Niños Sanos: Healthy Children

A Collaborative Project
Between OAG (Child Support) and HHSC (Medicaid)

Final Report

Submitted to:
Texas Office of the Attorney General
Division of Child Support

Submitted by:
Jane Venohr, Ph.D. and Miko Khan, B.A.

CPR
Center for
POLICY
RESEARCH

1570 Emerson Street
Denver, CO 80218
303 / 837-1555
FAX: 303 / 837-1557
www.centerforpolicyresearch.org

August 31, 2011

Prepared under Office of Child Support Enforcement Grant #08-C0067 to Texas Office of the Assistant Attorney Division of Child Support. Points of view expressed in this document are those of the author and do not necessarily represent the official position of the State.

Acknowledgments

The Center for Policy Research (CPR) would like to thank many individuals for their help on this project. Specifically, CPR would like to acknowledge the following personnel from the Office of Attorney General (OAG) and Health and Human Services Commission (HHSC) for their collaboration efforts: Sylvia Aguilar (HHSC), Myrta Arteaga (OAG), Cynthia Barbosa (OAG), Andrea Bross (OAG), Disa Campbell (OAG), Patricia Canamar (HHSC), Nichole Carrera (HHSC), Thomas Casarez (OAG), Joyce Carter (HHSC), Jay Corbett (OAG), April Elyabouri (OAG), Wlliam Fehr (OAG), Martha Fitzwater (OAG), Kathleen Franzoni (OAG), David Garcia (HHSC), Abigail Gonzalez (OAG), Annaliese Heiligenstein (formerly with OAG), Scott Hilger (OAG) Frances Jaquez (HHSC), Chere Jones (HHSC), Hailey Kemp (formerly with OAG), Yvonne Martinez (HHSC), Victor Mantilla (OAG), Grace Moser (HHSC), Melissa Munoz (OAG) , Bo Platt (OAG) , Venancio Rodriguez (OAG), April Smith (OAG) Theresa Vasquez (HHSC) Cecile Young (formerly with OAG), and Ted White (OAG) . In addition, CPR would like to thank the numerous representatives from health insurance carriers who provided information for the brochure.

Table of Contents

APPENDICES

TABLES AND FIGURES

Executive Summary

The *Niños Sanos* demonstration project, which translates to "Healthy Children," began in September 2007 and continued through August 2011. The project was funded by a Section 1115 demonstration grant through the federal Office of Child Support Enforcement (OCSE). Through a collaborative effort between the Texas Office of the Attorney General (OAG) Texas Child Support Division and the Texas Medicaid agency within the Health and Human Services Commission (HHSC), the demonstration project aimed to increase the number of children in the child support caseload receiving healthcare coverage.

When the *Niños Sanos* project was conceived in 2007, forging a child support and Medicaid collaboration to reduce the number of uninsured children in the child support caseload was unprecedented. Historically, child support-Medicaid collaboration has been limited to reducing Medicaid costs through several avenues including support orders requiring parents to enroll their children in employer-sponsored insurance and collecting cash medical support from noncustodial parents whose children were enrolled in Medicaid. Yet, in Texas, child support may also require parents to apply for Medicaid/CHIP or seek private, child-only insurance. The child support caseload, which consists mostly of very low-income families, also appeared to be a good source for finding and enrolling uninsured children eligible for Medicaid or CHIP.

Treatments and Expected Outcomes

The major treatment proposed for the demonstration was the creation of joint staff positions through the collaboration of the child support agency (OAG) and the Medicaid agency (HHSC). The *Niños Sanos* staff would not only serve as medical support facilitators in order establishment cases, but they would also be able to determine Medicaid eligibility. They would be located in three child support offices in Bexar County (San Antonio), supervised by HHSC, and have access to both the OAG and HHSC automated systems. *Niños Sanos* staff would gather information useful for the establishment of appropriate medical support orders. If the parents did not have employer-sponsored insurance available at a reasonable cost, the demonstration design called for *Niños Sanos* staff to first present private, child-only insurance options to parents and then to explore Medicaid/CHIP enrollment. This sequence, which prioritizes private health insurance coverage over Medicaid for medical support orders, is consistent with Texas statute. In all, the project was expected to increase healthcare coverage among IV-D children from all available sources: employer-sponsored insurance; private, child-only insurance; and Medicaid/CHIP. In turn, *Niños Sanos* staff would follow-up on cases to ensure continuous healthcare coverage for children. The included assisting families with Medicaid/CHIP eligibility or redetermination if the parents no longer had access to affordable private coverage.

Project Cases and Evaluation Method

The project was conducted in two main phases and included two pilots that varied slightly in treatment or the selection criteria used to identify cases. In total, the project considered over 3,000 cases from June 2008 through June 2010. This included cases subject to the core treatment, non-treatment cases, and the pilots. From June 2008 through December 2010, most cases came into the project because they were scheduled for a Child Support Review Process (CSRP) order establishment conference. Beginning in January 2010, cases were selected for the project immediately after an order was established through CSRP. This change was made so that *Niños Sanos* staff, who were experienced Medicaid eligibility workers, could better focus on Medicaid/CHIP applications and redeterminations, rather than the details of medical support, in which they had little to no experience.

The project was evaluated through process, outcome and impact analyses conducted by the Center for Policy Research (CPR). The impact analysis consisted of comparisons of outcomes between over 2,000 cases randomly assigned to treatment and non-treatment groups. Outcomes were assessed from case intake data recorded by *Niños Sanos* staff on data collection forms. Staff also recorded the actions taken/treatments applied on the data collection form. The case-level data from the forms were matched to case-level data downloaded from TXCSES, the OAG automated system that tracks medical support and child support order establishments and compliance. CPR retrieved downloads at three different times: November 2009, November 2010, and April 2011. In addition, process information was collected from HHSC and OAG administrators, supervisors and staff, including *Niños Sanos* staff, through interviews and other sources. The case data were limited to what was provided to *Niños Sanos* staff or available from TXCSES, which does not always capture whether children are currently enrolled in private insurance plans.

Project Outcomes and Findings

Findings from the Impact/Process Analysis

- *OAG (child support)/HHSC (Medicaid) collaboration was challenging because of cultural agency differences. Nonetheless, both OAG and HHSC administrators learned a great deal about the other agency and were able to collaborate effectively.* The HHSC is responsible for finding and enrolling Medicaid/CHIP-eligible children such that economically disadvantaged children have healthcare coverage. This can conflict with the OAG's procedures and processes that conform to state statute to secure medical support from private health insurance coverage first, if it is available at a reasonable cost, and to consider Medicaid as secondary coverage or coverage of last resort.

- *A true "joint staff" position, one that was overseen by both the HHSC and OAG, was not feasible.* Several logistics, including personnel rules, precluded true joint staff positions. Due to one proposed treatment being the facilitation of Medicaid enrollment, project architects decided to use the existing HHSC job classification of "Medicaid eligibility worker" for *Niños Sanos* staff positions.

- *Medicaid eligibility workers (aka* Niños Sanos *staff) provided expertise on Medicaid/CHIP, but were not sufficiently skilled or knowledgeable about medical support and private insurance options to promote healthcare coverage from private sources.* OAG and HHSC concurred that having an in-house Medicaid/CHIP expert, who also could access the HHSC automated system, was helpful to child support offices. However, in hindsight, it was unrealistic to expect one staff person to be experienced in all of the areas— such as Medicaid enrollment, medical support, and private insurance plans— envisioned for the joint staff positions. Further, HHSC staff can only determine whether an application is complete at the local office. Actual Medicaid and CHIP eligibility is determined at centralized offices that processes applications.

- *Private, child-only insurance options are few, not always affordable, and complicated.* Few insurance carriers offered private, child-only insurance or cooperated with the development of a project brochure containing simplified information about them. Premiums for private, child-only insurance range from $50 per month to over $300 per month per child depending on the level of health benefits and pre-existing conditions. The precise premium amount could not be determined without an application and applications must be submitted for one individual or family unit. Further, differences in benefits (*i.e.*, what is covered at one rate and the exceptions to that rate) are overwhelming and make side-by-side comparison of health plans virtually impossible.

- *Telephone contact is too limiting; thus several different methods of contact with parents and their employers are needed. Niños Sanos* staff's contact with parents in pre-CSRP cases was sidelined and controlled because the OAG did not want demonstration's efforts to interfere with the establishment of the financial child support order. *Niños Sanos* staff were rarely able to communicate with parents in person.

Findings from the Impact Analysis

- Niños Sanos *treatments increased healthcare coverage among children in the child support caseload.* Based on information gathered by *Niños Sanos* staff, most (78 percent) of the pre-CSRP treatment cases had healthcare coverage for all children immediately following treatment. This was significantly more than the rate among pre-CSRP non-treatment cases (71 percent) at intake.

- *All of the increase was from more Medicaid enrollments.* The difference in healthcare coverage rates can be attributed to a higher Medicaid/CHIP enrollment rate among pre-CSRP treatment cases

than pre-CSRP non-treatment cases. *Niños Sanos* staff were skilled at facilitating Medicaid because they were experienced Medicaid eligibility workers.

- Niños Sanos *treatments did not increase healthcare coverage from employer-sponsored insurance and private, child-only insurance plans.* This is consistent with the finding from the process/implementation analysis that *Niños Sanos* staff were more effective at facilitating Medicaid enrollments than private insurance.

- Niños Sanos *staff indirectly affected the frequency with which medical support was ordered.* This occurred because their efforts led to more orders for custodial parents to pursue children healthcare coverage through Medicaid/CHIP.

- *Over time, medical support establishment rates were the same between pre-CSRP treatment and non-treatment cases.* However, the initial information provided from *Niños Sanos* staff had a lasting effect, in that treatment cases continued to have more orders for Medicaid/CHIP applications over time than non-treatment cases.

- Niños Sanos *staff did not stabilize Medicaid enrollment over time.* This indicates that *Niños Sanos* staff's efforts to help parents with Medicaid redeterminations were not successful or that the failure of parents to submit redetermination materials was not the only factor that caused changes in Medicaid status.

- Niños Sanos *staff did not affect compliance with medical support orders.* This reflects that *Niños Sanos* staff took few actions to ensure compliance.

Findings from the Outcomes Analysis

- *Most children in child support cases have healthcare coverage from Medicaid/CHIP. Few have coverage from private health insurance. Coverage rates are higher for younger children.* On average, in about 60 percent of project cases, children had healthcare coverage through Medicaid/CHIP.

- *Medicaid receipt appears to be fairly stable.* Over a 17-month period, the Medicaid status changed in a small share of cases.

- *Few parents take up private, child-only insurance.* Private, child-only insurance was the source of healthcare for less than 1 percent of the project cases.

- *Employer-sponsored insurance is not available or not available at a reasonable cost in many cases were the parents have verified employment.*

- *Cash medical support is often ordered, particularly in Medicaid cases, but rarely is the amount of medical support set at the highest amount permissible under statute.* The median cash medical support amount ordered is $25 to $30 per month depending on case type and Medicaid status. This is much less than the 9 percent of gross income permissible under statute for most noncustodial parents' incomes, even those who earn minimum wage.

- *Compliance with Medicaid-application orders and employer-sponsored insurance appear to be relatively high and consistent over time.* This was true of both treatment and non-treatment cases. This suggests that medical support orders are set reasonably such that parents can comply.

- *National Medical Support Notices (NMSNs) are issued just as frequently when the custodial parent is ordered to provide children with healthcare coverage through employer-sponsored insurance as when the noncustodial parent is.*

- *There are few cases in which the children have dual healthcare coverage (*i.e.*, both Medicaid and private healthcare coverage).* Private insurance is ordered in about 20 percent of cases in which the children have active Medicaid status, but when compliance with employer-sponsored insurance is factored in, the percentage of cases with actual dual enrollment is lower.

- *Not all noncustodial parents are ordered to pay cash medical support in cases that have active Medicaid. For those with orders, the cash medical support receipts are relatively small.* Cash medical support is distributed to the HHSC when the children have active Medicaid cases. Among cases that were active Medicaid at the final follow-up period, the amount of cash medical support actually received in cases requiring cash medical support averaged $100 over the six months preceding the date of the final follow-up. This is less that what the average Medicaid payment per child is (*i.e.*, $2,400 per year in fiscal year 2007).

Conclusions

The project was successful in getting more healthcare coverage for children and increasing the number of medical support orders. All of the increase came from Medicaid/CHIP. The project was not effective at increasing coverage from private insurance such as employer-sponsored insurance or private, child-only insurance.

Policy and Operations Implications

- *Medicaid/CHIP outreach in child support offices may be more effective in the future as Medicaid expands to cover more children, particularly older children. Furthermore, it may be useful to place an in-house Medicaid experts with access to the HHSC automated system within local child support offices.* The successes of the

project suggest that Medicaid/CHIP outreach in child support offices can be useful, but under existing Medicaid/CHIP eligibility requirements, child support agencies should not expect a large volume of Medicaid/CHIP applications emanating from child support offices today. That, however, may change as more states expand their Medicaid income eligibility requirements to meet federal healthcare reform requirements that will become effective in 2014. To that end, HHSC and OAG may want to equip the child support agency to conduct "express lane eligibility" for Medicaid/CHIP once Texas expands its Medicaid income eligibility thresholds. Another option (or supplement) would be to place an in-house Medicaid experts with access to the HHSC automated system within child support offices. This has the added advantage of making HHSC information readily available for the purposes of establishing medical support orders.

- *State health insurance exchanges, as mandated by healthcare reform, can provide what private, child-only insurance could not for uninsured, Medicaid/CHIP-ineligible children. However, to be effective, states must be able to order parents to apply for insurance from the exchange. To enforce these orders, data-sharing agreements and automated interfaces between exchanges and child support agencies are also needed.* The Affordable Care Act (ACA) mandates the establishment of state health insurance exchanges that will offer affordable, quality health insurance options by 2014. ACA ensures the affordability of these plans through tax credits that limit insurance premium costs to a sliding scale based on income. In addition, ACA standardizes healthcare plans and benefits.

- *If ACA is successful at increasing the number of employers offering quality, affordable insurance, there should be more orders for children's health insurance coverage from parents' employer-sponsored insurance. There will also be a greater need to evaluate each parent's plan as there will be more cases in which both parents have access to employer-sponsored insurance. In addition, there will be a greater need to enforce these orders. This will require more interaction between the child support agency and employers.* ACA requires large employers to offer health insurance or pay a tax penalty. It also encourages small employers to provide quality, affordable insurance through subsidies. To handle this increase, child support agencies should explore ways to streamline gathering information about insurance premium costs from large employers and state insurance exchanges for small employers. Similarly, child support agencies should explore more efficient ways for enforcing these orders.

- *Federal direction on the future role of medical support is needed in light of recent federal initiatives aimed to increase healthcare coverage among children. Under current rules and statutes, medical support is often used to offset Medicaid costs, but the* Niños Sanos *demonstration shows that there is conflict between this use of medical support and the initiatives to obtain healthcare coverage for more children.* HHSC administrators and *Niños Sanos* staff felt like their efforts to increase healthcare coverage among IV-D children through Medicaid/CHIP outreach were thwarted by federal and state statutes that prioritize healthcare coverage from private health insurance for medical support. They felt they could not approach

parents about Medicaid/CHIP options until it was clear that neither parent had access to private healthcare coverage at a reasonable cost. HHSC administrators and *Niños Sanos* staff also verbalized their Medicaid clients' frustrations with having to use the noncustodial parent's insurance first when obtaining healthcare services for their children.

Although much of what was learned from the *Niños Sanos* project has implications concerning the implementation of healthcare reform, it does not touch on all of the medical support issues resulting from healthcare reform. Today, children's healthcare policies are at a critical turning point. To be effective, medical support policies should be re-assessed in the light of what these changes mean for the future. When the *Niños Sanos* demonstration was conceived, the number of children who lacked healthcare coverage was growing at an alarming rate. Since then, several national and states initiatives to ensure that all children, particularly low-income children, have healthcare coverage have been launched. Child support agencies no longer need to seek new insurance coverage options to ensure all children in the child support caseload have healthcare coverage. However, it is important that medical support has a clear and defined role in the future affairs of children's healthcare.

Chapter 1
Introduction

The following report discusses the process, outcomes, and impact of the *Niños Sanos* demonstration project, or "Healthy Children" project. Through a collaborative effort between the Texas Office of the Attorney General (OAG) Texas Child Support Division and the Texas Medicaid agency within the Health and Human Services Commission (HHSC), the demonstration project aimed to increase the number of children in the state of Texas OAG child support caseload receiving healthcare coverage. The project was funded by a Section 1115 demonstration grant through the federal Office of Child Support Enforcement (OCSE) that was awarded to the OAG. The three-year grant began in September 2007 and extended through August 2011 with a no-cost extension.

When this project was conceived in 2007, Texas had a critical need for improved healthcare coverage for its children and there was a statewide concern that not all children eligible for Medicaid/CHIP were indeed enrolled. The fact that 22 percent of all Texas children were uninsured in 2007 while the national average for uninsured children was 11 percent underscores the gravity of this deficiency. Although not all uninsured children are eligible for child support, the Texas OAG was well-positioned to help reduce the number of uninsured children in its caseload. OAG has the authority to establish and enforce medical support orders that essentially compel parents to obtain healthcare coverage for their children. This includes orders to enroll the child in either the noncustodial or custodial parent's employer-sponsored healthcare plan, orders to seek private, child-only insurance, and orders to apply for Medicaid/CHIP. Furthermore, because families in the OAG caseload are largely low income, the OAG caseload appeared to be a good source for finding Medicaid/CHIP-eligible children not already enrolled in the program in order to help them to enroll.

Subsequently, the *Niños Sanos* project was designed, forging an OAG-HHSC collaboration that would increase healthcare coverage among children in the OAG caseload. The underlying premises of the project design assumed that OAG children needed assistance with Medicaid/CHIP enrollment and that there was a need for private, child-only health insurance options in cases where parents lacked employment-related insurance and children were ineligible for Medicaid/CHIP. Two principle project strategies were developed from these premises:

- *Joint Staff (0.5 FTE OAG/child support & 0.5 FTE HHSC/Medicaid).* One strategy was the development and use of staff that were jointly hired by OAG and HHSC in field offices. These project staff members would assist with the establishment of appropriate medical support orders as well as Medicaid applications and redeterminations. The project staff had access to the automated systems of both agencies with which it would be able to achieve better and integrated outcomes for project cases.

- *Identification of Reasonable Cost, Alternative Health Insurance.* Another strategy was the exploration and use of private, child-only insurance to reduce the number of children without healthcare coverage in the OAG caseload. Project architects believed that by identifying alternative sources of insurance and making this information available to parents, the number of OAG children with healthcare coverage would increase.

The expected outcomes of the demonstration project were:

- An increase in the percentage of children with healthcare coverage from any source,
- An increase in private insurance coverage including employer-sponsored insurance available to custodial and noncustodial parents and child-only insurance plans,
- An increase in healthcare coverage through Medicaid and CHIP,
- Fewer lapses in healthcare coverage for the children, including, Medicaid due to more families completing Medicaid redeterminations, and
- Greater compliance with medical support orders including orders for private insurance, orders to enroll in Medicaid, and orders to pay cash medical support.

The *Niños Sanos* project was conducted in three of the Texas OAG field offices serving Bexar County, which encompass the San Antonio area. Administrators from OAG and HHSC spent the first year of the project planning for implementation and the evaluation of the project. This included the development of staffing configurations, a data-sharing agreement between OAG and HHSC, and securing the hardware necessary to support access to the HHSC systems from an OAG office. Subsequently, a brochure was created that supplied simplified information about private, child-only insurance. It was later published and distributed in 2009.

Also in the first year, an initial pilot of the treatment was launched and an evaluation plan that randomly assigned treatment and non-treatment groups was designed. Project operations began in October 2008 and continued through June 2010. Treatment cases received special attention and intervention from project staff, while cases in the non-treatment group were handled traditionally as matters of usual practice. Specifically, participants in the treatment group received intervention including 1) assessment of unfulfilled healthcare coverage needs, 2) exploration of healthcare coverage options, 3) assistance with Medicaid/CHIP applications and redeterminations, 4) discussion of private healthcare options, and 5) the sharing of information with the child support officer.

The last year of the project was devoted to evaluation of the treatment and included a one-year or multi-year follow-up on most project cases. The evaluation design consisted of an experimental approach in which outcomes were compared between cases randomly assigned to treatment and non-treatment groups. It was predicted that the treatments would lead to better outcomes for cases. The Center for Policy Research (CPR) analyzed the outcomes from both groups over the three-year

period to evaluate the efficacy of the project treatments. CPR also evaluated the treatment by analyzing changes in medical support performance over time. In addition, CPR conducted a process analysis.

Since the *Niños Sanos* project was conceived, several national initiatives have made or will make sweeping changes to the availability and provision of children's healthcare coverage. The consequences of these initiatives on state approaches to medical support, including the approach tested in *Niños Sanos*, were examined as part of the last year of the project. The 2009 reauthorization of the Child Health Insurance Program (CHIPRA) extends Medicaid/CHIP's reach to more children. In 2010, U.S. Secretary of Health and Human Services, Kathleen Sebelius, launched a campaign to find and enroll all uninsured children eligible for Medicaid/CHIP. In 2010, Congress also adopted the Affordable Care Act (ACA)[1]. Among its many provisions, the healthcare reform will expand Medicaid/CHIP, provides other options for affordable, quality healthcare coverage for children and families, and mandates health insurance coverage. The bulk of healthcare reform measures become effective in 2014. Although none of the initiatives specifically address the unique circumstances of children in child support caseloads, they will undoubtedly increase the number of children in the child support caseload eligible for Medicaid/CHIP. One study (Burnszynski 2010) predicts that 80 percent of children receiving child support nationally will be enrolled in Medicaid/CHIP.

The federal Office of Child Support Enforcement (OCSE) has already issued changes in medical support policies that conform to the goals of these initiatives and anticipates additional modifications in the future (*e.g.*, Turetsky, 2010b). These changes encourage healthcare coverage among all children and from any source and break away from medical support's fixation on employer-sponsored insurance. They also encourage state child support agencies to collaborate with their Medicaid/CHIP agencies to design and adopt policies that increase Medicaid/CHIP enrollment among Medicaid/CHIP-eligible children in the child support caseload. As is, most states, including Texas, have statutes and policies that are in accordance with over 20 years of previous federal regulations requiring the pursuit of the healthcare coverage from parents' employment and essentially treating Medicaid as the last resort for healthcare coverage for children.

Organization of Report

The report contains nine chapters. The first chapter is the introduction.

- Chapter 2 provides background information about medical support and other background information pertinent to the project.

[1] There are actually two laws: the Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act (Pub. L.111–152) was enacted on March 30, 2010. They are usually referred to collectively as the Affordable Care Act (ACA).

- Chapter 3 provides a project overview and summarizes the underlying premises of the project design.
- Chapter 4 describes project cases including treatment and non-treatment cases.
- Chapter 5 provides more details about the evaluation approach.
- Chapter 6 describes how the project was and treatments were implemented. It identifies implementation issues, as well modifications to the project design that were necessary for the project to begin operating and for treatments to be properly applied.
- Chapter 7 analyzes the outcomes of the project cases. It includes both outcomes and impact analyses. The impact analysis consists of comparisons between treatment and non-treatment cases.
- Chapter 8 summarizes the reactions of OAG and HHSC administrators and *Niños Sanos* staff.
- Chapter 9 presents conclusions.

Chapter 2
Background on Medical Support

Until recently, federal and state medical support statutes, rules, and policies have centered on getting health insurance for the children from the noncustodial parent's employer and reducing Medicaid costs. The alarming growth in the number of uninsured children in the last 15 years has recently fueled some child support agencies to take additional measures to ensure that more children in the child support caseload have healthcare coverage. In 2008, 2010 and 2011, federal regulations were broadened to assist child support agencies trying to increase the number of children with healthcare coverage. Still, federal policy asserts that medical support should be avoided in cases where parents have access to affordable, private coverage to reduce Medicaid expenditure.

Medical Support: Federal Requirements and State Practices

Historically, child support-Medicaid collaboration has been limited to avoiding Medicaid costs and securing third-party liabilities for Medicaid children who also have private insurance. Child support agencies establish and enforce orders for private insurance, they are responsible for informing the Medicaid agency of private coverage, and the Medicaid agency uses that information for cost avoidance and to collect third-party liabilities. When a child enrolled in Medicaid receives healthcare services, the private insurance carrier is first billed in most circumstances. Medicaid only pays for what the insurance plan does not cover. In situations where the private insurance carrier is not billed first, the Medicaid agency pursues payment from the liable insurance carrier.

Overall, most of the major medical support tools available to states result from federal regulations, although each state structures its medical support tools somewhat differently. Federal regulations require that each state develop a set of child support guidelines to be followed when establishing and modifying child support orders. Federal regulations require that each state's guidelines address the healthcare needs of the children. This can include provisions that give tribunals the authority to order one or both parents to provide private health insurance or "cash medical support," or both. Cash medical support orders require that one parent contribute to the cost of the child's insurance premium paid by the other parent, they determine how parents will pay for the child's uninsured medical expenses, they require the noncustodial parent to pay an amount to offset coverage if the child receives Medicaid or healthcare from another government entity, or they require some combination of these provisions.

As shown in Figure 1, Texas statute provides for all of these options and prioritizes private insurance over cash medical support. This is congruent with the 2008 federal regulations that require IV-

D agencies to petition for private health insurance if it is available to a parent at a reasonable cost and accessible to the child, and if not, to petition for cash medical support.

Figure 1.1
Selected Provisions of Texas Statute Pertaining to Medical Support
Texas Statutes, Family Code, Chapter 154, Subchapter A

Sec. 154.064. MEDICAL SUPPORT FOR CHILD PRESUMPTIVELY PROVIDED BY OBLIGOR. The guidelines for support of a child are based on the assumption that the court will order the obligor to provide medical support for the child in addition to the amount of child support calculated in accordance with those guidelines.

SUBCHAPTER D. MEDICAL SUPPORT FOR CHILD
Sec. 154.181. MEDICAL SUPPORT ORDER. (a) The court shall render an order for the medical support of the child as provided by this section and Section 154.182 in:
(1) a proceeding in which periodic payments of child support are ordered under this chapter or modified under Chapter 156, (2) any other suit affecting the parent-child relationship in which the court determines that medical support of the child must be established, modified, or clarified, or(3) a proceeding under Chapter 159.
(b) Before a hearing on temporary orders or a final order, if no hearing on temporary orders is held, the court shall require the parties to the proceedings to disclose in a pleading or other statement:
(c) In rendering temporary orders, the court shall, except for good cause shown, order that any health insurance coverage in effect for the child continue in effect pending the rendition of a final order, except that the court may not require the continuation of any health insurance that is not available to the parent at reasonable cost to the obligor. If there is no health insurance coverage in effect for the child or if the insurance in effect is not available at a reasonable cost to the obligor, the court shall, except for good cause shown, order health care coverage for the child as provided under Section 154.182.
(d) On rendering a final order the court shall:(1) make specific findings with respect to the manner in which health care coverage is to be provided for the child, in accordance with the priorities identified under Section 154.182, and
(2) except for good cause shown or on agreement of the parties, require the parent ordered to provide health care coverage for the child as provided under Section 154.182 to produce evidence to the court's satisfaction that the parent has applied for or secured health insurance or has otherwise taken necessary action to provide for health care coverage for the child, as ordered by the court.
(e) In this section, "reasonable cost" means the cost of health insurance coverage for a child that does not exceed nine percent of the obligor's annual resources, as described by Section 154.062(b), if the obligor is responsible under a medical support order for the cost of health insurance coverage for only one child. If the obligor is responsible under a medical support order for the cost of health insurance coverage for more than one child, "reasonable cost" means the total cost of health insurance coverage for all children for which the obligor is responsible under a medical support order that does not exceed nine percent of the obligor's annual resources, as described by Section 154.062(b).

Sec. 154.182. HEALTH CARE COVERAGE FOR CHILD. (a) The court shall consider the cost, accessibility, and quality of health insurance coverage available to the parties and shall give priority to health insurance coverage available through the employment of one of the parties if the coverage is available at a reasonable cost to the obligor.
(b) In determining the manner in which health care coverage for the child is to be ordered, the court shall render its order in accordance with the following priorities, unless a party shows good cause why a particular order would not be in the best interest of the child:
(1) if health insurance is available for the child through a parent's employment or membership in a union, trade association, or other organization at reasonable cost, the court shall order that parent to include the child in the parent's health insurance,
(2) if health insurance is not available for the child under Subdivision (1) but is available to a parent at reasonable cost from another source, including the program under Section 154.1826 to provide health insurance in Title IV-D cases, the court may order that parent to provide health insurance for the child, or
(3) if health insurance coverage is not available for the child under Subdivision (1) or (2), the court shall order the obligor to pay the obligee, in addition to any amount ordered under the guidelines for child support, an amount, not to exceed nine percent of the obligor's annual resources, as described by Section 154.062(b), as cash medical support for the child.
(b-1) If the parent ordered to provide health insurance under Subsection (b)(1) or (2) is the obligee, the court shall order the obligor to pay the obligee, as additional child support, an amount equal to the actual cost of health insurance for the child, but not to exceed a reasonable cost to the obligor. In calculating the actual cost of health insurance for the child, if the obligee has other minor dependents covered under the same health insurance plan, the court shall divide the total cost to the obligee for the insurance by the total number of minor dependents, including the child

Figure 1.1
Selected Provisions of Texas Statute Pertaining to Medical Support
Texas Statutes, Family Code, Chapter 154, Subchapter A

covered under the plan.
(b-2) If the court finds that neither parent has access to private health insurance at a reasonable cost to the obligor, the court shall order the parent awarded the exclusive right to designate the child's primary residence or, to the extent permitted by law, the other parent to apply immediately on behalf of the child for participation in a government medical assistance program or health plan. If the child participates in a government medical assistance program or health plan, the court shall order cash medical support under Subsection (b)(3).
(b-3) An order requiring the payment of cash medical support under Subsection (b)(3) must allow the obligor to discontinue payment of the cash medical support if:
(1) health insurance for the child becomes available to the obligor at a reasonable cost, and(2) the obligor:
(A) enrolls the child in the insurance plan, and
(B) provides the obligee and, in a Title IV-D case, the Title IV-D agency, the information required under Section 154.185.
(c) In this section: (1) "Accessibility" means the extent to which health insurance coverage for a child provides for the availability of medical care within a reasonable traveling distance and time from the child's primary residence, as determined by the court.(2) "Reasonable cost" has the meaning assigned by Section 154.181(e).

Sec. 154.1826. HEALTH CARE PROGRAM FOR CERTAIN CHILDREN IN TITLE IV-D CASES.
(b) In consultation with the Texas Department of Insurance, the Health and Human Services Commission, and representatives of the insurance industry in this state, the Title IV-D agency shall develop and implement a statewide program to address the health care needs of children in Title IV-D cases for whom health insurance is not available to either parent at reasonable cost under Section 154.182(b)(1) or under Section 154.182(b)(2) from a source other than the program.

Sec. 154.1827. ADMINISTRATIVE ADJUSTMENT OF MEDICAL SUPPORT ORDER. (a) In each Title IV-D case in which a medical support order requires that a child be enrolled in a health care program under Section 154.1826, the Title IV-D agency may administratively adjust the order as necessary on an annual basis to reflect changes in the amount of premium costs associated with the child's enrollment.

Sec. 154.183. MEDICAL SUPPORT ADDITIONAL SUPPORT DUTY OF OBLIGOR. (a) An amount that an obligor is ordered to pay as medical support for the child under this chapter, including the costs of health insurance coverage or cash medical support under Section 154.182:
(1) is in addition to the amount that the obligor is required to pay for child support under the guidelines for child support,(2) is a child support obligation, and(3) may be enforced by any means available for the enforcement of child support, including withholding from earnings under Chapter 158.
(b) If the court finds and states in the child support order that the obligee will maintain health insurance coverage for the child at the obligee's expense, the court shall increase the amount of child support to be paid by the obligor in an amount not exceeding the actual cost to the obligee for maintaining health insurance coverage, as provided under Section 154.182(b-1).
(c) As additional child support, the court shall allocate between the parties, according to their circumstances:
(1) the reasonable and necessary health care expenses, including vision and dental expenses, of the child that are not reimbursed by health insurance or are not otherwise covered by the amount of cash medical support ordered under Section 154.182(b)(3), and (2) amounts paid by either party as deductibles or copayments in obtaining health care services for the child covered under a health insurance policy.

The standard practice among most states, including Texas, has been to order one or both parents to provide health insurance if it is available through the parent's employment and to order ways in which parents will share the cost of the child's uninsured medical expenses. Pursuant to federal regulations effective in 2008, this practice has been expanded in most states to consider the cost of insuring the child using state-determined definitions of reasonable cost. Texas statute, however, already provided for a consideration of reasonable cost prior to the imposition of the 2008 federal requirement.

In most states, including Texas, orders for private insurance typically apply to health insurance that becomes available through future employment as well. If health insurance is currently available, the child's share of the actual premium cost will be factored into the determination of the final support award. In Texas, the cost of the child's health insurance is subtracted from the noncustodial parent's income before the determination of the support award. If the custodial parent is ordered and actually carries the child's health insurance, the noncustodial parent may be ordered to pay an additional amount to the custodial parent to offset the child's premium costs.

Texas and a few other states routinely order cash medical support from noncustodial parents without employment-related insurance whose children are enrolled in Medicaid. These states and Texas have the authority to order a custodial parent to apply for Medicaid/CHIP. For almost a decade, Sacramento County offered and ordered a private, child-only insurance option in IV-D cases where the noncustodial parent did not have access to employment-related insurance. In 2009, Texas passed legislation that enabled a similar provision but interest in it waned after the passage of federal healthcare reform because insurance carriers needed to focus their efforts on developing healthplans that would comply with the new federal requirements. A few other states have attempted Sacramento's approach, but like Texas, most of these initiatives have failed to launch or become a major success.

With some exceptions, federal regulations require that custodial parents cooperate with the establishment of medical support orders if their children receive Medicaid. Federal regulations also require IV-D agencies to use the National Medical Support Notice (NMSN) to notify employers and healthplan administrators that a parent has been ordered to enroll his or her child(ren) in an employer's healthplan. The NMSN compels the child's immediate enrollment without waiting for the employer's open enrollment period or the parent's consent. The NSMN requires that employers inform the IV-D agency whether they are able to enroll the child. Uncooperative employers may be assessed a state-determined fine. Texas relies on a private vendor to routinely issue and track NMSNs, but child support staff will issue a NMSN if they find one is needed while working a case. Some states, such as Texas, have dedicated staff and/or interactive websites to accommodate and improve employer responses to NMSNs. States have discretion as to whether to use NMSNs to enforce custodial parents to comply with children's private health insurance order. Texas exercises that discretion.

In addition, federal regulation requires automated links between the IV-D and Medicaid agencies. The IV-D agency must inform the Medicaid agency when it establishes or modifies a medical support order and must periodically communicate with the Medicaid agency to determine whether there has been a lapse in private insurance coverage in IV-D/Medicaid cases. In Texas, a private vendor handles these exchanges. The Medicaid agency uses information about private insurance to pursue third-party liabilities since Medicaid is the last-resort payer. Information available from various states

indicates dual enrollment (*i.e.*, enrollment in both Medicaid and private insurance) is the situation for about 3 to 9 percent of IV-D cases (Center for Policy Research, 2011). Dual enrollment does not occur in IV-D/CHIP cases because enrollment in private insurance precludes CHIP eligibility. Some states have more or less capacity and functionality in their IV-D/Medicaid interfaces. States vary in the frequency and parameters of the data exchanges, whether Medicaid cases are automatically referred for IV-D services, and whether a state uses periodic data matches between IV-D cases and insurance carriers to locate a child's or parent's access to private insurance.

Texas: Medical Support Outcomes and Processes

Texas leads most states in medical support outcomes. The Texas Office of the Attorney General served 1,237,045 child support cases in 2010, about 1,015,017 of which had a medical support order established. In 92.2 percent of Texas IV-D cases, medical support was ordered and established, and in 61.5 percent of cases medical support was provided as ordered in 2010 (OCSE, 2011). Comparatively, the national percentage of child support cases with established medical support orders was 79.7 percent. Medical support was actually provided as ordered in only 32.5 percent of IV-D cases nationally (OCSE, 2011). In 2010, the OAG saved $300 million through medical support that required noncustodial parents to provide health insurance for dependents who are also on Medicaid, helped HHSC recover $51 million in third-party liabilities from insurance carriers, providers, and pharmaceutical companies, and avoided $210 million in Medicaid costs (Key, 2011).

OAG attributes much of its above-average success to a long history of implementing cutting-edge medical support strategies. Texas was one of the first states to establish procedures and automation to facilitate the child support agency's assistance with third-party liabilities for Medicaid, use periodic matches to large insurance databases to identify private healthcare coverage, implement and automate the National Medical Support Notice (NMSN), and routinely order cash medical support.

OAG's medical support establishment policy complies with federal requirements and state statute: an OAG petition to the court or administrative authority for child support must also include medical support. This medical support provision may include health insurance available for the child through a parent's employment at a reasonable cost, insurance available to the parent from another source, or cash medical support. Texas statute defines insurance to be reasonable in cost if it does not exceed 9 percent of the responsible parent's annual gross income. Further, Texas statute stipulates that up to 9 percent of the noncustodial parent's gross income can be ordered for cash medical support when the noncustodial parent does not provide health insurance for the child. That amount can be prorated among all of the noncustodial parent's cases if he or she has multiple orders. OAG distributes collections of cash medical support to the HHSC in Medicaid cases and to the custodial parent in non-Medicaid cases. The distribution to HHSC defrays Medicaid costs. The distribution to the custodial parent is intended to defray his or her out-of-pocket expenses for the child's health insur-

ance premium or other medical expenses. In addition to health insurance, Texas statute provides that either or both parents can be ordered to pay a share of the child's medical expenses not covered by insurance.

Medical Support Practices in Bexar County

In Bexar County, Texas, the OAG first attempts to get parents to agree to an order through a settlement conference called a Child Support Review Process (CSRP). If a CSRP order is not established or the case has some unusual or special circumstance, OAG will use the regular court process to establish the order. The following outlines the OAG's establishment policy in Bexar County.

- Bexar County OAG has a general intake unit that processes all initial applications for IV-D services. Once the unit determines that an order needs to be established, it assigns a case to one of four OAG field offices based on zip code and uses a courier to send case information to the appropriate office.

- The local OAG office usually schedules a CSRP with the parents within 10 days of receiving the case from intake. OAG sends a packet to the parents that contains an explanation of the CSRP process, a description of the information that parents need to bring to the CSRP, and, in some offices, the prerequisite forms, such as the "health insurance availability form," that are used to identify health insurance that may be available to the child.

- At the CSRP, the Child Support Review Officer (CSO) meets with the parents. Health insurance coverage is just one of several topics addressed. OAG sends agreements reached in CSRP to a judge for final approval. Upon the judge's signature, the agreement becomes a legally binding child support order.

- A CSRP may be rescheduled if the parents fail to show. Alternatively, the OAG may petition the court to establish the order, in which case the court will, in accordance with state statute, also address medical support.

- Once an order is established, the information is entered into an automated system, TXCSES. If cash medical support is ordered, it is entered into the system separately from the cash child support order and is called "current child support."

OAG's enforcement of medical support orders also complies with federal regulations and state statute. OAG contracts with a private vendor for most of its medical support actions. The vendor is responsible for issuing and monitoring NMSNs, conducting periodic matches with insurance carriers and issuing an NMSN when they find new insurance, informing HHSC of available private insur-

ance in joint Medicaid-OAG cases so that the HHSC can pursue third-party liabilities, conducting outreach to employers on medical support, maintaining employer repositories noting employer-sponsored insurance, and performing other administrative medical support actions. The vendor is also responsible for tracking medical support actions and posting requisite medical support information on TXCSES. Few instances of medical support enforcement require direct involvement of an OAG enforcement worker. Nonetheless, OAG staff can track when an NMSN was issued and other medical support information from the TXCSES system.

OAG enforcement staff become directly involved in medical support only when there is an order for unreimbursed medical expenses that requires enforcement, or when the obligated parent discontinues payment of cash medical support (as permissible under state statute) because he or she has obtained new insurance for the children through his or her employer or another source. Both situations occur infrequently. The minimum criteria for enforcing orders for unreimbursed medical expenses (*e.g.*, the custodian incurred at least $500 in unreimbursed medical expenses for the child and is unable to demonstrate the expenses were paid in full) are restrictive and infrequently invoked. Similarly, cases rarely involve obligors who have no access to private insurance at a reasonable cost (the situation that predicates a cash medical support order) but who get a better job and subsequently acquire insurance.

Medicaid/CHIP Enrollments in Texas

Texas HHSC offers numerous Medicaid enrollment options, as well as programs for children. Families can apply for Medicaid at regional offices or via U.S. mail or Internet. (Most of the HHSC's regional offices are located in separately from child support offices.) In addition, Medicaid eligibility workers are often located at places frequented by low-income mothers (*e.g.*, birthing hospitals). Some Medicaid programs even allow for enrollment after the child has received the medical service. This is convenient for families of Medicaid-eligible children who need emergency care but did not enroll the child in Medicaid prior to the emergency. Medicaid applicants must submit supporting documentation (*e.g.*, paystubs) with their application. Eligibility workers can assist parents with completing the requisite paperwork and documentation. A centralized office then certifies Medicaid eligibility and finally the eligibility worker notifies the family of certification.

Since children must be Medicaid ineligible prior to determining CHIP eligibility, the CHIP application is still processed by the centralized Medicaid office. Once a child is determined to be ineligible for Medicaid, the child's application is forwarded to a vendor who certifies CHIP enrollment.

There are over two million children enrolled in the Texas Medicaid program and about a half-million Texas children enrolled in Texas CHIP (HHSC, 2009). Children cannot be simultaneously enrolled in Medicaid and CHIP. About 150,000 of Medicaid children and an unknown number of CHIP

children reside in Bexar County. HHSC requires re-determination every six months for individuals to remain enrolled in Medicaid. States generally use this re-determination tool in a number of ways (like re-assessing Medicaid eligibility based on changes in income) in an effort to reduce chances of fraud. HHSC, however, attempts to limit the lapses in parents' Medicaid coverage by notifying parents when a redetermination is due. HHSC also offers Medicaid enrollment retrospectively where an uncertified, but Medicaid eligible, child has a medical emergency or other medical event.

The income eligibility threshold for Texas Medicaid varies with the children's age. The income eligibility threshold is 185 percent of the federal poverty level for infant children less than one year old, 133 percent of the federal poverty level for children between ages one through five years old, and 100 percent of the federal poverty level for children six years old or more. The income eligibility threshold for Texas CHIP is 200 percent of the federal poverty level. Families participating in CHIP usually pay a fee based on a sliding scale that is $50 or less per family every 12 months. CHIP may also assess copayments ranging from $7 to $10 for doctor visits and $50 to $100 for hospital visits. In contrast, there are no fees or copays for children enrolled in Medicaid. In all, Medicaid benefits are extensive and often better than the benefits provided by private health care coverage (Texas Department of Insurance, 2011). Medicaid benefits include regular checkups and office visits, dentist visits and cleanings, eye exams and glasses, hospital care, mental health care, prescription drugs, and vaccines.

Recent Federal Changes

The above discussion summarizes federal, state, and local medical support during most of the project. In 2010, however, federal medical support regulations began to change to accommodate national initiatives directed at increasing healthcare coverage among children. As identified earlier, these initiatives include CHIPRA, the 2010 DHHS campaign to find and enroll all uninsured children eligible for Medicaid/CHIP, and the adoption of federal healthcare reform. OCSE is issuing changes in medical support policies. These changes back down from the federal medical support requirements issued in 2008. Only Texas and a few other states have adopted and implemented all of the measures necessary to fully comply with the 2008 requirements. In late 2010, OCSE announced that states could continue with what they were doing prior to the 2008 federal medical support, proceed with implementation of the 2008 federal rules, adopt policies that improve enrollment of Medicaid/CHIP eligible in collaboration with Medicaid/CHIP, or a combination of these factors. Most states elected to continue with what they were doing even if it included some of the revisions the state had made to conform to the 2008 federal medical support requirements.

In 2011, OCSE also gave states the option to include Medicaid/CHIP coverage in their definition of medical support coverage in federal reports used to monitor child support performance among

states. This essentially weakens the stance that private healthcare coverage should always be prioritized over Medicaid/CHIP when establishing medical support orders. It also comports with what Oklahoma found in its strategic planning effort to improve healthcare coverage among IV-D children (Wilson, 2011). Specifically, Oklahoma found it in the best interest of the child and more cost effective to pursue cash medical support when the children are enrolled in Medicaid than to pursue private health insurance. Medicaid enrollment is more stable and provides better healthcare benefits than many private plans. Further, Oklahoma produced evidence that Medicaid expenditures were no different between children with private healthcare coverage and those without private healthcare coverage and that compliance with cash medical support orders distributed to Medicaid would generally exceed third-party liabilities reaped from private insurance coverage.

To date, Texas has made no changes in its medical support policies or practices based on the federal loosening of medical support requirements, but there was no need to do so since Texas was in full compliance with federal requirements.

Healthcare Reform

Some experts have begun to analyze the impact of national healthcare reform measures (*i.e.*, the Affordable Care Act) on medical support, but the full impact cannot be known until the detailed rules for implementing healthcare reform measures are developed and made available. Some of the key provisions of the healthcare reform are insurance plans offered through state insurance exchanges, the mandate for health insurance coverage, and controls on the out-of-pocket expenses of insurance premiums and costsharing (*i.e.*, co-pays, co-insurance, and deductibles).

By 2014, all U.S. citizens and legal residents should have affordable, quality insurance available to them from one of three sources: their employers, Medicaid (and CHIP for children), and state health insurance exchanges. ACA extends Medicaid eligibility to all Americans (including childless adults) to incomes up to 133 percent of the federal poverty level. ACA requires employers to provide qualified health insurance coverage to their employees or pay a penalty. ACA exempts small employers (*i.e.*, those with 50 or fewer employees) and effectively exempts employers that have no employees receiving an insurance tax credit. An insurance plan is qualified if it provides a certain level of essential benefits, including preventive care, and its costsharing is at least 60 percent of the actuarial value of the plan (*i.e.*, the plan covers at least 60 percent of the expected population's healthcare costs while enrollees themselves pay 40 percent in co-pays, deductibles, and co-insurance). State insurance exchanges will connect those without employer-sponsored insurance to private insurance plans that also are required to provide a minimum level of essential benefits, tax subsidies for insurance premiums, and costsharing subsidies. Insurance options from exchanges will also be made available to small employers.

Beginning in 2014, ACA mandates that citizens and legal residents have qualified health coverage or face a tax penalty. Qualified health coverage includes employer-sponsored insurance, insurance purchased through a state exchange, Medicaid, CHIP, Tricare, and other coverage. Failure to fulfill the mandate for insurance is not a criminal offense, but could result in deductions from tax refunds. ACA provides for numerous exceptions, such as those facing financial hardship. The Secretary of the U.S. Department of Health and Human Services (DHHS) may identify other exceptions. Those seeking exceptions must be certified through the exchange. The mandates extend to dependents, hence, it covers children. ACA relies on the IRS definition of "dependent." Under the Internal Revenue Service Code, this would mean the custodial parent. Often in divorce settlements, however, the parents agree to split the tax credits associated with the children (*e.g.*, if there are two children, each parent claims one child as a dependent, and if there is one child, each parent claims the child every other year). DHHS is expected to provide more guidance on the mandate in the near future, and the guidance may address the unique situations of children whose parents file separate tax returns because of divorce, they are unmarried and live in separate households, and other circumstances.

The costs of insurance and out-of-pocket medical expenses for children will change due to ACA. This is important to determining whether a parent has insurance available at a reasonable cost and medical support orders covering out-of-pocket medical expenses. Although the details are still being ironed out, exchange-purchased insurance will be offered on a sliding scale, with an allowable maximum of 9.5 percent of income at 400 percent of the federal poverty level. ACA also indirectly caps employer-provided insurance at 9.5 percent of income. Available tax credits, as well as Medicaid eligibility, will relate to "modified adjusted gross income" (MAGI), which essentially consists of the IRS's definition of adjusted gross income less 5 percent. The disregarded 5 percent replaces state-defined work disregards since the MAGI must be used to determine income eligibility for some Medicaid programs beginning in 2014. In addition, costsharing subsidies are available to those participating in an insurance plan from a state exchange. The sliding scale starts with an actuarial value of 94 percent for those at the lowest income rung. ACA also sets maximum out-of-pocket healthcare expenses at levels that relate to health savings accounts. So far, there are no rules on how healthplans can achieve these costsharing limits. They may vary copays, co-insurance, and deductible amounts. For example, A Kaiser Family Foundation (Levitt and Claxton 2011) contracted with three actuarial firms to estimate how insurance carriers may design their healthplans below ACA costsharing limits. For actuarial value of 60 percent (the minimum for qualified healthplans), the plans varied from an annual deductible of $6,350 per person and no co-insurance to an annual deductible of $2,750 per person and 30 percent co-insurance.

To date, although many parents are likely to obtain insurance from state exchanges, there is no requirement for exchanges and child support agencies to share information. Most federal and state child support administrators are aware of the potential conflict between the parent mandated to

provide insurance for the child under ACA and the parent who is ordered to provide health insurance, but believe it makes no sense to make policy changes at the state level until the mandate is fleshed out in federal rules or until OCSE provides guidance. No state is known to have considered ACA insurance premium thresholds in its definition of reasonable cost of insurance for the purposes of determining medical support orders. Similarly, no state is known to considered ACA costsharing provisions in its statutes and rules pertaining to medical support orders.

Chapter 3
Overview of Project Design and Demonstration Sites

The project was first designed in 2007 to address two principle problems of IV-D cases within the OAG. Administrators believed that 1) not all children eligible for Medicaid/CHIP were being enrolled, and 2) a notable share of children with newly established OAG orders were not eligible for Medicaid/CHIP and their parents lacked employer-provided insurance or it was not available at a reasonable cost.

The project sought to resolve these problems by facilitating Medicaid and CHIP enrollment during the OAG establishment process reasoning that during the process of establishing a medical support order it would be most practical to identify children who lacked health insurance. The National Medical Child Support Working Group (HHS and DOL, 2000) originally recommended incorporating Medicaid/CHIP eligibility determination and enrollment of uninsured children into the order establishment process. This group has essentially set the agenda for medical support in the 21st century. In addition to recommending that child support agencies explore coverage through Medicaid or CHIP for children whose parents lack access to employer-sponsored coverage at a reasonable cost, the Working Group also recommended federal rule changes that would authorize IV-D agencies to enroll children in Medicaid. By placing Medicaid eligibility workers in IV-D offices as part of the *Niños Sanos* demonstration, the OAG effectively achieved the same intent envisioned by the Working Group's recommendation. Secondly, and consistent with another recommendation of the Working Group (HHS and DOL, 2000), the project promoted the creation of more coverage options for children including the development of affordable, private insurance options.

Some underlying problems with Medicaid/CHIP enrollment that *Niños Sanos* sought to address were unexpectedly resolved prior to project implementation. The precipitous and unexplained decline of 80,000 children in Medicaid (Kaiser Network, 2006), coupled with a significant drop in CHIP enrollments (Dunkleberg, 2006), was later shown to be a function of the reduction in HHSC staff from state cutbacks and staffing issues at the time. Once these problems were resolved, Medicaid and CHIP enrollments increased, with the numbers currently exceeding 2006 levels. Higher rates of Medicaid and CHIP enrollments translate into a substantially higher proportion of Medicaid and CHIP children in establishment cases than previously anticipated. This pattern is revisited in the section of this report dealing with program outcomes.

Project Design and Key Treatments

Key components of the project design consisted of the following:

- Development of an advisory group of OAG and HHSC administrators to better serve their shared caseload,
- Creation and use of child support/Medicaid joint staff positions, and
- Identification and promotion of alternative insurance options for parents who lacked affordable employment-related insurance coverage for their children.

OAG/HHSC Advisory Group

Support and direction from both state and regional OAG and HHSC administrators was critical to the project design. Through the project, a steering committee comprised of OAG Field Operations staff, IV-D attorneys, and representatives from the Texas Health and Human Services Commission (HHSC) was organized in January 2008. The steering committee directed the integration of OAG and HHSC services and the development of the policies, procedures, and infrastructure needed to support the joint staff and promote alternative insurance options.

An "interagency cooperation contract" was drawn up between the OAG and HHSC in August 2008. The contract specified the following:

- HHSC will out-station staff at child support offices to determine Medicaid eligibility and information useful to the establishment of the medical support obligation. HHSC will be responsible for personnel issues and the supervision of the out-stationed staff.
- OAG will provide workspace and a suitable work environment (*e.g.*, supplies and parking) for the out-stationed HHSC employees.
- OAG and HHSC will share the costs of the staff.
- OAG and HHSC will collaborate to develop policies and procedures as needed for the effective implementation of the demonstration that comply with all state laws and federal regulations.
- HHSC staff will be trained on OAG's security policy and will sign an acknowledgement statement.
- OAG and HHSC agree to protect the other agency's data to which it has access. Neither agency shall make use of or further disclose of any information obtained in the course of performing the functions of the demonstration except as authorized and in accordance with governing statutes, codes, rules, and regulations.
- OAG and HHSC will follow a set of procedures (as specified in the interagency cooperation contract) in the event of any fraud or abuse associated with the performance of the contract.

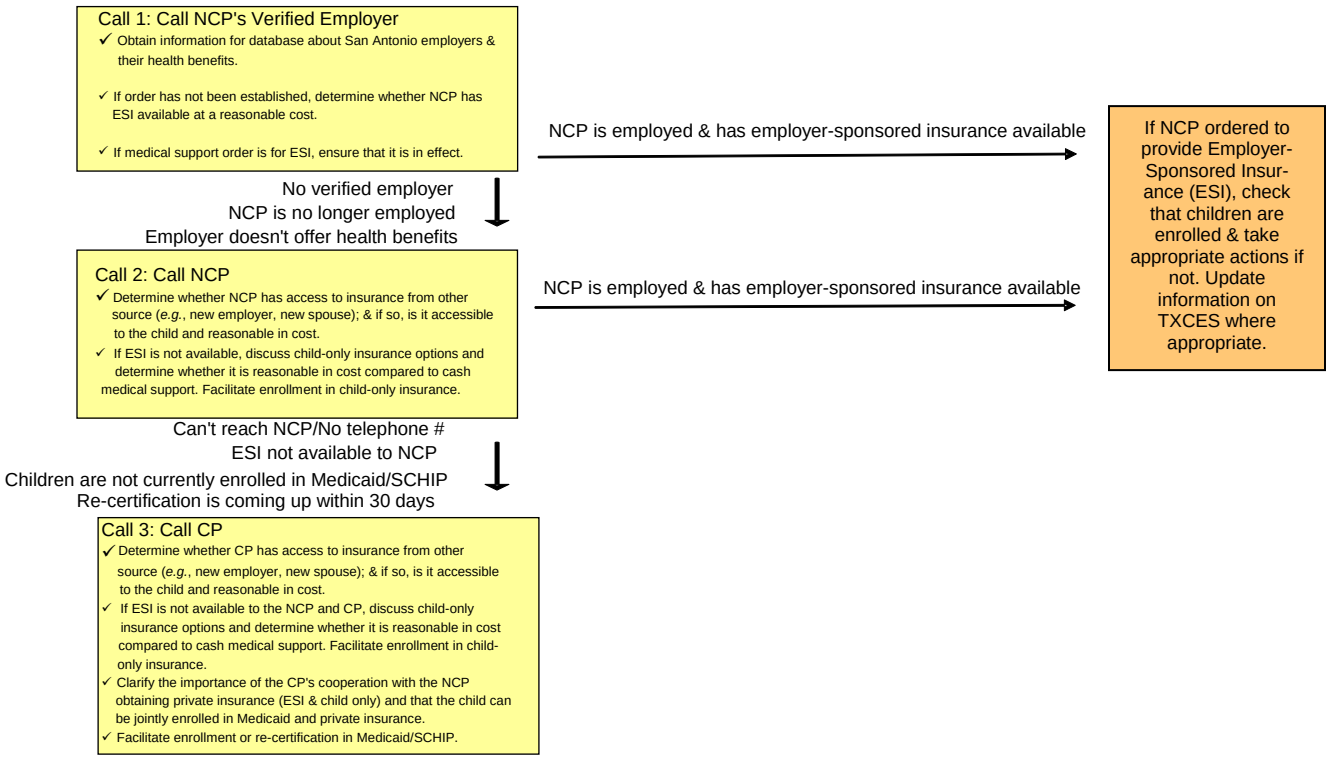
Joint Staff

The project's major treatment consisted of the creation and use of joint child support/Medicaid staff positions. Their job duties included:

- Assisting with the establishment of appropriate medical support obligations,
- Monitoring new medical support obligations and taking appropriate follow-up actions,
- Determining Medicaid/CHIP eligibility,
- Re-determining Medicaid/CHIP eligibility,
- Informing parents who lack healthcare options for their children of alternative sources of coverage and assisting them with enrolling in this coverage,
- Assisting with the identification of these alternative healthcare options,
- Training other staff on medical support, and
- Acting as a resident "Medicaid/CHIP expert" to OAG staff.

Joint staff were also responsible for contacting parents and their employers directly to determine what types of health insurance options were available to the children. Figure 3.1 displays the protocol followed by joint staff for contacting non-custodial and custodial parents, and their employers.

Figure 3.1. Protocol of Joint Staff Working Pre-CSRP Cases



Alternative Insurance Options

Another project treatment was the identification and promotion of alternative insurance options available to parents who lacked affordable employment-related healthcare options for their children. The project design called for HHSC and the OAG to work together to identify alternative sources of insurance available to children, including information developed by the Texas Department of Insurance (TDI) about private, child-only insurance plans. The information was to be made available to parents and OAG staff when establishing medical support orders.

Demonstration Sites

Bexar County, Texas was selected as the site for the demonstration project. It was considered a prime location for project testing due to the large volume of order establishment cases and the high rate of uninsured children in the area. Table 3.1 compares selected socio-economic characteristics of Texas and Bexar County. Bexar County had a total population of 1.7 million residents in 2010 and 47 percent of families were female-headed households, with children under the age of 18, that were at or below the poverty level. The percentages of children under age of 18 enrolled in Medicaid underscores the degree of poverty in both Texas and Bexar County. Over a third of children in both Texas and Bexar County received Medicaid in 2009. As stated earlier, for a child age 6 or older to be income eligible for Medicaid in Texas, family income must be less than 100 percent of the federal poverty level.

Table 3.1 also shows that 16 percent of children under age 18 lacked health insurance in Texas, while 13 percent of children under age 18 lacked health insurance in Bexar County. The lower rate in Bexar County may be attributed to the military bases located in the San Antonio area. As shown in Table 3.1, a higher proportion of Bexar County children have Tricare/military health coverage than do all Texas children. Nonetheless, the Bexar County offices selected for the demonstration generally did not serve the area in which military personnel generally live.

Table 3.1. Selected Socio-Economic Characteristics of Texas and Bexar County
(Source: 2009 American Community Survey and 2010 U.S. Census)

	Texas	Bexar County
Total Population (2010)	25,145,561	1,714,733
Population under age 18	6,888,479	462,619
Female-headed Families with Children Under Age 18		
Number of families	863,481	63,465
Percentage of families at or below poverty level	49%	47%
Median Family Income		
All families	**$56,607**	**$53,898**
Female-headed families with children under age 18	**$22,112**	**$23,443**
Percentage of children under age 18 without health insurance coverage	16%	13%
Percentage of children under age 18 with employer-provided insurance	45%	48%
Percentage of children under age 18 with Tricare/Military coverage	3%	7%
Percentage of children under age 18 with Medicaid coverage	35%	39%

Bexar County contains five child support offices and six HHSC offices that assist clients with Medicaid applications. Only four of the child support offices have the capacity for customer contact and the establishment and enforcement of orders. Each of these four offices represents one region (East, West, North, and South) of Bexar County. The fifth OAG office processes intakes and delegates them to the respective regions for appropriate establishment and enforcement actions. With the exception of the West OAG and HHSC offices, which are located in different buildings of the same office development, none of the OAG and HHSC offices is located in close proximity to each other. Project staff were assigned to three of the OAG offices in Bexar county (West, East, and South) that encompass the San Antonio area. The fourth office, San Antonio North, was excluded from project treatments because its demographics differed significantly from the other three San Antonio offices.

Table 3.2 compares state and Bexar County OAG (child support) caseload data. Among the 1,236,852 open child support cases in 2010 in the state of Texas, 73,018 cases came from the three Bexar County demonstration offices. Of these cases, medical support was ordered in 44,595 cases, however medical support was actually provided as ordered in only 30,297 cases, leaving 14,298 orders unordered. As computed from Table 3.2, the compliance rates with medical support orders were 67 percent in Texas overall, 69 percent in Office 203, 67 percent in Office 205, and 68 percent in Office 211. The compliance with orders for health insurance were 48 percent in Texas statewide, 47 percent in Office 203, 48 percent in Office 205, and 47 percent in Office 211.

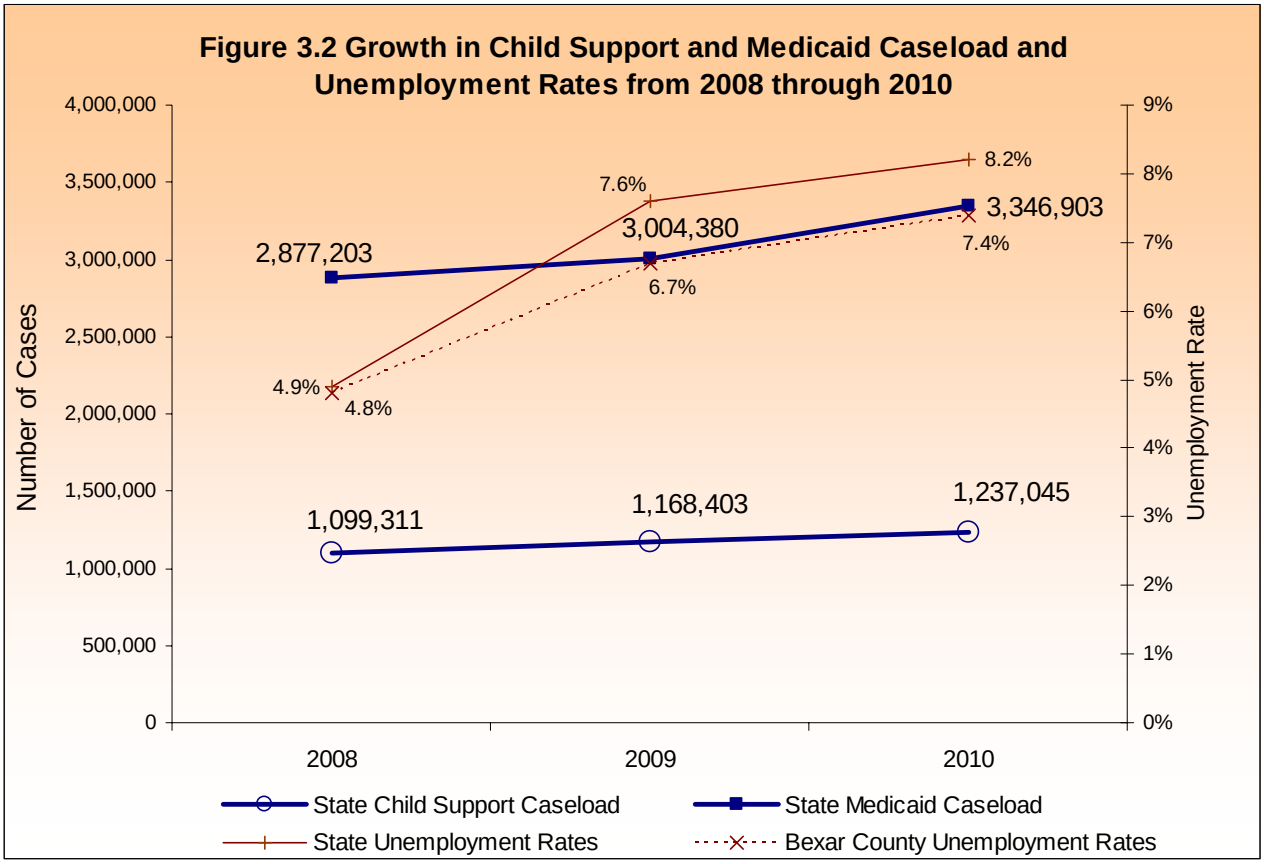
Orders for health insurance offer one method by which medical support can be ordered. Another method is ordering cash medical support, which are either distributed to the family or the Medicaid agency when the children are enrolled in Medicaid. As shown in Table 3.2, cash medical support distributed to the Medicaid agency yields substantial amounts: $52.5 million in Texas and $0.8 to $1.2 million in each of the demonstration offices.

Table 3.2. Selected Characteristics of Child Support Cases in Texas and Demonstration Offices
(Source: OAG 2010)

	Texas	Bexar County Demonstration Offices		
		Office 203 (San Antonio West)	Office 205 (San Antonio East)	Office 211 (San Antonio South)
Open cases	**1,236,852**	**24,019**	**27,406**	**21,593**
Open cases with established orders	**1,015,017**	**21,419**	**23,746**	**18,216**
Open cases in which medical support is ordered	**744,350**	**15,349**	**16,407**	**12,839**
Open cases in which medical support is ordered and provided	**496,109**	**10,567**	**10,990**	**8,740**
Open cases in which health insurance is ordered	**713,779**	**14,812**	**15,542**	**12,052**
Open cases in which health insurance is provided as ordered	**345,320**	**6,904**	**7,503**	**5,667**
Number of children determined eligible for Medicaid in open cases	**619,729**	**17,126**	**14,897**	**13,843**
Number of children determined eligible for Medicaid in open cases covered by private health insurance	**112,516**	**3,333**	**2,751**	**2,701**
Cases with medical coverage received from any source	**812,631**	**17,283**	**18,273**	**14,804**
Amount of cash medical support received that was assigned to the state	**$52,535,350**	**$1,208,464**	**$1,033,057**	**$863,407**

The Economic Recession

The demonstration project was conducted during the course of a national economic recession that began December 2007 and ended June 2009. The recession increased unemployment rates, as well as the demand for public assistance. In turn, this translated into fewer opportunities for employment-sponsored health insurance and higher Medicaid enrollments. Figure 3.2 shows that the Texas child support and Medicaid caseload increased over time along with an increase in the Texas and Bexar County unemployment rates.



Identifying Cases Appropriate for the Demonstration

The cases initially selected for treatment by *Niños Sanos* staff were new child support cases ready for establishment of a child support order using in-office, administrative procedures (CSRP). However, there was a slight modification in the cases targeted for treatment during the course of the project. In general, the first phase of the project that was conducted from October 2008 through December 2009 of the project targeted cases scheduled for an order establishment conference (CSRP). The second phase of the project was conducted from January 2010 through June 2010 and targeted cases right after the establishment of an order through CSRP.

Initially, *Niños Sanos* reviewed all cases scheduled for an establishment conference (CSRP) in three child support field offices in San Antonio to determine whether the children currently had any healthcare coverage, including Medicaid or CHIP, and to identify other information useful to medical support. Only after assessing private coverage, were *Niños Sanos* staff instructed to offer assistance with Medicaid/CHIP enrollment in treatment cases. This instruction was consistent with Texas statute that places a priority on ordering private healthcare coverage and ordering Medicaid as

a last resort when establishing a medical support order. Because the initial volume of potential Medicaid/CHIP applicants among CSRP cases was small, the project directors temporarily expanded the targeted caseload to cases scheduled for hearings and modification. This did not markedly increase the volume of potential Medicaid/CHIP cases and the Medicaid/CHIP enrollment rate ensuing from the project continued to be low.

As discussed in more detail later, OAG administrators granted *Niños Sanos* staff limited interaction with parents. There was concern that *Niños Sanos* staff were unqualified to address all the child support concerns of parents and that their repeated efforts to engage parents might overwhelm and alienate parents or slow down the process of establishing financial child support orders. OAG administrators did not believe the demonstration project should in any way impede or hamper the establishment of a financial child support order, particularly because the percentage of cases with established orders is a key performance measure.

Beginning in 2010, *Niños Sanos* staff worked on cases with newly established medical support orders rather than cases scheduled for an establishment conference. OAG administrators believed this would be a more appropriate time for *Niños Sanos* staff to identify children in cases that were potentially eligible for Medicaid/CHIP because the medical support would be already established. This would rid any possibility that *Niños Sanos* staff could affect the outcome of the order establishment. Moreover, this allowed *Niños Sanos* staff to use the medical support order as an impetus for intervening in a case. *Niños Sanos* staff were instructed to first review the medical support order and then determine whether the parents and employers, if appropriate, had complied with the order. Only after performing these tasks were *Niños Sanos* staff instructed to inform the parents of Medicaid/CHIP options and assist with Medicaid/CHIP enrollment or renewals.

Niños Sanos workers were permitted to contact employers by telephone to obtain information about employer-provided insurance. Although they were not permitted to telephone parents during the pilot, they were allowed to communicate with parents in person in cases where their children lacked current coverage but could be Medicaid/SCHIP eligible. After full operations began, *Niños Sanos* staff could telephone parents. Initially, lengthy, generic information about private, child-only insurance published by the Texas Department of Insurance was distributed to parents lacking private coverage during the CSRP by the child support officer and by *Niños Sanos* staff at the court.

Generating Groups Treatment and Non-Treatment Cases

To assess the impact of project treatments in a rigorous manner, the evaluation design required that all eligible cases be randomly assigned to one of two groups based on the last digit of the noncustodial parent's (NCP) Social Security number (SSN). Cases with an NCP's SSN ending in an even number were assigned to the treatment group while those ending with an odd number were assigned

to the control group. *Niños Sanos* staff were instructed to research and intervene in the even-numbered treatment cases prior to their scheduled CSRP and/or court hearing and to complete a data collection form for all cases in both treatment groups. This random assignment was applied to all cases worked through December 2009. As of January 2010, random assignment ceased. This occurred so that *Niños Sanos* staff could work a sufficient number of post-CSRP treatment cases for statistical analysis. (As discussed above, as of January 2010, the cases targeted for treatment switched from before the CSRP establishment conference to immediately following the CSRP conference if an order was indeed established.)

Chapter 4
Project Cases and Treatment Phases

Overview of Project Cases

The caseload worked by *Niños Sanos* staff can be broken down by the four phases of the project. The first phase was an initial pilot that included some, but not all, of the treatments. The other three phases involved all available treatments, but the criteria for selecting cases varied among the phases. The second phase and fourth phase produced the vast majority of project cases and consumed most of *Niños Sanos* staff's efforts. The major difference between the second phase and the final phase was subtle. In the last phase, *Niños Sanos* staff worked cases shortly **after** the child support order was established through a CSRP (Child Support Review Process), while in the second phase *Niños Sanos* staff worked cases just **before** the case was scheduled for a CSRP establishment hearing.

The below bullets summarize each of the phases separately.

- *Initial Pilot.* Staff worked pre-CSRP establishment cases and court cases from April through October 2008. At this time, staff could only take limited actions on cases because OAG and HHSC were still developing, arranging, and agreeing on processes, protocols, and other logistics.
- *Core Demonstration of Pre-CSRP establishment cases.* By October 2008, OAG and HHSC have finalized the majority of logistics necessary for staff to use all project treatments. Staff engaged the core demonstration through December 2009.
- *Second pilot targeting former Medicaid cases.* In late 2008, the project experimented with a second pilot targeting former Medicaid cases in which the noncustodial parents were paying. The underlying theory is that these cases may have failed to complete their Medicaid redetermination or they may no longer be eligible for Medicaid. In the former situation, *Niños Sanos* staff would help initiate the Medicaid redetermination process. In the latter situation, *Niños Sanos* staff would explore other healthcare coverage options including child-only, private insurance.
- *Core-Demonstration of Post-CSRP cases.* Beginning in 2010, *Niños Sanos* staff worked cases shortly after the child support order was established through a CSRP. The rationale for switching treatment from **before** to **after** CSRP was the time after CSRP provided a better opportunity to discuss medical support and present Medicaid/CHIP options. The establishment of the child support order takes precedent before the CSRP and eclipses Medicaid/CHIP enrollment and redeterminations.

Table 4.1 compares and contrasts information about the four phases. Much of the report's analyses focus on cases generated from the second and fourth phases. This includes about 2,500 cases. The other two phases (the initial pilot and the pilot targeting Medicaid cases) were conducted over shorter time periods and used to inform subsequent modifications to the project. In all, over 3,000 cases came through the *Niños Sanos* project.

Table 4.1. Number of Cases Analyzed for Each Project Phase			
	Number of Cases	Targeted Cases	Time Period
Initial Pilot of Selected Treatments Total	573 cases	Pre-CSRP cases and cases scheduled for court	July-October 2008
Core Demonstration (Pre-CSRP establishment cases) Non-treatment Treatment Total	1,087 cases 990 cases 2,077 cases	Pre-CSRP establishment cases	October 2008-December 2009
Second Pilot of Former Medicaid Cases Non-treatment Treatment Total	0 cases 215 cases 215 cases	• Former Medicaid cases • Medicaid ordered • Cash medical support order more than $50 • Medical support payments received	November-December 2008
Post-CSRP Cases with Orders Established Non-treatment Treatment Total	0 cases 505 cases 505 cases	Post-CSRP order establishment cases	January –June 2010

Overview of Pilots

The initial pilot and pilot targeting former Medicaid cases provided insightful information to the project even though they were not integral to the overall project.

Initial Pilot

When *Niños Sanos* staff came on board in April 2008, not all of the tools, resources, and OAG-HHSC protocols were in place. Nonetheless, from April through October 2008, *Niños Sanos* staff began reviewing cases and took what actions they could to familiarize themselves with the child support office and its activities, the automated systems, data collection forms, and assignment of cases to treatment and non-treatment groups. In addition, they completed data collection forms that were eventually compiled and analyzed by the evaluator. The analysis of pilot case data informed subsequent changes to the project.

During the pilot, *Niños Sanos* staff reviewed 573 cases using information from the OAG and HHSC automated systems to determine whether either parent had access to private health insurance and if the children were not currently enrolled in Medicaid or CHIP. If there appeared to be no healthcare coverage from any source in a treatment case, *Niños Sanos* staff attempted contact with the parents to

inform them of Medicaid/CHIP and to offer their assistance with Medicaid/CHIP enrollment. *Niños Sanos* staff attempted contact via telephone in CSRP establishment cases and made in-person contact in child support cases scheduled for court hearings.

The evaluator compiled 434 of the pilot cases into a database. Analysis of the pilot cases not only confirmed that many children in the child support caseload lacked healthcare coverage, but it also revealed many findings that informed subsequent project direction and barriers. It found that among the 18 percent of pilot cases that appeared to lack coverage and could potentially benefit from *Niños Sanos* intervention, most were terminated CSRPs, cases that failed to appear for CSRPs, and court cases. This finding suggested that child support actions, particularly those actions that were part of the CSRP process, may not reach children who lack healthcare coverage. An order is not always established when CSRP is terminated or the parents fail to appear to the CSRP conference. The *Niños Sanos* staff's research on a case cannot affect what is ordered as medical support if there is no order established. For example, the research finding will not help determine if the noncustodial parent is ordered to provide insurance or the custodial parent is ordered to apply for Medicaid if there is no order established.

Another problem is that some of the cases scheduled for CSRP may eventually became court cases since OAG will resort to the court order establishment process if the CSRP establishment process fails. Local OAG administrators decided there was not sufficient physical space within the courts to station *Niños Sanos* staff there. In the initial pilot phase, however, the project experimented with placing *Niños Sanos* staff in the court. *Niños Sanos* staff participating in the court pilot found they the courts to be a successful venue for identifying parents whose children could benefit from Medicaid/CHIP and actually helping these parents with the Medicaid/CHIP application process.

Another finding that informed subsequent project direction and barriers is that children in most (81 percent) of the pilot cases appeared to have healthcare coverage, so there was no need for *Niños Sanos* intervention in the majority of the cases. From another angle, however, this underscores the challenge of the project to find the minority of child support cases in which children do indeed lack healthcare coverage. The source of the healthcare coverage consisted of Medicaid (61 percent of pilot cases), CHIP (4 percent of pilot cases), and private insurance (16 percent of cases). As realized later, many cases must be reviewed to find those in which there are Medicaid/CHIP-eligible children who are not currently enrolled.

Second Pilot Targeting Former Medicaid Cases

The second pilot experimented with targeting cases with established orders that were also former Medicaid cases. This seemed like a reasonable alternative to targeting pre-CSRP cases based on the findings from the analysis of pilot cases. Targeting cases with established orders that were also former Medicaid cases could possibly identify cases in need of assistance from *Niños Sanos* staff to

facilitate Medicaid/CHIP redetermination or enrollment in other healthcare options including child-only insurance plans. To this end, OAG administrators selected cases in the Bexar County caseload in which the OAG system indicated that the medical support order directed coverage from Medicaid or CHIP, but the OAG system did not indicate current Medicaid receipt, there was a medical support order for at least $50 per month, and the noncustodial parent was paying. The last two criteria aimed to find cases in which the children were no longer Medicaid eligible due to income but the parent or parents could possibly afford private, child-only insurance. A total of 215 cases met these criteria and were assigned to *Niños Sanos* staff in November 2008. As a first step to the review, *Niños Sanos* staff checked whether child was actually enrolled in Medicaid and CHIP using the HHSC automated system rather than the OAG system. In the vast majority of cases, it was found that the children were indeed still enrolled in Medicaid/CHIP. This lead to corrections to ensure accurate Medicaid information on the OAG system.

Description of Cases in Core Demonstration Phases

In this section, the description of cases is limited to those cases worked in the core demonstration phases of the project. This consisted of the bulk of the project cases and absorbed most of the efforts and time of *Niños Sanos* staff. The cases worked in these phases are further broken down into three categories:

- Non-treatment, pre-CSRP cases,
- Treatment, pre-CSRP cases, and
- Treatment, post-CSRP cases.

Each treatment group is compared to the non-treatment, pre-CSRP cases.

Table 4.2 describes the age of the cases and their orders from each of the three offices at the time of project intake. The project intake years in Table 4.2 reflect the shift from working pre-CSRP cases to post-CSRP cases in 2010. Pre-CSRP cases were worked in 2008 and 2009 and all post-CSRP cases were worked in 2010. Table 4.2 indicates some differences in the split between non-treatment and treatment cases in Offices 203 and 211, specifically, Office 201 had a larger share of treatment cases than non-treatment cases, while Office 211 experienced the opposite, that is, a larger share of non-treatment cases than treatment cases. The reason for this is unclear. The evaluator's interviews with staff and double-checks of case numbers confirmed that staff were properly using random assignment protocols to generate treatment and non-treatment groups.

Table 4.2 also shows the age of the IV-D case and the age of the child support order. The difference between the ages reflects how much time it took to establish a child support order. There were small differences in case ages between the two groups. Most pre-CSRP cases did not have an order

established, while most post-CSRP cases did have an order established. This is consistent with case selection criteria. *Niños Sanos* staff identified most pre-CSRP cases from lists of cases scheduled for CSRP establishment conferences, but a few offices also included cases scheduled for CSRP order modifications. There was a small proportion of post-CSRP cases without orders established that were probably pending final court approval.

Table 4.2. Characteristics of the IV-D Cases at Project Intake (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases (n = 1,087)	Pre-CSRP Cases (n = 990)	Post-CSRP Cases (n = 505)
Project Intake Year			
2008	18%	15%	0%*
2009	82%	85%	0%*
2010	0%	0%	100%*
Child Support Office			
Office 203 (San Antonio West)	29%	35%*	41%*
Office 205 (San Antonio East)	25%	27%	28%
Office 211 (San Antonio South)	45%	37%*	31%*
Age of the IV-D Case			
Less than 1 year	45%	52%*	50%
1–2 years old	11%	11%	15%*
3–5 years old	11%	13%	12%
5 or more years	23%	15%*	16%*
Missing	10%	9%	7%*
Age of the Order at Intake			
Less than 1 year old	2%	3%	56%*
1-3 years	4%	4%	9%*
4 or more years	6%	3%	11%*
Not applicable: order establishment case	89%	90%	15%*
Missing	0%	0%	9%*

*Statistically different from the non-treatment group at $\rho < 0.05$.

Table 4.3 describes the number of children in the project cases and their ages. Most cases (*i.e.*, 85 to 89 percent), depending on the subgroup, had one or two children. Child age affects Medicaid eligibility income thresholds in Texas, as it does in most states. The age of the youngest child in most pre-CSRP cases (*i.e.,* 72 to 74 percent of treatment and non-treatment cases, respectively) was five years old or younger. Post-CSRP cases comprised somewhat older children. Only 59 percent of post-CSRP cases involved cases in which the youngest child was five years old or younger.

Table 4.3. Age and Number of Children in Project Cases (Percentage of Cases)			
	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Number of Children	(n = 1,087)	(n = 990)	(n = 505)
1 child	64%	62%	65%
2 children	23%	24%	24%
3 children	10%	10%	8%
4 or more children	3%	4%	3%
Age of Youngest Children	(n = 933)	(n = 821)	(n = 409)
Child less than 1 years old	30%	28%	16%*
Ages 1–5 years old	44%	44%	43%
Ages 6–18 years old	25%	27%	39%*
Ages 19 or older	1%	1%	2%

*Statistically different from the non-treatment group at $\rho < 0.05$.

Table 4.4 describes the parents' employment status for all project cases at the time of intake. Specifically, it notes whether the child support agency was able to verify employment for either parent. Employment can be a source of the parent's income used to establish the child support order amount. Employment can also be the gateway to collecting child support from income withholding or obtaining healthcare coverage for children if the parent's employer offers health benefits and the cost of insuring the child is reasonable. The noncustodial parent's employment was verified in just under half of the pre-CSRP cases and just over half of the post-CSRP cases. The employment verification rate may be higher in post-CSRP cases than pre-CSRP cases because employment verification is typically part of the order establishment process.

The verified employment rates were lower among custodial parents than they were among noncustodial parents. This reflects the high incidence of public assistance received by custodial parents.

Table 4.4. Parents' Employment Status at Project Intake (Percentage of Cases)			
	Non-Treatment	Treatment	
	Pre-CSRP Cases (n = 1,087)	Pre-CSRP Cases (n = 990)	Post-CSRP Cases (n = 505)
Noncustodial Parent			
Verified employment	47%	48%	58%*
No verified employment	53%	52%	42%*
Custodial Parent			
Verified employment	39%	36%	48%*
No verified employment	61%	64%	52%*

*Statistically different from the non-treatment group at $\rho < 0.05$.

Table 4.5 displays the number of additional child support cases that parents had. The information was collected for pre-CSRP cases only. The number of child support cases can be considered when determining whether employer-sponsored insurance is reasonable in cost or the amount of cash medical support order. These amounts are capped at nine percent of the noncustodial parent's gross income. The cap applies across all orders. For example, if the noncustodial parent's gross income is $1,000 per month, his or her combined cash medical support orders cannot exceed $90 per month.

Table 4.5. Number of Additional Child Support Cases Among Parents (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Noncustodial Parent	(n = 394)	(n = 384)	Not Available
No additional cases	25%	20%	
1 additional case	31%	26%	
2 additional cases	12%	12%	
3 or more additional cases	6%	7%	
Unknown	25%	35%*	
Custodial Parent	(n = 379)	(n = 399)	Not Available
No additional cases	20%	19%	
1 additional case	31%	28%	
2 additional cases	14%	8%*	
3 or more additional cases	4%	5%	
Unknown	31%	41%*	

*Statistically different from the non-treatment group at $\rho < 0.05$

Table 4.6 describes the order amounts for project cases. The average order consisted of similar amounts among non-treatment and treatment groups. It averaged $266 per month among non-treatment cases, $275 per month among pre-CSRP treatment cases, and $256 per month among post-CSRP treatment cases. The median order amounts also consisted of similar amounts: $239 per month among non-treatment cases, $243 per month among pre-CSRP treatment cases, and $222 per month among post-CSRP treatment cases. The fact that the medians amounts are less than the average amounts is driven by a few relatively high orders. As shown in the table, however, only a small fraction of orders are more than $500 per month (*i.e.*, 12 percent of non-treatment cases, 11 percent of both pre-CSRP treatment cases and post-CSRP treatment cases).

Table 4.6. Amounts of Child Support Orders at Project Intake (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Order Established	(n = 1,087)	(n = 990)	(n = 505)
Yes	51%	65%*	93%*
No/Don't Know	49%	35%*	7%*
Monthly Child Support Order	(n =532)	(n =613)	(n =452)
$0	15%	16%	25%
$1- $100	2%	18%*	1%
$101-$250	35%	26%*	31%
$251-$500	36%	30%*	32%
$501 or more	12%	11%	11%
Average	$266	$275	$256
Median	$239	$243	$221

*Statistically different from the non-treatment group at $\rho < 0.05$.

Chapter 5
Evaluation Method

The Center for Policy Research (CPR) was contracted to conduct an independent evaluation of the *Niños Sanos* demonstration. The method of evaluation is described in detail in this chapter. CPR employed process, outcomes, and impact analyses. An experimental approach was used to examine the impact of the project by comparing outcomes of treatments cases to the outcomes of cases using routine processes. The analysis of the treatment cases is also used for the outcomes analysis. In addition, CPR analyzed outcomes by comparing changes in medical support performance among the project offices to the state as a whole over time. Process information and other information that helped put the findings from the outcomes and impact analyses into context were obtained from interviews, periodic meetings and discussions with project staff, HHSC and OAG administrators, and others.

Major Research Questions

CPR originally set out to answer a series of key research questions about medical coverage in the child support program. They are as follows:

- Did the demonstration increase the percentage of children with healthcare coverage?
- Did private coverage increase? From what source: custodian's employer, noncustodial parent's employer, or private child-only insurance?
- What is the availability of employer-sponsored medical insurance in the child support caseload? How many custodial and noncustodial parents qualify for such coverage? What is the average and median cost of adding dependent children to an employee's policy?
- Did Medicaid coverage increase? Did more custodial parents follow through with the order to enroll children in Medicaid? Were there fewer lapses in Medicaid because the project helped parents with the Medicaid recertification process?
- Did SCHIP coverage increase? Did more custodial parents follow through with the order to enroll children in SCHIP?
- Did the demonstration increase the percent of OAG cases in which healthcare coverage matches the medical support order?
- Did the demonstration increase the amount of cash medical support ordered and collected?
- Did the demonstration increase third-party recoveries for Medicaid costs?
- How were case medical support orders established? What percentage of net income did they comprise? Did compliance vary by the cash medical support amount (*e.g.*, 5 percent verses 9 percent)? Did it vary with the noncustodial parent's income, total obligation (child support plus cash medical support), amount of arrears, incidence of multiple orders, etc.?

- How often does healthcare coverage change? Are there periods when the child is uninsured? Why? What policies (*e.g.*, periodic review, order modification) could help fill likely gaps in healthcare coverage?
- Were there offsets in Medicaid and SCHIP costs?
- Did the demonstration efforts reduce the need to enforce orders for unreimbursed medical costs?

Research Methods and Data Sources

The experimental research approach, which was used for the outcomes and impact analyses, requires a random assignment of cases to treatment and non-treatment groups. Cases were assigned based on the last digit of their Social Security number. *Niños Sanos* staff were instructed to assign even-number cases to the treatment group and odd-numbered cases to the non-treatment group. With the exception of telephone reminders to parents about scheduled dates for CSRP establishment hearings, *Niños Sanos* staff were instructed to take actions in treatment cases and no actions in non-treatment cases. Project cases were initially identified from lists of cases scheduled for CSRP establishment conferences. Beginning in January 2010, project cases were identified from lists of cases with recently established orders. There were a sufficient number of establishment cases flowing through the three demonstration sites to detect statistical differences between non-treatment and treatment groups.

An experimental approach was used to examine the impact of *Niños Sanos* treatments on pre-CSRP establishment cases. In all, as shown earlier in Table 4.1, there were 2,077 pre-CSRP establishment cases that came into the project between October 2008 and December 2009. This included 1,089 non-treatment cases and 990 treatment cases. In addition, there were three other phases to the project, including two pilots, that are also described in Table 4.1. The initial pilot of 573 cases were also randomly assigned to treatment and non-treatment groups. The second pilot of 215 cases and the final phase of projects cases that included 505 cases, however, did not involve random assignment. Instead, all cases were subject to treatment. The second pilot consisted of the review of former Medicaid cases. *Niños Sanos* staff worked cases shortly after an order was established through CSRP in the final phase. The case volumes of the second pilot and final phase were too small to divide into treatment and non-treatment groups and still be adequate for statistical analysis.

Pre/Post Comparisons

Both treatment and non-treatment cases were tracked over time. Staff completed a data collection form for all cases at intake and elaborated on forms for treatment cases after initial treatments were applied. The treatments occurred typically within weeks of intake. *Niños Sanos* staff answered the

questions on the data collection form based on their look-ups of information from the HHSC and OAG automated systems, the actions they took on a case, the responses they received from parents and employers they were able to contact, and their own assessment of the case. In all, the project relied on four data collection form. The first data collection form was used for the pilot and revised in October 2008. The revised version was used for most project cases, but was revised again in January 2010 to accommodate the switch from targeting pre-CSRP establishment cases to targeting cases immediately following a CSRP establishment. In addition, *Niños Sanos* staff were to complete a follow-up data collection form for post-CSRP order establishment cases 45 days after completing the first form. Appendix A contains copies of all of the data collection forms except the one used for the initial pilot.

Data collection forms were completed for 2,999 cases. A list of these cases was sent to OAG to pull subsequent information about the cases, such as medical support orders and compliance, as tracked by OAG's automated system. Appendix B contains a list of the data fields and the data codebook for data retrieved from OAG. Three separate downloads of information were conducted for the project. The first download occurred in November 2009, the second download occurred in November 2010, and the final download occurred in April 2011. This allowed for a comparison of the treatment cases before and after treatment and a comparison of the non-treatment cases between intake and follow-up periods. Several factors affected the timing of the downloads. The first download was delayed until a sufficient number of treatment cases that had been in the project for at least six months were available and due to limited availability of OAG information technology staff. The second download occurred about a year after the first download. The final download was timed to allow for the longest time period possible while still allowing sufficient time for analysis. In all, 2,833 cases were matched to TXCSES downloads. The 166 unmatched cases were excluded from analysis. Depending on when a particular case entered a project, some cases had as little as one year of follow-up data, while other cases had as much as two and a half years of follow-up.

Trend Data on Medical Support Performance

CPR also examined trend data from medical support performance for fiscal year 2007, 2008, 2009, and 2010. Texas tracks the same medical support performance data tracked by the federal Office of Child Support Enforcement to compile data for its annual reports to Congress. This includes the number of orders with medical support established and orders for the parent(s) to provide health insurance coverage for their children and for cash medical support. Orders to provide health insurance coverage are also tracked separately. In addition, the measures "cases in which medical support is ordered and provided" and "cases in which health insurance is ordered and provided" are tracked. The federal measures before 2010 do not count Medicaid as health insurance coverage. Before 2011, Medicaid could only be counted as medical support if cash medical support was ordered and actually received.

Qualitative Analysis

A final component of the evaluation was qualitative. It assessed the perceived helpfulness of placing Medicaid staff at the child support agency to promote medical coverage of children, the viability of various private insurance options for IV-D children, and the reactions of parents, employers, and insurance carriers to efforts to improve coverage for children and expand the use of private insurance. This qualitative research was conducted in interviews and focus groups with project staff and administrators from HHSC and OAG, and *Niños Sanos* personnel. Among the questions posed were the following:

- What are the barriers and benefits to inter-agency cooperation in the medical support area? What specific challenges did HHSC and OAG encounter in designing and implementing *Niños Sanos*?
- What alternative collaborative and staffing arrangements might the OAG pursue to achieve the goals of expanding medical coverage for children and improving the use of private insurance options?
- What are the benefits and limitations of Medicaid for children in the child support caseload? Is it the preferred source of medical coverage? Why? Why not? How can Medicaid coverage be offered and continued in a more systematic manner so that all eligible children are enrolled and there are fewer lapses of coverage?
- What are the benefits and limitations of SCHIP for children in the child support caseload? Is it the preferred source of medical coverage? Why? Why not? How can SCHIP be offered and continued in a more systematic manner so that all eligible children are enrolled and there are fewer lapses of coverage?
- What are the benefits and limitations of employer-sponsored insurance for children in the child support caseload? How many employers provide it? What are the average and median costs associated with these policies for employees, dependents, and families? What deductible levels are they choosing? How often do employers change insurance companies? What do they expect to be doing about health insurance in the next several years?
- What are the benefits and limitations of child-only insurance for children in the child support caseload? What are the features of plans that are currently available? What are average and median policy levels? What are deductibles? What does the application process entail in terms of time and cost? What do insurance companies expect to do in the way of generating and amending child-only policies in the next several years?
- What policies and approaches do custodial parents favor for generating medical coverage for their children? What policies and approaches do noncustodial parents favor for providing medical coverage for their children?
- What lessons can be drawn about effective methods of providing medical support for children in the caseload?
- What lessons can be drawn about effective methods of improving the medical support performance measure for the State of Texas?

Appendix C contains the complete interview guide.

Research Limitations

There were several limitations to the research and data collection.

- *Niños Sanos* staff did not always adhere to the random group assignment because of their passionate desire to help needy children. In some cases in which the children lacked healthcare coverage and should have been assigned to the non-treatment group, *Niños Sanos* staff offered information and assistance about Medicaid enrollment. Compounding the problem was protocol that required *Niños Sanos* staff to contact all parents in both treatment and non-treatment cases to remind them of the scheduled CSRP conference. During these telephone calls, it was difficult for *Niños Sanos* staff to refrain from offering Medicaid/CHIP information and enrollment assistance when a parent mentioned that the child(ren) lacked healthcare coverage.
- At first, *Niños Sanos* staff did not adequately complete data collection forms, nor did they follow all of the process steps. In particular, staff often skipped the step that requiring them to attempt to make contact with the parents and employers. They were also not always diligent with following up on cases after a CSRP occurred. Further, when staff did actually take action, they did not always record it. An attempt was made to address these problems, in late January 2009 through staff training and enhanced supervision efforts.
- It was not possible to obtain CHIP information and other detailed information about Medicaid/CHIP enrollments, denials, and renewals. TXCSES, the OAG automated system, only captures Medicaid status, not CHIP status and it does not always have the most up-to-date information about a child's healthcare coverage. TXCSES Medicaid status does not always perfectly match what is recorded on the HHSC system. CPR sought CHIP information from HHSC, but they would not provide it. Therefore, most of the follow-up information was limited to what could be retrieved from TXCSES. Staff had difficulty acquiring missing information directly from parents because parents are not always forthcoming about changes in their employer-provided health insurance.
- Initially, there were also issues with noting Medicaid status in TXCSES, however, these problems were resolved early in the project.
- A limited amount of information was gathered about the availability of employer's health benefits and the cost of those benefits. The source of that information was self-reports that employers and parents provided *Niños Sanos* staff, but staff did not have contact with employers and parents in many cases and when they did, interviewees were not always forthcoming with that information. Although TXCSES does have a place to record insurance cost, that data field is rarely populated.
- A limited amount of information was gathered from parents on the children's subsequent private health insurance coverage as well. Obtaining the information from follow-up interviews with parents is not a reasonable option because *Niños Sanos* staff were only able to successfully contact about 18 percent of the custodial parents at intake. Parents were the information source about details about their available healthcare coverage (*e.g.*, whether a step-parent had available coverage), their interest and understanding of child-only, private health insurance plans and Medicaid/CHIP, and other information. This limited information to what is available from

TXCSES, which was very sparse. TXCSES only noted if there was a medical support order for private coverage and more detailed insurance information was often unrecorded.

- Follow-up periods were not uniform across cases because of the range of time periods between project intake and points in time of TXCSES downloads. TXCSES data were downloaded at three different points in time: November 2009, November 2010, and May 2011.
- The major difficulty encountered while conducting research was the deficiency of usable data gathered from pre-CSRP child support cases in which medical support orders were not yet established. Once the project design was revised to target post-CSRP cases in which medical support had been established for data collection, more illuminating data was able to be gathered.

Chapter 6
Implementation of the Project and Treatments

Implementing project treatments as originally designed presented many challenges. Coordinating efforts between Child Support (OAG) and Medicaid (HHSC) was challenging due to conflicting agency policies and procedures. Creating joint staff positions and getting staff to a point where they could productively work cases proved to be more difficult than anticipated. The amount of effort required to create, manage, and support joint staff positions was underestimated. Providing alternative insurance options to parents also proved more difficult in practice than expected. During project implementation, caseworkers also experimented with intervening in select enforcement cases and had limited success. Over time, collaboration between OAG and HHSC grew, particularly at the regional level. Child Support and Medicaid collaboration was integral to this project, and through their determined dedication, they were able to overcome challenges and implement treatments that produced successful outcomes.

The implementation of the first phase of project treatments began in October 2008. The low volume of new Medicaid/CHIP enrollment among treatment cases targeted within the first phase was discouraging. On several occasions, projects administrators discussed changes to the project that would allow for more effective intervention. This led to a subtle change in the cases targeted for treatment beginning in January 2010, in which revised data collection forms were used. Cases were targeted for treatment immediately following order establishment through the CSRP process rather than before the CSRP establishment conference was scheduled. Project administrators hoped that after the order was established, parents would be more receptive to discussions about Medicaid/CHIP and other healthcare options and less overwhelmed by the setting of a financial child support order.

State and federal regulations in effect during the course of the project posed ongoing challenges to Medicaid outreach and enrollment. Texas statute prioritizes private coverage over Medicaid/CHIP coverage as the primary source of medical support. Thus, increasing healthcare coverage among IV-D children through Medicaid/CHIP in this project was perpetually difficult. OAG policies also reflected the state statute. OAG essentially required the exhaustion of private coverage options before Medicaid/CHIP could be discussed with a parent. In addition, determining that private insurance was not available or not available at a reasonable cost was a very time-consuming and tedious process. By the time that determination had been made, the opportune moment to discuss Medicaid/CHIP and private child-only insurance options with parents was often lost. This provided another reason for switching *Niños Sanos* treatments from before order establishment to immediately after order establishment when the parents would be more receptive to figuring out how they would

fulfill their orders to provide medical support, as well as provide healthcare coverage for their children.

Child Support-Medicaid Collaboration

Within the first year of the project, the Child Support (OAG)-Medicaid (HHSC) steering committee met monthly and sometimes weekly to address the many tasks and details of creating and managing joint staff, and in particular the roles and responsibilities of each agency within the collaborative project design. The delineations of roles and responsibilities between agencies concerned access to the other agency's automated system, setting up computer lines, how to abide to each agency's data confidentiality requirements, the extent that staff could update information on either agency's automated system, responsibilities for mailings and returned addresses, responsibilities for telephones and voice mails, and other logistics. After the first year, the committee agreed upon adjustments to the project and made more allowances to expand interagency collaboration. Once revisions were made to the project design and the cooperation agreement was finalized, operations began and the committee was able to meet less frequently.

By October 2008 when the project was ready for full operations, several lessons had already been learned from the collaboration. One of the major outcomes was increased understanding and appreciation for each agency's goals. Over the course of planning the implementation of the project, administrators from the two agencies identified a variety of cultural and procedural differences that had surfaced. A list of the most significant conflicts follows:

- HHSC's mission is to get health coverage for every child and routinely enroll parties in Medicaid if they are eligible conflict with OAG views of Medicaid as a less desirable option for medical support and its preference for pursuing private coverage first and using Medicaid as secondary insurance.

- HHSC refers to the people it serves as "clients," while the OAG terms them "customers."

- Clients can reach HHSC workers directly by telephone and/or at their office. The agency promotes direct access between customers and workers. The OAG has a call center that receives all incoming calls and protects workers from direct contact so that they can get their "work done."

- OAG is focused on generating and enforcing court orders. The agency has mainly legal relationships with its customers. Medicaid is more nuanced. The relationship between HHSC and its clients is less legally focused.

- The unit in HHSC cases is the child while the unit in OAG cases is the case comprised of a noncustodial and custodial parent pair and their children.

- Both HHSC and OAG have large case volumes but many more clients call and visit Medicaid offices than the OAG offices.

Niños Sanos Staff Positions

Originally, the project called for joint staff with knowledge of HHSC and Medicaid policies to work in OAG child support offices. Specifically, each of the three field offices participating in the demonstration would have one joint staff worker. It was anticipated that these staff would help process Medicaid/CHIP applications and redeterminations in child support cases. However, early in the project it was found that interagency, joint staff positions were not feasible due to differences between OAG and HHSC personnel rules and policies For example, the agencies offer different job titles, pay scales, and holidays. Staff are also entitled to have one set of employer-employee grievance policies.

To avoid delays and problems associated with the creation of new job titles, the steering committee decided to use an existing HHSC position for *Niños Sanos* staff positions. It was believed that it would be easier to use an existing job classification within the HHSC than to create a new one. The existing position most suitable to the job duties of the proposed staff was "Medicaid eligibility worker." This ensured that the hired staff would be able to facilitate Medicaid eligibility that was critical to the project treatment. HHSC and OAG teamed on the interviews that resulted in the HHSC hiring staff. All of the hired staff were experienced Medicaid eligibility workers. Once staff were selected and classified, they were supervised by HHSC personnel but were placed within OAG offices

HHSC supervision of *Niños Sanos* staff caused problems because workers based at OAG offices were distant from their HHSC supervisor, and on-site OAG managers had no line of supervision. Much of the staff's day-to-day activities involved working from OAG-generated lists and performing OAG functions that were outside the HHSC supervisor's knowledge base.

Staff Skills, Roles, and Duties

It appeared, project architects made over zealous demands of workers in their design. Most experienced HHSC or OAG workers lacked skills and knowledge of their counterpart agencies that were necessary to perform all of the proposed "joint" job duties. For example, experienced Medicaid workers need not have any knowledge of medical support establishment and enforcement. Similarly, experienced child support workers need not know Medicaid eligibility rules. Still, another

problem was that most HHSC and OAG positions do not require a working knowledge of alternative healthcare options, so staff were not literate about health-benefit terms such as "pre-existing conditions," "co-pays," and "maximums." These issues limited how fully some of the planned treatments were implemented. Some of these issues, however, were partially overcome through training efforts. For example, once the project team realized staff had trouble navigating HHSC screens relevant to medical support, additional staff training was developed and administered.

Another difficulty Medicaid eligibility workers faced was that they were accustomed to working only with custodial parents and not with noncustodial parents or parent's employers. Noncustodial parents and their employers however are critical players for securing employment-related insurance and other insurance options for IV-D children. It was a mistake to expect that staff, who were trained Medicaid eligibility workers but who lacked OAG experience, would be able to assist the OAG with discovery and verification of employer-sponsored insurance or other insurance options readily.

Misconception of Immediate Medicaid/CHIP Determination

Project architects also misunderstood how the Medicaid/CHIP application process worked. Project architects envisioned that the joint staff would be able to determine Medicaid/CHIP eligibility immediately, that is, the same day of the application. This would be ideal for setting of the medical support order because than the child support officer would truly know if the children were eligible for Medicaid or CHIP. They may pursue different amounts of cash medical support depending on whether the children are eligible for Medicaid, CHIP or neither. One reason is that Medicaid does not assess premiums or copays while CHIP does on a sliding scale. Further, if it was known at the time of order establishment that the children were not eligible for Medicaid/CHIP other options such as private, child-only insurance could be explored.

The reality, however, was that workers could just accept Medicaid/CHIP application process and review them for completeness and to ensure that parents submitted all of their supporting documentation (*e.g.*, paystubs), but could not determine eligibility on the spot. HHSC staff at a centralized office determined Medicaid eligibility. The CHIP process was more complicated. Medicaid and CHIP require the same application. HHSC first determines the children are ineligible for Medicaid, then the application is referred to a private vendor for CHIP determination.

Staff Access to and Use of Automated Systems

Niños Sanos staff also struggled with using automated data-tracking systems. It can take years for one worker to master the automated system of either the OAG or the HHSC. It was unfair to expect the same staff person to learn an entirely new system of the counterpart agency in but a few months. This problem was compounded by HHSC's transition from one automated system (SAVERRS) to another (TIERS), which necessitated understanding two HHSC systems rather than just one.

Simply, gaining overlapping access to each agency's automated system created yet another difficult logistical issue unforeseen in the interagency agreement. Before the project, there was no need for an OAG office to access the HHSC automated systems. Obtaining access required the installation of new lines and security clearances. The staff, classified as HHSC staff, needed authorization to access the OAG system and even higher-level authorization to post information to the OAG automated system. The authorization granted to staff was limited such that they had to call upon OAG personnel to correct errors that they found in a child's Medicaid status in the system.

Another issue is that HHSC workers could not allow parents to apply for private insurance on their office computers. To help clients apply during an office visit, a kiosk was needed in the building lobby or an extra computer at the office that would be available for public use and could be used for application and enrollment procedures.

Staff Attrition

Staff attrition was a significant problem during the opening months of the project. Several staff left the project for newly created and better positions within HHSC. The exaggerated turnover saw five different staff members fill the same three project positions within the first nine months of the project. The churn taxed local HHSC and OAG supervisors because they constantly had to train and re-train staff.

Actions on Cases Taken by *Niños Sanos* Staff

Niños Sanos staff was charged with the major duty of contacting and assisting parents and employers in which a CSRP conference for an order establishment was pending. For pre-CSRP cases, they attempted to gather information about the existing health insurance status of IV-D children that could be used to set the medical support order. They were also charged with offering information and assistance with Medicaid/CHIP applications and redeterminations and private child-only health insurance options.

Tables 6.1 through 6.6 below exhibit the implementation activities performed by *Niños Sanos* staff and the success rates of their efforts. Their performance influenced project outcomes discussed later in this report. Staff achieved limited success when contacting parents and their employers in both pre- and post-CSRP cases. Staff had difficulty gathering information on the health insurance available to children in pre-CSRP cases and were able to provide little assistance to parents in pre-CSRP cases. However, staff achieved more successful results when the project was revised to focus on post-CSRP cases.

Contact with Parents and Employers

Project staff were instructed to contact employers and parents via telephone. They first called employers prior to the CSRP conference to determine whether health benefits were available. They called parents in both treatment and non-treatment cases to remind them of the scheduled CSRP. In telephone calls with parents in treatment cases, they were also to obtain additional information about healthcare coverage. In post-CSRP cases, staff were to call parents after their orders were established to verify that the child had medical support provided as ordered and to assist the custodial parent with Medicaid, CHIP, or another option.

Table 6.1 shows the percentage of cases for which staff had contact information for employers and parents and for which contact was attempted and actually made. The noncustodial parent's employer was contacted first because Texas law prioritizes available and affordable employer-sponsored insurance as the first choice for medical support. Staff often had telephone numbers for employers and parents that they did not always attempt to contact. Among pre-CSRP cases, staff attempted to contact about a quarter (27 and 25 percent, respectively of treatment and non-treatment cases) of the employers of noncustodial parents and about a fifth (20 and 22 percent, respectively of treatment and non-treatment cases) of the employers of custodial parents. In other words, staff attempted to contact only two-thirds of the employers for which they had telephone numbers in pre-CSRP cases. Staff were largely unsuccessful at speaking with employers.

When unable to contact employers, staff attempted to telephone the noncustodial parent and then the custodial parent. Staff had contact information for 63 to 87 percent of noncustodial parents depending on the subgroup, attempted to reach 8 to 23 percent, and ultimately contacted 2 to 10 percent depending on the subgroup. The patterns in Table 6.1 shows that staff had telephone numbers for custodial parents, attempted contact with custodial parents, and ultimately contacted custodial parents more often than noncustodial parents. Staff had telephone numbers for over 90 percent of the custodial parents and attempted contact with the custodial parent in about 40 percent of the cases regardless of the case subgroup. Successful contact with the custodial parent varied considerably by subgroup and was made in 17 percent of the non-treatment, pre-CSRP cases, 11 percent of the treatment, pre-CSRP cases, and 28 percent of the post-CSRP cases. The last line of Table 6.1 shows staff were able to make contact with someone—the noncustodial parent, the custodial parent, or an employer of a parent—in about one-third of all cases regardless of the subgroup.

For the analysis, leaving telephone messages was not considered successful contact. If it had been, it still would not have substantially increased the percentages shown in Table 6.1. *Niños Sanos* staff reported leaving messages for employers in only one or two percent of cases and messages for parents in only about four to two percent of cases depending on the subgroup considered.

In general, telephone contact patterns were not statistically different between the treatment and non-treatment, pre-CSRP cases. There were, however, many statistically significant differences between the pre- and post-CSRP treatment cases. More telephone numbers were usually available for post-CSRP cases than pre-CSRP cases because by the time an order is established, employment and telephone numbers are usually verified by the child support agency. *Niños Sanos* staff, however, attempted contact and made less contact in post-CSRP cases than pre-CSRP cases. This is because *Niños Sanos* staff often relied on mail rather than telephone contact. The notable exception is contact with custodial parents. Among pre-CSRP cases, *Niños Sanos* staff typically contacted custodial parents to remind them of the CSRP conference or provide information. In contrast, *Niños Sanos* staff typically contacted custodial parents in post-CSRP cases to clarify information about their Medicaid application or redetermination.

Table 6.1. Telephone Contact in Cases (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases (n = 1,087)	Pre-CSRP Cases (n = 990)	Post-CSRP Cases (n = 505)
Percentage of cases with telephone numbers for…			
Employers of noncustodial parents	38%	39%	54%*
Employers of custodial parents	33%	29%*	46%*
Noncustodial parents	63%	64%	87%*
Custodial parents	95%	93%	92%
Percentage of cases in which staff attempted contact with….			
Employers of noncustodial parents	25%	27%	6%*
Employers of custodial parents	22%	20%	3%*
Noncustodial parents	29%	32%	8%*
Custodial parents	38%	41%	41%
Percentage of cases in which staff successfully contacted…			
Employers of noncustodial parents	12%	13%	4%*
Employers of custodial parents	9%	10%	2%*
Noncustodial parents	7%	8%	2%*
Custodial parents	17%	11%*	28%*
Any of the above	32%	35%	33%

*Statistically different from the non-treatment group at $\rho < 0.05$.

Although fewer employers were contacted in post-CSRP cases than in pre-CSRP cases, employer contact in post-CSRP cases produced better results. *Niños Sanos* staff were able to confirm insurance benefits and employment more often in post-CSRP cases than pre-CSRP cases because the established child support order, which was now existence, gave staff more clout with the employer. For example, *Niños Sanos* staff were able to confirm employer health benefits in only 39 percent of the pre-CSRP treatment cases and 73 percent of the post-CSRP treatment cases.

Table 6.2 also illustrates that *Niños Sanos* staff issued National Medical Support Notices (NMSNs) in 27 percent of post-CSRP cases and in less than one percent of pre-CSRP cases. NMSNs are critical to securing the child's enrollment in the employer's insurance plan because they order the employer to immediately enroll the child. An NMSN can only be issued if medical support is actually ordered, so in most pre-CSRP cases it cannot be issued. The table demonstrates that *Niños Sanos* staff initiated no NMSNs to custodial parents. Federal regulations give states discretion to issue NMSNs to custodial parents, while NMSNs can be issued to custodial parents in Texas, it was not a common practice of *Niños Sanos* staff. As seen later, however, the private contractor issued NMSNs to custodial parents frequently.

Table 6.2. Results from Contact with Employers (Percentage of Successfully Contacted Employers)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Contacted Employers of Noncustodial Parents	(n = 133)	(n = 132)	(n = 11)
Confirmed employer health benefits	48%	39%	73%
Confirmed parent's employment	32%	32%	100%*
Issued verification of parent's employment form	25%	21%	18%
Issued National Medical Support Notice (NMSN)	0%	1%	27%*
Contacted Employers of Custodial Parents	(n = 100)	(n = 99)	(n = 8)
Confirmed employer health benefits	45%	31%*	63%
Confirmed of parent's employment	42%	31%	100%*
Issued verification of parent's employment form	19%	23%	13%
Issued National Medical Support Notice (NMSN)	--	--	--

*Statistically different from the control group at $\rho < 0.05$.

Reminders about Insurance Availability Forms

Table 6.3 shows the results of reminding parents about the health insurance availability forms that are often part of package of materials and forms sent to the parent prior to the CSRP. Table 6.3 does not include a column for post-CSRP cases because the package is only sent prior to CSRPs. The form asks parents whether they have health insurance available and the cost of the insurance. Completed forms are to be returned or brought to the CSRP establishment conference. The CSRP officer can use the information to help establish an appropriate medical support order. Supervisors of local child support office, however, have discretion as to whether to include the health insurance availability form in the pre-CSRP package. *Niños Sanos* staff were to remind all parents in pre-CSRP treatment and non-treatment cases about the health insurance availability form. However, they were to probe for more information and offer more assistance to treatment cases only. These reminders were generally futile. As evident in Table 6.1, *Niños Sanos* staff were rarely able to successfully contact parents. Further, Table 6.2 illustrates that only about half of successfully contacted parents

remembered receiving the form and a smaller proportion reported that they had completed and returned the form. The latter finding suggests that the forms themselves were largely ineffective in obtaining information about child's health insurance options available through the parents. The problem is similar to the universal problem of getting parents to complete and return financial statements used to determine child support award amounts, as experienced by most child support offices across the nation.

Table 6.3. Results from Reminding Parents about Health Insurance Availability Forms (Percentage of Successfully Contacted Parents)

	Non-Treatment	Treatment
	Pre-CSRP Cases	Pre-CSRP Cases
Contacted Noncustodial Parents	(n = 78)	(n = 77)
Remembered receiving form	56%	44%
Returned completed form	42%	27%
Has not returned completed form	14%	17%
Did not remember receiving form/missing	44%	56%
Contacted Custodial Parents	(n =188)	(n =191)
Remembered receiving form	52%	47%
Returned completed form	39%	32%
Has not returned completed form	13%	15%
Did not remember receiving form/missing	48%	53%

*Statistically different from the control group at $\rho < 0.05$.

Medical Support Issues Discussed with Parents

Table 6.4 provides the frequencies at which particular issues were discussed in telephone conversations between *Niños Sanos* staff and parents. As evidenced by the table, *Niños Sanos* staff could not refrain from providing information in non-treatment cases as instructed. When asked about this in routine progress meetings, project staff reported that it was difficult to adhere to the treatment protocol when actual contact with parents was so rare and children were in need. Consistent with their expertise as Medicaid eligibility workers, *Niños Sanos* staff tended to discuss Medicaid/CHIP options more so than other options. For example, Medicaid/CHIP was discussed in 39 percent of the non-treatment cases in which the staff made successful contact with the custodial parent. About two-thirds of these custodial parents expressed interest in Medicaid/CHIP. Most of those who were uninterested had private health insurance available.

Table 6.4 also illustrates that telephone contact was rarer in post-CSRP cases. As mentioned earlier, *Niños Sanos* staff tended to use mail more often in post-CSRP treatments. They reserved telephone contact in post-CSRP cases to clarify Medicaid application or redetermination information.

Table 6.4. Types of Medical Support Issues Discussed with Parents over the Telephone (Percentage of Successfully Contacted Parents)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Contacted Noncustodial Parents	(n = 78)	(n = 77)	(n = 8)
General information about medical support	24%	14%	100%*
Pros and cons of private insurance over cash medical support	24%	17%	100%*
Private child-only insurance options	26%	14%	0%
Requested copy of NCP's insurance card via telephone	NA	NA	25%
Contacted Custodial Parents	(n = 188)	(n = 191)	(n = 68)
General information about medical support	42%	22%*	13%*
Pros and cons of private insurance over cash medical support	31%	24%	0%*
Private child-only insurance options	36%	21%*	0%*
Medicaid/CHIP options	39%	30%	15%*

*Statistically different from the control group at $\rho < 0.05$.

Assistance to Parents

Table 6.5 illustrates that *Niños Sanos* staff were generally able to provide little help on pre-CSRP cases. Specifically, they helped on few Medicaid applications and redeterminations. One limitation, however, was that *Niños Sanos* staff may have provided information about Medicaid applications and redeterminations but the actual application or redetermination form was received elsewhere by HHSC. In this situation, *Niños Sanos* staff would not know they had assisted, and thus would not record it on the data collection form.

Table 6.5 identifies one way that *Niños Sanos* staff were able to help. It was in the sharing of information with the Child Support Officer (CSO). *Niños Sanos* staff shared information that they had gathered about the child's healthcare coverage with the CSO who facilitates the CSRP establishment conference in 70 percent of the treatment cases and 57 percent of the non-treatment cases.

Table 6.5. Assistance Provided by *Niños Sanos* Staff in Pre-CSRP Cases (Percentage of Cases)

	Non-Treatment	Treatment
	Pre-CSRP Cases (n = 1,087)	Pre-CSRP Cases (n = 990)
Assisted NCP with child-only insurance enrollment Assisted CP with child-only insurance enrollment	<1% <1%	0% <1%
Assisted with Medicaid application Assisted with Medicaid redetermination	<1% <1%	2% 1%
Shared information gathered about healthcare coverage with Child Support Officer	57%	70%*

*Statistically different from the control group at $\rho < 0.05$.

Table 6.6 summarizes the interventions made in post-CSRP cases. In general, it shows that *Niños Sanos* staff were able to take more action and were more successful in post-CSRP cases. When reviewing post-CSRP cases, *Niños Sanos* staff would compare the child's healthcare coverage to what was ordered as medical support. If *Niños Sanos* staff obtained new information, they would note it in the OAG automated tracking system. For example, if *Niños Sanos* staff discovered a change in employment as well as employer-sponsored insurance, staff would note it in the OAG automated tracking systems. *Niños Sanos* staff obtained updated health insurance information in 11 percent of the post-CSRP cases and other new information useful to the child support agency in 17 percent of the post-CSRP cases.

When reviewing post-CSRP cases, *Niños Sanos* staff found it appropriate to mail requests for copies of insurance cards to employers or noncustodial parents in 4 percent of the post-CSRP cases. The OAG requests insurance cards so that they can keep them on file. Nonetheless, as shown in Table 6.6, few requests produced insurance cards.

Medicaid applications were mailed to 9 percent of the custodial parents in post-CSRP cases, and Medicaid redetermination forms were mailed to 16 percent of the custodial parents in post-CSRP cases. *Niños Sanos* staff mailed Medicaid applications in post-CSRP cases in which the medical support order indicated government coverage, but the HHSC automated tracking system did not indicate that the children were indeed enrolled in Medicaid. In addition, staff mailed Medicaid redetermination forms in post-CSRP cases in which a medical support order indicated government coverage, and the HHSC automated tracking system indicated that the HHSC redetermination form had not been returned. There was, however, some duplication of efforts among *Niños Sanos* staff and

HHSC, as HHSC also sent reminders about Medicaid redeterminations to parents of when their redeterminations were due.

Table 6.6 also shows the frequency of clarifications made by *Niños Sanos* staff in telephone conversations with custodial parents. Most frequently, staff clarified terms of medical support orders. Parents did not always realize that there was a court order to apply for Medicaid or that the noncustodial parent was court-ordered to provide employer-sponsored insurance. Staff reported that parents were receptive to these clarifications. The second most frequent clarification regarded Medicaid reviews. Staff often had to clarify information needed about household size used to determine income eligibility, and types of income and expenses that are taken in to account when determining eligibility.

Table 6.6. demonstrates that staff found few parents in need of clarification about child-only, private insurance. Most parents simply did not believe child-only private insurance was affordable and believed it more sensible to apply for Medicaid/CHIP or take the risk that the children would be without healthcare insurance than pay for insurance that they may never use.

Table 6.6. Assistance Provided by *Niños Sanos* Staff in Post-CSRP staff (Percentage of Cases)

	Treatment Post-CSRP Cases (n =505)
Obtained Information Useful to OAG	
Updated health insurance information	11%
Other useful information	17%
Mailings	
Request for copy of insurance card	4%
Medicaid application	9%
Medicaid redetermination form	16%
Information about child-only insurance	<1%
Clarifications via Telephone	
Medical support order	18%
Medicaid application	1%
Medicaid review	7%
Child-only insurance	<1%
Received or Returned	
Insurance card	1%
Medicaid application	1%

Alternative Private Insurance Options

The HHSC and the OAG worked together to identify alternative sources of insurance available to children. Using the information developed by the Texas Department of Insurance (TDI) and with

the help of the Center for Policy Research (CPR), they developed simplified materials about child-only insurance options. It was designed to be distributed to parents during the CSRP and at other opportune times. At the project offset, TDI provide online information for consumers to help them find healthcare coverage, including a step-by-step guide for parents seeking healthcare coverage for their children and a list of insurance carriers that provide child-only insurance. Some of these carriers had interactive websites where a parent can enter basic information (***e.g.***, zip code, age, and gender of the child) and receive an estimated insurance premium cost. When the demonstration project first began, TDI listed 17 carriers of child-only insurance, but it appeared that only a few operated in Bexar County, and the premium estimates ranged from less than $100 per month to over $300 per month depending on the level of health benefits and pre-existing conditions. A breakdown of the insurance coverage and premium amounts for all of the TDI carriers operating in Bexar County was too much information to include in an informational brochure for parents.

The CPR project evaluator/technical consultant obtained more information from carriers of child-only insurance and developed a simplified, easy-to-understand brochure that compared four child-only health plans. Appendix D includes a copy of the brochure. The brochure and its translated Spanish version were made available in the waiting rooms of demonstration offices. In addition, CSRP officers were to distribute the brochure only after it appeared that employment-related insurance was not a viable option for the children. This avoided inundating parents with too much information while keeping the focus on the establishment of a financial child support order. CSRP officers found few opportunities to distribute the brochures because it was not certain that employment-related insurance was not an option and, more often, because it was apparent that neither parent could afford private, child-only insurance.

The development of the brochure was a difficult process. Few insurance carriers cooperated with CPR. To address this problem, CPR sent letters to 26 insurance carriers, inviting them to cooperate with the development of simplified information on child-only health plans. The intent was to be able to provide parents with information about other healthcare options for their children. This information would be made available during the CSRP, which is when healthcare provisions of the child support order are discussed. This would potentially offer a viable option for healthcare coverage for children whose parents lack affordable employer-sponsored insurance and are ineligible for Medicaid or SCHIP. The 26 insurance carriers were identified by the TDI as providing child-only insurance or from a list of attendees at a HHSC bidders' conference pertaining to SCHIP. In addition to the letter, CPR attempted follow-up contact with all of the insurance carriers via telephone or email. Four insurance carriers ultimately agreed to cooperate. They sent CPR detailed information about their numerous health plan options and costs. CPR simplified the health plan information supplied by the four carriers. This simplification was necessary because each carrier uses different terminology and develops its own list of benefits and plan features (***e.g.***, deductibles, co-insurance, lifetime maximum) that can amount to a dozen to two dozen items. Further, specific healthcare options

(*e.g.*, immunizations) may be listed differently among carriers. For example, "child immunizations" may be covered under the item "well-child care" under one carrier and "preventive care" under another. To simplify the information and make it comparable across health plans, CPR used information from the insurance plan offered to State employees to develop a template that standardized health benefit terminology. The template also helped to identify which particular health plan of a carrier was most appropriate for the brochure.

Eventually, CPR identified one health plan from each of the cooperating insurance carriers. The selected plans best met state statutory requirements of child health plans, had premium costs below what would be considered reasonable for a noncustodial parent with a gross income of $1,800 per month, covered visits and standard immunizations, and would likely have nominal out-of-pocket expenses for average healthcare utilization. CPR then worked with the insurance carriers to develop side-by-side comparisons of their healthplans, including comparisons of premiums, co-pays, how to apply, contact information, and other details.

Practicality of Private Child-Only Insurance

Although OAG and HHSC administrators were hopeful that private, child-only insurance could fill a gap in healthcare coverage options for IV-D children, they also realized that parents would only take it up if it were affordable. Noncustodial parents, in particular, would have no financial incentive to seek private, child-only insurance if it was more than what they paid in cash medical support orders. OAG administrators expressed concerns because they knew from experience that the amounts that the courts ordered as cash medical support were inconsistent and frequently fell below the threshold of nine percent of income established in the guideline ($91 for minimum-wage earners). OAG staff cited that $25 and $50 cash medical support order amounts were quite common. This weakened incentives for parents to look for or consider private child-only plans. The premiums for the plans in the brochure ranged from $50 to $160 per month per child.

Another major problem that occurred during the project was some insurance carriers also discontinued the open enrollment of child-only insurance plans as they re-assessed their underwriting in light of the new health plan requirements imposed by the national healthcare reform that became law in 2010.

Still another problem is that OAG and HHSC workers were uncomfortable with the limited number of insurance carriers presented in the brochure. They felt pressured to present all the private health insurance options that were available and not limit "private enterprise" by endorsing any single vendor. OAG was particularly sensitive to this because of another OAG initiative that occurred during the course of the project. That initiative aimed to create a group insurance plan for child-only insurance that was to be created through a competitive procurement. However, that did not materialize, largely because insurance carriers needed to concentrate their efforts to compliance with

federal healthcare reform rather than developing new child-only insurance options when all of the new rules in which insurance will operate due to healthcare reform were still being determined.

Pilot of Former Medicaid Cases with Orders

To better utilize staff's expertise on Medicaid enrollment, the project also experimented with intervening in existing orders in which the custodial parent was ordered to apply for Medicaid but in which the automated system, TXCSES, did not indicate enrollment. When project stakeholders met in September 2008, they discussed whether the targeted population for healthcare intervention could be expanded to include enforcement cases. Healthcare coverage often changes after order establishment. It was believed that enforcement cases with changes in healthcare coverage might benefit from the attention and assistance of *Niños Sanos* staff. At the same time, it was important that project staff not duplicate the activities of a vendor responsible for identifying changes in health plan carriers and sending NMSNs when there is a carrier change or change in employment.

This led project stakeholders to develop criteria for selecting a subset of enforcement cases for *Niños Sanos* staff to work. Since the *Niños Sanos* staff were experienced Medicaid eligibility workers, it was decided that they would focus on cases that might need help with Medicaid redetermination. Another goal was to find cases that could benefit from child-only insurance plans. Considering these criteria, it made sense to select paying cases with at least $50 in cash medical support and medical support orders that call for the enrollment of children in Medicaid but appear to be inactive Medicaid cases. It was possible that it was more cost effective for noncustodial parents in such cases to obtain child-only insurance rather than to pay cash medical support. Texas statute provides that a noncustodial parent may discontinue cash medical support if that parent obtains healthcare coverage for their child(ren) and informs the custodial parent and OAG of the coverage. More importantly, child-only insurance could benefit children who lacked healthcare coverage at the time and were not eligible for Medicaid or CHIP.

In November and December 2008, OAG identified 215 enforcement cases that met the selection criteria and assigned them to *Niños Sanos* staff. The staff then researched the current Medicaid status for these cases using HHSC's automated system rather than the OAG system. They found that the Medicaid code was wrong on the OAG system in over half of the cases. Although the OAG system indicated that the children were no longer enrolled, HHSC's records showed that the children were, in fact, still enrolled in Medicaid. OAG then directed staff to correct the Medicaid code in its automated system.

Niños Sanos staff found few enforcement cases (six cases) in which they believed they could help with Medicaid re-determination. They found no cases that they believed could benefit from child-only insurance. *Niños Sanos* staff did not investigate the availability of employer-sponsored insurance

in most of the cases with verified employers. If employer-sponsored insurance was available at a reasonable cost, an order modification would be necessary to compel the children's enrollment in the health-plan, despite whether the children's Medicaid/CHIP status may have changed, because existing orders were for cash medical support

Other Issues with Implementation

There were many nuances and frustrations identified by HHSC and OAG administrators and staff over the course of figuring out how to get healthcare coverage for all children in the child support caseload.

- Custodial parents frequently did not provide noncustodial parents with the information they needed to enroll a child in an employer-sponsored or child-only policy, such as the child's Social Security number.

- Custodial parents frequently did not want private insurance if they qualified for Medicaid. The advantages of Medicaid are that it is reliable, it does not change if the noncustodial parent changes jobs, custodial parents do not have to worry about the noncustodial parent paying premiums, and they do not have to deal with the noncustodial parent.

- A policy of mandatory referral from Medicaid to child support meant that children were already enrolled in Medicaid when their cases were opened at the child support agency.

- Custodial parents did not understand that they could have both Medicaid and private insurance, with Medicaid serving as supplemental insurance.

- Custodial parents did not realize that after the child turns six years old, the income eligibility for Medicaid is 100 percent of the federal poverty level and that they may be dropped or the quality of coverage drops to major medical or reimbursement for incurred medical expenses only.

- Custodial parents did not have an incentive to pursue private insurance because Medicaid coverage is widely available and even if the quality is reduced, there is the option for another Medicaid program that allows reimbursement for incurred medical expenses.

- It was difficult for HHSC workers to get details on employer health insurance, such as premiums, because they needed to speak with the appropriate person in Human Resources and did not always have the appropriate contact information.

The major lesson learned within the first year of the project was that the project itself was premised on a flawed assumption. Although it was believed that many children in order establishment cases lacked healthcare coverage and would be eligible for Medicaid, thereby justifying the plan to place Medicaid eligibility workers in child support offices and instructing them to contact employers and parents in CSRP cases, this turned out not to be the case. It was found that most cases scheduled for CSRP (75 percent) already had healthcare coverage established and contacting parents to offer assistance with Medicaid applications or redetermination and was difficult and ineffective. Despite reviewing over 1,000 cases, staff identified only 13 percent as potential new Medicaid cases and ultimately assisted only 3 percent with the application or redetermination process. As a result of the findings, the project was revised to work cases just after order establishment over the final months of project operations (*i.e.*, beginning January 2010).

Chapter 7
Outcomes and Impacts

The Center for Policy Research (CPR) assessed the outcomes of the *Niños Sanos* demonstration using two different analyses. One analysis considered changes in medical support performance measures among offices participating in the demonstration. The other analysis compares outcomes of treatment and non-treatment groups.

Changes in Medical Support Performance over Time

First, to determine the impact of the demonstration, CPR examined whether medical support outcomes improved over time more among local offices participating in the demonstration than statewide. CPR conducted the analysis using OAG medical support performance data from its automated system. This includes medical support measures developed by OAG and standard federal Office of Child Support Enforcement (OCSE) performance measures such as those tracking orders for medical support and health insurance.

The analysis relies on annual data from federal fiscal year (FY) 2007, which started October 1, 2006, and ended September 30, 2007, through FY2010. The *Niños Sanos* demonstration began in August 2007. A limited number of project treatments were piloted over the summer of 2008 and full operations began in October 2008. CPR examined the annual performance data for significant changes over time and differences in performance among local offices and statewide. CPR employed three medical support performance measures. The bullets below describe these measures.

- Figure 7.1 shows the percentage of ordered IV-D cases with medical support orders, which may include an order for one or both parents to provide private health insurance available to the parent from his or her employment or private insurance from another source, an order for the noncustodial parent to pay cash medical support to offset insurance premiums paid by the custodial parent or Medicaid expenses, orders that require one or both parents to pay for the child's uninsured medical costs, or a combination of these.

- Figure 7.2 shows the percentage of ordered cases with medical support that was **both** ordered and provided. Thus, the measure displayed in Figure 7.2 imposes an additional criterion (*i.e.*, provided) to the measure displayed in Figure 7.1, (*i.e.*, ordered). If the noncustodial parent is ordered to pay cash medical support, it is considered provided if cash medical support payments are received.

- Figure 7.3 shows the percentage of ordered cases with orders for private health insurance. This measure is a subset of ordered OAG cases with medical support orders (as shown in Figure 7.1). It excludes medical supports for cash medical support or unreimbursed medical expenses.

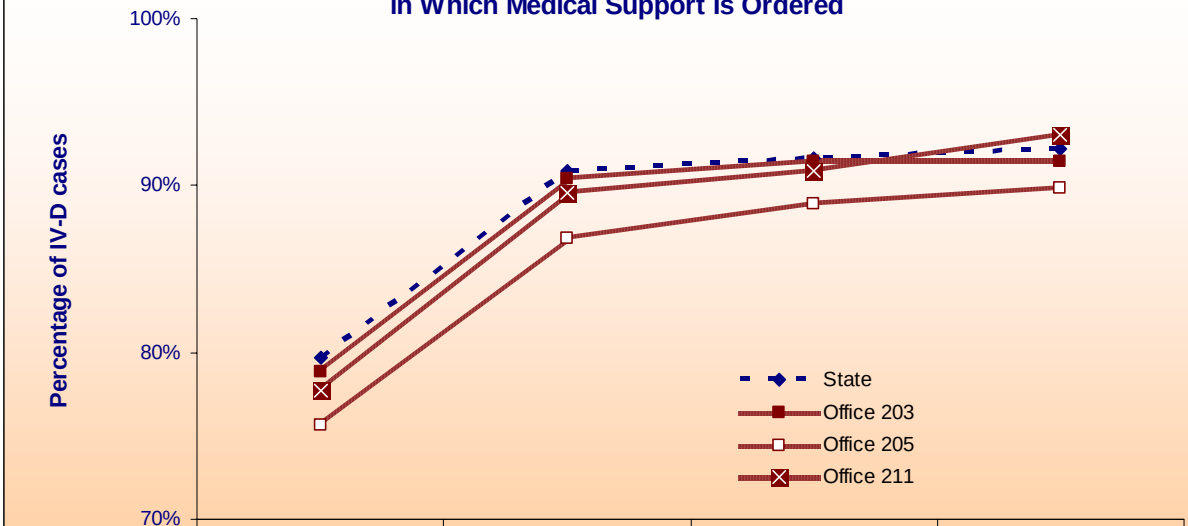
As of FY2010, the percentage of IV-D cases with orders in which medical support was also ordered was 92.2 percent statewide (see Figure 7.1). The percentage of IV-D cases with orders in which medical support was ordered and provided was 61.5 percent statewide (see Figure 7.2). The percentage of IV-D case with orders in which health insurance was ordered was 88.4 percent statewide (see Figure 7.3).

When the project began in FY2007, most of the local offices participating in the demonstration lagged behind the state in medical support performance. By FY2008, medical support performance increased for the state and the demonstration offices. The increases were larger among the demonstration sites than across offices statewide. This caused the gap in medical support performance between the project sites and state to narrow. This suggests that *Niños Sanos* was somewhat successful at improving medical support outcomes in FY2008.

In FY2009 and FY2010, medical support performance continued to increase for the state and demonstration offices but the increases were not as large as they were from FY2007 to FY2008. The state continued to out-perform the demonstration sites on most medical support indicators. Due to Bexar County's above-average poverty and public assistance rates, Bexar County offices may face more socio-economic hurdles to medical support than the state as a whole. This, however, does not explain why some demonstration offices were able to exceed the state's performance on some medical support measures in some years. For example, Office 211 exceeded the state's performance on two of the three medical support indicators in FY2010 and Office 203 exceeded the state's performance on one indicator in FY2009 and another indicator in FY2010.

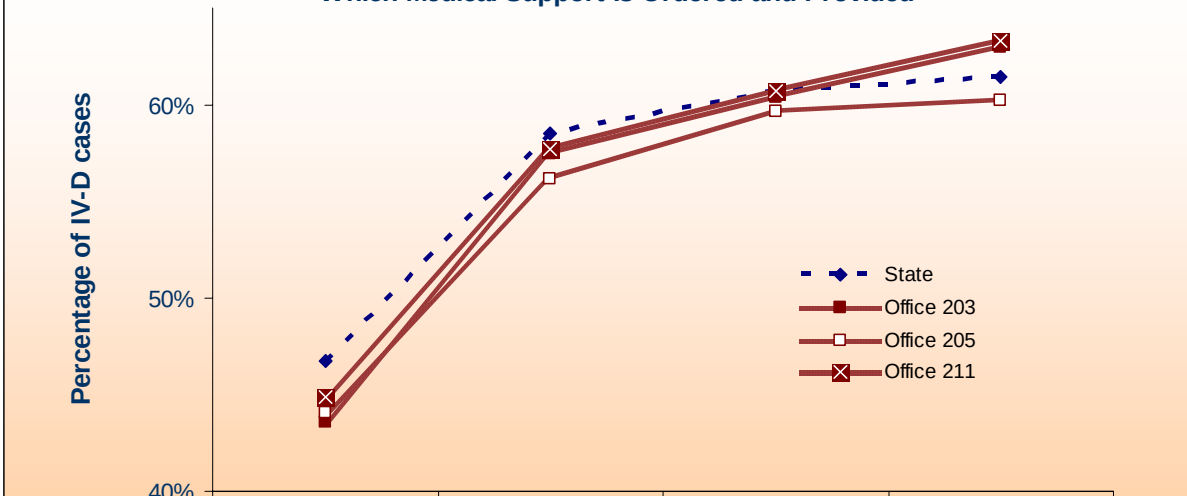
On the other hand, the trend differences in medical support performance between demonstration sites and the state are not robust. Albeit statistically significant, the percentage point gain among demonstration sites was often only within a few points above the statewide average, and increases tended to slow after FY2008, which is when Texas implemented major statutory changes to medical support that were legislated in 2007. The statutory changes may have precipitated the large increases in medical support outcomes from 2007 to 2008 statewide as well as in the demonstration offices. The launching of the *Niños Sanos* demonstration in 2007 may have magnified the increases from FY2007 to FY2008 among the demonstration offices. The awareness of medical support issues may have increased in 2008 due to the novelty of the *Niños Sanos* demonstration and, in turn, staff may have been more earnest about initiatives to improve medical support.

Figure 7.1. Percentage of IV-D Cases with Orders in Which Medical Support Is Ordered



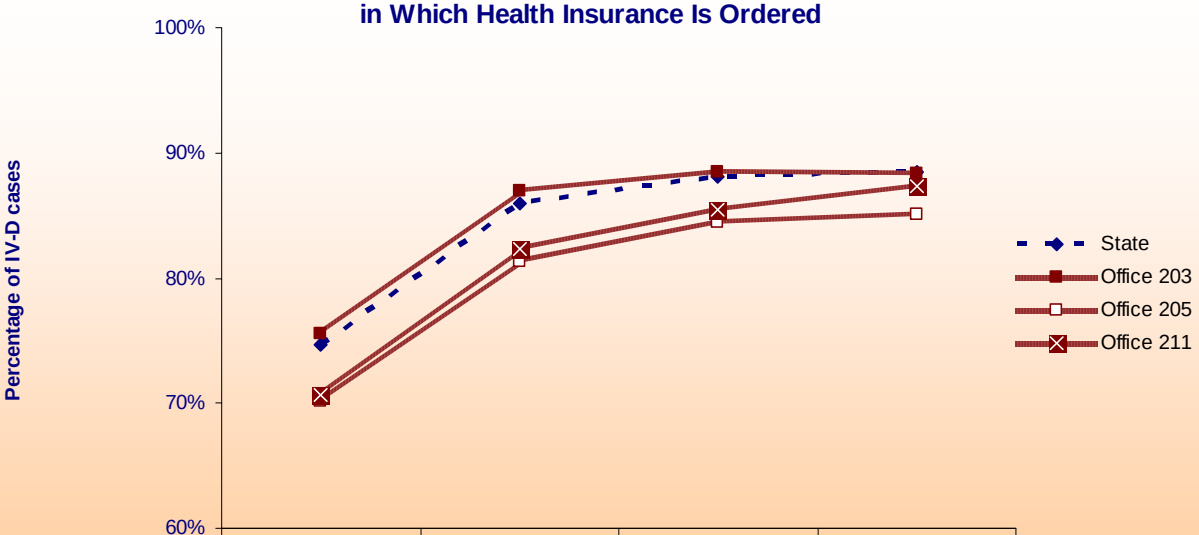
	FY2007	FY2008	FY2009	FY2010
State	79.7%	90.8%	91.6%	92.2%
Office 203	78.8%	90.4%	91.4%	91.5%
Office 205	75.6%	86.8%	88.9%	89.8%
Office 211	77.7%	89.5%	90.9%	93.0%

Figure 7.2. Percentage of IV-D Cases with Orders in Which Medical Support Is Ordered and Provided



	FY2007	FY2008	FY2009	FY2010
State	46.8%	58.5%	60.7%	61.5%
Office 203	43.6%	57.4%	60.3%	63.0%
Office 205	44.1%	56.2%	59.6%	60.2%
Office 211	44.8%	57.7%	60.7%	63.3%

Figure 7.3. Percentage of IV-D Cases with Orders in Which Health Insurance Is Ordered



	FY2007	FY2008	FY2009	FY2010
State	74.6%	85.9%	88.1%	88.4%
Office 203	75.6%	87.0%	88.4%	88.3%
Office 205	70.2%	81.4%	84.5%	85.1%
Office 211	70.6%	82.3%	85.5%	87.3%

Outcomes of Treatment and Non-Treatment Cases

A major objective of *Niños Sanos* was to increase healthcare coverage among children in the child support caseload. Another major objective was to reduce lapses in healthcare coverage among IV-D children, that is, to stabilize healthcare coverage among children. To analyze whether *Niños Sanos* successfully met these objectives, CPR compared the medical support outcomes of treatment and non-treatment cases at several different points of time. Comparisons consisted of the following:

- Treatment and non-treatment cases were compared at intake/initial treatment and intake, respectively. The initial treatments occurred typically within a few weeks after intake. *Niños Sanos* staff recorded outcomes and statuses at these times on the data collection forms.

- The outcomes of treatment and non-treatment cases were compared at time of the first follow-up using data retrieved from the OAG automated system. This typically occurred within a year following project intake for most cases. For example, if case intake occurred in 2008, the first follow-up occurred in 2009. As discussed in Chapter 5, case follow-up data was taken from OAG's automated system in November 2009, November 2010, and April 2011.

- The outcomes of treatment and non-treatment cases based on data tracked by the OAG automated system were compared at the time of the last follow-up, which occurred in 2011 for all cases. The amount of time that elapsed between intake and the last follow-up varied among cases. For example, if the case intake occurred in 2008, the amount of time between intake and last follow-up would be almost three years, but if a case intake occurred in 2010, the amount of time between intake and last follow-up would be one year. For 2010 intakes, the first and last follow-up would be the same.

Differences in Rates and Sources of Healthcare Coverage

An expected outcome of *Niños Sanos* treatments was that more children in the child support caseload would have healthcare coverage. Project designers anticipated that the increase would come from all sources. Increases in private healthcare coverage were anticipated because *Niños Sanos* staff would make direct contact with parents and their employers to determine the availability of employer-sponsored insurance and other private insurance. Increases in coverage from child-only insurance were anticipated because parents would have access to clear information about child-only insurance. Increases in coverage of Medicaid/CHIP were also anticipated because competent *Niños Sanos* staff members would reach out to parents and ably assist them with Medicaid/CHIP applications and redeterminations.

Table 7.1 below compares children's healthcare coverage after treatment (or intake for non-treatment cases) based on information available to project staff. The rate of healthcare coverage was higher among pre-CSRP treatment cases (78 percent) than pre-CSRP non-treatment cases (71 percent). This suggests that the *Niños Sanos* treatments were successful at facilitating healthcare coverage among pre-CSRP cases. However, the rate did not increase for post-CSRP treatment cases. The rate of healthcare coverage did not differ significantly between post-CSRP treatment cases (69 percent) and pre-CSRP non-treatment cases (71 percent). Without a pure control group, however, it cannot be concluded that *Niños Sanos* treatments were ineffective in post-CSRP cases.

Table 7.1 also shows that most of the increase in healthcare coverage among pre-CSRP treatment cases came from Medicaid/CHIP enrollment and there was virtually no increase from private insurance coverage or child-only insurance. This conclusion is reached by comparing the source of healthcare coverage among pre-CSRP treatment and pre-CSRP non-treatments cases. Medicaid/CHIP was the source of healthcare coverage for 65 percent of pre-CSRP treatments and 60 percent of pre-CSRP non-treatment cases. There was little difference in the proportions of cases with coverage from private insurance (*i.e.,* the private insurance rate was 12 and 14 percent, respectively, among pre-CSRP treatment and non-treatment cases) and there was no difference in the proportions of cases with coverage from child-only insurance (*i.e.*, the private child-only insurance was less than 0.5 percent for both pre-CSRP treatment and non-treatment cases). These results

suggest that *Niños Sanos* staff were more effective at facilitating Medicaid/CHIP enrollment than healthcare coverage from other sources. Their training as Medicaid eligibility workers undoubtedly contributed to their effectiveness at facilitating Medicaid/CHIP enrollment. Their lack of knowledge and experience about private insurance, including child-only insurance, limited their ability to facilitate healthcare coverage from other sources.

Employer-sponsored insurance was the source of healthcare coverage among more post-CSRP cases than pre-CSRP cases, as shown in Table 7.1. It was the source of healthcare coverage for 17 percent of the post-CSRP cases and 12 and 14 percent, respectively, of the pre-CSRP non-treatment and treatment cases. The coverage status was unknown in fewer post-CSRP cases (10 percent) than pre-CSRP cases (23 and 17 percent of pre-CSRP non-treatment and treatment cases, respectively). Once an order was indeed established, such as was the situation in post-CSRP cases, the child support agency should know the most about the children's coverage.

Private, child-only insurance was the source of healthcare for less than one percent of the project cases. In all, seven cases (including pre-CSRP treatment and non-treatment cases and post-CSRP treatment cases) had coverage from child-only insurance. Medical support was ordered in five of these cases. In four of the cases, the noncustodial parent was ordered to provide private insurance from a source other than an employer. In one of the cases, the custodial parent was ordered to provide private insurance from a source other than an employer. All of these cases involved less than two children, the noncustodial parent had verified employment in five cases, and the custodial parent had verified employment in two cases. The financial child support orders ranged from $200 to $555 per month in these cases.

Table 7.1 Children's Healthcare Coverage after Treatment/Intake (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases (n = 1,087)	Pre-CSRP Cases (n = 990)	Post-CSRP Cases (n = 505)
Children's Coverage			
All children have healthcare coverage	71%	78%*	69%*
Some or all children do not have coverage	6%	6%	15%*
Children's coverage is unknown or missing	23%	16%*	16%*
Source of Coverage			
Medicaid/CHIP	60%	65%*	58%*
Private, employer-sponsored insurance	12%	14%	17%*
Private, child-only insurance	<0.5%	<0.5%	<0.5%
None	5%	4%	14%*
Don't know	23%	17%*	10%*

* Statistically different from the non-treatment group at $\rho < 0.05$.

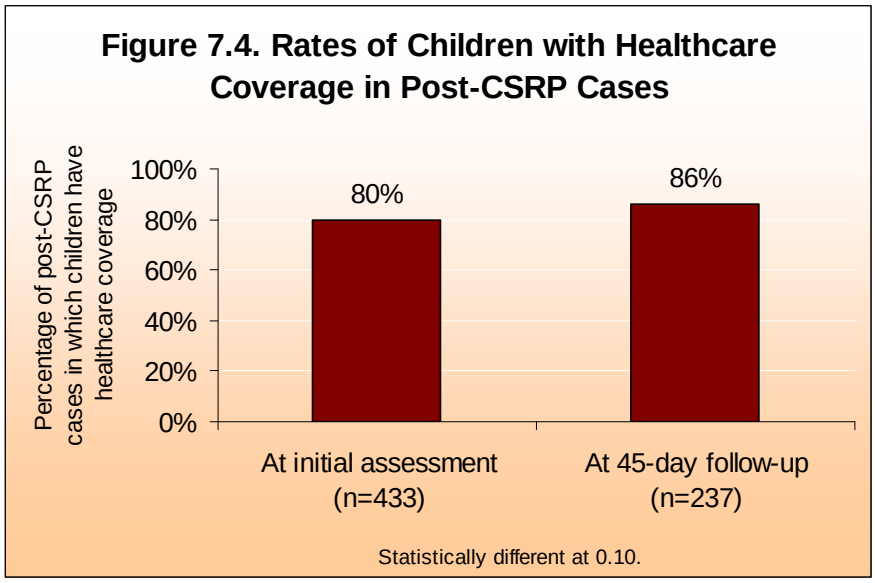


Figure 7.4 displays the change in rates of healthcare coverage in post-CSRP cases from an initial assessment to a 45-day review of the case. *Niños Sanos* staff conducted both the initial assessment and the 45-day review. The 45-day window allowed sufficient time for any actions that *Niños Sanos* staff may have taken to have an impact. Some examples of the actions that *Niños Sanos* staff may take within 45 days are following up with an employer about employer-sponsored insurance in cases where the noncustodial parent is ordered to provide private insurance or initiating a Medicaid/CHIP application and determining eligibility. Figure 7.4 is limited to post-CSRP cases because there were not enough pre-CSRP cases with subsequent reviews to conduct a similar analysis. The information in Figure 7.4 also excludes cases in which the healthcare coverage was unknown so it includes a smaller sample than that shown in Table 7.1 and the percentages are somewhat different. The figure shows that the rate of coverage increased by 6 percentage points from the initial assessment to the 45-day review. (The difference is statistically significant at $\rho < 0.10$.) This provides evidence that *Niños Sanos* intervention helped increase the percentage of children with healthcare coverage in post-CSRP cases.

Medicaid or CHIP was the source of healthcare coverage at the 45-day follow-up for all but one of the post-CSRP cases that lacked healthcare coverage during *Niños Sanos* staff's initial assessment. Employer-sponsored insurance was the source of healthcare coverage for the remaining case. *Niños Sanos* staff' mailed a Medicaid/CHIP application to over half of these cases following the initial assessment. *Niños Sanos* staff did not mail a Medicaid/CHIP application when the HHSC automated system indicated that the family had already applied for Medicaid/CHIP. For most of these applicants, eligibility for Medicaid/CHIP was pending. In one case, however, the family failed to pay the CHIP fee and it resulted in CHIP suspension. In this particular case, *Niños Sanos* staff explored whether the children were Medicaid eligible and provided information about child-only private insurance to the family.

The impact of the Medicaid staircase— that is, the income eligibility threshold is less for older children— is evident by difference in healthcare coverage rates between cases involving older children and cases involving younger children. The healthcare coverage rate is 69 percent in pre-CSRP

cases where the youngest child is six years old or more and 79 percent in pre-CSRP cases where the youngest child is less than six years old. The difference is statistically significant ($\rho < 0.05$).

Medical Support Orders: Rates and Sources of Healthcare Coverage

Differences in medical support orders are examined for several reasons. Project designers believed that *Niños Sanos* staff would be able to obtain more thorough and accurate information about available coverage options that could be used to set more realistic medical support orders. Further, *Niños Sanos* staff would be more knowledgeable of Medicaid/CHIP if the children were indeed enrolled in Medicaid/CHIP. *Niños Sanos* staff shared this information with CSOs responsible for conducting CSRPs. In turn, The CSO could use this information to encourage the parents to agree to a suitable and appropriate medical support order. Typically, medical support orders reflect the child's healthcare coverage at the time of order establishment. Parents may seek modifications to their medical support orders if their child's healthcare coverage subsequently changes.

Table 7.2 shows that medical support orders were established more often in treatment cases, both pre-CSRP and post-CSRP, than in pre-CSRP, non-treatment cases. They were established in 43 percent of pre-CSRP, non-treatment cases, 56 percent of pre-CSRP, treatment cases, and 93 percent of post-CSRP, treatment cases. Pre-CSRP treatment cases have a higher rate of medical support than pre-CSRP non-treatment cases because *Niños Sanos* staff made more and better information available for the CSRP establishment conference. As shown earlier in Table 6.5, *Niños Sanos* staff shared their research findings more often with CSOs in pre-CSRP treatment cases than those in pre-CSRP non-treatment cases. Other research (*e.g.*, Argys and Peters, 2003, Peters, *et al.*, 1993) finds that when parents have more and better information, such as information about the child's needs and living circumstances, the parents are more likely to reach an agreement about the child support award. The same appears to be true of medical support orders, that is, when the parents have more and better information about each parent's access to healthcare coverage for the children and the cost of that coverage, the parents are more likely to agree to a medical support order. Medical support orders were established in 60 percent of all cases (*i.e.*, both treatment and non-treatment) in which *Niños Sanos* staff **shared** information with CSOs. Medical support orders were established in only 4 percent of all cases (*i.e.*, both treatment and non-treatment cases in which *Niños Sanos* staff **did not share** information with the CSOs. What is not clear is whether CSOs would have obtained the same information on their own. It is unlikely, however, that the high rate of medical support orders among post-CSRP cases relates to the *Niños Sanos* process. Post-CSRP cases were entered into the project because they were identified as cases in which the parents had reached an agreement about the order in the CSRP establishment conference, so an order should have already been established in these cases.

The findings presented in Table 7.2 also suggest that *Niños Sanos* staff were more effective at facilitating medical support orders directing the custodial parent to apply for Medicaid/CHIP. The rate of orders for Medicaid coverage is statistically higher in pre-CSRP and post-CSRP treatment cases (64 percent) than in pre-CSRP non-treatment cases (57 percent). CSOs believed that the Medicaid/CHIP status information that *Niños Sanos* staff provided was better than that available from other sources because *Niños Sanos* staff retrieved the information from the HHSC automated system, which is the definitive source of Medicaid enrollment. Nonetheless, there are other factors besides Medicaid enrollment that are considered when determining a medical support order. Under Texas statute, private health insurance is prioritized over Medicaid regardless of whether the children are currently enrolled in Medicaid. Further, private insurance does not preclude Medicaid enrollment although it does preclude CHIP enrollment. Insurance from the noncustodial parent's employer was ordered in 12 percent of the Medicaid treatment cases and 18 percent of the Medicaid non-treatment cases.

Table 7.2. Characteristics of Medical Support Orders After Treatment/Intake (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Medical Support Order Established	(n = 1,087)	(n = 990)	(n = 505)
Yes	43%	56%*	93%*
No/Don't Know	57%	44%*	7%*
Ordered Source of Healthcare Coverage	(n=468)	(n=557)	(n=472)
Noncustodial parent's employer	31%	25%*	14%*
Custodial parent's employer	11%	9%	6%*
Noncustodial parent's private insurance[a]	1%	1%	15%*
Custodial parent's private insurance[a]	1%	2%	
Medicaid	57%	64%*	64%*

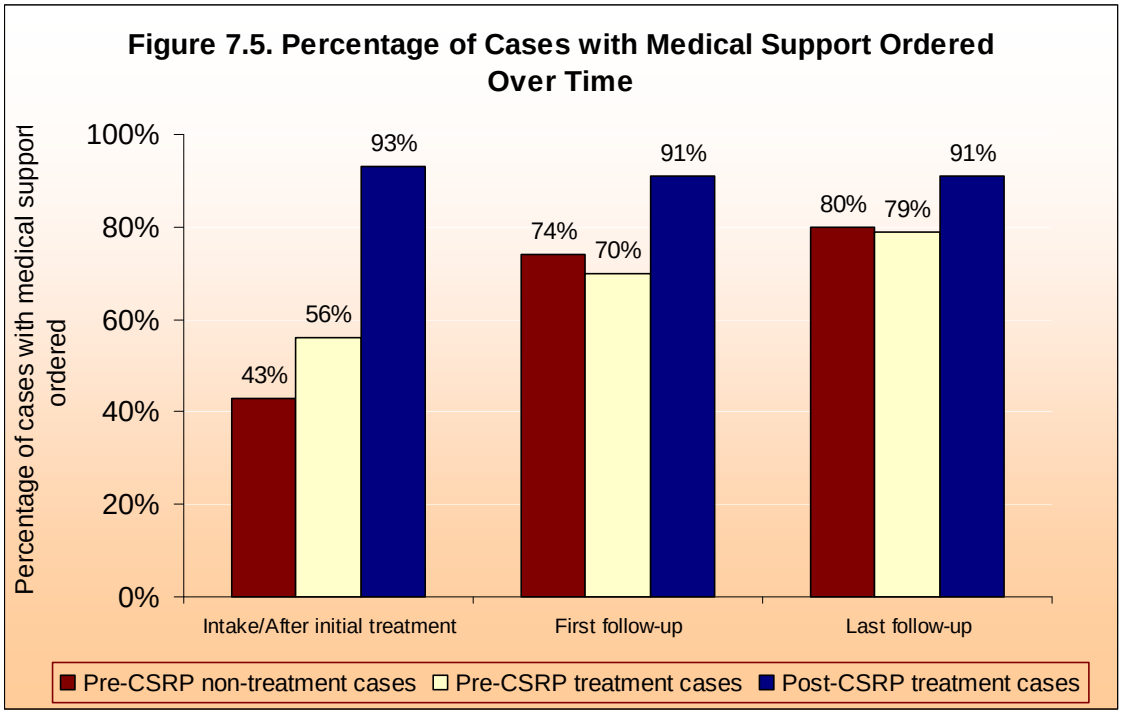
[a] The percentage in the column tracking post-CSRP cases contains the percentage when noncustodial parent's private insurance and custodial parent's private insurance are combined.
*Statistically different from the non-treatment group at $\rho < 0.05$.

Figure 7.5 compares the medical support establishment rates at different time periods. It includes the medical support establishment rates in Table 7.2, which are the rates at intake/initial treatment, as well as the medical support rates at the first follow-up and the final follow-up. This measure is slightly different than the measure shown in Figure 7.1 that tracked the percentage of *ordered* cases with medical support orders. The percentage shown in Figure 7.1 includes cases in which a financial child support order was never established. This was the situation in some CSRP cases. Parents might reunify or the petition for child support order may be withdrawn for other reasons.

As evident in Figure 7.5, the medical support establishment rate increases over time among both pre-CSRP treatment and non-treatment cases. As time elapsed, an order was more likely to be

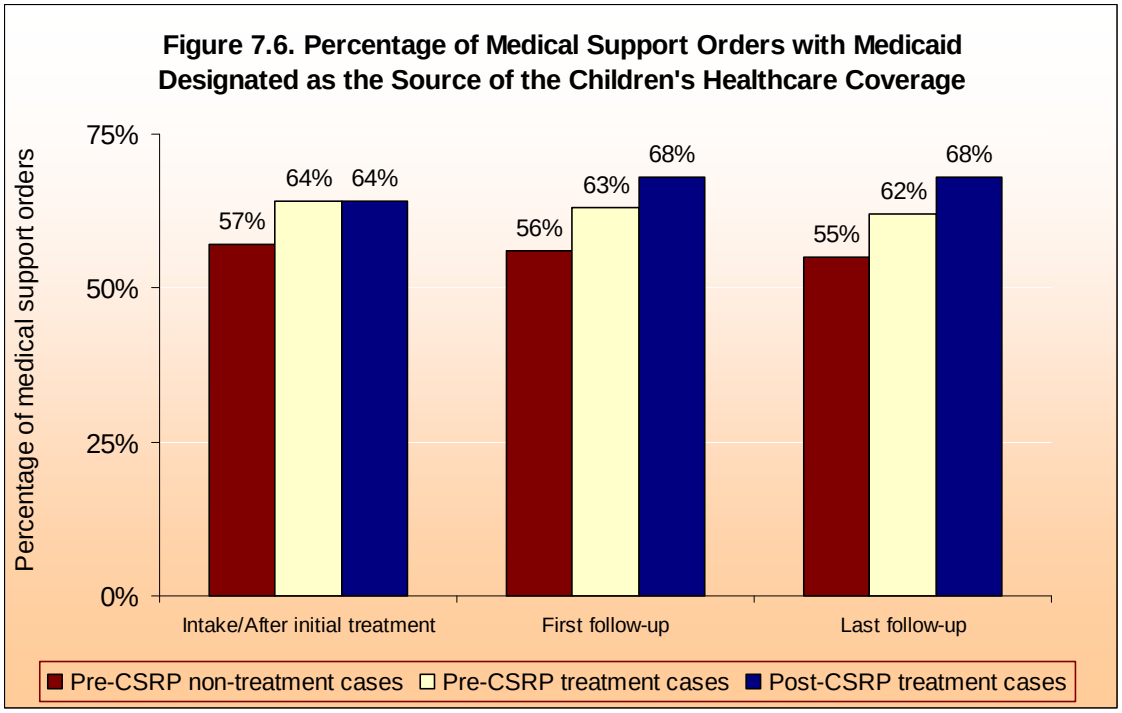
established. As more medical support orders were established, the gap in the medical support establishment rate observed at intake/initial treatment between pre-CSRP treatment and non-treatment cases narrowed. For example, the gap in medical support establishment rates among pre-CSRP treatment and non-treatment cases was nearly 13 percentage points at the start of the project. In contrast, the gap narrowed to a 1 percentage point difference in medical support establishment rates among pre-CSRP cases (*i.e.*, 79 and 80 percent, respectively, for treatment and non-treatment cases, as shown in Figure 7.5) by the last follow-up period. As more time elapsed, more information about medical support became available.

Figure 7.5 also demonstrates an anomaly among post-CSRP treatment cases. The medical support order establishment rate appears to have decreased from 93 percent at intake/initial treatment to 91 percent at the first and final follow-ups. The anomaly actually reflects a decrease in the number of cases in which medical support was known. There were 505 post-CSRP cases available for analysis at intake/initial treatment. That count was reduced to 444 post-CSRP cases at follow-up. Some of the post-CSRP cases were closed and some could not be matched to the data extracts that were the source of the follow-up data.



Although the proportion of cases with medical support orders established increases over time, Medicaid is ordered more often in treatment cases than non-treatment cases consistently across all three time periods examined. Figure 7.6 illustrates this trend by comparing the percentage of medical support orders over time by treatment and non-treatment cases, in which Medicaid is the source of coverage. It shows the rates of Medicaid-ordered cases are seven percentage points different

between pre-CSRP treatment and non-treatment cases at all three time periods considered. The differences between the treatment and non-treatment groups also continue to be statistically significant. This suggests that the Medicaid status information provided by *Niños Sanos* staff influenced the medical support order and that influence did not wane over time.



Orders for Employer-Sponsored Insurance and Reasonable Cost

As detailed in Chapter 4, over half of noncustodial and custodial parents were employed at intake. Nonetheless, employer-sponsored insurance was ordered to 24 percent of employed noncustodial parents in all pre-CSRP treatment cases, 14 percent of employed noncustodial parents in all post-CSRP treatment cases, eight percent of employed custodial parents in all pre-CSRP treatment cases, and six percent of employed custodial parents in all post-CSRP treatment cases. This suggests that most employers of parents with child support cases do not offer health insurance or if it is offered, it is unreasonable in cost. The root cause could be determined from available data. These percentages also suggest that employer-sponsored insurance was also ordered in several cases where employment was not verified at intake.

Orders for Cash Medical Support

Texas Family Code § 154.182(b)(2) requires the court to order cash medical support when a child participates in a government medical assistance program such as Medicaid. This requirement only applies if the amount of cash medical support is deemed reasonable in cost (*i.e.*, it is does not exceed

9 percent of the noncustodial parent's annual resources). The courts also order the obligor to pay the obligee cash medical support when neither parent has insurance available from employment or another source [Texas Family Code § 154.182(b)(3)]. If the obligee is ordered to provide coverage, however, the financial child support order is to be increased by the child's share of the insurance premium costs. In short, cash medical support is most likely to be ordered when the Medicaid is ordered but can also be ordered if the custodial parent is ordered to provide healthcare coverage for the children and in other case circumstances.

Application of statute should only result in orders for cash medical support if medical support has been ordered. Further, based on statute, cash medical support should be ordered in most Medicaid-ordered cases. Table 7.3 displays the frequency at which cash medical support is ordered and the median monthly amount of cash medical support ordered in treatment and non-treatment cases for three groups, Group 2 is a subset of Group 1 and Group 3 is a subset of Group 2. The groups are:

1) All project cases,
2) All project cases with medical support ordered—based on information in Table 7.2, this includes 43 percent of the pre-CSRP non-treatment cases, 56 percent of the pre-CSRP treatment cases, and 93 percent of post-CSRP treatment cases, and
3) All project cases with medical support ordered in which Medicaid is the source of healthcare coverage.

When examining all of the project cases, the findings in Table 7.3 suggest that the *Niños Sanos* treatment produced more orders for cash medical support. This outcome is actually a by-product of more medical support orders being established in *Niños Sanos* treatment cases and that process resulting in Medicaid being ordered more often in *Niños Sanos* treatment cases. When only Medicaid-ordered cases are examined, the frequency at which cash medical support was ordered does not vary significantly between treatment and non-treatment cases. Specifically, as evidenced in Table 7.3, cash medical support is ordered in 91 percent of both pre-CSRP treatment and non-treatment cases. Overall, this suggests that the *Niños Sanos* treatment had no impact on cash medical support orders. Differences in cash medical support between treatment and non-treatment groups do not appear to manifest over time either. For example, by the time of the final follow-up, cash medical support orders were established in 97 and 96 percent of the Medicaid-ordered, pre-CSRP, non-treatment and treatment cases, respectively.

In addition, the results in Table 7.3 suggest little variation in the cash medical support order amounts, as well as them being relatively small amounts. The median amount of cash medical support order was $25 to $30 per month depending on the particular subgroup. Although not shown in Table 7.3, the cash medical support order was less than $50 per month for three quarters of pre-CSRP treatment cases with cash medical support orders. This indicates that the maximum allowable amount of cash medical support is rarely ordered. In the majority of cases, the noncustodial

parent likely earns more than minimum wage or it is presumed that the noncustodial parent's income is equivalent to full-time minimum wage earnings, which is about $1,300 gross per month. The maximum amount of cash medical support that could be ordered at this full-time, minimum wage rate would be about $300 per month.

Table 7.3. Characteristics of Cash Medical Orders After Treatment/Intake (Percentage of Cases)

	Non-Treatment	Treatment	
	Pre-CSRP Cases	Pre-CSRP Cases	Post-CSRP Cases
Cash Medical Support Ordered (All cases)	(n = 1,087)	(n = 990)	(n = 505)
Yes - amount is greater than zero	37%	49%*	62%*
Yes - amount is zero	8%	7%	27%*
No	55%	45%*	11%*
Cash Medical Support Ordered (Cases with medical support ordered only)	(n = 468)	(n = 557)	(n = 472)
Yes - amount is greater than zero	61%	67%*	67%
Yes - amount is zero	16%	10%*	28%*
No	24%	23%	5%*
Cash Medical Support Ordered (Cases with Medicaid ordered only)	(n = 265)	(n = 354)	(n =294)
Yes - amount is greater than zero	91%	91%	93%
Yes - amount is zero	7%	7%	6%
No	2%	2%	1%
Median Monthly Cash Medical Support Order			
All cases	$25	$25	$25
Cases with medical support ordered	$30	$30	$25
Cases with Medicaid ordered	$25	$30	$25

*Statistically different from the non-treatment group at $\rho < 0.05$.

Compliance with Medical Support Orders

This section investigates compliance with medical support orders by the most common types of medical support ordered: that is, orders for the parents to apply for Medicaid, orders for the noncustodial parent to provide employer-sponsored insurance, and cash medical support orders. *Niños Sanos* were to monitor treatment cases and take various actions to ensure that medical support was provided as ordered. For example, in Medicaid-ordered cases, *Niños Sanos* staff were to facilitate Medicaid enrollments and redeterminations. Still, another example, when the ordered source of healthcare coverage was through the noncustodial parent's employer, *Niños Sanos* staff were to contact parents and employers to ensure that healthcare coverage was in place as well as follow-up with employers if they did not complete and return a National Medical Support Notice (NMSN). The

NMSN, in addition to other requirements, demands that the employer and healthplan administrator enroll the child in the parent's employer-sponsored healthplan even if the parent does not authorize it. Employers must return NMSNs to inform the child support agency whether they enrolled the child in the employer-sponsored insurance and if not, explain why. One reason that employers may not enroll the child is that the noncustodial parent no longer works for the employer.

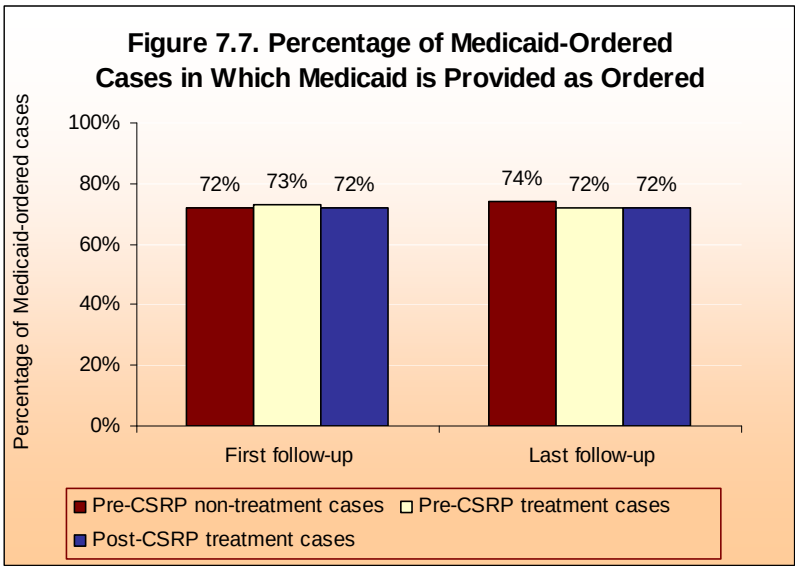
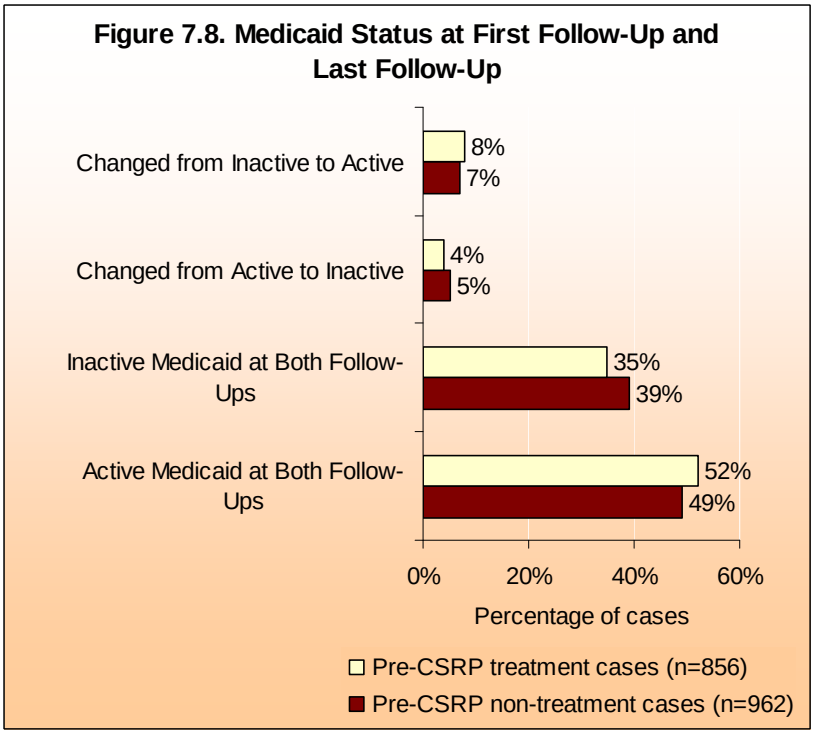


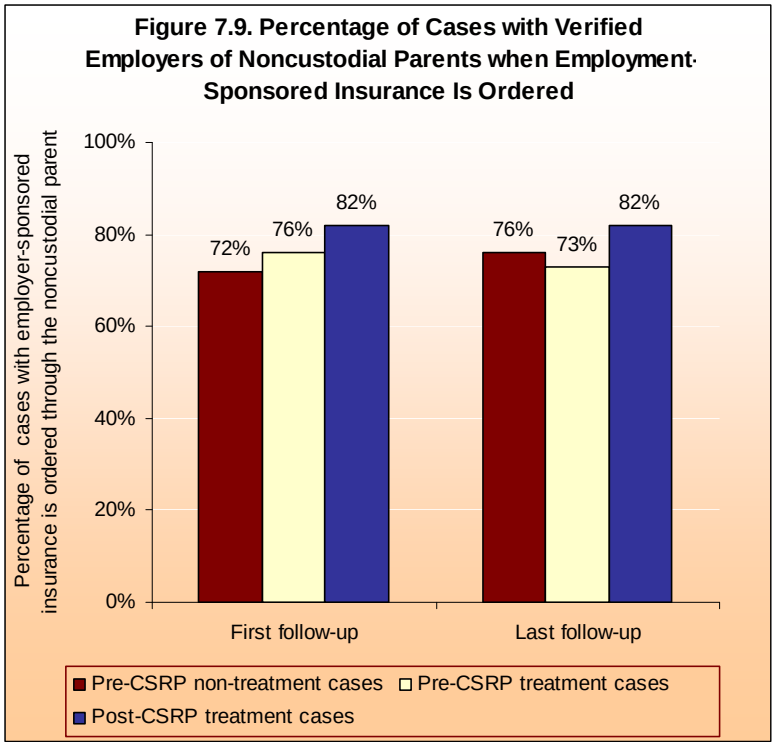
Figure 7.7 takes the information presented earlier in Table 7.2 about Medicaid-ordered cases a step further by examining whether parents actually complied with the medical support order for Medicaid. Figure 7.7 examines compliance with orders requiring parents to apply for Medicaid for their children. It shows no difference in actual Medicaid enrollment rates in Medicaid-ordered cases. Enrollment rates are consistently 72 to 74 percent for all case types and both follow-up periods. This indicates that the *Niños Sanos* staff's help with Medicaid enrollment and redetermination did not improve compliance.

One factor that may contribute to the fairly consistent percentage of Medicaid-ordered cases in which Medicaid is provided as ordered is that there is not a lot of variation in Medicaid status over time. Figure 7.8 examines whether Medicaid status changed in pre-CSRP cases from the first follow-up to the final follow-up. As shown in Figure 7.8, Medicaid status changed in 12 percent of the cases between the first and final follow-up. The percentage did not vary between treatment and non-



treatment cases. If *Niños Sanos* treatments were effective at facilitating Medicaid redeterminations, the percentage of Medicaid status changes would be less among treatment cases than non-treatment cases. However, this would not be conclusive. Whether the children continue to be Medicaid eligible is another factor that may influence changes in Medicaid status over time. The children may become ineligible if the household income increases or as the children age because a lower income threshold applies to younger children.

The time elapsed between follow-ups varied from one year to about two and a half years. It is unknown whether children who were no longer enrolled in Medicaid at the final follow-up had healthcare coverage from another source. It is also unknown what factors precipitated Medicaid enrollment in those cases that became new Medicaid cases at the final follow-up. For example, it is unknown whether the parent previously providing children healthcare coverage lost his or her job due to the economic recession.

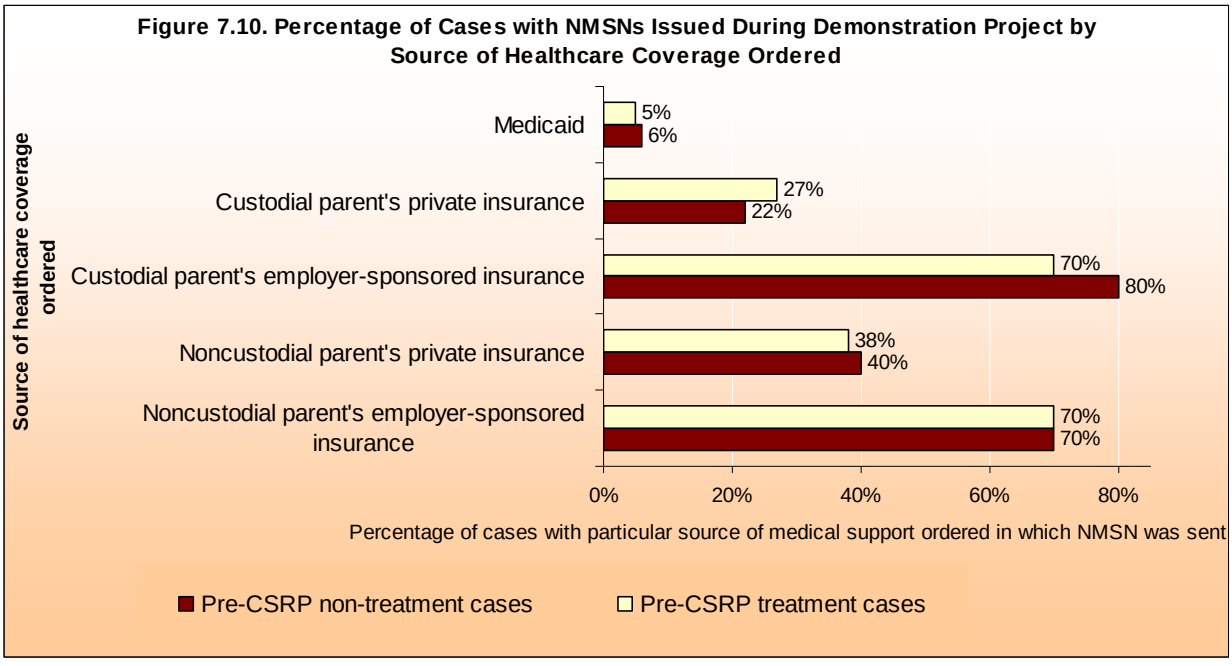


Compliance with orders to provide the children's healthcare coverage through the noncustodial parent's employment cannot be directly measured because of data limitations. Instead, the noncustodial parent's employment status is used as a proxy. Child support agencies maintain current information on whether the noncustodial parent is employed because this information is necessary for wage garnishments. If a noncustodial parent continues to be employed, it is more likely that there will be compliance with orders for employer-sponsored insurance. If a noncustodial parent is no longer employed, the children cannot be enrolled in employer-sponsored insurance. The limitation of using employment as a proxy, however, is employers do not always offer health benefits or that the children are indeed enrolled in the employer-sponsored healthplan if it provided. Figure 7.9 shows the noncustodial parent's employment at the first and last follow-up. There are no statistical differences in employment rates (72 and 76 percent, respectively) among pre-CSRP non-treatment and treatment cases in which the noncustodial parent's employer-sponsored insurance is ordered as the source of the child's healthcare coverage. The employment rate of post-CSRP treatment cases in

which the noncustodial parent's employer-sponsored insurance is ordered (82 percent) is more than that of pre-CSRP cases, but the difference is statistically insignificant. Further, the information shown in Figure 7.9 suggests that there is some stability in employment in cases where employment-sponsored insurance available to the noncustodial parent is ordered. Nonetheless, the actual rate of children with employer-sponsored insurance is likely to be smaller than the verified employment rate because employers do not always offer health benefits and when they do offer them, they might not be reasonable in cost.

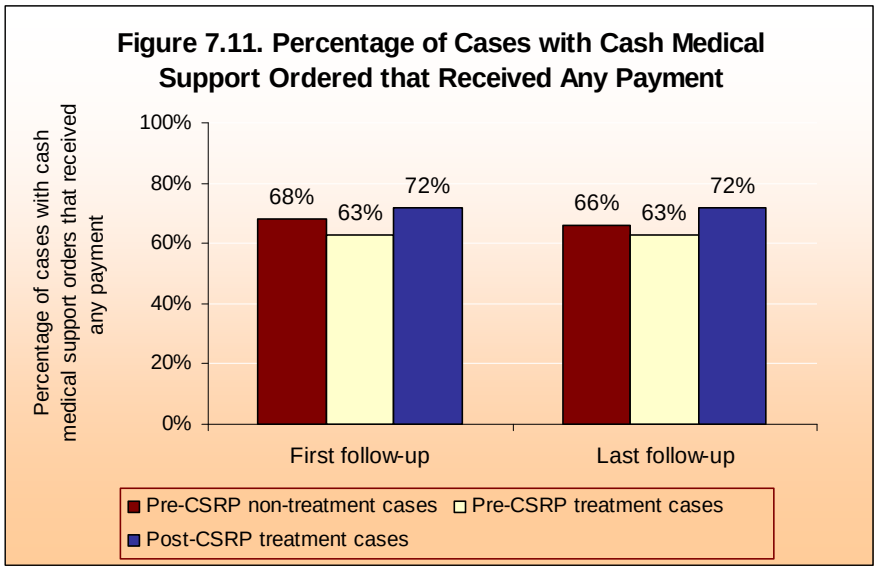
One reason that *Niños Sanos* staff did not affect outcomes in cases where employer-sponsored insurance is ordered is because *Niños Sanos* staff rarely sent out NMSNs. (This finding was presented in Chapter 6.) *Niños Sanos* staff were suppose to send them in treatment cases in which employer-sponsored insurance was not provided as ordered. If they had done so, there would be more NMSNs issued in treatment cases than non-treatment cases by the time of the first follow-up. Figure 7.10 illustrates that this did not occur. Figure 7.10 displays the percentage of NMSNs sent during the project period from any source including the private vendor that was contracted to send NMSNs on a routine basis. Child support and *Niños Sanos* staff sent NMSNs on as-needed basis while working a case. Figure 7.10 illustrates that NMSNs were sent during the demonstration project in 70 percent of both pre-CSRP treatment and non-treatment cases in which the ordered source of the child's healthcare coverage was the noncustodial parent's employer-sponsored insurance.

Figure 7.10. Percentage of Cases with NMSNs Issued During Demonstration Project by Source of Healthcare Coverage Ordered



In addition, Figure 7.10 illustrates other interesting findings about NMSNs. They were sent just as frequently or more frequently when the source of the child's healthcare coverage was the custodial parent's employer-sponsored insurance. (Sending NMSNs when healthcare coverage is ordered through the custodial parent's employer-provided insurance is a state policy option.)

Few *Niños Sanos* treatments were directed at compliance with cash medical support. Figure 7.11 shows that the 63 to 68 percent of cases with cash medical support ordered received any payment toward cash medical support during the six months prior to the follow-up period. The percentages for treatment and non-treatment cases were not significantly different.



Medicaid, Healthcare Coverage, and Medical Support

Table 7.4 explores the healthcare coverage and medical support outcomes of Medicaid cases only. Medicaid cases deserve special treatment for two reasons. Several recent federal initiatives have expanded or are expanding Medicaid coverage. One study (Burnszynski 2010) estimates that in the future, 80 percent of IV-D children nationally will also be enrolled in Medicaid. Until recently, medical support policies have been directed at reducing the government's cost of Medicaid. Texas estimates the savings from medical support orders are nearly one billion dollars annually (Texas Office of the Attorney General 2009). Medical support can reduce Medicaid costs in several ways. Health insurance can be ordered from the noncustodial parent if he or she has access to it through employment or another source and it is reasonable in cost. Medicaid enrollment does not preclude eligibility for other private insurance. If a child has both Medicaid and private health insurance, the insurance carrier is obligated to pay precedent to Medicaid. If private health insurance is not available, cash medical support can be ordered to reimburse the costs of the children's participation in Medicaid.

Table 7.4 examines project cases where the OAG automated system indicated the children on the case were enrolled in Medicaid at the time of the final follow-up. Medical support was established in 82 percent of both the pre-CSRP treatment and non-treatment Medicaid cases and 93 percent of the post-CSRP Medicaid cases. The majority of Medicaid cases specified Medicaid as the source of healthcare coverage for the medical support order. The second most frequently ordered source was the noncustodial parent's employer-sponsored insurance. It was the ordered source of healthcare coverage for 10 to 17 percent of Medicaid cases.

Cash medical support was ordered in the majority of Medicaid cases. Under old federal performance rules, Medicaid did not count as medical support unless cash medical support was ordered and provided. However, in 2011, OCSE began counting Medicaid as healthcare coverage regardless whether cash medical support was ordered or provided. Table 7.4 shows that cash medical support orders were set at zero more often in post-CSRP Medicaid cases than pre-CSRP Medicaid cases. One explanation for why cash medical support in Medicaid cases was not ordered was because it was not reasonable in cost. This situation can occur when the noncustodial parent has very low income or multiple child support orders. The extent that noncustodial parents in the project had very low incomes cannot be analyzed because of insufficient data. Instead, CPR examined the noncustodial parent's employment status and financial child support because they are indicators of low income. The analysis was limited to post-CSRP Medicaid cases because they had a significant share of zero medical support orders while pre-CSRP Medicaid cases did not. CPR also examined the noncustodial parent's number of orders. Results from CPR's data analysis show that noncustodial parents with zero-dollar medical support orders were actually more economically advantaged than those with non-zero medical support orders. They were more likely to be employed and have higher child support orders, which usually reflect a higher income. The employment rates were 65 and 59 percent among those with zero-dollar orders and non-zero dollar orders, respectively. The average financial child support order was actually higher when the cash medical support was set at zero rather than a non-zero amount (*i.e.*, the child support order averaged $327 and $238 per month, respectively, and the difference was statistically significant). This suggests that noncustodial parents with zero-dollar medical support orders had more income than those with non-zero orders.

CPR also examined the noncustodial parent's number of orders. In Medicaid cases, the average number of child support orders among noncustodial parents with medical support orders set at zero was more than those with non-zero amounts (the average number of orders were 2.3 and 1.5, respectively, but the difference is not statistically significant). This suggests that multiple orders were indeed a consideration but not the only consideration when setting a cash medical support order at zero. Medicaid savings from orders for private health insurance cannot be realized unless the children are actually enrolled in the insurance plan. As discussed earlier, compliance with orders to provide the children's healthcare coverage through the noncustodial parent's employment could not be directly measured because of data limitations. Instead, the noncustodial parent's employment status was used as a proxy. For both Medicaid and non-Medicaid cases in which the child's healthcare coverage is ordered through the noncustodial parent's employment, the noncustodial parent's employment is verified in 73 to 82 percent of cases depending on whether the case came into the project as a treatment case or before or after the CSRP. When the analysis is limited to Medicaid cases, the percentages are 67 to 77 percent depending on the case type. (The difference is statistically significant at $\rho < 0.10$.) This suggests that compliance with orders to provide the children's healthcare coverage through the noncustodial parent's employment are somewhat lower among Medicaid cases than non-Medicaid cases.

Table 7.4. Characteristics of Medicaid Cases at Final Follow-Up (Percentage of Medicaid Cases)			
	Non-Treatment	Treatment	
	Pre-CSRP Cases (n=568)	Pre-CSRP Cases (n=523)	Post-CSRP Cases (n=258)
Medical Support Order Established			
Yes	82%	82%	93%
No	18%	18%	7%
Ordered Source of Healthcare Coverage			
Noncustodial parent's employer	17%*	11%*	10%*
Custodial parent's employer	2%	2%	1%
Noncustodial parent's private insurance[a]	3%	3%	4%
Custodial parent's private insurance[a]	1%	2%	2%
Medicaid	58%*	63%*	76%*
None Ordered	18%	18%	7%*
Cash Medical Support Ordered			
Yes - amount is greater than zero	60%	63%	72%*
Yes - amount is zero	2%	3%	20%*
No	38%	34%	8% *

*Statistically different from the non-treatment group at $\rho < 0.05$.

Medicaid savings from cash medical support orders depend on two factors: the amount of the cash medical support order and the amount actually paid in cash medical support. Table 7.5 shows that the amount of medical support ordered, when actually ordered and ordered at a non-zero amount, in Medicaid cases is nominal. It averages $31 to $39 per month and ranges from $5 to $350 per month. Although not displayed in the table, CPR's analysis showed that over three-quarters of cash medical support orders in Medicaid cases are less than $50 per month.

Table 7.5 displays the amount of cash medical support arrears accrued at the time of the last follow-up as well as the total amount of cash medical support owed and paid in the six months preceding the last follow-up period for Medicaid cases. The low amount of cash medical support arrears reflects that cash medical support orders are relatively small and usually newly ordered. (It takes time for arrears to accrue.) Similarly, the amount paid in cash medical support over a six-month period was relatively low. The total cash medical support payments over a six-month period in Medicaid cases averaged $66 to $67. This is a small proportion of actual Medicaid expenditures on children. According to the Kaiser Family Foundation (2011), the average Medicaid payment per child enrollee in Texas was $2,400 per year in fiscal year 2007. The average compliance rate was 49 percent for non-treatment cases and 43 percent for pre-CSRP treatment cases and 50 percent for post-CSRP treatment cases. Therefore, the difference in compliance was minimal among treatment and non-treatment cases.

Ordering higher amounts for cash medical support would unlikely yield more cash medical support collections. The median amount of financial child support arrears in these Medicaid cases was about $4,000 and financial child support orders average about $300 per month in these Medicaid cases. If noncustodial parents do not pay their financial child support obligations they are unlikely to pay their medical support obligations as well. Another factor that constrains payments is multiple orders, over half of the noncustodial parents in Medicaid had two or more child support obligations.

Table 7.5. Cash Medical Support Orders[a] in Medicaid Cases at Final Follow-Up

	Non-Treatment	Treatment	
	Pre-CSRP Cases (n=338)	Pre-CSRP Cases (n=332)	Post-CSRP Cases (n=194)
Monthly Cash Medical Support Order			
Average	$38	$39	$31
Median	$30	$30	$25
Range (minimum to maximum)	$5 - $300	$5 - $350	$5 - $129
Cash Medical Support Arrears			
Average	$397	$461	$273
Median	$220	$304	$161
Range (minimum to maximum)	$0 - $3,438	$0 - $4,943	$0 - $5,202
Cash Medical Paid in Last Six Months			
Average	$112	$100	$95
Median	$ 50	$ 34	$ 50
Range (minimum to maximum)	$0 - $1,300	$0 - $1,068	$0 - $982
Cash Medical Support Compliance Rate			
Average	49%	43%	50%
Median	33%	19%	33%
Percentage of Cases by Amount Paid			
Paid nothing	41%	37%	37%
Partial payment	42%	40%	46%
Full payment	16%	23%	18%

[a] Includes cases with non-zero cash medical support orders only.
*Statistically different from the non-treatment group at $\rho < 0.05$.

Data Limitations

Not all of the research questions planned for the evaluation could be addressed due to data and process limitations. Such research questions concerned reasonable cost of insurance and CHIP. The *Niños Sanos* staff were only able to obtain insurance premium amounts and incomes in a small number of cases. Assessing reasonable cost of insurance requires information about insurance premiums and parents' incomes. The parents who *Niños Sanos* staff were able to contact rarely had

employer-provided insurance and when they did, they did not always know the precise premium amounts. Similarly, *Niños Sanos* staff had a difficult time obtaining parent income information. The only source of this information would be the income used to establish the child support order but obtaining that would have been a tedious process as it is not recorded on the automated system. CHIP, also, is not tracked separately from Medicaid in the OAG automated system. This limited the ability to conduct analysis of CHIP issues independently. Nonetheless, *Niños Sanos* staff recorded CHIP and Medicaid eligibility separately for the pilot. They found that CHIP is used infrequently relative to Medicaid. In September 2008, it was found that among all establishment cases, 61 percent were enrolled in Medicaid while only four percent were enrolled in CHIP. The issues concerning CHIP and Medicaid are very different because Medicaid does not assess premiums or co-pays while CHIP does. As such, CHIP can be treated more similarly to private health insurance within the framework of medical support while Medicaid cannot.

Chapter 8
Reactions to the Project

The Center for Policy Research (CPR) conducted qualitative research based on the experiences of the *Niños Sanos* demonstration from staff, supervisors and administrators from HHSC and OAG, and other *Niños Sanos* personnel. Interviews were conducted in 2010 (see the interview guide in Appendix C) and other information was shared through project update and planning meetings that were held in person and through teleconferences. Interview questions focused on the effectiveness of the roles of *Niños Sanos* staff in increasing healthcare coverage among children, improving medical support outcomes, the practicality of various private insurance options for IV-D children, and the reactions of parents, employers, and insurance carriers to demonstration efforts to increase health-care coverage for children and improve medical support.

Staff reported on both the merits and limitations of the project. They reported that the project was successful in that it fostered a good rapport between the HHSC and the OAG, increased understanding of medical support and Medicaid, provided a Medicaid resource in child support office that was useful to child support staff, produced a simplified informational brochure for parents on private insurance options, and more.

On the other hand, staff identified many limitations and issues with the project. First, the project was handicapped from the beginning because the original grant designers left the project before it was put into practice, causing much confusion. Throughout the course of the project, staff struggled with interagency collaboration and staffing configurations, adhering to the experimental design, the affordability of private insurance for parents. Staff felt that the emphasis put on private insurance was unreasonable when few parents had employer-sponsored insurance and the majority of children were low-income and eligible for Medicaid. OAG staff reported that at first they were very optimistic and excited about the *Niños Sanos* project. However, over time, as staff realized the difficulty of implementing project initiatives and their limited practical success, they became less enthusiastic.

Reactions to Specific Approaches and Treatments

Project Need

The project was premised on the underlying presumption that a significant share of children in the child support caseload lacked healthcare coverage. The supposition was that children would benefit from *Niños Sanos* interventions that would connect them to Medicaid/CHIP or private, child-only insurance for those children lacking access to affordable employer-sponsored insurance and ineligible for Medicaid/CHIP. OAG and HHSC had conflicting views on how to approach this problem.

Several OAG administrators believed that many families in need would find Medicaid/CHIP on their own. To that end, they found an extensive search of child support cases for Medicaid-eligible children who are not currently enrolled in Medicaid to be unnecessary. They believed that if a family is seeking child support, that family has most likely already sought assistance through other means, such as TANF and Medicaid, before coming to the child support agency.

HHSC administrators and *Niños Sanos* staff took a different perspective. They had encountered parents in the child support caseload who needed help with Medicaid eligibility determination and re-enrollment. They believed they could have helped a greater number of children in the child support caseload had they been able to discuss Medicaid/CHIP with parents up-front. They felt that the OAG's process of exhausting the potential for private health insurance for the purposes of establishing a medical support before considering Medicaid/CHIP stymied their outreach to Medicaid-eligible children who currently lacked healthcare coverage.

Nonetheless, all of the interviewees believed that the private, child-only insurance options available were rarely practical for families. All of the interviewees recognized that child support families tend to be very low income and many could not afford child-only, private insurance plans that were available.

Interagency Collaboration and Competing Agency Priorities

Interviewees reported that they found the interagency collaboration to be challenging. One OAG administrator said,

> "Everyone touts collaboration, but it is difficult when you get down to the nitty gritty. It's great to have a good working relationship, but actual collaboration is really difficult."

Interviewees believed that the project goal of combining child support (OAG) and Medicaid (HHSC) was infeasible. Each agency had

> "totally different cultures with different goals,"

and they

> "do different jobs. The HHSC measures its success based on how many people they can sign up for Medicaid, whereas the OAG measures its success based on how much money they can collect for child support.

HHSC administrators reported that, accordingly, the OAG did not want the *Niños Sanos* staff to enroll families in Medicaid because they did not get credit for these enrollments.[2] Instead, the OAG wanted project staff to try to enroll children in private insurance first. If the child had no access to private insurance options and private, child-only insurance was too expensive, the OAG wanted project staff to enroll children in CHIP. If the child was not eligible for CHIP, the OAG then wanted the worker to look at Medicaid as a last resort.

Child Support staff felt that the project conflicted with their priorities at the OAG. Staff reported that simply collecting child support was difficult enough:

> "We are struggling just to collect the money we are owed right now. We cannot afford to expand our goals. Helping parents get on Medicaid is not an appropriate task for the IV-D agency."

Further, staff members felt that medical support collections naturally should come second to child support collections. This is partly because child support gets more public attention than medical support. Also, in practice, if a NCP pays $500 a month in child support and does not make his $25 a month medical support payment, the OAG is satisfied that the family at least receives that $500 a month. "We're not going to go after the parent for that extra $25 a month," said another interviewee.

> "It becomes an issue of priority" and "medical support becomes secondary."

Joint Staff Positions

It was found that the joint staffing configuration between the two agencies was especially problematic. In addition to differences in their goals and cultures, staff reported that differences in agency automated systems made for a great deal of confusion. Different agency rules such as confidentiality requirements made the use of the automated systems by combined staff impractical. According to one interviewee, the information on the OAG automated system was often "outdated and incorrect" and this would result in project staff "targeting families for the project who did not even need to be targeted."

Niños Sanos staff had previously worked as Medicaid eligibility workers within the HHSC. Their expertise was in getting many people covered by Medicaid and they continued to pursue this objective while working on the project even though it conflicted with the stated project goals. OAG staff

[2] When the project was in operation, federal performance measures for medical support did not recognize Medicaid as medical support unless cash medical support was also ordered and provided. That was changed, however, in 2011.

felt that project staff should have been hired from outside of the two agencies and trained in health-care options and child support instead of importing them from the HHSC.

Project staff members were supervised in part by the HHSC and in part by the OAG unofficially. OAG interviewees held the view that when placing a worker full-time in one office, the worker should be supervised by that office. In this project, HHSC had official control of project staff members, so OAG could not effectively tell staff what to do.

Reaching Out: To Whom and When

The questions of "To whom?" and "When?" *Niños Sanos* staff should reach out, also raised significant issues. *Niños Sanos* staff were more comfortable reaching out to custodial parents than noncustodial parents and employers because they had previously only been responsible for reaching out to custodial parents in their former roles as Medicaid eligibility workers.

Confounding the experimental research design was that *Niños Sanos* staff often reached out to parents in non-treatment cases. When asked about this, HHSC staff described their qualms with the project's experimental model. They felt that the purposeful neglect of not providing services to the non-treatment group was unfair. Therefore, they often did not obey the random assignment to treatment and non-treatment groups. Instead, they provided services anyway, to the immediate benefit of the needy families but to the detriment of determining whether this project was useful and how more help could be provided in the future. In addition, *Niños Sanos* staff could not always document the outcomes of their outreach efforts because Medicaid applications would often be sent to parents who would return them to the HHSC and not to *Niños Sanos* staff.

Most of the staff directly involved in the demonstration believed that it worked best once revisions were made to the project design and intervention with parents occurred post-CSRP rather pre-CSRP. Staff said that they

> "didn't see the benefit of working pre-CSRP cases [because] you don't know what you're faced with until after the CSRP or court. Quite often, you can't get all of the facts beforehand. You often don't even get all of the facts after the CSRP or court. After the order is established, you have a better chance of knowing who has a job and what private insurance may be available, and what the parents' income and resources look like."

They also found that parents were more likely to take actions on their cases after order establishment and once there was a court order telling them exactly what they needed to do.

Once the project was restructured to focus on post-CSRP cases *Niños Sanos* staff felt that they could better focus on what they were trained to do (*i.e.*, Medicaid applications and redeterminations) and thereby they were able achieve more successful outcomes. Also, potential conflict with the medical support establishment process, as determined by statute, was eliminated once intervention was applied after medical support orders were established.

When handling cases at this point later in the CSRP process, one project worker remarked that she really enjoyed her work. She reported that she was able to work on a huge number of cases from all three child support offices. She said that it was much better to work the cases after orders were established because she knew exactly what type of healthcare coverage parents were ordered to provide.

Private, Child-Only Insurance Options

The original grant writers had proposed that the Texas Department of Insurance (TDI) would provide training to the project staff about private, child-only insurance options. Yet, when the time came and OAG approached TDI about training, TDI said that it did not train people and had no detailed information to provide the project staff members. It was unclear whether the people who had originally written the grant had discussed training with TDI and, if they had, whom they had coordinated with. Recognizing this need for information on private, child-only insurance options, CPR stepped in and developed a brochure.

The private insurance brochure compiled by CPR was widely liked by the majority of staff working on the project. HHSC administrators said that they liked the brochure because it gave four clear options of insurance companies with simplified information. However, as with all private insurance options, *Niños Sanos* staff could only provide parents with the informational brochure. They could not help the parents apply for private insurance or ensure that the parents actually got coverage. Still, HHSC staff said that the brochure came too late in the project.

Before the brochure was developed, *Niños Sanos* staff found that the available information about private, child-only insurance options was too uncertain and overwhelming to share with parents. Despite inquiries, no private insurance companies could give staff a clear idea of what it would take to insure someone through their plans. This made staff feel uncomfortable exploring private insurance options with parents. They were not familiar with the private insurance terminology (*e.g.*, co-pay and deductibles). Other problems resulted from the individual underwriting of insurance policies on a family or individual basis. This meant the cost of private insurance varied greatly from family to family or person to person based on age, pre-existing conditions, and other factors. It also meant that parents would not know the precise cost of the insurance until they applied and were approved. Likewise, the courts would not have the information in a timely matter such that it could be used to establish an appropriate medical support order.

Some HHSC interviewees believed that if the OAG had selected one or two insurance companies to contract with,[3] it would have greatly helped *Niños Sanos* staff make referrals for private insurance. This would have allowed the *Niños Sanos* staff to become more familiar with their specific application processes and their costs.

HHSC administrators reported that it was not possible to fully explore private insurance options with parents in any case, because insurance companies required that the parents themselves complete the application and provide the information. HHSC administrators did stress that they had no problem referring parents to private insurance when the children were not eligible for Medicaid or CHIP. However, all they could do was make a referral: they could not be sure that the parents would, in fact, apply or follow through at all.

Other Themes

HHSC administrators, OAG administrators, and *Niños Sanos* staff shared many of the same views about what were the positive and negative aspects of the project.

- *All agreed that they learned a great deal about the other agency, particularly the other agency's approach to serving families.* Medicaid administrators learned that OAG's very procedural approach to medical support was dictated by federal and state statute. Similarly, child support administrators and staff learned how involved the Medicaid/CHIP application and eligibility determination processes are. Interviewees also reported that project outreach was successful because different staff, like Child Support Officers (CSOs), who often are the first staff to extensively communicate the parents coming into the child support system, became more informed as a result of the project and could share information with the parents up-front.

- *Regional OAG and HHSC developed a good rapport that led to better communication and information sharing between agencies and, in turn, made better information available to parents.* Interviewees reported that through the project they were able to develop a good rapport between OAG and HHSC, and that it was helpful to build open and improved communication between the two agencies. This allowed staff to better guide and interact with clients so that they were more cooperative with child support. Also, they found that having, albeit limited, access to both HHSC and OAG automated systems was very helpful. As a result, they were even able to clear up many discrepancies between the two systems' records.

[3] Texas legislation was passed late in the demonstration that would have made this feasible, but private insurance carriers were not interested because their attentions had shifted to federal healthcare reform that was passed shortly after the enabling Texas legislation was passed.

- *Having a Medicaid expert located in a child support office is helpful.* OAG administrators and *Niños Sanos* staff agreed that it was helpful to have someone with Medicaid expertise available in the child support office not only to address issues specific to the *Niños Sanos* project, but also to address Medicaid issues that arose in other child support cases. Some OAG administrators also reported that they did like having *Niños Sanos* staff available on-site as a direct resource for parents. They reported that the project provided a "nice, one-stop shop for parents." CSOs appreciated having an HHSC staff person available to answer questions about Medicaid and to obtain up-to-date Medicaid information relevant to the child support case from the TIERS system.

- *Pursing employer-provided insurance for Medicaid eligible children is awkward for families and the HHSC.* HHSC administrators said that they felt the name of the project, meaning "healthy children," was misleading. They thought the project was not really about keeping children healthy and enrolled in healthcare coverage, but instead served a different agenda: to enroll children in private healthcare and reduce state expenses on Medicaid or CHIP. OAG interviewees understood this view, but pointed out that the OAG's obligation was to follow what is in the statute.

  HHSC staff were uncomfortable with finding children who were eligible for Medicaid and getting them enrolled in private insurance. The project staff found it difficult to tell parents, who were obviously low-income, that they needed to use private health insurance first even if their children were eligible for Medicaid. The parents did not understand why they should use private insurance when Medicaid is free and provides good coverage for their children and most private health insurance would not provide the same level of benefits. It was difficult to explain to parents the terms of copays and other cost-sharing components of dual enrollment. Parents had difficulty understanding or believing that children would receive the same healthcare benefits at no cost when dually enrolled and that private health insurance would pay first and Medicaid secondarily. Staff acknowledged the difficulties that custodial parents experience when using the noncustodial parent's employer-provided insurance for their children's healthcare. Custodial parents do not always have an insurance card or the most current insurance card from the noncustodial parent's employer. Albeit, staff recognized this was because the custodial parent in some cases failed to provide the children's social security number to the noncustodial parent. Often, the custodial parents would try to use the noncustodial parent's insurance while at the doctor's office only to find out that the benefits plan had changed or the insurance coverage had stopped.

- *Recognizing Medicaid as health insurance or healthcare coverage.* At the beginning of the demonstration, both OAG and HHSC agreed that, pursuant to federal policies, Medicaid should not be called "health insurance" and by itself it was not "healthcare coverage." One reason is that, until 2011, Medicaid was not considered medical support by the federal Office of Child Support Enforcement (OCSE) performance measures unless cash medical support was also ordered and paid.

This issue was reflected in OAG administrators' complaints that they had not seen a change in the number of children with health insurance from the beginning to the end of the demonstration. One OAG administrator did admit, however, that he did not view Medicaid as a sufficient source of healthcare coverage and noted that Medicaid is "a totally different beast." He said, "I have always had a very large number of cases covered by Medicaid and not covered by private insurance."

- *Most interviewees had not considered the impact of healthcare reform or other recent federal initiatives that extend Medicaid/CHIP's reach.* Most interviewees were involved in field operations and were not as well versed in federal initiatives as those charged with setting policy. When probed about whether child support offices would be suitable for Medicaid "express lane" eligibility, one OAG interviewee said,

  > "I think we can train child support people to do just about anything, including determining Medicaid eligibility. But I don't think this would be a good idea. There are just two different philosophies."

  He reiterated the before-mentioned conflicts on agency cultures and goals. When parents come into the child support office, many CSOs are reluctant to believe anything the parents say, which does not lend itself to determining eligibility for benefits. They also believed that if the OAG offered expedited eligibility, it would not necessarily improve the number of IV-D children with healthcare coverage because many IV-D children are already enrolled in Medicaid and if they are not, custodial parents typically already know about the HHSC and the services it provides. For the OAG, their concern was not so much a matter of getting kids enrolled in Medicaid but getting them private insurance resources as well.

Some interesting views that were unique to either OAG and HHSC interviewees are identified below.

- *If private insurance is the priority, child support should collaborate with Department of Insurance, not the Medicaid agency.* If obtaining private insurance for IV-D families was the major goal the project, HHSC staff felt that the OAG should have collaborated instead with the TDI or a private insurance company on this grant. HHSC administrators felt that, in the vast majority of cases, private insurance is simply not a viable option for families in the IV-D caseload. Even when parents have access to employer-sponsored insurance, many of the parents cannot afford the coverage for their families or change jobs so often that coverage is sparse and inconsistent.

- *Custodial parents prefer Medicaid for their children's healthcare coverage.* Overall, *Niños Sanos* staff reported that the obvious preference among parents is for Medicaid. Most parents simply do not even want deal with private insurance. One interviewee reported,

> "Most of our clients opt for Medicaid because it's cheaper for them. Often, it's also cheaper for the noncustodial parent because cash medical support is cheaper than private insurance"…"It's a little less taxing on their pocket. It's a lot easier for them to pay for that cash medical support rather than have it pulled out of their pocket. SCHIP is somewhere in between. It's better than private insurance, but not as good as Medicaid."

Another *Niños Sanos* worker said,

> "Medicaid and SCHIP are more affordable and offer more benefits than private health insurance. So, it is the preferred. Although [parents] understand that Medicaid can be a supplemental insurance they don't want to even bother."

A third *Niños Sanos* interviewee provided more insight into this problem, saying,

> "Both custodial and noncustodial parents want Medicaid, but don't think about it until an accident happens. Fortunately, Medicaid applications and assistance is available for these families through Medicaid spend-down programs."

When this staff member examined parents' income, number of children, the cost of adding children to employees sponsored or private plans, expenses, etc., she determined that about 30 percent of these people would actually be able to afford private insurance. For others however, it would eat up their entire paycheck. Thus, perhaps the major project initiative of obtaining private insurance coverage for IV-D children was not very realistic.

Recommendations of Interviewees

Administrators from the OAG and HHSC and *Niños Sanos* project workers were asked for their recommendations on how to improve the effectiveness of the project and increase healthcare coverage among IV-D children. First, the OAG recommended filling the gap for those without private insurance and those that were not Medicaid/CHIP eligible, although they believed that vast amount of their caseload was probably Medicaid/CHIP eligible. The general consensus about how to do this was to get better information from TDI or private insurance companies about insurance that

the OAG and the project staff members could actually use. In particular, they favored selecting one or two private insurance options that they could present to parents who did not have other options. Ideally, those options would be affordable and readily accessible and would not require a determination of reasonable cost.

One OAG interviewee also suggested that if Medicaid eligibility was based on the noncustodial parent's income rather than the custodial parent's income, it would make a significant difference in how many children got coverage. Other interviewees believed that that "having one application form and one place to refer parents to for healthcare coverage would be great." Staff also recommended that "more collaboration with Texas Works" might be beneficial because, "they can help obligors get jobs or better jobs that offer private insurance."

In the end, OAG staff members felt that the only way OAG could help with healthcare coverage was if there were some type of government plan to which they could help parents apply. They hoped that healthcare reform would create some sort of a statewide or national program for healthcare coverage and believed that "this was the only way that these families [would] get coverage."

HHSC administrators echoed some of the same suggestions as their OAG colleagues. Administrators made the following four concise recommendations for improving the project:

- Contract with one or two private insurance companies so that staff can become experts on the costs and application process,
- Get staff people who are familiar with private insurance especially if Medicaid is not going to be the agreed upon option for children,
- Allow OAG to get credit for children who are covered by Medicaid or at least accept that many of these children are going to get Medicaid coverage under medical support performance standards, otherwise the partnership does not work, and
- Explore the option of the court ordering the noncustodial parent to pay the Medicaid premium for his family instead of just ordering cash medical support. In order words, allowing a Medicaid buy-in.

In addition, HHSC administrators discussed using Medicaid or CHIP funds to subsidize employer-sponsored insurance that was deemed unreasonable in cost. If a parent had an employer-sponsored health plan that he or she was not using because of cost, the HHSC workers could determine whether the Medicaid premium or the private insurance premium was cheaper. Then they could allocate Medicaid dollars to pay for the cheaper premium. They felt the project was also beneficial in instances when they could use Medicaid as a secondary insurance source for the family if the private insurance coverage was incomprehensive or did not cover all of the family members.

Niños Sanos staff recommended making parents, who were ordered to obtain Medicaid during the CSRP, meet with the Medicaid eligibility worker right then. At that time, it would be most effective to explain the Medicaid process to parents and how it interacts with medical support. Another suggestion was to place the Medicaid eligibility workers directly in the courts, because the best window of opportunity for project staff to enroll children in Medicaid is precisely at the time of order establishment. Also because CSRPs and Medicaid interviews have high no-show rates, project staff believed that court was the best place to process Medicaid applications. One interviewee reflected,

> "When I was going to court, I would have six people on the bench waiting for Medicaid applications. They were required to be there. It was fresh on their plate"…"They already slotted the whole day for court, [and] they [were] ready to take care of business on that day."

Another *Niños Sanos* worker suggested that cases in which there were many changes in circumstances should be the ones that are targeted for Medicaid/SCHIP outreach. Due to the unstable circumstances of these cases, it would be best to enroll children in these programs in which coverage is more stable and does not expire based on a parent's employment status.

Finally, project staff also recommended that there be even more information sharing between the HHSC and the OAG. Each agency has information that the other agency could benefit from, particularly about fluid households, that is, households in which the noncustodial repeatedly parent moves in and out. This might also save the agencies money. Noncustodial parents who live with the custodial parent often do not realize that the OAG will come after them if the children are enrolled in Medicaid until their court orders are established. This process is expensive. Staff believed this could be avoided if the parents updated the Medicaid agency when they became a two-parent household then eligibility could be re-determined using the combined income of both the noncustodial and custodial parents.

Chapter 9
Summary and Conclusions

Texas has been aggressive in pursuing initiatives to improve the medical support outcomes in its child support caseload. Texas consistently ranks as one of the leading states in medical support performance. The *Niños Sanos* demonstration project was undertaken in effort to further improve this performance, and namely, to increase the number of children in the IV-D caseload with health-care coverage. The major treatment proposed for the demonstration was the creation of joint staff positions through the collaboration of the child support agency (OAG) and the Medicaid agency (HHSC). The *Niños Sanos* staff would not only serve as medical support facilitators in order establishment cases, but they would be able to determine Medicaid eligibility. *Niños Sanos* staff would gather information useful for the establishment of appropriate medical support orders. If the parents did not have employer-sponsored insurance available at a reasonable cost, the demonstration design called for *Niños Sanos* staff to first present private, child-only insurance options to parents and then to explore Medicaid/CHIP enrollment. This sequence, which prioritizes private health insurance coverage over Medicaid, is consistent with Texas statute. In all, the project was expected to increase healthcare coverage among IV-D children from all available sources: employer-sponsored insurance; private, child-only insurance; and Medicaid/CHIP. *Niños Sanos* staff would also follow-up with cases to ensure continuous healthcare coverage for the children. The follow-up would include assistance with Medicaid redeterminations and Medicaid eligibility for those in which affordable, private health insurance was no longer available.

The demonstration project began in September 2007 and ended in August 2011. The first year of the project was essentially devoted to developing the joint staff positions and planning project implementation. In April 2008, HHSC, with input from OAG, hired three *Niños Sanos* staff members who were placed in three Bexar County (San Antonio area) child support offices. In their first few months of employment, they received cross-training on child support and OAG and HHSC automated systems and conducted a pilot of partial treatments on 573 cases. The demonstration became fully operable by October 2008, and operations ran through June 2010. The last year of the project was essentially devoted to gathering data for the evaluation and analyses that were conducted by the Center for Policy Research (CPR).

During the operations period, more than 2,700 cases entered the project. Most (about 2,000) cases entered the project because they were scheduled for a Child Support Review Process (CSRP) order establishment conference. There were two exceptions. In November through December 2008, *Niños Sanos* staff worked 215 former Medicaid cases in which the medical support order directed the custodial parent to apply for Medicaid and the noncustodial parent was complying with an order to pay cash medical support. The supposition was that these cases would benefit from the private, child-only insurance option or help with Medicaid redetermination, which were offered through the

Niños Sanos demonstration. The other exception occurred in cases worked after January 2010. *Niños Sanos* staff worked these 515 cases immediately following an order establishment through CSRP. The supposition was that *Niños Sanos* staff could be more effective at ensuring all children had healthcare coverage after the medical support order was established. Only the pre-CSRP cases were divided (in almost equal numbers) into treatment and non-treatment groups through random assignment. The former Medicaid cases and post-CSRP cases were not; rather, all received treatments.

CPR determined the impact of the *Niños Sanos* treatments by comparing the outcomes of the pre-CSRP treatment group to those of the pre-CSRP non-treatment group. CPR also analyzed the outcomes of the post-CSRP treatment cases. CPR assessed outcomes from case intake data recorded by *Niños Sanos* staff on data collection forms. Staff also recorded the actions taken in treatment cases on the data collection form. The case-level data from the forms were matched to case-level data downloaded from TXCSES, the OAG automated system that tracks medical support and child support order establishments and compliance. CPR retrieved downloads at three different times: November 2009, November 2010, and April 2011.

Furthermore, CPR also conducted process and outcome analyses. Some of the secondary research questions concerned the source of children's healthcare coverage, cash medical support, compliance with medical support orders, changes in medical support and medical support compliance over time, and other issues. Of particular interest to the process analysis were how the OAG (child support)/HHSC (Medicaid) collaboration proceeded; the identification of private, child-only insurance options; how that information was made available to parents; and whether parents actually enrolled their children in private, child-only insurance.

Along with the data gathered from data collection forms and TXCSES downloads, CPR took from other data sources. These consisted of the medical performance data tracked by OAG at an office and state level from fiscal year 2007 through fiscal year 2010 and information data collected from HHSC and OAG administrators, supervisors and staff, including *Niños Sanos* staff, through interview, routine progress reports held by teleconference, and in-person meetings. The data were limited to what was available from TXCSES, which does not always capture whether children are currently enrolled in private insurance plans.

Summary of Findings

The evaluation yielded many interesting findings.

Implementation/Process Analysis Findings

Implementation of the *Niños Sanos* demonstration project and treatments as originally planned proved to be difficult. The major lessons learned from implementation are bulleted below.

- *OAG (child support)/HHSC (Medicaid) collaboration was challenging because of cultural agency differences. Nonetheless, both OAG and HHSC administrators learned a great deal about the other agency and were able to cooperate and implement the project.* One major difference that caused conflict throughout the project was the difference in agency missions. The HHSC is responsible for finding and enrolling Medicaid/CHIP-eligible children such that economically disadvantaged children have healthcare coverage. This can conflict with the OAG's procedures and processes that conform to state statute to secure medical support from private health insurance coverage first, if it is available at a reasonable cost, and to consider Medicaid as secondary coverage or coverage of last resort. Many other OAG procedures and processes are directed at reducing Medicaid costs. For example, noncustodial parents may be ordered to pay cash medical support that is distributed to the HHSC to offset Medicaid costs if their children are indeed enrolled in Medicaid.

- *A true "joint staff" position, one that was overseen by both the HHSC and OAG, was not feasible.* One of the perceived benefits of joint staff positions was that it would bridge the gap separating agencies and allow for access to both agency's automated systems, and this would improve outcomes. The reality, however, is that several logistics interfered with the joint staff positions. It was found that staff must, instead, be subject to one set of personnel rules and supervision from one agency. Since the ability to facilitate Medicaid enrollment was a key treatment, project architects decided to use the existing HHSC job classification of "Medicaid eligibility worker" for *Niños Sanos* staff positions. HHSC supervised the staff, but they were located within OAG offices.

- *Medicaid eligibility workers (aka* Niños Sanos *staff) provided expertise on Medicaid/CHIP, but were not sufficiently skilled or knowledgeable about medical support and private insurance options to promote healthcare coverage from private sources.* OAG and HHSC agreed that it was useful to have a Medicaid expert located in the child support office, particularly one that could obtain the most current information from the HHSC automated system. However, in hindsight, it was unrealistic to expect one staff person to be experienced in Medicaid eligibility determination, understand the legal obligations of child support and medical support, and be able to explain the benefits and cost of private health insurance plans to parents. Their backgrounds as Medicaid eligibility workers also explain why *Niños Sanos* staff were uncomfortable calling noncustodial parents and employers. Medicaid eligibility workers usually deal with custodial parents and most of their contact is initiated in person or through mailings. Medicaid eligibility workers typically only use the telephone to clarify information on a Medicaid application. Another limitation is workers could only de-

termine whether an application was complete. Actual eligibility for Medicaid/CHIP was determined from a centralized office.

- *Private, child-only insurance options are few, not always affordable, and complicated.* Although the Texas Department of Insurance (TDI) had identified 17 insurance carriers that provided private, child-only insurance, only four insurance carriers cooperated with the development of simplified information about private, child-only insurance plans. The premium estimates ranged from about $50 to over $300 per month per child depending on the level of health benefits and pre-existing conditions. This exceeds what most families in the child support caseload can reasonably afford. Each insurance carrier offers nearly a dozen different plans that vary in cost and benefits. In addition to prohibitive costs, comparing benefits between plans is difficult. The many facets to benefits — what is covered at one rate versus another, what is not covered, how benefits differ in- and out-of-network, how maximums are applied, and other nuances— are overwhelming. Furthermore, rarely do insurance carriers use the same terminology or cost structures needed to make side-by-side comparisons.

- *Telephone contact is too limiting, thus, several different methods of contact with parents and their employers are needed.* *Niños Sanos* staff's contact with parents in pre-CSRP cases was sidelined and controlled by OAG. The OAG did not want the *Niños Sanos* demonstration to interfere with the establishment of financial child support orders because order establishment is core to the child support mission. For this reason, the OAG did not want *Niños Sanos* staff present at CSRP conferences and limited their contact with parents to the telephone or mailings. This very much frustrated *Niños Sanos* staff. During the rare occasions when they were able to communicate with parents directly, they found that they could be more helpful.

Findings from the Impact Analysis

Most of the impact analysis concerned differences in outcomes between pre-CSRP treatment and pre-CSRP non-treatment cases. The impact of treatments on post-CSRP cases cannot be fully assessed because there was no pure, non-treatment group for post-CSRP cases.

- Niños Sanos *treatments increased healthcare coverage among children in the child support caseload.* Based on information gathered by *Niños Sanos* staff, most (78 percent) of the pre-CSRP treatment cases had healthcare coverage for all children immediately following treatment. This was significantly more than the rate among pre-CSRP non-treatment cases (71 percent) at intake. The rate of healthcare coverage among post-CSRP treatment cases (61 percent) was not significantly different from that of the pre-CSRP non-treatment group. Nonetheless, the percentage of cases with medical support ordered and provided was significantly higher among the demonstration offices than across the state as a whole.

- *All of the increase was from more Medicaid enrollments. Assistance with Medicaid enrollment was a core treatment of the* Niños Sanos *demonstration.* Most of the difference in healthcare coverage rates can be attributed to a higher Medicaid/CHIP enrollment rate among pre-CSRP treatment cases compared to that of pre-CSRP non-treatment cases (*i.e.*, 65 and 60 percent, respectively). As experienced Medicaid eligibility workers, *Niños Sanos* staff were skilled at facilitating Medicaid.

- Niños Sanos *treatments did not increase healthcare coverage from employer-sponsored insurance and private, child-only insurance plans.* There was no statistical difference between the rates of healthcare coverage from private insurance for the pre-CSRP treatment and non-treatment cases. The rate of healthcare coverage from private insurance was only 12 to 14 percent depending on the subgroup. This corroborates the process analysis finding that *Niños Sanos* staff were more effective at facilitating Medicaid enrollments than private insurance enrollments.

- Niños Sanos *staff indirectly affected the frequency with which medical support was ordered because their efforts led to more orders for custodial parents to apply for Medicaid/CHIP.* Medical support was ordered at a higher rate for pre-CSRP treatment cases than for pre-CSRP non-treatment cases at the time of intake/initial treatment (*i.e.*, 56 and 43 percent, respectively). Medicaid/CHIP was the ordered source of coverage in more pre-CSRP treatment cases than pre-CSRP non-treatment cases (64 percent compared to 57 percent). This reflects that child support officers (CSOs) who facilitated order establishment conferences put more faith in the Medicaid information that *Niños Sanos* staff shared with them. In turn, this made them more comfortable with pursuing orders for Medicaid/CHIP. Most OAG staff believed that *Niños Sanos* staff had more current and accurate data on Medicaid/CHIP status than what was in the OAG automated system. This is important because child support staff and judges are generally more comfortable ordering medical support that matches the child's current source of healthcare coverage.

- *Over time, medical support establishment rates were the same between pre-CSRP treatment and non-treatment cases. Yet, the initial information provided from* Niños Sanos *staff had a lasting effect in that treatment cases continued to have more orders for Medicaid/CHIP applications over time than non-treatment cases.* By the time of the last follow-up, the medical support establishment rates between pre-CSRP treatment and non-treatment cases were almost the same (79 and 80 percent, respectively). This is because over time more information useful to the order establishment process became available. The *Niños Sanos* process did not contribute to the new information. However, pre-CSRP treatment cases continued to have a higher rate of Medicaid/CHIP ordered (62 percent) than pre-CSRP non-treatment cases (55 percent) at the time of the last follow-up. This indicates that the Medicaid information provided by *Niños Sanos* staff in the order establishment process had a lasting effect.

- Niños Sanos *staff did not stabilize Medicaid enrollment over time.* There was no statistical difference in the rates of children going on, off, or remaining on Medicaid over time between pre-CSRP treatment and pre-CSRP non-treatment cases. This suggests that *Niños Sanos* staff's efforts to help parents with Medicaid redeterminations were not successful or that the failures of families to submit redetermination applications was not the only factor that caused changes in Medicaid status. Children may also gain or lose eligibility based on changes in family income, household size, or other determinants of eligibility.

- *Niños Sanos staff did not affect compliance with medical support orders.* In pre-CSRP cases, compliance rates were no higher in treatment cases than non-treatment cases regardless of whether the type of medical support ordered was for the custodial parent to apply for Medicaid/CHIP or was for the noncustodial parent to provide children's healthcare coverage through employer-sponsored insurance. This reflects that *Niños Sanos* staff took few actions to ensure compliance.

Findings from the Outcomes Analysis

The demonstration project also yielded many insights on medical support outcomes in general.

- *Most children in child support cases have healthcare coverage from Medicaid/CHIP. Few have coverage from private health insurance. Coverage rates are higher for younger children.* About 60 percent of cases, on average, had children's healthcare coverage through Medicaid/CHIP. Only 12 to 17 percent of cases, on average, had children's healthcare coverage through private insurance such as employer-provided insurance or private, child-only insurance from either the custodial or noncustodial parent. Coverage rates (from any source including Medicaid/CHIP or private insurance) among pre-CSRP cases reached 79 percent when the youngest child in the case was five years old or less and 69 percent when the youngest child in the case was six years or older. The age difference reflects Medicaid's current income eligibility staircase that sets a lower threshold for older children.

- *Medicaid enrollment appears to be fairly stable.* Only about ten percent of pre-CSRP cases that had active Medicaid status at the first follow-up became inactive Medicaid by the time of the final follow-up. The time elapsed between the follow-ups was about 17 months for most cases.

- *Few parents take up private, child-only insurance.* Private, child-only insurance was the source of healthcare for less than one percent of the project cases. One reason is that it is not affordable: the healthplans in the brochure offered private, child-only insurance at $50 to $160 per month per child. All of these cases with private, child-only insurance involved two or fewer children. Based on the financial child support orders in cases with private, child-only insurance, the noncustodial parent's net income in these cases is estimated to range from $1,000 to $2,200 per

month. However, the custodial parent provided private, child-only insurance in a few of these cases.

- *Employer-sponsored insurance is not available or not available at a reasonable cost in most cases.* Over half of noncustodial and custodial parents were verifiably employed at intake, but employer-sponsored insurance was only ordered among one-quarter to one-half of employed noncustodial parents and one-eighth of employed custodial parents. This suggests that many employers do not provide health benefits and if they do provide it, it is often not reasonable in cost.

- *Cash medical support is often ordered, particularly in Medicaid cases, but rarely is the amount of medical support set at the highest amount permissible under statute.* Cash medical support was ordered in 37 to 62 percent of project cases. The range varied depending on pre-CSRP/post-CSRP status and treatment/non-treatment status. Regardless of case type, cash medical support was ordered in over 90 percent of cases that were active Medicaid at intake. This complies with statute, which requires it to be ordered in Medicaid cases as long as it is reasonable in cost. Medical support can be set up to 9 percent of the noncustodial parent's gross income. The median cash medical support amount is $25 to $30 per month depending on case type and Medicaid status. This is much less than 9 percent for most incomes, even low incomes.

- *Compliance with Medicaid-application orders and employer-sponsored insurance appear to be relatively high and consistent over time.* Children were enrolled in Medicaid in over 70 percent of the cases in which the custodial parent was ordered to apply for Medicaid/CHIP. This was true at both the first and final follow-up periods. Assuming that consistent verified employment means that employer-sponsored insurance is stable, a similar trend was noted in cases where the noncustodial parent was ordered to provide employer-sponsored insurance. The noncustodial parent had verified employment in over 70 percent of these cases at the times of the first and final follow-up.

- *National Medical Support Notices (NMSNs) are issued just as frequently when the custodial parent is ordered to provide children healthcare coverage through employer-sponsored insurance as when the noncustodial parent is.* For example, NMSNs were issued in 70 percent of the pre-CSRP treatment cases in which the custodial parent was ordered to provide children healthcare coverage through employer-sponsored insurance and 70 percent of the pre-CSRP treatment cases in which the noncustodial parent was ordered to provide children healthcare coverage through employer-sponsored insurance. Federal regulations require NMSNs be sent when the noncustodial parent is ordered to provide employer-sponsored insurance, but states have discretion to issue NMSNs if the custodial parent is ordered to provide employer-sponsored insurance.

- *There are few cases in which the children have dual healthcare coverage (*i.e.*, both Medicaid and private healthcare coverage).* Private insurance is ordered in about 20 percent of cases in which children have active Medicaid status, but when compliance with employer-sponsored insurance is factored in, the percentage of cases with actual dual enrollment is lower. Not all noncustodial parents in Medicaid cases with employer-sponsored insurance orders have verified employers. In fact, the percentage of noncustodial parents in Medicaid cases with verified employment who are ordered to provide insurance through employment is statistically lower than the percentage among all noncustodial parents with employer-sponsored insurance ordered. Without verified employment, employer-sponsored insurance is unlikely to be available.

- *Not all noncustodial parents are ordered to pay cash medical support in cases that continue or become active Medicaid. For those with orders, the cash medical support receipts are relatively small.* Cash medical support is distributed to the HHSC when children have active Medicaid cases. Among cases that had active Medicaid at the final follow-up, 60 to 72 percent had cash medical support ordered. This is a smaller share than the share of noncustodial parents ordered to pay cash medical support when their children were active Medicaid at the time of the order establishment. The decreasing share reflects that medical support orders are typically not modified in cases where the children were not active Medicaid at the time of the initial order establishment but became active Medicaid later. Nonetheless, the median cash medical support order was $25 to $30 per month and ranged from $5 to $329 per month at the final follow-up. The amount of cash medical support actually received in cases that were supposed to pay cash medical support ranged from a total of $0 to $1,300 over the six months preceding the data extract date and averaged $100 over the six-month period. Payments of cash medical support are significantly less what the average Medicaid payment per child is in Texas (*i.e.*, $2,400 per year in fiscal year 2007).

Conclusions and Implications for Policy and Operations

The project was successful in getting more healthcare coverage for children and increasing the number of medical support orders. All of the increase came from Medicaid/CHIP and because more orders for the custodial parent to apply for Medicaid/CHIP were issued. The project was not effective at increasing coverage from private insurance such as employer-sponsored insurance and private, child-only insurance. The successes of the project are attributed to the fact that *Niños Sanos* staff were experienced Medicaid eligibility workers. The failures are attributed to *Niños Sanos* staff having no knowledge of child support and private health insurance other than what they had learned in training and to private, child-only insurance being an unrealistic option for low-income families.

Policy and Operations Implications

- *Medicaid/CHIP outreach in child support offices may be more effective in the future as Medicaid expands to cover more children, particularly older children. Child support offices could also continue to benefit from having Medicaid/CHIP information, including information from the HHSC automation, available in-house.* The successes of the project suggest that Medicaid/CHIP outreach in child support offices can be useful, but under existing Medicaid/CHIP eligibility requirements, child support agencies should not expect a large take-up of Medicaid/CHIP. That, however, may change as more states expand their Medicaid income eligibility requirements to meet federal healthcare reform requirements that will come into effect in 2014. One study estimates that 80 percent of IV-D children will be Medicaid eligible in the future. This is significantly more than what was observed in the *Niños Sanos* demonstration. In the future, child support cases with older children, in particular, may benefit from Medicaid/CHIP outreach in child support offices. As seen from the *Niños Sanos* data, cases involving older children are more likely to lack healthcare coverage. Older children in child support cases may be newly eligible for Medicaid as states eliminate the income eligibility staircase associated with the child's age (*i.e.*, different income eligibility thresholds for infants, one to five year olds, and six year olds and over). Child support agencies may want to use "express lane eligibility" to get coverage for these older children once Medicaid eligibility is expanded. Recently authorized through federal legislation, express lane eligibility enables some state agencies, including child support agencies, to conduct Medicaid/CHIP eligibility determinations. Child support offices could also continue to benefit from having in-house Medicaid/CHIP experts and access to the HHSC automated system. OAG find such resources helpful to the establishment of appropriate medical support orders.

- *State health insurance exchanges, as mandated by healthcare reform, can provide what private, child-only insurance could not for uninsured, IV-D children ineligible for Medicaid/CHIP. However, to be effective, states must be able to order parents to apply for insurance from the exchange. To enforce these orders, data-sharing agreements and automated interfaces between exchanges and child support agencies are also needed.* The Affordable Care Act (ACA) mandates the establishment of state health insurance exchanges that will offer affordable, quality health insurance options by 2014. ACA ensures the affordability of these plans through tax credits that limit insurance premium costs to a sliding scale based on income. In addition, ACA standardizes healthcare plans and benefits. All exchange insurance plans must provide an essential level of services and preventive care. For exchange insurance plans to effectively fill the health insurance gap in the child support caseload, states must be able to order parents to apply for exchange insurance. To enforce these orders, data-sharing agreements and automated interfaces between child support and the exchanges must be established. Information from the exchange, such as the out-of-pocket expense for the insurance premium, could also be used by the child support agency to set appropriate medical support orders.

- *If ACA is successful at increasing the number of employers offering quality, affordable insurance, there should be more orders for children's health insurance coverage from parents' employer-sponsored insurance. There will also be a greater need to evaluate each parent's plan because there should be a greater number of cases in which both parents have access to employer-sponsored insurance. In addition, there will be a greater need to enforce these orders. This will require more interaction between the child support agency and employers.* ACA requires large employers to offer health insurance or pay a tax penalty. It also encourages small employers to provide quality, affordable insurance through subsidies. To handle this increase, child support agencies should explore ways to streamline gathering information about insurance premium costs from large employers and state insurance exchanges for small employers. Similarly, child support agencies should explore more efficient ways for issuing and returning NMSNs and enabling employers to notify the child support agency when healthcare benefits cease because the parent's employment was terminated or due to some other reason.

- *Federal direction on the role of medical support is needed in light of recent federal initiatives aimed to increase healthcare coverage among children. Under current rules and statutes, medical support is often used to offset Medicaid costs, but the* Niños Sanos *demonstration shows that there is conflict between this use of medical support and initiatives to increase healthcare coverage among children in the child support caseload.* HHSC administrators and *Niños Sanos* staff felt that their efforts to increase healthcare coverage among IV-D children through Medicaid/CHIP outreach were thwarted by federal and state statutes that prioritize healthcare coverage from private health insurance for medical support. They felt they could not approach parents about Medicaid/CHIP options until it was clear that neither parent had access to private healthcare coverage at a reasonable cost. HHSC administrators and *Niños Sanos* staff also verbalized their Medicaid clients' frustrations with dual enrollment. Custodial parents would not always know of insurance policy terminations or policy changes, not have an insurance card or the current insurance card, and felt they were burdening the healthcare provider by forcing them to bill the insurance carrier first. If the objective of medical support is to have the noncustodial parent contribute to the cost of the child's healthcare coverage, HHSC administrators and *Niños Sanos* staff felt there were better approaches than dual enrollment. For example, noncustodial parents could contribute to the cost of Medicaid or CHIP.

The *Niños Sanos* project does not touch on all of the medical support issues resulting from healthcare reform. It does not address the potential conflict between the parent mandated to provide health insurance pursuant to healthcare reform and the parent ordered to provide health insurance pursuant to the medical support order. It also does not address the need to review polices that direct how parents in child support cases share the costs of the child's insurance premium and out-of-pocket medical expenses. These costs will change significantly due to healthcare reform.

In conclusion, children's healthcare policies are at a critical turning point. To be effective, medical support policies should be re-assessed in light of what these changes will mean for future. When the

Niños Sanos demonstration was conceived, the number of children who lacked healthcare coverage was growing at an alarming rate. Since then, several national initiatives to ensure that all children, particularly low-income children, have healthcare coverage have launched. Recent operational and policy changes to Texas Medicaid/CHIP have also reduced the number of Texas children who lack healthcare coverage. With others increasing their efforts, child support agencies need not try to create new insurance coverage options to ensure that all children in the child support caseload have healthcare coverage. However, it is important that medical support has a clear and defined role in the future arena of children's healthcare.

References

Argys, L.M. and H.E. Peters (2003). "Can Adequate Child Support Be Legislated? A Model of Responses to Child Support Guidelines and Enforcement Efforts," *Economic Inquiry*, 41(3): 463-479

Burnszynski, Jennifer (2010). "Colloquium Weighs Child Support's Role in Promoting Children's Health Care Coverage," *Child Support Report,* Vol. 32, No. 11 (November 2010), Federal Office of Child Support Enforcement, Washington, D.C.

Center for Policy Research (July 2011) *Medical Child Support: State Strategies Re-examined.* Prepared under Office of Child Support Enforcement Grant #08-C0067 for Texas Office of the Assistant Attorney Division of Child Support. Center for Policy Research. Denver, Colorado.

Dunkelberg, Anne (September 29, 2006). *Medicaid and CHIP Enrollment Update*. Center for Public Policy Priorities. Austin, Texas, Downloaded from www.texaschip.org/MedicaidandCHIPEnrollment Update9-29-06.pdf on September 30, 2009.

Federal Office of Child Support Enforcement (2011). *Child Support Enforcement, FY 2010 Preliminary Report*. Department of Health and Human Services Administration for Children and Families, Office of Child Support Enforcement.

Texas Health and Human Services Commission (HHSC), *Medicaid and CHIP Enrollment Statistics*, Austin Texas, Downloaded from http://www.hhsc.state.tx.us/research/CHIP/ChipDataTables.asp on September 30, 2009.

Kaiser Family Foundation (2007). "Texas: Medicaid Payments per Enrollee, FY2007." Retrieved on August 17, 2011. http://www.statehealthfacts.org/profileind.jsp?ind=183&cat=4&rgn=45&cmprgn=1

Kaiser Network (March 13, 2006). *Texas Medicaid Enrollment Drops Among Children*. Downloaded on September 30, 2009. http://www.medicalnewstoday.com/articles/39255.phwww.texaschip.org/.../MedicaidandCHIPEnrollmentUpdate9-29-06.pdf

Key, Alicia (2011). "Child Support: It Is the Government Program that Works and We Can Prove It," Presentation to the National Child Support Enforcement Association Policy Briefing. Washington D.C., January 24, 2011.

Levitt, Larry and Claxton, Gary (April 2011). *What the Actuarial Values of Health Care Mean*. Publication Number 8177. Kaiser Family Foundation, Washington, D.C.

Peters, H.E., L.M. Argys, E.E. Maccoby and R.H. Mnookin (1993). "Enforcing Divorce Settlements: Evidence from Child Support Compliance and Award Modifications." *Demography,* 30(4): 719-35.

Texas Office of the Attorney General (August 2009). *Effectiveness of Child Support in Reducing Public Assistance Obligations SYF2008*. OAG, Austin, Texas.

Texas Department of Insurance (2011). *Children's Medicaid and CHIP*. Austin, Texas. Retrieved on August 17 , 2011. http://www.tdi.state.tx.us/pubs/consumer/cb071.html

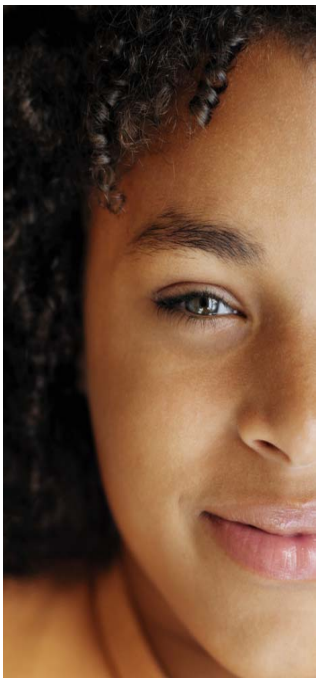
Turetsky, Vicki (2011). "Request for Comments on Proposed Instructions for Completing the OCSE-157 Form." Federal Office of Child Support Enforcement Dear Colleague Letter (DCL-11-10). OCSE , Washington, D.C. http://www.acf.hhs.gov/programs/cse/pol/DCL/2011/dcl-11-10.htm.

Turetsky, Vicki, (2010a). "State Child Support Enforcement Program Flexibility to Improve Inter-operability with Medicaid and CHIP." Federal Office of Child Support Enforcement Action Trans-mittal AT-10-10. OCSE , Washington, D.C.
http://www.acf.hhs.gov/programs/cse/pol/AT/2010/at-10-10.htm

Turetsky, Vicki (2010b). "Health Reform for Children Is on the Horizon." Child Support Report (January 2010). 32(1). U.S. Department of Health and Human Services Office of Child Support Enforcement, Washington, D.C.

U.S. Department of Health and Human Services and Department of Labor (2000). *Million Children's Health: Our Shared Responsibility, the Medical Child Support Working Group's Report*. Washington, D.C.

Wilson, Elizabeth (2010). *Progress Report: Plan 2010: Indentifying Medical Child Support Solutions for Oklahoma's Children,* Grant Number 90FD0163. Reporting period is January 1, 2010 through March 31, 2010. Oklahoma Department of Human Services, Oklahoma City, Oklahoma.



APPENDIX A: DATA COLLECTION FORMS

Ninos Sanos Grant: Staff Data Collection Form

1. Worker:	**2.** Group Assignment: ☐ Treatment ☐ Control
3. Case Source: ☐ Before CSRP ☐ Right after order estab. ☐ 6 months after order estab. ☐ List of cases with existing orders	
4. SAVERR	**5.** TIERS Case#:_____
a. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____
b. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____
c. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____

Case information on order to be established *(Pre-populated from TXCSES electronically)*

6. Office Number:	**7.** Date Pulled from TXCSES:
8. Order: ☐ CSRP Date CSRP scheduled: Date CSRP held: ☐ Court Date court hearing scheduled: Date court hearing held:	
9. OAG TXCSES Case#:	
10. Order Type: ☐ Never TANF ☐ Active ☐ Non-interstate ☐ Cases w/MSPP1 of $50 or more	
11. Number of children on the case: _____ Date of Birth of Children 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___	
12. Date opened child support case: ___/___/___	**13.** Monthly child support order amount: $ ☐ NA
14. Order effective date: ___/___/___	**15.** Last order effective date: ___/___/___
16. Parent ordered to provide coverage: ☐ CP-employer sponsored ☐ CP private ☐ Medicaid ☐ NCP-employer sponsored ☐ NCP private	
17. Monthly cash medical order amount: $ ☐ NA	
18. Date of last payment (current support): ___/___/___	**19.** Amount of last payment: $
20. Amount of payment post-order 30 days: $ 60 days: $ 90 days: $	

	a. Custodial Parent	b. Noncustodial Parent
21. Parent Name:		
22. Parent Address		
23. Telephone number:		
24. Number of additional OAG cases parent has:		
25. Verified employer name:		
26. Verified employer address:		
27. Verified employer telephone number:		

Section 2. Verified Employer: First Point of Contact

	a. Custodial Parent	b. Noncustodial Parent
28. Was there telephone contact with verified employer?	☐Yes, talked to employer ☐ Left msg. ☐ Attempted, did not reach ☐ Automated, could not get through ☐ Did not attempt ☐N.A	☐Yes, talked to employer ☐ Left msg. ☐ Attempted, did not reach ☐ Automated, could not get through ☐ Did not attempt ☐N.A
29. Were you able to speak with someone about employer offered health benefits?	☐Yes, talked to employer ☐N.A ☐ Yes, spoke with HR ☐No ☐ Left msg.	☐Yes, talked to employer ☐N.A ☐ Yes, spoke with HR ☐No ☐ Left msg.
30. Were you able to confirm employer offered health benefits?	☐ Confirmed employer offers health benefits ☐ Employer does not offer health benefits	☐ Confirmed employer offers health benefits ☐ Employer does not offer health benefits
31. Were you able to confirm employment? If no, were you able to get new employer information?	☐Yes ☐No ☐Yes ☐No	☐Yes ☐No ☐Yes ☐No
32. New employer address: New employer telephone number:		
33. Does current employer provide health insurance	☐Yes ☐No	☐Yes ☐No
34. Name of health plan available:		
35. Type and Premium Amount *(per month)*	☐ Employee only $_____ ☐ Employee+child $_____ ☐ Family $_____	☐ Employee only $_____ ☐ Employee+child $_____ ☐ Family $_____

	☐ Other_____ $_____ ☐ None	☐ Other_____ $_____ ☐ None
36. Who is enrolled in this plan? *(number)*	____Self ___Spouse ____Child(ren)	____Self ___Spouse ____Child(ren)

Employer Actions Taken:

37. Faxed/emailed VOEL to obtain employee specific information	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
38. Issued NMSN letter	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
39. Updated TXCSES case log	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
40. Employer will provide summary of plan benefits	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
41. Other _____	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA

Section 3. Noncustodial Parent: Second Point of Contact

42. NCP Name	**43.** NCP Phone #:
44. Does NCP remember receiving health insurance availability form in the CSRP packet?	☐Yes ☐No ☐ NA
45. Has/will NCP return form to child support office?	☐Yes ☐No ☐ NA
46. Do you have employer sponsored health insurance?	☐Yes, enrolled ☐No, not enrolled → Reason: ☐ Too expensive ☐ Not eligible ☐ Not offered
47. If so, source of child(ren)s health care coverage:	☐ Employer sponsored ☐ Other Private ☐ Medicaid ☐ SCHIP ☐ Private child only
48. If child has private insurance, who is the policy carrier?	☐ NCP ☐ CP ☐ NCP spouse ☐ CP spouse
49. Name of health plan available:	
50. Type and Premium Amount of NCPs insurance *(per month)*	☐ Employee only $_____ ☐ Employee+dependant $_____ ☐ Family $_____ ☐ Other_____ $_____ ☐ None ☐ Don't know
51. Who is enrolled in this plan? *(number)*	____Self ___Spouse ____Child(ren)

NCP Actions Taken

52. Was there contact with noncustodial parent? *If "yes" to Q47, answer #48-54, otherwise skip to #55* ?	☐Yes, talked to NCP ☐No ☐Bad/disconnected phone ☐ Left message ☐Did not attempt to phone ☐N.A, no phone #
53. Provided NCP general information on medical support.	☐Yes ☐No ☐ NA
54. Provided NCP information on affordable options for healthcare coverage for children.	☐Yes ☐No ☐ NA
55. Discussed alternative private child only coverage.	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
56. Discussed pros and cons of private insurance over cash medical support.	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
57. Assisted parent with child-only enrollment.	☐Yes ☐No
58. Updated TXCSES case log.	☐Yes ☐No
59. Reviewed case file for NCP income: (*provide gross monthly income)*	☐Yes ☐No Amount: $_____

Section 4. Custodial Parent: Third Point of Contact

60. CP Name	**61.** CP Phone #:
62. Does CP remember receiving health insurance availability form in the CSRP packet?	☐Yes ☐No ☐ NA
63. Has/will CP return form to child support office?	☐Yes ☐No ☐ NA
64. Do you have employer sponsored health insurance?	☐Yes, enrolled ☐No, not enrolled ⟶ Reason: ☐ Too expensive ☐ Not eligible ☐ Not offered
65. If so, source of child(ren)s health care coverage:	☐ Employer sponsored ☐ Other Private ☐ Medicaid ☐ SCHIP ☐ Private child only
66. If child has private insurance, who is the policy carrier?	☐ NCP ☐ CP ☐ NCP spouse ☐ CP spouse
67. Name of health plan available:	
68. Type and Premium Amount of CPs insurance *(per month)*	☐ Employee only $_____ ☐ Employee+dependant $_____ ☐ Family $_____ ☐ Other_____ $_____ ☐ None ☐ Don't know
69. Who is enrolled in this plan? *(number)*	____Self ___Spouse ____Child(ren)

CP Actions Taken

70. Was there contact with custodial parent?	☐Yes, talked to CP ☐No ☐Bad/disconnected phone ☐ Left message ☐Did not attempt to phone ☐N.A, no phone #
71. Discussed alternative private child only coverage.	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
72. Discussed pros and cons of private insurance over cash medical support.	☐Yes, parent interested ☐No ☐Yes, parent not interested ☐ NA
73. Discussed Medicaid/SCHIP options.	☐Yes, parent interested ☐No ☐Yes, parent not interested ☐ NA
74. Provided CP general information on medical support.	☐Yes ☐No ☐ NA
75. Provided CP information on affordable options for healthcare coverage for children.	☐Yes ☐No ☐ NA
76. Assisted parent with child-only enrollment.	☐Yes ☐No
77. Updated TXCSES case log.	☐Yes ☐No
78. Reviewed case file for CP income: (*provide gross monthly income)*	☐Yes ☐No Amount: $_____

Niños Sanos Staff Assessment and Actions

79. Do all children on this case have health care coverage? ☐Yes ☐No ☐Don't know

80. What is the health care coverage for child(ren)?
☐Medicaid/SCHIP ☐ Private employer-sponsored ☐Private-Child only ☐No ☐Don't know

81. Did you assist custodial parent in Medicaid application? ☐Yes ☐ No ☐N/A

82. Did you assist in Medicaid Redetermination application? ☐Yes ☐ No Application Date: _____

83. Is this a potential Medicaid/SCHIP case? ☐Yes ☐ No ☐N/A

84. Did you assist in eligibility determination and application? ☐Yes ☐ No Application Date: _____

85. Is this a potential private child-only case? ☐Yes ☐ No ☐N/A

86. Did you assist in eligibility determination and application? ☐Yes ☐ No Application Date: _____

87. Was the information gathered worth sharing with CSO? ☐Yes ☐ No

88. Did you share information with CSO? ☐Yes ☐ No ☐N/A

89. Notes.

Ninos Sanos Grant: Staff Data Collection Form 1: Revised 2010 Form

1. Worker:

2. Group Assignment: ☐ Treatment ☐ Control

3. Case Source: ☐ Before CSRP ☐ Right after order estab. ☐ 6 months after order estab. ☐ List of cases with existing orders

4. SAVERR

a. Case#:_____ Program Type: _____

b. Case#:_____ Program Type: _____

c. Case#:_____ Program Type: _____

5. TIERS Case#:_____

EDG number:_____ Program Type:_____

EDG number:_____ Program Type:_____

EDG number:_____ Program Type:_____

Case information and Actions Needed

6. Office Number:

7a. Date Pulled from TXCSES:

7b. Current Medicaid Status (when pulled/worked): ☐ All children on Medicaid ☐ Some children on Medicaid ☐ No Medicaid

7c. Next Medicaid Review is within 60 days of when pulled/worked: ☐ Yes ___/___/___ date ☐ No ☐ Don't know

8. Order: ☐ CSRP Date CSRP held: ___/___/___ ☐ Court Date court hearing held: ___/___/___

9. OAG TXCSES Case#:

10. OAG Case Type: ☐ Active Medicaid (N/M) ☐ Active TANF (A/_) ☐ Currently no services (N/_) ☐ Other_____

11. Number of children on the case: _____

Date of Birth of Children 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___

12. Date opened child support case: ___/___/___

13. Monthly child support order amount: $ ☐ NA

14. Original order effective date: ___/___/___

15. Last order effective date: ___/___/___

16. Parent ordered to provide coverage:
☐ CP: employer-sponsored ☐ Medicaid/CHIP ☐ NCP: employer sponsored ☐ Other (specify)_____

17. Monthly cash medical order amount: $ ☐ NA

18. Date of last NMSN: ___/___/___

19. Date of Last MINS update: ___/___/___

20a. Was NMSN sent since last order date? ☐ Yes ☐ No

20b. Is MINS information more than 6 months old? ☐ Yes ☐ No

20c. Was NMSN sent more than 30 days ago? ☐ Yes ☐ No

21. Does the NCP have a verified employer (when pulled/worked) ☐ Yes___/___/___ Verification date ☐ No ☐ Don't Know

22. Does the CP have a verified employer (when pulled/worked) ☐ Yes___/___/___ Verification date ☐ No ☐ Don't Know

23. Action matrix (Circle cell(s) indicated actions to be taken. This is based on responses to above questions)

	NMSN Status **(20a and 20c)**			Sent more than 30 days ago			Sent in last 1-30 days			Not sent since last order date		
	Is MINS Info more than 6 months old or missing (20b)?			Yes		No	Yes		No	Yes		No
Order Coverage (Q16)		*Is there a verified employer? (Q20d-e)*		Yes	No		Yes	No		Yes	No	
	Medicaid Review in 60 days (Q7c) Yes	No										
NCP employer	Contact CP			contact employer & CP	Contact NCP & CP		Contact CP			Issue NMSN & contact CP	Contact NCP & CP	
CP employer				contact employer & CP	Contact CP		Contact CP			Issue NMSN & contact CP	Contact CP	
Other				Contact CP			Contact CP			Contact CP		
Medicaid	Contact CP if not Medicaid											

	a. Custodial Parent	b. Noncustodial Parent
24. Number of additional OAG cases parent has:		

Section 2. Employer Contact if Needed as Indicated on Q23

	a. Custodial Parent	b. Noncustodial Parent
25. Verified employer name:		
26. Verified employer address:		
27. Verified employer telephone number:		
28. Was there telephone contact with verified employer?	☐Yes, talked to employer ☐ Left msg. ☐ Attempted, did not reach ☐ Automated, could not get through ☐ Did not attempt ☐N.A	☐Yes, talked to employer ☐ Left msg. ☐ Attempted, did not reach ☐ Automated, could not get through ☐ Did not attempt ☐N.A
29. Did the employer remember receiving the NMSN?	☐Yes ☐No ☐N.A.	☐Yes ☐No ☐N.A.
30. Were you able to confirm employer offered health benefits?	☐ Confirmed employer offers health benefits ☐ Employer does not offer health benefits	☐ Confirmed employer offers health benefits ☐ Employer does not offer health benefits
31. Were you able to confirm employment? If no, were you able to get new employer information?	☐Yes ☐No ☐Yes ☐No	☐Yes ☐No ☐Yes ☐No
32. New employer address: New employer telephone number:		

Employer Actions Taken:

37. Faxed/emailed VOEL to obtain employee specific information	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
38. Issued or Reissued NMSN letter	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
39. Updated TXCSES case log	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA
41. Other _____	☐Yes ☐No ☐ NA	☐Yes ☐No ☐ NA

Section 3. Noncustodial Parent Contact if Needed as Indicated on Q23

42. NCP Name	**43**. NCP Phone #:
43. Are you currently employed?	☐Yes ☐ Temporary Unemployed ☐No
46. Do you have employer sponsored health insurance?	☐Yes, enrolled ☐Offered, but not enrolled → Reason: ☐ Too expensive ☐ No employer sponsored insurance offered ☐ Not eligible
49. Name of health plan available:	
51. Who is enrolled in this plan? *(number)*	____Self ___Spouse ____Child(ren)

NCP Actions Taken

52. Was there contact with noncustodial parent? *If "yes" to Q52, answer #53-59, otherwise skip to #60*	☐Yes, talked to NCP, date_____ ☐Bad/disconnected phone ☐ Left message ☐Did not attempt to phone ☐N.A, no phone #
53. Provided NCP general information on medical support.	☐Yes ☐No ☐ NA
54. Requested copy of NCP's insurance card via telephone	☐Yes ☐No ☐ NA
55. Discussed alternative private child only coverage such as child-only insurance	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
56. Discussed pros and cons of private insurance over cash medical support.	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
57. Other _____ _____ (e.g., order modification???)	☐Yes ☐No ☐ NA
58. Mailed request for copy of insurance card	☐Yes, date_____ ☐No ☐ NA
59. Updated TXCSES case log.	☐Yes ☐No

Section 4. Custodial Parent Contact if Needed as Indicated on Q23

60. CP Name	**61.** CP Phone #:
62. Do you have an active health insurance card for your children?	☐Yes ☐No ☐ NA
63. If so, what is the source of the health coverage?	☐ NCP Employer sponsored ☐ Medicaid/CHIP ☐ CP Employer sponsored ☐ Other (specify)_____
64. Do you have employer sponsored health insurance?	☐Yes, enrolled ☐Offered, but not enrolled → Reason: ☐ Too expensive ☐ No employer sponsored insurance offered ☐ Not eligible
67. Name of health plan available:	
69. Who is enrolled in this plan? *(number)*	____Self ___Spouse ____Child(ren)

CP Actions Taken

70. Was there contact with custodial parent?	☐Yes, talked to CP ☐No ☐Bad/disconnected phone ☐ Left message ☐Did not attempt to phone ☐N.A, no phone #
71. Discussed alternative private child only coverage.	☐Yes, parent interested ☐Yes, parent not interested ☐No ☐ NA
72. Discussed pros and cons of private insurance over cash medical support.	☐Yes, parent interested ☐No ☐Yes, parent not interested ☐ NA
73. Discussed Medicaid/SCHIP options.	☐Yes, parent interested ☐No ☐Yes, parent not interested ☐ NA
74. Provided CP general information on medical support.	☐Yes ☐No ☐ NA
75. Other _____ _____ (e.g., order modification???)	☐Yes ☐No ☐ NA
76. Mailed request for copy of insurance card	☐Yes, date_____ ☐No
77. Mailed or provided Medicaid application	☐Yes, date_____ ☐No
78. Mailed or provided Medicaid review/renewal notice	☐Yes, date_____ ☐No
79. Updated TXCSES case log.	☐Yes ☐No

Niños Sanos Staff Assessment

80. What was sent to the parent(s)? (check all that apply.	☐ Request to NCP for insurance card ☐ Request to CP for insurance card ☐ Child-only Insurance info to CP ☐ Nothing	☐ notice of Medicaid review ☐ Medicaid application ☐ Child-only Insurance info to NCP ☐Other (specify)_____

81. Do all children on this case have health care coverage as of _____(date)? ☐Yes ☐No ☐Don't know

82. What is the health care coverage for child(ren)?
☐Medicaid/CHIP ☐ Private employer-sponsored ☐Private-Child only ☐No ☐Don't know

83. Notes.

Ninos Sanos Grant: Staff Data Collection Form 2:

PART 1: Copy information from Form 1

(This information is to help you find the form later and complete Part II as you continue to work the case)

4. SAVERR	**5.** TIERS Case#:_____
a. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____
b. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____
c. Case#:_____ Program Type: _____	EDG number:_____ Program Type:_____
6. Office Number:	**7a.** Date Pulled from TXCSES:
9. OAG TXCSES Case#:	
42. NCP Name	**60.** CP Name

80. What was sent to the parent(s)? (check all that apply)

- ☐ Request to NCP for insurance card
- ☐ Request to CP for insurance card
- ☐ Child-only Insurance info to CP
- ☐ Nothing
- ☐ notice of Medicaid review
- ☐ Medicaid application
- ☐ Child-only Insurance info to NCP
- ☐ Other (specify)_____

PART II Niños Sanos Staff Follow-Up

Complete as information within 45 days of date in 7a.

All information accurate as of: _____/_____/_____ (Date).

81. Was a copy of the insurance card received? ☐Yes, from NCP ☐Yes, from CP ☐ Yes, from employer ☐No ☐ Not requested

82. Was a Medicaid application returned?
Yes, date_____ ☐ No, skip to Q87 ☐ Never sent, skip to Q87

83. Application was also for: ☐ Adult Medicaid ☐ TANF ☐ Food Stamps/SNAP ☐ Child Medicaid Only

84. Application was compete: ☐Yes ☐No ↓ ☐ NA

85. Missing: ☐ Income documentation ☐ Documentation of childcare expenses ☐ Other (specify)_____

86. Medicaid application was: ☐ Approved, date_____ ☐ Still pending, date_____ ☐ Denied , date_____ ☐ Other, specify_____

87. Did you and CP talk via telephone to clarify or obtain more information about…..
☐ Medicaid application ☐ Medicaid review ☐ Medical support order ☐ Child-only insurance ☐ Other (specify)_____ ☐ N/A

88. Do all children on this case have health care coverage? ☐Yes ☐No ☐Don't know

89. What is the health care coverage for child(ren)?
☐Medicaid/SCHIP ☐ Private employer-sponsored ☐Private-Child only ☐No ☐Don't know

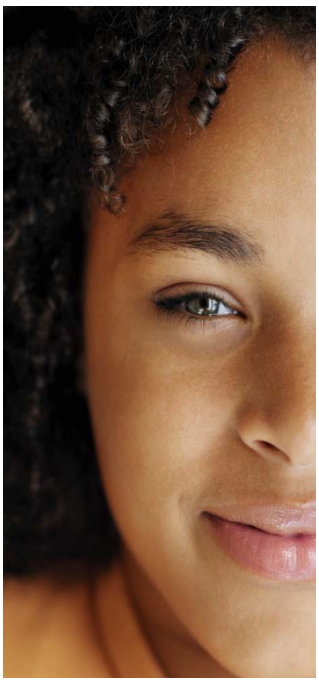
90. Is this a potential Medicaid/SCHIP case? ☐Yes ☐ No ☐N/A

91. Is this a potential private child-only case? ☐Yes ☐ No ☐N/A

92. Did you obtain information to update the MINS screen on this case? ☐Yes ☐ No

93. Did you obtain other information useful to OAG for this case (e.g., new employment info)? ☐Yes, specify_____ _____ ☐ No

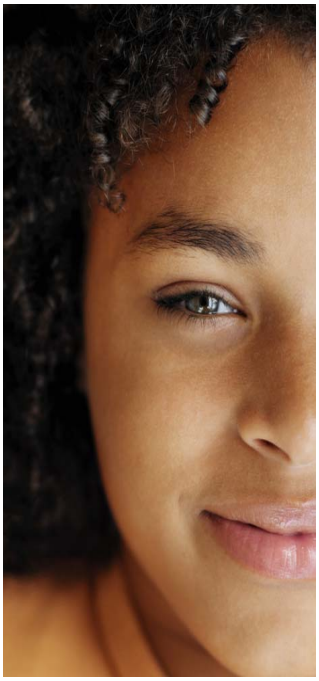
94. Notes.



APPENDIX B: DATA DICTIONARY FROM TXCSES

TXCSES Data Field	Description
CPRID	CPR's internal id
Case ID	TXCSES id
Cause No.	id for OAG use
Active□Employer	Id of NCP's active employer
Active□Employer□Confirmed Date	Date NCP's last employer confirmed
CS□Arrears	Total child support arrears as of download date
MS□Arrears	Total cash medical arrears as of download date
Last□CS□Payment□Date	Most recent child support pymnt (date)
Last□CS□Payment□Amt	Most recent child support pymnt (amt)
Total□CS□Paid□Last 6 Mos	Total child support paid in last 6 mos
Last□MS□Payment□Date	Most recent cash med support pymnt (date)
Last□MS□Payment□Amt	Most recent cash medical support pymnt (amt)
Total□MS□Paid□Last 6 Mos	Total cash medical support paid in last 6 mos
MINS Mbr Id	Medical insurance member id-- only exists if ordered
MINS Employer ID	Medical insurance employer id-- only exists if ordered
MINS Premium	Medical insurance premium (amt paid for child)
MINS Prem Freq	Med insur prem frequency: b-biweekly, m-monthly, w-weeky
Carrier	Medical insurance carrier-- only exists if ordered
Cvrg Type	Type of medical insurance: C-comprehensive
Cvrg Cd 1	Coverage type 1: MD- medical, DN- Dental
Cvrg Cd 2	Coverage type 2: MD- medical, VI- vision
Other Cvrg	Other coverage: ER- emergency room
Cvrg End	Medical insurance: Coverage end date
Enroll Stat	Enrollment Status: A-active I-inactive
Enroll Date	Enrollment start date
Enroll End	Enrollment end date
NMSN Mbr Id	NMSN member id
NMSN EMPL Id	NMSN employer id -
NMSN Sent Date	Date NMSN sent
NMSN Term Date	Date of NMSN termination
Last Update	Date NMSN last updated
Total Num Orders	Total number of orders owed by NCP
Last Eff Date	Last order effective date
Last Med Code	Medical support is ordered as….
Last Ord Desc	Most recent action on case.
Last CSPP1 Amt	Child support order amount as of Download date
Last CSPP1 Freq	Frequency of child support order (all M- monthly except one B bi-weekly)
Last MSPP1 Amt	Cash medical support order amount as of download date
Last MSPP1 Freq	Frequency of child support order
Next Eff Date	Previous order effective date (prior to order currently in effect)
Next Med Code	Medical support of previous order
Next Ord Desc	Previous action on case
Next CSPP1 Amt	Previous child support order amount
Next CSPP1 Freq	Frequency of previous child support order amt
Next MSPP1 Amt	Previous cash medical support amount
Next MSPP1 Freq	Frequency of previous cash medical support amount
First Eff Date	Date orginial order was established
First Med Code	First medical support order
First Ord Desc	First action on case
First CSPP1 Amt	First child support order amount
First CSPP1 Freq	Frequency of payment of first order
First MSPP1 Amt	First medical support order amount
First MSPP1 Freq	Frequency of payment of first medical support order
Last□CSRP□Crt□Date	Last CSRP date
Last□Judicial□Crt□Date	Last Judicial date
NCP Name	NCP's name

TXCSES Data Field	Description
NCP Gender	NCP's gender (M-male, F-female)
NCP Mbr ID	NCP's member id
NCP Birth Date	NCP's birthdate
NCP Phone	NCP's Phone
NCP Employer Count	Number of NCP employers
CP Name	CP's name
CP MBR ID	CP's member id
CP Phone	CP's phone
CP Relation to Dep	CP's relationship to child
Nbr of Kids	Number of children on order
Dep1	Dependent 1 person's id
Dep1 DOB	Depndent 1's Date of birth
Dep1 Lives With CP	Dependent 1 lives with CP
Dep2	Dependent 2 person's id
Dep2 DOB	Depndent 2s Date of birth
Dep2 Lives With CP	Dependent 2 lives with CP
Dep3	Dependent 3 person's id
Dep3 DOB	Depndent 3s Date of birth
Dep3 Lives With CP	Dependent 3 lives with CP
Office	
Case Status	Case status (A-active, C-closed…
Initiating/ Responding	Interstate status (I- intiating, R-responding) as of download date
Last AIW Sent	Date that last income withholding order sent
Case Type	Case type (A- active TANF, F- former TANF, N- never TANF, N- never TANF, Medicaid) as of download date
Case Class	Case Class as of download date



APPENDIX C: INTERVIEW GUIDE

Exit Interview with Ninos Sanos Staff

1. One goal of this project was Medicaid/Child Support Collaboration.
    a. What did you learn about child support from your experience?
    b. What do you think child support workers learned from you?
    c. Based on your experiences, where do you think Medicaid/Child support need to work better together?
    d. Based on your observations, what were the greatest challenges to Medicaid/child support collaboration?
2. Based on your observations, what are the benefits and limitations of Medicaid for children in the child support caseload? Is it the preferred source of medical coverage? Why? Why not? How can Medicaid coverage be offered and continued in a more systematic manner so that all eligible children in the IVD caseload are enrolled and there are fewer lapses of coverage?

3. Based on your observations, what are the benefits and limitations of CHIP for children in the child support caseload? Is it the preferred source of medical coverage? Why? Why not? How can CHIP be offered and continued in a more systematic manner so that all eligible children in the IVD caseload are enrolled and there are fewer lapses of coverage?

4. What are the benefits and limitations of employer-sponsored insurance for children in the child support caseload? How can it complement Medicaid/CHIP? How does it conflict?

5. What are the benefits and limitations of child-only insurance for children in the child support caseload? What are the features of plans that are currently available? What are average and median policy levels? What are deductibles? What does the application process entail in terms of time and cost? What do insurance companies expect to do in the way of generating and amending child-only policies in the next several years?

6. What policies and approaches do custodial parents favor for generating medical coverage for their children? What policies and approaches to noncustodial parents favor for providing medical coverage for their children?

7. The major goal of this demonstration was to increase the numbers of children in the IVD caseload with healthcare coverage. One way that the demonstration tried to accomplish this was to place Medicaid eligibility workers, like yourself, in child support offices to facilitate Medicaid eligibility/redetermination.
    a. Based on your first-hand experience, what worked and what didn't work with this approach? What were the specific challenges?
    b. What could have been done differently that would have resulted in more children with healthcare coverage?
    c. Should certain child support case types be targeted for assistance? If so, what case types?

Interview Guide for OAG and HHSC Staff Members

One reason OAG applied for this project was the high rate of TX children without healthcare. Was this assumption correct?

- Does TX have a problem with children lacking health coverage?
- Are there eligible children in the child support system who lack Medicaid? CHP?
- Are there eligible CSE children who are not enrolled in employer-sponsored plans
- Were these assumptions incorrect? Correct at the time of proposal but not later?
- Is increasing healthcare coverage an appropriate goal for child support?

Originally, the intervention was timed to occur prior to CSRPs. Later it occurred after orders were established. At both time points it was hard to find cases that lacked healthcare coverage and staff were limited in how they could help.

- When is it appropriate to look for eligible children who may not be enrolled?
- Before orders are established? After orders are established? At the court? Not at all?
- Do most cases scheduled for CSRP have healthcare coverage so no room to improve?
- Do few parents need help with enrollment/redeterminations in Medicaid/CHP?
- What help to parents actually need with medical support?
- What help do they currently get from CSE, the OAG vendor handling medical support and where are there are gaps?
- Does the CSE worker who does CSRPs handle relevant medical insurance issues?
- Does the vendor OAG uses for medical support handle all relevant issues?

A key strategy for this project was to use staff jointly hired by child support and Medicaid and base them at the child support offices. What were strengths/weaknesses?

- Was it helpful to have Medicaid workers at child support?
- Did project staff have the requisite skills? Did they need more cross-training?
- Did they need to know more about child support in order to help CSE with discovery and verification on employer sponsored insurance and other options?
- Did they need to know more about other aspects of Medicaid/CHP to help CSE?
- Did child support staff ask them for help with odd-ball cases?
- Did they need to know more about private insurance to discuss with parents?
- Did the arrangement lead to confusion about their true employers and supervisors
- Other benefits of co-location? Other problems with co-location?
- Were there issues with computer access, work culture, expectations and goals across the two agencies?

Another key strategy for this project was to explore employer-sponsored and child-only private insurance for kids in the OAG caseload. How effective was this?

- Are employer-sponsored plans realistic for IV-D children?
- Was the brochure on private child only insurance used? Was it helpful?
- How did parents react? How did staff react? Were these plans used?
- Is child only insurance a reasonable option for kids in the child support system?
- Is it too expensive? Is it unrealistic to just insure children without parents?
- How did the AG's initiative of child-only private insurance affect the brochure?
- How did national healthcare reform affect interest in/reactions to child only plans

It was expected that project staff would contact parents in all cases to discuss healthcare, assist them with redeterminations, and remind them about CSRPs. Further, project staff would contact employers to facilitate child enrollment when appropriate. Why didn't this happen more routinely?

- Why didn't project staff contact parents and employers more routinely?
- Did staff share info about healthcare they got from parents with CSE? Was it useful?
- Besides project staff and the health insurance inquiry form, how else can CSE learn about healthcare arrangements that parents have?
- Why did they learn little even when project staff made contact?
- How else can CSE help parents with their Medicaid/CHP plans?
- Is this a priority? Why? Why not?

It was expected that project staff would contact employers to create a database of employer sponsored healthcare arrangements. Why didn't this happen more regularly?

- Why didn't project staff contact employers more routinely?
- Was it hard to get to the employer representative who was knowledgeable?
- Did staff generate useful info about healthcare plans by talking with employers?
- Why did they learn so little even when they made contact?
- Does this type of info go out of date too quickly to be useful?
- How else can CSE learn about healthcare plans employers have?
- Is this a priority? Why? Why not?

What were reactions to the project by line staff and administrators in OAG and HHSC?

- Were HHSC workers bored/underutilized? Was it okay to be away from public
- Was this an orphan project that was conceived by OAG/HHSC staff who left?
- Did everyone feel that they should wait to see how healthcare reform played out?
- Was this very low on the list of priorities for child support?

How could the effectiveness of the project been improved?

- Updating one system with data generated on the other
- OAG getting CP wage data and using it to determine Medicaid eligibility?
- Having different staff? A different region/office?
- Targeting a different type of child support case?
- What worked and what didn't work?

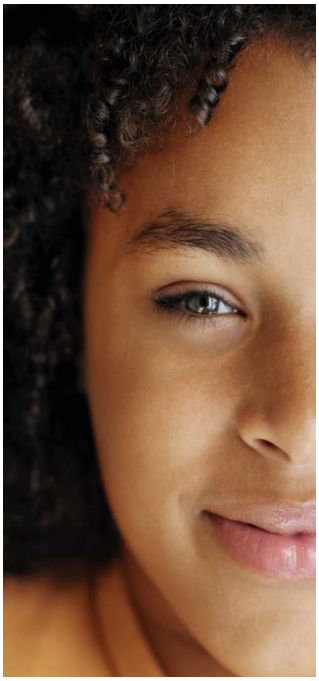
How should OAG increase enrollment of children in healthcare?

- Use automation, periodic matches to large insurance databases, automate NMSNs
- Change the definition of reasonable cost for insurance to exceed 9 percent gross
- Have the vendor who handles medical support actions take on more duties
- Offer CHP in a more systematic manner to all IVD children so fewer lapses?
- Order CPs to provide insurance? Order enrollment in Medicaid/CHP?

Based on your knowledge and experiences, how should healthcare reform affect child medical support?

- Does child support want to do express lane eligibility for Medicaid/CHP?
- Why? Why not?
- Is there the potential for overlap between medical support enforcement and federal enforcement of mandated health insurance that will become effective in 2014?

- Due to Medicaid/CHP expansion and the low-incomes of the IV-D population is prioritizing private insurance over Medicaid/CHP efficient? Should healthcare reform make Medicaid/CHP the preferred form of medical coverage for most IV-D children? Does this change CSE's role in medical support



APPENDIX D: BROCHURE OF PRIVATE, CHILD-ONLY INSURANCE PLANS

Common Health Insurance Terms

monthly premium
The monthly cost of the plan coverage. You must pay this amount every month regardless of whether your child uses any of the plan's benefits.

co-payment
Also known as a "co-pay," this is the amount you have to pay to receive certain medical services. When a co-pay is required, you will have to pay it at the time your child receives services. For example, if your insurance has a $25 office visit co-pay, you will have to pay $25 when your child goes to the doctor's office.

deductible
The amount you will be required to pay in a year before the insurance company pays for some of your services. Some health care services—typically a child's immunizations or preventive care—can be used without having to pay the annual deductible (check the plan details to determine when the deductible does and does not apply).

coinsurance
The percentage you must pay of your child's medical services after you pay the annual deductible. If someone gives two numbers, such as "80/20," the second number (20% in this case) is the amount you have to pay. All of the plans in this brochure have a 20% coinsurance.

annual out-of-pocket maximum
The greatest amount you will have to pay for one year. After you pay this amount, the insurance company will pay 100% of the rest of your child's covered medical services.

lifetime maximum coverage
The maximum amount the insurance company will pay for your health services for as long as you are covered by the plan. If the company spends the lifetime maximum on your child, then you will need to find new health care coverage.

pre-existing condition
A condition that requires care or treatment and exists when you apply for health care coverage. If your child has a pre-existing condition, it will, in some cases, not be covered by insurance and may disqualify your child for coverage. This information will be outlined in the plan brochure or statement of benefits under the "pre-existing conditions clause."

Other Helpful Resources

Texas Children with Special Needs
A plan available for children under the age of 21 with extraordinary medical needs, disabilities, and chronic health conditions that will have lasted at least 12 months or for people of any age with cystic fibrosis. If your child has an expensive medical condition, this could be a good option for you.
Visit: www.dshs.state.tx.us/cshcn
Or Call: 800-252-8023

Texas Health Insurance Risk Pool
A plan for those who are:

- legal residents of Texas and are either a U.S. citizen or have been a U.S. permanent resident for 3 years;
- unable to obtain private or public health care coverage; and
- have a serious medical problem (visit the website to see the list of qualifying conditions).

If someone in your family qualifies for the Health Insurance Risk Pool, then everyone in your family receives coverage. If your child gets denied private coverage due to a pre-existing condition, this may be a good option.
Visit: www.txhealthpool.com/
Or Call: 888-398-3927

Partnership for Prescription Assistance
Helps people who have difficulty paying for prescriptions or insurance costs by connecting them to other organizations that offer financial assistance.
Visit: www.pparx.org
Or call: 888-4PPA-NOW

Attach your Niños Sanos caseworker's business card here.

Niños Sanos
Healthy Children

Your child needs health care coverage. Here are some options.

This brochure outlines some **private child-only insurance plans** that are reasonable in cost and available in Bexar County. If you do not have insurance available through your job and your child does not qualify for Medicaid or CHIP, then **this information is for you**. Keep in mind that these plans are only some options. For more information about other health care options—including those that cover you—contact the health plan providers or visit: www.texashealthoptions.com/

This information is presented by the Niños Sanos project based on information collected in April 2009.

Carrier and Plan Name	Blue Cross Blue Shield of Texas PPO Select® Choice Plan IV	Aetna PPO Benefits Plan 2500	Assurant Health John Alden Life Insurance Company (Underwriter) Limited Benefit Plan B	Celtic CeltiCare Preferred PPO
Monthly Premium	Range from $73 to $163 for 1 to 18 year olds.*	Age 1: $140 Ages 2-18: $93	Ages 0-17: $51 18 year old: $83**	Range from $115.21 - $156.07 for 1 to 18 year olds depending on your zip code.***
Preventive/ Well Child Care	Immunizations paid 100% through age 7. Plan pays up to $300 per child per year. $25 co-pay. Deductible does not apply. No waiting period.	Immunizations paid 100%. There is no per exam limit for well child care. $30 co-pay. Deductible does not apply. No waiting period.	Immunizations covered 100% (no co-pay) for children under age 6. Preventive care office visits do not count towards the 4 office visits per year maximum (see below). No waiting period.	Plan pays up to $300 per child per year. Includes $50 towards annual eye exam. There is no co-pay and the deductible does not apply. 90 day waiting period.
Office Visits	$25 co-pay, consultation only.	Co-pay is $30 for office and $40 for specialist visits. Unlimited visits. Deductible does not apply. No referral needed to see a specialist.	$25 co-pay. Plan covers 4 visits per person per year up to $150 per visit. You do not need a referral to see a specialist.	$15 co-pay for 2 visits/year. After that, visits subject to deductible and 20% coinsurance. No referral needed to see a specialist.
Specialist Visits	Deductible, 20% coinsurance, and $25 co-pay. No referral needed.			
Hospital Services	Deductible and 20% coinsurance	Deductible and 20% coinsurance	Pays up to $750/day for illness and $1,000/day for injury. Pays $100,000 max. for hospital/year.	Deductible and 20% coinsurance
Emergency Room	Deductible and 20% coinsurance	$100 co-pay (waived if admitted), plus deductible and 20% coinsurance.	Pays up to $250 for each of 2 visits/year after $100 emergency room fee (waived if admitted).	$250 deductible (waived if admitted), plus annual deductible and 20% coinsurance.
Urgent Care Facilities	$25 co-pay, plus annual deductible and 20% coinsurance.	$50 co-pay. Deductible and coinsurance do not apply.	$200 deductible. Plan pays 80% up to a maximum of $500 per year (the same applies to outpatient medical services).	$15 co-pay, plus annual deductible and 20% coinsurance.
Prescription Drug Costs	$200 deductible. Co-pay is: $10 for generic, $30 for preferred brand, and $45 for non-preferred brand medications. Plan pays maximum of $3000/year.	$500 deductible (does not apply to generic drugs). Co-pay is $15 for generic, $35 for preferred brand, and $50 for non-preferred brand medications. Pays up to $5000/year.	No deductible. Co-pay is $10 for generic, $50 for preferred brand, and $75 for non-preferred brand medications. Plan pays up to $250/year.	$500 deductible (Does not apply to generic drugs.) Co-pay is: $20 for generic, $40 for preferred brand, and $75 for non-preferred brand medications.
Dental/Vision Services	Add-on dental plan available for $29/month for individual or $60.20/month for parent plus children.	Add-on dental plan available for $16/month for child or $48/month for parent plus children. Vision discount program included.	Add-on dental-vision plan available for $9.95 per month for entire family.	No add-on dental. $50 of preventive care coverage can go to vision exam.
Deductible	$1500 per person (does not apply to preventive care or consultation office visits)	$2500 (does not apply to well child care, urgent care, office, or specialist visits)	$200 (only for outpatient medical services)	$1500 per person (does not apply to preventive care or the first 2 office visits/year)
Annual Out-of-Pocket Max.	$3000 per person, includes payments made for coinsurance	$5000 per person, includes deductible	There is no out-of-pocket maximum	$3500 per person, includes payments made for the deductible and coinsurance
Lifetime Max. Coverage	$5,000,000	$5,000,000	$1,000,000	$7,000,000
Need More Information?	Visit https://osc.hscil.com/tx to purchase insurance online. Or call (800) 531-4456.	Call Melissa Lopez, San Antonio sales rep, at 210-887-7754, visit Aetna.com, or call 1-800-My-Health.	Call Sean Seamster, Marketing Rep, at 800-379-6762 ext. 5 or 210-734-0854 ext. 5. Apply online at AssurantHealth.com.	Visit www.celtic-net.com or call (800) 779-7989.
Application Fee	$30 per family.	None.	None.	No fee if you apply online. $25 fee for paper applications.
Families This Plan Might be Good For♦	Families who: ▪ frequently travel (BCBS has a large network of hospitals and doctors nationwide), ▪ have children who need to visit a doctor soon after applying for insurance (for example, if the child needs a physical or immunizations for school) because there is no waiting period for preventive care, and ▪ have a parent and 4 or more children that need coverage (due to price breaks to the monthly premium).	Families who: ▪ visit the doctor frequently (plan offers unlimited doctor and specialist visits), ▪ need to visit a doctor soon after applying for the insurance (for example, if the child needs a physical or immunizations for school) because there is no waiting period for preventive care, and ▪ may need urgent care for injuries such as a broken bone, sprained wrist, or a cut that requires stitches because the plan offers low cost care ($50 co-pay) at urgent care facilities.	Families who: ▪ need a low monthly rate, ▪ want an add-on dental and vision plan at a low cost for the entire family, ▪ have more than 4 children that need health insurance (there are price breaks when more than 4 children apply for insurance), and ▪ want a low rate to visit the doctor and get generic prescriptions.	Families who: ▪ need coverage fast and have Internet access (there is no fee to apply online and applications are usually processed within 48 hours), ▪ want a low office visit co-pay, and ▪ have a parent and 4 or more children that need coverage (due to price breaks to the monthly premium).
Families This Plan May Not be Good For♦	Families who: ▪ need a low monthly premium, ▪ have children who need to visit a specialist (visits to a specialist require the deductible, 20% coinsurance, and a co-pay), or ▪ have children that may need to go to the doctor for more than just a consultation or a check-up (for example, if a child needs lab work or an x-ray) since these services are subject to deductible and 20% coinsurance.	Families who: ▪ need a lower monthly premium, ▪ have children that may need to go to hospital or emergency room while they are covered by this plan due to the higher ($2500) deductible, or ▪ have children who are on non-generic prescriptions since there is a $500 prescription drug deductible (this deductible does not apply to generic drugs).	Families who: ▪ have expensive prescriptions (the plan will only pay $250 per year for prescriptions, anything above that amount will come out of your pocket), ▪ have children who need frequent or expensive emergency services, or ▪ have children who need costly hospital or outpatient services (for example a CAT Scan or chemotherapy) because there is no annual out-of-pocket maximum.	Families who: ▪ have children who are on non-generic prescriptions since there is a $500 prescription drug deductible (this deductible does not apply to generic drugs). ▪ need a low monthly premium, or ▪ have children that will need to go to the doctor more than twice a year (3 or more office visits are subject to the deductible and 20% coinsurance).

Rates are illustrative of in-network benefits only and subject to change. Please do not send money in response to this offer. You are required to complete an application to be considered for coverage. Benefit exclusions and limitations may apply. *Other factors such as pre-existing conditions, weight, height, and tobacco use may increase the premiums. **If you apply before the 15th of the month, you are eligible for coverage effective the 1st of the following month. If you apply after the 15th of the month, you are eligible for coverage effective the 15th of the following month. ***Most online applications are processed within 48 hours. ♦Based on costs, waiting periods, and availability of certain services/coverage.

Dear: XXX

This is to invite you to participate in a special project in Bexar County on medical child support funded by the Federal Office of Child Support Enforcement. We anticipate that healthplans that participate in this project may experience a variety of benefits.

- More inquiries and enrollments in private, child-only health plans;

- Local, state and national publicity due to the presentation of project results to the Federal Office of Child Support and to state and local child support agencies both within and outside of Texas.

- Experience with working with the child support population in advance of an anticipated requirement by 2014 that child support agencies throughout the United States be measured on their ability to establish and enforce medical support orders for all children in their caseload.

The project is being conducted at three child support offices in San Antonio and evaluated by the Center for Policy Research (CPR), a non-profit research organization. The goals of the project are to:

- Expand actual health care coverage for children in the child support system;
- Identify child-only, private health insurance options in Bexar County;
- Prepare a simplified brochure listing key features of these private options;
- Distribute the brochure to parents in the child support system who lack affordable, employer-sponsored insurance, but can afford child-only, private health insurance; and
- Facilitate the enrollment process so that parents can easily select and enroll in a suitable plan.

To participate in this project, we are requesting that you send us information on your lowest-cost, child-only health plan option that satisfies State rules and meets the minimum requirements of a health plan that the court will order a parent to obtain for his/her child. These are as follows:

- The Texas Family Code at section 101.015 defines "Health insurance" as insurance coverage that provides basic health care services, including usual physician services, office visits, hospitalization, and laboratory, X-ray, and emergency services, that may be provided through a health maintenance organization or other private or public organization, other than medical assistance under Chapter 32, Human Resources Code.

In addition to these plan features, we are hoping that participating companies will be able to offer San Antonio parents a fixed premium plan, an expedited enrollment process, and no application fee. Finally, we hope that participating companies will designate a customer service representative to work with us to help to implement and evaluate this project.

The following is a draft list of information we are seeking from you for the brochure.

- Name of health plan;
- Contact for enrollment: name, phone number, address and email;
- Application fee; preferably $0 or conditions under which the fee could be waived;
- Length of time to process the application;
- Premium per child per month or a range of premiums for a specific age group;
- Any disclaimers about the premium (e.g., it is an estimate, the date it will no longer be effective, it may vary depending on pre-existing conditions, and if possible, a listing of any pre-existing conditions that may prevent coverage);
- Deductibles, out-of-pocket maximums, and co-pays;
- Any extra dental, vision, mental health or behavioral services.

We are sending this letter to all companies that the Texas Department of Insurance (TDI) and we have identified as possibly providing child-only insurance. We will publish information in our brochure on all relevant plans for which we receive the requested information. We are also enclosing an example of a brochure from Sacramento County, which provides this information to parents who have child support cases.

We need to hear from you and receive the information listed above by February 15, 2009. Please contact Jane Venohr at 303-837-1555 or email jvenohr@centerforpolicyresearch.org if you would like more information and/or are interested in participating in this project.

We look forward to hearing from you.