STATE PRACTICES IN MEDICAL CHILD SUPPORT CROSS-PROGRAM COORDINATION

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I. Background and Purpose for the Study

Health care costs are a significant portion of state budget expenditures. In the current constrained state fiscal environment, it is even more important that resources are targeted effectively. By coordinating their work, child support enforcement, Medicaid, and State Children's Health Insurance Program (SCHIP) agencies can ensure that children are enrolled in the health care coverage that is most appropriate for them, maximizing private coverage for those children to whom it is available and affordable and reserving public resources for those who do not have access to affordable private coverage.

The purpose of this study is to describe state efforts to coordinate the child support enforcement program, Medicaid, and SCHIP in order to secure and sustain appropriate health care coverage for child support-eligible children[1]. The report documents both successes in cross-program coordination as well as challenges to effective coordination.

The child support enforcement program serves many of the same children as Medicaid and SCHIP. Nearly three-quarters of child support-eligible children are estimated to be eligible for Medicaid or SCHIP. Approximately half are covered by private employer-sponsored insurance through their parent's or stepparent's employer, and fifteen percent have no health care coverage. A third of child support-eligible children are covered only by Medicaid or SCHIP. [2]

Ensuring that children have access to health care coverage through the provision of private insurance by one or both parents is an important part of child support enforcement efforts. The health care coverage and medical expenses paid on behalf of these children are usually referred to as medical child support. State family law governs the establishment of child support orders, whether or not they are established through the IV-D child support system. State child support guidelines must consider the provision of health care coverage as part of the child support award process. State child support agencies must petition the court or administrative hearing officer for medical child support from noncustodial parents for all custodial children who are receiving services under Title IV-D, whenever such coverage is available at reasonable cost. The IV-D program can use a variety of methods to enforce medical child support orders for children in their caseload.

Earlier research has examined national trends in private and public health insurance coverage, particularly for children in single parent and child support-eligible families. This report focuses on states efforts to improve how child support, Medicaid, and SCHIP agencies work together to finance and sustain health insurance coverage. Specifically, the study asks:

- What are the factors that encourage IV-D agencies to work with SCHIP and Medicaid agencies to enroll eligible children? What types of challenges limit coordination among the three agencies?

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[1] Child support-eligible children are defined as children who do not live with both of their biological parents and are therefore potentially eligible to receive services through the child support enforcement program established under Title IV-D of the Social Security Act.

[2] Aron 2002: 23-25

- What is the effect of federal policy on state efforts to coordinate between the Medicaid, SCHIP, and child support enforcement programs to secure appropriate health care coverage for children?

- What are three innovative states doing to coordinate IV-D, Medicaid, and SCHIP agencies in dealing with medical child support? Why have these agencies collaborated and what are the goals of these collaborations? What approaches are they employing? Which agencies initiate the collaboration toward which agencies? At what level (e.g. county, state) are these collaborations taking place? Are the courts involved?

The remainder of this section describes the methods for answering these questions and initial findings from a Panel of Experts. Chapter II presents the main findings from site visits concerning the child support-health insurance coordination efforts of three innovative states—Connecticut, Minnesota, and Texas. The Appendix describes in detail the approaches used in these states. The discussion in Chapter III draws on these state case studies to examine the challenges to coordination across the three key programs. Chapter IV considers factors promoting cross-program coordination in the three states. The summary of the study findings appears in Chapter V.

Methodology

The work for this study began with a literature review and continued with the convening of a Panel of Experts. Both were undertaken to identify potentially innovative state statutes, policies, programs, and practices that demonstrate effective coordination. The literature review and additional networking to find innovative practices contributed to the identification of candidates from child support, Medicaid, and SCHIP to serve on the expert panel. Panel members included high-level officials or the Director of state SCHIP, Medicaid, and child support programs from six states and a representative from the American Public Human Services Association representing the directors of all three programs. During the meeting, the panelists discussed issues to consider in cross-program coordination. These issues were investigated through site visits to states with innovative practices.

Second, three states with innovative cross-program coordination initiatives were selected for more comprehensive study (see Exhibit A below for state-specific information). Two-day site visits were conducted in these states. Respondents included state executive branch officials, local agency staff, and representatives from the judicial branch. Finally, interviews were conducted in one local site in each state with caseworkers, local attorneys handling IV-D cases, and judicial officials. In each of the three states, we visited the local site that state staff considered to have implemented the innovation better or more thoroughly than most other sites. It is important to note that although state officials were interviewed at each site, the findings presented here are more likely to represent the status of the county or counties visited and may not necessarily reflect practices in other parts of the state.

This research was not intended to be a "state of the field" study. Instead, states were selected for in-depth study because they had already established innovative agency collaboration for medical child support. The innovative practice in each state had been operational long enough to be considered fairly steady state in its design, although staff may continue to find ways to improve operations.

Observations of the Expert Panel

To learn more about medical child support coordination at the state and local level, we convened a meeting of current and former representatives from state IV-D, Medicaid and SCHIP programs and the organization representing state directors of these programs, the American Public Human Services Association. Panelists noted a number of factors that promote medical child support coordination. These include:

- The presence of a widely shared goal in the U.S. of securing health care coverage and healthy outcomes for children;

- Broad support among a extensive array of state and local agencies and the public for the SCHIP program;

- Co-location of child support, SCHIP and Medicaid in the same building (locally and at the state level), which generates communication and collaboration between staff of the three programs; and

- Effective communication of the cost avoidance and containment potential to public health care coverage when broader private coverage is obtained for children, based on the hypothesis that this strategy saves money by relying on private coverage instead of using scarce public funds.

Panelists mentioned additional factors promoting coordination that include having clear laws and regulations to force appropriate action, support from the legislature and governor, cross-program training of agency staff, and judicial education.

Panelists also pointed to the challenges that can limit coordination. These include:

- Inadequate information exchange between the program staff, particularly Medicaid and child support enforcement and especially at the local level;

- Court backlogs that prevent judicial personnel from weighing private and public health care options and ruling in a timely manner;

- Insufficient staff resources to spend on coordination over medical child support;

- A perception of mission conflict between child support agency staff and public health care agency staff. Child support staff focus on delivering all child support services to

parents, while public health agency staff emphasize the goal of attracting eligible children into health programs through outreach and enrollment;

- In some cases referred from Medicaid or SCHIP to the child support agency, the parent does not want child support services, making it difficult for the child support agency to provide services on their case.

The next section describes the nature of cross-agency coordination in the three case study states. Sections III and IV brings together the findings from these states in examining factors that limit and actors that promote coordination aimed at expanding the use of medical child support to increase appropriate health care coverage for children.

II. Site Visit Findings: State Designs in Innovative Practices

Three states, Connecticut, Minnesota and Texas, were selected for in-depth interviews of key officials and observation of operations because of their distinctive and varied approaches toward medical child support cross-program coordination. Each state took a different approach to coordinating between their Medicaid, SCHIP, and child support enforcement programs in order to maximize the enrollment of children in the appropriate health care coverage.

Connecticut and Texas adopted legislation that encourages courts to consider the appropriateness of private or public coverage for children in child support cases. In Connecticut, the principal innovation of interest is comprehensive legislation implemented in 1999 that guides the actions of Family Support Magistrates regarding health care coverage for public child support cases. When a child support case comes before the court, the magistrate makes a standard order for both parties to provide medical and dental coverage through an employer, union, or "another group plan" meaning the Health Care for Uninsured Kids and Youth (HUSKY) program, Part B (Connecticut's SCHIP program). Connecticut's approach is unique in several respects. Explicit legislation guides the child support process toward insuring parental contributions to health insurance. Staff in the HUSKY (SCHIP) program have been trained to recognize applications from non-custodial parents and to coordinate them with the IV-D agency and with the custodial parent. Connecticut's Support Enforcement Services receives automatic notice about job changes of the non-custodial parents into new jobs (using the new hire data base) and can order employers to insure contributions by non-custodial parents to health coverage. Connecticut's approach requires some contribution by non-custodial parent, whether the child is in private health insurance, Medicaid, or SCHIP.

In Texas, changes in Family Code relating to medical child support were accompanied by a comprehensive SCHIP outreach and enrollment initiative, begun in 2000. The Texas Family code mandates a five-priority scheme for courts to use to determine how to order health care coverage for children. This scheme clearly delineates the obligations of both parents and looks at private and public health care coverage options as appropriate. One interesting aspect of the Texas approach is its use of a public-private partnership (TexCare) to engage in publicity and outreach campaigns to increase health care coverage among child support-eligible children.

Another is the automatic efforts of the child support agency to refer custodial parents to TexCare and to send information about children, custodial parents, and non-custodial parents to the state's Medicaid and SCHIP enrollment broker. One limitation of the Texas approach is that the enrollment brokers do not permit non-custodial parents to apply directly for Medicaid or SCHIP on behalf of their children.

Minnesota sought to provide more effective medical child support enforcement services to Medicaid recipients by offering a financial incentive to county human service agencies beginning in 1990. This incentive encourages the county child support agencies to pursue medical child support, just as other incentives support paternity establishment. A key strength of the Minnesota approach is how well collaboration runs in two directions. Where the case is appropriate, local child support staff make referrals to local specialists dealing with medical child support. When parents of children with non-custodial parents apply for Medicaid, the health officials refer the case to the child support agency.

In the remainder of this section of the report, we describe highlights from the three states' innovations in medical child support cross program coordination.[3] We summarize the innovation and lay out its goals, origins and the implementation. We discuss the processes and operations of each state agency involved, as well as local office and court processes and operations, including the roles and responsibilities of contractors. We conclude by noting the sources and amounts of funding for the operation.

[3] For a more detailed description of each state's innovation, please see Appendix I.

Connecticut's Legislative Initiative and Associated Judiciary Practices

In 1999, the Connecticut legislature passed a statute[4] that directs the court or Family Support Magistrate to include in each support order in a IV-D case a provision for the child to be named as a beneficiary by either parent of any medical or dental insurance available to the parent on a group basis through an employer or union, *at reasonable cost.* If such insurance is not available to either parent at reasonable cost, then the provision for health care coverage may include an order for either parent to apply for and maintain coverage under the Health Care for Uninsured Kids and Youth (HUSKY) program, Part B. HUSKY Part B is Connecticut's name for the SCHIP program. HUSKY Part A is Medicaid. Noncustodial parents will only be ordered to apply for HUSKY Part B if they are found to have sufficient ability to pay the appropriate premium. If a noncustodial parent is unable to provide medical insurance coverage and the custodial parent applies for HUSKY Part A or B (Medicaid or SCHIP), the noncustodial parent may be ordered to make a contribution to offset the custodial parent's (or state's) premium.

In recognition that a large number of children in the IV-D program could benefit from SCHIP, the state legislation establishing SCHIP[5] defined an applicant to include noncustodial parents who are under order to apply for HUSKY Part B coverage on behalf of children when reasonably priced private health insurance coverage is unavailable.

Organization of Agencies

The Department of Social Services (DSS) is the umbrella agency in Connecticut responsible for administering 90 legislatively-authorized human services programs, including the child support program, Medicaid and SCHIP. There is a regional administrator responsible for each of five services regions, and each region oversees several local offices among the 15 local offices across the state that are delivering child support and medical services.

The Deputy Commissioner for Programs in DSS plans and develops child support regulations, policies and procedures, and coordinates and monitors the implementation of services. Coordination is undertaken with the Family Support Magistrates who hear IV-D child support cases, the Assistant Attorneys General who present child support cases before the court, and staff in the Support Enforcement Services (SES)/Court Operations Division[6] of the Judicial Branch of state government. Medicaid and SCHIP are split between the Medical Administration and Policy Division and the Medical Care Operations Division of DSS. The SCHIP program is a combination program, meaning that it is both a Medicaid expansion and a stand-alone program.

Origins and Goals

[4] Public Act 99-279

[5] Public Act 97-1

[6] SES handles court-based enforcement activities such as motions for contempt and enforcing wage withholding and medical support orders, as well as review and modification of orders, processing incoming interstate cases, and operating the Central Registry.

The origins of the legislation and associated promising practices in Connecticut's medical support coordination initiatives can be traced to a June 1998 report by the federal Department of Health and Human Services' Office of the Inspector General (OIG) entitled, *Review of the Availability of Health Insurance for Title IV-D Children*.[7] The report concluded that thousands of children in the child support program were receiving Medicaid benefits at full cost to the state because private health insurance was unavailable or unaffordable to noncustodial parents and despite the fact that Connecticut courts ordered noncustodial parents to provide medical support. The report recommended two approaches to the problem. One was that the state should implement policies and procedures to require noncustodial parents to pay all or part of the Medicaid premiums for their dependent children. The second was to require that noncustodial parents contribute toward the premium payment for a newly-established, reasonably priced, comprehensive statewide health insurance plan.

Connecticut's legislation and associated practices led to more coordination between the HUSKY and child support programs. Such coordination was and is aimed at instituting more ways that noncustodial parents can contribute to the health care coverage costs of their children, and save public costs to HUSKY. The OIG report had estimated that the state could save $11.4 million in annual combined state and federal Medicaid costs by following the OIG recommendations.

Implementation

The Commissioner of DSS agreed to consider OIG's first recommendation (requiring noncustodial parents to contribute to Medicaid premium costs) as a legislative change and budget option during the 1999 legislative session. The state's establishment of the SCHIP program addressed OIG's second recommendation. Implementation of SCHIP began in June 1998, offering affordable health care coverage for uninsured children of low-income families with incomes above the eligibility cutoff for Medicaid.

Because each agency needed a better understanding of the legislation and the HUSKY program, special training was provided to DSS and SES child support staff, staff from the Attorney General's office, and Family Support Magistrates. Training covered the HUSKY program and its functions and benefits, as well as the role of the enrollment broker with which Connecticut contracts to provide SCHIP and Medicaid eligibility and enrollment functions. Training also covered how various statutory provisions in the HUSKY legislation were to be implemented at the state and local level for child-support eligible children.

Current Agency Operations

[7]Office of Inspector General, Department of Health and Human Services. June 1998. Review of Availability of Health Insurance for Title IV-D Children. A-01-97-02506. Boston, MA: Office of Audit Services.

This section discusses ongoing operations in the child support agency and the medical assistance agency as well as variations in the way some judicial officials handle medical support cases. The following description reflects operations as they existed at the time of our visit in August of 2002. State officials were contemplating some revisions to operations at that time.

Child Support Agency. The Connecticut IV-D program serves both clients who must cooperate with child support to receive TANF or Medicaid and those who apply on their own for child support services. In TANF and Medicaid public assistance cases, information about the noncustodial parent is obtained by the public assistance eligibility worker and passed on to the child support program. The overwhelming majority of orders are established by the child support investigator who files a support petition with the superior court.[8] The noncustodial parent is served with a legal petition and request for documentation of his income, employment, and health insurance availability to be provided before the court date. In any public assistance or non-public assistance case where the health insurance information cannot be obtained prior to the court date, the noncustodial parent fills out a financial affidavit in court and both parents are asked about medical coverage. Magistrates often order continuances while the necessary health insurance information is obtained and verified. Continuances are also necessary when requesting that either parent apply for HUSKY, as the parties await eligibility determination.

The IV-D case is brought before the court's Family Support Magistrate[9] by the Assistant Attorneys General. They call on the child support investigator who has prepared the case information to testify. The Magistrate assesses the availability of health care coverage. When the child is presently uninsured, the Magistrate makes a standard order for both parties to provide medical and dental coverage through employer- or union-provided insurance at reasonable cost, or "another group plan," and the case must return to court after eligibility is determined. The Magistrate may make a general reference to applying for HUSKY by ordering application to "another group plan," or may specifically order HUSKY. If the custodial parent already has insurance for the child or returns to court having been found eligible for HUSKY A or B, the noncustodial parent can be ordered to pay part of the premium.

In Hartford, each of three Magistrates we interviewed defines reasonable cost slightly differently. One said he caps it at 10 percent of gross income and that with low-wage obligors that usually means $30 per week; another said he caps it at nine percent of gross income. A third magistrate observed that DSS has been reluctant to impose a single definition of reasonable cost on the courts, and she does not want them to do so.

After the cash and medical support orders are established, the investigator refers the case to Support Enforcement Services for follow-up on insurance applications, monitoring for compliance, and enforcement. For example, SES staff receive automatic notice from the New Hire database if a noncustodial parent changes jobs and they issue a new order for insurance to the new employer. Similarly, SES staff can order the employer to enroll a child on a noncustodial parent's policy.

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[8] A small minority of orders are established by the noncustodial parent signing a voluntary Agreement to Support.
[9] Non-IV-D cases are handled by judges.

HUSKY officials noted the importance of coordination with child support officials to working out problems that may arise when the noncustodial parent applies for HUSKY. At one point, unless the noncustodial parent provided all the necessary information about the custodial parent, the HUSKY enrollment broker staff rejected the applications on the grounds that they could only take application from custodial parents. Later, HUSKY officials reeducated enrollment broker staff on how to facilitate the enrollment process for IV-D children, so that upon receipt of a HUSKY application from noncustodial parents, staff would send a blank HUSKY application to the noncustodial parent instructing him to send it on to the custodial parent. Alternatively, staff could send a letter to the custodial parent, directly requesting that she fill out an enclosed HUSKY application to accompany the one submitted by her child's noncustodial parent.

Finally, additional coordination occurs between HUSKY and child support officials over revisions to the HUSKY application. Revisions have been made to clarify which custodial parents must be referred to child support services when applying for HUSKY and who is exempt. In addition, the agency must *offer* the full array of child support services even to those exempt from mandatory referral.

Medical Assistance Agency. When a noncustodial parent is ordered by a Magistrate to apply for HUSKY, the parent calls the toll-free phone number of the enrollment broker and provides his address, employer, income and other information over the phone or requests a mail-in application. Upon return of a signed application to the enrollment broker, all information is entered into the broker's automated system, a noncustodial parent flag is attached to the file, and custodial parent information is sought. Upon receipt of the companion custodial parent application, eligibility determination can be completed. If the child is found eligible for HUSKY A/Medicaid, the record is sent to the DSS Central Office for data entry into the Medicaid automated system and issuance of the Medicaid card. Then, the parent selects the managed care plan she prefers. At that point, the case is transferred to the parent's local DSS office for ongoing monitoring and redetermination.

In cases found eligible for HUSKY B/SCHIP, the enrollment broker rather than central office grants eligibility and notifies the selected managed care plan that bills are to be sent to the non-custodial parent (if he was ordered to contribute to premium costs). The noncustodial parent is notified by letter of the plan the child is enrolled in and of his share of the premium. Should the noncustodial parent stop paying the premium, the broker notifies the custodial parent that the child's coverage is frozen. The custodial parent may ask the noncustodial parent to resume payments or notify the child support worker, who notifies SES to take enforcement action.

Funding Sources and Amounts

No new state funding was authorized or appropriated for these practices or the coordination they entailed. The activities were absorbed into regular IV-D administrative costs, the regular judiciary/court expenses, Medicaid/SCHIP administrative costs, and into the administrative costs in the judicial branch's SES.

Minnesota's Bonuses Paid to Counties for Enforcement of Medical Support

One key initiative reviewed in Minnesota is a statute requiring the state to pay $50 to county child support agencies for enforcing medical child support obligations on behalf of each child on public assistance.[10] The bonus applies when the noncustodial parent is under court order to provide dependent health insurance coverage. The state pays bonus payments for each child in a child support/public assistance case and each time in the course of a year that the county agency identifies or enforces previously unidentified health insurance coverage. The bonus incentive funds earned by each county must be reinvested in the county child support enforcement program. The county is not allowed to reduce its own funding to the program by the amount earned from bonuses.[11]

Organization of Agencies

Minnesota's Department of Human Services supervises both the child support and public health care programs. Child support operations are supervised by the DHS Economic and Community Support Strategies division, while the DHS' Health Care Administration supervises Medicaid and MinnesotaCare[12] as well as the SCHIP program.

Unlike most other states, Minnesota counties play a major role in administration, partly because they contribute financially to human services administration and benefits. The result is that child support enforcement and medical assistance programs are state-supervised but county-administered. Some describe the county social services agencies as virtually autonomous entities from their state agency, though the state agency provides oversight. Thus, much of the implementation and operation of medical child support coordination must be understood from the county level. We visited one of the three integrated service centers in Dakota County for this study of promising practices. Dakota County is the third most populous county in the state.

Origins and Goals

Minnesota traces the origins of its practice of paying bonuses to counties for enforcement of medical child support orders to a precedent involving state bonuses to counties on other performance standards and to a 1990 conversation between a Dakota County child support agency official and the state child support director. At that time, counties in Minnesota were receiving state bonuses for some for paternities established, child support orders established, and orders modified. (States now receive incentive payments from the federal government for

[10] Public assistance cases include Minnesota Family Investment Program (MFIP), medical assistance (MA), MinnesotaCare for pregnant women or children under 21, and Title IV-E Foster Care.
[11] Minnesota Statute 256.9791 Medical support bonus incentives.
[12] The state provides health insurance coverage for children under age two living at or below 280 percent of the federal poverty level (FPL) and for children age two and up and their parents living at or below 275 percent of FPL, through their MinnesotaCare program. This program began in 1992. As a result, and because the program could not be grandfathered into SCHIP, the state has a very small number of children enrolled in SCHIP.

reaching these objectives.) No bonuses were paid for medical support. The county official remarked to the state director that the state's policy was for counties to pursue medical as well as cash child support, but that counties tended to focus on activities for which incentives were paid. The county official urged that bonuses be added for medical support enforcement in order to get county staff to pay attention to that task and in order to demonstrate to the County Board of Commissioners (appropriators of county funds to child support administration) the return on investment of resources in medical support. The state director approved the idea, directed the department to draft a legislative proposal and a statute was adopted in 1990.

In Minnesota, the goal of medical support coordination and enforcement is to help families become self-sufficient while obtaining *good* health insurance coverage for children. To Minnesota officials, good coverage often combines private coverage and Medicaid so that children have fully sufficient coverage for all health needs. The non-custodial parent's private insurance and/or contribution to the premium for Medicaid's managed care plan can lower the state's contribution to public coverage. One means of achieving these goals is county bonuses that encourage child support workers to attach as high a priority to medical child support enforcement and coordination with health programs as to establishing paternities and child support orders.

Implementation

DHS began by issuing an instructional bulletin to all Boards of County Commissioners, the Director of each County Agency, and the Child Support and the Medical Assistance supervisors in each county. The memo included definitions of medical support enforcement and the bonus policies, the methodology for calculating the bonus due, how to enter information into the child support automated and manual systems (depending on county), and data reporting requirements to DHS.

At the state level, coordination occurred between child support and Benefits Recovery staff in the Health Care Administration. This was necessary because the policy called for bonuses to be paid only for children with medical child support orders that are established and enforced *after* a family had a public assistance case opened. The Benefits Recovery staff had to verify on a quarterly basis that the medical assistance case was receiving private health insurance coverage during the quarterly bonus period.

In Dakota County, coordination meetings were held between the child support director, supervisors and caseworkers, and their counterparts responsible for integrated eligibility determinations and case management for the welfare, Medicaid, Food Stamps, Emergency Assistance, and General Assistance cases. Child support officials and staff emphasized that as soon as a family is enrolled in public coverage and the application notes that the child has a parent not living with them, the integrated worker should refer the case to child support. This referral triggers an investigation into whether private coverage was ordered, so as to secure coverage or a premium reimbursement.

Early implementation called for a tiered bonus structure, based on the percentage of cases in which a medical support order was enforced. That proved unnecessarily complex. In 1994,

DHS paid a flat $50 for each child in a public assistance case (Medicaid or TANF) for each time in a year a private health insurance order is successfully enforced (i.e. each time new coverage is identified and enforced.) To illustrate with an extreme case, consider a noncustodial parent with three children on public assistance who changes employers three times in a year. Each employer offers reasonably priced dependent health insurance to the noncustodial parent. In this illustration, if the medical team enrolls those children at all three employers, the county will earn $450 in medical health insurance bonus money that year for enforcing the single noncustodial parent's medical support order.

Current Agency Operations

Child Support Agency. In Minnesota, medical support statutes mandate that the courts are to order the parent with the better group dependent health and dental insurance coverage or health insurance plan to name the minor child as a beneficiary. Private coverage through a group, employer or union is preferable. However, if dependent health insurance is not available to either the noncustodial or custodial parent, the court may require one of three options for the noncustodial parent: 1) to obtain other dependent health or dental insurance, 2) to be liable for reasonable and necessary medical or dental expenses for the child, or 3) to pay $50 per month to be applied to the medical and dental expenses of the child or to the cost of health insurance dependent coverage. This amount is added to the guideline amount for cash support. If the available dependent insurance does not cover all reasonable and necessary medical or dental expenses of the child, the court may require the noncustodial parent, depending on his or her financial ability, to be liable for a portion or all of these expenses.[13]

How do these policies become operational? We consider routine operations in Dakota County for either a child support case with a new order or a case in which the office has just been notified of a new hire.[14] This description does not necessarily apply to operations in all counties.

In an effort to distribute efficiently the responsibilities for medical child support, Dakota County maintains a staff of regular child support workers and two separate medical support specialists who conduct all medical support coordination and enforcement activities. To determine if it is appropriate to pursue private coverage, the child support worker reviews the case and determines that: 1) the noncustodial parent has been ordered to carry insurance for one or more children in the case; 2) no current insurance information exists in the child support automated system; 3) the noncustodial parent has a current employer or is currently paying support; and 4) a current address for the noncustodial parent is available in the child support automated records. The child support worker also makes sure that appropriate information for insurance is in the current order and any available wage information is entered in the system.

Once the child support worker has verified the information, one of the team's two medical specialists sends out a form letter to the noncustodial parent within two days of a new hire report or within 30 days from the effective date of a court order, reminding him of his court

[13] Minnesota Statute 518.171 Medical Support

[14] The PRISM system, the automated child support case and financial management system, automatically notifies workers of new hires, because there is a data match between the state's New Hire Database and PRISM.

ordered obligation to provide health insurance coverage. This form letter is called the Notice of Medical Support Obligation and Enforcement. The medical specialist also sends a form letter to the employer's human resources contact to determine what insurance if any is available. If reasonable coverage is available but not in place, he/she sends out an order to the employer to enroll the child or children on that insurance. If insurance is in place or obtained, the medical team will verify the information with the insurance company and enter the policy information in the system. The specialist then notifies the regular child support caseworker, gives them the insurance information, and advises them to review the case regularly to watch for job jumping or multiple orders in multiple counties.

If no insurance is available to the noncustodial parent or insurance does not seem to be available at a reasonable cost[15], the medical team specialist sends the referral back to the child support worker who determines the next step. This can include asking the court to modify the medical provisions of the order by ordering an alternative, such as a dependent-only policy through an independent insurer or requiring medical support payments applied to insurance premiums, medical expenses, or reimbursement for Medical Assistance or MinnesotaCare expenditures.

Medical Assistance Agency. When a parent applies for Medicaid or MinnesotaCare in the Dakota County office, they are given the integrated Minnesota Health Care Programs Application.[16] If they indicate on that application that one or more of their children have a parent not living with the child, they are given or mailed a child support questionnaire to fill out and return within 30 days. If the application is approved, a Medicaid card will be issued. If the family is found eligible but the custodial parent does not return the child support information, the child remains eligible for Medicaid but the parent will be removed from the case. If the applicant is poor and pregnant and found eligible, regardless of her compliance with the requirement to cooperate with child support, she will remain eligible for Medicaid through her pregnancy and 60 days postpartum. After that time, if she does not comply and does not show good cause for noncooperation, she will be removed from the case.[17]

If appropriate, the child support referral is made right away, even before the 30 days of waiting for the custodial parent's information has passed. When the Medicaid or MinnesotaCare

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[15] An exact measure of reasonable cost is a county decision. In Dakota County, workers consider it to be 5 percent of gross monthly income.

[16] All counties take applications for Medicaid on a single, integrated application form for all medical assistance programs in Minnesota. With MinnesotaCare, counties can opt to take applications in the county service center or not. Dakota County is one of approximately 35 of the 87 counties in the state that have opted to take applications. In the remaining 52 counties, the applicant mails the application to the state office. If the applicant is found eligible for MinnesotaCare and there is noncustodial parent indicated, the applicant is referred back to county medical staff to initiate the coordination with child support enforcement for private medical child support.

[17] The federally funded health care programs require custodial parents and caretakers of children who are requesting or receiving MinnesotaCare or MA to assign their rights to medical support payments from the child(ren)'s non-custodial parent. Unless an order for medical insurance is already in place and in force, the custodial parent or caretaker must also cooperate with the county child support enforcement office, known as IV-D, to establish paternity, establish an order for medical support, and/or enforce an existing order unless the caretaker shows good cause for non-cooperation (MDHS Health Care Programs Manual, Chapter 0906.13).

application is approved for a household that includes a referral child, an electronic referral is sent to the child support worker via an automated file exchange. If the case is a Medicaid-only public assistance case, the worker will contact the custodial parent to ask if she only wants medical child support enforcement or full child support services.[18] Very often, the custodial parent will exercise her option to have full child support services.

Once the referral is made, the medical assistance management information system is automatically updated if the child support enforcement agency finds or enrolls the child in a heath insurance plan. At this point, the medical assistance worker examines the policy (i.e. co-payments, coverage, deductibles) to determine if it is appropriate (i.e. accessible and affordable). The medical assistance worker may determine that private coverage is appropriate. If this is the case, the custodial parent will be sent a letter notifying them to use the private coverage as primary and medical assistance as secondary.

Minnesota has increased the value it receives from its health care programs because of savings from medical child support. The state contracts with prepaid health plans, paying them capitated monthly rates for beneficiaries enrolled in Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare. Most of the enrollees in Minnesota's three health care programs are in managed care. State staff annually summarize revenues collected on behalf of children on Medicaid through third party liability. Because the amount of third party payments is continuously tracked for all Medicaid HMO's, the state is able to use that information to negotiate lower capitation rates with HMO's in subsequent years.

Funding Sources and Amounts.

Funding of the administration of Minnesota's child support program comes from a state appropriation, the county's own funding appropriated by the Board of Commissioners, federal incentive payments, and the 66 percent Federal matching funds allocated to states, much of which the state CSED passes through to counties. The state also passes on much of what it earns in federal incentive funds to the counties, based on their performance.

Funding of the state bonus program, as well as other types of bonuses, comes from a state appropriation. Since 1996, the Dakota County statistician has been tallying total earnings from all bonuses. In that year, total bonuses were $79,550 and medical support bonus payments totaled $18,050 of that total. By 2001, total bonuses had grown to $145,800 and medical support bonuses represented $22,000 of that total. At the state level, it was reported that for 2001, the state paid out to counties $3,794,728 in total bonuses, of which $381,150 (about ten percent) was paid for medical support bonuses.

Texas' Collaboration through TexCare

[18] The state DHS maintains a Joint Committee on Good Cause Exemptions, whose purpose is to review documentation accompanying MinnesotaCare applications for good cause exemptions from the requirement to cooperate with child support enforcement, where the applicant is claiming domestic violence or other appropriate reasons as the grounds for not cooperating.

TexCare is an umbrella campaign that allies several state government agencies with private sector companies, community-based organizations (CBOs), and Texas families in order to raise awareness of options for children's health insurance in Texas. Established by the Health and Human Services Commission (HHSC) in concert with the passage of SCHIP legislation in May 2000, TexCare provides education and marketing for SCHIP, Medicaid, and private health insurance, to ensure that Texas' children have access to health care coverage. The Office of the Attorney General (OAG) and the HHSC maintain a collaborative relationship through the TexCare initiative in order to integrate TexCare outreach and Title IV-D activities. This coordinated effort, referred to as the Title IV-D Outreach Project, is an integral part of the effort of Texas agencies to increase the number of children who have health care coverage.

A second part of the Texas initiative is its comprehensive medical support legislation. For many years, Texas law has contained detailed provisions concerning the medical child support obligations. It incorporates a priority scheme that guides the courts in determining the manner in which medical support should be ordered. In 2001, the Texas Legislature examined the issue of uninsured children in the state and made several amendments to the Family Code that strengthened provisions dealing with medical child support.

Organization of Agencies

The Health and Human Services Commission (HHSC) has oversight responsibilities for designated Health and Human Services Agencies, such as the Department of Health and the Department of Human Services.[19] HHSC also administers certain health and human services programs, including the Texas Medicaid Program and SCHIP. While operations and claims processing for the Medicaid andSCHIP program reside in the HHSC, Medicaid eligibility determination, acute care and EPSDT are located in the Department of Human Services. DHS is also the agency responsible for TANF and Food Stamps.

Entirely separate from HHSC is the Texas Office of the Attorney General (OAG). Led by the Attorney General, the agency has four Deputy Attorneys General for Child Support, General Counsel, Litigation, and Criminal Justice. Under the Deputy Attorney General for Child Support, the key person involved with TexCare is the General Counsel for Child Support. Other units under the Deputy Attorney General for Child Support are the Administrative Law Judge Section, Administrative Operations, Field Operations, Information Technology, Program Monitoring, and Program Operations.

Origins and Goals

Goals. The TexCare Partnership, now simply called TexCare, is fundamentally about coordination between agencies in order to increase the number of Texas children who have

[19] The Texas Health and Human Service Agencies include not only the Texas Health and Human Services Commission and the Department of Health, but also the Department of Human Services, Department of Mental Health and Mental Retardation, Department of Protective and Regulatory Services, Department on Aging, Commission for the Blind, Commission for the Deaf and Hard of Hearing, Commission on Alcohol and Drug Abuse, Rehabilitation Commission, Interagency Council on Early Childhood intervention Services, and Health Care Information Council.

health care coverage. More specifically, the goal of TexCare and its outreach and education campaign is to provide access to children's health insurance options by supplying information and educating the public about SCHIP, Medicaid, and private health insurance.

The more specific collaboration between the OAG and HHSC has three goals: 1) to increase the number of insured children in Title IV-D; 2) to integrate TexCare outreach and Title IV-D activities; and 3) to provide affordable health care coverage options for low-to-moderate income noncustodial parents.

The Texas Family Code was amended in order to provide policy guidance to the courts for establishing medical support orders.[20] The changes were also intended to clarify the various health care options available to children and to streamline the medical child support process by including Medicaid and SCHIP in the establishment process and requiring parties to disclose health care coverage details. Previously only private health insurance was considered, and there was no specific disclosure requirement.

Origins. In May 1999, the 76th Texas Legislature passed a bill authorizing the creation of SCHIP.[21] The Texas Healthy Kids Corporation, which had partnered private health insurance companies and health maintenance organizations to offer private health insurance to low-income Medicaid-eligible children, was dissolved and slowly phased out because over 95 percent of its enrollees were estimated to be eligible for SCHIP.

TexCare was created to facilitate the rollout of SCHIP. Under the TexCare Partnership, fifty diverse CBOs were awarded contracts to do outreach across Texas including county health departments, non-profit organizations, religious organizations, and local health clinics. Each organization was given TexCare educational materials that could be adapted to best fit their particular grass-roots effort and the predominant language spoken by their target population. The CBOs worked with SCHIP staff to set specific goals and performance measures and to propose specific outreach activities. Outreach efforts were launched in early spring 2000 and SCHIP enrollment got into full swing a couple of months later.

Interest from the state legislature helped generate strong support for outreach efforts specifically to uninsured children from the child support caseload. It was clear that SCHIP would be relevant to the low-income population in the IV-D caseload, and so the HHSC and OAG formed a closer collaborative relationship. HHSC and OAG had already established a relationship because of the Texas Healthy Kids initiative and the mandatory child support referrals of TANF clients applying for Medicaid. Their partnership became more active in 2000, and in March 2001, the two agencies entered into an interagency contract. The contract formalized the OAG's outreach activities and specified the types of information exchange that would occur, including the transfer of the CHIP enrollment file to allow the OAG to track IV-D children who were in CHIP and identify children who do not have health coverage identified.

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[20] Amendments made changes to Sections 101.015, 154.181, 154.182, 154.188, and Section 32.025 of the Human Resources Code.

[21] Please see appendix for full description of the state's SCHIP planning and implementation.

As part of the state's commitment to addressing the health insurance needs of children, the Legislature amended the Texas Family Code in 2001. For many years the priority among Texas courts was to establish and collect on cash support orders, with little focus on medical support. In 2001, the Legislature reexamined the medical child support provisions and passed new legislation that made medical support a more visible issue and medical support orders more enforceable.

Implementation

In Spring 2000, training about TexCare and the new SCHIP program began. Staff from TexCare CBO's, SCHIP, and the OAG began the process of training the judiciary, attorneys, county staff involved with child support in the HHSC and OAG, and parents. Outreach to local child support offices included mass mailings of TexCare brochures to field offices and courthouses, presentations and trainings at child support manager and attorney meetings, and trainings at local DHS offices. To reach judges OAG staff made presentations about SCHIP and TexCare, supplied family law judges and Title IV-D Masters with SCHIP brochures and sent them a direct mailing, and provided SCHIP training to Masters and Judges. Outreach to attorneys involved publishing an article in the State Bar Newsletter, creating an internet link from the State Bar website to the TexCare website, presenting to local bar associations, and distributing information at conferences.

Together with the HHSC, the OAG initiated specific efforts to reach parents of uninsured children, especially those who receive child support. Activities included producing and distributing brochures, airing of radio and television public service spots, writing articles for publications read by those constituencies, distributing information packets at conferences, direct mailings to each constituency, internet links between TexCare's and each group's web sites, and the opening of application assistance offices via contracts between HHSC and Community-Based Organizations (CBOs) in 30 of Texas' 254 counties. Special outreach initiatives were directed at custodial parents. TexCare applications were sent to 80,000 custodial parents in child support cases where the noncustodial parent had been ordered to provide health care coverage for his children, but had not done so. This mailing frustrated some custodial parents, because they felt that it implicitly relieved the noncustodial parent of their obligation to provide private health insurance for their child or children. The outreach methods to custodial parents changed after this first attempt. For instance, the OAG created TexCare information packets to send to custodial parents in all new Title IV-D cases.

Changes to the Texas Family Code and Human Resources Code. Texas law has for many years provided a priority scheme for courts to use to determine how to order health care coverage for children. These five priorities are written into the family code. The code was updated and strengthened by the Legislature in light of the new health care coverage options available and the renewed focus on increasing the number of Texas children who have health care coverage. These changes streamlined the medical child support process by including Medicaid and SCHIP in the process of establishing awards and by requiring parties to disclose health care coverage details. Previously, only private health insurance was considered and there was no specific disclosure requirement. The new legislation also defined terms used in the bill text such as 'health insurance' and 'reasonable cost.'

The five uniform steps in the family code reflect these changes. If insurance is available through the obligor's employment or union at a reasonable cost (defined in state statute as the cost of a health insurance premium that does not exceed 10 percent of the responsible parent's net income in a month), the court orders the obligor to add the child to the policy. If the insurance is not available through the obligor's employment or union but it is available at a reasonable cost through the obligee's employment or union, the court orders the obligee to add the child to the policy and the obligor to pay additional support to the obligee for the costs of the insurance. If insurance is not available through either parent's employment or union, the court orders the obligor to provide insurance from another source if it is available at a reasonable cost. If neither parent has access to health insurance, the court orders the custodial parent or, to the extent permitted by law, the noncustodial parent to apply for Medical Assistance (Medicaid and SCHIP). If the child is eligible, the obligor is ordered to pay additional support to the obligee for the cost of the health care coverage. If none of these options are viable, the court orders the obligor to pay the obligee an additional reasonable amount each month as medical support.

Taken together, these legislative changes prioritized and strengthened the medical support provisions. The OAG Child Support Division responded to the legislation by creating several new forms for the court process. Every new applicant for child support services, other than custodial parents whose children are on Medicaid, receives the form "Important Information about Children's Health Insurance Program." The "Health Insurance Information Needed for Court" form goes to parties who are scheduled for a court hearing, and the "Health Insurance Availability Form" is to be completed and filed with the court in every legal action where child support or medical support are addressed. This series of forms is meant to establish the health insurance status of every child before the case enters the courtroom, so that the Master can make the most informed decision concerning medical support.

Staff from the OAG put on a seminar in the summer of 2001 at the University of Texas Law School to review the amendments to Section 154 with IV-D Masters. The new legislation was also discussed at the Advanced Family Law Course and the Annual Title IV-D Master Conference.

Current Agency Operations

Child Support Agency. The following describes routine operations for a new child support case, and the interactions that case will have with TexCare. When custodial parents contact the OAG Child Support Division or are referred by the Department of Human Services (DHS) in order to establish a child support order, they will be informed about TexCare by child support staff. They may also hear about TexCare because the call center's number is listed on the OAG's call menu. Also, a form entitled "Important Information about Children's Health Insurance Program" is sent to the new applicants, unless they are already receiving Medicaid.

In preparation for taking the child support case to court, the "Health Insurance Information Needed for Court" form and the "Health insurance Availability Form" are sent to both custodial and noncustodial parents. This form is filed with the court every time a child support or medical child support order is addressed in court. In general, parents often do not fill

out the insurance availability form and OAG staff must follow up with the parents in order to evaluate the child's health coverage options before the court date. If the information has not been gathered by the court date, the information will be obtained during the proceedings, sometimes even by calling the employer's human resources department from the courtroom.

When the case comes before the Title IV-D Master, the court uses the five priorities to determine the best solution for health care coverage. In some counties such as Bexar County, Community Based Organizations perform TexCare outreach in courthouses. In San Antonio, CBO staff approach families waiting in the courthouse and those leaving courtrooms in order to give them TexCare information.

Medical Assistance Agency. Custodial parents may apply for TexCare by calling the state's contracted enrollment broker, by coming in to fill out an application at a local CBO or human services office, by working with CBO staff to fill out an application and send it in, or by downloading the forms off the internet and sending them to the enrollment broker. Broker staff members feel that the number of noncustodial parents attempting to apply for coverage has decreased substantially since the new legislation was passed. However, if a noncustodial parent calls, a broker staff member explains that only custodial parents are permitted to apply.[22] The staff sends out an application to the custodial parent if the noncustodial parent provides them with address information for the custodial parent.

The enrollment broker receives the application and screens it for completeness and eligibility. If the case appears to be Medicaid eligible, the self-declared asset questions are examined. If it still appears to be Medicaid eligible, the application is forwarded to the Department of Human Services (DHS) through an electronic interface between the enrollment broker's automated system and DHS's automated system and the paperwork is delivered to local DHS offices. Local DHS caseworkers make the final Medicaid determination. If the applicant is not Medicaid eligible but is SCHIP eligible, the enrollment broker's system automatically generates a SCHIP enrollment packet that is sent to the family. The family completes the enrollment form and returns it to the broker. There is also a box to check on the application if the parent wants a referral to OAG. There is currently no system in place for the enrollment broker to make an automated referral to the OAG, but there are plans to fill this gap in the process.

As part of HHSC and OAG interagency agreement, the enrollment broker also receives a data file monthly from the OAG, assembled by an OAG contractor, containing the names and addresses of the children and custodial parents for cases where the noncustodial parent has been ordered to provide health insurance, but such insurance has been found to be not available because: 1) the employer or union does not provide dependent insurance coverage; 2) the noncustodial parent is ineligible for the insurance coverage; or 3) the insurance is not available at reasonable cost to that parent. The enrollment broker sends these families a letter on OAG stationary explaining that OAG has no records of insurance coverage for the child. The letter supplies a number to call for parents whose children have coverage, so that they can give the

[22] Although Texas does not allow noncustodial parents to apply for SCHIP, there is no federal prohibition on their application.

policy information to the OAG for child support enforcement services. The packet includes a TexCare application so that the custodial parent may apply for SCHIP and Medicaid if their children are not covered.

Funding Sources and Amounts

There has been no special funding for the coordination and outreach initiatives of TexCare. Legislation stipulated that the state could not use any state general revenue funds for administration unless the state could draw down federal matching funds for each of those dollars. Two exceptions are: 1) an allowance for state general revenue funds to be used for SCHIP coverage of immigrant children residing in the U.S. for less than five years; and 2) an allowance for state general revenue funds to be used for the incremental premium subsidies for children in the state employees' State Kids Insurance Program.

In each year since 2000, the sources of funding have been a combination of Federal funding for Medicaid, SCHIP, and IV-D and their required state matches, now being met with tobacco settlement receipts.

III. Challenges to Cross-Program Coordination

A major purpose of the project was to identify challenges to cross-program coordination. This section considers possible challenges based on the comments of respondents in the three states we visited and the observations of the Expert Panelists, who represent five additional states.[23]

Respondents reported a wide variety of challenges, some apparently state-specific but many falling into common themes. We group them into five broad categories. They include challenges that: 1) relate to the objectives and goals of the agencies; 2) derive from legislation or regulations; 3) involve ongoing operations, some administrative operations and some judicial or court-based; 4) involve financing or funding; or 5) are external to both the medical assistance and child support programs and their operations.

Goals and Objectives of the Coordinating Agencies

Conflict between agency and program goals and objectives can pose challenges to cross-program coordination. Some field visit respondents, as well as child support representatives on our Expert Panel, perceive a conflict between the goals of the child support and medical assistance programs. They see the goals of the child support program as providing cash and medical support for children in custodial families by securing private resources from the noncustodial parent to reduce or eliminate the custodial parent's dependence on public assistance. To achieve this goal, the child support agency must ensure cooperation from custodial and noncustodial parents in establishing both paternity and child support orders for cash and health insurance and must enforce those orders. Some officials in medical assistance

[23] These states include Utah, Massachusetts, Oregon, Iowa, and Maryland.

agencies view the child support agency's objectives as including the delivery of every child support service at the agency's disposal, whether the custodial parent wants them or not.

On the other hand, officials in both the medical assistance and child support agencies said that they see the goals of medical assistance programs as reaching out to ensure that as many eligible children as possible have access to health care. Therefore, their objectives are to reach out to eligible children in low-income families and enroll them in public health care.

Given these inter-agency, inter-program conflicts in goals and objectives, it can be difficult for the three programs to send a common message to families that need public health care coverage. Thus, in some cases, there is tension over the Medicaid requirement for cooperation with child support. Though federal law and regulation requires that Medicaid applicants[24] be referred to and cooperate with child support services, some state medical assistance officials believe this policy discourages Medicaid enrollment in cases where the parent applying for Medicaid does not want child support services. In many states with joint applications for Medicaid and SCHIP, questions to a custodial mother about child support (such as the existence of a noncustodial father and about acknowledging the requirement to cooperate fully with child support) may lead her to terminate the application before enrolling her child in public health care coverage. Medicaid officials in the three states cited this concern, as did the child support officials on the Expert Panel.

This tension challenges coordination because it can prevent both agencies from realizing their goals. When coordination does not appear to help each agency reach its goals, the incentive to coordinate declines. The goal of medical assistance agencies to maximize enrollment of eligible children in public health care is impeded if parents do not apply for public health care because they do not wish to comply with the cooperation requirement. When a custodial parent is referred to the child support enforcement agency, but refuses to cooperate, the child support enforcement agency is less able to meet its goals. One response in Connecticut is the revision of their joint Medicaid-child support application to better meet the goals of both programs. The draft language states,

> *If you are a parent or a caretaker living with a child and you want HUSKY coverage for yourself, you must agree to cooperate with child support. This means that you will give us information about parents who do not live in the home and help us pursue medical support. If you do not agree to cooperate, you cannot get HUSKY for yourself; however, your children can still qualify for HUSKY. Pregnant women do not have to provide information about the father of the unborn child. Also, if you do not want to cooperate because you may be subjected to abuse by the absent parent, you may ask for an exemption from this requirement. If you do not want assistance for your self, you do not have to*

[24] Applicants for Medicaid coverage for the custodial parent are required to cooperate with child support as a condition of eligibility; however, if the applicant is only applying for coverage for a child, cooperation is not required.

cooperate with child support. However, we can help you receive child support and medical support for the children if you want us to.

This screening statement provides clear information to a custodial parent and also invites those who might not have thought about receiving full child support services, to consider doing so.

Legislative and/or Regulatory Issues

Both state and local respondents cited legislative or regulatory issues that challenge coordination.

Preference for Noncustodial Parents Carrying Coverage. Many officials and staff in the three states, as well as child support officials on the Expert Panel, expressed the view that the long-standing regulatory preference for non-custodial parents (rather than custodial parents) to carry health insurance for their children is outmoded. Moreover, they noted that the preference for noncustodial coverage can hinder coordination between agencies in their attempts to achieve a seamless transition between private and public coverage.

Our respondents viewed the long-standing preference as outdated for many reasons. First, in cases where children live in another part of the state or in a different state from their non-custodial parent, they often cannot access participating providers in the noncustodial parent's Health Maintenance Organization or Preferred Provider Organization. Second, non-custodial parents frequently do not sustain long-term employment with the same employer, which threatens continuity of their child's coverage.[25] Third, rising employment levels among low-income, TANF, and former-TANF mothers make them at least as likely to have access to employer-provided health insurance coverage as the noncustodial parent. Those mothers' employer-provided insurance can be more usable for the children than the noncustodial parent's insurance. These issues raised by the respondents are similar to those identified by the Medical Child Support Working Group.[26]

Respondents also observed that non-custodial parent coverage of the child can hinder or complicate the child's medical treatment and payment for that treatment. Custodial parents are far more likely to make decisions about taking children to the doctor or a hospital, and respondents felt that their access to those providers would be facilitated by the custodial parent carrying the health insurance. Also, many health insurance companies appear to be unaware that when the non-custodial parent holds the coverage, they are required to send an insurance card to the uncovered custodial parent to be used for the child.

Child support, Medicaid, and SCHIP staff find that the transition between private and public coverage can be made more difficult by the preference for the noncustodial parent, because custodial parents are key in determining eligibility for public health care coverage.

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[25] See Sorensen and Oliver (2002).

[26] Medical Child Support Working Group. 2000. *21 Million Children's Health: Our Shared Responsibility.* Report to the Honorable Donna E. Shalala and the Honorable Alexis M. Herman Washington, D.C., June.

Noncustodial parents cannot easily apply for SCHIP because a completed application and eligibility determination require the custodial parent's income and asset information. Similarly, Medicaid eligibility for the child depends in part on the custodial parent's income and asset information. In addition to these application issues, another complication is that if the noncustodial parent loses his job or stops paying the premiums for private insurance, the custodial parent may be unaware of the situation until the child needs medical treatment. At that point, it can take several months between the time the custodial parent learns that private coverage has lapsed and the time she applies and is found eligible for public coverage for the child. Therefore there may be a gap in coverage for the child. For these reasons, Texas does not allow the non-custodial parent to apply for SCHIP, although there is no federal prohibition against their application. Connecticut officials commented that, in retrospect, they would prefer that legislation not allow Family Support Magistrates to direct noncustodial parents to apply for public coverage. They have since taken administrative steps to ensure that the custodial parent files the ultimate application, even if the noncustodial parent files the initial application.

Defining Reasonable Cost. The current definition of reasonable cost is another challenge to medical support coordination, according to administrative agency and judicial officials. HHS regulations currently define reasonable cost as any health care coverage available through the obligor's employment.[27] Respondents felt that the current federal definition of reasonable cost, because it does not take account of noncustodial parents' income, can deter judges, masters, and hearing officers from ordering the child into the most appropriate coverage. In Texas, for example, prior to legislative changes made in 2001, the IV-D Masters implicitly defined reasonable cost in their own way. Now the courts use a uniform definition, and IV-D Masters feel that assists them in making medical child support orders more consistent and appropriate.

Operational Challenges

Most of the challenges to medical child support cross-program coordination can be characterized as operational, some arising in or among the administering agencies and some arising out of judicial practice.

Operational Challenges for and among Administrative Agencies

Sharing Confidential Information. The need to protect confidential information in increasingly challenging for many programs. Inter-agency coordination relies greatly on data sharing, and the confidentiality requirements for certain types of client information make data sharing a complex issue. Respondents spoke about this problem, particularly as it pertains to the safety of custodial parents and their children. In cases where a custodial parent who has claimed a "good cause" reason to not cooperate fully with child support on the grounds of domestic violence or child abuse concerns, the need to guard against divulging the address or employer of the custodial parent to unauthorized individuals is especially critical. The SCHIP enrollment brokers in Connecticut and Texas mentioned the types of measures they employ to maintain confidentiality of information provided by the IV-D agency including flags on data files in the system and repeated staff training to review information sharing protocols. The brokers are

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[27] 45CFR section 303.31(a)(1) (1990).

aware that the sharing of confidential information between agencies that ends up endangering the safety of a custodial parent or child would immediately create roadblocks to data sharing, which is a necessity for effective inter-agency coordination.

Automated Interfaces. Other administrative barriers noted relate to automation. Some state officials cited the absence or inadequacy of automated interfaces between the data processing systems maintained by the child support, Medicaid, and SCHIP programs as a barrier to coordination. This problem slows communication about families who interact with several agencies. In Texas, continued dependence on a very old mainframe computer system makes such interfaces technically unfeasible. And in Connecticut and Texas, where the states contract with enrollment brokers to take applications and determine initial eligibility for SCHIP and Medicaid, staff pointed specifically to the absence of an automated referral between the database of the public health care enrollment broker and the child support agency's database. In particular, the broker could not automatically refer a family found ineligible for public coverage to the child support agency for attempts to secure private coverage.

Challenges to Judicial Operations

In addition to challenges to cross-program coordination arising within agencies, barriers to coordination sometime resulted from the judicial system.

Court Docket Backlogs. As previously mentioned, an important aspect of inter-agency coordination is sharing the primary goal of ensuring that as many children as possible have access to health care coverage. Part of achieving that goal is finding coverage for children on the IV-D caseload by making sure that medical child support is treated as a priority. Child support agency officials, judges, and hearing officers all pointed to the difficulty in making medical support a priority for children when court docket backlogs prevent ordering cash and medical support in a timely manner. Backlogs can mean that children go uninsured for several months while they wait for their case to come before the court. For example, Connecticut's Family Support Magistrates noted that despite substantial increases in their caseloads over the past decade and increases in the number of difficult, time consuming pro se case; they have had no authorization to increase the number of Magistrates since 1991. The result is that Magistrates have higher dockets full of more complex cases, and some children experience gaps in health coverage while waiting for their case to be resolved. With less time for magistrates to review private and public health care options and make appropriate rulings, medical support becomes less of a priority and the uniform goals shared by agencies are threatened.

Issuing Case Continuances. Judges, Magistrates, and IV-D hearing officers observed that waiting for health insurance eligibility information in order to establish an order causes delays and court continuances. And this exacerbates docket backlogs, in so far as a case must be brought before the judicial officer twice, rather than once.

A decision matrix implicitly employed by hearing officers and masters has the hearing officers and masters asking the following questions of noncustodial and custodial parents and their IV-D attorneys in court:

- Is private coverage available to either the noncustodial or custodial parent?
- Does the child have access to this coverage (that is, is it fee-for-service or, if a managed care plan of the noncustodial parent's employer, does the child reside in an area proximate to the network of providers)?
- Is the cost reasonable?
- Does one parent have better coverage?
- Is the child eligible for Medicaid or SCHIP (if accessible and affordable coverage is not available)?

Attempts by public attorneys to assemble the answers to these questions before the hearing are often unsuccessful. They may communicate the need for this information (insurance policy services covered, service area of managed care plan, deductible amounts, co-insurance, availability of dependent coverage, and premium amounts) to both parents weeks before the hearing date, yet one or both parents forget to bring it with them.

Financing and Funding

Some child support officials pointed to the lack of a Federal performance standard against which to measure states' medical support performance, and a corresponding Federal incentive payment, as posing a challenge to inter-agency coordination. These officials felt that the absence of a performance measure and an associated financial incentive payment creates a disincentive to give medical support the same priority that they accord to paternity establishment, establishing orders, and collecting payments, actions that *have* performance measures and financial incentives. They suggested that a financial incentive that rewards states based on the percentage of cases that have appropriate medical coverage, not simply private coverage, would promote inter-agency coordination between those responsible for SCHIP, Medicaid, and child support enforcement. A few state child support officials in the three study states expressed a reluctance to make additional improvements to medical support for fear that enhanced funding for medical support in future legislation or regulations will contain Maintenance of Effort stipulations.

External Challenges to the Success of Coordination Efforts

Officials we interviewed in all three states mentioned that the stigma some families associate with the Medicaid program can limit the success of coordination efforts and ultimately limit agency coordination. One goal of coordination is to increase the health care coverage of children. Child support agencies can assist in achieving this goal not only by insuring the contributions of non-custodial parents but also by facilitating applications for public health care coverage when appropriate. However, some families who are comfortable applying for SCHIP

may not wish to enroll in Medicaid.[28] Thus, when child support staff encourages custodial parents to complete the joint Medicaid/SCHIP application, some families found eligible for Medicaid instead of SCHIP may decline to participate in Medicaid. This reduces the effectiveness of medical child support coordination.

[28] State officials said that their awareness of this issue influenced design and implementation of SCHIP in their states. When implementing SCHIP, with its income eligibility thresholds extending considerably higher on the household income scale than Medicaid, they attempted to make the program seem more universal and family-friendly. And as summarized in Section II, states mounted aggressive outreach campaigns to find eligible families and welcome them into the program.

IV. Factors that Promote Cross-Program Coordination

A key goal of our site visits was to understand what factors promote cross-program coordination, from the perspective of state and local staff. In general, officials and staff cited many more factors that promote medical child support cross-program coordination than that pose challenges to coordination. We group factors that promote coordination into the same five categories used to describe challenges to coordination: those that: 1) address the goals and objectives of the agencies; 2) derive from legislation or regulations; 3) involve ongoing operations; 4) are related to financing or funding; or 5) are external to both the medical assistance and child support agencies.

Goals and Objectives of the Coordinating Agencies

Respondents saw having coordination as a goal, and clearly articulating that goal, as very important. According to statute, Connecticut's Department of Social Services' statewide advisory council is responsible for increasing the capacity of the Department to collaborate with others in order to meet human services needs. Officials we interviewed spoke about how important it is that their agency mission statements include written emphasis on coordination and inter-agency partnerships. The Director of the Bureau of Child Support Enforcement in DSS said that her goal is for children to be able to move smoothly from Medicaid to SCHIP to private insurance (and back again if need be) as family circumstances change. To that end, coordination with the Medical Administration and Policy Division of DSS is written into her work plan and that of the Central Office Program Manager. Respondents also find it helpful that top officials of the agency articulate coordination as one of their objectives to other state agency staff and to the local office level.

Coordination is facilitated by all agencies having a shared goal of securing health care coverage for children. This is especially true when this goal is strongly supported by the Legislature and the Governor. For example, in Minnesota's Department of Human Services, the supervising agency for both public health insurance and the child support program, officials told us of their shared goal of getting children covered by *good* health insurance.

In addition, both state and some local officials spoke about how the change in their mission to support self-sufficiency has made medical support an even higher priority. There has been a substantial shift in the makeup of the child support caseload, from one where at least half the families received AFDC or TANF to one where the majority of the caseload is former- and never-TANF or Medicaid-only recipients. Since most custodial parents served by child support enforcement are employed and health care coverage is important for sustaining employment, medical child support coordination has a higher priority. Officials in Connecticut observed that custodial parents used to value child care as the most important supportive service to employment retention, but now appear to value health care coverage most.

Legislative or Regulatory Factors Promoting Coordination

Specific Legislation. According to state and local executive branch officials in the three states, state legislation that guides the actions of judicial officials (judges, IV-D Masters, Magistrates) during child support hearings is a key facilitator of cross-program coordination. Some legislation emphasizes the importance of ordering medical support as well as cash support and requires consideration of both private and public health care coverage. As a result, judicial officials pay more attention to medical support and consider private and public coverage to ensure that more children are enrolled in health care coverage. Since Connecticut's legislation was adopted, when a child support case comes before the court and a child in the case is uninsured, the Magistrate makes a standard order for both parties to provide medical and dental coverage through an employer or union-provided insurance or "another group plan." The phrase "another group plan" is designed to include SCHIP or Medicaid, as specified in the legislation.

Courts Defining Reasonable Cost by Affordability. Additionally, officials in two states said that effective judicial decision-making is facilitated by having a working definition of reasonable cost, such as one linked to percent of income.[29] Given declines in the affordability of employer-sponsored health insurance over the past decade, premiums for private insurance can sometimes pose an extremely high burden for low-income workers. In Danbury, Connecticut, magistrates have developed their own definitions of reasonable cost. Magistrates cap health insurance costs to the noncustodial parent at nine to 10 percent of gross income, a figure which works out to be about $30 per week for low-income parents. In Texas, the legislature adopted changes to the Family Code[30] that define reasonable as "the cost of a health insurance premium that does not exceed ten percent of the responsible parent's net income in a month." Parents are required to inform the court as to whether or not they have access to private insurance at a reasonable cost.

This means that the Master needs to know the cost of potential private and public insurance and in order to make informed decisions about which to order. IV-D Masters and judges think that this definition makes medical child support orders more consistent and appropriate. Thus, Masters play a large role in coordinating between private coverage and Medicaid and SCHIP.

Operational Factors Promoting Coordination

Officials and staff we interviewed spoke about several operational factors that encourage cross-program coordination and are under the purview of the administering agencies for child support, SCHIP and Medicaid.

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[29] Federal regulations require IV-D agencies to pursue medical support when it is available at reasonable cost, defined as any health care coverage available through employment.

[30] SB 236 amended Chapter 154 of the Family Code relating to issuance of medical support orders.

Leading by Example. When top officials of the three programs at the state and local level develop individual relationships with one another and they are directly involved in collaboration activities, their interactions significantly contribute to collaboration because they are leading by example. In all three states, officials expressed collegiality and appreciation for the efforts of their counterparts in the other agencies.

Collaboration between Medical Assistance and Child Support Agency. Top officials often responded that they have been coordinating for quite some time for reasons other than medical child support. This established a precedent that made it easier to coordinate on medical support. In 1999, the Texas medical assistance agency began reaching out to a broad audience of stakeholders including child support staff for the purpose of extensive SCHIP outreach. This led to cross-program coordination and information sharing over medical child support. In 2000, officials from the Minnesota child support agency convened their own Medical Support Working Group that brought together a broad range of state and local agency officials (from medical assistance, TANF, child support officials), CBO officials, and private stakeholders from the physician, hospital, employer and insurance communities. The purpose was to identify and recommend strategies and activities to improve medical support, and to secure buy-in for the recommendations from all stakeholders. The working partnerships forged during the six months of meetings that group held have been sustained since that time.

Also for several years Minnesota has used a Good Cause Exemption Review Committee, made up of representatives from the TANF, Medicaid, and child support agencies. They meet regularly to review written claims and documentation of domestic violence or threats of domestic violence filed by mothers as grounds for not cooperating with child support enforcement as a condition of program enrollment. This precedent for inter-program collaboration provided a natural segue to coordination over medical support information exchange and referral.

Training. Respondents commented on the vital role that training plays in facilitating coordination over medical support enforcement. They noted that training on policy, new legislation, and expectations are important for local agency staff, attorneys involved in IV-D cases, and the judiciary. Officials pointed out that training, when combined with legislation guiding judicial practices, was particularly effective in facilitating medical support coordination with the judiciary. In Connecticut, training for the judiciary was provided through a state training center, seminars by the Attorney General's office, a state SCHIP outreach contractor, and sessions at national meetings. These training initiatives underscored new statutory requirements, such as ordering either parent to apply for public coverage when private coverage is deemed unavailable at reasonable cost and ordering the noncustodial parent to contribute towards premium costs in Connecticut's HUSKY program.

Child support workers in Connecticut received training about the HUSKY program, its functions, benefits, and the roles of the HUSKY enrollment broker, while enrollment broker staff received training in child support and the need for cross-referrals between HUSKY and the child support enforcement program. The mutual awareness of each other's programs stimulated by such cross-training has improved coordination.

Shared Staff Responsibility. A recurrent theme in our interviews were that several methods are used to share staff responsibility for establishing and enforcing medical support orders and enforcing them.

Strategic use of contractors to perform some duties that would otherwise be performed by local agency staff frees workers to engage in coordination. In Connecticut and Texas, enrollment brokers under contract to the medical assistance agency free public caseworkers from many time consuming eligibility determination and paper processing tasks. In Texas, a separate child support agency contractor refers uninsured children in the child support caseload to the enrollment broker for possible enrollment in public insurance, relieving child support workers from performing these tasks.

In Texas, child support officials acknowledged state medical assistance officials and staff for their willingness to take much of the responsibility for SCHIP and Medicaid outreach to the child support caseload. Medical assistance officials took responsibility for preparing and mailing outreach material. This left child support officials with the task of identifying audiences to target, such as attorneys, family law judges, custodial parents, non-custodial parents, IV-D Masters, birthing center and hospital staff. They also decide on the SCHIP educational materials and training, which media to use with each audience (e.g. newsletter, Public Service Announcements, conference presentations, brochures in child support offices), and how to gauge which counties contained the largest child support caseloads and could thus benefit most from SCHIP application assistance centers. The Office of the Attorney General funded all printing and postage costs.

Dakota County, Minnesota now assigns all medical child support enforcement to two specialists. These specialists carry substantially reduced regular child support caseloads, which enables them to communicate with employers and insurance companies. The specialists also can spend more time coordinating with Benefits Recovery staff in the Health Care Administration over open medical assistance cases, and obtaining verification that those cases were receiving private health insurance coverage during the quarterly bonus period.

Collaborating to Redesign Medical Assistance Application. Collaborating to redesign a joint medical assistance application can both clarify child support cooperation requirements and minimize the perceived stigma surrounding Medicaid. In Connecticut and Texas, coordination was facilitated by CSE, Medicaid, and SCHIP officials revising the joint Medicaid/SCHIP application together. Medicaid and SCHIP local office and enrollment broker staff told officials that the cooperation language on the application prevented some families from completing the application process. Child support officials reported that it led to incomplete cooperation from custodial parents and therefore, unworkable cases. So they revised the applications.

The revised joint SCHIP/Medicaid application in Texas, designed cooperatively by officials of the three programs, asks if there is a parent not living with any of the children. It then asks, "Do you want to be referred to the Office of the Attorney General for help establishing paternity and obtaining medical or child support for your children?" The revised draft Medicaid/SCHIP application in Connecticut similarly gives custodial parents more choices about

whether and how they wish to cooperate with the child support agency, and encourages more of them to complete their applications.[31]

The new questions on Connecticut's application are expected to result in child support referrals of only workable full-service cases or cases in which cooperation in obtaining medical child support is a mandatory condition of Medicaid receipt. The application also provides information about the child support services available to custodial parents. The new design also makes custodial parents more likely to complete their SCHIP/Medicaid application when given the choice to cooperate for medical child support only or full child support services. Thus, redesign facilitates coordination by addressing each agency's concerns about child support referral.

Making the application and eligibility determination processes for Medicaid and SCHIP as similar as possible also facilitates coordination between the public health care programs and private coverage. In cases where private coverage is unavailable, child support staff refer, or courts direct, families to apply for public coverage. Connecticut chose to use the same name for the SCHIP and Medicaid program (HUSKY). Minnesota uses a single Minnesota Health Care Programs Application. The Texas joint Medicaid and SCHIP application is called the TexCare Application. Some states make the programs more alike by eliminating the face-to-face interview requirement and by requiring similar proof of assets. Both changes to applications and eligibility determination processes can make coordination between Medicaid and SCHIP more seamless.

Using Automated Data Tools. Among the three states, officials at the state and local level, including administering agency staff, contractors, attorneys, judges and hearing masters, pointed to several tools that promote coordination. Interfaces between the automated data systems in Medicaid, SCHIP and child support speed sharing of information on custodial and noncustodial parents, including their last known address and employer, availability of health insurance, whether it was included in the child support order, and whether there has been an application for Medicaid or SCHIP.

In particular, nearly every respondent cited the great advances provided by the child support agencies State Directory of New Hires, which they call the "new hire database."[32] They said because this automated tool makes new employers known to the child support agency, they can quickly contact the employer's human resources office for health insurance availability, benefits, and employee cost.

In Texas, the local prosecuting attorneys who try child support cases pointed to the ease with which they are able to use their computer network to check the new hire database for a

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[31] See revised language discussed in Section III, Challenges to Cross-Program Coordination, Goals and Objectives.
[32] The State Directory of New Hires is one of the new requirements for state child support programs mandated by PRWORA of 1996, as is a National Directory of New Hires. The law requires employers to report certain information on all newly hired employees within twenty days of the date of hire to the state child support agency. The information includes the employee's name, address, and social security number, and the employer name, address, and Federal Employer Identification Number. The data is matched by state child support staff against child support records to locate noncustodial parents, establish an order, or enforce an existing order.

noncustodial parent's employer. They particularly rely on this source in the many cases where the noncustodial parent failed to fill out the Health Insurance Availability Form prior to the hearing. Then, the attorneys can call the employer's human resources office from the courthouse to inquire about health insurance coverage. If private insurance does not appear to be available, they can also use the SCHIP website to assess whether the client may be eligible for SCHIP. This type of background work by the attorneys to determine the availability of affordable and accessible private coverage for the child can help the Masters weigh private coverage against public health care and make an informed ruling without issuing a continuance.

Financial and Funding Factors that Promote Coordination

A variety of financial and funding factors across the three states seemed to stimulate coordination to improve medical child support. First, coordination was associated with cost savings to Medicaid, which provided an increased incentive for agencies to work together. In Connecticut and Minnesota, where nearly all medical assistance recipients are in managed care plans rather than fee-for-service, Medicaid officials coordinate with the child support agency to search for private health insurance coverage, because it leads to Medicaid cost savings in capitation rates. State Medicaid staff annually summarize revenues collected on behalf of children on Medicaid through third party liability. Because the amount of third party payments is continuously tracked for all Medicaid HMOs, the state is able to use that information to negotiate lower capitation rates with Health Maintenance Organizations in subsequent years.

The HHS Office of the Inspector General's report on Connecticut is another case in point. The report estimated that-some increased Medicaid costs could be reduced through closer coordination between the medical assistance agency and child support agency, which spurred closer coordination.

Second, having a specific source of funding for SCHIP and its outreach and coordination activities facilitates these efforts. In Texas, the tobacco settlement helped to solidify planning for and execution of a very broad SCHIP and Medicaid outreach effort. The tobacco funds made it possible, in particular, for the medical assistance agency to pay for some of the mailings about health care options and other kinds of outreach that were conducted among families in the child support caseload.

Third, financial incentives for medical child support activities promote coordination by putting those activities on a par with other child support activities for which federal incentives are offered (e.g. establishing paternity and child support orders. In Dakota County, Minnesota, the medical child support enforcement bonus raised medical support on the county human services agency's priorities, particularly because the counties share the costs of administering human services programs with the state. This policy has reduced the cases per worker in the county we visited to the lowest ratio in the state. Child support workers willingness to coordinate with their medical assistance counterparts in the county office is maximized because of the tangible benefit that accrues from the bonuses that such coordination earn.

External Factors Promoting Cross-Program Coordination

Some factors external to the agencies and courts played a substantial role in stimulating coordination between officials and staff of the three programs. In Minnesota and Texas, the Governors personally got involved in championing more widespread health care coverage for the state's children. This tended to popularize the importance of "covering kids" in the minds of the public and of public officials and their staff. In Minnesota, the Governor's original goal was universal coverage of children. In Texas, the Governor continued championing the cause of outreach and finding eligible children for SCHIP or Medicaid throughout the start-up, implementation, and operation of the SCHIP program.

Also in Texas, officials in the child support agency and the medical assistance agency all commented on the important role that powerful advocacy for SCHIP-child support coordination from within the state legislature played in their subsequent coordination activities with one another.

To counter some low-income families' negative perceptions of the Medicaid program, several efforts were undertaken to promote Medicaid/SCHIP coordination and enrollment. As noted, Connecticut chose HUSKY as a single name for its Medicaid and SCHIP programs to minimize the distinction between the two programs. Texas chose the name of TexCare for its broad partnership to promote enrollment in SCHIP, Medicaid, and private health insurance.

Finally, state officials said they are aware that they need to do better in educating families to understand that the joint application can lead to a finding of Medicaid, rather than SCHIP, eligibility. They hypothesize that by reducing the element of surprise when an applicant family learns that they have been found eligible for Medicaid, the family may be more likely to take up the Medicaid coverage. To illustrate one such effort, the TexCare application states, "I further understand and agree that this application could lead to my child(ren)'s enrollment in either the Children's Health Insurance Program or Medicaid." They also intend to more clearly promote the benefits of Medicaid and its decoupling from TANF. With such efforts, Medicaid and child support staff hope to be better able to coordinate to maximize the number of child support-eligible children included in health care coverage and to ensure seamless transitions from private to public coverage, including SCHIP.

V. Summary of Findings

Some states have made efforts to maximize the number of child support-eligible children who are enrolled in appropriate health care coverage by improving coordination between their child support enforcement activities and their public health care coverage programs. This study focuses on the coordination efforts of three states—Connecticut, Minnesota, and Texas. The analysis also draws on expert views about how best to link child support and health care coverage in order to sustain appropriate health care coverage for child support-eligible children.

Several findings emerge from this project. First, coordination is a complex job. It is facilitated by having common goals and objectives, clear legislative guidelines, a collaborative attitude among top officials, funding for coordinating activities, staff training, data sharing, cooperative efforts at outreach and intake, and shared staff responsibilities among the programs. Second, the initiatives in three states show considerable promise for improving the coordination between the child support and health care coverage systems. Communication and cooperative efforts are increasingly common in all three states, as is the understanding of guidelines about the sequence of methods for financing health care coverage for children (from requiring parents to include children on employer-sponsored programs to using noncustodial parent contributions to offset some of the cost of Medicaid or SCHIP).

The study also detailed challenges to implementing medical child support policies. Staff and experts pointed to problems in assuring continuity of coverage when noncustodial parents provide health insurance, as well as when the noncustodial parent and child live in different geographic areas. Judicial backlogs and delays in making and adjusting awards pose additional challenges. Confidentiality and automation issues can make sharing data problematic. Coordinating between parents in the application process for public health care coverage is another common challenge.

Notwithstanding the coordination challenges, states are undertaking impressive initiatives to deal effectively with medical child support. Site visits and comments by outside experts documented examples of successful collaboration and efforts at continuing improvements in this field.

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Appendix I: Detailed Summaries of State Approaches

Connecticut's Legislative Initiative and Associated Practices among the Judiciary

In 1999, the Connecticut legislature passes a statute that directs the court or Family Support Magistrate to include in each support order in a IV-D case a provision for the child to be named as a beneficiary by either parent of any medical and dental insurance available to the parent on a group basis through an employer or union. The statute goes on to state that:

> *… if such insurance coverage is unavailable to the parent at reasonable cost, the provision for health care coverage may include an order for either parent to apply for and maintain coverage on behalf of the child under the HUSKY Plan, Part B.*[33] *The noncustodial parent shall be ordered to apply for the HUSKY Plan, Part B only if such parent is found to have sufficient ability to pay the appropriate premium. In any IV-D support case in which the noncustodial parent is found to have insufficient ability to provide medical insurance coverage, and the custodial party is the HUSKY Plan, Part A or Part B applicant, the provision for health care coverage may include an order for the noncustodial parent to pay such amount as is specified by the court or Family Support Magistrate to the state or the custodial party, to offset the cost of any insurance payable under the HUSKY Plan, Part A or Part B.*[34]

Organization of Agencies

The Department of Social Services is the umbrella agency in Connecticut responsible for administering 90 legislatively-authorized human services programs, including the child support program, Medicaid and SCHIP. There is a regional administrator responsible for each of five services regions, and each region oversees at least several local offices among the 15 local offices across the state that are delivering child support and medical services.

The Deputy Commissioner for Programs in DSS plans and develops child support regulations, policies and procedures, and coordinates and monitors the implementation of services. Coordination is undertaken with the Family Support Magistrates who hear IV-D child support cases, the Assistant Attorneys General who present child support cases before the court, and staff in the Support Enforcement Services (SES)/Court Operations Division[35] of the Judicial Branch of state government. Medicaid and SCHIP are split between the Medical Administration and Policy Division and the Medical Care Operations Division of DSS. The SCHIP program is a combination program, meaning that it is both a Medicaid expansion and a stand-alone program.

[33] The HUSKY Plan, Part B is Connecticut's name for the SCHIP program. Part A is Medicaid. HUSKY is the acronym for Health Care for Uninsured Kids and Youth.

[34] Public Act 99-279

[35] SES handles court-based enforcement activities such as motions for contempt and enforcing wage withholding and medical support orders, as well as review and modification of orders, processing incoming interstate cases, and operating the Central Registry.

Goals, Origins and Implementation

Goals. The goals of Connecticut's legislation and associated practices were to promote more coordination between the HUSKY and child support programs. Such coordination was and is aimed at instituting more ways that noncustodial parents can contribute to the health care coverage costs of their children, and save public costs to HUSKY. The OIG report had estimated that the state could save $11.4 million in annual combined state and federal Medicaid costs by following the OIG recommendations.

It is also apparent that coordination is a significant goal for each agency involved in the operation of child support and public health insurance programs. The Department of Social Services strives to be a caring and responsive organization that effectively and efficiently delivers the highest quality services to help their customers improve the quality of their lives and achieve and maintain maximum self-sufficiency. To that end, DSS is under a statutory requirement that the Commissioner establish a statewide advisory council. This council's mission involves consulting with and advising the Commissioner on the development and delivery of human services for Connecticut's families and individuals who need assistance [in maintaining or achieving their full potential for self-direction, self-reliance and independent living]. Among the responsibilities of the Council are to identify service delivery gaps and changing service needs, and to increase the capacity of the department to *collaborate* and plan with other human service agencies to maximize the utilization of existing resources.

The goal of the Director of the state's Bureau of Child Support Enforcement is for children to move smoothly from Medicaid to SCHIP to private insurance (and back again if need be) as family circumstances change. To that end, coordination with the Medical Administration and Policy Division is written into her work plan and into the work plan of the Central Office Program Manager.

Officials of the HUSKY program observed that their principal mission goal has been to enroll the maximum number of eligible children in HUSKY Part A or B and, to that end, to conduct an aggressive outreach effort. However, with recent budget shortfalls in the state, HUSKY no longer spends its own funds on outreach. Instead, the program in 2002 relies on a separate Children's Health Council, the state's lead agency for the Covering Kids and Families program funded by The Robert Wood Johnson Foundation, facilitates state and local efforts to design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs, and aims to simplify enrollment processes and to coordinate existing coverage programs for low-income children.

The Director of Medical Care Administration speaks to the need for collaboration, regularly, in his written communications; and other officials who work with HUSKY point to the coordination they promote between the enrollment broker and local offices.

Origins. Connecticut's 1999 statute was in part the result of a report from a study by the Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services.

The OIG study reviewed a computer file extract of Connecticut IV-D children enrolled in Medicaid from April 1, 1996 through March 31, 1997, whose noncustodial parents had court orders to provide medical support. The objective of the review was "…to determine whether children under the Child Support Enforcement Program are receiving Medicaid benefits because private health insurance is unavailable or unaffordable to noncustodial parents."[36] The report found that more than half of noncustodial parents from the sample cases could not meet their medical support obligations because their employers did not offer health insurance or the insurance was not available at a reasonable cost. However, OIG also found that the same noncustodial parents could afford to pay all or part of Connecticut Medicaid premiums. The study concluded that the state of Connecticut could increase the number of noncustodial parents providing medical support for their children and save an estimated $11.4 million (Federal and State combined) in annual Medicaid costs by implementing alternative arrangements. OIG recommended two alternatives. The first was for Connecticut to implement policies and procedures to require noncustodial parents to pay all or part of the Medicaid premiums for dependent children. The second was for the state to establish a statewide health insurance plan that provided reasonably priced comprehensive health coverage for children and required noncustodial parents to contribute to premiums.

Implementation. The state of Connecticut agreed that the OIG's findings had merit and responded by examining both recommendations. The Commissioner of the Department of Social Services agreed to consider OIG's first recommendation of requiring noncustodial parents to pay all or part of Medicaid premiums as a legislative change and budget option for the 1999 legislative session. The state's establishment of the SCHIP program under Title XXI of the Social Security Act addressed OIG's second recommendation to establish a statewide health insurance plan for children. Connecticut implemented affordable health coverage under the HUSKY Plan in June 1998 for uninsured children of low-income families with incomes above the eligibility cutoff for Medicaid. Accompanying language from the statute establishing SCHIP[37] defined an applicant to include noncustodial parents who are under order to apply for HUSKY Part B coverage on behalf of children when access to reasonably priced health insurance coverage is unavailable.

During the 1999 legislative session, the Commission for Child Support Guidelines expanded and clarified child support provisions by adding a new subsection.[38] The subsection requires every child support award to include a provision for either parent to contribute to the health care coverage of the child. Either parent may name the child as beneficiary of health insurance carried at a reasonable cost. However, if insurance is not available at a reasonable cost, the order may require application for HUSKY, and the noncustodial parent's monetary contribution toward premium costs is established as part of the support order.[39]

[36] Office of Inspector General, Department of Health and Human Services. June 1998. Review of Availability of Health Insurance for Title IV-D Children. A-01-97-02506. Boston, MA: Office of Audit Services.
[37] Public Act 97-1
[38] Subsection (g) in section 46b-215a-2a
[39] State of Connecticut, Commission for Child Support Guidelines. "Child Support and Arrearage Guidelines." Effective August 1, 1999.

Subsequent HUSKY statutory provisions amended several sections of child support legislation.[40] Some allow a Family Support Magistrate to order either parent to apply for and maintain HUSKY. If the custodial family is in HUSKY A or B, the Magistrate may order the noncustodial parent to pay a set amount to the state or the custodial parent to offset premium costs. However, such payment may not be ordered if it would reduce the amount of current child support required under the guidelines. The last provision is seen by nearly all respondents to our interviews as setting up an inequity between those noncustodial parents ordered to provide private coverage, and those noncustodial parents ordered to reimburse the state or custodial parents to offset the cost of public insurance premiums.

Because each agency needed a better understanding of the legislation and HUSKY, training was provided to child support staff as well as to the Family Support Magistrates. Training consisted of two parts. The first piece was about the HUSKY program, its functions, benefits, and the role of the enrollment broker that is contracted to screen applicants for SCHIP and Medicaid eligibility and to enroll families. The second piece was a discussion about the new legislation and how it was going to be implemented. Magistrates received only the HUSKY training, while all child support workers and Support Enforcement Services (SES)[41] staff received both parts of the training. Staff from the Attorney General's office went to either training. Children's Health Project (CHP) staff, one of several HUSKY outreach contractors, ran the HUSKY training. Several child support investigations supervisors from regional office were identified to be trainers for all child support staff on how the statute was to be implemented. SES adopted the same training manual used by those supervisors and adapted it to train SES staff. Training sessions were held in all five regional and 15 local offices across the state, except for staff from particularly small offices who were brought together for combined trainings.

Some of the fifteen local child support offices, such as the Danbury office, implemented with greater ease than others because of smaller IV-D caseloads and lighter court dockets, as compared with Hartford and New Haven, and more open dialogue with Magistrates. When legislation for medical orders was initiated, the child support program did not receive any additional funding or staff in order to address it. However, the supervisor moved caseloads around to try to spread out Medicaid-only cases, and instead of creating specialized positions the lead investigator has become very knowledgeable about medical support.

Current Child Support Operations

The Connecticut IV-D program serves both clients who are mandated to cooperate with child support as a prerequisite for TANF or Medicaid receipt and those who apply for child support enforcement services. In cash assistance and Medicaid public assistance cases the information about the noncustodial parent is obtained by the cash assistance/Medicaid eligibility

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[40] PA 99-279, Section 46b-215, Sections 28, 29, 30, and 31

[41] SES handles court-based enforcement activities such as motions for contempt and enforcing the wage withholding and medical support order, as well as review and modification of orders, processing incoming interstate cases, and operating the Central Registry. They would also handle license revocations when applicable, though we were told SES rarely uses this enforcement tool.

worker and referred to the child support program. Child support enforcement staff locate the noncustodial parent, establish paternity, and establish orders. Orders may be established through noncustodial parent signature of an Agreement to Support (ATS), which specifies the support amount calculated based on the noncustodial parents finances and is submitted to the court for approval. The child support office prefers handling more cases this way, rather than by legal petition, because paternity and support orders are established sooner, and it is better for arrearage management. However, very few orders are established this way. As an example, for State Fiscal year 2002, statewide, there were 8847 orders established through legal action, and 167 by an Agreement to Support. All available information is entered into the Connecticut Child Support Enforcement System (CCSES).

At this point in TANF and Medicaid cases, the investigator may know the noncustodial parent's ability to provide health insurance from investigating the noncustodial parent's employment and income. For a non-public assistance case, the custodial parent can be interviewed during the application interview, and the insurance status of the children and any possible coverage by either parent can be examined. Otherwise the information may not be known until the noncustodial parent fills out a financial affidavit and both parents are asked about medical coverage, which both take place in court. Child support staff are encouraged to determine coverage before going to court so that they can request an appropriate order from the Magistrate. However, they often are unable to gather sufficient information, which leads to many continuances with some of the Magistrates. Continuances are also necessary when requesting that either parent apply for HUSKY (especially for cases in which the noncustodial parent is self-employed or employed and health insurance is either not available or available at an unreasonable cost), as the parties await eligibility determination.

The IV-D case is brought before the court's Family Support Magistrate[42] by the Assistant Attorneys General. They call on the DSS child support investigator who has worked up the case to testify. Each Magistrate handles the medical support portion of the order differently. The Magistrate must first determine the nature of each parent's health plan or lack thereof. If the child is uninsured, the Magistrate will make a standard order for both parties to provide medical and dental through an employer-provided or union-provided insurance or "another group plan", and the case will come back to court after eligibility is determined for health coverage. A Magistrate may make a general reference to applying for HUSKY by ordering application to "another group health plan," or may specifically order HUSKY. If the custodial parent has already established insurance for the child or returns to court having been found eligible for HUSKY A or B, the noncustodial parent may be ordered to contribute towards the cost of the premiums.

In interviews with three Magistrates in Danbury, we learned that each one defines reasonable cost slightly differently but more specifically than the federal definition. One magistrate said they cap it at 10 percent of gross income and that with low-income obligors this usually works out to $30 per week. Another said they cap it at nine percent of gross income, but agreed it usually works out to $30 per week for low-income obligors. Another Magistrate

[42] Non-IV-D cases are handled by judges.

observed that DSS has been reluctant to impose a single definition of reasonable cost on the courts, and they do not want them to do so.

After the order is established, the child support investigator refers the case to Support Enforcement Services and if the child was uninsured at the time of the order, the parents begin the insurance application process. If the noncustodial parent adds the child to his employer or union policy, he notifies the child support investigator that he has complied. If the custodial parent already has insurance for the child, or returns to court having been found eligible for HUSKY A or B, the noncustodial parent can be ordered to contribute towards the premium costs. The SES support enforcement officer monitors the case to ensure that the noncustodial parent maintains insurance coverage for the child or continues to contribute towards the cost of the premiums, and officer may use any necessary tools to that end (i.e. income withholding, license suspension, etc.).

If the noncustodial parent changes jobs, SES will receive automated notice of the change from the CCSES New Hire database, review the case, and issue a new order for insurance to the new employer. If the noncustodial parent has already established insurance for himself at his new job but not for the child, SES can order the employer to enroll the child on the noncustodial parent's plan. If the noncustodial parent is not enrolled on the new insurance plan, SES can bring the parent back to court for failure to obtain or maintain health insurance. The noncustodial parent will be ordered to enroll himself and the child (if reasonably priced insurance is available from the employer) and bring proof back to the court, or be threatened with jail time. If reasonably priced insurance is not available from the new employer, the noncustodial parent can be ordered to apply for HUSKY. Even if the noncustodial parent's application is rejected because the custodial parent must ultimately apply and provide her income information, the noncustodial parent can present the rejection letter as proof of compliance with his court order.

If the custodial parent adds the child to her employer or union policy or the child is enrolled on HUSKY A or HUSKY B, the case returns to court to arrange the noncustodial parent's contribution towards premiums. If the noncustodial parent fails to contribute toward the premium at any point, SES will file for contempt and bring the noncustodial parent back to court. No contribution from the noncustodial parent may be ordered, if the child is enrolled in a HUSKY plan and a premium contribution would lower the dollar value of the cash child support order.

HUSKY officials noted the importance of coordination with child support officials to working out kinks when the noncustodial parent applies for HUSKY. Unless the noncustodial parent provided all the necessary information about the custodial parent, HUSKY enrollment broker staff rejected the applications on the grounds that they could only take application from custodial parents. HUSKY officials reeducated enrollment broker staff on how to facilitate the enrollment process for IV-D children, such that upon receipt of a HUSKY application from noncustodial parents, staff would send a blank HUSKY application to the noncustodial parent instructing him to send it on to the custodial parent. Alternatively, staff could send a letter to the

custodial parent, directly, requesting that she fill out an enclosed HUSKY application to accompany the one submitted by her child's noncustodial parent.

More recently, there has been additional coordination between HUSKY and BCSE staff over revisions to the HUSKY application. BCSE staff had become frustrated, over the referral of parents applying for public health care coverage for their children to child support enforcement for services. Experts in Connecticut and other states submit that many such custodial parents referred to CSE eschew child support services and do not cooperate in a manner sufficient to "work the case." Thus, the child support caseload becomes populated with unworkable cases. To correct this problem, BCSE officials asked HUSKY officials to add a screening question to the HUSKY application. It not only corrects that problem, but also invites those who might not have thought about receiving full child support services, to consider doing so and indicate their decision. Though still in draft form, and not yet approved by all parties for distribution, the new application contains a section called, *Parents Who Do Not Live in the Household,* which explains under what circumstances a custodial parent must cooperate with child support (when they want HUSKY coverage for themselves) and how they may be exempted from this requirement. It also asks whether the custodial parent would like to obtain services even if they do not want HUSKY for themselves. If the custodial parent agrees to pursue support, they fill out an information chart that asks for the name of the noncustodial parent, name of the child, parent's address, and name/address/phone number of the parent's employer.

Finally, coordination between BCSE and SES seems to be thorough. The flow of cases from BCSE, where they are made "enforceable orders" to SES, where they are "enforced" is smooth, and staff we spoke with in both groups seem to be on the same page both about how the process flows now, and how it will flow with the introduction of the National Medical Support Notice on October 1, 2002.[43]

Current Medical Assistance Operations

If the Magistrate determines that insurance is not available at a reasonable cost, the Magistrate may order the noncustodial parent to apply for HUSKY. To apply for HUSKY, the noncustodial parent calls the 1-800 number of the enrollment broker and a customer service representative takes down his or her pertinent information. The noncustodial parent may proceed with the application over the phone or choose to receive a mail-in application. If the noncustodial parent proceeds by phone, the information is entered onto an application and the pre-printed form is sent to the noncustodial parent for verification and a signature. The application is mailed back and given to an eligibility specialist for processing. If the court order

[43] By October 1, 2001, all states were required to implement the Federal Office of Child Support Enforcement's National Medical Support Notice (NMSN), unless the state needed to pass enabling legislation. NMSN will standardize the information to be shared, timelines, and roles and responsibilities for sharing health insurance information between the child support agency, employers, and health plan administrators. . Subsequent to our early September visit to Connecticut, BCSE planned to initiate on October 1 the National Medical Support Notice (NMSN). The state BCSE has contemplated many changes to process and paper flow necessitated by NMSN implementation, and coordinated with the courts, SES, HUSKY officials, and the enrollment broker, over how it will work.

is not attached to the application or any other information is required, the enrollment broker's customer service representative will request it.

The file receives a noncustodial parent flag in the enrollment broker's computer system, and a blank application is sent to the noncustodial parent to send to the custodial parent. At the parents' request or if there is a restraining order in place, the broker's representative may get the custodial parent's address and information from the child support caseworker, in order to mail the application directly to the custodial parent for completion. Confidentiality of the custodial parent's information is maintained at all times by broker staff, and staff receive regular retraining on the confidential nature of child support information.

Once the custodial parent's application is received, eligibility is based upon the custodial parent's self-declared income and other expense verifications. If the custodial parent does not send back the proper information, the noncustodial parent will receive a denial letter. Or if the child is already enrolled in HUSKY A, the HUSKY B application will be closed and a letter sent to the noncustodial parent. Each of these letters sent to the noncustodial parent may be used as proof that he or she has complied with the Magistrate's order.

If the appropriate information is received from the custodial parent and the case is determined to be eligible for HUSKY A, it is sent to the Presumptive Eligibility Unit in the DSS Central Office for "granting" as a HUSKY A case. The data will be entered into the Medicaid automated system, the system issues the Medicaid/HUSKY A card, and the case file is transferred back to the appropriate local office for ongoing monitoring and redetermination. If the case is eligible for HUSKY B, the enrollment broker handles the case and "grants" HUSKY B.[44] The specialist processes the application and faxes the information to the appropriate managed care organization with a notice that it is a medical support case and that the bills are to be sent to the noncustodial parent. The managed care plan issues its own card to the custodial parent, and the family does not receive a CONNECT card. A determination letter to the custodial parent is automatically generated by the ACS system, and the specialist sends a designated manual letter to the noncustodial parent to inform him of what program the child has been enrolled in, and how much the premium is. He or she is instructed to contact his child support worker with any payment questions. If the noncustodial parent stops paying the premium, the broker's automated system sends a locked-out notice to the custodial parent, indicating that without payment the child's coverage is frozen. This can generate a successful plea from the custodial to noncustodial parent to resume payments, or a call of complaint to the child support worker, who notifies SES to step in and enforce.

Local Variation in the Courts. In Hartford, we had the opportunity to discuss the legislation with three Family Support Magistrates in the Hartford court, including the Chief Magistrate. They pointed to the variation in their courtroom practices. One Magistrate said he

[44] In HUSKY, Level B1 coverage is premium free with modest co-payments to families of four with incomes between $32,653 and $41,477. HUSKY Level B2 coverage requires a $30 per child and $50 per family monthly premium and modest co-payments and is available to families with incomes between $41,478 and $52,950. Level B3 coverage costs between $137 and $200 per month per child in premiums, plus co-payments, and is available to families with incomes over $52,950.

issues "a standard order for medical and dental insurance where available from an employer or union *or other group plan* at reasonable cost." He does not define other group plan, but means for it to imply HUSKY. When asked how the noncustodial parent understands this to be a directive to apply for HUSKY, this Magistrate said that if the noncustodial parent states that his employer does not offer health insurance, or states that it is available at a cost the Magistrate deems too high for the guideline, the Magistrate will suggest looking into HUSKY. He also stated that he often does not have to define it, because the custodial parent usually knows about HUSKY. Finally, he noted that if the case is brought back before him by SES for contempt, due to the noncustodial parent's failure to obtain any health insurance coverage, that is a second chance for the Magistrate to probe and learn that employer-sponsored coverage is unavailable or too costly, and to suggest that HUSKY will fulfill the order for "or other group plan."

This same Magistrate also recognized how difficult it is to ascertain which parent has a better policy, given that only a few minutes may be spent on each case.[45] He said that some policies have very poor coverage for children, usually without dental, and he often has to issue a continuance until the child support investigator can obtain comparative information on custodial parent or noncustodial parent policies as compared to HUSKY.

A second Magistrate stated that, contrary to the practice of the first Magistrate, he far more frequently orders the noncustodial parent to reimburse the custodial parent (or the state) for HUSKY premiums, once the custodial parent applies for HUSKY and is found eligible. But he noted that this involves some complicated math, because in gauging his order against the guidelines, he must combine the cost of premium reimbursement with the cost of unreimbursed medical expenses. Unlike the first Magistrate, this second Magistrate rarely issues continuances, but rules with the information on health insurance presented at the first hearing.

Both of these Magistrates and the Chief Magistrate were critical of the language in statute that established SCHIP that sets up an inequity between the way the guidelines handle noncustodial parent employer-sponsored health insurance coverage and the way the Public Act directs Magistrates to handle noncustodial parent reimbursement of HUSKY premiums. The guidelines take net income, establish a basic child support obligation, and allow for a deduction from the basic obligation for child's health insurance premium if the noncustodial parent is a low-income obligor. The statute permits the Magistrate to order the noncustodial parent to reimburse the state or the custodial parent for HUSKY premiums, but "In no event may such order include payment to offset the cost of any such premium if such payment would reduce the amount of current support required under the child support guidelines."

[45] The Magistrates informed us that while their caseloads have increased dramatically since 1991, and pro se cases have increased 50 percent in that time, there has been no authorization to increase the number of Family Support Magistrates since 1991. One Magistrate estimated that if he were to consider everything he was supposed to consider on a given case, and think it all through before ruling, he would get through six cases per day. Instead, for example, he hears 75 to 80 requests for modification, alone, on Fridays.

Funding Sources and Amounts

No new funding was authorized or appropriated for these practices. The activities were absorbed into regular IV-D administrative costs, the regular judiciary/court expenses, and into the administrative costs in the judicial branch's SES. Thus, medical support ordering and enforcement activities are funded with the 66 percent FFP and 34 percent state funds.

Minnesota's Bonuses Paid to Counties for Enforcement of Medical Support

The principal initiative studied in Minnesota is a statutory requirement and practice wherein the state pays $50 to each county for each child in a public assistance case (receiving cash assistance or medical assistance) in which a private health insurance order is successfully enforced. This bonus payment is made for each child in a child support case and each time in the course of a year that a private health insurance order is enforced. Thus, if a noncustodial parent with three children on public assistance changes employers three times in a year, and each employer is found to have reasonably priced dependent health insurance available to the noncustodial parent in which the medical team assures enrollment, the county will earn $450 in medical health insurance bonus money that year for enforcing that single noncustodial parent's medical support order.

Organization of Agencies

Minnesota's Department of Human Services supervises both the child support and public health care programs. Child support operations are supervised by DHS' Economic and Community Support Strategies division, while Medicaid and MinnesotaCare[46] as well as the SCHIP program are supervised by DHS' Health Care Administration.

Unlike most other states, however, Minnesota counties have a major role in administration, partly because they contribute financially to human services administration and benefits. The result is that child support enforcement and medical assistance programs are state-supervised but county-administered. Some describe the county social services agencies as virtually autonomous entities from their state agency, though the state agency provides oversight and intervenes when there are problems. Thus, much of the implementation and operation of medical child support coordination must be understood from the county level. We visited one of the three integrated service centers in Dakota County for this study of promising practices. Dakota County is the third most populous county in the state.

[46] The state provides health insurance coverage for children under age two living at or below 280 percent of the federal poverty level (FPL) and for children age two and up and their parents living at or below 275 percent of FPL, through their MinnesotaCare program. This program began in 1992. As a result, and because the program could not be grandfathered into SCHIP, the state has a very small number of children enrolled in SCHIP.

Goals, Origins and Implementation

Goals. In Minnesota, the goal of medical support coordination and enforcement of it is to help families become more self-sufficient by obtaining *good* health insurance coverage for children. And they stress that good coverage, which ideally means combining private coverage and Medicaid for a child, can lower public costs as compared to Medicaid alone, because the private insurance or the non-custodial parent's contribution to the premium for Medicaid's managed care plan, can lower the state's contribution to public coverage premiums. More specifically, the goal of county bonuses is to raise medical child support enforcement and coordination around it to the same level of priority among county child support workers as is establishing paternities and child support orders, by making success in medical child support enforcement fiscally remunerative.

It is important to note that the stated goals of all the participating agencies are in line with the overall goals of the practice itself. The state Department of Human Services (DHS) mission statement says that the Department works with many others to help people meet their basic needs so they can live in dignity and achieve their highest potential. In order to achieve this, the agency emphasizes its partnership with Minnesota's counties. DHS views this partnership as essential to finding innovative solutions to problems, delivering services, and serving taxpayers' desire for cost-efficient and effective government. As shown in Exhibit B, Minnesota is the only county-administered state we visited and one of the few states that require counties to contribute financially to human services administration and benefits.

Officials we interviewed in the Policy and Planning Unit of CSED report that the mission of that agency is to establish paternity, establish support orders, and enforce those orders for children. Every child support order in the state must include an order for basic cash support, one for medical support, and, if appropriate, one for child care support. With respect to medical coverage, officials stressed that the philosophy and goal of the state is to obtain *good* health insurance coverage for children – that this is the right thing to do for Minnesota's children. But they also stressed that the state can meet the goal of good coverage for children (i.e. obtain some private coverage while leaving open a Medicaid case for that child) and still lower public costs. CSED is developing a new strategic partnership plan, but it is not yet available for public review.

Officials in the Health Care Eligibility and Access unit of the Health Care Administration in DHS also noted that the philosophy and goals of their Administration is to "cover kids" – i.e. children are entitled to good health care coverage. An original goal of Governor Ventura's administration was universal coverage for children. However, dramatic revenue shortfalls in 2002 caused serious mid-year budget cuts, and he was forced to retreat from that goal.

State health care staff also pointed to their strong partnerships with counties on outreach. And they noted a $750,000 annual grants program to community-based organizations for outreach to potential Medicaid and MinnesotaCare enrollees.[47] Interviewees in Health Care

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[47] Minnesota had a subsidized health insurance program for the low-income population who cannot afford many private policies well before the enactment of SCHIP. Called MinnesotaCare, this program began in 1992. As a result, and because the program could not be grandfathered into SCHIP, the state has a very small number of

Eligibility and Access observed that the mission of covering the maximum number of children possible with health insurance can be overridden in some counties, where worker's traditional role has required them to memorize the eligibility rules and screen clients out from public coverage. To overcome this disparity between the state's philosophy and some counties' philosophies, two efforts are underway. The Health Care Administration has instituted a Steering Committee of County Directors to design a health care program delivery system that improves access and outreach for all Minnesotans. Second, the state plans to fully automate medical assistance eligibility determination in a Web environment over the next year, so that county medical assistance staff no longer have to memorize and exercise the eligibility rules. This move is seen as one that will open county doors wider to eligibility and enrollment in public health insurance.

Origins of Practice. Minnesota's practice of paying bonuses to counties for enforcement of medical child support orders traces its origins to a precedent for state bonuses to counties on other performance standards, and to a 1990 conversation between a Dakota County child support agency official and the state child support director. At that time, counties in Minnesota received bonuses for some of the same accomplishments that states now receive incentive payments from the federal government –paternities established, orders established – as well as for orders modified. No bonuses were paid for medical support. The county official remarked to the state director that the state's policy was for counties to go after medical as well as cash child support, but that counties tended to focus on activities for which incentives were paid. The county official urged that bonuses be added for medical support enforcement in order to get county staff to pay attention to that task and in order to demonstrate to the County Board of Commissioners (appropriators of county funds to child support administration) the return on investment of resources in medical support. The state director approved the idea, directed the department to draft a legislative proposal, and a statute was adopted in 1990.

Implementation. In October 1990, DHS issued instructions[48] to all Boards of County Commissioners, the Director of each County Agency, and the Child Support and the Medical Assistance supervisors in each county, directing them on implementation of the new medical support bonus program. This memo included definitions, methodology for calculating the bonus due, how information would be entered into the child support automated system for counties linked to that system, and how information would be entered manually for counties not linked to the system. It specified how and when counties would report data to the Commissioner of DHS on the number of cases receiving medical assistance as a ratio of the number of cases in which the court has established an obligation to provide medical coverage.

At the state level, coordination occurred between child support and Benefits Recovery staff in the Health Care Administration. This was necessary because the policy called for bonuses to be paid only for children with medical child support orders that are established and enforced *after* a family had a public assistance case opened. Thus, Benefits Recovery staff had

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children enrolled in SCHIP. In 2000, the latest year for which data were available, there were 363,605 enrollees in Medicaid, 123,365 in MinnesotaCare, and 24 in SCHIP. Thus, this report refers frequently to MinnesotaCare – a SCHIP-like program – rather than SCHIP.

[48] Instructional Bulletin #90-75G

to verify on a quarterly basis that the medical assistance case was receiving private health insurance coverage during the quarterly bonus period.

In Dakota County, meetings were held between the child support director, supervisors and caseworkers and their counterparts who conduct integrated eligibility determinations and case management for the welfare, Medicaid, Food Stamps, Emergency Assistance, and General Assistance cases. Child support staff educated those integrated workers to encourage them to do paper referrals of public assistance cases to child support in instances where the medical assistance application indicates there is a non-custodial parent. In particular, child support staff impressed upon the other programs' integrated workers that as soon as the family is enrolled in public coverage and the application noted a child has a parent not living with them, the case should be referred to child support. This will trigger an investigation into private coverage in order to secure coverage or a premium reimbursement.

In the early years, the state to paid each county a dollar amount per case according to the percentage of cases in which a medical support order was enforced. Counties that exceeded 80 percent of their cases with medical support orders enforced, earned a $25 per case bonus. For counties that successfully enforced between 50 and 80 percent of cases, the bonus amount was $20 per case; and for counties below 50 percent, the per case bonus was $15. This was laid out in the instructions described above. In 1994, the policy was changed to $50 per case across the board.

Current Routine Child Support Operations

In Minnesota, medical support statutes establish that the courts are to order the parent with the better group dependent health and dental insurance coverage or health insurance plan to name the minor child as a beneficiary. Private coverage through a group, employer or union is preferable. However, if dependent health insurance is not available to either the noncustodial or custodial parent, the court may require one of three options for the noncustodial parent: 1) to obtain other dependent health or dental insurance, 2) to be liable for reasonable and necessary medical or dental expenses for the child, or 3) to pay $50 per month to be applied to the medical and dental expenses of the child or to the cost of health insurance dependent coverage. This amount is added to the guideline amount for cash support. If the available dependent insurance does not cover all reasonable and necessary medical or dental expenses of the child, the court may require the noncustodial parent, depending on his or her financial ability, to be liable for a portion or all of these expenses.[49]

The following describes routine operations in Dakota County for either a child support case with a new order, or a case in which the office has just been notified of a new hire[50]. It is important to note that this description does not pertain to operations in all counties. In an effort to equitably distribute the responsibilities for medical child support, Dakota County maintains a

[49] Minnesota Statute 518.171 Medical Support

[50] The PRISM system, the automated child support case and financial management system, automatically notifies workers of new hires, because there is a data match between the state's New Hire Database and PRISM.

staff of regular child support workers and two separate medical support specialists who conduct all of medical support coordination and enforcement activities.

To determine if it is appropriate to pursue private coverage, the child support worker reviews the case and determines that certain conditions exist: 1) the noncustodial parent has been ordered to carry insurance for one or more children in the case; 2) no current insurance information exists in the child support automated system; 3) the noncustodial parent has a current employer or is currently paying; and 4) a current address for the noncustodial parent is available in the child support automated records. The worker also assures that appropriate information for insurance is in the current order and any wage information they have available is entered in the system.

Once the child support worker has verified this information, one of the team's two medical specialists sends out a form letter to the noncustodial parent, within two days of a new hire report or within 30 days from the effective date of a court order, reminding him of his court ordered obligation to provide health insurance coverage. This form letter is called the Notice of Medical Support Obligation and Enforcement. The medical specialist also sends a form letter to the employer's human resources contact to determine what insurance if any is available. If reasonable coverage is available but not in place, he/she sends out an order to the employer to enroll the child or children on that insurance. If insurance is in place or obtained, the medical team will verify the information with the insurance company and enter the policy information in the system. The specialist then notifies the regular child support caseworker, gives them the insurance information, and advises them to review the case regularly to watch for job jumping or multiple orders in multiple counties.

However, if there is no insurance available to the noncustodial parent or it does not seem to be available at a reasonable cost[51], the medical team specialist sends the referral back to the child support worker who determines the next step which can include asking the court to modify the medical provisions of the order by ordering an alternative such as a dependent-only policy through an independent insurer or medical support payments to be applied to insurance premiums, medical expenses, or reimbursement for Medical Assistance or MinnesotaCare expenditures.

Current Routine Health Agency Operations

When a parent applies for Medicaid or MinnesotaCare in the Dakota County office, they are given the integrated Minnesota Health Care Programs Application.[52] If they indicate on that application that one or more of their children have a parent not living with the child, they are

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[51] An exact measure of reasonable cost is a county decision. In Dakota County, workers consider it to be 5 percent of gross monthly income.

[52] All counties take applications for Medicaid on a single, integrated application form for all medical assistance programs in Minnesota. With MinnesotaCare, counties can opt to take applications in the county service center or not. Dakota County is one of approximately 35 of the 87 counties in the state that have opted to take applications. In the remaining 52 counties, the applicant mails the application to the state office. If the applicant is found eligible for MinnesotaCarte and there is noncustodial parent indicated, the applicant is referred back to county medical staff to initiate the coordination with child support enforcement for private medical child support.

given or mailed a child support questionnaire to fill out, which they have 30 days to return. The application is processed and approved or denied whether or not the child support questionnaire has been returned. If the application is approved, the Medicaid card will be issued. If the parent never returns the child support information, the child remains eligible for Medicaid but the parent will be removed from the case. If the mother is pregnant, regardless of her compliance with the requirement to cooperate with child support, she will remain eligible for Medicaid through her pregnancy and six weeks following birth.

If appropriate, the child support referral is made right away even before the 30 days of waiting for the custodial parent's information has passed. When the Medicaid or MinnesotaCare application is approved for a household that includes a referral child, an electronic referral is sent to the child support worker via an automated file exchange. If the case is a Medicaid-only public assistance case, the worker will contact the custodial parent to ask if she only wants medical child support enforcement, or full child support services.[53] Very often, the custodial parent will exercise her option to have full child support services.

Once the referral is made, the medical assistance management information system is automatically updated when the child support enforcement agency finds (or enrolls the child in) a heath insurance plan. At this point, the medical assistance worker looks at the policy (i.e. co-payments, coverage, deductibles) to determine if it is appropriate. The medical assistance worker may determine that the dependent should be simultaneously covered by Medicaid or MinnesotaCare and private coverage. If this is the case, the custodial parent will be sent a letter notifying them to use the private coverage as primary and medical assistance as secondary.

Minnesota has increased the value it receives in its health care programs through managed-care purchasing because of savings that result from medical child support. The state contracts for capitated monthly rates with prepaid health plans for Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare recipients. Most of the enrollees in Minnesota's three health care programs are in managed care. State staff annually summarize revenues collected on behalf of children on Medicaid through third party liability. Because the amount of third party payments is continuously tracked for all Medicaid HMO's, the state is able to use that information to negotiate lower capitation rates with HMO's in subsequent years.

Role of Coordination between CSED and DHS. Coordination between state CSED and the Health Care Administration occurs on several additional fronts. When the state legislature in 2000 asked the Department of Human Services to develop recommendations on medical support statutes for the 2001 legislative session, DHS formed a Medical Support Workgroup composed of a wide range of stakeholders. These included representatives from the Health Care Administration (Medicaid and MinnesotaCare) the state Council of Health Plans, the Department of Health, DHS' Benefits Recovery, the Insurance Federation of Minnesota, employers, and the

[53] The state DHS maintains a Joint Committee on Good Cause Exemptions, whose purpose is to review documentation accompanying MinnesotaCare applications for good cause exemptions from the requirement to cooperate with child support enforcement, where the applicant is claiming domestic violence or other appropriate reasons as the grounds for not cooperating.

counties. They met several times and developed consensus recommendations in their final report issued in December 2000.

As of the end of 2002, the state was conducting a competition for further study of the role of the child support program in increasing access to medical coverage for children. The RFP seeks, as one of the study's principal outcomes, an analysis of communication and coordination between the child support program and health care assistance programs, and recommendations for improvement.

The state DHS maintains a Joint Committee on Good Cause Exemptions, whose purpose is to review documentation accompanying MinnesotaCare applications for good cause exemptions from the requirement to cooperate with child support enforcement, where the applicant is claiming domestic violence or other appropriate reasons as the grounds for not cooperating. The committee is made up of representatives from the TANF, medical assistance, and child support programs. They meet bi-weekly to rule on good cause claims. Counties maintain similar joint committees to review TANF, Child Care Assistance, and Medical Assistance applications for good cause exemptions.

Finally, respondents from both the health and child support divisions in DHS pointed to the strategic plan that is under development and the greater emphasis that it will place on coordination and partnerships between medical assistance, child support enforcement, child care, employment services, and TANF, and between the state and its county offices.

Funding Sources and Amounts

Funding of the whole child support program's administration in Minnesota comes from a combination of a state appropriation, the 66 percent Federal matching funds allocated to states, much of which the state CSED passes through to counties, federal incentive payments, and the county's own funding appropriated by the Board of Commissioners. The state also passes on much of what it earns in federal incentive funds to the counties, in return for their performance on the OCSE 157 Annual Data Report.

Funding of the state bonus program, for all four types of bonuses, comes from a state appropriation. Since 1996, the Dakota County statistician has been tallying total earnings from all bonuses. In that year, total bonuses were $79,550 and medical support bonus payments totaled $18,050 of that total. By 2001, total bonuses had grown to $145,800 and medical support bonuses represented $22,000 of that total.

At the state level, it was reported that for 2001, the state paid out to counties $3,794,728 in total bonuses, of which $381,150 (about ten percent) was paid for medical support bonuses.

Texas SCHIP Outreach to the Child Support Program through TexCare

TexCare is an umbrella campaign, established by the Health and Human Services Commission (HHSC) in concert with the passage of SCHIP legislation in May 2000, that allies several state government agencies with private sector companies, community-based organizations, and Texas' families in order to raise awareness of options for children's health insurance in Texas. It provides education and marketing for SCHIP, Medicaid, and private health insurance, to ensure that Texas' children have health care coverage. The Office of the Attorney General (OAG) and the HHSC maintain a collaborative relationship through the TexCare initiative in order to integrate TexCare outreach and Title IV-D activities. This coordinated effort, referred to as the Title IV-D Outreach Project, is an integral part of the effort of Texas agencies to increase the number of children who have health care coverage.

A secondary piece of Texas' initiative is its comprehensive medical support legislation. For many years, Texas law has contained extensive provisions concerning the medical support portion of a child support obligation. More specifically, it contains a priority scheme that guides the courts in determining the manner in which medical support should be ordered. However, in 2001 the Texas Legislature examined the issue of uninsured children in the state and made several amendments to the Family Code that served to strengthen those provisions.

Organization of Agencies

The Health and Human Services Commission (HHSC) has oversight responsibilities for designated Health and Human Services Agencies such as the Department of Health and the Department of Human Services[54], and administers certain health and human services programs including the Texas Medicaid Program, State Children's Health Insurance Program (SCHIP), and Medicaid waste, fraud, and abuse investigations. While operations and claims processing for the Medicaid (as well as SCHIP) program reside in the HHSC, Medicaid eligibility determination, acute care and EPSDT are located in the Department of Human Services. DHS is also the agency responsible for TANF and Food Stamps.

Entirely separate from HHSC is the Texas Office of the Attorney General (OAG). Led by the Attorney General, the agency has four Deputy Attorneys General for Child Support, General Counsel, Litigation, and Criminal Justice. Under the Deputy Attorney General for Child Support, the key person involved with TexCare is the General Counsel for Child Support.[55]

[54] The Texas Health and Human Service Agencies include not only the Texas Health and Human Services Commission and the Department of Health, but also the Department of Human Services, Department of Mental Health and Mental Retardation, Department of Protective and Regulatory Services, Department on Aging, Commission for the Blind, Commission for the Deaf and Hard of Hearing, Commission on Alcohol and Drug Abuse, Rehabilitation Commission, Interagency Council on Early Childhood intervention Services, and Health Care Information Council.

[55] The person holding this position for the past several years and integrally involved with the TexCare Partnership departed her position the week before our visit. However, her successor has been with OAG for many years, and the Deputy General Counsel was closely involved with the predecessor General Counsel and with the successor. She and the new General Counsel participated in our interviews.

Other units under the Deputy Attorney General for Child Support are the Administrative Law Judge Section, Administrative Operations, Field Operations, Information Technology, Program Monitoring, and Program Operations.

Goals, Origins and Implementation

Goals. The TexCare Partnership, now simply called TexCare[56], is fundamentally about coordination between agencies in order to increase the number of Texas children who have health care coverage. More specifically, the goal of TexCare, as an outreach and education campaign, is to provide access to children's health insurance options by providing information and educating the public about SCHIP, Medicaid, and private health insurance.

The more specific collaboration between the OAG and HHSC has three specific goals: 1) To increase the number if insured children in Title IV-D; 2) To integrate TexCare outreach and Title IV-D activities; and 3) To provide affordable options for low-to-moderate income noncustodial parents.

The amendments made to the Texas Family Code during the 77th Legislative Session were made in order to provide policy guidance to the courts when fashioning medical support orders. [57] The changes were also intended to clarify the various health care options available to the courts and to streamline the medical child support process by including Medicaid and SCHIP in the establishment process and requiring parties to disclose health care coverage details. Previously only private health insurance was considered, and there was no specific disclosure requirement.

Origins. The Texas legislature had already adjourned in May 1997 when SCHIP was passed into law, so legislation concerning the state-designed SCHIP program could not be enacted until the next session.[58] The Texas Department of Health, HHSC, and staff from the Legislature and the Governor's office began designing SCHIP as soon as the Federal legislation was passed, and used the time available before the next legislative session to prepare the state legislative package. Staff contacted other states that had implemented SCHIP earlier to find out what was working and what was not.

The agencies also continuously sought public input through statewide town hall meetings in late 1998. By the time the legislature reconvened, there was enormous grassroots support for the program including major support from the statewide SCHIP Coalition, which consisted of advocates, associations of hospitals, medical and dental personnel, pediatricians and rural health representatives, and legal groups. Public support combined with support from Governor Bush and Lieutenant Governor Perry as well as the possibility of funding the program with the state

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[56] TexCare was originally called the TexCare Partnership. It was recently changed because the 'Partnership' part of the name seemed to be confusing to consumers.
[57] Amendments made changes to Sections 101.015, 154.181, 154.182, 154.188, and Section 32.025 of the Human Resources Code.
[58] The Texas legislature convenes in alternating years, not annually.

government's proceeds from the Texas settlement with the tobacco industry created an unusual environment of support for the SCHIP legislation.

In May 1999, the 76th Texas Legislature passed a bill[59] authorizing the creation of SCHIP. The Texas Healthy Kids Corporation that had partnered private health insurance companies and health maintenance organizations to offer private health insurance to low-income Medicaid-eligible children was dissolved and slowly phased out because over 95 percent of its enrollment was estimated to be eligible for SCHIP.

TexCare was created in response to the rollout of SCHIP. Under the TexCare Partnership brand, fifty diverse CBOs were awarded contracts to do outreach across Texas including county health departments, non-profit organizations, religious organizations, and local health clinics. Each organization was given TexCare educational materials that could be adapted to best fit their particular grass-roots effort and the predominant language spoken by their target population. The CBO's worked with SCHIP to set specific goals and performance measures and to propose specific outreach activities. Outreach efforts were launched in early spring 2000, and SCHIP enrollment got into full swing a couple of months later.

Due to interest in the state legislature, there was strong support for outreach efforts specifically for uninsured children from the child support caseload. This involved closer collaboration between HHSC and OAG. The collaboration was not required by the legislation, but it was clear that SCHIP would be relevant to the low-income population in the IV-D caseload. HHSC and OAG had already established a relationship because of the Texas Healthy Kids initiative and the mandatory child support referrals of TANF clients applying for Medicaid. However, a more active partnership was established in 2000, and in March 2001 the two agencies entered into an interagency contract. This formalized the OAG's outreach activities and the specific types of information exchange that would occur including the transfer of the CHIP enrollment file. That allows the OAG to track IV-D children who have been enrolled in CHIP and identify children who do not have health coverage identified.

As part of the state's commitment to addressing the health insurance needs of children, the Legislature amended the Texas Family Code. For many years the priority among Texas courts was to establish and collect on cash support orders, with little focus on medical support. In 2001, the Legislature seriously re-examined provisions and passed new legislation that has made medical support a more visible issue and medical support orders more enforceable.

Implementation. Education for staff in all of the agencies concerning the TexCare and more specifically about the new SCHIP program was the main focus in Spring 2000. Staff from TexCare CBO's, SCHIP, and the OAG began the process of training the judiciary, attorneys, staff involved with child support in HHSC and OAG, medical staff, and parents.

OAG and HHSC staff both received training and provided outreach. TexCare brochures were mailed to all child support field offices for delivery to courthouses, and presentations were made at the annual meetings of both the Child Support Division Managers and the Child Support

[59] Senate Bill 445

Division Attorneys. Both agencies also sent staff to do training about TexCare in local child support field offices and local DHS offices. Those offices in turn sent letters to and met with local schools, county health boards, and hospitals. TexCare applications and posters were placed at numerous locations for parents to complete.

An article was published in "In Chambers," a publication for judges, about SCHIP and TexCare. OAG staff made presentations about SCHIP and TexCare to various groups of county judges and at the Title IV-D Masters[60] annual meetings. They also provided family law judges and Title IV-D Masters with SCHIP brochures, sent a direct mailing to all 40 Title IV-D Masters and 100 Family Court Judges, and provided direct localized SCHIP training to Masters and Judges. OAG staff made separate presentations to the Presiding Judges of the Administrative Judicial Regions who in turn provided the information to the judges in their respective regions. OAG staff also worked with the Texas Center for the Judiciary to distribute information about SCHIP and TexCare to all statewide and regional judicial conferences.

For attorneys, an article was published in the State Bar Newsletter, an internet link created from the State Bar website to the TexCare website, and information distributed at the Marriage Dissolution Institute in Fort Worth and at the Advanced Family Law Conference. Local Bar associations received presentations about TexCare, and staff and attorneys working for the Department of Protective and Regulatory Services (the locus of child welfare services in Texas) were given TexCare brochures to give to relative caretakers of foster care children.

The OAG together with the HHSC initiated specific efforts to reach parents of uninsured children and more specifically uninsured children receiving child support also began in earnest. Activities employed included the production and distribution of brochures, airing of radio and television public service spots, articles written for publications read by those constituencies, information packets for distribution at their conferences, direct mailings to each constituency, internet links between TexCare's and each group's web sites, and the opening of application assistance offices via contracts between HHSC and Community-Based Organizations (CBOs) in 30 of Texas' 254 counties. Special outreach attempts were also directed at custodial parents. TexCare applications were also mailed to 80,000 custodial parents from existing child support cases where the noncustodial parent had been ordered to, but not supplied, health care coverage for his children. Some custodial parents objected to this because they felt that the noncustodial parents should provide private health insurance for their child or children. Different outreach methods for custodial parents were employed after this first attempt. For instance, the OAG created TexCare Partnership information packets to send to custodial parents in all new Title IV-D cases.

Changes to the Texas Family Code and Human Resources Code. Texas law has for many years provided a priority scheme for courts to use to determine how to order health care coverage for the child. These five priorities are written into the family code, which was updated and strengthened by the Legislature in light of the new health care coverage options available and the renewed focus on increasing the number of Texas children who have health care

[60] Special Court Masters, rather than judges, hear all IV-D child support cases in Texas. Masters are appointed, while judges are elected.

coverage. If insurance is available through the obligor's employment or union at a reasonable cost, which is defined in state statute as "the cost of a health insurance premium that does not exceed 10 percent of the responsible parent's net income in a month," the court orders the obligor to add the child to the policy. If the insurance is not available through the obligor's employment or union but it is available at a reasonable cost through the obligee's employment or union, the court orders the obligee to add the child to the policy and the obligor to pay additional support to the obligee for the costs of the insurance. If insurance is not available through either parent's employment or union, the court orders the obligor to provide insurance from another source if it is available at a reasonable cost. If neither parent has access to health insurance, the court orders the custodial parent to apply for benefits under a public medical assistance program (Medicaid and SCHIP). If the child is eligible, the obligor is ordered to pay additional support to the obligee for the cost of the health care coverage. If none of these options are viable, the court orders the obligor to pay the obligee an additional "reasonable amount" each month as medical support.

In accordance with the above changes, additional language stipulated that a parent who fails to provide court-ordered health insurance is liable for the necessary medical expenses of the child regardless of whether the expenses would have been paid by the insurance, and for the cost of insurance premiums that the obligee has incurred on behalf of the child.

In addition, a new provision amended language relating to the issuance of medical support orders. It established that before a hearing on a temporary or final order, the parties involved in the proceeding must disclose several details concerning the health coverage status of the child. If the child is covered by private health insurance, the parties have to submit the plan information. If there is no private health insurance, the parents must state whether the child is on Medicaid or SCHIP, the cost of the premium, and whether either parent has access to private health insurance at a reasonable cost. If there is insurance in place for the child when rendering a temporary order, the court will, except for good cause shown, order that insurance continue pending a final order. When rendering a final order, except for good cause shown, the court requires that the parent ordered to provide health coverage produce evidence that steps have been taken to secure coverage or that coverage has been secured.

The Legislature also clarified the definition of health in Human Resources legislation as coverage that provides basic health care services (i.e. physician services, office visits, hospitalization, etc.) that may be provided through a health maintenance organization or other private or public organization (including SCHIP), other than medical assistance. (Medicaid). [61] In essence, this change was a technical correction and textual amendment to clarify the legislation's intent. Instead of having a 'Provision for Health Insurance' in the Family Code, there is instead, a 'Provision for Medical Support' that treats health insurance coverage and coverage by medical assistance under the state Medicaid plan differently. These specific types of coverage are to be treated differently and ordered separately by the court using the five priorities.

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[61] HB 1365, Section 101.015

Further legislation simplified the application process for Medicaid and SCHIP.[62] The critical changes require a single consolidated application for a child under age 19 for Medicaid and SCHIP, permit the application to be submitted by mail instead of through a personal appearance at a department office, and simplify recertification. Before SCHIP was implemented, the medical assistance application was one page front and back, but after the legislative changes requiring SCHIP and Medicaid to be on the same application, the length of the application grew. The previously conceived application had removed questions about income and paternity because focus groups felt it was invasive, but with Medicaid on the same application those questions had to be returned to the form. However, the form change was viewed positively because it streamlined the application process. Previously, when the questions were removed from the application and a case was found to be Medicaid eligible, the applicants were sent a separate form with asset questions, but many people never returned those forms and were never granted Medicaid eligibility. The hope is that fewer applicants will now fall through the cracks, increasing the likelihood of medical child support enforcement.

Taken together, these legislative changes prioritized and strengthened the medical support provisions. The OAG Child Support Division responded to the legislation by creating several new forms for the court process. Every new applicant for child support services, other than custodial parents whose children are on Medicaid, receives the form "Important Information about Children's Health Insurance Program." The "Health Insurance Information Needed for Court" form goes to parties who are scheduled for a court hearing, and the "Health Insurance Availability Form" is to be completed and filed with the court in every legal action where child support or medical support are addressed. This series of forms is meant to establish the health insurance status of every child before the case enters the courtroom, so that the Master can make the most informed decision concerning medical support.

Staff from the OAG put on a seminar in the summer of 2001 at the University of Texas Law School to go over the amendments to Section 154 with IV-D Masters. The new legislation was also discussed at the Advanced Family Law Course and the Annual Title IV-D Master Conference.

Current Routine Child Support Operations

The following describes routine operations for a new child support case, and the interactions that case will have with TexCare. When a custodial parent contacts the OAG Child Support Division or is referred by the Department of Human Services (DHS) in order to establish a child support order, they will be informed about TexCare by child support staff. They may also hear about TexCare because the call center's number is listed on the OAG's call menu. Also, a form entitled "Important Information about Children's Health Insurance Program" is sent to the new applicant, unless they are already receiving Medicaid.

In preparation for taking the child support case to court, the "Health Insurance Information Needed for Court" form and the "Health insurance Availability Form" are sent to both custodial and noncustodial parents. This form is filed with the court every time a child

[62] SB 43 amended Section 32.025

support or medical child support order is addressed in court. In general, many times parents do not fill out the insurance availability form and OAG staff must follow up with the parents in order to establish the state of the child's health coverage before the court date. If the information has not been gathered by the court date, the information will be obtained during the proceedings, sometimes even by calling the employer's human resources department from the courtroom.

When the case comes before the Title IV-D Master, the court uses the five priorities (see Changes to the Texas Family Code and Human Resources Code Section, above) to determine the best solution for health care coverage. In addition to addressing new orders, IV-D Masters also handle requests to modify orders. This may include orders that contain the previous legislation's language that the noncustodial parent must carry the health insurance, and so the medical support issue must be re-visited. IV-D Masters are also seeing more motions for enforcement of medical support since it has become a more visible issue in child support cases. If the noncustodial parent is behind in payments for medical support, the court may determine that the parent is in contempt. There may be a medical arrearage determined and an interest rate of six percent may be added to the amount owed (this rate used to be 12 percent).

Current Routine Health Agency and Contractors' Operations

Custodial parents may apply for TexCare by calling the state's contracted enrollment broker at their call center, by coming in to fill out an application at a local CBO or human services office, by working with CBO staff to fill out an application and send it in, or by downloading the forms off the internet and sending them to the enrollment broker. Broker staff feel that the number of noncustodial parents attempting to apply for coverage has decreased substantially since the new legislation was passed. However, when they receive noncusotidal parent calls, broker staff explain the process and send out an application to the custodial parent if the noncustodial parent provides them with address information for the custodial parent. When the enrollment broker receives the application, it is prepared for eligibility determination and screened for completeness.

All documentation is electronically scanned, so that staff in the enrollment division can continue the eligibility determination process using electronic information instead of paper, which lessens the chance of misplacing verifications. If the application data are complete, the eligibility is calculated through the electronic system. If the application is incomplete, the family is sent a request to provide the missing information to complete the application. If the family returns the necessary information, the eligibility is determined. If there is no response from the family concerning the needed information within 90 days, then the application is "timed out."

If the case appears to be Medicaid eligible, the self-declared asset questions are examined. If it still appears to be Medicaid eligible, the application is forwarded to the Department of Human Services (DHS). This referral occurs through an electronic interface between the enrollment broker's automated system and DHS's automated system. The case information is also sent via an overnight delivery service to local DHS offices across the state based upon ZIP Code, and the local DHS caseworkers make the final Medicaid determination. If

DHS determines the applicant Medicaid ineligible due to additional information, the case will be sent back to the enrollment broker's system through the interface.

If the applicant is not Medicaid eligible but is SCHIP eligible, the enrollment broker's system automatically generates a SCHIP enrollment packet that is sent to the family. The family completes the enrollment form and returns it to the broker. If an initial premium/enrollment fee is necessary, the enrollment broker requests that the payment be sent to a bank in Dallas designated to receive these payments. If the payment comes back to the enrollment broker, instead, finance department staff can manually enter the information. The broker receives a file every day from the designated bank in order to match cases with premium payments.

If the child is not eligible for SCHIP or Medicaid, the family is sent a Commercial Insurance Resource Guide published by the Texas Department of Insurance that describes other insurance options. If the child is eligible for SKIP – the insurance program for state employees' children -- the application is referred to the Employee Retirement System of Texas. There is also a box to check on the application if the parent wants a referral to OAG. However, there is currently no system in place for the enrollment broker to actually make an automated referral, but there are plans to fill this gap.

The broker receives a data file monthly from the OAG, assembled by a separate contractor to OAG, containing the names and addresses of the children and custodial parents for cases where the noncustodial parent has been ordered to provide health insurance, but such insurance has been found to be not available because: 1) the employer or union does not provide dependent insurance coverage; 2) the noncustodial parent is ineligible for the insurance coverage; or 3) the insurance is not available at reasonable cost to that parent. The enrollment broker sends these families a letter on OAG stationary explaining that OAG has no records of insurance coverage for the child. The letter supplies a number to call for parents whose children have coverage, so that they can give the policy information to the OAG. For parents whose children are not covered, the packet includes a TexCare application so that the custodial parent may apply for SCHIP and Medicaid.

Local Child Support Agency and TexCare Community-Based Organization Operations. The local site visited for this study was Bexar County, home to one of the three largest cities in Texas – San Antonio – as well as outlying areas that include suburbs and sparsely-settled rural areas. Bexar County has two Title IV-D Masters. One Master travels out to rural areas to hold court sessions, while the other remains in San Antonio. There are six OAG offices in San Antonio itself, one interstate office that handles approximately 12,000 to 16,000, one non-TANF office that handles 10,000 cases or less, and four other large offices that handle between 25,000 and 32,000 cases each. Staffing varies across the large offices but in one of them, thirty child support investigators handle approximately 30,000 cases. Only the Assistant Attorneys General deal with the medical support orders for each case, though, rather than child support investigators.

The medical child support process in Bexar County has been evolving. For many years, the focus was only on cash support payments but now there is a growing emphasis on medical

support that reflects the growing emphasis statewide in Texas. Approximately 30 to 50 percent of the IV-D cases that come before the IV-D Masters have private coverage through employment, though this varies by place of residence, and approximately 80 percent of the cases are current or former TANF clients or Medicaid referrals. OAG staff estimate that 90 percent of the noncustodial parents in the caseload are employed but many are with small employers in the area who do not provide health coverage. Frequent job change is also common, and so orders are written with very specific language so that they can be enforced.

OAG staff in San Antonio mentioned several changes that have been positive for the child support process, including the new National New Hire Database that has made the investigation of current employers much easier for cases that involve parents who frequently change jobs. Additionally, the state's wage withholding order form includes language directing the employer to enroll the child on the firm's insurance policy. Staff report that this speeds up the desired outcome of children's health care coverage, because it avoids waiting for the noncustodial parent to take the initiative with the employer's human resources office.

Bexar County is one of a few court systems in the state that actively works with the CBOs contracted by TexCare. Catholic Charities under the supervision of the United Way is one of those contractors to TexCare, and has an office in the courthouse in San Antonio. One IV-D Master allows the CBO staff to work in their courtroom with custodial parents to explain TexCare and to assist them in filling out the applications (if the noncustodial and custodial parent have not been determined to have employer-sponsored coverage available at reasonable cost).

Another IV-D Master prefers that the CBO staff approach custodial parents in the hallway before their case is heard or after the medical support order is complete. So while families sit on benches outside of the courtroom, bilingual CBO staff hand out information to custodial parents and assist parents with the application process. Given enough time, the staff may invite the custodial parent back to the courthouse CBO office to make a preliminary eligibility determination.

Funding Sources and Amounts

There has been no special funding for the coordination and outreach initiatives of TexCare. Legislation stipulated that the state could not use any state general revenue funds for administration unless the state could draw down federal matching funds for each of those dollars. Two exceptions are: 1) an allowance for state general revenue funds to be used for SCHIP coverage of immigrant children residing in the U.S. for less than five years; and 2) an allowance for state general revenue funds to be used for the incremental premium subsidies for children in the state employees' State Kids Insurance Program.

In each year since 2000, the sources of funding have been a combination of Federal funding for Medicaid, SCHIP, and IV-D and their required state matches which are met using tobacco settlement receipts.