Evaluation of Strategies to Improve Medical Support Enforcement in Washington State

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INTRODUCTION

As part of their monthly child support obligations, the State of Washington orders most non-custodial parents (NCPs) to enroll their dependent children in a private medical insurance plan if the NCP has access to one at a reasonable cost. Enforcing these medical support orders (medical support enforcement) is among the most complicated task performed by Washington's Division of Child Support (DCS). For most caseworkers—in Washington known as Support Enforcement Officers (SEOs)—medical enforcement is less emphasized than the collection of cash support. This is due, in part, to the federal government's relatively new performance measurement system, which emphasizes dollars collected for child support and has no corresponding performance measure for medical support. Over the years, the State has developed training programs and work processes designed to improve medical support enforcement. However, State officials believe most Washington SEOs still lack the special expertise needed to effectively enforce the complex obligations.

Given these inherent complexities and barriers that face medical support enforcement, Washington's IV-D officials have long considered devoting a special and separate effort to medical support enforcement. Broadly, this report's purpose is to describe Washington's efforts to address medical support enforcement and analyze initial results. Specifically, the two related approaches to improve medical support enforcement involve:

- **Creating a Headquarters Medical Unit (HMU)**, using existing staff of the IV-D division. This approach subscribes to the general hypothesis that a centralized approach to medical support would be more effective and efficient than the current process, which leaves enforcement in the hands of 800 individual SEOs across the state.

- **Contracting with private vendors to conduct matches of child support and health insurance records.** Through this intervention, the State shared child support records with two competing private vendors. The vendors searched their own proprietary databases to determine whether they could find active, or recently terminated, health insurance policies held by the cases' NCPs. After verifying matches between the child support records and their databases, the vendors returned a list of potentially enforceable insurance policies.

By exploring the costs and benefits of centralization and data matches, the Washington IV-D division has two overarching program objectives in mind: 1) enrolling more children in private medical insurance plans, and 2) ensuring that private insurers are covering healthcare costs, wherever appropriate, for medical

support eligible children, which should directly reduce claims on the State's Medicaid program.

Each of the demonstrations involved random assignment of treatment and control cases. DCS selected 2,000 cases from the Fife field office for centralized HMU enforcement, which took place during February-October 2003. DCS identified 2,000 control cases from Fife that received standard medical support enforcement from Fife SEOs. For the data matching demonstration, DCS drew randomly from the statewide caseload and created three sets of 4,000 cases with orders for support. DCS sent 4,000 cases to each of the two competing private vendors. DCS used the remaining 4,000 cases as controls.

STATUS QUO MEDICAL SUPPORT ENFORCEMENT

A key to this evaluation is an understanding of the status quo enforcement processes that the two demonstrated strategies are designed to complement or replace. This report provides a detailed discussion of the State's current medical support enforcement efforts and the common challenges voiced by SEOs.

The enforcement of medical support in Washington State requires efforts from both the Division of Child Support (DCS) and the Medicaid agency's Coordination of Benefits (COB) office. DCS is responsible for establishing and enforcing the medical support obligations. Since 1989, nearly all child support obligations in the State include an obligation that the NCP provide medical support—a responsibility that the NCP often shares with the custodial parent. Through complementary activities, both DCS and COB identify Medicaid-eligible children who are enrolled—or could be enrolled—in a non-custodial parent's health insurance policy. If DCS successfully enrolls a Medicaid-eligible child in an NCP's health insurance policy, COB coordinates the payments of medical claims to ensure that the newly discovered private insurer becomes the primary payer for the medical services covered by their policy.

In interviews, SEOs noted a number of factors that complicate the medical support enforcement process:

- **Fiscal incentive to pursue medical support is weak.** The collection of child support dollars is specifically emphasized through federal performance measures, while medical support is not. These cases may receive less attention until the federal or state government develops a clear, measurable performance measure.

- **Washington's premium limits reduce opportunities for enforcement.** In Washington, the amount of child support that goes to medical coverage generally cannot exceed 25 percent of withholdings for current support.[1] In

[1] Although most of the Washington orders contain the 25% limit, the law does allow the court to order health insurance coverage even if the cost exceeds 25% of the basic child support obligation. A few Washington orders contain that exception.

interviews, SEOs noted that NCP wages are frequently insufficient to provide health insurance given this limit.

- **NCPs change jobs frequently.** Frequent job changes result in more work for SEOs who must keep track of the withholding notices sent to employers, and more changes to insurance eligibility for dependents. Because insurance is often available for employees only after a waiting period, it can also mean less time eligible for insurance when it is available.

- **Within jobs, insurance changes frequently--especially in union jobs.** SEOs reported that eligibility and coverage policies change frequently, even when the NCP does not change jobs. In some union jobs, an employee's insurance eligibility is contingent on the number of hours worked in a given month.

- **Number of insurers is large and constantly changing**. The sheer number of insurers in a state presents a challenge to the IV-D division. A single insurer may have a number of different agents or plans, and in order to successfully recover paid medical expenses, the IV-D caseworker needs to pinpoint the precise type of coverage.

Through interviews with SEOs, most agreed they act on the medical support aspect of a case only when they discover that a NCP has a new job, which requires sending the employer the National Medical Support Notice. Within the first few weeks of the NCP's new job, the SEO typically determines whether the NCP's employer offers affordable insurance or not. Once the SEO makes that determination, he rarely considers medical support for the case until the NCP changes jobs again. SEOs estimated that the medical support enforcement function represented five percent or less of their overall workloads.

SEOs recognized a number of factors that could change the availability of health coverage, including the expiration of waiting periods for insurance, an employer's decision to change insurers, temporary lapses in coverage because of hours worked, and wage increases. Employers would not report changes in any of these factors to SEOs.

FINDINGS FOR THE HMU

BACKGROUND

The HMU operated on the premise that the dynamic nature of NCP employment and associated changes in health insurance made enforcement of medical support different from (and often more challenging than) other aspects of child support enforcement. The experiment involved a total of 4,000 randomly selected cases from the Fife office. These 4,000 were randomly assigned into treatment (HMU) and control (standard enforcement) groups.

The HMU staff consisted of one Support Enforcement Officer (SEO), two Support Enforcement Technicians (SET), and one part-time supervisor. The HMU operated from the Division of Child Support's headquarters office in Olympia. The HMU conducted a universal, rather than a targeted, review of child support cases. To be eligible for the demonstration, a case had to have a child support order. A targeted approach could have limited the HMU reviews to cases with medical support orders, or cases with wage withholding in place, or cases in which a child is enrolled in Medicaid. Program designers opted for the more universal approach to ensure equitable medical support enforcement across the entire caseload.

WORK PROCESSES AND OUTCOMES

Specifically, DCS charged the HMU with two tasks:

- **Assess the accuracy of medical support enforcement data.** Given the likelihood of federal performance measures on medical support, DCS directed the HMU staff to assess the accuracy of data related to medical support in the State's management information system.

  During February-October 2003, the HMU reviewed data for each of the treatment cases and found inaccuracies in roughly half. Some of the inaccuracies related to the most basic aspects of data about a case, such as the type of case (TANF, Medicaid, Nonassistance) under review. Other changes related to the more basic medical support enforcement tasks, including updating information about medical forms that had been sent to and received from employers.

- **Review cases for existing or potential health coverage.** The HMU's core purpose was to identify cases in which an NCP had health insurance available through an employer or union. The HMU would determine if the coverage was available for dependents and, if so, at what cost. Given the project's overarching goal of generating Medicaid savings, cases that involved a Medicaid-eligible child were of particular interest.

  Through intensive case-by-case reviews, the unit separated the treatment cases into four broad groups:[2]

  1. *Permanently unenforceable cases*. 631 cases were unenforceable either because the NCP was not obligated to provide support or the child was no longer on the case.

[2] The numbers above total 2,027 rather than 2,000 (the number of cases that the HMU reviewed). This is because the base unit of analysis that the HMU used for their work was the number of NCPs in the treatment group (2,027) rather than the number of custodial parent/child pairings (2,000). Since an NCP can be involved in more than one case at any given time (i.e., can have children with more than one custodial parent), the total is higher when based on NCP/child pairings than when based on custodial parent/child pairings.

2. *Temporarily unenforceable cases.* 718 cases were not meeting enforceable obligations for reasons already known to DCS (e.g., NCP was unemployed, incarcerated, or did not have health insurance available through an employer at reasonable cost). Cases required a change in circumstances (e.g., new job, wage increase, release from jail) before the NCP could meet his or her obligation.

3. *Cases meeting medical support obligations*. 334 cases involved an NCP who had a dependent child enrolled in third-party insurance coverage.

4. *Cases warranting an enforcement action*. 344 cases warranted an enforcement action because a) an active order was in place and b) DCS did *not* know why the NCP was failing to provide medical support. For these cases, HMU sent notices to employers to explore the availability of medical support. DCS uncovered new insurance information for 127 cases. Of those 127 cases, 53 involved a Medicaid-eligible child.

The number of cases with the potential to generate Medicaid savings (53 of 2,027) was small but perhaps not surprising. The challenges facing the HMU are similar to those that routinely face medical support initiatives across the country. The HMU attempted to identify NCPs with stable, good paying jobs with health coverage, who are associated with children who are not only enrolled in Medicaid but used its services. The HMU impacts suggest that combination is exceedingly rare. Challenging the unit's success further is Washington's limit on premiums, which negates the medical support obligation if the cost of available coverage exceeds 25 percent of the NCP's basic child support obligation. As growth in health insurance premiums has outstripped wage growth in recent years, the premium limit affects a growing share of the agency's cases.

Over the 10 quarters following the HMU experiment, the formal impact study indicates that the HMU shows some promise for increasing enrollment in third party coverage and may somewhat lower Medicaid claims paid. The effort did not, however, translate into lower Medicaid enrollment rates.

CONCLUSIONS AND RECOMMENDATIONS

The findings argue against the implementation of a statewide HMU in the form it took during the demonstration. The unit's very broad scope, which addressed all cases with orders for cash support, is unlikely to prove cost-effective. Moreover, any medical support enforcement strategy—centralized or not—will struggle to produce benefits if the State's premium limit remains in place.

If DCS is interested in pursuing the HMU concept in another form, the State should consider the following recommendations:

- **Delay implementation until complementary medical support reforms are in place**. Washington's limit on premiums (25 percent of the basic support obligation) restricts opportunities for medical support enforcement and will limit the impacts of any enforcement strategy. Complementary medical support reforms, including the conversion of medical support to cash or allowing NCPs to contribute to Medicaid or SCHIP premiums, could improve the cost-effectiveness of an HMU or other intensive efforts to enforce medical support.

- **Target cases for review.** The number of caseworkers required to staff the HMU could be reduced if they reviewed only a targeted set of cases. Our probability analysis suggests the likelihood of discovering third-party coverage increases for cases in which the NCP has an order in excess of $300 per month. If Medicaid savings remains the goal, DCS should target current and former TANF cases, which are much more likely to involve a child who is, or has been, Medicaid eligible.

- **Define and prioritize the primary goals of the HMU.** It is important to note that targeting a particular case population might not lead to increased Medicaid recoupments because there is limited overlap between NCPs who have dependents on Medicaid and NCPs who have access to private medical insurance. This points to the larger question of defining the goals of medical support enforcement in Washington State. Will the HMU seek to reduce costs to Medicaid? Or will its goal be to increase the number of children who are enrolled in private insurance? The HMU will be structured differently—and target a different set of cases—depending on the goal they attempt to achieve.

- **Address mail separation problems.** Much of the confusion between the Fife field office and the HMU can be traced to the fact that the current mail routing system cannot send incoming mail to more than one place. Consequently, HMU staff would mail medical support notices and the field office staff would receive replies. Upgrading to a centralized mail imaging system that would allow mail to be routed to multiple recipients would be a critical prerequisite to successful implementation of the HMU.

- **Implement the HMU in phases.** The HMU intervention was not intended to identify all of the potential problems that could arise with full-scale implementation, nor to find solutions to the problems that did arise. Additionally, there will be a learning curve for both HMU and field office staff during the first phases of implementation. New problems would almost certainly arise during full-scale implementation that would require time and effort to address. Working with field offices one at a time to bring them into the process would smooth the transition. Since the Fife field office already has some experience with HMU activities, it would be a logical starting place. Other field offices could be brought in incrementally to allow time for training and development of an efficient work flow.

FINDINGS FOR THE DATA MATCHES WITH PRIVATE VENDORS

BACKGROUND

Washington's second demonstration involved matching data with private companies that maintain large, national-scale databases on health insurance coverage for individuals. As with the HMU, the goal of the data match was to find NCPs who either have enrolled—or could enroll—Medicaid-eligible children in third-party insurance plans. The strategy assumes that the matching process provides a quick and efficient method to update the health insurance status of a large volume of NCPs.

In this demonstration, the State of Washington contracted with two private vendors: Public Consulting Group (PCG) and Health Management Systems (HMS). Each company provides medical support services to a number of child support agencies across the country, providing services that range from data matching to comprehensive medical support enforcement. Washington limited the scope of this demonstration to data matching. Under the terms of their contracts, each vendor received 4,000 cases drawn randomly from the statewide caseload of cases with orders for cash support. In addition, the State established a control group of 4,000 randomly selected cases that received standard medical support enforcement through SEOs in field offices across the state.

VENDOR MATCHING PROCESSES

The State transferred the data to the vendors in March 2004, and the vendors returned the matched data during June-July 2004. Key implementations issues included:

- **One-time match with state was atypical for the vendors**. In most contracts, vendors maintain an ongoing relationship with their clients; matches can occur quarterly, monthly, or even weekly, depending on the needs of the clients. This ongoing relationship allows vendors to continually refine both their databases and those of their clients so that, over time, results might improve. Also, as part of the research methodology, the State did not share its own medical support information with the vendors. Consequently, in a number of cases, the vendors were providing insurance information that was already known to DCS, COB, or both. While this practice would make no sense under an on-going relationship with the vendors, the State viewed the approach as a check of vendors' accuracy, as well as the quality of the DCS medical databases.

- **Neither vendor had a significant representation of Washington insurers in its database prior to the demonstration**. **Efforts to incorporate Washington insurance information varied by vendor**. With few or no Washington insurers in their databases, vendors were required to establish new relationships and exchange data with local insurers if they wanted Washington data. PCG started to forge such

relationships but ultimately deemed the effort infeasible given the demonstration's abbreviated timeframe. When it conducted its matches, PCG's database included two of Washington's Top 20 insurers (United Health Care, Aetna Life) that together wrote only 2.4 percent of health premiums in the state. By contrast, HMS incorporated data from the state's top four insurers (Premera Blue Cross, Regence Blue Shield, Group Health Cooperative, and PacificCare of Washington), which together wrote 71 percent of premiums.

- **Data format and definition of a "match or hit" differed by vendor**. The vendors had different ways of reporting data that drove their respective definitions of a "match". PCG's data were *child-centered*, and generally each child had no more than one match. By contrast, HMS data were *policy-centered* and a single insurance policy could generate multiple matches—one for each individual covered by the policy. Consequently, if the two vendors were working from identical insurance databases, HMS's method of reporting should systematically generate more matches. The DCS analyst charged with processing the data found PCG's child-centered reporting method considerably easier to work with.

- **Given their different definitions of a match, incorporation of Washington insurers, and other work processes, the number of matches generated by the vendors differed substantially**. HMS returned a database with 4,982 lines of information. PGC returned a database with 2,403 lines of information.

DCS PROCESSING OF MATCHED DATA

Once the two vendors created and verified their respective data matches, DCS had to determine how to put the new information to use. Under the Washington contract, the vendors delivered a disk that contained a list of cases with new insurance information. Shortly before the vendors delivered their findings, DCS hired a medical support specialist to process the vendor data. This DCS employee spent 586 hours analyzing each "match" individually to determine whether the information was accurate and whether it was actually new information for DCS and for COB. Although DCS's processing of the vendor records differed in some details, it generally included the following steps:

- **Step 1: Isolate information on active policies for major medical coverage held by non-custodial parents**. DCS requested and received a sizable quantity of data that it ultimately did not use intensively. DCS set aside most information on policies that were terminated or that limited coverage to vision, pharmacy, or dental services. DCS also set aside policies held by custodial parents. Historically, DCS has not enforced medical support obligations against the custodial parent. After this step, the residual matches represented active policies for major medical

coverage held by non-custodial parents. PCG had 373 matches in the category; HMS had 1,312.

- **Step 2: Refer NCPs with active policies but non-enrolled children to field staff**. PCG and HMS each identified cases in which the NCP held an insurance policy but had not enrolled dependent children. The DCS analyst referred the cases (65 cases identified by PCG and 60 identified by HMS) to enforcement staff in DCS field offices.

- **Step 3: Set aside lines with duplicate, erroneous, or outdated information**. Each vendor provided some duplicate information. Moreover, both vendors provided information on some policies held by "unknown" individuals who ultimately turned out to be custodial parents, grandparents, or stepparents. In addition, some records related to individuals who were formerly dependent children but had since been emancipated. Finally, some of the information related to individuals in other states who happened to share names and birthdays with Washington IV-D case members and were erroneously matched. Once DCS removed duplicate, erroneous, and outdated data, PCG's number of matches deemed useful fell to 268; HMS's fell to 864.

- **Step 4: Set aside lines already known by DCS or COB**. By the demonstration's design, the State did not share its own insurance information (known by either DCS or COB) with the vendors prior to the data match, so all parties anticipated the vendors would return insurance information that was already known to the State. When DCS separated those "known" matches, PCG was left with 96 matches and HMS with 349.

- **Isolate cases with a Medicaid-eligible child.** Given the goal of Medicaid savings, DCS was primarily interested in identifying insurance coverage for children enrolled in Medicaid. When DCS screened the matches for current Medicaid eligibility status, only 17 PCG matches and 28 HMS remained. This step closed the gap between the PCG and HMS outcomes, suggesting that, while HMS's efforts to include more Washington insurers generated more matches, a sizeable share of those additional matches were associated with non-Medicaid children.

CONCLUSIONS AND RECOMMENDATIONS

While one of the vendors showed some success with increasing third party coverage, overall, the vendor experiment did not result in measurable Medicaid savings, a reduction in Medicaid claims, or a substantial increase in third party coverage.

The data matching demonstration provided DCS with a relatively inexpensive introduction to a strategy used by a number of other states. Both DCS and the two vendors faced a number of challenges in implementation that limited the

effectiveness of this first attempt to match medical records. With the experience behind them, all parties involved would have a much clearer sense of how to operate if they attempted to match data in Washington again. DCS would know better what data they should ask and pay for. The vendors would benefit from an introduction to Washington insurers and the State's legal and regulatory climate as it relates to accessing health insurance.

In addition to the implementation challenges discussed above, two key factors will restrict impacts. First, the data match experiment ran into the same truism of medical support enforcement that hindered the HMU: NCPs who have both access to health insurance and Medicaid-eligible dependents are a rare find. Second, Washington's premium limit creates an additional condition for success: the NCP must not only have access to insurance but must also have a sizable order for cash support.

The following findings are evident from review of the vendors' results and from descriptions of the processes employed by the vendors and DCS.

- **Implementing a statewide data match with either of the vendors involved in this experiment would probably not result in substantial Medicaid savings for Washington State.** With a more targeted approach (described in more detail in later bullets), more success might be achieved.

- DCS's broad request for data made sense for a demonstration but would likely never prove cost-effective under on-going implementation. In their first interactions, the vendors were eager to provide, and DCS was eager to see, the full complement of data related to all the demonstration cases. As a consequence, the vendors provided large quantities of data that DCS quickly dismissed, including major medical policies held by custodial parents and policies that were either terminated or that covered limited services (e.g., vision, pharmacy, and dental). The $20,000 cap on payments essentially provided a risk-free means for DCS to explore the utility of the range of data that the vendors could return.

  Should DCS consider a second engagement with either vendor, the agency should narrow its focus considerably. First, DCS should not request data that it does not anticipate using. Under current practice, DCS does not enforce medical support against custodial parents. Eliminating that information from the matching process would lower costs and ease DCS's post-match processing effort. Second, in any future matching efforts, DCS should share its own information with vendors, which would further reduce the number of matches returned.

- **No industry standard exists for reporting data or for the definition of a match; conflicting definitions of a match contributed to difficulties in analyzing the vendors' results**. The vendors had

different ways of reporting data that drove their respective definitions of a "match". Given their different reporting methods and match definitions, applying identical per-match contract terms to both vendors made no sense. In future matching relationships with these vendors or any others, DCS should work carefully, in advance of writing the contract, to determine precisely how data are reported. As the client, DCS should be able to dictate how data are organized and, given the definition, how much it is willing to pay for each piece of information.

- **DCS failed to anticipate the scope and complexity of the post-match task of analyzing the vendor data.** However, a mid-project adjustment resulted in competent review of vendor data. At the outset of the demonstration, the DCS had not foreseen the necessity of processing and analyzing the vendor matches. In a mid-project adjustment, DCS elected to process the matches centrally, using a single SEO, full time over a three-month period. Processing of matched data is a common problem. In other states, the vendors have overcome the problem by developing methods to directly download insurance information into state management information systems or by providing staff to enter the data.

  By DCS's assessment, the individual selected to process the vendors' matches was among the most knowledgeable medical support SEOs in the state. Notes and records suggest the SEO implemented a highly detailed and rigorous review of the matches, and the SEO's role proved critical to the demonstration. DCS could have further expedited the post-match review by training the SEO in the use of database software (e.g., Microsoft Access), which would have simplified data analysis.

- **Matched data from the two vendors varied in their quality and ease of use; however, the ultimate results were similar.** Though HMS's database was more representative of the insured population in Washington State than was PCG's, it also contained far more errors and duplicate information. In the end, however, the number of lines of information that were useful to DCS was very similar. This suggests that increased efforts to find the target population may ultimately be ineffective.

Chapter 1 Introduction

BACKGROUND

As part of their monthly child support obligations, the State of Washington orders most non-custodial parents (NCP) to enroll their dependent children in a private medical insurance plan if the NCP has access to one at a reasonable cost. Enforcing these medical support orders (medical support enforcement) is among the most complicated tasks performed by Washington's Division of Child Support (DCS). For most caseworkers—in Washington known as Support Enforcement Officers (SEOs)—medical enforcement is less emphasized than the collection of cash support. This is due, in part, to the federal government's relatively new performance measure system, which emphasizes dollars collected for child support and has no corresponding performance measure for medical support. Over the years, the State has developed training programs and work processes designed to improve medical support enforcement. However, State officials believe most Washington SEOs still lack the special expertise needed to effectively enforce the complex obligations.

At the same time, medical support has become increasingly important to DCS's key mission and goals as well as to the State of Washington.

- **Medical cost avoidance has taken on an added importance as Temporary Assistance for Needy Families (TANF) recoupments have declined**. The child support program's ability to save money has fostered its political support. For years, a key goal of child support enforcement was the reduction, or recoupments, of cash assistance payments (Aid to Families with Dependent Children, and later TANF). Washington's welfare reform has greatly reduced the state's cash assistance rolls; current TANF collections represent only 7 percent of total collections in Washington State. To some observers, the loss of related TANF savings has eliminated one of the important advantages of, and arguments for, funding child support enforcement.

- **With the potential for TANF recoveries greatly diminished, medical insurance recoveries on Medicaid cases may represent an important source of revenue**. A key function of medical support enforcement involves identifying instances in which a non-custodial parent has either enrolled a child under a health insurance plan or could enroll a child at a reasonable cost. In either of these cases, the goal of enforcement is to ensure a child has private health coverage, wherever appropriate, and that the private insurer is reimbursing healthcare providers for all their appropriate claims. By linking children to appropriate private coverage, the State reduces claims to its Medicaid program (for those children who are Medicaid-eligible).

- **Rapidly rising medical costs have increased State Medicaid expenditures**. Recent growth in per capita spending on health care has outstripped inflation almost twofold. In Washington, growth has been particularly strong in the Medicaid program, which is funded in equal parts by the federal and state governments. In the current fiscal year, Medicaid spending represents approximately 16 percent of the total state budget—policymakers are now considering changes that would reduce benefit levels. Any efficiencies or savings that do not require reductions in service (like medical support savings) would be noticed and appreciated by policymakers and budget overseers in these difficult budget times.

- **Federal government will likely add a measure to track and reward state performance on medical support enforcement**. The federal government sets targets for SEOs regarding monetary recoveries for child support, tying performance incentives to their degree of success in reaching those targets. The US Department of Health and Human Services has been considering the addition of a new performance measure that sets goals for medical support enforcement.

While the potential benefits of increased medical support recoupments are great, child support experts have long recognized medical support as particularly difficult to enforce. At least three factors contribute to the area's inherent complexity:

- **High job turnover among non-custodial parents (NCPs).** As with all aspects of child support, medical support is more difficult in cases in which a non-custodial parent changes jobs frequently. The Office of Child Support Enforcement (OCSE) analyses of new hire data indicate that only 15-20 percent of parents with new withholding orders retain the same job and withholding order 12 months later. As parents change jobs, health insurance status changes too.

- **Changing coverage with a single employer**. Even if an NCP does not change jobs, it's possible, perhaps even likely, that his or her health provider will change occasionally. As medical costs have risen sharply, many employers have resorted to switching insurers frequently in order to keep costs down. If employers do not notify the IV-D division of changes, medical support records become out of date and inaccurate, making recoveries difficult and in some cases impossible.

- **Large number of insurers**. The sheer number of insurers in a state presents a challenge to the IV-D division. A single insurer may have a number of different agents and plans. In order to successfully recover paid medical expenses, the IV-D caseworker needs to pinpoint the precise type of coverage and billing center.

Given these inherent complexities and barriers that face medical support enforcement, Washington's IV-D officials have long considered devoting a special and separate effort to medical support enforcement. Broadly, this project's

purpose is to describe Washington's efforts to address medical support enforcement and analyze initial results.

THE DEMONSTRATIONS

Washington implemented two efforts to establish and collect medical support. The two related approaches to improve medical support enforcement involve:

- **Creating a Headquarters Medical Unit (HMU)**, using existing staff of the IV-D division. This approach subscribes to the general hypothesis that a centralized approach to medical support would be more effective and efficient than the current processes, which leave enforcement in the hands of 800 individual SEOs across the state.

- **Contracting with private vendors to conduct matches of child support and health insurance records.** Through this intervention, the State shared child support records with two, competing private vendors. The vendors searched their own proprietary databases to determine whether they could find active, or recently terminated, health insurance policies held by the cases' NCPs. After verifying matches between the child support records and their databases, the vendors returned a list of potentially enforceable insurance policies.

By exploring the costs and benefits of centralization and data matches, the Washington IV-D division has two overarching program objectives in mind:

1. Enrolling more children in private medical insurance plans, and

2. Ensuring private insurers are covering healthcare costs, wherever appropriate, for medical support-eligible children, which should directly reduce claims on the State's Medicaid program

In the following two sections, we provide a brief overview of the two approaches.

HEADQUARTERS MEDICAL UNIT (HMU)

The HMU operated on the premise that effective medical support enforcement requires the focused and persistent attention of specially trained staff. Similar centralized models have been implemented in Washington and across the country to improve results for other child support enforcement tasks, including the enforcement of interstate cases and parent locate functions.

In February 2003, Washington created a Headquarters Medical Unit (HMU), which consisted of enforcement officers and one part-time supervisor. The HMU was located in the Division of Child Support's Olympia state headquarters office. The state charged the HMU staff with reviewing cases for 2,000 randomly selected NCPs in the Fife office for potential medical support recoveries (see

Figure 1.1 for geographic coverage of the Fife field office). The state identified and tracked 2,000 similarly situated cases from Fife that served as a control group. The State limited the experiment to Fife because—in 2003—Fife was the only field office that had fully converted its child support records from paper to an electronic digital format. Fife's early conversion made centralized enforcement feasible for the first time.

The regular SEOs located in the Fife field office continued to send notices to enroll children in health insurance simultaneously with wage withholding notices. From that point, however, the HMU took over for the remaining aspects of medical support enforcement. They ensured that the Support Enforcement Management System database contained accurate and up-to-date medical information for child support families, sent notification to employers to discover new insurance, and tracked responses from employers. In essence, the HMU staff completed all of the time-consuming and complicated medical support enforcement tasks that are typically completed by SEOs in the field offices.

PRIVATE VENDOR DATA MATCHES

High volume data matching is a highly common child support enforcement strategy that evolved during the 1990s. Child support agencies routinely compare child support records to employment security, bank, motor vehicle, and tax records in attempts to locate NCPs and verify their earnings and assets. In these other areas, data matching has proven a highly cost-beneficial means of discovering and updating key aspects of the child support case.

During the past decade, a number of states have extended data matching to medical support enforcement. In this demonstration, the State simultaneously entered contracts with two private vendors that routinely compete for data matching contracts. Each vendor holds and maintains large, national-level databases with information about health insurance coverage for individuals and families. Under typical agreements, an IV-D division submits cases to private vendors for their review. The vendor trolls their proprietary databases to identify children in IV-D cases who are, or could be, covered by private health insurance. The vendor then returns a list of cases (also called "hits" or "matches") that they believe are eligible for medical cost recovery.

In a typical, on-going relationship, a vendor may charge a state $40 to $50 for each case identified as potentially eligible for a medical recovery or future medical support. Once the vendor identifies a case to the state, a special recovery team within the state's Medicaid department seeks reimbursement for any relevant Medicaid payments made while a client has been privately insured.

The private vendor experiment involved 12,000 cases. Unlike the HMU pilot, cases for the private vendor demonstration were drawn from across the state, which was possible because all field offices had completed the paper-to-digital record conversion by early 2004 (the beginning of the private vendor experiment). Each vendor received a separate list of 4,000 cases with orders for cash support.

The State also randomly selected 4,000 control cases that received standard medical support enforcement from field office SEOs.

Figure 1-1. Number of participants and location of Washington's medical support interventions

Source:ECONorthwest, 2005

PURPOSE OF THE REPORT

In order for division management to consider possible expansion of one or both of these approaches, decision makers must know precisely the processes employed in the pilot effort and completely understand the corresponding processes they replaced in the field offices. Managers of state child support divisions outside of Washington will also be interested in a careful documentation of each of the demonstration's key aspects (HMU and private vendors) should the approaches prove cost-beneficial.

With those evaluative goals, this report has two complementary purposes:

1. Documentation of work processes used to enforce medical support under the status quo, the HMU, and private vendor demonstration

2. Estimation of program impacts on Medicaid spending

Below we describe the research methods used to support those research goals.

DOCUMENTATION OF WORK PROCESSES

This process study documents precisely how the proposed approaches evolved from the planning stages into implementation. As the demonstration proposes two distinct efforts, the study describes the implementation processes separately. This report presents important background information about the process used in the experiment, to provide context for understanding the results and to begin to move toward recommendations for next steps.

We initiated the process study with a review of existing research focusing on medical support enforcement, the potential for increased support enforcement to lead to recoveries or avoided costs in state sponsored health care programs, and potential policy solutions that would improve existing medical support enforcement processes and results. A summary of this research is provided in Chapter 2.

Before documenting the processes involved in the demonstration, evaluators visited and interviewed front-line caseworkers and office supervisors from the Fife DCS field office. These staff oversaw and executed medical support activities for the 2,000 control cases in the HMU demonstration. In these interviews, evaluators focused on careful documentation of baseline medical support processes.

The study of the HMU process relied heavily on interviews with those who participated in the HMU and with the managers who supervised the effort. In the interviews with HMU staff, the evaluation team documented the SEOs' day-to-day medical support procedures. This included step-by-step process descriptions for cases in different conditions (for example, cases eligible for medical support with/without existing coverage, cases eligible for a medical support modification, cases with existing coverage for which a Medicaid recovery is feasible). The discussions with the HMU staff additionally focused on training and special resources received for medical support enforcement processes.

Evaluators also interviewed staff of the State's Medicaid recovery team (Coordination of Benefits, or COB). Of particular interest in these interviews was the perceived improvement (or lack thereof) of the accuracy, completeness, and timeliness of DCS information. Clearly, some of the features can be measured with statistical analyses (e.g., percent of cases returned to HMU for additional information), but the process study captures additional qualitative impressions of the relationship between HMU and COB staff.

Illustrating the full range of processes involved with the private vendors was impossible because they consider their practices proprietary and shared only broad descriptions of their off-site activities. However, the evaluation team was able to interview private vendor representatives regarding important implementation steps (such as the process undertaken by vendors to gain access to insurers' databases).

The evaluation team also explored a number of important questions surrounding the working relationships between COB and the private vendors. Evaluators carefully documented the need for interaction with the two competing vendors, whether data were submitted in a workable form, and how willing and able vendor representatives were to answer clarifying questions about their work.

ESTIMATION OF PROGRAM IMPACTS ON MEDICAID EXPENDITURES

The State designed both the HMU and private vendor matching demonstrations with the goal of reducing Medicaid expenditures. Because each of the demonstrations incorporate random assignment, a comparison of Medicaid expenditures on medical support-eligible children in the treatment and control groups provides the State with statistically reliable estimates of the programs' net effects.

To determine the impacts of the HMU, we requested a complete accounting of *case-level* Medical claims (paid and denied), cost recoveries, and payments to managed-care providers for all the Medicaid-participating children in the treatment and control groups. Any measured differences in the net Medicaid expenditures could be attributed to the HMU activities. Given the nature of Medicaid payments and recoveries, we allowed sufficient time for impacts to materialize. The intensive HMU efforts started in February 2003 and ended in October 2003. At the outset of the study, we anticipated that the HMU's impacts, if any, would begin no sooner than May or June 2003 and could persist well into 2004. In this report, we look at claims data through the 10 quarters following the HMU intervention.

To calculate the impacts of the private vendor approach, we will compare the average net Medicaid expenditures (net of any Medicaid costs recovered) of the cases worked by the private vendor to those of the control cases, over the follow-up period. As with the HMU, random selection will allow us to reliably attribute any difference in Medicaid expenditures between the three groups (Vendor 1, Vendor 2, Control) to the vendors' matches.

The private vendors returned their information to the State during June-July 2004, and the State processed the vendors' matches during July-September 2004. Consequently, we anticipate Medicaid impacts, if any, would materialize no sooner than August 2004 and persist through 2005. The evaluation takes that timeline into consideration, measuring impacts through June of 2005.

ORGANIZATION OF THE REPORT

This balance of this report consists of five chapters:

- *Chapter 2: National Issues Related to Medical Support Enforcement* provides policy and practice background regarding medical support enforcement across the United States. This chapter also describes the attempts of other states to address medical support enforcement in light of a potential new federal performance measure.

- *Chapter 3: Medical Support Enforcement in Washington* describes the overall child support enforcement process in Washington. It focuses on description of baseline medical support enforcement processes.

- *Chapter 4: HMU Interventions* describes in detail the efforts of the HMU to improve medical support enforcement in Washington State. This chapter also provides preliminary results of the impacts that the HMU intervention had on Medicaid expenditures in the state.

- *Chapter 5: Vendor Intervention* provides a detailed description of the vendors' processes and the work undertaken by DCS to incorporate the results of vendors' data matches into their own database system.

- *Chapter 6: Conclusions* provides the process study conclusions. While the purpose of this report is to document the process of undertaking interventions, the data collected while completing the process study nonetheless point to some possible conclusions. Those are described in this chapter.

Chapter 2 National Perspectives on Medical Support Enforcement

OVERVIEW

Medical support enforcement has evolved significantly during the past two decades. In 1987, federal audits found States largely out of compliance with federal medical support mandates. With the passage of subsequent federal and state laws, today most child support orders—and nearly all in Washington State—include requirements that the NCP provide medical support under certain circumstances.

Since the mid 1990s, several trends have raised medical support's profile. First, the implementation of welfare reform resulted in a sharp reduction in cash welfare caseloads. As welfare expenditures shrank, so did child support retained by states to reimburse themselves for welfare payments. Consequently, with a smaller welfare program, the reputation of child support programs as "budget savers" gradually eroded. However, while cash welfare caseloads were falling, State Medicaid rolls were increasing. In recognition of these trends, top federal and state officials began to recast the purpose of child support as a program that potentially recouped not only cash welfare expenditures but also avoided spending in Medicaid, and to a lesser degree, Food Stamps and other social service programs.

With its potential to reduce Medicaid spending, the prominence of medical support enforcement accelerated during the late 1990s. This chapter describes the national context that inspired and shaped Washington's demonstration. Specifically, the chapter provides an overview of medical support's evolution in federal law and then turns to recent federal and state activities to improve enforcement.

EVOLUTION OF MEDICAL SUPPORT IN FEDERAL LAW

Since 1985, state child support agencies have been required to request that health care coverage be included in the child support order when the custodial parent does not have private coverage and coverage is available to the nonresident parent through his employer. Federal and state governments have two key interests in enforcing medical support:

- **Expanding access to health coverage**. Aggressive enforcement can help ensure that children have access to medical insurance. Children without insurance have substantially reduced access to health care services, including critical preventative care such as childhood immunizations, vision and hearing screening, and other services.

- **Avoiding or recovering Medicaid costs**. Enrolling children in private insurance decreases the cost of providing public health programs such as Medicaid and SCHIP, which are increasingly straining government budgets.

During the 1990s, Congress passed several laws aimed to improve the medical support enforcement process, and consequently improve access to private insurance among child support-eligible children. The more prominent pieces of legislation include:

- **The Omnibus Budget Reconciliation Act of 1993***,* permits IV-D agencies to establish medical support orders when the NCP has access to coverage, and granted the authority to garnish wages, salary, and other income (including tax refunds) from NCPs who are not meeting their medical support obligations. This act also required states to pass laws to prevent insurers from denying coverage on the basis of residency or dependency requirements.

- **The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)***,* requires IV-D agencies to notify employers of NCP's medical support obligation, and requires employers to enroll that NCP's children if insurance is available. PRWORA also added a provision to help to avoid lapses in health coverage for dependents.

- **Title 45 of the Code of Federal Regulations, §303.31(b)(1)**, requires medical support orders to be established when the NCP has access to health insurance through an employer at a reasonable cost.

- **The Child Support Performance and Incentive Act of 1998 (CSPIA***),* (Public Law 105-200, effective October 1, 2001), encourages states to enforce medical support orders and provide health care coverage to uninsured children. Developed the National Medical Support Notice (NMSN) and requires employers to accept and respond to it.

- **Federal Employees Health Benefits Children's Equity Act of 2000.** This act applied existing child and medical support regulations to federal employees. Prior to this act, decision-makers could order NCPs who were federal employees to provide health care coverage for their children, but compliance was strictly voluntary and there was no enforcement mechanism.[1]

BARRIERS TO MEDICAL SUPPORT ENFORCEMENT

The Child Support Performance and Incentive Act (CSPIA) established the Medical Child Support Working Group to examine problems with the medical support enforcement system. In June 2000, the Working Group identified a number of barriers to effective enforcement that should shape federal and state policy in the area.

- **Noncustodial parents change jobs frequently**. Non-custodial parents, like most Americans, change jobs frequently. In 1998, the median employee tenure was approximately three and a half years, and estimates of turnover within the IV-D noncustodial parent population are more frequent. Of nonresident fathers who did not provide health care coverage to their children in any month of 1993, only half worked for the full year and only about a quarter had a private health plan all year.[2] Further, those who are not currently providing health insurance (the population that enforcement would seek) are less likely to have stable access to insurance throughout the year. Even among NCPs who are working full time all year, just 51 percent of those who are not currently providing insurance have year-round access to insurance, compared to 91 percent of those who are providing.[3]

  Lack of stability in employment is not the only factor affecting stability of insurance access. Even among those who maintain work with the same employer, insurance coverage can change because of change in company policy, eligibility criteria, or during any open enrollment periods. Additionally, because in many cases, employees do not become eligible to receive insurance until they have worked a job for a certain period of time (often six months), even when insurance is available at a new job and there is no gap between employment, there are likely to be lapses in coverage for the noncustodial children.

  Tracking job and insurance changes represents a major administrative challenge for support enforcement officers (SEOs), many of whom already have reached their maximum caseload without spending the additional time that would be required to aggressively pursue medical support. Currently, SEOs lack incentives to prioritize medical support enforcement and maintain accurate current medical databases.

- **Employers do not universally offer health care coverage for dependents; often, when it is available, it is costly.** A 1998 study by the DHHS Office of the Inspector General found that 63 percent of the nonresident parents did not provide health care coverage as required under the medical support order because health care coverage from an employer was either not available at all or was not available at reasonable cost.[4] A GAO study further emphasizes this challenge. Using data from the 1990 child support and alimony supplement to the Current Population Survey, they estimated that about half of NCPs with medical support orders in place provided health care coverage as required, and 30 percent were estimated to be able to provide coverage.[5]

  Even when dependent coverage is available, eligibility is often based on length of employment, hours worked, or employment status (coverage is typically not available to part-time or temporary workers). The working group found that low wage employees are not offered family health coverage as often as higher-income employees. Further

complicating this situation is the fact that, to cover the rising cost of health care, employers have tended to reduce coverage or increase the amount of the employee's contribution. Some states have created policies to address this issue, and have devised definitions of "accessible" that take into consideration both cost to the employee and stability of the coverage.

- **Many health plans are not fully portable and therefore, cannot provide health care coverage for children who live distant from the insured parent**. Nationally, between 25 and 30 percent of all noncustodial parents live in a different state from their children, and only 40 percent of non-custodial fathers live in the same city or county as their children. These numbers have been increasing; between 1999 and 2003, the number of interstate cases rose 8 percent.[6] Even among NCPs who have access to insurance for dependents, coverage may not extend to non-resident children if they live outside of an HMO service area. The use of HMO coverage is increasing; in these plans "out-of-network" providers are more expensive or coverage is less extensive.[7] Further complicating this situation is the fact that many Preferred Provider Organizations and Point-of-Service plans may allow coverage for children living outside of the service area, but out-of-network providers often result in restricted benefits or higher out-of-pocket expenditures.[8] Coverage provided through an HMO in California may not be useful for a dependent in Washington, and may not be the most efficient use of an NCP's medical support dollars.

- **Low-income parents of Medicaid-eligible children face above average barriers to stable employment and access to employer-provided health insurance.** The working group found that there is little difference between the availability of employment-based health care coverage for custodial and non-custodial parents when employment and income are taken into account. Because income and access to medical insurance are closely related and custodial and non-custodial parents are likely to share similar barriers related to employability, if the child qualifies for Medicaid and/or SCHIP, it is less likely that his NCP will have adequate employment to provide insurance coverage.

Nearly all of the challenges described above are more pronounced for families and NCPs who are living below 200 percent of the poverty line. These NCPs are less likely to have stable work, their employers are less likely to provide dependent coverage for health insurance, and have greater difficulty meeting premiums. For example, Wheaton (2000) found that 85 percent of NCPs who worked full-time all year and earned at least 200 percent of the poverty line provided coverage for the full length of the study, while just 4 percent of those who worked full-time all year and were below 200 percent of the poverty line provided coverage.[9]

FEDERAL AND STATE INITIATIVES TO IMPROVE MEDICAL SUPPORT ENFORCEMENT

Informed by the Working Group's findings, federal and state governments are actively working on an array of policy and program coordination strategies aimed to improve medical support enforcement. At the federal level, officials are considering the implementation of a medical support performance measure that would join the existing five child support measures. As with the existing five measures, the federal government would link performance in medical support—in some way—to state incentive payments. Like Washington, states across the country are designing policies and procedures to improve the accuracy of their medical support data and strengthen enforcement.

The balance of this chapter details the federal effort to measure medical support performance and state efforts to improve performance.

PROPOSED MEDICAL SUPPORT PERFORMANCE MEASURE

Since passage of CSPIA in 1998, there has been ongoing discussion about the possibility of enacting a new performance indicator that would measure the effectiveness of state child support enforcement agencies in establishing and enforcing medical support obligations. This new performance measure would be included with the existing five (discussed earlier in this chapter) when determining incentive dollar distribution to state child support enforcement agencies. To date, however, no new performance measure has been developed or implemented. Given the relative success of performance measures for encouraging improvement in other areas of child support and the rapidly rising costs of providing Medicaid and SCHIP programs, this conversation is likely to continue.

CSPIA required the Secretary of Health and Human Services, in collaboration with the states and the Medical Child Support Working Group, to submit a report to Congress containing recommendations for the new indicator by October 1, 1999. In initial discussions, just seven states were able to provide medical support enforcement data, and some of those states had concerns about the validity of the data they had provided. Other data sources (including the U.S. Census) were found to be unsatisfactory for the required purposes. Additionally, an ongoing effort to implement separate statutory requirements related to medical support was impacting medical support enforcement practices at the local level, complicating data collection and the development of indicators. The Working Group recommended postponing the development of the new indicator. [10] Despite ongoing discussion of the need for an indicator, it has not been added to the list of performance measures already in place to guide child support practices.

While it is difficult to estimate the impacts that a new performance measure might have, child support staff have indicated that they currently make only limited efforts to pursue medical support because they believe their primary

efforts should be spent in retrieving cash support payments. A major justification for this approach is that the federal match is greater for collection of cash payments than pursuit of medical support.[11] From this perspective, adding an incentive might increase SEO attention to medical support.

The following are some possible indicators of success in medical support enforcement that might be used as performance measures. None have been formally considered; this list is therefore very preliminary.[12].

1. Percent of IV-D cases with medical support orders compared to all orders

2. Percent of medical support ordered as provided compared to all cases with orders

3. IV-D cases with health care coverage of any kind provided compared to all cases

Achieving medical support enforcement goals continues to be a national priority even without a formal performance measure in place. The most recent Child Support Enforcement Strategic Plan (2005- 2009) contains specific goals and objectives that direct state agencies to focus attention on medical support. [13] The indicators described in the strategic plan to measure progress toward medical support goals may provide some clues regarding emerging performance measures. The following section outlines the working group's key recommendations.

MEDICAL CHILD SUPPORT WORKING GROUP'S POLICY RECOMMENDATIONS

The previously discussed Medical Child Support Working Group made a number of policy recommendations aimed at expanding coverage to child support eligible children by redefining who is obligated to pay for insurance coverage and under what circumstances. The goal of these recommendations is not to increase cost recovery for Medicaid and/or SCHIP, but rather to increase access to medical coverage in general. However, any new enrollments in private insurance could potentially result in cost recovery or avoidance for public programs. Consequently, these recommendations are worth the consideration of state IV-D agencies even if their main goal is to reduce public expenditure. Broadly, these recommendations include:

- Consider stability of employment when determining whether to pursue private health care coverage from an NCP or CP. Lack of job stability affects a parent's ability to provide health care coverage, and pursuing coverage from parents who have a history of frequent job changes can increase administrative costs for both IV-D agencies and employers.

- Unless coverage is offered at no or very low cost, parents whose income is near the poverty line should not be required to provide health insurance. Relative to income, it is much more costly for low-income parents to

provide coverage than it is for other families. Additionally, low-income parents are less likely to have access to insurance to begin with; medical support enforcement for these clients is an administrative expense that is unlikely to meet with returns.

- Consider the geographic reach of the NCP's insurance before requiring him/her to provide it. If children do not have geographic access to the dependent health care that is available through their noncustodial parent's employer, the coverage is not useful and purchase should not be required.

- When no accessible private insurance is available at a reasonable cost, child support clients should be encouraged to enroll in Medicaid and/or SCHIP if they are eligible.

States have enacted a variety of changes—both legislatively and in practice—that address these recommendations. New York State's legislature has provided the court system with guidelines for ordering parents to provide health insurance in support proceedings, provided that the insurance is available at reasonable cost and is accessible to the child. The new legislation (Chapter 624 of the laws of 2002) requires courts to assess the availability of health insurance in every support proceeding. Parents will be held responsible to provide insurance. When neither parent has appropriate insurance available, the court directs the custodial parent to apply for public coverage. Cost sharing between the CP and the NCP is allowed. [14]

In a model ordinance, New Jersey has defined both "accessible coverage" and "stable coverage." Their definitions follow Working Group recommendations, emphasizing that coverage should meet both definitions in order to be considered.[15] The Working Group defines coverage as accessible, "if the covered children can obtain services from a plan provider with reasonable effort by the custodial parent." Among other refinements to this broad definition, the national Working Group recommends that primary care should be "available within the lesser of 30 minutes or 30 miles of the child's residence." Health care is deemed to be stable if it can reasonably be expected to remain effective for at least one year, based on the employment history of the providing parent. [16]

Minnesota also adopted a standard for "reasonable" coverage, defining it as coverage that is available within a 30 mile or 30 minute radius of the child's house for standard care, and 60 miles or 60 minutes for specialty care. Given the inherent difficulty of access in more rural areas, Minnesota's Working Group recommends that this presumption be rebuttable.[17]

Minnesota's Working Group also made recommendations aimed at assuring the NCPs are paying a reasonable cost for the coverage that they provide to dependents. Taking the national Working Group's recommendation, they recommend that low-income (below 150 percent of the poverty line) parents not be required to contribute to medical support at all. Parents with income between 150 and 275 percent of poverty would be expected to contribute up to 5 percent of their adjusted gross income to medical support.[18]

In an attempt to refine what is considered to be reasonable cost for an NCP to pay to cover custodial children, Washington NCPs cannot pay more than 25 percent of their basic support obligation for insurance premiums.[19] This premium limit is described in greater detail in Chapter 3: Current Conditions.

In Texas, when no employer-based health care is available, the court will order the noncustodial parent to apply for coverage through the Texas Healthy Kids Corporation. Connecticut has a similar requirement, though either parent can be required to enroll the child.

STATE INITIATED STRATEGIES TO IMPROVE MEDICAL SUPPORT ENFORCEMENT

Given the increasing cost of providing state-sponsored health programs and the possibility of the implementation of a new federal performance measure related to progress toward medical support goals, many states are beginning to work toward improving their enforcement practices. This section briefly summarizes some of the major strategies that might be used to improve results in the medical support area and provides examples of the measures that some states have taken. It also includes a review of existing literature on state innovations, providing some discussion about how states are implementing these improvements and any preliminary results that are available. The strategies and implementation methods discussed are not comprehensive, but rather are meant to provide examples of the types of measures that are being implemented across the country.

- **Centralize medical enforcement.** One possibility for improving performance on complex medical support enforcement tasks is to train a subset of SEO staff to focus exclusively on medical support enforcement. These staff can be centralized in one office and deal with all statewide cases, or can be located in regional offices. Because medical support represents a relatively time intensive and complex enforcement task that requires specialized knowledge (such as familiarity with insurance policies) specialized attention to the task may help to improve performance. In 2000, New York State began a multi-year review of all IV-D support orders to determine whether medical support has been ordered and, if not, to produce the orders. This review also included an update of the state's child support enforcement database, Child Support Management System (CSMS). This ongoing project was designed to identify cases that required review for health care coverage, improve data for automatic issuance of the National Medical Support Notice, and aid the state in accurate federal reporting in anticipation of a medical support performance measure. As of April 2004, 52 percent of cases with orders also have medical support orders in place.[20]

- **Conduct data matches**. Part of the difficulty involved in medical support enforcement is administrative in nature: frequent changes in employment and/or insurance status complicate efforts to maintain accurate databases.

As a result, SEOs may not have access to the eligibility and plan information necessary to enforce medical support orders. Matches with databases that contain insurance information can help to alleviate this problem and discover new NCP insurance policy information. A number of private vendors maintain proprietary databases; states can pay the vendors to complete a data match for them. At least 35 states currently pay for at least some services that vendors offer.

- **Convert medical support to cash support**. In this model, an NCP would be required to contribute directly to the government's Medicaid and/or SCHIP programs. The U.S. Department of Health and Human Service's Office of the Inspector General (OIG) has conducted a series of studies designed to assess the potential for this method to reduce a state's publicly funded health care costs for both the SCHIP and the Medicaid program. OIG estimates states could recoup between 44 and 77 percent of the cost of enrollment in publicly funded medical care, depending on the number of eligible IV-D children and the cost of enrollment in the state.

- **Improve coordination with Medicaid agency**. Another source of information available to some states is Medicaid and/or SCHIP databases. Medicaid offices often track private insurance availability to recover Medicaid costs. Increased coordination between the child support enforcement and Medicaid offices is another strategy for improving medical support enforcement. This can take the form of data matches with Medicaid databases, information sharing among caseworkers in the two agencies, or both.

- **Consider the custodial parent's ability to provide coverage**. Increasingly, child support agencies are recognizing that other members of a custodial child's family (including the custodial parent or step parents) might be better positioned to provide private coverage. If the NCP lives out of state or out of an HMO service area, has unstable employment, cannot afford premiums, or does not have insurance available, one option is to consider the ability of other family members to provide instead. This situation also has the advantage of allowing the custodial parent more direct access to the child's insurance plan information, and more accurate knowledge of any lapses in coverage.

  New York State began using the NMSN on December 22, 2003. Issuance of the NMSN against older orders revealed that, while parents may have insurance available, it is often not provided by the court-obligated parent. DCSE has subsequently developed a policy for alternative coverage.[21] Under recent legislation, courts are to consider health care coverage available to both parents when making determinations about who should be obligated to cover health insurance costs. New Jersey has also begun to move in this direction; they completed a feasibility study of model review and adjustment practices for medical support obligations. The state developed a set of guidelines for addressing private health care coverage

as part of this study. Guidelines suggest that when equal coverage is available from both parties, the coverage available to the custodial parent should be ordered because it provides the custodial parent with more direct control over health care choices for the child.[22]

- **Subsidize employee premiums through Medicaid or SCHIP**. States can subsidize the costs of employer-based insurance for people who are eligible for Medicaid or SCHIP. Doing so allows states to use federal matching funds, in addition to state dollars, to buy their beneficiaries into private coverage at a lower cost than providing public coverage. [23] Though this option is not a policy change that could occur within the child support enforcement system, implementing it could nonetheless impact the families who pay and receive child support by increasing the accessibility of employer sponsored insurance programs to working poor NCPs.

  While Washington's Medicaid program currently pays an eligible individual's premium for an employer plan, other states also use a Medicaid section 1115 waiver or SCHIP funds. Massachusetts, for example, uses both sources to subsidize employer-sponsored insurance for workers making less than 200 percent of the federal poverty level. The program pays an employee's entire share of premiums except for $10 per child and $25 per dependent adult. This would markedly decrease the cost for NCPs who are obligated to cover their dependent children. Some studies in states that have implemented this option have shown limited results because of the relatively low number of poor uninsured who have access to employer-sponsored health care but are currently enrolled in Medicaid. However, such programs do increase access to private insurance for some people, and can result in savings to Medicaid.[24]

  Iowa, Pennsylvania, Texas, Illinois, Oregon, Wisconsin, Maryland, New Jersey, and Rhode Island all have programs that in some way provide subsidies for private insurance.[25]

- **Provide state-funded incentives for medical support enforcement**. In some ways, the success of the national performance measure initiative may have come at the expense of medical support enforcement, which does not have a performance measure associated with it. One method of encouraging SEOs and local support enforcement offices to increase their attention to medical support activities is to measure attainment in the medical support arena and incentivize progress toward specific goals. This possibility is discussed in detail earlier in this chapter.

  California provides a $50 per case incentive payment to local child support agencies that obtain new private health care coverage or restore lapsed coverage. In Minnesota, counties receive a $50 payment for each child participating in the state's Medicaid program for which private coverage through a non-custodial parent is identified and enforced. This money is to be reinvested in the child support program.[26]

[1] Roberts, Paula. Center for Law and Social Policy. Memorandum, "New regulations on obtaining health care coverage from non-custodial parents who are federal employees," November 24, 2003.

[2] Wheaton, Laura. The Urban Institute. Prepared for the U.S. Department of Health and Human Services. "Nonresident fathers: To what extent do they have access to Employment-based health care coverage?" June 2000. This report available online at: http://fatherhood.hhs.gov/ncp-health00/index.htm

[3] Wheaton, Laura. The Urban Institute. Prepared for the U.S. Department of Health and Human Services. "Nonresident fathers: To what extent do they have access to Employment-based health care coverage?" June 2000. This report available online at: http://fatherhood.hhs.gov/ncp-health00/index.htm.

[4] U.S. Department of Health and Human Services, Office of Inspector General (OIG). "Review of availability of health insurance for Title IV-D children." Report A-01-97-2506. June 1998.

[5] U.S. General Accounting Office (GAO). "Medicaid: Ensuring that noncustodial parents provide health insurance can save costs". GAO/HRD-92-80, 1992.

[6] U.S. Department of Health and Human Services, Office of Child Support Enforcement. "Child support enforcement FY 2003 preliminary data report." June, 2004. Report available online at: http://www.acf.dhhs.gov/programs/cse/pubs/2004/reports/preliminary_data/#fig9.

[7] Roberts, Paula, Center for Law and Social Policy. Failure to thrive: the continuing poor health of medical child support, June, 2003.

[8] Wheaton, Laura. The Urban Institute. Prepared for the U.S. Department of Health and Human Services. "Nonresident fathers: To what extent do they have access to Employment-based health care coverage?" June 2000. This report available online at: http://fatherhood.hhs.gov/ncp-health00/index.htm.

[9] Wheaton, Laura. The Urban Institute. Prepared for the U.S. Department of Health and Human Services. "Nonresident fathers: To what extent do they have access to Employment-based health care coverage?" June 2000. This report available online at: http://fatherhood.hhs.gov/ncp-health00/index.htm.

[10] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement. "Report to the congress on development of a medical support incentive for the child support enforcement program." June 23, 1999.

[11] U.S. Department of Health and Human Services, Office of the Inspector General. "Medical insurance for dependents receiving child support." June 2000. This report available online at: http://oig.hhs.gov/oei/reports/oei-07-97-00500.

[12] Telephone interview with Jennifer Burzinski. Child Support Policy Analyst. US Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation.. October 15, 2004.

[13] U.S. Department of Health and Human Services, National Child Support Enforcement Strategic Plan, FY 2005-2009.

[14] Bean, Margot, presentation. "Golden Opportunities for Children," National Child Support Enforcement Association Annual Training Conference and Expo. August 1-4, 2004. Palm Springs, CA.

[15] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

[16] The Medical Child Support Working Group, 21 Million Children's Health: Our Shared Responsibility, Report to the Hon Donna Shalala, Secretary of the Department of Health and Human Services and the Hon. Alexis Herman, Secretary of Labor, June, 2000. This report is available online at: http://www.acf.hhs.gov/programs/cse/rpt/medrpt/index.html

[17] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

[18] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

[19] WAC 388-14A-4100.

[20] Bean, Margot, presentation. "Golden Opportunities for Children," National Child Support Enforcement Association Annual Training Conference and Expo. August 1-4, 2004. Palm Springs, CA.

[21] Bean, Margot, presentation. "Golden Opportunities for Children," National Child Support Enforcement Association Annual Training Conference and Expo. August 1-4, 2004. Palm Springs, CA.

[22] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

[23] Katz, Aaron and Carlos Domingues-Karasz. Health Policy Analysis Program, University of Washington School of Public Health and Community Medicine. "Selected policy options for strengthening employer-based health insurance in Washington State." Briefing Paper No. 2, May 14 and 15, 2002.

[24] Katz, Aaron and Carlos Domingues-Karasz. Health Policy Analysis Program, University of Washington School of Public Health and Community Medicine. "Selected policy options for strengthening employer-based health insurance in Washington State." Briefing Paper No. 2, May 14 and 15, 2002.

[25] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

[26] Roberts, Paula. "Failure to thrive: the continuing poor health of medical child support." June 2003.

Chapter 3 Medical Support Enforcement In Washington State

OVERVIEW

The enforcement of medical support in Washington State requires efforts from both the Division of Child Support (DCS) and the Medicaid agency's Coordination of Benefits (COB) office. DCS is responsible for establishing and enforcing the medical support obligations. Since 1989, nearly all child support obligations in the State include an obligation that the NCP provide medical support—a responsibility often shared with the custodial parent. Through complementary activities, both DCS and COB identify Medicaid-eligible children who are enrolled—or could be enrolled—in a non-custodial parent's health insurance policy. In instances in which the agencies successfully enroll a child in an NCP's health insurance policy, COB coordinates the payments of medical claims and ensures the private insurer becomes the primary payer for the medical services their policy covers.

This chapter details the processes used by DCS and COB to enforce medical support and describes the means by which they share information. The chapter concludes with a discussion of barriers to medical support enforcement in Washington State.

DCS MEDICAL SUPPORT PROCESSES

In addition to establishing and collecting cash support, Washington's 800 SEOs are responsible for:

- Ensuring that medical support is established in all new child support cases
- Once established, ensuring that the NCP enrolls eligible children in employer-provided health plans—if the plans are available and provided at a reasonable cost (that is, for a monthly premium that does not exceed 25 percent of the basic child support obligation).

Most SEOs in Washington work all aspects of the child support case from paternity and order establishment to the collection of current and past-due support. Frontline SEOs typically carry caseloads of 650. Washington organizes its case around the NCP. Within the field offices, SEOs are organized into teams. Each team has a supervisor (who carries no caseload) and two or three lead workers, who carry a three-quarters caseload. SEOs typically agreed that this caseload is manageable, but that if additional duties were required, it might result in less accurate and thorough enforcement.

Most Washington field offices identify a Medical Support Officer, also referred to as a medical support coordinator. The employee is responsible for finding current and accurate insurance information, advising SEOs on medical enforcement issues, and interpreting court orders. The Medical Support Officer also acts as an SEO and carries a full caseload in addition to medical enforcement responsibilities.

Medical support enforcement has been a part of SEO activities for more than a decade, since a 1987 federal audit of medical support enforcement found essentially no compliance with medical support requirements across the U.S. In response to the federal audit, DCS hired a specialist to conduct trainings for SEOs. The specialist also created and regularly updated a resource newsletter and a handbook. The medical support enforcement job function was further formalized when, in 1989, Washington State's withholding orders were modified to include medical support along with wage withholding orders.

ESTABLISHMENT

For the large majority of support orders entered on or after May 13, 1989, the NCP must provide health insurance for dependent children if coverage is available through the NCP's employer or union. In most cases, medical support is not the exclusive responsibility of the NCP. In fact, more than half of orders call on the custodial parent to share insurance responsibility with the NCP. Table 3-1 describes who is responsible to provide insurance coverage among all Washington State orders and how many of those orders are on cases where children receive Medicaid.

Table 3-1. Party obligated to provide insurance among Washington State and Medicaid cases, 2004

Party obligated to provide medical insurance	All Washington orders		Orders with children on Medicaid	
	Number	*Percent*	*Number*	*Percent*
NCP and CP share responsibility	90,121	53%	15,958	57%
NCP alone	67,340	40%	10,944	39%
CP alone	6,503	4%	568	2%
Order does not address insurance	4,505	3%	645	2%
Total Washington orders	**168,469**	**100%**	**28,115**	**100%**

Source: Division of Child Support
Note: Total represents open Washington order cases with enforceable cash and medical orders.

In nearly all of the cases – 93 percent for all cases and 96 percent for Medicaid cases—the NCP is obligated to cover at least a portion of the insurance. If both the NCP and the CP are required to provide, then both have an obligation regardless of whether the other party provides coverage. However, under State law, DCS enforces only the NCP's medical support obligation. While the agency may occasionally learn about medical coverage available through the custodial parent, the agency has neither the ability to record the information nor the authority to act on it.

ENFORCEMENT

Washington uses the newly implemented National Medical Support Notice (NMSN) to notify employers of an NCP's medical support obligation and request that the NCP's non-custodial children be enrolled in the employer's private insurance.[1] DCS sends an NMSN to an NCP's employer when there is a support order requiring the NCP to provide health insurance coverage. When employers receive an NMSN, they must provide information about the health insurance plan and policy as requested in the notice as well as any necessary claim forms or membership cards to both DCS and the custodial parent (CP). The employer must withhold premiums from the NCP's net earnings if the NCP is required to pay part or all of the premiums for coverage under the health insurance plan.[1] When the NCP is eligible for dependent coverage, and the children are not already enrolled, the employer must enroll the non-custodial child(ren) in an insurance plan, withholding any employee contributions required for health insurance premiums from the NCP's wages.[2] They must then notify the NCP, each child, and the custodial parent that coverage of the children will become available.[3]

The Washington Administrative Code provides guidance on the following situations that could complicate the enrollment procedures described above:

- **The NCP is eligible for appropriate insurance, but his/her income is insufficient to withhold health insurance premiums.** An NCP's medical support obligation cannot exceed 25 percent of his/her basic child support obligation. Additionally, the total child support obligation cannot exceed 50 percent of the NCP's net monthly income.[4] Limits include the premium attributable to coverage for the child(ren), but the premium attributable to coverage for the NCP is included only when DCS requires the employer or plan administrator to enroll the NCP in a health insurance plan in order to obtain coverage for the children. (See #2 below for further information.) Even if the medical insurance premium is within the limits set by the order or the 25 percent limit, the 50 percent limitation still applies.

  If the NCP's income is insufficient to cover the medical support order, the employer or plan administrator must notify DCS that enrollment cannot be completed because the noncustodial parent's net earnings are too low. The employer or plan administrator must also notify DCS of the amount of the premium.[5]

- **The NCP is eligible for health insurance but has not enrolled in his/her own plan.** In order to obtain coverage for the children, the NCP must first be enrolled in the plan. If the NCP is eligible but has not elected to enroll in an insurance plan that has dependent coverage, the employer

[1] The regulations guiding the use of the NMSN are found in the Washington Administrative Code (WAC) 388-14A-4122 through 388-14A-4165.

must enroll the NCP and the children in the least expensive plan that provides accessible coverage.[6]

- **The NCP is eligible for insurance and has enrolled in an employer-sponsored plan, but has not selected a plan that has dependent coverage.** If the employer offers more than one insurance plan, the plan administrator must enroll the children in the plan in which the NCP is enrolled. If the NCP has elected to enroll in a plan that does not provide coverage for the child, the employer is not required to change the NCP's plan to one that provides accessible coverage for the children.[7]

- **The employer provides health insurance, but the NCP is not yet eligible for coverage.** If the NCP is subject to a waiting period that expires within 90 days from the date the plan administrator receives the NMSN, the plan administrator must enroll the children immediately. If the waiting period expires more than 90 days from the date of receipt, the plan administrator must notify the employer, DCS, the NCP and the CP of the waiting period, and then enroll the children when the waiting period has expired.[8]

If the employer does not maintain or contribute to plans providing dependent coverage or if the NCP is not eligible for insurance (for example, if the NCP is a part-time employee), the employer need take no action beyond responding to the NMSN.[9] Noncompliance with the NMSN subjects the employer or union to a fine of up to $1,000, depending on the length of time that the employer does not comply.[10]

If the employee is eligible for insurance and dependent coverage is available at a reasonable cost, DCS directs the employer to enroll the child in the health plan. In every case in which health insurance is available, the SEO must obtain accurate information on the insurance carrier, including the name and specific address of the associated claims processing center. A given carrier may process claims at multiple sites, so SEOs must make sure they obtain the correct information for the policy in question.

Given the large number of potential carriers (inside and outside Washington State) and the fact that a given carrier may have multiple processing sites, the DCS's Support Enforcement Management System (SEMS) contains hundreds of insurance identifier codes referred to as "carrier codes." Assuming an employer provides the insurer's detailed billing information, the SEO enters the appropriate carrier codes into the case record.

If insurance is not available, the SEO codes the database appropriately. Lack of insurance availability is very common. In addition to the employer simply not offering insurance, other common reasons for non-availability include:

- **Insurance premiums exceed the State limit**. Insurance is available but at a price that exceeds the maximum required under Washington State law.

- **Insurance does not cover child's place of residence**. Some health plans—particularly managed care plans—may cover the geographic area where the NCP resides but will not cover the geographic area where the child resides.

- **Insurance available only after a waiting (vesting) period**. Many employers require new employees to work for several months before they or their dependents become eligible for health benefits.

- **Insurance temporarily unavailable**. Workers who have coverage through trade unions often must exceed a monthly minimum number of hours worked in order to activate their coverage. Consequently, the availability of insurance may vary from month to month.

In cases in which insurance is not available but could be in the near future (for example, for new employees in a waiting period), SEOs set a review code in the SEMS system, which prompts the SEO to check back with the employer after a specified period of time. If insurance availability is unlikely with the existing employer, the SEO codes the case as lacking insurance. In such instances, the SEO is unlikely to consider medical support enforcement for that case until the NCP changes employers, which triggers a new medical support enforcement notice.

Given their frequent contact with employers, SEOs often have specialized knowledge regarding employer benefit policies and practices and, in some cases, the expected insurance premiums. Based on this knowledge, if it is obvious that the NCP and/or the dependent will not be eligible for insurance, some SEOs may enter "no insurance available" into the automated system without sending a notice. In this situation, the new employer will receive a wage withholding order, but will not receive a medical support withholding order.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) section of the Medical Assistance Administration (the State's Medicaid agency) is an important partner in medical support enforcement. COB plays two key roles:

- **Identification of third-party insurance coverage**. Although DCS holds the primary responsibility for identifying third-party insurance coverage for child support clients, COB maintains a database of Medicaid client information that is useful for verifying and updating the DCS database.

- **Cost avoidance and cost recovery of Medicaid claims**. With information on third-party insurance coverage in hand, COB coordinates the payment of medical claims between Medicaid and private insurers. COB ensures that the private insurer is the payer of first resort for all medical procedures covered under their policies. The COB estimates that about 10 percent of the Medicaid population has external insurance coverage.

Below, we describe each of COB's roles in more detail.

IDENTIFICATION OF THIRD-PARTY INSURANCE

In addition to insurance information received from DCS, COB staff uncover third-party insurance information from a number of sources, including

- Self-reported information from the Medicaid clients
- Insurance information listed in court orders,
- Information from the Community Service Office
- Policy information provided on Medicaid claims submitted by health providers. Differences between information on the screen and information on a claim might also trigger caseworkers to update insurance information in the database.

COB has on-line access to a number of insurers' databases, including Regence Blue Shield, Blue Cross, Group Health, First Choice, and DEERS, which they can use to verify coverage on a case-by-case basis.

COB has also experimented with data matches with Washington-based insurers—a process similar to the one employed by the private vendors in the demonstration. COB officials deemed past attempts at data matching of limited benefit because the matched data added little new information and became out-of-date quickly. Based on their own experience with matches, COB officials counseled DCS against conducting the data matching demonstration.

COST AVOIDANCE AND COST RECOVERY

COB caseworkers determine the fiscal responsibility for healthcare services provided to the State's Medicaid beneficiaries. When COB staff discover active third party medical insurance for a client, they review Medicaid claims activity on the case prospectively and retrospectively to determine who should cover the cost of service.

- **Prospective claim denials**. For periods *after* the discovery of third party insurance, COB caseworkers deny healthcare provider claims for Medicaid reimbursements for services that are covered by the third party policy. COB tracks the dollar amount of these prospectively denied claims, which are considered "cost avoidance." Transferring the responsibility for the claim from Medicaid to a third-party insurer generates direct and immediate savings for clients enrolled in fee-for-service programs.

Prospective savings for clients enrolled in Washington's managed care version of Medicaid (Healthy Options) are less direct and not immediate. For recipients enrolled in Healthy Options, the State pays a monthly per capita

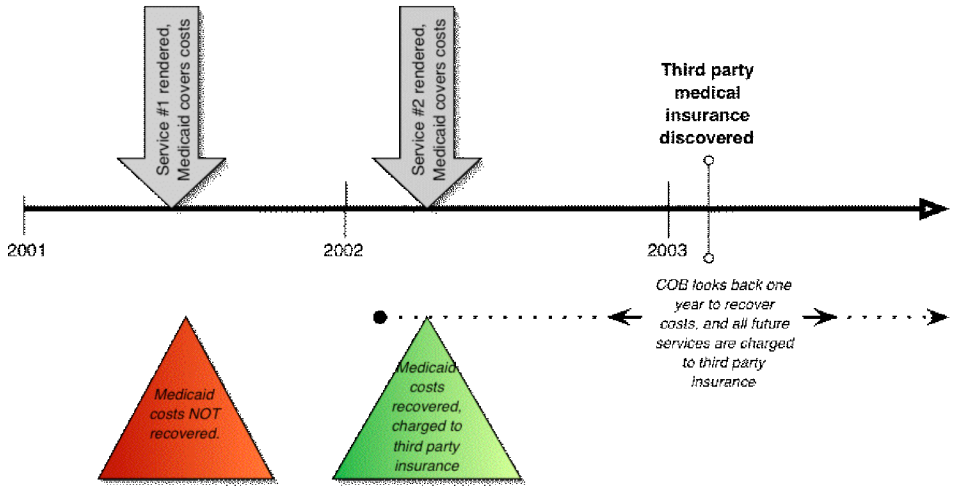
amount to the managed care provider unrelated to the actual level of service accessed by the client. Upon discovery of third party insurance, state policy calls on the Medicaid agency to move the client from Healthy Options—which would end the monthly per capita payments—to a fee-for-service arrangement. Once the client is in the fee-for-service program, COB can then transfer responsibility for individual claims to the third-party insurer. *In short, Medicaid savings for Healthy Options clients can occur only when, and if, the agency transitions the client from the managed care to the fee-for-service arrangement.*

- **Retrospective claim recoveries.** With each discovery of third party coverage, COB caseworkers "look back" at recent Medicaid claims to determine whether the agency recently paid for services that should have been covered by the third-party insurer. COB caseworkers typically limit their search up to 12-months immediately preceding the discovery of active insurance. Third-party reimbursement for past Medicaid claims is deemed "cost recovery." COB attempts retrospective cost recovery for major medical coverage and dental, pharmacy, and vision coverage. It does *not* attempt cost recovery for Medicaid cases served through managed care providers. For Medicaid clients enrolled in managed care, the *managed care provider* has the responsibility of recovering costs from the third-party insurer. The State's capitated payments to Medicaid managed care providers implicitly assume those providers are recovering some costs from third-party providers.

Figure 3-1 illustrates COB's prospective and retrospective cost recovery timeline for a hypothetical case in which DCS discovered active insurance in February 2003. Going forward, COB denies Medicaid claims for medical services covered by the insurer for as long as the insurance is active (so called cost avoidance). Discovery of third party insurance does not directly affect the client's eligibility for Medicaid. Most beneficiaries remain on the Medicaid caseload; however, Medicaid becomes a secondary payer.

In this illustrative case, COB would review Medicaid claim activity during the March 2002-February 2003 period. If they discover that Medicaid paid for a service covered by the insurer, they attempt to recover the cost from the insurer.

Figure 3-1. COB Cost Recovery Timeline



Source: ECONorthwest
Note: Contents from Coordination of Benefits Office, staff interview, December 20, 2004

DATA EXCHANGE BETWEEN DCS AND COB

Given that both DCS and COB are independently investigating and identifying third-party insurance coverage, prompt and accurate data exchanges between the two agencies are critical. The agencies' management information systems are not compatible, so information sharing is achieved through periodic (typically monthly) data matches.

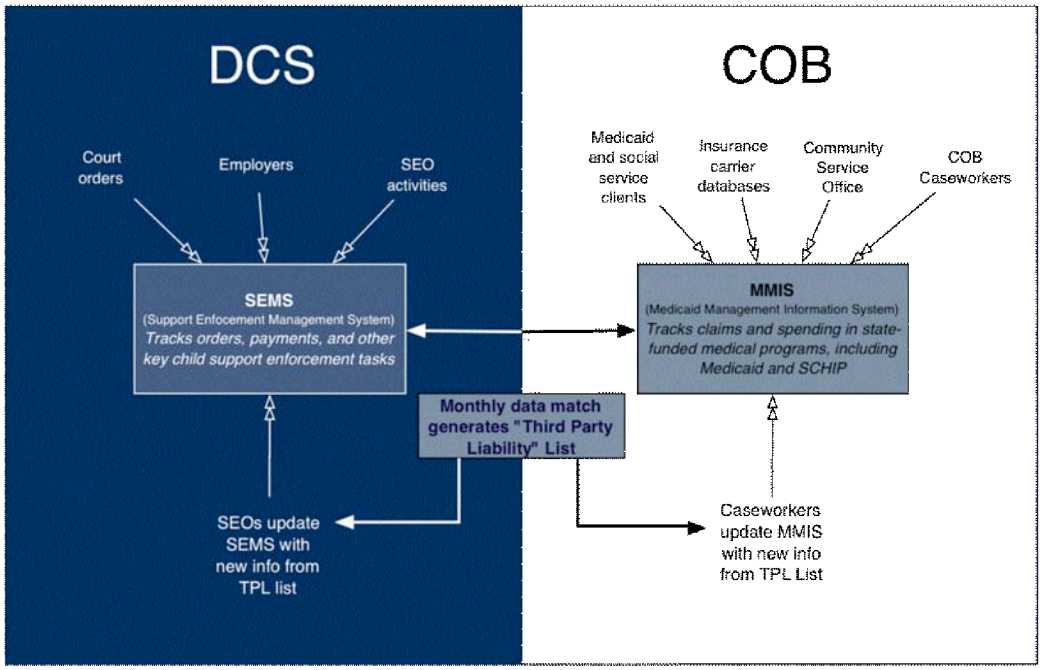
Figure 3-2 illustrates the data exchange between DCS and COB.

- **New information originating from DCS**. Through its on-going medical support enforcement activities, DCS uncovers insurance information for some cases before COB does. Each month, COB accepts and reviews the DCS updates. For each recipient with updated insurance information, COB caseworkers verify the DCS data with private insurers—typically through their on-line access to the insurer's database.

- **New information originating from COB**. Through their variety of identification and verification methods, COB will uncover information in advance of DCS. In a common example, COB may forward a claim to a third-party insurer and later discover the insurance has expired. Through the monthly data match, COB would flag the change in insurance status. With each data match, COB reports all inconsistencies between its database and DCS's. DCS then distributes a list of inconsistencies to medical support coordinators in each of its field offices. The medical support coordinator has the responsibility of either updating the affected cases or distributing the information to the individual SEOs who update the data. This responsibility, however, is not always a priority.

The dynamic nature of health coverage for NCPs makes a timely exchange of data critical to successful enforcement. If delays in the exchange are lengthy, an NCP could lose or change coverage in the interim, which would restrict COB's attempts to recover past Medicaid claims or avoid future ones. And even if the NCP retains coverage, the delay will affect how far back COB will seek reimbursement for past Medicaid claims. For example, if DCS discovers insurance coverage in January 2004, but COB first learns of the coverage in May 2004, COB would attempt cost recovery beginning in May 2003 and thereafter. In short, insurance information becomes outdated quickly, so the sooner the two agencies learn what information the other one has, the more effective is medical support enforcement.

Figure 3-2. Medical support data transfers between DCS and COB



Source: ECONorthwest

BARRIERS TO MEDICAL SUPPORT ENFORCEMENT

In interviews, SEOs noted a number of circumstances that complicate the medical support enforcement process described above. Overall, medical support enforcement has not been an area of focus for SEOs or for DCS. The status quo enforcement process, when it occurs, can be inefficient and imprecise, leading ultimately to missed enforcement opportunities.

SEOs are not unwilling to consider medical support – in fact, nearly all of the SEOs interviewed for this process study stressed that medical support enforcement should be a more important part of their jobs than it is. Rather, the problem lies in the *process* currently used to identify and track NCPs' eligibility for insurance coverage over time. Washington's current medical support enforcement process does not account for the many dynamic variables that are

involved in insurance coverage. Ultimately, these barriers result in the discovery of fewer available insurance policies.

- **Fiscal incentive to pursue medical support is weak.** The collection of child support dollars is specifically emphasized through federal performance measures, while medical support is not. Though the importance of medical support enforcement is recognized, employees who excel at this job function are not rewarded for it. One SEO noted that there are a growing number of cases that require only medical support enforcement, rather than both medical and child support enforcement. These cases may receive less attention until the federal or state government develop a clear, measurable performance measure.

- Washington's premium limits reduce opportunities for enforcement. In Washington, the amount of child support that goes to medical coverage cannot exceed 25 percent of an NCP's basic child support obligation. Additionally, total child support withholding including medical support cannot exceed 50 percent of an employee's net income. In interviews, SEOs noted that NCP wages are frequently insufficient to provide health insurance given this limit. In fact, the premium limit is so low that SEOs sometimes opt out of rigorous enforcement of medical support orders when the net income is low. This is an increasingly important issue as premium costs for insurance coverage continue to rise faster than wages.

Table 3-2. Premiums for dependents from Washington carriers[2], 2004

Cost for dependent insurance	Premera Blue Cross	Regence Blue Shield	Group Health Cooperative	Average
$500 deductible individual plan	$168	$114	$144	$142
$1000 deductible individual plan	$153	$100	$136	$130

Source: Insurer websites, accessed December 12, 2004
Notes: Rates represent individual plans
All rates are per child, per month for comprehensive coverage except Regence Blue Shield. Regence has a different cost structure for families with more than one child. The price listed in Table 3-2 for Regence is the rate for a single child; for two or more children, they charge $216 for their $500 deductible plan and $191 for the $1000 plan.

Table 3-2 reports premium rates for dependent coverage from three major carriers in Washington State: Premera Blue Cross, Regence Blue Shield, and the Group Health Cooperative. For comprehensive coverage with a $500

[2] Plan information:
Premera Blue Cross: "Personal Prudent Buyer Program, Option 1", Effective beginning June, 2004
Regence Blue Shield: "Individual Selections"
Group Health Cooperative: "Individual and Family Plan", rates for Western Washington, Effective April 1, 2004 - March 31, 2005

deductible, the average per child cost would be $142 per month. With a $1000 deductible, it drops to $130 per month.

Assuming an average monthly per child cost of $136, an NCP's total support order would need to be at least $544 per month to support the cost of comprehensive insurance for the child. An NCP earning Washington's minimum wage of $7.16 per hour for a full-time job might have an after-tax monthly income of about $1,100 per month[3]. That NCP's maximum wage withholding (based on the 50% rule) would be $550, barely enough to meet the premium limit to provide insurance. A withholding order of that amount would leave the NCP with just $550 for monthly expenses. DCS child support records show that many of Washington's NCPs do not pay child support orders in an amount sufficient to cover these insurance costs; the average monthly support order amount in the Fife child support region is $348. In the State of Washington as a whole, the amount is lower at $315.[4]

- **NCPs change jobs frequently.** Frequent job changes result in more work for SEOs who must keep track of the withholding notices sent to employers, and more changes to insurance eligibility for dependents. Because insurance is often available for employees only after a waiting period, it can also mean less time eligible for insurance when it is available. This situation complicates not just medical support enforcement, but child support enforcement in general.

- **Within jobs, insurance changes frequently, especially in union jobs.** SEOs reported that eligibility and coverage policies change frequently, even when the NCP does not change jobs. In some union jobs, an employee's insurance eligibility is contingent on the number of hours worked in a given month. This can result in highly variable eligibility that would be difficult to track even if frequent communication between SEOs and employers were possible.

- **Forms are complicated for employers to complete.** If insurance is available, the medical support enforcement form requires employers to forward a portion of the form to the insurer to begin coverage for the dependent. This process and, more broadly, the form itself can be confusing for employers who have not previously dealt with medical support enforcement.

- **Interstate orders are difficult to enforce.** When SEOs in Washington attempt to enforce medical support orders for NCPs who are in other

[3] Minimum wage earners would have a weekly income of $286.40. The Federal Employer's Tax Guide (Circular E, effective January 2005) determines an $11 weekly tax for wage earners at that level, assuming two withholding allowances claimed (one for self and one for dependent). Since Washington does not have a state income tax, the take home pay for this NCP would be $1101.60.

[4] Averages do not include interstate orders.

states, the situation is further complicated. Requirements for provision of child support vary from state to state, and NCPs who cross state lines can be particularly difficult to locate. SEOs do not necessarily have jurisdiction to enforce court orders in other states.

- **Court orders are improperly completed.** SEOs noted that court orders for child support are sometimes incorrectly executed. This is especially true in the case of self-executed divorces, which are increasingly common. When this happens, SEOs have to send the court order back to the prosecutor, which slows the process of enforcing both child support and medical support.

- **Medical support enforcement training occurs infrequently.** SEOs reported that training on medical support enforcement occurs as part of the initial job training, but that team trainings specific to medical support enforcement are rare. A Medical Support Officer is available in every office to answer questions and provide resources, but official trainings have happened only when new innovations occur (such as the new national medical support form that was recently introduced).

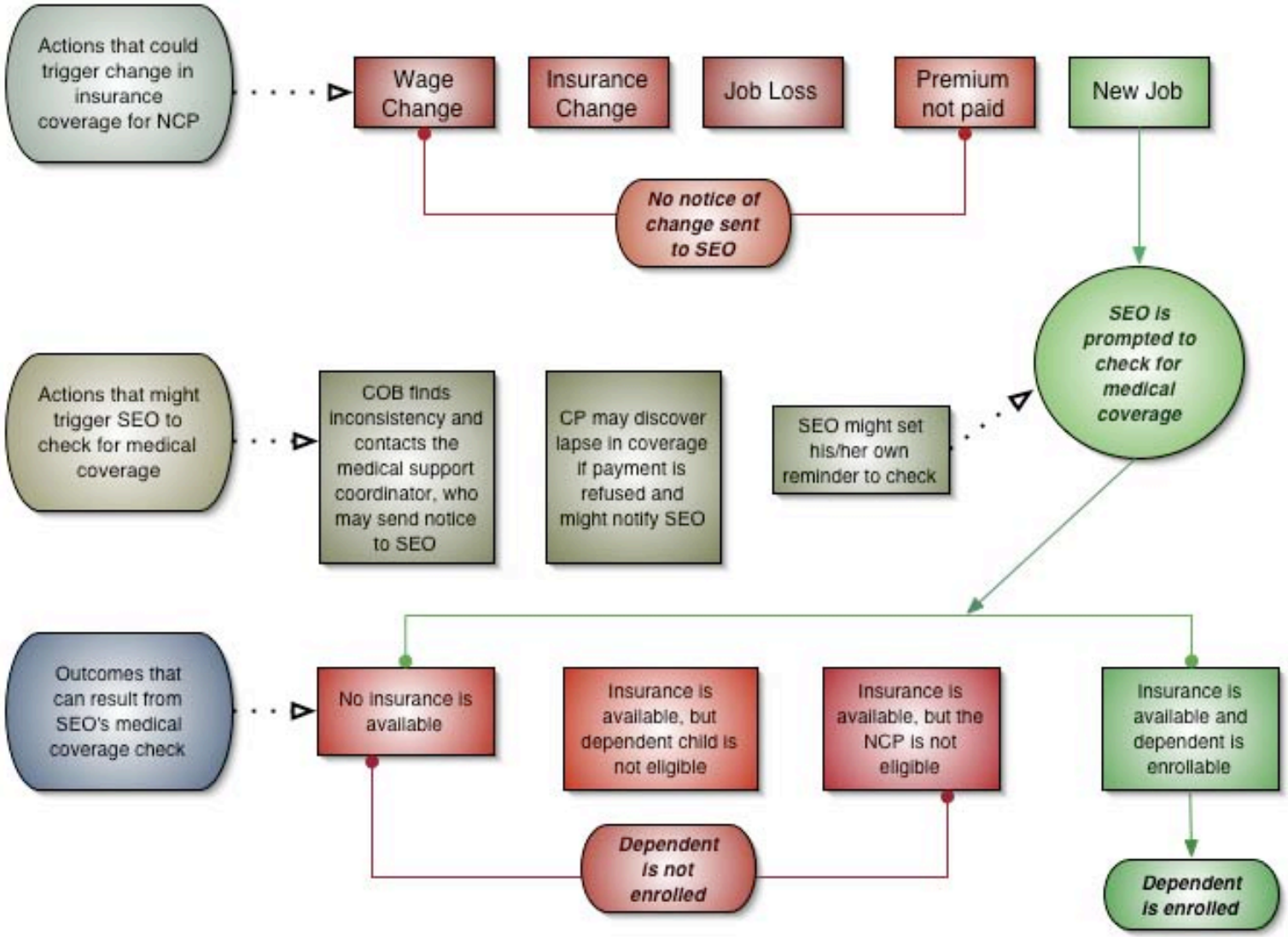
- **Insurance carrier codes are voluminous and difficult to correctly find.** SEOs are instructed to enter the carrier code that corresponds to the insurance information provided by the employer or third party administrator when there is a code available. The carrier codes are created and maintained by the COB for their use in Medicaid billings. DCS uses the codes to more easily transfer the insurance information from DCS to COB. COB may create multiple codes for one insurance provider (such as Aetna) if they have multiple billing departments or billing addresses. When an NCP is eligible for insurance with a company that has not been assigned a carrier code, or when the SEO cannot otherwise locate a code, the SEO can use a "generic carrier code" and type the insurance carrier name, address, and phone number in a SEMS case comment. The generic code tells COB that insurance is available but the caseworker will have to access the SEMS case comment screen to obtain the information. Identifying the correct code and updating the SEMS system can sometimes be time consuming for the SEO.

Recently, DCS and COB conducted a thorough, statewide review of cases in which the generic code was used, to determine if specific insurer information was available.

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits information available to custodial parents and SEO.** HIPAA, an act aimed at assuring medical privacy for individuals, makes it difficult for third parties such as SEOs and custodial parents to gain information about benefits that are available to the dependent in question when the non-custodial parent is the holder of the policy.

- **Numerous changes to insurance policies and eligibility can occur without the SEO's knowledge.** Perhaps the most serious impediment to accurate support enforcement is the number of variables that can impact insurance eligibility that occur without the knowledge of the SEO tracking the case. In general, once an SEO has recorded that insurance is either available or not available, no subsequent event triggers the SEO to reconsider medical support for that case *while the NCP remains in the job*. However, as just discussed, insurance changes occur frequently, and are not tied just to employment changes. Sometimes, the employee is not eligible for insurance for a period of time after a new hire (often 6 months). The SEO may send notice to the employer shortly after the hire is made. If the employer does not tell the SEO that the NCP will be eligible after a waiting period or if the SEO does not set a review code to remind him to check back with the employer, the SEO will never be prompted to consider medical coverage again even though the employee will be enrollable in time. Insurance eligibility can also change as a result of a wage increase or decrease, changes the employee makes during an open enrollment period, changes in company policy about insurance eligibility, changes in the insurance company's policy about eligibility or services covered, and, in the case of union employees, changes in the number of hours worked over time. The SEO is not alerted when any of these changes occur. Consequently, the SEMS database frequently contains inaccurate information. Unfortunately, one of the few mechanisms to alert SEOs of a change occurs when a custodial parent tries to access insurance for a dependent, and discovers that coverage has lapsed. Figure 3-3 provides further context for this difficulty.

Figure 3-3. Current Medical Support Enforcement Process, Washington State, 2004



[1] WAC 388-14A-4122.

[2] WAC 388-14A-4125.

[3] WAC 388-14A-4130.

[4] WAC 388-14A-4100.

[5] WAC 388-14A-4125.

[6] WAC 388-14A-4140.

[7] WAC 388-14A-4145.

[8] WAC 388-14A-4130.

[9] WAC 388-14A-4124.

[10] WAC 388-14A-4123.

DRAFT

Chapter 4 Headquarters Medical Unit

OVERVIEW

Child support agencies in Washington and elsewhere often turn to centralization to execute activities that are complex or dissimilar from other enforcement functions. Through this demonstration, Washington State explored whether a specialized medical support staff, operating from the agency's headquarters, could improve the enforcement of medical support orders. The controlled experiment took place during February to October 2003 and involved cases from the Fife, Washington field office. Specifically, through the demonstration, the State sought to learn whether Medicaid savings—resulting from improved enforcement of medical support obligations—could offset the incremental cost of the HMU activities.

This chapter provides information about the creation and goals of the HMU, describes the day-to-day activities of the HMU staff, and reports primary findings on the unit's impacts on state spending. The HMU operated under a true experimental design with cases randomly assigned to treatment (HMU enforcement) and control (status quo enforcement) cases. The experimental design permits a precise estimate of the HMU's impacts on State Medicaid spending.

The chapter concludes with a number of implementation strategies should the State consider extending the HMU concept beyond its experimental stage.

EVOLUTION OF THE HMU DEMONSTRATION

PLANNING AND SITE SELECTION

Washington first considered centralizing medical support in its Olympia headquarters office in 1994. However, planning for the HMU demonstration did not begin in earnest until 2002. The HMU operated on the premise that the dynamic nature of NCP employment and associated changes in health insurance made enforcement of medical support dissimilar to and often more challenging than other aspects of child support enforcement. Moreover, DCS was aware that field staff did not devote significant time and effort to the area, in part because federal performance measures emphasized the traditional core activities of paternity and order establishment and the collection of cash support. In fact, a 1994 study indicated that medical support enforcement represented only 3.4 percent of field office operations.

By 2002, two developments coincided that increased the agency's interest in testing the HMU concept.

1) **Pending federal performance measure on medical support**. By 2002, the federal government had fully implemented its performance measures on paternity establishment, order establishment, current collections, past-due collections, and cost-effectiveness. The federal Office of Child Support Enforcement had indicated a sixth measure was in development. Pending implementation of the measure inspired Washington and other states to review and test best practices in medical support enforcement.

2) **Implementation of digital child support records.** Also in 2002, DCS was in the process of converting its child support case records from a paper to a digital format. The advent of digital child support records significantly improved the feasibility of centralized, remote enforcement of medical support. With digital records, Olympia-based staff could access a detailed record on a case as easily as staff in the local field office.

While digital records were on their way statewide, by 2003, implementation was complete in only the Fife field office. Rather than delay the HMU experiment until every field office was digitized, DCS limited the geographic scope to Fife.

The Fife office manages cases from South King County, Pierce County, and all of the Kitsap Peninsula. The largest portion of cases (50 percent) comes from King County; most of the remaining cases (40 percent) are located in the Kitsap Peninsula. The cases include active, former, and never TANF cases. Though job duties and caseloads in the Fife office are similar to those in other Washington DCS offices, the Fife caseload is unique in a couple of ways. First, two nearby military bases—Fort Lewis Army Base (population 25,353) and McChord Air Force Base (population 9,772) —affect both the type of caseload profile and type of insurance available (that is, relatively high prevalence of CHAMPUS). Second, other than the US military, the area lacks large employers, which are more prevalent in the adjacent Seattle area (for example, Boeing, Microsoft, Amazon.com). Consequently, Fife's SEOs must be knowledgeable about the insurance and wage withholding policies and practices for a disparate group of smaller employers. Some SEOs suggested that the caseload in Fife is more difficult to manage than in other parts of the state; this sentiment was not unanimous.

CASE SELECTION

The experiment involved a total of 4,000 randomly selected cases from the Fife office. DCS randomly assigned the cases into two equally-sized groups:

- **HMU treatment group**. HMU reviewed the accuracy of all medical support-related information on the case and sent medical notices to employers as necessary. The treatment group consisted of 2,000 NCPs, representing 2,027 cases, because an NCP can be involved in multiple cases (i.e. have dependents with more than one custodial parent).

Throughout the discussion that follows, each "case" represents a dependent child(ren)/custodial parent pairing rather than an NCP. The numbers will therefore total to 2,027 rather than 2,000.

- **Control group**. The control group received standard medical support enforcement from SEOs in the Fife field office. Neither HMU staff nor Fife SEOs knew which cases were in the control group.

DCS elected to conduct a universal, rather than targeted, review of child support cases. A targeted approach could have limited the HMU reviews to cases with medical support orders, or cases with wage withholding in place, or cases in which a child is enrolled in Medicaid. Program designers opted for the more universal approach to ensure equitable medical support enforcement across the entire caseload.

Table 4.1 presents information collected from the child support demographic and orders files for the children of the NCPs assigned to the HMU and Control groups. As expected, the vast majority of the children were being cared for by a parent. In about 5 percent of the cases, the custodial adult was the child's grandparent, aunt or uncle, or other relative or guardian. The monthly order amount owed by the NCP for the child averaged $254. The arrears obligation averaged just $35, because most NCPs had zero arrears (20 percent of all NCPs had arrears).

In three-quarters of all cases, the NCP was responsible for providing medical support; the CP alone was responsible for medical support in only 5 percent of the cases. Only 7 percent of the cases were TANF cases, although this reflects the current status, as opposed to the status at entry into the IV-D program. About 41 percent of cases classified as non-TANF had TANF arrears. Similarly, about 49 percent of cases classified as Medicaid had TANF arrears.

HMU ACTIVITIES

In February 2003, Washington created an HMU, which consisted of one Support Enforcement Officer (SEO), two Support Enforcement Technicians (SET), and one part-time supervisor. The HMU office was located in the Division of Child Support's headquarters office in Olympia. Two of its members previously served in the Fife DCS office, one as an SEO and the other as an Office Assistant Senior (OAS). The third previously worked as an SET in another area of the DCS headquarters office.

While most medical support activities for the HMU cases were executed by HMU staff, one function remained the responsibility of the Fife field office. For HMU cases in which an NCP was newly hired during the experimental period, the Fife field staff still held the responsibility of sending the medical enrollment notice directing the employer to enroll children in health insurance. From that point, however, the HMU took over for remaining aspects of medical support enforcement. Review of cases began in February and was completed in October;

Table 4.1: Characteristics of Children in the HMU Experiment

Characteristic	Sample
Demographics	
Gender	
Female	49.3%
Male	50.7%
Age	
Under 3	3.8%
3-5	10.7%
6-10	24.2%
11-18	46.1%
Over 18	15.2%
Relationship Status	
Relationship of CP to child	
Child or step-child	95.8%
Nephew or niece	0.8%
Grandchild	2.8%
Other	0.4%
No relationship	0.2%
Child Support Measures	
Average monthly order amount ($)	253.98
Average arrears obligation ($)	35.06
Medical responsibility	
No effective order	15.6%
CP responsible	5.2%
NCP responsible	72.9%
No one responsible	6.3%
Type of order	
Divorce/dissolution	29.6%
Temporary court order	2.3%
Paternity order	11.5%
URESA	2.1%
Other court order	9.5%
Administrative order	4.6%
Consent order	0.4%
Agreed settlement	3.5%
Other	36.6%
Type of current case	
TANF	7.2%
Non-TANF	65.7%
Fostercare	0.6%
Non- IV-D	0.5%
Child care	0.0%
Medicaid	15.6%
No case type	10.3%
Sample Size	6,389

Source: The Lewin Group calculated using Washington DCS data

training slowed progress for the first month, and one of the three HMU staff members did not join the team until April.

Specifically, DCS charged the staff with two tasks:

- **Assess the accuracy of medical support enforcement data.** Given the likelihood of a federal performance measure on medical support, DCS directed the HMU staff to assess the accuracy of data related to medical support in the State's management information system. While improved data accuracy may or may not result in Medicaid savings, the exercise would give the agency a sense of the quality of its data and a preview of the challenges it might face in preparing for future federal audits associated with an anticipated performance measure.

- **Review cases for existing or potential health coverage.** The core purpose of the HMU was to identify cases in which an NCP had health insurance available—through an employer or union. The HMU would determine if the coverage was available for dependents and, if so, at what cost.

In the remainder of this section, we describe the outcomes of these two key tasks as reported by HMU staff.

ASSESSING DATA ACCURACY

An important prerequisite to effective medical support enforcement in Washington is the availability of accurate information in the Support Enforcement Management System (SEMS) database. If SEMS does not accurately reflect the insurance coverage available, SEOs cannot effectively enforce medical support. A major part of HMU activities including the "cleaning" of the SEMS database, to assure that medical support orders were in place and that medical insurance codes were up-to-date. These activities included:

- Updating the medical insurance screen with insurance information

- Sending the Notice of Insurance Coverage to the custodial parent when appropriate

- Verifying the accuracy of child support order information in SEMS and making corrections when necessary

- Checking for Medicaid coverage on non-TANF assistance cases

- Processing Third Party Liability (TPL) reports

In essence, the HMU staff completed the time-consuming work of cleaning the data in the SEMS system to assure that medical support enforcement could occur efficiently. They updated medical screens in the SEMS system, followed up with employers, and assured that the right code was entered for each insurance

company. Most of these updates were specific to medical information, but staff also made changes to the system in general when they discovered inconsistencies or inaccuracies in a case. In their work to update the SEMS system, the HMU staff were essentially completing the work that any Support Enforcement Officer would undertake on a daily basis. However, their ability to focus attention on the task led to the discovery of a broad range of data inaccuracies.

Of the total number of cases that the HMU reviewed, only about half (1,025) did not require data changes or updates. Table 4.2 summarizes the changes that HMU made in the SEMS system during their review process. Some of the changes were to the most basic components of data about a case, such as the type of case (TANF, Medicaid, Nonassistance) under review. Others were changes related to the more basic medical support enforcement tasks, including updating information about medical forms that had been sent to and received from employers. In the 2,027[1] cases under review, nearly 1,300 data updates were needed.

[1] As noted above, "case" here refers to the number of child/custodial parent pairings involved in the treatment group (2,027) rather than the number of NCPs (2,000).

Table 4.2. HMU data update summary, 2004

Data problems resolved	Number
"Medical" screen updated	*365*
Coverage found to be terminated, termination date added	152
Updated code for "reason coverage not provided"	49
Changed code for who is covered under the policy	153
Code for insurance carrier corrected	124
New carrier code added	18
Description of the type of case corrected	*432*
Enforcement Services Updated	*56*
Case listed as child and medical support changed to child supprt (CS) only	42
Case listed as CS only change to CS and medical support	11
Case listed as CS and medical support changed to medical support only	3
"Order" Screen corrected	*321*
Premium limit increased	236
Code for party responsible to provide insurance changed	101
Date through which court order is valid was entered	42
No order in file	4
Updated "Forms Screen" to reflect responses from employers to medical response forms	*111*
TOTAL	***1285***

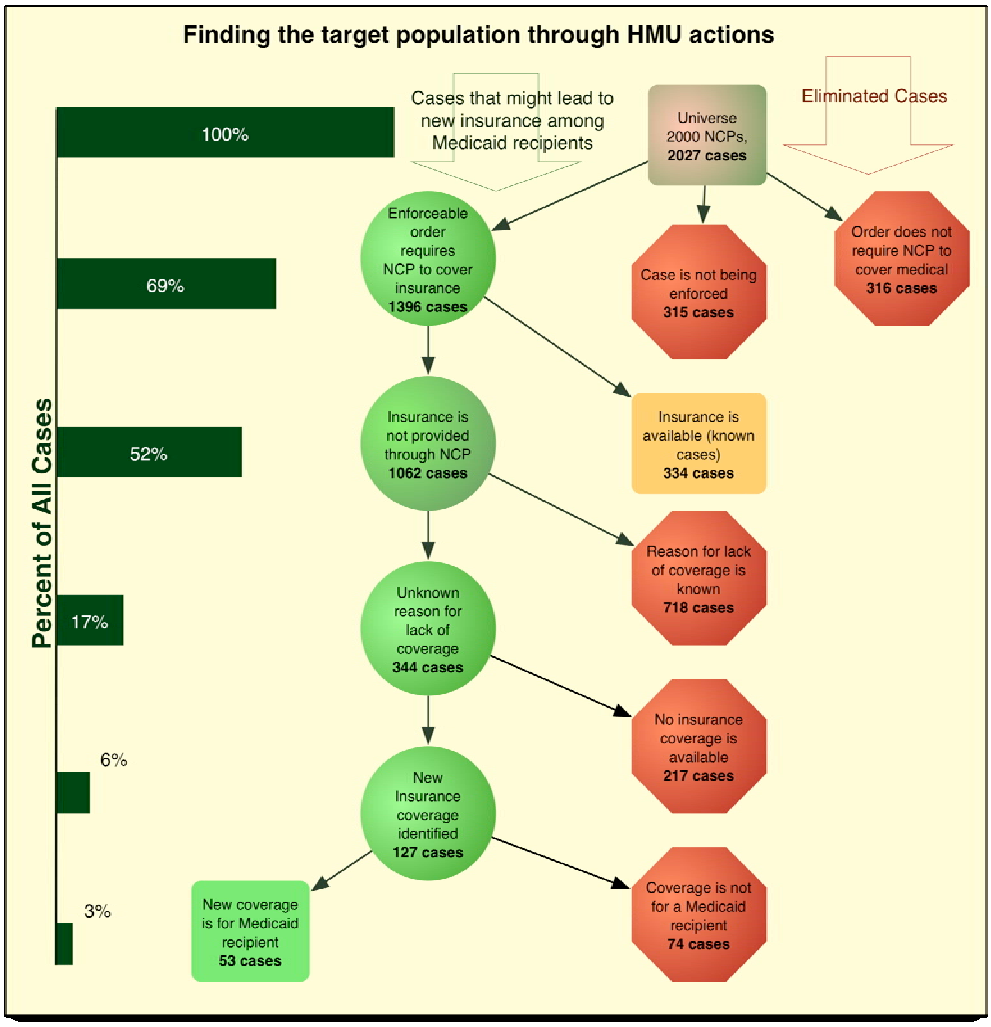
Source: Division of Child Support

Once all screens were up-to-date and accurate, the HMU staff set a review code in the SEMS data management system to remind SEOs to verify and, if necessary, update the medical support information for the case in six months.

DISCOVERY OF COVERAGE

Through their review of 2,027 cases, HMU staff discovered 53 cases in which new insurance information was available for the target population (eligible children who had previously been accessing Medicaid). Figure 4-1 describes these results graphically, showing the path that led from 2,027 cases down to 53, and explaining why cases were eliminated at each step. Each red octagon represents cases that were determined, for some reason, to be unable to provide insurance, while each green circle represents cases that still might be discovered to provide insurance for the target population. Additional details are provided in the text following Figure 4-1, with descriptions of the cases that were eliminated and of those that remained.

Figure 4-1. HMU Case Review Results, 2004



Source: ECONorthwest, based on Division of Child Support analysis of HMU results

- **The HMU test case universe (100 percent of treatment cases).** HMU staff began their case-by-case review of the 2,027 cases by removing cases for which enforcement actions would not be necessary, including cases with no medical support order in place. Of the 2,027 total cases, about 16 percent (316 cases) did not have a medical support order requiring the NCP to provide insurance. Without this order in place, DCS has no authority to require the NCP to provide medical support. For these orders, if appropriate, the HMU referred cases for possible order establishment. These 316 cases without orders were divided into three categories:

    1) Medical coverage was not addressed in the order at all (141 cases, 45 percent)

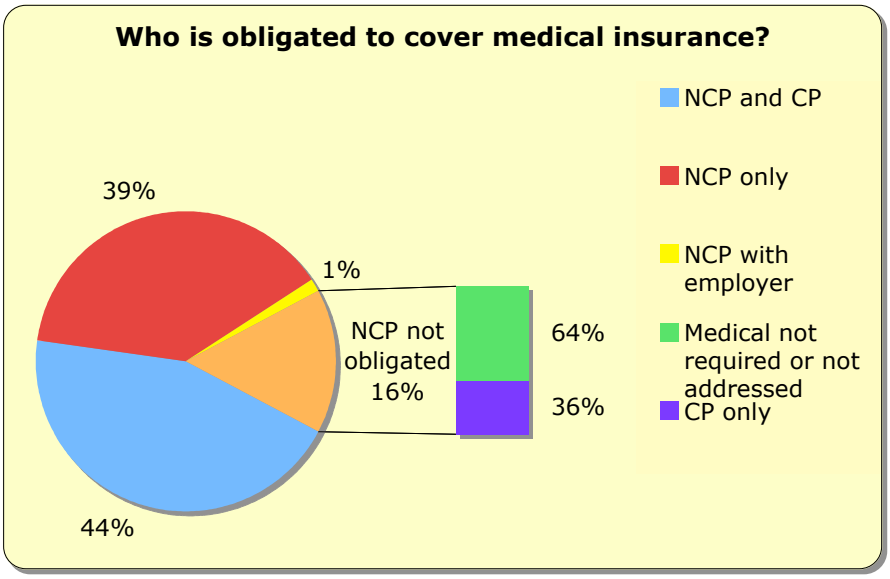
    2) The custodial parent was required to provide insurance; the NCP has no medical responsibility (115 cases, 36 percent)

3) Though insurance coverage was addressed, it was not a required part of the support order (60 cases, 19 percent)

The remaining 1,711 cases had orders in place that required the NCP to provide insurance. In many of those cases, the NCP was not the only person obligated. Just over half (53 percent) of the cases required both the NCP and the CP to provide medical insurance. An additional 2 percent obligated the NCP to provide coverage with an employer contribution. A total of about 46 percent of cases obligated the NCP only to provide coverage.

Figure 4-2 shows the full distribution of medical insurance coverage responsibility among all test cases, including those cases in which an NCP was not obligated. An NCP was only obligated to cover some portion of insurance costs in 84 percent of the HMU test cases.

Figure 4-2. Distribution of medical insurance coverage obligations among HMU test cases, 2004



Source: ECONorthwest, based on Division of Child Support analysis

- **Order requires NCP to provide insurance, and the case is enforced (69 percent of treatment cases).** An NCP was obligated to provide at least some portion of the cost of coverage for 1,711 cases. Of these 1,711 cases, 315 (18 percent) were not currently being enforced. Cases might have a valid order but not be enforced for three reasons:

  1) **Emancipated child.** The order is for a child that has reached the age of 18 and been emancipated. This represented 131 (42 percent) of the 315 cases that were not enforced.

  2) **Child no longer on the case.** In these instances, the child may be living with the NCP, or the location of the child was

unknown. 113 of the 315 cases that were not being enforced fell into this category.

3) **Custodial parent declined support enforcement services.** In 69 of the cases (22 percent), the custodial parent declined support enforcement services.

Removing the non-enforced cases left a total of 1,396 cases that had enforceable orders in place. Of those 1,396 cases, the SEMS system showed active coverage successfully provided through the NCP for 334 cases. Since DCS staff were already aware of this insurance and the child was covered, no additional enforcement actions were necessary. These cases are represented in a yellow box in Figure 4-1 above.

Table 4.3. Reasons for lack of coverage in HMU experiment, 2004

Reason for lack of coverage	Number of cases	Percent
No known location for NCP	334	47%
Insurance not available through employer	226	31%
NCP receiving unemployment assistance	56	8%
NCP on public assistance	37	5%
NCP is incarcerated	31	4%
NCP is self-employed	28	4%
NCP receiving workers' compensation	6	1%
Total	*718*	*100%*

Source: Division of Child Support, 2004

- **Enforceable order, but insurance is not provided through NCP (52 percent of treatment cases).** The verification of active coverage for 334 cases left 1,062 cases in which the NCP was not providing medical support as ordered. This means that, before the HMU took any enforcement actions, just over 75 percent of all cases with valid, enforceable support orders in place were not meeting their medical obligations. Of those that were not meeting their obligation, 68 percent (718 cases) were not providing support for reasons that were known to DCS. These reasons are outlined in Table 4.3.

  For the largest number (47 percent) of cases, NCPs were not providing insurance coverage because their location was unknown at the time that the demonstration occurred. The next largest group could not provide insurance because it was not available through their employer. Insurance might not have been available for a variety of reasons, including:

  1) The premium limit was exceeded

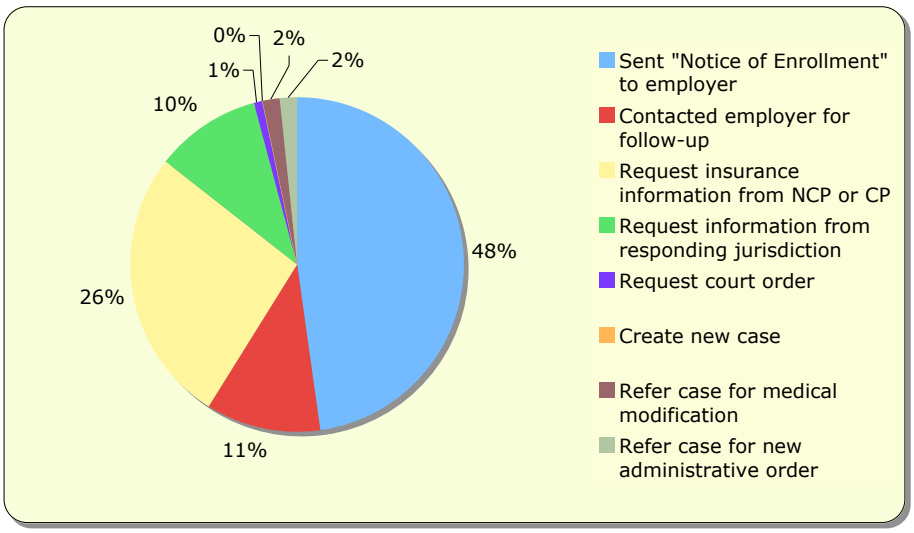
2) Employer does not offer medical insurance for dependents

3) NCP is not enrolled in insurance

4) NCP is not eligible to enroll in insurance

- **Unknown reason for lack of coverage (17 percent of treatment cases).** The HMU targeted enforcement actions for 344 cases for which the reason for lack of coverage was not known. If the SEMS system showed that, though it was properly ordered, no active coverage was provided, HMU sent notices to employers to discover if insurance was available. In some cases, they called the employer to verify results. Once HMU staff had identified an insurance carrier, they updated the SEMS database. If the SEMS system showed that active coverage was provided, HMU staff checked the insurance carrier code to make sure that it accurately reflected the coverage provider, including the proper billing address. If carrier information was not correct, they updated the information.

Figure 4-3. Results of HMU enforcement actions, 2004



Source: Division of Child Support
Note: This table notes that the total number of enforcement actions taken was 366; this is higher than the number of cases for which actions were needed (344) because some cases required more than one enforcement action.

These represented 32 percent of enforceable cases where insurance was not already provided. Figure 4-3 summarizes the actions that the HMU took and the results achieved because of those actions.

Overall, about 32 percent of the HMU's enforcement actions successfully resulted in new medical information. For the largest number of cases (159), the HMU SEO sent a "Notice of Enrollment" to the NCP's employer, which requested the employer to verify the availability of insurance and then, if the dependent is eligible, enroll him for coverage. This action had a success rate of about 35 percent. Direct contact with the employer resulted in the highest rate of new information (about 45 percent

of contacts were successful), but was also the most time consuming of the possible actions.

- **New insurance coverage identified (Six percent of treatment cases).** The HMU's work resulted in new insurance information for a total of 127 cases.

- **New coverage is for Medicaid recipient (Three percent of treatment cases).** Of the 127 new private insurance policies that were discovered, 53 covered children who had previously accessed Medicaid for health care. About half of the new insurance policies could result in savings to Medicaid.

STAFF PERCEPTIONS OF THE HMU

We interviewed HMU staff and SEOs in the Fife field office to explore their views about the efficacy of centralizing the medical support function. HMU staff generally saw value in the centralized effort and pointed to the large number of inaccuracies in SEMS's medical screens as evidence for the need of a more intensive approach to medical support enforcement. HMU staff highlighted two challenges that persisted during the demonstration:

- **Interstate cases proved challenging despite the centralized, focused effort**. If the NCP was living out of state, identifying an employer and sending the medical support notice was more difficult. Moreover, in a number of instances, HMU staff had to correct the SEO's misapplication of Washington's premium limit, which does not apply to out-of-state child support orders.

- **Mail processing could not be tailored for the HMU demonstration.** The current system of sorting incoming mail does not permit a separation of medical support mail from all other mail related to case. As a consequence, during the demonstration, an employer's response to an HMU insurance inquiry was sent to SEOs in Fife rather than the HMU in Olympia. The SEO who received the mail may or may not have been aware of the HMU's action. Similarly, clients and employers who had questions about medical enforcement had no way to reach HMU employees, and often called SEOs in Fife instead. This generated confusion for the SEOs, the clients, and the employers.

SEOs in the Fife office offered mixed reviews of the centralized medical support office. Because of the inherent complexity of the task, a focused area of expertise in medical support enforcement requires time and attention for development that may not be feasible given the workload of most SEOs. On the other hand, a caseworker in the HMU will not be as familiar with all other aspects of the case, and may therefore make less informed decisions. The following is a summary of potential benefits and drawbacks to the HMU, as offered by SEOs.

- **The HMU could improve accuracy of medical information, ultimately resulting in cost savings to the State**. Because the HMU staff would focus their professional efforts on medical support only and would gain specialized knowledge in the area, their medical support enforcement efforts might represent an improvement over the status quo.

- **The HMU allows SEOs to focus on child support enforcement**. One SEO estimated that, while medical support represents only about 5 percent of her total workload, about 20-25 percent of the calls that she receives are medical support related. Medical support specialists can eliminate some of that workload, allowing SEOs to improve their child support enforcement capabilities.

- **The HMU could process the growing number of cases that are for medical support only.** These cases currently receive less SEO attention, because there is no specific performance incentive to pursue them.

- **Centralization fails to take advantage of special field office expertise about employers..** A variety of methods of enforcing medical support can be used, and the SEO generally uses his or her judgment to determine which is most appropriate to a specific case. SEOs can send a letter to the NCP, can send the National Medical Support Notice (NMSN) to employers, or can send a letter to employers. Without understanding the specifics of a given order, the HMU uses the NMSN almost exclusively, which can result in confusion on the part of NCPs, CPs, and employers, and may even reduce the chance of compliance. Additionally, several SEOs mentioned that they have developed relationships with particular employers, and are familiar with their insurance rules and regulations. When notices for insurance are sent as a result of HMU efforts, it generates work and confusion for the employers and may jeopardize the relationship that the SEO has worked to develop.

- **Centralized medical support can be more difficult for employers.** Under the current system, when employers have questions about a case, they have just one DCS employee to call. The addition of the HMU means that, potentially, employers could have to call the HMU for medical and insurance questions and the SEO for all other questions.

- **HMU generates work for SEOs in field offices.** Because DCS is unable to separate medical support mail from general child support mail, when HMU staff send out medical support notices to employers, responses are returned to the SEOs. While this effect might taper over time if the HMU were implemented full scale, it generated confusion and duplication of efforts for HMU staff and SEOs during the experiment.

- **The HMU could lead to duplication of efforts and/or unclear job delineations.** Medical support enforcement and child support enforcement activities are similar in many ways, and may overlap. Policies and job

descriptions should be clearly defined and communicated to avoid confusion.

SHORT-RUN IMPACTS ON STATE SPENDING

Implementation of the HMU has two expected impacts on state spending:

- **Decrease in Medicaid spending**. In implementing the strategy, DCS anticipated that intensive enforcement of medical support would decrease state spending on Medicaid by shifting the cost of providing medical coverage to some NCPs and their third-party insurers.

- **Increase net DCS enforcement costs**. More intensive enforcement usually implies more staff and resources. In the case of medical support enforcement, DCS recognized field offices spent only limited time and resources on medical support in the past. The net cost of the HMU has two components. The *cost* of creating the central unit less the *savings* associated with reduced work in the field office.

Below, we detail our estimates on Medicaid savings and net HMU administrative costs during the first 18 months of the experiment.

IMPACTS ON MEDICAID SPENDING

We estimated the impact of the HMU intervention on Medicaid and third party coverage incurred by Medicaid and the third party providers over the 10 quarters following random assignment. The goal of the HMU model was to enroll more children in private medical insurance plans, thereby increasing the healthcare claims incurred by private insurers, and reducing claims incurred by the state. Thus, if the HMU approach was successful, we would see a negative impact on both Medicaid eligibility and Medicaid claims and a positive impact on third party coverage.

The length of the follow-up period (10 quarters) was selected to capture the full impact of the HMU intervention. There are several reasons why the impacts may not be seen immediately, requiring the longer follow-up period to assure. First, as discussed above, the State encountered start-up delays in hiring and training three full-time staff. When staff found a case in which the NCP was required to provide medical coverage, several steps were required before new medical information was obtained from the third party insurer, all of which took time. As discussed earlier, HMU staff contacted employers, requested new information from the NCP or CP, and in some cases requested court or administrative orders.

Additionally, for those cases in which DCS successfully discovers health insurance and enrolls a child, DCS still has to inform the Medicaid agency's Coordination of Benefits office, so they can enforce the third party insurance. Put simply, medical support enforcement takes time.

Finally, while the HMU unit reviewed the cases for potential medical support recoveries, the state would seek reimbursement from third parties only when it is determined that the third party was liable for past *fee-for-service* claims paid by the state. It is important to note that many children in the state's Medicaid program are enrolled in Healthy Options, Washington's Medicaid managed care program. In this program, the state pays a monthly fee to managed care providers for individuals enrolled in their Healthy Options plans; these fees cannot be recovered. Thus, any savings will occur only *after* the state learns the child is eligible for private health insurance and stops paying the managed care premiums. These savings would emerge later in the 10-quarter follow-up period.

Table 4.4 presents the impact of the HMU intervention on Medicaid and third party coverage. The term *coverage* refers to Medicaid eligibility and third party enrollment. As the first set of rows shows, the HMU intervention had little to no impact on reducing Medicaid coverage. About 34.9 percent of the HMU group was eligible for Medicaid in quarter six compared with 35.3 percent of the Control group. This difference is negative, but not statistically significant, meaning we cannot attribute the decrease to the HMU intervention. Only in the first quarter do we see some change which might be attributed to the intervention.

Another measure of the impact on coverage is the number of months eligible for Medicaid during the follow-up period. Again, Table 4.4 shows that the HMU intervention did not have an impact on Medicaid coverage. While the number of months of Medicaid coverage was lower for the HMU group than for the Control group, this difference was not statistically significant.

Turning to the impact on third party coverage, we see that the intervention increased third party coverage, from 12.7 percent in quarter ten for the Control group to 15 percent for the HMU group. This 2.3 percentage point difference is statistically significant. The impact on third party coverage is also found when examining the number of months of coverage. The HMU intervention increased the number of months of third party coverage over the follow-up period from 3.3 months to 4 months, a statistically significant increase.

Figure 4-4 illustrates the growth of Medicaid and third party coverage over the follow-up period. As this figure shows, there was virtually no difference in Medicaid coverage rates between the HMU and Control groups. This was not true for third party coverage. By the end of the follow-up period, the graph shows an increase in third party coverage.

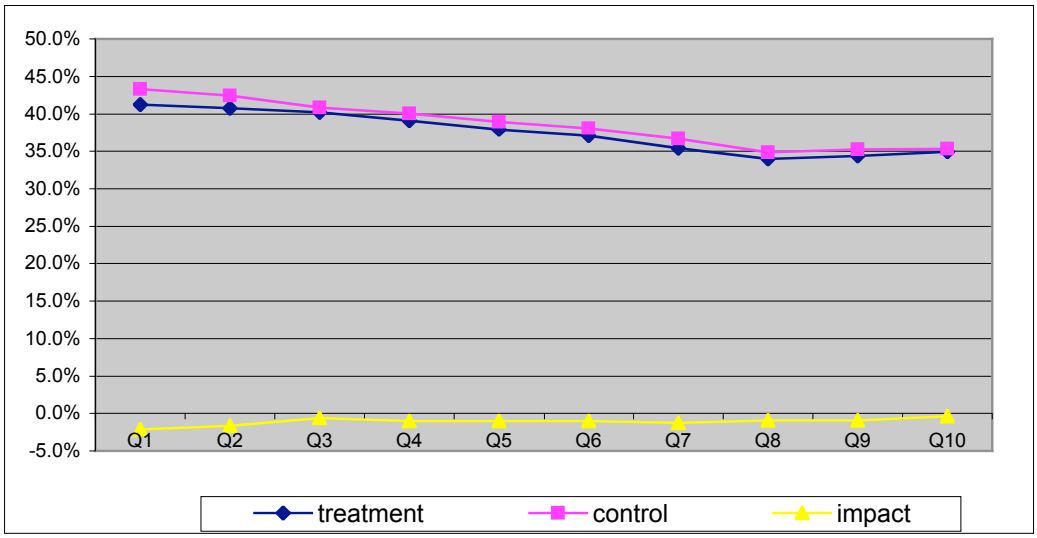
The HMU intervention shows some promise for reducing Medicaid claims paid to save the state some public insurance expenditure. Over the 10 quarters of the intervention, the average claims were down about $350, a statistically significant change that is more likely to result from the intervention activities than from chance alone. The savings were evident only in long-run analysis.

Table 4.4: Impacts of the HMU on Medicaid and Third-Party Insurance Enrollment and Medicaid Claims, January 2003-October 2004

	Treatment Group	Control Group	Impact		p-value
Percent covered by health care program by quarter following assignment					
Medicaid coverage					
Quarter 1	41.2%	43.3%	-2.1%	*	0.0870
Quarter 2	40.8%	42.5%	-1.6%		0.1832
Quarter 3	40.2%	40.9%	-0.6%		0.6126
Quarter 4	39.1%	40.1%	-1.0%		0.4112
Quarter 5	37.9%	39.0%	-1.1%		0.3869
Quarter 6	37.1%	38.1%	-1.0%		0.4118
Quarter 7	35.4%	36.7%	-1.3%		0.2999
Quarter 8	33.9%	34.8%	-0.9%		0.4453
Quarter 9	34.3%	35.3%	-0.9%		0.4397
Quarter 10	34.9%	35.3%	-0.4%		0.7322
Third party coverage					
Quarter 1	10.7%	9.2%	1.5%	**	0.0406
Quarter 2	11.8%	9.7%	2.1%	***	0.0076
Quarter 3	12.5%	10.4%	2.1%	***	0.0086
Quarter 4	13.3%	11.1%	2.2%	***	0.0075
Quarter 5	13.7%	11.3%	2.5%	***	0.0031
Quarter 6	14.2%	11.5%	2.6%	***	0.0017
Quarter 7	14.5%	11.7%	2.8%	***	0.0011
Quarter 8	14.6%	12.4%	2.3%	***	0.0078
Quarter 9	14.9%	12.5%	2.3%	***	0.0064
Quarter 10	15.0%	12.7%	2.3%	***	0.0090
Number of months covered by health care program following assignment					
Medicaid coverage					
In Year 1 (Quarters 1-4)	4.6	4.8	-0.16		0.2429
In Quarters 1-6	6.7	6.9	-0.23		0.2481
In Quarters 1-10	10.7	11.0	-0.33		0.3007
Third party coverage					
In Year 1 (Quarters 1-4)	1.4	1.2	0.23	**	0.0126
In Quarters 1-6	2.2	1.9	0.37	***	0.0070
In Quarters 1-10	4.0	3.3	0.67	***	0.0048
Percent with claims paid					
Medicaid claims					
Ever in Year 1 (Quarters 1-4)	43.2%	44.3%	-1.1%		0.3961
Ever in Quarters 1-6	46.2%	46.9%	-0.7%		0.5804
Ever in Quarters 1-10	48.4%	49.2%	-0.9%		0.4978
Average claims paid ($)					
Medicaid					
Quarters 1-4	$ 532.3	$ 582.7	$ (50.3)		0.4962
Quarters 1-6	$ 824.9	$ 966.9	$ (142.0)		0.2543
Quarters 1-10	$ 1,345.0	$ 1,696.0	$ (351.0)	*	0.0872
Sample Size	3,129	3,260			

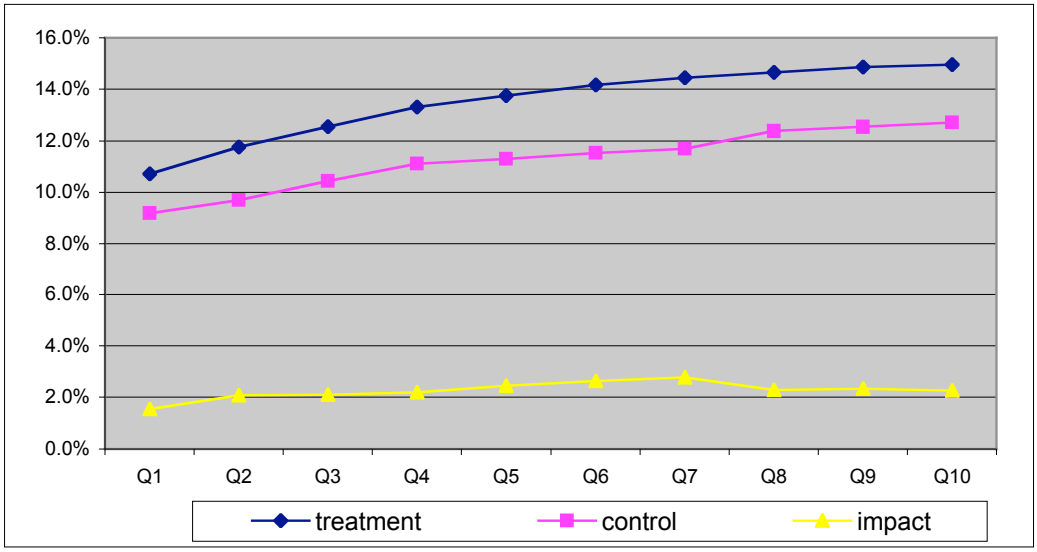
Source: The Lewin Group calculated using Washington DCS and Medicaid data

Figure 4-4: Percentage of Treatment and Control Cases Enrolled in Medicaid, January 2003-October 2004



Source: The Lewin Group calculated using Washington DCS and Medicaid data

Figure 4-5: Percentage of Treatment and Control Cases Enrolled in Third-Party Coverage, January 2003-October 2004



Source: The Lewin Group calculated using Washington DCS and Medicaid data

Finally, we used the data from the experiment to estimate the probability of having third party coverage in the 18 months following assignment to the program. Based on a logistic regression model, Table 4.5 shows the coefficient of several characteristics increase the likelihood of having third party coverage, including: An NCP who is medically responsible for the child, having a child under the age of six; having a current or former connection to the TANF program; and having a monthly order amount that is at least $300 all have significant and positive effects on third party coverage. Being assigned to the HMU group also increased coverage.

Table 4.5

Variable	Coefficient	Statistical Significance
Intercept	-2.7634	***
NCP is at least 35 years old	0.0858	
Child is less than 6 years old	0.441	***
Currently or formerly on TANF	0.3329	***
NCP is medically responsible for child	0.4285	***
NCP has arrears	-0.0239	
Monthly order amount is at least $300	0.1471	*
In HMU group	0.2184	***

IMPACTS ON DCS COSTS

DCS is interested in calculating the net cost of the HMU activities should they pursue broader implementation of the approach. The *net* cost of the HMU treatment equals the operational costs of the HMU itself *minus* the costs of enforcing medical support for the control cases (or the status quo cost of medical support). Put differently, the cost of a centralized unit would be partially offset by the savings associated with eliminating medical support as an activity in the field offices.

The estimate begins with a calculation of the HMU's costs. During January 2003-October 2003, the State estimates HMU personnel required $99,664 in salary and benefits to cover three full time enforcement staff (one Support Enforcement Officer Level III and two Support Enforcement Technicians) and one supervisory position.[1] These costs were divided as shown in Table 4.6 below.

Table 4.6. Staff expenditures for implementation of HMU, 2004

Employee	Hours	% of total hours	Salary	Benefits	Salary and Benefits	% of total costs
Supervisor	246	6%	$4,427	$1,107	$7,915	8%
SEO III	1,480	35%	$3,818	$955	$41,066	41%
SET	1,042	25%	$2,841	$710	$21,514	22%
SET	1,480	35%	$2,712	$678	$29,170	29%
Totals	**4,248**	**100%**			**$99,664**	**100%**

Source: Division of Child Support

To estimate the medical support costs associated with the 2,000 control cases enforced through the Fife field office, we draw on a 1994 study that estimated about 3.4 percent of *field office resources* are required to carry out typical medical support activities.[2] "Resources" include staff time for all field office employees,

including support staff and management who do not typically carry a caseload. While the study is more than a decade old, responses to our interviews suggested SEOs devote roughly 3 to 5 percent of their time to medical support enforcement.

For the purposes of this study, we will assume 3.4 percent of office operational costs remains a reasonable approximation of the medical support's costs. Fife field office has an average monthly payroll of $452,256,[2] so medical support's share would be 3.4 percent of that total or $15,377 per month for all 18,900 cases. However, the control group's 2,000 cases represented only 10.6 percent of Fife's total. That implies the Fife office spent $1,627 per month to enforce medical support on control cases. Over the eight month period, the office spent $13,016.

Therefore, we estimate the net cost of the HMU treatment equals the cost of the HMU activities ($99,664) less the cost of status quo enforcement ($13,016), or $86,648.[3]

CONCLUSIONS

The HMU intervention shows promise for marginally increasing third party coverage, and may show promise for reducing Medicaid claims paid. The intervention did not, however, measurably reduce the number of children covered by Medicaid. The findings should come as no surprise because the HMU staff independently estimated that they uncovered new insurance information for only 53 of the 2027 cases in the treatment group. While our impact study found that the HMU measurably increased the share of Medicaid children with third-party coverage, the effort did not translate into lower Medicaid enrollment rates or claim payments.

This study suggests that the challenges facing the HMU are similar to those that face medical support initiatives across the country. DCS is essentially attempting to identify NCPs with relatively stable, good paying jobs with health coverage, who are associated with children who are not only enrolled in Medicaid but used its services. The HMU impacts suggest the combination is exceedingly rare. Challenging the unit's success further is Washington's limit on premiums, which negates the medical support obligation if the cost of available coverage exceeds 25 percent of the NCP's basic child support obligation. As growth in health insurance premiums has outstripped wage growth in recent years, the premium limit affects a growing share of the agency's cases.

The findings presented here argue against the implementation of a statewide HMU in the form it took during the demonstration. The unit's very broad scope,

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[2] Average for the six month period between July and December, 2004 for all staff. Provided by Division of Child Support.

[3] When comparing these costs, it is important to note that the initial data updates that the HMU completed added to the costs of the experiment; once these activities were completed, the HMU functioned more efficiently. The cost of running the experiment may not be directly indicative of the cost of state-wide implementation of the HMU.

which essentially addresses all cases with orders for cash support, is unlikely to prove cost-effective. Moreover, any medical support enforcement strategy—centralized or not—will struggle to produce benefits if the State's premium limit remains in place.

If DCS is interested in pursuing the HMU concept in another form, the State should consider the following recommendations:

- **Delay implementation until complementary medical support reforms are in place**. Washington's limit on premiums (25 percent of the basic support obligation) restricts opportunities for medical support enforcement and will limit the impacts of any enforcement strategy. Complementary medical support reforms, including the conversion of medical support to cash or allowing NCPs to contribute to Medicaid or SCHIP premiums, could improve the cost-effectiveness of an HMU or other intensive efforts to enforce medical support.

- **Target cases for review.** The number of caseworkers required to staff the HMU could be reduced if they reviewed only a targeted set of cases. Our probability analysis—presented earlier in this chapter—suggested the likelihood of discovering third-party coverage increases for cases in which the NCP has an order in excess of $300 per month. If Medicaid savings remains the goal, DCS should target current and former TANF cases, which are much more likely to involve a child who is, or has been, Medicaid eligible.

- **Define and prioritize the primary goals of the HMU.** It is important to note that targeting a particular population might not lead to increased Medicaid recoupments because there is limited overlap between NCPs who have dependents on Medicaid and NCPs who have access to private medical insurance. This points to the larger question of defining the goals of medical support enforcement in Washington State. Will the HMU seek to reduce costs to Medicaid? Or will its goal be to increase the number of children who are enrolled in private insurance? The HMU will be structured differently—and target a different set of cases—depending on the goal it attempts to achieve.

  When it is instated, the federal medical support performance measure could determine which cases the HMU would target and help to define its goals. Earning incentive dollars through progress toward the federal performance measure would become a key function of the HMU.

- **Address mail separation problems.** Much of the confusion between the Fife field office and the HMU can be traced to the fact that the current mail routing system cannot send incoming mail to more than one place. Consequently, HMU staff would mail medical support notices and the field office staff would receive replies. Upgrading to a centralized mail imaging system that would allow mail to be routed to multiple recipients would be a critical prerequisite to successful implementation of the HMU.

- **Implement the HMU in phases.** The HMU intervention was not intended to identify all of the potential problems that could arise with full-scale implementation, nor to find solutions to the problems that did arise. Additionally, there will be a learning curve for both HMU and field office staff during the first phases of implementation. New problems would almost certainly arise during full-scale implementation that would require time and effort to address. Working with field offices one at a time to bring them into the process would smooth the transition. Since the Fife field office already has some experience with HMU activities, it would be a logical starting place. Other field offices could be brought in incrementally to allow time for training and development of an efficient work flow.

- **Achieve a mutual understanding of the importance of the HMU.** There may be some resistance from field offices regarding a full-scale implementation of the HMU. Two reasons for this resistance are:

    1) The HMU may require some field offices to give up vacancies in their SEO staff. This leaves the field offices with fewer SEOs to pursue cash support, a key performance measure for federal incentive dollars. Many staff members value the relationships that they have developed with employers and clients. Handing off medical support duties to the HMU means that employers and clients will have multiple points of contact, providing fewer opportunities to foster relationships.

    2) The HMU will need to work closely with field office management and SEOs to explain the importance of their role in the overall provision of child support services.

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[1] Division of Child Support, 2005.

[2] Aaron Powell, 1994. Statistics provided by Gaye McQueen, Medical Support Program Manager, Washington Division of Child Support.

Chapter 5 Private Vendor Data Matches

OVERVIEW

Washington's second medical support demonstration involved matching data with private companies that maintain large, national-scale databases on health insurance coverage for individuals. The goal of the data match is to find NCPs who either have enrolled—or could enroll—Medicaid-eligible children in third-party insurance plans. The strategy assumes that the matching process provides a quick and efficient method to update the health insurance status of a large volume of NCPs.

In this demonstration, the State of Washington contracted with two private vendors: Public Consulting Group (PCG) and Health Management Systems (HMS). Each company provides medical support services to a number of child support agencies across the country, providing services that range from data matching to comprehensive medical support enforcement. Washington limited the scope of this demonstration to data matching. Under the terms of their contracts, each vendor received 4,000 cases drawn randomly from the statewide caseload of cases with orders for cash support. In addition, the State established a control group of 4,000 randomly selected cases that received standard medical support enforcement through SEOs in field offices across the state.

The vendors received cases in March 2004 and returned their matched data during June-July 2004. The State assigned a lead medical support SEO to process the vendors' matched data, updating case insurance information wherever necessary and appropriate.

This chapter describes the work processes undertaken by the vendors and the State in the data match demonstration. Specifically, the chapter provides a detailed description of the process that each of the vendors used to complete the data match and describes DCS's early findings on the utility of matches. Additionally, the chapter describes the impacts that the vendor experiment had on reducing Medicaid expenditures and third party coverage.

VENDOR CASE REVIEW PROCESS

A number of states have contracted with private vendors to assist in the identification of cases eligible for medical support. The private vendors hold large, national-level databases that track health insurance coverage for individuals and families. Under typical agreements, a IV-D division submits cases to a private vendor for their review. The vendor then returns a list of information (also called "hits" or "matches") consisting of health insurance information for NCPs and other parties of a child support case. In a typical, on-going relationship, a vendor may charge a state $40 to $50 for each case identified as potentially eligible for

major medical coverage and $15 to $20 for each case identified with other ancillary types of coverage (for example, prescription drugs, vision).

By contract, the State paid both PCG and HMS $40 for each "hit or match," up to a cap of $20,000 total. The two vendor contracts were nearly identical. Each defined the consideration to be paid to the contractor as follows:[1]

a. Total consideration payable to the Contractor for satisfactory performance of the services under this Contract is the Contract Maximum Amount of $20,000, which includes any and all expenses.

b. DCS shall pay the Contractor for each successful hit or match where the Contractor was able to confirm that an individual is enrolled in an active health insurance policy.

c. DCS shall pay the Contractor $15 for each confirmation that health insurance coverage has been terminated for an individual.

d. DCS shall pay the Contractor $25 for each successful hit or match where the Contractor was able to confirm that an individual has prescription coverage provided by a source other than through an individual's primary health insurance plan.

e. DCS shall not pay the Contractor for any other services provided under this Contract, unless pre-approved and mutually agreed upon by DCS.

Neither contract explicitly defined "hit," saying only that, "The contractor shall run the IV-D records through the Contractor's proprietary medical insurance locate databases to identify individuals who are or should be covered by private health insurance." "Health Insurance" was defined in the contracts as "coverage for all medical services related to an individual's general health and well being. These services include, but are not limited to: medical/surgical (inpatient, outpatient, physician care), medical equipment, pharmacy products, optometric care, dental care, orthodontic care, preventive care, mental health care and physical therapy."[2]

This payment arrangement is atypical for vendors, which usually do not have a cap on the amount they might be paid. The experiment was unusual for the vendors in other ways as well. In most contracts, vendors maintain an ongoing relationship with their clients; matches can occur quarterly, monthly, or even weekly, depending on the needs of the clients. This ongoing relationship allows vendors to continually refine both their databases and those of their clients so that, over time, results might improve. Also, as part of the research methodology, *the State did not share its own medical support information with the vendors.* Consequently, in a number of cases, the vendors were providing insurance information that was already known to DCS, COB, or both. While this practice would make no sense under an on-going relationship with the vendors, the State viewed the approach as a check of vendors' accuracy, as well as the quality of the DCS medical databases.

The State delivered a list of 4,000 cases with orders for support that had *not* received intensive medical support attention. The cases were randomly drawn from offices throughout Washington. Full implementation of digital case records permitted the geographic expansion of the demonstration from Fife (in HMU) to the entire state (for the private vendor experiment). As with the HMU experiment, active, former, and never TANF cases were included. The State made no special attempt to overrepresent Medicaid-eligible children in the sample.

The State delivered the cases to vendors on March 15, 2004; PCG returned results on June 24, 2004 and HMS returned results July 9, 2004.

PCG DATA MATCH PROCESS

Public Consulting Group, Inc. (PCG) is a management consulting firm providing insurance identification, verification, and medical support enforcement services, third party liability recovery services, casualty and trauma identification and recovery services, operations improvement, and other management advisory services to government and private health and human services providers. PCG has also been contracted to complete portions of the medical support enforcement process in Massachusetts, North Carolina, Texas, and Arkansas.[3]

In many of their contracts, PCG's medical support enforcement process consists of three phases described below:

- **Phase I Data Matching.** PCG conducts a data match with their proprietary database, which includes information from absent parent files, state and federal new hire databases, and some carrier files. PCG also searches information about custodial parents and the dependents to discover potential insurance information. In an on-going relationship, these matches would occur on a monthly, quarterly, or annual basis depending on the data source and the needs of the client. When conducting data matches, PCG matches the client file attributes for Social Security Number, name, and date of birth with their database to assure that matches are accurate. They use a proprietary data exchange technology to complete the matches that recognize similar names. For example, "Tony" and "Anthony" or ""William" and "Bill" would be recognized as potential "hits" for a first name match.

- **Phase II Verification of Results.** PCG verifies the results of every record and insurance eligibility identified through the match process through several methods. For those cases in which PCG had on-line access to files, the first step is to verify information directly with the insurance carrier. As part of the employer verification, PCG sends a hard copy survey (called the Medical Support Compliance Form, or MSCF) to the employer to verify insurance. If they cannot get the information needed, they will follow up with a telephone verification

process. The telephone verification process is scripted, and a "Team Leader" monitors phone calls for quality control.

- **Phase III Completion**. PCG updates the appropriate state databases and sends notice of coverage to custodial parents. In this phase, they also conduct quality control activities; they eliminate any duplicate information and verify that the information they are providing is new to the client. PCG does not charge clients for duplicate hits or hits that are already in the client's database. Depending on contractual arrangements with the client, PCG might complete all of the activities traditionally associated with medical support enforcement on an on-going basis, including the generation of National Medical Support Notices and the initiation of new medical support orders.

In the contract with the State of Washington, however, PCG completed an abbreviated form of their services. The process for Washington State differed in the following important ways.

In Phase I, PCG completed a one-time data match between the 4,000 DCS cases and PCG's proprietary database. The match provided PCG's best information at a single point in time; they used the National Commercial Match, the Absent Parent Match, DEERS Match, Custodial Parent and dependent files, and employer identification and verification to discover new insurance, rather than the full list of potential match sources described above. Several of these sources were specific to Washington State, including the absent parent, CP and dependent files, and employer files. However, because of the time limited nature of the demonstration, PCG did not compare the DCS cases against the local employment services files or state new hires files. PCG made only limited, and ultimately unsuccessful, attempts to add Washington-specific carriers (including Regence Blue-Shield) to their proprietary database during the demonstration. At an early stage of the project, PCG concluded that the demonstration's duration was too short to permit a significant expansion of their insurer database.

Additionally, in a typical, on-going relationship, PCG would have conducted periodic data matches using the same cases to capture changes in insurance status over time. PCG did complete the full verification process (Phase II), with the exception of sending hard copy MSCF forms to employers. Due to the limited time available under the contract, PCG opted to contact employers directly. Finally, PCG was forced to eliminate the quality control measures in Phase III because they did not have access to Washington's database to eliminate duplicate information or verify that the hits they were returning were new to the state.

HMS DATA MATCH PROCESS

The second vendor that Washington State contracted with was Health Management Services (HMS).[4] HMS provides medical support identification, verification, and enrollment activities to five state Child Support Enforcement

agencies and 21 state Medicaid agencies, including those in Colorado, Connecticut, Florida, Maryland, and Ohio.

Like PCG, the services that HMS provided for DCS were more limited than what they might provide for clients with on-going contracts. In a typical contract, HMS would first undertake a market analysis to determine the top carriers in the state or region, and then work to gain access to these carriers' databases so that they can have the most useful information possible. Their existing database consists of 121 carriers and 110 million insurance records. However, these records may not be appropriate for finding insurance for NCPs residing in the client state or region. Once they have updated their database, they conduct a match against two sources: their proprietary medical support enforcement files and the newly acquired private insurance carrier files. Their data match software matches records based on Social Security Number, date of birth, demographic characteristics, and name, and scores each hit according to the degree to which these attributes are similar in the databases.

They then verified the results through one of two means:

(1) **Web-based verification**. HMS has on-line access to certain carrier records; they used this method when applicable. They use a proprietary platform that can automatically access web-based records. This platform can complete and document several hundred verifications per hour.

(2) **Telephone verification**. This involves placing a call to a customer service representative with the carrier to verify that the data match was accurate. HMS typically telephone verifies even those potential hits that were verified through their web-based platform. Like PCG, their verification calls are scripted.

Verification is sometimes supplemented through hard copy questionnaires for targeted groups of employers. Figure 5-2 depicts HMS' process graphically.

For Washington, HMS followed the general outline described above with some variations. A summary of the steps HMS took to fulfill their contract with DCS follows:[5]

1) **Carrier recruitment.** HMS completed a market analysis to determine top carriers in Washington State and recruited Regence Blue Shield, Premera Blue Cross, Pacificare, and several other major carriers. HMS encountered numerous problems in this process. Some carriers were not familiar with the research project, were not inclined to release eligibility data, or simply did not want to participate. Several carriers required HMS to sign confidentiality agreements, which HMS agreed to do. In at least one case, DCS was required to subpoena the data from the carrier. These issues were all eventually resolved, and HMS gained access to the information they needed to complete their match.

2) **Conduct data match.** HMS completed the data match according to their typical process, using the information from the newly acquired Washington carriers.

3) **Verification.** HMS verified the insurance company name, address, and phone number, as well as the policyholder name, policy number, group number, dates of coverage, and the dependents covered by the insurance. HMS used telephone verification for every potential match, and additionally used on-line verification for some potential matches.

4) **Employer Questionnaires.** HMS sent letters to all employers with more than one employee listed within the child support case file provided by DCS, requesting updated insurance information. The questionnaires were mailed to 86 employers covering 370 NCPs with known employer addresses.

INSURANCE CARRIER REPRESENTATION IN VENDOR DATABASES

The two vendors included data from different insurance carriers in their data matches with DCS files. Table 5-1 includes the top 20 insurance carriers in Washington State and shows which of the vendors had data from those carriers in their proprietary databases at the time that they conducted their data matches.

In their report to the State of Washington[6], PCG states that their database includes many of the "top 20 commercial insurance carriers in Washington State," (p. IV-10) listing in that category the carriers with asterisks to their left in Table 5-1. PCG also listed the "top 20 carriers for this engagement that would be pursued in a full term contract" (p. IV-11), which included: "Mega Life & Health, Union Labor Life Insurance, Health Net Life Insurance, and Midwest National." Of the carriers that PCG considered "top 20," only United Healthcare, Aetna Life Insurance, and the Mega Life Insurance Company were listed among the top 20 carriers by the Insurance Commissioner of Washington. Even if PCG had succeeded in acquiring data from these three carriers, they would only have had access to 3 percent of the premiums written in the state. Additionally, several of the carriers that PCG included in their data match database for Washington (including one carrier that they considered to be top 20) are carriers that handle dental or pharmacy coverage only; this type of coverage is less useful to the Division of Child Support, which is concerned about ensuring that major medical coverage is available for child support eligible children.

In contrast, HMS's database included 11 of the top carriers in Washington, and 82 percent of the premiums written.

Table 5-1. Top insurance carriers in Washington included in vendor databases

		Insurance Carrier	Share of Premiums Written	PCG	HMS
Top 20 insurance carriers in Washington	1	Premera Blue Cross	25.1%		✔
	2	Regence Blue Shield	20.8%		✔
	3	Group Health Cooperative	17.9%		✔
	4	Pacificare of Washington, Inc.	7.5%		✔
	5	Community Health Plan of Washington	4.5%		
	6	Group Health Options, Inc.	4.2%		✔
	7	Molina Healthcare of Washington, Inc.	4.3%		
	8	Kaiser Foundational Health Plan NW	3.6%		
	9	KPS Health Plans	1.6%		✔
	*10	United Healthcare Insurance Company	1.3%	✔	✔
	11	Standard Insurance Company	1.1%		
	12	LifeWise Health Plan of Washington	1.1%		
	13	RegenceCare	1.0%		✔
	14	Unum Life Insurance Company of America	1.0%		
	15	Asuris Northwest Health	1.0%		
	16	Columbia United Providers, Inc	0.9%		
	*17	Aetna Life Insurance Company	0.9%	✔	✔
	18	The Mega Life Insurance Company	0.8%		✔
	19	Metropolitan Life Insurance Company	0.7%		
	20	Aetna Health Inc., Washington	0.7%		✔

Source: Top 15 Insurance Carriers in Washington, 2003 Insurance Commissioner's Annual Report, Appendix E, Top 40 Insurance Companies by Line of Business in Washington.
Note: Asterisks (*) show those carriers that PCG defined as "top 20 carriers"

DCS PROCESSING OF MATCHED DATA

At the outset of the demonstration, the State had no plan for how they were going to review and enter the vendor results into the SEMS system. The vendor information is highly time sensitive given the dynamic nature of NCP insurance and job status. DCS considered two options:

- **Option 1 Dissemination of vendor data on a case-by-case basis to individual SEOs**. Through this approach, the State would distribute vendor data to SEOs who would be responsible for reviewing, and if appropriate, acting on it in a timely manner.

- **Option 2 Centralized processing of vendor data**. Through this alternative, a medical support specialist would process all the private vendor information.

Once the two vendors created and verified the data match, DCS had to determine how to put the new information to use. Again, under on-going relationships, the vendors may directly enter the new insurance information into

the state's child support system. However, under the Washington contract, the vendors delivered a disk that contained a list of cases with new insurance information.

Shortly before the vendors delivered their findings, DCS concluded Option 2 had the highest likelihood of making full use of the vendor data. The State hired the lead enforcement worker from the HMU unit, which had since disbanded, to process the vendor data. This DCS employee spent 586 hours analyzing each "hit" individually to determine whether the information was accurate and whether it was actually new information for DCS and for COB.

DCS FINDINGS FOR PCG DATA

PCG returned results to DCS in a Microsoft Excel database, where each line of information represented a child whom PCG felt had access to some form of insurance. If one policy covered multiple children, the database would contain a line for each child. Table 5-2 shows an example of what a "line" of information might look like. The remainder of this discussion of results will refer to lines of information as the basis of the evaluation.

Table 5-2. PCG "line" example

Child First Name	Child Last Name	SS #	Policy #	Carrier	NCP Name
Bob	Doe	999999999	01110110-1	Blue Cross	Kevin Doe
Jane	Doe	888888888	01110110-1	Blue Cross	Kevin Doe
Alice	Smith	777777777	2435-67	Safeco	John Smith

Source: DCS, 2005

Note: Per research protocol, ECONorthwest did not have access to the databases that the vendors returned. The table above is an example of what the database looked like, based on conversations with DCS employees who worked with the data. It is not the actual database, which had considerably more fields containing other information.

Table 5-3 shows the results that PCG reported to DCS, in the categories that PCG defined for the data. They found a total of 1,370 active policy lines and 1,033 terminated policy lines. As defined in the contract, without the $20,000 cap in place, DCS would have owed $40 for each individual enrolled in an active health insurance policy and $15 for each terminated policy. Based purely on the results reported here, PCG could have billed DCS $70,295.

Table 5-3. PCG Reported Results, 2004

PCG's results, as reported to DCS	
Total active policy lines	**1,370**
Active Major Medical Insurance Coverage	*583*
NCP is policyholder	332
CP is policyholder	181
Dependent is policyholder	29
Other party is policyholder	41
Active Pharmacy coverage	*293*
Active Dental/Vision/Pharmacy	*494*
Total terminated policies lines	**1,033**
Terminated major medical insurance coverage	*382*
NCP is policyholder	115
CP is policyholder	201
Dependent is policyholder	36
Other party is policyholder	30
Terminated Pharmacy only coverage	*260*
Terminated Dental/Vision/Pharmacy	*391*
Total lines	**2,403**

Source: PCG Invoice Number 050155 to DSHS-Division of Child Support, for Washington MSE Pilot 00000512, October 4, 2004.

Once results were returned to DCS, a staff member worked through the lines one by one to determine which were useful. Of the 2,403 total lines, DCS was most interested in those with active major medical insurance; consequently, much of their analysis focused on these lines.

Table 5-4 describes how the 583 instances of major medical coverage for children that PCG reported were culled down to a total of 17 NCPs who were within the target population (had new insurance eligibility with dependent care for a child who was on Medicaid). The results are described in greater detail in text below.

- **Step 1: Isolate active, major medical lines with NCP or "other" as policyholder.** DCS was interested in focusing their analysis on those lines that were most likely to eventually lead to Medicaid recoupments. With that in mind, DCS began with lines that PCG reported as having active major medical coverage, with the NCP as the policyholder. These were the lines that were most likely to result in finding the target population (children who currently access Medicaid, but who are eligible for private insurance through their non-custodial parent). They set aside all of the terminated policy lines that PCG had reported, as well as the active policies where the custodial parent or dependent was the policyholder and the lines that were not for major medical coverage.

Table 5-4. DCS analysis of PCG results, 2005

Work Step		Number of lines associated with each action	Total lines of information remaining after each work step
Total lines reported by PCG			2,403
Step 1: Isolate active, major medical lines with NCP or "other" as policyholder	Step 1 set asides:		
	Terminated cases	1,033	
	Dental/vision coverage	494	
	Pharmacy coverage	293	
	CP as policyholder	181	
	Dependent as policyholder	29	
	Cases remaining after Step 1		373
Step 2: Send possibly enforceable lines to SEOs	Step 2 referrals for action:		
	Possibly enforcable cases	65	
	Cases remaining after Step 2		308
Step 3: Set aside lines with duplicate, erroneous, or outdated information	Step 3 set asides:		
	Duplicate cases	5	
	Non-DCS children	11	
	CP or CP relative was subscriber	20	
	Different NCP's mother was subscriber	1	
	Spouse of emancipated child was subscriber	2	
	Identified policy was Medicaid coverage	1	
	Cases remaining after Step 3		268
Step 4: Set aside information known to DCS/COB or unusable	Step 4 set asides:		
	Information known to DCS (in SEMS)	144	
	Information new to DCS but unusable	7	
	Information known to COB	21	
	Cases remaining after Step 4		96
Step 5: Isolate Medicaid cases	Step 5 identifies non-Medicaid cases:		
	Information relates to non-Medicaid cases	79	
	Cases remaining after Step 5		17

Source: Analysis, Division of Child Support
Graphic, ECONorthwest

To these, DCS added in lines where active major medical coverage was available, and the policyholder was coded as "other." This step left a total of 373 lines.

- **Step 2: Send possibly enforceable lines to SEOs.** Upon review, 65 lines provided information that could lead to enforcement action. The cases represented employer-verified instances in which the NCP had insurance available but the children were not covered. The DCS analyst sent these cases through to field-based SEOs for further review.[1] After making these referrals, 308 lines remained.

- **Step 3: Set aside lines with duplicate, erroneous, or outdated information.** DCS individually analyzed each of the 308 total lines for active major medical coverage where either the NCP or "other" was the policyholder, removing lines that proved not to be useful for finding the target population. DCS discovered five lines that duplicated policy information (i.e., multiple lines of information referred to the same policy for the same child).

[1] Of these 65 cases, 18 eventually led to enforcement actions. These enforcement actions did not necessarily lead to enrollment in medical insurance, nor were they necessarily lines of information that represented target population. Actions included basic medical support enforcement activities, such as sending a National Medical Support Notice or an update to the carrier information in the SEMS database.

For 11 lines, DCS found that the child listed as the dependent was not actually a DCS client. Discovering this information typically required calling the insurance company to verify the state of residence for the child in question. Usually, the names of the children and/or NCP were identical or very similar to children who were DCS clients, but the child reported by DCS lived in another state. The DCS employee who completed the analysis of PCG results reported that analysis of these lines were a relatively time consuming process; one particular phone call required two hours before the DCS employee could be certain that the child that PCG reported was not a Washington State IV-D child.

DCS set aside an additional 23 lines in which the policyholder was not the NCP (most of which had been coded as "other" in the PCG database). Because the NCP was not the subscriber, these lines were essentially unenforceable. For 20 lines, the policyholder was actually the custodial parent or a relative of the custodial parent. For one line, a different NCP's mother was the policyholder (the child was getting coverage from someone unconnected with his own case, but part of the DCS client rolls). Two of the lines were found to represent insurance in which the policyholder was the spouse of an emancipated child support dependent.

In one final line for this step, the policy that PCG reported was not private insurance, but rather Medicaid coverage.

At the conclusion of Step 3, a total of 268 lines remained.

- **Step 4: Set aside information known to DCS/COB or unusable.** DCS compared the remaining 268 cases to the SEMS and MMIS (maintained by COB to track Medicaid information) databases to determine how much of the information that PCG reported was new to the State of Washington, and how many lines showed new coverage for Medicaid clients. In 144 instances, DCS's SEMS database already held the information provided by PCG. In other 21 instances, the information was new to DCS but known by Medicaid's Coordination of Benefits (COB) office.

  For seven lines, the information was new to DCS but unusable. For example, PCG might have provided information about a policy that was new to DCS, but because DCS had recently learned that the NCP had changed employment, the new policy information was not useful.

  Ninety-six lines remained at the conclusion of Step 4.

- **Step 5: Isolate Medicaid cases**. As a final step, DCS reviewed the remaining line and found 17 were associated with Medicaid-eligible children.

The DCS employee logged 268 hours in his analysis of the PCG data. Given this employee's salary and benefits, DCS expended $7,436 on analysis of PCG's data.

DCS FINDINGS FOR HMS DATA

Like PCG, HMS returned results to DCS in a Microsoft Excel database. That database, however, was designed differently than PCG's. For PCG, each line of information represented one child; for HMS, however, each line of information represented one insurance policy/coverage pairing. For example, if one policy covered multiple children, an NCP, and the NCP's spouse, the database would contain a line for each child, a line for the NCP, and a line for the NCP's spouse. This method of reporting meant that HMS returned a much higher number of lines than did PCG. Table 5-5 shows an example of what a "line" of information might look like in HMS's database.

Table 5-5. HMS "line" example

Policy #	Carrier	NCP Name	SS #	Insured
01110110-1	Blue Cross	Kevin Doe	999999999	Bob Doe
01110110-1	Blue Cross	Kevin Doe	888888888	Jane Doe
01110110-1	Blue Cross	Kevin Doe	123456789	Kevin Doe
2435-67	Safeco	John Smith	777777777	Alice Smith

Source: DCS, 2005
Note: Per research protocol, ECONorthwest did not have access to the databases that the vendors returned. The table above is an example of what the database looked like, based on conversations with DCS employees who worked with the data. It is not the actual database, which had considerably more fields showing the custodial parent and other information.

In July 2004, HMS returned a data disk with more than 10,000 lines of information. Initial DCS review showed a large number of duplicates and other errors in the information. HMS corrected some of these, and returned a new disk in August 2004 with 4,982 lines of information for active policies and 2,155 lines of information for terminated policies. The lines were not grouped into categories beyond active and terminated.

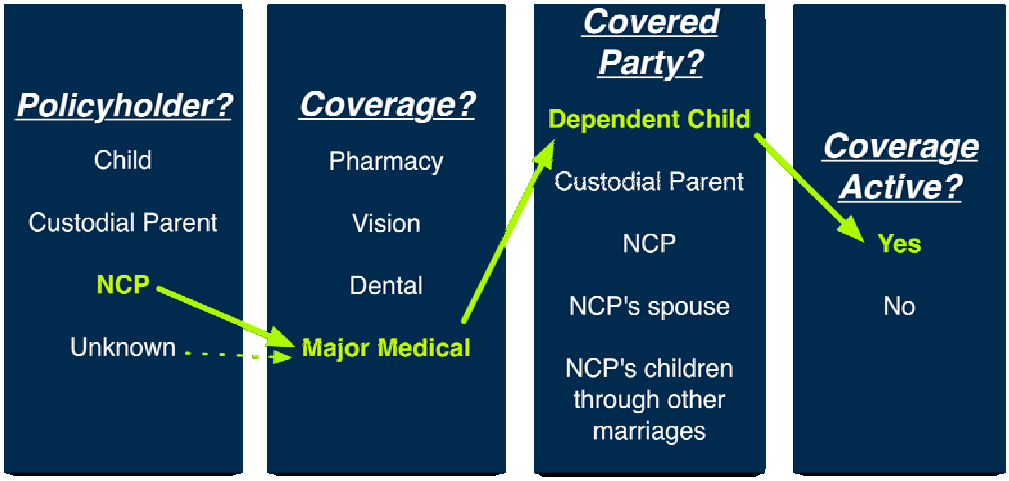
HMS sent additional data disks to DCS after that with further refinements to the data, including the addition of results from Group Health, a major Washington carrier. By the time they received these disks, however, DCS had already invested a fair amount of time in analysis of the August disk and did not carefully consider the additional information. The discussion that follows is based on the August HMS deliverable.

HMS sent DCS an invoice which calculated the amount that DCS would have paid, had the $20,000 price cap not been in place. The invoice showed a possible amount due of $142,240.[7]

Each line that DCS analyzed represented one insurance policy, and could have any combination of the information shown in Figure 5-3 below. A policy could be for any type of coverage (dental, vision, pharmacy, major medical, etc.), and could have any individual connected with the case as either the policyholder or

the insured party. In reviewing the data that HMS returned, DCS's task was to isolate those cases in which the NCP was the policyholder, the coverage was for major medical insurance, the dependent child was the covered party, and the coverage was active. This pairing of data variables is represented in green in Figure 5-3. As for PCG, DCS also considered those cases in which the policyholder was coded as "unknown," because some of them might have resulted in new information about insurance policies for children. These cases were considered separately from the cases that had the NCP as a policyholder. This is shown with a dashed line in Figure 5-3.

Figure 5-3. HMS hit combinations



Source: ECONorthwest, 2005

Many lines contained blank cells for information about policy type and other key policy information. DCS filled in these blanks where possible based on other information in the spreadsheet. For example, HMS might have listed available coverage through the carrier "Champus," but left the type of coverage blank. DCS knew that Champus provides only major medical coverage, and filled in the blanks cells accordingly. Had DCS not taken this step, the resulting number of cases that were ultimately useful to DCS would have been lower.

Table 5-6 describes how the 4,982 lines of information that HMS reported were culled down to a total of 28 NCPs who were within the target population (had new insurance eligibility with dependent care for a child who was on Medicaid). The results are described in greater detail in text below.

Table 5-6. DCS Analysis of HMS results

Work step		Number of lines associated with each action	Total lines of information remaining after each work step
Total lines reported by HMS			4,982
Step 1: Isolate active, major medical lines with NCP or "other" as policyholder	Step 1 set asides:		
	Terminated, minor medical or non NCP policyholder	3,291	
	Miscoded pharmacy coverage	177	
	Coverage for CP	145	
	NCP is dependent	57	
	Cases remaining after Step 1		1,312
Step 2: Send possibly enforceable lines to SEOs	Step 2 referrals for action:		
	Possibly enforcable cases	60	
	Cases remaining after Step 2		1,252
Step 3: Set aside lines with duplicate, erroneous, or outdated information	Step 3 set asides:		
	Duplicate cases	57	
	Policies associated with emancipated children	20	
	Wrong child	7	
	CP or CP Spouse was subscriber	118	
	Policyholder is spouse of emancipated child	6	
	Information for non-medical enforcement cases	47	
	Coverage not available to child	133	
	Cases remaining after Step 3		864
Step 4: Set aside information known to DCS/COB or unusable	Step 4 set asides:		
	Information known to DCS (in SEMS)	469	
	Information new to DCS but unusable	21	
	Information known to COB	25	
	Cases remaining after Step 4		349
Step 5: Isolate Medicaid cases	Step 5 isolates Medicaid cases:		
	Information relates to non-Medicaid cases	321	
	Cases remaining after Step 5		28

Source: Division of Child Support

- **Step 1: Isolate active, major medical lines with NCP or "other" as policyholder.** As a first step, DCS set aside 3,291 lines associated with terminated policies or policies associated with minor medical coverage, as well as policies held by the custodial parent or the dependent child. DCS found 177 lines coded as major medical that, upon further investigation, proved to be pharmacy coverage. DCS set aside an additional group of lines because coverage was not for a dependent. In 145 instances, coverage was for the custodial parent and in 57 instances, coverage was for the NCP.

  This left 1,312 cases at the end of the first step.

- **Step 2: Send possibly enforceable lines to SEOs.** The DCS analyst found 60 lines that showed enforcement potential. The cases represented employer-verified instances in which the NCP had insurance available but the children were not covered. In these instances, the DCS analyst forwarded the information to SEOs in the field for enforcement actions.

- **Step 3: Set aside lines with duplicate, erroneous, or outdated information.** DCS worked the remaining 1,252 lines of information (which included both NCP and unknown policyholders) to determine whether the HMS information might lead to enforcement opportunities. DCS used the following general steps to evaluate those lines of information:

1. Match information in the HMS database with the MI screen (Medical Insurance) in the SEMS system. Does the MI screen provide the same carrier, policy number, and other insurance information?

2. Check other information in the SEMS system. If the MI screen does not match HMS's data, is there anything else in the SEMS system (such as the case comments) that explains the discrepancy?

3. Call insurance company for verification when necessary.

DCS set aside cases for a variety of reasons.

DCS removed 57 lines of duplicated policy information. Upon evaluation, these lines were found to have the same data for policy holder, dependent, NCP name, and other cells. In some cases, the policy number was off by a single letter or number.

DCS discovered 20 lines associated with children who were emancipated and, therefore, were no longer on the IV-D caseload.

DCS removed seven lines of coverage for children who were not child support clients in the State of Washington. These lines were particularly difficult and time consuming to investigate. For each, DCS contacted the insurance company to verify the child's identity by comparing information in the insurance database against information in the child support database. DCS compared the last four digits of the social security number, address, father or mother's name, and the address of the father or mother.

DCS removed lines of information for policies where someone other than the NCP was the subscriber. A total of 118 lines where the custodial parent or the spouse of the custodial parent was the subscriber were removed. All 118 of the lines had been coded as "unknown" subscriber in the HMS database. DCS discovered these cases through comparison of the HMS database with the SEMS database. An additional six lines, where the spouse of an emancipated child was providing coverage, were removed.

The information in 47 of HMS's lines was for a case that DCS was no longer enforcing. These included cases with no order, cases in which the child was emancipated, or cases in which the order had been changed.

One line was removed because the coverage for the NCP was Medicaid.

The premium limit was exceeded for 133 lines, meaning that DCS could not enforce the order even if insurance was available for a dependent.

- **Step 4: Set aside information known to DCS/COB.** This step primarily involved comparing HMS's database to the information in the SEMS system and COB's MMIS system to see how many of the remaining lines contained information that was new to the State of Washington.

  Of the 864 lines, DCS had information in the SEMS system for just over half of them (about 469 of the lines). While the remaining lines were all new information to DCS, not all of the information was useful. The policy may not have supported dependent children, or the premium limit may have been exceeded. The DCS analyst deemed another 21 lines "unusable" for case-specific reasons including the lack of a medical support order. For 25 lines, the information provided by HMS was new to DCS but already known by Medicaid's COB office.

- **Step 5: Isolate Medicaid cases**. The completion of Step 4 left 349 lines for review. The DCS analyst reviewed the Medicaid enrollment status of each case and found 28 lines represented new insurance information associated with Medicaid-eligible children.

To arrive at these results, the DCS analyst logged 312 hours. Given this employee's salary and benefits,[2] DCS expended $8,657 on analysis of HMS's data.

STATE PERSPECTIVES ON DATA MATCHING

Several factors beyond the control of the vendors may have impacted the results presented above. The Washington experiment was a demonstration project, and did not represent the typical ongoing relationship that HMS and PCG have with their client organizations. Washington did not provide the vendors with information from their databases about known insurance information, and so expected to receive some "hits" from the vendors for insurance coverage that was already in their databases. Also, because the two data matches described here happened at one point in time, the usefulness of the information produced would be expected to wane over time. Given those caveats, discussion of the two vendors' results follows.

In interviews, SEOs in the Fife DCS office and caseworkers in the COB section had mixed feelings about the potential benefits of contracting with a vendor. The following is a summary of potential benefits and drawbacks to the

[2] Salary and benefit information provided by Division of Child Support.

vendor intervention, as defined by SEOs and caseworkers. It is general in scope, and does not consider the results of this experiment.

PERCEIVED ADVANTAGES

- **SEOs can access improved insurance information without additional staff resource expenditure.** The major advantage of contracting with a vendor is that SEOs will not be required to track insurance information. Depending on the type of contract that Washington chooses to enter with a vendor, it is possible that SEOs would not be involved in medical support enforcement at all, but instead would contract out all duties to a vendor.

- **Access to information that may not be available through the COB system.** Because the vendors maintain national insurance databases, they may have more complete information about availability than either SEOs or COB caseworkers. This is especially true with out-of-state cases.

PERCEIVED DISADVANTAGES

- **Improved data may not actually result in savings.** At least one SEO and one COB caseworker expressed skepticism about the potential cost savings that could come from contracting with a vendor. If the NCPs don't have enough money to overcome the premium limits or don't have access to insurance, sending more notices to their employers cannot result in more children enrolled in private insurance.

- **Vendors' "hit" doesn't take into consideration the quality of the insurance available**. The information that vendors return may not provide data about the quality of coverage. If only catastrophic insurance is available, for example, enrolling the child in the plan may not improve his medical insurance situation.

- **COB essentially provides the services that a vendor could provide already.** Vendor data matches are designed to find insurance information that SEOs have not discovered and inform them to attempt to enroll the dependent in that insurance. COB already performs this activity on a monthly basis.

- **Data matches are outmoded forms of identifying coverage.** COB is in the process of moving to real time web-based access to insurers' databases, which provides more accurate, timely information than a data match. While both PCG and HMS mentioned that they have agreements with some carriers for online access, they primarily use this access to verify results after they complete a data match.

- **When the vendor returns data to DCS, it may require additional work and processing before it can be useful to SEOs.** Unless the vendor is contracted to complete the entire medical support enforcement process,

SEOs will still need to interpret results from the vendor and make changes to their databases before enforcement can occur.

IMPACTS

We estimated the impact of the vendor data match intervention on Medicaid and third party coverage incurred by Medicaid and the third party providers over the four quarters following the data matches. As with the HMU experiment, the goal of the vendor experiment was to enroll more children in private medical insurance plans, thereby increasing the healthcare claims incurred by private insurers and reducing claims incurred by the state. Thus, if the vendor approach was successful, we would see a negative impact on both Medicaid eligibility and Medicaid claims, and a positive impact on third party coverage.

Table 5.7 presents the impact of the data match on Medicaid and third party coverage. The term *coverage* refers to Medicaid eligibility and third party enrollment. As the first set of rows shows, neither vendor's data match had an impact on reducing Medicaid coverage. The HMS group cases, at the end of the fourth quarter, had nearly the same coverage as the control group (about 59 percent). The PCG group was slightly lower (about 1.2 percent) than the control group, but the difference was not statistically significant, meaning we cannot attribute the decrease to PCG's data match activities.

Another measure of the impact on coverage is the number of months eligible for Medicaid during the follow-up period. Again, Table 5.7 shows that the vendor intervention did not have an impact on Medicaid coverage. For PCG, while the number of months of Medicaid coverage was lower for the test group than for the control group, this difference was small and not statistically significant. For HMS, Medicaid coverage was slightly higher in the test group than in the control group.

Turning to the impact on third party coverage, we see mixed results. The HMS intervention increased third party coverage from 6.8 percent in quarter four for the control group to 7.6 percent for the HMS group. This 0.87 percentage point difference is small but statistically significant. The PCG intervention also slightly increased third party coverage, but the increase (0.23 percentage points) was not statistically significant and cannot be attributed to PCG's data match activities. The impact on third party coverage is not found when examining the number of months of coverage.

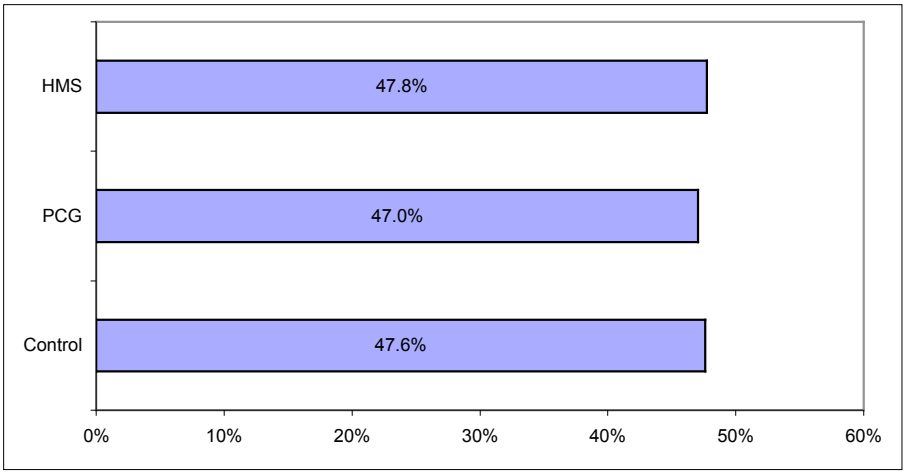
Figure 5-4 shows the percent of cases with a Medicaid claim for HMS, PCG, and the Control group. The three are essentially the same, showing no difference between the control group and the two sets of cases in the data match groups. Figure 5-5 shows the average Medicaid claims paid. We would expect to see a lower number in the two experimental groups if the vendors' data matches had an impact. They are, in fact, slightly lower than the control group, but the difference is not statistically significant.

Table 5-7. Vendor impacts

	HMS Group	Control Group	HMS Impact		p-value	PCG Group	Control Group	PCG Impact	p-value
Percent covered by health care program by quarter following assignment									
Medicaid coverage									
Quarter 1 (Jul-Sep 2004)	56.7%	56.6%	0.05%		0.9481	55.5%	56.6%	-1.17%	0.1625
Quarter 2 (Oct-Dec 2004)	57.6%	57.4%	0.19%		0.8200	56.3%	57.4%	-1.06%	0.2022
Quarter 3 (Jan-Mar 2005)	58.3%	58.3%	-0.07%		0.9312	57.1%	58.3%	-1.28%	0.1221
Quarter 4 (Apr-Jun 2005)	59.0%	59.1%	-0.08%		0.9256	57.9%	59.1%	-1.22%	0.1400
Third party coverage									
Quarter 1 (Jul-Sep 2004)	7.6%	6.8%	0.77%	*	0.0734	6.7%	6.8%	-0.08%	0.8478
Quarter 2 (Oct-Dec 2004)	7.9%	6.9%	0.94%	**	0.0315	6.7%	6.9%	-0.22%	0.5990
Quarter 3 (Jan-Mar 2005)	7.9%	7.1%	0.83%	*	0.0604	7.1%	7.1%	0.04%	0.9229
Quarter 4 (Apr-Jun 2005)	7.6%	6.8%	0.87%	**	0.0471	7.0%	6.8%	0.23%	0.5919
Number of months covered by health care program following assignment									
Medicaid coverage									
In Quarters 1-4	6.88	6.87	0.01		0.9093	6.73	6.87	-0.14	0.1677
Third party coverage									
In Quarters 1-4	0.88	0.78	0.10		0.0396	0.77	0.78	-0.007	0.8801
Percent with claims paid									
Medicaid claims									
Ever in Quarters 1-4	47.8%	47.6%	0.2%		0.8563	47.0%	47.6%	-0.6%	0.4886
Average claims paid ($)									
Medicaid									
Quarters 1-4	$ 783.0	$ 843.7	$ (60.7)		0.4763	$ 771.0	$ 843.7	$ (72.7)	0.3650
Sample Size	7,117	7,062				7,147	7,062		

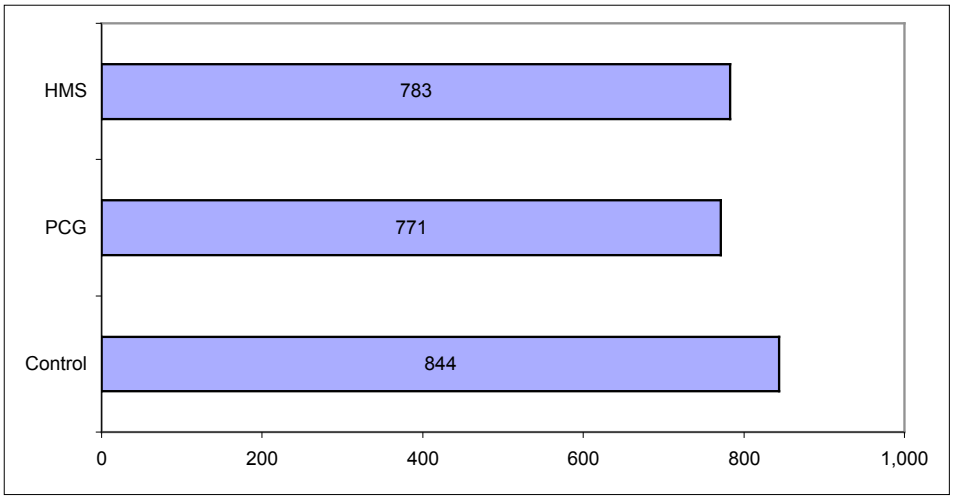
Source: The Lewin Group

Figure 5-4. Percent of cases with a Medicaid claim, July 2004 - June 2005



Source: The Lewin Group

Figure 5-5. Average Medicaid claims paid July 2004 - June 2005



Source: The Lewin Group

CONCLUSIONS

While one of the vendors showed some success with increasing third party coverage, overall, the vendor experiment did not result in measurable Medicaid savings, a reduction in Medicaid claims, or a substantial increase in third party coverage.

The data matching demonstration provided DCS a relatively inexpensive introduction to a strategy used by a number of other states. Both DCS and the two vendors faced a number of challenges in implementation that will likely limit the effectiveness of this first attempt to match medical records. With the experience behind them, all parties involved would have a much clearer sense of how to operate if they attempted to match data in Washington again. DCS would know better what data they should ask and pay for. The vendors would benefit from an introduction to Washington insurers and the State's legal and regulatory climate as it relates to accessing health insurance.

In addition to the implementation challenges discussed above, two key factors restricted impacts. First, the data match experiment ran into the same truism of medical support enforcement that hindered the HMU: NCPs who have access to health insurance and who have Medicaid-eligible dependents are a rare find. Second, Washington's premium limit creates an additional condition for success. Namely, the NCP must not only have access to insurance but must have a sizable order for cash support, as well.

The following findings are evident from review of the vendors' results and from descriptions of the processes employed by the vendors and DCS.

- **Implementing a statewide data match with either of the vendors involved in this experiment would probably not result in**

substantial Medicaid savings for Washington State. With a more targeted approach (described in more detail in later bullets), more success might be achieved.

- **DCS's broad request for data made sense for a demonstration but would probably not prove cost-effective under on-going implementation.** In their first interactions, the vendors were eager to provide (and DCS was eager to see) the full complement of data related to all the demonstration cases. As a consequence, the vendors provided large quantities of data that DCS quickly dismissed, including major medical policies held by custodial parents and policies that were either terminated or that covered limited services (e.g., vision, pharmacy, and dental). The $20,000 cap on payments essentially provided a risk-free means for DCS to explore the utility of the range of data that the vendors could return.

  Should DCS consider a second engagement with either vendor, the agency should narrow its focus considerably. First, DCS should not request data that it does not anticipate using. Under current practice, DCS does not enforce medical support against custodial parents. Eliminating that information from the matching process would lower costs and ease DCS's post-match processing effort. Second, in any future matching efforts, DCS should share its own information with vendors, which would further reduce the number of matches returned.

- **No industry standard exists for reporting data or for the definition of a match; conflicting definitions of a match contributed to difficulties in analyzing the vendors' results.** The vendors had different ways of reporting data that drove their respective definitions of a "match". PCG's data were *child-centered*, and generally each child had no more than one match. By contrast, HMS's data were *policy-centered* and a single insurance policy could generate multiple matches—one for each individual covered by the policy. Consequently, if the two vendors were working from identical insurance databases, HMS's method of reporting would systematically generate more matches.

  Given the vendors' different reporting methods and match definitions, applying identical per-match contract terms to both vendors made no sense. In future matching relationships with these vendors or any others, DCS should work carefully, in advance of writing the contract, to determine precisely how data are reported. As the client, DCS should be able to dictate how data are organized and, given the definition, how much it is willing to pay for each piece of information. The DCS analyst charged with processing the data found PCG's child-centered reporting method easier to work with.

- **DCS failed to anticipate the scope and complexity of the post-match task of analyzing the vendor data. However, a mid-project adjustment resulted in competent review of vendor data.** At the outset of the demonstration, the DCS had not foreseen the necessity of processing and analyzing the vendor matches. In a mid-project adjustment, DCS elected to process the matches centrally, using a single SEO, full time over a three-month period. DCS spent $16,260 and 586 hours in labor costs to analyze the information that the two vendors returned. Post-processing of matched data is a common problem. In other states, the vendors have overcome the problem by developing methods to directly download insurance information into the state management information system or by providing staff to enter the data.

  By DCS's assessment, the individual selected to process the vendors' matches was among the most knowledgeable medical support SEOs in the state. Notes and records suggest the SEO implemented a highly detailed and rigorous review of the matches, and the SEO's role proved critical to the demonstration. DCS could have further expedited the post-match review by training the SEO in the use of database software (e.g., Microsoft Access), which would have simplified data analysis.

- **Matched data from the two vendors varied in their quality and ease of use; however, the ultimate results were similar.** Though HMS's database was more representative of the insured population in Washington State than was PCGs, it also contained far more errors and duplicate information. In the end, however, the number of lines of information that were useful to DCS was very similar. This suggests that increased efforts to find the target population may ultimately be ineffective.

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[1] Definition from: DSHS Central Contract Services, Long-Format Personal Service Contract. Contract with PCG signed 3/11/04. Contract with HMS signed 3/11/04.

[2] Definition from: DSHS Central Contract Services, Long-Format Personal Service Contract. Contract with PCG signed 3/11/04. Contract with HMS signed 3/11/04.

[3] Public Consulting Group, Inc. *Demonstration & Evaluation of Centralized Medical Support Enforcement,* produced for the State of Washington Division of Child Support, June 24, 2004.

[4] Health Management Systems, "Medical support enforcement research project," produced for the State of Washington Department of Social and Health Services, Division of Child Support, July 9, 2004.

[5] Summarized from: Health Management Systems, "Medical support enforcement research project," produced for the State of Washington Department of Social and Health Services, Division of Child Support, July 9, 2004. Supplemented with information from an interview with HMS researchers Summer Thurston-Evans, Chuck Anderson, and Keith Reinold, Septebember 24, 2004.

[6] Public Consulting Group, Inc. *Demonstration & Evaluation of Centralized Medical Support Enforcement,* produced for the State of Washington Division of Child Support, June 24, 2004.

[7] Health Management Systems, Invoice # 12473. September 30, 2004.

Chapter 6 Conclusions

With the increased cost of health insurance and the related rise in state Medicaid expenditures, effective medical support enforcement strategies have taken on a new importance. Moreover, with the federal government poised to implement a performance measure related to medical support, child support agencies across the country are actively exploring best practices.

This study reviewed two related and innovative approaches to medical support enforcement. Each drew on an approach that, in its general form, had been tried and tested in the child support context. The Headquarters Medical Unit (HMU) employed the concept of *centralization* and focused the efforts of a specially trained staff on medical support. Centralization has proven effective in other areas of enforcement—like locate or interstate enforcement—in which tasks are particularly complex or dissimilar from other aspects of enforcement. The private vendor experiment used *data matching*, which, in other areas of enforcement, has proven useful in locating NCPs and investigating their employment status, earnings, and assets.

The findings of this report suggest that, *within the context of Washington's related regulations on medical support*, neither of the approaches will achieve of the State's goal of generating measurable Medicaid savings in the short-run. For the HMU, an analysis of Medicaid records for randomly selected treatment and control indicates intensive, centralized medical support enforcement did increase the percent of cases with third-party insurance coverage but failed to create Medicaid savings. While it is too early to formally estimate Medicaid savings for the data matching demonstration, DCS's own analyses indicate that the matches yielded new insurance information in only a small number of cases involving Medicaid-eligible children.

Advocates of either approach could argue that DCS's implementation of the demonstration was imperfect and did not precisely replicate full-implementation conditions. For the HMU, DCS did not alter the computer system to direct medical support mail to centralized staff nor did it intensively train field staff on their altered roles on centrally enforced cases. In the case of data matching, the compressed timeframe resulted in one vendor foregoing matches with key Washington State insurers and the other struggling to provide data in a format that the agency could easily use. While these implementation challenges may have played a role in limiting the strategies' effectiveness, we believe a number of other factors—described below—were more important determinants of the demonstrations' impacts.

In the two immediately preceding chapters, we have drawn a number of conclusions specific to each of the interventions. For a comprehensive list of those findings, we refer the reader to Chapters 4 (HMU) and 5 (Data Matching),

respectively. In these final concluding remarks, we highlight implementation issues and challenges that were common to both interventions.

- **Impacts of enhanced enforcement were limited by the small number of Medicaid-eligible children associated with NCPs with health insurance.** As the National Working Group on Medical Support Enforcement and others have concluded, the income of a custodial parent is a strong predictor of the income of a non-custodial parent. Given these correlations, we would expect Medicaid-eligible children living in poor or near-poor households of their custodial parents to be more likely to be associated with poor and near-poor non-custodial parents. Enforcing *cash* support on poor and near-poor NCPs has always proven challenging. However, wage withholding and minimum guideline orders have ensured that everyone can pay something. Enforcing medical support for the population is even more challenging and requires that the NCP not only have a job, but have a job with employer-sponsored health benefits. The findings from both interventions suggest the Medicaid-eligible child/insured NCP pair is exceedingly difficult to find.

- **Washington's premium limit further restricts potential medical support enforcement**. Further restricting the likelihood for impacts in this study was Washington's existing limit on premiums (25 percent of the NCPs basic child support obligation). The limit essentially raises the bar for a successful outcome, requiring not only that the NCP have a job with benefits, but that the job be sufficiently well paying. In practice, the limit makes medical support enforcement an "all or nothing" proposition. Once the limit's threshold is crossed, the medical support obligation is temporarily unenforceable on the NCP. Moreover, for NCPs with premiums near the limit, inequities exist, with NCPs just below the limit providing medical support and NCPs just above it avoiding the obligation. The inflexibility of the premium limit restricted the savings potential of both interventions. Had Washington had more flexible methods in place to enforce medical support (e.g., conversions of medical support to cash support or Medicaid premium sharing), the potential for Medicaid savings would have been higher.

- **Broad scope of case review made sense for a limited demonstration but would be cost-ineffective for full implementation**. The HMU and data matching demonstrations started with a broad scope—all active cases with an order for cash support. For the purposes of this demonstration, the State selected the broad case population to get a comprehensive assessment of the effectiveness of its status quo enforcement policies. Should the DCS wish to reexamine either approach, it should—to the extent allowable under federal and state law—target enforcement to cases with certain profiles. Assuming the premium limits remain in place, the following two characteristics would be sensible screens:

1. **NCP has wage withholding in place and a cash order in excess of a certain threshold (e.g., $400).** Cases with wage withholding for a sizable order would increase the likelihood the NCP is currently employed, has a job with health insurance, and could afford the premium.

   and

2. **Child support case is either current/former TANF or medical only**. Targeting future intensive enforcement or data matches to current/former TANF and medical only cases would increase the likelihood that the child is Medicaid eligible or has been in the recent past.

- **Medicaid impacts depend, in part, on how quickly the State transitions children off of the State's managed care program (Healthy Options)**. For children enrolled in Medicaid's Healthy Options (managed care) program, discovery of private, third party coverage generates Medicaid savings only if the child transitions from the Medicaid managed care program to a Medicaid fee-for-service arrangement. Without such a transition, the State continues paying the same monthly payment to the Healthy Options providers despite the discovery of the new insurance coverage. In this demonstration, it is unclear how quickly, and under what circumstances, the state's Medicaid agency implemented those transitions.

- **New information on health insurance available through the custodial parent generated no Medicaid savings.** Both methods of enforcement, and particularly data matching, uncovered information on health insurance held by the custodial parent. While State orders increasingly require the custodial parent to share in the responsibility for medical support, DCS has no authority, or even means, to enforce the obligation once established. In fact, DCS's management information system—SEMS—has no field to even record information on a custodial parent's policy. Other states have expanded the scope of their programs and enforce the custodial parent's obligation. Had Washington had such a policy in place during the demonstration, the likelihood for Medicaid savings would have increased.

- **Study failed to quantify the benefit of newly enrolled non-Medicaid children in health insurance policies**. Because of data limitations, this study does not rigorously quantify the private benefit of enrolling non-Medicaid eligible children into third party insurance programs. The benefit of new insurance for these non-Medicaid children is important because in many cases—unlike their Medicaid-eligible counterparts—they are transitioning from no insurance to some insurance. While such transitions do not directly generate Medicaid savings, they do reduce the number of uninsured children in the state—another important and worthy goal.

April 29, 2005

Mr. Charley Barron
Manager, Fiscal Management Legal Affairs
State of Washington
Department of Social and Health Services
Division of Child Support

Dear Mr. Baron:

Health Management Systems, Inc. (HMS) would like to thank the Department of Social and Health Services, Division of Child Support (DCS) for allowing us to respond to the draft report, "Evaluation of Strategies to Improve Medical Support Enforcement in Washington State." As you are aware, HMS and DCS devoted considerable human and technical resources to this project—and as a result, learned some important lessons about medical support enforcement in Washington.

Based on our review of the draft report, HMS presents the following comments and requests the draft report be revised to reflect the noted clarifications:

Definition of Match "Hit" and Format of File Deliverable

HMS had conversations with DCS soon after contract execution regarding potential data match outcomes and types of information we could deliver to DCS based on the contract Statement of Work. The 4,900 separate records HMS delivered to DCS were in accordance with DCS direction given during these early conversations. HMS informed DCS that they would receive multiple policy records where there were minimal differences in the data (i.e., slightly different policy numbers) due to source data inconsistencies. The intent of providing DCS with these combinations of information was to allow DCS to identify records for pursuit.

The report states that HMS's deliverable contained many blank cells on policy type and other key policy information and that DCS completed these blanks where possible. Again, HMS conveyed to DCS in early contract discussions that we would not be able to provide 100% of the data due primarily to lack of cooperation from carriers and that we would not infer information we could not collect through verification (as DCS did with the TRICARE/CHAMPUS coverage type).

Further, although DCS dismissed many records HMS delivered as not immediately useful under this demonstration project, we feel that this information represented significant potential value for DCS. These records (e.g., NCP limited coverage policies such as pharmacy-only, health insurance held by the custodial parent) contain leads for potential major medical coverage through the NCP and can support potential future policy changes.

Under long-term data match projects for our other state agency clients, HMS and the agency carefully define the target population and deliverables and refine this information over time to best meet agency needs and to provide maximum value to the state. Unfortunately, the limited scope

and duration of the Washington demonstration project afforded a comparably limited opportunity to shape this project to address DCS needs.

Washington Insurer Database

The report states that HMS's data matches used data from the top four insurers in Washington, which together underwrite 71% of private health insurance premiums in the state. Table 5.1 of the report designates only these four carriers as being part of HMS's database. In fact, as described in HMS's report to DCS dated July 9, 2004, HMS obtained eligibility data from and matched with 13 of the top 20 Washington carriers in Table 5.1. These carriers underwrote 84% of premiums in the state in 2003. We request Table 5.1 be revised accordingly.

Wrong Information

Table 5.6 of the report reflects 19 records removed for "Wrong Information," which is defined in the report text as children with insurance coverage but no longer on the DCS case rolls. Because DCS included these children in the original case population provided to HMS, we feel that the label "Wrong Information" is not accurate and request that this label be revised to "Emancipated Children."

Savings to the State

HMS agrees with the report findings that Washington State's Medicaid program will not realize measurable savings in the short-run through this demonstration project. However, upon extrapolating the results of this study, HMS believes that significant Medicaid savings would result from a match of a targeted case population to a nationwide health insurance eligibility database.

Further, HMS feels that, as we have seen in other states and as described in the draft report, the state would generate considerable savings if it were to change its reasonable cost requirements and enforce custodial parents' obligation to provide medical support.

As stated in the report, the state can also realize savings by enrolling non-Medicaid children into private health insurance plans. Many of these children may be enrolled in other state-funded programs or may have been uninsured. In addition, future federal medical support performance measures will most likely include funding based on a state's medical support outcomes for all children in the IV-D program, not only those enrolled in Medicaid.

* * * * * * *

In conclusion, HMS believes there is significant value in providing **supplemental** health insurance data match services to child support and Medicaid agencies, augmenting their existing health insurance identification and enrollment activities. In fact, the majority of the data match projects HMS currently performs for state agencies are supplemental to the state's activities. In each of those states, HMS receives and matches to data representing a subset of the total case population. We tailor our deliverables to the state's specific needs based on ongoing discussions and enhancements.

HMS suggests DCS consider evaluating the feasibility of a data match approach in the future. HMS can provide access to an extensive, nationwide health insurance database, real-time matches, cost-effective health insurance verification and enrollment, and maintenance of an employer insurance database--all on a supplemental basis.

I enjoyed working with you and other DCS personnel throughout the course of this project. Please do not hesitate to contact me at 978-867-2111 or email at kreinold@hmsy.com if you have any questions or need further clarification.

Sincerely,

Keith Reinold
Vice President, Contract Management

PCG

April 26, 2005

Mr. S. Ray L. Weaver
State of Washington
Department of Social and Health Services
Division of Child Support
712 Pear Street, SE
Olympia, WA 98507-9162

Re: Draft report comments, "Evaluation of Strategies to Improve Medical Support Enforcement in Washington State."

Dear Mr. Weaver;

Thank you for the opportunity to respond to portions of the preliminary draft report prepared by ECONorthwest "Evaluation of Strategies to Improve Medical Support Enforcement in Washington State." We found their analysis thorough and concise. As far as the conclusions drawn by ECONorthwest as a result of their analysis, while we agree with some, we found several others that we believe to be inaccurate. This demonstration grant was a huge undertaking for Washington Child Support [DCS] and was well facilitated. The variables surrounding Medical Support services are many and often times intertwined, making it difficult to identify and synthesize improvement strategies. We applaud the Washington Department of Child Support undertaking this worthwhile effort.

We would like to offer the following response to the draft sections we were given access to including Executive Summary; Chapter 1: Introduction, Chapter 5: Private Vendor Data Matches; and Chapter 6: Conclusion.

- **One time match with state was atypical for the vendors.**

  The success and strength of PCG's services rest in our ability to meet and exceed our client's expectations and to provide quality customer service. Each of PCG's medical support processes referenced in Chapter 5 [page 5-3 to 5-6] are always considered a "work in progress" as we grow in familiarity with our client's data and needs and as we implement each phase of our services, refining and adjusting to improve the quality of the results. It was understood from the onset of this demonstration that PCG would only be able to provide a much abbreviated version of our medical support identification and verification processes, thus severely limiting the outcomes.

  Not only is a one time match atypical, but limiting the types of matches performed is atypical as well. Due to the time frame and availability of data, PCG was limited to matching with commercial carrier files. Our full scope MSE service would have

involved matching with state wage files, new hire files, employer files and additional state agency files. All of these efforts would have yielded a significant number of additional identified insurance coverage for dependents.

- **Neither vendor had a significant representation of Washington insurers in its database prior to the demonstration.**

Lack of Washington based carrier data files was a known variable at the start of the demonstration grant. The very first action PCG takes at the start of a new full service medical support contract is to seek access to that client states top insurance carriers files through data exchange agreements or web-based access. The agreement with the state agency provides PCG authority to get these files. Prior to the existence of the grant agreement between the State of Washington and PCG, PCG would have been denied any request for carrier file access. For the Washington engagement we referred to the "AIS Directory of Health Plans" to help us identify the top Washington carriers. Because of time constraints, PCG staff did not have access to the Insurance Commissioner of Washington's carrier listing. As reported in the preliminary draft, attempts were made to obtain Washington Carriers not in PCG's current data base but failed due to time constraints. Typically, the development of these agreements and receipt of carrier files takes, on average, anywhere from three to six months. PCG match results in full service, ongoing contracts are directly proportional to the number of Carriers insurance records we have access to. Because the Washington demonstration grant only asked for a one time carrier match process, the match results were negatively affected.

- **Data format and broad definition of a "match or hit" caused adjustment difficulties for Washington staff when analyzing the provided results.**

The agreement, as reported in Chapter 5, on the types of data and file format were very open ended as Washington did not want to limit the potential results that a vendor may provide. At the time of submission PCG was not aware that Washington would ultimately severely limit its final analysis to only those dependents on Medicaid whose NCP was the policy holder. As required by the contract, PCG submitted all verified matches to Washington without the benefit of knowing if the dependent was a Medicaid Recipient or not; regardless of the policy holders relationship to the child; regardless of the type of insurance coverage including major medical and closed policies; voluntarily provided minor policies such as prescription, dental, and vision coverage to help paint the larger picture. It was also, understood that PCG would submit all verified policies without the benefit of knowing if Child Support or COB already had knowledge of the coverage. PCG works on a contingency fee basis; there for we work very closely with our clients to ensure that the results we provide them are of value to them. In ongoing contracts, these definitions are tightly defined and refined when ever required by the client.

A PCG file layout with our final submission was provided to Washington, segmented for ease of analysis to show the variety and types of matches provided. PCG worked closely with the state to ensure the file layout met their needs and to ensure understanding of the results provided. We also offered to resubmit the data in another format if it was required. PCG services are client driven. There is no required file layout for PCG clients. In all contracts, PCG staff work with clients and adapts our submissions to meet the clients' specific upload file requirements.

- **Sample population was limited.**

If the ultimate focus on this demonstration grant was to only consider the potential impact for Medicaid savings and cost recovery, then PCG contends that the population of cases selected should have included those cases within the IV-D caseload that do not have Medical Support Orders. If a Medicaid dependent has third party insurance coverage, then COB may include this in their cost recover and avoidance efforts regardless of whether or not there is a medical support order in effect. In addition, PCG has not been privy to the actual demographics of the 4,000 cases randomly selected. We would be interested to see if the cases selected and given to PCG were representative of the total caseload demographics as a whole.

- **DCS findings for PCG Data.**

PCG feels that the narrowing of the target population by DCS for the final analysis to only Medicaid dependents whose NCP is the policy holder severely undermines not only the potential cost benefit to COB but also the program benefits to the DCS program as a whole. We offer the following comments [using Table 5-4 from Chapter 5 of the draft report as reference] in this regard;

- <u>DCS eliminated 1,033 Terminated policies from analysis.</u>

  PCG feels that DCS may have under estimated the potential value of this information. Medicaid Agencies can retroactively pursue terminated policies for 12-24 prior months for recoveries [depending on state regulations]. This information could have been provided to COB for potential recovery work.
  The Federal Office of Child Support [OCSE] proposed medical support performance measurement will most likely include counting a IV-D case where the child had insurance coverage at any point in a 12 month period. Receiving terminated policy information may help DCS increase their medical support performance results and potential federal incentive.

- <u>DCS eliminated 210 policies where the NCP was not the policy holder.</u>

  PCG feels that DCS may have under estimated the potential value of this information. PCG provided 518 dependents with active major medical insurance coverage. DCS removed 210 from the analysis as coverage was provided by someone other than the NCP. Medicaid Agencies can pursue cost

recovery activities and cost avoid regardless of who the policy holder for the covered dependent child and whether or not there is a medical support order in effect. In particular, it is becoming more of an insurance industry standard to see the dependent listed as the policy holder rather than the person who is paying the premium for the coverage. By removing 210 dependents from the analysis, DCS denied COB the potential opportunity for Medicaid retroactive recovery and future savings through cost avoidance.

OCSE's proposed medical support performance measurement will most likely include counting a IV-D case where the child has medical coverage regardless of who the third party policy holder is. Receiving all active major medical policies regardless of the policy holder may help DCS increase their medical support performance results and potential federal incentive.

- DCS eliminated 293 Pharmacy only coverage and 494 other minor policies from analysis.

PCG concurs that there is no added value to child support to receive this type of minor policy information, unless their state law requires it. We supplied this information to demonstrate the possibility of other types of potential match results available. We would like to point out though that this information if provided to COB would be of potential value to their program for cost recovery and cost avoidance determinations.

- DCS eliminated 65 possible enforcement opportunities.

While we understand that DCS had to limit the analysis due to time and money constraints, PCG feels that DCS may have under estimated the potential value of this information in the final analysis. The 65 cases represented employer verified instances where the NCP had insurance available but the children were not covered. If DCS had mailed NMSN's on these potential enforcements, PCG conservatory estimates that anywhere from 16 to 26 enrollments would have occurred.

- DCS eliminated 40 erroneously submitted policies.

PCG apologizes for their submission. The possibility of this occurrence for a one time upload file was discussed with DCS in advance. In a normal ongoing contractual relationship, prior to invoicing, all PCG clients provide a response file to PCG of those policies that they feel were submitted in error. PCG only receives payment for policies that the client accepts for upload onto their system. PCG's goal for all contracts is to have a submission error rate of less than 1%.

- DCS eliminated 151 policies as they were known on the SEMS database.

As referenced in Chapter 5 [page 5] in a normal contract, PCG would receive on the child support eligibility file all currently known insurance coverage.

PCG

PCG's last QC step would be to remove any insurance coverage that is already known to the client prior to submission.

Due to the delay in DCS completing their analysis of work submitted, PCG contends that the insurance information provided, at the time of submission may not have been known to COB. A 3 month delay in researching the submission allowed the information submitted to grow stale and the potential for the information to have been found by other sources thus nullifying what at the time of submission by PCG was a newly identified insurance policy.

In addition, the report fails to provide detail regarding the analysis performed to determine if the records submitted were a "duplicate" of a records already existing on SEMS. PCG would be interested in knowing how many fields were analyzed to identify the duplication. For example, in our experience we have found that NCPs can often switch employment where the new employer offers insurance through the same carrier as the previous employer. The indicator for this potential change in employment would be a change in policy group number. Looking only at name and carrier fields, the record would appear to be a duplicate, but would actually be a newly identified coverage with a new employer. It was unclear from the report if the record analysis looked at the group number field.

Also, while PCG understands that DCS SEMS regularly provides COB with any new insurance information they may have for Medicaid dependents, it would have been interesting to see the analysis taken a step further and a quality control check completed of the COB system to see if they actually had record of those 151 policies and how accurate and complete the data was within those records.

- DCS eliminated 79 policies as they represented non-Medicaid clients.

PCG feels that DCS may have under estimated the potential value of this information. OCSE proposed medical support performance measurement will include counting all IV-D cases with medical support orders regardless of their status as Medicaid or non-Medicaid. Receiving all newly identified active major medical policies for all eligible cases will increase DCS medical support performance results and potential federal incentive.

- DCS eliminated 21 policies that were found already on the COB database.

Due to the delay in DCS completing their analysis of work submitted, PCG contends that the insurance information provided, at the time of submission may not have been known to COB. A 3 month delay in researching the submission allowed the information submitted to grow stale and the potential for the information to have been found by other sources thus nullifying what at the time of submission by PCG was a newly identified insurance policy. In addition, this elimination brings the question to mind if COB provides DCS

with regular updates on any insurance coverage they may find for Medicaid dependents that are also IV-D dependents. Again, it would be an opportunity for DCS to improve their medical support performance results. In all PCG Medical Support Contracts, PCG requests both the Medicaid and Child Support eligibility files in order to share coverage information on mutual clients found in both programs.

- Result

DCS analysis found in chapter 5 [page 11] concluded that "17 children might be enrolled in private insurance coverage under 17 different NCP's."

PCG finds exception to this phasing. It should read "17 Medicaid eligible children are enrolled in private insurance coverage that neither DCS nor COB was previously aware of. Because of the delay in analysis of PCG submissions, PCG contends that a portion of our submissions were not known to DCS and COB and were incorrectly eliminated there by reducing the final results. We also strongly believe that DCS devalued the potential savings to Medicaid from PCG's results by making their definition of successful too narrow. And finally, we strongly believe that by not including an analysis of nonmedicaid insurance policies provided, DCS missed an opportunity to determine how ready they are for the new federal performance measurements and incentives.

- **Conclusions on Vendor Data Matching**

ECONorthwest conclusions drawn from the vendor data matching demonstration included;

- Important lessons learned by DCS on how to operate and manage a data matching contract.
- Effective outcomes by vendors were limited due to challenges faced during implementation, compressed time frames, and limited resources.
- Suggestion that the savings impact using data matching vendors to Medicaid maybe limited.

In addition, ECONorthwest conclusions found in Chapter 6 believed that a number of other factors were more important determinants to the demonstration impacts listed in chapter 5 for vendor data matching demonstrations. PCG agrees that the conclusions drawn did impact the potential match rate provided but would like to offer the following thoughts to add to future decisions regarding vendor data matching services.

Data match contracts are not intended to replace a Child Support or Medicaid workers efforts but are designed supplement and support states medical insurance programs by helping to find insurance coverage that may have been missed by agency staff. PCG strongly believes that if this had been a full term medical support contract covering at least a 12 month period that our match results would have been greatly enhanced for all

the reasons cited by us in this letter. And while we applaud DCS for their efforts here and see the educational added value attained through this grant, we do not believe a one time match pilot to provide enough empirical data to base any long reaching conclusion on the effectiveness, fiscal impact or program improvements that DCS would realize in their MSE program through use of an outside contractor.

One of the most important reasons why Child Support Agencies should continue to consider utilizing data matching vendors to supplement their medical support work is the contingency fee based nature of the contracts. A state only pays for new policies that they determine are of value to them, setting the definitions specific to their needs. All other "behind the scenes" work a vendor does to find and verify the insurance policy is transparent to the state and present no risk to the client. In the case of a new Medicaid policy provided, Medicaid recovers the cost of the contractor fee within the first month of submittal. For Child Support, facing pending data reliability audits and performance incentives, improved medical support performance will soon become a financial consideration as well.

I want to thank you for allowing PCG to participate in your demonstration grant to evaluate strategies to improve Medical Support Enforcement in Washington State. I hope our results and comments prove useful to your agency.

If you have any further questions or need additional clarifications please do not hesitate to contact me at (617)426-2026 or email me at bbobo@pcgus.com.

Sincerely

Sean Curtin
Manager