Every Child Equal

What Texas Parents Want from Children's Medicaid

A report to

The Texas CHIP Coalition

by the Center for Public Policy Priorities,

and Orchard Communications, Inc.

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EXECUTIVE SUMMARY

INTRODUCTION

Texas' future will be largely determined by the choices we make about our children today. Our state's ethnic makeup and our economic base are changing. We will soon be a "majority minority" state, and though we have a booming economy for many, our poverty rate for children remains extraordinarily high, especially among Hispanics and African-Americans. This presents a substantial challenge to building the well-educated, healthy workforce Texas needs to continue to prosper. While important progress is being made in education, we are falling behind in covering our children's health needs. Despite bold and positive steps by our State leaders in the past four years, there are more uninsured children in Texas today than prior to 1997.

These children — 1.4 million — go without basic checkups, frequently delay seeking care until easily treatable problems become more serious, and often simply live with chronic problems that affect their ability to read and perform in school. The new Children's Health Insurance Program (CHIP) is available for many children **above** the poverty line. However, approximately 600,000 other children, those living in the poorest families, are eligible not for the new CHIP program, but only for Medicaid.

Who are these children? For nine out of ten children, their parents work at low wage jobs – they are our sales clerks, home health aides, social service workers, beauticians, bank tellers, landscapers, construction workers, fast food servers, data entry workers, receptionists, security workers, custodians, cooks, drivers, and so on. They make up to a maximum of $17,050 for a family of four, or $22,677 for parents with younger children. Many work in businesses which have had to drop all insurance benefits, or raise the employee's contribution so high that most low-wage workers cannot afford it. They are a growing segment of Texans who work, but lack any realistic prospect for getting health insurance through their job.

These children are found disproportionately among the fastest growing parts of our population; 56% are Hispanic, 28% are Anglo, and 14% are African American. Many are

in families that have moved from welfare to work in recent years, losing Medicaid health insurance even though their children are still qualified to enroll. *(See: Who Are Texas' Uninsured Children? Page 17)*

It is time for our state leaders to take the next step in getting equal access to health care for our poorest children. This is a matter of wise investment. It will cost state funds to draw down the federal matching funds; yet it will free up overburdened local property taxes for other vital public causes like education. This investment, which could be made with tobacco settlement funds, would also mean equal access to a medical home, more preventive care, improved health status and higher educational attainment for our poorest children.

It is a matter of fairness as well. Our poorest children deserve the same access to health services that we have for our higher income CHIP children. If we want families to work and successfully stay off welfare they must have help with health insurance when it is not available through their employer. Solutions **are** available. Poor children in most other states no longer face the same Medicaid barriers we still have in Texas.

The state has a great opportunity to take the next step: to make wise investments, and to treat our poorest children fairly — the same as we treat CHIP-eligible children. To give **every** Texas child a healthy start in life.

BACKGROUND

The Problem: Many Uninsured Children Are Already Eligible for Medicaid Of the approximately 1.4 million uninsured Texas children, almost 600,000 are in families with incomes at or below the federal poverty income line ($17,050 annual income for a family of 4 in 2000), and just under 500,000 uninsured children fall in the CHIP eligibility range (below 200% of poverty)[1]. These are sobering statistics, because the great majority of children in poverty could enroll in Medicaid, and need not be uninsured. **Under federal law, children eligible for Medicaid cannot enroll in CHIP**, so the new CHIP program alone cannot directly reduce the numbers of uninsured children among Texas' *working poor*.[2] **Texas cannot make real progress in reducing the ranks of uninsured children unless we find a way to dramatically improve Medicaid enrollment of children in our least-prosperous families.**

The state of Children's Medicaid enrollment. Uninsured children not accessing Medicaid benefits available to them is a national phenomenon. A 1996 study estimated that 4.7 million children nationwide were uninsured, but eligible to enroll in Medicaid.[i] Studies of state-by-state rates of Children's Medicaid "participation" (the ratio of the number of people actually enrolled in the program, to those who *could* enroll under the program rules) have found Texas to be below the national average.[ii] And, because Texas had one of the largest drops in the number and percent of children enrolled in Medicaid in the late 1990s — over 220,000 from January 1996 through November 1999 — it is reasonable to assume

[1] Another 330,000 uninsured children have incomes above the CHIP limits. Source: Texas Health and Human Services Commission.
[2] Families that work, but whose earnings leave them at or below poverty.

that our Children's Medicaid participation rate has declined even further, compared to the national average.

Private Insurance Is Not Filling the Gap. Of course, a decline in Medicaid enrollment would not be a bad thing if it were offset with a corresponding improvement in the number of children with good private insurance coverage. Unfortunately, studies find that a recent increase in private insurance coverage (less than 1%) was not nearly enough to make up for the 3% decline in Medicaid coverage. As a result, the percent of children with insurance coverage *dropped* in the 1995 to 1999 period, with most of the decline concentrated among "low-income" children, defined as those in families at or below 200% of poverty.[3,iii] Medicaid is the only option available to many Texas children in working poor families, whose parents lack coverage through their jobs. Only 16% of Americans with incomes below poverty get insurance through a family member's job, and only 15% of children below poverty are covered through a parent's job. Forty-two percent (42%) of workers earning less than $20,000 per year cannot access a health benefit at work, compared to only 14% of workers earning $35,000 or more.[iv] (See page 13: *Background: Why So Many Uninsured Texas Children?*)

New research on Texas parents and Medicaid. To better understand why so many parents do not take advantage of Medicaid for their uninsured children, a study was undertaken which conducted focus groups and one-on-one in-depth interviews across Texas with the parents of children currently enrolled in, or potentially eligible for, Children's Medicaid. This report describes this Texas research, recent national research on barriers to Medicaid enrollment, the current status of participation in Children's Medicaid in Texas, and national Medicaid trends. Federal guidelines for simplifying eligibility policy are explained, and the steps other states have taken are outlined. Finally, the findings of the Texas Study are summarized, and recommendations for an array of actions Texas should take to make Medicaid more accessible for Texas low-income working families are offered.

WHAT FEDERAL LAW ALLOWS, WHAT STATES ARE DOING, AND WHERE TEXAS STANDS

States are free to simplify Medicaid eligibility. Federal law and regulations have only minimal requirements for states related to children's Medicaid eligibility. The key **requirements** include a signed application, Social Security numbers for applicant children, documentation of immigration status of children who are "qualified aliens" (e.g., legal permanent resident immigrants), and an income and eligibility verification system.

It is also worthwhile to note what states are *not* required to do. There is **no requirement for a face-to-face interview**, and states are free to adopt mail-in applications for children's Medicaid. States are **not required to collect documentary proof of eligibility-related questions other than the immigration status** of legal immigrants, described above. States **do not have to impose any resource or asset limit on children's Medicaid.** States are **not required to terminate children's eligibility immediately when family income increases.**

[3] Translated, this means families with incomes at or under two times the income defined as poverty level. In 2000, a family of four would have a pre-tax income of $34,100.

Federal law allows states to offer periods of guaranteed eligibility (such as Texas CHIP offers) up to 12 months. Re-certification is required at least every 12 months, but need not be face-to-face.

WHAT'S WORKING: SUCCESSFUL ELIGIBILITY POLICIES IN OTHER STATES

In the last three years, other states have responded to low children's Medicaid participation with a variety of strategies to increase children's Medicaid enrollment, and to allow for a seamless application process between Medicaid and CHIP (*See Appendix C*). As this report went to press,

- **38 states (plus the District of Columbia) have stopped requiring a face-to face interview for children's Medicaid.** Three more states (Georgia, New Mexico, and New York) allow community-based enrollment outside the welfare office.
- **To facilitate the mail-in application process, many states are also reducing the number of** documents they require parents to provide. **For example, seven states require no income documentation for children's Medicaid.** These states verify income using third-party databases.
- **40 states (plus the District of Columbia) have dropped the resource or "assets" test for children's Medicaid.** Missouri applies a $250,000 asset cap to above-poverty children.
- **Fifteen states have adopted 12 month continuous eligibility for Children's Medicaid,** plus Florida has 12 month continuous eligibility for children under age 5, and 6 month continuous for children 6 and older. Also, 35 states only require re-certification for children's Medicaid every 12 months (Texas currently requires a visit every 6 months).

Best practices. Indiana, Oklahoma, and Florida have been recognized for their recent successful initiatives to improve Medicaid enrollment of uninsured children. All three states attribute their success to **marketing Children's Medicaid as health insurance, not welfare**, **aggressive outreach**, new shorter **mail-in applications** with **simplified documentation** requirements, and **no assets test.**[v]

CURRENT TEXAS POLICIES AMONG MOST COMPLEX IN U.S.

Extra Steps Required to Enroll and Retain Children in Texas Medicaid. Parents can enroll a child in CHIP entirely by mail; no interview or appointment is required. However, parents of children who are eligible for Medicaid must go to a Texas Department of Human Services (DHS) office for a full, face-to-face eligibility interview, even if the parent applies using the new TexCare Partnership children's health insurance application. A substantial number of families have to go to DHS to enroll a younger child, while their older child can be enrolled with ease in CHIP. As this report went to press, about 27% of children's TexCare Partnership applications had been referred for a face-to-face interview at a DHS office. No information was available as to whether those children had been successfully enrolled in Medicaid.

How CHIP and Medicaid requirements differ in Texas. Major differences include:

Mode of Application. CHIP applicants enroll entirely by mail; parents of Medicaid applicants must complete an in-person interview at a DHS office.

Period of Eligibility. CHIP eligibility is for 12 full months, regardless of any change in family income. Parents of children in Medicaid must report income changes within 10 days; if income is too high the child loses eligibility in the following month.

Re-certification. CHIP parents must update eligibility information by mail annually. Medicaid parents must re-visit the DHS office every 6 months, even if they have had no income changes.

Assets Test. Texas CHIP eligibility is not affected by non-income assets a family may have. For Texas Children's Medicaid, a family may not have more than $2,000 in assets such as money in the bank, savings, land, automobiles, pension benefits, etc.[4] A family home and one automobile are exempted from this limit for children. Fair market value in excess of $4,650 of any car not exempted counts toward the family's $2,000 limit.

Proof, Verification, Documentation. Parents applying for CHIP must mail in proof of income, child care expenses or child support paid to another household (if they want those costs deducted from income), and copies of the child's immigration documents for a legal immigrant child. Parents applying for Texas Children's Medicaid must provide **all of the above**, plus: **birth certificate or school records** (Texas-born can be verified through Texas Department of Health); proof of **assets**, **residence**, and **domicile** (who lives in the household); **terminated income**; **past employment history**; and **other insurance**, if a child has other health insurance[5] (See Appendix D).

Medical Support Enforcement. When a single parent applies for CHIP, it does not trigger any state government child support or medical support enforcement actions. But, when a parent applies for Medicaid for a child who has an absent (non-custodial) parent, federal law requires the state to pursue *medical* support for that child. Federal law says children *cannot* be denied Medicaid because their parent is designated as non-cooperating; only the *parent* can be denied Medicaid.[6]

In August 2000, DHS announced a plan to reduce the number of required documentary verifications, standardize income verification policies across the state, and inform clients about alternate forms of proof. The agency also proposes to allow parents to re-certify for children's Medicaid by mail, but would still require a face-to-face application at DHS. These new policies, when implemented, will represent an important first step toward creating equitable treatment for parents of Medicaid-eligible children.

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[4] Limit is increased to $3,000 if the family includes a disabled member.

[5] Unlike CHIP, a child can have other insurance and still enroll in Medicaid. Federal law requires that the private plan pay all bills first, so that Medicaid will only pay for any benefits the private insurance does not cover. For example, many private plans do not cover prescription drugs, eyeglasses, hearing aids, or nursing services that children with complex health conditions may need. Texas has programs devoted to detecting and recovering costs from liable insurance plans.

[6] A teen parent *can* be denied Medicaid for non-cooperation in providing information about her/his child's absent parent.

FINDINGS: THE BARRIERS

Texas research is consistent with national studies. Texas focus groups and interviews revealed views of low-income parents that echo the top concerns reported by major nationwide surveys.

Finding: There is a critical lack of clear, accurate information about Children's Medicaid eligibility. Confusion, misinformation, and lack of knowledge about children's Medicaid eligibility were a problem with a majority of parents in this study. Many mistakenly believed that their children could not get Medicaid if the parent was *not* getting Temporary Assistance for Needy Families (TANF) cash assistance, or if the parent *was* working, or if there were two parents in the home.

Finding: Appointments to apply and re-certify for Children's Medicaid are time-consuming, inefficient, not family-friendly, and inappropriate for the needs of working parents. Long waiting times at the DHS were a common complaint, though appointments proceed much more quickly in some smaller cities and rural areas of the state. Experiences range from fast service with less than a 30 minute wait, to waiting all day and being told to return another day. Parents complain of lost wages due to lengthy appointments. Procedures vary widely from office to office. Many parents had to wait long beyond their scheduled time. Some offices tell parents to appear in the morning of a particular day, and have them wait indefinitely until they are seen.

Offices are not equipped to accommodate children, and lack access to food or drink while waiting, changing tables for infants, and reading materials. Parents reported that leaving the waiting area to use the restroom, change a diaper, or quiet a fussy child could result in losing their appointment.

Finding: Confusing and inconsistently applied documentation requirements and lost documents discourage parents. Parents reported that documents required were unpredictable and inconsistent. What is accepted as adequate proof by one worker or one office may not be adequate for another worker or in another town. A number of parents reported that documents provided to DHS offices were subsequently lost.

Finding: "Assets Test" is seen as a deliberate barrier to limit enrollment, undermining employment and self-sufficiency: virtue is punished. Many parents had experienced denial based on very small amounts of excess assets. Standards that do not allow them to save for a child's college, or deduct college tuition are seen as counter to self-sufficiency. Virtually all parents were unaware that *one* family car is not counted for children's Medicaid. Parents see the assets test as a disingenuous barrier, which rewards the dishonest and punishes those who are truthful.

Finding: Customer service at DHS offices is rated poorly by more than 75% of participating parents. Complaints about staff demeanor range from merely abrupt or condescending to overtly rude or hostile treatment. The greatest number of complaints are directed at the front-desk or first-contact staff, who are likely to have the least skills and training and the most turnover, and can create an unpleasant atmosphere for a large number of people. Parents commented on the high pressure, unrealistic workloads, and poor equipment that eligibility workers must live with, and recommended that customer service

training was needed for the DHS workers. About 20% of parents commented on experiences with *good* eligibility workers.

Finding: "Stigma" attached to Medicaid is not universal or clear-cut. Parents with Medicaid experience expressed approval for the program, along with strong expressions of gratitude for the benefits it provides their children. Roughly half the parents participating in the focus groups view Medicaid as health insurance or help with medical expense for low-income families. The other half regard Medicaid as "part of welfare." For these parents, pride or shame were significant disincentives to enrolling their children. Some enrollment practices, in particular medical support enforcement activities and asset documentation, contribute to this stigma.

Finding: Medical Support Enforcement policies create several barriers to enrolling children. Intrusive personal questions related to medical support were a frequent complaint of parents responding to the study. DHS workers and Attorney General's staff routinely query custodial parents about sexual contacts, in settings that are not always private. Others say they are pressured for information at each re-certification, despite the lack of any contact with, or connection to, an absent parent. More than one **married** parent was required to provide medical support enforcement data, on the presumption that their spouse would leave in the future (*See Appendix E*)

Finding: Families that include immigrants report special barriers to enrollment. Many parents are still afraid that Medicaid use by their child may prevent another family member from getting a "green card" or becoming a citizen.[7] In addition, parents remain concerned that DHS or Attorney General's workers may report their non-applicant family members to the Immigration and Naturalization Service (INS).

Finding: Concerns about quality of Medicaid health services, or poor treatment of Medicaid patients by providers, are significant for some parents. A number of parents believe that better doctors limit the number of Medicaid patients they accept because payment is too low. Some parents believe that they are treated with less respect by frontline staff when they are using Medicaid. Some parents with Medicaid managed care experience felt they faced additional barriers to care. Despite these concerns, the majority of parents with prior Medicaid experience would rather their children be enrolled than not.

Finding: For some parents, episodic Medicaid enrollment is seen as good stewardship of public resources. A number of parents indicated that they deliberately only enrolled their children when pressing health issues arose, because they did not want to "abuse" the privilege of access to the benefits. Preventive well-child care was seen as less important than conserving public resources by these parents.

Finding: One Size Does Not Fit All. The barriers expressed by certain parents were not shared by all, so a variety of steps must be taken to address the concerns of a diverse group of parents.

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[7] Except when fraud is involved, there is no negative impact on either legal status or naturalization. Only if an individual relied completely on Medicaid institutional long-term care for his support would Medicaid use result in denial of legal permanent resident immigration status.

RECOMMENDATIONS (SEE FULL REPORT FOR COMPLETE DETAILS)

SIMPLIFY THE PROCESS:

- **Adopt a mail-in option for children's Medicaid applications.** This would make Medicaid policy consistent with CHIP, eliminate the hassle of a trip to the DHS office for low-income working parents who only want Medicaid for their children, and reinforce a new image of Medicaid as health insurance, not welfare. If implemented, DHS' recent proposal to allow mail or telephone re-certification for Medicaid-only clients will be a major step in the right direction, but the state should go further and adopt mail-in application as well.

- **Minimize the documents required for children's Medicaid applications, making the requirements for CHIP and Medicaid identical.** To make a mail-in application workable, documents to mail in along with the application must be streamlined to require only proof of income and immigration documents for legal immigrants. The newly-proposed reductions in verifications slated for 2001 would represent an important first step toward this goal.

- **Eliminate the "assets" test completely for children's Medicaid.** This would make Medicaid policy consistent with CHIP, make the task of enrolling vastly simpler for both parents and DHS staff, and allow parents to have some prudent savings for college and retirement.

- **12 Month Continuous Coverage; 12 month re-certification periods.** This would make Medicaid policy consistent with CHIP, save work for both parents and DHS staff, end the current problem of children rolling on and off the Medicaid rolls due to small and temporary income fluctuations, and relieve health care providers of the challenge of verifying current coverage for children. Children's access to primary and preventive care would be improved.

- **Invest in Public Information and Outreach to Low-Income Parents to Raise Awareness about Children's Medicaid.** Promote Medicaid as Health Insurance, Not "Welfare" — Just Like CHIP. Parents must be informed that Medicaid is an option for children in working families, and two-parent families. Working poor parents need to know about Medicaid's higher income limits for children, and that Medicaid is not tied to TANF cash assistance. Outreach should be broad-based, and sustained over time. Texas will need to promote the value of ongoing coverage and medical homes if we want to change the episodic enrollment pattern that some parents see as conserving scarce state resources.

- **Make reliable application assistance widely available outside the DHS office.** Many parents want a "live" person to answer their questions. Community-based application "assisters" could help families who want to use a mail-in application. Toll-free numbers for assistance or referral must be adequately staffed and trained, and able to meet quick-response standards like those required of state contractors.

- **Ensure an adequate number of eligibility staff at DHS offices.** Staff will still be needed to process mail-in applications, and to serve families who want to apply for Food Stamps or TANF. The major cuts in DHS eligibility workers in the last four

years, despite only small application declines, may put customer service improvements out of reach. Staffing, funding, and planning should be enhanced to improve DHS capacity to train workers in an adequate and timely fashion.

- **Emphasize Customer Service at DHS offices, and adopt policies that work for working parents.** DHS could improve customer service by creating incentives or performance measures related to reliability and rapid turn-around of applications, like Oklahoma's 20-day processing of children's Medicaid applications. Commitment to the goal of dignified treatment — equal to the commitment to reducing Food Stamp error rates — is needed. Special attention may need to be paid to the first-contact front desk staff.
- Raising the priority Texas Medicaid places on enrolling eligible children, and providing convenient and dignified enrollment processes, will require support from our legislature and statewide elected officials. Recent DHS proposals to begin streamlining eligibility policies are evidence of the agency's commitment to serving Texas' low-income families. State leaders must give agencies an unambiguous green light to vigorously pursue enrollment of uninsured children, and that directive must be backed with adequate appropriations and adequate numbers of state workers.
- **Address parents' concerns about quality of care.** Some concerns may be addressed through outreach describing Medicaid's comprehensive benefits for children. If Medicaid payment standards fall too far below market rates, and doctors and other providers drop out or limit their Medicaid patient numbers, it may be impossible to erase the perception that the program offers a poorer standard of care.
- **Address mixed-immigration families concerns re: DHS and AG.** DHS has taken steps to train staff about the rights of immigrants in the application process. Still-widespread fears call for more outreach by trusted community-based organizations, to spread the word that Medicaid is "safe." Official reassurance by DHS and the Attorney General (e.g., signs and flyers in their offices and official messages on forms explaining DHS policy) could be especially effective in reducing fear.
- **Review policies to ensure that optimizing Medical and Child Support does not come at the expense of children's health care.** Requiring absent parents to support their children is an important public policy goal, but **not more** important than children's access to health care. The pursuit of child support from an absent parent should not burden the custodial parent so much that leaving the child uninsured is preferable. A workgroup of agency staff and advocates should be convened to review current policies and propose revisions to better balance these two important public policy goals.

THE COST OF CHANGE: THE FINAL BARRIER

Offsets. Though the federal government will pay for about 62% of the costs of children enrolled in Medicaid, major progress toward enrolling the 600,000 uninsured Texas children below poverty will nevertheless require significant new expenditures in the state's budget.

Offsetting these costs are benefits documented in ample research on the poor health outcomes of children who lack health insurance. Furthermore, choosing not to maximize Medicaid enrollment of children in Texas results in a direct cost-shift to local governments and taxpayers who support public hospitals, local health departments, and tax-exempt non-profit charity providers. It also throws away the enormous federal match ($2 in federal funds for every $1 Texas spends) that could be supporting those costs. Taxpayers deserve to have these federal tax dollars returned to Texas, and not re-distributed to other states that are more successful in enrolling their children.

Real World Examples. The great majority of states that have already simplified Medicaid access for children presumably were prepared to pay for that growth. Still, the only states that have seen really large jumps in enrollment in the last several years are those that have actually expanded Medicaid by raising the income eligibility cap significantly, like Indiana, Oklahoma, and New Mexico (increased Medicaid coverage from 100% FPL to 150%, 185% and 200% FPL respectively).[vi]

The real impact of these policy changes in Texas will not be that they make more children eligible, but rather that they make parents of children who were already eligible for Medicaid willing to participate in the program for the first time. It is very difficult to predict how much and how quickly enrollment in Children's Medicaid will increase if the application and re-certification processes are simplified. Some factors that should be taken into account are:

- other states' actual caseload growth rate experience with simplified eligibility,
- other states' ratio of eligible to actually enrolled children with simplified eligibility, and
- Texas' historically very low rate of denials for assets.

Detailed analysis of the cost of simplified eligibility will be released by Project Alberto, Texas' "Covering Kids" Initiative, by October 2000.

Tobacco Settlement funds could be dedicated to ensuring adequate funding for children's health insurance. The 76th Legislature committed some of the Tobacco Settlement funds to CHIP. Equity and fairness suggest that we should be just as committed to insuring the children of the working poor as we are children in families just above poverty. Texas should take this historic opportunity to make a long-term investment in the future: our children.

WHO GETS MEDICAID AND CHIP?

When Medicaid was created in 1965, eligibility for the program was limited largely to Americans who were getting cash assistance, either through the Aid to Families with Dependent Children program (AFDC - now TANF), or through Supplemental Security Income (SSI, for the elderly poor and disabled poor). Each state was responsible for setting up its own systems to enroll and keep track of families getting AFDC. **From 1984 to 1990, Congress passed a series of laws expanding Medicaid eligibility to more and more children, who no longer had to have any connection to the AFDC cash "welfare" program. The 1996 federal welfare law finally severed the link between AFDC and Medicaid, decreeing that even parents no longer had to be getting cash assistance to enroll in Medicaid** (states are still free to grant Medicaid automatically to all TANF recipients; however, de-linking requires that poor families be able to enroll in Medicaid even if they do not participate in TANF). In 1997, Congress passed a bill that gave states the ability to cover all children below poverty in Medicaid immediately, and to create CHIP programs for children in families above the Medicaid income limits.

Current Texas Medicaid income limits vary by the age of the child:

- Infants can be covered up to their first birthday in families at/below 185% of poverty ($31,543 for a family of 4 in 2000)
- Young children can be covered up to their 6th birthday in families at/below 133% of poverty ($22,677 for a family of 4 in 2000)
- Children can be covered up to their 19th birthday in families at/below 100% of poverty ($17,050 for a family of 4 in 2000)
- Children can be enrolled in CHIP if they do not fall into one of these Medicaid groups, but who are in families at/below 200% of poverty ($34,100 for a family of 4 in 2000).

THE CHALLENGE

TO REDUCE RANKS OF UNINSURED CHILDREN, TEXAS MUST INCREASE MEDICAID ENROLLMENT

Many Uninsured Children Are Already Eligible for Medicaid. The public debate leading to the 1999 creation by the Texas Legislature of a Children's Health Insurance Program (CHIP) resulted in a new, widespread awareness about the characteristics of Texas' uninsured children. Of the estimated 1.4 million uninsured children, it is thought that about 600,000 are in families with incomes at or below the federal poverty income line ($17,050 annual income for a family of 4 in 2000). In contrast, just under 500,000 uninsured children are thought to fall in the CHIP eligibility range[8]. These are sobering statistics, because the great majority of children in poverty could enroll in Medicaid, and theoretically need not be uninsured. **Under federal law, children eligible for Medicaid cannot enroll in CHIP,** so the new CHIP program cannot directly reduce the numbers of uninsured children among Texas' *working poor*.[9] The clear conclusion: **Texas cannot make real progress in reducing the ranks of uninsured children unless we find a way to dramatically improve Medicaid enrollment of children in our least-prosperous families.** And to reach that goal, we must learn *why* so many Texas families currently do not enroll their children in Medicaid, even though they could.

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[8] Another 330,000 uninsured children have incomes above the CHIP limits. Source: Texas Health and Human Services Commission.

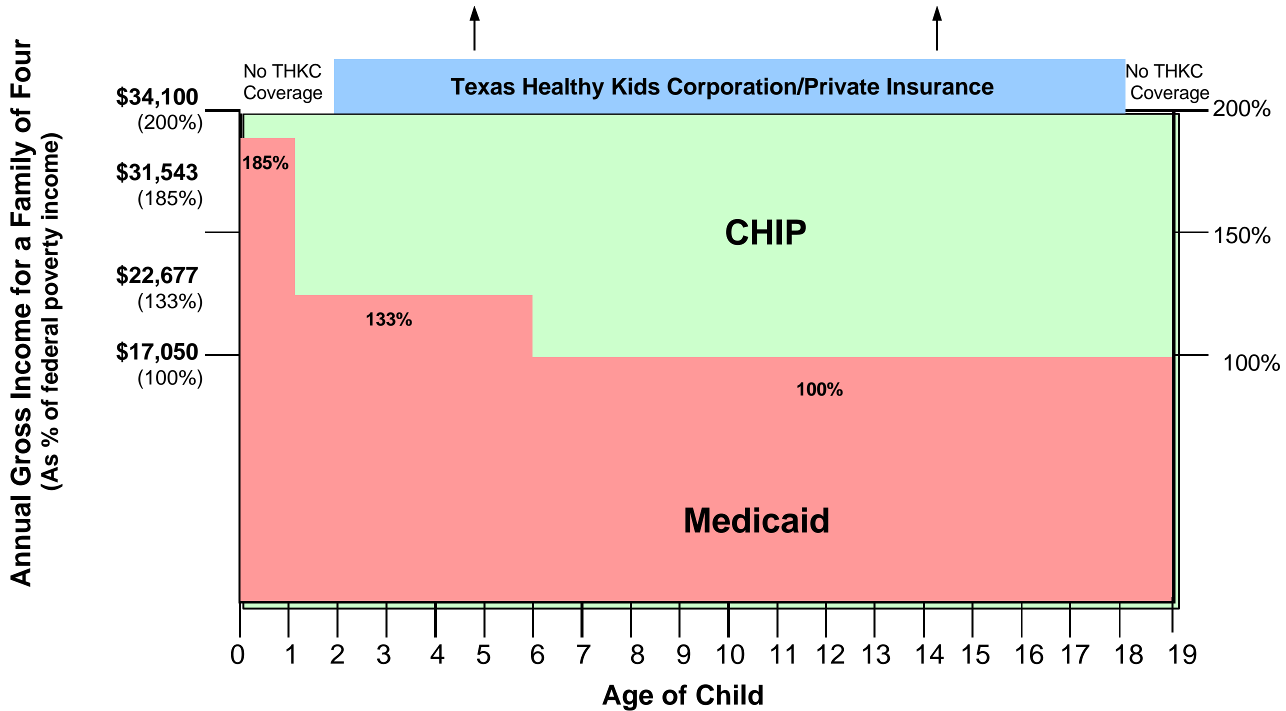
[9] Families that work, but whose earnings leave them at or below poverty. A family of 4 headed by a minimum wage worker would be at 60% of the poverty income line.

BACKGROUND: WHY SO MANY UNINSURED TEXAS CHILDREN?

- Texas has the highest percentage of uninsured citizens (27%, 4.9 million people) of any state.[vii]
- Texas' history and economic make-up does not favor employer-provided or public health benefits: low employment in manufacturing; little organized labor; high employment in small businesses, retail and service jobs; restrictive Medicaid eligibility, particularly for adults; higher-than-average percentage of working families that are below poverty or just above poverty; higher-than-average percentage of children as a portion of our total population.
- In the early 1990s employer-sponsored health insurance coverage declined, but began to recover in the second half of the decade. But from 1995 on Medicaid enrollment declined more than private insurance grew, resulting in a growing pool of uninsured. The decline in private insurance (and, of course in Medicaid) was worst among low income adults and children.[viii]
- Over 220,000 children lost Medicaid coverage in Texas from 1996 to the end of 1999. Much of this decline was due to children leaving cash assistance "welfare," but not making the transition to the children's non-welfare Medicaid for which many remain eligible.

New research on Texas parents and Medicaid. This report seeks to shed light on why so many uninsured children are not enrolled in Medicaid in our state, and proposes solutions aimed at making real progress in reducing the number of uninsured children. As the key component of this report, a qualitative study was conducted which convened focus groups across the state with parents of children currently enrolled in, or potentially eligible for, children's Medicaid. To allow more in-depth and personal comments from parents, one-on-one in-depth interviews supplemented the focus groups. The findings of this Texas research are described in this report, along with a summary of recent national research on barriers to Medicaid enrollment. We describe the current status of participation in children's Medicaid in Texas, comparing Texas' experience to national trends. Federal guidelines for simplifying eligibility policy are explained, and the steps other states have taken are outlined. Finally, based on the Texas study's findings, recommendations for an array of actions Texas should take to make Medicaid more accessible for Texas low-income working families are offered.

As the graphic below illustrates, the combination of Medicaid's stair-step eligibility and the federal requirement that Medicaid-eligible children enroll in Medicaid, not CHIP, results in significant numbers of families having one child in Medicaid, and another in CHIP. For example, a family at 125% of poverty with a 4 year old and 8 year old child must enroll the younger child in Medicaid, and the older child in CHIP.



- Some children from families in the Medicaid income categories may not be eligible for Medicaid due to a state-imposed assets test ("countable" assets must be less than $2,000 per family). These children will be eligible for CHIP.

- Coverage ends when birthday indicated on scale is reached.

- Texas Healthy Kids Corporation will stop enrolling new children after 9/15/2000. After 9/15, families will be referred to the private insurance market. Children who have THKC coverage may have to seek private coverage when their THKC health plan's contract ends, probably within one year.

Texas CHIP Coalition

THE STATE OF CHILDREN'S MEDICAID ENROLLMENT

Texas Medicaid Participation Below National Average. Texas is not alone in having significant numbers of children eligible for, but not enrolled in, Medicaid. A 1998 report estimated that 52% of U.S. children eligible for Medicaid were actually enrolled.[ix] How does Texas compare to this national trend? In 1994-1995, an estimated 68.9% of children in poverty nationwide were enrolled in Medicaid, compared to 63.7% in Texas. Though a number of states had even lower rates of Medicaid participation, Texas still had the highest estimated percentage of *uninsured* children in poverty at 23%.[x] Even though other states had lower rates of Medicaid enrollment, children there apparently had a better chance of getting coverage through a parent's job than in Texas, so their overall rate of uninsured children was better than for our state. Because Texas children are less likely to have access to private insurance than in many other parts of the country, children faced with barriers to Medicaid are more likely to remain uninsured as a result.

National Medicaid Rolls Declined in Wake of Welfare Reform. Unfortunately, since the early to mid-1990s (the period of the estimates above), Texas has seen a large decline in children's Medicaid enrollment. Once again, our state was not alone in experiencing this trend. Medicaid enrollment dropped nationwide, despite the fact that the federal welfare reform laws included provisions that were supposed to insure that *no one would lose Medicaid just because they lost cash assistance*. In fact, in a legal sense, the number of Americans eligible for Medicaid was *expanding* during this period. Still, not everyone who left the welfare rolls was able to keep their Medicaid benefits. Nationally, about 59% of people who lost welfare-linked Medicaid from 1995 to 1997 were transferred into *non*-welfare Medicaid coverage.[xi] However, during a comparable period, only about 22% of the number of Texas children who left welfare-linked Medicaid were added to the non-welfare Medicaid groups.[xii]

Who Are Texas' Uninsured Children?

- 88% are from working families; 63% have a parent employed year-round and full-time.
- 58% are in families **above** poverty (and 42% below).
- Two-thirds are in 2-parent families, though children in single-parent homes are more often uninsured.
- 81% have parents who are not insured.
- 56% are Hispanic, 28% Anglo, and 14% African-American.
- About 17% are U.S. citizen children with one or more non-citizen parents. Another 9% are non-citizen children with a non-citizen parent.[xiii]

Texas Lost Ground on Children's Medicaid: Parents Unaware Children Still Eligible. Total children's Medicaid enrollment in Texas dropped by over 220,000 (a 17% decline) from January 1996 to November 1999. During the same period, children enrolled in welfare (AFDC/TANF) dropped by over 253,000. Families leaving welfare, but not keeping their children enrolled in Medicaid, caused much, (though not all) of the drop in children's Medicaid enrollment. Texas Department of Human Services (DHS) data show that only 21% of Texans leaving welfare since 1995 got the temporary "Transitional Medicaid" coverage available to families leaving welfare because of increased earnings. It seems that the vast majority of families leaving welfare in Texas just walked away from the program without communicating with DHS.[xiv] Studies nationwide and in Texas have concluded that most parents leaving welfare were unaware that they and their children were in almost all cases still eligible for Medicaid after they left welfare. *(This research is described later in this report.)*

A 1999 report comparing the 12 states with the largest numbers of uninsured children found that Texas had the greatest numerical drop *and* the greatest percentage drop in children covered by Medicaid. One factor in Texas' bottom-of-the-heap ranking was that the other 11 states had already implemented their CHIP programs and benefited from improved children's Medicaid enrollment resulting from CHIP outreach. (Very few states did outreach to encourage Medicaid enrollment prior to CHIP.) But, when the data are analyzed looking only at the period *before* other states implemented CHIP, Texas is still at the bottom; one other state (Ohio) has the same percentage decline as Texas, with 2 more states (Florida and Illinois) close behind.[xv] To summarize: Texas has had a significant loss of enrollment in children's Medicaid in recent years, and it appears that our loss has been among the worst in the nation.

Private Insurance Not Filling the Gap. Of course, a decline in Medicaid enrollment would not be a bad thing if it were offset with a corresponding improvement in the number of children with good private insurance coverage. Unfortunately, recent studies find that private insurance coverage has increased only slightly (less than 1%), not nearly enough to make up for the 3% decline in Medicaid coverage. As a result, total children's insurance coverage *dropped* in the 1995 to 1999 period, with most of the decline concentrated among "low-income" children,

defined as those in families at or below 200% of poverty.[10xvi] Medicaid is the only option available to many Texas children in working poor families, whose parents lack coverage through their jobs. (See page 13: *Background: Why So Many Uninsured Texas Children?*)

CHIP AND TEXCARE PARTNERSHIP BRING A NEW COMMITMENT TO INSURING TEXAS CHILDREN

April 2000 marked the start-up of the TexCare Partnership, a state contractor that accepts applications for children's health insurance, enrolling eligible children directly in CHIP, and referring families to Medicaid and the Texas Healthy Kids Corporation[11] if a child appears qualified for those programs instead of CHIP. The state has 50 local contracts for community-based outreach and application assistance activities, and many of the contracts are with collaboratives that include multiple community-based organizations (CBOs) and nonprofit and public agencies. The funds available to these contractors (a total of $5 million for CBO outreach plus $2 million for marketing to cover a 2-year period) are modest. For comparison, California has budgeted $20 million per year (more than five times Texas' budget) for their CHIP-Medicaid outreach, though the number of uninsured children in that state is only about 15% higher than in Texas. Still, the outreach and marketing for CHIP represent Texas' first-ever attempt to do broad-based outreach to encourage participation in public insurance programs.

Signs of Progress. On a hopeful note, most researchers believe that the considerable energy states are devoting to CHIP outreach will soon be reflected in a significant reduction in the number of uninsured children, and improved Medicaid participation by children. In Texas, a new state law that directed DHS to inform parents on welfare that their children can continue to benefit from Medicaid after cash welfare is ended may have begun to have an impact. From December 1999 to February 2000 (the latest months data available), before official CHIP outreach efforts had even begun, enrollment in Texas children's non-welfare Medicaid began to increase after years of decline. Still, much work remains to be done, as children's enrollment remained over 192,000 below the January 1996 level.

STATES ARE FREE TO SIMPLIFY MEDICAID ELIGIBILITY

Much of the paperwork that Texas Medicaid still requires is a hold-over from old AFDC and Food Stamp policies that no longer affect Medicaid at all. Today, states have an enormous amount of freedom to adapt income limits for both children and families in Medicaid, and to streamline eligibility processes in almost any way imaginable — without risk of incurring federal penalties. In fact, the Health Care Financing Administration (HCFA: the part of the U.S. Department of Health and Human Services that runs Medicare, Medicaid and CHIP) has been *encouraging* states for several years to simplify eligibility procedures for children's Medicaid to improve participation and allow for seamless coordination of Medicaid and CHIP, and most other states have responded. Official HCFA guidance in September 1998 clarified exactly what federal law requires from states for Children's Medicaid, and made recommendations for simplification.

[10] Translated, this means families with incomes at or under two times the income defined as poverty level. In 2000, a family of four would have a pre-tax income of $34,100.
[11] As this report is published, it appears that THKC coverage will be phased out.

WHAT THE LAW REQUIRES FOR CHILDREN'S MEDICAID ELIGIBILITY

Federal law and regulations have only minimal requirements for states related to children's Medicaid eligibility. (*See Appendix B for a more detailed description.*) The key requirements are:

- a signed application, including the applicant's attestation that the information is truthful (under penalty of perjury),
- Social Security numbers for applicant children (cannot be required of non-applicants, such as parents),
- Documentation of immigration status from "qualified aliens" (e.g., legal permanent resident immigrants) and verification of that status with INS,
- States must have an income and eligibility verification system to check federal and state agency databases to verify income; they are *not* required to collect income documentation from applicants.

States are also required to meet some consumer protection standards: no delay in application; mandatory out-stationed workers in certain hospitals and clinics; decision within 45 days; notice of decision and reasons for denials; ready access to simple, understandable information on eligibility rules, rights, responsibilities, and appeal and fair hearing rights.

It is also worthwhile to note what states are *not* required to do.

- **There is no requirement for a face-to-face interview.** States are free to adopt mail-in applications for children's Medicaid.
- **States are not required to collect documentary proof of eligibility-related questions other than the immigration status of legal immigrants, described above.** For example, states do not have to request proof of income, age, residency, or resources (states *do* have to have a system for using other sources of information to verify income, as described above).
- **States do not have to impose any resource or asset limit on children's Medicaid.**
- **States are not required to terminate children's eligibility immediately when family income increases.** Federal law allows states to offer periods of guaranteed eligibility (such as Texas CHIP offers) up to 12 months. Re-certification is required at least every 12 months, but need not be face-to-face. 12 month re-certification differs from 12 month continuous coverage in this way: under 12 month re-certification, parents must still report changes promptly, and coverage can be lost if income increases.

WHAT'S WORKING: SUCCESSFUL ELIGIBILITY POLICIES IN OTHER STATES.

Many other states have responded to low children's Medicaid participation with a variety of strategies. In many cases, states have adopted these policies in the last three years, in response to both the unintended decline in children's Medicaid enrollment in the wake of federal welfare reform, and to allow for a seamless application process between Medicaid and CHIP (*See Appendix C*). As this report went to press,

- **38 states (plus the District of Columbia) had stopped requiring a face-to face interview for children's Medicaid.** Three more states (Georgia, New Mexico, and New York) allow community-based enrollment outside the welfare office. Even more states (42 plus D.C.) have stopped requiring a face-to-face interview to *re-certify* for children's Medicaid.
- **To facilitate the mail-in application process, many states are also reducing the number of** documents they require parents to provide along with their children's Medicaid application. **For example, seven states require no income documentation for children's Medicaid.** These states verify income using third-party databases.
- **40 states (plus the District of Columbia) had dropped the resource or "assets" test for children's Medicaid.** Also, Missouri has dropped the test for most Medicaid children, and applies a $250,000 asset cap to above-poverty Medicaid applicants.
- **Fifteen states have adopted 12 month continuous eligibility for Children's Medicaid,** plus Florida has 12 month continuous eligibility for children under age 5, and 6 month continuous for children 6 and older. Also, 35 states have reduced the frequency of re-certification for children's Medicaid to once every 12 months (Texas currently requires a visit to a DHS office every 6 months).

Indiana. At a May 2000 hearing of the U.S. House of Representatives Committee on Ways and Means, representatives from 3 states described their state's actions aimed at increasing enrollment in children's Medicaid. Indiana has turned around its trend of declining children's Medicaid enrollment. After a 9% decline in Medicaid enrollment between 1997 to 1998, the state added over 49,000 children to Medicaid from December 1998 through June 1999.[12] [xvii]

A state Medicaid official noted that a key to Indiana's success were efforts to **change the perception of Medicaid "from welfare to health care."** When the state first decided to expand children's Medicaid to 150% FPL as phase I of its CHIP program, the state committed to an **aggressive outreach program** with three major components: "de-stigmatize" Medicaid and CHIP, reach out to local communities, and simplify the enrollment processes.

To achieve the first goal, the state **marketed Medicaid and CHIP under a single name, "Hoosier Healthwise,"** and began issuing eligibility cards identified with that name rather than "Medicaid." Outreach beyond welfare offices resulted in 500 community enrollment centers that accept the mail-in Healthwise applications, including social service and child care providers, health clinics, and hospitals. **New mail-in applications** were also available by calling a widely advertised toll-free number. Enrollment was simplified, with **a new 2-page application** that can be turned in at an enrollment center or by mail. Income **verification requirements were**

[12] Indiana expanded Medicaid to 150% FPL under CHIP law, and created a separate state CHIP program for children from 150-200% FPL. 45,000 of the newly enrolled children were eligible under the states old Medicaid guidelines; that is, not under the expansion to 150% FPL.

simplified, with greater acceptance of self-declaration of other eligibility information. Indiana has dropped the assets test for children's Medicaid, and adopted 12 month continuous eligibility. **Outreach** was targeted to ethnic communities, and each county received outreach funds. As a result, the state has enrolled more than its original goal for Medicaid and CHIP, and is one of only 13 states to expend all of its 1998 federal CHIP allotment.[xviii]

Oklahoma. Oklahoma's Medicaid Director described her state's success in increasing children's Medicaid enrollment, due in large part to a major eligibility expansion to 185% of poverty for children.[13] Like Indiana, the state adopted a new approach to children's Medicaid, identifying as key strategies eligibility simplification and working to eliminate stigma by marketing the program as health insurance. Using the new CHIP funds, in December 1997 the state **adopted a 2-page children's Medicaid application which can be mailed in, has no assets test, and requires very little documentation of applicants (even income is self-declared).** Another important feature of Oklahoma's approach has been **outreach** efforts of all 47 counties and 5 state agencies.[xix]

Florida. Florida is one of a tiny handful of states where more children are enrolled in Medicaid today than prior to welfare reform. This success is of special interest because Florida's choices resemble Texas: the state did not expand Medicaid (except to add below-poverty teens in 1998, just as Texas did), has Medicaid eligibility limits identical to Texas, and a separate state CHIP program covering children up to 200% FPL. Florida's welfare reform administrator attributes their high children's Medicaid participation to two strategies. The first is **improved informing of families** receiving Medicaid and cash assistance about the opportunities for continued Medicaid coverage after the parents move into the workplace. The second effort is an overhaul of the application process for children's Medicaid. The state now offers a **one-page application, envelope supplied, which can be submitted by mail**. Applications are widely available through child care centers, schools, community-based organizations, clinics, and hospitals. As a result, during the period from December 1998 to June 1999, when Texas lost 48,000 children from Medicaid, Florida's program grew by 53,000 children.

CURRENT TEXAS POLICIES AMONG MOST COMPLEX IN U.S.

Extra Steps Are Required to Enroll and Retain Children in Texas Medicaid. Unfortunately, current Texas Medicaid policies make a true *joint application* for Medicaid and CHIP impossible. Texas' state policy treats children seeking health insurance very differently depending on their family's economic status. Parents can enroll a child in CHIP entirely by mail; no interview or appointment is required. However, parents of children who are eligible for Medicaid are still required to go to a Texas Department of Human Services (DHS) office for a full, face-to-face eligibility interview. This interview is required even if the parent applies using the new TexCare Partnership application. A substantial number of families have to go to DHS to enroll a younger child, while their older child can be enrolled with ease in CHIP. As this report went to press, about 27% of children whose applications had been reviewed by TexCare Partnership appeared to be Medicaid-eligible, and their families were referred for a face-to-face eligibility interview at a DHS office. No information was available as to whether those children had been successfully enrolled in Medicaid.

[13] States are allowed to use CHIP funds to expand Medicaid, create a separate state program, or to do both.

How CHIP and Medicaid requirements differ in Texas. The requirement for a face-to-face interview is not the only difference between CHIP and Medicaid enrollment requirements. Texas children's Medicaid requires many more documents and proofs than CHIP (*see Appendix D*). The major differences between the current requirements of the two programs are summarized below:

Mode of Application. Parents of CHIP applicants can enroll wholly by mail; parents of Medicaid applicants must complete an in-person interview at a DHS office. Offices are generally open only Monday to Friday, 8 to 5. DHS has piloted extended hours in selected offices across the state, but since clients must go to the office where their past paperwork is located, both outreach about and access to the extended hours are limited. *(Mail-in applications are a state option available to Texas.)*

Period of Eligibility. A child enrolled in CHIP retains eligibility for 12 full months, regardless of any change in family income during that year; parents of children in Medicaid must report changes in income within 10 days and if income increases above Medicaid limits the child loses eligibility in the following month. *(12 month continuous eligibility for children's Medicaid is a state option available to Texas.)*

Re-certification. Parents of children enrolled in CHIP must update eligibility information by mail annually. Parents of children in Medicaid must re-visit the DHS office every 6 months to repeat the eligibility interview, even if they have had no changes in income.[14] *(12-month re-certification is a state option available to Texas.)*

Income Limits. Children eligible for CHIP must have family income at or under 200% of the federal poverty income limit (FPL), and they cannot be eligible for Medicaid. Children's Medicaid income limits are: 185% FPL for newborns to age 1; 133% FPL for children until they turn 6, and 100% FPL for children until they reach age 19. Both programs look at pre-tax income, though they do allow monthly work expense deductions of $120 per adult worker, and child care expense deductions up to $200 per month for a child under age 2, $175 per month for children age 2 or older. In theory, the two programs are using consistent income-counting methods; however, at this early stage of CHIP implementation, there appear to be some real problems and challenges in achieving consistency.[15] Medicaid counts as income other regular support, such as unemployment compensation, child support, social security, and some support from relatives or non-relatives, in addition to earnings from employment.

Assets Test. Eligibility for Texas' CHIP program is not affected by non-income assets a family may have, such as money in the bank, savings, land, automobiles, pension benefits, etc. Texas Medicaid for children says that a family may not have more than $2,000 in such assets.[16] Important resources not counted toward the limit include: the family home and one automobile. For vehicles other than the one exempted, any fair market value of the car in

[14] 12 month re-certification differs from 12 month continuous coverage in this way: under 12 month re-certification, parents must still report changes promptly, and coverage can be lost if income increases.

[15] Of primary concern is that some families are being sent to a DHS office inappropriately because TexCare, in an effort to keep the CHIP application process simple, has not counted income or assets that ultimately make the child ineligible for Medicaid. Then, the family must go back to CHIP.

[16] Limit is increased to $3,000 if the family includes a disabled member. The exemption of one vehicle is for children's Medicaid <u>only</u>; ALL vehicles are considered in an adult's Medicaid application.

excess of $4,650 counts against the family's $2,000 limit. *(Dropping the "assets test" for children's Medicaid is a state option available to Texas.)*

Proof, Verification, Documentation. Parents who enroll children in *CHIP* with the mail-in CHIP application must include:

- Copies of documents to prove the stated income. Application instructions request "pay check stubs for the last two months, OR copies of the most recent federal tax form OR other proof of self-employment OR a letter from an employer."
- Applicants who wish to get child care deductions, or deductions for child support they pay to another household, must send proof of those expenses.
- Parents applying for a child who is a legal immigrant must send copies of the child's immigration documents.

Parents who apply for Texas children's *Medicaid* currently must provide the following proofs:

- Copies of documents to prove the stated income. DHS official policy calls, somewhat ambiguously, for a *minimum* of "the 4 most recent pay periods" to be verified, which could require an applicant to provide pay stubs for one month or four, depending on how often they are paid. DHS currently allows local offices to adopt more demanding requirements if they believe accuracy will be improved, and advocates across Texas report that many offices do require additional proof.[17]
- The same proofs for child care, child support paid, and immigration status described above for CHIP are also required for the children's Medicaid application.
- Birth certificate or school records must be submitted to prove the child's age (Texas-born children can be verified through Texas department of health's Vital Statistics database).
- Many of the resources described previously must be documented, particularly bank and savings accounts.
- Residence. Parent must provide document such as utility bill, lease, drivers license.
- "Domicile." Parent must get a landlord or other unrelated person to sign a form verifying who lives in the household.
- "Terminated Income." A parent who has changed employment recently must provide written proof of the change (e.g., prove that no further pay checks will be coming from a given employer).
- Past Employment History. DHS requires parents to document the last 12 months employment history for all employable family (or household) members.
- Other insurance. If a child has other health insurance, a parent provides the insurance card.[18]

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[17] For example, the Texas Association of Community Health Centers is administering "Project Alberto" to study barriers to children's participation in Texas Medicaid under a "Covering Kids" grant from the Robert Wood Johnson Foundation. Researchers for Project Alberto report encountering inconsistent policies at different DHS offices located within the same DHS region.

[18] Unlike CHIP, a child can have other insurance and still enroll in Medicaid. Federal law requires that the private plan pay all bills first, so that Medicaid will only pay for any benefits the private insurance does not cover. For example, many private plans do not cover prescription drugs, eyeglasses, hearing aids, or nursing services that children with complex health conditions may need. Texas has programs devoted to detecting and recovering costs from liable insurance plans.

In August 2000, the Commissioner of DHS announced a plan to reduce the number of required documentary verifications, based on the recommendations of a workgroup that included DHS staff and advocates. DHS anticipates accepting self declaration of date of birth, kinship relationships, third party resources, domicile, terminated income, and past employment history. Also, the agency plans to standardize income verification policies across the state, and ensure that clients know that alternate forms of proof can be accepted. The agency also proposes to allow parents to re-certify for children's Medicaid by mail or telephone, but would still require a face-to-face application at DHS. These new policies, if implemented as proposed by January 2001, will represent an important first step toward creating equitable treatment for parents of Medicaid-eligible children. *(Adopting the same documentation requirements for children's Medicaid as are now required for CHIP is a state option available to Texas.)*

Medical Support Enforcement. When a single parent applies for CHIP, it does not trigger any state government child support or medical support enforcement actions. But, when a parent applies for Medicaid for a child who has an absent (non-custodial) parent, federal law requires the state to pursue *medical* support for that child. The difference between medical support enforcement and child support enforcement is not particularly meaningful for the custodial parent trying to enroll children in Medicaid, because the information she or he must provide is essentially the same. In Texas, DHS asks the custodial parent to provide fairly extensive information about the absent parent at the time they apply for their child's Medicaid, and the State Attorney General's office follows up with additional questions (See Appendix E). If the custodial parent does not provide all the requested information, she or he can be designated as "non-cooperating," resulting in benefit reductions for the parent.

Federal law says children *cannot* be denied Medicaid because their parent is designated non-cooperating; only the *parent* can be denied Medicaid.[19] No special effort is made to inform the parent that their children cannot be denied Medicaid because of their own non-cooperation. As a result, some parents who are unaware of the policy and who do not wish to trigger an Attorney General's investigation simply abandon the Medicaid application, leaving the child uninsured.

[19] A teen parent *can* be denied Medicaid for non-cooperation in providing information about her/his child's absent parent. Also, until very recently, DHS was denying some children Medicaid when their custodial parent was deemed non-cooperating, as a result of a "budgeting" policy which has now been prohibited by federal Medicaid authorities, and dropped by DHS.

VOICES OF TEXAS PARENTS

A QUALITATIVE STUDY OF BARRIERS TO MEDICAID ENROLLMENT FOR CHILDREN IN TEXAS

WHY STUDY TEXAS?

National studies have offered in-depth policy analyses and quantitative survey findings from representative samplings of the national population about barriers to Medicaid enrollment (recent studies are summarized later in this report). However, state-by-state variation in eligibility policies calls for a closer, in-depth look at barriers from a Texas perspective. Texas, with its highly diverse population (from both cultural and geographic perspectives) and stringent Medicaid eligibility guidelines, begs for a closer look.

The new study conducted for this report was designed to ask working parents of potentially Medicaid-eligible Texas children about their attitudes and perspectives on the Medicaid process and product. Qualitative research was chosen as the best method to gain in-depth understanding of what prevents people from applying or re-certifying, and how they may respond to changes in the process. A mix of qualitative techniques was used because in-depth interviews allow more personal points of view, while focus groups offer an insight into how groups talk to one another. Understanding the "word on the street" is central to gaining an understanding of misperceptions or misapprehensions caused by incorrect information, a lack of understanding, or the conveyance to others of bad experiences. This is especially critical since the majority of respondents say they initially learned about Medicaid from a friend or family member.

STUDY DESIGN

Orchard Communications, Inc., was contracted to conduct qualitative research among working Texas families who have children potentially eligible for Medicaid, based on income range, size

of household, and age of children.[20] Between February and May 2000, focus groups and in-depth interviews were conducted with a total of 142 Texans in eight locations (Dallas, Houston, San Antonio, El Paso, Tyler, Amarillo, Waco, and McAllen/Pharr).[21] Field sites were chosen to represent the cultural and geographic diversity of Texas, and included men and women from rural and urban areas; African-American, Caucasian, and English- and Spanish-speaking Hispanics (first and second generation). Individuals were recruited from those with incomes at 150% and below of the Federal Poverty Level (FPL). Depending upon the age of the child, respondents' children were potentially eligible for Medicaid or CHIP.

Focus group moderators and interviewers used a uniform guide designed to gather information in the following broad general areas:

- Challenges of parenting today in general, and in providing health care for children, specifically.
- Top-of-mind impressions about Medicaid.
- How people learn about Medicaid.
- Descriptions of and opinions about the application process, including time taken, waiting room experiences, providing documentation, and interactions with DHS staff.
- Descriptions and opinions about the re-certification process.
- If applicable, descriptions of how Medicaid benefits have been utilized, and opinions about the quality of care and service provided.
- Opinions about barriers to enrollment.
- For Spanish-speaking Hispanics, perspectives on special barriers for families that include immigrants.
- Field-test of ideas for improved access including:
    - 12-month continuous eligibility
    - Telephone application
    - Mail-in application
    - Out-stations for applying
    - Shorter application
    - Elimination of resource documentation

A complete description of the methodology is provided in Appendix A.

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[20] Some national findings were echoed in a previous Orchard Communications, Inc. study on behalf of the Texas Department of Health Bureau of Children's Health Insurance during the summer of 1999. That qualitative study revealed that many parents of uninsured children who will apply for CHIP may actually be eligible for Medicaid. The findings alluded to significant barriers that would prevent parents from following-through with the application if, upon applying for CHIP, they were notified instead of potential Medicaid eligibility. Schechter, Cathy, "A Marketing Identity for the Texas Children's Health Insurance Program," produced by Orchard Communications, Inc., for the Texas Department of Health, Bureau of Children's Health Insurance, 1999.

[21] 88 individuals participated in focus groups; another 54 sat for in-depth interviews.

FINDINGS

Parents' Education, Marital Status

Respondents for this study were recruited based on potential eligibility for Medicaid, using income, household size, and age-of-children as screening criteria. Respondents, 89% of whom are women, generally report that they were the ones who made decisions about their children's health care and health insurance. Sixty-five percent (65%) are married or have common-law partners, 33% are single/never married, or single/divorced, and 2% are widowed. Seventeen percent (17%) have more than three children. A little over half of the respondents (51%) have a high school diploma or GED, and 23% have "some college," with "some college" often referring to junior college or advanced vocational training. Eleven percent (11%) report being college graduates (and one post-graduate). Twelve percent (12%) report having middle school education or less; the majority of these are first generation Hispanic immigrants.

Occupations

The majority of the respondents in this study work outside the home. Only 7% of respondents in the study were unemployed. Of the 32% reporting that they are housewives, most are women in traditional marriages with working husbands. Fifteen percent (15%) of working respondents are employed in office/clerical jobs, such as customer service (e.g., airline personnel, retail sales), secretarial, data entry, and cashier. Among the men who participated, the majority work in trades like welding, painting, factory work or construction labor. Six participants (4%) are self-employed, including a seamstress, restaurant co-owner, upholsterer, two locksmiths, and a home-based entrepreneur who sells clothing. A number of working respondents also work as paraprofessionals, such as nurse or teacher aides; a few were college-degreed substitute teachers. Other jobs mentioned included cooks, custodians, sales representatives, warehouse workers, students (3%), and one pastor.

Challenges of Parenting

A general picture of the average respondent is one of a working parent who, by her/his own description, struggles to earn an adequate living to support the family. Some of the female respondents discussed their transition from welfare to work, and the satisfactions and frustrations of working under their circumstance (e.g., lack of proper daycare or after school care).

When asked what the major challenge of parenting today was, most parents discussed the high cost of providing children with what they need; the quality of education; discipline; guiding them on the right path vis-à-vis teaching morals, and watching their peer groups. Single parents often discuss the difficulty of raising children alone and of spending quality time with them.

Health Care Challenges

When asked what their specific challenges were for providing adequate health care, responses generally related to the high cost of care, medications, or health insurance; the difficulties and frustrations of today's health care system; and/or, maintaining eligibility for Medicaid. Many working respondents who receive their own insurance benefits on the job are unable to afford the high additional cost they must pay out-of-pocket if they want coverage for their families. After weighing the cost vs. the potential benefits, they consciously decide to remain uninsured. Many of these workers pay for medical expenses out-of-pocket, use credit cards, or (along the border areas) take their children to Mexico for basic health care. For the self-employed, migrant, or seasonal workers, affordable insurance is virtually impossible to find. A number of these respondents describe their attempts to locate affordable insurance, to no avail.

> "***We have made a conscious decision not to insure our family. My husband has a small business. It costs--in order to get insurance through that, we have to get insurance for all of his employees. So we can't afford that. We're stuck in a situation where the two company owners can't get insurance because they have to insure everyone else. Our business isn't that big.***" --Dallas

Other working respondents have tried, with varying degrees of success, to get or continue to get Medicaid benefits for their children, and discuss the challenges of remaining in the system. Many of these respondents have recently lost eligibility because of slight increases in income, or through the acquisition of a later model car. They are often heard to say that they are "$5 over the limit," or "just a dollar over the limit." Within this group, there is a higher degree of frustration with the process, because they say it does not take into account the reality of living on today's wages with the high cost of living.

Whether or not a respondent had past experience with Medicaid or with health insurance, there was widespread dissatisfaction expressed with the quality of health care available. Many complaints were heard about a lack of continuity in health-care providers, and insensitivity in clinics and hospitals. Most parents express a desire for an "old-time family doctor," described as one who knows their children's history, or even remembers their child's name. Quality of care based on perceived lack of continuity of care within the health care system is a major challenge for many respondents, who want their children to have good care. This is especially true for parents who struggle with children who have chronic health problems such as asthma or diabetes.

PAST EXPERIENCE WITH MEDICAID

Responses to questions about past experience with Medicaid generally yielded three categories of people: (1) those who currently have Medicaid for their children, (2) those who have accessed Medicaid in the past and currently do not have it, and (3) those who have never accessed the system at all. For the two groups who do not currently access Medicaid, barriers are enumerated. Each of the barriers will be addressed in greater detail through this report. What follows is a summary of each group's perceptions of the program, based on past experience.

Those who currently have Medicaid for their children. Of the 59% of respondents overall who have had experience with children's Medicaid within the past five years, roughly half report still having it for at least one child. Within this group, widespread expressions of approval for the program were heard, along with strong expressions of gratitude for the benefits it provides their children.

> "[*My husband's] company was in the process of getting insurance for him, and I was going to be on the policy and my son was going to be on the policy and we were going to pay for me and my son. And it turned out I got pregnant right before the policy was to begin. They denied me because they called it a pre-existing condition…so my son and my husband are covered on the insurance, but I had Medicaid. And if it wasn't for Medicaid…I spent a month in the hospital this summer and I lost the baby. But Medicaid stepped in and … paid for everything. It was a lifesaver.*" --Dallas

While many complaints were heard about the amount of time and effort it takes to maintain certification, this segment tended to complain much less about the process, and to express the idea that it was "okay." While some respondents perceive that Medicaid should only to be used for emergencies (lest the benefit run out or be drained from "those who need it more" [22]), many others talk about taking children for Texas Health Steps check-ups, and also taking positive advantage of the dental and vision benefits.

Those who have accessed Medicaid in the past and currently do not have it. The parents who have had experience in the past five years, but who currently do **not** access the Medicaid program for their children, differ slightly in attitudes from those with children currently enrolled. These respondents also generally approve of the program, and express gratitude for the time they had it. However, many who have lost it carry strong resentment and even anger toward a process that they say is often capricious and doesn't consider the reality of the working poor. Many of these respondents perceive that they either cannot get benefits, or have lost benefits, because they were able to attain some small measure of prosperity vis-à-vis new-found work, purchase of a car, or a gift. Yet, they don't believe that they can afford insurance for their children at the cost it is usually offered on the job.

In fact, many of these parents' children may still be eligible for Medicaid, but the parents do not reapply because of one or more of the following misperceptions:

- The belief that they are not eligible for benefits because they have gotten a job.
- The belief that they are not eligible for benefits because other benefits, such as TANF, have been denied.

[22] These comments reflect a common, **but erroneous**, belief that Medicaid benefits may be time-limited.

- The belief that they are not eligible because they have been denied Medicaid benefits in the past, specifically either upon re-certification, or first application.
- The belief that they are not eligible for Medicaid because they own a late model car or in some cases, a home.
- Lack of awareness that the Medicaid income limit for children is much higher than for adults, and lack of awareness that the value of one car is exempt from the assets test for children.
- A lack of time for gathering extensive documentation, or "going down there," to spend time in the waiting room at DHS.
- Avoidance of re-certification for a variety of reasons (difficulty getting time off work, treatment by DHS staff, paperwork, etc.) until an emergency arises.
- Anger because of a negative experience with a particular caseworker:

> "***Well I had my purse. She said, 'Where did you get your purse?' And I told her, 'none of your business. I'm talking about my residence, me and my child. Nothing else matters.' And she said, 'Well I need to know with your attire how are you supporting yourself?' …. I'm telling you, you got your documents right here. You can have that….I didn't want it….It just wasn't worth it.***" -- Houston

For some single mothers, an unwillingness to reveal information about the child's father for fear of unwanted involvement from the Attorney General's office in child support or medical support matters, or an aversion to the nature of questions asked (e.g., information about last sexual contact, number of contacts, etc.)

- A perception that the quality of medical care and service is sub-standard, based on past experience; therefore, they would rather "pay out of pocket" and wait to reapply only for pregnancy or emergency.

- San Antonio respondents in particular complain about the difficulty of finding providers in a managed care setting. Waco respondents (where managed care has **not** been implemented) also complain about a lack of providers who accept Medicaid.

THOSE WHO HAVE NEVER ACCESSED THE SYSTEM AT ALL

Forty-one percent (41%) of respondents, who were recruited specifically because they may be potentially eligible for Medicaid based on income, household size, and age of children, report that they have never accessed the system. These respondents offered the following reasons why they have never applied before:

A lack of awareness that the program even exists, or that they may be eligible.

- Confusion between Medicaid and Medicare; a belief that "Medicaid" is only for old people, single mothers, or the poor.
- A belief that Medicaid is strictly "welfare," and being so linked, is not available to working families.

- A basic pride that precludes asking for help, or of "going down there," to apply for benefits at DHS, which is perceived to be "dirty" and "full of sick children."
- Word-of-mouth news that applying for Medicaid is "a hassle," "a lot of red tape," and "not worth the time."
- The perception that Medicaid provides access only to poor quality health care providers and facilities.
- It should be noted that many of these families, upon being told about CHIP, say they will apply because they can pay a premium for it. They widely perceive that if they pay for the product (CHIP), the quality of service and care will be better than Medicaid, which is free.
- Some income-eligible respondents describe how they pay for employer-sponsored insurance, sometimes at a very high price, and considerable sacrifice of other family needs. Those who have the opportunity to insure their families through employers such as the Houston Independent School District or City of Houston, (cited by respondents as employers who offer high-quality, affordable insurance for the whole family) say they would prefer to pay for insurance than apply for Medicaid.

> "***My husband works for the city of Houston, and we have NYLcare for the family. Medicaid is state-funded. I've heard that it's a hassle. Anything that's free is going to be a hassle.***" --Houston

"TOP-OF-MIND" OPINIONS ABOUT MEDICAID

Gratitude. When asked what comes to mind when they think of Medicaid, those respondents currently receiving Medicaid benefits, and many who have received them in the past, express gratitude for the availability of help. For these individuals, top-of-mind associations relate to the program's helpfulness and assistance with medical bills. A few people equate Medicaid with health insurance, and use it as a health insurance plan.

> "***You can go at any time, anywhere, they're going to assist you. It's a big help to many families.***" --McAllen

> ***"[We had it]…in the beginning of the long haul with our business, and I was grateful….they covered me and my son for a year after he was born, and it was a wonderful thing.***" --Dallas co-owner of family business

Emergency Assistance. Many respondents, especially in the Hispanic community, equate Medicaid with emergency assistance, and use it only in emergency situations. Many along the border, in particular, take their children to Mexico for basic health care needs, but enroll or re-certify in the event of a pregnancy, emergency illness, or need for a specialist.

> "***I am not so concerned with Medicaid. I would be concerned in something big, like surgery or a long treatment. But for minor sickness, I prefer to take them to Juarez.***" --El Paso

The Process. Some respondents who have recently lost Medicaid benefits have top of mind associations that revolve around the process, such as "paperwork," "long waits," or "rude

caseworkers." Many of these individuals express anger and resentment at a system they find to be "stupid," or describe in a variety of ways as invasive. For these individuals, possession of certain cars or amounts of cash on hand at a particular moment disallowed them; therefore, they often express the view that the rules and rule-enforcers are capricious and mean-spirited. The net effect has been a loss of health insurance coverage for their children, and increased out-of-pocket expenditure or debt over health care.

> "***It's a tremendous amount of paperwork…we don't always see the same person[caseworker], and one person may be a little more lenient with you and work on things because they know you're trying to work with it, and then you'll get someone else and it's by the book.***" --Amarillo

> "***The worker left through the back door to look at the truck. Because the truck has 65,000 miles on it, very little mileage. I tell them, it's from '94, and it's 2000. [he said]… 'No, we're not going to help you. Look, you have leather seats, you don't qualify.' The seats look very bad.***"[23] --McAllen

> "***I just didn't want to go no more because I was like, about my first experience, if I have to go back, I'll have to go through this again. I'm not going to go, so I pretty much just put it off.***" --Amarillo

Linkage with Welfare. Those who have accessed Medicaid in the more distant past, or never at all, express a strong distaste to its linkage with welfare. That is, Medicaid is seen as a part of a package that includes Food Stamps, cash assistance (TANF or AFDC), housing and daycare subsidies. It may also be strongly associated with a local health care facility that is perceived by some to offer poor-quality "charity care" or to primarily serve trauma victims. For these individuals, the stereotypical recipient is a single, non-working mother of multiple children. If they have never been in this situation, or if they have "risen out" of this situation, they generally do not want to "go down there," as it symbolizes a downward spiral or return to something that they are working hard to avoid.

> "***When I hear Medicaid and Food Stamps, to me it is for lazy people.***" --El Paso

> "***…welfare mothers. Some of them work, and some of them don't….Medicaid in my mind is a big government nightmare. I would rather stay home than go to Harris County Hospital or Ben Taub.***" --Houston father

Limited Health Care Choices. Many respondents, whether they have current or past access to Medicaid, or have never accessed it at all, associate the program with "limited choices in health care." A number of respondents, particularly those in the San Antonio, Waco, and Amarillo areas, additionally associate Medicaid with a limited choice of providers. Complaints about providers include the ideas that only less-skilled or foreign doctors who speak little English accept Medicaid; "starter" doctors accept Medicaid to get their practices off the ground; or, that better doctors establish quotas of Medicaid patients they will take.

> "***I think that it's nice that they're offering something for people, but you know, I don't think we get the cream of the crop doctors. … if you can afford your own insurance, you***

[23] Again, most parents were completely unaware that one vehicle could be disregarded for purposes of children's Medicaid, and it appears that eligibility workers do not consistently inform parents on this subject.

have the option to say, 'I don't like your service.' Fine, and take your money and spend it elsewhere. But if you're in a program like Medicaid, you can't." --Dallas

Poor Treatment by Providers. Many respondents note that when it becomes known that they are on Medicaid, they perceive that the service they receive from pharmacists and frontline staff is less respectful than what they would receive if they had "regular" insurance. A significant number report that the stigma associated with Medicaid is most acutely felt in these situations. A number of respondents say that the stigma associated with Medicaid as the reason their children remain uninsured. Pride remains a significant barrier to utilizing Medicaid.

While it is beyond the scope of this study to verify whether reported poor treatment and lower quality care is perceived or real, the perception is strong enough among some respondents to prevent them from accessing benefits to which they may be entitled.

"***I remember one pharmacist who saw the card, then he just looked at me funny. I was ashamed…I won't apply again.***" --Waco[24]

Managed Care Complexity. For some Houston and San Antonio respondents, managed care was discussed as a point of concern. In San Antonio especially, respondents offered a variety of negative opinions about managed care options, the need for a primary care provider, and the (inaccurately) perceived loss of access to the emergency room, even for legitimate emergencies. One Houston respondent has dropped out of Medicaid because she no longer understands it.

"***Many doctors, even those in the provider book, are not accepting new clients. It took me a long time to find a doctor who would take care of my baby.***" --San Antonio

"***I was on Medicaid with my kids when they broke it into all these different health plans, and it got real complicated and I believe they were trying to do something good for people. But it got real complicated there for awhile about it, and it led me to just get off of it. I don't have a health plan right now. If my kids get sick, I have to go to the doctor with them so I'm looking for something I can afford right now.***" --Houston

FIRST AWARENESS OF MEDICAID

A significant majority of respondents report that they heard about Medicaid for the first time from a friend or family member. However, some Hispanic respondents in particular said they heard about Medicaid from a health care provider, whether WIC, the hospital where a child was born, or the doctor's office. Caucasians and African-Americans were slightly more likely to have heard about Medicaid from a DHS office. A few respondents heard about it from a high school teacher or guidance counselor.

One effect of having family and friends as the primary sources of information about Medicaid is the conveyance of information about enrollment, re-certification, and eligibility that is often distorted or incorrect. The following quote reflects the depth of misinformation, and shows how gaining first awareness from lay sources can confuse those who may be seeking medical assistance. **This parent, like a great many participants, was completely unaware that welfare reform provisions such as time limits do not apply to Medicaid benefits.**

[24] This episode suggests that, like many parents, this pharmacist was unaware of the higher income limits for children's Medicaid. Many providers are similarly misinformed or uninformed.

"***Medicaid went through a change, a process change. This is what they did. I just happen to know the facts. If you had a high school diploma, they let you have it for 12 months. If you didn't have a high school diploma, you could get it for 18 months. If you had college, you could only get it for nine months. In other words, what they did is they hooked up with Texas Works and the people were all on Medicaid, they made us start going over there for six-hour sessions.***" --Houston respondent, explaining Medicaid to 10 other people in a focus group

THE ENROLLMENT & RE-CERTIFICATION PROCESS

For some parents, a pregnancy, illness, or health crisis brought them in contact with an out-stationed DHS eligibility worker, and the enrollment process was very simple. The majority of respondents who did not enroll for the first time through a health care provider, or who did not receive Medicaid as part of their application for Food Stamps or TANF, typically describe making an initial telephone call or walk-in visit for an appointment at DHS. The descriptions of events and conditions found by these respondents in DHS offices statewide are consistent, and resonate among the vast majority of the parent participants. The experience of applying for children's Medicaid is typically characterized by the following: (A more detailed description of each item, with supporting quotes, follows.)

- Long waits in uncomfortable surroundings
- Confusion over documentation and eligibility requirements
- A strong feeling that the application invades their privacy
- Rude treatment by DHS staff
- Inconsistent interpretations of the rules by various caseworkers
- Lengthy waiting to hear if eligibility has been determined

WAITING: PART I

The vast majority of respondents describe arriving at DHS for their appointment, then having to endure a long and tedious waiting process. When asked about how long they waited, the average wait time mentioned is 2-3 hours in larger urban areas (Houston, Dallas, San Antonio). For smaller towns, such as Longview and Waco, the average time mentioned was about 45 minutes. Many complain about the requirement to have an appointment, only to have the appointment seemingly disregarded by DHS staff. Several respondents questioned why DHS bothers to require appointments at all.

Taking care of children at the DHS office presents a major challenge for many respondents. Small children with nothing to do become bored, restless and noisy. They describe great discomfort at people "looking at them," yet they cannot remove their children to quiet them for fear of losing their appointment. One respondent in El Paso mentioned the fact that they don't have diaper-changing tables, which makes it difficult for women with babies to wait long periods.

"***Yesterday I think it was, I was in the welfare office from 7:45 in the morning until they finally see me at ten after three o'clock in the afternoon. Me and my son. He was frustrated, he was yelling, he was running all over, he had just gotten tired…I had called them the day before and they told me, 'well come in at 7:45 in the morning.' So I went***

ahead and they had me sitting there…if I had known it was going to take that long I would have been prepared. I didn't have no money, nothing. I was bored with my kid. They don't have no toys in those places. They don't have little snack bar things…oh man, I was mad. " --Amarillo

Respondents describe the waiting room as "boring," with nothing to do but "watch the people come and go," and "look at posters on the walls." Many complain that if you leave the room, you may lose your slot if your name is called while you are not there. Yet, despite long waits and a required presence to guarantee being seen, food and drink are often prohibited. Snack and soft drink machines are usually not available.

> "*Participant 1:* ***Might as well pack a lunch, and then you're scared to get up to go to the bathroom for fear you're going to get called.***
> *Participant 2:* ***They call your name…that's it…***
> *Participant 3:* ***Then they move you to the end of the list.*** " --Dallas focus group participants.

While some respondents say they have viewed videos at a DHS office, the majority with experience in the system do not mention a video or access to television while waiting. Several respondents expressed approval at the new job search computers introduced by the Texas Workforce Commission at certain DHS offices.

APPLICATION AND DOCUMENTATION

Respondents describe a wide variety of problems relating to the complexity and density of the application and eligibility determination process.

Documentation: Unclear Requirements, Lost Documents, Inconsistent Policy. When asked how they know what documentation to bring to the DHS office upon applying for Medicaid, many who have accessed Medicaid say they had received a checklist enumerating the list of what is needed. Others report that the process of discovering what documentation to bring is arrived at with great difficulty. Regardless, the process of gathering documentation is described as time-consuming and overwhelming.

> *Participant 1:* ***I had no idea what to bring, and everything kept changing. 'Bring this, bring that. Well we don't understand. We have to review this. Well come back.' And it is really very hard on me because….***
> *Participant 2:* ***It's time-consuming.***
> Participant *3:* ***Very taxing.***
> *Participant 1:* ***It hurt.***
> *Participant 2:* ***Yeah, here I was trying to go to school, hold down a part-time job and then be sure my 15-year old was being watched over.*** –Dallas focus group respondents

Many respondents describe the lengths to which they go to obtain what they understand to be the required documentation, only to arrive and be informed that they are missing other documentation. Most respondents said they understood that they have two weeks to get their

documents in; if they miss the deadline for getting further documentation they have to start the application process over again. A few respondents complained that after either faxing documents or going back to take documents in, they never heard whether they were eligible. After checking again, it was discovered that documentation was lost.

> ***"There was a certain amount of time she had to get some kind of documentation back to them and she showed up like a day late, and she had to completely start the process over again, go back and get the employment and all of that information, the income, the bills, the whole deal. I just listen to her complain about it."*** --Houston

Respondents also say that caseworkers and/or locations are inconsistent in what documentation they require. For example, one Amarillo respondent said it was easier to apply in the Panhandle than Brownsville, where they require that applicants bring in receipts for all purchases. Complaints about inconsistent documentation requirements from place to place, and caseworker to caseworker, are common.

> "***In Brownsville, it's harder over there….They have to have receipts. If you buy clothes, you need a receipt. If you buy groceries, you need a receipt. Anything you buy, you need a receipt. So it's harder over there.***" –Amarillo

Many respondents say they understand that DHS asks for so much documentation in order to prevent abuse of the system. They also say that in order to be honest, they don't mind producing reasonable documentation, including their social security number, proof of residence and income, etc. However, even the most compliant and grateful respondents complain about how cumbersome, repetitious, and time-consuming the required documentation is for re-certification, especially if things do not change that much within 3-6 months.

> "***They ask you for electricity receipts, water, everything. Work, bank accounts, what you're driving. That your boss fills out this form, but you're already there, and you tell them that you're not at work, and oh now, then again…it's very complicated. Every time you have an appointment, you have to bring the same papers.***" --McAllen

Invasion of Privacy. Many respondents currently or formerly on the program characterize the application and interview as invasive because they ask personal questions about a wide range of topics, from amount spent on toilet paper and sanitary napkins, to the frequency of sexual contact with a child's father. Even though some questions about personal items are part of the Food Stamps or TANF application, those who go to apply for Medicaid only are still asked the questions because the applications for all three programs are usually bundled together.

> ***"You tell him that you don't want stamps, I don't want stamps, the only thing I want is that you give the Medicaid for a month so my daughter can have [dental] surgery. It is the only thing, and they say, 'but you qualify for the check,' but I say, 'my husband is at work, right, I only want medical treatment…He told me, no, you need to want all three of them or you won't qualify.***" --McAllen

The questions asked by caseworkers on behalf of the Attorney General's office on medical or child support enforcement, in particular, evoke feelings of strong consternation, particularly with single mothers who may need the coverage most. However, in in-depth interviews, (notably

African-American and Hispanic) some **married** respondents revealed that private questions about the children's father were posed by DHS workers, including physical descriptions "in case they have to file child support on him one day."

> *Participant 1:* ***They asked you what the dad's name.***
> *Participant 2:* ***And if you don't put it, you automatically don't get it. That's disqualification right there…***[25]
> *Participant 3:* ***They ask if you got more kids and this and that, what does it matter? ….***
> *Participant 1:* ***How many times did you actually have encounters. You're supposed to count them….***
> *Participant 4:* ***Do you have pictures?***
> *Participant 1:* ***They ask if anyone else could, anyone else been with…I mean, that's between you and the sheets and the wall. I was so frustrated. Wait a minute, I'm going through a divorce and you want to know? I know who my kid's daddy is. Can you get him and make him pay? And do we have other kids? Who cares what he's got, he not taking care of what he has. They ask a whole bunch of stupid questions….What difference is it gonna make…? You are still the mama.***" --Dallas focus group participants

> "***They made me sign a paper saying my husband's name and if he were to go, that he'd have to pay child support. And they say, 'Well just in case he leaves you, you have to sign it.' And I don't think my husband is going to leave me….They make you sign a paper with all this information, his height, his color of hair, his eyes, you know everything, like he was already gone and you have to search for him to pay child support. And I tell them, 'Well, he's not going to leave me.' And she goes, 'Well, we have to have it in case he does.***'" –-Amarillo

> "***This comment I made about (highly personal questions), you may think I am wrong, true, but not long ago a lady was crying when she left the office and I asked her if she needed help and she said no, because it was so offensive to her what they were asking, even asking her with what money she bought her sanitary napkins for her menstruation. I say those things are private, what do they care?*** --El Paso

Fear of Sharing Documentation with INS. For many first generation immigrants, the prospect of a visit to the DHS office is characterized as "scary," particularly because they do not understand how all the information gathered is utilized. Rumors abound that the DHS computer systems are hooked up with the INS, leading to border arrests of the undocumented family members of lawful Medicaid enrollees. Based on this fear alone, many parents with U.S. citizen children potentially eligible for Medicaid, never try to apply. Those who do find the experience anxiety-provoking. *(See box, Immigrants and Children's Medicaid.)*

> "***I had fear at the beginning. I would go with great fear and called upon all saints when I went to apply.***" --El Paso

For Hispanics, fear is not limited only to immigrants. One **U.S.-born** Hispanic respondent in Amarillo complained that they asked her for a residence card or some proof that she is a citizen.

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[25] It is important to note that, per federal law, children may NOT be denied Medicaid due to either parents' non-cooperation with medical or child support. However, it is clear this parent was not aware of that protection.

"I didn't have my voter's card either, so she put a red tape around my file that said, 'Danger,' 'Watch Out' or something like that. She said she couldn't get me on Medicaid because I needed to prove I was a citizen. She said I needed to bring my voter's card or something like that. That was mean, because they had given me Medicaid in the past without my voter's card, but this time she said, 'Uh uh, you need to bring something in." I said, my driver's license? You can check my record or something? She said, 'No, I need to see your papers.'" --Amarillo[26]

Proof of employment and residency. Proof of employment and residence often requires applicants to bring letters to DHS from employers and landlords. For many respondents, asking for a letter evokes great shame and embarrassment. Some question why pay check stubs or tax return documents are not enough to prove income.

"***In my case, my husband's salary varies because he works in construction and sometimes he doesn't work as much as other weeks. Well they ask me for six [weeks pay stubs] and a letter signed by the employer. So every time [I re-certify], I have to go to the employer and fill one out. I feel embarrassed.***" --Amarillo

"***I think it's a degrading experience, as far as the information they want to know. OK, I'm willing to take my lease up to them and show them to verify where I live and how much rent I pay, but no, that's not good enough. I have to go to my landlord and say, 'Well I'm applying for Medicaid, I need you to fill this out to verify that I live here…it's such a rigorous process, you know you just get frustrated with it and say forget it. It's not worth it.***" --Houston

[26] Federal regulations prohibit agencies from requiring citizenship verification based on an applicant's appearance, accent or surname.

IMMIGRANTS AND CHILDREN'S MEDICAID

Texas focus groups and interviews revealed special concerns and barriers to enrollment among families that include one or more non-citizen (see findings). Census data show that 18% of Texas children live in a family in which one or more of the parents is not a U.S. citizen (including both legal and undocumented immigrants), and among Texas children below 200% FPL, 27% are in such mixed-immigration families.[27] Attention must be given to the barriers faced by these families if Texas is to succeed in substantially reducing the number of uninsured children. Similar concerns are reported by other states. It is useful to understand the current law and policy context for this issue.

- Undocumented immigrant children cannot enroll in regular Medicaid, and have never been able to do so (health care providers can be reimbursed for emergency care provided to undocumented children who in all other respects would be Medicaid–eligible). No official estimates exist of what percentage of the 600,000 uninsured Texas children below poverty are undocumented, and thus ineligible for Medicaid.
- Medicaid-income children with "green cards" (legal permanent residents) can enroll in Medicaid, or in Texas' state-funded CHIP. Children must use the latter program if they arrived in U.S. on or after 8/22/96 and have been in the U.S. less than 5 years. After the five-year period is up, they can enroll in "regular" Medicaid.
- The immigration status of a family member is irrelevant to the eligibility of an individual child. This means that the U.S.-born child of an undocumented parent is entitled to Medicaid on the same terms as any other U.S. citizen child.
- Parents who apply for Medicaid or CHIP for their children cannot be required to provide immigration documents or Social Security numbers (SSN) for themselves; only the information for the child seeking benefits is required.
- 1999 INS rules promise immigrants that their own use of, or a family member's use of Medicaid will not jeopardize their ability to get a green card or eventually become a citizen.[28]
- Federal requirements for DHS reporting to INS are quite narrow, and generally eligibility information must be kept private. DHS will share information with INS if a non-citizen has committed fraud, owes repayment for excess benefits issued and refuses re-payment, or if a person formally under final order of deportation actually applies for benefits (the latter being very unlikely to occur).

A major federal effort has been made to safeguard the ability of mixed-citizenship families to seek health care. The link between Medicaid and Medical Support Enforcement has not been as carefully examined. While parents applying for a child's Medicaid do not have to provide parental SSN or immigration information to DHS, the AG's office does ask for this information in pursuit of medical support. In addition, many custodial parents fear that DHS or the the AG's office may also report non-custodial parents (from whom medical support is sought) to the INS. Though the AG's office has no formal policy of communication with INS, more investigation is needed to determine why these fears are so widespread.

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[27] Unpublished analysis of U.S. Census data prepared by the Urban Institute and provided to the Center for Public Policy Priorities.

[28] There are two exceptions to this statement. A person who is entirely dependent on Medicaid institutional long-term care for his support would not be granted a green card. Also, if benefits are received fraudulently, e.g., income is falsified, it could be grounds for deportation or denial of citizenship.

The Assets Test: Misunderstood, Seen as Barrier to Self-Sufficiency. When asked about their opinion of assets test questions, respondents make it clear that they support income limits and verification in Medicaid, and want to see them enforced. However, they regard the asset limits and the process for verifying assets as unfair and fraught with abuses. Asset questions are the ones that evoke the most extreme negative opinions by those respondents who have accessed Medicaid presently or in the past. Because many families believe that these questions have resulted in denial of eligibility ("I'm just a dollar over the limit," or "My car is too new"), many respondents see the questions as "an invitation to lie:" a way that the state encourages fraud or discourages people from applying at all. A number of respondents complained that they were "denied for telling the truth," and believe that other families are lying to get health insurance. In fact, perceptions of widespread lying and abuse of Medicaid are a barrier to many people from applying to begin with. Many **non-participating** respondents express the idea that they, "don't want people to think I'm like the ones who abuse the system."

Many take particular issue with the question about automobiles. They find a "Catch-22" in the idea that you have to have an old car (or no car), yet are expected to hold down a job. They ask aloud how you are expected to "better yourself," without transportation. Parents' responses made it clear that **an overwhelming majority did not understand that they could have one "good" car exempted for purposes of qualifying for children's Medicaid.** Also, parents' responses suggest that eligibility staff have discouraged families from applying based on a single vehicle, failing to distinguish between the vehicle standard for adult Medicaid and Food Stamps, and the more generous standard for children's Medicaid.

> "***It was an old car; it had been paid for a long time. They told her it was worth, like, $1,500. They told her to sell the car and come back…because it was an asset and it needed to be sold so she could qualify. They told her to sell the only mode of transportation she had so she could qualify to get Medicaid for her daughter.***" --Dallas

A number of respondents also talk about the perils of offering information about cash on hand and bank accounts. In-depth discussions about how the "cash on hand" question works reveals that they may have more in their checking accounts at various times of the month, depending on when they pay their bills. They complain that DHS may be looking at a snapshot of their financial picture, i.e. cash on hand, without looking at the other part of the picture, i.e. the bills they have to pay in the near future.

> "***If you have $200 or $300 and they think it's too much, they say, 'until you spend all that money, [then] we will give you benefits again.' Well, it <u>is</u> all spent, just that the checks have not cleared yet. Then bring me all the receipts so we can see that you have spent that money.***" --El Paso

Hispanic respondents, in particular, complain about being denied because they have established savings accounts for college for children. One El Paso respondent complained that the state subtracts what is spent on daycare or elder care from the equation, but does not take into account the expenses of families who send children to college. This Houston respondent echoes the sentiments of many working respondents who need assistance with health insurance.

> ***"Why should I hand over what's taken me years for my children's savings account for their future, just to have something for the moment?….I don't feel that I should have to give up every last dime to get this medical assistance."*** --Houston

Experiences with DHS staff

While a number of respondents (roughly 20%) tell stories of caseworkers who were nice and tried to help them, over three-fourths of respondents who have currently or in the past accessed the system, report incidents in which they were treated poorly by DHS office workers and caseworkers. The perceived poor treatment is described in a variety of ways, from short, abrasive, condescending speech, to being ignored by staff who make personal conversation amongst themselves, while a large number of people wait. The following two quotes echo what many respondents say:

> "***They give the impression…you need me, I don't need you. Now what you want?*** -- Dallas

> "***They act like the aid comes from their pockets, and that's not true.***" -- McAllen

Respondents attribute the behavior of DHS staff to a variety of factors, including the fact that workers are burned out, overworked, and have poor equipment to work with. Other respondents note that turnover is high in DHS offices, and observe how this affects their case. Some respondents simply believe that caseworkers don't know what they're doing.

> "***They don't even know why they're asking these questions.***" *--Dallas*

Many respondents say they believe that eligibility determination "depends on the caseworker," indicating that they see them as capricious in their interpretation of the rules. The conventional wisdom is that if you get a nice one, they'll do everything they can to help you qualify. If you get a "mean one," they will take pleasure in denying the benefits. A few respondents in the Valley talk about "flirting" with their caseworker to get their way, and there are sometimes suggestions that the caseworkers are corrupt.

> "***They all think differently. Not all of them give you the same information. If I go with one, he tells me, 'look the four of them qualify.' The period they give you for Medicaid ends, you go again, and they tell you only 2 of them qualify.***" --McAllen

A number of respondents talked at great length about the kind of training that DHS staff should have on a regular basis to provide better customer service. One Dallas respondent pointed out that if Medicaid is to increase the number of children served, it would need to address staff attitudes towards their clients and make them more accountable for their behavior.

> "***I think that training is very important, and their people skills should be evaluated through some kind of … system..***" --Dallas

> "***Maybe if they get an orientation, maybe they'll know. Maybe they've forgotten something. They need a little reminder. The difference between Medicaid and Food Stamps or different types of help that they do.***" --Amarillo

Waiting: Part II

Waiting to hear about whether or not the family is eligible is described by some respondents as anxiety-provoking, especially if they are currently faced with high medical bills, or the prospect of high bills. They wonder aloud why eligibility cannot be determined on the spot. A few

respondents complain that they never hear back from DHS, are treated discourteously when they call to find out what has happened, often to find the documents or files have been misplaced.

> "*Participant 1:* ***The approval process felt like it took forever after I finally got them everything. It still took them forever to tell me I got Medicaid…like over a month.***
> *Participant 2:* ***Yeah, I was like two and a half months pregnant, and I didn't get it until five months.***" --Dallas

THE RE-CERTIFICATION PROCESS

For those who go to be re-certified, the process is generally described as slightly easier than the initial application, simply because they know more what to expect. However, the burden of continuing to gather the resource documentation is onerous for many people, and complaints about it were common in all field sites. This El Paso respondent offers an example of what many say about re-certification.

> "***If my husband has overtime for more than one week, it works against my Medicaid eligibility because I have to report it within ten days. To reapply, I then have to wait for four pay stubs.***" --El Paso

When asked their opinion of having 12-month continuous eligibility for Medicaid, respondents who have accessed the program unanimously agreed that it made more sense.

> "***Re-certification is a nuisance for me, because very little ever changes. It could be easier if I just sent a note saying nothing had changed.***" --Waco

Some respondents complain that re-certification has become more burdensome lately; that you are more likely to be turned down, especially if you have recently gotten a job, and that with a job, you have to go "down there" too much.[29] Many people never return because they don't think they will be re-certified.

> ***"I got Medicaid when I wasn't working, but now that I'm working at the daycare center, I know I won't qualify. I need to go back, but I just haven't done it."*** --San Antonio

BARRIERS TO MEDICAID ENROLLMENT

Misinformation. When asked what barriers they perceive for people who might need Medicaid for their children, but haven't applied, many respondents say that basic facts about the program — what it is, and who is eligible — are not known by many people. This was evidenced in the course of this study as many respondents indicated a basic confusion between Medicaid and Medicare. This confusion emerged in two ways; for one thing, people often use the two names interchangeably. For another, a number of respondents state the belief that "*I am paying for this out of my pay check every two weeks, and yet when I need it, it's not there*," thus indicating that they believe payroll deductions are made for Medicaid, rather than Medicare. **It was also clear that the substantial majority believed (also inaccurately) that Food Stamp and TANF policies**

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[29] DHS has, in fact, recently increased the frequency of re-certifications for many working families getting Food Stamps. It is highly unlikely that these families are aware that this demand is related to their Food Stamp benefit, rather than their children's Medicaid.

affected Medicaid, and did not understand that both income and asset standards for Medicaid are different for children than for their parents.

> "***A lot of people don't even know what it is, much less that they qualify. They may have pride. But it's done nothing but help me. Nobody cares, nobody's going to make fun of you for being on Medicaid.***" --San Antonio

> "***People don't think they're going to qualify. They're just going to end up wasting their day.***" --Amarillo

> "***You have a lot of working poor…and a lot of these people go from job to job and sometimes they qualify, and sometimes they don't. Sometimes they're unemployed, and sometimes they're not…so you go in and out of it so much that you don't want to go through the revolving door.***" --Houston

All Children Should Have Insurance. A significant number of respondents express frustration with the entire health care system, and often compare it to Canada or European countries with socialized medicine. They lament that all children, regardless of their economic class or ethnic group, should be eligible for Medicaid. The following quotes reflect the beliefs of many.

> "***I would give Medicaid to every child, regardless of having money or not.*** " --Amarillo

> " ***Without economic considerations, every child equal.***" --El Paso

Other Barriers. Other barriers mentioned include:

The linkage of Medicaid with Food Stamps and TANF ("welfare"). Many respondents would prefer to have a separate Medicaid office, or separate Medicaid specialists.

> "***I dislike welfare personally just because it has a negative connotation, based on being African-American, I can't speak for any other culture….But Medicare (sic), health care is okay, because we all need it.***" --Dallas

The perceived "hassle" of paperwork and documentation.

> " ***Take off the questions about the cars, and the letter from the boss.***" --McAllen

> "***A lot of the questions they ask over and over again. Like where do you live? How old are you? What is your address? And all that, you know, over and over. And then there were questions on there about the father's name and the mother's name, and I was the grandmother, the guardian. Didn't have anything about me on there.***" --Tyler

The perceived slowness of the eligibility determination process.

> "***In Colorado, they'll go ahead and approve you if they think you're going to be approved. Here, I'm missing his birth certificate, his shot record, his social security. There, they work with you. Here, they're so picky.***" --Amarillo

Poor conditions in the DHS office, and concerns about poor treatment.

> "***I felt like part of a herd of cattle in this disgusting facility, waiting all day, and nobody gave a damn."*** --Houston

Perceived lower quality of health care and service.

> " ***The person with the private insurance or cash goes first.***" --McAllen

"*My doctor doesn't see Medicaid patients.*" --Waco

Immigrants perceive barriers unique to their circumstance.

"*They do not come to apply because they are afraid.*" --San Antonio

There is widespread perception that even if the children were born in this country (and thus are U.S. citizens), if a parent is undocumented, the child cannot get Medicaid because the parent won't be able to provide all the papers they need. Some respondents perceive discrimination (i.e., harsher treatment) by caseworkers because of language barriers or immigration status. Some also reported that caseworkers expressed disapproval over the number of children in their family. A few respondents say that immigration attorneys have told them they shouldn't ask for government assistance for their children while they are in the process of applying for legal permanent residency status (a green card). Many immigrants are fearful of repercussions from the INS if they apply for benefits.[30]

RESPONSES TO PROPOSED CHANGES TO THE ENROLLMENT PROCESS

The following changes were suggested to respondents to get their impressions and attitudes about them:

- **Twelve month continuous eligibility.** Among those who are currently accessing Medicaid, or who have recently been on Medicaid, there was unanimous agreement that 12-month continuous eligibility is desirable.
- **Telephone applications.** Most respondents agree that they would appreciate any systemic change that obviated the need to "go down there," thereby saving time, wages, and "the hassle." The majority thought telephone would be more than adequate to record changes for re-certification purposes. However, many respondents who have accessed Medicaid also expressed the fear that telephone applications stood a large chance of being lost or incomplete.
- **Application by Mail.** Most respondents approve of applying by mail to save time and prevent having to go to DHS. Like the telephone application, many respondents said that the mail would be one of the preferred ways to record changes or re-certify. However, as with telephone applications, a number of respondents with experience at DHS fear their materials will be lost.
- **Applications at "out-stations."** Stationing DHS workers in schools and health care provider offices received highly favorable responses by a significant majority of respondents, with only one respondent saying she thought applying at the school office would embarrass her children. Schools and daycare centers, especially, were viewed as a good place to station DHS caseworkers.
- **Shorter application.** Overall, a shorter application that would eliminate repetitious questioning was expressed to be a highly desirable change by the majority of respondents.

[30] See page 40, *Immigrants and Children's Medicaid.* Federal rules guarantee immigrants that children's lawful use of Medicaid will not prevent a parent from getting a green card.

- **Removal of assets test and resource documentation.** The majority of respondents want to see questions about automobiles and bank accounts removed from the application, as they have been for Texas' CHIP application. They also want to eliminate the need to ask employers, landlords, and neighbors for letters attesting to their situation. At the same time, about one-fourth expressed strong concern about, and support for, enforcing income standards and preventing fraud and abuse of the system.
- **Questions about the child's father.** A number of respondents, single mothers in particular, take issue with questions (such as last sexual contact with the father), or about whereabouts of the child's father, perceived to be invasions of privacy.

MEDICAID PARTICIPATION BARRIERS

WHAT THE NATIONAL RESEARCH SAYS

Because the high numbers of Medicaid-eligible uninsured children have been a national problem, a number of studies searching for the causes of low Medicaid participation have been conducted over the last decade. The studies share many common findings, and reveal that there are multiple factors discouraging enrollment. Importantly, the findings of the Texas focus groups and interviews conducted for this report echo strongly the issues identified in these national studies.

Kaiser Commission. A recent and authoritative study was prepared by the Kaiser Commission on Medicaid and the Uninsured and entitled *Medicaid and Children: Overcoming Barriers to Enrollment: Findings from a National Survey*. This January 2000 report is based on a national survey and focus groups[31] with two types of families: families with children currently enrolled in Medicaid, and families whose children are Medicaid-eligible, not enrolled, and uninsured. It offers important insight into the families with uninsured Medicaid-eligible children, and how they differ from the profile of currently-enrolled families. Because the study used a random-sample survey, the findings represent good estimates of the actual beliefs of parents of Medicaid-eligible children. Key findings of the study include:

- **Uninsured, Medicaid-eligible children are concentrated in two-parent working families.**
- **"Stigma" of the program itself does *not* appear to be a real barrier to Medicaid enrollment.** In fact, 93% of the parents of uninsured Medicaid-eligible children said they would enroll their children if possible.
- **Concern about quality of medical care in Medicaid is found among parents with <u>no</u> experience with Medicaid, but not those who had actually used the program.**

[31] 1,335 parents were surveyed, and six focus groups were conducted.

- **More than one-third of parents who had never applied have negative feelings about going to a "welfare office."**
- **Misinformation about children's Medicaid eligibility is a major barrier; more than three-quarters of parents who had never applied think children's Medicaid was time-limited.**
- **Outreach is not reaching most parents of Medicaid-eligible, uninsured children;** three-quarters have never received any information about children's Medicaid.
- **Two-thirds of parents of uninsured Medicaid-eligible children previously tried to enroll their children. Among these parents, most common reasons for not *completing* enrollment were:**
    - difficulty with required documentation (72%),
    - overall hassle of enrollment process (66%), and
    - complexity of the process (62%).
- **Parents who had never applied said they had not because** they
    - did not think their children were eligible (58%)
    - did not know where or how to apply (56%),
    - believed the process would take too long (52%),
    - the eligibility office was not open during hours when they could go there (44%),
    - the eligibility office was too hard to get to (39%),
- **Language can be an important barrier for parents with limited English proficiency.** Half of Spanish-speaking parents says lack of access to translation and Spanish language materials kept them from applying or completing enrollment.
- **There is no single approach or change that will remove the barriers to children's Medicaid.** Instead, multiple changes are needed: outreach and education for parents, changing policies to attract working uninsured families, and presenting the program not as "welfare," but as health insurance for low-income families. Parents of uninsured Medicaid-eligible children identified the following policies that would make them "much more likely" to enroll their children:
    - Mail-in or telephone enrollment (60%),
    - Enrollment office open evenings or weekends (55%),
    - Better treatment at enrollment office (55%),
    - Enroll at doctors' office or clinic (54%),
    - Shorter enrollment form (53%),
    - Automatic enrollment when my child enrolls in school lunch (53%),
    - A toll-free number to get questions answered about how to apply before going to enroll (53%),
    - Enroll at child's school or day-care (51%),
    - Help from someone who speaks my language (50%).[xx]

George Washington University. A study released July 2000 interviewed 1,400 low-income parents at community health centers across the U.S. The authors report that the primary factor affecting families' willingness to enroll in Medicaid was how they were treated by Medicaid workers and health care providers. Over 60% of the parents reported they did not feel trusted, respected, or valued as a person when they applied for Medicaid. More than one-third said that Medicaid enrollment required answering "unfair personal questions," and about a quarter said people are treated poorly when they apply for Medicaid, and that the enrollment process is

humiliating. Fewer than half the parents knew that TANF work requirements and time limits did not apply to parents and children on Medicaid. Well over half the parents named as major barriers to Medicaid enrollment ignorance about where and how to apply, confusion about who is eligible, and fear among immigrants. Logistical barriers like long and complex applications, inconvenient eligibility office hours, and transportation and translation needs were identified by 25-40% of parents. Based on these results, the authors recommend changes consistent with the other studies reported here: expand access to enrollment outside of the welfare office, eliminate unnecessary questions, conduct aggressive community education about Medicaid, and address language barriers and immigration concerns of special populations.[xxi]

Arizona Study. Other recent studies reinforce the Kaiser Commission's findings, as well as this Texas study. Like Texas, Arizona has been among the states with the highest percentage of uninsured children. The Arizona Children's Action Alliance sponsored 11 statewide focus groups to discuss parents' perceptions of enrollment and re-certification of children in the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program. The June 1999 report, *Children Without Health Insurance: Listening to Arizona's Parents,* found three major themes in the complaints of parents of Medicaid-eligible, uninsured children:

(1) excessive, intrusive, and complicated paperwork,
(2) time-consuming and burdensome appointment procedures, and
(3) demeaning interactions with eligibility staff.

Working parents reported that they had to take time off their jobs without pay to apply and re-certify, and that they never knew how long the appointment would take. Some mothers of young children noted that they had no provisions for child care, and eligibility staff were disapproving when they brought their children with them to the office. The parents reported that eligibility offices could not be relied on to have sufficient Spanish-speaking staff, and some had even been asked by state workers to provide their own interpreters.[32] Parents in families that included a non-citizen reported fearing immigration consequences of enrolling their U.S. citizen children in Medicaid, and some said Medicaid eligibility workers threatened to report them to INS if they enrolled their children in Medicaid.

Finally, a number of parents reported that the requirements to provide information about a non-custodial parent for medical support purposes were burdensome, particularly when the parent lacked accurate and recent information about the absent parent. Parents objected to questions about their recent sexual activity, raised (presumably) in the context of collecting Medical Support Enforcement information.

Some of the solutions recommended by the Arizona Children's Action Alliance were:

- mail-in applications
- more out-stationed eligibility staff
- extended eligibility office hours
- less frequent (12 month) re-certification
- reduce required documentation, and provide applicants with clear checklists of remaining requirements
- improve working conditions for eligibility staff

[32] Federal law requires state Medicaid programs to provide interpreters for all applicants who need them.

- introduce incentives for workers to enroll families and children
- increase emphasis on customer service

As with the Kaiser study, the Arizona researchers did not encounter stigma associated with children's Medicaid (though they had expected to). The parents of Medicaid-eligible uninsured children indicated that they needed health benefits for their children and were motivated to apply. Many had participated in WIC, and thus were not opposed to using public benefits they perceived to be important to providing good care for their children. [xxii]

Studies of State Eligibility Administration and Staff. A December 1999 report from the Urban Institute looked at the challenges faced by agencies in five states,[33] and focuses on how they handle Medicaid enrollment. The state officials reported that no incentives for retaining and improving Medicaid enrollment were built into their programs, that complexity of the program hampered their ability to educate parents about their options, and that difficulty retaining good eligibility staff in a booming economy undermined their ability to improve enrollment. [xxiii] In another study of state Medicaid administrators and eligibility workers by Health Management Associates, Medicaid program staff reported that most potential eligibles did not understand that Medicaid was not limited to cash welfare recipients, and that most also believed (inaccurately) that Medicaid was subject to welfare's time limits and work requirements. As in the Urban Institute study, workers said Medicaid enrollment was given low or no priority, compared to the "work-first" focus of welfare reform. Computer systems did not automatically retain children on Medicaid, and families did not know to ask to continue those benefits. These Medicaid workers and administrators recommended several key strategies to improve Medicaid participation, including:

- improve education of parents leaving welfare about access to ongoing Medicaid for themselves or their children,
- develop outreach strategies that market Medicaid as health coverage (i.e., not "welfare"), and
- train eligibility workers on new Medicaid policy and the new emphasis on encouraging Medicaid enrollment.[xxiv]

Stigma: Prescription for a Cure. Some observers fear that the past link between Medicaid and cash assistance "welfare" will forever taint Medicaid and foil attempts to improve children's enrollment in the program. The findings of our Texas research suggest that parents want health insurance for their children, not "welfare." The Kaiser study found a resounding majority of parents eager to insure their children. Still, parents expressed a strong preference for a mail-in application, and a desire to avoid the "welfare office."

A report produced recently for the nationwide Covering Kids program funded by the Robert Wood Johnson Foundation looks at the issue of stigma as it affects Medicaid and CHIP participation.[xxv] A key observation is that stigma is generated through person-to-person contact. **This means that the way the application and re-certification process is conducted, and the manner in which applicants are treated, are the most important factors in creating stigma — but it also means changing those practices can help eliminate stigma.** Based on their review of 25 years of research on stigma (including the new studies described above), the authors recommend the following strategies to reduce stigma:

[33] California, Colorado, Florida, Minnesota, and Wisconsin.

- allow mail-in applications, and keep re-certification simple,
- eliminate differences between the CHIP and Medicaid application and enrollment process, because they exacerbate Medicaid stigma,
- review old welfare-based Medicaid requirements that are no longer needed,
- refer to Medicaid and CHIP as "health coverage,"
- provide customer service training to eligibility staff,
- ensure provider reimbursements are adequate for Medicaid and CHIP, to avoid creating a negative reputation for "cheap" health care, and
- expand out-stationed enrollment opportunities to schools and other places families go.

TEXAS FINDINGS AND RECOMMENDATIONS

How this Research Relates to National Studies. Our Texas focus groups and interviews revealed much about the diverse views parents have of the children's Medicaid eligibility process. Clearly, the range of themes voiced by these low-income parents was consistent with the findings of other national and state research on the topic of barriers to Medicaid. However, we also heard some issues raised that have not been a key focus of other reports.

It is important to note that focus groups and interviews like those conducted in this study are intended to collect so-called "qualitative" detailed information about parents experiences, beliefs, biases, and feelings about Medicaid. This is the kind of information that cannot be collected well through a scientific survey. As such, focus group research makes an important and unique contribution to the understanding of this topic. However, it should not be confused with survey data that is based on random sampling, which can be used to estimate representative beliefs across a given population. (Much of the Kaiser Commission report described was based on a random-sample survey with a statistically significant sample size.) So, to say that 50% of focus group respondents made a particular complaint is not equivalent to 50% of respondents in a random-sample survey making a certain complaint.

This distinction probably accounts for some of the differences between the most common complaints and concerns of our respondents, and those reported by the Kaiser study. It is also very important to remember that Kaiser's study collected results across the country, not just in Texas. Medicaid programs vary considerably from state to state, and though there are clearly common themes among parents (e.g., Arizona's report), different states' programs have different strengths and weaknesses. Given this fact of life, we would expect that the concerns of Texas low-income parents would be in some respects different from parents in another state.

Finding: There is a critical lack of clear, accurate information about children's Medicaid eligibility. Confusion, misinformation, and lack of knowledge about children's Medicaid eligibility were a problem with a majority of parents in this study. Many mistakenly believed that their children could not get Medicaid if the parent was *not* getting TANF cash assistance, or if the parent *was* working, or if there were two parents in the home. Parents had not received Medicaid outreach in the past, and many felt clear, consistent, accurate information was not readily available from DHS.

Finding: Appointments to apply and re-certify for children's Medicaid are time-consuming, inefficient, not family-friendly, and inappropriate for needs of working parents. Long waiting times at the DHS were a common complaint, though appointments seem to proceed much more quickly in smaller cities and rural areas of the state than in the large metro areas. The range of experience was from very efficient service with less than a 30 minute wait, to waiting all day and being told to return another day. Procedures vary widely from office to office, but many parents noted that while they were required to make an appointment, they still had to wait long beyond their scheduled time. Some offices do not schedule a definite appointment time, but instead tell parents to appear in the morning on a particular day, and have them wait indefinitely until they are seen.

Lacking child care, many parents must take children with them to the appointment, but offices are not equipped to accommodate children. Parents reported a lack of access to food or drink while waiting, absence of changing tables for infants, and a lack of reading materials or other forms of diversion. Parents reported that leaving the waiting area to use the restroom, change a diaper, or quiet a fussy child could result in "losing your place in line."

Finding: Confusing and inconsistently applied documentation requirements and lost documents discourage parents. Parents reported that documents required were unpredictable and inconsistent, that the list of necessary documents provided by DHS was not sufficient to ensure that their application would be accepted as complete. What is accepted as adequate proof by one worker or one office may not be adequate for another worker or in another town. This has created the perception that policy is capricious, and that it is "easier" to enroll in Medicaid in some parts of the state than in others. Quite a few respondents reported problems with lost documents or applications, especially when additional information had to be sent in after the initial appointment, or during the frequent turn-over in eligibility workers.

Finding: "Assets Test" is seen as a deliberate barrier to limit enrollment, undermining employment and self-sufficiency: virtue is punished. Many parents had experienced denial based on very small amounts of excess assets. They noted that the state's articulated goal of promoting employment and self-sufficiency was inconsistent with standards that do not allow them to save for a child's college, or allow deductions for tuition (though child care can be deducted). Many parents were not aware that *one* family car is not counted for children's Medicaid (probably because this exemption is NOT available in Food Stamps, or for the parent's own Medicaid eligibility). The $2,000 limit on total assets was repeatedly seen as being so intractable that parents, who had been denied Medicaid for reporting truthfully about their assets, were convinced that most families who succeed in enrolling must *not* be telling the

truth. In other words, they see the assets test as a disingenuous barrier, which rewards the dishonest and punishes those who are truthful.

Finding: Customer service at DHS offices is rated poorly by more than 75% of participating parents. Complaints about staff demeanor range from merely abrupt or condescending to overtly rude or hostile treatment. The greatest number of complaints are directed at the front-desk or first contact staff, who are likely to have the least skills and training and the most turnover. Unfortunately, these staff are the "face" of the office and can create an unpleasant atmosphere for a large number of people. Interestingly, parents commented on the high pressure, unrealistic workloads, and poor equipment that eligibility workers must live with. They see the resulting burnout the workers evidence, and very high turnover that prevents any continuity in service to a family. A number of parents commented that customer service training was needed for the DHS workers, that there appeared to be inadequate oversight by supervisory staff to prevent poor treatment of clients, and that they would not be able to stay employed in their own jobs if they treated customers as poorly as they were treated. Importantly, about 20% of parents commented on experiences with *good* eligibility workers.

Finding: "Stigma" attached to Medicaid is not universal or clear-cut. Parents with Medicaid experience expressed approval for the program, along with strong expressions of gratitude for the benefits it provides their children. Roughly half the parents participating in the focus groups view Medicaid as health insurance or help with medical expense for low-income families. The other half regard Medicaid as "part of welfare." For these parents, pride or shame were significant disincentives to enrolling their children. The lack of public education about the availability of Medicaid to children in working families contributes to their sense that enrollment of children of working parents is inappropriate. Some enrollment practices, in particular medical support enforcement activities and asset documentation, contribute to this stigma.

Finding: Medical Support Enforcement policies create several barriers to enrolling children. Intrusive personal questions related to medical support were a frequent compliant of single parents responding. Both DHS workers and Attorney General's staff routinely query parents about any recent sexual contacts with a non-custodial parent, which is deeply offensive to many parents. To make matters worse, in some DHS offices these questions are asked in settings that are not private (e.g., a parent sitting in an open-sided booth talking to a DHS worker). Other parents simply complained that they were pressured for information they lacked and could not get, and that they were pressured for "cooperation" repeatedly at each re-certification, despite the absence of any contact with or connection to an absent parent.

Of serious concern was the experience of several currently-married parents who reported that their workers had demanded they provide detailed physical descriptions of their spouse, of the sort usually reserved only for locating an absent parent. These parents were told that, in case the spouse eventually left, the worker was prospectively collecting medical support enforcement data. Finally, increasingly widespread rumors that the Attorney General's Child Support Division reports undocumented parents to INS are creating unwillingness for single immigrant mothers to apply for Medicaid for their U.S. citizen children. The Office of the Attorney General has no official practice of reporting to INS, so further investigation will be needed to determine why clients believe the practice exists.

Finding: Families that include immigrants report special barriers to enrollment. In addition to concerns related to Attorney General's possible cooperation with INS, many parents

are still confused about what possible impact Medicaid use by an individual or his family member may have on getting a "green card" (permission for legal permanent residence) or becoming a citizen.[34] In addition, parents remain concerned that DHS workers may report their non-applicant family members to INS.

Finding: Concerns about quality of Medicaid health services, or poor treatment of Medicaid patients by providers, are significant for some parents. Several types of concerns about care and its delivery were voiced. A number of parents believe that better and more experienced doctors limit the number of Medicaid patents they accept because payment is too low. Some parents believe that they are treated with less respect by frontline staff and pharmacists when they are using Medicaid. Finally, some parents with Medicaid managed care experience felt they were unable to present a child at the Emergency Room for legitimate emergencies. It is important to note that these responses seemed to be localized in certain focus groups sites, and absent in others. This makes sense given the substantial disparity in provider participation and managed care structures across Texas; local realities do vary considerably. It is important to note that, despite these concerns, the majority of parents with prior Medicaid experience would rather their children be enrolled than not.

Finding: For some parents, episodic Medicaid enrollment is seen as good stewardship of public resources. A number of parents indicated that they deliberately only enrolled their children when pressing health issues arose, because they did not want to abuse the privilege of access to the benefits. Preventive well-child care was seen as less important than conserving public resources by these parents.

Finding: One Size Does Not Fit All. The barriers expressed by certain parents were not shared by all. Some parents had no complaints about customer service, while others were most turned off by prior treatment at DHS offices. Many parents' number one priority is to never have to set foot in a "welfare office." Others want the option of someone well-trained, courteous, and willing and able to help them apply. Some parents are quite comfortable viewing children's Medicaid as a support for their low-income working families, but others will need to have the program presented to them in a new light before they will be willing to consider enrolling their children.

The proposals that follow represent a range of strategies designed to reflect the array of barriers that currently discourage Texas' low-income working parents from enrolling their uninsured children in Medicaid.

[34] Except when fraud is involved, there is no negative impact on either legal status or naturalization. Only if an individual relied completely on Medicaid institutional long-term care for his support would Medicaid use result in denial of legal permanent resident immigration status.

RECOMMENDATIONS

SIMPLIFY THE PROCESS:

Adopt a mail-in option for children's Medicaid applications. This change would make Medicaid policy consistent with CHIP, and would eliminate much of the hassle of a trip to the DHS office for low-income working parents who only want Medicaid for their children. It will also reinforce a new image of Medicaid as health insurance, not welfare, and help diminish the resistance many working families have to going to the "welfare office." A new DHS proposal to allow re-certifications, but not applications, to be processed by mail is a positive move in the right direction, but the state should go further and adopt mail-in **application** as well. *Thirty-eight states (plus D.C.) now accept mail-in applications for children's Medicaid.*

Minimize the documents required for children's Medicaid applications, making the requirements for CHIP and Medicaid identical. To make a mail-in application workable, required documents to mail in along with the application should be streamlined to require only proof of income and immigration documents for legal immigrants. When implemented, the recently-announced DHS plan to reduce required documentation represents an important first step toward creating equitable treatment for parents of Medicaid-eligible children; the next step should be to eliminate remaining inconsistencies in required documentation. *Many states have greatly reduced required documents for children's Medicaid; seven states do not even require proof of income.*

Eliminate the "assets" test completely for children's Medicaid. This change would make Medicaid policy consistent with CHIP, make the task of enrolling vastly simpler for both parents and DHS staff, and allow parents to have some prudent savings for college and retirement. When Texas field-tested the CHIP application, responses to questions about assets

were so negative that they were deleted; they should be deleted for children's Medicaid application as well. *Forty states plus D.C. have dropped the assets test for children's Medicaid.*

12 Month Continuous Coverage; 12 month re-certification periods. This change would make Medicaid policy consistent with CHIP, would save work for both parents and DHS staff, and would end the current problem of children rolling on and off the Medicaid rolls due to small and temporary income fluctuations. Improved access to a consistent source of preventive and primary care would be one of the most important benefits of continuous coverage. Health care providers would be relieved of the challenge of verifying current coverage for children, a major complaint in the current system. *Fifteen states have adopted 12-month continuous eligibility for children's Medicaid, and 35 states have a 12-month re-certification period for children's Medicaid.*

IMPROVE ACCESS AND SERVICE QUALITY:

Invest in Public Information and Outreach to Low-Income Parents to Raise Awareness about children's Medicaid. Promote Medicaid as Health Insurance, Not "Welfare" — Just Like CHIP. Because many parents mistakenly believe their children are not eligible for Medicaid (e.g., because the parents work, do not get TANF, or are a two-parent family), clear information needs to be widely distributed. Changes in policy and procedure are newsworthy information for low-income families, and should be widely reported via the news media. Outreach to low-income parents should be broad-based and ongoing. Outreach will have limited impact, however, unless preceded by simplification, and wedded to application assistance. Texas will need to promote the value of ongoing coverage and medical homes if we want to change the episodic enrollment pattern that some parents see as conserving scarce state resources. Promotion of the program as health care, not welfare, needs to be targeted to providers, too. Many are as unaware as working poor parents of Medicaid's higher income limits for children, and the fact that many if not most Medicaid parents are in working families. Respectful treatment of these families is a critical element for elimination of stigma.

Make reliable application assistance widely available outside the DHS office. While only a state employee can make the final decision about Medicaid eligibility, many states are using networks of community-based application "assisters" to provide help to families who want to use a mail-in application, but are most comfortable with a "live" person to answer their questions. The network of community-based organizations now contracting to do CHIP outreach are an obvious resource, but many other CBOs are likely to want to help, and could contribute a significant volunteer effort. Toll-free numbers for assistance or referral must be adequately staffed and trained, and able to meet quick-response standards like those required of state contractors.

Ensure an adequate number of eligibility staff at DHS offices to process the demand for applications. Early CHIP experience is creating concerns that DHS may not be able to promptly process Medicaid applications referred by CHIP. Even if a majority of children's applications are processed via mail and with a simpler process due to fewer required documents, staff will still be needed to process the mail-in applications. Moreover, some families will continue to want to apply for both Medicaid and Food Stamps at the DHS office. Despite an application decline of only 2.5% since 1996, the Legislature cut DHS eligibility workers by 18.5% in that period —

more than 665 positions in 2000 and 2001. Good customer service can never become a reality while staff are staggering under workloads that call for many more employees. Staff shortages have also taken a toll on worker training; therefore, staffing, funding, and planning should be enhanced to improve DHS capacity to train workers in an adequate and timely fashion.

Emphasize Customer Service at DHS offices, and adopt policies that work for working parents. With an adequate number of employees, and a reduction in needlessly complex paperwork, DHS could serve families better by embarking on a concerted effort to improve customer service. Even for parents using a mail-in option, DHS could improve customer service by creating incentives or performance measures related to reliability (e.g., applications and documents mailed in or faxed are not lost), and rapid turn-around of applications, like Oklahoma's 20-day processing of children's Medicaid applications.

A new approach is also needed for parents who prefer an office interview to the mail-in process, or who want to apply for Food Stamps at the same time as Medicaid. Evening and weekend hours (currently being piloted in a limited number of sites around Texas) should be made available statewide. Scheduling systems should offer the option of true appointments at a specific times for some, and drop-in options for others. Scheduling systems should all include provisions to ensure that applicants can use the restroom or phone, remove a noisy child or change a diaper, without losing their allotted appointment.

The complaints of inconsistent and inaccurate applications of DHS policy may be helped by a more realistic workload and a simpler process. Eventually, inconsistencies could be drastically reduced through the Texas Integrated Eligibility Redesign System (TIERS) computer system being developed to replace the 30 year old computer system now in use. State-of-the-art computer support could eliminate many eligibility errors by reducing the enormous amount of deeply detailed information which workers now have to master in order to serve clients well.

Many have noted that the very nature of asking for assistance is likely to render parents highly sensitive to perceived offenses when they come to apply. Still, the dominant view among parents in these interviews and focus groups is that poor treatment is the expected outcome, and not the exception. While it will never be possible for 100% of parents to be satisfied that they have been treated with dignity, a renewed and deeper commitment to the goal of dignified treatment — perhaps on an equal par to the commitment to reducing Food Stamp error rates — is strongly recommended as a customer service reform. Special attention may need to be paid to the first-contact front desk staff who can have such a large impact on the experiences of the families who must use the DHS system.

Raising the priority Texas Medicaid places on enrolling eligible children, and providing a convenient and dignified enrollment process, will require strong support from our legislature and statewide elected officials. It would be a mistake to assume that the burdensome eligibility processes currently administered by DHS are a reflection of a lack of commitment to serving Texas' low-income families. Recent DHS proposals to begin streamlining eligibility policies are evidence of the agency's good faith. In reality, the primary constraint on the Texas Health and Human Services Commission and DHS is budgetary. In recent years the pressure to contain Medicaid costs and cut the numbers of state employees — and thus reduce the state's Medicaid budget costs — have been unrelenting. Our state leadership must give the agencies an unambiguous green light to vigorously pursue enrollment of uninsured children, and that directive must be backed with adequate appropriations and adequate numbers of state workers.

Address parents' concerns about quality of care. Some of these concerns may be addressed through outreach describing Medicaid's comprehensive benefits for children (e.g., dental services, eyeglasses, hearing aids, etc.). The focus group findings also suggest that many parents remain confused about the "rules" for Medicaid managed care coverage, and perceive that it limits, rather than expands, their access to health care. Care must be taken to ensure that Medicaid managed care is not so troublesome that parents find it easier to access the indigent health care system as an uninsured person. Still, low physician participation, and the perception that "good" doctors limit Medicaid business, are complaints in areas both with and without managed care. To the extent that parents are correct — that is, if they **do** have difficulty finding doctors they trust who will accept Medicaid — outreach and education alone cannot remove the barrier to enrollment. The state will need to take steps to improve provider participation in Medicaid, which will likely require attention to reimbursement rates in and outside of Medicaid managed care. If Medicaid payment standards fall too far below market rates, it may be impossible to erase the perception that the program offers a poorer standard of care.

Address mixed-immigration families concerns re: DHS and AG. DHS has taken steps internally to begin training staff about the rights of immigrants in the application process. Still, the response of parents in these focus groups and interviews (as well as reports from community-based organizations statewide) make it clear that fears of immigration problems and reporting to INS are alive and well. Renewed outreach by trusted community-based organizations and churches must spread the word that Medicaid is "safe." Official reassurance by DHS and the Office of the Attorney General (e.g., signs and flyers in their offices and official messages on forms explaining agency policy) could be especially effective in reducing fear. Finally, efforts must be made to review the policies of DHS and the Attorney General's Office with regard to Child Support Enforcement and communications with the INS, to ensure that they are consistent with federal regulations, and that policies can be clearly explained to parents applying for their children.

Review policies to ensure that optimizing Medical and Child Support does <u>not</u> come at the expense of children's health care. Requiring parents to support the children they have brought into the world is an important public policy goal which most Texans strongly support. However, the pursuit of medical support is **not <u>more</u> important** than children's access to health care. Unfortunately, current interactions between medical and child support activities and Medicaid undermine Texas' ability to enroll some children in Medicaid. This is an area of state policy in which substantial improvements should be attainable, if effort is simply focused on modifying current practices to better balance these two important public policy goals.

Steps needed include a review of current policies to ensure that children are not being punished, by lack of health insurance, for the omissions of either their custodial or absent parent. Custodial parents must be clearly informed about how the link between children's Medicaid and medical support works, and the potential consequences for them and the absent parent. Informing should prominently feature the fact that their children cannot be denied Medicaid even if they fail to cooperate with medical support activities, as this is guaranteed under federal law. Practices should be reviewed to ensure that parents with concerns about domestic violence or harassment by an absent parent are consistently getting the exemption from medical support they need, and which the law promises them.

Parents who simply have no connection to an absent biological parent must not have to struggle at each Medicaid re-certification to re-establish this fact. Of enormous importance is a re-

evaluation of the need for questions about sexual contacts, the circumstances under which they are asked, and how they are handled. The development of stricter standards governing the use of these intrusive inquiries, and oversight of these standards should follow. In this sensitive area, a search for best practices across the country would be especially useful. Finally, the practice of "prospective" collection of medical support information from **married** parents on the presumption that the marriage will fail should be prohibited in all but the most exceptional circumstances (for example, if the custodial parent making application offers to provide this information because he/she anticipates the departure of a spouse). If a workgroup of agency staff and advocates were convened to review current policies and propose revisions, it is likely that many of these problems could be effectively overcome.

THE COST OF CHANGE
THE FINAL BARRIER

Why has Texas not already eliminated more of these barriers to Medicaid enrollment of children? Clearly, the cost of success is the key factor dampening the state's willingness to embrace policies that would streamline access to children's Medicaid. Though insuring children is far less expensive than covering adults, and though the federal government will pay for about 62% of the costs of all new children enrolled in Medicaid, major progress toward enrolling the 600,000 uninsured Texas children below poverty will nevertheless require significant new expenditures in the state's budget. Important facts and issues related to the value of investing public dollars in insuring Texas children are provided below.

The cost of inaction. A large body of scientific research has documented the negative consequences for children who lack health insurance: delayed treatment of acute, chronic, and even serious illness and injury. Deferred attention to health problems can worsen developmental delays, or result in students falling behind. Educators report the challenge of teaching children who are sick, need dental work, or lack eyeglasses. In addition, schools lose funding related to absences due to illness and dental disease. Finally, society must consider the message we send to our poorest children by sustaining these barriers: that we are content to allow them to be deprived of a basic standard of medical care simply because their parents are less economically successful. That it is good enough that their parents can take them to an emergency room when they are severely ill or injured. That they do not deserve the "luxury" of ready access to primary care for their strep throat, ear infection, or minor injury.

Many costs simply are shifted to City and County budgets and taxpayers. Uninsured Texas children who experience illness and injury are often treated by publicly-funded organizations like public hospitals and local health departments. Tax-exempt non-profit charity providers also make a major contribution, as do voluntary efforts of physicians and other health care professionals. While children account for a much smaller share of costs of care for the

uninsured than adults, they still represent a major cost driver for local governments — and local taxpayers — in Texas. Choosing not to maximize Medicaid enrollment of children in Texas results not only in a direct cost-shift to local taxpayers, but also throws away the enormous federal match ($2 federal funds for every $1 Texas spends) that could be supporting those costs. Taxpayers deserve to have these federal tax dollars returned to Texas, and not re-distributed to other states that are more successful in enrolling their children.

Most states have already taken these steps; budget crises have not resulted. As described in this report, the great majority of states have already simplified Medicaid access for children by adopting mail-in applications and dropping the assets test. Nearly one-third of the states guarantee 12 months of continuous eligibility for children on Medicaid. These steps have been taken because states **want** to see an increase in children's Medicaid caseloads, and presumably are prepared to pay for that growth. Still, it is worth noting that the only states that have seen really large jumps in enrollment in the last several years are those that have actually expanded Medicaid by raising the income eligibility cap significantly, like Indiana, Oklahoma, and New Mexico (increased Medicaid coverage from 100% FPL to 150%, 185% and 200% FPL respectively).[xxvi] Moreover, most states have not yet recouped the dramatic **drops** in children's Medicaid enrollment they experienced in the wake of welfare reform.[xxvii] As of February 2000, Texas Medicaid was still 192,000 children below the enrollment level in January 1996, so we have a long way to go before we will reach "new territory" in caseloads.

Size and rapidity of caseload increases very hard to predict. It is very difficult to make reliable predictions of how much and how quickly enrollment in children's Medicaid will increase if the application and re-certification processes are simplified. **This is because the real impact of these policy changes is not that they make more children eligible, but rather that they make parents of children who were already eligible for Medicaid willing to participate in the program for the first time.** It is difficult to quantify the response of parents to reduced hassle, and even harder to distinguish the impact of adopting mail-in applications from that of dropping the assets test, or adopting 12-month continuous eligibility. Some factors that clearly should be taken into account are:

- other states' actual caseload growth rate experience with simplified eligibility,
- other states' ratio of potentially eligible to actually enrolled children with simplified eligibility, and
- Texas' historically very low rate of denials for assets.

Project Alberto, Texas' project in the Robert Wood Johnson Foundation's nationwide "Covering Kids" Initiative, has been studying barriers to children's Medicaid enrollment, and piloting reforms in selected sites around Texas since Fall 1998. Project Alberto is refining preliminary estimates of the cost of simplified eligibility, using actual pilot results, more refined analysis of actual Texas Medicaid cost experience data, and new experience data from the CHIP rollout. They hope to release best estimates by Fall 2000.

Continuous eligibility does not make new children eligible; highest costs are already paid for by Medicaid. Research by Texas' Project Alberto suggests that only about a quarter of the children who enroll in Texas Medicaid in a given month actually experience continuous coverage for 12 months. Some of these children lose coverage due to a reported increase (often short-term) in earnings or assets. Unfortunately, a large percentage of these children lose coverage simply because their parents cannot or do not succeed in re-certifying them at the 6 or 12-month interval. Thus, most of the children who would benefit from continuous eligibility

are already eligible for Medicaid coverage. Actuarial experts who attempt to model the costs of continuous eligibility agree that the new additional months of coverage should be less expensive than the average cost of a month of coverage in the absence of continuous eligibility.[xxviii] Medicaid will pay for up to three months worth of prior medical bills for a newly-enrolled child, and "Medically Needy" coverage increases the income caps slightly for children with significant medical expenses. As a result, it is believed that the majority of major medical expenses of Medicaid–eligible uninsured children are already being picked up by Medicaid, because providers help families re-enroll to get those large bills paid. What would be added with continuous coverage are the costs of primary and preventive care, and the benefits of continuity of care in a medical home.

Is there an alternative? If Texas does not follow the lead of our neighbor states and a majority of the country in streamlining eligibility policy for children's Medicaid, could these 600,000 children get health insurance by other means? Census data show that only 16% of Americans with incomes below poverty get insurance through a family member's job, and only 15% of children below poverty are covered through a parent's job. Low-income workers often lack access to health benefits; 42% of workers earning less than $20,000 per year cannot access a health benefit at work, compared to only 14% of workers earning $35,000 or more.[xxix] Except for the largest and most prosperous employers, the prevailing practice in Texas is for the employer to pay only the worker's premium, with the employee paying any dependent or spouse premium out-of-pocket. The state of Texas, with its many thousands of workers, must pay $158 per month above the worker's premium to add coverage of a child or children. Most smaller employers fare much worse, and face even higher premiums. Employers of workers earning $8 per hour (full-time employment at this wage will leave a family of three just below the poverty line in 2000) are not likely to pick up the cost of a benefit worth $1,900 per year. And if families between 100% and 200% of poverty are expected to pay only $15-$18 per month for CHIP premiums, how can we expect families below poverty to pay hundreds of dollars per month? In an ideal world, perhaps all employers would pay a living wage, with good benefits. As long as they do not, society must find other ways to provide all children access to a healthy start in life.

Tobacco Settlement funds could be dedicated to ensuring adequate funding for children's health insurance. The 76th Legislature committed Tobacco Settlement funds to CHIP. Equity and fairness dictate that we should be just as committed to insuring the children of the working poor, as we are to covering children in families just above poverty. Future tobacco settlement funds can be used to finish the job by ensuring that the children of Texas' poorest working families are not left out of health insurance coverage. While tobacco funds are not limitless, the projected settlement payments are more than adequate to fund CHIP, finance growth in children's Medicaid, and still leave adequate funds to enhance smoking prevention efforts. While it may be tempting to divert these funds to pay for roads, prisons, or even tax cuts, Texas should take this historic opportunity to make a long-term investment in the future: our children.

Notes:

[i]. T. Selden, J. Banthein, and J. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled," *Health Affairs* (May/June 1998):192-200.
[ii]. C. Winterbottom, D. Liska, and K. Obermaier, *State-Level Databook on Health Care Access and Financing,* (Washington: Urban Institute, 1995), pp. 124-125; Frank Ullman and John Holahan, "An Explanation of Estimates of Uninsured Children," Urban Institute, October 1997.
[iii]. Leighton Ku and Brian Bruen, "The Continuing Decline in Medicaid Coverage," (Washington: Urban Institute, December 1999), Table 3; Peter Cunningham and Michael Park, "Recent Trends in Children's Health Insurance Coverage: No Gains for Low-Income Children," (Washington: Center for Studying Health System Change, April 2000).
[iv] Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey," (Washington: Employee Benefits Research Institute, January 20000); John Budetti and Janet Shikles, "Can't Afford to Get Sick: A Reality for Millions of Working Americans, the Commonwealth Fund 1999 National Survey of Worker's Health Insurance" (New York: Commonwealth Funds, September 1999).
[v]. Testimony by Lynn Mitchell, M.D., M.P.H., Medicaid Director, Oklahoma Health Care Authority, Committee on Ways and Means, Subcommittee on Human Resources, U.S. House of Representatives, May 16, 2000.
[vi]. Eileen Ellis and Vernon Smith, *Medicaid Enrollment in 21 States, June 1997 to June 1999,* (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2000.
[vii] Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey," (Washington: Employee Benefits Research Institute, January 20000).
[viii] Leighton Ku and Brian Bruen, "The Continuing Decline in Medicaid Coverage," (Washington: Urban Institute, December 1999); Peter Cunningham and Michael Park, "Recent Trends in Children's Health Insurance Coverage: No Gains for Low-Income Children," (Washington: Center for Studying Health System Change, April 2000); John Holahan and Niall Brennan, "Who Are the Adult Uninsured?" (Washington: Urban Institute, March 2000).
[ix] T. Selden, J. Banthein, and J. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled," *Health Affairs* (May/June 1998):192-200.
[x] Frank Ullman and John Holahan, "An Explanation of Estimates of Uninsured Children," Urban Institute, October 1997.
[xi] Leighton Ku and Brian Bruen, "The Continuing Decline in Medicaid Coverage," (Washington: Urban Institute, December 1999), Table 2.
[xii] CPPP analysis of Texas Health and Human Services Commission and Texas Department of Human Services caseload data. Over 190,000 Texas children left welfare-linked Medicaid, but only 42,000 children (22%) were added to the non-welfare Medicaid groups from January 1995 to December 1997.
[xiii] Families, USA, *Deep in the Heart of Texas: Uninsured Children in the Lone Star State,*(Washington: Families USA, February 1999).
[xiv] CPPP analysis of Texas Health and Human Services Commission and Texas Department of Human Services caseload data.
[xv] Families USA, *One Step Forward, One Step Back,* (Washington: Families USA, October 1999), pp. 2-3; also CPPP analysis of unpublished data tables provided by Families USA.
[xvi] Leighton Ku and Brian Bruen, "The Continuing Decline in Medicaid Coverage," (Washington: Urban Institute, December 1999), Table 3; Peter Cunningham and Michael Park, "Recent Trends in Children's Health Insurance Coverage: No Gains for Low-Income Children," (Washington: Center for Studying Health System Change, April 2000).
[xvii] Eileen Ellis and Vernon Smith, *Medicaid Enrollment in 21 States, June 1997 to June 1999,* (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2000), 12-14; U.S. Department of Health and Human Services "State Children's Health Insurance program Status Report, Updated as of October 27, 1999," internet: http:www/hcfa.gov/init/chstatus.htm, April 13, 2000.

[xviii] Testimony by Kathleen Gifford, Assistant Secretary, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration,, Committee on Ways and Means, Subcommittee on Human Resources, U.S. House of Representatives, May 16, 2000.
[xix] Testimony by Lynn Mitchell, M.D., M.P.H., Medicaid Director, Oklahoma Health Care Authority, Committee on Ways and Means, Subcommittee on Human Resources, U.S. House of Representatives, May 16, 2000.
[xx] Michael Perry, Susan Kannel, R.B. Valdez, and Christina Chang, *Medicaid and Children: Overcoming Barriers to Enrollment,* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2000).
xxi. Jennifer P. Stuber, Kathleen Maloy, Sara Rosenbaum, and Karen Jones, "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?" (Washington: George Washington University Center for Health Services Research and Policy, July 2000).
[xxii] Arizona Children's Action Alliance, *Children Without Health Insurance: Listening to Arizona's Parents.* (Phoenix: The Rabidoux Foundation, June 1999)
[xxiii] Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist, Findings from a Five-State Study,* (Washington: Urban Institute, December 1999); Testimony by Marilyn Ellwood, Senior Fellow, Mathematica Policy Research, Inc., Committee on Ways and Means, Subcommittee on Human Resources, U.S. House of Representatives, May 16, 2000.
[xxiv] Testimony by Vernon Smith, Ph.D., Principal, Health Management Associates, Lansing, Michigan, Committee on Ways and Means, Subcommittee on Human Resources, U.S. House of Representatives, May 16, 2000.
[xxv] Barbara Matecera Barr, "Stigma: A Paper for Discussion," (Princeton: Robert Wood Johnson Foundation, February 2000).
[xxvi] Eileen Ellis and Vernon Smith, *Medicaid Enrollment in 21 States, June 1997 to June 1999,* (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2000.
[xxvii] Families USA, *One Step Forward, One Step Back,* (Washington: Families USA, October 1999).
[xxviii] Lewin and Associates, "*Continuous Eligibility for Children Under Medi-Cal: Cost Estimates for Six-Month and Twelve-Month Options,"* (Oakland: Medi-Cal Policy Institute, May 1999); Unpublished analysis of DHS Medicaid data by Steve Scarborough of Health Data Partners for Project Alberto, Texas Covering Kids project.
[xxix] Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey," (Washington: Employee Benefits Research Institute, January 20000); John Budetti and Janet Shikles, "Can't Afford to Get Sick: A Reality for Millions of Working Americans, the Commonwealth Fund 1999 National Survey of Worker's Health Insurance" (New York: Commonwealth Funds, September 1999).

APPENDIX A:

METHODOLOGY FOR TEXAS FOCUS STUDIES AND INTERVIEWS

Specifications for respondent recruitment and lines of inquiry were designed by Cathy Schechter (Orchard Communications, Inc.) and Beatriz Noriega (Focus Latino), with oversight from Sister Helen Brewer (Daughters of Charity, Austin), Anne Dunkelberg (Center for Public Policy Priorities),and DeAnn Friedholm, (former Medicaid director for the State of Texas). In order to represent the cultural and geographic diversity of those Texans eligible or potentially eligible for Medicaid, eight field sites were chosen to represent the proportionate numbers of Texas respondents eligible for Medicaid. Screeners were designed to recruit participants for focus groups and interviews utilizing the following criteria.

INCOME Individuals were recruited from 150% and below of the Federal Poverty Level (FPL). Depending upon the age of the youngest child, respondents were potentially eligible for Medicaid or CHIP.

LOCATION In an attempt to represent the ethnic diversity of Texas, groups were held in the following eight locations: Dallas, Houston, San Antonio, El Paso, Tyler, Amarillo, Waco, and McAllen/Pharr. Rural and urban perspectives were represented in Tyler, Amarillo, Waco and McAllen/Pharr, where recruiters sought respondents from surrounding areas.

ETHNICITY In order to represent the cultural diversity of Texas and allow for maximal response, groups were assembled in six locations by ethnicity, with one mixed group of African-Americans and Caucasians in Houston, and a mixed group of Caucasians and English-speaking Hispanics in Amarillo. Of the six homogeneous focus groups, two were held with African-Americans (Tyler, Dallas), four in "Spanglish", with first and second generation Hispanics in the Rio Grande Valley, El Paso, San Antonio, and Houston. A balance of people from the African-American, Caucasian, and English- and Spanish-speaking Hispanic communities were recruited for in-depth interviews, proportionate to the statewide population eligible for Medicaid.

GENDER The majority of respondents were female; 13 men also participated in either focus groups or in-depth interviews.

RECRUITMENT In order to recruit individuals who conform to potential eligibility requirements for Medicaid, potential respondents were screened over the telephone based on the following criteria:

- Respondents must fall within eligibility guidelines according to household size, age of youngest child, and income eligibility.
- Respondents must be decision-makers regarding the children's health and health insurance.
- Respondents must not work in advertising, media, insurance, or as professional medical providers.

In addition, during the telephone screening survey, information was gathered from potential respondents regarding their age, educational level, occupation, marital status, and past experience with Medicaid.

Orchard Communications, Inc. subcontracted with local marketing firms with extensive expertise in focus group recruitment in their local communities. In most areas, telephone surveys were conducted in certain zip code designations with random respondents deemed to be potentially eligible. In smaller venues, such as Tyler, Amarillo, and Waco, respondents were recruited from where it was thought the target audience may be working, such as local small businesses, workforce commission offices, and temporary agencies.

PARTICIPANT PROFILES

Between February and May, 2000, a total of 88 individuals participated in focus group discussions, and 54 sat for one-on-one in-depth interviews, for a total of 142 participants altogether. Cathy Schechter of Orchard Communications, Inc. conducted English focus groups and interviews; all Spanish focus groups and interviews were conducted by Beatriz Noriega of Focus Latino. Table 1 offers demographic profiles of respondents.

Table 1: Participant Profiles

Total Number of Respondents: 142

Gender	**Ethnicity**[xxix]
Female………………………… 89%	African-American…………………23%
Male……………………………11%	Caucasian…………………………19%
	Spanish-speaking Hispanic………...35%
	English-speaking Hispanic…………12%
	Bi-lingual Hispanic………………. 11%
Marital Status	**Age of Parent or Guardian**
Married…………………………62%	18-30……………………………35%
Common Law……………………3%	31-35……………………………19%
Single……………………………33%	36-40……………………………23%
Widowed………………………... 2%	41-45……………………………13%
	46-55……………………………10%

Number of Children in Household	Education
1 Child……25%	Grade School……2%
2 Children……34%	Middle School……12%
3 Children……24%	High School Grad……51%
4 or more……17%	Some College……23%
	College Graduate……11%

Been on Medicaid in Past 5 Years?	Number of Respondents/Location
Yes……59%	Amarillo……10
No……41%	Dallas……27
	El Paso……18
	Houston……29
	McAllen……19
	San Antonio……19
	Tyler……12
	Waco……8

LINES OF INQUIRY

The focus group and interview guides were designed to gather information in the following broad general areas:

- Challenges of parenting today in general, and in providing health care for children, specifically.
- Top-of-mind associations about Medicaid.
- How people learn about Medicaid.
- Descriptions of and opinions about the application process, including time taken, the experience of the waiting room, providing documentation, and DHS staff.
- Descriptions and opinions about the re-certification process.
- If applicable, descriptions of how Medicaid benefits have been utilized, and opinions about the quality of care and service provided.
- Opinions about barriers to enrollment.
- Field-test of ideas about how to streamline the eligibility determination process.
- For Spanish-speaking Hispanics, perspectives on special barriers for immigrants.

DATA ANALYSIS

Focus groups and in-depth interviews were audio-taped. Focus group audio-tapes were transcribed to provide verbatim records. Tapes of in-depth interviews were reviewed and summarized. Researchers read the transcripts and summaries and coded for word usage and

theme, as well as sorting quotations and themes by audience segment. A hybrid analytical method was used, drawing on content analysis, a quantitative way of looking at qualitative data, and deviant case analysis. Contents were analyzed for recurring themes, experiences, and opinions; certain responses were coded and tallied for frequency. High frequency among a random sample typically guarantees the same findings within the next sample. Deviant case analysis considers exceptions about particular topics; researchers use these exceptions to refine the analysis.

Participant profiles were entered onto Excel spreadsheets and tallied to create a numerical framework for analyzing responses by ethnic group, marital status, gender, and other considerations. However, this study does not in any way constitute a quantitative survey of these respondents. Readers are cautioned to remember the limits of qualitative research. The number of respondents is a small representative sampling of eligible populations, chosen from a limited universe. Findings should be considered directional, and not statistically definitive.

APPENDIX B:

WHAT FEDERAL LAW REQUIRES FROM STATES FOR CHILDREN'S MEDICAID ELIGIBILITY

From HCFA State Medicaid Director Letter 9/10/98 (emphasis added):

"The Federal requirements for the application and enrollment process for Medicaid (including CHIP-related Medicaid programs) are explained in 42 CFR 435.900ff. Specifically, States must:

1. Give individuals the opportunity to apply for Medicaid without delay. Pregnant women and infants must have the opportunity to apply for Medicaid at required outstation locations other than welfare offices.
2. Require a written application on a form prescribed by the State Medicaid agency and signed under a penalty of perjury. The application must be filed by the applicant, an authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
3. Provide written (or oral, if appropriate) information to all applicants on Medicaid eligibility requirements, available services, and the rights and responsibilities of applicants and recipients. The State also must have pamphlets or bulletins that explain the eligibility rules and appeal rights in simple, understandable terms.
4. Obtain the Social Security number (SSN) of the applicant. **(Note that the SSN cannot be required of other family members who are not applying for Medicaid).**
5. If the applicant is a qualified alien, obtain documentation of satisfactory immigration status and verify immigration status with INS. **(Note that this requirement does not apply to parents if the parents are not applying for Medicaid).**
6. Take action on applications within a time standard set by the State (not to exceed 45 days for individuals who apply on a basis other than disability) and inform the applicant about when a decision can be expected.
7. Record in each applicant's case record facts to support its eligibility decision.
8. Send a written decision notice to every applicant. If the application is denied, the notice must include the reasons for the denial, the specific regulations supporting the action and an explanation of the applicant's right to a hearing."

"**Federal law requires no verification of information pertaining to eligibility for children under Medicaid other than**

- **the requirement for verification of immigration status of qualified aliens, and**
- **the post-eligibility requirement in Section 1137 for an income and eligibility verification system (IEVS).**

Under IEVS, the State must request information from other Federal and State agencies to verify the applicant's income and resources. The applicant must be informed in writing, at the time of application, that the agency will be requesting this information."

APPENDIX C:

SIMPLIFIED ELIGIBILITY FOR CHILDREN'S MEDICAID: WHAT THE STATES HAVE DONE

	Governor	Dropped Face to Face Interview	Dropped Asset Test	12-month Continuous Eligibility[10]
Alabama	Don Siegelman (D)	yes	yes	yes
Alaska	Tony Knowles (D)	yes	yes	---
Arizona	Jane Hull (R)	yes	yes	---
Arkansas[1/2]	Mike Huckabee (R)	---[1]	---[2]	---
California	Gray Davis (D)	yes	yes	---
Colorado	Bill Owens (R)	yes	---	---
Connecticut	John G. Rowland (R)	yes	yes	yes
Delaware	Thomas R. Carper (D)	yes	yes	---
D.C.		yes	yes	---
Florida	Jeb Bush (R)	yes	yes	Under age 5
Georgia[3]	Roy Barnes (D)	---[3]	yes	---
Hawaii[4]	Benjamin J. Cayetano (D)	yes[4]	yes	---
Idaho	Dirk Kempthorne (R)	yes	---	yes
Illinois	George H. Ryan (R)	yes	yes	yes
Indiana	Frank O'Bannon (D)	yes	yes	yes
Iowa	Tom Vilsack (D)	yes	yes	---
Kansas	Bill Graves (R)	yes	yes	yes
Kentucky	Paul E. Patton (D)	yes	yes	---
Louisiana	Mike Foster (R)	yes	yes	yes
Maine	Angus S. King Jr. (I)	yes	yes	---
Maryland	Parris Glendening (D)	yes	yes	---
Massachusetts	Argeo Paul Cellucci (R)	yes	yes	---
Michigan	John Engler (R)	yes	yes	---
Minnesota	Jesse Ventura (Reform)	yes	yes	---
Mississippi	Kirk Fordice (R)	yes	yes	yes

	Governor	Dropped Face to Face Interview	Dropped Asset Test	12-month Continuous Eligibility[6]
Missouri[5]	Mel Carnahan (D)	yes	---[5]	---
Montana	Marc Racicot (R)	---	---	---
Nebraska	Mike Johanns (R)	yes	yes	yes
Nevada[8]	Kenny C. Guinn (R)	---[8]	---	---
New Hampshire	Jeanne Shaheen (D)	yes	yes	---
New Jersey	Christine T. Whitman (R)	yes	yes	---
New Mexico[3,4]	Gary E. Johnson (R)	---[3,4]	yes	yes
New York[3]	George E. Pataki (R)	---[3]	yes	yes
North Carolina	James B. Hunt Jr. (D)	yes	yes	yes
North Dakota	Edward T. Schafer (R)	yes	---	---
Ohio[7]	Bob Taft (R)	yes	yes	yes[7]
Oklahoma	Frank Keating (R)	yes	yes	---
Oregon	John Kitzhaber, M.D. (D)	yes	---	---
Pennsylvania	Tom Ridge (R)	yes	yes	---
Rhode Island	Lincoln Almond (R)	yes	yes	---
South Carolina	Jim Hodges (D)	yes	yes	yes
South Dakota	William J. Janklow (R)	yes	yes	---
Tennessee[1]	Don Sundquist (R)	---[1]	yes	--
Texas	George W. Bush (R)	---	---	---
Utah[2,4]	Michael O. Leavitt (R)	---[4]	---[2]	---
Vermont	Howard Dean, M.D. (D)	yes	yes	---
Virginia	James S. Gilmore III (R)	yes	yes	---
Washington	Gary Locke (D)	yes	yes	yes
West Virginia[8]	Cecil H. Underwood (R)	---[8]	yes	---
Wisconsin	Tommy G. Thompson (R)	---	yes	---
Wyoming[4]	Jim Geringer (R)	---[4]	yes	---

Information in this table was prepared by the **Center on Budget and Policy Priorities** for the Kaiser Commission on Medicaid and the Uninsured, based on a telephone survey of state Medicaid/CHIP officials (r*evised, March 2000).* For more information about the survey, contact Donna Cohen Ross or Laura Cox at 202-408-1080. Information on state Governors is from the National Governors Association's web page, http://www.nga.org.

1. In Arkansas and Tennessee mail-in applications are used for children in the Medicaid expansion groups under 1115 waiver only. Applicants eligible under pre-waiver guidelines are required to have a face-to-face interview. Arkansas gives 12 month continuous eligibility to children eligible under the 1115 waiver, but not those eligible under pre-waiver Medicaid categories.
2. Arkansas and Utah still count assets in determining Medicaid eligibility for some "poverty level" children.
3. In Georgia a separate Medicaid application is still in use; a face-to-face interview is required when the separate Medicaid application is used, but it can be done outside the Medicaid office. In New Mexico a face to face interview is required, however a child may enroll through a community-based Medicaid On-Site Application Assistance (MOSAA) provider using a shortened application to meet this requirement. In New York, a contact with a community-based "facilitated enroller" will meet the face to face interview requirement.
4. The Medicaid agency will permit a telephone interview.
5. Missouri has eliminated the asset test for applicants eligible under pre-1115 waiver expansion guidelines. Children in the waiver expansion group are subject to asset test of $250,000.
6. A child is enrolled for 12 months, regardless of changes in family income or circumstances.
7. Ohio will implement continuous eligibility for children to 200% FPL in July 2000.
8. In NV and WV, children who apply using traditional Medicaid application must complete face-to-face interview, but children who apply using a CHIP application who are found income-eligible for Medicaid do not have to be interviewed.

APPENDIX D:

THE PROJECT ALBERTO-COVERING KIDS INITIATIVE SUMMARY OF FORMS AND VERIFICATIONS NEEDED TO APPLY FOR MEDICAID AND CHIP

Total Number of Forms Needed to Apply for Medicaid:	5 - 19
Total Number of Forms Needed to Apply for CHIP:	1
Total Number of Verifications Needed to Apply for Medicaid:	7 - 25
Total Number of Verifications Needed to Apply to CHIP:	1 – 4
Total Number of Forms the Medicaid Applicant Must Sign:	3 - 10
Total Number of Forms the CHIP Applicant Must Sign:	1
Total Number of Other Signatures the Applicant Must Get to Apply for Medicaid:	4 - 15
Total Number of Other Signatures the Applicant Must Get to Apply for CHIP:	0 - 1

TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

APPENDIX E:

DEPARTMENT OF HUMAN SERVICES AND ATTORNEY GENERAL CHILD AND MEDICAL SUPPORT FORMS

MC:

Office of the Attorney General
State of Texas
Child Support Division

JOHN CORNYN
Attorney General

PATERNITY INFORMATION GATHERING

Form Sequence Number: **Application Sequence Number:**

IF YOU ARE NOT THE MOTHER OF THE CHILD OR IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT:
SI USTED NO ES LA MADRE DEL NIÑO O SI NECESITA ASISTENCIA PARA COMPLETAR ESTE FORMULARIO, POR FAVOR LLAME AL NÚMERO:

I. INFORMATION ABOUT YOU (THE MOTHER OF THE CHILD)
(Please Print All Information)

1. Your full legal name ______________________ Your maiden name ____________
   Last First, Middle

2. What is your relationship to the child(ren)? ______________________

3. Your mailing address ______________________
   Address City State ZIP Code

4. Your physical address/telephone number ______________________
   Street City
   ____
   State ZIP Code County Telephone Number

5. Your employer's name/telephone number/address ______________________
   Name Telephone Number
   ____
   Address City State ZIP Code

6. Please provide the following information about yourself:

Date of Birth	Birthplace (city and state)	Social Security Number	
Driver License or ID number (include state)	Sex	Race	
Height	Weight	Hair Color	Eye Color
List any physical or mental impairments, medical problems, etc.		What is your language preference? (Check one only) ☐ English ☐ Spanish	
List identifying information (for example, glasses scars, tattoos, marks, etc.)			

7. Give information where we can contact you other than home:
   ____
   Relationship to you Name Telephone Number
   ____
   Address City State ZIP Code
   ____
   Relationship to you Name Telephone Number
   ____
   Address City State ZIP Code

8. Are you currently receiving TANF (welfare) benefits? ☐ Yes ☐ No Have you received TANF benefits in the past? ☐ Yes ☐ No If yes, list all dates: ______________________

9. Are you or the children receiving Medicaid benefits ? ☐ Yes ☐ No If yes, please provide the Medicaid number: __________

10. Do you have another attorney or agency helping you with your child support case? ☐ Yes ☐ No If yes, list the name of agency or attorney and address: ______________________

11. Are you pregnant now? ☐ Yes ☐ No If yes, who is the biological father? ______________________
    When is the baby due? ______________________

MC: PATERNITY INFORMATION GATHERING

Form Sequence Number: Application Sequence Number:

I. INFORMATION ABOUT YOU *(continued)*

12. Please list all marriages (current and previous):

Husband's Name	Date of Marriage	Common law marriage or marriage license?	Date of separation	Date of divorce

Husband's Name	Date of Marriage	Common law marriage or marriage license?	Date of separation	Date of divorce

II. INFORMATION ABOUT THE BIOLOGICAL FATHER OF THE CHILD

(Please Print All Information)

1. His full legal name ______________________ Alias/Nicknames ____________

   Last, First, Middle Initial

2. Present [ ] or last known [ ] address/telephone number ______________________

   Address Telephone Number

   City State ZIP Code

3. Current employer's name/telephone number/address ______________________

   Name Telephone Number

   Address City State ZIP Code

4. Previous employer's name/telephone number/address ______________________

   Name Telephone Number

   Address City State ZIP Code

   What is the date you last knew he was with this employer? ______________

   Approximately current monthly wages $ ______________

   If he is unemployed, what does he usually earn? $__________ What type of work (plumber, mechanic, fast food, etc.) does he usually do? Answer even if he is unemployed.______________

5. His Description:

Date of Birth	Birthplace (city and state)		Social Security Number
Driver License or ID number (include state)		Sex	Race
Height	Weight	Hair Color	Eye Color
List any physical or mental impairments, medical problems, etc.		What is his language preference? (heck one only) ☐ English ☐ Spanish	
List identifying information (for example, glasses, scars, tatoos, marks, etc.)			
Do you have a photograph of the biological father? ☐ Yes ☐ No If yes, please include a photograph when you return this form.			

6. Has he been in jail or prison? ☐ Yes ☐ No If yes, Date __________ Location ______________

   City State

7. Has he been on probation or parole? ☐ Yes ☐ No If yes, please provide name of parole or probation officer and location. ______________________

   Name City State

8. Has he served in the military? ☐ Yes ☐ No If yes, what branch? ______________

   Dates of service: From ____________ To ____________ Did he retire? ☐ Yes ☐ No

9. Does he receive any benefits (food stamps, TANF, retirement, Worker's Compensation, Social Security, etc.?)

   ☐ Yes ☐ No If yes, what type of benefits: ______________________

MC:

PATERNITY INFORMATION GATHERING

Form Sequence Number: **Application Sequence Number:**

II. INFORMATION ABOUT THE BIOLOGICAL FATHER OF THE CHILD *(continued)*

10. List information about his vehicle: Year of car/truck ______________ Make ______________

Model ______________ Color ______________ License plate number (include state) ______________

11. Does he own any land or have any substantial property or assets? ☐ Yes ☐ No If yes, list below:

Real estate ______________ Registered vehicles (other than the one listed above) ______________

Financial ______________ Other ______________

12. Please provide information about the biological father's relatives:

His mother's name	His mother's maiden name		Telephone number
Address	City	State	ZIP Code
His father's name			Telephone number
Address	City	State	ZIP Code
Friend or other relative's name			Telephone number
Address	City	State	ZIP Code

13. Provide any other information about the biological father's whereabouts (stays with friends, frequents bars, etc.)

____

14. Is he a member of a union? ☐Yes ☐ No If yes, please provide name and location of union:

____

15. Has he been employed by the federal or state government? ☐ Yes ☐ No If yes, what agency did he work for?

______________ What was his job title? ______________

16. What high school/college did he attend? ______________

Address of school ______________
Address City State ZIP Code

17. Marital Status: Is he currently married? ☐ Yes ☐ No If yes, whom did he marry? ______________

When did he marry? ______________ Where did he get married? ______________

18. Does the biological father have other child(ren) under 18 years of age? ☐ Yes ☐ No If yes, how many? _____

19. Why do you believe this person is the biological father of your child?

____

____

MC:

PATERNITY INFORMATION GATHERING

Form Sequence Number: **Application Sequence Number**

III. INFORMATION ABOUT THE CHILD

(Please Print All Information)

1. Please complete the following information:

Full legal name of child First Middle Initial Last		Date of birth	Place of Birth (city and state)
Child's Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	
Does the child live with you? ☐ Yes ☐ No	Race	Weight at birth (pounds and ounces)	

2. Was this child born (check one) ☐ early? ☐ late? ☐ on time?

3. Do you have any other children by the biological father? ☐ Yes ☐ No If yes, please list names: __________

4. Does this child have a relationship with the biological father? ☐ Yes ☐ No

5. Do you want this child to have the biological father's last name? ☐ Yes ☐ No If no, why not: __________

6. Fathers have visitation rights with their children. Would you have any reason, such as family violence, to want to limit the father's rights to visitation with this child? If so, please list reasons and attach any proof you may have, such as police reports, criminal records, restraining orders, or names, addresses and phone numbers of witnesses.

7. Is this child currently enrolled in a health plan? ☐ Yes ☐ No

If yes, who is the provider? ☐ Mother ☐ Alleged father ☐ Other __________

What is the cost to cover the child? List amount: $ ______ per ______ Effective date ______

Name/address of insurance company: __________
Name

Address City State ZIP Code

What is the insurance Group Number? __________ Policy Number? __________

IV. INFORMATION ABOUT THE MOTHER'S RELATIONSHIP WITH THE BIOLOGICAL FATHER

(Please Print All Information)

1. When was the first time you had sexual intercourse with the biological father? ____/____/____
Month Day Year

What was the frequency? __________ When was the last time? ____/____/____
Month Day Year

2. Where did you live when you became pregnant with this child? __________
City State

What was the date of conception? __________

3. Did the biological father live in Texas during the sexual relationship? ☐ Yes ☐ No If no, then what state? ______

4. Did the sexual relationship occur in Texas? ☐ Yes ☐ No If no, then what state? ______

5. Who knew of your relationship with the biological father (friends, neighbors, landlord, etc.)?

Relationship to you **Name** **Address**

Relationship to you **Name** **Address**

IV. INFORMATION ABOUT THE MOTHER'S RELATIONSHIP WITH THE BIOLOGICAL FATHER *(continued)*

6. Did the biological father ever admit to you or anyone that he is the father? ☐ Yes ☐ No

   If yes, to whom?____________________

   What did he say? ____________________

7. When was the last time you spoke to or saw him? __________ Where?__________

8. What kind of relationship did you have with the biological father? ☐ Date regularly ☐ Going to get married

   ☐ Living together If so, how long? ____________________

9. Will he admit he is the father of this child? ☐ Yes ☐ No If yes, do you think he will sign the necessary papers to become the legal father of this child? ☐ Yes ☐ No

10. Father's name as listed on birth certificate ____________________ Please attach a copy.

11. Has the biological father ever visited this child? ☐ Yes ☐ No If yes, how often? __________

12. Do you have any letters of proof that the biological father is the father of this child? ☐ Yes ☐ No If yes, please hold on to the letters.

13. Did the biological father ever give money for bills or for the needs of this child? ☐ Yes ☐ No If yes, please attach a list of amounts and dates. Keep receipts if you have any.

14. Do the parents of the biological father know about this child? ☐ Yes ☐ No If yes, have they given the child gifts or money? ☐ Yes ☐ No Visited this child? ☐ Yes ☐ No

15. What is the current relationship between the mother and the biological father of the child?
    ☐ Never Married ☐ Married ☐ Divorced

    Date of Marriage Ceremony: __________ County: __________ St: ______

16. If you are divorced or have any court order (divorce order, paternity order, custody order, protective order, etc.) of any kind regarding this child please attach a copy of the order to this form. If you are unable to provide a copy of the order, you must provide the following:

Date	Cause/Case number	County	State	Court

17. Are there any legal actions pending that affect the child listed above? ☐ Yes ☐ No If yes, please attach a copy of the pending legal action to this form. If you are unable to provide a copy you must provide the following:

Date	Cause/Case number	County	State	Court

    Attorney name and address: ____________________ Telephone Number __________

18. Did you have a sexual relationship with anyone other than the biological father, before, during, or after 90 days of the date that you became pregnant with this child ? ☐ Yes ☐ No If yes, when? __________

    Name, address, and telephone number of the person ____________________

    ____

19. Have you or any other person ever named any other man as the father of this child? ☐ Yes ☐ No If yes, who was named?

    ____

MC:

PATERNITY INFORMATION GATHERING

Form Sequence Number: **Application Sequence Number**

V. INFORMATION ABOUT THE PRESUMED FATHER (MOTHER'S LEGAL HUSBAND)

(Please Print All Information)

PLEASE COMPLETE THIS SECTION IF YOU HAD A HUSBAND AT THE TIME (WITHIN ONE YEAR) OF THIS CHILD'S CONCEPTION OR BIRTH AND THE HUSBAND IS NOT THE FATHER OF THE CHILD.

1. **His full legal name** ______________________ **Alias/Nickname** ____________
   Last, First, Middle Initial

2. **Present [ ] or last known [ ] address/telephone number** ______________________
   Address Telephone Number
   ____
   City State ZIP Code

3. **Current employer's name/telephone number/address** ______________________
   Name Telephone Number
   ____
   Address City State ZIP Code

4. **Previous employer's name/telephone number/address** ______________________
   Name Telephone Number
   ____
   Address City State ZIP Code

5. **His description:**

Date of Birth	Birthplace (city and state)		Social Security Number
Driver License or ID number (include state)		Sex	Race
Height	Weight	Hair Color	Eye Color
List any physical or mental impairments, medical problems, etc			
List identifying information (for example, glasses, scars, tattoos, marks, etc.)			
Do you have a photograph of the presumed father? ☐ Yes ☐ No If yes, please include a photograph when you return this form.			Approximate Birth Year

6. **What is the current relationship between the mother and the presumed father of the child?**
   ☐ Never Married ☐ Married ☐ Divorced

   Date of Marriage: ____________ **County:** ____________ **St:** ____________

   If you are divorced or have any court order (divorce order, paternity order, custody order, protective order, etc.) of any kind regarding this child please attach a copy of the order to this form. If you are unable to provide a copy you must provide the following:

Date	Cause/Case number	County	State	Court

7. **Are there any legal actions pending that affect the child listed above?** ☐ Yes ☐ No **If yes, please attach a copy of the pending legal action to this form. If you are unable to provide a copy you must provide the following:**

Date	Cause/Case number	County	State	Court

IV. COMMENTS

Please write any additional comments you may have.

____

____

____

MC:

Office of the Attorney General
State of Texas
Child Support Division

John Corn

INFORMATION GATHERING

Form Sequence Number:

Application Sequence Number:

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT:

SI NECESITA ASISTENCIA PARA COMPLETAR ESTE FORMULARIO, POR FAVOR LLAME AL NÚMERO:

I. INFORMATION ABOUT YOU (THE CUSTODIAL PARENT OR PERSON WITH CUSTODY) (Please Print All Information)

1. Your full legal name ________ Last, First, Middle Initial ________ Maiden name (if applicable) ________
2. What is your relationship to the children? ________
3. Your mailing address ________ Address City State ZIP Cod
4. Your physical address/telephone number ________ Street City
   State ZIP Code County Telephone Number
5. Your employer's name/telephone number/address ________ Name Telephone Number
   Address City State ZIP Cod
6. Please provide the following information about yourself:

Date of Birth	Birthplace (city and state)			Social Security Number	
Driver License or ID number (include state)				Alias/Nicknames	
Sex	Race	Height	Weight	Hair Color	Eye Color
List any physical or mental impairments, medical problems, etc.				What is your language preference? (check one only) ☐ English ☐ Spanish	
List identifying information (for example, glasses, scars, tattoos, marks, etc.)					

7. Give information where we can contact you other than home:

   ____
   Relationship to you Name Telephone Numb
   ____
   Address City State ZIP C
   ____
   Relationship to you Name Telephone Numb
   ____
   Address City State ZIP C

8. Are you currently receiving TANF (welfare) benefits? ☐ Yes ☐ No Have you received TANF benefits in the past? ☐ Yes ☐ No
   If yes, list all dates: ________
9. Are you or the children receiving Medicaid benefits? ☐ Yes ☐ No If yes, please provide the Medicaid number: ________
1 Do you have another attorney or agency helping you with your child support case? ☐ Yes ☐ No If yes, list the name of agency or attorney and address ________
11. Is the mother of the child(ren) pregnant now? ☐ Yes ☐ No ☐ Unknown If yes, who is the biological father? ________
    When is the baby due? ________

MC:

INFORMATION GATHERING

Form Sequence Number: Application Sequence Number:

II. INFORMATION ABOUT THE NON-CUSTODIAL PARENT (NCP) *(continued)*

11. List information about the non-custodial parent's vehicle: Year of car/truck________ Make________
Model________ Color________ License plate number (include state)________

12. Does the non-custodial parent own any land or have any substantial property or assets? ☐ Yes ☐ No If yes, list below
Real estate________ Registered vehicles (other than the one listed above)________
Financial________ Other________

13. Please provide information about the non-custodial parent's relatives:

Mother's name	Mother's maiden name		Telephone number
Address	City	State	ZIP Code
Father's name			Telephone number
Address	City	State	ZIP Code
Friend or other relative's name			Telephone number
Address	City	State	ZIP Code

14. **Provide any other information about the NCP's whereabouts (stays with friends, frequents bars, etc.):**________

15. **Is the NCP a member of a union? ☐ Yes ☐ No If yes, please provide name and location of union:**________

16. Has the NCP been employed by the federal or state government? ☐ Yes ☐ No If yes, what agency did the NCP work for?________
________ What was the non-custodial parent's job title?________

17. Has the NCP made any large gifts or cash payments directly to your children? ☐ Yes ☐ No If yes, please explain:________

18. Is the NCP buying/renting a house or apartment? ☐ Yes ☐ No If yes, provide details:________
________ What is the monthly mortgage/rent payment? $________

19. Does the NCP make monthly car/truck payments? ☐ Yes ☐ No If yes, give amount $________

20. Does the NCP have parents, relatives, or friends who could loan money to the NCP to pay child support owed? ☐ Yes ☐ No
If yes, who?________

21. What high school/college did the NCP attend?________
Address of school________
Address City State ZIP Code

22. Marital Status: Is the non-custodial parent currently married? ☐ Yes ☐ No If yes, whom did the NCP marry?________
When did the non-custodial parent marry?________ Where did the non-custodial parent get married?________

23. Does the NCP have other child(ren) under 18 years of age? ☐ Yes ☐ No If yes, how many?________

24. Do you wish to keep identifying information and addresses about you or your child(ren) private and not disclosed in court documents? If so, you will have to f
an Affidavit of Non-Disclosure explaining a protective order has been entered, or the release of your address may result in physical or emotional harm. If thi
case, please explain below. If you have them, provide us with any documents, orders or reports.

____

____

MC:

INFORMATION GATHERING

Form Sequence Number:

Application Sequence Number:

III. INFORMATION ABOUT THE CHILDREN (Please Print All Information)

1. Please provide information about all your children:

Full legal name of child Last, First, MI 1)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 2)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 3)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 4)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 5)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 6)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 7)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 8)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 9)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No
Full legal name of child Last, First, MI 10)	Date of birth	Place of birth (city and state)
Child's Social Security Number	Sex	Race
List any physical or mental impairments, medical problems, etc.	Name of biological father	Does this child live with you? ☐ Yes ☐ No

MC:

INFORMATION GATHERING

Form Sequence Number: Application Sequence Number:

III. INFORMATION ABOUT THE CHILDREN *(continued)*

(Please Print All Information)

2. Are all the children listed enrolled in a health plan? ☐ Yes ☐ No If no, which children are enrolled: ____________________

3. Who is the provider of the health insurance? ☐ Custodial parent ☐ Non-custodial parent ☐ Other____________________

4. What is the cost to cover your child(ren)? List amount $__________ per __________ Effective date____________________

5. Name of insurance company____________________

6. Address of insurance company____________________

7. Health Insurance Group Number____________________ Health Insurance Policy Number____________________

IV. INFORMATION ABOUT THE CHILD SUPPORT OBLIGATION AND POSSESSION OF THE CHILDREN (Please Print All Information)

1. What is the current relationship between the mother and the father of the children?

   ☐ Never Married ☐ Married/living apart ☐ Divorced

   Date of Marriage Ceremony:____________________ County:____________________ St:_____

2. If there is a court order of any kind regarding the children (divorce order, paternity order, custody order, protective order, etc.), you must provide the following information:

Date of court order	Case/Cause number	County	State	Court

   If you have a copy of this order, please include it when you return this form.

3. Are there any legal actions pending that affect the children of the marriage? ☐ Yes ☐ No If yes, please provide the following information:

Date of Filing	Case/Cause number	County	State	Court

4. What is the amount of child support that the non-custodial parent is ordered to pay? $__________ How often?__________

5. Since the divorce or establishment of the support obligation, have any court orders modified the amount of child support due?

   ☐ Yes ☐ No If yes, please explain:____________________

6. Have you and the non-custodial parent (NCP) lived together since the last court order that set the amount of child support payments?

   ☐ Yes ☐ No If yes, please explain and list the dates:____________________

7. In your opinion, will the NCP claim that there should be credits, offsets, or reductions in the amount of child support owed? ☐ Yes ☐ No

   If yes, answer the following:

   a. Have you made any "out-of-court" agreements with the NCP in regards to reducing, increasing, or permitting non-payment of child support? ☐ Yes ☐ No If yes, please explain:____________________

   b. Did you promise the NCP any credits or reductions in child support payments in exchange for making repairs to your house or car, paying medical or dental bills, paying rent or making house payments for you, etc.?

      ☐ Yes ☐ No If yes, please provide details:____________________

8. Have the children belonging to both you and the NCP lived with the NCP in excess of the visitation period defined by the court order?

   ☐ Yes ☐ No If yes, please provide details:____________________

9. Have you had continuous possession of the children belonging to both you and the non-custodial parent since the last court order?

   ☐ Yes ☐ No If no, please provide details:____________________

Texas Department of Human Services

PARENT PROFILE QUESTIONNAIRE (Complete one form for each absent parent.)
CUESTIONARIO SOBRE LOS PADRES (Llene un cuestionario para cada padre o madre ausente.)

I. INFORMATION ABOUT YOU/INFORMACION SOBRE USTED

Name/Nombre	Social Security No./Núm. de Seguro Social	Relationship to Children/Parentesco con l
Address (Street, Apt. No., City, State, ZIP)/Dirección (Calle, Apt. Núm., Ciudad, Estado, ZIP)		Date of Birth/Fecha de N
Telephone No./Address Where Messages Can Be Left/Teléfono/Dirección Donde le Podemos Dejar Recados		

II. INFORMATION ABOUT PARENTS OF CHILDREN/INFORMACION SOBRE LOS PADRES DE LOS NIÑOS

Are both mother and father living with the children?
¿Viven los niños con su padre y su madre? .... ☐ Yes/Sí

If you answered "Yes," do not complete this form. Sign and return to the local Department of Human Services office.

If you answered "No," complete the form.

Si marca "Sí," no llene el cuestionario. Fírmelo y devuélva a la oficina local del Departamento de Servicios Humanos.

Si marca "No," llene el cuestionario.

III. INFORMATION ABOUT THE ABSENT PARENT/INFORMACION SOBRE EL PADRE O LA MADRE AUSENTE

Name (last, first, middle)/Nombre (apellido, primero, segundo)	Social Security No./Núm. de Seguro Social	Date of Birth/Fecha de N
Current Address/Dirección Presente		Telephone No./Teléfono
Last Known Address (if different)/Ultima Dirección Conocida (si es diferente)		Telephone No./Teléfono
Current Employer/Patrón Actual	Address/Dirección	Telephone No./Teléfono
Previous Employer/Patrón Anterior	Address/Dirección	Telephone No./Teléfono

Height/Altura	Weight/Peso	Color of Eyes/Color de Ojos	Color of Hair/Color del Cabello	Sex/Sexo	Race/Raza

Has the absent parent ever been in jail?
¿Ha estado encarcelado alguna vez el padre o la madre ausente? . ☐ Yes/Sí ☐ No ▷ If "Yes," where?/Si marca "Sí," ¿dónde? ▷ When?/¿Cuándo?

Check any of the following benefits that the absent parent receives:/Marque entre los siguientes beneficios los que recibe el padre o la madre ausente:

☐ Social Security Benefits/Beneficios de Seguro Social
☐ Veteran's Benefits/Beneficios de Veterano
☐ Workman's Compensation/Compensación del Seguro Obrero
☐ Unemployment/Compensación por Desempleo
☐ Other:/Otro: ______

Give the names of people who might know where the absent parent can be located: / Dé el nombre de personas que podrian saber dónde se encuentra el padre o la madre ausente:	ADDRESS/DIRECCION	TELEPHO TELEFO

IV. INFORMATION ABOUT THE CHILDREN you and the absent parent had together (include adopted children)
INFORMACION SOBRE LOS NIÑOS que son hijos tanto de usted como del ausente (incluya los hijos adoptivos)

FULL LEGAL NAME OF CHILD (Last, First, Middle) / NOMBRE COMPLETO Y LEGAL DEL NIÑO (Apellido, Primero, Segundo)	PLACE OF BIRTH (City, State) / LUGAR DE NACIMIENTO (Ciudad, Estado)	DATE OF BIRTH (month, day, year) / FECHA DE NACIMIENTO (mes, día, año)	SEX / SEXO	Does child live with you? ¿Vive el niño con usted?		Do recei or M on an ¿Reci AFDC bajo
				Yes/Sí	No	Yes/S

MC:

Form Sequence Number:

INFORMATION GATHERING

Application Sequence Number:

IV. INFORMATION ABOUT THE CHILD SUPPORT OBLIGATION AND POSSESSION OF THE CHILDREN *(continued*

10. Has the non-custodial parent made any child support payments directly to you (instead of through the court registry)? ☐ Yes ☐ No If yes, please provide t amount of each payment on the enclosed "Affidavit of Direct Payments" form. Complete both sides of the Affidavit, have the Affidavit notarized and return it

11. Why do you believe the non-custodial parent is behind in child support payments? (example: visitation disputes, alcohol or drug problems, financial problems pay, etc.)

____

____

12. How much do you believe the non-custodial parent is behind on child support payments?______________

13. Does the non-custodial parent have an excuse for not paying child support (physical/mental disability, injury, etc.)?
☐ Yes ☐ No If yes, please explain:

____

14. What action, if any, do you believe should be taken against the non-custodial parent?______________

COMMENTS

Please write any additional comments you may have.

____

____

____

____

____

____

____

____

____

____

VI. REQUIRED SIGNATURE

I declare all information provided in this form is true and correct.

I consent to any action by the Office of the Attorney General to obtain a decree establishing child support or paternity of the child. I understand that the Attorn General of Texas does not represent me.

______________________________ ______________
(Signature) (Date)

Texas Department
of Human Services

PARENT PROFILE QUESTIONNAIRE (Complete one form for each absent parent.)
CUESTIONARIO SOBRE LOS PADRES (Llene un cuestionario para cada padre o madre ausente.)

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Telephone No./Address Where Messages Can Be Left/Teléfono/Dirección Donde le Podemos Dejar Recados

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If you answered "Yes," do not complete this form. Sign and return to the local Department of Human Services office.

If you answered "No," complete the form.

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Si marca "No," llene el cuestionario.

III. INFORMATION ABOUT THE ABSENT PARENT/INFORMACION SOBRE EL PADRE O LA MADRE AUSENTE

Name (last, first, middle)/Nombre (apellido, primero, segundo)	Social Security No./Núm. de Seguro Social	Date of Birth/Fecha de N

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Current Employer/Patrón Actual	Address/Dirección	Telephone No./Teléfono
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Height/Altura	Weight/Peso	Color of Eyes/Color de Ojos	Color of Hair/Color del Cabello	Sex/Sexo	Race/Raza

Has the absent parent ever been in jail?
¿Ha estado encarcelado alguna vez el padre o la madre ausente? . ☐ Yes Sí ☐ No ▷ If "Yes," where?/Si marca "Sí," ¿dónde? ▷ When?/¿Cuándo?

Check any of the following benefits that the absent parent receives:/Marque entre los siguientes beneficios los que recibe el padre o la madre ausente:

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- ☐ Veteran's Benefits / Beneficios de Veterano
- ☐ Workman's Compensation / Compensación del Seguro Obrero
- ☐ Unemployment / Compensación por Desempleo
- ☐ Other:/Otro: ____

Give the names of people who might know where the absent parent can be located: Dé el nombre de personas que podrían saber dónde se encuentra el padre o la madre ausente:	ADDRESS/DIRECCION	TELEPHO TELEFO

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INFORMACION SOBRE LOS NIÑOS que son hijos tanto de usted como del ausente (incluya los hijos adoptivos)

FULL LEGAL NAME OF CHILD (Last, First, Middle) NOMBRE COMPLETO Y LEGAL DEL NIÑO (Apellido, Primero, Segundo)	PLACE OF BIRTH (City, State) LUGAR DE NACIMIENTO (Ciudad, Estado)	DATE OF BIRTH (month, day, year) FECHA DE NACIMIENTO (mes, día, año)	SEX SEXO	Does child live with you? ¿Vive el niño con usted?		Do recei or M on an ¿Reci AFDC bajo
				Yes/Sí	No	Yes/S

Form

A. Does the absent parent currently have medical insurance that is covering the children?
¿Tiene al presente el padre/la madre ausente un seguro médico que cubre a los niños? .... ☐ Yes Sí

If "Yes," what is the name of the insurance company?
Si marca "Sí," ¿cuál es el nombre de la compañía de seguros? ____________

B. When was the last time the absent parent visited, wrote, or telephoned you or the child(ren)?
¿Cuándo fue la última vez que el/la ausente visitó, escribió o telefoneó a usted o al niño (a los niños)? ____________

RELATIONSHIP BETWEEN MOTHER AND FATHER OF CHILD(REN)
RELACION ENTRE EL PADRE Y LA MADRE DEL NIÑO (DE LOS NIÑOS)

Were mother and father of children married?
¿Estaban casados el padre y la madre del niño (de los niños)? . ☐ Yes Sí ☐ No ▷ If "Yes," answer both A and B. If "No," skip
Si marca "Sí," llene A y B. Si marca "No," si

A. Type of Marriage (check one):/Tipo de Matrimonio (marque uno):

☐ Marriage Ceremony
Ceremonia Matrimonial ▷

Where (county/state)/Dónde (condado/estado)	When (month/day/year)/Cuándo (mes/dí

☐ Common Law (if common law, answer the following):
Matrimonio Consensual (si fue matrimonio consensual, conteste las siguientes preguntas):

Did you live together?
¿Convivieron? .... ☐ Yes Sí

If "Yes," give date you began living together (month/year):
Si convivieron, ¿cuándo comenzaron a vivir juntos? (mes/año) .... ____________

Did you tell others that you were married?
¿Dijeron a otras personas que estaban casados? .... ☐ Yes Sí

Did you file joint tax returns?
¿Hicieron una declaración conjunta del impuesto sobre los ingresos? .... ☐ Yes Sí

Were you both single and free to marry?
¿Estaban los dos solteros con la libertad de haberse casado? .... ☐ Yes Sí

Did the parents use the same last name?
¿Usaban el mismo apellido el padre y la madre? .... ☐ Yes Sí

B. Current marital status to this absent parent (check one):/Relación actual con esta padre (o con esta madre) ausente (marque una

☐ Separated (if you have legally filed for separation, indicate where and when you filed and the cause number):
Separados (si han pedio una separación legal, indique dónde y cuándo y dé el número de la causa):

Where (county/state)/Dónde (condado/estado)	When (month/year)/Cuándo (mes/año)	Cause No./Núm. de la C

☐ Divorced (if divorced, answer the following):
Divorciados (si están divorciados, conteste las siguientes preguntas):

Where (county/state)/Dónde (condado/estado)	When (month/year)/Cuándo (mes/año)	Cause No./Núm. de la C

C. If never married, answer the following:/Si nunca se casaron, conteste las siguientes preguntas:

Has the father stated that he is the father?
¿Ha declarado el padre que es padre del niño (de los niños)? .... ☐ Yes Sí

Did he put it in writing?
¿Ha hecho la declaración por escrito? .... ☐ Yes Sí

If "Yes," do you have a copy?
Si la hizo por escrito, ¿tiene usted una copia? .... ☐ Yes Sí

Would he sign a statement saying that he is the legal father?
¿Firmaría el padre una declaración reconociendo que es padre legal del niño (de los niños)? ... ☐ Yes Sí ☐ No ☐ Unsure No Sé

VI. CHILD SUPPORT/SOSTENIMIENTO PARA NIÑOS

Has the court ordered child support?
¿Ha ordenado la corte pagos de sostenimiento para niños? .... ☐ Yes Sí

If "Yes," (a) how much per month?
Si marca "Sí," (a) ¿cuánto por mes? $ ____________

(b) when was it last paid?
(b) ¿cuándo se hizo el último pago? ____________

If "No," has absent parent paid child support voluntarily or provided any other assistance?
Si marca "No," ha pagado voluntariamente el padre o la madre ausente sostenimiento, o ha dado otra ayuda? .... ☐ Yes Sí

Signature—Applicant/Firma—Solicitante ____________ Date/Fecha ____________

Office Address	MC	Telephone No.	BJN

FOR DHS USE ONLY/PARA USO DE LA AGENC

Were father and mother ever married? ☐ Yes ☐ No	Could AP be located in a emergency? ☐ Yes
Signature—Worker	Date

AUTHORIZATION FOR CHILD/MEDICAL SUPPORT SERVICES AND ASSIGNMENT OF CHILD/MEDICAL SUPPORT RIGHTS

AUTORIZACION PARA SERVICIOS DE SOSTENIMIENTO PARA NIÑOS/SOSTENIMIENTO MEDICO Y ASIGNACION DE LOS DERECHOS A SOSTENIMIENTO PARA NIÑOS/SOSTENIMIENTO MEDICO

I have read Form 1707-D, or I have had it read to me. I authorize the Attorney General of Texas to provide to me, free of charge, all of the child support and medical support services that are appropriate for my children. I understand that by choosing to have child support services provided by the Attorney General,

- my children will have the benefit of full child support and medical support services available to them.
- I must cooperate as the law requires to help the Attorney General provide child support and medical support services to my children.

I understand that I am authorizing the Attorney General of Texas to sign and cash any checks, money orders, or other written forms of payment made payable to my order or that require my signature which the Attorney General receives while providing child support services for my children. I understand that according to my authorization and assignment, child support provided to my children will be paid to the Attorney General of Texas for distribution according to the law. This means that my children will receive all of the child support collected by the Attorney General that the law permits.

If my children receive AFDC, I also understand that the Attorney General will keep child support payments collected according to this assignment, that are made payable to me or to my order. I will receive any money from such payments as the law may allow, in addition to the regular AFDC checks that I will receive for my children.

I understand that if my children

- receive AFDC, this authorization for child support and medical support services is required as a condition of eligibility for AFDC benefits,
- receive Medicaid only, this authorization for medical support services is required as a condition of eligibility for Medicaid, and I may voluntarily take advantage of full child support services available to me at no charge.

I UNDERSTAND THAT BY SIGNING BELOW, I AM ASSIGNING MY RIGHTS TO CHILD SUPPORT AND MEDICAL SUPPORT AS REQUIRED BY LAW FOR MYSELF, AND FOR ANY OTHER PERSONS FOR WHOM I CAN LEGALLY MAKE AN ASSIGNMENT, TO THE STATE.

Leí la Forma 1707-D, o me la leyeron. Autorizo al Procurador Gene de Texas a que me proporcione gratis todos los servicios Sostenimiento para Niños y Sostenimiento Médico que sean apropia para mis niños. Comprendo que al elegir los servicios de cobranza sostenimiento para niños y sostenimiento médico,

- mis niños tendrán a su disposición el beneficio de servic completos de sostenimiento para niños y sostenimiento médico.
- tengo que colaborar como la ley requiere para ayudar al Produra General en la provisión de los servicios de sostenimiento para niño sostenimiento médico a mis niños.

Comprendo que con esto autorizo al Procurador General de Texa firmar y a cambiar cualquier cheque, giro u otra forma de pago escrito pagaderos a mi nombre o que requiran mi firma, que reciba Procurador General mientras provea servicios de sostenimiento p mis niños. Comprendo que de acuerdo con mi autorización asignación, los pagos de sostenimiento para mis niños se harán Procurador General de Texas para su distribución de acuerdo cor ley. Esto quiere decir que mis niños recibirán la parte que la ley perm del sostenimiento para niños cobrado por el Procurador General.

Si mis niños reciben AFDC, comprendo, también, que el Procura General se quedará con los pagos de sostenimiento para ni pagaderos a mi o en mi nombre cobrados de acuerdo con e asignación. De esos pagos yo recibiré la cantidad que la ley perm además de los cheques regulares de AFDC que recibo para mis niño

Comprendo que si mis niños

- reciben AFDC, esta autorización para servicios de sostenimiento p niños y sostenimiento médico se requiere como condición elegibilidad para los beneficios de AFDC.
- reciben solamente Medicaid, esta autorización para servicios sostenimiento médico se requiere como condición de elegibili para Medicaid, y que puedo voluntariamente aprovechar gratis servicios completos de sostenimiento para niños que tengo a disposición.

COMPRENDO QUE AL FIRMAR ABAJO ASIGNO AL ESTAD SEGUN LO REQUIERE LA LEY, MIS DERECHOS SOSTENIMIENTO PARA NIÑOS Y SOSTENIMIENTO MEDICO, MISMO QUE LOS DERECHOS DE CUALQUIER OTRA PERSO POR QUIEN LEGALMENTE PUEDO HACER LA ASIGNACION.

X ______________________________ ______________

Signature–Client or Representative/Firma–Cliente o Representante   Date/Fecha

I wish to claim good cause for not cooperating with child support requirements. The situations that justify good cause have been explained to me. I agree to provide evidence to support this claim of good cause within 20 days.

Quiero declarar que tengo motivo justificado para no colaborar con requisitos de sostenimiento para niños. Me han explicado en cu situaciones se puede decir que hay motivo justificado. Me comprome dar, en un plazo de 20 días, pruebas de que tengo motivo justificado.

X ______________________________ ______________

Signature–Client or Representative/Firma–Cliente o Representante   Date/Fecha

I have provided the client with a copy of the information on cooperation and assignment. I have provided the client with information on good cause if requested. I have witnesed the client's signature.

Le he dado al cliente una copia de la información sobre colaborac y asignación. Si el cliente pidió información sobre motivo justifica se la di. Presencié la firma del cliente.

X ______________________________ ______________

Signature–Witness/Firma–Testigo   Date/Fecha

Texas Department
of Human Services

AUTHORIZATION FOR CHILD/MEDICAL SUPPORT SERVICES AND ASSIGNMENT OF CHILD/MEDICAL SUPPORT RIGHTS

AUTORIZACION PARA SERVICIOS DE SOSTENIMIENTO PARA NIÑOS/SOSTENIMIENTO MEDIC Y ASIGNACION DE LOS DERECHOS A SOSTENIMIENTO PARA NIÑOS/SOSTENIMIENTO MEDIC

J

The Texas Department of Human Services is required to send information to the Office of the Attorney General's Child Support Division on the absent parents of children who are receiving AFDC and/or Medicaid. According to state and federal laws, a child's legal and natural parents have a duty to support that child even if the parents are away from home.

REQUIREMENT TO COOPERATE

As a condition of AFDC and Medicaid eligibility you must agree to cooperate with the Department of Human Services and the Office of the Attorney General by:

- **providing information about the absent parent(s),**
- **helping to locate the absent parent,**
- **helping to establish paternity, and**
- **appearing at court hearings or other proceedings to establish child support and/or medical support.**

Your cooperation may benefit you and your children by:

- **locating the absent parent,**
- **legally establishing the identity of the child's parent(s),**
- **establishing child support payments,**
- **establishing medical support,**
- **supplementing your AFDC grant with a $50 child support payment, and**
- **ensuring rights to future Social Security, veterans, or other governmental benefits.**

You may:

- **claim good cause for not cooperating if you believe that cooperation would result in physical or emotional harm to yourself or the child.**
- **refuse child support services, but not medical support services, if you are a Medicaid only recipient.**

If you are interested in good cause or medical support services only, it is your responsibility to discuss this with your case worker before you sign this form.

ASSIGNMENT OF FINANCIAL AND MEDICAL SUPPORT RIGHTS

State law provides that when your children are certified for AFDC you must give to the Texas Department of Human Services all rights to establish and collect child support from any person for the benefit of any child for whom you are receiving or will receive AFDC. The child support includes, but is not limited to, any amount of back support that has not been paid at the time of the AFDC application. You must turn in to the Office of the Attorney General any money that is given to you by the absent parent while you are receiving AFDC.

When your children are certified for Medicaid only or Medicaid with AFDC you must assign your rights to medical support to the Texas Department of Health from any third party that can be held responsible for paying medical bills for any child for whom you are receiving or will receive Medicaid coverage.

El Departamento de Servicios Humanos de Texas tiene la obli mandar información sobre el padre ausente de los niños recibiendo AFDC y/o Medicaid a la División de Sostenimiento de la Procuraduría General de Texas. Según las leyes e federales, aunque el padre legal o de sangre esté ausente d tiene el deber de sostener a sus hijos.

REQUISITOS DE COLABORACION

Una de las condiciones para ser elegible para AFDC y para M colaborar con el Departamento de Servicios Humanos y la Pr General:

- dando información sobre el padre ausente,
- ayudando a encontrar al padre ausente,
- ayudando a establecer la paternidad, y
- estando presente en las audiencias de la corte o en otros para establecer sostenimiento para niños y sostenimiento mé

Su colaboración será para el bien de usted y de su hij posiblemente podrán:

- encontrar al padre ausente,
- establecer legalmente la identidad del padre del niño,
- establecer los pagos de sostenimiento para niños,
- establecer sostenimiento médico,
- suplementar la concesión de AFDC con $50 de sostenimi niños, y
- asegurar los derechos a futuros beneficios de Seguro S veteranos o de otros programas del gobierno.

Usted puede:

- alegar que tiene motivo justificado para no colaborar si cr colaboración podría dar lugar a daño físico o emocional a us niño.
- rechazar, si es cliente solamente de Medicaid, los servicios nimiento para niños, pero no los servicios de sostenimiento m

Si quiere alegar motivo justificado o si quiere recibir solamente de sostenimiento médico, es responsabilidad de usted discutir con el trabajador de su caso antes de firmar este papel.

ASIGNACION DE DERECHOS A SOSTENIMIENTO ECON MEDICO

La ley estatal dice que cuando sus niños sean certificados pa usted debe ceder al Departamento de Servicios Humanos de derecho a establecer y a cobrar todo sostenimiento para niños de cualquier persona en beneficio del niño para el cual usted r a recibir AFDC. El sostenimiento para niñosincluye pero no s cualquier cantidad de sostenimiento que se le debía cuando hi citud de AFDC. Mientras reciba AFDC, usted tendrá que dar curaduría General cualquier dinero que el padre ausente le dé a

Mientras sus niños sean certificados para Medicaid solament Medicaid y AFDC, usted tiene que ceder al Departamento de Texas los pagos de sostenimiento médico de cualquie responsable de pagar las cuentas médicas de algún niño pa recibe usted, o va a recibir, la cobertura de Medicaid.

contin

MC:

PATERNITY INFORMATION GATHERING

Form Sequence Number: Application Sequence Number

VII. ENTIRE HOUSEHOLD
PLEASE PRINT

PLEASE LIST ALL YOUR CHILDREN THAT ARE IN YOUR HOUSEHOLD:

Full legal name (as shown on birth certificate):	Date of birth:	Name of biological father:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

VIII. REQUIRED SIGNATURE

I declare all information provided in this form is true and correct:

I consent to any action by the Office of the Attorney General to obtain a decree establishing child support or paternity of the child. I understand that the Attorney General of Texas does not represent me.

(Signature) (Date)