in schools, the newly employed outreach workers approached school principals and/or nurses for permission to conduct outreach. They then adopted a variety of techniques to educate parents about SCHIP, such as sending fliers to parents, attending PTA meetings and parent-teacher conferences, and arranging enrollment contests, awarding a pizza party, for example, to the class that enrolled the greatest number of children into *TexCare*. In addition to their work in schools, outreach workers spend approximately one day each week at the CMC emergency room, and another day working in other community settings such as churches.
- ***McLennan County Youth Collaboration/Communities In Schools (MCYC/CIS), Waco:*** MCYC/CIS is a community-based organization dedicated to connecting community resources with young people in school. By 1998, the organization was already active in Medicaid outreach to children; the large numbers of local children not enrolled in Medicaid had spurred them to action. Drawing on local partners, including two local hospitals, clinics, the Public Health District, and two local businesses, MCYC/CIS developed a children’s health campaign to get children into Medicaid. This placed the group in an ideal position to bid successfully for the SCHIP outreach contract. On receiving the *TexCare* contract, MCYC/CIS continued and further enhanced its outreach work, again focusing on reaching and enrolling the school population. They developed and used their own outreach materials to inform high school students about SCHIP, and for younger children, they worked closely with Head Start. The collaboration also carried out a variety of other outreach activities. In the summer and fall of 2000, for example, they created locally-produced radio advertising with the financial support of businesses and radio stations. They have also worked extensively with local businesses and the City of Waco to educate low-wage employees otherwise faced with steep insurance bills.
- ***Lawyer’s Committee for Civil Rights, San Antonio:*** San Antonio has a very high proportion of both documented and undocumented immigrants. Reasoning that immigrant-related barriers to health insurance might be prevalent in such a community, HHSC gave a grant to the Lawyer’s Committee for Civil Rights, a legal-defense CBO that focuses on immigrant’s rights, for the sole purpose of reaching out to and educating immigrants about SCHIP and Medicaid. Outreach workers at the Lawyer’s Committee—all of whom are Hispanic—have worked hard to build trust in the community by identifying and becoming involved with community members, and then offering services, in the form of educational classes and materials, on topics such as “public charge,” citizenship application, and government health programs, in the hopes of encouraging parents to apply for *TexCare* on behalf of their children.

D. EXPERIENCES AND LESSONS LEARNED

According to most key informants we interviewed, as the statewide campaign has become refined and better funded over time, it has also become considerably more effective. Unlike the basic message of the early media campaign, viewed widely as inadequate and unfocused, the greater specificity of recent advertisements is perceived as being more effective in attracting applicants. The inclusion of “price points” was identified as an especially important feature of the new effort. The provision of information about public charge and other issues relevant to immigrants, however, is still described as “insufficient.” For the most part, other shortfalls in the first phase of outreach have also been rectified. CBOs reported that they were initially not provided with sufficient amounts of state outreach materials, and did not like the fact that they were prohibited from including a local hotline number on their own literature. Now, they have access to more and “better” state materials, and are allowed to advertise their own hotline number. Similarly, the centralized hotline run by Birch and Davis, once slow in answering calls and disorganized in mailing requested application forms, has also improved as a result of increased staffing levels, as well as a more aggressive commitment to customer service, as enforced by state officials.

State administrators, the Governor’s and legislative staff, and advocates all agree that CBOs have been an essential and effective component of outreach for SCHIP. Still, most CBO contractors reported that they did not receive nearly the amount of financing they requested from the HHSC, and other members of CBO coalitions voiced frustration that the “train the trainer” model resulted in all contract monies remaining in the hands of the main CBO contractors. In the face of these problems, CBOs were still widely praised for their effective performance and their success in:

- Building large coalitions of diverse organizations, thus generating energy at the local level;
- Designing locally-customized outreach strategies;
- Building trust in local communities through personal contact; and
- Administering local hotlines.

In particular, CBOs were praised for their ability to design and test alternative strategies to see what works and what does not. In doing so, they have encountered both success and unexpected challenges; certain partners they have sought out in the community have sometimes proved the lynchpin of their success, while others have proved a source of frustration. In San Antonio, for example, church-based outreach was described as the most successful component of the local outreach campaign, owing to the generous support from the clergy and the strong trust that many immigrants place in their institutions of faith. Outreach workers in Waco, on the other hand, described churches as “difficult places to get into,” and instead found schools to be more open to outreach. Dallas enrollers, on the other hand, noted that the response they received from schools was “very mixed,” with some very willing to take part in the effort and others “too busy” or “not interested.”

The response of families to *TexCare* outreach has also reflected the challenges faced by outreach efforts. Some parents, it appears, need to have a great deal of exposure to the program before they express an interest. In Dallas, for example, three-quarters of the parents approached by an outreach worker in an area with low SCHIP enrollment rates expressed a lack of interest. Mass mailings to parents, as well, tended to elicit a very low response—1 to 3 percent—in both Dallas and San Antonio. Explaining this apparent lack of interest is difficult, but often, it appears to be related to immigration issues, and an educational gap about the nature of health insurance.

Immigration issues are still a dominant barrier in Texas, despite clarification by the Immigration and Naturalization Service (INS) of the fact that an individual does not become a “public charge” by enrolling in SCHIP or Medicaid. Although dropping the requirement that applicants supply social security numbers as part of the SCHIP application was reported to have allayed some fears, all our key informants cited public charge-related concerns as an ongoing barrier to SCHIP. The situation was most talked about in San Antonio, with its large numbers of both documented and undocumented immigrants, where key informants described how difficult it can be to even find, much less gain the trust of, immigrant families. Fears of the INS and deportation were very real for parents, even if their children were citizens or legal residents. According to one local outreach worker, significantly more resources need to be targeted to reaching immigrant families and publicizing the INS clarification.

Parents not fully comprehending the need for health insurance was another reported barrier, most particularly in communities used to accessing health care in emergency rooms, and among parents whose children are rarely ill. In contrast, in the largely Mexican-immigrant population in San Antonio, the understanding gap was more associated with the “strange” notion that every American did not automatically receive free health care.

Overcoming these barriers has proved challenging, but extensive and sustained outreach seems to be making a difference. As one outreach worker in Dallas reported, “...parents need to hear a message seven times before it will sink in. They need to hear about SCHIP on the radio in the morning, then see the “SCHIP lady” in the yellow T-shirt at school, and then be contacted by a CBO, before they’ll actually sit down and fill out an application.” Building trust through personal contact was the other principal factor that seemingly encourages parents to apply for their child(ren).

To avoid the potential for marketing abuses by health plans, HHSC officials decided not to include them in their outreach strategy. Thus, although the plans occasionally fund and produce their own billboards and media advertising, they are essentially prohibited from actively marketing *TexCare*. Expressing envy of the model used in New York State where managed care organizations directly market the *Child Health Plus* program and provide application assistance to potential enrollees, health plan officials we interviewed commented that HHSC is “missing a real opportunity to take advantage of our knowledge of the market place,” and also the opportunity to educate newly insured families regarding how to seek care in a managed care system. State officials maintain, however, that they have strived to balance their desire to involve plans in outreach, while also protecting consumers from marketing excesses that can arise in a highly competitive health plan market.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

During the two-year planning phase of SCHIP in Texas, HHSC spent a great deal of time considering options for a simplified enrollment process.⁵ Observing the successes and failures of other states, they first set out to design a simple, family-friendly application form, a priority supported by the CHIP Coalition. After several drafts, each vetted by focus groups, a form was produced that could be used to determine eligibility for *TexCare*, and, if ineligible, for Medicaid. The form is two pages long and is printed in both English and Spanish. Clear “rights and responsibilities” language accompanies the form’s instructions.

Although the form was designed to be simple, HHSC officials felt it important to be able to provide families with assistance in its completion when needed. Two primary strategies were thus implemented to further facilitate the application process: at the state level, applicants can call the toll-free hotline and receive help from staff at Birch and Davis; at the local level, applicants can receive hands-on assistance in completing the form from any of the 50 community-based outreach contractors, or the staff of their coalition networks, charged with providing application assistance.

Another measure intended to simplify the process was allowing applicants to mail in applications, thus eliminating the need for a face-to-face interview with eligibility staff. Reasoning, too, that creating a “single point of entry” was the most efficient way to handle the expected high volume of applications, review them for eligibility, and triage them between

⁵See Tables 3 and 4 for specific SCHIP and Medicaid eligibility policies.

TABLE 3: SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid ^a
Retroactive eligibility	No	Yes, 90 days from first day of month of application
Presumptive eligibility	No	No
Continuous eligibility	Yes	Yes, 6 months
Asset test	No	Yes
U.S. citizenship requirement	Yes, or qualified alien	Yes, or qualified alien

SOURCE: Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: Texas*. March 2000 website: <http://www.hcfa.gov/init/txeval98.pdf>

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

^a Children's coverage groups.

TABLE 4: APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid ^a
APPLICATION		
Form		
Joint form	Yes	Yes
Length	2 pages, front and back	2 pages, front and back ^b
Languages	2 (English and Spanish)	2 (English and Spanish)
Verification Requirements		
Age	No	Yes
Income	Yes	Yes
Deductions	Yes	Yes
Assets	No	Yes
State residency	No	Yes
Immigration status	Yes	Yes
Social security number	No	Yes
Enrollment Procedures		
Mail-in application	Yes	No
Phone application	Yes	No
Internet application	Yes ^c	No
Hotline	Yes	Yes
Outstationing	No	Yes
Community-based enrollment	Yes	Yes
REDETERMINATION		
Same form as application	No	Yes
Pre-printed form	Yes	No
Mail-in redetermination	Yes	No
Income verification required	No, unless has changed	Yes
Other verification required	Yes, if any changes	Yes

TABLE 4 (continued)

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000; Centers for Medicare and Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: Texas*. March 2000 website: <http://www.hcfa.gov/init/txeval98.pdf>.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

^aChildren's programs. Since changed as a result of simplification legislation.

^bFull length Medicaid application is 8 pages long

^cAs of July 1, 2001.

TexCare and Medicaid according to "screen and enroll" rules, HHSC contracted with Birch and Davis to perform as the single-point-of-entry administrator. Most recently, HHSC has tested and implemented a new online application form, called "EZ-App," which provides interactive assistance for parents as they complete an application form on a computer screen.⁶

For monitoring efficiency, HHSC implemented an application tracking system which assigns a number to every application so that it can be traced through the system, from the point of application to enrollment. This system troubleshoots if, for example, an application is "lost" in the system. In addition, the system permits the state to measure the productivity of every CBO involved with application assistance.

While the SCHIP application was designed to be simple and efficient, applying for Medicaid via the DHS remained burdensome in Texas. Unlike SCHIP, the process required a face-to-face interview between applicants and local social services staff, included an assets test, and required both child support and income documentation from absent parents. With the contrast sharply apparent and the successes of SCHIP as a backdrop, during the 2001 legislative session,

⁶The EZ-App system will not permit parents to actually submit their applications via the Internet. Rather, since a signature is required, parents can complete the form on line, print out a hard copy, and then mail in the signed document.

advocates and other members of the Coalition lobbied hard for Medicaid simplification, with the goal of aligning the policies and procedures of the two programs. In June 2001, a Medicaid simplification bill (SB 43) was signed into law by Governor Perry, achieving many, though not all, of the alignments that advocates sought (described below).

B. ENROLLMENT PROCESS

Simplifying the enrollment process for *TexCare*—built around the simplified form, mail-in process, local-level application assistance, and centralized processing—created the clearest pathway to coverage under SCHIP. However, families may also gain access to the program through more traditional means, namely by applying for Medicaid at a local DHS agency and then being “deemed” SCHIP-eligible (if family income is too high for Title XIX) and having their paperwork referred to the single-point-of-entry contractor. The typical steps a family completes through each of these avenues are delineated below.

Applying for SCHIP via the mail-in application and/or with the help of an application assistor. Utilized by roughly 75 percent of SCHIP enrollees, the mail-in application process proceeds as follows:

- Parents can either obtain an application form by calling Birch and Davis, or contacting their local CBO or DHS office. Alternatively, they may be approached with a form by an outreach worker in a setting such as a hospital or community center. If interested in making an application on behalf of their child(ren), parents can complete the form on their own and mail it in. Alternatively they can receive assistance from any of several sources. At the local level, parents can set up an appointment with an outreach worker either in their home, at the worker’s office, or a neutral site. During the appointment the worker takes the parent through the form, step by step, and identifies the various items that must be submitted to verify information on the application. If a parent has all required documents, the worker mails the form in to Birch and Davis on behalf of the applicant. Otherwise, the parent will take the form away to complete and mail in on their own, equipped with a list of the verification items they need to collect, and may seek further assistance from the outreach worker if necessary. A second option is to receive assistance from Birch and Davis staff over the phone. Parents can call the vendor’s helpline and ask for advice on filling out the form or, as was originally intended, helpline

staff can actually take the application over the phone (with the parent relaying necessary details) and send it to the parent with a request to sign and return it with documentation.

- Once mailed, the application is then processed by Birch and Davis and, using an automated computer system, the child is determined eligible for either *TexCare* or Medicaid.
- If the child is determined eligible for *TexCare*, Birch and Davis send the family an “enrollment packet” containing provider directories, instructions, and forms for selecting a health plan (which is mandatory) and a primary care provider (which is not mandatory). Parents also can complete a child health status screening form which permits them to identify if their child has special health care needs. CBOs, health plans and Birch and Davis are not allowed to assist families with health plan selection; if a parent requires logistical assistance with the enrollment packet, they must direct their request to Birch and Davis. Parents must return enrollment forms to Birch and Davis within 45 days of receipt, and forward the first month’s premium in a separate envelope to the banking facility (Bank One). Upon receipt, Birch and Davis forward the enrollment information to the selected health plan, which then contacts the parents and provides a welcome packet and card for the child and, if necessary, assists with the choice of a PCP.
- If the child *appears* to be eligible for Medicaid, the parent is sent a series of three questions to determine whether their assets exceed those permitted by Medicaid. Specifically, they are asked:
 - In the last six months, have you been denied eligibility for Medicaid because you have excess assets?
 - Do you have two or more cars, trucks, or other vehicles worth more than \$6,650 each?
 - Does anyone in your household have more than \$2,000 in bank accounts, cash on hand, or anywhere else?

If the parent confirms that one or more of these statements is correct, their child is judged ineligible for Medicaid and is placed into *TexCare* (and the enrollment process continues as detailed above). If the parent answers “no” to all three questions, their child is deemed Medicaid eligible and Birch and Davis forward the child’s application to the local DHS office in the family’s local community. This information is sent electronically, within 24 hours, and a hard copy “back up” of the completed application is also sent by Federal Express within three days. If DHS agrees with Birch and Davis’ determination, they contact the parent to arrange a face-to-face interview. If the parent does not respond to this request, the child’s application is voided at the end of the month. In the case that DHS disagrees with the eligibility determination—most likely because of a different interpretation of countable income—the child (and his/her application) is “deemed back” to Birch and Davis for a re-assessment.

Applying via DHS. Under this scenario, the method used by roughly 25 percent of SCHIP enrollees to date, the application process proceeds as follows:

- A parent can either walk into or call a county DHS office and inquire about applying for Medicaid or SCHIP. Conversely, a parent may encounter an outstationed DHS worker at a hospital or federally-qualified health center and discuss the process for applying for coverage. If the parent is interested in applying for *TexCare*, DHS staff will refer them to the Birch and Davis hotline or to an application assistance worker in their community. (Sometimes, these workers are housed in the same sites as DHS staff, most often in the case of a large clinic or hospital setting). If the parent is interested in applying for Medicaid for either their child or their whole family, they will be asked to complete the full Medicaid application form (state regulations prohibit DHS staff from using the *TexCare* application form in the DHS office) during a face-to-face interview with DHS staff. According to state and local DHS staff we interviewed, families are encouraged to apply for all the public assistance programs for which they may be eligible, often including cash assistance and/or Food Stamps. This process requires the families to complete a much longer set of application forms and submit a larger number of documents to comply with documentation rules of these programs. If, at the end of this process, the child is found to be Medicaid eligible they are enrolled. If they are found to be SCHIP eligible, however, their application information is forwarded electronically to Birch and Davis, who then follows up by sending them the enrollment packet (discussed above). Importantly, no further action is required of the family; Birch and Davis accept the eligibility determination decisions of DHS and automatically enroll referred children into *TexCare*.

C. REDETERMINATION PROCESS

Every child enrolled in SCHIP must have their eligibility redetermined every 12 months. Conversely, for Medicaid enrollees, this process must take place every six months. For each program, eligibility redetermination proceeds as described below:

- Under *TexCare*, eligibility redetermination is referred to as “renewal.” In the 10th month of a child’s eligibility period, parents are sent a pre-printed renewal form containing the information submitted with their original application. If the parent chooses to re-enroll their child they must sign and return the form, simply indicating where any information or circumstances have changed over the previous months. If family income has increased, for example, parents must submit new pay stubs and return these, along with the signed form, to Birch and Davis. Families are also required to submit enrollment fees or premiums within the first 2 months of the next coverage period. To encourage parent to renew eligibility, Birch and Davis send both the health plans and outreach contractors a list of children approaching their redetermination date. This list enables health plans

and CBOs to contact parents, discuss the importance of ongoing coverage for their children, and assist them, if needed, with the renewal application. If families do not respond to Birch and Davis' notice, they are sent a second renewal form in the 11th month of their child's coverage, and if the form is not returned within 90 days, the child is considered not to have reapplied.

- The redetermination process for Medicaid takes quite a different form. First, as stated above, eligibility must be redetermined every 6 months. Two months before enrollment expires, parents are sent an appointment letter identifying a date and time when they are to appear at the county DHS office, as well as a blank Medicaid application form. The parent must complete the form and a face-to-face interview at a local DHS office, and resubmit verification of income and any other items that have changed. Parents may reschedule their appointments with DHS if the time provided is inconvenient. However, if the parent does not respond to the request for redetermination, no additional reminders are sent, and coverage for their child is terminated at the end of the eligibility period.

D. EXPERIENCES AND LESSONS LEARNED

The HHSC set itself a target of enrolling 428,000 children by September 2001, 18 months after the start of *TexCare*. At the time of our site visit, 14 months after the program was launched, just over 370,000 children had been enrolled. As detailed in Table 5, by September 2001, the state had enrolled just over 432,000 children, a little over their target.⁷ “A juggernaut” was the term used to describe this dramatic rate of enrollment in Texas—in just over one year, the number of children enrolled in SCHIP totaled nearly 30 percent of the total child enrollment in the Medicaid program,⁸ and SCHIP coverage was estimated to have been extended to nearly one-third of uninsured children in the state.⁹ Now a source of great pride and satisfaction among those involved in its implementation, *TexCare*'s success was widely attributed to effective

⁷As of 09/04/01, current enrollment coupled with children whose applications have been found eligible but are not yet enrolled in a health plan is 525,436

⁸According to the Kaiser Family Foundation, Texas enrolled 1,565,407 children in its Medicaid program in FY 1998.

⁹According to the Kaiser Family Foundation, there were 1,521,880 uninsured children in Texas in 1999.

TABLE 5: ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	Sep 2001 ^a
Number ever enrolled in federal fiscal year (FFY)	-	50,878	130,519	-
Number enrolled at year end (point in time)	34,826	28,490 ^b	200,716	432,745
Percent change in point-in-time enrollment	-	-17% ^b	+644%	+105%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: June 2000*. Kaiser Commission on Medicaid and the Uninsured, January 2001; Vernon K. Smith, *CHIP Program Enrollment: December 2000*. Kaiser Commission on Medicaid and the Uninsured, September 2001; Centers for Medicare & Medicaid Services (CMS), *State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* website: <http://www.hcfa.gov/init/fy99-00.pdf>; Texas Department of Health Services. *Cumulative DHS CHIP Status Report (Updated Weekly): CHIP Enrollment and Referrals*, September 04, 2001. TexCare Partnership website <http://www.hhsc.state.tx.us/chip/DHSrpt.pdf>

^aMost recent enrollment data available.

^bThe decline from 1998 to 1999 is a reflection of the fact that the Medicaid expansion acceleration population under Title XXI (Phase I of SCHIP) is declining under the terms of the mandated expansion.

outreach, a simple application process, efficient and responsive staff and management at the state level, and widespread political, media and community-based support.

The simple application form and availability of assistance at the local level were cited widely as having encouraged families to enroll their children into the program. Notably, documentation requirements are generally viewed as “fair.” Personal contact and support from CBO staff were perceived as critical in ensuring that families completed their applications, though it was reported that there is in fact considerable variation between CBOs in their success in submitting fully completed applications. Indeed, the vendor reported that roughly 35 percent of all the forms they receive are incomplete, largely because the signature is omitted, questions regarding current health insurance coverage are left unanswered, or documentation of income is missing. The commitment of local CBOs to solving problems has, however, resulted in sustained improvement. In addition, the data tracking systems put in place by the HHSC can

identify CBOs that are responsible for a disproportionate share of incomplete forms and permit corrective action to be taken. Another tool that is helping to improve the rate of “complete” applications is the EZ-App, rolled out in July 2001, which allows applicants to complete the form online and provides assistance at every step. The system is designed such that applicants cannot proceed to the next screen on the form until each question is answered correctly and completely.

Perceptions of the efficiency of Birch and Davis vary. Although the single point of entry system they manage appears to be operating relatively well now, there were a few months early on during which it was reported that they were unable to handle the application volume. Even at the time of the site visit, a far lower proportion of forms was filled out by phone operators than was originally envisioned, due in part to hotline staff having insufficient time. (Insufficient time on behalf of applicants was also cited as contributing to the low proportion of applications completed by phone.)

The “screen and enroll” procedures implemented by Birch and Davis have, in one sense, been very successful. Sharing information and “images” of applications electronically with local DHS offices has proven an effective way to quickly refer children from *TexCare* to Medicaid. However, the large differences between SCHIP and Medicaid eligibility rules has severely undermined the ability of the system to smoothly refer children from one program to the other. We learned, for example, that about 12 percent of the children referred by Birch and Davis to DHS are “deemed back” to the vendor due to alternative interpretations of household composition or family income. Not surprisingly, this outcome was described as “very frustrating and confusing” for families.

A second problem with “screen and enroll” grows from apparently high number of children whose parents do not follow up on their referrals to Medicaid—HHSC data indicate that 59

percent of referrals are denied Medicaid eligibility for procedural reasons, such as failing to make their appointment or failing to provide necessary information and documentation.¹⁰ In all, less than 25 percent of those children referred to DHS enroll in Medicaid. The problem of “Medicaid stigma” was described as “huge” and “deeply entrenched,” and we heard reports of families feeling “intimidated by local DHS offices,” and of being “treated rudely” and subjected to “long wait times.” According to community-based enrollers, these factors often result in families simply refusing to apply for Medicaid.

The dramatic disconnects between SCHIP and Medicaid eligibility rules, coupled with the apparent adverse effects of consumer stigma, helped build support for the passage of a far-reaching Medicaid simplification bill. Proposed by a Democratic Senator and backed by the CHIP Coalition, the bill passed in June 2001 and applied to Medicaid many of the same policies that appeared to have made *TexCare* enrollment such a success, including a simpler application form, eliminating the requirement for a face-to-face with DHS staff at initial enrollment, reduced income verification requirements, continuous eligibility extended from six to 12 months, and no face-to-face interview at redetermination (on the condition that the child is up-to-date with his/her immunization and well-child schedules). The original bill had also called for an elimination of the assets test; this measure was not passed, however families will be permitted to self declare their assets information. Interestingly, support for elimination of the assets test waned when it became known that fully one-third of the children who have been enrolled in *TexCare* were found eligible for Medicaid on the basis of their income, yet were denied

¹⁰1% are denied because they are ineligible for income, and yet not eligible for SCHIP, 12% are deemed back to SCHIP and 4% are already enrolled in Medicaid. Figures as of September 4, 2001. Texas Department of Health Services. Cumulative DHS CHIP Status Report (Updated Weekly): CHIP Enrollment and Referrals, September 5, 2001.

eligibility for the program due to excess assets. Therefore, eliminating the assets test would have required Texas to face the task of transferring potentially tens of thousands of children from *TexCare* to Medicaid, a step that surely would have met severe resistance from families. From a fiscal standpoint, legislators also did not relish the prospect of losing the enhanced federal matching dollars for these children if their coverage was switched to Medicaid. Therefore, even child advocates admit some comfort with the fact that the assets test was not eliminated, for it permitted children to remain in the preferred SCHIP program.

Assets test issues notwithstanding, key informants were grateful for and “excited” by the prospect of Medicaid simplification, and stunned by the support that was lodged for the \$123 million bill. Passage of the bill promises to eliminate many of the procedures that helped engender families’ negative opinions of the program, and implementation is seen as a big step toward reinventing Medicaid and, hopefully, achieving much better rates of enrollment within the program. As one advocate put it, “Things will be better both for us and our clients.”

Retention in Texas is not currently perceived as problematic, although state officials had had minimal experience with the process at the time of our interviews, which occurred only shortly after the first anniversary of the program, and admitted that the program was too young to reach any firm conclusions. Initial renewal figures are encouraging, however: state officials report that 85 percent of children were reported to have completed the renewal process and, of these, only 11 percent were being found ineligible (most often because children have “aged out” of the program, been found to have incomes in the Medicaid-eligible range, or have obtained private insurance). According to community-based enrollers, the pre-printed renewal application, coupled with the mail-in process, is simple and, so far, popular with families.

V. CROWD OUT

A. POLICY DEVELOPMENT

The prospect that SCHIP might stimulate “crowd out,” or the substitution of public for private coverage, was a prominent concern during the design phase of the *TexCare* Partnership for Children. The complex and nuanced debate involved fiscal conservatives, free-market/minimal-government advocates, moderates, and liberals, with opposing forces not drawn cleanly along party lines. In simple terms, conservatives argued that the potential for substitution would increase the higher the state moved its upper income eligibility threshold, and this rationale was used, in part, to defend the Governor’s proposal that Texas’ SCHIP income threshold should be at 150 percent of poverty. Liberals, on the other hand, felt strongly that the state’s income level should be higher—200 percent—but recognized that agreeing to a waiting period to deter crowd out might be a reasonable trade-off. In the end, a deal was struck—Texas expanded eligibility to 200 percent of poverty and a 3-month waiting period was imposed.

In fact, most participants in the SCHIP development process, including many of the informants we spoke with who were members of the CHIP Coalition, did not believe that much potential for crowd out existed in Texas. Texans have lower rates of employer-sponsored health insurance coverage than average Americans. Only 57.6 percent of children in Texas have employer-sponsored coverage, compared to 66.7 percent of children in the United States.¹¹ Among adults, the same disparity exists, with only 65.1 percent of adults having employer-

¹¹Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children," *Snapshots of America’s Families II: A View of the Nation and 13 States from the National Survey of America’s Families*. Washington, D.C.: Urban Institute.

sponsored coverage in Texas compared to 72.3 percent in the United States.¹² What coverage does exist among lower-income working families was described as often being very expensive and/or limited in scope. Realizing this, Texas incorporated numerous “exceptions” to the 3-month waiting period, which are discussed in more detail below.

B. POLICIES AND PROGRAM CHARACTERISTICS

The primary strategy employed by Texas to deter crowd out under SCHIP is a 3-month waiting period during which children must be uninsured prior to enrolling in the program. To determine insurance status at the time of application and to explore whether a child qualifies for any of the available exceptions to the waiting period, the *TexCare* application first asks: *Does (the) child currently have health insurance or Medicaid?* Following this, the form inquires whether the child may have had, but dropped, health insurance in the previous 90 days and permits parents to indicate one or more reasons why this insurance was dropped, including: parent’s job ended; loss of Medicaid eligibility; change in parents’ marital status; and parent’s COBRA coverage ended. Anyone indicating that insurance was ended for any of these reasons is excused from the waiting period, based on the rationale that termination of coverage was not an active choice, but rather a result of a circumstances beyond the applicant’s control. (Such “no fault” exceptions are very common among SCHIP programs nationally.¹³)

What is less commonly seen among states, however, is Texas’ policy to exempt from the waiting period insured children whose parents are judged to be paying *too much* for existing

¹²Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults," *Snapshots of America’s Families II: A View of the Nation and 13 States from the National Survey of America’s Families*. Washington, D.C.: Urban Institute.

¹³A. Westpfahl Lutzky and Ian Hill, 2001. *Has the Jury Reached a Verdict? States’ Early Experiences with Crowd Out Under SCHIP*. Washington, DC: The Urban Institute, June 2001.

health coverage. Specifically, Texas included an exception for insured children whose parents are paying premiums and other cost sharing amounting to more than ten percent of total family income. According to HHSC officials, this policy was designed to address one of the problems of “underinsurance,”¹⁴ and the inequitable circumstance that can arise when a family purchased expensive insurance for their child prior to SCHIP, only to find themselves excluded from the broader and less expensive SCHIP program after the program was created.

C. EXPERIENCES AND LESSONS LEARNED

Most informants interviewed for this study expressed the belief that consumer-based crowd out was not occurring under *TexCare*. For example, community-based enrollers in Dallas estimated that only “1 in 30 applicants” have any form of insurance when they apply, while those in Waco reported that, at most, this figure was “1 in 10.” Furthermore, community-based enrollment staff in all the communities we visited consistently reported that they actively discouraged families with insured children from dropping that coverage in order to sign up for SCHIP, citing the potential risk that families might lose all coverage for their children if they did not qualify for SCHIP. State data appear to confirm that low-levels of potential for crowd out exist—a survey of new enrollees conducted during the early stage of program implementation found that only about 4 percent of applications were denied because children already possessed insurance. Still, some providers and health plan representatives feared that more consumer-based crowd out was occurring than appeared on the surface, either due to families dropping their children’s coverage or lying about that coverage on the application form.

¹⁴Underinsurance is commonly used to describe the situation when one’s current coverage is either very expensive or limited in scope.

On the employer side, too, we heard little concern that employers were changing their behavior in the aftermath of SCHIP's passage by either dropping or reducing their contributions to dependent coverage. However one informant described having heard of employers in the Rio Grande Valley who were no longer offering dependent coverage and/or were "encouraging" their employees to seek coverage for their children under SCHIP.

Of notable interest, "literally thousands" of families were reported to be qualifying for coverage under the "10 percent of income" exemption because, as one advocate put it, "some parents are paying through the nose for very limited private coverage." Moreover, most informants with whom we spoke felt that the exemption was "equitable and fair" and were not overly concerned that letting these particular families drop their children's coverage to enroll in SCHIP might be construed as crowd out. The only contrary opinions were expressed by health plan administrators who saw the exemption as "too liberal" and contributing to serious adverse selection. State policymakers admitted that it was, indeed, possible that parents who were motivated to purchase insurance for their children prior to SCHIP may be more likely to be those whose children had obvious needs for care.

VI. BENEFITS COVERAGE

A. POLICY DEVELOPMENT

In 1997, just two years prior to the creation of *TexCare*, Texas implemented the Texas Healthy Kids program, administered under the auspices of the newly-created Texas Healthy Kids Corporation (THKC). Modeled after the Florida “Healthy Kids” program, it was designed as a “public/private partnership,” pooling funds to support health insurance coverage for children living below 185 percent of poverty. The THKC, a private, not-for-profit entity, set out to raise private and philanthropic donations to subsidize enrollee premiums, and received temporary state funds to help cover administrative costs during start up. Importantly, the program covered only preventative and primary care, and was still relatively small—15,000 enrollees—at the time federal SCHIP legislation was passed.

The fact that the THKC, with its limited benefits, was in place significantly affected the deliberations that surrounded the development of the *TexCare* benefit package. Specifically, as it became clear that the state would pursue a separate program under Title XXI, the possibility emerged that the program might cover benefits that were significantly less broad than Medicaid’s. But from the start, the state’s interagency task force and the CHIP Coalition were committed to pushing for coverage that would go well beyond ambulatory care and products typically offered by commercial insurance. Within the CHIP Coalition, a “Benefits Group” was formed and charged with developing proposals for the new program. In this group were several individuals representing Medicaid, public health and the Title V/Children with Special Health Care Needs program, pediatricians, advocates, and representatives of prominent Children’s

Hospitals across the state. Not surprisingly, therefore, the proposal they developed encompassed comprehensive benefits tailored to meet the full range of needs of children.

B. POLICIES AND PROGRAM CHARACTERISTICS

TexCare does not offer children the same open-ended protection that is offered by the Medicaid program—it includes no EPSDT-like language guarantees that enrolled children will be covered for any service that is deemed medically necessary. However, the benefits covered by the program are broad and compare well with those of Medicaid.

Texas selected its State Employees Health Benefit Package as its benchmark, a package which also happened to be that offered by the HMO with the largest enrollment in the state. With that as a starting point, the Benefits Group began reviewing the benchmark and identifying gaps and/or areas where the package was not ideally designed to meet children's needs; resulting from this process, mental health, substance abuse, and rehabilitative therapy services were all strengthened. The package that was finally adopted covered the same array of services as Medicaid, with the following exceptions:

- Restorative dental services were limited to an annual cap of \$300 per child;
- Family planning and contraceptive services were omitted; and
- Medicaid EPSDT protections were not included.

In addition, certain services such as durable medical equipment and prescription drugs¹⁵ had placed on them upper limits that are more stringent than Medicaid's. State officials pointed out that coverage of some benefits is actually richer under SCHIP, when compared to Medicaid. For

¹⁵As of March 1, 2002, *TexCare* benefits will be expanded to cover the equivalent of the Medicaid open drug formulary package.

example, the program permits more flexible coverage of mental health and substance abuse treatment services, allowing enrollees to substitute inpatient for outpatient covered days (or vice versa) when upper limits are reached.

C. EXPERIENCES AND LESSONS LEARNED

We found almost universal agreement among the informants we interviewed, including child advocates, that the *TexCare* benefit package was quite generous and appeared to be meeting the needs of the vast majority of enrollees. Few informants reported hearing of serious gaps in coverage, or witnessing situations where children needed services that were not covered. This was true even for children with special health care needs, and attributed by one informant to “...advocates for CSHCN who worked so hard to ensure that the package was broad.” This individual also observed that, “with the Title V program available as a back-up, it seems these children are well covered.”

Local enrollment staff cited *TexCare*'s coverage of dental services and prescription drugs as “real selling points” of the program. Nevertheless, it was against these two services that complaints were most commonly lodged. The \$300 annual limit on restorative dental services was identified by several key informants as a weakness; “...these children are coming in with years of dental neglect...\$300 only begins to address the significant needs they present.” Less frequently, we heard that the formulary of covered drugs under *TexCare* is “too limited.” Key informants did not report hearing of problems related to the program's lack of coverage of family planning and contraceptive services; one provider in Dallas thought this was because “Planned Parenthood has done a good job taking up the slack.”

State officials and other key informants were quick to point out that *TexCare*'s coverage easily surpassed that of private insurance products commonly offered in the state. Specifically,

they identified its broader and more flexible coverage of behavioral health services (and, for example, the fact that enrollees don't need a referral from a primary care physician to seek mental health care); more liberal limits on most ambulatory and acute services; coverage of vision, dental and hearing services; and coverage of physical, speech, and occupational therapy without limits. Finally, these individuals also pointed out that *TexCare's* cost sharing requirements are dramatically lower than those commonly used in private insurance.

Once again, however, health plan officials had the most negative things to say. In reference to *TexCare's* benefits policies, they reported "...the program is, if anything, *too* generous and is contributing to serious adverse selection." The fact that complaints over the benefit package have been so few and far between actually made some advocates nervous. These individuals were not confident that *TexCare's* systems were well set up to deal with complaints and grievances. They worried that consumers might not be aware of their rights or the avenues through which they could voice concerns. Overall, however, advocates were optimistic that the package was working quite well for Texas' children, and were much more concerned about whether delivery systems were affording children good access to covered benefits, an issue that is discussed in the next section.

VII. SERVICE DELIVERY

A. POLICY DEVELOPMENT

The original goal of state officials for *TexCare* was to design a mandatory managed care-based service delivery system. Knowing that HMO coverage would not be feasible in rural areas (in part due to resistance among providers to managed care), the state issued a Request for Proposals for HMOs to serve children in designated urban districts. In response, 12 health plans submitted proposals and received approval as *TexCare* carriers; of these, six were already participating in Medicaid managed care. The provider networks extended by the approved health plans were quite similar to those offered by Medicaid and included most, if not all, of the traditional safety net providers that serve Medicaid recipients.

To design a model for the state's rural areas, HHSC officials sought the input of various provider and insurance communities and issued a separate RFP for service delivery in non-urban areas. No viable proposal was received, however, so the state developed an "Exclusive Provider Organization," comprising a recruited network of primary and specialty care physicians, under contract with the state to serve *TexCare* enrollees on a fee-for-service basis, with claims processing and network support contracted through a healthcare administrator.

Developing a managed care model for dental coverage proved a challenge for the state, again largely because of resistance by dentists. As a result, a fee-for-service indemnity model was implemented for dental services.

Reasoning that utilization, and thus costs, for SCHIP enrollees would mimic those of the Medicaid population, and without any other data on which to base rates, HHSC officials decided to closely pattern its payment structure for *TexCare* after that of Medicaid. At the time of our

visit, health plans and providers were finding these payments inadequate, a situation apparently exacerbated by a high rate of enrollment and unexpectedly high per child utilization. As a result, *TexCare* had begun to experience provider capacity problems and enrollees in certain parts of the state reportedly were having trouble accessing care. Negotiations to deal with this issue, including raising payments, were in process at the time of our site visit.¹⁶

B. POLICY AND PROGRAM CHARACTERISTICS

1. Service Delivery Arrangements

From the outset there was little interest among health plans in *TexCare*. Commercial plans were put off by the prospect of low rates and a benefits package more akin to Medicaid than private insurance, a product in which they were unwilling to participate. Furthermore, managed care plans were unwilling to operate in the rural areas of Texas owing to widespread provider resistance to managed care in these areas. As a result, just 12 HMOs bid on and were approved to render care in SCHIP. Of note, 8 of these health plans are organized around university-based children's hospitals, and 3 around large urban hospital districts, and thus rely heavily on community safety-net providers with a history of indigent care provision. The vast majority of participating plans, therefore, had a natural incentive to serve the SCHIP population, since *TexCare* paid for children that they had previously served *gratis*.

The EPO that was developed for the rest of the state was patterned after a Primary Care Case Management (PCCM) model, comprising a recruited, identifiable network of providers. In all, 4,800 primary care and specialty physicians were signed up in the network. However, EPO physicians are not paid a case management fee because, according to the HHSC, the administrative costs associated with paying such a fee would have counted against the federal 10

¹⁶Since our visit, the HHSC negotiated a rate increase of, for the average plan, 19.7 percent.

percent cap on such expenditures under SCHIP. The EPO contractor is the Clarendon Insurance group, which subcontracts management responsibilities to USA Managed Care Organization (USA-MCO).

Under the current arrangement, the EPO operates in 170 rural counties containing 31 percent of the Texas population, and roughly 30 percent of SCHIP enrollees. Conversely, risk-bearing HMOs operate in the remaining 84 counties, which encompass the urban centers of Dallas, Austin, and San Antonio in the central portion of the state, Houston in the east, El Paso in the southwest, and Lubbock and Amarillo in the northwest region. These plans serve roughly 70 percent of *TexCare* enrollees. At most, no more than three HMOs operate in any given county. Therefore, the environment was described by the Texas Association of Health Plans as similar to the health plan market in general in Texas: minimally competitive, with enrollees' choice somewhat limited.

Under Medicaid, Texas has implemented service delivery arrangements that rely less upon managed care. Just 50 counties, mostly a subset of the "HMO counties" under *TexCare*, are covered by 12 managed care plans and a PCCM model. Enrollment in managed care is not mandatory, so parents have the option of obtaining care for their children through the traditional fee-for-service system. The remaining 204 counties offer only fee-for-service to Medicaid enrollees. Although only six of the 12 HMOs that participate in Medicaid also participate in *TexCare*, the provider networks offered by the two programs are quite similar because providers that traditionally serve Medicaid clients also tended to sign up to participate in *TexCare*. This similarity arises from the fact that the SCHIP statute in Texas requires plans to offer contracts to providers defined by the state as "significant traditional providers," a definition HHSC adopted based on provider participation in the Medicaid and THKC programs.

The scope of services that are within the responsibility of SCHIP plans differs somewhat from Medicaid. Most prominently, children with special health care needs (CSHCN) enrolled in SCHIP are required to enroll in the managed care health plans in *TexCare*, whereas children who are eligible for Medicaid by virtue of their SSI eligibility are not required to enroll in managed care but receive their care on a fee-for-service basis. *TexCare* health plans also have responsibility for delivering behavioral health services and administering the program's pharmacy benefits. In contrast, prescription drugs and behavioral health are “carved out” of the contracts of plans participating in Medicaid managed care.

2. Payment Arrangements

What is notable about payment rates in *TexCare* and Medicaid are their similarity. For health plans, capitation rate structures are somewhat different—SCHIP pays based on 5 different rate cells, while Medicaid rates fall into 7 cells—however average per capita payments were almost identical at the time of our visit, given that they were based on the same historical cost experience. Therefore, according to the health plan administrators we spoke with, health plans typically pay network physicians according to the Medicaid fee schedule (although they sometimes pay more). With regard to fee-for-service, the EPO employs the same fee schedule as used by Medicaid. So, whether participating in a health plan network or the EPO, providers are usually paid the same rates under *TexCare* as they are under Medicaid.

Although the payment rates are similar, the populations covered by the capitations paid to health plans differ between SCHIP and Medicaid—SSI-eligible children are exempt from mandatory Medicaid managed care, however no similar exemption for children with chronic illnesses and disabilities exists for SCHIP. This circumstance has created tensions between HHSC and health plans, with health plan administrators claiming that the Medicaid-based

capitation rates used under *TexCare* do not reflect the cost of serving children with special health care needs, and HHSC officials stating that they accounted for the SSI-related risk group when building SCHIP rates.

During the first year of the program, *TexCare* rates were held constant. At the time of our site visit, however, additional monies had just been earmarked by the legislature to increase rates and fees for both Medicaid and SCHIP. For Medicaid, \$197 million was allocated to increase provider rates between 2001-2003, with \$50 million of that directed toward increased professional services fees for “high volume” providers and EPSDT screenings, \$35 million for “high volume” outpatient hospital fees, and \$35 million for Medicaid managed care plans.¹⁷ For *TexCare*, however, neither the amount earmarked for fee increases nor the manner in which these funds would be dispersed had been decided.¹⁸

C. EXPERIENCES AND LESSONS LEARNED

Depending on both the informant interviewed and the community visited, perceptions of access to care under *TexCare* varied considerably. Quoting their study showing that every enrolled child has access to a provider within 30 miles of their home, HHSC reported that access to care by-and-large met contractual standards. Key informants in the four urban areas we visited agreed—access was typically characterized as “great,” although there were concerns about a shortage of pediatric sub-specialists. Three of the urban areas we visited—Austin, Dallas and San Antonio—are served by capitated health plans which have networks that were described as “broad and deep,” and it was reported that physicians in these plans’ networks were, for the

¹⁷There is no fixed percentage increase to all providers. The changes will not align Medicaid with commercial or Medicare rates.

¹⁸Once again, since our visit, HHSC has negotiated a rate increase with the plans which average 19.7 percent, based on the recognition that initial rates were artificially low.

most part, accepting new patients. Similarly, statewide, HHSC data indicate that roughly 80 percent of physicians participating in either health plans or the EPO are accepting new *TexCare* patients. Informants in Waco, which is served by the EPO, also described the access picture favorably. Under Medicaid managed care, which also is most prevalent in urban areas, informants reported that access to care mirrored that of SCHIP.

Relative to urban areas we visited, rural and border areas were described as having very poor access for both *TexCare* and Medicaid enrollees, suggesting that the problem transcends service delivery model differences—SCHIP relies on its EPO in these regions while Medicaid uses fee-for-service arrangements—and is a function of the population and economic dynamics of those areas of the state. In the areas cited to have access problems, there appeared to be both absolute shortages of doctors, as well as shortages of doctors willing to accept any or new *TexCare* and/or Medicaid patients. These shortages are exacerbated by the programs' reportedly "lousy rates," which pose a barrier to further recruitment and limit the capacity of currently participating providers from accepting additional *TexCare* and Medicaid patients. Doctors we spoke with said that, because of the fee similarities, they considered *TexCare* and Medicaid to be "the same program." Consequently, there was considerable concern among many informants that low fees would drag down and stigmatize the new program among providers just as had occurred with Medicaid.

Though current access problems were described as primarily occurring in rural and border areas, several key informants warned of an "impending access crisis" statewide. Provider associations, in particular, were adamant in describing poor access as the "Achilles heel of SCHIP and Medicaid." The perceived "crisis" was described as starting with the low rates paid to plans and providers. However, the problem was also seen as exacerbated by the huge surge in enrollment that has occurred under *TexCare* and the very real stresses that high enrollment rates

have placed on system capacity. Some informants believed that insufficient system capacity was resulting in families being forced to seek care in hospital emergency rooms; indeed, hospital officials we met with reported that ER use rates were as high as ever. However, HHSC officials refute this claim based on their survey of new enrollees carried out in fall 2000, which showed a 50 percent shift in use from ERs to physician offices.

Furthermore, it appears that utilization rates among *TexCare* children are higher than among Medicaid recipients, resulting in greater pressure on risk-bearing managed care plans. For example, state data indicate that 77 percent of children use at least one service during their first three months of coverage under *TexCare*, a rate reportedly much higher than typically seen under Medicaid. “Pent up demand” was given by HHSC officials as the reason for high use rates; “...these children appear to be sicker than we thought they would be.” Although utilization, per child, appears to level off and decrease with continued months of coverage, every month’s cohort of new enrollees has been large enough to include children with significant levels of initial need for services, as evidenced by high initial utilization, a fact that has surprised HHSC officials.

Though the HHSC perceives that health plans are coping well with the onslaught of both high enrollment and utilization, the health plans claimed that the situation was “killing them” financially. Claiming that they are losing at least \$1 million per month, the plans state that they are “heading for disaster.” Indeed, in September 2001, the Houston-based Texas Children’s Health Plan threatened to pull out of SCHIP, citing \$9.7 million in losses to date.¹⁹ The plans primarily attribute their financial losses to their obligation to treat children with special health care needs and those with behavioral health problems, and believe that the Medicaid-based rates

¹⁹BNA’s Health Care Policy Report, Vol. 9, No. 35, 9/10/01; Action was taken and Texas Children’s Health Plan did not pull out.

they are paid do not account for the higher cost of serving these children (once again, a belief disputed by HHSC officials). To solve the problem, health plan officials expressed a desire to see one or more reforms quickly made to the system, such as rate increases to better reflect the case mix of *TexCare* enrollees, or the creation of a supplemental payment structure to compensate plans when they enroll a child with special health care needs. In addition, plans suggested that Texas switch to a single open enrollment period per year, rather than ongoing open enrollment, to help curtail adverse selection.

Texas Medical Association representatives believe that the situation may worsen after implementation of Medicaid simplification and resulting expected increases in Medicaid enrollment. The fear is that physicians will decide that they can no longer afford to have *TexCare* and Medicaid enrollees make up increasing proportions of their patient caseloads. Such a problem came to a head in El Paso County, which has the highest proportion of children enrolled in *TexCare*, during the spring of 2001. It was reported that 20 of 26 pediatricians recently stopped treating SCHIP enrollees, citing an inability to make up for the program's "inadequate" rates with sufficient volume of commercially insured patients.²⁰

To the key informants who told us they were concerned about these issues, the only sustainable solution to the access problem is a substantial fee increase; the Texas Medical Association claimed that bringing rates up to levels comparable to those of Medicare would be the only way to recruit new physicians.²¹ Monies recently earmarked for SCHIP and Medicaid fee increases were perceived as insufficient, and described as a "finger in the dam." Although

²⁰ Lopez, Dallas Morning News, 7/9/01.

²¹According to the Texas Medical Association, increasing Medicaid fees (not including SCHIP) to Medicare rates for professional services would cost an estimated \$285 million over the biennium (in addition to the \$197 million already allocated).

the state is currently considering further increases, particularly in order to create incentives for the providers in the border areas to continue their participation, not one of our informants was optimistic that there would be substantial changes in the near future. Health plan officials even thought Medicaid fee increases, in the absence of SCHIP increases, could work against them, stating "...physicians will see that they're getting paid more under Medicaid, and then expect us to match those rates for children served under *TexCare*." Governor Perry has acknowledged the need to rectify payment problems before new populations are added to the program, and HHSC officials have indicated that they will soon renegotiate rates with the health plans to arrive at more fair, actuarially based rates.²²

²²Once again, since our visit, the HHSC has negotiated a rate increase with health plans averaging 19.7 percent. The new rates are based on actual health plan experience and are actuarially sound.

VIII. COST SHARING

A. POLICY DEVELOPMENT

Whether or not to include cost sharing in *TexCare* was not a controversial question during the program’s development. There was virtually (or near) consensus among designers that cost sharing should be a feature of the program, that this was appropriate given the belief that SCHIP should serve as a “bridge” between public and private coverage, and that it would help distance the program from Medicaid and welfare. Furthermore, philosophically, cost sharing was seen as a device for promoting personal responsibility and a way to instill “pride of ownership” among parents who purchased insurance for their children. Finally, cost sharing was viewed as a design feature that would help garner political support for the expansion.

Using federal program rules as a guide, the CHIP Coalition and HHSC set out to design cost-sharing provisions that would take maximum advantage of the flexibility offered. As such, and with the goal of making the program “as much like private insurance as possible,” the state adopted policies that included income-adjusted premiums and copayments, an annual enrollment fee (for the lowest income families), and deductibles (for the highest income families).

B. POLICIES AND PROGRAM CHARACTERISTICS

As detailed in Table 6, Texas does not fully subsidize coverage for any of its *TexCare* enrollees.²³ Rather, for the lowest income families earning incomes between 100 and 150 percent of poverty, an annual fee of \$15 per family is levied. (State officials explicitly chose an

²³As described in Section I, as of October 2002, the federally-mandated phase-in of poverty-level coverage for children under age 19 born after September 30, 1983, will be complete. Thus Texas’ initial Title XXI Medicaid expansion—for children ages 15 to 19 living in families with income below 100 percent of poverty—will be subsumed within Title XIX.

TABLE 6: COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	Yes
100-150% FPL	\$15 annually per family
>150% FPL	None
Premiums by family income	Yes
< 150% FPL	None
151-185% FPL	\$15 monthly per family
186-200% FPL	\$18 monthly per family
Consequences for non-payment of premiums	Yes
Disenrollment	Yes, after 30-day grace period Yes, 90 days. During this period the family must pay any delinquent premiums from prior enrollment as a condition for re-entry into the program.
Black-out period	
Copayments	Yes
>150% FPL	\$2 per office visit; \$5 per emergency room visit; \$1-\$2 for prescription; annual copayment cap of \$100 per family
151-185% FPL	\$5 per office visit; \$25 per emergency room visit; \$5 for generic prescriptions, \$10 for brand-name prescriptions
186-200% FPL	\$10 per office visit; \$35 per emergency room visit; \$5 for generic prescriptions, \$10 for brand-name prescriptions
Deductibles	
186-200% FPL	\$10 per office visit; \$35 per emergency room visit; \$5 for generic prescriptions, \$10 for brand-name prescriptions

SOURCE: National Governor’s Association. State Children’s Health Insurance program Plan Summaries. Texas S-CHIP Plan Summary. website: <http://www.nga.org/cda/files/TXSCHIP.pdf>

NOTE: SCHIP=State Children’s Health Insurance Program (Title XXI). FPL = Federal Poverty Level.

annual fee for this group, rather than a monthly premium, to keep things simple for more vulnerable families.) For families with incomes between 150 and 200 percent of poverty, two levels of monthly premiums are imposed: \$15 per family for those with incomes between 151 and 185 percent of poverty; and \$18 per family per month for those with incomes between 186 and 200 percent of poverty.

Copayments, as well, are imposed on all *TexCare* groups. For families with incomes below 150 percent of poverty, copayments of \$2 for office visits, \$1 or \$2 for prescription drugs, and \$5 for emergency room visits are required. Copayment amounts increase slightly for higher income families. Specifically, for those with incomes between 151 and 185 percent of poverty,

copayments are \$5 for office visits; \$5 for generic prescription drugs and \$10 for name-brand drugs; and \$25 for ER visits. Finally, for families in the higher income bracket (186 to 200 percent of poverty), copayments are \$10 for office visits; \$5 for generic and \$10 for name-brand drugs; and \$35 for ER visits.

Of particular note, Texas is the only state in the nation to include a deductible among its cost-sharing policies. Specifically, for families with incomes in the highest bracket (186 to 200 percent of poverty), the state imposes a \$200 annual family deductible for inpatient hospital services and a \$50 annual deductible for outpatient hospital services.

As part of the *TexCare* application process, families are required to submit their first annual fee or monthly premium; payment is required as a condition of completing enrollment in a health plan. Following this payment, the state's vendor—Birch and Davis—invoices families in the premium-paying groups on a monthly basis and accepts payments in the form of either a check or money order. Families are permitted to pay premiums in lump sums covering either 6 or 12 month periods, but no discount is offered in return for doing so, so very few families follow this course. If a family falls behind in paying its premium(s), Birch and Davis sends out reminder notices during a two-month “grace period” (thus families have 90 days to pay any given month's premium). If a family fails to pay by the end of this period, however, the child is disenrolled and prohibited from reenrolling for a three-month “black out” period.

Collection of copayments is the responsibility of participating providers. From our interviews with health plans, we learned that MCOs typically do not reduce their fees to providers by the copayment amounts, thus providers have the financial incentive to collect these

user fees which constitute a bonus, of sorts, on top of normal fees.²⁴ Finally, families are responsible for tracking their total out-of-pocket costs under *TexCare*, collecting receipts via the “shoebox method.” Families with incomes below 150 percent of poverty are exempt from premiums and copayments once they have paid \$100 in any given year, while higher income families are protected by SCHIP’s statutory ceiling of 5 percent of total income.

C. EXPERIENCES AND LESSONS LEARNED

Texas officials report that 75 percent of enrollees to date are in the “annual fee” group, having incomes below 150 percent of poverty. Among the 25 percent of enrollees falling in the premium-paying groups, just over three-quarters pay \$15 per month (ie, by earning incomes between 151 and 185 percent of poverty) and just fewer than one-quarter pay \$18 per month (i.e. by earning incomes between 186 and 200 percent).

After more than a year of experience, key informants we spoke with almost universally reported the impression that cost sharing was not causing problems for enrollees. No informants expressed any sense that the premiums and the enrollment fee was deterring enrollment. Rather, families were reported to view the prices as “the deal of the century,” “too good to be true,” or “extremely affordable.” Furthermore, local organizations and providers believed that families felt a certain pride contributing to the cost of their children’s coverage. We even heard the opinion expressed that premiums were “empowering” families; that is, since families were paying for this coverage, they felt freer to ask questions or felt they had more right to complain if some aspect of the program was unsatisfactory. HHSC officials are gratified by these responses:

²⁴The EPO reportedly intended to reduce its fees by the copayment amounts, but strong provider resistance persuaded the network administrator to back away from this policy.

“I think that if we had made this program free, families would have probably been more skeptical of it, or dismissed it as welfare.”

State data appear to bolster the finding that premiums are not causing families hardship. Birch and Davis reports that the application completion rate for families in premium-paying groups are the equivalent of those in the annual fee group. Similarly, rates of disenrollment are no higher among premium payers, and only 1.5 percent of these families are being disenrolled for nonpayment of premiums. To make premium payment easier in the future, HHSC is working with its vendor on the design of the “EzPay” system, through which families will be able to elect to have their premiums automatically deducted from their checking accounts. (Movement in this direction was spurred by requests from approximately 1,000 families who expressed interest in having more automatic methods for paying premiums.)

Local providers, advocates, and community-based organizations had no sense that copayments were affecting utilization, either. (As discussed in the previous section, utilization is high amongst SCHIP enrollees.) In fact, health plan administrators consider cost sharing to be “too low,” and ineffective at encouraging more appropriate use of the ER and brand-name prescription drugs. For Medicaid, health plans blamed the lack of a copay for an “astonishing abuse of ER.” We heard mixed reports on how, or whether, families were being affected by the hospital deductible. One local hospital official reported her impression that hospitals might be waiving the deductible—“...most of our hospitals have a tradition of providing charity care, so may not be comfortable imposing a deductible.”

State officials plan to closely monitor the potential negative effects of cost sharing in the future. Planned activities include both ongoing tracking of disenrollment rates for nonpayment of premiums and surveys of families who drop out of the program to explore whether cost issues factor into decisions to disenroll.

IX. FAMILY COVERAGE AND PREMIUM ASSISTANCE PROGRAMS

To begin with, state policymakers have focused their time and energies on the design and early implementation of the still relatively new *TexCare* program. Of note, this scope of interest was later broadened to include an intense debate over the merits of Medicaid simplification and the need to better align the enrollment policies of the two programs (as was discussed in Section IV). However, little, if any, attention has been paid to considering or requesting Section 1115 waivers for Title XXI. For example, there has been almost no discussion among legislators or SCHIP administrators of expanding coverage to include the parents of SCHIP enrollees. In fact, it was broadly felt among the key informants we spoke with that there was very little political support for a “family coverage waiver” at this time. One bill was introduced during the 2001 session that included funding for a family “buy in” demonstration project in one county, but this was vetoed by the Governor. Advocates and children’s hospital officials reported they were hesitant to endorse a family coverage expansion. They expressed both a preference for “letting the kids’ program run for another year or two” before making significant changes, as well as a fear that expanding coverage would “dilute or erode the political support for *TexCare* that’s been built over recent years.”

In 2001, the legislature passed a bill authorizing HHSC to study the feasibility of, and request, a waiver to allow SCHIP to subsidize employer-based coverage for children and their parents. The fact that there was precedent for such a program already—under Medicaid, the Health Insurance Premium Payment System subsidized ESI for 3,500 families across the state—paved the way for considering whether such a program could work under SCHIP. Politically, this effort seemed to have garnered a fair amount of support for several reasons: it is

philosophically in keeping with the widely-held view that public/private partnerships are “good;” it is seen as another strategy for “bridging the gap” between public and private insurance; and conservative legislators look favorably on the program for it would keep enrollees covered through “more mainstream” insurance. At the time of this writing, HHSC had not yet begun working on a feasibility study of this program waiver.

X. FINANCING

Texas annually receives the second largest SCHIP allotment in the country. Yet, in federal fiscal year 2000, it only spent 14 percent of its allotment. State officials explain that this low level of spending is due to the relatively late launch date for the *TexCare* Partnership and express considerable confidence that, given the program's success with enrollment during its first year, it will be able to spend its full allotment in future years. Details of Texas' spending and funding allotments under Title XXI are shown in Table 7.

The state share of funding for *TexCare*—24.4 percent—was generated from the state's settlement with the tobacco industry. This settlement garnered \$15.3 billion in new revenue for the state, all of which was earmarked by the Governor and legislature for health programs.

At the time of our site visit the near term outlook for ongoing political, and thus fiscal, support for the program was quite bright. *TexCare* has quickly become a popular program, is widely viewed as being off to a an effective start, and has garnered strong political support. Momentum for expanded children's coverage over the last year was strong enough even to spur the normally anti-Medicaid legislature to consider and pass a major simplification bill that will significantly alter Medicaid eligibility policies and procedures and bring them in line with those of *TexCare*.

The picture is not entirely rosy, however. Texas, like most states across the country, is experiencing some economic slowdown and the state fiscal environment is tightening. This development, coupled with the dramatic enrollment increases under SCHIP made several of the informants we spoke with a bit nervous about the future. As one executive branch staff put it, "If

TABLE 7: SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	\$561.3	\$1.3	0%	14%	
1999	\$558.7	\$38.5	7%		
2000	\$502.8	\$72.1	14%		\$561.3

SOURCES: Centers for Medicare & Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending*. Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year.

this program keeps growing like this, or if it outgrows its resources, we may have to begin thinking about things like enrollment caps.”²⁵

²⁵After the site visit, however, HHSC conducted a round of consultations with stakeholders who voiced strong support for continuing the program in its current form, and the Governor indicated that any funding needs above and beyond current appropriations would be absorbed in the overall state budget of \$115 billion.

XI. OVERARCHING LESSONS LEARNED

Texas was the object of much national criticism during the first years following the creation of SCHIP. In 1997, the state possessed the highest rates of uninsurance among low-income children in the nation (32 percent versus the national average of 21 percent);²⁶ its Medicaid program retained some of the lowest income eligibility thresholds nationally and had done less to simplify and facilitate children's access to coverage than most states;²⁷ and even among children who were eligible for Medicaid, many did not participate and remained uninsured (41 percent compared to 28 percent, nationally).²⁸ Given this high level of need, Texas' slow adoption of significant expansions of coverage under Title XXI was viewed by many policymakers, analysts, and advocates as irresponsible. Yet Texas officials claim that their approach—to carefully plan and build support for their initiative, and observe and learn from the mistakes of other states—was effective. Recent enrollment data lend support to the claim—in just over one year since the launch of *TexCare*, the state enrolled over 430,000 children—a figure placing Texas as the third largest SCHIP program in the nation.

²⁶ Niall Brennan, John Holahan, Genevieve Kenney. “Snapshots of America’s Families: Health Insurance Coverage of Children,” from the *Assessing the New Federalism Project*. Washington, DC: The Urban Institute, 1999.

²⁷ Donna Cohen Ross and Laura Cox. “Application and Enrollment Procedures for Children’s Health Coverage: Results from a 50-State Survey,” from the Kaiser Commission on Medicaid and the Uninsured. Washington DC: The Kaiser Family Foundation, December 1999.

²⁸ Lisa Dubay, Genevieve Kenney, and Jennifer Haley. “What Do We Know About Children’s Participation in Medicaid and SCHIP?” *Assessing the New Federalism, Series B*. Washington, DC: The Urban Institute, forthcoming 2001.

Key informants we interviewed identified many overarching lessons about designing and implementing a child health insurance program in Texas learned over the past three years. These lessons are summarized below.

- ***By not enacting its separate program until spring 2000, Texas left thousands of potentially eligible children uninsured. Yet state officials believe that taking time to carefully plan a new program resulted in smoother and more rapid eventual enrollment.*** As stated above and in earlier sections of this report, Texas officials spent the two years between the '97 and '99 legislative sessions preparing for the launch of *TexCare*. The design effort was characterized by inclusiveness—the Medicaid agency formed and managed an interagency work group; participated in the broad-based CHIP Coalition to consider the various available options; and conducted a large number of public hearings and consumer focus groups to solicit community input into the program's design. These efforts, further informed by observations of strategies that seemed to succeed, and fail, in other states, guided the development of a program that included a simple enrollment process, community-based application assistance, an appealing and far-reaching marketing campaign, broad coverage of benefits tailored to meet the needs of children, and cost sharing designed after private insurance. By the time of the program's launch, *TexCare* was already known and supported by a broad coalition of politicians, policymakers, agencies, health plans, and advocates, and the apparently effective outreach campaign and eligibility process fueled very rapid take-up rates by Texas families.
- ***Political and environmental factors dictated that Texas pursue the separate program option under SCHIP, a move that state and local officials believe has resulted in a more successful program.*** The Texas Medicaid program, like those in many states, had built up a bad reputation over the 30 years preceding SCHIP. To legislators, Medicaid equated with “everything that was bad” about welfare and constituted a chronic drain on state coffers. To providers, the program was historically very unpopular for its low reimbursement rates and perceived complex administration. And to consumers, the program's county welfare-based eligibility system had fostered strong negative sentiments. Given these sentiments, most state and local officials quickly agreed that a pure Medicaid expansion held little promise of turning around the state's poor record in insuring children. Therefore, Texas set about designing a program modeled after private insurance. And, after a very positive first year of implementation, *TexCare* appears to enjoy widespread and strong support from most sectors, including politicians, state and local government officials, consumers, and child advocates. Notably, providers and health plans were much less enamored of the new program, as will be described below.
- ***Compared to enrollment, Texas has until recently placed significantly less emphasis on service delivery and payment issues, and access problems appear to be emerging as a result.*** Key informants readily admit that primary emphasis had been placed, during the first year of implementation, on outreach and enrollment under *TexCare*. However, the very success that Texas has achieved in rapidly enrolling children has placed considerable stress on the capacity of service delivery networks, and health plans and

providers report that there are insufficient funds to support proper delivery of care. In designing its program, HHSC officials used historical Medicaid cost experience to derive rates, assuming that SCHIP enrollees would have similar levels of need and rates of utilization as their Medicaid counterparts. However providers viewed Medicaid rates as unfairly low to begin with, and the surge in enrollment and higher-than-expected rates of utilization under *TexCare* are only making matters worse. Health plans rightly point out that the capitation payments they receive, which roughly equate to those paid under Medicaid, do not reflect the higher costs associated with serving children with special health care needs and claim that they are losing vast sums of money each month. Pediatricians withdrawing from SCHIP and Medicaid in El Paso, and health plans closing down operations in Houston, are recent signs that access problems for children enrolled in the programs do exist. On the plus side, this issue was already “on everyone’s radar screen” and the legislature authorized during the 2001 session new monies to be directed toward provider and plan rate increases. Providers, however, remained pessimistic that rates would be raised to the level they believed was needed. As *TexCare* matures, HHSC officials admit more focus will need to be paid to how well the program is affording access to those children who have been enrolled.

- ***A multi-faceted outreach strategy, critically relying on community-based organizations, appears to have succeeded in reaching families with uninsured children.*** While Texas’ marketing and advertising campaign was widely praised as effective (especially as it was refined over time), it is the community-based component that is credited with having had the most impact on enrollment. Following the advice of regional and local level officials who argued that they were in the best position to reach out to members of their communities, and acknowledging the tremendous variation that exists across a state the size of Texas, HHSC designed a strategy that placed contract monies in the hands of well-known and respected community organizations and extended considerable flexibility to these groups to build coalitions and conduct outreach in the manner they deemed appropriate. Local groups, while only wishing that more monies were provided, have embraced the initiative and enthusiastically worked to sign up children, often focusing on the “hard to reach.”
- ***Effective implementation is also facilitated by state officials who “listen.”*** Key informants at the state level and those involved with the CHIP Coalition generally praised HHSC officials for their open-ness and creativity during both the design and early implementation phases of *TexCare*. Specific comments were made about their wisdom in opening up the planning process to so many stakeholders, and their ability to respond quickly to problems as they arose (for example, developing a corrective action plan with Birch and Davis when it became apparent that their toll-free hotline was grossly understaffed). Local officials were no less forthright in their praise of HHSC: “They don’t think like bureaucrats,” “...they have a service mentality,” were comments made in reference to HHSC’s willingness to consider new ideas and permit local organizations to design their own plans and make their own decisions. Such behavior on the part of the administering agency has helped foster very positive and broad-based support for *TexCare*.

- ***Implementing simplified enrollment under SCHIP can spur important “spill over” for Medicaid eligibility simplification.*** During its first year of implementation, the very simple, and apparently effective, enrollment process of *TexCare* stood in stark contrast to that traditionally used by Medicaid. In fact, the significant differences between SCHIP and Medicaid eligibility rules and procedures effectively undermined the ability of the programs to efficiently transfer and refer children between the two programs. Advocates and others seized the example of *TexCare* to point out that enrollment processes, when simplified, could succeed in facilitating coverage. Furthermore, they lobbied the legislature arguing that it was inequitable and unfair to continue subjecting lower income families applying for Medicaid to more complex rules than were used for higher income groups. To the delight and amazement of many informants we interviewed, the legislature ultimately agreed and passed a bill that will bring most, if not all, of Medicaid’s enrollment procedures in line with those of *TexCare*. This important “spill over” (ie, of lessons learned under SCHIP and applied to Medicaid) holds considerable promise, many believe, to destigmatize Medicaid and help the program reach many more eligible children.

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APPENDIX A
KEY INFORMANTS

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