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Increasing Healthcare Coverage for Children:
A New Coordinated Approach
Findings from Colorado

October 15, 2004

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Executive Summary

In 2001, the Colorado Division of Child Support Enforcement (DCSE) received a Section 1115 demonstration grant from the Federal Office of Child Support Enforcement (OCSE) to test a new approach to reducing the number of uninsured children receiving services through the child support (IV-D) office. The approach sought medical coverage through private insurance, Medicaid, SCHIP, and other sources.

Increasing the number of children with healthcare coverage is a goal of high social importance. Research has clearly demonstrated the devastating effects of the lack of healthcare coverage for children. Those children are (1) less likely to have access to a regular source of medical care or to seek care for injuries, (2) more likely to use emergency room care, and (3) less likely to be immunized. Unmet healthcare needs impede children's ability to learn and grow into healthy and productive adults.

Child support agencies are uniquely situated to deal with healthcare coverage. Federal regulations require that medical support be established and enforced in all child support cases. Further, the IV-D caseload tends to involve more economically disadvantaged families and parents, many of whom are unemployed, have low incomes, or work in jobs without insurance benefits. Providing coverage for all children in the IV-D caseload could increase the overall numbers of children with healthcare coverage statewide and nationally.

PROJECT GOALS, OBJECTIVES, AND APPROACH

The goals and objectives of the demonstration project were to:

1. Analyze the child support caseload to better understand the current obstacles and impediments to providing healthcare coverage;
2. Develop and pilot new and innovative processes, collaborations, and automated linkages for medical child support, Medicaid, and SCHIP (known as CHP+ in Colorado);
3. Increase healthcare coverage for children within the project area; and
4. Analyze the potential for Medicaid savings by identifying private healthcare coverage options.

The project established an advisory board to oversee operations. The board members included administrators from DCSE, Medicaid, and CHP+ and staff from the contracted technical consultant and evaluator.

The MSF Approach

Two Colorado counties — Denver and Mesa — served as the project demonstration sites. The primary intervention tested in those sites was the use of Medical Support Facilitators (MSFs) to:

- Determine whether healthcare coverage was actually being provided and was consistent with what was recorded on the DCSE automated system, ACSES;
- Assess which type of healthcare coverage was available and appropriate for the child(ren) — private, Medicaid, or CHP+ — if healthcare coverage was not currently being provided;

- Ensure the child(ren) were enrolled in the appropriate coverage type;
- Compare available private plans and make recommendations for establishing a medical support order; and
- Monitor the enrollment period to ensure seamless and continuous coverage.

Targeted Population

The project targeted IV-D cases that needed a child support order established and cases that had a current support order. In establishment cases, healthcare coverage can be addressed upfront (i.e., determining whether private coverage is available at a reasonable costs and facilitating the Medicaid or CHP+ enrollment if private coverage is not available). The project included establishment cases where the noncustodial parent had been successfully served and a conference hearing was scheduled.

The project also included cases with a current support order (i.e., enforcement cases). Enforcement cases compose the bulk of the IV-D caseload and since they are older than establishment cases, more time has elapsed in which the status of healthcare coverage for the children may have changed. This makes them ideally situated targets to fulfill the primary objective of the intervention: increase the number of children with healthcare coverage. In order to pursue this objective, all enforcement cases **not** enrolled in Medicaid were placed in the pool for random selection into the project. In these non-Medicaid/enforcement cases, the MSF would (1) pursue private coverage if available at a reasonable cost, (2) ensure that private coverage was still in place in cases where the IV-D agency had information indicating private coverage, or (3) assist the custodial parent with applying for Medicaid or CHP+ in cases where private coverage was not available at a reasonable cost.

Federal law and State guidelines require that current support orders also provide for the child's healthcare coverage. This enables the IV-D agency to establish and enforce medical support in enforcement cases. These actions can result in private coverage; and, in turn, offset Medicaid costs. Consequently, the project also targeted Medicaid/enforcement cases with verified locate information (i.e., paying cases or cases where there was a verified address for the noncustodial parent's employer). The MSF used locate information to contact the noncustodial parent and the noncustodial parent's employer. The project architects excluded Medicaid/enforcement cases where the noncustodial parent was not paying and there was not verified locate information because the MSF cannot pursue private coverage without locate information.

Other Project Treatments

In addition to the MSF process, this project took several other actions designed to improve healthcare coverage among the IV-D caseload. They included:

- Facilitating collaboration and coordination among the child support, Medicaid, and CHP+ programs;
- Developing automated processes to streamline the CHP+ application process among IV-D cases; and
- Conducting an insurance identification match between the child support caseload and a master list of insurance eligibility files developed from insurance carriers.

Project Timelines

The total project lasted about two years. Project design and start-up (e.g., hiring a contractor and county staff) encompassed the first seven months of the project. MSFs began receiving weekly downloads of cases randomly selected for the project in June 2003 and received their last download of cases in January 2004. They continued working on cases through April 2004. The evaluation was conducted from May through September 2004.

PROJECT OUTCOMES

The evaluation compared the outcomes of cases assigned to an experimental group to outcomes from a control group and the children's healthcare coverage pre- and post-treatment. The major findings from the MSF intervention are summarized in the table below and supported by data displayed in Exhibits I and II.

Major Findings from the MSF Intervention

- **The MSF intervention resulted in a significant increase in healthcare coverage among enforcement cases.** The increase in healthcare coverage was measured two ways: (1) differences in coverage for experimental enforcement cases at time 1 (case selection) and time 2 (project follow-up); and (2) differences in coverage between experimental and control cases. As shown in Exhibit I, the first method showed an 11 percent increase in health care coverage among enforcement cases. As shown in Exhibit II, the second method showed a 9 percent increase in health care coverage. The increases are statistically significant using either method, which indicates that the MSF intervention was effective at increasing healthcare coverage among children in enforcement cases.

  Based on these findings, if the MSF process were implemented statewide, about 20,000 more Colorado children would have healthcare coverage.

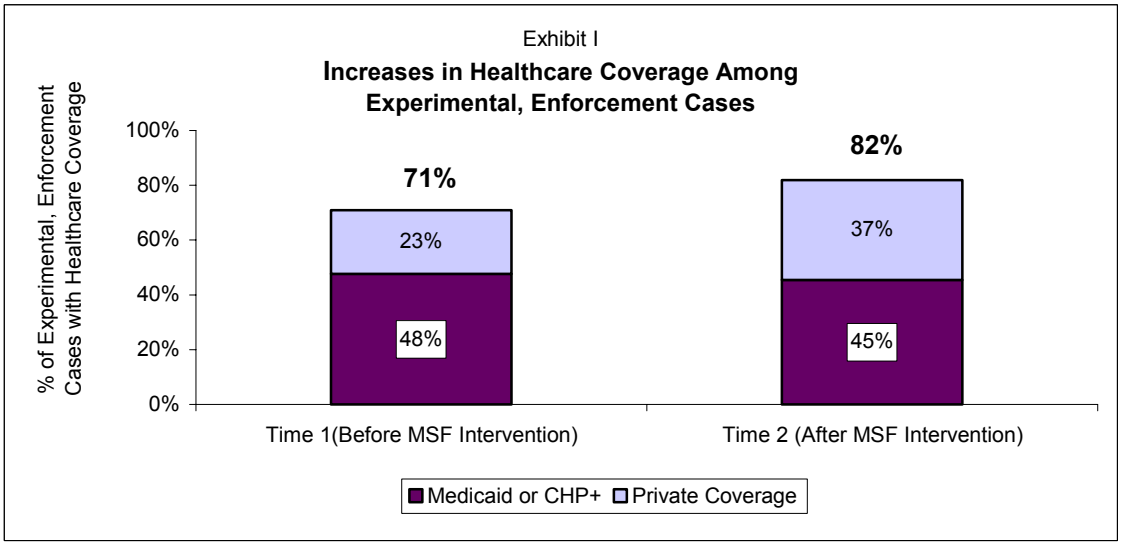
- **There were no substantial gains in healthcare coverage among establishment cases mainly because most of them were already enrolled in Medicaid.** Most of the establishment cases (81%) were enrolled in Medicaid before a child support order was established. In contrast, only 44 percent of enforcement cases were enrolled in Medicaid. As shown in Exhibit II, the MSF process resulted in a 4 percent increase in coverage among establishment cases, but the increase is not statistically significant.

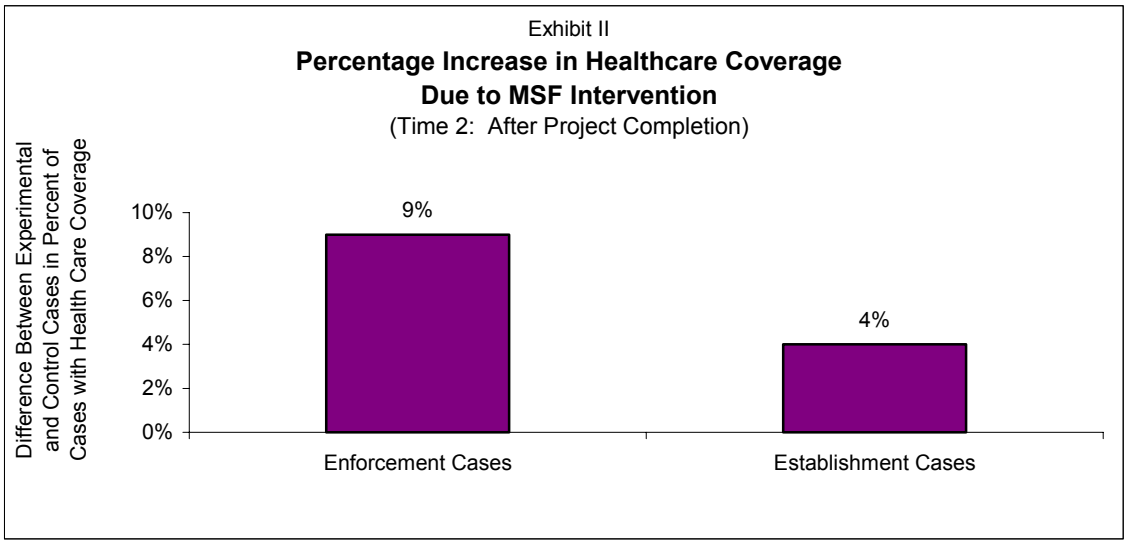
- **Despite gains in coverage, not all children in experimental cases were insured at the end of the project.** The goal of the project was healthcare coverage for **all** children. It was not achieved. At project follow-up, 18 percent of the experimental enforcement cases did not have coverage and 8 percent of the experimental establishment cases did not have coverage. There were multiple reasons why coverage could not be obtained: (1) parents lacked private coverage and employment; (2) children were ineligible for public coverage; (3) the CHP+ enrollment cap imposed halfway through the project aggravated the problem of ineligibility; (4) parents were not interested in obtaining assistance; (5) employers did not return the National Medical Support Notice; and (6) other reasons.

- **There were substantial offsets to Medicaid costs due to the MSFs and the child support enforcement process.** Private coverage lowers Medicaid costs through replacing Medicaid coverage with private coverage, providing third-party reimbursements in cases where the child is still eligible for Medicaid, and cost avoidance (i.e., child support payments render the children income ineligible for Medicaid). We found that 9 percent of the Medicaid cases worked by the MSFs became privately insured during the course of the project. If this result could be replicated statewide, we estimate a $7.6 million savings in Medicaid costs per year. The savings would be higher if we added third-party reimbursements.

- **Few cases sought a review and adjustment to the order due to the MSF intervention.** One anticipated outcome was an increase in requests for a review and adjustment of the financial child support order in cases where the custodial parent was providing coverage, but the noncustodial parent had been ordered to provide coverage. Although this situation existed in 18 percent of project cases, there were no requests for review and adjustment.

Another approach tested in this project was matching a database of insurance eligibility files to child support cases. The database identifies individuals covered by private or government health insurance plans (e.g., commercial insurance plans, BC/BS plans, MCOs, Tricare). The match generated few cases with workable information.





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OTHER FINDINGS

The project identified several trends and characteristics of healthcare coverage of interest. One of the most striking was the high number of children enrolled in Medicaid, particularly among establishment cases. This redirected the project's focus from increasing the number of children with healthcare coverage to offsetting Medicaid costs.

- **Most children in IV-D establishment cases were insured through Medicaid.** The majority of establishment cases (81%) were enrolled in Medicaid. The percentage of enforcement cases enrolled in Medicaid was much lower (45%).

- **There were significant numbers of uninsured children in IV-D enforcement cases**. We estimated that 25 percent of the project's IV-D enforcement cases lacked healthcare coverage. In contrast, 14 percent of all Colorado children lack healthcare coverage.

- **Changes in healthcare coverage occur over time.** As family circumstances change, healthcare coverage may also change. Over the 10 months of program operations, the MSFs found changes in healthcare coverage in 7 percent of the cases in which they conducted a quarterly review. Although a calendar quarter is just a snapshot in time, the findings suggest that a higher proportion of cases would have had changes if the review had been for a longer period. This pattern of frequent change is illustrated by the differences in coverage among establishment and enforcement cases. At project onset, there was more than a 10 percent gap between enforcement and establishment cases in the proportion with healthcare coverage. Since most establishment cases eventually become enforcement cases, this suggests that cases should be tracked over a longer period to better understand changes in healthcare coverage.

- **The insurance policy holder is typically the parent in cases where the children have private coverage.** The policyholder in cases where the children have private coverage is typically the noncustodial parent (62% and 70% of enforcement and establishment cases, respectively). The next common holder of the policy is the custodial parent (33% and 27% of enforcement and establishment cases, respectively). Only a few cases had coverage through the stepparent (5% and 3% of enforcement and establishment cases, respectively).

- **Cases in which both parents have employer-provided coverage are rare.** Project architects carefully planned for several situations that may be complicated. In cases where both parents have employer-provided coverage, this required an assessment of reasonable costs as well as the best care for the child. This situation occurred in 6 percent of the cases processed by the MSFs.

- **Colorado's definition of reasonable costs is less restrictive than that of the National Medical Support Working Group**. The Colorado Child Support Guidelines define insurance premium costs as being reasonable if they are less than 20 percent of the parent's gross income. The National Medical Support Working Group suggests a threshold of 5 percent. Colorado's definition resulted in 70 percent

of the cases passing the reasonableness definition in which the test was made. If the Working Group's threshold were applied, only 30 percent of the cases would have passed the test.

- **Several enhancements could be made to the automated system that would improve medical support.** Many of the MSF's tasks and approaches could be made more efficient through enhanced automation. For example, some of the notices sent by the MSFs could be automated. Also, a similar level of automation used to seamlessly update income withholding upon notification of changes in the noncustodial parent's employment could be applied to update employer-provided healthcare coverage information.

- **Cooperation between child support agencies and public healthcare provider agencies is vital to increasing healthcare coverage for children.** Through its advisory board, the project facilitated cooperation among multiple agencies. Yet, technical problems prevented data sharing among them.

- **Parents do not always cooperate even though it would benefit the child.** Some of the actions taken by the MSFs required the cooperation of the parents in non-public assistance cases. Despite concerted efforts of the MSFs, some of these parents did not respond to the MSF's offer of assistance.

- **Employers do not always return the National Medical Support Notice (NMSN).** Just over one half of the NMSNs were returned.

- **The project encountered several non-programmatic obstacles that prevented it from securing healthcare coverage for all children.** Among the most important was the cap on CHP+ enrollment that occurred halfway through the project. That cap eliminated CHP+ as an option for those children whose parents did not have access to employer-provided coverage and who were ineligible for Medicaid. A second obstacle was the limited availability of employer-provided coverage to parents. The majority of employed parents work at low-paying jobs where healthcare benefits are uncommon.

RECOMMENDATIONS

1. Include Medical Support Facilitators in all child support enforcement offices.

2. Review medical support coverage in enforcement cases frequently.

3. Work more closely with public healthcare provider agencies in order to maximize the number of children covered and minimize costs by identifying and enrolling children who are receiving Medicaid but who could be enrolled in private coverage.

4. Enhance the automated child support enforcement system, ACSES, to seamlessly update healthcare information and automate as much of the MSF process as possible.

5. Vigorously enforce the requirement that employers respond to the NMSN.

6. Train all child support enforcement staff on the importance of ensuring medical support for each order and make it a priority in each office.

7. Work closely with the parents. In particular, make certain the inform the custodial parent of any changes to employment which might affect healthcare coverage.

8. Fully fund CHP+ so that no cap on enrollment is imposed.

Chapter I

Introduction

The Colorado Division of Child Support Enforcement (DCSE) received a Section 1115 Grant from the Federal Office of Child Support Enforcement (OCSE) to test a new approach to reducing the number of uninsured children through coordinating medical child support with available private insurance coverage, Medicaid, State Children's Health Insurance Program (SCHIP), and other sources of health care coverage. The approach builds upon the medical child support requirements in the child support enforcement system.

Nationally, about nine million children lack healthcare coverage.[1] In Colorado, the number of children lacking healthcare coverage is about 170,000. Increasing the number of children with healthcare coverage is a goal of high social importance. Research has clearly demonstrated the devastating effects of the lack of healthcare coverage for children. Children lacking healthcare coverage are less likely to have access to a regular source of medical care or to seek care for injuries, are more likely to use emergency room care, and are less likely to be immunized. Unmet healthcare needs impede children's ability to learn and grow into healthy and productive adults.

Child support agencies— which are also called IV-D agencies because Title IV-D of the Social Security Act authorizes the child support program— are uniquely situated to deal with healthcare coverage. Medical support for children is one of the issues that must be addressed in each child support case. Further, the IV-D caseload tends to involve more economically disadvantaged families and parents, many who are unemployed, have low incomes, or work in jobs without insurance benefits. Providing coverage for all children in the IV-D caseload could increase the overall numbers of children with healthcare coverage nationally and statewide.

PROJECT BACKGROUND

Federal Child Support Requirements and Healthcare Coverage

Medical child support enforcement has been part of federal child support enforcement requirements since 1984. At that time, states were required to include provisions for healthcare coverage in state child support guidelines and the IV-D program was required to pursue private healthcare coverage when available. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) included a requirement that healthcare coverage be addressed in all child support orders. In addition, the court or decision-making body is to request that the child be enrolled in the noncustodial parent's healthcare insurance plan, if available at a reasonable cost from his or her employer.

Notwithstanding such requirements, providing healthcare coverage for children through the child support system has often proven to be complex and difficult. The model for medical child support was premised on the availability of employment-based health insurance through the noncustodial parent. But, as access to employer-based healthcare coverage has declined for low-income workers and the cost has increased, the

[1]Henry J. Kaiser Family Foundation, State Health Facts Online, Healthcare Coverage and Uninsured, *Distribution of Children 18 and Under by Insurance Status, 2001-2002*. Available at http://statehealthfacts.kff.org.

system has not been flexible enough to ensure that other types of healthcare coverage are coordinated for low-income families.

Cognizant of these issues, the Child Support Performance and Incentives Act of 1998 required the Secretary of Health and Human Services and the Secretary of Labor to establish a Medical Child Support Working Group to identify barriers to effective medical support enforcement. Among the specific charges of the Working Group was to make recommendations to coordinate medical child support with Medicaid and SCHIP. The Working Group released its report in June 2000 with a comprehensive set of recommendations addressing such issues as the new National Medical Support Notice (to inform employers and providers of medical support requirements), the priority of withholding from income for medical support and other child support obligations, alternatives to a model focused on noncustodial parent employer-related health insurance, and other measures to eliminate impediments to medical support enforcement.[2]

Colorado Child Support Requirements and Healthcare Coverage

Even before federal requirements were imposed, Colorado had many requirements in place to facilitate the child's healthcare coverage from a parent's employer-provided healthcare plan. Before the National Medical Support Notice (NMSN) was required, Colorado used its own notice, called the Health Insurance Premium (HIP) notice. In cases where a parent was ordered to provide healthcare coverage, a HIP was typically sent to the parent's employer in tandem with the Income Withholding Order. The HIP required the enrollment of the children under the same insurance policy that currently insured the parent. Complying with federal requirements, Colorado adopted the NMSN and discontinued usage of the HIP in 2002.

In addition, the Colorado Child Support Guidelines requires that the support order provide for the child's current and future health care needs. This includes the consideration of healthcare insurance coverage for the children and the payment of the insurance premium, deductibles and copayments. The Colorado Guidelines specify that the actual costs of the health insurance premium attributable to the child for whom support is being determined is to be added to the basic child support obligation and divided between the parents in proportion to their adjusted gross incomes. The Colorado Guidelines also provide a definition of reasonable costs. The Colorado Guidelines define reasonable cost as 20 percent or less of the parent's gross income. Further, if the guidelines adjustment for the premium payment results in an order amount of $50 per month or less, the costs may be determined as unreasonable.

Current Gaps in Healthcare Coverage

Despite these efforts, a number of children still lack healthcare coverage for a variety of reasons. Some of these children have no private healthcare coverage available through their parent's employer. Often, neither the child support agency nor the custodial parent learns of changes in employment and the need to apply for other public or private coverage until the child's insurance has lapsed. This can leave the child uninsured for several months. Other children have private insurance available through their parents, but they are not

[2]The Medical Child Support Working Group, *21 Million Children's Health: Our Shared Responsibility*, Report to the Department of Health and Human Services and Department of Labor, Washington, D.C. (June,2000).

enrolled.[3] Still, others are eligible for Medicaid or SCHIP but they are not aware that they are eligible or they are not enrolled for other reasons.[4] Finally, some children are eligible for only part of the year and need coverage for gaps. Child support agencies along with Medicaid and SCHIP agencies do not routinely monitor the changing status of these families and do not take a proactive approach to ensuring that the children have continuous healthcare coverage.

COLORADO PROJECT GOALS, OBJECTIVES, AND APPROACH

The goals and objectives of this project are to:

1. Analyze the child support caseload to better understand the current obstacles and impediments to providing healthcare coverage;
2. Develop and pilot new and innovative processes, collaborations, and automated linkages for medical child support, Medicaid, and SCHIP (which is known as CHP+ in Colorado);
3. Increase healthcare coverage for children within the project area; and
4. Analyze the potential for increased Medicaid savings through identification of private healthcare coverage.

Key to the project was an establishment of and guidance from an advisory board comprised of DCSE, Medicaid, and CHP+ administrators, along with staff from the contracted technical consultant and evaluator.

Pilot New Approach

The new approach piloted in this project centered upon the use of Medical Support Facilitators (MSFs) to:

- Determine whether healthcare coverage was actually being provided and was consistent with what was recorded on the DCSE automated system, ACSES.
- Assess which healthcare coverage was available and appropriate for the child(ren): private, Medicaid, or CHP+, if healthcare coverage was not currently being provided;
- Ensure the child(ren) were enrolled in the appropriate coverage;
- Compare available private plans and make recommendations for establishing an order; and
- Monitor the enrollment span to ensure seamless and continuous coverage.

In addition to the MSF process, this project also took several other actions aimed to improve healthcare coverage among the IV-D caseload. They included:

- Facilitating the collaboration and coordination among child support, Medicaid, and CHP+;
- Developing automated processes to streamline the CHP+ application process among IV-D cases; and

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[3]According to a recent report by the Urban Institute between 42 and 51 percent of nonresident fathers who do not provide healthcare coverage to their children (within the first four months of 1993) have access to employment-based dependent healthcare coverage in at least one of those months. However, the report also notes that the potential for reduction in the number of children without private coverage depends on the extent to which the additional coverage would duplicate the coverage of custodial families who provide healthcare coverage. If all custodial families who provide healthcare coverage to their children correspond to the 3.6 to 4.4 million nonresident fathers who have access to dependent coverage, then between 100,000 and 900,000 additional custodial families without private coverage could receive coverage. Laura Wheaton, *Nonresident Fathers: To What Extent do They Have Access to Employment-Based Healthcare Coverage?* Urban Institute, Washington, D.C. (June 2000).

[4]Center for Medicare and Medicaid Services, *The States' Children's Health Insurance Program Annual Enrollment Report*, *FFY 2001*, Baltimore, Maryland. Available at: http://www.cms.hhs.gov/schip/annual-reports/year-report.asp?year=2001.

- Conducting an insurance identification match between the CSE caseload and a master list of insurance eligibility files developed from insurance carriers.

Overview of MSF Approach

The new coordinated approach was aimed at obtaining healthcare coverage for **every child** in the IV-D caseload and was designed to provide seamless and continuous coverage for children so that there were no lapses in healthcare coverage. First, this coordinated approach sought to enroll children in private health insurance where such insurance was comprehensive, affordable, and accessible. This required the coordinated efforts of the child support agency, the courts or administrative units establishing medical child support orders, and employers to ensure that private insurance coverage was identified and the children were enrolled as soon as possible.

The MSFs were placed within the administrative unit handling child support cases to review cases and make a determination of the appropriateness of private health insurance. They followed protocols developed within the project to make inquiries for information on potential coverage and determine appropriateness. If private health insurance was appropriate, an order for medical support was obtained (if not already in existence), the employer was notified through the issuance of the NMSN, the children were enrolled, and continued eligibility and enrollment was monitored.

Where private health insurance coverage was not available or not appropriate, the child support agency routinely reviewed Medicaid and SCHIP eligibility and identified eligible recipients. Child support agencies are uniquely suited to this task because they already have access to information on the children's healthcare coverage and the parent's income, employment, and other financial information. Under the new coordinated approach, the MSF was able to use web browser software to determine the children's potential eligibility for Medicaid and CHP+.

If the children were eligible, Medicaid and CHP+ information was made available to the parents, the application forms were automatically generated, and eligibility decisions coordinated with the Medicaid or CHP+ agency.[5] Mechanisms for automated information exchange between the child support agency, Medicaid, and CHP+ were implemented so that children could be promptly enrolled in the appropriate healthcare coverage with minimal or no delays or disruptions. Streamlining and simplifying the application process further expedited the enrollment process.

Continued monitoring of cases ensured that, as family and employment information changed, appropriate health coverage for the children was maintained. To facilitate this, information was shared between the child support agency, Medicaid and CHP+ agencies, and the courts or administrative units responsible for ensuring that child support orders provide healthcare coverage.

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[5]A key recommendation following welfare reform is to simplify SCHIP eligibility. See, for example, Alan Weil and John Holahan, *Health Insurance, Welfare, and Work*, Welfare Reform and Beyond, Policy Brief No. 11, The Brookings Institute, Washington, D.C. (December 2001).

Overview of Project Automation

The project developed automation to assist the MSF in enrolling children in public health care coverage when private coverage was not available. This included streamlining the enrollment process through a direct Web-based linkage with the CHP+ program, which also screens for Medicaid eligibility.

Overview of Insurance Eligibility Match

The purpose of the insurance eligibility match was to supplement MSF activities by using extant automated data. Data from numerous health insurance carrier providers were combined to form one file listing all individuals with insurance eligibility and matched against the Colorado child support caseload. The information was used by the MSF to identify available private insurance to dependents, noncustodial parents, and custodial parents.

PROJECT PILOTS SITES

The project was tested in two Colorado counties: Denver and Mesa. Denver City and County is Colorado's largest county, most urban, and serves as the interstate hub for the Rocky Mountain Region. Although Mesa County and Grand Junction, its county seat, are considered large relative to other Colorado municipalities, it is actually relatively small. Mesa County also serves as a regional center to several rural counties with economic bases in tourism, agriculture, mining, and construction. Exhibit 1 compares and contrasts some of the characteristics of Denver and Mesa Counties to the State using Census, Bureau of Labor Statistics and DCSE data.

Another critical difference between Denver and Mesa Counties is that Denver County has more staff than Mesa County. This proved important because the MSF needed to coordinate with other staff working on project cases due to other child support enforcement issues (e.g., reviewing the financial support award amount). In Mesa County, the staff size is small enough that the MSF was on a first-name basis with each staff member. This was unreasonable in Denver County due to the staff size.

Exhibit 1 Selected Characteristics of Denver and Mesa Counties and the State of Colorado			
	Denver County	**Mesa County**	**State of Colorado**
Population (2000)	554,636	116,255	4,301,261
Race and Hispanic Origin (2000) (% of total population)			
• White, Non-Hispanic	51.9%	87.0%	74.5%
• African American, Non-Hispanic	10.8%	0.4%	3.7%
• Asian, Non-Hispanic	2.8%	0.6%	2.3%
• Native American, Non-Hispanic	0.7%	0.6%	0.7%
• Other, Non-Hispanic	2.1%	1.4%	1.8%
• Hispanic of Any Race	31.7%	10.0%	17.1%
Number of Families (2000)	120,305	31,729	1,092,352
Number of Female-Headed Families with Children (2000)	17,709	3,033	109,279
Average Family Size (2000)	3.14	2.94	3.09
Median Family Income (1999)	$48,195	$43,009	$55,883
Percent of Families with Children with Poverty Income or Less (1999)			
• All Families	16.6%	11.0%	9.2%
• Married-Couple family	9.7%	4.4%	4.7%
• Female householder, no spouse present	32.6%	33.6%	26.1%
• Male householder, no spouse present	15.0%	16.7%	12.4%
Percent of Female-Headed Families with Children by Family Income (1999)			
• Less than $10,000	24.8%	24.7%	18.4%
• $10,000- $29,999	42.2%	51.4%	42.1%
• $30,000-$59,999	24.9%	20.9%	30.7%
• $60,000-$99,999	5.3%	2.6%	6.6%
• $100,000 or more	2.7%	0.4%	2.3%
Unemployment Rate (2003)	7.4%	5.7%	6.0%
Child Support Enforcement (2003) Statistics			
• Total Caseload	25,381	5,113	138,862
• Cases with Current Orders	21,364	4,483	117,672
• Number of Orders Established in 2003	2,005	371	10,447
• Percent of Current Support Paid	49.6%	53.4%	55.2%
• Number of County & Contract Staff	149	20	658

TARGETED POPULATION

After much discussion, the Advisory Group decided that the project should target enforcement cases with current orders as well as establishment cases. Many of the proposed methods for improving healthcare coverage are at the front end. The time of the order establishment is an ideal opportunity to determine whether private coverage is available; and, if so, if one parent can provide coverage that serves the child's health care needs better than the other parent. Yet, the reality is that many uninsured children are not involved in new cases but already have orders established.

According to federal and state law and regulations, if there is an order for current support, there should also be an order for medical support and the IV-D agency has authority to enforce this. This makes enforcement cases suitable candidates to target interventions aimed at increasing healthcare coverage among children.

Some enforcement cases are uninsured because of changes in case circumstances, such as a parent changing employment, which also causes changes in insurance coverage; but, it is possible that some gaps among enforcement cases are system issues. For example, in modifying ACSES to accommodate the NMSN, some assumptions were made about healthcare coverage when migrating the data. This may have resulted in the numbers of children appearing to be insured in ACSES being overstated. Further, although there are many policies and procedures aimed at **obtaining** private coverage when available, there are fewer policies and procedures in place for **identifying** when private coverage **ceases**. The net impact is that ACSES may show that a child is covered through a private policy, when it has actually been terminated.

Based on this shared understanding, the Advisory Group found it imperative to paint a true picture of healthcare coverage among all DCSE cases, so opted for including both establishment and enforcement cases in the MSF intervention.

PROJECT TIMELINES

The project was originally scheduled for 17 months, but was extended for another six months. The first seven months of the project were devoted to program design and start-up. This included the hiring of a contractor, development of project design and a procedures manual, hiring of Medical Support Facilitators (MSFs) in the pilot counties, MSF training, and the development of automated interfaces.

The MSFs began receiving cases in June 2003. They received their final download of cases about eight months later, in January 2004. During the next four months of the project, the MSFs continued to work the cases they were assigned. This included quarterly reviews, when appropriate. The final months of the project were devoted to evaluation.

EVALUATION

The pilot was rigorously evaluated using two methods: experimental approach; and, pre- and post-comparisons. Based on project case criteria, which are discussed later in the report, appropriate cases were randomly assigned to an experimental or control group in Denver and Mesa Counties. To control workflow, new cases were selected weekly. Experimental cases were flagged on the automated system, ACSES, so all child support technicians working the case would be informed of the case's status. The technical consultant and evaluator only knew of control cases.

Data were collected from two sources: the automated system (ACSES) and the MSFs. Data from ACSES was downloaded at two different times: the time in which the case was selected; and, June 2004, which was six months after the MSFs stopped receiving new cases. This allowed for pre- and post-intervention comparisons. In addition, since information was collected from both time periods for both the experimental and control groups, it allowed for a comparison of the differences in the differences; precisely, the difference

between the experimental and control groups in the difference from the first time period and the second time periods.

The second data source was a data collection instrument (DCI) completed by the MSFs. It was only completed for experimental cases. Created specifically for this project, the DCI served as much as a case-tracking tool as it did as a data source for the evaluation. The MSFs noted all actions and findings on each experimental case on the DCI.

ORGANIZATION OF THE REPORT

The remainder of this report is organized into four chapters. Chapter II describes the process developed. Chapter III describes implementation issues. Chapter IV discusses project outcomes. Chapter V provides a summary and recommendations.

Chapter II

Project Design and Approach

This Chapter details how the MSF approach was designed, then provides a general description of the approach. The full approach is detailed in the MSF manual, provided in Appendix I.

PROJECT DESIGN

An Advisory Group comprising State DCSE, Medicaid and CHP+ administrators was convened to help design the ideal approach. The Advisory Group also included the Federal Project Officer from OCSE Region VIII and administrators from the Counties participating in the project. The Committee began meeting November 2003, about a month after the grant was issued.

In addition, a technical contractor was hired in February 2003 to help on several specific project tasks, namely to:

- Create linkages and coordination with other agencies;
- Develop a procedures manual based on the recommended approach developed by the Advisory Group; and
- Develop the evaluation plan and data collection instruments for the evaluation and analysis of case data.

The first task of the Advisory Group was to review DCSE's winning grant application to the Federal OCSE to refine the project, particularly the targeted population and the roles of the MSFs. The Advisory Group also reviewed the workflow, evaluation plan, process issues, and training materials. A subgroup was formed to flesh out the details, then report their recommendations back to the Advisory Group. The subgroup included the project manager from DHS/CSE, the project manager from PSI (the contractor), the work process developer from PSI, and several CSE staff from Denver and Mesa Counties. The subgroup started with the targeted population and then developed flowcharts of likely case scenarios to develop the MSF process.

Defining the Targeted Population

DCSE's winning grant application only targeted new cases (i.e., establishment cases) in its proposed approach. After much discussion, the Advisory Group decided upon including enforcement cases with current support orders as well. The rationale was that since the primary goal of the project was to obtain healthcare coverage for all children in the IV-D caseload, enforcement cases should also be included because they compose the majority of the cases and are likely to involve many uninsured children.

The Advisory Group decided not to include enforcement cases without current orders (i.e., arrears only or closed cases). In most of these cases, the children are emancipated; the custodial parent elected to no longer use IV-D services; or the case is closed for another reason. Further, since medical support is typically included in the order for financial support, there would be little that the MSF could do in these cases since much of the process revolves around the enforcement of medical support.

The Advisory Group also decided to target enforcement cases most likely to benefit from the MSF intervention. Consequently, they excluded Medicaid cases in locate status, specifically, where the noncustodial parent's employer is not verified. Since Medicaid already covers children in these cases, the first goal of the project (i.e., obtaining healthcare coverage for children in the IV-D caseload) was already met. Further, locate is the only task that the MSFs could perform in these cases. Locate activities are not the primary function of the MSFs and could have taken a lot of their time and effort that could otherwise be used toward activities more directly related to medical support.

For similar reasons, the Advisory Group recommended including establishment cases with a verified locate. This allowed the MSF to focus on establishment cases where both parents were likely to be involved and have a better chance of an order being established.

Per some concerns from project stakeholders, the Advisory Group reviewed the merits of including cases prior to the establishment of medical support. Some of the concern was partially founded on the fact that the MSF might be able to do little to assist with obtaining healthcare coverage for children in default orders. The Advisory Group appreciated the concern, but concluded that it made more sense for the MSF to be involved at the time of order establishment, rather than after, so they could assist with the establishment of orders that reflect the best health care choices for the children.

A final consideration was whether to include interstate cases. Given the short duration of the project, it was decided to not only exclude interstate cases but to also limit cases to Denver and Mesa Counties. Interstate cases and cases from other Colorado counties were excluded because one possible outcome of the MSF intervention may be an order modification, which would be difficult and more time consuming to initiate if another state had controlling jurisdiction over the order or another county needed to become involved.

Identifying the Targeted Population

Once the targeted population was defined, the next step was developing selection criteria that could be applied to ACSES, the automated system, to identify targeted cases. Most of the selection criteria were congruent with standard ACSES fields (e.g., interstate status, county, enforcement/establishment case category, Medicaid status, whether current support is ordered, locate status).

Identifying appropriate establishment cases was more difficult due to the rapid changes and scheduling of hearings innate to the order establishment process. If establishment cases meeting project criteria were pulled monthly, the order may have already been established and the MSF would have missed the window of opportunity to intervene. The timing would be better if establishment cases were pulled weekly, specifically, order establishment cases where the noncustodial parent had been successfully served and a conference hearing was scheduled. This would allow the MSF to be involved in the conference hearing, which is when a stipulation is likely to occur if it does occur, but it also limits selection to order establishment cases where the noncustodial parent is more likely to appear.

PSI and DCSE project staff developed an automated data extract and report based on the above case criteria to create the case lists for the MSFs each week. Every Friday, CSE ran the data extract from ACSES. The

file was automatically transferred to PSI, where it underwent another process to select and assign experimental and control cases for each week. Once the assignments were made, the report was posted on a website – comedsupport.com – and the MSFs downloaded their caseloads from there.

Defining the Role of the MSF

The following MSF responsibilities were defined before hiring the MSFs and developing the detailed MSF process.

- The MSF is to record actions taken on cases and collect relevant case data that could not be downloaded from ACSES.
- When assigned a case, the MSF is to determine the current disposition of the healthcare coverage of the children. This includes identifying whether the children are currently enrolled in Medicaid or CHP+, whether a National Medical Support Notice (NMSN) has been issued and, if so, the status of the NMSN; and whether medical support is ordered.
- The MSF is to contact the parent(s) and their employers, when appropriate, to determine if the children currently have healthcare coverage or whether private healthcare coverage is available. This includes contacting employers to determine whether COBRA coverage is in place in cases where a parent is ordered to provide medical support but the parent's employment has been terminated.
- The MSF is to be involved in the order establishment process in experimental cases where there is private coverage available. The MSF's involvement includes determining whether the costs of the coverage for the children are reasonable.
- In a similar vein, the MSF is to be involved in any experimental cases where a review and adjustment action is being taken.
- The MSF is to follow up on NMSNs to determine if they resulted in healthcare coverage and if not, take the appropriate action.
- The MSF is to inform the appropriate child support worker in cases where the MSF finds private healthcare coverage and the parent with the coverage is not the same parent ordered to provide medical support or a medical support order has not yet been established. In experimental establishment cases, the MSF would inform the establishment worker. In experimental enforcement cases, the MSF would inform the enforcement worker assigned to the case.
- The MSF is to inform custodial parents in cases where private healthcare coverage is unavailable at a reasonable cost of Medicaid and CHP+ and assist with applications if the custodial parent decides to pursue Medicaid or CHP+ coverage.
- The MSF is to follow up on cases where the custodial parent indicates that the insurance card is no longer accepted or there are other coverage issues. The purpose of the follow-up is to ensure that the children do indeed have healthcare coverage, and if they do not, the MSF is to take the appropriate actions to obtain healthcare coverage.
- The MSF is to periodically follow-up with experimental cases to determine if the children still have healthcare coverage. If not, the MSF would pursue healthcare coverage.

The Advisory Group also recommended against initiating a contempt action in cases where the custodial parent is ordered to provide medical support but does not, because the results of the action could be harmful to the children's financial well-being.

Designing the Process

Once the targeted population was identified and the roles and responsibilities of the MSFs clearly defined, the subgroup identified typical and atypical scenarios to determine the appropriate process. Some of the processes required a high-level understanding of laws and regulations particularly concerning the guidelines, filing of non-cooperation, review and adjustment, and others. This required consultation with Advisory Group members and others. Below are examples of some of the issues considered.

- Whether a credit for the child's share of the health insurance premium could be given when determining the financial award amount in a conference hearing based on a promise of enrollment and evidence of actual premium costs are not provided.
- Whether a case could be closed for non-cooperation if the custodial parent is ordered to provide healthcare coverage for the children and has access to healthcare coverage at a reasonable cost, but does not enroll the children.

In all, the subgroup collaborated to develop a logical, efficient process for enrolling children in private healthcare coverage, or in Medicaid or CHP+. This collaboration focused on developing a streamlined process that would not only ensure healthcare coverage, but also meet the research objectives of the project by making sure the MSFs captured all relevant data and steps for each case. This process began as a flowchart with a corresponding narrative that was reviewed by all members of the project.

Preparing for and Designing the Evaluation

The data evaluation plan included determination of sample size and extensive identification of the data needed for analysis. PSI determined the sample size based on the number of cases in each county fitting case selection criteria.

Defined Data to Be Extracted for Creating the Case Lists

In order to create a caseload for purposes of the study, PSI worked with its own evaluation team, the subcontracting evaluator, and State and County CSE staff to determine the data elements to extract from ACSES to capture the most relevant information for study purposes. The data list went through several iterations within the team before final agreement was reached on those data that were critical, that could be extracted from ACSES relatively easily, and that would provide valuable insights for the study.

Defined Additional Data Elements for MSFs to Collect

Not all data to be analyzed for project purposes is captured in ACSES. Working with the data analyst, the subgroup identified items helpful in defining the MSF process, but also provided guidance and insight regarding private medical coverage availability. Because these data elements are not captured in ACSES, a separate data collection instrument was developed for the MSFs to complete as they worked the cases.

Initially, MSFs completed the data collection instrument on a physical sheet that was faxed to PSI staff for analysis. This was an interim process as PSI considered fully automating the data collection instrument on the Internet as a web page. After several internal meetings, PSI determined the cost of creating and maintaining the website would be too expensive. Therefore, a user-friendly version of the data collection instrument was created in Excel. MSFs completed this version on-line and emailed the completed instruments to PSI for analysis. A copy of the data collection instrument is provided in Appendix II.

Developed File Formats and Parameters for Data Match with HMS

Once data elements and processes for the MSFs were developed, State CSE staff and PSI project staff met with the HMS team to determine how to proceed with the data match. Since the match was to be against CSE's entire Colorado caseload, the team determined that the files should go directly from CSE to HMS. The team established a file format, parameters for the match, and a time frame to proceed.

Integrating Multiple Agencies

Medicaid and CHP+ were integrated into the project through the Advisory Group as well as at the County level. A senior state official from Medicaid and the CHP+ director were invited to participate in the Advisory Group to provide ideas on how to integrate the process with those two programs. In Mesa County, the MSF had previously worked in Medicaid, so was quite familiar with both the application process and the staff doing Medicaid eligibility. This gave her a significant advantage in assisting families with the application. In Denver, the Medicaid eligibility staff are completely separate from the child support staff and they do not have any kind of coordination. The MSF in Denver did not have any kind of relationship with the Medicaid staff, which made the process much more difficult for her.

PROJECT APPROACH

In addition to the MSF process, the project approach included training and outreach. The outreach was geared toward other child support technicians to inform them about the project and to secure their cooperation with the MSF. The training is described in detail below.

Training

Working with State staff, PSI developed and trained on:

- A user manual, including procedures for the MSFs to follow;
- A data collection instrument designed to capture non-ACSES data and to track case progress; and
- The basics of Medicaid and CHP+ eligibility and how to assist families in filling out the applications, tracking the applications and doing follow-up.

After all stakeholders agreed to the MSF process, the MSFs were trained not only in medical support case processing, but also in collecting data and completion of the data collection instrument. PSI conducted a two-hour on-line training for the MSFs in the month prior to the assignment of cases. Because the training was conducted over the Internet, there were no travel costs for either MSF. The visual part of the training over the Internet was supplemented with an interactive conference call in which MSFs were encouraged to ask questions as the PowerPoint slide show was presented.

Anticipating that the new processes would require some tweaking and close monitoring, PSI held weekly meetings with the MSFs. The purpose of these meetings was to ensure that the processes were operating as planned, that the cases were being received on time, and to get feedback from the MSFs and refine the process as deemed necessary. As front line workers, it was made clear to the MSFs that their success was absolutely critical to the success of the project and they needed to be active members of the team. In this vein, they were encouraged to ask questions and offer suggestions for improving the process. Both counties developed letters to customers and other forms as part of the project.

Based on the flowchart and narrative, PSI developed a user-friendly manual for the MSFs to use. This manual includes background information on the project and public medical coverage. Step-by-step instructions for the MSFs were included, along with references to appropriate sections of the Colorado policy manual. As the MSFs began to work cases and use the manual, several updates and additions were made, such as a letter that can be sent to custodial parents who potentially are eligible for Medicaid or CHP+.

In addition to case processing steps, the MSFs also received training on how to complete the data collection instrument and the reasons for the additional documentation. The MSFs were instructed on all steps of the process and were requested to report any difficulties they encountered. The MSF process was dynamic and subject to change as it was implemented and short-cuts or non-value-added steps identified.

MSFs also were trained on the basics of Medicaid and CHP+ eligibility and how to access the C-CHAMP system for CHP+, to verify enrollment or look up application status. This allowed them direct access to let families know where their application was in the eligibility determination process, as well as giving them information on who had applied and who was accepted.

THE MSF PROCESS

The MSF Manual included in Appendix I provides the detailed MSF process. It is also summarized below for the benefit of the reader. Exhibit 2 at the end of this Chapter is an abbreviated flowchart of the MSF process.

Step 1: Receive Case

The MSF receives experimental cases from the automated case assignment on a weekly basis. The list contains both establishment and enforcement cases. The MSF makes appropriate notes on ACSES to inform others that the case is part of the project. After the pilot, cases could be received based on new hire hits if a County decided to continue with the MSF approach.

MSFs will also review cases on a quarterly basis. Reviews are discussed in this Step because they are essentially treated as a new project case since the healthcare coverage of the children or the circumstances of the parents pertaining to healthcare coverage may have changed.

Step 1a: Determine if Medical Support Is Ordered

To enforce medical support, at least one of the parties must have been ordered to provide medical insurance.

a. If one of the parties has been ordered to provide medical insurance, the MSF continues the process of securing private coverage.
b. If medical insurance has not been ordered, yet there is already a current child support order in existence, the MSF takes steps to get medical insurance ordered. The steps the MSF takes to get support ordered depends on whether the custodial parent on the case is receiving public assistance. If the custodial parent is receiving public assistance, the MSF refers the case to the review and adjustment technician to begin the review process. If the custodial parent is not receiving public assistance, the State cannot begin the modification process without a request

from one of the parties. The MSF sends out the Right to Request letter to each party when no medical support is ordered and the case is non-public assistance and also sets a calendar review for 14 days to check on whether one of the parties actually requested a review. One of the parties must request the review in order to get medical support ordered. If one of the parties requests a review, the MSF refers the case to the review and adjustment technician to modify the order to include medical support language. If neither party requests a review in a non-public assistance case and there is no medical language in the order, the MSF cannot pursue medical enforcement. The case returns to a monitoring mode for 90 days.

Mesa County added the step of checking the status of the NMSN.

Step 2: Determine whether Children Are Covered by Medicaid or CHP+

The MSF first checks ACSES to determine whether the children on the case are covered by Medicaid. If the children are not covered by Medicaid, the MSF determines whether the children are covered by CHP+ through C-CHAMPS.

Step 3: MSF Contacts Employer

- If the children are covered by Medicaid or CHP+, the MSF contacts the noncustodial parent's employer to determine if the employer provides healthcare coverage.
- If the children are not covered by Medicaid or CHP+, the MSF contacts both parties' employers to determine if either employer provides healthcare coverage.

The contact may be made by telephone, standard employment verification letter, or, as Mesa County developed, a customized letter. For some employers that the MSFs are familiar with, they may already know whether that particular employer provides healthcare coverage. No new contact is necessary for these employers. The MSF is also to contact the noncustodial parent's previous employer, when appropriate, to determine if COBRA coverage is available.

In cases where the noncustodial parent does not have verified employment, the noncustodial parent is ordered to provide coverage, and the children are enrolled in Medicaid or CHP+, the MSF cannot do any more so the case is set aside until the quarterly review, when the process is repeated.

Step 4: Assess Private Healthcare Coverage

Based on the information collected in Step 3, the MSF determines if the child is currently covered. This may be supplemented with an inquiry to the parent(s) to determine if the child is covered by a stepparent. Mesa County developed an insurance questionnaire letter for this purposes.

Step 4a: If Coverage Is Available and an Establishment Conference Is Pending

If an establishment conference is pending, the MSF provides the coverage information including the insurance premium amount, if known, to the establishment technician. A chronology entry regarding the details of the costs of insurance coverage is also made on ACSES. The information is provided to ensure that the parent providing coverage gets credit in the calculation of the award amount based on the Colorado Child Support Guidelines. Once the order is established, the MSF updates ACSES with insurance policy details.

Step 4b: If Noncustodial Parent Is Voluntarily Providing Coverage

If the noncustodial parent is voluntarily providing coverage, the MSF will need to determine whether a NMSN should be sent.

Step 4c: If Private Coverage Is Available to at Least One Party, but Not Being Provided by the Noncustodial Parent

The MSF is to determine whether the cost of coverage is reasonable per Colorado Statutes. The noncustodial parent (and the custodial parent, if ordered) is required to provide available insurance only if the cost of the insurance is reasonable.

- If the cost of coverage is reasonable to the noncustodial parent and the custodial parent is not providing private coverage, the MSF sends a NMSN.
- If the cost of coverage is reasonable to the noncustodial parent, yet the custodial parent is already providing coverage, the MSF contacts the custodial parent to help determine whether to send the NMSN . The MSF should work with the custodial parent to help determine the best coverage (if more than one plan is offered) based on factors such as accessibility, care continuity, and mandatory benefits. If the decision is to send the NMSN, the custodial parent should understand that the noncustodial parent may be entitled to a review of the child support obligation that could result in a downward modification. The custodial parent should understand that if the NMSN is not sent, the order should be modified to include language that either party should provide insurance. The child support obligation may also be adjusted to give the custodial parent credit for providing insurance. The MSF provides the Right to Request letter to the custodial parent if the order language needs to be modified. If the custodial parent does not request the review within 15 days, the MSF sends the NMSN.
- If coverage is not found to be available at a reasonable cost, the MSF treats the case as if insurance is unavailable to the noncustodial parent.
- If insurance is unavailable to the noncustodial parent, or is not available at a reasonable cost, the MSF then determines whether insurance is available to the custodial parent. The MSF is to contact the custodial parent by telephone in most cases to determine whether insurance coverage is available to the custodial parent or if the children are already covered. The MSF should obtain the cost of insurance to the custodial parent and determine whether it is reasonable under Colorado statutes. If coverage is available to the custodial parent at a reasonable cost, the MSF encourages the custodial parent to enroll the children in the available coverage. The MSF explains the benefits of coverage and that the custodial parent is entitled to a dollar-for-dollar credit based on the child support guidelines that may result in an increase in child support. If coverage is not available to the custodial parent, or is not available at a reasonable cost, the MSF continues to locate available sources of coverage.

Step 4d: If Private Coverage Is Not Available

If the employer indicates insurance is not available, the MSF updates ACSES. The employer may also indicate that the noncustodial parent is not yet eligible to receive insurance, but will become eligible 90 days after hire. The MSF updates ACSES so that the MSF receives a tickler in 90 days to recheck the availability of insurance.

If private coverage is unavailable to either parent or is determined to be unreasonable in costs, the MSF determines whether coverage is available through a stepparent. If coverage of the children is available to the spouse of either parent, the MSF encourages the appropriate party to enroll the children in the available coverage. If coverage is not available to the current spouse, the MSF continues to locate available sources of coverage.

If no option for private coverage exists, the MSF conducts a prescreening of the custodial parent to assess possible qualification for CHP+ or Medicaid. This requires contact with the custodial parent by telephone. Based on the responses the custodial parent provides in the prescreening, the MSF can assess the likelihood of qualification for Medicaid or CHP+. If the custodial parent is probably eligible for Medicaid or CHP+, the MSF proceeds with application in one of the two programs. If the custodial parent does not appear to be eligible for either Medicaid or CHP+, the case is placed in a monitoring status and will be reviewed again in three months.

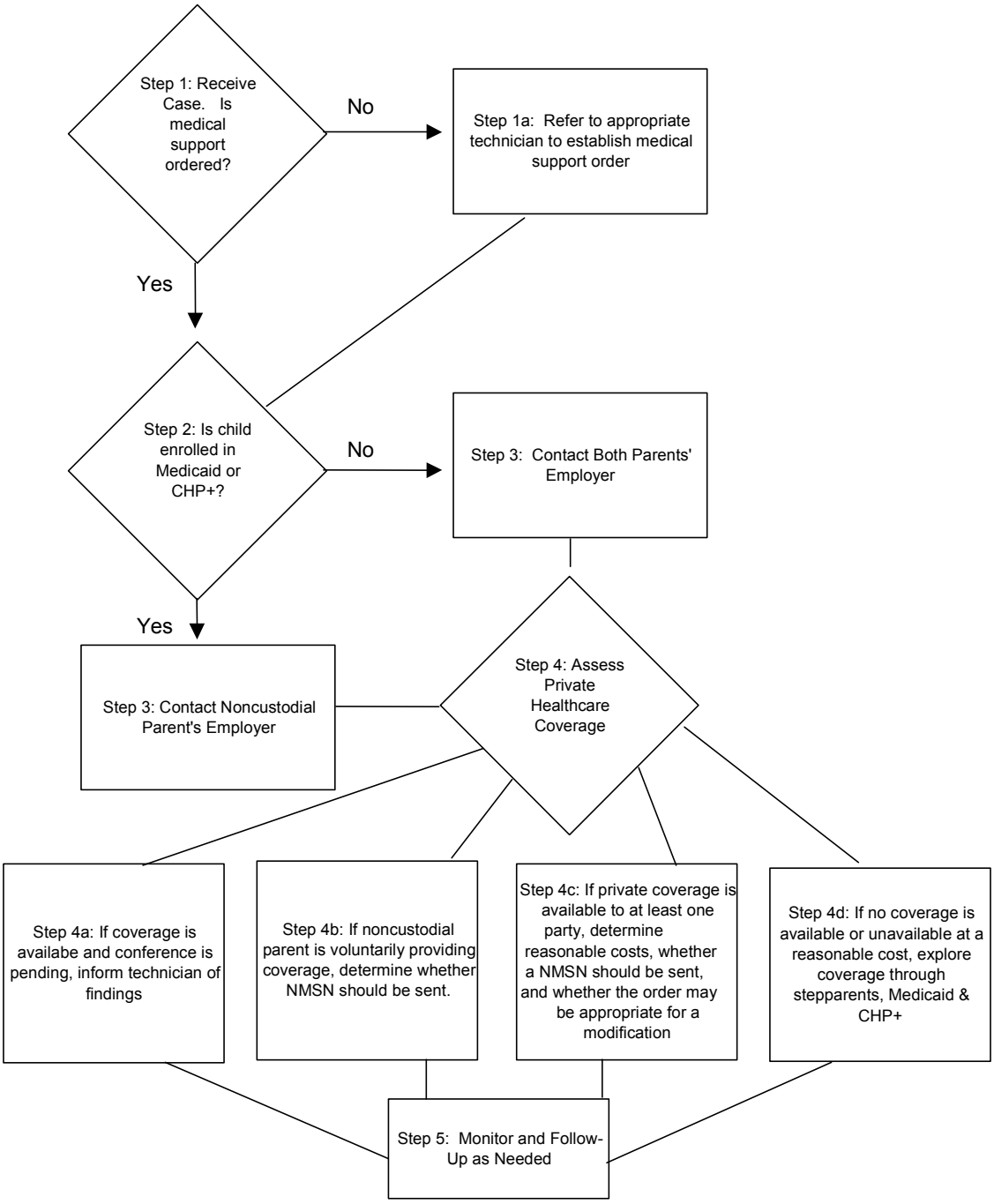
If the custodial parent appears to be eligible for either CHP+ or Medicaid, the MSF proceeds with a series of other steps to track whether the custodial parent responds based on whether the application is mailed or schedules an interview for the custodial parent to meet with the MSF to complete the application together. The MSF also assists in getting the application processed.

Step 5: Monitor and Follow-Up as Needed

The action taken here depends on the status of medical coverage for the family. If a NMSN was sent to the employer, the MSF follows up to make sure the employer responded and that the children are enrolled. If the children become enrolled in Medicaid or CHP+, the MSF repeats the entire process on a quarterly basis. If the children are covered by private insurance, the MSF does not need to do anything. The MSF will be alerted to a lapse in coverage through the weekly extract, or based on a phone call from one of the parties, from the employer, or from the technician on the case. In appropriate cases, such as where the noncustodial parent is paying premiums but not through an employer, the MSF telephones the provider to see if premiums are being paid and coverage is maintained.

If the family is denied Medicaid or CHP+ coverage, the MSF will review the case in 90 days to assess for possible eligibility at that time. If the custodial parent calls the MSF and requests assistance before the 90 days are up, the MSF works with the family to improve their chances of approval.

Exhibit 2
Schematic of MSF Process



Chapter III

Lessons Learned from Implementation and Other Issues

Inherent to any piloted innovation are the lessons learned during implementation. This Chapter details implementation issues along with other issues that influenced project outcomes. It also discusses the lessons learned from these experiences. These were assessed through interviews with key project staff and stakeholders conducted by an independent evaluator.

Overall Experience

At the time this chapter was written, the quantitative results were not known. Most stakeholders wanted to see the numbers prior to making conclusions on the project. Nonetheless, Mesa County found the project affected office culture. Other workers began to ask questions about medical support and are now sending NMSNs to employers along with wage assignments on a routine basis. Workers are putting updates about medical support on ACSES. The project has made medical support more visible and valued. Instead of putting it on the "back burner," workers are handling the issue "up front." Mesa County plans to incorporate medical insurance coverage in regular casework at the County. This includes having Medicaid applications on hand for new establishment cases. In Mesa County, the MSF had previously worked in Medicaid, so was quite familiar with both the application process and the staff doing Medicaid eligibility. This gave her a significant advantage in assisting families with the application.

Denver County, in part because of a change in personnel (a key project champion retired prior to the conclusion of the project), and in part because of significant differences in both caseload volumes and office structure, did not as enthusiastically embrace some of the medical support concepts as did Mesa County. However, they are reviewing how it might make sense to incorporate some of the most effective procedures into their routine processes for handling cases. In Denver, the Medicaid eligibility staff are completely separate from the child support staff and they do not have any coordination. The MSF in Denver did not have any kind of relationship with the Medicaid staff, which made the process much more difficult for her.

Number of Medicaid Cases

Project architects were surprised by the large numbers of IV-D cases where the children were enrolled in Medicaid. DCSE closely monitors the number of current public assistance cases (i.e., TANF); former public assistance cases, and never public assistance cases. Monthly management reports include counts by these three case types, but DCSE does not routinely report the number of IV-D cases enrolled in Medicaid. In fact, the federal performance incentive formula considers the number of these three case types but it does not consider Medicaid counts. In summary, the number of IV-D/Medicaid cases is generally not a number tracked.

The number of Medicaid cases was a surprise with implications for two reasons. First, it affected the process. Project architects anticipated a greater number of cases where the children had no healthcare coverage or private coverage was available to one or both parents, so had designed the project accordingly. Secondly, it

redirected the project's mission. The project goal was to obtain healthcare coverage for IV-D children and an objective was to obtain private healthcare coverage first. Since the goal of healthcare coverage for the children was already achieved in Medicaid cases, the only intervention the MSF could take was to try to obtain private coverage. In other words, the large number of Medicaid cases partially shifted the project's mission from increasing the numbers of children with healthcare coverage to offsetting Medicaid costs.

Program and System Issues with Medicaid and CHP+

Due to State budget issues, CHP+ enrollment was capped in November 2003. This was about half way through the nine-month period in which the MSFs processed cases. It severely limited the mission of the project, since CHP+ was incorporated in the project design as a solution to obtaining affordable healthcare coverage for children. In addition, other administrative and automation issues with CHP+ hurt the project. The CHP+ vendor responsible for enrollment changed midstream. CHP+'s automated system was also inaccessible to MSFs for about three months due to technical problems.

In addition, budget shortfalls and the pending implementation of a new statewide computer system for Medicaid and CHP+ eligibility and enrollment management created difficulties because neither program had staff available to really fully participate in the medical support project, particularly at the State level. However, as noted above, in Mesa County, the MSF's prior relationship with Medicaid and the fact that the caseload was much smaller, allowed the MSF there to develop more of a relationship with Medicaid and more easily facilitate getting eligible families enrolled.

Manual Updating of ACSES Healthcare Information

The MSFs found maintaining current healthcare information on ACSES time consuming and cumbersome given the numerous alerts pertaining to medical support and the manual effort required if an action was to be taken. For instance, ACSES alerts the child support technician when an automatic wage assignment is generated, but the child support technician must manually include the NMSN with the assignment. Still another example is that ACSES alerts the enforcement technician when a noncustodial parent changes jobs and automatically changes the wage assignment, but the enforcement technician must manually deactivate NMSN. With large caseloads, the MSFs felt it was impossible to keep up with all of these manual actions.

Identified Needs for Changes in ACSES

As explained above, while employment termination was recorded, a corresponding entry terminating health insurance was not made. Updating health insurance information on ACSES was simply not a priority, but, as a result of this project, staff seem to be more inclined to keep ACSES updated.

Moreover, several improvements to ACSES that would benefit medical support enforcement were identified through the project.

- An automatically generated letter to the custodial parent when private health insurance is found. Currently, the technician might forget to get the information to the custodial parent and it is not acted upon.
- An automatically generated letter to the custodial parent when the noncustodial parent's employment status changes. Sometimes, the first time a custodial parent learns of a lack of insurance is when she is

denied at the doctor's office. This would alert custodial parents that there might be a lapse in insurance coverage.

- An automated alert to remind workers to check for health insurance when new hire information is found. Wage assignment reminders are sent, but there is no mention of health insurance.
- An automatic alert to remind workers to check the health insurance status if the noncustodial parent loses his job. This involves going to different insurance screens. Changing the employer screen does not automatically produce changes on the insurance screen or lead the workers to the insurance screen using automatic shortcuts.
- System generated letters on a quarterly basis requesting updated information from noncustodial parents on their health insurance status. The updates could also include changes in jobs, addresses, and medical insurance and help the agency keep track of noncustodial parents while keeping ACSES information "fresh."

Lack of Cooperation from Parents and Employers

The MSFs believed their greatest challenge was securing the cooperation of the custodial parents. Denver County felt that, in paying cases especially, custodial parents were unwilling to assist the MSF for fear of "rocking the boat." Another obstacle was the absence of current contact information for the parties. Employers were also not always forthcoming in cooperating with information requests and NMSNs. To help combat this lack of cooperation from both parents and employers, the MSFs tried different approaches, such as phone calls and a variety of letters that ranged from purely requesting information to a detailed description of the project and the research purposes of the information the custodial parents were asked to provide.

Changes to the MSF Process

A few unanticipated events and circumstances necessitated changes to the MSF process shortly after the MSFs began receiving cases. First, the process design incorporated data from the matched insurance eligibility files because it was assumed this would occur before the MSFs began getting cases to work. The match did not occur until later, and, unfortunately, as discussed in more detail in the next chapter, did not produce a great deal of information that could be used by the MSFs.

Another anticipated circumstance was the number of enforcement cases without medical support provisions (i.e., the order did not provide for one or both parties to carry healthcare coverage for the children). The Colorado Child Support Guidelines require medical support and it is routinely provided for in IV-D established orders. It appears that many of these cases had existing orders that were established privately prior to becoming IV-D cases. In response to this, the process was revised such that these cases were to be referred for review and adjustment. Yet, this caused another step in the process because regulations require a request for a review from at least one of the parties if the case is not a public assistance or foster care case. In these situations, a letter informing the parties of their right to review was sent. In public assistance and foster care cases, child support rights have been assigned to the State, so the State can pursue a review on its own.

While most of these issues were small and the solutions were simple, the cumulative impact was some confusion in processes and data collection. It would have been beneficial to pre-test the process for one or two months to iron out some of the details before embarking on a full pilot.

Changes in Staff and Committee Members

With the MSF role clearly defined (see previous Chapter), the Counties conducted their own MSF hiring decisions. Mesa County originally placed a seasoned child support technician into the MSF position. She was to dedicate half of her time to the project and the other half to her other duties leading review and adjustments for the County. After a couple of months into processing cases, it was discovered that the level of work required exceeded a half-time position. Another MSF was hired. The second MSF previously worked as a Medicaid-Food Stamps caseworker. The Denver County MSF was promoted within the County to an MSF after three years performing a child support clerical role. She was to be closely supervised by one of the County's trainers who had several years of experience as a child support enforcement technician.

Despite the high caliber of the staff assigned to the project, there were numerous changes in project staff that affected the project. The changes occurred at all levels, ranging from changes in an MSF, an MSF supervisor, staff with the technical consultant and the evaluator due to job advancement, retirement, and other reasons. This affected the continuity of the project, which is critical for such a short-term project. The retirement of the MSF supervisor was an unfortunate loss because she had developed a keen understanding of the project through her early contributions in designing the detailed approach. Despite these losses, there were also some gains in new staff. For example, the MSF hired in the middle of project operations, was a quick learner and stellar worker, and she was able to quickly make up for lost time and brought renewed enthusiasm to the project through her strong belief in the project's goals.

Caseload and Data Collection

In planning for the project, the Counties agreed that the caseload seemed a reasonable size for the MSFs to handle; yet, when the project was in full swing, the MSFs sometimes found their workload overwhelming. There were new cases coming in weekly; actions to be taken on existing cases; quarterly reviews to be conducted; and, data to be entered. To create a more reasonable workload, the MSFs did not collect data on control cases, although that was the original intention. Denver County also scaled back the MSF intervention such that the child support technician assigned to the case took most of the actions and the MSF functioned more as a monitor.

Need for Immediate Feedback and Monitoring

The MSFs sent completed data collection instruments to PSI for monitoring and to develop a database to be merged with ACSES data. PSI provided the MSFs with intermittent feedback on some cases and more comprehensive feedback through monitoring reports at the time of the interim report and shortly after the MSFs stopped receiving cases. PSI also worked closely with the MSFs in their last few months to ensure that all experimental cases had completed data collection instruments.

One of the counties thought it would be more helpful to get immediate feedback, particularly with regards to whether the data collection instrument was being completed correctly and whether data had been received. Unfortunately, since the project was new and of short duration, there was not sufficient time to develop routine monitoring reports that would provide immediate feedback to the MSFs.

Differences Due to County Size and Staffing

Due to the size of the staff in Denver County, details of the project and the importance of medical coverage became quickly lost, although all supervisors explained the project to their staff. Another issue was that following up on NMSNs and other actions was more difficult in Denver County because it had many more staff to coordinate with than Mesa County. In Denver County, there are 80 child support technicians. In contrast, there are a little more than a dozen in Mesa County.

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Chapter IV

Project Outcomes and Caseload Characteristics

As discussed in the previous chapters, the primary goal of the demonstration project was to increase the number of children in IV-D cases with healthcare coverage. The project objectives were to:

- Obtain private coverage when available at a reasonable cost;
- Help families enroll in CHP+, Medicaid, or another program if private coverage was not available; and
- Facilitate seamless and continuous coverage among children when insurance eligibility changes or coverage ends.

In addition, the project sought to obtain a better understanding of the IV-D caseload and current obstacles and impediments to providing health care coverage. The project also tested the utility of matching IV-D cases to insurance eligibility data files compiled by aggregating data across insurance carriers, and whether a mass mailing of NMSNs would have been more effective at obtaining healthcare coverage.

Project outcomes are assessed through comparing healthcare coverage and other case specifics before and after the MSF intervened. In addition, comparisons are made between cases randomly assigned to the experimental (i.e., the MSF intervention) and control groups.

This Chapter presents the outcomes of the project. First, we summarize the evaluation design and data collection methods.

EVALUATION DESIGN AND DATA COLLECTION

Evaluation Approach

A two-pronged approach was planned to evaluate the effectiveness of the demonstration. First, cases were randomly assigned to experimental and control groups. Experimental cases were sent to the MSFs for intervention. Control cases received no special treatment and were subject to routine case processing and staff assignment. Secondly, healthcare coverage and other case information at the time of project selection were compared to the case information after the demonstration project ended.

Experimental and Control Cases

Child support technicians and MSFs were not informed as to which cases were selected for the control group, but were informed which cases were selected for the experimental group. An indicator was added to ACSES, Colorado's automated system, so other child support technicians would know to coordinate with the MSF on any actions concerning medical support in experimental cases.

Comparisons Over Time

Changes in healthcare coverage were compared between two time periods: (a) the time that the case was selected into the project; and (b) as of June 2004. The time elapsed between the two periods varied among cases because of the rolling sample used to pull cases. A weekly rolling sample was pulled in order to smooth

the workload among MSFs and maintain comparability between the experimental and control cases. The first weekly sample was drawn in June 2003 and the last was drawn in January 2004. This spans 35 weeks or eight months. As a result, cases were tracked for about five to 12 months depending on the week they were selected into the project.

Selection of Project Cases

As discussed in Chapter II, both establishment and enforcement cases were selected for the project. All enforcement cases have current child support orders, arrears only cases are excluded from the project. Additional criteria were imposed on enforcement cases to target those more likely to have or afford private coverage. In summary, the cases selected for the project included:

- Categories 4 and 6 cases (establishment cases in need of a support order or both paternity and support order), where the noncustodial parent has been served and a settlement conference has been scheduled;
- Categories 1 and 2 cases with a current order (paying enforcement cases or cases without payments but the noncustodial parent's employer is verified) regardless of Medicaid status; and
- Category 3 cases with a current order (enforcement cases without payments and verified employer of the noncustodial parent) that are not enrolled in Medicaid.

In addition, the project excluded all interstate cases and cases where either parent has an out-of-state mailing address.

Cases meeting the above criteria were placed in a pool for random selection. Each week, the targeted number of cases was randomly selected from the pool using a computer program designed specifically for this project. In turn, a list of cases assigned to the experiment was sent to each MSF. The targeted weekly sample sizes were: 11 Denver County experimental, enforcement cases; 11 Denver County control, enforcement cases; 9 Mesa County experimental, enforcement cases; 9 Mesa County control, enforcement cases; 10 Denver County experimental, establishment cases; 10 Denver County control, establishment cases; 6 Mesa County experimental, establishment cases; and 6 Mesa County control, establishment cases. The targeted sample sizes were designed to test experimental and control differences between enforcement cases as well as establishment cases. Although it included some over sampling, it was not designed to test differences in the outcomes between counties. Mesa County has too few establishment cases to draw both experimental and control groups over the short time period. In fact, if there were an insufficient number of establishment cases in Mesa County in a particular week to fulfill both the targeted experimental and control counts, the targeted count for the experimental cases was first met.

As shown in Exhibit 3, the targets were met for enforcement cases but not establishment cases. A few enforcement cases were eliminated because they were duplicated in the sample selection, but the over sampling more than sufficiently compensated for this. Both Mesa and Denver Counties were short in the expected number of establishment cases meeting project criteria. This was anticipated in Mesa County, but not Denver County. The shortage was handled the same way in Denver County as it was in Mesa County. Most importantly, it did not affect the validity of the random sample because all establishment cases were selected into the project. The only limitation is that all control establishment cases are from Denver County. The ideal would have been to have control establishment cases in both counties.

Exhibit 3 Number of Randomly Selected Cases by Case Assignment, Category and Site							
	Enforcement Cases				Establishment Cases		
	Category 1	Category 2	Category 3	ALL	Category 4	Category 6	ALL
Denver County							
• Experimental Cases	326	44	13	**383**	204	116	**320**
• Control Cases	290	59	33	**382**	122	37	**159**
• ALL	616	103	46	**765**	326	153	**479**
Mesa County							
• Experimental Cases	243	55	6	**304**	52	19	**71**
• Control Cases	236	47	23	**306**	0	0	**0**
• ALL	479	102	29	**610**	52	19	**71**
ALL PROJECT CASES							
• Experimental Cases	569	99	19	**687**	256	135	**391**
• Control Cases	526	106	56	**688**	122	37	**159**
• ALL	1,095	205	75	**1,375**	378	172	**550**

Data Sources and Collection

Data were collected from two sources: ACSES and the data collection instrument completed by the MSF. ACSES data were downloaded at two time periods: (1) at the time that the case was selected into the project; hence, this would vary depending on which week the case was selected into the project; and (2) June 2004, which is about five months after the MSFs stopped receiving cases and about two months after MSFs stopped working cases. The same data fields were collected from both time periods: IV-D and public assistance status; marital status of the custodial parent; parents' and children's date of births, parents' race; Medicaid enrollment flag; insurance record flag; health insurance status record; how order was entered (e.g., stipulation or default); monthly support order; parent ordered to provide medical support; number of children; and arrears balance. The second download also included order modification data.

The MSFs completed the data collection instrument by collecting information from multiple sources: the parents; the parents' employers; ACSES, Medicaid; CHP+; and other sources when appropriate.

Data Limitations

There were two significant data limitations. First, there was an error in the ACSES datum indicating Medicaid enrollment at time of project selection. Since Medicaid enrollment is updated nightly on ACSES, we could not backtrack to determine the Medicaid status at the time of case selection on control cases. Medicaid status at time of case selection, however, was available for experimental cases because the MSF verified Medicaid enrollment among all experimental cases and entered that information into the data collection instrument.

Secondly, CHP+ data is not linked to ACSES, so CHP+ information was only collected for experimental cases through the MSF data collection instrument. Hence, there is no CHP+ data for control cases.

PROJECT OUTCOMES

This discussion is organized around the following topics stemming from the goals and objectives.

- Increases in the number of children with healthcare coverage.
- Source of coverage, since one objective is to first seek private coverage when available at a reasonable cost, then utilize Medicaid or CHP+.
- Medical support orders, since they are tools used by child support enforcement to provide continuous healthcare coverage among children in the IV-D caseload.
- Cost savings, specifically, savings realized from utilization of private insurance rather than public insurance.
- Comparison to alternative approaches. This includes outcomes from a one-time insurance identification match between child support enforcement cases and a data file of those eligible for healthcare coverage. The file was compiled from insurance carriers. Also included is a discussion of the impact of a mass mailing of National Medical Support Notices (NSMNs).

Children with Healthcare Coverage

Baseline: Healthcare Coverage before MSF Intervention

In order to examine whether the number of children with healthcare coverage increased due to MSF intervention, it is important to first consider the baseline. We define the baseline to be the percentage of children with healthcare coverage at the time the case was selected into the project. This is prior to the MSF intervention. The baseline descriptions also consider characteristics of the case that may influence the ease in which healthcare coverage can be obtained for uninsured children (e.g., whether the noncustodial parent's employer is verified). Enforcement and establishment cases are discussed separately because the MSF process differs between enforcement and establishment cases.

Baseline: Enforcement Cases without Coverage

According to the Kaiser Family Foundation, 86 percent of all Colorado children have healthcare coverage.[6] In contrast, less than three quarters (71%) of the enforcement cases randomly selected for the project have healthcare coverage.[7] We believe that this percentage understates the actual percentage of children among the IV-D enforcement caseload with healthcare coverage because of the case selection criteria used. The project excluded some enforcement cases where the children are enrolled in Medicaid and the noncustodial parent's employer is not located. These were excluded because the children are already insured and private insurance could not be explored without a located employer. If all enforcement cases with current orders had been

[6]The Henry J. Kaiser Family Foundation compiles and compares health care statistics among states and publishes them on line at http://statehealthfacts.kff.org. The statistics are compiled from 2001-02 data.
[7]This is based on coverage verified by the MSFs. Overall, ACSES matched the MSFs findings in 72 percent of the cases.

considered, we estimate that about 75 percent of children in the IV-D enforcement caseload with current orders have healthcare coverage.[8]

Some of the characteristics of uninsured, project enforcement cases suggest that there may be an opportunity to improve the number of children with healthcare coverage, particularly through the noncustodial parent's private insurance.

- *About 86 percent of the uninsured, enforcement cases are paying cases.* If the noncustodial parent is paying, it is more likely that the noncustodial parent may have employer-provided healthcare or can afford private healthcare coverage for the children.
- *The noncustodial parent's employer is known in 60 percent of the uninsured, enforcement cases.* If the employer is known, there is a greater opportunity to access employer-provided health insurance.
- *Some uninsured, enforcement cases do not have an order to carry insurance.* A medical support order is a precursory step to securing healthcare coverage. Less than a quarter (21%) of uninsured, enforcement cases did not have a medical support order.[9] Among these cases, 78 percent were paying cases and the noncustodial parent's employer was known in 60 percent of the cases. Denver County had more uninsured, enforcement cases without medical support orders than Mesa County.

The prospects of obtaining private health care coverage through the custodial parent appear to be relatively low among uninsured, enforcement cases.

- *Over half (53%) are former TANF.* Former TANF status is an indicator of low income among custodial parents. Low-paying jobs are less likely to have employer-provided insurance. One study of former Colorado TANF recipients found that their median annual earnings after three years of employment were only $16,360. In 2000, two thirds of former Colorado TANF families had earnings below the poverty level.[10] Former TANF recipients tend to have sporadic employment and hold jobs in low-skilled, low-paying sectors (e.g., food service, temporary agencies) that often do not provide health insurance.[11]

Baseline: Establishment Cases without Coverage

Due to data limitations, it is impossible to compute the comparable percentage of establishment cases with healthcare coverage at time of project selection. Recall that establishment cases enter the project at the time the conference settlement is scheduled. At this time, Medicaid enrollment is known, but private coverage

[8]The estimate is based on the following assumptions: the split between Category 1/Category 2/Category 3 cases with current orders is 35%/26%/39%; all active TANF cases are enrolled in Medicaid; active TANF cases comprise 23 percent; and 83 percent of Category 3 former and never TANF cases are enrolled in Medicaid. Data Sources: Colorado DCSE Report MM410 (January 2004); ad hoc report compiled by Anne Stanek, Colorado DCSE; and ACSES download for this project.

[9]Although obtaining medical coverage is part of the guidelines, it sometimes slips through the cracks, particularly if the order was privately established prior to the case entering the IV-D system. This is the situation in most of these cases.

[10]Vincent M. Valvano, D. Goldsmith, S. Cowan, S. Robinson, M. Muniz, L. French, *Evaluation of the Colorado Works Program: Fourth Annual Report, Part 1 – TANF and Colorado Works Expenditures, Caseload Trends, and TANF-Funded Child Welfare Activities,* Berkeley Policy Associates, Oakland, CA (November 2002) #598-5.

[11]The correlation between income and availability of employer-provided healthcare coverage is well documented. For example, in 1998, 40 percent of workers earning less than $7 per hour were not offered employer-based coverage compared to only 4 percent of workers earning $15 per hour or more. Henry J. Kaiser Family Foundation, *The Uninsured and Their Access to Health Care*, Washington, D.C. (February 2002) #1420-03.

may not be known. The child support technician or MSF investigates private coverage as part of the order establishment process.

Nonetheless, it appears that higher numbers of establishment cases have healthcare coverage than enforcement cases. At the time of project selection, a higher proportion of establishment cases are enrolled in Medicaid than enforcement cases (81% among project establishment cases compared to 44% among project enforcement cases). The higher number of establishment cases enrolled in Medicaid may reflect the large numbers of TANF cases that are fulfilling cooperation requirements. (Most TANF cases also enroll in Medicaid.) Almost half (41%) of the establishment cases are currently enrolled in TANF; whereas, only eight percent of enforcement cases are currently enrolled in TANF. Further, as discussed earlier, some types of enforcement cases enrolled in Medicaid were excluded from project selection.

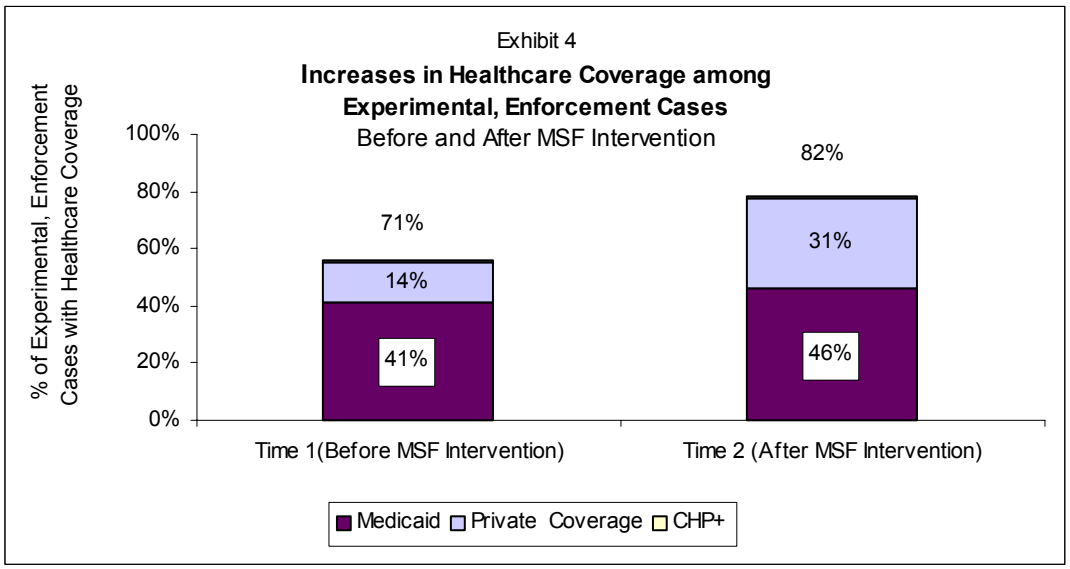
Unlike enforcement cases, the prospects of obtaining private insurance among establishment cases appeared low at project onset. The noncustodial parent's employer is verified in under a third (28%) of the establishment cases at project onset. In part, the low numbers of establishment cases without verified employers may be explained by the cases being relatively new and still being worked. Nonetheless, the lack of verified employers is important to healthcare coverage because without an identified employer, employer-provided insurance cannot be obtained.

Increases in Coverage Due to MSF Intervention

Exhibit 4 displays the increases in healthcare coverage among experimental, enforcement cases. The percent of cases with healthcare coverage increased from 71 percent at project onset to 82 percent after the MSF intervention. This is an 11-percentage point net increase and is statistically significant. The percentage increase would have been more had there not been a few cases (less than 1%) that went from insured to uninsured.

As evident in Exhibit 4, most of the gain is realized through private coverage. The specific source of healthcare coverage among the newly insured is:

- Private insurance through the noncustodial parent (5%);
- Private insurance through the custodial parent (2%);
- Medicaid (4%); and
- CHP+ (less than 1%).

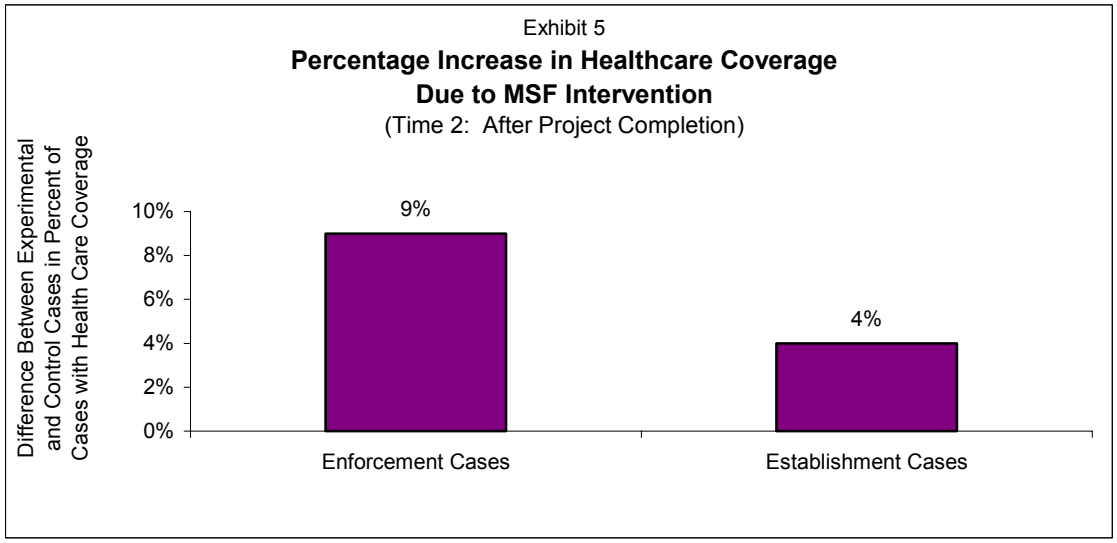


The gains in healthcare coverage are mostly among paying cases and in cases where the noncustodial parent's employer was known. Among the cases that went from no healthcare coverage to healthcare coverage, 91 percent were paying cases and 67 percent had verified employment. In contrast, 86 percent of all uninsured, enforcement cases were paying cases and 60 percent had verified employment when selected for the project.

Differences between Experimental and Control Cases

Before discussing differences between experimental and control cases, a data caveat is reiterated. Due to data limitations discussed earlier, we cannot calculate the percent of cases with healthcare coverage among control cases the same way as we did among experimental, enforcement cases in Exhibit 4. Exhibit 4 reflects verified health care coverage. The MSFs verified healthcare coverage among experimental cases, but not among control cases. The only information about healthcare coverage on the control cases is from ACSES.

Based on ACSES data only, Exhibit 5 displays the percentage point gap in healthcare coverage between experimental and control cases after the completion of the project. At project completion, 9 percent more of the experimental enforcement cases have health care coverage than control enforcement cases. This is consistent with the finding from Exhibit 4, that shows an 11-percentage point increase in the percent of experimental, enforcement cases with healthcare coverage between project entry and after MSF intervention.



As evident in Exhibit 5, the gap in the percentage of cases with healthcare coverage is smaller between experimental and control establishment cases (4%). The increase is statistically significant among enforcement cases, but it is not among establishment cases. These findings indicate that the MSF intervention is effective at increasing healthcare coverage among enforcement cases, but has less impact on establishment cases. The difference is partially explained by the higher level of Medicaid enrollment among establishment cases (81%) than enforcement cases (44%). Since more establishment cases have public coverage, there is not as much opportunity to improve on the rate of cases with healthcare coverage.

Based on these findings, if the MSF process was implemented statewide, about 20,000 more Colorado children would have healthcare coverage.

Changes in Healthcare Coverage over Time

The fact that more establishment cases have healthcare coverage than enforcement cases raises another question:

> "What happens to healthcare coverage— including Medicaid coverage— over time as the case transitions from being an establishment case to an enforcement case?"

To thoroughly answer this question would require tracking cases for a longer period of time than the duration of this project. The MSFs worked cases for about 10 months. Over this time, MSFs were able to conduct first and second quarterly reviews on some of the cases selected early into the project. The MSFs found changes in the children's healthcare coverage in seven percent of the cases with quarterly reviews. About one third of the changes are from public healthcare coverage to private healthcare coverage; about another one third of the changes are from public healthcare coverage to no coverage; and almost 20 percent of the changes are a flip from one parent providing private healthcare coverage to the other parent providing private healthcare coverage.

Although the number of cases with changes in healthcare coverage from one quarter to the next quarter is not large, the fact that more establishment cases have healthcare coverage than enforcement cases suggests that changes occur over a longer time period. On average, enforcement cases are seven years old. This is a sufficient amount of time for changes in circumstances that would result in termination of Medicaid or private coverage. In all, the difference between establishment and enforcement cases underscores the importance of frequent reviews and that positive results can be achieved from frequent reviews that focus on healthcare coverage.

Remaining Gaps in Healthcare Coverage

Despite the concerted and dedicated efforts of the project and the MSFs, not all children in experimental cases are covered by healthcare insurance at the end of the project. Almost one out of five (18%) of experimental, enforcement cases and almost one out of ten (8%) of experimental, establishment cases remained uninsured after the project was over. In some of these cases, the problem was an issue of timing, particularly among establishment cases and cases selected later into the project. Continuances and other issues delayed the establishment of the financial and medical support order. In many cases selected late into the project, NSMNs were sent but not yet returned.

In addition, some children remain uninsured because affordable private coverage from a parent's employer was not available and the children were ineligible for public insurance. The statewide cap on the number of children that could be enrolled in CHP+ exacerbated the problem. In many of these the cases, the MSF searched for alternative, low-cost healthcare coverge through the Internet and explored other sources. Exhibit 6 provides some of the actual case stories of the uninsured.

Exhibit 6
Case Stories of the Uninsured
(from actual project cases)

Case 1: Father is ordered to provide medical support. Mother earns $1,840 per month. Her employer offers health insurance benefits, but the premium is $300 per month. She cannot afford it. The children were previously insured through the father's employer, but he recently lost his job.

Case 2: Father is ordered to provide medical support. Mother earns $1,600 per month. Her employer does not provide health insurance benefits. The children are ineligible for Medicaid and CHP+. Although the children were previously insured through the noncustodial parent's employer, insurance was terminated because co-pays have not been paid in full.

Case 3: Father is ordered to provide medical support. Mother earns $1,600 per month. Her employer provides health insurance benefits, but she can only afford the premium costs for herself, not the premium costs for insuring dependents. The father's new employer also provides health insurance coverage, but it was determined to be unreasonable in costs.

In summary, the barriers to healthcare coverage among cases without coverage at project follow-up are:

- Lack of private coverage (87% of the experimental cases without coverage lack private coverage);
- Lack of employment (10% of the custodial parents are unemployed and 66% of the noncustodial parents in experimental cases with no coverage do not have verified employment);
- Medicaid or CHP+ ineligible (50% of the experimental cases with no coverage that were pre-screened for public insurance are not eligible);
- CHP+ would not accept new enrollments beginning November 2003;

- Medical support is not ordered (26% of experimental cases with no coverage do not have medical support orders);
- Parent(s) are not interested in obtaining assistance (neither parent responded in 24% of the experimental cases with no coverage and the MSF attempted contact);
- NMSN was sent, but not returned (the employer did not respond in about 25% of the experimental cases with no coverage and a NMSN was sent).[12]

The percentages of cases facing each barrier are not cumulative, so it does not add up to 100 percent. Some cases face more than one of the barriers listed above.

Compared to experimental cases **with** healthcare coverage, experimental cases **without** healthcare coverage at the end of the project are more likely to:

- Be of minority race or ethnicity;
- Be older IV-D cases;
- Involve divorced parents; and
- Involve older children and parents.

Healthcare Provider

A premise of this project was that the first choice of healthcare coverage is private insurance if available at a reasonable cost. Medicaid and CHP+ are the providers of second and third choice. Exhibit 7 shows the percent of cases by the sources of healthcare coverage for six different groups: experimental, enforcement cases; control, enforcement cases; all enforcement cases; experimental, establishment cases; control, establishment cases; and all establishment cases. This is the status after the project was completed. The breakdowns for the control cases do not include CHP+ due to data limitations discussed earlier. The major sources of healthcare coverage among the IV-D caseload are: public coverage (i.e., Medicaid, CHP+); or, private coverage through either parent.

Exhibit 7 shows that both enforcement and establishment cases in the experimental group are more likely to have private healthcare coverage than control cases.

- 39 percent of the experimental, enforcement cases have private coverage compared to 32 percent of the control enforcement cases. This difference is statistically significant. It suggests that the MSF intervention was successful at obtaining more private coverage among enforcement cases.
- 7 percent of the experimental, establishment cases have private coverage compared to 3 percent of the control enforcement cases. This difference is not statistically significant.

[12]This is based on information from only one of the counties participating in the project. It considers only experimental cases without coverage at project follow-up.

Exhibit 7
Source of Insurance
Cases with Healthcare Coverage
(Time 2: After Project Completion)

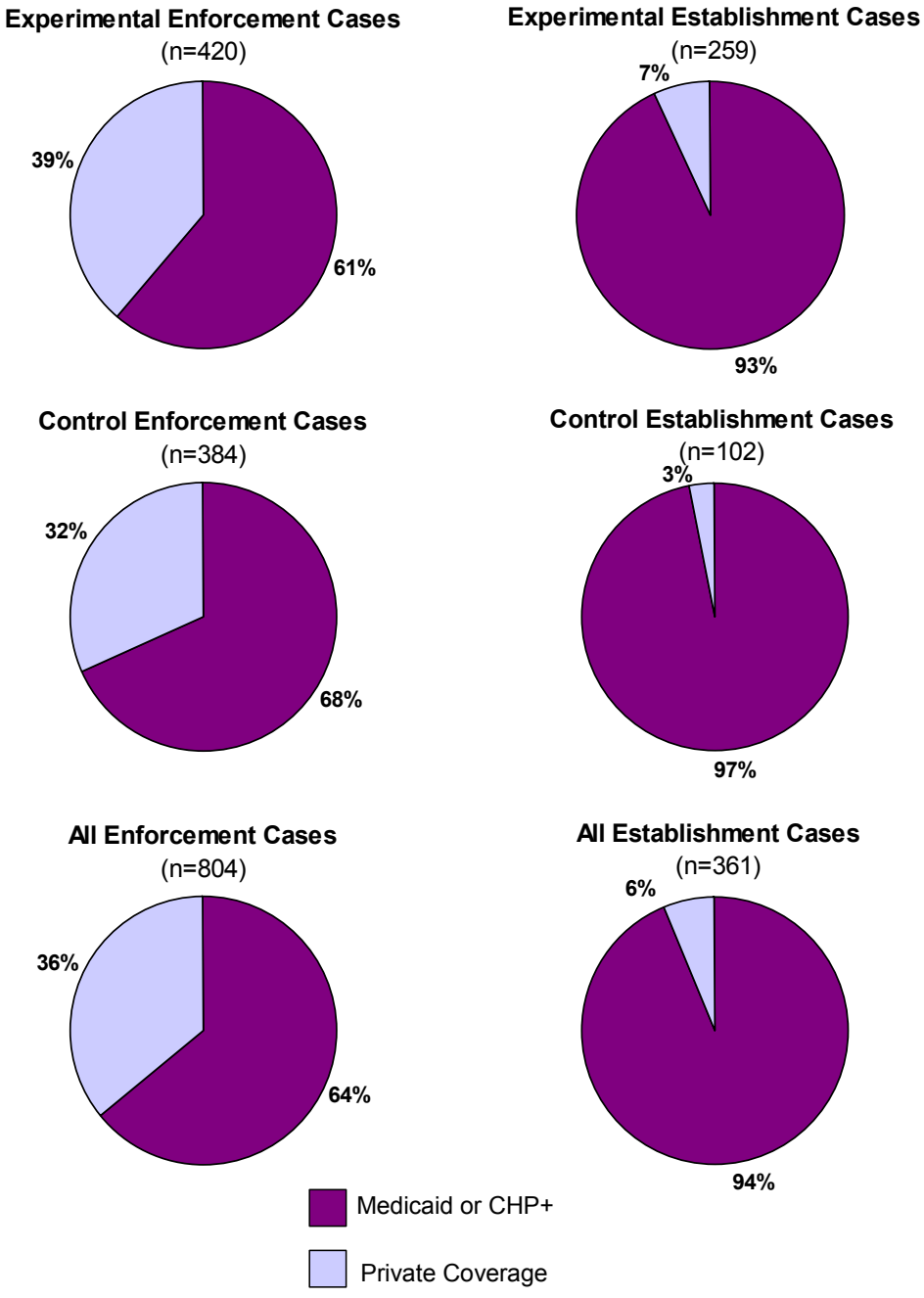
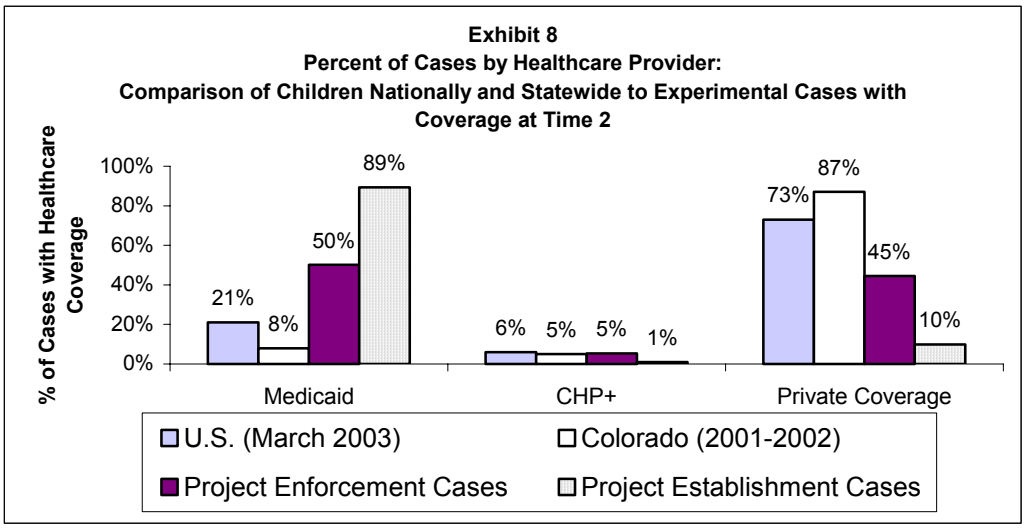


Exhibit 8 compares healthcare providers among children nationally and statewide to healthcare providers among project cases.[13] As evident in Exhibit 8, disproportionate shares of project cases are insured through Medicaid.



Medicaid

Nationally, about 21 percent of insured children are covered by Medicaid.[14] The comparable figure among all Colorado children is 8 percent.[15] As shown in Exhibit 8, Medicaid is the provider in 50 and 89 percent of project enforcement and establishment cases, respectively. The relatively high percentage of cases enrolled in Medicaid is indicative of the low-income population that characterizes the IV-D caseload. Although income information is not available for most project cases, it can be deduced that the majority of IV-D families have low income. One study found that over two thirds of all IV-D families had family income under $30,000 in 1995.[16] This is well below median family income in Colorado according to the most recent Census ($57,114 per year in 2002) even if it was updated for inflation.[17] In experimental cases where both parents' incomes are available, the combined income is about $28,000 per year. Medicaid eligibility is tied to the poverty guidelines. The current poverty guidelines for a custodial parent with one child and a custodial parent with two children are $12,490 and $15,670 per year, respectively.[18]

[13]Data is based on experimental cases only to include CHP+ status.
[14]Henry J. Kaiser Family Foundation, State Health Facts Online, Healthcare Coverage and Uninsured, *Distribution of Children 18 and Under by Insurance Status, 2001-2002*. http://statehealthfacts.kff.org/
[15]*Ibid.*
[16]Matthew Lyon, "Characteristics of Families Using Title IV-D Services in 1995," Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (May 1999).
[17]U.S. Census Bureau, 2002 American Community Survey, Table P101.
[18]*Federal Register*, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

CHP+

Nationally, about 6 percent of insured children are covered by State Children Health Insurance Programs.[19] The comparable figure among all Colorado children is 5 percent.[20] As shown in Exhibit 8, children are insured by CHP+ in a comparable percentage (5%) of project enforcement cases, and a smaller percentage (1%) of project establishment cases. In large part, the small percentage of children insured by CHP+ is because CHP+ is the third insurance provider of choice. Private coverage and Medicaid are the first and second choices, respectively. Among project cases, the low numbers of CHP+ cases is also due to the CHP+ enrollment cap, which became effective November 2003, and other administrative and automated system issues that occurred over the course of the project. There was a change in the vendor that operates CHP+'s enrollment program during the project and the MSFs could not access the automated system for more than a month due to system problems.

Private Coverage

Nationally, about 73 percent of insured children are covered through private coverage.[21] The comparable figure among all Colorado children is somewhat higher (87%).[22] In contrast, about 45 and 10 percent of project enforcement and establishment cases, respectively, are insured by private coverage. The relatively low percent of IV-D cases with private coverage is indicative of the typical employment situations of the custodial and noncustodial parents whom compose the IV-D caseload. Many are unemployed or work at jobs without health insurance benefits.

Parent Providing Coverage

Exhibit 9 shows which parent provides coverage among cases with private coverage. The noncustodial parent provides private coverage in 62 and 70 percent of enforcement and establishment cases, respectively. The custodial parent provides coverage in 33 and 27 percent of enforcement and establishment cases, respectively. The noncustodial parent's spouse provides coverage in 1 percent of enforcement cases and 3 percent of establishment cases. The custodial parent's spouse provides coverage in 4 percent of the enforcement cases and none of the establishment cases.

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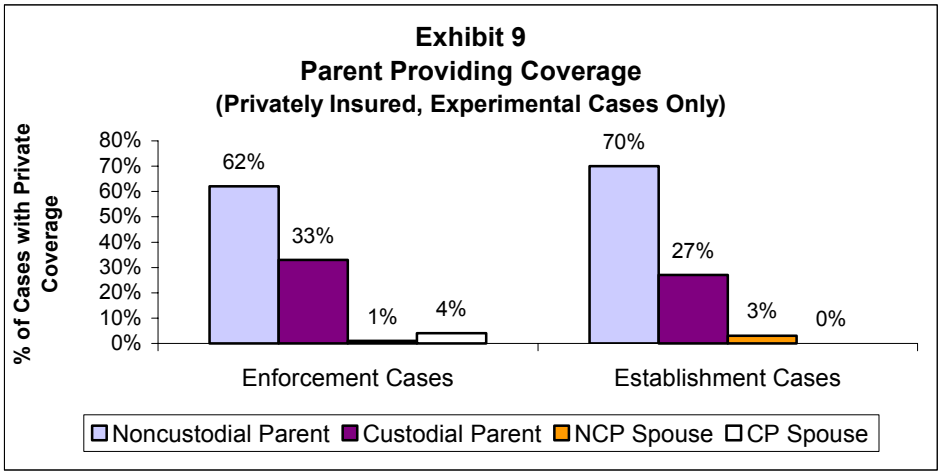
[19]Henry J. Kaiser Family Foundation, State Health Facts Online, Medicaid and SCHIP, *SCHIP Enrollment, June 2003.*
[20]Ibid. Estimated from *SCHIP Enrollment, June 2003* and *Distribution of Children 18 and Under by Insurance Status, 2001-2002.*
[21]Henry J. Kaiser Family Foundation, State Health Facts Online, Healthcare Coverage and Uninsured, *Distribution of Children 18 and Under by Insurance Status, 2001-2002.* http://statehealthfacts.kff.org/
[22] Ibid.



Cases Where Both Parents Have Private Coverage

While investigating availability of healthcare coverage, the MSFs discovered some experimental cases (about 6%) in which both parents have employer-provided healthcare coverage available. In these cases, the MSF is to work with the custodial parent to determine which healthcare coverage is the best for the children based on accessibility, care continuity, and mandatory benefits. Although both parents have insurance available, the child was not dually insured in any of these cases. The only exception is questionable: in this case, the noncustodial parent provides medical coverage and the custodial parent provides dental and vision insurance coverage. There are no modifications to the medical support order or changes in coverage among these cases over the course of the project.

Consideration of Reasonable Costs

When establishing or modifying a medical support order, the MSF was to determine whether healthcare coverage is available from the parent's employer at a reasonable cost. Yet, these circumstances presented themselves in only a few cases (less than 1% of the experimental cases). One of the reasons is that few noncustodial parents in establishment cases have access to private coverage.

Among experimental cases in which an order was established during the project, only 12 percent of the noncustodial parents have private coverage available, and 33 percent of the noncustodial parents have verified employment. Restated another way, the findings are:

- about one out of ten noncustodial parents in establishment cases have health insurance available through their employer; and
- about one out of three *employed* noncustodial parents in establishment cases have health insurance available through their employer.

These findings differ from other studies; in part, the differences may be due to the differences in the population examined. For example, a national study found that about 58 percent of employers offer health insurance, but it was based on all employers, not specific sectors in which noncustodial parents are more

likely to be employed.[23] Another study found that at least 42 percent of nonresidential fathers who do not provide healthcare coverage for their children actually have access to healthcare coverage through their employer, but this study included IV-D and non-IV-D cases.[24] Jobs paying lower wages are less likely to offer health insurance and noncustodial parents in the IV-D caseload are more likely to work at lower-paying jobs.[25]

The issue of reasonable cost could also be raised in an order review, but at least one party would have to request a review. A review was requested in less than one percent, but a reasonable cost calculation was not recorded in any of these cases

The costs of healthcare coverage were determined to be reasonable in 70 percent of the cases. The costs were determined to be unreasonable in the remaining 30 percent of the cases. Colorado statute provides that a premium payment that exceeds 20 percent of a parent's gross income is considered unreasonable; whereas, the National Medical Child Support Working Group recommends a threshold of 5 percent.[21] If the Working Group's definition would have been applied, the costs of healthcare coverage would have been determined to be reasonable in 30 percent of the cases.

We examined the costs of insurance in all cases where private coverage was being provided and cost and income information were available. The monthly cost for dependent coverage ranged from $0 to $371 and averaged $162. The insurance premium composed 2 to 37 percent of the noncustodial parent's gross income.

Differences in the Parent Ordered to Provide Coverage and the Parent Actually Providing Coverage

Another project concern is cases where the parent providing coverage is not the same parent ordered to provide medical support. This is an issue because the guidelines factor in the child's share of the healthcare coverage premium in determining the support award amount. If the noncustodial parent is ordered to provide medical support, but the custodial parent is actually providing healthcare coverage, the award amount may be set too low. Conversely, if the custodial parent is ordered to provide medical support, but the noncustodial parent is actually providing healthcare coverage, the award amount may be set too high.

Data collected by the MSFs on experimental cases identify whether the parent ordered to provide medical support is the same parent providing medical coverage. Among experimental, enforcement cases with private coverage, the parent ordered to provide healthcare coverage for the children matches the parent actually providing healthcare coverage for the children in 81 percent of the cases. In the remaining 19 percent of the cases where the order did not match the actual parent carrying insurance:

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[23]JM Branscome, *Changes in Job-Related Health Insurance 1996-99*, MEPS Chartbook No. 10, AHRQ Publ, No. 02-0030. Agency for Healthcare Research and Quality, Rockville, Maryland (2002).
[24]Laura Wheaton, *Nonresident Fathers: To What Extent Do They Have Access to Employment –Based Health Care Coverage?* Report to the Office if Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services, Urban Institute, Washington, D.C. (2000).
[25]Several recent studies indicate that noncustodial fathers are as poor as their custodial parent counterparts. For example, see Elaine Sorensen and Chava Zibman, *Poor Dads Who Don't Pay Child Support: Deadbeats or Disadvantaged?* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* B-30 (April 2001).
[21]C.R.S. §14-10-115(13.5)(g).

- the noncustodial parent is ordered to provide medical coverage, but the custodial parent is actually providing it (18% of the cases); and
- the custodial parent is ordered to provide medical coverage, but the noncustodial parent is actually providing it (1% of the cases).

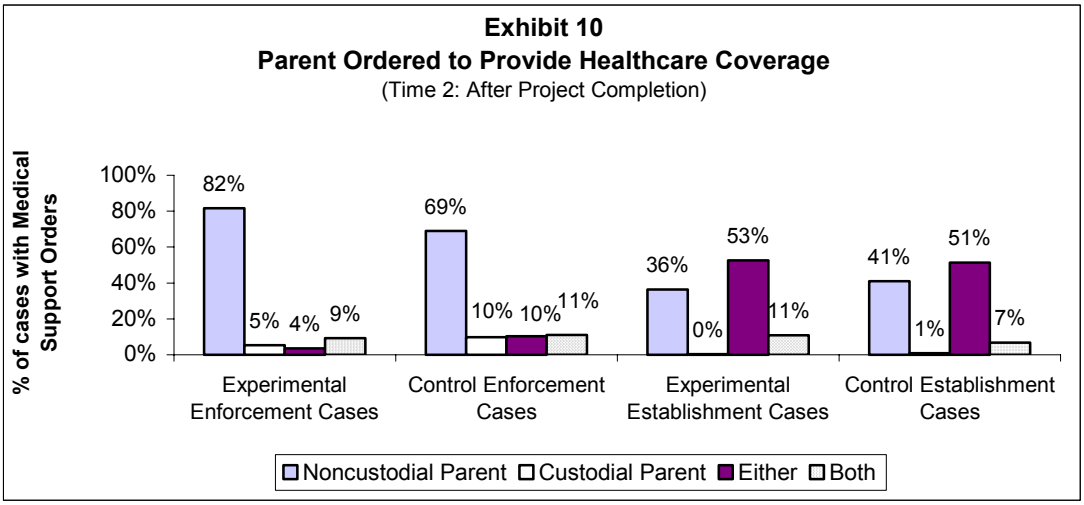
All of these cases are non-public assistance cases; hence, at least one party must request a review to modify the medical support order. As part of the MSF process, the MSFs were to notify the parties of their right to review. None of the parents in this particular circumstance requested a review. In many of these cases (57%), the noncustodial parent was not paying support, so a modification would not have resulted in any more current payment. In interviews with County staff, they also suggested that custodial parents did not want to pursue modifications in these cases because they did not want "to rock the boat" with the other parent.[26]

Another issue is that some orders provide that either parent is to carry health insurance for the children if available at a reasonable cost. In these cases, it is unlikely that the financial order appropriately credits the parent actually paying the insurance premium. Either parent is ordered to provide healthcare coverage in two percent of the experimental, enforcement cases where the children are actually insured through one parent's employer healthcare plan. In addition, both parents are ordered to provide coverage in another nine percent of these cases, but only one parent actually provides coverage in these cases. Among these cases, 60 percent are insured through the custodial parent's employer and the remaining 40 percent are insured through the noncustodial parent's employer. Similar to the cases where the custodial parent actually provided coverage but the noncustodial parent is ordered to provide coverage, none of the parents in these cases requested a review.

Medical Support Orders

Exhibit 10 summarizes which parent is ordered to provide healthcare coverage for the children. It shows that medical support is ordered to the noncustodial parent more often in enforcement cases than establishment cases. Among establishment cases, once an order is established, it is more common to order medical support to either party. The differences between enforcement and establishment cases reflect shifts in philosophy over time. Enforcement cases, which are older cases, were more likely to be established when the belief was that the noncustodial parent would provide coverage. The common practice today is to order either parent to provide healthcare coverage if available at a reasonable cost.

[26]Other studies have also found that many custodial parents do not pursue review and adjustments of financial support orders as well because they do not want to "rock the boat" with regards to payment and visitation issues. These studies also found that in non-paying cases, some custodial parents just do not want to bother. For example, see Policy Studies Inc., *Oregon Child Support Updating Project: Final Report*: Report to the State of Oregon, Denver, Colorado (April 1991).



Cost Savings

There are several ways that private healthcare coverage avoids and offsets the costs of public healthcare coverage.

- If private insurance is available and appropriate, it may replace public insurance. If there is private insurance but the children are still eligible for public insurance, private insurance may supplement as a third-party payor.
- According to a recent study, Medicaid may be avoided due to child support if the noncustodial parent is providing healthcare coverage for the children or the payment of child support renders the family financially ineligible for Medical assistance.[27]

Third-Party Reimbursement

If there are no changes in the custodial family's income (including changes in child support payments), we would expect the MSF action alone to increase the numbers of cases dually enrolled in Medicaid and private insurance. Medicaid has for many years recognized the benefits of pursuing third party payors as the primary payment source for Medicaid beneficiary services. It has become an increasingly important function, however, as Medicaid budgets and caseloads continue to grow. Rather than cut services or cut populations served, Medicaid is becoming more aggressive in pursuing third party payors as a means to help fill budget gaps that otherwise would force more unpopular cuts. In some experimental cases (6%), the children are enrolled in Medicaid, but there is also private healthcare coverage. In fact, private coverage was obtained during this project in about half of these cases. This results in Medicaid savings.

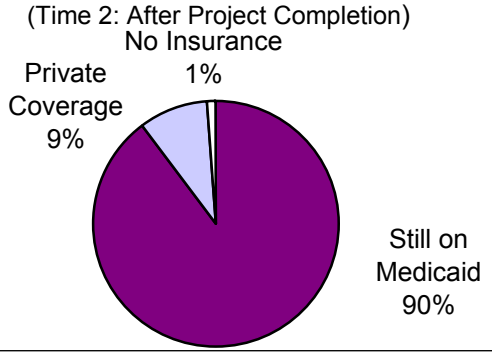
Replacing Public Insurance with Private Insurance

Private insurance may replace Medicaid if the children become income ineligible. Child support counts as income. Also, age of the child factors into Medicaid eligibility since the income threshold is lowered at age six. In these situations, the MSF actions and the establishment and enforcement of medical support can provide a healthcare safety net. Exhibit 11 examines changes in healthcare coverage among children enrolled

[27]Laura Wheaton, *Child Support Cost Avoidance in 1999, Final Report.* Report to the Federal Office of Child Support Enforcement; Urban Institute, Washington, DC (June 2003).

in Medicaid at project onset.[28] It shows that only 1 percent of the cases that were initially enrolled in Medicaid were uninsured at the end of the project. Through the MSF intervention, NMSNs and other child support processes, child support enforcement was instrumental in obtaining private insurance coverage in 9 percent of the project experimental cases enrolled in Medicaid within a year. The percentage is somewhat higher among enforcement cases (15%) and lower among establishment cases (4%). If these results were replicated statewide among similarly situated enforcement and establishment cases, we estimate a $7,600,000 savings in Medicaid costs per year.[29]

Exhibit 11
Changes in Healthcare Among Medicaid Cases
(Time 2: After Project Completion)



As an aside, it appears that increased income from child support contributed to Medicaid ineligibility among these cases. Most (78%) of the cases rolling off Medicaid to private insurance received child support payments. In contrast, about half (50%) of cases remaining on Medicaid received child support payments. In addition, the order amounts were higher among cases rolling off Medicaid to private insurance than those remaining on Medicaid. (The average order amounts were $341 and $234 per month, respectively.) Higher support orders would also result in more income for the custodial-parent family.

Aging of the child appears to have some impact, but not as large as increased income from child support. The age of the youngest child averages 9 years old in cases rolling off Medicaid to private insurance, whereas the age of the youngest child averages 7 years old in cases remaining on Medicaid. The income eligibility threshold for Colorado Medicaid drops from 133 percent of the poverty level to 100 percent of the poverty level when the child reaches age six.

Cost Avoidance

Additional cost savings could be realized through cost avoidance; that is, cases avoid Medicaid because they have private coverage that is enforced through child support or they have sufficient income from child support to be income ineligible for Medicaid. Calculating cost avoidance is beyond the scope of this study;

[28]This includes experimental cases only because the Medicaid status of control cases is not known at project onset.
[29]This is calculated using the per capita rate of $1,372 per Medicaid eligible child for State Fiscal Year 2004. Colorado Department of Health Care Policy and Financing, *Budget: Medical Service Premiums,* Exhibit U: History of Per Capita Costs, Denver, Colorado, page EU-1.

however, other evidence suggest that for every child support dollar collected, Medicaid costs are reduced by 2 to 4 cents depending on whether the child support is collected for a private or IV-D case.[30]

Alternative Methods to Increasing Healthcare Coverage

This project piloted a MSF approach to increasing and improving healthcare coverage among children in the IV-D caseload. The strength of the MSF approach is that it allows for human intervention, which is a benefit for two reasons. First, as evident in the discussion above, the actions and measures to be taken vary tremendously depending on the circumstances of the case. It takes critical thinking skills to determine the appropriate actions and measures for a particular case. Secondly, the MSF approach allows for human compassion; that is, that one-on-one interaction that is sometimes necessary to gain cooperation from parents and employers and propel action.

There are at least two alternatives to the MSF approach:

- Matching IV-D cases to insurance eligibility files; and
- Mass mailing of National Medical Support Notices (NSMNs).

Match to Insurance Eligibility Files

Child support enforcement cases were matched to a database of insurance eligibility files maintained by HMS. The database identifies individuals covered by private or government health insurance plans (e.g., commercial insurance plans, BC/BS plans, MCOs, Tricare). It started with over 400,000 DCSE records including parents and children. HMS matched about 23 percent of the cases, but the match was limited to 100 verified matches statewide. Most of the matches (91 cases) are Denver County cases and none are Mesa County cases.

In reviewing the matched information, Denver County found much of the matched information was already known or the case was arrears only. Denver County found that only 24 cases contained information that could be useful to enforcing or establishing medical support. This mostly included information on insurance coverage in cases where there was not an active NMSN. This translates into about useable information being discovered in about only six percent of all cases.

Mass Mailing of NMSNs

Another approach to increasing the numbers of children with healthcare coverage is to mail NMSNs to all employers of noncustodial parents. This is certainly a less costly option since it requires less skilled staff and could even be automated. Yet, such a mass mailing would be limited to only those cases where the noncustodial parent's employer's address was known. Due to the MSF intervention, however, the MSFs were able to locate employers that were previously unknown to the system. Through the MSFs efforts, 29 percent more NMSNs were sent than would have been sent if only the address information available from ACSES was relied upon.

[30] *Supra* note 27.

Over a quarter (27%) of the NMSNs sent resulted in private healthcare coverage. The percentage does not differ remarkably between cases in which the employer's address is available through ACSES and cases in which the MSF located the employer.

Due to data limitations, we were only able to calculate the return rate on NMSNs from one county. It is 51 percent. The return rate includes any NMSNs returned regardless whether they resulted in coverage.

Chapter V

Conclusions and Recommendations

The goal of the National Medical Child Support Working Group, which issued its report to the U.S. Secretary of Health and Human Services and the U.S. Secretary of Labor in June 2000, was to increase healthcare coverage for children.[31] A principle of the Working Group was that it is in the best interest of children and the nation that the maximum number of children has access to heath care coverage. Lack of such coverage affects children's current and future health and their ability to become productive citizens.

The Working Group recognized that private healthcare coverage should come first, but that if private healthcare coverage that is comprehensive, accessible, and affordable cannot be provided by parents, children should be enrolled in public healthcare coverage. The Working Group also recognized that seamless coverage is critical to meeting the needs of children. As circumstances of families change, the system should be flexible enough to ensure that children do not experience gaps in healthcare coverage. The premise of the Working Group's report was that the child support program is ideally positioned to work with IV-D families over time, track their healthcare coverage status, and assist families in obtaining healthcare coverage for children.

This demonstration project tested a number of recommendations central to the model for medical support enforcement recommended by the Working Group. The conclusions and recommendations which follow are intended to assist the State of Colorado and other states in better coordinating their efforts to increase healthcare coverage for children.

ORGANIZATION OF CHAPTER

In this Chapter, we begin by discussing the major conclusions reached from the evaluation of this demonstration project:

1. **There are significant numbers of uninsured children in the IV-D caseload.**
2. **The healthcare status of children in the IV-D caseload changes as families circumstances change over time.**
3. **The use of Medical Support Facilitators (MSFs) within child support offices was successful in increasing the number of children in the IV-D caseload with healthcare coverage.**
4. **A larger number of children in the IV-D caseload have healthcare coverage than expected. This finding redirected the project's focus towards finding private coverage to reduce Medicaid costs in addition to the primary goal of increasing the numbers of children with healthcare coverage.**
5. **Opportunities exist to realize significant state savings by getting more children enrolled in private healthcare coverage.**

[31]The Medical Child Support Working Group, *21 Million Children's Health: Our Shared Responsibility*, Report to the Department of Health and Human Services and Department of Labor, Washington, D.C. (June,2000).

6. **Program and systems issues need to be resolved in order to maximize the number of children with healthcare coverage.**
7. **Cooperation between child support agencies and healthcare provider agencies is vital to increasing healthcare coverage for children.**
8. **Other non-programmatic barriers need to be overcome in order to ensure that all children have healthcare coverage.**

Next, we offer recommendations intended to assist the State of Colorado in better coordinating its efforts to provide healthcare coverage for children:

1. **Include Medical Support Facilitators in all child support enforcement offices.**
2. **Review medical support coverage in enforcement cases frequently.**
3. **Work more closely with public healthcare provider agencies in order to both maximize the number of children covered and to limit costs by identifying and enrolling children who are on Medicaid but who could be enrolled in private coverage.**
4. **Enhance the automated child support enforcement system, ACSES, to seamlessly update healthcare information and automate as much of the MSF process as possible.**
5. **Vigorously enforce the requirement that employers respond to the NMSN.**
6. **Train all child support enforcement staff on the importance of ensuring medical support for each order and make it a priority in each office.**
7. **Work closely with the parents and make sure the custodial parent especially is informed of any changes to employment which might affect healthcare coverage.**
8. **Fully fund CHP+ so that no cap on enrollment is imposed.**

Lessons learned from this project may also be of value to other states, most of which face similar challenges in providing healthcare to its children.

CONCLUSIONS

1. **There are significant numbers of uninsured children in the IV-D caseload.** The findings from this project suggest that fully twenty-five percent of cases with current orders lacked healthcare coverage. Opportunities exist to increase the percentage of cases with healthcare coverage, particularly through private coverage.

2. **The healthcare status of children in the IV-D caseload changes as families circumstances change.** The healthcare status of children in IV-D families changes frequently throughout the life of the case as family relationships and employment status changes. Even in the short period of time that this project operated, 7 percent of cases with quarterly reviews experienced changes in healthcare coverage. Changes may be from public healthcare coverage to private, children may lose coverage, or the parent providing coverage may change. This is further illustrated by the fact that in enforcement cases, the custodial parents was providing medical coverage in 18 percent of the cases even though the noncustodial parent was ordered to provide it. A change in the parent providing coverage is an issue because the guidelines factor in the child's share of the healthcare coverage

premium in determining the support award. Frequent reviews of healthcare status are needed to ensure seamless coverage for children. In addition, custodial parents must be able to depend on healthcare coverage for their children and not wonder whether the coverage is still good at any point in time.

3. **The use of Medical Support Facilitators (MSFs) within child support offices was successful in increasing the number of children in the IV-D caseload with healthcare coverage.** This project was founded on the premise that the IV-D program is ideally situated to increase the numbers of children with healthcare coverage. Child support orders that include provisions that a parent(s) must provide healthcare coverage for the children if available at reasonable cost and the enforcement of these orders help increase the numbers of children with healthcare coverage. In this project, MSFs located in local child support offices coordinated medical support enforcement efforts and facilitated enrolling families in appropriate healthcare coverage. MSFs were provided with special training and an MSF manual, developed for this project, which provided them with a structured approach to obtaining medical support orders and monitoring cases to ensure continued coverage. In addition, the use of MSFs may facilitate a change in culture in the child support office so that medical support becomes more visible and a higher priority to other caseworkers. MSF intervention significantly increased the percent of enforcement cases with healthcare coverage from 71 percent to 82 percent. Based on the results from the two counties where the MSF process was piloted, if the MSF process was applied statewide, about 20,000 more children would be insured in Colorado within the first year of the project.

4. **A larger number of children in the IV-D caseload have healthcare coverage than expected. This redirected the project's focus towards finding private coverage to reduce Medicaid costs in addition to the primary goal of increasing the numbers of children with healthcare coverage.** The percent of enforcement cases where the children have healthcare coverage was 71 percent when the project began. Among establishment cases, 81 percent were enrolled in Medicaid when the project began. If private coverage was also accounted for, the percentage of establishment cases with healthcare coverage for the children would be even higher among establishment cases. In all, the numbers of children with healthcare coverage among the IV-D caseload are higher than what was anticipated, particularly with Medicaid coverage. Consequently, in these cases the primary goal of the project (obtaining healthcare coverage) was already fulfilled to a large extent and the MSFs activities were shifted to the secondary objective of obtaining private coverage to reduce Medicaid costs. Indeed, even as the percentage of cases with healthcare coverage increased from 71 percent to 82 percent after MSF intervention, the percentage on Medicaid or CHP+ decreased from 48 percent to 45 percent.

5. **Opportunities exist to realize significant state savings by getting more children enrolled in private healthcare coverage.** The establishment and enforcement of medical support orders, particularly the obtainment of private coverage, provides a healthcare safety net for children. It also reduces Medicaid costs through cost avoidance and third party reimbursements. Although we did not measure all of these cost savings, if the state could realize the nine percent switch in Medicaid to

private coverage that was experienced in the two piloted counties, this would result in more than $7.6 million savings to Medicaid in a year.

6. **Program and systems issues need to be resolved in order to maximize the number of children with healthcare coverage.** One obstacle encountered by the MSFs was that Colorado's Automated Child Support Enforcement System, ACSES, was not as fully automated to facilitate seamless coverage as it could be. For instance, if a noncustodial parent changes jobs, the wage assignment is automatically deactivated, but the insurance is not automatically deactivated. Instead, the technician is sent an alert and must manually update the information. No automatic letters are sent to the custodial parent about changes of employment and insurance status. With large caseloads, the MSFs felt it was impossible to keep up with all these manual actions. Another problem is that a substantial percentage (49 percent) of employers did not respond to the NMSN. Accurate and current health insurance information on the child support automated system is a key prerequisite to efficient and effective medical support enforcement.

7. **Cooperation between child support agencies and public healthcare provider agencies is vital to increasing healthcare coverage for children.** It is essential that the MSF have the full cooperation of healthcare provider agencies and access to simple expedited processes, preferably automated, to get children enrolled in public healthcare (Medicaid and CHP+) where that is appropriate. Cooperation among agencies for this project was facilitated through the use of a multiple agency advisory board. Nonetheless, technical problems were not always easily surmounted. For example, during the period of time that this project was conducted technical problems with CHP+'s automated system made it inaccessible for a period of time.

8. **Other non-programmatic barriers need to be overcome in order to ensure that children have healthcare coverage.** Lack of employment for noncustodial and custodial parents limit options for healthcare coverage since it precludes employer-based healthcare coverage. Even when parents are employed, fewer and fewer employers provide healthcare benefits to employees, especially in the low-wage labor market in which many custodial and noncustodial parents in the IV-D system are employed. As a consequence, Medicaid and CHP+ is increasingly the only option for low-income parents in Colorado. And, unfortunately, some low income working families continue to fall through the cracks. They do not have employer-based coverage (only about one out of three employed noncustodial parents in establishment cases have health insurance available through their employer) and yet they are ineligible for Medicaid or CHP+. Another problem that occurred during this project is that a cap was imposed on the children's health program, CHP+, which limited the number of children that could be enrolled in that program. In order to be effective, healthcare programs for children need to be adequately funded.

RECOMMENDATIONS

The following recommendations are based upon the conclusions drawn from this project as described above.

1. **Include Medical Support Facilitators in all child support enforcement offices.** The MSF processes developed for this project can serve as a model for similar statewide efforts. Some flexibility may be necessary in the approach due to different county sizes and staffing abilities.

2. **Review medical support coverage in enforcement cases frequently.** The findings from this project reinforce the need for continual monitoring of healthcare coverage since families circumstances change frequently. Healthcare coverage child support cases needs to be closely monitored in order to ensure seamless coverage for children.

3. **Work more closely with public healthcare provider agencies in order to both maximize the number of children covered and to limit costs by identifying and enrolling children who are on Medicaid but who could be enrolled in private coverage.** As we point out in this report, significant cost savings could accrue to the state through such efforts.

4. **Enhance the automated child support enforcement system, ACSES, to facilitate seamless coverage and tracking of healthcare.** Keeping health insurance information current on the child support automated system and automating as much as the process as possible are key prerequisites to efficient medical support enforcement.

5. **Vigorously enforce the requirement that employers respond to the NMSN.** In order to maximize the number of children with private healthcare coverage, it is crucial that employers respond to the NMSN. This requirement should be vigorously enforced by following up with employers that do not respond. The state could also address in state law the consequences for an employer who does not respond, such as by an appropriate fine.[32]

6. **Train all child support enforcement staff on the importance of ensuring medical support for each order and make it a priority in each office.** Regardless of whether MSFs are employed in all local child support offices, all child support caseworkers need to be educated on the importance of medical support and the need to ensure that all child support orders include appropriate medical support provisions.

7. **Work closely with the parents and make sure the custodial parent especially is informed of any changes to employment that might affect healthcare coverage.** Informing custodial parents of potential changes to healthcare coverage provides good customer service and creates a partnership between the agency and the parent to ensure the maximum benefit for the children. Advance warning of a lack of insurance empowers the custodial parent to seek other forms of coverage to ensure seamless coverage for the children.

[32] The federal Office of Child Support Enforcement has issued a strong encouragement to states to address this issue. U.S. Department of Health and Human Services. *PIQ-02-03,* December 20, 2002.

8. **Fully fund CHP+ so that no cap on enrollment is imposed.** Capping enrollment in the CHP+ program seriously compromises the availability of healthcare coverage for children in low income working families in Colorado.

Performance. Service. Integrity.

Appendix I
MSF User Manual

TABLE OF CONTENTS

A. INTRODUCTION

1. What is the MSF Project?

Colorado successfully applied for a federal grant which allows for the development of an innovative coordinated approach to increase the number of children in IV-D cases with healthcare coverage. The expected results and benefits of this project are:

- Analyzing the child support caseload to better understand the current obstacles and impediments to providing healthcare coverage;
- Developing new and innovative processes, collaborations, and automated linkages for medical child support, Medicaid, and Colorado's SCHIP, CHP+;
- Increasing healthcare coverage for children within the project area; and
- Analyzing the potential for increased Medicaid savings through identification of private healthcare coverage.

The State of Colorado identified Mesa and Denver counties as the pilot counties for this project. The project lasts for one year, from February 2003 to February 2004. The actual working of cases by the medical support facilitator (MSF) begins mid-May, 2003 and goes through January 2004. This timeframe ensures that enough cases will have been worked to properly analyze the process and determine how effective the MSF process is at obtaining medical support. These data will also help the State determine to what extent to implement the process statewide.

2. What is the MSF?

As part of the pilot, the State of Colorado created a new position in the Denver and Mesa County child support offices, the Medical Support Facilitator (MSF). The role of the MSF is to obtain medical coverage for children in IV-D cases assigned to the MSF. This position is responsible for more than the traditional IV-D enforcement of medical support. The MSF takes the extra step of ensuring the children are actually covered by either private medical insurance (paid for by either party, not just the NCP), Medicaid or CHP+. If private coverage is not available, the MSF assists the CP in applying for CHP+ or Medicaid for the children.

The MSF works from a list of cases known as the experimental cases. The results from the experimental cases will be compared to cases meeting the same initial criteria and placed in the control group.

It is vitally important that children have access to medical care. According to the June 2000 Medical Child Support Working Group's report to Department of Health and Human Services Secretary, Donna E. Shalala, and Department of Labor Secretary, Alexis M. Herman,

> "Of the 21 million children who are eligible for child support enforcement services [nationally], approximately 3 million are without health care coverage. These children have substantially less access to health care services, including preventive care that ensures childhood immunizations, vision and hearing screening, and dental care. Health care services are also far more likely to be delayed due to cost. Unmet health care needs reduce a child's ability to grow into a healthy and productive adult."
>
> *Medical Child Support Working Group Report, Executive Summary, p. vii, June 2000.*

This manual describes the general policies and procedures the MSF uses in the process of securing medical coverage.

3. Legal Basis

The MSF project approach diverges from the traditional medical support enforcement approach in that the MSF takes a broader role in working with both parents to secure the most appropriate health care coverage for the child(ren).

In the past, caseworkers establishing medical support orders have only looked at the health care coverage available to the NCP to determine whether health care coverage was available at a reasonable cost. If health care coverage was not available to the NCP through employment, the inquiry stopped. This project considers not only the resources of the NCP, but also the CP's options for insurance coverage.

A premise of this project is that private insurance provided by one of the parties is the ideal form of coverage. However, if private coverage is not available at a reasonable cost, the MSF seeks to ensure public health care coverage and assists the CP in completing Medicaid or CHP+ applications.

Current IV-D rules and regulations are still applicable.

(a) Federal regulations

45 C.F.R. 303.31 requires that:

- All child support orders will be established/modified to include a provision for medical support.
- All orders for medical support will be enforced when it is available through the obligor's employer and not otherwise provided.
- The IV-D agency must provide the custodial parent with information pertaining to the health insurance policy which has been secured for the dependent child(ren) pursuant to a medical support order.

45 C.F.R. 303.6 sets the following timeframes for enforcing orders for health care coverage:

- The IV-D agency must enforce an order for health care coverage:
  - Within 30 calendar days of establishing an order; or
  - Within 60 calendar days of identifying non-compliance with an order or locating the non-custodial parent—whichever occurs later.

45 CFR 303.32 requires states to use the NMSN to enforce health care coverage. The IV-D agency must send the NMSN to the employer within 2 business days of the obligor being reported to the State Directory of New Hires if the obligor is ordered to provide health care coverage. Colorado implemented use of the NMSN on July 2, 2002.

This section also requires the IV-D agency, in consultation with the custodial parent, to promptly select from available plan option when the plan administrator reports that there

is more than one option available under the plan. IV-D agencies are not expected to provide legal advice on which plan to choose.

> **Note:** If the employer does not provide health care coverage for employee dependents, there would be no need for the IV-D agency to send the NMSN for those employees. However, the IV-D agency should make an appropriate notation in the individual case record of the unavailability of health care coverage through that employer.

(b) Required State Laws

Required state laws relating to medical child support are found at 42 USC 1396g-1.

Insurance companies cannot deny enrollment of a child under the health coverage of the child's parent on the ground that **(A)** the child was born out of wedlock, **(B) t**he child is not claimed as a dependent on the parent's Federal income tax return, or **(C)** the child does not reside with the parent or in the insurer's service area. The insurer must also permit a parent to enroll any child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

Employers and insurance agencies also are required to honor enrollment applications made from the other parent or from the IV-D agency. Insurance companies are required to provide information to the custodial parent to permit the custodial parent to submit claims for covered services without the approval of the noncustodial parent; and to make payment on claims submitted.

Colorado defines at C.R.S. 14-10-115(13.5)(g) when the cost of medical coverage is deemed to be “reasonable”. Medical insurance is reasonable in Colorado if:

- the premium for health care coverage is less than 20 percent of the paying parent’s gross income, or
- the application of the premium to the guidelines results in a monthly support order of $50 or greater.

4. Process Summary

This section gives basic information about the process and steps in the MSF procedure. Specific information about how to use this process is explained in greater detail later in this manual.

The process begins when the MSF receives experimental cases from the automated case assignment. These are received weekly. The list contains both establishment and enforcement cases. After the pilot, cases may be received based on new hire hits.

Basic procedures for the MSF process are:

- Obtain case from the MSF extract;

- Look up case in HMS (unless the information is already provided in the MSF extract);
- Contact parties or their employers for coverage availability;
- If insurance is available, send the National Medical Support Notice (NMSN) to secure coverage;
- If insurance is not available, assist the CP in completing the Medicaid/CHP+ application; and
- Following up on the case to ensure coverage is continuing.

MSFs review the cases on a quarterly basis. At that time, the circumstances of the parties may have changed since the last contact. For instance:

- The CP or NCP may report that the children are no longer covered by the NCP's insurance;
- The NCP may have left the employment through which previous coverage was provided;
- The CP, based on the encouragement of the MSF, may have enrolled the children in the CP's or CP spouse's plan;
- The NCP's spouse may be providing coverage; or
- The children may now be eligible for CHP+ or Medicaid.

The changes in the details of the case over the life of the project must be recorded by the MSF to accurately evaluate the effectiveness of the project.

5. Definitions

ACSES – the automated child support enforcement system (ACSES) is the Colorado statewide computer system used to track child support cases.

Adjustment - a change in the amount of child support or an addition of or change to provisions for medical support.

CHP+ - The Child Health Plan *Plus*, Colorado's insurance program for low-income children.

C-CHAMP - The Colorado statewide computer system used in tracking CHP+ cases.

Medicaid – A federal and state health care program for low-income families and individuals and for those with severe disabilities.

National Medical Support Notice (NMSN) – the document completed by the child support office and mailed to the employer instructing the employer and the plan administrator to enroll the NCPs children in the employer's medical insurance plan.

SCHIP – States Children's Health Insurance Program. Each state has some form of an SCHIP program. In Colorado, it is the Child Health Plan *Plus*, or CHP+, program.

6. Medicaid V. CHP+

Medicaid is a federal and state healthcare program for low-income families and individuals, as well as those who have severe disabilities. It is an entitlement program, meaning that persons who qualify for Medicaid in the state in which they live are entitled to receive benefits through the program. There are some basic federal requirements each state must meet for its Medcaid program, but there are considerable differences among states in terms of benefits, populations served, coverage periods, and application and eligibility requirements. The federal government pays states a $1 match for every $1 they spend on their Medicaid programs. Medicaid rules are in Title XIX of the Social Security Act.

SCHIP, or the States Children's Health Insurance Program, is also a federal and state health care program for low-income children. It was created in 1997 as Title XXI of the Social Security Act. The federal government pays states $2 for every $1 they spend on their SCHIP program. States were given the option to expand existing Medicaid programs using SCHIP funds, or create stand-alone programs, or do a combination of the two. Colorado was the first of 14 states that chose to create a stand-alone SCHIP program. In 1997, the Colorado State Legislature created the Children's Basic Health Plan, also called the Child Health Plan *Plus* or CHP+. Children who *qualify* for Medicaid are automatically ineligible for CHP+, even if they are not currently enrolled in Medicaid. Children who have other insurance at the time of application for CHP+ and children whose parents or guardians have access to Colorado State employee benefits are also automatically ineligible for CHP+. Legal immigrants who have had an Alien Registration Number for less than five years are ineligible, as are illegal immigrants and children who do not reside in Colorado.

7. Record Keeping and Documentation

As the MSF works the cases, all activity must be documented. This is not only a federal requirement, but also a necessity for purposes of assessing the success of the pilot. By keeping accurate record of case activity and results, the State will be in a better position to determine whether the MSF role should be expanded statewide.

To capture the activity, the MSF will make updates in two places: ACSES and a data collection instrument (DCI) developed specifically for the pilot. The DCI is included as Exhibit A. The DCI was developed to capture information that was not included in ACSES. Therefore, while the MSF should not have to document the same information twice, there may be instances where a minimum amount of duplication occurs.

B. PROCESS OVERVIEW

A flowchart depicting the entire MSF process is provided in Exhibit B. Exhibit C reflects the accompanying narrative describing the steps in more detail.

The MSF completes several items on the DCI at the beginning and at the end of the process. This is to gauge how the status of the case changed during the process. This information is as follows:

Section	Item to be Recorded
A	CP's current marital status
	CP's health insurance status
	CP's income at the beginning of the project
	CP's income at the end of the project
B	NCP's current marital status
	NCP's health insurance status
	NCP's income at the beginning of the project
	NCP's income at the end of the project
C	The current status of medical coverage for the children
D	CP's employer at the beginning of the project
	CP's employer at the end of the project
E	NCP's employer at the beginning of the project
	NCP's employer at the end of the project

The MSF updates the DCI throughout the process. The items to be captured are indicated below with the process description.

C. RECEIVE THE CASE

8. Sources of cases

The MSF receives cases from two sources:

1. The MSF extract

The MSF accesses a secure website to download the caseload for the week. The Denver County MSF can access only Denver County cases. the Mesa County MSF can access

only Mesa County cases. State and PSI administrators can access both counties' cases. This spreadsheet includes:

- NCP first and last names
- NCP SIDMOD (State ID number)
- NCP employer flag (regarding employer verification status)
- CP first and last names
- CP SIDMOD (State ID number)
- CP Medicaid status (has Medicaid or does not have Medicaid)
- Household number
- Category (enforcement 1, 2, or 3; establishment 4 or 6)
- Case status (AC-active public assistance, NC-non public assistance, BC-former public assistance)
- Insurance status (current, none, pending NMSN sent, not applicable, employee not eligible)
- Insurance provider (NCP or CP)
- Medical order (NCP ordered, CP ordered, both ordered, either ordered, no order)
- All Covered (are all children in the household covered, yes or no)
- Conference date (if applicable)

The MSF also uses this website to access the data collection instrument where the MSF stores additional information regarding the case.

2. From ACSES

As a regular step in completing the medical coverage process, the MSF sets ticklers in ACSES to check on the status of a case. Cases are reviewed quarterly. A prompt from ACSES in the form of an alert tells the MSF it is time to review cases previously processed to determine if further action is required.

9. Types of cases

The experimental cases selected for the MSF are based on a set of criteria identified by the project partners. The cases meet the following criteria:

- Must be an in-state case (neither party resides or works outside of Colorado);

- Must be from either Denver or Mesa county; and
- Must have a current AC, NC, or BC open on the system.

(c) Establishment

Among the cases the MSF receives are cases in which an order for support has not yet been established. These cases must be in a category 4 or 6, with an open APA in which there has been successful service.

The MSF works with the establishment technician to ensure appropriate credit is given to the providing party when the support amount is calculated.

(d) Enforcement

MSFs also process cases in which there is an existing order for support. These enforcement cases must be a in a category 1, 2 or 3. However, category 3 cases with Medicaid are excluded from the mix. ACSES also excludes category 2 cases without a verified employer.

These cases may be eligible for a review of the support amount if the cost of providing insurance was not considered when the obligation was ordered. The order may also need to be reviewed if the language provides for the NCP to provide insurance, but the CP is actually providing the coverage.

D. DETERMINING PRIVATE COVERAGE

The first option for finding medical coverage for children is always private coverage rather than Medicaid or CHP+. Typically, one of the parents obtains private coverage through his or her employer. A step-parent may also be providing coverage.

10. HMS Information

Health Systems Management, or HMS, maintains a database of people insured by major insurance companies. As part of the MSF project, HMS performed a match of the Colorado IV-D caseload against its database of insured individuals. The MSFs will receive approximately 50 verified matches each. A verified match includes:

- An individual from the CSE database (NCP, CP or child) with current health insurance coverage;
- Specific policy and coverage information (e.g., insurance provider, major medical, dental, pharmacy, termination dates, etc.)

The MSF records in Section F of the DCI whether the information received from the data stored in ACSES was accurate, or can insert the verified data from HMS.

There were data matches performed on nearly the full Denver and Mesa County CSE caseloads. However, this demonstration project only covered HMS verifying 100 of

those matches. CSE is currently working with HMS to determine if verification will be done on the remaining matches, or if those will be sent to the MSFs for "lead" purposes only.

11. Contacting Parties and Employers

To determine the current status of insurance (already provided or available), the MSF contacts either the parties or their employers, or both. Direct contact with the parties is the best source of information, but sometimes follow-up with the employer is required. For instance, the CP may claim no coverage, but the NCP says all premiums have been paid.

When contacting the parties, the MSF may either telephone or write a letter. An in-office visit is not necessary, but may be helpful. The MSF can also either call the parties' employer or send an employment verification letter to determine whether coverage is being provided through the NCP's or CP's employer. Faxing the letter to the employer is also an option and can expedite the process, as well as saving postage costs.

Through this contact, the MSF obtains the following information:

1. Whether the children on the case are covered and, if so, which children;
2. The details of any policy information, including begin and end dates;
3. The cost to the employee of coverage with or without children;
4. If coverage has been terminated or changed, the reason for the termination or change;
5. If coverage is not available, the point at which coverage might become available; and
6. If the party has recently become unemployed, whether COBRA coverage is available.

(e) Updating ACSES

Letters are generated from the system and appointment calendars are maintained on ACSES. Any contact made with the parties or employers must be recorded in ACSES. This is completed by making a diary entry in the chronology (CHRON, or chrnadd) screen. The entry should include the name of the party contacted, what topics were discussed, and the result of the discussion.

The employer may also indicate that the NCP is not yet eligible to receive insurance, but will become eligible in 90 days from the date of hire. The MSF updates ACSES to receive a tickler in 90 days to recheck the availability of insurance at that time.

(f) Updating the MSF DCI

Any contact with the parties or their employers must be recorded in the data collection instrument (DCI). This is to gauge how much of the MSF's time is spent contacting parties and for what purpose. Any attempt to contact the CP is also

recorded to help measure success of cases when the CP is difficult to reach. The MSF completes sections A – D of the DCI to capture contact with parties and their employers.

E. SECURING PRIVATE COVERAGE

12. National Medical Support Notice (NMSN)

The National Medical Support Notice is the document completed and mailed to the employer to enroll the children in the employee's medical plan. A copy of the NMSN is found in Exhibit D. To complete the NMSN, refer to CSE Procedure 2.7. Current Colorado policy is to send NMSNs only to the NCP's employer.

Colorado does not currently enforce medical support obligations against custodial parents. Therefore, the next step after determining that private coverage is available depends on which parent is providing, or should be providing the insurance.

13. Coverage Provided by the Non-custodial Parent

If coverage is already voluntarily being provided by the NCP, the MSF must send a NMSN to the employer. If coverage is available, but not being provided, the MSF must determine whether the cost of the coverage is reasonable under Colorado statute.

The NCP (and the CP if ordered) is required to provide available insurance only if the cost of the insurance is reasonable. Colorado Statutes (C.R.S. 14-10-115(13.5)(g) define reasonable as:

1. Child's share of insurance does not exceed 20% of obligor's gross income and
2. Child's share does not result in a child support order of less than $50 per month.

In determining reasonableness, the MSF uses the on-line spreadsheet to calculate 20% of the NCP's gross income. If the child's share does exceed 20%, the MSF determines the cost of insurance is unreasonable and can stop there. If, however, the child's share does not exceed 20% of the NCP's income, the MSF uses the ACSES guidelines module to calculate whether the order would be less than $50 per month after giving appropriate credit. If the order would be less than $50 per month, the cost of insurance is unreasonable.

If coverage is **not** found to be available at a reasonable cost, the MSF treats the case as if insurance is unavailable to the NCP (or the CP).

If the cost of coverage is reasonable to the NCP, yet the CP is already providing coverage, the MSF contacts the CP to determine whether to send a NMSN to the NCP's employer to enroll the children in the NCPs insurance. The MSF works with the custodial parent to help determine the best coverage (if more than one plan is offered) based on factors such as accessibility, care continuity, and mandatory benefits.

Even if insurance is available to the NCP at a reasonable cost, the CP may already be providing coverage and may not want the NCP to provide it. The MSF must research the language of the order and determine whether the CP, NCP, both parties, or either party is

ordered to provide insurance. If the CP (or his/her spouse) is already providing coverage, but only the NCP is ordered to provide insurance and it is available to the NCP at a reasonable cost, then the CP must request a review of the order to get the language changed so that either party can provide insurance. The MSF provides the Right to Request form to the CP who has 15 days to return the request. If the CP has not requested a review within 15 days, the MSF sends the NMSN to the employer.

If the CP is not providing coverage, then the MSF mails the NMSN UNLESS one of the following apply:

a) the NCP is already under a NMSN;
b) the cost of coverage is unreasonable;
c) the insurance is not useful to the kids due to geographic restrictions; or
d) the NCP's spouse is providing insurance.

(g) Following Up with the Employer

The MSF notes the sending of the NMSN by marking it as "pending" on ACSES. This creates an automated tickler for the MSF to follow up if no response from the employer is received within 20 days. The MSF contacts the employer to determine the current status of the coverage and why no response has been received.

(h) Updating ACSES

Refer to CSE Procedure 2.7 for instructions on updating ACSES with medical support information.

(i) Updating the MSF DCI

The MSF completes the following sections of the DCI to reflect the above activity:

Section	Activity
A	Contact with the CP
C	Private coverage information
E	Contact with NCP employer
F	Verify if HMS and ACSES were accurate
G	Any consultation with the CP regarding the NMSN, or referral to the establishment or R&A technicians
H	Whether a reasonableness calculation was completed

14. Coverage provided by the Custodial Parent

The MSF contacts the CP, by telephone in most cases, to determine whether insurance coverage is available to the CP or if the children are already covered. The MSF obtains the cost of insurance to the CP and determines whether it is reasonable under Colorado statutes.

If coverage is available to the CP at a reasonable cost, the MSF encourages the CP to enroll the children. The MSF explains the benefits of coverage and that the CP is entitled to a dollar-for-dollar credit on the child support guidelines that may result in an increase in child

support. If the CP wants to pursue a modification to the support, the MSF provides the Right to Request letter to the CP. The review and adjustment technician processes the modification portion of the case.

15. Effect on the Order

Establishment Case

If the child is covered by the NCP's insurance and the case is in the establishment phase, a settlement conference with the NCP may be scheduled already. At this conference, the guideline amount for current child support is calculated and an agreed order may be entered.

The MSF makes a chronology entry regarding the cost of insurance coverage. This entry is forwarded (emailed) to the technician who will use the information to complete the guidelines calculation at the establishment conference.

Note: If the MSF knows that coverage is available (but not actually being provided) to either party, the MSF provides this information to the technician as well. Credit may be given in anticipation of actual coverage by either parent.

Enforcement Case

If a support order already exists for the case, the order may be eligible for a review based on the MSF activity in one of two ways:

1. The support amount should be reviewed after giving proper credit to the party actually providing insurance.

2. The medical ordered language should be modified to reflect that either party is responsible for providing insurance.

When speaking with the parties, the MSF clearly explains what effect the action may have on the guidelines and the support amount. If the CP wants the NMSN sent, the CP should understand that the NCP may be entitled to a review of the child support obligation that could result in a downward modification. The CP should understand that if the NMSN is not sent, the order may be modified to include language that either party should provide insurance. The child support obligation may also be adjusted to give CP credit for providing insurance.

If the order needs to be modified to reflect that either party should provide insurance or to adjust the amount of support, the MSF makes a referral to the review and adjustment technician to initiate the review process, if appropriate. Note that the child support office can initiate the review only in active foster care or public assistance cases. However, either party can also initiate the process. The MSF provides the parties with the Right to Request letter in appropriate circumstances.

Currently, many orders direct the NCP to provide insurance. Colorado now enters orders that direct either party to provide insurance. If the order directs the NCP to provide insurance but the CP is the party actually providing insurance, the order needs to be modified to change the medical support provision. If the order under review already directs either party to provide insurance, then the order doesn't need to be modified.

(j) Updating the MSF DCI

The MSF may refer the case to either the establishment or review and adjustment technician. The MSF may also provide the parties with the Right to Request letter. The MSF records this activity in Section G of the DCI.

16. Spouse as a Source

In many cases, a parties' current spouse, or the step-parent of the children, provides medical coverage for the children. If coverage of the children is available to the spouse of the CP or NCP, the MSF encourages the appropriate party to enroll the children in the available coverage. The MSF updates the DCI at Section H to record whether the spouse enrolled the children.

F. APPLYING FOR CHP+ AND/OR MEDICAID

If no option for private coverage exists, the MSF assists the CP in applying for CHP+ or Medicaid. This section explains the role of the MSF in the application process.

17. Prescreening the CP

The MSF conducts a prescreening of the CP to assess possible qualification for CHP+ or Medicaid. This prescreening can be done over the phone or in person. The prescreening consists of an extremely high-level series of questions intended to determine whether the CP ***might*** be eligible for CHP+ or Medicaid. Because the application process is quite lengthy, the prescreening is intended to avoid the application process if it is clear the CP is ineligible.

The MSF observes the following guidelines in determining whether the CP should complete an application:

1. Does the CP or his/her children own any assets such as a home, a car, or a savings account? If so, is the equity value of the asset more than $1,000?
2. Are the CP's children U.S. citizens or have they had an Alien Registration Number for at least five years?
3. If neither the CP or his/her children own any assets worth more than the above amount, and if the CP or his/her children have little or no income, and if the children are U.S. citizens, they are probably qualified for Medicaid.
4. How many children live in the CP's home? (A)
5. How many parents, guardians live in the CP's home? (B)
6. Add A + B to determine family size. Does the CP's current household income and family size fall at or below the figures in this table? (Note: All members living in the household that are related by blood or marriage are considered as part of the "family" for calculating CHP+ household income.)

Note: Certain expenses may be deducted from a family's gross income, so families can make more than this and still qualify for CHP+.[1]			
Family Size	**Monthly Income**	**Family Size**	**Monthly Income**
1	$1,384	4	$2,836
2	$1,868	5	$3,320
3	$2,352	6	$3,804

[1] Deductions may be taken for the following:

- Money you pay a child care center/home or relative to take care of your child or parent;
- Money that *you pay* in child support or alimony
- Money you pay for health insurance for yourself or your spouse through your job, or
- Money you pay for current medical or dental bills for someone in your family.

Based on the responses the CP provides in the prescreening, the MSF assesses the likelihood of qualification for Medicaid or CHP+. If the CP does not appear to be eligible for either Medicaid or CHP+, the case is placed in a monitoring status and will be reviewed again in three months.

If the CP is probably eligible for Medicaid or CHP+, the MSF proceeds with the application process. If the CP does not appear eligible, the MSF places the case in a monitoring mode and checks the case in three months to determine if the circumstances have changed.

(k) Updating the MSF DCI

The MSF completes section A, question 12 when the CP is pre-screened. This is to track the effectiveness of the pre-screening step and whether it is successful in avoiding completing applications that are later denied.

18. Completing the Application

If the CP appears to be eligible for either CHP+ or Medicaid, the MSF either mails the application to the CP, or schedules an interview for the CP to meet with the MSF to complete the application together. Exhibit E contains a checklist for the MSF to follow to ensure the application is completed correctly.

Application Mailed

When the MSF mails the CP the application, the MSF sets a tickler in ACSES for ***15 days***. If 15 days have passed since the application was mailed and the application has not been returned, ACSES sends the alert to the technician assigned to the case. The technician then forwards the alert to the MSF.

The MSF contacts the CP to determine the status of the application. The MSF ensures the CP received the application, advises the CP of the benefits of medical coverage for the children, and encourages the CP to complete the application.

When the application is returned, the MSF updates ACSES to indicate it has been returned and then reviews the application to check for completeness and accuracy. The MSF ensures all aspects of the application are completed correctly before forwarding the application to the Medicaid/CHP+ office. If the MSF needs additional information, the MSF contacts the CP by telephone.

Interview Set

If the CP is scheduled to come to the office to complete the application, notify the CP in advance of all required documents necessary for completing the application. These include:

- Paystubs or employer letter showing ALL FAMILY income for the previous month (except income from children age 18 and under). For example, if CP applies in March, he/she needs to show all paystubs with a check date in February. If CP gets paid weekly, he/she must provide paystubs for EACH WEEK in February.
- If CP is married, CP must also provide paystubs from spouse.

(l) Updating ACSES

All activity must be recorded in ACSES. Appointments are set using ACSES.

(m) Updating the MSF DCI

The MSF tracks response rates based on the method of outreach. If the application was mailed, the MSF completes Section A of the DCI, including question 13.

19. Tracking the Application

After reviewing the application, the MSF forwards the Medicaid/CHP+ application to the either the Medicaid or CHP+ office for processing.

Send to Medicaid
If the MSF determines the CP has no income and no assets, the MSF sends the application to the appropriate county Medicaid office. The MSF sets a ticker for 30 days if sent to the Medicaid office to see if coverage has been approved.

Send to CHP
If the MSF is not sure of eligibility, the MSF sends it to the CHP+ office who conducts a pre-screen for Medicaid. If the CHP+ office believes the case is Medicaid eligible, the case goes to their internal Medicaid techs.

The MSF sets a ticker for 15 days if sent to the CHP+ office to see if coverage has been approved.

Coverage Approval
If Medicaid is approved for the family, ACSES is automatically updated with this information. For CHP+ approval, the MSF looks the case up on C-CHAMPS. The MSF will monitor the case as necessary. This means reviewing for potential private coverage on a quarterly basis. The MSF sets a tickler on ACSES for 90 days out.

Coverage Denial
If the family is denied Medicaid or CHP+ coverage, the MSF reviews the case in 90 days to assess for possible eligibility at that time. If the CP calls the MSF and requests assistance before the 90 days is up, the MSF works with the family to improve their chances of approval.

(n) Updating the MSF DCI

The MSF records the details of coverage, or denial, for the children in Section C of the DCI. The MSF also captures in Section A whether the CP was approved or denied after a prescreening.

G. QUARTERLY MONITORING

The action taken at quarterly intervals depends on the last status of medical coverage for the family.

- If the children are covered by private insurance, the MSF doesn't need to do anything. The MSF will be alerted to a lapse in coverage through the weekly extract, or based on a phone call from one of the parties, or from the employer or from the technician on the case.
- In appropriate cases, such as where the NCP is paying premiums that are not through the employer, the MSF telephones the provider to see if premiums are being paid and coverage is maintained.
- If the children become enrolled in Medicaid or CHP+, the MSF repeats the entire process on a quarterly basis.

Performance. Service. Integrity.

Appendix II
Data Collection Instrument

Data Collection Items for Medical Support Facilitator to Record

Date Started:		**Date Finished:**		**Quarterly Review Date:**	
Household Number:					

A. CP Information:

	Married	Divorced	Separated	Never Married	Widowed
1. CP's Current Marital Status: *(place X)*					

	Medicaid	Private
2. CP's Health Insurance Status:		

3. Income at beginning of project:	
4. Income at end of project:	

	Date	In person	Mail	Telephone	Purpose	Successful? (Y/N/)
5. Date of Contact with CP:						
6. Date of Contact with CP:						
7. Date of Contact with CP:						
8. Date of Contact with CP:						
9. Date of Contact with CP:						

	Yes	No
10. Did you ever schedule a meeting with CP in which the CP failed to appear or reschedule?		

~~**11.** Number of attempted, ***but unsuccessful*** , contacts with CP:~~

	Yes	No
12. Did you conduct a pre-screening for CHP+ or Medicaid eligibility?		
a. If so, did you determine the CP was probably eligible?		
b. If you did determine CP was probably eligible, was she eventually approved?		
c. If you did not determine the CP was probably eligible, why not?		

13. CHP+/Medicaid Application Process – **only complete if application was MAILED**

Date mailed	Person mailed to	Return date (also indicate if not returned)	Follow-up needed due to errors?

B. NCP Information:

	Married	Divorced	Separated	Never Married	Widowed
14. NCP's Current Marital Status: *(place X)*					

	Medicaid	Private
15. NCP's Health Insurance Status:		

16. Income at beginning of projec

17. Income at end of project:

	Date	In person	Mail	Telephone	Purpose	Successful? (Y/N)
18. Date of Contact with NCP:						
19. Date of Contact with NCP:						
20. Date of Contact with NCP:						
21. Date of Contact with NCP:						

~~**22.** Monthly Cost for Employee Coverage:~~ _____

~~**23.** Additional Monthly Cost for Dependent Children Coverage:~~ _____

C. Children Coverage Information

	Child 1	Child 2	Child 3	Child 4	Child 5
NAME					
CHP+					
Application Date					
Rejected/ Approved date					
Rejection reasons					
Start date					
End Date					
Medicaid					
Application Date					
Rejected/ Approved date					
Start date					
End Date					
Private					
Medical					
Dental					
Vision					
Medical Begin date					
Medical end date					
Medical Termination of Private Coverage Explanation					
Change in Medical Coverage: Date and Explain					

D. CP Employer Information:

	Yes	No
24. Is CP Employed at the beginning of the project?		

25. Employer at the end of the project:

	Date	In person	Mail	Telephone	Purpose	Successful? (Y/N/)
26. Date of Contact with er:						
27. Date of Contact with er:						
28. Date of Contact with er:						

29. Monthly Cost for Employee Coverage:		
30. Additional Monthly Cost for Dependent Children Coverage:		

E. NCP Employer Information:

	Yes	No
31. Is NCP employed at the beginning of the project?		

32. Employer at the end of the project:

	Date	In person	Mail	Telephone	Purpose	Successful? (Y/N/)
33. Date of Contact with er:						
34. Date of Contact with er:						
35. Date of Contact with er:						

36. Monthly Cost for Employee Coverage:		
37. Additional Monthly Cost for Dependent Children Coverage:		

F. Private Insurance Status and Verification

38. Private Insurance Identified in HMS Match:

	Yes	No	Date	How verified
a. Is the child really covered?				

39. Private Insurance Identified in ACSES:

	Yes	No	Date	How verified
a. Is the child really covered?				

G. Actions by MSF

	Yes	No	Date
40. Did you consult with CP regarding whether to send the NMSN?			

a. If so, what was the decision?

b. If NMSN was not sent, what were the reasons?

	Yes	No	Date
41. Did you make a referral to R&A?			

	Yes	No	Date
42. Did you provide one of the parties with a Right to Request a Review letter?			

	Yes	No	Date
43. Did you send information to the establishment technician for use at a settlement conference?			

H. Results

	Yes	No
44. If you encouraged the CP to enroll the children, did enrollment actually occur?		

	Yes	No
45. If you encouraged the spouse (step parent) to enroll the children, did enrollment actually occur?		

	Yes	No
46. Did you complete a reasonableness calculation for the NCP?		

	Yes	No
a. If so, was the cost of coverage determined to be unreasonable?		

b. Attach copy of calculation (if guidelines were completed)

Cost of insurance as percentage of NCP income: **#VALUE!**

I. Other

	Yes	No
47. Is either party ordered to provide medical support?		

	CP	NCP	Both	Either
a. If so, which party is ordered to provide it?				

	Yes	No
48. Are children currently covered by NCP or NCP's spouse?		

	Yes	No
49. Are children currently covered by CP or CP's spouse?		

	Yes	No
50. Is medical insurance available through NCP's employer?		
a. If available and not provided, what is the reason?		
not eligible		
not reasonable		
not ordered		

	Yes	No
51. Is the NCP incarcerated?		