Medical Support Collaboration Meetings Summary

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Department of Health and Human Services
Administration for Children and Families
Office of Child Support Enforcement

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Executive Summary

Purpose

The Administration for Children and Families (ACF) hosted five regional meetings during the summer of 2005 that brought together state directors from Medicaid, State Children's Health Insurance Program (SCHIP), Child Welfare/Federal Foster Care and Adoption Assistance (IV-E) and Child Support Enforcement (IV-D) to collaborate on ways to increase medical support for children. By encouraging states to explore the ways their programs interact, another goal of the meetings was to achieve Medicaid cost savings through child support enforcement. Finally, in response to the Child and Family Services Review (CFSR) findings, a third goal was to examine ways to improve health care services for children in foster care by increasing the collaboration of child welfare agencies with Medicaid and child support enforcement. In addition to state program directors, federal central office and regional office staff from the Office of Child Support Enforcement, Children's Bureau and Centers for Medicare & Medicaid Services (CMS) also attended these meetings.

This report summarizes the proceedings from the five regional meetings. It also includes the specific action plans that the federal and regional staffs and the program directors from individual states developed during the course of the meetings. These plans will be the basis for following up the collaborations begun at these meetings. This report should also provide a mechanism for sharing the information presented at the meetings with interested parties who did not attend.

Results

There were a total of 389 attendees at the five regional meetings (though several people attended more than one meeting and are "double counted" in this total). At least one program director from 53 of the states and territories attended the meetings. (Minnesota was not able to send staff to participate.) Those states produced an action plan for following up the regional meeting. Generally, these plans included proposals to create multi-agency task forces, improve cross-program communication and collaboration, investigate data sharing and other automated system enhancements, and improve policy coordination.

Some common issues of substantial concern to attendees emerged from the discussions. First, state Medicaid programs that have a fee-for-service system may be unable to accept cash medical support collected by the child support agencies for certain services. Participants requested that federal officials explore and seek solutions to this problem.

State child welfare and Medicaid agencies often refer all new applicants and cases to the child support enforcement program, including cases in which cooperation with child support efforts is neither required nor requested. The child support enforcement program has strict provisions limiting when a state IV-D

program can close a case. Inappropriate referrals impact state performance in child support performance measures and can lead to a loss of financial incentives and/or the imposition of financial penalties. During the conferences, state child welfare, Medicaid and IV-D program representatives began to understand the importance of working together to determine cases that are appropriate for referral.

Based on an Office of the Inspector General (OIG) report and Federal Child and Family Services Reviews, child welfare cases were provided with insufficient services for mental health, physical health and dental care in both rural and urban communities. Child welfare agencies are eager to work with Medicaid to locate and improve access to Medicaid providers for their caseloads.

Child welfare agencies have not been using the Federal Parent Locator Service (FPLS) to its fullest potential for permanency planning. As a result of these meetings, child welfare staffs recognize the valuable location data that the FPLS can provide and will work to increase its use.

Follow-Up

Participants indicated that they were appreciative of the opportunity to collaborate with the other programs at the meetings and encouraged follow up meetings to determine progress in federal and state action plans and to share individual state successes. Regional offices will work with individual states to help them implement their action plans. ACF and CMS are committed to investigating issues that might require action at the federal level.

With a congressional mandate that HHS establish a medical support performance measure and standard for inclusion in the IV-D program's financial incentive formula, state child support agencies are focusing on ways to improve their medical support performance to maximize the incentives they will earn. These efforts will result in savings to Medicaid programs and improved state performance for incentive purposes.

OCSE hopes to convene another round of meetings in the spring of 2006. Child welfare and CMS participants are investigating whether there is funding available for follow-up meetings. The regional offices are discussing with their states the best ways to continue the collaborations that began at the regional meetings and will present their recommendations by the end of 2005 so that planning for next spring can begin soon.

I. INTRODUCTION

Goals of the Meetings

The Administration for Children and Families (ACF) hosted five regional meetings during the summer of 2005 that brought together state directors from Medicaid, State Children's Health Insurance Program (SCHIP), Child Welfare (IV-E) and Child Support Enforcement (IV-D) to collaborate on ways to increase medical support for children. By encouraging states to explore the ways their programs interact, another goal of the meetings was to achieve Medicaid cost savings through child support enforcement. Finally, in response to the CFSR findings, a third goal was to examine ways to improve health care services for children in foster care by increasing the collaboration of child welfare agencies with Medicaid and child support enforcement. In addition to state program directors, these meetings were also attended by federal central office and regional office staff from the Office of Child Support Enforcement (OCSE), Children's Bureau and Centers for Medicare & Medicaid Services (CMS).

Impetus

There were four major forces driving these meetings. First, in August 2004, federal and state child support enforcement partners agreed to extend and enhance their National Child Support Enforcement Strategic Plan for FY 2005-2009. In the plan, the child support enforcement community emphasized meaningful medical support for children by creating a stand-alone new goal that "all children in IV-D cases have medical coverage," rather than having medical support as a subset of other strategic plan goals. This addition underscored the increased importance to the program of obtaining medical support for children.

The child support enforcement community recognizes that it has a unique role in increasing the extent to which children receive health care coverage. However, they also realize that state child support efforts to obtain medical support for children cannot succeed without close collaboration among Medicaid, SCHIP, and title IV-E agencies. In the Strategic Plan, securing health care coverage for children is articulated both in terms of establishing support orders with a medical support component and in actually securing health care coverage. These medical support efforts will aim at not only obtaining coverage, but also at placing the financial responsibility for that coverage with families to the greatest extent possible. The plan recognizes the need for the active cooperation of other components of Federal, state and local government, including Medicaid, SCHIP, and child welfare programs. Increased cooperation among these programs will benefit all four programs as well as the families and children they serve.

The second major driving force leading to the regional meetings was the CFSR, which is the mechanism by which ACF guides improvements in the child welfare system nationally. The CFSR is a results-oriented, comprehensive review

system designed to assist states in improving outcomes for families and children who come into contact with their public child welfare systems. Every state has participated in the initial phases of the CFSR and has engaged in the associated program improvement planning (PIP) process which is monitored by ACF. The goal of the reviews is to help states focus on systems change which will improve outcomes for families and children. As a result of concerns related to health, dental, and mental health care, many states focused on improving health care services for children in foster care in their PIPs. Because children in federally-funded foster care (title IV-E) qualify for Medicaid services, states recognize that it is imperative that the child welfare agencies work with Medicaid, SCHIP, and IV-D programs to secure health care coverage and medical support.

The third impetus for the collaborative meetings came from inspections conducted by the Office of the Inspector General (OIG) of seven states related to the use of Medicaid by children in foster care. These inspections resulted in a variety of recommendations which also underscore the need for program collaboration. Included in the OIG recommendations are the following:

- ✓ promote the importance of obtaining medical histories for foster children,
- ✓ ensure that foster care providers are given available medical information for the foster children in their care,
- ✓ increase the number of Medicaid health care providers willing to provide services to foster children,
- ✓ promote timely medical and mental health assessments of children entering foster care and adequate preventative health care,
- ✓ develop and maintain current and accurate lists of health care providers participating in the Medicaid program by area or community, and
- ✓ give case workers and foster care providers current lists of Medicaid providers willing to treat foster children.

The final impetus for the meetings was the Administration's desire to increase children's access to public and private health care coverage. In his FY2006 budget, the President has proposed several initiatives to do this, including one to decrease the number of uninsured children by working with states to enroll eligible children in Medicaid and SCHIP, and one that would allow states to seek medical child support for children from both the custodial and noncustodial party. These initiatives would require the close collaboration of state IV-D, Medicaid, SCHIP, and other agencies.

Presentation of Information

This report documents both the substance and the outcomes of the regional medical support meetings. Section II presents background material on the planning for the meetings and Section III discusses the format of the meetings as well as a summary of the agendas. The plenary sessions are summarized in sections IV, V, and VI. The next three sections – VII, VIII, and IX – summarize the outcomes from the breakout sessions at the meetings. Section X addresses the Next Steps that are anticipated as follow up to this series of meetings.

The appendices contain more detailed information about the meetings, including conference locations, dates, roster of participants, and agendas. There is also information about the materials in the meeting notebook given to each participant, including summaries of the best practice presentations. Finally, the last section of the appendix details the individual state plans.

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II. Background on Planning for Meetings

Attaining medical coverage for children has been a concern for the child support enforcement program for many years. As noted above, increasing medical coverage is now one of five program goals in the new Strategic Plan. However, the child support community is also well aware that health insurance costs are rising and that fewer and fewer private sector employers are offering health coverage to their workers, especially coverage that is affordable. Therefore, the child support enforcement program staff was eager to increase its efforts to collaborate with other government programs to develop new approaches that might help meet this new and important goal.

Medical Child Support Working Group Report

The Medical Child Support Working Group Report, "21 Million Children's Health: Our Shared Responsibility," which was issued in June 2000 by the Secretaries of Health and Human Services and Labor, contained 76 recommendations for improving health care for children. Among these, it suggested that "IV-D should work with Medicaid and SCHIP, as well as with private insurers, to assure that the child is enrolled in appropriate health care coverage." Chapter Six, Moving Toward Seamless Coverage: Improving Coordination and Communication Among Private and Public Health Care Coverage, was devoted to this theme. OCSE's Strategic Plan also recommends that the agency "use specific collaboration protocols with other agencies that serve our clients, emphasizing timely, accurate data exchange." It is against this backdrop that the Federal Office of Child Support Enforcement established contact with the Centers for Medicare & Medicaid Services and the Children's Bureau in an effort to plan regional meetings to collaborate on this initiative.

Joint Letter

A joint letter from Dennis Smith (Director of the Center for Medicaid and State Operations) and Dr. Wade Horn (Assistant Secretary for Children and Families) was developed to invite and encourage state directors of child support enforcement, Medicaid, SCHIP, and child welfare to participate in these regional meetings. There would be a total of five meetings during June, July and August 2005. The states and territories in the ten HHS regions of the country were divided among these meetings. Complete information on meeting locations, dates, and participant rosters is included in Appendix A.

Staff in each region took responsibility for developing the meeting agendas, and because there was good communication and teamwork among the regions' meeting planning teams, the same basic information was covered at each meeting and a similar agenda resulted for all meetings. Essentially, staff wanted to present background material on each of the programs represented; give attendees suggestions about how collaboration among the programs could help

each program improve results and decrease costs; provide examples of best practices in collaborations that already exist; and allow time for the states to develop action plans that they could take with them for follow up after the meetings.

III. Format of the Meetings/Agenda

Each of the five meetings followed a similar format, with slight variations because of regional circumstance or preference. Planning for the meeting agendas was spearheaded by regional staff in consultation with their state directors. The staff that planned the Kansas City meeting, which was the first of the scheduled meetings, developed an agenda that was agreed upon by central office staff from OCSE, CMS and the Children's Bureau. This agenda was shared with other regions as they worked to develop their meeting agendas. After the success of the first meeting, the regions were encouraged to use as much of the Kansas City meeting format as possible. For copies of the individual agendas, see Appendix B.

Welcome

At each meeting, regional administrators and representatives from the four federal programs – child support, child welfare, Medicaid, and SCHIP – welcomed meeting participants. They underscored the need that each program sees to obtain health coverage for children and to maximize the fiscal benefits of cross program collaboration. They set the tone of collaboration that was to be a hallmark of each of the regional meetings. While speakers recognized that there are barriers to cooperation and coordination of efforts, they talked about the importance of creating a dialogue among the different program staff as a first step in the efforts to work together.

Plenaries

The first plenary panel focused on "Program Intersections." Representatives of the federal programs provided meeting participants with some essential background information about each of their programs as well as a summary of the major issues currently facing each of them, emphasizing why collaboration among the programs is especially important now.

The second plenary panel also focused on "Program Intersections" and attempted to dispel some of the myths that may be perceived as barriers to cooperation among the programs. Panelists shared their views of what is possible through enhanced, strategically-driven collaborations. For example, participants were given information on data requirements as they relate to sharing sensitive customer data across programs. Panelists also emphasized the fiscal benefits of collaboration in such simple activities as sharing information in order to speed children's safe exit from foster care. Panelists also discussed new projects to enhance medical support and access to health coverage at the national and state levels.

The third plenary session invited state experts to share "Best Practices" that are being used in their states to enhance results through cross-program

collaboration. These sessions were designed to introduce participants to cross-program approaches to illustrate cooperative strategies with demonstrated results. In general, states from the regions where the meetings were held were the presenters, though this was not always the case. Two of the featured states – Massachusetts and Texas – presented at more than one meeting. Details about these Best Practices are included in Appendix D.

Breakout Sessions

The first breakout session grouped several states' participants with federal central office and regional office representatives. The purpose of this session was to identify program goals and strategies that have common ground across programs. Participants were also asked to discuss what links their programs together and to think about the benefits that could be gained from creating or enhancing these strategic links. By combining several states in the breakout groups, participants had an opportunity to exchange ideas in a small group setting and to ask each other about how they handled common issues. After these sessions, a "reporter" presented each group's findings to the entire conference.

The second breakout session gave participants the opportunity to meet with others from their own individual states for the purpose of developing a state plan for follow up. They were asked to think about future collaborations and to develop goals, strategies and indicators, and to identify necessary resources and next steps that they could all agree to take upon returning to their respective offices. At the same time that the states were meeting individually, federal and regional staff held their own meeting to develop their plan of action to follow up the conferences, as well. Finally, each group reported the results of these breakout sessions to the larger audience. The results of the sessions are included later in this report. The federal plan is presented in Section IX. The state plans for follow up are summarized in Section VIII and included in detail in Appendix E.

IV. Program Intersections: Why Collaborate Now?

In this opening plenary session, a group of panelists from child support, Medicaid and SCHIP, and child welfare provided information about each of their programs and how the programs are required to work together. They also discussed the major driving forces behind the renewed emphasis on enhanced collaboration among the programs.

Child Support Enforcement

The child support enforcement program has added a stand-alone medical support goal to its five-year national strategic plan. In the future, financial incentives may be tied to the states' ability to ensure that children have medical support orders as well as access to health care coverage. Without a thorough understanding of public health programs in the states, like Medicaid and SCHIP, and the understanding of how the public programs work with the private sector, it will be difficult for states to enhance health care availability or to develop creative ways to meet their ambitious goal.

The child support enforcement program is concerned about cost effectiveness and its role in recovering and avoiding costs in other programs, including Medicaid, SCHIP and IV-E child welfare. They recognize that effective collaborations and efficient processes, especially in data interface, will benefit children and families by promoting family self-sufficiency. This can create increased cost savings and avoid future costs to public programs.

Child Welfare

Child welfare representatives noted that children in federally-funded (IV-E) foster care are entitled to child support services in addition to Medicaid. Additionally, locating an absent parent can lead to giving that parent (or relatives of the parent) custody of a child, thus achieving "permanency," which is one of their program goals. Assisting children in moving out of the foster care system can result in cost savings to states. Furthermore, each child welfare speaker emphasized the fact that the federal program has recently conducted Child and Family Services Reviews for all of the state programs. In response, states are developing plans to address the issues that surfaced in these CFSRs. Among the important findings in these reviews was the need for children in foster care to have better access to health and mental assessments, preventive care and follow-up care. This is a prime concern for child welfare and an important impetus for their desire to increase collaboration with Medicaid.

Medicaid and SCHIP

Medicaid staff emphasized the size and increasing burden of the Medicaid program's budget at the federal and state levels, the flexibility that states have in designing their Medicaid programs, and the need for state Medicaid, SCHIP,

child support enforcement, and child welfare agencies to work together to increase the participation of parents and other liable third parties in the cost of the program.

Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 and is jointly funded by the Federal and state governments (including the District of Columbia and the territories). It is the largest source of funding for medical and health-related services for people with limited income.

The portion of the Medicaid program that is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each state by a formula that compares the state's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent or greater than 83 percent. Currently it ranges from 50-76 percent. The Federal government also shares in the state's expenditures for administration of the Medicaid program at generally 50 percent. Because of the entitlement nature of Medicaid, the amount of total federal outlays for Medicaid has no statutory limit.

As the safety net for much of the nation's low-income uninsured population, the Medicaid program has taken on an increasing responsibility for providing health coverage for this segment of the nation's population. For the five-year period from 1998 to 2003, total enrollment in the program increased by 30 percent. According to CMS figures, enrollment is expected to increase from 54 million enrollees in 2003 to 65 million in 2015, a 21 percent increase.

Consistent with the rapid rise in enrollment, overall Medicaid expenditures increased by 62 percent from $153 billion to $248 billion for the five-year period. Beginning in 2004, the rate of increase in Medicaid spending is projected to exceed the rate of increase in overall health care spending.

The SCHIP program was established by the Balanced Budget Act of 1997 as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough to purchase private insurance. In order to be eligible for SCHIP, a child must not be covered under a group health plan or under health insurance coverage. SCHIP offers states three options when designing their programs. They can expand Medicaid eligibility to children who previously did not qualify for the program; design a separate children's health insurance program entirely separate from Medicaid; or combine both the Medicaid and separate program options. As of September 30, 1999, each of the states and territories had an approved SCHIP plan in place. The portion of the SCHIP program that is paid by the Federal government is known as the enhanced FMAP. The enhanced FMAP currently ranges from 65 to 83 percent.

While Medicaid is an entitlement program (i.e., if you are eligible and you apply, the state must provide coverage), SCHIP is not an entitlement program. Each state is given a certain allotment of federal money each year. Therefore, states can impose caps and waiting lists in the program.

If a child who is covered under Medicaid can be enrolled in private health insurance, that child is not necessarily disqualified from Medicaid coverage. Rather, Medicaid becomes the payer of last resort. Therefore, by collaborating with child support to determine when private coverage is available for a child, Medicaid agencies can achieve cost savings. However, under SCHIP rules, if a child is covered by private insurance, that child is no longer eligible for SCHIP coverage. Because of the SCHIP cap, switching one child to private coverage means that a new child can be covered by SCHIP. Also, SCHIP can work with state child support and welfare agencies to collect cash medical support payments from obligors in order to pay the deductibles or co-payments required by the SCHIP program. Thus, the Federal government, states and children would benefit from collaboration between the Medicaid, SCHIP, and child support enforcement programs that would lead to increased identification of medical support and private health insurance coverage for children in the child support enforcement system.

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V. Program Intersections: Breaking Down Myths and Barriers to View the Possibilities

After the introductory plenary session, a second plenary invited panelists to discuss in greater detail the ways in which the four major programs could work together to increase medical support for children. Specifically, the moderator asked these panelists to comment on some commonly perceived barriers to program collaboration in order to dispel any myths that might exist and to encourage enhanced cooperation among the programs.

Research Findings

At four of the sessions, Jennifer Burnszynski, a social science analyst from the Office of the Assistant Secretary for Planning and Evaluation discussed recent research findings illustrating the need for close collaboration among the programs. Ms. Burnszynski presented child and family health insurance trends that show decreases in private coverage, increases in public coverage (especially in SCHIP), and increases in the cost of insurance premiums. About one third of all children rely on Medicaid and SCHIP. She discussed the overlap in populations served by Medicaid, child support and SCHIP and reviewed research findings about health care coverage specifically among the child support population as well as the availability of employer-sponsored health insurance for noncustodial and custodial parents. Finally, she mentioned the studies done by the HHS Office of the Inspector General (OIG) on cost avoidance and the potential for cost savings from child support enforcement activities that enroll children in private health insurance.

Medical Support Requirements

Lily Matheson, Director of OCSE's Policy Division (and others from her division at some meetings) discussed the mandate for child support enforcement programs to seek private health insurance and the importance to the child support enforcement program of working together to improve results in obtaining health care services for children. They mentioned the medical support indicators in the new Strategic Plan and the possibility of a medical support incentive measure in the future.

Importance of Cross-Program Coordination

Richard Fenton, Deputy Director of the Family and Children's Health Programs Group in the Center for Medicaid and State Operations at CMS, reiterated the importance of coordinating with child support enforcement as a way to reduce Medicaid costs by identifying private health insurance that may be available to Medicaid-eligible children. Patsy Buida, a Foster Care specialist at the Children's Bureau (and other Children's Bureau representatives) discussed the goals and measures that are part of the Child and Family Services Reviews conducted in

each state and the resulting Program Improvement Plans (PIPs) that are now in place in the states. Many of the state plans for follow up emphasize improving access to medical services for foster care children. Another important cross-program connection is the need to locate absent parents to include them in the case planning process, highlighting the need for child welfare access to parent locate information.

Access to Data

Donna Bonar, Associate Commissioner, OCSE Office of Automation and Program Operations, and others from her division discussed the types of information available from the expanded FPLS as well as other data matches that are being conducted at the federal level. She talked about the main sources of federal data, the entities that have legislative authority necessary to access this data, and provisions governing data safeguards. OCSE policy staff reviewed the rules about who may access what child support information and for what purposes. Child welfare may access FPLS data and the state parent locator data. Medicaid may access IV-D system data.

Child welfare program specialists emphasized the need to work with child support enforcement to locate noncustodial parties using FPLS and state parent locator data resources. Locating the noncustodial party can assist in reducing the length of time a child is in foster care placement and help achieve permanency goals.

Panelists talked about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and how those rules might affect access to data. Mr. Fenton asserted that Medicaid has always treated the confidentiality of data as an important aspect of the program and the Medicaid rules are as or more stringent than the HIPAA requirements. However, it is also permissible under Medicaid rules for health plan administrators to share individually identifiable information about Medicaid applicants or recipients with child support enforcement as long as the sharing is in the furtherance of the Medicaid program.

Data Match with Department of Defense

OCSE is planning to expand a pilot data match with the Department of Defense (DOD) to all states. The pilot matched child support cases in New York and Ohio to records of enrollees in the Defense Manpower Data Center (DMDC) Defense Enrollment Eligibility System (DEERS) where information about medical coverage is stored for military members and their families. The pilot not only uncovered cases where children were already enrolled in medical coverage but the state child support office was unaware of this coverage, but also provided information about cases in which the child was eligible but not yet enrolled. Interestingly, the pilot also showed that a surprisingly large number of children were covered by neither the custodial nor noncustodial party, but by another

"sponsor" – usually a stepparent. This match gave the state child support agencies vital information that they could then follow up.

Referral of Cases

One of the program intersections in which problems arise is when cases are referred to child support enforcement. Panelists focused on the "appropriate" referral of cases from Medicaid and IV-E child welfare programs, and discussed circumstances in which it may be better not to refer a case to child support enforcement. (For example, many of the child welfare cases are short-term. A child might be returned to his or her home within 48 hours.) If child support has cases that are open but that are not able to be followed up on effectively, the state could lose incentive payments.

Cash Medical Support

Panelists explored what occurs when child support agencies collect cash medical support. The panelists discussed that under certain circumstances, Medicaid may accept cash payments from the child support agency. However, in some cases, for example when Medicaid services are delivered through a fee-for-service system as opposed to managed care, the Medicaid agency may not accept cash payments other than those which were specifically collected for the delivered services. SCHIP can accept cash contributions from the NCP to cover SCHIP costs. Ms. Burnszynski presented research findings on various methods that states have used to defray the costs of SCHIP and Medicaid with co-pays, premium payments and cash medical support. Waivers may allow state Medicaid agencies to find ways to accept cash medical support.

On the Horizon

Panelists discussed where their programs are headed in the future and what is on the horizon. In Medicaid, there is currently a commission exploring ways to achieve $10 billion in program savings. The program is under scrutiny from a variety of sources and the issues are a major focus at the state and federal levels. In child support, new proposals may require states to look at both the custodial and noncustodial parents when setting medical support orders.

OCSE conducted a feasibility study on matching data records at the federal level with private insurers. While there is evidence that such a match would be cost effective and is of great interest to the states, there is no current legislative authority to conduct such a match.

Child welfare staff noted that there will be a second round of CFSRs in the near future. There will continue to be a strong focus on finding ways to provide health care services to children in foster care. One of the items reviewed during the CFSR includes the involvement of both parents in the case plan. This is an area where states need to improve.

The research staff noted that states are exploring ways to provide child-only health insurance plans. Georgia has a grant to investigate the feasibility of such a plan. Medical health care spending accounts are also on the horizon.

VI. Best Practices

At each of the regional meetings, there was time on the agenda allotted for presentations on current "best practices" that focused on innovative ways in which cross-program collaborations were already taking place in certain jurisdictions in order to address children's medical support issues.

Example States: Massachusetts and Texas

A total of 12 different states presented best practices at the five meetings. Massachusetts and Texas presented their projects at more than one of the conferences. Alabama, Arkansas, California, Georgia, Missouri, New York, Ohio, Oklahoma, Oregon and South Dakota also gave examples of many different kinds of collaborations in different stages of implementation. In Massachusetts, for example, the child support agency and the state's Medicaid agency have been working in partnership since 1995 on various information exchange projects. This collaboration, which now goes well beyond data sharing, has resulted in a cumulative cost savings to the Commonwealth for FY05 of close to $50 million. The data sharing efforts lead to finding private health insurance for Medicaid recipients. Cumulative cost savings are accrued when private health insurance pays for services that Medicaid would otherwise cover for eligible individuals.

In 1998 the Texas Office of the Attorney General (OAG) obtained the services of a vendor to enforce medical support obligations administratively. The vendor seeks out and identifies sources of private insurance and effects enrollment, predominantly through employers. The vendor conducts matches with insurance carriers, sends insurance surveys to employers, sends enrollment letters to employers, monitors for responses to the National Medical Support Notice (NMSN), provides insurance enrollment information to the OAG and custodial parents, and sends NMSNs to employers as needed. The vendor also uses quarterly and monthly wage data from the Texas SWA agency to search for employment information about NCPs and initiates medical support enforcement action when appropriate. The vendor provides a report of children who are on SCHIP and private health insurance at the same time. The vendor also provides missing and corrected SSNs that are updated on child support cases. The Texas IV-D agency (OAG) has had an interagency agreement with the Texas Medicaid Agency for almost 20 years. Medicaid gives incentive payments to the OAG for medical support enforcement actions on Medicaid-active children who are also on IV-D.

Other collaboration efforts range from data matching to shared systems. Summaries of the presentations, and available PowerPoint slides, are included in Appendix D of this report.

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VII. Common Goals and Program Links

At most of the conferences, the first breakout session was intended to have participants focus their discussion on the common goals of the four programs. Each small group consisted of representatives from several states as well as a few federal central office and regional office staff members. The groups were asked to address three key questions:

1. What are the program goals and strategies that have common ground across the programs?

2. What are the specific links that join the programs together?

3. What specific value or cost/benefit may be gained from creating or enhancing these strategic links?

In general, the discussions provided an excellent forum for states to learn from each other about how they handle many of the same problems. These discussions laid the foundation for many of the ideas that were then translated into states' action plans at the second breakout sessions. The following is a summary of the points made in this first session.

1) What are the Program Goals and Strategies That Have Common Ground Across the Programs?

When asked to discuss their programs and to look for the common goals and strategies among them, the participants' comments generally fell into five main categories. First, there was the recognition that these programs all provide services to children and families and they have a mutual interest in making health care services available to the populations they serve. Second, the fact that they are each government programs lent some commonality to their goals and strategies. In addition, the programs each face budget constraints and automation issues. Finally, they all focus on encouraging responsible and engaged parenting. Below are more specific common goals and strategies, grouped into these general categories described above.

Concern for Providing Health Care Coverage

Participants agreed that in each of their programs they are concerned with providing children with medical support and/or health coverage that is comprehensive, affordable, accessible, and provides a continuity of care. Program directors see a critical need to have sufficient numbers of service providers offering medical, dental, and mental health services to their clients or customers. They recognize that the programs often serve the same populations of children and families and they all seek to strengthen and provide stability to the families they serve and to improve the health outcomes for these families.

Government Programs

Participants also discussed the common concerns resulting from their each being government-subsidized assistance programs. They recognize the need to improve collaboration across programs at all levels (federal, state, and local) in order to overcome intra- and inter-departmental barriers. They see a need to keep the judicial and legislative branches in their states informed about medical support issues and initiatives that they are contemplating. In addition, while they all strive to provide high quality service, they also seek to reduce the dependency of their clients on their programs.

Budget Constraints

Each program is faced with critical budget concerns as well. Each program strives to decrease costs so that it can serve more people. Programs want to operate efficiently and spend tax dollars wisely. They aim to achieve savings through cost containment, cost avoidance and cost recovery and they recognize that by increasing collaboration they might be able to decrease costs and avoid duplicating services.

Parental Involvement

All four programs agree that parents should be accountable and responsible for their children. They understand that parents – both custodial and noncustodial – need to be engaged in the process of achieving family self-sufficiency. Often, identifying or locating a noncustodial parent (or NCP's relatives) is a first step in this process. Part of this parental responsibility should be providing medical coverage.

Automated Systems

Finally, automated systems are common concerns of the four programs. Each program seeks access to cross-program data that is accurate and timely to enhance decision-making. Each sees a common need to use automation to facilitate interagency collaborations and data exchanges.

2) What are the Specific Links That Join the Programs Together?

In discussing the specific links that join their programs, the participants' comments again fell generally into the same five broad categories. For example, they acknowledged that they serve many of the same populations, creating an intersecting, if not completely overlapping, client base. Case management decisions by one program can affect clients of another program. Federal foster care, for example, depends on Medicaid health care providers to provide health care services to children in foster care.

Government Program Collaboration

As government programs, the links vary from state to state depending, to some degree, on whether or not they are "housed" bureaucratically under the same umbrella agency. Issues such as program eligibility determinations, assignment of rights, cooperation and referrals might be handled more efficiently if the programs worked cooperatively. Participants recognize that each of their programs might be the entry point for service to these families. Particularly with regard to referrals, participants recognized the critical importance of referring only those cases that were deemed to be "appropriate," though there is some question about how best to define that term. Government programs have to contend with federal funding and federal oversight. They have specific missions that are defined and governed by statutes and regulations. State staff have to cope with legislative and gubernatorial expectations for their programs as well as with politics in general. Finally, participants found that they are linked in their need to work with criminal justice agencies and court orders as well as with other programs such as TANF, Head Start, and their state education departments.

Attention to Costs

Regarding budget issues, during the discussions participants learned how collecting child support can lead to cost avoidance for the other programs. For example, obtaining private health insurance coverage for children should lead to reduced Medicaid and SCHIP costs. Participants might also assist each other in fraud prevention, cost efficiency (by limiting duplication of efforts) and in maximizing child support financial incentives and reducing program penalties. Also, locating an absent parent may provide a child in foster care with the relative resources needed to exit the foster care system. Shortening the length of time children are in foster care can have a positive impact on the state budget because of the reduction of the associated monthly costs.

Engaged Parenting

The desire to encourage responsible and engaged parenting is also a link among the programs. As a corollary, the increase in divorce rates and in the percentage of non-marital births affects all programs as well. Developing the custodial parent's cooperation and the assignment of rights is a common link. Child welfare staffs understand the value that child support can provide by locating children's relatives for possible placement and permanency planning.

Data Sharing

The programs recognized that their automated systems can also be links. They are all data- and outcome-driven programs. There currently are valuable data matches and there is the potential for more information sharing to improve decision-making and to reduce costs. Each program could benefit from having automated access to private insurance coverage information as well as vital

statistics information. Programs recognize the need for providing better information to case workers and, at the same time, there is an understanding that there can be major privacy issues involved in information sharing. All partners must agree to levels of confidentiality and security for the data and there must be clarity about how the data will be used. All programs also recognize the value of the data in the FPLS and may want to seek expanded access to this data. As well, they felt that they could all benefit from data matches with insurance companies, though they would like federal assistance with this. They recognize the need for more standardization of data elements in order to increase these automated links.

3) What Specific Values Would be Created or Enhanced by Collaborating?

Finally, after spending time in these break-out sessions focusing on shared program goals as well as common links, participants had an increased understanding of how each of their programs could benefit from increasing collaboration efforts.

Better Outcomes for Children

Collaborating to obtain increased health coverage for children, for example, would lead to better health outcomes for children. Child support and Medicaid, working together, could help keep children out of foster care by relieving economic stressors faced by many of these families. Pro-active measures can be taken to keep children safe through information sharing among the programs. Providing quality program referrals would improve the likelihood that cases could be worked successfully.

Collaborative Problem Solving

As representatives of government programs, participants from the four different agencies felt that they could and should work together to solve problems. For example, by collaborating on outreach and community awareness, they could jointly emphasize their roles of improving children's lives and supporting family self-sufficiency. In addition, by communicating across programs they can help each other understand and be aware of any changes in their programs, whether these are changes in legislation or in their automated systems. Each such change can impact every program and there are advantages to dealing with the impacts of changes sooner rather than later. Participants need their caseworkers to understand these links and to communicate across programs. They discussed the importance of referring only "appropriate" cases to child support, correctly identifying "locate only" cases, and the problems that can be caused by ignoring these issues. They also recognize the need to acknowledge the limits of each program, i.e., each program alone cannot meet all the service expectations of its clients.

Increased Efficiency and Funding

By the end of the discussion, many participants developed a better appreciation of how working together might bring increased incentive funding via the child support enforcement program. Collaboration also has the potential to increase efficiency, enhance savings, reduce Medicaid fraud, and improve the use of limited resources, especially by data sharing across programs. Locating absent parents for children involved in child welfare can reduce the length of time a case is open, resulting in effective cost avoidance. Discovering available and affordable private health insurance will lead to increased savings. Participants also see the potential in multi-agency grant applications as a route to increase funding.

Better Support for Children

Participants recognize that improving child support collections and increasing parental responsibility or parental involvement might prevent children from entering foster care. There could be fewer children at risk if there were better financial and emotional support from noncustodial parties (NCPs). Locating noncustodial parties could help the child welfare agency achieve permanency for a child more quickly by allowing staff to place that child with the NCP, placing the child with a relative of the NCP, or terminating the NCP's parental rights and allowing staff to place the child elsewhere. Obtaining better information about Medicaid health providers could also help child welfare ensure that foster children have access to the healthcare they need.

Data Sharing

Finally, collaboration efforts could lead to enhanced automation and data matching or data sharing which, in turn, could decrease duplication of effort, lead to better referrals and increased data reliability, save time, identify parental resources and improve continuity of care.

Collaboration and coordination of efforts by the programs would also benefit employers and private insurance companies by minimizing the number of contacts from state agencies and decreasing duplication of effort. For example, some states are trying to combine Medicaid and child support enforcement matches against private insurance company files.

Other Potential Collaborators

In these small break-out sessions, states also discussed what other interested parties or stakeholders need to be part of the discussion and planning for these collaborative efforts in the future. Among the groups that they identified were the following: court personnel, tribes, state legislatures, state budget officers, state

insurance commissioners, labor department personnel, state chief information officers, employer association representatives, major employers (government & private), Temporary Assistance for Needy Families (TANF) staff, and state health department staff.

VIII. State Plans for Follow-Up

In breakout sessions with others from their own home state, representatives of the programs developed plans to continue their efforts after they returned home from the conferences. The approach to creating these plans varied slightly from conference to conference, but generally states were asked to think about their common goals and then to develop strategies to achieve those goals. Sometimes they also identified resources they would need or barriers they had to overcome to achieve these goals.

Common Themes

In spite of their differences, many of the states cited common themes. A number of states suggested creating workgroups or collaborative task forces to help them achieve their goals and to begin the cross-program conversation. Many mentioned the necessity to train staff about the different programs. Another common theme among states was the need for increased information by the various programs and many mentioned the importance of enhancing existing automated systems to accomplish this increased communication. Several states also planned to review their policies and procedures in order to remove any existing barriers to cooperation among the programs. Finally, several states cited the need for outreach among the programs, particularly because they often serve the same populations. A complete list of the state plans is included in Appendix E.

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IX. Federal Plan

At four of the five conferences, the agenda allotted time for attendees from the federal central office and regional offices to meet together as a group in order to develop a plan to follow up on action items identified at the conferences. These federal meetings took place during the time that each state's program directors were meeting in breakout sessions of their own. The following is the consolidated federal/regional plan, consisting of all items that were identified as requiring follow-up at each of the conferences. (Note that many of the items have been combined because they were identified by more than one of the federal discussion groups.)

Regional Office Follow-Up

- Regional offices should be the catalyst to help states follow up on their state-specific action plans. For example, the regional offices can help facilitate state and/or regional meetings. They can help identify, and possibly help to remove, any program or administrative barriers to further collaboration. They should monitor and track the goals and strategies developed by the states.

- Develop a list of those barriers that need to be presented to federal staff in Washington.

- Help to ensure that systems staffs from the various programs (that were not at these meetings) are brought into the collaboration process at the state level to facilitate their understanding of how the programs intersect and to ensure that systems are developed that can work together.

- Obtain copies of RFPs that states have developed with vendors who do data matching. Share these with other states so that states can see the various types and ranges of activities that are in the contracts. (For example, in Texas the contractor doesn't just match data but is also responsible for sending out the medical support notices. Other states give vendors a more restricted role.)

- Assist states with OCSE Special Improvement Project (SIP) grants and Section 1115 Demonstration grant proposals and explore whether OCSE Technology Transfer funds may be used in this effort.

- Coordinate with state Title XIX and IV-D agencies to refine the definition of an "appropriate referral." The same thing should happen for IV-D and IV-E agencies.

- Region IV (Atlanta) should help Georgia with its low income health insurance project. That region should also share the Georgia Section 1115 Demonstration grant process and results with other states.

- Regional Offices for VIII (Denver), IX (San Francisco), and X (Seattle) agreed to meet with their respective states in October 2005 for follow-up to this meeting.

- Regions can look to the National Resource Centers for technical assistance.

OCSE/Medicaid/SCHIP/Child Welfare Central Offices Follow-Up

- All programs should work together to explore ways for everyone to share information. (For example, sometimes hospitals get information regarding Third Party Liability that might be useful to child support.)

- The federal offices should try to engage the governors' staffs and budget officers. There should be outreach to the National Governors' Association, the National Association of State Budget Officers and, possibly, the National Conference of State Legislatures (NCSL). This is necessary so that these audiences will understand the efficiencies and cost savings to be gained by fostering cooperation among the programs. OCSE should consider including state budget, court and legislative representatives in future meetings.

- Continue to meet with each other and try to coordinate at the federal level. For example, Medicaid staff should be invited to ACF User's Group meetings. (These annual meetings are sponsored by states and the states' systems staffs, who develop the agendas. State systems development staffs attend the meetings, which recently have tended to be added on at the end of the annual American Public Human Services Association – Information Systems Meetings. They include concurrent sessions on IV-A, IV-D, IV-E and General Technology.)

- Medicaid and Child Welfare should work together to help states increase ways to help health providers. Identifying more available health insurance coverage will help with the access-to-provider supply issue.

- Clarify policies relating to mandatory and "appropriate" referrals and then educate states and workers and issue further guidance, if necessary.

- Investigate the possibility of developing a website for sharing information among the four programs. This website could include information about best practices as well as issue briefs. Staff from any of the programs could visit this website to gain information about the collaboration efforts. The site could maintain on-line Questions & Answers that address the issues and concerns of states and other stakeholders.

- Get on the agendas of each others' state and national conferences to continue the education process that is beginning and to focus on reducing interagency barriers.

- Consider including representatives from IV-A (TANF) at future meetings.
- Consider using the OCSE Tri-Regional Arrears Management Workgroup as a framework for ongoing medical support collaborative activities.
- Consider federal mandates when leverage (e.g., with legislators) appears necessary.
- Automation requirements/recommendations: Inventory how many states are attempting to interface their systems. Federal regional offices could commit to work with IV-D and IV-E in the states to make sure they have a process for locating parents for permanency planning. (Note: South Carolina Child Welfare has a manual process to request locates from IV-D. There is a need to study what can be done manually versus requiring automation in interim periods or on a smaller scale.) Create a joint workgroup to develop standardized data elements.
- At the federal level, explore using parent buy-in options for SCHIP as a solution to medical support because it might provide the most consistent medical coverage.
- OCSE and others at the federal level need to look at policy goals and performance indicators associated with helping kids get private health insurance. In all the discussions about developing medical support indicators, we have determined that every effort for getting medical support will count towards incentives.

CMS Follow-Up

- Can re-interpretation of the "efficient and effective" part of the Medicaid statute allow for more access to data that Medicaid matching programs have? Research how federal funding works to support this. (The issue is the access to data Medicaid may have from private health insurance data matching on non-Medicaid children that may be IV-D children.)
- CMS should analyze its statutes to address the issues raised at these meetings, such as Medicaid confidentiality.
- Research and evaluate the need for federal legislative action regarding Medicaid acceptance of cash medical support in fee-for-service when a child has not utilized Medicaid services.

Children's Bureau Follow-Up

- Research and evaluate the need for federal legislative action regarding Child Welfare access to the Federal Parent Locator Service to locate non-parental relatives of children needing placement services.

OCSE Follow-Up

- Investigate the possibility of pursuing with DOD a change in their policy under which a custodial party must go into a military office/unit to get an ID so she can enroll children in insurance. Research federal law that requires a federal agency to enroll the child if the NCP doesn't.
- As states explore "appropriate referrals," we may want to look at rule changes regarding opening and closing cases.
- Explore whether there are any ways OCSE staff can participate in the Medicaid Reform discussions to educate them regarding potential child support enforcement cost savings to Medicaid.
- The "reasonable cost" definition needs to be changed. Currently, health insurance is considered reasonable in cost if it is employment-related or other group health insurance, regardless of the service delivery mechanism. However, as the cost of health insurance increases, employees are having difficulty meeting these costs. (OCSE should issue the proposed rule on medical support as soon as possible.)
- Work to increase access to the FPLS by child welfare agencies. There should be help at the federal level to ascertain which IV-E agencies are accessing the FPLS and how this can be improved.
- Publish a report of these meetings to share with stakeholders. This should include a compilation of all suggestions from all five regional meetings. There should be a Table of Recommendations with required follow-up steps. Additionally, there should be follow-up with a report on accomplishments flowing from these meetings.
- Research and evaluate the need for federal legislative action regarding a national federal match against health insurance provider data bases.

Federal Central Office and Regional Office Joint Follow-Up

- Plan next year's conferences/meetings for next Spring (consider states legislative sessions when planning dates).

- When working together, it is important that we understand that SCHIP is very different from Medicaid, with different rules and models.
- Get commitments from staff on what they will complete by next year's meetings.
- Regions should continue to try to identify "best practices" and disseminate materials about these programs. Then, these can be publicized (either on ACF and CMS web sites or on a special web site) and included on the agendas of the Spring follow-up meetings.

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X. Next Steps

At the conclusion of each conference, state participants left with specific plans of action they had developed to address the issues they identified at the state level. Some of the states' plans were quite detailed and included, for example, specific time frames for establishing advisory committees made up of the directors, fiscal officers, and information technology staff. Regional offices are working with each state to implement these action plans.

Federal central office staff members have continued to meet to plan for the creation of this report; for implementing some aspects of the federal action plan; and for a second round of conferences to be held in the Spring. ACF and CMS staff participated in some follow-up meetings and also committed to investigating issues that might require action at the Federal level.

At a meeting in October that followed the OCSE 15th Annual Training Conference, central and regional office staff met to discuss plans for continued collaboration and made substantive suggestions for the next round of conferences. Regional staff also received draft copies of the state plans to review with their states and of the federal plan to ensure that the recommendations were captured accurately for this final report. There were additional follow-up phone calls with regional and central office staff and the following decisions were made regarding the next round of meetings:

1. A second round of meetings will be held at ACF Regional Offices in May 2006.
2. There will be two meetings instead of five: May 2-3 and May 23-24.
3. This year's meetings will include the nine Tribes with fully operational IV-D programs.
4. There will be an effort to match "trainer" states with "student" states in order to continue to share some collaboration best practices that have developed. States felt that learning about "best practices" was one of the most important benefits from the first round of meetings.
5. The meetings will focus on several specific issue areas that emerged from the first set of meetings.

Another joint Dear Colleague letter from Dennis Smith, Director, Center for Medicaid and State Operations, and Wade Horn, Assistant Secretary for Children and Families, is in the process of being developed and will be sent to State Child Support Enforcement Program Directors, Medicaid Directors, Child Health Insurance Program Directors, Child Welfare Directors, Tribal Child Support Enforcement Program Directors, ACF Regional Administrators, CMS Regional Administrators, and Regional Program Managers to urge their participation at the next round of meetings.

This report will be shared with States and meeting participants and will be placed on the OCSE website so that it will be available to any interested parties.

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XI. Appendices

Appendices A through E appear on the following pages:

A: Conference Locations, Dates and Participants – p. 43

B: Conference Agendas – p. 59

C: Information in the Conference Notebooks – p. 81

D: Best Practices Summaries and PowerPoint Presentations – p. 83

E: State Plans for Follow-Up – p. 147

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Appendix A: Conference Locations, Dates, and Participants

Five regional meetings were held over the course of the summer of 2005. The first meeting for states from Regions V and VII was held in Kansas City, Missouri on June 28 and 29 at the Country Club Plaza Marriott Hotel. Participants came from Illinois, Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska, Ohio, and Wisconsin. (Minnesota was not able to send staff to participate.) In addition, there were regional and federal representatives from CMS, ACF, the Children's Bureau, and OCSE at each meeting. The complete attendee rosters from this and all other meetings follow.

The second meeting for states from Regions VIII, IX and X was held in Reno, Nevada on July 19 and 20 at the Circus Circus Hotel. Participants in this meeting came from Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

The third meeting was held simultaneously in Little Rock, Arkansas on July 19 at the Peabody Hotel. There were representatives from each program at each meeting and much of the same information was covered. The meeting in Little Rock was for representatives from Region VI states: Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

The fourth meeting was for Region IV states and it was held at the Charleston Place Hotel in Charleston, South Carolina on August 10 and 11. Participants at this meeting came from Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Contractors from Policy Studies Incorporated also attended this meeting in order to make a presentation on Georgia's efforts to develop low-cost health insurance options.

The fifth and final meeting was held at the Park Plaza Hotel in Boston, Massachusetts on August 17 and 18. States from Regions I, II, and III were invited to this conference and representatives attended from Connecticut, the District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, the Virgin Islands, Virginia, and West Virginia.

Final rosters from each conference are included on the pages that follow.

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Roster: Kansas City

Increased Medical Support….Meeting: Region V & VII
ATTENDEE ROSTER
Kansas City, MO
June 28-29, 2005

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Roster: Kansas City, *continued*

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Roster: Reno

Region VIII/IX/X Medical Support Meeting
Attendee Roster
Reno, Nevada
July 19-20, 2005

NOTE: Sorted alphabetically by REPRESENTATION with STATES/TERRITORIES listed first then OTHER organizations then FEDERAL/REGIONAL OFFICES

Representation	First Name	Last Name	Title	Organization	Address	City	State	Zip Code	Office Phone	Ext.	Email
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California	Patricia	Aguiar	Branch Chief, Foster Care and Adoptions Program Policy	California Dept. of Social Services Child and Youth Permanency Branch	744 P Street MS 14-73	Sacramento	CA	95814	916-657-1937		Pat.aguiar@dss.ca.gov
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California	Eric	Morikawa		CA Dept. of Health Services Third Party Liability Branch	P.O. Box 997425 MIS 4719	Sacramento	CA	95899-7425	916-650-6482		Emorikaw@dhs.ca.gov
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Roster: Reno, *continued*

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Roster: Reno, *continued*

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Roster: Little Rock

Region VI Medical Support Meeting
Attendee Roster
Little Rock, Arkansas
July 19, 2005

NOTE: Sorted alphabetically by REPRESENTATION with STATES/TERRITORIES listed first, then OTHER organizations, then FEDERAL/REGIONAL OFFICES

Representation	First Name	Last Name	Title	Organization	Address	City	State	Zip Code	Office Phone	Fax Number	E-mail
Arkansas	Cecile	Blucker	Assistant Director	Department of Health and Human Services Division of Children and Family Services Office of Financial & Administrative Support	P.O. Box 1437 Slot S 560 700 Main Street	Little Rock	AR	72203	(501) 682-8432		cecile.blucker@arkansas.gov
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Arkansas	Pat	Page	Assistant Director	Department of Health and Human Services Division of Children and Family Services Office of Legislative Analysis, Research & Planning	P.O. Box 1437 Slot S 560 700 Main Street	Little Rock	AR	72203	(501) 682-8544		pat.page@arkansas.gov
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Arkansas	Dorothy	Vance		Department of Health and Human Services Division of Medical Services	Donaghey Plaza South Suite 1100	Little Rock	AR	72203-1437	(501) 683-2916		dorothy.vance@medicaid.state.ar.us
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Louisiana	Ruth	Kennedy	Medicaid Deputy Director/ LaChip Director	Department of Health & Hospitals	1201 Capital Access Road P.O. Box 91030	Baton Rouge	LA	70821-9030	(225) 342-9240	(225) 342-9508	rkennedy@dhh.la.gov
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New Mexico	Jeff	Thompson		Human Services Department Children, Youth and Families Department Protective Services Division	P.O. Drawer 5160	Santa Fe	NM	87502-5160	(505) 827-8400		JLThompson@cyfd.state.nm.us
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Roster: Little Rock, *continued*

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OCSE	Leon	McCowan	ACF Regional Administrator	OCSE Region VI	1301 Young Street Room 914	Dallas	TX	75202	(214) 767-9648	(214) 767-3743	lmccowan@acf.hhs.gov
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Roster: Charleston

Region IV Medical Support Meeting
Attendee Roster
Charleston, SC
August 10-11, 2005

NOTE: Sorted alphabetically by REPRESENTATION with STATES/TERRITORIES listed first then OTHER organizations then FEDERAL/REGIONAL OFFICES

Representation	First Name	Last Name	Title	Organization	Address	City	State	Zip Code	Office Phone	Ext.	Fax	Email
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Alabama	Greta	Felton		CMS								Gfelton@medicaid.state.al.us
Alabama	Janice	Grubbs	Policy Analyst	Alabama Dept of Human Resources Child Support Enforcement Division	S. Gordon Persons Building 50 Ripley Street PO Box 304000	Montgomery	AL	36130-4000	(334) 756-2209		(334) 756-2369	jgrubbs@dhr.state.al.us
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South Carolina	Carolyn	Roach	Director	Division of Medicaid Policy and Planning	PO Box 8206 1801 Main Street/J837	Columbia	SC	29202	(803) 898-3967		(803) 255-8350	RoachCA@dhhs.state.sc.us
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Tennessee	Bill	Duffey	IV-D Director	Department of Human Services Child Support Services	Citizens Plaza Building 400 Deadrick Street, 12th Floor	Nashville	TN	37248-7400	(615) 313-4880		(615) 532-2791	bill.duffey@state.tn.us
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Roster: Charleston, *continued*

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Roster: Boston

Attendee Roster
Boston, MA
August 17-18, 2005

NOTE: Sorted alphabetically by REPRESENTATION with STATES/TERRITORIES listed first then OTHER organizations then FEDERAL/REGIONAL OFFICES

Representation	First Name	Last Name	Title	Organization	Address	City	State	Zip Code	Office Phone	Ext.	Fax Number	Email
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Maine	Stephen	Hussey	Director	Department of Human Services Division of Support Enforcement & Recovery	11 State House Station 268 Whitten Road	Augusta	ME	888941	(207) 287-2886		(207) 287-2886	stephen.l.hussey@maine.gov
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Roster: Boston, *continued*

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Roster: Boston, *continued*

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Appendix B: Conference Agendas

Conference agendas listed below are inserted on the following pages:

Kansas City/Regions V & VII - June 28, 2005 – p. 61

Reno/Regions VIII, IX & X - July 19, 2005 – p.65

Little Rock/Region VI - July 19, 2005 – p. 69

Charleston/Region IV - August 10, 2005 – p. 71

Boston/Regions I, II & III - August 17, 2005 – p. 77

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Centers for Medicare and Medicaid Services

Regional Meeting: Region V and VII States

Increased Medical Support for Children and Medicaid Cost Savings through Child Support Enforcement, Medicaid, SCHIP and Child Welfare Collaboration

AGENDA

Tuesday, June 28, 2005

7:30 AM - 8:30 AM	Registration & Continental Breakfast	*Foyer, 2nd Floor*
8:30 AM - 10:15 AM	Opening Session	*Grand Ballroom, 2nd Floor*

Welcome and Opening Remarks

Thomas W. Lenz, CMS Regional Administrator, Region VII HHS
Richard Fenton, Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS/HHS
Dr. Susan Orr, Associate Commissioner, Children's' Bureau, ACYF/ACF/HHS
Tiffany Barfield, Special Assistant to the Commissioner, Office of Child Support Enforcement, ACF/HHS
Linda Lawrence, ACF Program Administrator, Region V HHS

Program Intersections: What is today's picture? Why collaborate now?
Connections between and among these highlighted programs are made today based primarily upon Federal and State requirements. These connections are often seen as individual and unrelated activities, and are not articulated in terms of broader goals. A group of panelists will provide information on required program connections, as well as the major driving forces that provide the new platform for enhanced collaboration.

Panelists:
Richard Fenton, Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS/HHS
Mary McKee, Child Welfare Program Specialist, ACF Region VII/HHS
Nancy Thoma Groetken, Child Support Program Specialist, ACF Region VII/HHS

10:15 AM - 10:30 AM	Refreshment Break	
10:30 AM - Noon	Session 2	*Grand Ballroom, 2nd Floor*

Program Intersections: Breaking down Myths and Barriers to View the Possibilities
When new initiatives and ideas are conceived, too often they are abandoned or implemented in a limited manner due to any number of barriers. Expert panelists

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will discuss commonly perceived barriers and separate the myth from the reality. They will share their view of what is possible through enhanced, strategically-driven collaborations. Up to date information on data requirements as they relate to sharing sensitive customer data across our highlighted programs will be provided. Hear what new projects are being considered to enhance medical support and access to health care coverage at the national and State level.

Panelists:
Donna Bonar, Associate Commissioner, Office of Automation and Program Operations, Office of Child Support Enforcement, ACF/HHS
Patsy Buida, Foster Care Specialist, Children's Bureau, ACF/HHS
Jennifer Burnszynski, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, HHS
Lily Matheson, Director, Division of Policy, Office of Child Support Enforcement, ACF/HHS
Richard Fenton, Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS/HHS

Moderator:
Nancy Thoma Groetken, Program Specialist, Administration for Children and Families, Region VII

Noon - 1:30 PM	Luncheon *(Provided)*	*Main Street Grill, 2nd Floor*
1:30 PM – 3:00 PM	Session 3	*Grand Ballroom, 2nd Floor*

Best Practices in the States
Some States have used innovative cross-program collaborative approaches to address important children's issues in their States. Invited State experts will share information about initiatives their States have undertaken, highlighting implementation steps, lessons learned, and results achieved.

To follow-up the best practices presentation, State Directors will interact with each other and invited State experts in a large group discussion to talk about individual Region V and VII State's approaches to children's health care coverage and begin to explore how collaborative strategies and medical support best practice initiatives could benefit their States.

Panelists:
Karen Melkonian, Counsel to the Commissioner, Policy and Procedures Unit, Child Support Enforcement, Department of Revenue, Massachusetts
Joe J. Pilat, Deputy Director, Office of Child Support, Ohio
Kathy Shafer, Deputy Director for Federal Operations, Office of the Attorney General, Child Support Division, Texas
Frederic M. Simmens, Director, Children Services Division, Department of Social Services, Missouri

Moderator: Daryl Wusk, Administrator, Office of Economic and Family Support, Department of Health and Human Services, Nebraska

3:00 PM – 3:15 PM Refreshment Break

3:15 PM – 5:00 PM	Session 4	*Grand, Plaza and Westport Rooms, 2nd Floor* *Mill Creek Room, 3rd Floor*

State/Federal Caucus Part 1: Creating Value through Enhanced Collaborations
Directors from each State will be grouped with Directors from another State and with Federal staff to caucus for the purpose of identifying program goals and strategies that have common ground across programs. What specifically links the programs together? What value can be gained from creating or enhancing these strategic linkages?

5:30 PM – 6:30 PM	Reception	*Seville Ballroom, 2nd Floor*

Wednesday, June 29, 2005

7:30 AM - 8:30 AM	Continental Breakfast	*Foyer, 2nd Floor*
8:30 AM – 9:30 AM	Session 5	*Grand Ballroom, 2nd Floor*

State/Federal Caucus Part 1 continued: Report Out
Small groups will report out on the dialogue from Part 1. Subject matter experts will address questions raised in the caucuses.

9:30 AM – 10:15 AM	Session 6	*Grand Ballroom, 2nd Floor* *Brushcreek and Mill Creek Rooms, 3rd Floor*

State Caucus and Federal Caucus Part 2: Creating a Plan
State Directors attending from each State will meet together to create a plan to take back to their State. Identify a goal, possible strategies and indicators, necessary resources, and next steps. Federal staff will meet together to create a plan for next steps that further enhance program collaborations.

10:15 AM - 10:30 AM	Refreshment Break	
10:30 AM - Noon	Session 6 (Continued)	*Grand Ballroom, 2nd Floor* *Brushcreek and Mill Creek Rooms, 3rd Floor*

State Caucus and Federal Caucus Part 2 continued: Creating a Plan
Continue small group discussions.

Report Out
Attendees will reassemble in the Grand Ballroom, and State and Federal small group spokespersons will share planning highlights from Part 2 caucuses.

Noon – 12:30 PM	Wrap-up & Adjourn	*Grand Ballroom, 2nd Floor*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Centers for Medicare and Medicaid Services
Regions VIII, IX, and X

Increased Medical Support for Children and Medicaid Cost Savings through Child Support Enforcement, Medicaid, SCHIP, and Child Welfare Collaboration

Reno, Nevada

AGENDA

Tuesday, July 19, 2005

7:30 AM – 8:30 AM **Registration & Continental Breakfast**

8:30 AM – 10:15 AM **Session 1** ***MANDALAY BALLROOM A***

Welcome and Opening Remarks

Sharon M. Fujii	*Regional Administrator, Region IX ACF, HHS*
Tiffany Barfield	*Special Assistant to the Commissioner, Office of Child Support Enforcement, ACF, HHS*
Richard Fenton	*Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS, HHS*
William Hornsby	*Child Welfare Program Specialist, Children's' Bureau, Administration on Children, Youth, and Families, ACF, HHS*

Program Intersections: What is today's picture? Why collaborate now?
Connections between and among these highlighted programs are made today based primarily upon federal and state/territorial requirements. These connections are often seen as individual and unrelated activities, and are not articulated in terms of broader goals. A group of panelists will provide information on required program connections, as well as the major driving forces that provide the new platform for enhanced collaboration.

Panel Presentation:

Moderator:
Linda Gillett *Child Support Enforcement Team Leader, ACF Region X, HHS*

Panelists:

John Henderson	*Lead Child Welfare Program Specialist, ACF Region X, HHS*
Linda Minamoto	*Assistant Regional Administrator, Division of Medicaid and Children's Health, CMS Region IX, HHS*
Rosanne Robinson	*Program Specialist, ACF Region VIII, HHS*

10:15 – 10:30 AM ***Refreshment Break***

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10:30 AM – Noon **Session 2** **MANDALAY BALLROOM A**

Program Intersections: Breaking down Myths and Barriers to View the Possibilities
When new initiatives and ideas are conceived, too often they are abandoned or implemented in a limited manner due to any number of barriers. Expert panelists will discuss commonly perceived barriers and separate the myth from the reality. They will share their view of what is possible through enhanced, strategically-driven collaborations. Up-to-date information on data security and privacy requirements as they relate to sharing sensitive customer data across our highlighted programs will be provided. Hear what new projects are being considered to enhance medical support at the national and state/territorial level.

Panel Presentation:

Moderator:

Nancy Thoma Groetken *Child Support Program Specialist, ACF Region VII, HHS*

Panelists:

Jennifer Burnszynski	*Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, HHS*
Richard Fenton	*Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS, HHS*
Wendy Lynn Gray	*Center for the Support of Families*
William Hornsby	*Child Welfare Program Specialist， Children's' Bureau, Administration on Children, Youth, and Families, ACF, HHS*
Lily Matheson	*Director, Division of Policy, Office of Child Support Enforcement, ACF, HHS*

Noon – 1:30 PM ***Lunch*** ***MANADALAY BALLROOM B***

1:30 PM – 3:00 PM **Session 3** **MANDALAY BALLROOM A**

Best Practices
Some jurisdictions have used innovative cross-program collaborative approaches to address important children's health care issues. Invited experts will share information about medical support initiatives their jurisdictions have undertaken, highlighting implementation steps, lessons learned, and results achieved.

To follow-up the best practices presentation, meeting participants will interact with each other and invited experts in a large group discussion to talk about individual approaches to children's health care coverage and begin to explore how collaborative strategies and medical support best practice initiatives could benefit their programs.

Panel Presentation:

Moderator:

Shirley K. Brown *Administrator, Child and Family Division, State of Montana*

Panelists:

Cindi Chinnock	*Director, Division of Child Support, Oregon Department of Justice*
Sandra Poole	*Deputy Director, California Department of Child Support Services*
Terry Walter	*Director, Division of Child Support, South Dakota Department of Social Services*

3:00 – 3:15 PM ***Refreshment Break***

3:15 PM – 5:00 PM **Session 4**

State/Territory/Federal Caucus -- Part 1: Creating Value through Enhanced Collaborations
Participants from each jurisdiction will be grouped with participants from other jurisdictions and with federal staff to caucus for the purpose of identifying program goals and strategies that have common ground across programs. What specifically links the programs together? What value can be gained from creating or enhancing these strategic linkages?

Group A	*(California, Washington, & Federal Representatives)*
Group B	*(Nevada, Colorado, & Federal Representatives)*
Group C	*(Alaska, Arizona, Wyoming, Montana, & Federal Representatives)*
Group D	*(Oregon, Hawaii, North Dakota, Utah, & Federal Representatives)*
Group E	*(Idaho, South Dakota, Guam, & Federal Representatives)*

Wednesday, July 20, 2005

7:30 AM – 8:30 AM **Continental Breakfast**

8:30 AM – 9:30 AM **Session 5** **MANDALAY BALLROOM A**

State/Territory/Federal Caucus -- Part 1 continued: Report Out
Small groups will report out on the dialogue from Part 1. Subject matter experts will address questions raised in the caucuses.

9:30 AM – 10:45 AM **Session 6**

State/Territory Caucus and Federal Caucus -- Part 2: Creating a Plan
Participants from each state/territory will meet together to create a cross-program plan, identifying goals, possible strategies and indicators, necessary resources, and next steps. Federal staff will meet together to create a plan for next steps that further enhance program collaborations.

California, Idaho, Montana, & Nevada	*MANDALAY BALLROOM A*
Alaska, Guam, Hawaii, & South Dakota	*MANDALAY 1*
Colorado, Oregon, Utah, & Wyoming	*MANDALAY 2*
Arizona, North Dakota, & Washington	*MANDALAY 6*
Federal Representatives	*MANDALAY 3*

Note: Time is allowed for caucus groups to build a refreshment break into their deliberations prior to reconvening at 10:45 for the plenary session report-out.

10:45 – Noon **State/Territory Caucus and Federal Caucus -- Part 2: Report Out** **MANDALAY BALLROOM A**

Noon – 12:30 PM **Wrap-up & Adjourn** **MANDALAY BALLROOM A**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Centers for Medicare and Medicaid Services

Increased Medical Support for Children and Medicaid Cost Savings through Child Support Enforcement, Medicaid, SCHIP and Child Welfare Collaboration

Region VI
Tuesday, July 19, 2005

7:30 A.M. – 8:30 A.M. Registration & Continental Breakfast

8:30 A.M. – 10:15 A.M. Opening Session

Welcome and Opening Remarks
Dan McDonald, Administrator CSE, Arkansas
Leon McCowan, Regional Administrator, ACF Region VI/ HHS
Marty Svolos, Division of eligibility, Enrollment, & Outreach, CMS Baltimore
Susan Orr, Associate Commissioner, Children's Bureau, ACF/HHS

The Big Picture-Why We Are Here
David Siegel, Acting Commissioner, ACF/OCSE

10:15 A.M. – 10:30 A.M. Refreshment Break

10:30 A.M. – Noon

Program Intersections: Breaking down Myths and Barriers to View the Possibilities
Moderator-Andrew Hagan, OCSE
Expert panelists will discuss commonly perceived barriers and separate the myth from the reality. They will share their view of what is possible through enhanced, strategically-driven collaborations. Up to date information on data security and privacy requirements as they relate to sharing sensitive customer data across our three programs will be provided. Hear what new projects are being considered to enhance medical support at the national and State level.

Yvette Riddick, Policy and Automation Liaison, Office of Child Support Enforcement
James Hicks, IT Specialist, Office of Child Support Enforcement
Patsy Buida, Foster Care Specialist, Children's Bureau
Katie Donley, Policy Specialist, Division of Policy,OCSE
Dr. Lynn Mitchell, OHCA, State Medicaid Director, Oklahoma

Noon – 1:30 P.M. Luncheon

1:30 P.M. – 2:30 P.M.

Best Practices in the States Moderator – Karen Anthony, OCSE
Some States have used innovative cross-program collaborative approaches to address important children's health care issues in their States. State and federal staff will share information about medical support initiatives States have undertaken, highlighting implementation steps, lessons leamed, and results achieved.

To follow-up the best practices presentation, State Director will interact and participate in a group discussion to talk about Region VI States' approaches to children's health care coverage explore how collaborative strategies and medical support best practice initiatives could benefit their States.

Dan McDonald, Administrator, Office of Child Support, Arkansas
Kathy Shafer, Deputy Director for Federal Coordination, Office of the Attorney General, Child Support Division, Texas
Ruth Kennedy, Deputy Director LA DHH, Louisiana
Lisa McGee, Deputy Council for County Operations, Division of Children and Family Services, Arkansas
Gary Martin. CMS, Dallas RO

2:30 P.M. – 2:45 P.M. Refreshment Break

2:45 P.M. – 3:45 P.M.

State/Federal Caucus Part 1: Goals and Strategies
Facilitators: Yvette Riddick, James Travis, OCSE
Discussion Leaders, Recorders, Reporters- To be determined by each Group
There will be 5 groups composed of the Directors of the three programs from each of the 5 Region VI States. They will caucus for the purpose of identifying program goals and strategies that have common ground across programs. What specifically links the programs together? What value can be gained from creating or enhancing these strategic linkages? Federal staff will meet together to create a plan for next steps that further enhance program collaborations.

3:45 P.M. – 5:00 P.M.

State/Federal Caucus Part 2: Creating a Plan and Report Out
The group will create a plan to identify goals, possible strategies, necessary resources, next steps and report out.

5:00 P.M. – 5:30 P.M. Wrap-up and adjourn

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

Increased Medical Support for Children and
Medicaid Cost Savings through
Child Support Enforcement, Medicaid, SCHIP and Child Welfare
Collaboration

Region IV
Draft Agenda
Wednesday, August 10, 2005

7:30 a.m. – 8:45 a.m. **Registration & Light Breakfast**

8:45 a.m. – 10:00 a.m. **Opening Session**

Welcome and Opening Remarks

Larry McKeown, Child Support Director, South Carolina
Carol Osborne, Director, State Programs, Region IV,
Administration for Children & Families
Tiffany Barfield, Special Assistant to the Commissioner,
Office of Child Support Enforcement
Rick Fenton, Deputy Director, Family & Children's Health
Programs Group, Centers for Medicaid and Medicare

The Big Picture – Why We're Here

Lily Matheson, Director, Division of Policy
Office of Child Support Enforcement, Central Office

10:00 a.m. – 10:15 a.m. **Refreshment Break**

Wednesday, August 10, 2005
Region IV Agenda – continued

10:15 a.m. – 11:45 p.m.

Program Intersections: Breaking down Myths & Barriers to View the Possibilities
Moderator: Nancy Thoma Groetken, Program Specialist, Office of Child Support Enforcement, Region VII

Panelists will discuss commonly perceived barriers and separate the myth from the reality. They will share their view of what is possible through enhanced, strategically-driven collaborations. Up-to-date information on data security and privacy requirements as they relate to sharing sensitive customer data across our three programs will be provided. Hear what new projects are being considered to enhance medical support at the national and State level.

Jane Morgan, Adoption Specialist, Children's Bureau
Linda Keely, Office of Child Support Enforcement
Kathleen Farrell, Director, Division of State Children's Health Insurance, Centers for Medicaid and Medicare
Jennifer Burnszynski, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, HHS, Washington, DC

12:00 p.m. – 1:30 p.m. **Lunch**

1:30 p.m. – 2:30 p.m.

Best Practices in the States – Moderator: Mary Gay, Program Specialist, Office of Child Support Enforcement, Region IV

Some States have used innovative cross-program collaborative approaches to address important children's health care issues in their States. Presenters will share information about initiatives States have undertaken, highlighting implementation steps, lessons learned, and results achieved.

Gretel Felton, Policy Director of Certification and Support, Alabama Medicaid Agency
Margaret Bonham, Director, Child Welfare, Alabama
Cindy Moss, Director of Operations, Georgia Child Support

Wednesday, August 10, 2005
Region IV Agenda – continued

2:30 p.m. – 2:45 p.m. **Refreshment Break**

2:45 p.m. – 3:45 p.m.

State/Federal Caucuses Part 1: Goals and Strategies
Facilitator: Ruth Walker Simpson, Program Manager, Child Welfare, Region IV
Moderators/Reports – Each Group Will Determine

There will be eight groups composed of the Directors/representatives of the three programs from each of the eight Region IV States. They will caucus for the purpose of identifying goals and strategies that have common ground across programs, and to discuss States' approaches to children's health care coverage. What specifically links the programs together? What value can be gained from creating or enhancing these strategic linkages? Each group will create a plan to take back to their State, identify a goal, possible strategies and indicators, necessary resources, and next steps.

3:45 p.m. – 5:00 p.m.

State/Federal Caucuses Part 2: Report Out

Small groups will report out on their plans.

5:00 p.m. – 5:30 p.m. **Wrap-up**

Region IV
Agenda
Thursday, August 11, 2005

7:30 a.m. – 8:30 a.m. **Light Breakfast**

8:30 a.m. – 9:45 a.m.

Georgia/North Carolina Health Insurance Projects

The Georgia and North Carolina Child Support agencies are developing projects to match Title IV-D children to available medical insurance, enforce the insurance, provide lower cost health insurance options and reduce Medicaid and SCHIP costs.

Robert Riddle, Director, Georgia Child Support
Ronnie Bates, Policy Specialist, Georgia Child Support
Barry Miller, Director, North Carolina Child Support
Beth Amos, Assistant Chief for Local Operations, North Carolina Child Support
Ben Rose, Chowan County Director of Social Services, North Carolina

9:45 a.m. -10:00 a.m. **Refreshment Break**

10:00 a.m. – 11:30 a.m.

Vendor Presentation - Overview of Research

Policy Studies, Inc., representatives will present information obtained concerning Georgia's efforts to develop low cost health insurance options and information.

Jane Venohr, Ph.D., Policy Studies, Inc.
Sue Williamson, J.D., Policy Studies, Inc.

Thursday, August 11, 2005
Region IV Agenda – continued

11:30 a.m. -1:00 p.m. **Lunch**

1:00 p.m. – 2:00 p.m.

State Caucuses – Low Cost Health Insurance

The State Directors or representatives of the programs will caucus to discuss interest and feasibility, issues, barriers, and resources concerning development of a low cost health insurance project in Region IV.

2:00 p.m. -2:15 p.m. **Refreshment Break**

2:15 p.m. -3:30 p.m.

State Caucuses – Report Out and Discussion

State groups will report out and discuss the health insurance project and next steps.

3:30 p.m.

Adjourn

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Centers for Medicare and Medicaid Services

AGENDA

Regions I, II & III Forum
MEDICAL SUPPORT FOR CHILDREN: A TRI-REGIONAL COLLABORATION

Wednesday, August 17

7:30 AM - 8:30 AM **Registration & Continental Breakfast**

8:30 AM -10:15 AM **Welcome and Opening Remarks**
Charlotte Yeh, Regional Administrator, CMS Region I
Hugh Galligan, Regional Administrator, ACF Region I

Plenary Session

The Big Picture: Why We're Here—Where We're Going
A review and discussion of medical support issues confronting the Child Support, Medicaid, SCHIP and Child Welfare programs, including trends in State and Federal medical expenditures, the focus on medical support in the 2005 OCSE Strategic Plan, the HHS Office of Inspector General's reviews on health services for Foster Care children and the ability of parents in child support cases to contribute towards Medicaid and SCHIP coverage, and other factors which have led to this and similar gatherings across the country. The panel will explore what can be achieved through enhanced, strategically-driven collaborations.

Panel:
Margot Bean, Commissioner, Office of Child Support Enforcement, HHS/ACF
Dr. Susan Orr, Associate Commissioner, Children's Bureau, HHS/ACF/ACYF
Richard Fenton, Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS/HHS
Lily Matheson, Director, Division of Policy, Office of Child Support Enforcement, ACF/HHS

Moderator: *David Lett, ACF Regional Administrator, Philadelphia*

10:15 AM -10:30 AM Refreshment Break

10:30 AM - Noon Plenary Session

Overcoming Real and Perceived Barriers
An expert panel will address commonly perceived barriers to collaboration by providing information on required program connections as well as the major driving forces behind the new focus on medical support enforcement. New platforms for enhanced collaboration, information on using the FPLS, and data requirements related to sharing sensitive customer data across our highlighted programs will be explored. Learn what new projects, including a Federal health insurance match, are being considered to enhance medical support at the national and State levels.

Panel:
Jennifer Burnszynski, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, HHS
Eileen Brooks, Director, Division of State, Tribal and Local Assistance, Office of Child Support Enforcement, ACF/HHS
Richard Fenton, Deputy Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, CMS/HHS
Helen Smith, Deputy Associate Commissioner, Office of Automation and Program Operations, Office of Child Support Enforcement, HHS/ACF
Junius Scott, Program Manager, ACF Youth & Family Services Division, New York

Moderator: *Mary Ann Higgins, ACF Regional Administrator, New York*

Noon - 1:30 PM Luncheon (Location TBA)

1:30 PM – 3:00 PM Plenary Session

Best Practices in the States
Some States have used innovative cross-program collaborative approaches to address important children's issues in their States. Invited State experts will share information about initiatives their States have undertaken, highlighting implementation steps, lessons learned, and results achieved.

Following the panel presentation, conference participants will have the opportunity to interact with each other and invited State experts in a general discussion about their own approaches to children's health care coverage and begin to explore how collaborative strategies and medical support best practice initiatives could benefit their States.

Panel:
Dianne Ewashko, Assistant Director, Division of Strategic Planning and Policy Development, NYS Office of Children and Family Services
Lee Sapienza, Chief, Bureau of Policy and Planning, New York Department of Child Support Enforcement
Karen Melkonian, Counsel, Child Support Enforcement, Massachusetts Department of Revenue

Moderator: *Diane Fray, Director, Bureau of Child Support Enforcement, Connecticut Department of Social Services*

3:00 PM - 3:15 PM Refreshment Break

3:15 PM - 4:30 PM Breakout Session

State/Federal Caucus (4 Breakout Sessions)
State teams representing the four programs and staff from Federal regional and central offices convene to identify program goals and strategies that share common ground. Teams will explore what can be gained from creating or enhancing strategic linkages, the barriers and impediments to effective collaboration, and the options available to reduce or eliminate them.

Facilitators TBA

Thursday, August 18, 2005

7:30 AM - 8:30 AM Continental Breakfast

8:30 AM - 9:30 AM Plenary Session

State/Federal Caucus Report Out
Groups will report on their discussions. Subject matter experts will address questions raised in the caucuses.

Moderator: *John Bellizzi, Acting Director, New York Division of Child Support Enforcement*

9:30 AM - 10:30 AM Breakout Session

State Caucus / Developing Action Plans (State Breakout Sessions)
States will caucus individually or with another State of their choice to identify their medical support goals and strategies. States will develop Action Plans that include, amongst other items, action steps to be taken, resource issues to be addressed, and indicators or measures to be used in gauging success.

Federal Caucus / Developing Next Steps
Federal staff will caucus to create a plan for next steps that further enhance program collaborations.

10:30 AM - 11:00 AM Refreshment/Checkout Break

11:00 AM - Noon Plenary Session

State Action Plans & Next Steps
A discussion highlighting the goals, strategies and Action Plans developed by the State caucuses, and the next steps anticipated at both the State and Federal levels.

Moderator: *Stan Gardner, ACF Assistant Regional Administrator, Boston*

Noon - 12:30 PM Wrap-up & Adjourn

Stan Gardner

Appendix C: Information in the Conference Notebooks

Participants at each of the conferences received notebooks that included a wealth of valuable information. The notebooks were three-ring binders that included printed copies of the pre-conference reading materials that were sent to many participants in advance of the meetings, as well as agendas, presentation slides, and other information.

The "Dear Colleague" joint letter from Dennis Smith, the Director of the Center for Medicaid and State Operations, and Wade Horn, the Assistant Secretary for Children and Families appeared at the beginning of each notebook. A Table of Contents for the binders followed. While not every conference followed the exact sequence detailed below, most of this information was included in the binders for each session.

Section I of the notebooks contained a detailed meeting Agenda as well as an Evaluation Form. The pre-reading material, which included background information about the child support enforcement program, a brief summary of Medicaid, a CMS Fact Sheet on Medical, SCHIP and Medical Child Support Enforcement, and information about child welfare, was in Section II. In Section III were a variety of handouts from the different presenters at the conferences, so this section varied from one meeting to another.

Section IV consisted of several important policy documents. The following documents were included in this section:

- OCSE Information Memorandum IM-99-01, Use of the Federal Parent Locator Service for Child Welfare Services, January 1999
- OCSE Dear Colleague Letter DCL 00-122, RE: *HCFA Letter to State Medicaid Directors,* December 2000
- *National Child Support Enforcement Strategic Plan FY 2005-2009*
- Medicaid and Medical Child Support, Questions and Answers
- SCHIP and Medical Child Support, Questions and Answers
- Compilation of Medicaid Federal Regulations 45 CFR 433.138-433.153 and 45 CFR 435.610 and links to corresponding State Medicaid Manual Section 3900
- ACF Fact Sheet: *Protecting the Well-Being of Children*

In Section V, the notebooks contained a number of articles under the heading "Research, Reports and Best Practices." These articles ranged from several

Office of Inspector General reports on "Children's Use of Health Care Services While In Foster Care" in a number of states, to a listing of medical support-related 1115 projects, to some medical support best practices in several states, to a report on cross-program coordination that was done by the HHS Office of the Assistant Secretary for Planning and Evaluation. Also included in this section was the Executive Summary of the Medical Child Support Working Group's report, *"21 Million Children's Health: Our Shared Responsibility."*

Section VI, entitled "Data," presents relevant data from a number of different reports including information from OCSE on states that have done medical insurance data matches, SCHIP enrollment data from CMS, the preliminary data report from OCSE for FY2004, information from the US Census Bureau on health insurance coverage in 2003, child welfare data from the Children's Defense Fund, and child welfare data from the Children's Bureau.

Finally, Sections VII and VIII in the binders included biographies of the speakers as well as either the attendance roster or a tab for the final roster that was sent to participants after the event.

Appendix D: Best Practices Summaries and PowerPoint Presentations

Handouts follow as below on succeeding pages:

Best Practices: The IV-E/IV-D Interface in Arkansas

California's Meds Match Project

Massachusetts Child Support/Medicaid Collaboration

New York's Medical Support Experience

New York Child Support Management System

Texas Medical Support

At each regional meeting, there were presentations on current "best practices" that focused on innovative ways in which cross-program collaborations were already taking place in certain jurisdictions in order to address important children's medical support issues. Where available, there are slides and/or handouts from these presentations. Other programs that were presented are summarized below.

Alabama:
Gretel Felton, Policy Director of Certification and Support, Alabama Medicaid Agency
Margaret Bonham, Director, Alabama Child Welfare

Gretel Felton discussed the work that Alabama is doing under a grant from the Robert Wood Johnson Foundation to increase collaboration among programs serving children and families. The aim of the grant is to use this collaboration to simplify and reduce duplication while increasing efficient use of resources. Because the programs each use a separate automated system, they began by doing a systems evaluation, which led to the development of common data elements for eligibility for the different programs. They then developed a common database for Medicaid, SCHIP, and Child Care. The individual programs can decide whether or not they want to pull data from this common database into their individual systems.

There is also an online web application into which a potential client can enter all the necessary information to determine for which program he or she is eligible. There are memoranda of understanding with the food stamps and foster care programs to share data. Programs are also able to check the SCHIP data.

Alabama's Medicaid program also conducts matches with the Department of Defense and Blue Cross/Blue Shield to learn about health insurance coverage and it can access new hire data from child support as well.

Margaret Bonham discussed the substantial collaboration that resulted from the fact that Alabama's child welfare program was under a consent decree. The judge in a particular country who serves on the department's Quality Assurance Committee noted that child support and child welfare were not sharing information or communicating well. The courts developed a checklist to assist social workers in understanding how they can work with the juvenile or family court judges in their counties in achieving safety and permanency for dependent children more quickly. Part of this checklist directs the social worker to contact the child support worker to ascertain whether the child support agency has identified and/or located the alleged or putative father.

Arkansas:
Lisa McGee, Office of Chief Counsel, Arkansas Department of Human Services

Arkansas has a program aimed at increasing child support collections from parents when their children are in the custody of the child welfare agency. When the child support program was part of the Department of Human Services (DHS), the Office of the Chief Counsel (OCC) did legal work to collect child support for DHS. However, in 1993 the child support program was transferred to another department. After that happened, child support was getting orders from the OCC but no referrals. Child support began having trouble locating foster children or parents to serve on legal cases to establish child support and the program wasn't getting the information it needed from case workers. Meanwhile, child welfare felt that it was taking too long for child support to establish orders and the OCC could no longer establish orders under state law.

The two agencies realized that they needed to understand and appreciate their separate missions and that staff needed to be educated and trained as well. They needed to use technology to improve the referral process and they needed to communicate more promptly if issues arose. They amended their State statute to allow the OCC to establish child support in child welfare cases (though OCC does not enforce or collect on these orders). The old paper referral form has been replaced by a computerized referral form that is completed by a child welfare worker and e-mailed from the IV-E eligibility unit to child support.

The State also worked with the Juvenile Court where judges had been reluctant to set child support orders because they didn't think that the families could afford to pay. They engaged a Court Improvement Project coordinator at the Administrative Office of the Courts. Now there is a better understanding of which families can afford to pay child support and that if more child support flows into the child welfare agency, there will be more services available to families.

Georgia:
Cindy Moss, Director of Operations, Georgia Child Support

The Office of Child Protection in Georgia worked with the State's Office of Child Support Enforcement on a Revenue Maximization project. Child Protection's goals were to determine medical eligibility for foster care children and to improve foster care referrals to child support. The agency felt that its processes were inefficient and that opportunities were being lost. (Staff have been working without the benefit of an automated child welfare system.) They created a work group whose goals were to establish paternity, eliminate redundancy and unnecessary steps, reduce the time it takes for OCSE to receive a referral from Family and Children Services and improve documentation.

The group looked at three counties for one month and found that 90% of the child welfare cases were already known to the child support system. One step was to combine the two forms – the 223 and the 227 – for use both at the 72-hour hearing (which is the point of investigation for child neglect) and for follow-up information. Instead of e-mailing these forms first to Medicaid eligibility and then later to child support, Child Protection plans to change so that both are emailed at the same time. (This change is currently being tested.) The anticipated result will be a reduction of forms and getting more accurate information to child support more quickly.

Georgia has a web-based system for child support. Clients receive either direct payments or debit cards. Child support pursues both parents when the child is in foster care in order to reimburse child welfare for services. Currently, the child welfare department can access child support's portal for constituent services in order to access payment history, orders, and demographic information.

Missouri:
Frederic Simmens, Director, Child Services Division, Department of Social Services

In Missouri, child welfare workers face challenges when they are trying to locate relatives of the children in foster care. Any time a child enters the custody of the welfare system, caseworkers determine whether that child is eligible for IV-E services and, if so, they make a referral to child support and then try to locate the parents. Even if the child is not IV-E eligible, a caseworker still makes a referral to IV-D in order to use the search services that are available. The Missouri Child Welfare department has begun contracting with the Department of Revenue to search for parents as well as relatives of the children in their caseloads. Child Welfare is seeking to establish authority to search tax databases at the state level.

Ohio:
Joe J. Pilot, Deputy Director, Office of Child Support

Ohio is a state-supervised, county administered child support system. In Ohio, the child welfare, Medicaid and child support programs are all in the same umbrella agency. In July 2002, the State contracted with a private vendor to provide electronic matches of the child support caseload with multiple health insurance carriers. When a case was matched, the State took the data and updated its child support system. Over a two-year period, the vendor processed 82,545 matches at a cost of $1.6 million for the automated upload. The State did not renew the contract because it felt that the benefits did not justify the cost of the project, which was approximately $21 per case.

Currently, Ohio relies on several manual processes to share information among the TANF, child welfare, child support and Medicaid programs and state staff feel that they are missing a lot of information. Child welfare has an automated interface with IV-D for eligibility, but not for data sharing. When child support completed a recent match with IV-E files, gaps were found between the two programs' caseloads. Ohio has provided cross-training to IV-D, IV-E and IV-A workers so that they understand each other's work and they may continue this in the future. While the Medicaid program recognizes that there are potential savings by working with IV-D, it has other more pressing priorities at the moment.

Oklahoma:
Dr. Lynn Mitchell, Medicaid Director, Oklahoma Health Care Authority
Charles Brodt, Oklahoma Director for Federal-State Health Policy, Oklahoma Health Care Authority

In Oklahoma, there is a concerted effort to integrate the Departments of Human Services, Health, Mental Health and the Medicaid agency. This collaboration began about three years ago when there were new directors for each of these programs. Dr. Mitchell has monthly meetings with the Department of Health and with the Department of Human Services, where child support and child welfare are housed. One lesson she has learned from this process, she stressed, is the importance of identifying the right people to be involved. (Seven key people went on a retreat and the major issues they would work on were identified.) She said these seven staff also had to agree to leave their "old baggage" at the door and to work together to solve problems. Finally, they committed to each other to keep talking in order to overcome any road blocks. They have been meeting now for 1½ years.

Medicaid used to be part of the Department of Human Services, but now it is a freestanding department. Still, there is good cooperation and coordination between Medicaid and child support regarding sharing information about who has private insurance. Medicaid is working with child support to do data

matching. There is a State law in Oklahoma that requires insurance agencies to do a data match with Medicaid. They can then pass this information back to child support. Meanwhile, child support has new hire data that will help the Medicaid agency. This cooperation has increased both cost recovery and cost avoidance. The Medicaid agency is also working on sharing its information with the child welfare agency regarding medical services to foster care children.

Oregon:
Cindi Chinnock, Director, Division of Child Support, Oregon Department of Justice

The Division of Child Support and the Department of Child Welfare signed a memo of understanding and established working groups to enhance collaboration between their programs. As a result of this MOU, the first project These agencies decided to undertake was to research and review the policies and procedures of both programs to ensure that their missions were being accomplished.

Next, the two programs moved to the operational level to look at location of parents, enforcement, compromise and compliance with orders, and discovery of income. They centralized their processes into two teams of child support case managers and workers who are the point of contact for workers throughout the State. Those child support workers obtained a specialized understanding of child welfare issues. They put together checklists for child welfare workers so the workers would understand who to contact, when, and for what purposes. This improved the overall cooperation between the agencies.

When child welfare has a case, a worker will check the available sources to see if he or she can locate the noncustodial party. If not, the worker will send an FPLS request to child support. When submitting an affidavit to court, child welfare will obtain confirmation from child support as to whether a response has been received.

Every case that is referred from child welfare to child support triggers a set of actions related to the financial and medical support of the children. Child support needs to know that the referral is a case that is worth the investment. There are issues yet to be resolved and the leadership of the programs agree about the overall direction they need to take. Child welfare case managers and child support workers are juggling different interested partners and pursuing another interested party (the father) may be overwhelming.

Both programs realize that they do have a common mission and medical support has become a clearer priority. However, they also realized that they needed to look at the positive and negative outcomes of this cooperation for both programs. Collection of child support from a parent who is also trying to meet the requirements of a plan for the return of children to his or her home complicates

many of the issues. This is an example of the value of having the programs work together and using the remedies allowed in Oregon law to address the issue.

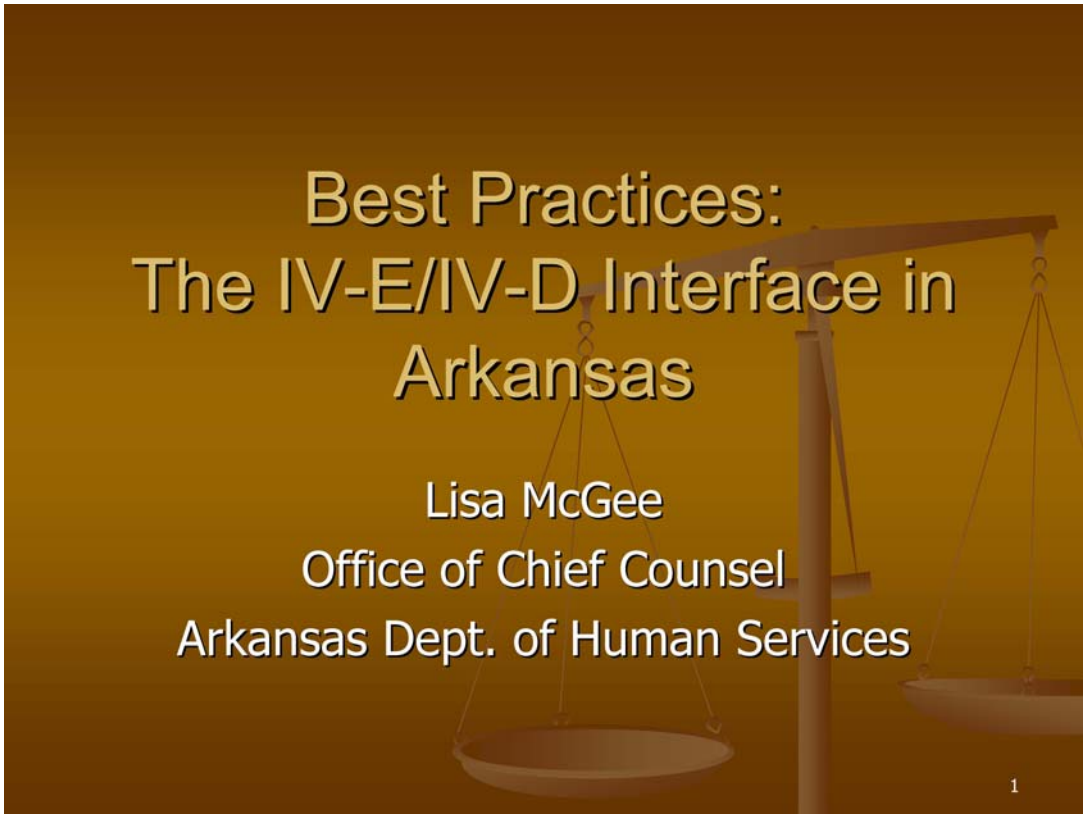
South Dakota:
Terry Walter, Director, Division of Child Support, South Dakota Department of Social Services

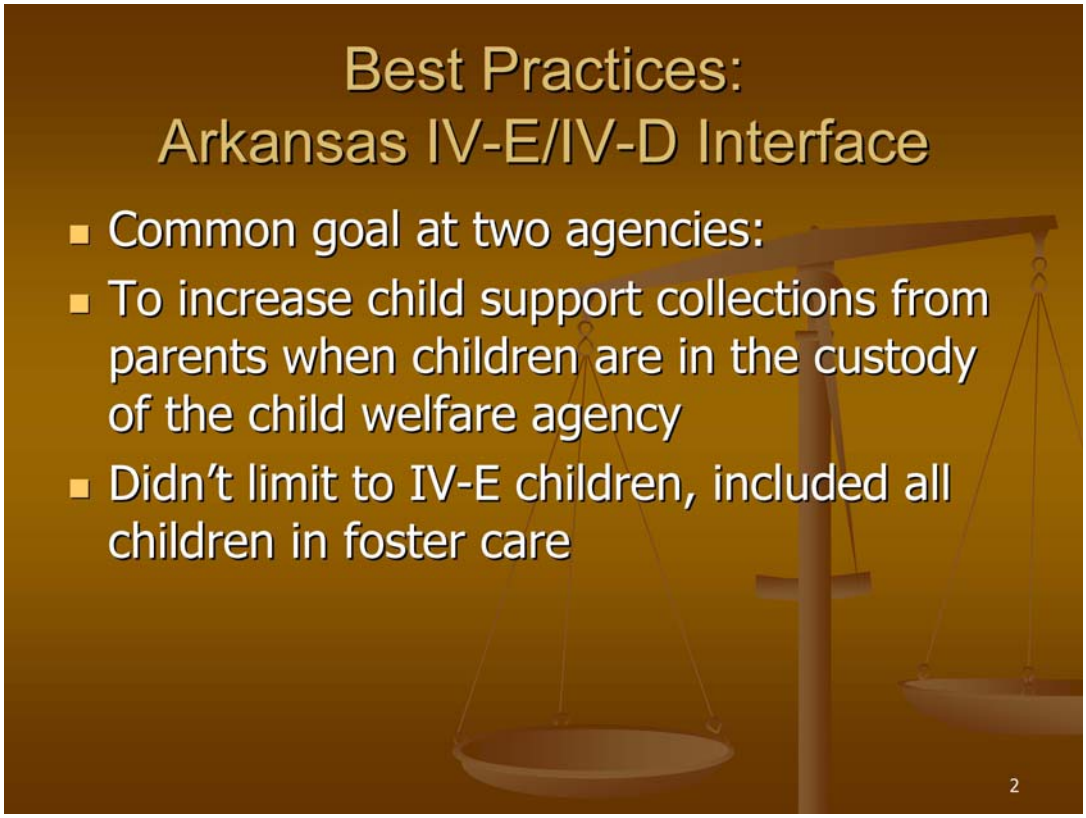
The South Dakota Divisions of Child Support (DCS), Medical Services (DMS), and Economic Assistance (DEA), and the Office of Recoveries, Fraud and Investigations (ORFI) are under the Department of Social Services umbrella agency. The DCS operates the child support enforcement program; the DEA determines eligibility for medical services (including Medicaid and SCHIP), TANF, Food Stamps, and Energy Assistance; the DMS administers the Medical program; and the ORFI administers TPL recoveries.

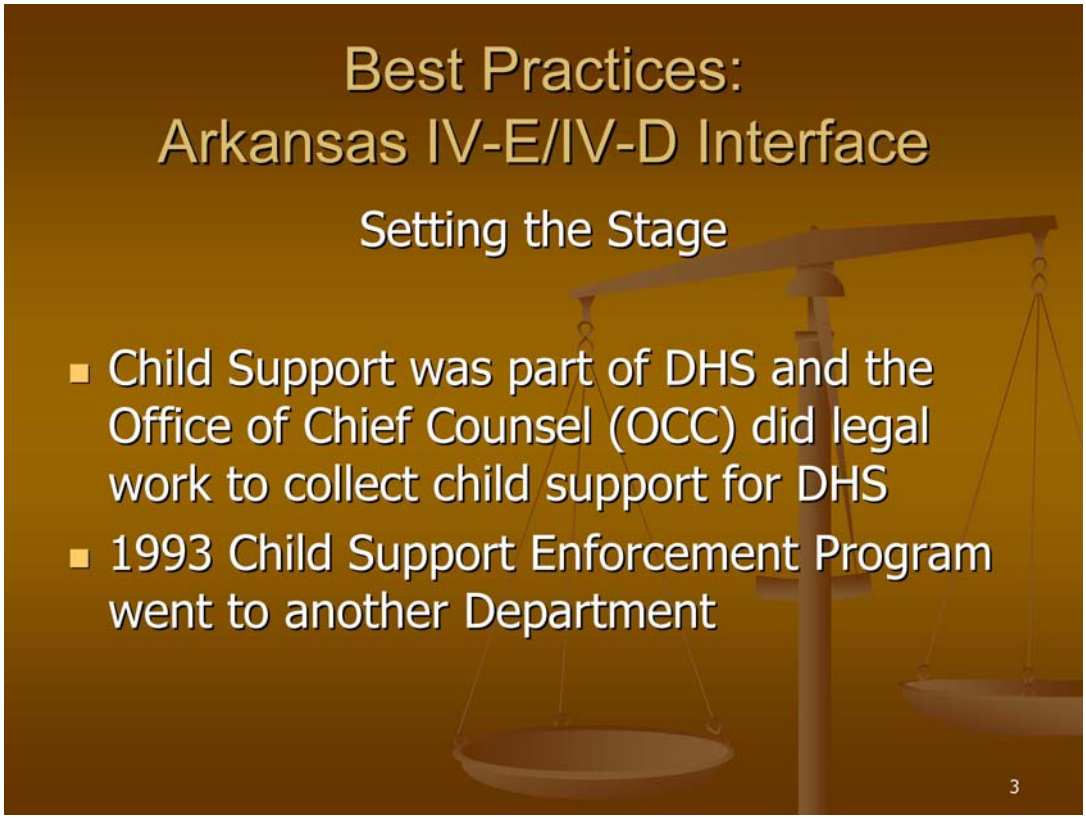
The DEA and DCS computer systems are integrated and have a “shared” insurance information panel that can be updated by designated staff in each of these programs, plus designated staff in DMS and ORFI. Insurance coverage information is entered into the “shared” panel in the DEA or DCS computer when obtained from a recipient or when verified by a worker.

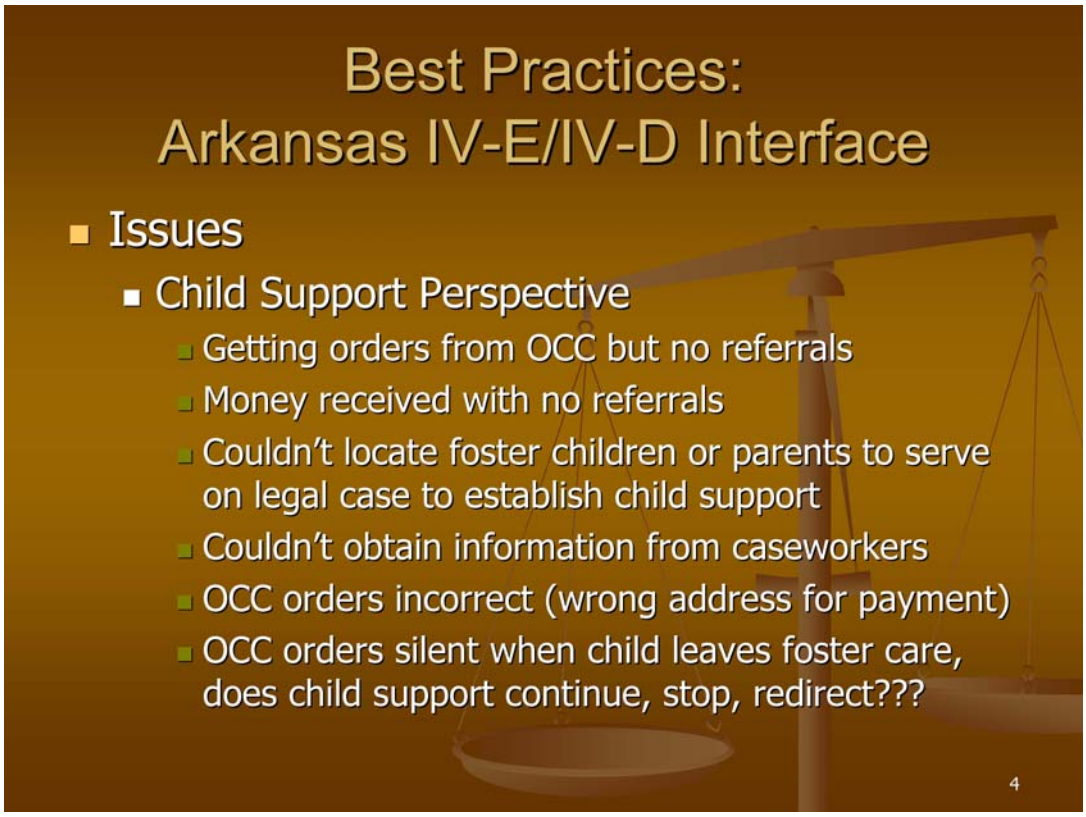
A vendor demonstration of an insurance matching process against national insurance company databases was provided to the Department of Social Services. In addition, the vendor provided an analysis of the potential benefits of such a process. South Dakota determined that there were potential cost avoidance, cost recovery and improved service benefits that could be realized by the multiple DSS programs by contracting with a private vendor to conduct data matching. To date, South Dakota estimates that the program has avoided costs totaling $4.3 million.

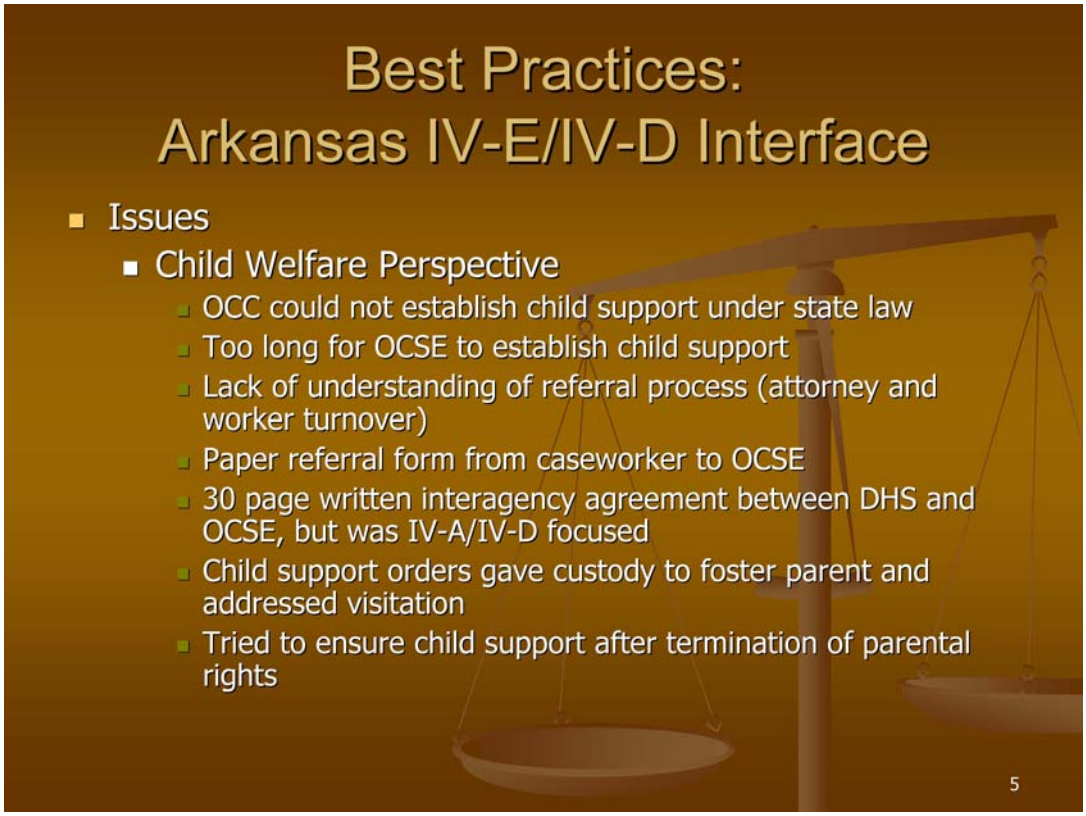
Best Practices: The IV-E/IV-D Interface in Arkansas

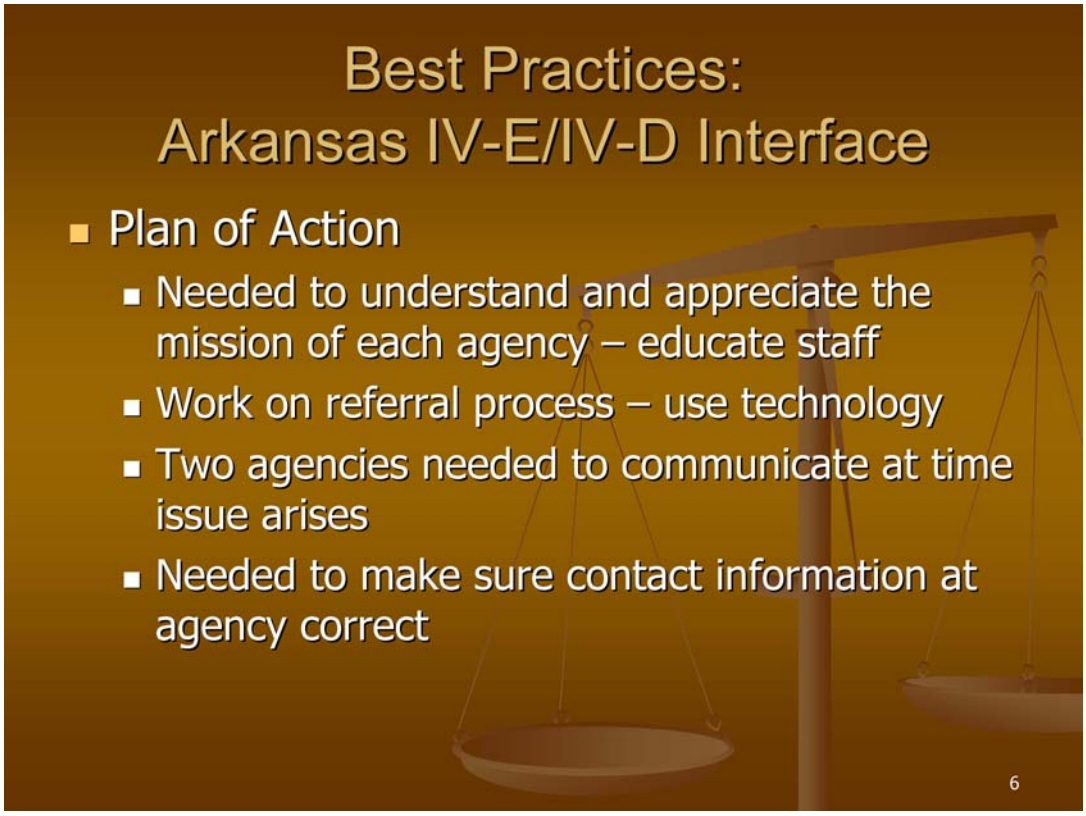


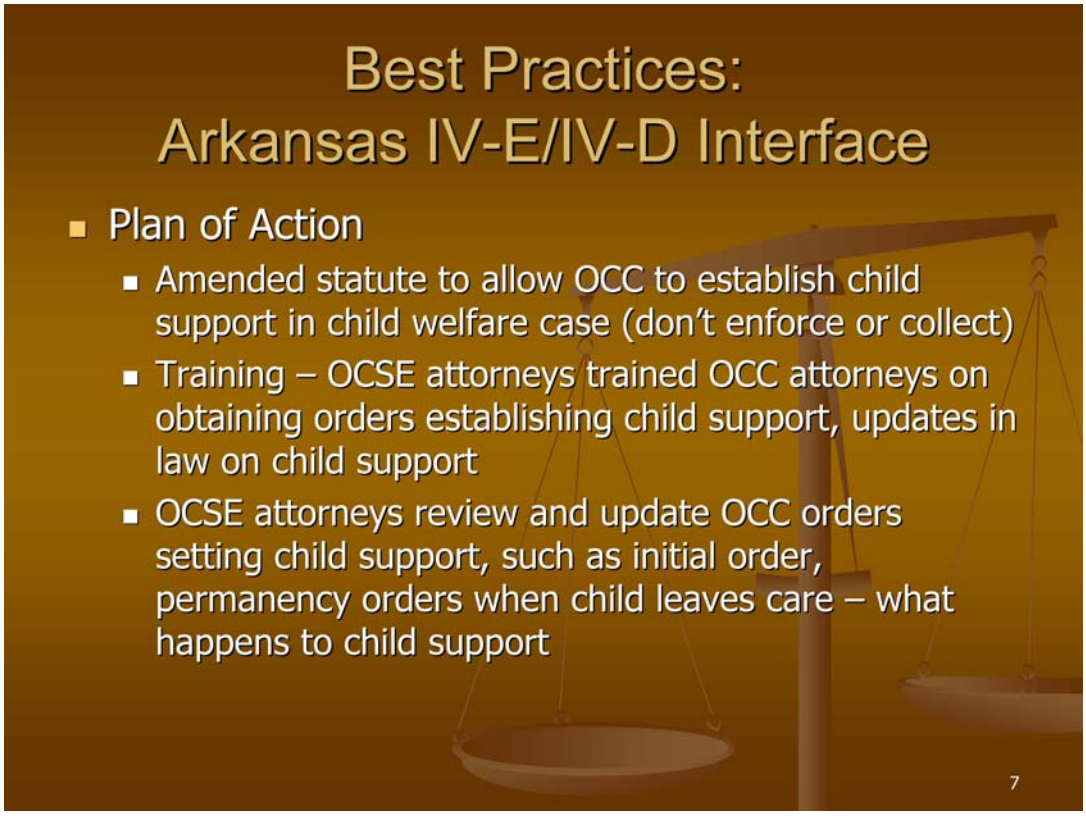


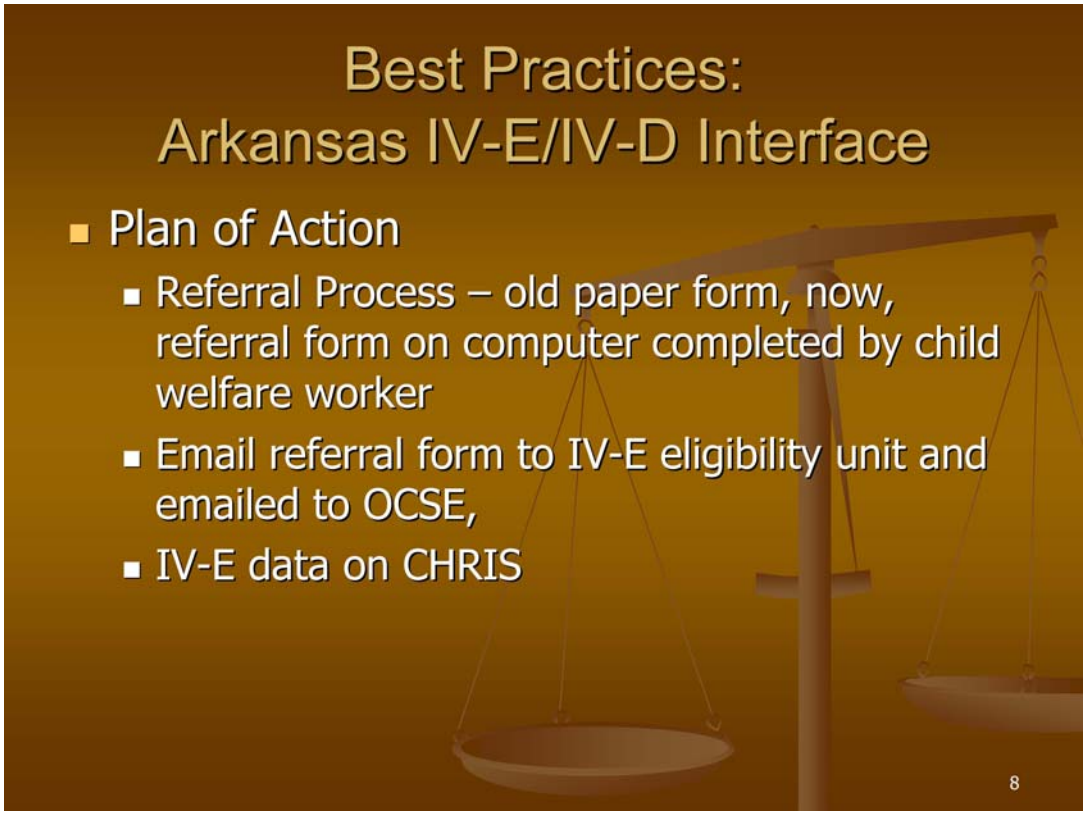

Best Practices:
Arkansas IV-E/IV-D Interface
Setting the Stage
Child Support was part of DHS and the Office of Chief Counsel (OCC) did legal work to collect child support for DHS
1993 Child Support Enforcement Program went to another Department
3

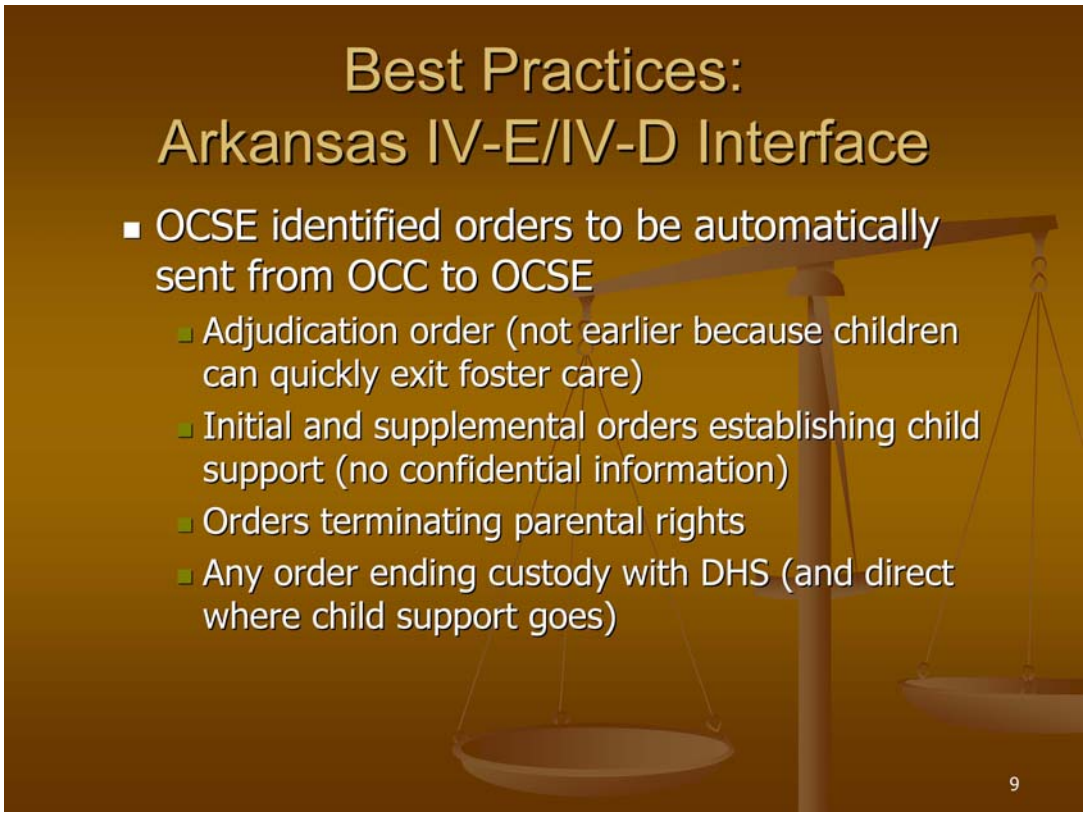

Best Practices:
Arkansas IV-E/IV-D Interface
Issues
Child Support Perspective
Getting orders from OCC but no referrals
Money received with no referrals
Couldn't locate foster children or parents to serve on legal case to establish child support
Couldn't obtain information from caseworkers
OCC orders incorrect (wrong address for payment)
OCC orders silent when child leaves foster care, does child support continue, stop, redirect???
4

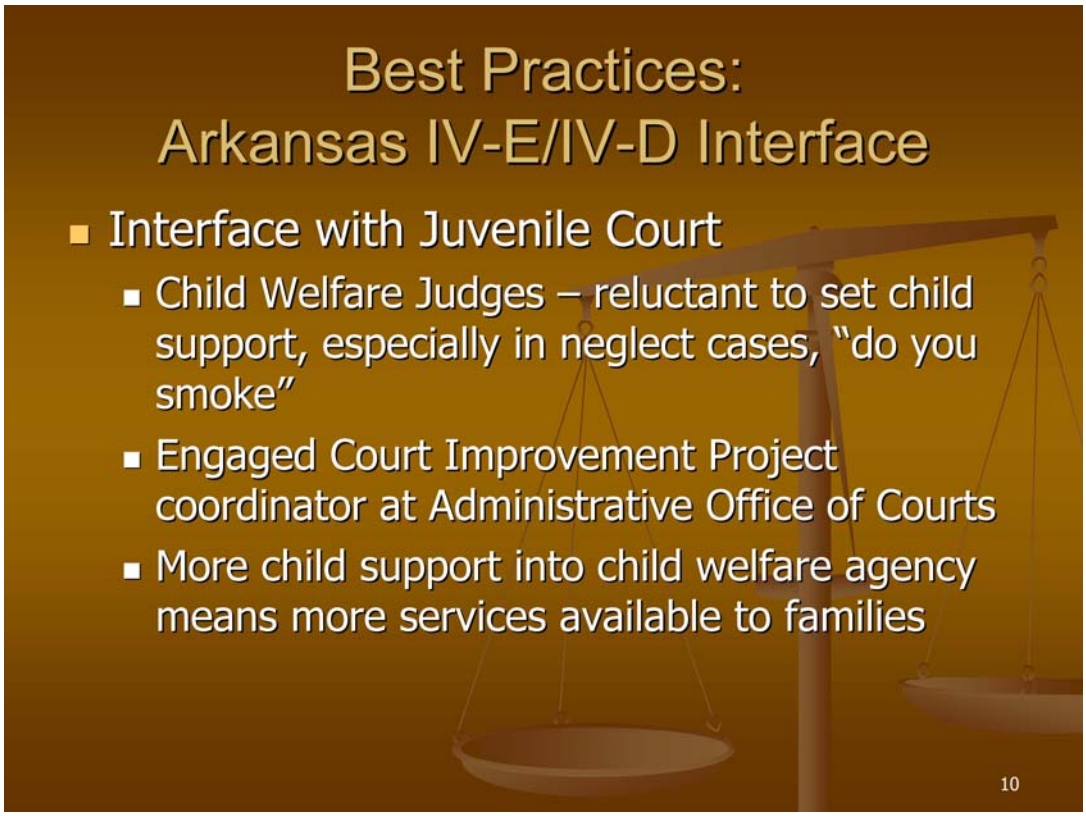

Best Practices:
Arkansas IV-E/IV-D Interface
Issues
Child Welfare Perspective
OCC could not establish child support under state law
Too long for OCSE to establish child support
Lack of understanding of referral process (attorney and worker turnover)
Paper referral form from caseworker to OCSE
30 page written interagency agreement between DHS and OCSE, but was IV-A/IV-D focused
Child support orders gave custody to foster parent and addressed visitation
Tried to ensure child support after termination of parental rights
5

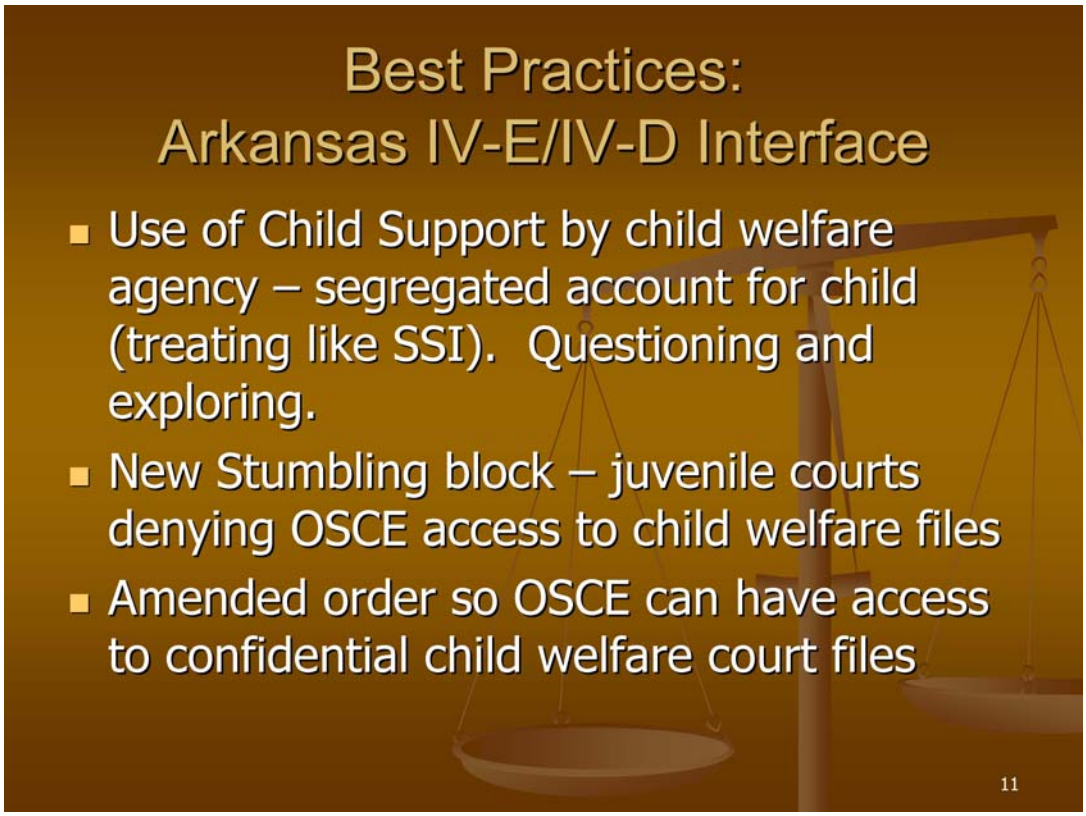

Best Practices:
Arkansas IV-E/IV-D Interface
Plan of Action
Needed to understand and appreciate the mission of each agency – educate staff
Work on referral process – use technology
Two agencies needed to communicate at time issue arises
Needed to make sure contact information at agency correct
6

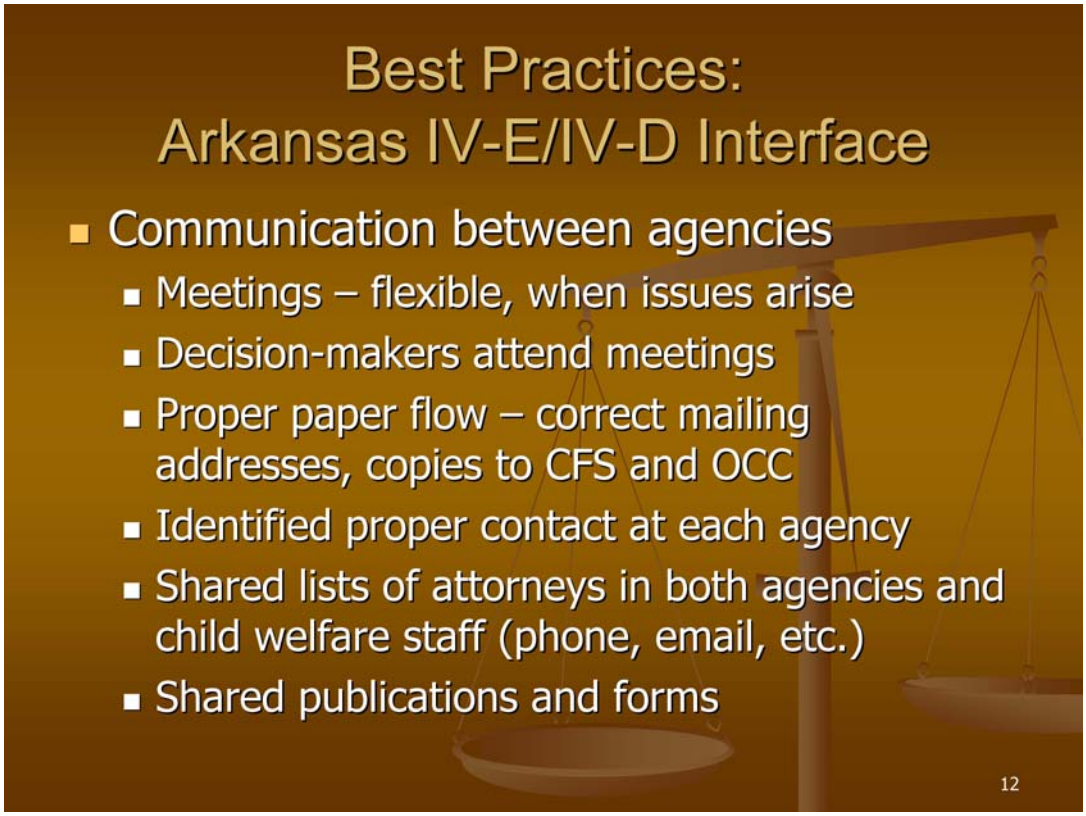

Best Practices:
Arkansas IV-E/IV-D Interface
Plan of Action
Amended statute to allow OCC to establish child support in child welfare case (don't enforce or collect)
Training – OCSE attorneys trained OCC attorneys on obtaining orders establishing child support, updates in law on child support
OCSE attorneys review and update OCC orders setting child support, such as initial order, permanency orders when child leaves care – what happens to child support
7

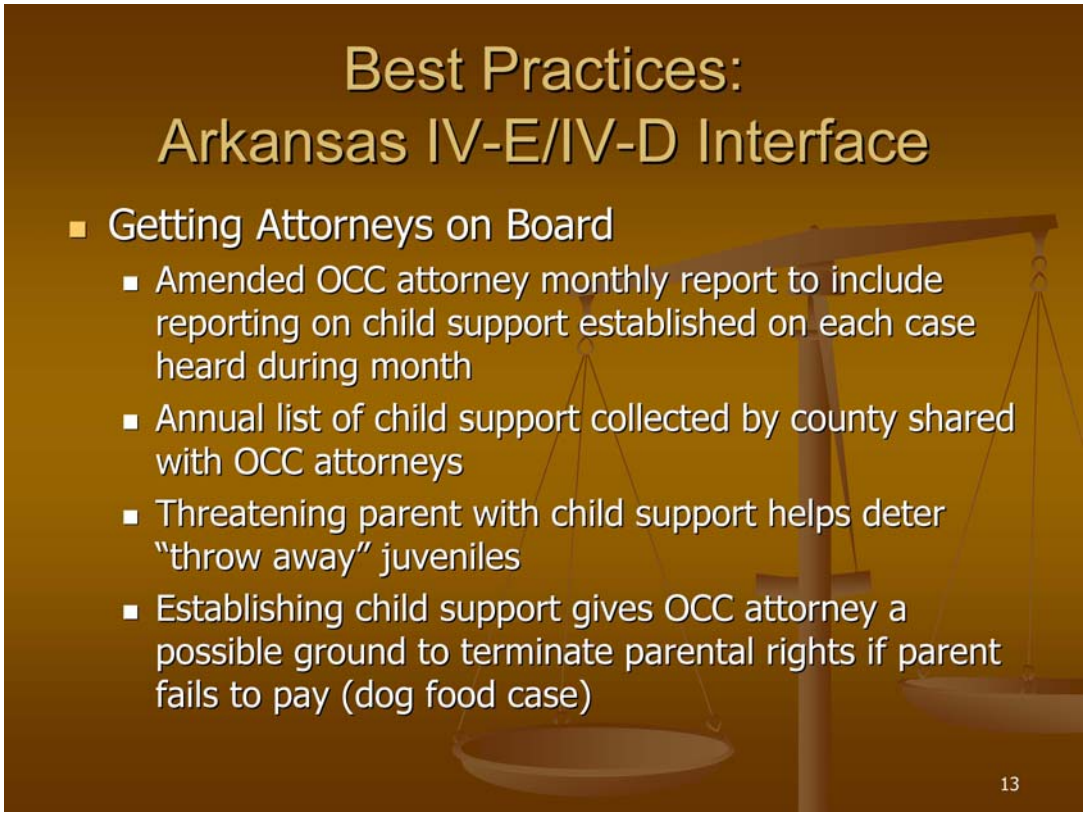

Best Practices:
Arkansas IV-E/IV-D Interface
Plan of Action
Referral Process – old paper form, now, referral form on computer completed by child welfare worker
Email referral form to IV-E eligibility unit and emailed to OCSE,
IV-E data on CHRIS
8


Best Practices:
Arkansas IV-E/IV-D Interface
OCSE identified orders to be automatically sent from OCC to OCSE
Adjudication order (not earlier because children can quickly exit foster care)
Initial and supplemental orders establishing child support (no confidential information)
Orders terminating parental rights
Any order ending custody with DHS (and direct where child support goes)
9


Best Practices:
Arkansas IV-E/IV-D Interface
Interface with Juvenile Court
Child Welfare Judges – reluctant to set child support, especially in neglect cases, "do you smoke"
Engaged Court Improvement Project coordinator at Administrative Office of Courts
More child support into child welfare agency means more services available to families
10


Best Practices:
Arkansas IV-E/IV-D Interface
Use of Child Support by child welfare agency – segregated account for child (treating like SSI). Questioning and exploring.
New Stumbling block – juvenile courts denying OSCE access to child welfare files
Amended order so OSCE can have access to confidential child welfare court files
11


Best Practices:
Arkansas IV-E/IV-D Interface
Communication between agencies
Meetings – flexible, when issues arise
Decision-makers attend meetings
Proper paper flow – correct mailing addresses, copies to CFS and OCC
Identified proper contact at each agency
Shared lists of attorneys in both agencies and child welfare staff (phone, email, etc.)
Shared publications and forms
12


Best Practices:
Arkansas IV-E/IV-D Interface
Getting Attorneys on Board
Amended OCC attorney monthly report to include reporting on child support established on each case heard during month
Annual list of child support collected by county shared with OCC attorneys
Threatening parent with child support helps deter "throw away" juveniles
Establishing child support gives OCC attorney a possible ground to terminate parental rights if parent fails to pay (dog food case)
13


Best Practices:
Arkansas IV-E/IV-D Interface
Arkansas Child Support Collections
2000 $42,421
2001 $77,247
2002 $186,724
2003 $161,122
14

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California's Meds Match Project

Healthy Families

The Healthy Families program provides services to eligible children and includes comprehensive health, dental, and vision benefits. Program eligibility is based on percentage of parents' income compared to the federal poverty level.

Procedure

Matched kids in California's child support caseload against the Medi-Cal Eligible Database System (MEDS) to find out how many children were Medi-Cal eligible and provided health insurance.

Profile of Represented Children

- Birth to 18 years of age in California's child support caseload
- Known social security numbers

Based on the above criteria, 2,541,812 children were included in the project.

Results

Of the total 2,541,812 children,

- 46% were eligible for Medi-Cal
- 51% had no match in the MEDS system

Aid Status of the Represented Children

- Former 62.7%
- Current 24.3%
- Never 10.6%
- Foster Care 2.4%

Health Coverage Breakdown

Of the 46% who were eligible for Medi-Cal:

- 2.7 %were covered by private insurance
- 2.3 %were covered by Healthy Families
- 1.0 % were covered by Medicare
- 0.2 % were covered by CHAMPUS
- 93%, while Medi-Cal eligible, showed no coverage within the system.

Analysis

By reviewing the data, researchers were able to determine which local child support agencies did a better job of identifying eligibility and enrolling children in Healthy Families.

Follow Up

The California Department of Child Support Services is currently conducting another MEDS match to identify the number of children with private health coverage versus Healthy Family enrollment as a precursor to health care coverage cost avoidance.

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Massachusetts Child Support/Medicaid Collaboration

Introduction

- The Massachusetts Child Support agency (DOR) and the Medicaid Agency have been working in partnership since 1996 on various information exchange projects.
- The group originally began meeting to ensure compliance with a state statute requiring data sharing (which also became part of federal law) and to ensure that DOR's new (in 1997) computer system contemplated all aspects of medical support enforcement.

Karen Melkonian, Counsel
MA Child Support Enforcement 1

Introduction cont . . .

- This collaboration, which now goes well beyond data sharing, has resulted in a cumulative cost savings to the Commonwealth of close to 50 million dollars.
- We continue to meet monthly to fine-tune our efforts, identify new methods of cost savings, advance new initiatives and achieve our common goal of enrolling as many children as possible in privately-sponsored health insurance.

Karen Melkonian, Counsel
MA Child Support Enforcement 2

Legal Authority

- Many of our efforts are required and supported by the following state and federal laws:
  - M.G.L. c. 62E requires DOR to provide information from the wage reporting and financial institution system to our Medicaid agency;
  - 42 U.S.C. 654a(f)(3) also requires us to share information with our Medicaid agency;

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MA Child Support Enforcement 3

Legal Authority cont . . .

- 45 CFR 303.30 and 303.31 specify what information we must provide to our Medicaid agency and what the IV-D agency must do in instances in which there is an assignment of rights; and
- 42 U.S.C. 654(29)(A) provides that the IV-D agency is responsible for making the determination of whether the recipient of Medicaid is cooperating in good faith with the State in establishing paternity of, or in establishing, modifying or enforcing a support order.

Karen Melkonian, Counsel
MA Child Support Enforcement 4

Information Sharing

- Cost savings is derived from sharing the following information with our Medicaid agency:
  - A list of noncustodial parents who are ordered to provide health insurance for their dependents;
  - Detailed health insurance information from employers including, plan and policy numbers; and
  - A list of individuals who are associated with the Medicaid program who appear on the wage reporting file and the 14-day new hire file.

Karen Melkonian, Counsel
MA Child Support Enforcement
5

Information Sharing cont . . .

- Our Medicaid agency provides to us:
  - Information about its recipients receiving Transitional Medical Assistance who do not have an assignment of rights; and
  - Cases in which an assignment of rights has been executed with the exception of child only and good cause cases.

Karen Melkonian, Counsel
MA Child Support Enforcement
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Overview of Cost Savings

- Our projected cost savings for FY05 is over 50 million dollars; and
- Cost savings numbers are derived from multiplying the per member/per month premium of $207 by the number of Medicaid recipients for whom we have found private health insurance.

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MA Child Support Enforcement
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Overview of Cost Savings cont …

- Our cost savings numbers are cumulative beginning from FY01.

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Breakdown of Cost Savings

1. The information we provide about noncustodial parents who are ordered to provide health insurance for their dependents.

- *Cumulative cost savings = $49 million.*

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MA Child Support Enforcement 9

Breakdown of Cost Savings cont . . .

How it works

- We give our obligor file with information about the custodial parent and dependent to our Medicaid agency;
- They match these lists with lists of dependents who receive Medicaid;
- A vendor matches the dependents who receive Medicaid and who have a noncustodial parent ordered to provide health insurance with third party health insurance files;

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MA Child Support Enforcement 10

Breakdown of Cost Savings cont . . .

- If the dependent is already enrolled, then the Medicaid agency can begin billing the insurance company; and
- If the dependent is not enrolled, then the agencies send a letter along with a second copy of the National Medical Support Notice.
- NOTE: This is successful because our Medicaid agency is able to link dependents with noncustodial parents.

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Breakdown of Cost Savings cont . . .

2. When DOR sends out the National Medical Support Notice, we include what we call a Third Party Liability Form (TPL) requesting more information about the insurance policy.

- *Cumulative cost savings = $500,000*

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MA Child Support Enforcement
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Breakdown of Cost Savings cont . . .

How it works

- We obtain this information from the employers in addition to the information on the National Medical Support Notice;
- This allows the Medicaid agency to begin billing the insurance company right away; and
- If we did not obtain this information timely, the Medicaid agency might not find out the detailed information about the insurance for between 60 and 120 days.

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Breakdown of Cost Savings cont . . .

3. Wage reporting file and 14 day new hire file data match.

- *Cumulative cost savings = $283,424*

How it Works

- Our Medicaid agency gives us its recipient file;
- We match it against our 14 day new hire and wage reporting files;
- We send employment information back to our Medicaid agency;

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MA Child Support Enforcement
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Breakdown of Cost Savings cont ...

- Our Medicaid agency sends letters to employers asking if the recipient has health insurance. If yes, the employer must enroll; and
- This match also finds custodial parents who have not informed the Medicaid agency about employment and health insurance availability.

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TIPS

- Meet on a regular basis. We began meeting every two weeks and are now meeting monthly.
- Update your interdepartmental service agreement to reflect any changes in vendors and sub-contractors. A suspended agreement results in the loss of a lot of savings.

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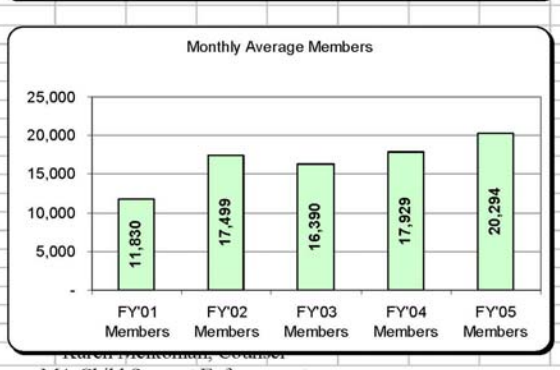
DMA/DOR Medical Support Initiatives

DOR Cost Savings	
FY'01 Cost Savings	$29,385,720
FY'02 Cost Savings	$43,468,137
FY'03 Cost Savings	$40,712,967
FY'04 Cost Savings	$44,536,671
FY'05 Cost Savings	$50,410,296

Monthly Average Members	
FY'01 Members	11,830
FY'02 Members	17,499
FY'03 Members	16,390
FY'04 Members	17,929
FY'05 Members	20,294



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MA Child Support Enforcement

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New York's Medical Support Experience

Medical Support for Children:
A Tri-Regional Collaboration

New York State
Division of Child Support Enforcement's
Medical Support Experience

ACF's 2005 Tri-Regional Conference
Boston, Mass

Prepared by
Lee Sapienza, Chief, Bureau of Policy and Planning
New York State Division of Child Support Enforcement

New York Medical Support Experience

A. Medical support and the Title IV-D program

IV-D role in health care coverage

Federal law, 42 U.S.C. §666 (a) (19) requires state child support agencies to obtain provisions for health care coverage in child support orders consistent with a state's child support guidelines and to enforce such provisions when a non-custodial parent is required to provide health care coverage through the issuance of the National Medical Support Notice to enroll the non-custodial parent's children in such coverage.

Section 201 of the Child Support Performance Incentive Act of 1998 provides that DHHS, in consultation with states and advocates, to develop a performance indicator that would measure the effectiveness of state child support agencies in establishing and enforcing medical support obligations.

National Strategic plan

The National Strategic Plan recognizes the IV-D role in providing medical coverage for children. A guiding principle of the plan is: reliable child support and medical coverage are particularly crucial for families striving for self sufficiency.

Goal 3 of the plan provides: **All children in IV-D cases have medical coverage.**

Objective A - to increase the % of IV-D cases with Orders for Medical Support.

Objective B- to increase the % of IV-D cases in which medical coverage is provided.

Strategy 4 of the plan is specific to medical support:

- Develop information about low cost health insurance available at the local level.
- Encourage judicial and State legislative leaders to highlight the importance of medical support.
- Develop a medical insurance matching and reporting program at the federal level.
- Measure state medical support performance with coverage as the primary goal.

lee.sapienza@otda.state.ny.us

B. NY's medical support experience - Getting health insurance right from the start - Agency Court collaboration

NY's new child support/health care legislation – Chapter 624 of the NY laws of 2002 provided the court system with guidelines for assessing and ordering parents to provide health insurance in support proceedings when it is available at reasonable cost and is accessible to the child. (Section 416 of the Family Court Act; Section 240 of the Domestic Relations Law).

This legislation emphasizes parental responsibility to obtain private health insurance and requires the court to assess the availability of health insurance coverage **in every support proceeding** so that where it is available parents will be held responsible to provide it.

Significant aspects of new law:

- **Health insurance in all support proceedings.** Requires review of health insurance availability in all support proceedings (including support establishment, modification and objections to COLA process for review and adjustment).
- **Defines health insurance.** Health insurance is defined broadly in terms of types of coverage and encompasses employer and organization based coverage including self insured.
- **Defines "available" health insurance** as that which is both reasonable in cost and accessible to the child.
- **Considers availability to both parents.** Either or both parties may be ordered to provide coverage immediately or when it becomes available at a reasonable cost at any point in the future.
- **Allows for agreements for alternative arrangements.** Such agreements allow ordered parties to provide coverage to the dependent(s) through an alternate "private" source when the alternate coverage is comparable to their available employer based coverage and both parties agree. The coverage may be provided through a step parent when such coverage can be extended.
- **Nexus to public coverage.** Examines all options available including where the court has determined that neither parent has health insurance available the court directs the custodial parent to apply for public coverage (either Medicaid or SCHIP).
- **Provides for cost sharing** on a pro rata basis between the parties.
- **Notice of changes in status.** Requires parties to promptly notify the other party and the child support agency of any change in health insurance status.
- **Provides for immediate issuance** of national medical support notice to the employer of the non-custodial parent when employment is known.

lee.sapienza@otda.state.ny.us

IV-D Agency Dialogue with Courts - NYDCSE has had ongoing dialogue with NY State Office of Court Administration regarding the new law. On November 19, 2003 OTDA/OCA held a joint conference in Albany to review the new law and its implementation with the courts and with local district management staff. Medicaid and SCHIP programs provided information to the court system on eligibility criteria for each program. In March of 2004 DCSE held its annual conference and presented medical support topics to courts, IV-D attorneys and IV-D District Directors.

C. Securing health insurance once it is ordered NMSN implementation-Agency/Employer/Plan Administrator Collaboration

The key to enforcing medical support is the optimal use of automating the National Medical Support Notice - State's are required to enforce health care provisions of support orders thru the use of the federally mandated National Medical Support Notice when NCP's have been ordered to provide health care coverage.

NY features of NMSN implementation include:

- **Automated identification of eligible cases** – NMSN's are issued where the ncp had been ordered to provide health insurance AND an employer is known are being issued NMSN.
- **Immediate issuance of NMSN** for new and modified orders where NCP's have been ordered to provide and the employer is verified.
- **Staggered implementation** of the under-care caseload. Essentially 10% per month of eligible cases were issued NMSN for the first year.
- **Central mailing of NMSN** – All NMSN documents are being mailed centrally through the SDU contractor.
- **Central data capture** of NMSN PART A and B information – All NMSN Part A and B documents are returned to our Processing Center for data capture to a file that updates the CSMS health insurance screens for each case. Health insurance carrier screens were developed in conjunction with Medicaid program to data capture necessary information for record keeping and referral purposes.
- **Cover letter** – Developed by DCSE to be issued with the NMSN to provide a quick reference for employers to understand the NMSN and the actions by them necessary to meet notice requirements.

- **Withholding worksheet** – Based on early review of employer complaints and questions regarding the NMSN, many of which involved payroll withholding questions, DCSE developed and issues a withholding limitations worksheet that employers can use to calculate CCPA withholding limitations with every NMSN.

- **Response addendum** – DCSE developed a "Response Addendum" which is issued with the NMSN to assist plan administrators in identifying the health carrier data elements requested by DCSE when responding to Part B of the NMSN. While employers are not required to respond using this form it assists plan administrators to identify the type of information being sought even when they choose to use their own form to respond.

- **60-day Reminder notice** – This automated process was developed by DCSE to identify employers who have not responded to NMSN and subsequently cause the system to issue a reminder notice.

- **HELPLINE** – The Processing Center provides a toll free helpline to handle employer and plan administrator inquiries. Continuous training is provided to the helpline desk staff as issues are identified. The DCSE looks to the processing center to proactively engage employers who have not complied with notice requirements.

- **FAQ** – Common questions received by our agency and by the processing center have been pooled into a FAQ for consistency for answering questions regarding the NMSN. The FAQ is available on the child support website: newyorkchildsupport.com.

- **Employer Outreach** – In conjunction with the NYS Department of Labor information regarding the NMSN was included in the DOL newsletter, a statewide employer publication, as well as a publication issued by the American Payroll Association (APA). DCSE has been actively reviewing employer compliance with NMSN and has been in contact with the most frequent non-compliers. E.g. NMSN's were sent to NYS Comptroller's Office. Coordinated large scale response to the NMSN was organized with NYS Dept of Civil Service for NYS employees. In addition, the DCSE has coordinated with State of NY Insurance Department which issued a letter to all licensed carriers in NYS notifying them of the requirement to comply with the NMSN. (See copy attached)

- **Data matching to reduce paper NMSNs** – As part of the implementation of NMSN in NYC, DCSE is working with NYC OCSE and NYC Office of Payroll Administration (OPA) to identify city workers who must provide health insurance. Updating through data matching

minimizes the need to issue paper copies of NMSNs. (Note: there are 9000 such city workers with child support obligations).

NMSN Total statistics since automated process began December 2003 as of **July 2005**:

- **391,211** - NMSN's have been issued to employers
- **152,885** - Part A's (Employer Response/HI not available) returned
- **69,577** - Part B's (Plan Administrator Response) returned
- **100,699** - Children verified as enrolled in TPHI as a result of NMSN
- **67,816** - Children enrolled in health insurance as a direct result of NMSN

(**Note**: Over 15,000 Medicaid active children have now been identified as having TPHI. Prior to the implementation of the NMSN (12/03), only 4,219 IV-D children on MA had TPHI.)

NMSN PART A statistics

Of the employer responses (Part A) supporting the claim that Health Insurance coverage is **unavailable**:

- **72%** indicated the employee no longer employed by the employer.
- **16%** responses indicated the employer did not maintain or contribute to plans.
- **9%** responses indicated the employee was not eligible to receive coverage.
- **3%** responses indicated that the employee's share of premium payments would cause salary or wage withholdings to excess federal CCPA withholding limitations.

D. More to be done, Next Steps with NMSN

Since completion of the staggered implementation, DCSE has taken the next steps to further secure health insurance through the issuance of the NMSN.

- **Reworded cover notice –** A cover letter, written to accompany the NMSN, was revised to help clarify the language in the instructions of the NMSN which were found to be confusing by some employers. E.g., some employers didn't understand that the NMSN requires them to complete and return the NMSN (either Part A or B in every case).

- **Assessing employer compliance** - Action to be taken with regard to issuance of NMSN's when no response is received after a "Reminder Notice" is issued 60 days after notice. (e.g. telephone contact by the

Helpline to non-responding employers, court enforcement through violation petition to employer).

- **Reviewing waiting period** cases in which plan administrators reported employee had a "waiting period" prior to eligibility for coverage. Agency follow-up required for additional action when "waiting period" date has been reached. Instructions to our vendor to correctly identify when a "waiting period" for coverage is noted.

- **Monitoring data quality** reviewing central processing of NMSN both for quality and timeliness of issuance and data capture of Part A and B information.

- **Updating the FAQ** to assist the central Helpline in providing timely and responsive answers to questions from employers and plans.

E. NY and OCSE and DFAS Accessing Other options: TRICARE

TRICARE - While the NMSN does not enforce medical coverage received by active duty, or retired, uniformed service members, the DMDC's acceptance of the NMSN as an inquiry document and their response identifying whether IV-D ncp's are active duty service members and stating dependents enrollment status in DEERS is an important interface particularly where other private insurance is not available to a child.

DCSE is developing procedures for districts to use to assist cp's and their dependents in getting enrolled in DEERS and receiving TRICARE.

DCSE has also participated in a match with OCSE and DMDC to identify ncp's, cp's who are military members and who have enrolled their children in TRICARE. Information from the data match will be uploaded onto the CSMS and shared with Medicaid program.

F. Counting kids with coverage

New child specific codes were developed to capture all medical support possibilities for establishment of parental obligations and enrollment of children.

Data capture/validation – DCSE and local districts have engaged in a state/local multi-year review of all IV-D support orders to ascertain if health insurance had been ordered with follow-up with parties and the court if it hasn't and updating of state's Child Support Management System (CSMS). This will identify cases that require review for third party health insurance coverage (e.g. Medicaid active), improve our data for automated issuance of medical support enforcement notices and will aid

the state in accurate federal reporting in anticipation of federal medical support performance measures.

When the Medical Support Indicator Validation Project began in **October of 2000 29%** of cases with orders recorded on CSMS were coded as having health insurance ordered. As of **July 2005, 55%** of cases with orders have health insurance ordered and recorded on CSMS. This is a continuously ongoing project.

G. Child Support and Medicaid-Health Insurance Information Exchange

IV-D / MEDICAID automated information exchange - DCSE is working with the state's Medicaid program to provide for an automated exchange of insurance information regarding IV-D parents and children with Medicaid recipient files when private health insurance is obtained. DCSE will provide Medicaid with health insurance information for IV-D children who are in receipt of MA that results from medical support enforcement. This information can then be uploaded to Medicaid file.

Medicaid is conducting data matches through a contractor to identity private insurance which will also be shared with IV-D program for both Medicaid and non-TANF IV-D cases. The goal is to maintain shared information on a monthly basis of IV-D and Medicaid files regarding enrollment of IV-D children in private insurance.

The automated data exchange began May of 2005.

In the first run, **16,667** new non-TANF major medical insurance records were identified and **15,051** new pa major medical insurance records were identified for IV-D cases from the match.

Cost Savings/avoidance – The NYS Office of Medicaid Management has calculated that the average annual **cost savings** for a child in receipt of Medicaid who is enrolled in private insurance is **$1,936.00** (FY Apr. '04 – Mar. '05). The OMM determined this by denied payments in 57,436 cases for individuals age 19 or under with available TPHI, had saved $111,219,714.00. (Note: The HCFA National average cost savings for TPHI coverage is $1,240)

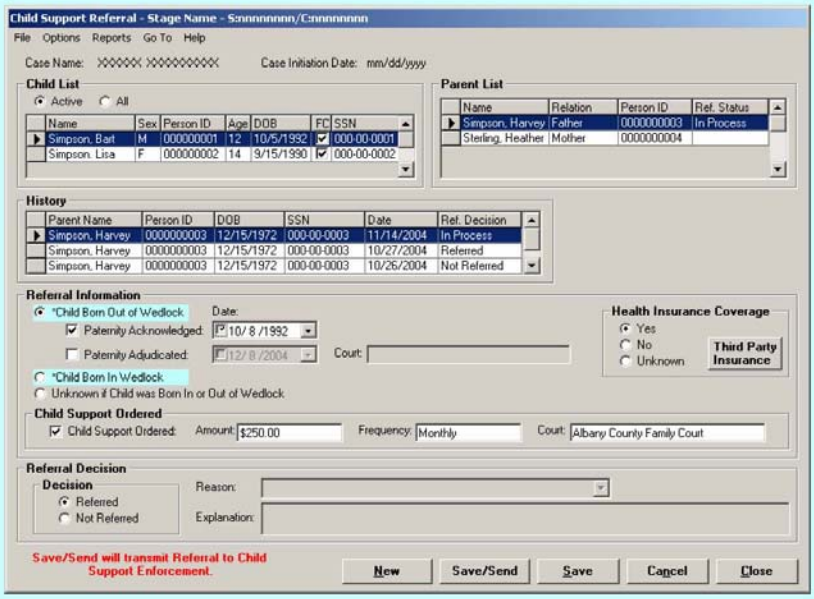
As such, by enforcing the health insurance provision of an order or, by identifying previously unknown TPHI coverage, the potential Medicaid cost savings for the approximately **15,000** children provided with private coverage by use of the NMSN in NYS is **$29,000,000.00 per year**.

New York Child Support Management System

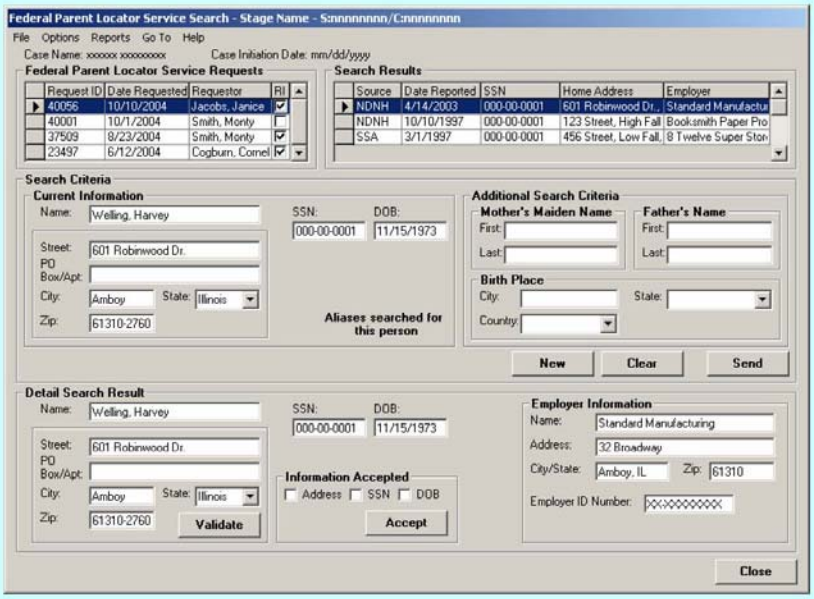
CSMS
Child Support Management System
(Title IV-D – Child Support Enforcement)

- CONNECTIONS supports an electronic interface to CSMS that will provide for:
  - Referrals to CSEU for children placed in foster care
  - Updates to to the status of children in foster care, e.g. change in placement or maintenance cost, change in IV-E status, or discharge.
  - Receipt of collections data to allow for Title IV-E Claim adjustments
- CONNECTIONS provides a method for electronically requesting and receiving information from the Federal Parent Locator Service.
- CONNECTIONS allows the user to review the information in the Putative Father Registry.

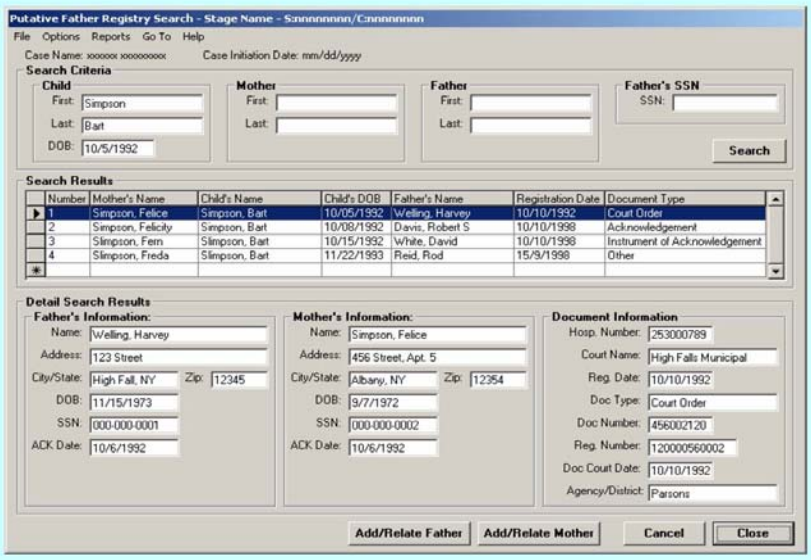
Child Support – Child Support Referral



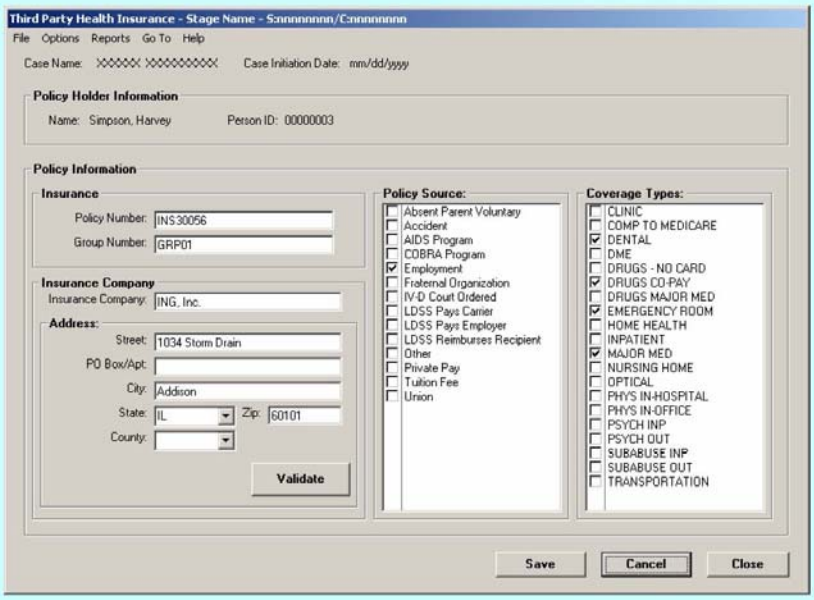
Federal Parent Locator Service Search



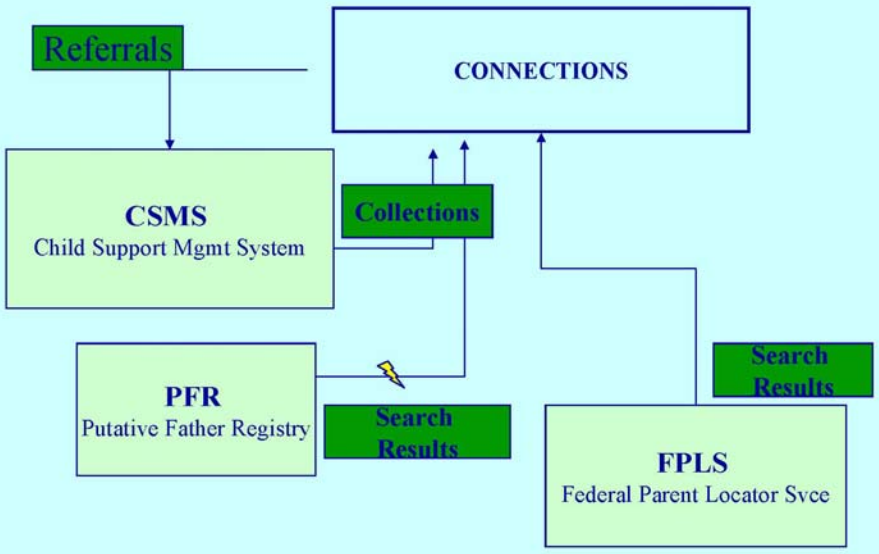
Putative Father Registry Search

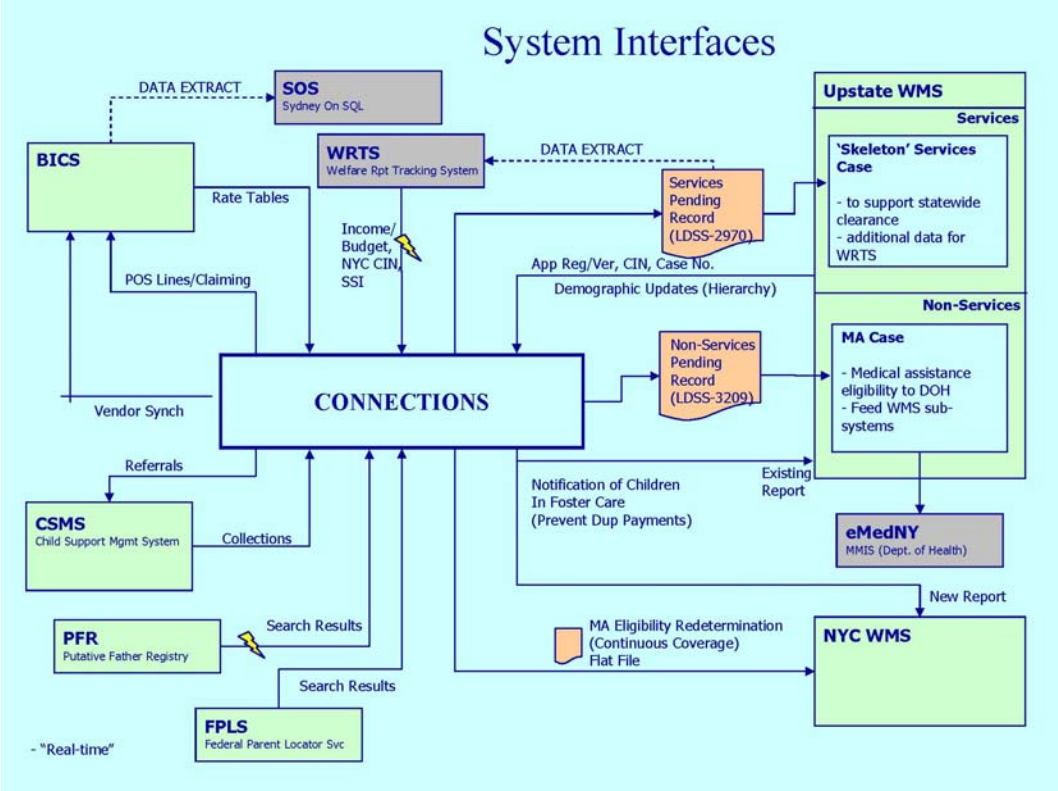


Third Party Health



IV-D Interface



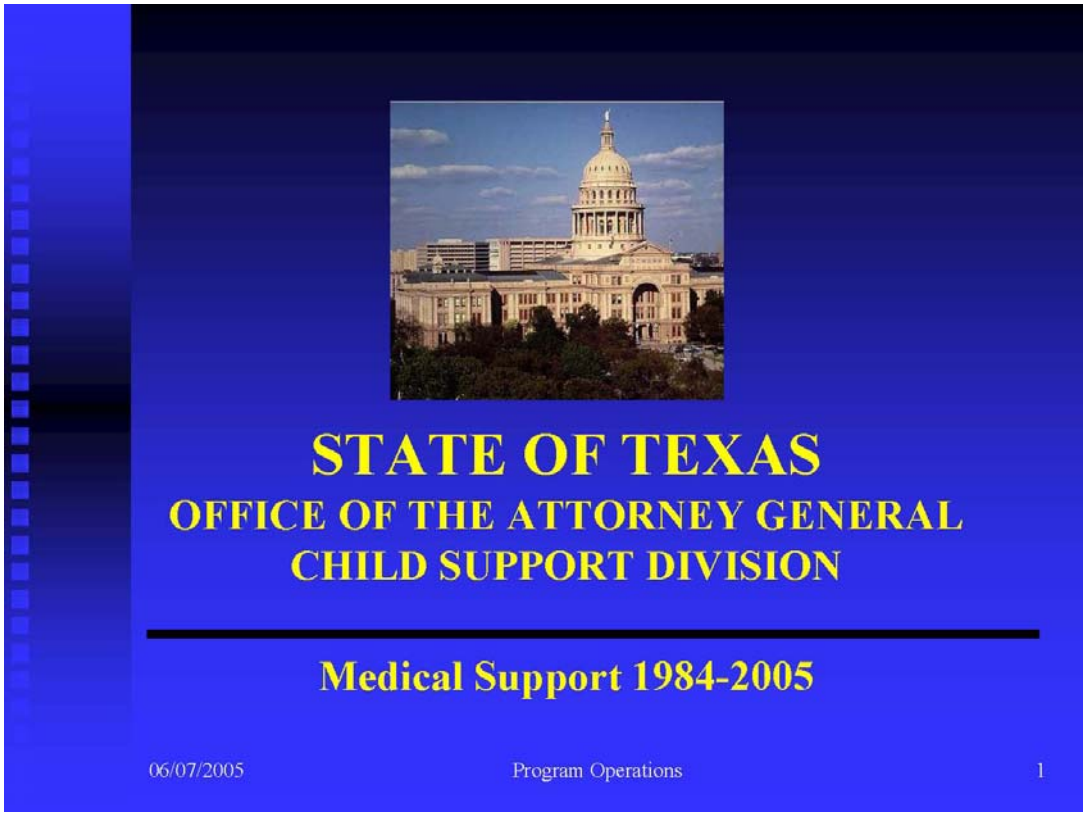


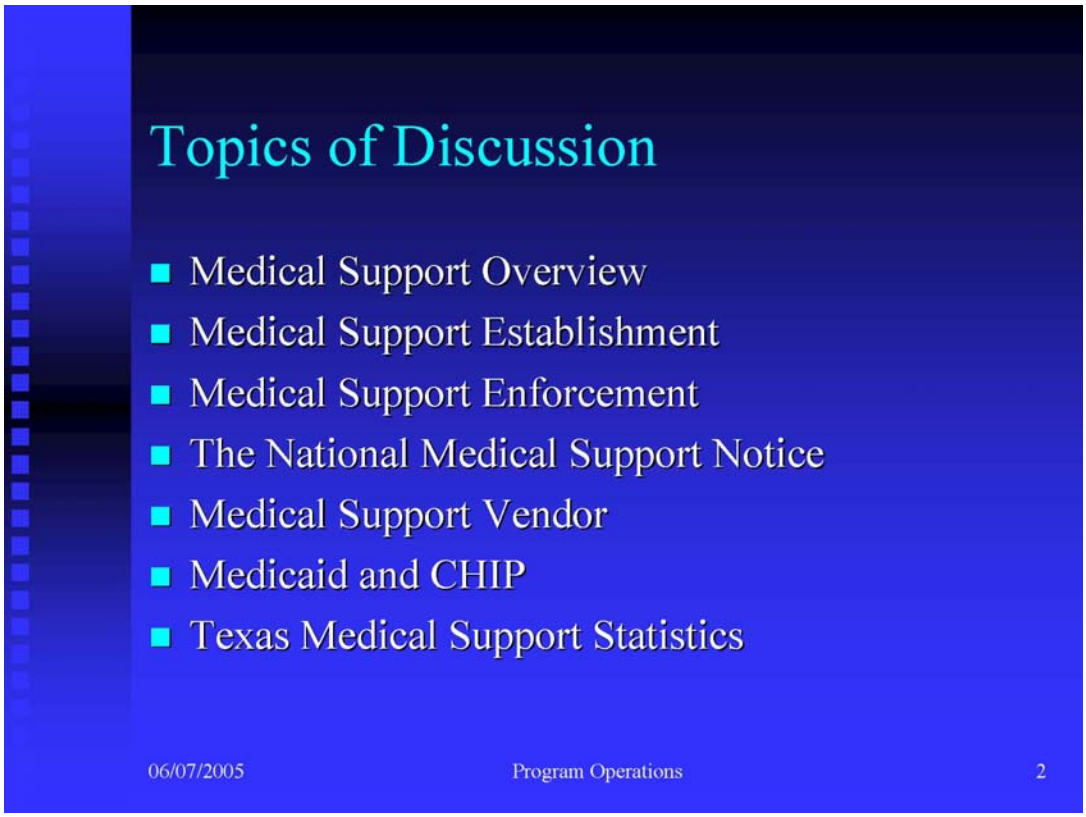
Interim Process

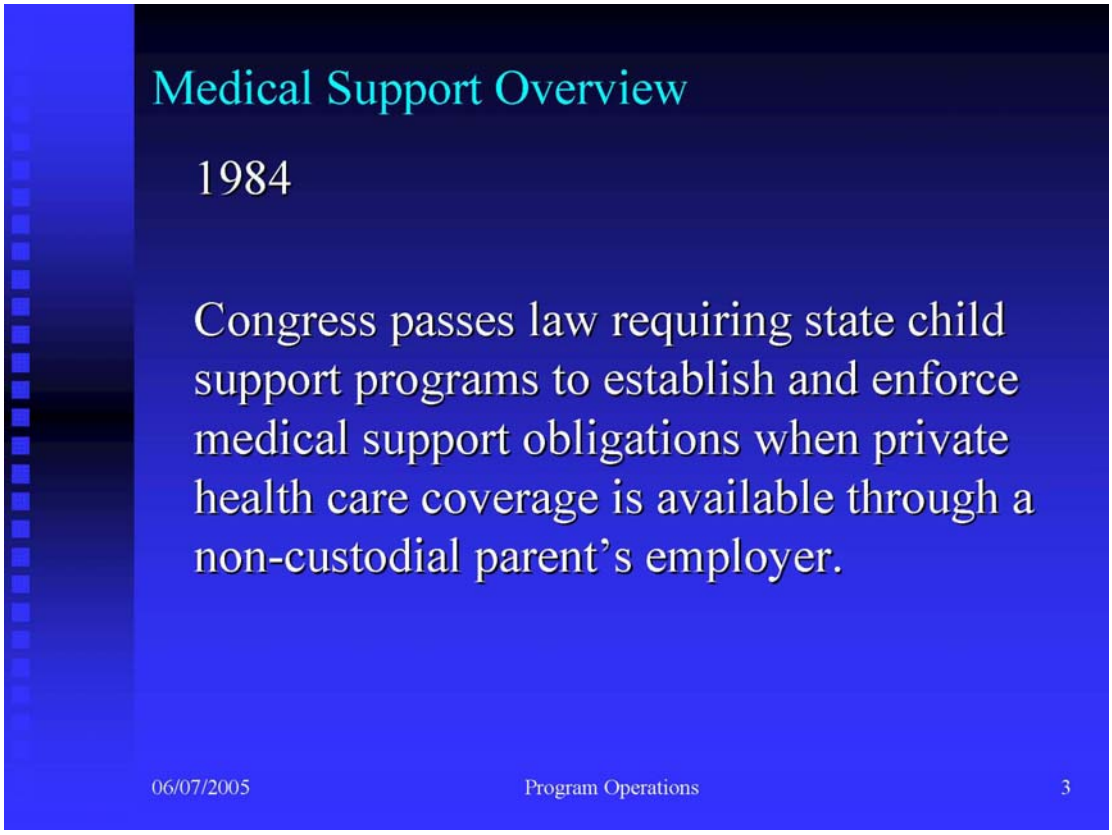
New OCFS/OTDA Administrative Directive

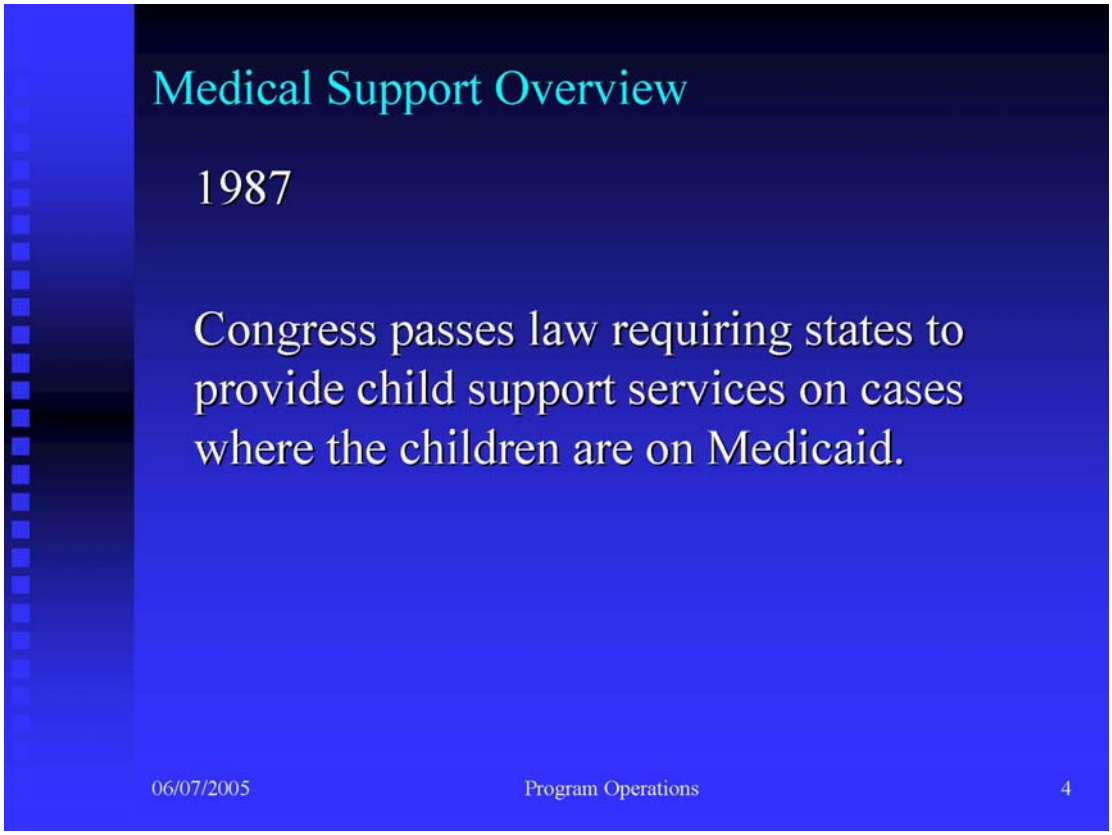
- Cooperative Process between child welfare and child support workers
- Locating Permanency Resources for children in foster care
- County DSS Child Welfare → DSS Child Support
- DSS Child Support via CSMS → FPLS
- FPLS → DSS Child Support
- DSS Child Support → Child Welfare staff

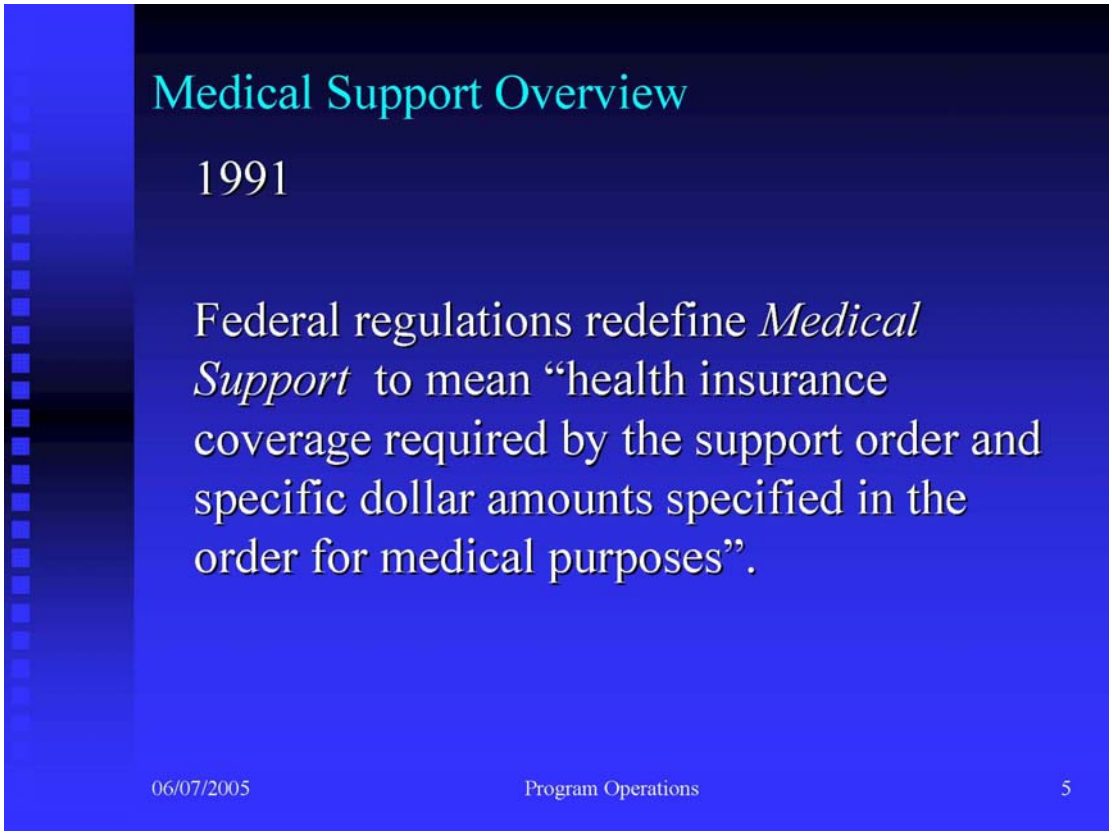
Texas Medical Support






Medical Support Overview
1984
Congress passes law requiring state child support programs to establish and enforce medical support obligations when private health care coverage is available through a non-custodial parent's employer.
06/07/2005
Program Operations
3


Medical Support Overview
1987
Congress passes law requiring states to provide child support services on cases where the children are on Medicaid.
06/07/2005
Program Operations
4


Medical Support Overview
1991
Federal regulations redefine *Medical Support* to mean "health insurance coverage required by the support order and specific dollar amounts specified in the order for medical purposes".
06/07/2005
Program Operations
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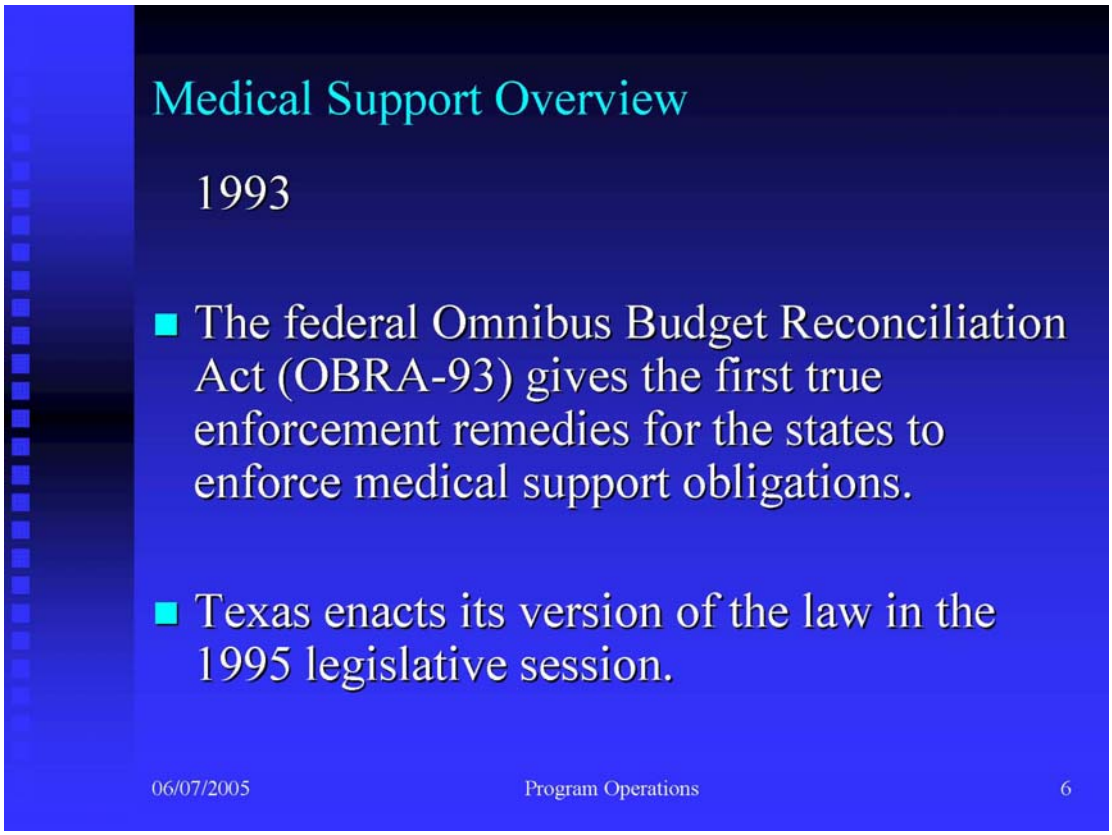
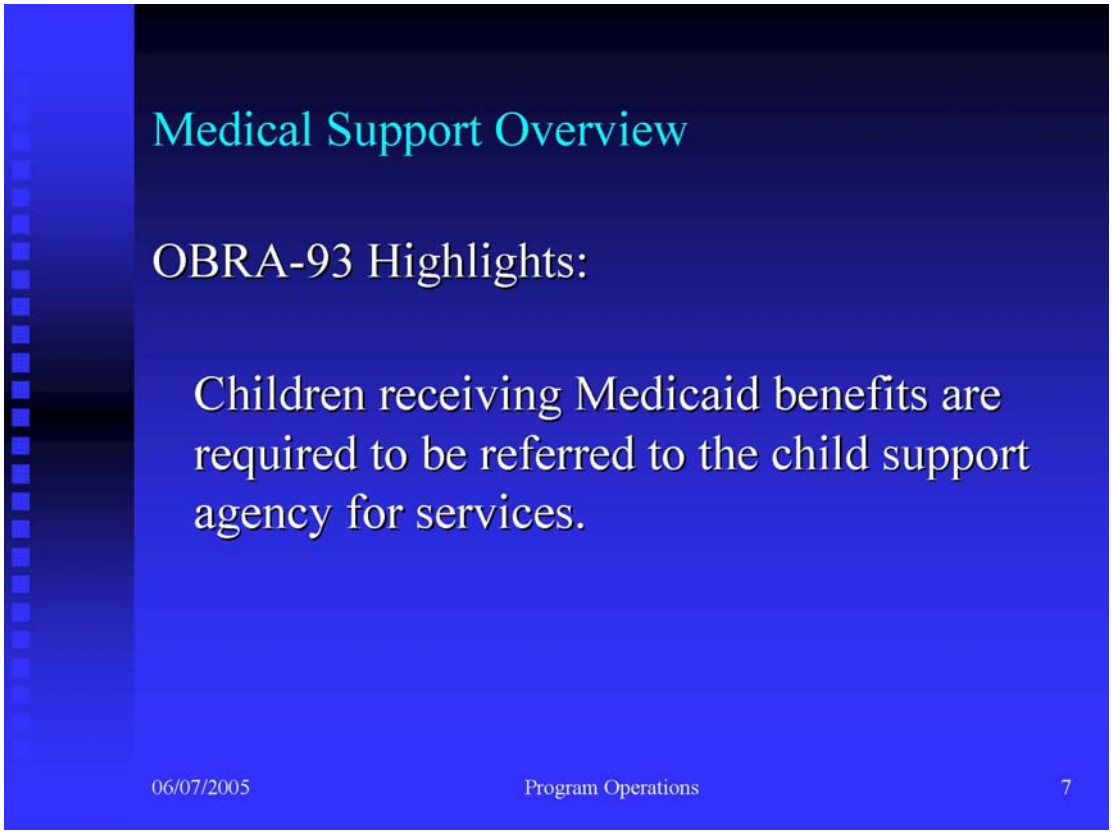
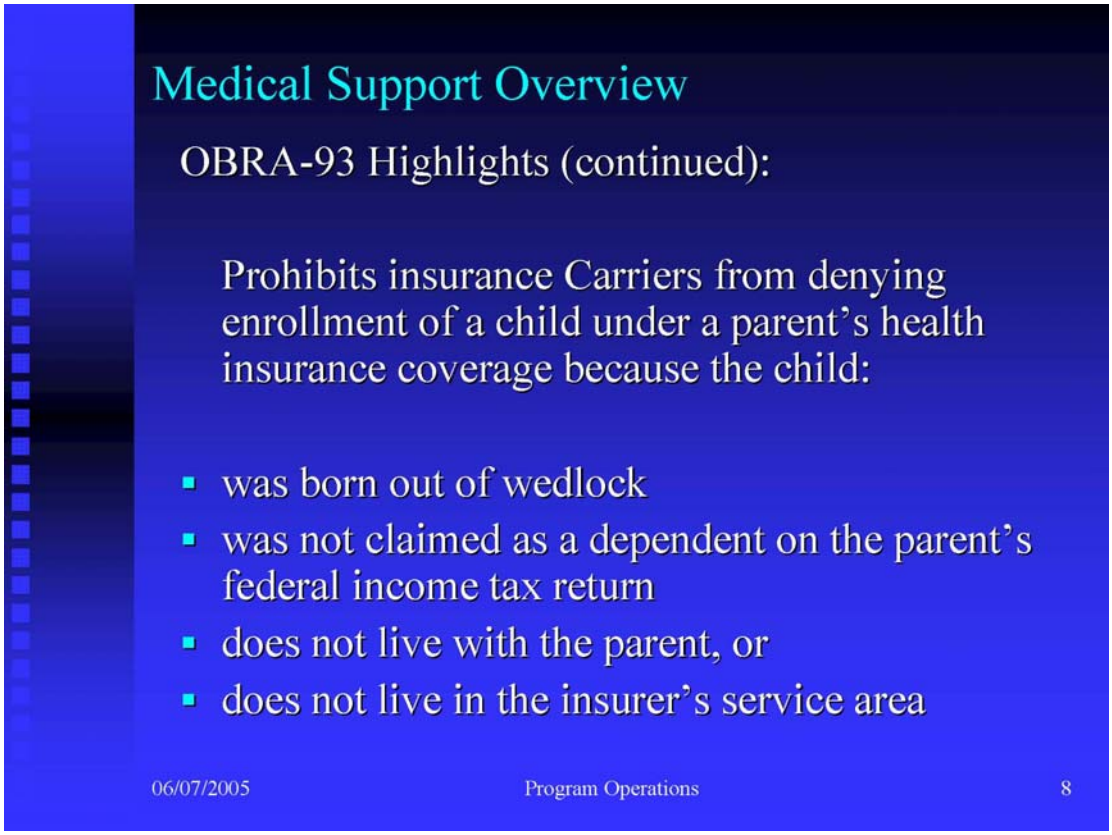
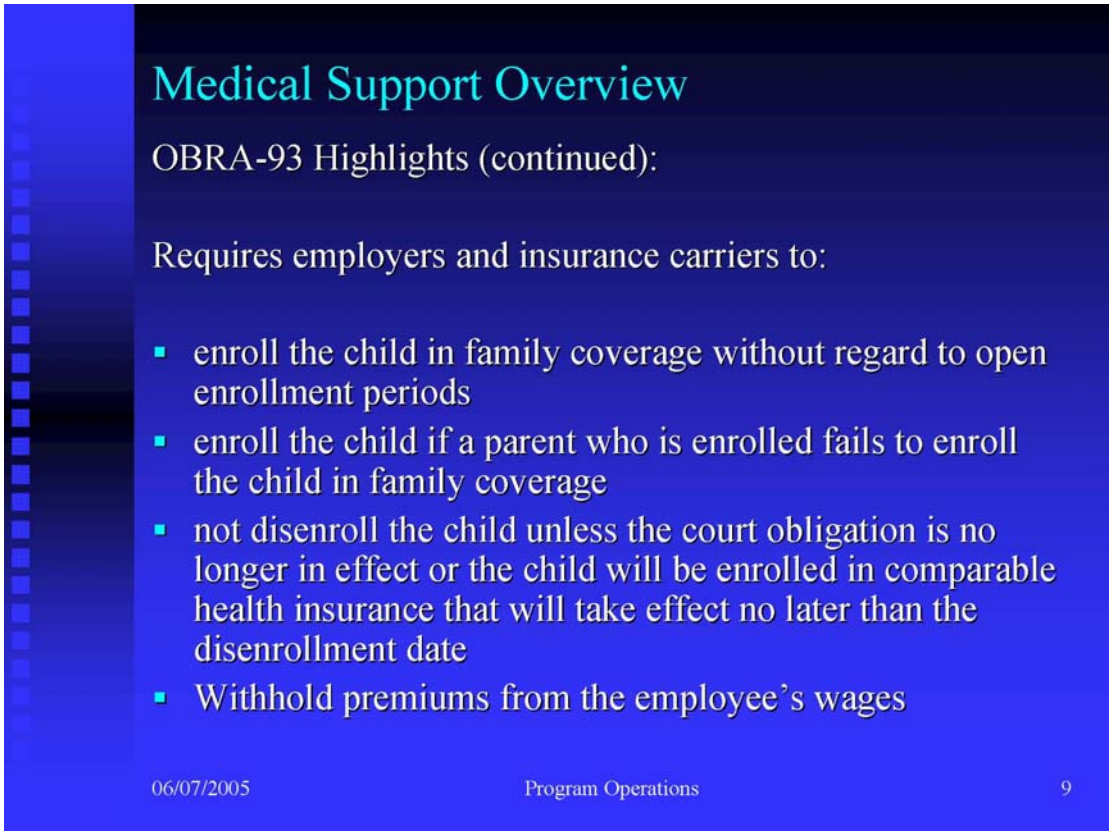
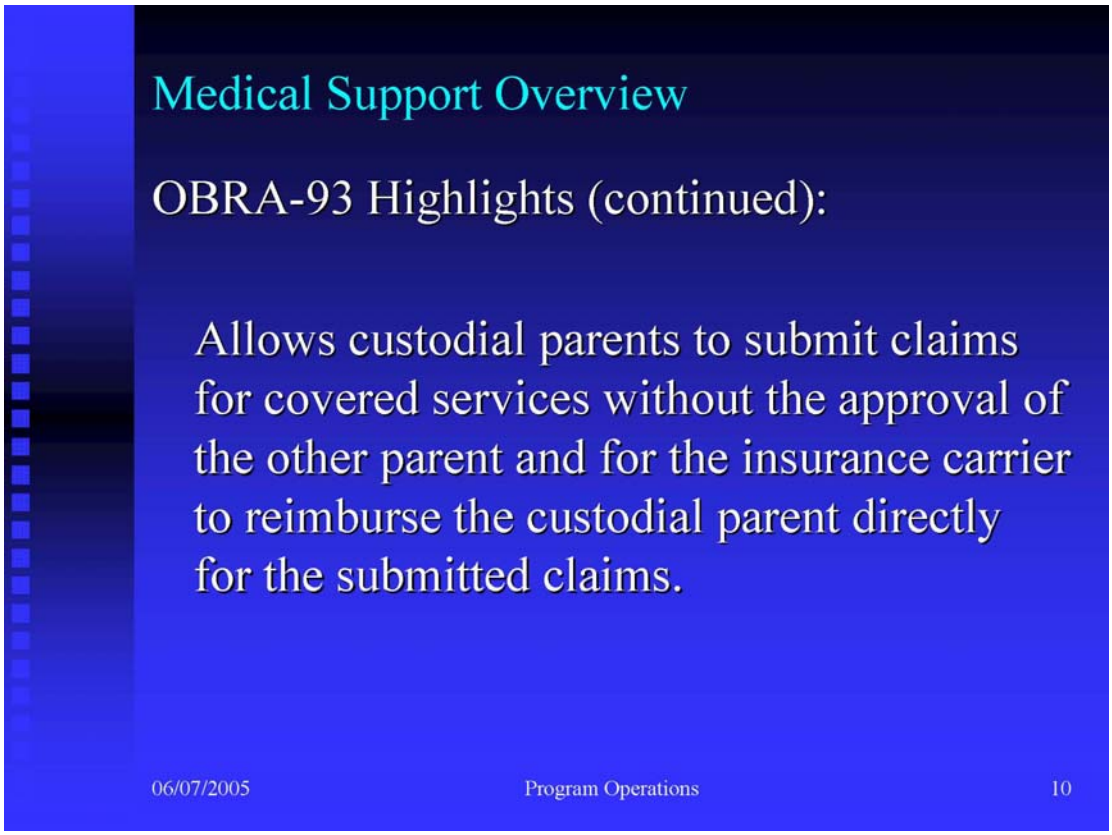
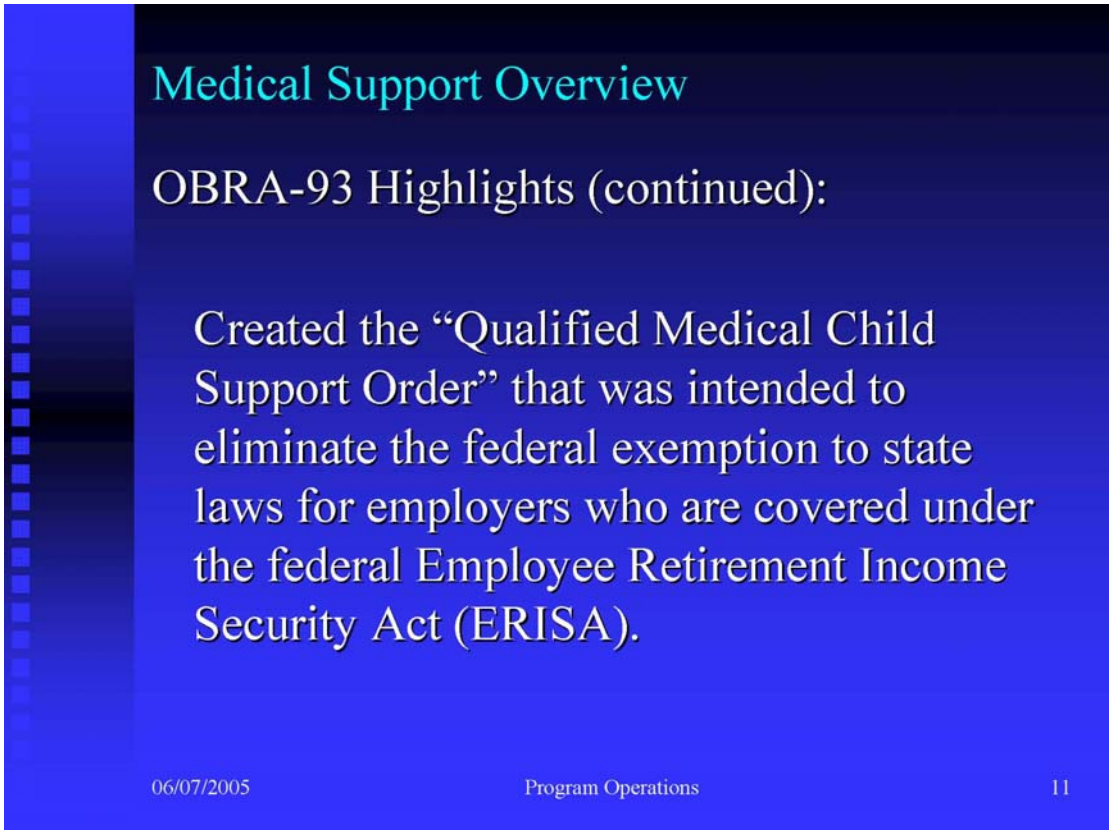

Medical Support Overview
1993
The federal Omnibus Budget Reconciliation Act (OBRA-93) gives the first true enforcement remedies for the states to enforce medical support obligations.
Texas enacts its version of the law in the 1995 legislative session.
06/07/2005
Program Operations
6

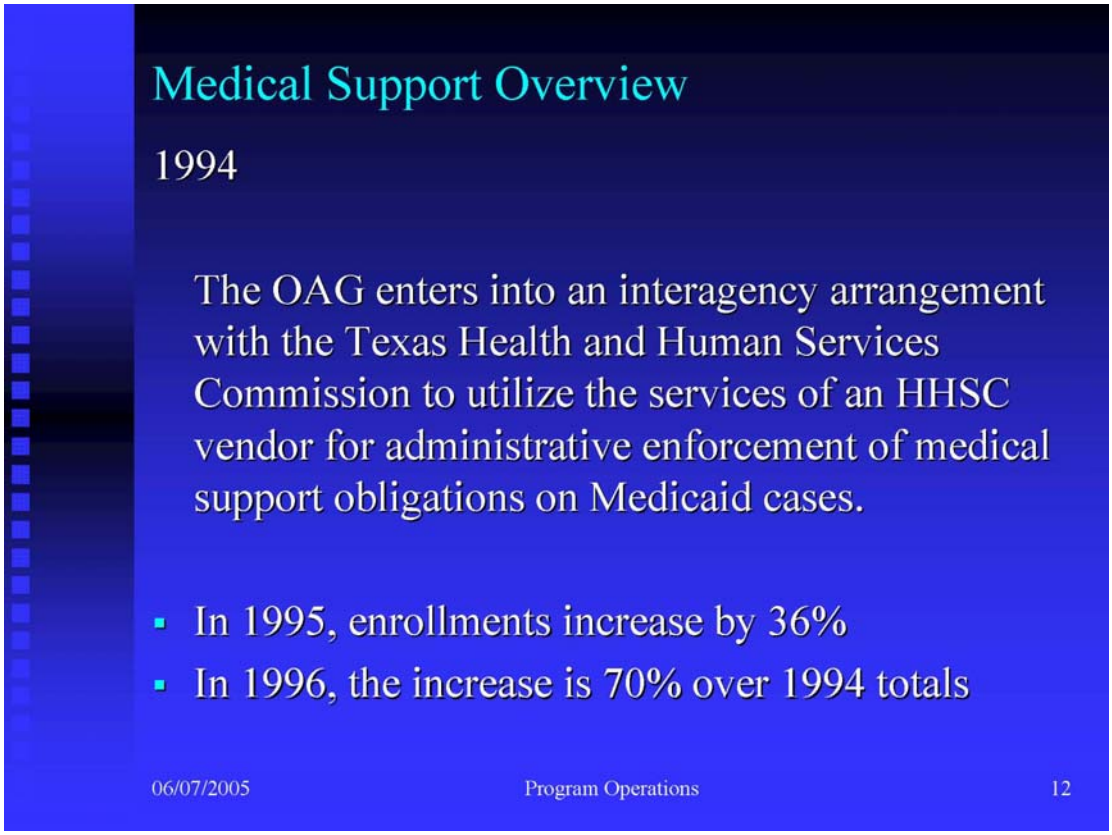

Medical Support Overview
OBRA-93 Highlights:
Children receiving Medicaid benefits are required to be referred to the child support agency for services.
06/07/2005
Program Operations
7

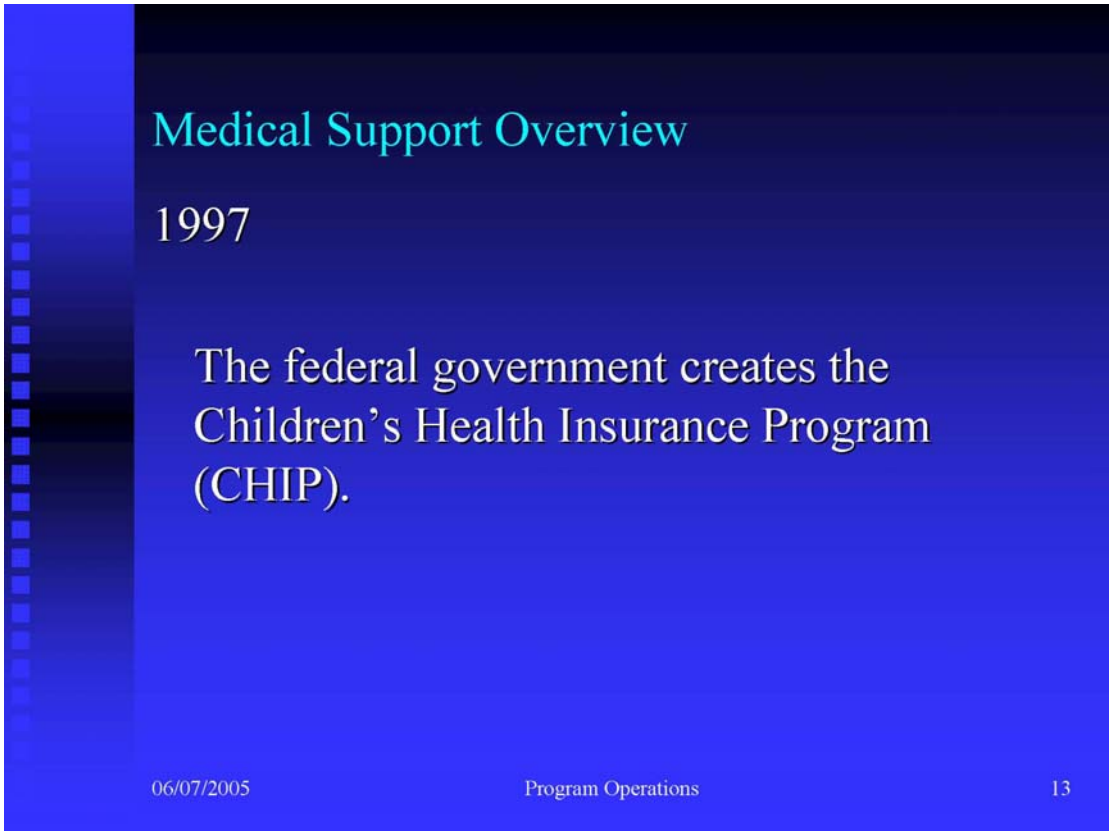

Medical Support Overview
OBRA-93 Highlights (continued):
Prohibits insurance Carriers from denying enrollment of a child under a parent's health insurance coverage because the child:
was born out of wedlock
was not claimed as a dependent on the parent's federal income tax return
does not live with the parent, or
does not live in the insurer's service area
06/07/2005
Program Operations
8

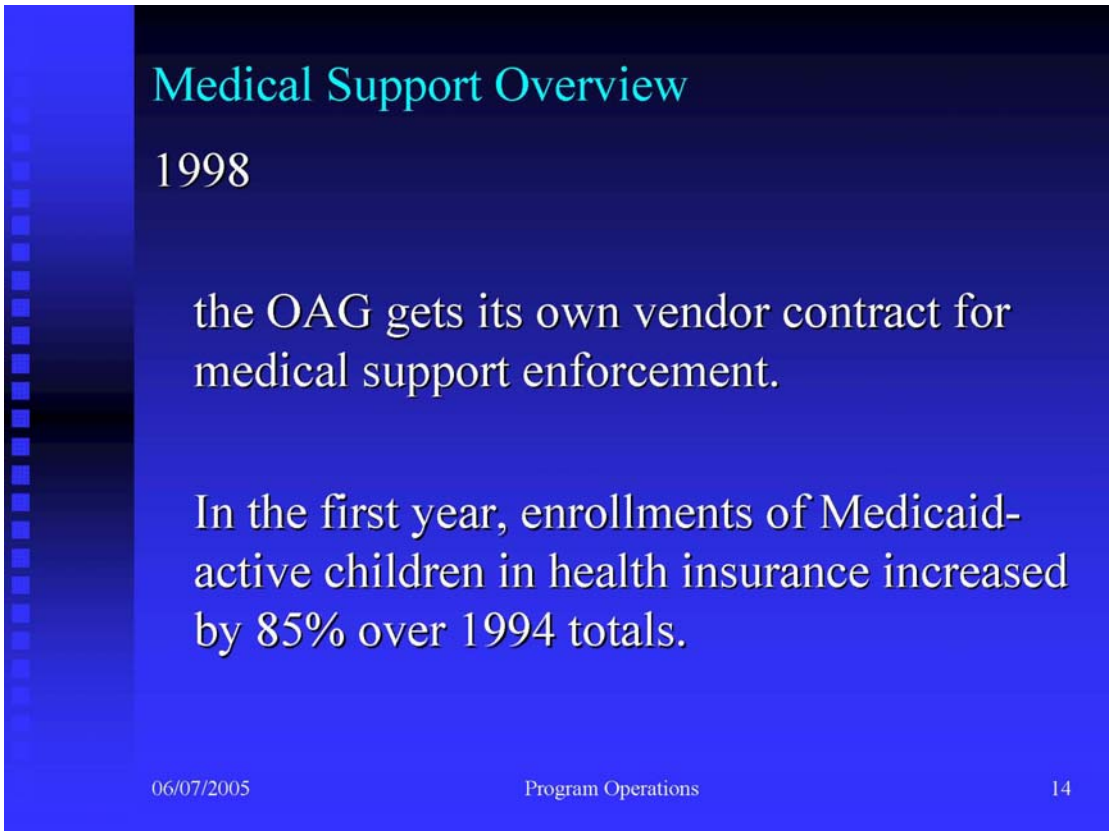

Medical Support Overview
OBRA-93 Highlights (continued):
Requires employers and insurance carriers to:
enroll the child in family coverage without regard to open enrollment periods
enroll the child if a parent who is enrolled fails to enroll the child in family coverage
not disenroll the child unless the court obligation is no longer in effect or the child will be enrolled in comparable health insurance that will take effect no later than the disenrollment date
Withhold premiums from the employee's wages
06/07/2005
Program Operations
9

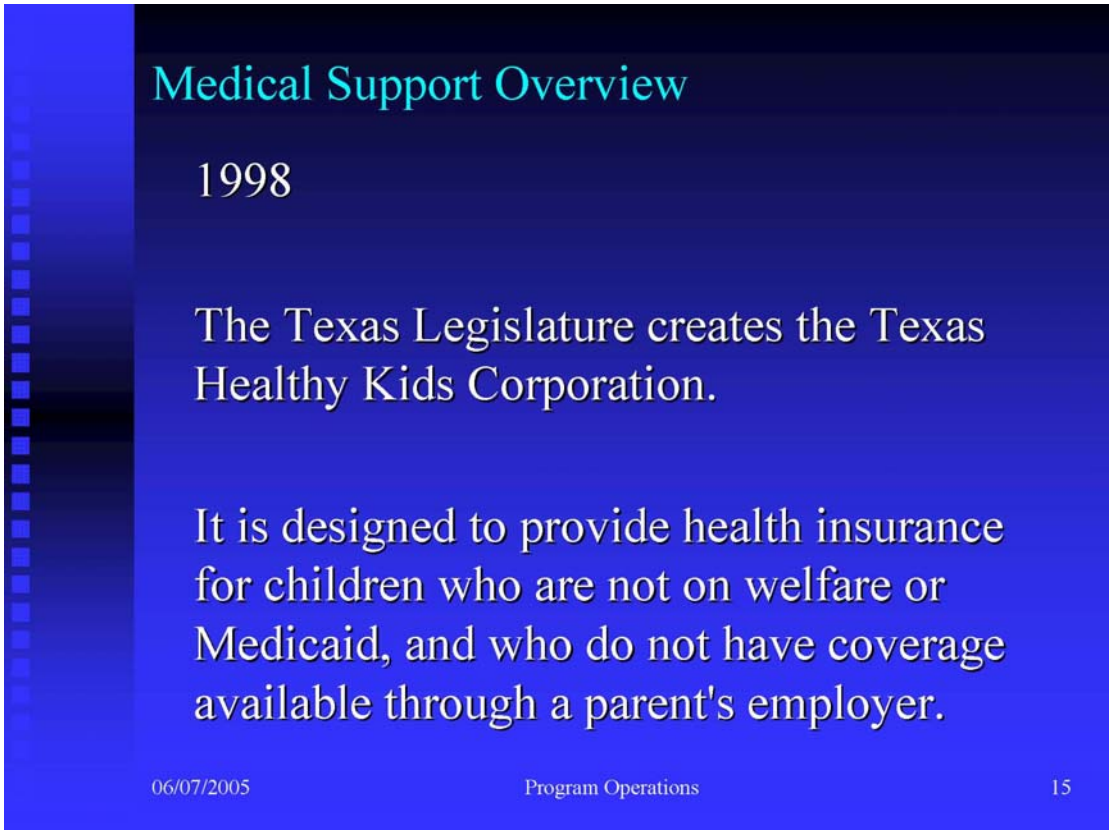

Medical Support Overview
OBRA-93 Highlights (continued):
Allows custodial parents to submit claims for covered services without the approval of the other parent and for the insurance carrier to reimburse the custodial parent directly for the submitted claims.
06/07/2005
Program Operations
10

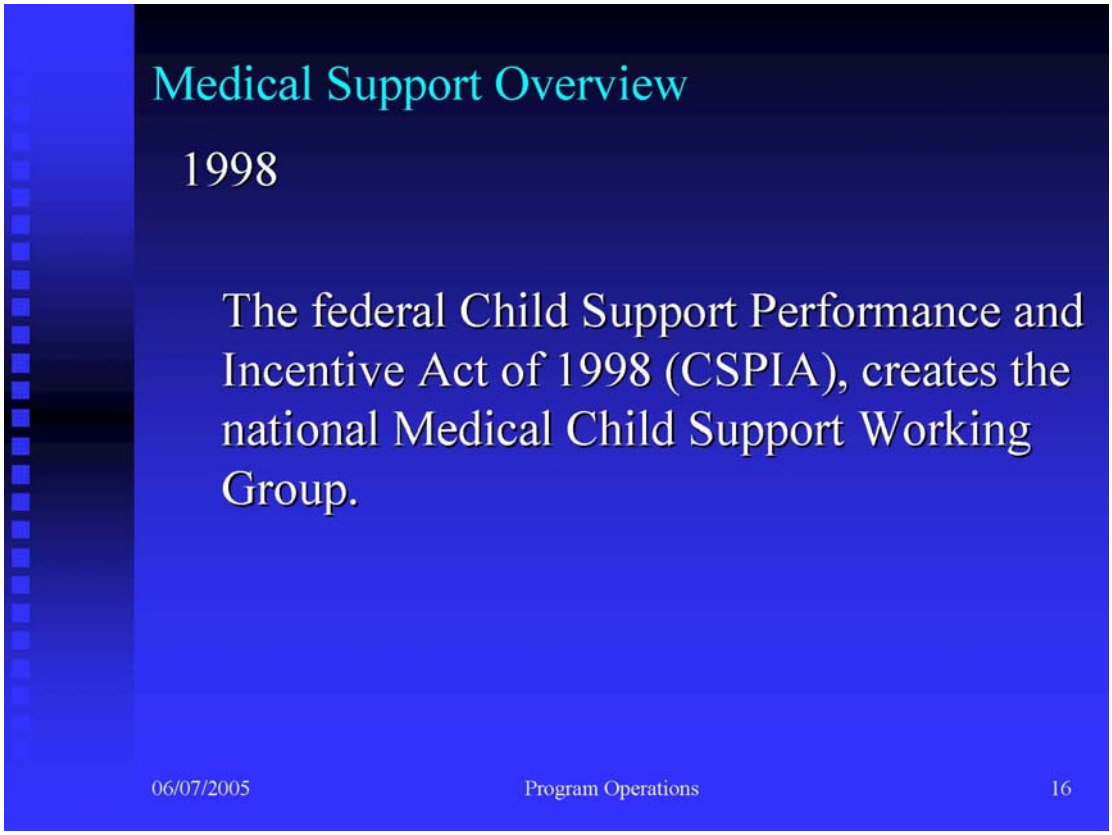

Medical Support Overview
OBRA-93 Highlights (continued):
Created the "Qualified Medical Child Support Order" that was intended to eliminate the federal exemption to state laws for employers who are covered under the federal Employee Retirement Income Security Act (ERISA).
06/07/2005
Program Operations
11

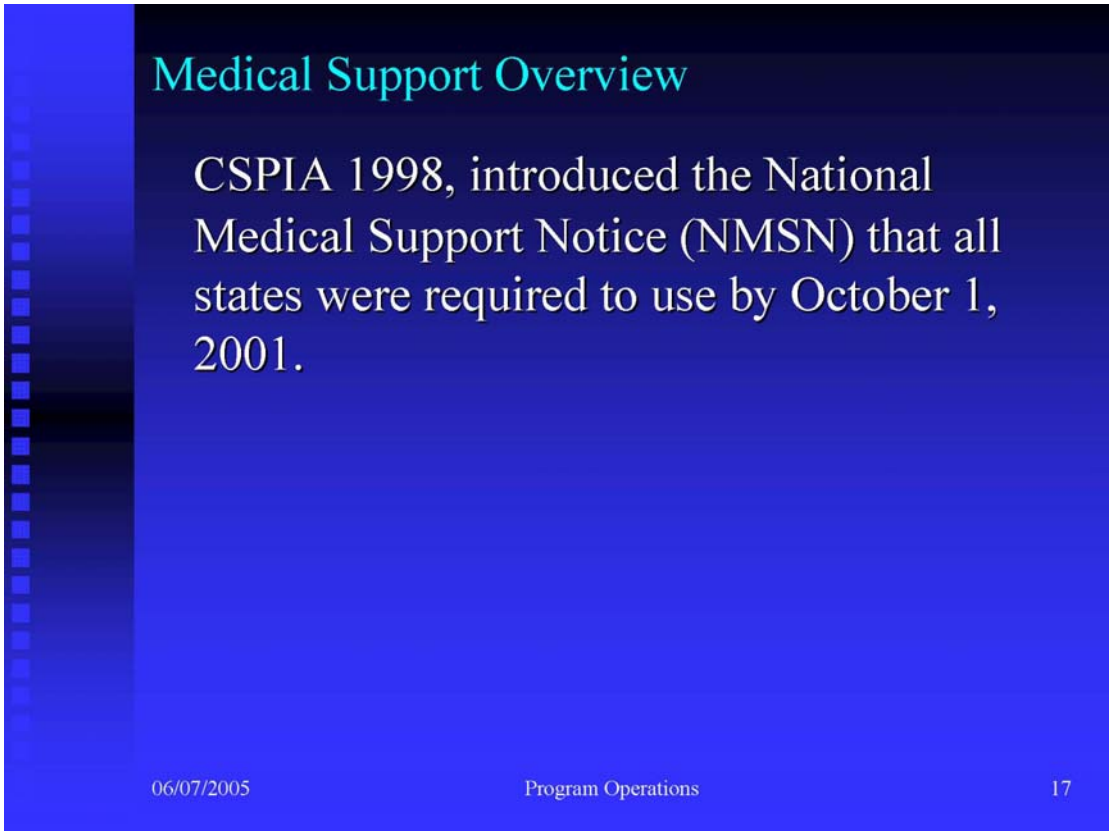

Medical Support Overview
1994
The OAG enters into an interagency arrangement with the Texas Health and Human Services Commission to utilize the services of an HHSC vendor for administrative enforcement of medical support obligations on Medicaid cases.
In 1995, enrollments increase by 36%
In 1996, the increase is 70% over 1994 totals
06/07/2005
Program Operations
12


Medical Support Overview
1997
The federal government creates the Children's Health Insurance Program (CHIP).
06/07/2005
Program Operations
13


Medical Support Overview
1998
the OAG gets its own vendor contract for medical support enforcement.
In the first year, enrollments of Medicaid-active children in health insurance increased by 85% over 1994 totals.
06/07/2005
Program Operations
14


Medical Support Overview
1998
The Texas Legislature creates the Texas Healthy Kids Corporation.
It is designed to provide health insurance for children who are not on welfare or Medicaid, and who do not have coverage available through a parent's employer.
06/07/2005
Program Operations
15


Medical Support Overview
1998
The federal Child Support Performance and Incentive Act of 1998 (CSPIA), creates the national Medical Child Support Working Group.
06/07/2005
Program Operations
16


Medical Support Overview
CSPIA 1998, introduced the National Medical Support Notice (NMSN) that all states were required to use by October 1, 2001.
06/07/2005
Program Operations
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Medical Support Overview
1999
The Texas Legislature passes legislation authorizing CHIP.
Most children on the Texas Healthy Kids Corporation program are eligible for the more affordable CHIP. The legislature abolishes THKC.
06/07/2005
Program Operations
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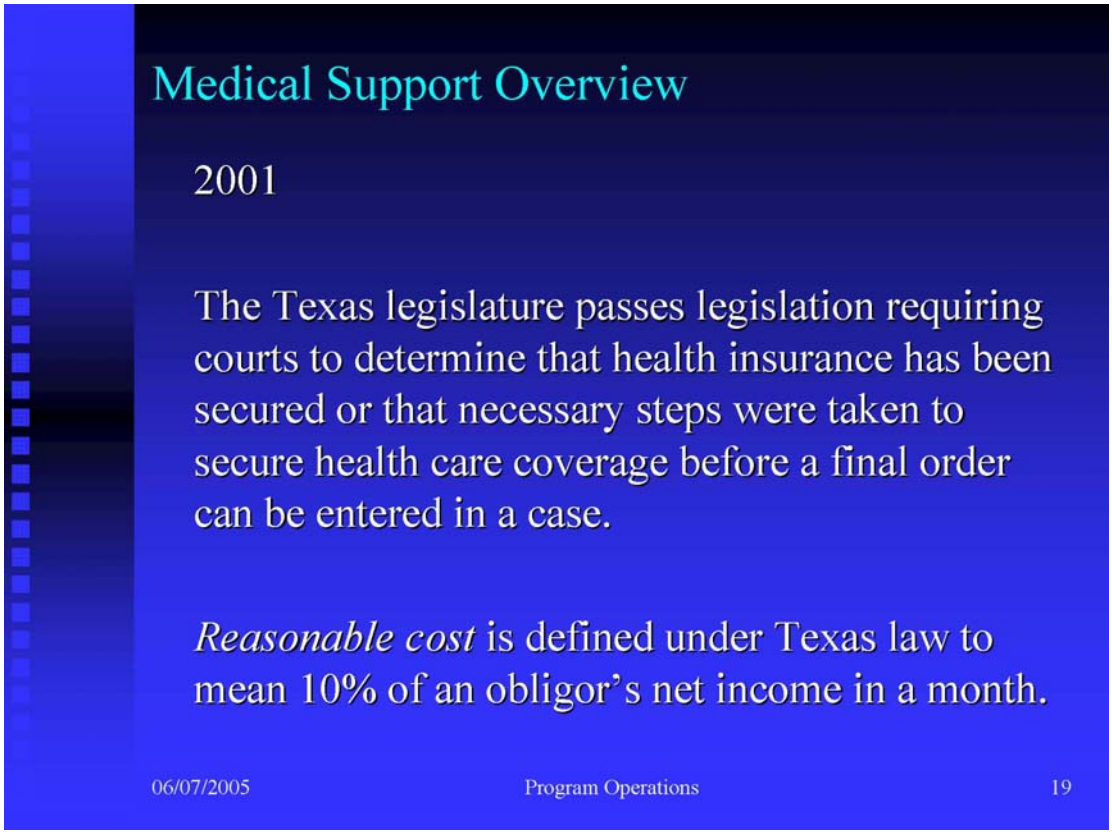
Medical Support Overview
2001
The Texas legislature passes legislation requiring courts to determine that health insurance has been secured or that necessary steps were taken to secure health care coverage before a final order can be entered in a case.
Reasonable cost is defined under Texas law to mean 10% of an obligor's net income in a month.
06/07/2005
Program Operations
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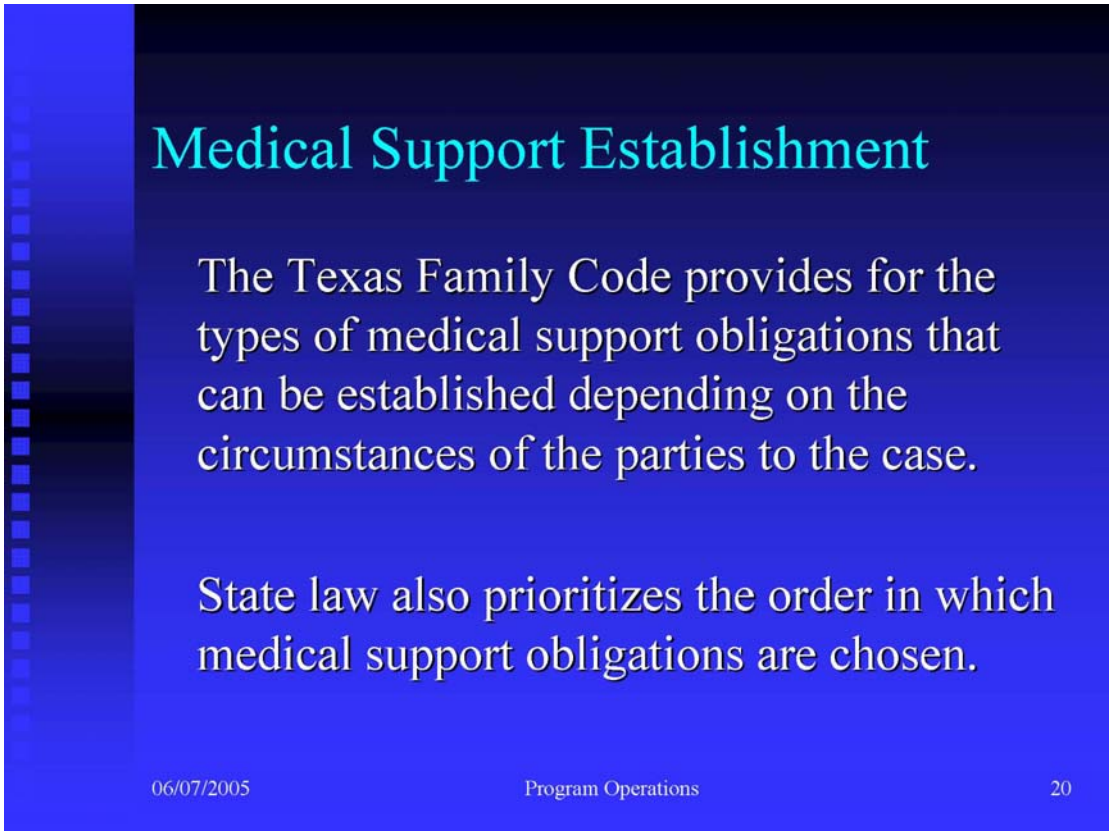
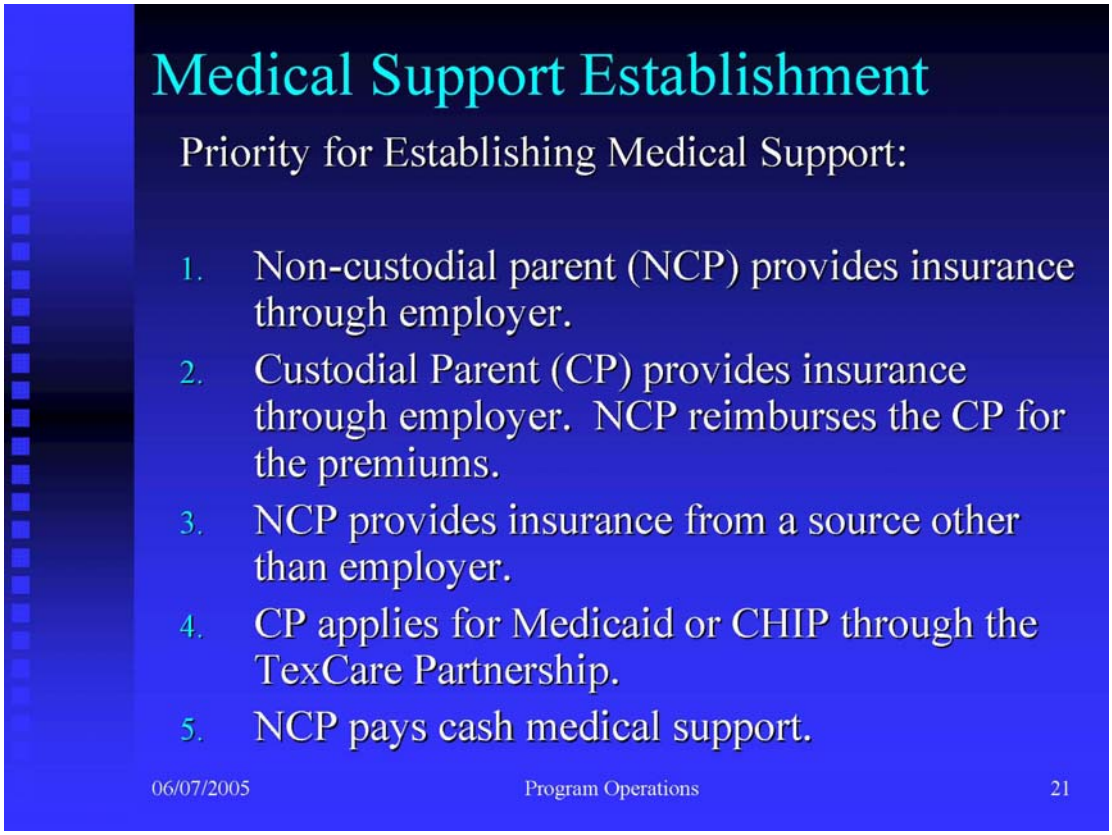

Medical Support Establishment
The Texas Family Code provides for the types of medical support obligations that can be established depending on the circumstances of the parties to the case.
State law also prioritizes the order in which medical support obligations are chosen.
06/07/2005
Program Operations
20


Medical Support Establishment
Priority for Establishing Medical Support:
1. Non-custodial parent (NCP) provides insurance through employer.
2. Custodial Parent (CP) provides insurance through employer. NCP reimburses the CP for the premiums.
3. NCP provides insurance from a source other than employer.
4. CP applies for Medicaid or CHIP through the TexCare Partnership.
5. NCP pays cash medical support.
06/07/2005
Program Operations
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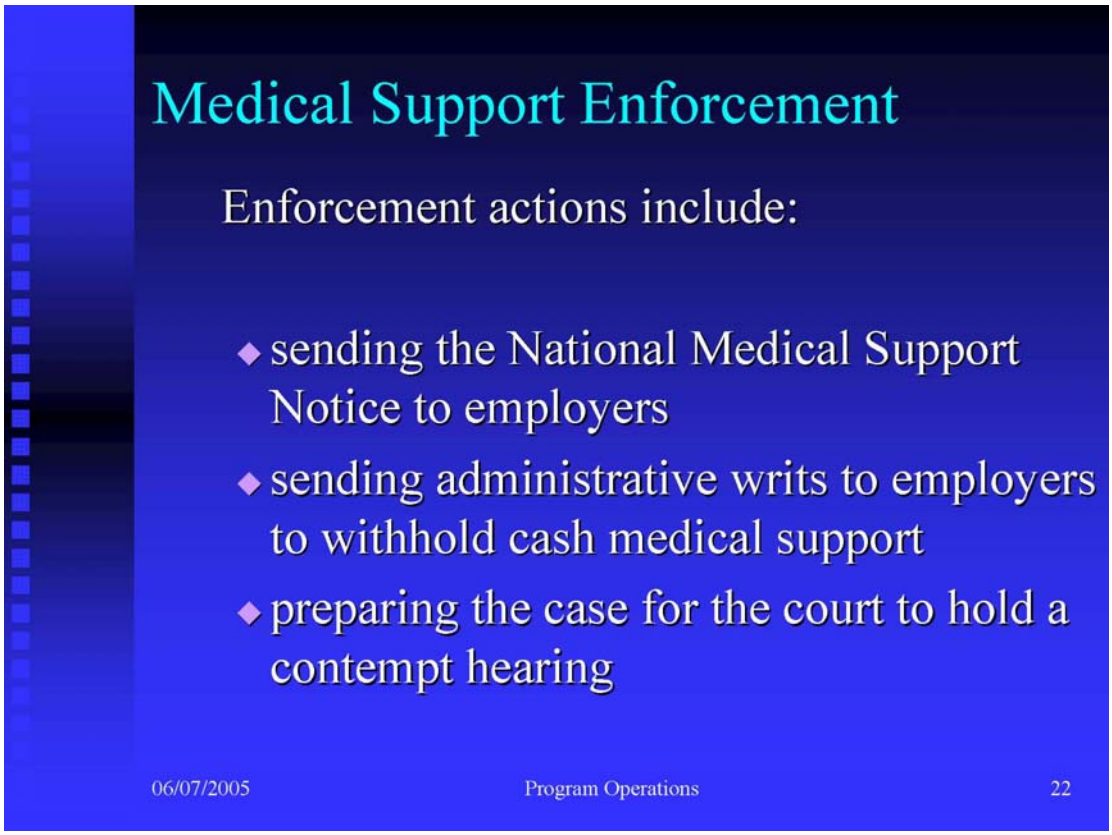
Medical Support Enforcement
Enforcement actions include:
sending the National Medical Support Notice to employers
sending administrative writs to employers to withhold cash medical support
preparing the case for the court to hold a contempt hearing
06/07/2005
Program Operations
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The National Medical Support Notice

- Federal law requires the National Medical Notice to be used by all state child support agencies to enforce health care coverage provisions of court orders against non-custodial parents.
- In Texas, the notice is issued by the OAG within two days of the confirmation of a new employer for a non-custodial parent.

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The National Medical Support Notice

- The notice is, by law, a Qualified Medical Child Support Order (QMCSO).
- In Texas, the notice consists of six parts:
  - Cover letter
  - QMCSO
  - Employer Response
  - Notice to Plan Administrator
  - Plan Administrator Response
  - Health insurance information forms

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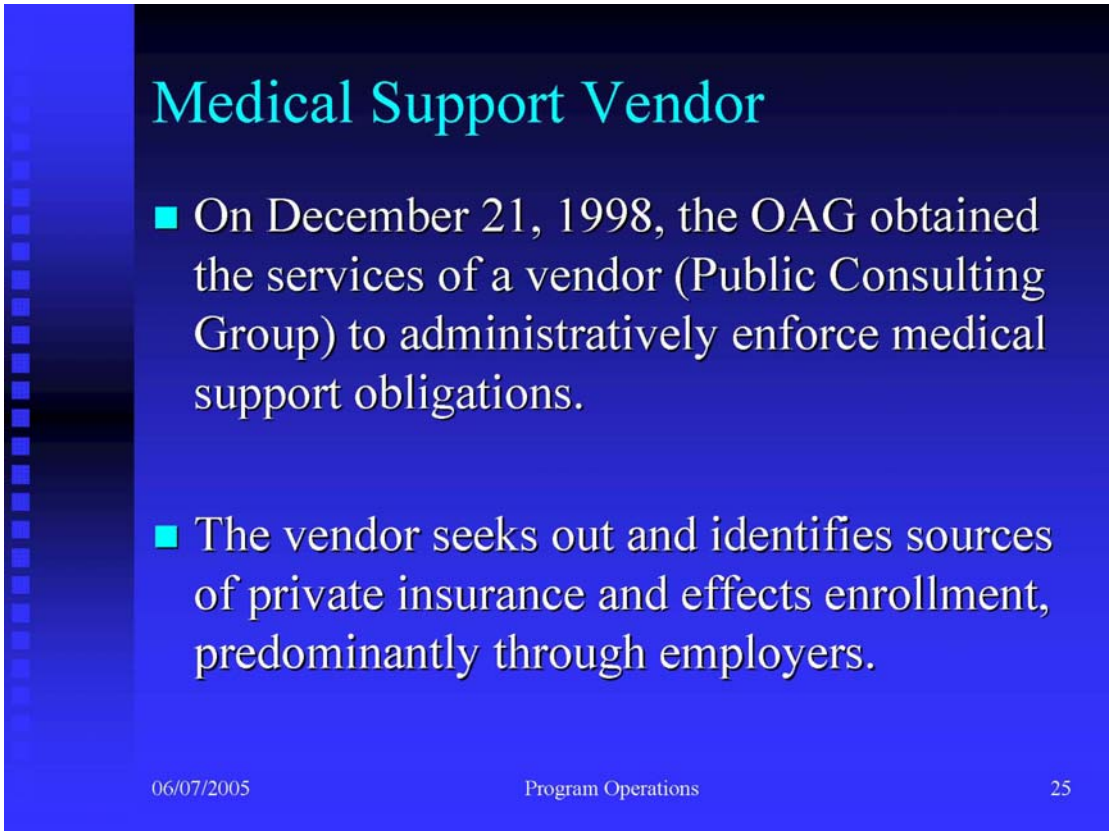
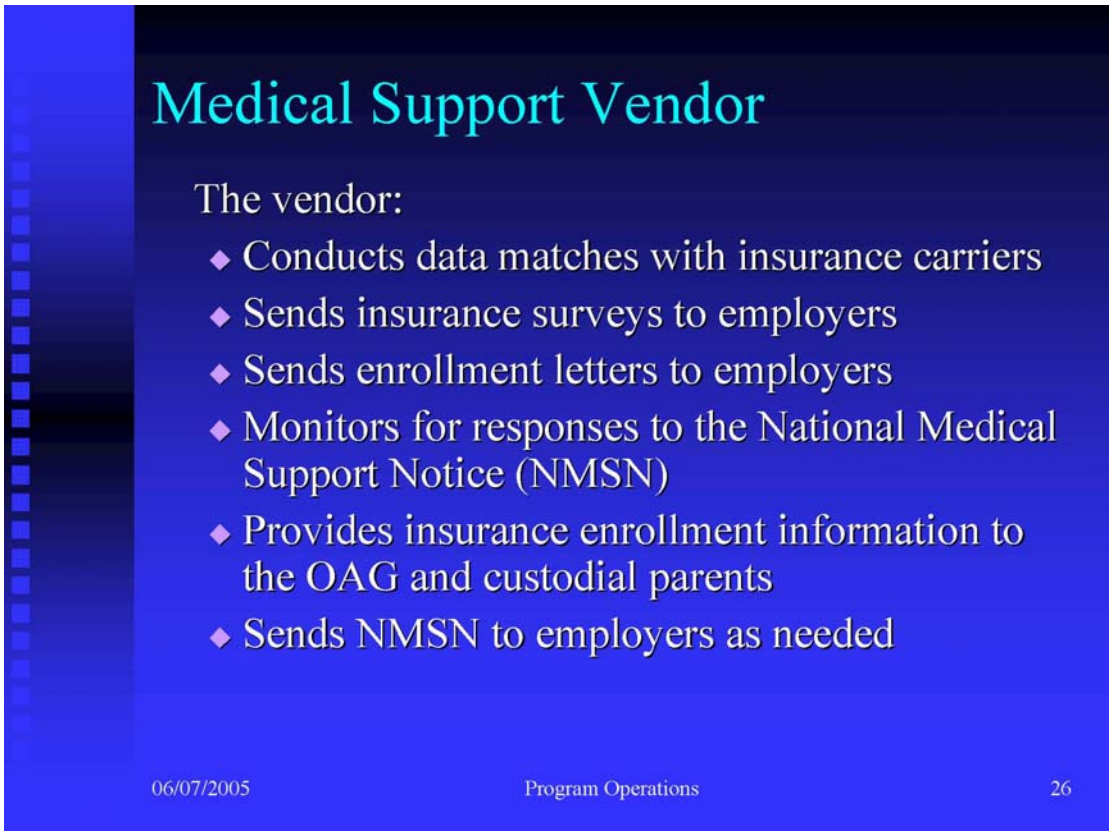
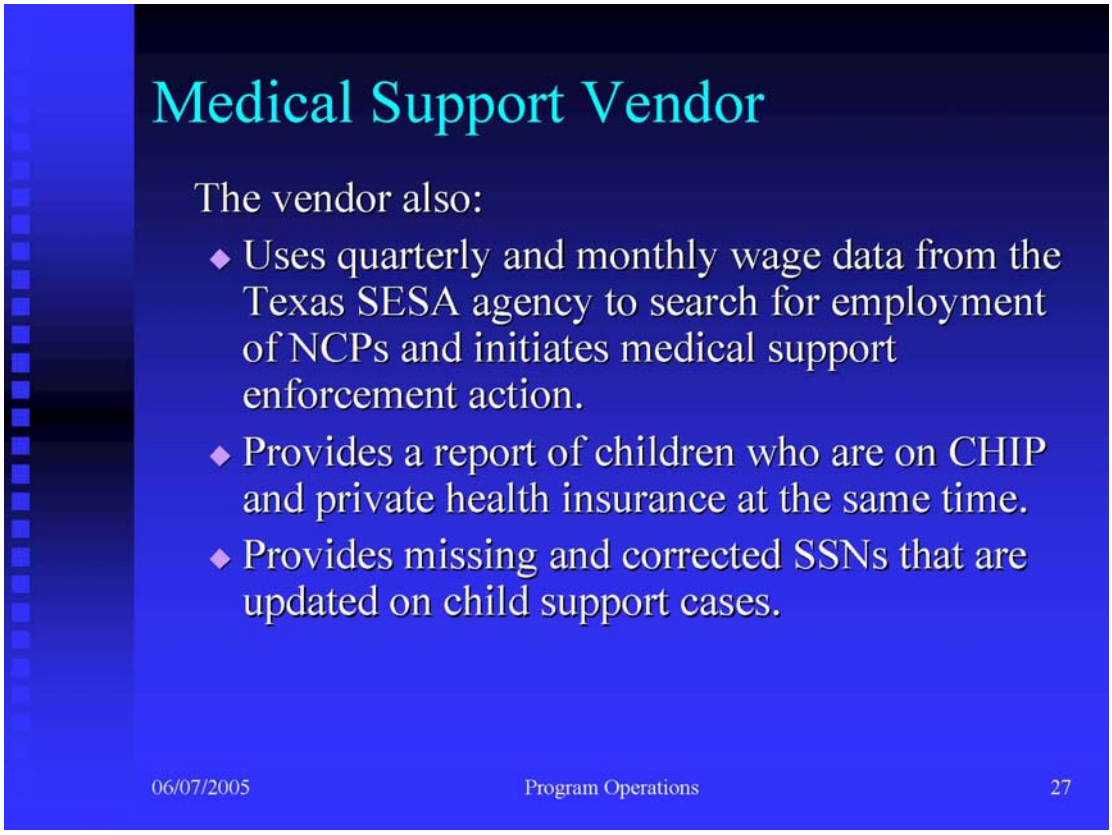

Medical Support Vendor
On December 21, 1998, the OAG obtained the services of a vendor (Public Consulting Group) to administratively enforce medical support obligations.
The vendor seeks out and identifies sources of private insurance and effects enrollment, predominantly through employers.
06/07/2005
Program Operations
25


Medical Support Vendor
The vendor:
Conducts data matches with insurance carriers
Sends insurance surveys to employers
Sends enrollment letters to employers
Monitors for responses to the National Medical Support Notice (NMSN)
Provides insurance enrollment information to the OAG and custodial parents
Sends NMSN to employers as needed
06/07/2005
Program Operations
26


Medical Support Vendor
The vendor also:
Uses quarterly and monthly wage data from the Texas SESA agency to search for employment of NCPs and initiates medical support enforcement action.
Provides a report of children who are on CHIP and private health insurance at the same time.
Provides missing and corrected SSNs that are updated on child support cases.
06/07/2005
Program Operations
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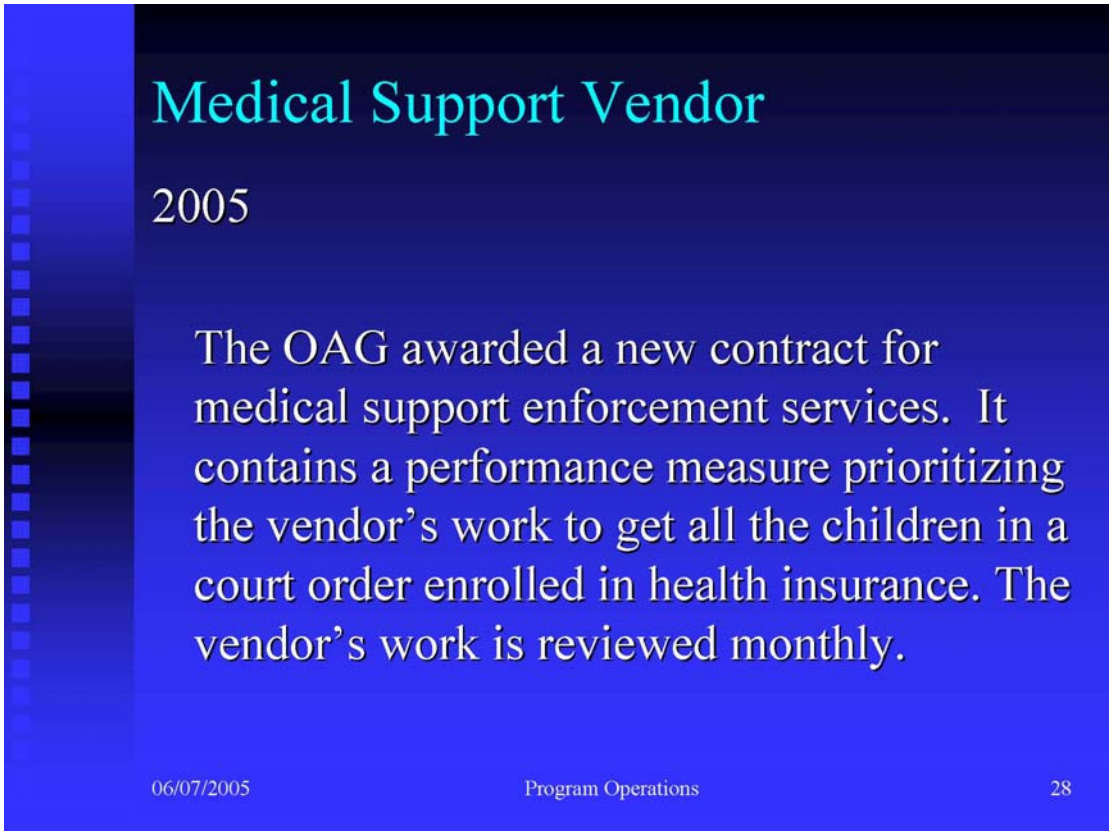
Medical Support Vendor
2005
The OAG awarded a new contract for medical support enforcement services. It contains a performance measure prioritizing the vendor's work to get all the children in a court order enrolled in health insurance. The vendor's work is reviewed monthly.
06/07/2005
Program Operations
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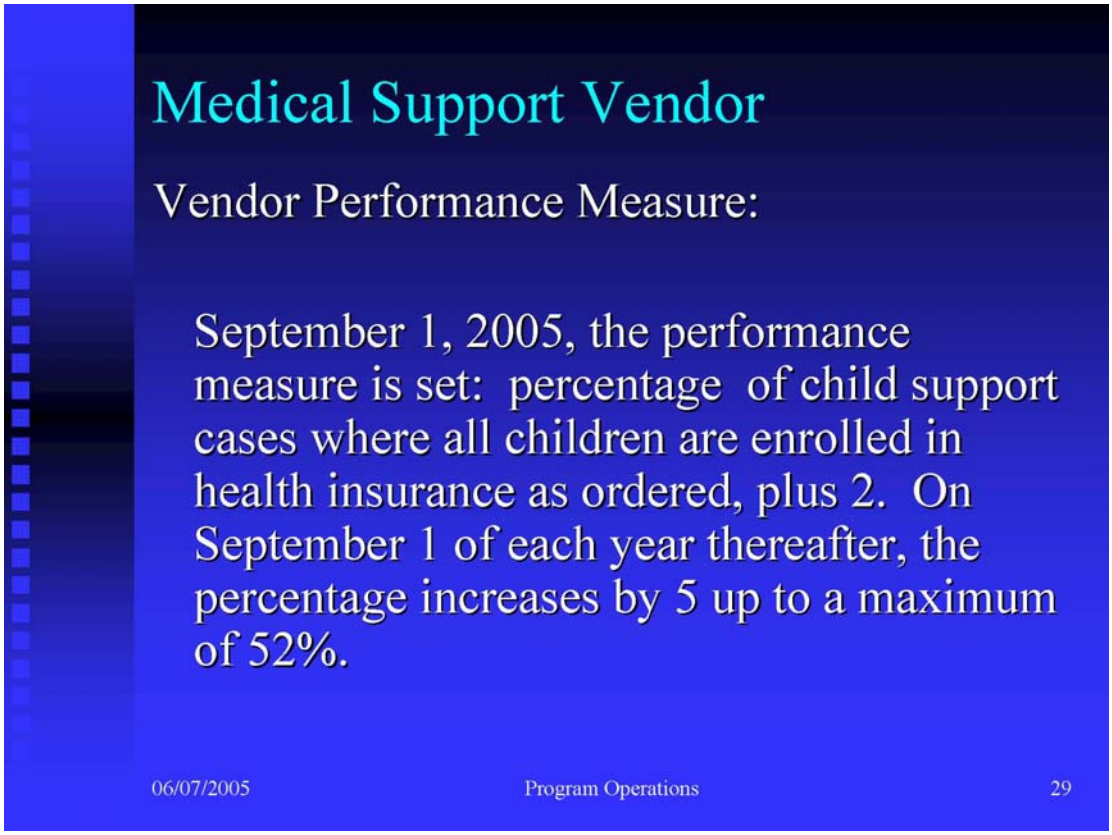
Medical Support Vendor
Vendor Performance Measure:
September 1, 2005, the performance measure is set: percentage of child support cases where all children are enrolled in health insurance as ordered, plus 2. On September 1 of each year thereafter, the percentage increases by 5 up to a maximum of 52%.
06/07/2005
Program Operations
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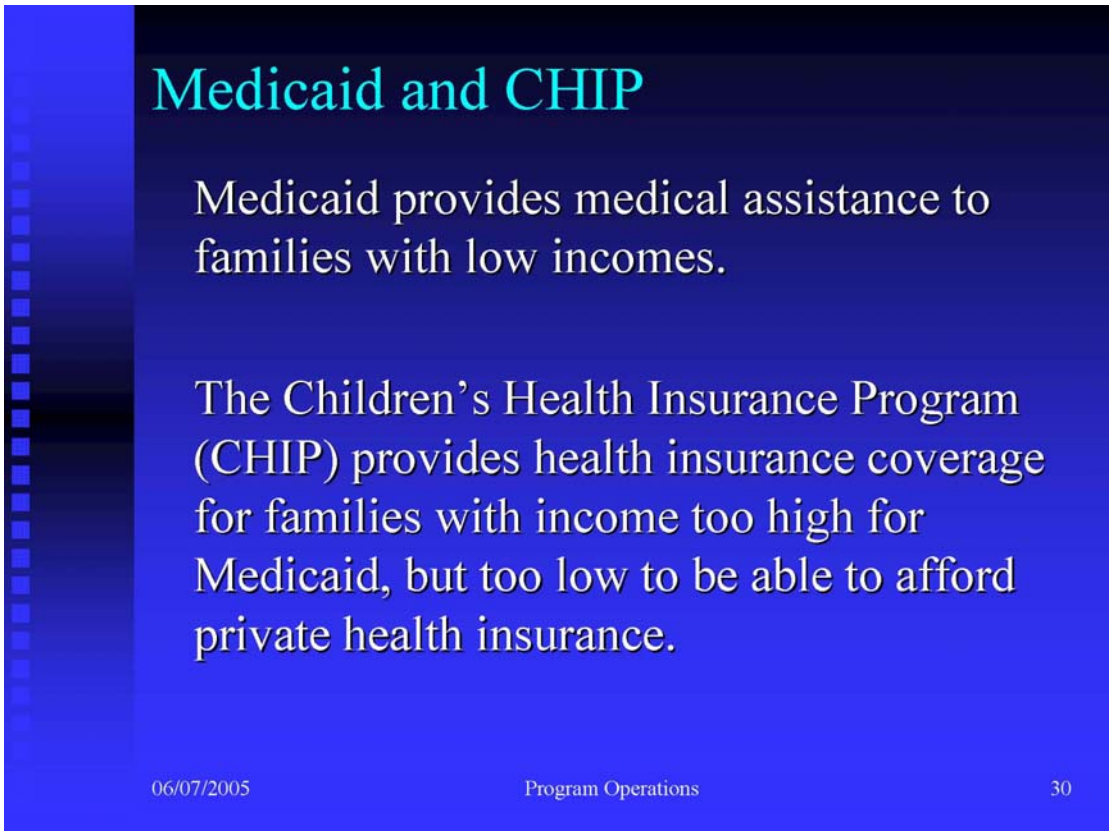
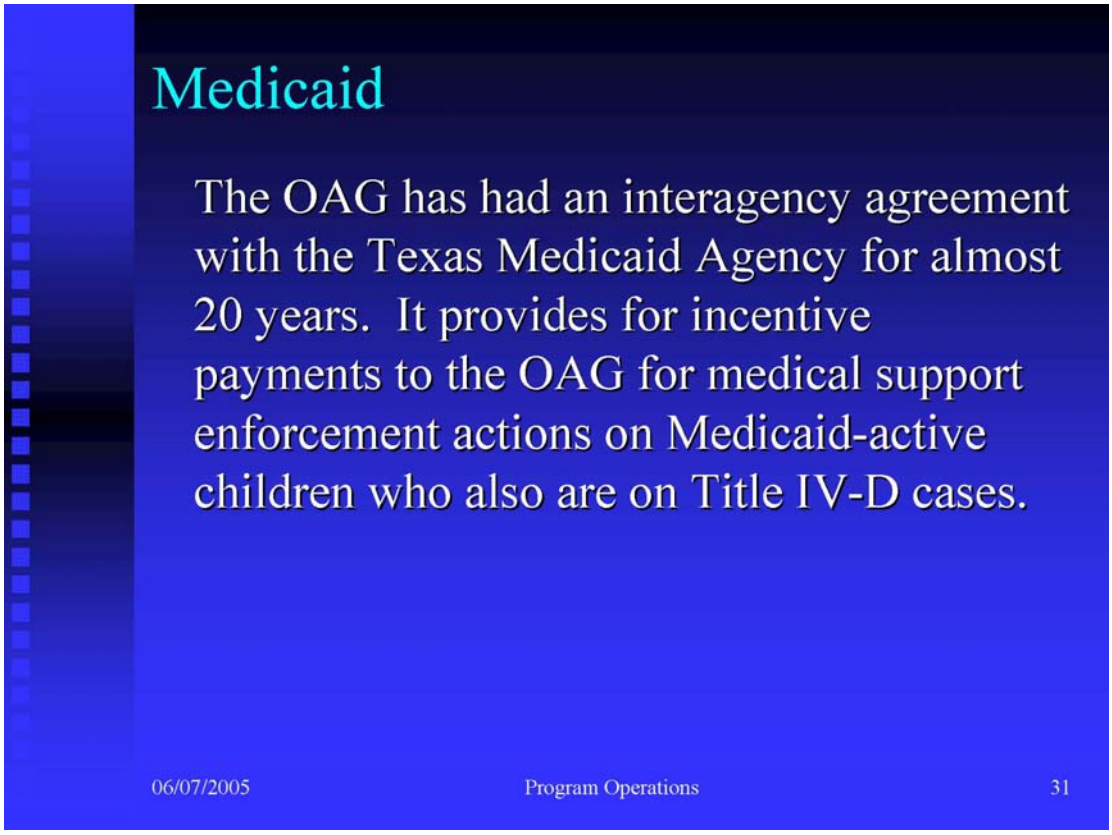

Medicaid and CHIP
Medicaid provides medical assistance to families with low incomes.
The Children's Health Insurance Program (CHIP) provides health insurance coverage for families with income too high for Medicaid, but too low to be able to afford private health insurance.
06/07/2005
Program Operations
30


Medicaid
The OAG has had an interagency agreement with the Texas Medicaid Agency for almost 20 years. It provides for incentive payments to the OAG for medical support enforcement actions on Medicaid-active children who also are on Title IV-D cases.
06/07/2005
Program Operations
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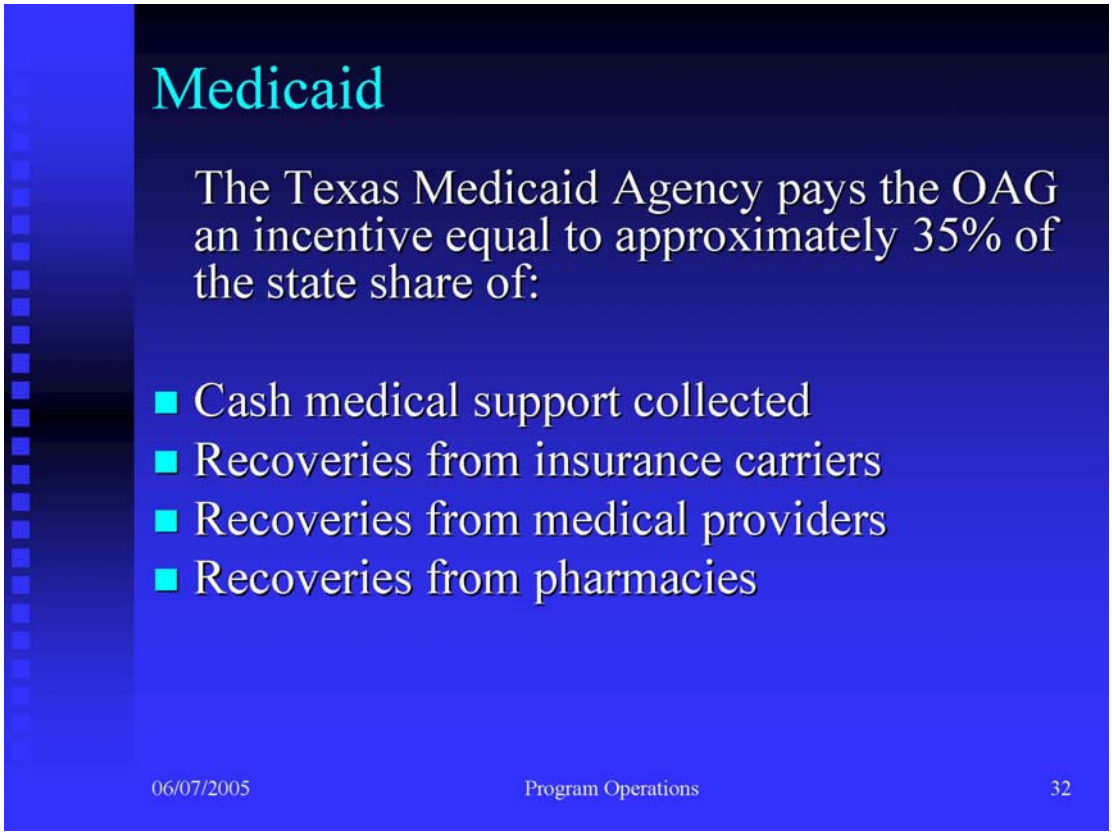
Medicaid
The Texas Medicaid Agency pays the OAG an incentive equal to approximately 35% of the state share of:
Cash medical support collected
Recoveries from insurance carriers
Recoveries from medical providers
Recoveries from pharmacies
06/07/2005
Program Operations
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CHIP
The TexCare Partnership conducts outreach for Medicaid and CHIP, and makes eligibility determinations for those programs. (www.texcarepartnership.com)
The OAG refers approximately 1,200 parents to the TexCare Partnership each month, and assists in outreach activities for CHIP.
06/07/2005
Program Operations
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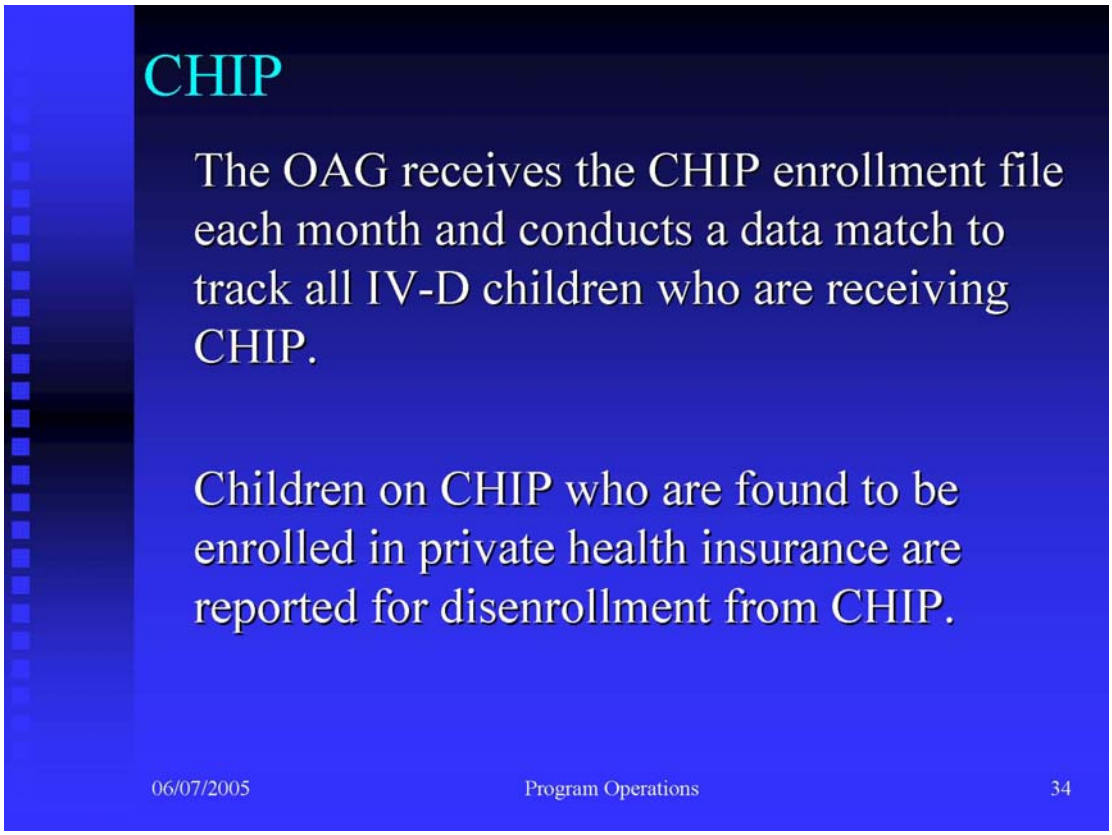
CHIP
The OAG receives the CHIP enrollment file each month and conducts a data match to track all IV-D children who are receiving CHIP.
Children on CHIP who are found to be enrolled in private health insurance are reported for disenrollment from CHIP.
06/07/2005
Program Operations
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CHIP

The OAG provides information about CHIP to custodial parents in various documents that are sent to them, such as court hearing notifications and information gathering forms.

When establishing orders in court, if insurance is not available to either party, the custodial parent calls the TexCare-Partnership from the courtroom to see if the children are eligible for Medicaid or CHIP.

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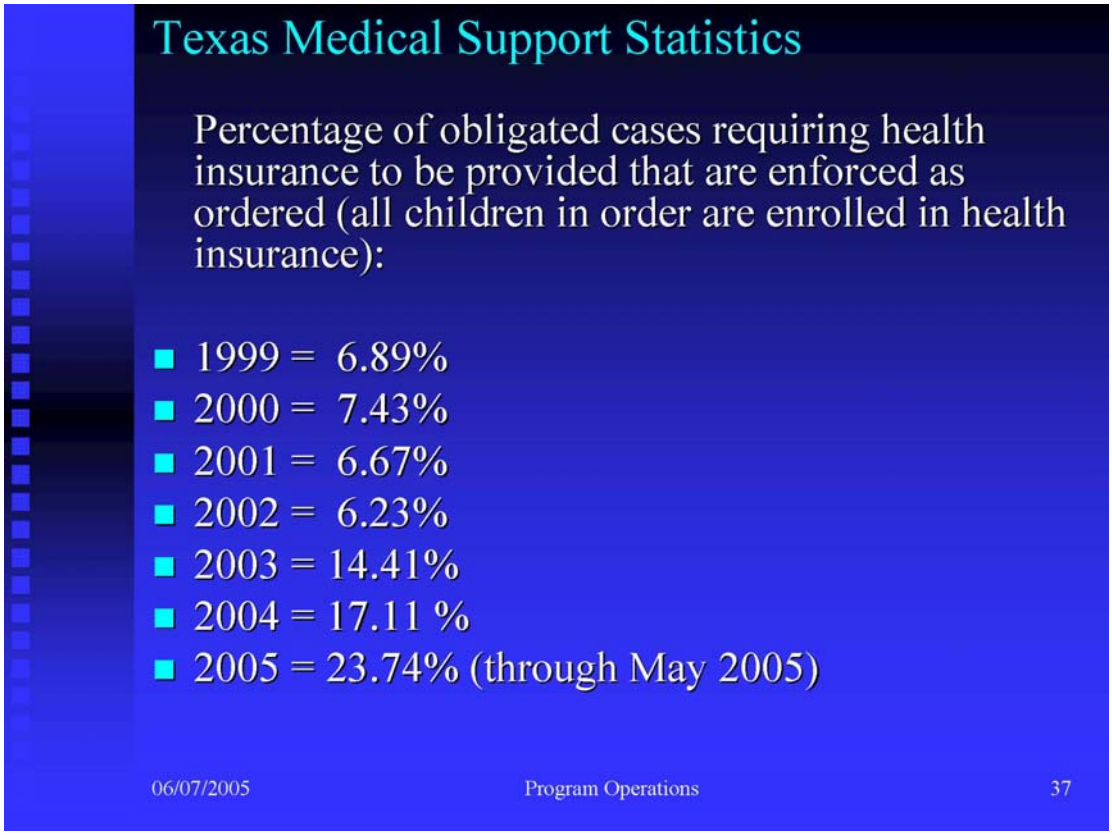
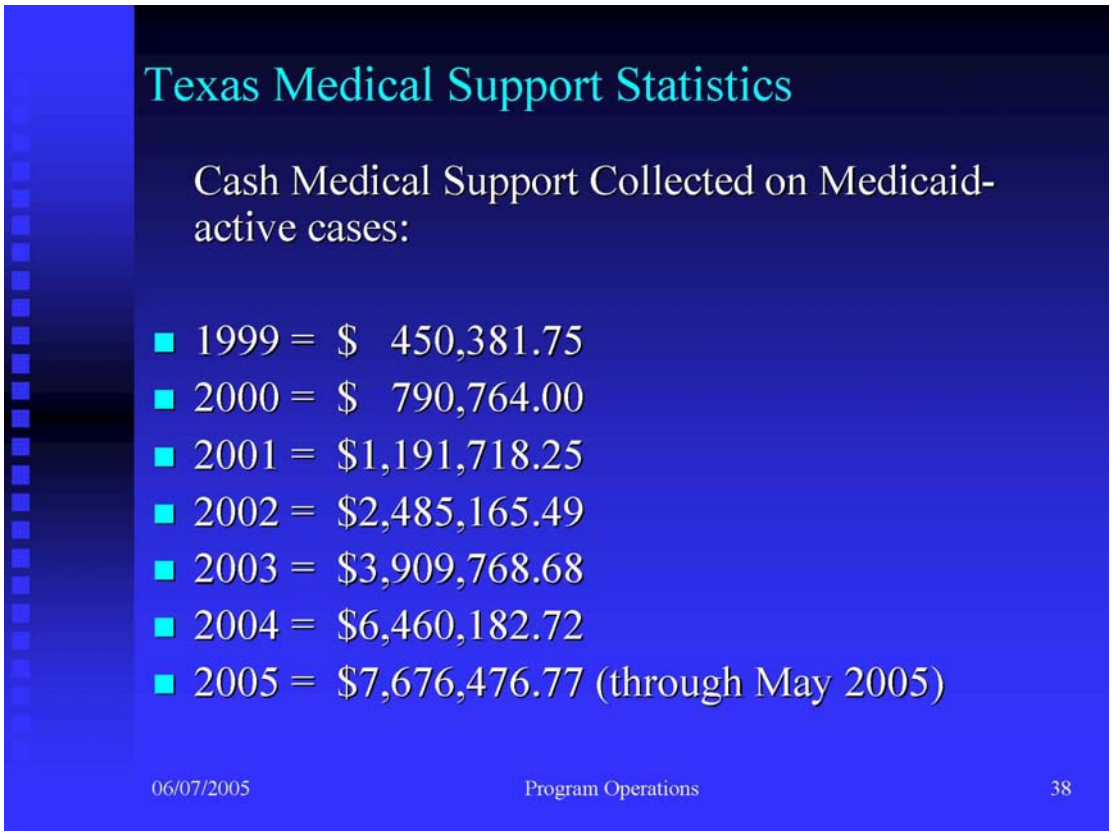
Texas Medical Support Statistics

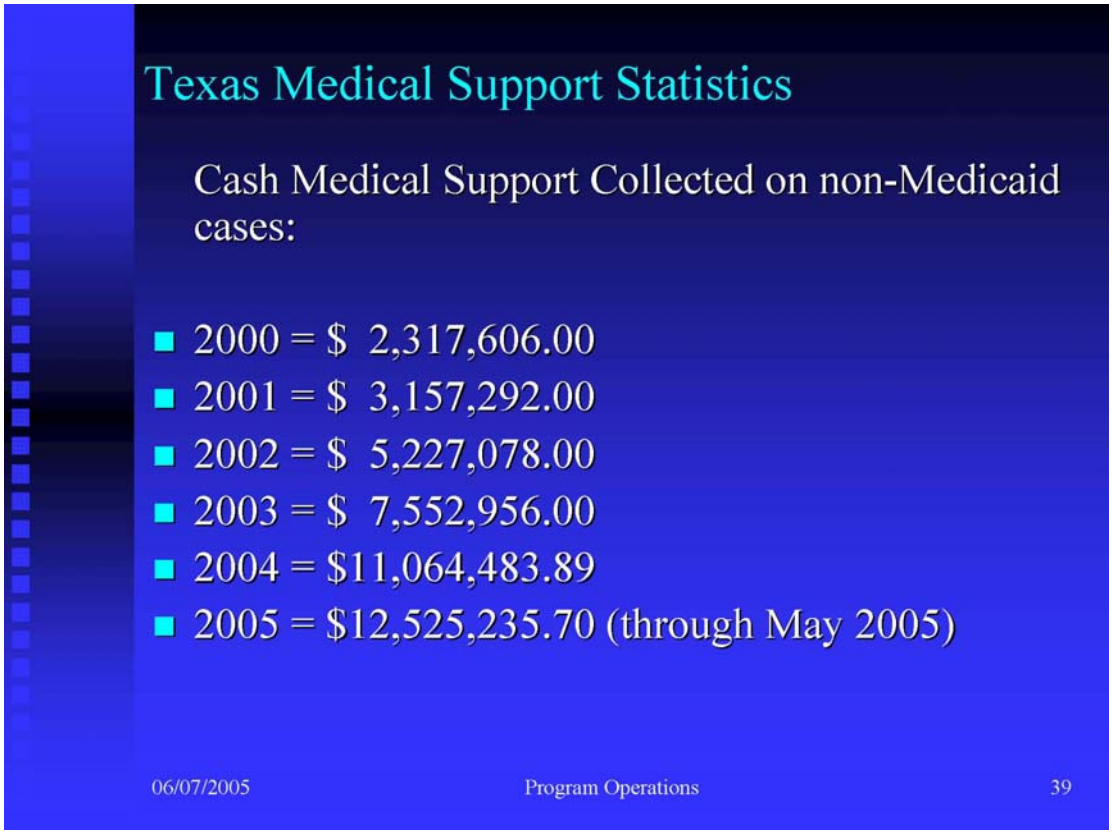
Through May 2005, the OAG caseload contained 1,021,467 children, of whom:

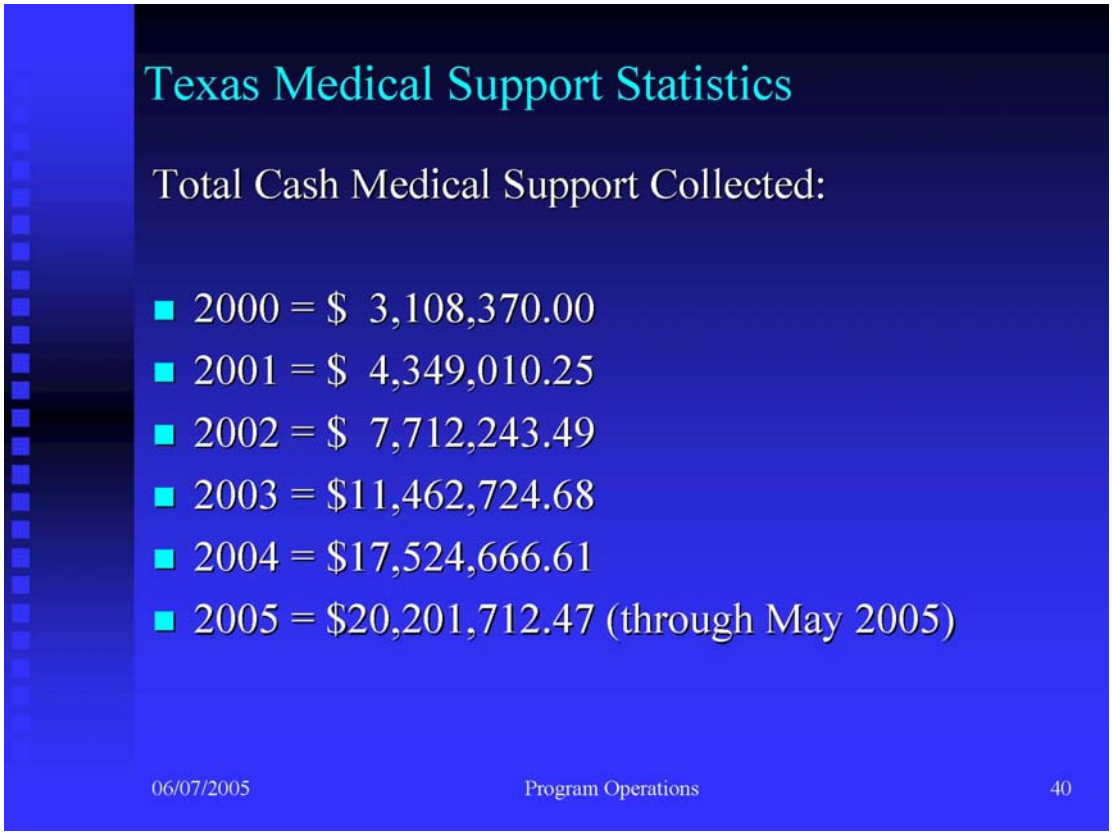
- 222,337 were enrolled in private health insurance (133,558 of these children were Medicaid-active)
- 83,573 were enrolled in CHIP
- 389,790 were receiving Medicaid

06/07/2005 Program Operations 36


Texas Medical Support Statistics
Percentage of obligated cases requiring health insurance to be provided that are enforced as ordered (all children in order are enrolled in health insurance):
1999 = 6.89%
2000 = 7.43%
2001 = 6.67%
2002 = 6.23%
2003 = 14.41%
2004 = 17.11 %
2005 = 23.74% (through May 2005)
06/07/2005
Program Operations
37


Texas Medical Support Statistics
Cash Medical Support Collected on Medicaid-active cases:
1999 = $ 450,381.75
2000 = $ 790,764.00
2001 = $1,191,718.25
2002 = $2,485,165.49
2003 = $3,909,768.68
2004 = $6,460,182.72
2005 = $7,676,476.77 (through May 2005)
06/07/2005
Program Operations
38


Texas Medical Support Statistics
Cash Medical Support Collected on non-Medicaid cases:
2000 = $ 2,317,606.00
2001 = $ 3,157,292.00
2002 = $ 5,227,078.00
2003 = $ 7,552,956.00
2004 = $11,064,483.89
2005 = $12,525,235.70 (through May 2005)
06/07/2005
Program Operations
39


Texas Medical Support Statistics
Total Cash Medical Support Collected:
2000 = $ 3,108,370.00
2001 = $ 4,349,010.25
2002 = $ 7,712,243.49
2003 = $11,462,724.68
2004 = $17,524,666.61
2005 = $20,201,712.47 (through May 2005)
06/07/2005
Program Operations
40

Texas Medical Support Statistics

Medicaid recoveries from insurance carriers and medical providers (* = does not include pharmacy):

- 1996 = $1,595,000.42
- 1997 = $2,157,547.12
- 1998* = $1,454,283.24
- 1999* = $3,427,258.21
- 2000 = $4,072,069.07
- 2001 = $6,412,358.23
- 2002 = $8,459,722.35
- 2003 = $8,564,767.00
- 2004 = $8,943,481.29
- 2005 = $8,684,147.32 (through April 2005)

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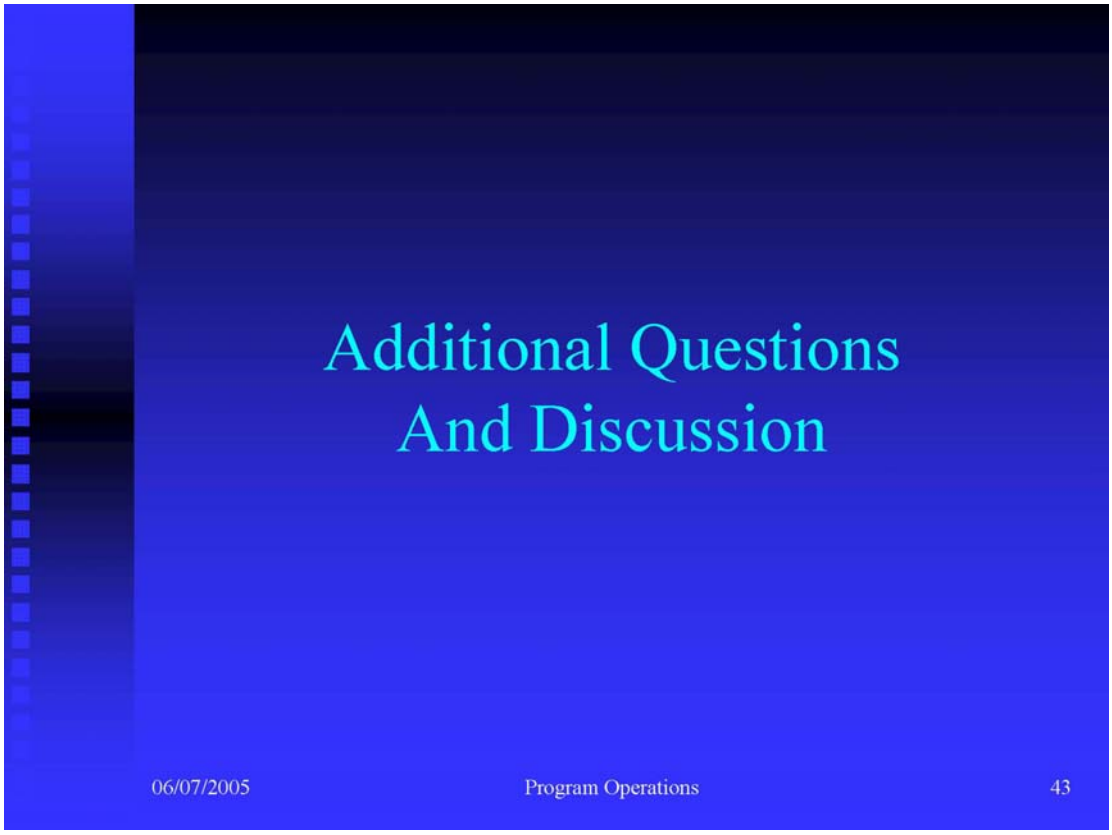
Texas Medical Support Statistics

Texas began issuing the National Medical Support Notice on July 1, 2003. The number of notices issued averages 20,827 per month.

- 2003 = 60,370
- 2004 = 284,182
- 2005 = 189,068 (through May 2005)

06/07/2005 Program Operations 42


Additional Questions
And Discussion
06/07/2005
Program Operations
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Appendix E: State Plans for Follow-Up

At each of the conferences, there were breakout sessions at which the representatives of each state met together. Described as an opportunity to develop ideas into plans to take back to the states, each state was asked to identify goals and possible strategies, with indicators or measures; list required action steps; and discuss resource needs. Each group chose a discussion leader, recorder and reporter. After the sessions, the reporter presented the state plan to the entire conference. Each state's plan is summarized below.

ALABAMA

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Children will be insured and as a result healthier
- ✓ Children miss fewer days of school and parents miss less work
- ✓ Prevention aspect
- ✓ Savings in public expenditures

Issues or Barriers to Program Collaboration

- ✓ Different language
- ✓ Varying systems, no interface
- ✓ Varying funding
- ✓ Varying eligibility criteria
- ✓ Difference in program philosophy
- ✓ Mental health issues
- ✓ Infrequency of communication
- ✓ Education staff (changing mindset) including employee training
- ✓ Difficult insurance market in Alabama

Strategies to Overcome Barriers

- ✓ Education and training, all levels
- ✓ Common goals
- ✓ Need to improve inter-agency as well as intra-agency
- ✓ Inter-agency meeting, brief on regular basis

Goals

- ✓ Develop a plan to
  - Share the vision
  - Ensure all children have access to health coverage
- ✓ Develop workgroup to determine where programs intersect

Next Steps

- ✓ Come up with a strategy
  - Training
  - Information sharing
  - Forum for information sharing
- ✓ Look at electronic information
- ✓ We may need a meeting among ourselves including system staff
- ✓ PDSA – plan, do, study, act – include front line workers

ALASKA

Goal #1

Locate to establish paternity and support orders with medical provisions through an interface measured by:

- ✓ Increase in number of identified fathers.
- ✓ Increase in number of family placements.
- ✓ The number of requests to locate made by child welfare.
- ✓ Percentage of fathers found.

Action Steps

- ✓ Director Approval.
- ✓ Determine what enhancements to the system are needed & what resources are necessary to implement.
- ✓ Train personnel.
- ✓ Policy and procedures changes.
- ✓ Review statutes and administrative code.

Resource Issues

- ✓ Should we use our own systems staff or contract out?
- ✓ Number of staff needed to test the system.
- ✓ Set up and delivery of training.

Goal #2

- ✓ Enhance employers' database to include an indicator of employer-provided insurance (to include carrier name) and provide for periodic review.
- ✓ Measured by decrease in number of employer complaints.

Action Steps

- ✓ Same as for Goal #1 above.
- ✓ Also look at possible coordination with the Department of Labor.

Resources

- ✓ Use of system staff time.

ARIZONA

Goal #1

Enhance and improve data interfacing.

- ✓ Determine what a "quality" case referral is – criteria.
- ✓ Eliminate conflicting (internal) policies to improve/align work between agencies.
- ✓ Support sister agency's objectives
- ✓ Enhance/improve interfacing data between agencies

Goal #2

Establish workgroups to strategize on meeting stated goals.

- ✓ Evaluate policies, statutes, and rules.
- ✓ Obtain support from management.
- ✓ Explore how sister agencies can work together to:
  - Keep kids out of foster care
  - Facilitate child medical and cash support

Goal #3

Estimate staffing requirements within workgroup(s).

- ✓ Identify funding for enhanced interface development.
- ✓ Involve agencies' financial and other staff for collection of data & cost/benefit analysis.
- ✓ Take proposals to management.

ARKANSAS

Goals

- ✓ Create a Collaboration Task Force from all four agencies to look at computer systems – need IV-A, IV-E, IV-D, Medicaid and Medicaid eligibility and chief counsel at the table. Need information technology people at the table, too. Child support agreed to take lead on putting together this task force.
- ✓ Explore sharing information from employment security with child welfare regarding parental income and employment. Child welfare wants to know if parent is employed so we don't pay daycare.

- ✓ Engage Department of Health and Human Services if IV-D, IV-E can access their data on birth certificates, death certificates, etc.

Impediments – Systems Communication

- ✓ Computer systems don't communicate IV-E to IV-D.
- ✓ Right now, IV-E has to key data manually into IV-A system to communicate via computer with IV-D system.
- ✓ IV-D communicates medical coverage to IV-A, but not back to IV-E.
- ✓ Question is whether to bill private medical insurance company first before we provide bills to Medicaid or should the third party liability unit retro bill private insurance. Given the high caseload of child welfare workers, it will cause considerable stress if a worker has to know a foster child has private insurance and who is the PCP, etc.
- ✓ Need unique identifier for all systems (IV-E, IV-A, IV-D) so agencies can be assured they are talking about the same child.

CALIFORNIA

Goal #1

- ✓ Improve/increase cross-program communication

Strategies

- ✓ Establish regular meetings between state SCHIP, Medicaid, Child Support and Child Welfare managers.

Action Steps

- ✓ State representatives here today from those agencies meet and detail meeting purpose/objectives.
- ✓ Talk to directors to get buy-in.
- ✓ Determine who should be in the group.
- ✓ Set meetings – establish dedicated facilitator.
- ✓ Develop and discuss common legislative priorities and activities
- ✓ Meet jointly with common advocacy groups.

Resource Needs

- ✓ Time
- ✓ Commitment

Goal #2

- ✓ Educate each other and our clients and communities about all the different medical/health care programs and expand distribution sites for applications.

Strategies/Action Steps

- ✓ Determine printing needs and costs/resources.
- ✓ Ensure this is on website.
- ✓ Train local county staff on application process and plan benefits.
- ✓ Target training for SCHIP program to child welfare for FM/VFM families.
- ✓ Continue meds match with child support population.
- ✓ Increase understanding of medical support measures and indicators with key stakeholders (judges/court).

Resource Issues

- ✓ Printing costs and resources
- ✓ IT resources

Goal #3

- ✓ Continue research and data collection on our common clients/populations.

Strategies/Action Steps

- ✓ Ensure use of parent locator system by child welfare.
- ✓ Explore date match between CWS/CMS and health and child support system.
- ✓ Explore ability to determine the number of child welfare cases where there is absent/unknown parent through CWS/CMS.
- ✓ Continue existing matches to inform status/progress.

Resource Issues

- ✓ IT
- ✓ Quality data

COLORADO

Goals

- ✓ Improve the self-sufficiency of families
- ✓ Improve the well-being of children
- ✓ All children have paternity established
- ✓ All children have medical and financial support

Strategies

- ✓ Improve Collaboration
  - Access for child welfare to CSE locate databases
  - Paternity establishment
  - Get memorandum of understanding with Medicaid
  - Increase the number of children with health care coverage

Action Steps

- ✓ Develop procedures for child welfare to access FPLS
- ✓ Improve the interface between Trails and ACSES.
- ✓ Develop a checklist/screen on Trails for referral to ACSES. Include medical if known.
- ✓ Training.
- ✓ Formula for cost avoidance regarding Medicaid.
- ✓ Improve interface with SCHIP. Child welfare will develop screen with referral info to link with child support.

CONNECTICUT

Goals & Strategies

- ✓ Improve communication between HUSKY (A&B) and child support to increase health care coverage for children, either through private coverage or cash to cover HUSKY premiums through continuation of child support/HUSKY work group to improve data gathering by eligibility through:
  - Revision of 348 (used to gather demographics regarding NCP and dependents).
  - Revision of cover sheet for information gathering for “mail in” HUSKY clients.
  - Revision of HUSKY application to gather appropriate NCP data to pursue child and medical support, and enter accurate paternity relationships.
  - Share best practices between regional offices.
  - Conduct joint eligibility and child support forums to share understanding of requirements by each program.
  - Revise noncustodial party screens on EMS (eligibility automated system) to improve and make data entry easier and more streamlined for staff.
- ✓ Establish process for using FPLS to locate NCPs to assist in potential foster care placement.
  - Analyze process for gathering NCP data by DCF for IV-E cases.
  - DCF to contact New Hampshire for information on use of fiscal specialists at court to gather information.

- Child support to share recent memo that narrowed the required child support data elements to essential/critical ones with DCF.
- Refine data gathering process, using revised 348 if appropriate.
- Establish procedure for referrals to child support and return of information to DCF.
- Long term - establish direct interface between child support automated system, and new IV-E automated system.

✓ Analyze/improve data match between child support and private insurance companies
- Determine cost benefits of match for CT. How does the match/obtaining of private insurance by NCPs impact the cost of CT managed care? What is the assumed percentage of child support cases/dependents with private insurance – how many dependents?
- Obtain additional cost and contract information on the options available: use of current vendor versus the child support consortium.
- What are requirements of SCHIP regarding private insurance? Is the "no private insurance" a federal or state mandate? Could private insurance be used as a wrap-around to reduce costs – state statutory change?
- Increase accuracy of financial information for DCF claim
- Short term to increase accuracy of DCF claim will need a manual matching by child support of each case to determine if IV-E or not IV-E.
- Mid-range: Use child support automated system and disks provided by DCF, or information in EMS to update data quarterly
- Long term: Establish direct interface between child support automated system, and new IV-E automated system

DELAWARE

Goals & Strategies

✓ Establish meetings to learn about and discuss the common goals of the Division of Child Support Enforcement, Division of Family Services, and the Division of Medicaid and Medical Assistance, and include the Regional Offices. DCSE will initiate the meetings.

✓ Explore partnering opportunities between Medicaid and DCSE in regard to Medicaid's TPL administrative contract with Health Management Services to collect and verify TPL information.

✓ Explore systems improvements across the three divisions to improve information sharing which would be of mutual benefit to each agency.

✓ Open dialogue with the Department of Technology and Information to explore opportunities to coordinate interactions and collaborations across agency information systems.

- ✓ Consider setting one or two main goals that can realistically be achieved in an environment of restrictive financial and manpower resources. Example.: Propose withholding support to a mother who does not cooperate with DCSE following her TANF case referral from the Division of Social Services
- ✓ Investigate the entire process of interfacing between child support and Medicaid in order to establish an information flow so the DCSE will have adequate data to meet the new Medical support incentives.
- ✓ Explore and make recommendation to change the referral process from IV-E to both child support and Medicaid to ensure that only appropriate referrals are made.
- ✓ Explore feasibility of child welfare staff's direct access to the Federal Parent Locator Service (FPLS) to enhance the ability to locate noncustodial parties or relatives and aid the agency in providing safety, permanence and well-being of children.

DISTRICT OF COLUMBIA

Goals & Strategies

- ✓ Establish court orders for reimbursement of Medicaid.
- ✓ Notify the Medicaid office of the establishment of all new court orders for Medicaid reimbursement.
- ✓ Notify the Medicaid office when the dependent(s) who is receiving Medicaid has been added to the noncustodial partie's health insurance plan or to an alternative plan so that the Medicaid office can make the private insurance primary and Medicaid secondary.
- ✓ Complete statistical report indicating the number of children under court order who are receiving Medicaid and the cost spent for medical services.
- ✓ Work with the Intake and Establishment Units to increase the number of active IV-E cases with regard to Medicaid.
- ✓ Establish meetings with the Medicaid office to discuss our goals and means of case processing.
- ✓ Work with the IT staff to enhance our data processing system so that upon receipt of the Medicaid termination notification, the system will automatically close the Medicaid Current Obligation and set up a Non-TANF Medical Obligation.
- ✓ Set up outreach meetings in an effort to inform employers of their responsibilities regarding the processing of the medical support court orders.
- ✓ Develop training so that each staff member understands the mission and goals of the Medical Support Unit.
- ✓ Comply with ultimate goal that each child in a court order be covered under a health insurance plan of some type.

FLORIDA

Goals

- ✓ More children covered.
- ✓ More parental responsibility.
- ✓ Identify and locate parents and relative potential parents.
- ✓ Increased communication.
- ✓ Establish cross training.
- ✓ Educate communities about medical programs.

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Child Welfare
  - Expedite permanency
  - Decrease in foster care payments
- ✓ SCHIP
  - Provide income to allow custodial parent to purchase insurance
  - Order NCP to obtain coverage
- ✓ Medicaid
  - More children insured
- ✓ Child Support
  - More children covered
  - Information on child's coverage
  - May increase Federal incentive payments

Issues or Barriers to Program Collaboration

- ✓ Don't know enough about program or staff
- ✓ Don't know how many other entities may need to be included
- ✓ Three different agencies, sometimes with different goals
- ✓ Reasonable cost at Federal level
- ✓ Pre-paid mental health from HMO
- ✓ Lack of automation in the agencies
- ✓ Lack of interface where automation does exist
- ✓ Outsourced activities; assist with eligibility for HealthyKids
- ✓ Funding for outsourced entities
- ✓ Assurance that outsourced entities are authorized to receive information and the safeguards they have to protect information
- ✓ Time and staff constraints
- ✓ Unique requirements

- ✓ Lack of cross training between agencies; why it is important to each entity and in judiciary

Strategies to Overcome Barriers

- ✓ Establish interagency meetings/teams.
- ✓ Explore avenues for automation to share information.
- ✓ Map out process in all agencies.
- ✓ Cross training at state program and local level.
- ✓ Standardize forms.
- ✓ Establish referral criteria.
- ✓ Public awareness campaign with SCHIP and Medicaid recipients to overcome the perception that CSE may be a barrier to receiving SCHIP and Medicaid.

Next Steps

- ✓ Establish quarterly meetings with agency; start with Foster Care in late September; identify other entities and agencies.
- ✓ Implement legislation to allow data exchange with SCHIP.

GEORGIA

Goals

- ✓ Medical coverage for all children in Georgia.
- ✓ New and better lines of communication.
- ✓ Continued collaboration and expand it with those who can make decisions; Make sure it filters down.
- ✓ Look at each other as a partner, not a liability.

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Medicaid and SCHIP, contract with private vendor to send National Medical Support Notice.
- ✓ 1115 grant viability; volume purchasing program.
- ✓ More children covered by health care.
- ✓ Elimination of duplication of error.
- ✓ Cost savings, cost avoidance, cost sharing.
- ✓ OCSE has locate resources for Child Welfare.
- ✓ Either absent parent or putative relatives and families who abscond.
- ✓ Consistency of policy and learning each others terminology.

Issues or Barriers to Program Collaboration

- ✓ No common automated system or interfaces between agency; different identification numbers.
- ✓ Organizational structures are different in each agency.
- ✓ Federal and state requirements for each system are different and become a barrier.
- ✓ Culture of organizations, don't talk the same language.
- ✓ Federal requirements regarding funding.

Strategies to Overcome Barriers

- ✓ Georgia is in the process of obtaining a SACWIS; OCSE has an interface going on with Department of Community Health effective November 12; Continued ongoing talks regarding data interfaces.
- ✓ Identify where all pieces fit.
- ✓ Sharing of organizational structures.
- ✓ Identify inconsistencies in federal requirements.
- ✓ Understanding rules of funding source and utilize optimal resources for the project.

Next Steps

- ✓ Follow up meeting to implement strategies.
- ✓ Set some targets to reach.
- ✓ Identify key champions.

GUAM

Goals & Strategies

- ✓ Increase health coverage for children.
- ✓ Share/exchange data between programs.
- ✓ Understand cash programs' operations better.
- ✓ Develop an integrated system.

Action Steps

- ✓ Update MOU and establish standard operating procedures.
- ✓ Communicate regularly; cooperate; conduct meetings via e-mail.
- ✓ Education and training – who needs to do what.
- ✓ Work with partners and stakeholders (i.e., employers, insurance companies).
- ✓ Get support from management.
- ✓ Coordinate with MIS Director and computer analyst to upgrade systems.

Resources

- ✓ Increase funding.
- ✓ Increase staff.
- ✓ Upgrade corporate systems.

HAWAII

Goals

- ✓ Strengthen families by:
  - Locating absent parents/fathers.
  - Obtaining medical support for children.
  - Providing children access to necessary health care.
- ✓ Maximize our state's financial resources.

Overall Strategies

- ✓ Continue our existing cross-system collaboration.
- ✓ Engage other internal and external stakeholders (e.g., staff, the court, county's attorneys, legislators, consumers, health providers, etc.)
- ✓ Obtain information from other states on cash medical support program and evaluate the feasibility for our state.
- ✓ Explore barriers to confidentiality and data sharing.
- ✓ (CW & CS) Implement the Federal Parents Locator Service information to child welfare.

Resources (Wish Lists)

- ✓ Staffing (all levels)
- ✓ Related administrative support (equipments, office space)
- ✓ Enhancing our respective automated systems
- ✓ Funding

IDAHO

Goals

- ✓ Resolve birth costs issues.
- ✓ Reasonable cost.
- ✓ Set standard for appropriate child welfare referrals to child support.
- ✓ All Idaho children have access to health care coverage.

Resources

- ✓ Cross-program collaborative meetings.
- ✓ Federal partners.

- ✓ Enhanced federal match dollars for automated systems interfaces – for example:
  - Interface with insurance companies.
  - Develop employer database.

Strategy

- ✓ All kids covered.
- ✓ Public/private partnerships.
  - Access card.
  - Tax incentives to employers.
  - Eliminate existing barriers to access to existing programs. i.e., CHIP and creditable insurance.
  - Financial responsibility of NCP:
    - According to income.
    - Medicaid expenditures.
  - Policy – Internal [what does this mean??]

ILLINOIS

- ✓ Examine exchange of data (what is already exchanged, what needs to be exchanged).
- ✓ Strengthen collaboration between three units, (parent collaboration).
- ✓ Identify list of players to bring to table (NCP services coordinator, state payment locator service manager; IT people, eligibility group, service intervention).

INDIANA

- ✓ CHIP will look at changing state legislation plan to disallow CHIP choice over private insurance.
- ✓ Review current TPL agreement for possible expansion to all populations.
- ✓ Include standard medical support language in all orders produced by localities throughout the states (do this from top-down).
- ✓ Work on having NCPs paying premiums for CHIP coverage.
- ✓ Look at areas in which we can contract together to see where we may have activities/resources that we don't want to overlap on.
- ✓ Make sure case managers in abuse/neglect system are interacting with eligibility caseworkers in Medicaid system (we don't know if this is currently the case).

IOWA

- ✓ Work on automated data matches with insurance carriers and with each other. Look at how it is being done. Iowa legislation from a year ago says that insurance carriers are to share data with Medicaid. In addition,

legislation from the most recent session included hawk-I, Iowa's SCHIP program, so insurance carriers now must share data with both programs.

- ✓ Issues with administrative rules regarding restrictions to sharing information among one another. Need to research what can be done.
- ✓ Look at child-only Medicaid cases and whether or not they need to be referred. How do they impact the issues? Are there inconsistencies at the federal level across programs? How are directives being given at the federal level and are they consistent?
- ✓ Explore the cash medical support issue: ordering cash benefits and how it relates to all three programs.
- ✓ TPL interface that goes on currently, IV-D info is sometimes old. This is partly because Medicaid likes historical info but IV-D likes new data.
- ✓ Transitional medical assistance: there is no new referral when a child goes from regular Medicaid to transitional Medicaid. Children are referred when they are approved for regular Medicaid. But, there is no effort to "un-refer" them either when they move to transitional Medicaid. Should they really work them? How should IV-D treat them?
- ✓ Discussed who isn't at the table today. Need office of field support (which deals with frontline staff and Medicaid).
- ✓ Inconsistency at the federal level – need to look at whether directives are consistent. Need IV-E to use FPLS in Iowa – currently not happening because of a lack of resources
- ✓ IV-E would like a list of Medicaid providers. However, there are problems with this because it often changes. However, it is a barrier in the IV-E program not to have that information available.
    - o Would like RFPs other states have used.
- ✓ Should TANF be included in the room?
- ✓ Set meeting in July – need to add: Offices of field support, Medicaid, TPL.

KANSAS

- ✓ Many of the same issues as Iowa above.
- ✓ FPLS data: Who can use it? How can we share it? It's a two-way street.
- ✓ Need to identify relevant information for each program and then figure out best process for sharing that information.
- ✓ Medicaid insurance match – want to do it.
- ✓ Cash medical support orders – these are rare. Maybe there should be more.
- ✓ Third party liability information. Medicaid has this information and it could prove useful to child support. How can they get systems to do a data exchange? It could be useful to child support.
- ✓ What do we want to do about people who don't have health insurance?
- ✓ Fatherhood initiatives could be shared. CW and CSE both have programs.
- ✓ Creating protocols for workers in different programs talking to each other.
- ✓ Cash medical support is a good idea. States and families both benefit from cash medical support.

- ✓ Will set up meeting to update Directors not in attendance.

KENTUCKY

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Cost Avoidance.
- ✓ Increased revenue.
- ✓ Permanency
- ✓ Continuity of health care.
- ✓ Improve quality of life and well being.

Existing Collaboration Efforts

- ✓ Child Support and Child Welfare systems interface.
- ✓ Child Support has performance indicators in Child Welfare's PIP (Program Improvement Plan).
- ✓ Work with Medicaid's contractor to locate insurance coverage.
- ✓ Medical Support indicators have been included in the strategic plan.

Issues or Barriers to Program Collaboration

- ✓ Time
- ✓ Communication

Next Steps

- ✓ Do a study to find out how many children would be impacted by cash medical support.
- ✓ Establish mutually agreed upon referral criteria for Medicaid cases.
- ✓ Identify resources to assist in tracking health care being provided to children in out-of-home care.

LOUISIANA

Goals

- ✓ Establish a collaborative work group that would be ongoing.
- ✓ Maximize use of available resources.
- ✓ Share resources where possible (e.g. joint mailings or mail about other programs).
- ✓ Determine key players to participate in collaboration.
- ✓ Involve front-line staff in work groups.
- ✓ Provide for the sharing of medical history and paternity information.

Strategies

- ✓ Apply for grants (private and federal) to enhance collaboration.
- ✓ Work to improve collaboration between agencies.

Action Steps

- ✓ Determine and bring the correct players to the table at a scheduled follow-up meeting.
- ✓ Clearly define how the agencies can work together.
- ✓ Send summary of this meeting to department heads for review and consideration to determine level of departmental support.
- ✓ Involve Louisiana's Children's Cabinet and other stakeholders (juvenile courts, juvenile probations, etc.).

Impediments

- ✓ Limited resources (staff, state dollars).
- ✓ Different perceptions of mission and goals among the different programs.
- ✓ Working with a universe of clients rather than triaging clients/cases for most potential.
- ✓ Data sharing/interface problems with computer systems that were designed independently.
- ✓ Lack of knowledge about the other programs.
- ✓ (Medicaid) DHH in Louisiana is tapped out. They have nothing to give.
- ✓ Federal regulations for programs are contradictory and confusing.

MAINE

Goals & Strategies

- ✓ Develop an Information Technology summit with participation of IT staff and program staff from:
  - Office of Integrated Access and Support (formerly BFI-eligibility and DSER and BMS staff including Third Party Liability staff).
  - Office of Information Technology Staff (formerly BIS handling ACES and NECSES computer systems).
  - Office of Integrated Services (formerly Bureau of Children and Family Services).
  - OIT staff handling the MACWIS system.
- ✓ Schedule a meeting between IV-E and IV-D staff to determine federal reporting requirements and how best to facilitate this by each program
- ✓ Develop Extensible Mark-up Language(XML) so that technology can be used and exchanged more easily for all programs
- ✓ Develop a procedure to obtain property tax transfer information from Maine Revenue Services to assist in location of missing noncustodial parties

- ✓ Encourage change in the federal requirement that states pay claims when third party coverage is available through a noncustodial party (with the state then being responsible for recovering the payment, e.g., “pay and chase"). These cost recoveries are inefficient and frequently fail because of technicalities in the claiming process over which the state has no control. The advent of HIPPA and vigorous computer matching have made this rule archaic and costly as third party data is fully verified and updated daily.

MARYLAND

Goal

- ✓ To ensure health coverage/medical support to as many Maryland children as possible.

Strategies

- ✓ Educate all shareholders regarding needs and gaps
- ✓ Define responsibilities and authorities for each partner
- ✓ Review and enhance IT systems that support mission
- ✓ Policy Review (Joint)
- ✓ Improve IV-E/IV-D Interface
  - Role of Child Support
  - Role of Child Welfare
  - Policy changes to coordinate efforts between programs better
- ✓ Look at relationship between MCHIP and child support for cost recovery opportunities.
- ✓ Explore additional capacity by allowing shareholders to retain and reinvest a portion of state savings from medical support efforts for:
  - IT Enhancement
  - Staffing
- ✓ Explore use of public and private databases to locate absent parents and child relatives for placement, and or support (+)
- ✓ Look at ex-offender population as a resource to children. Create special policies for this population.

On-Going Communication Strategies

- ✓ Joint participation on each others’ steering/planning groups with stake holders and business partners (education, courts, advocates, etc.)
- ✓ Develop a joint agenda to float up to the cabinet level for support.

MASSACHUSETTS

Goal: Build on the existing collaboration for cost savings

- ✓ Improve the quality of information the Medicaid agency sends to IV-D regarding noncustodial parties. This allows the IV-D agency to pursue health insurance orders for Medicaid recipients, thereby saving costs for the Commonwealth.
- ✓ Systemically identify which Medicaid cases can be closed on the IV-D agency's system because there is no longer an assignment of rights.
- ✓ Collaborate on closing the custodial party's receipt of Medicaid when that parent is uncooperative.
- ✓ Continue to work together to put into operation an electronic interface that may help improve the quality of the information on the referrals from the Medicaid agency to the IV-D agency and provide staff with updated information about the status of a Medicaid case.

Goal: Draft legislation that re-defines 'reasonable' cost

- ✓ Collaborate on legislation that provides alternatives to ordering health insurance only through the noncustodial party. The alternatives could include ordering the custodial parent to provide, ordering the noncustodial party to contribute toward the Medicaid premium, and ordering the noncustodial party to pay cash if no other option is available.
- ✓ Collaborate to derive a cash amount that would constitute reasonable cost if health insurance were not available to the custodial or noncustodial party.
- ✓ Coordinate the implementation of the legislation by conducting cross-agency trainings.

MICHIGAN

- ✓ Expand cooperation – Establish a work group including juvenile justice, foster care (county), adoption system, state budget office, department of education, and mental health with goals of workshop to increase collaboration, maximize cost savings, understanding each others' programs; increasing continuity of care
- ✓ Investigate different ways to handle genetic testing
- ✓ Get IV-E involved in FPLS information; sharing information re incentive payments for paternity establishment

MINNESOTA

Did not attend conference.

MISSISSIPPI

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Update contact information for continued eligibility.
- ✓ Decrease Medicaid and SCHIP spending through cost avoidance.
- ✓ Decrease recovery efforts.

Issues or Barriers to Program Collaboration

- ✓ Data elements.
- ✓ Lack of understanding of each program's requirements.
- ✓ Sharing of information between management and line staff (visa versa) with some level of understanding.

Strategies to Overcome Barriers

- ✓ Local meetings with the various state agencies involved.
- ✓ Develop action plan.
- ✓ Monthly meeting with sister agencies.

Goals

- ✓ Get partners to the table.

MISSOURI

Goal: Increasing Health Insurance Coverage for Children

- ✓ Shifting Medicaid costs to appropriate, responsible party, when possible shifting Medicaid costs to parents.
- ✓ Contract out medical support enforcement?
- ✓ Look at actual cost savings other states have been able to achieve – Expectation is cost savings would pay for contractor services (such as in TX).
  - Meet again and fully explain programs to each other to understand how they work and how they might achieve cost savings.
  - Working together can lead to increased incentives and decreased Medicaid costs.
  - Dental care for child welfare – pilot program in Kansas City.
  - Getting RFPs from other states.
  - Indicators/measures for success: decrease in Medicaid expenditures.

Goal: Improve Dental Care Access for Children

- ✓ Do this by collaborating to make dental care acceptable in one city (i.e.: Kansas City).
- ✓ Plan and evaluate effectiveness of Jackson County program. If successful, this would be expanded to other counties/state-wide.
- ✓ Indicator = dental care utilization data.
  - Expand use of and access to FPLS.

MONTANA

Goal #1

- ✓ Better coordination between programs

Strategy

- ✓ Data exchange.
  - Pulling correct data.
  - Sharing more information among programs (outreach).
  - Website links and presentations at meetings and conferences.

Goal #2

- ✓ Location of parents and creating resulting orders.

Strategy

- ✓ FPLS.
- ✓ Another shot at County, Atty and Judges.

Goal #3

- ✓ Continuity of Medical Coverage.

Goal #4

- ✓ Cost Effectiveness/Avoidance.

Strategy

- ✓ Common employer database.
- ✓ Child Support Order/family contribution order on all.

Goal #5

- ✓ Provide health care coverage for all children who need it, regardless of their financial status.

Strategy

- ✓ HB 667.
- ✓ Include children's mental health involvement.

Resource Issues

- ✓ Program costs.
- ✓ Human Resource costs.
- ✓ State money associated with expansion of coverage.

NEBRASKA

- ✓ They do post cash back to Medicaid.
- ✓ Fix the disconnect among Medicaid and TPL and Child Support and CW.
- ✓ Exchange information on health insurance availability.
- ✓ Child Welfare using parent information and FPLS – how to share information and protocols.
- ✓ Paternity establishment – Child support and child welfare connections to be worked on.

NEVADA

Goal # 1

Diligent Search (NCP)

- ✓ Identify what agreements we need.
- ✓ Identify way for CW to locate NCP
  - For purpose of finding parent.
  - For child support.
  - For medical support.

Measurement

- ✓ Number of referrals versus hits.
- ✓ Cost
  - Agreements Needed
    No more than 90 days we will identify what agreements are needed
    WCDSS, CCDS, CSE, DCFS, Medicaid
  - Ways to locate NCP
    Establish task force using existing PIP committee.

Resources

- ✓ Staff dedicated to project.

- ✓ Possible interfaces.

Goal #2

Identifying TPL

- ✓ Enhance Communication between SCHIP.
- ✓ Explore possible legislative changes.
  - Establish task force with key players.

Measurement

- ✓ Increase in the recovery
- ✓ Cost avoidance.

Goal #3

- ✓ Identify data required for referral to the specific program.
- ✓ Collaborate with the courts to educate them on referrals to CSE for CW purposes.

Measurement

- ✓ Explore measurement of quality of referrals (rejections).
- ✓ Number of referrals vs. hits.
- ✓ Cost

NEW HAMPSHIRE

- ✓ We identified the need for a representative from IV-A to join our discussions around Medicaid and medical support issues.
- ✓ Child support will explore the use of contracted services to address Medical Support requirements. The feasibility of medical support to be included as part of the upcoming SDU contract will be evaluated.
- ✓ Policy implications for child support include the need for rulemaking and/or legislation to address child support guidelines to include medical support provisions.
- ✓ IV-E/IV-D referral process, data exchange and access to FPLS, will be reviewed.
- ✓ Outreach and training with the Family Court system is needed. Child Support Attorneys have begun preliminary trainings for the Rockingham County IV-D Case Resolution Pilot Project. In preparation for statewide expansion, trainings should include Medical Support Enforcement and information for courts on the SCHIP program (Healthy Kids).
- ✓ DCSS will coordinate a workgroup for policy and IT staff from each of the three program areas to identify data exchange capabilities and to collaborate on policy issues impacting our mutual clients.

NEW JERSEY

Need Notes

Refining work they've already done

- ✓ Referral, training, change of beneficiary.
- ✓ Working with child welfare as they build SACWIS system.
- ✓ NJ will be redesigning its child support system later this year.

Have been active with Medicaid and SCHIP – are working on matching programs

- ✓ Working on improving data that's exchanged.
- ✓ In court facilitator program re medical support.

NEW MEXICO

Goals

- ✓ Work with judicial system so that foster care cases have child support language written into them from the beginning. Train judges.
- ✓ Keep up communication lines by quarterly work group meetings that have been established by IV-D and IV-E quarterly or routine.
- ✓ Exchange of telephone contact information regularly so that case workers can work with their peers IV-D to IV-E to Medicaid.
- ✓ Do system changes within confines of budget.
- ✓ Pilot the "SWAT Team" approach.

Action Plans – Steps

- ✓ Get formal Memorandum of Understanding between agencies. MOU has been drafted by CSED.
- ✓ Identify the key players on a new workgroup.
- ✓ Implement a SWAT Team approach based on our Las Vegas Office (NE Region).

Impediments to Collaboration

- ✓ Data sharing; interfaces; cost of system changes and getting these changes prioritized to the top so that they can get done in one year; consistency in the way case management is handled in the automated systems (member-based vs. case-based). The IV-E agency completed a certification of their computer system facts and these changes included changes recommended by child support (by having an existing work group of IV-D/IV-E agency collaboration).
- ✓ Lack of knowledge of each other's business. We need to eliminate any preconceptions we might have come in with.

- ✓ Lack of dedicated resources for this issue. CSED has applied for a State Improvement Grant to staff a workgroup. The IV-E agency has a planning and design team in place and this is how they pay for staff to talk to IV-D.
- ✓ Lack of understanding of how our IV-D to Medicaid interface works and how data can be extracted. The Child Support Enforcement Division is part of a Department-wide "Task Force on Medical Cost Recovery." This should aid in understanding.
- ✓ Lt. Governor oversees the Children's Cabinet consisting of Human Services Department, CYFD, Aging, and Health Department. This top management buy-in can help facilitate.

NEW YORK

Goals and Strategies

- ✓ Continue the implementation and evaluation of the Title IV-D / Title XIX medical support data match.
- ✓ Continue the implementation and evaluation of the process for using the national medical support notice to secure health care coverage.
- ✓ Consider data matching between the Title IV-D and Title XXI programs to identify IV-D children with private coverage and link children without private coverage who are not eligible for Title XIX coverage to the State's SCHIP program.

NORTH DAKOTA

Goal:

Ensure parents meet the responsibility to their children – including financial, medical, physical and emotional support.

Should we formalize this with a memorandum of understanding?

1. Eight Regional Meetings (CS, CW, TANF, MS)

Purpose:

Awareness
Know who counterparts are
Know why they do what they do
Know impact to family of each program
Problem Resolution

Audience:

Regional Reps
Regional CS Enforcement
Eligibility Workers

Social Workers
County Staff

Other meeting options:
PolyCom
Family Support Meeting

2. What are the policies we want to implement/impact?

Review DHS policy, state law and Administrative Rules for appropriateness and flexibility for implementing collaboration opportunities. Revise as needed:

Parent Responsibility vs. taxpayer responsibility

Accepting Cash Medical Support. May need to push for a law change or request a waiver for accepting.

Buy In to SCHIP as a "reasonable cost" insurance. Would we need to establish a cap to cover a risk.

Options as we look at expanding Managed Care – what kind of changes (federal or state) would be needed to accept Cash Medical Support and use toward a premium.

Definition of Health Insurance in law
Not allow high deductible policies – not truly accessible coverage
Establish minimum standards
If high deductible plans are used, require a cash payment for kids' coverage?

Medicaid Payment of coinsurance when the noncustodial party has been court ordered to pay for all or a portion of these costs. Review what is currently done and how a judgment can be added to the process (Quarterly, Semi-Annual, Annual). Need to have Ray Feist involved in this discussion.

Assignment of rights on Title XIX (Yes, Per Jim Flemming e-mail 7-28-05)

What does the law say about room and board – consider changing if we are unable to collect to pay a portion of room and board charges.

Filing for additional adjustments – who does this and when?

Options with private insurance to negotiate a reasonable cost coverage.

Should we be considering a CS Referral for SCHIP Cases?

Review Implementation process and ensure all relevant players are involved and doing their part. Addressing the impediments. (Copy of South Dakota research)

Start a pool- (Georgia Project) – Mike has made a contact and is waiting to hear.

Are medical support orders in all court orders?
Appropriate language?
- Order parent to apply for coverage (TX model)
- Follow through with PCG/Federal DFAS enrollments

3. Improve Medicaid program access

4. Data Sharing

Paul and Mike – review the policy on and cost of electronic linkages between FC and CS
Review FC Cases – do we have an active referral on all of them?
Referrals for cases that are open less than 5 days – what instructions have been given to the Regions for working these referrals?

How are Non-IV-E cases getting to Child Support?
- Applications are triggered by:
- Do all of them come across?

Review how Foster Care children are entered in for Medicaid eligibility and then how that information flows to Child Support
- Policy for opening cases? Is it followed?
- Timing of referrals?
- Accuracy of Data?

MMIS Planning for 270/271 – Being able to share data we are able to access from other payers and carriers.
Staff from CS to be involved in Design and Use of Data: Barb Seigel/Terry / Kevin James

Match for insurance coverage
- What laws provide for Room and Board treatment in all policies?

Barb Koch from Medical Services is researching whether the main carriers cover Psychiatric Inpatient Treatment Facilities (RTC's)

Use of IV-E for "emotional" support
- Visitation – ombudsman

5. Permanency Planning
   Will come out of meetings, data sharing

6. National Medical Support Notices
   Who is monitoring these things? Is there an opportunity to use services, such as those proposed by PSI.
   Returned?
   Entered?

7. Create a list of employers not providing insurance (Maggie – contact Dr. Baird about this information)

8. Any special considerations for working with the Tribes?

NORTH CAROLINA

Issues or Barriers to Program Collaboration

- ✓ Disconnect in the information exchange among the three programs even though we serve the same clients.
- ✓ High cost of medical insurance.
- ✓ Lack of enthusiasm of Division of Medical Assistance/TPR for cash Medicaid recoupments.

Strategies to Overcome Barriers and Next Steps

- ✓ Appoint a standing committee, meeting regularly with representatives from all three programs.
- ✓ Meeting with Child Support, DSS, and DMA directors to discuss cash medical support.
- ✓ Work out an SCHIP recoupment process and an interface between child support and SCHIP.
- ✓ Promote ACTS (IV-D system) access for child welfare workers.
- ✓ Implement a IV-D low cost group medical insurance program for children.

Goals

- ✓ Ensure all three programs have as much information as possible about their customers; participant and medical insurance information.
- ✓ Maximize medical coverage for children in all programs.
- ✓ Maximize recoupments for Medicaid and SCHIP expenditures.
- ✓ Maximize incentives for CSE.

OHIO

- ✓ Work to move issue up on everyone's agenda.
- ✓ Continue discussion with Medicaid and Child Welfare.

- ✓ Gather and analyze data to determine potential cost savings/avoidance that could happen. Present data and move forward in all offices.
- ✓ Establish timelines to achieve goals.
- ✓ Consider legislation for either cost sharing or cost recovery (use TX has model).
- ✓ Investigate possibilities of looking at data warehouse and coming up with joint solutions without needing a full-blown system to system match.

OKLAHOMA

Goals

- ✓ Reestablish interface between Medicaid and DHS in Oklahoma.
- ✓ Motivate judges to address child support and medical support in child welfare cases.
- ✓ Develop and improve statewide system for addressing child support, either in OHH or district court.
- ✓ Improve training between CSE & CW – cross-training, web-based, analyze extent of use and effectiveness of training.
- ✓ ADAs' county director needs to be involved in training on child support issues.
- ✓ Find a way to fund medical support activities and experience cost avoidance for Medicaid agency.
- ✓ Educate judges on child support duties in child welfare cases and motivate them to order child support.
- ✓ Ensure that child welfare custody children have same quality and coordination of care that non-custody children do.

Action Strategies

- ✓ Medicaid waver sought already by OHCA (Medicaid) to participate in cost of insurance when it is available to CP – can this waiver be extended to have Medicaid share in cost if NCP has employer-sponsored insurance but it's cost prohibitive. Need to know how much more than 50% of NCP's disposable income would be needed to enroll children.
- ✓ Get reports on county basis for judges in child welfare cases.
- ✓ When child welfare asks judges for information on Child & Family Services reviews annually, ask for feedback on child support issues, too. CSED would develop questions they want child welfare to ask and CSED gets copies of data results.
- ✓ Between OHCA and OKDHS CW & CSE should collaborate on what statistics we want judge to have.
  - Copy of TX agreement.
  - Proposal for contract between OHCA & OKDHS.
  - Any limitations because of the way they fund Medicaid?

- Possible pilot project similar to the one that Orange County does to project Medicaid savings.

✓ Pursue legislation that would require a hierarchy for ordering child support (like Texas Courts are directed to do).
✓ Put child welfare children in Sooner Care managed care system for continuity of care.
✓ Training for Judges & Asst. DA's that work child welfare cases.

Barriers

✓ Lack of data system interface between OK Health Care Authority, the Medicaid Agency, and OK Department of Human Services.
✓ Lack of uniformity in how and whether child support is addressed in child welfare cases.
✓ Lack of coordinated effort regarding paternity issues in child welfare and child support enforcement and courts and DAs that handle the cases.
✓ Assistant DAs doing juvenile cases tend to be the newest - CW, CSE worker, CSE attorneys and ADA – high turnover.
- CSE worker 46% turnover annually.
- CW worker 25% turnover annually.

✓ Not enough full time employees or money to pay contractors to provide the required medical support services.

OREGON

Goals

✓ Increase the number of children in Oregon who are covered by medical insurance.
- Indicators - % of children covered, type of coverage.

✓ Identify and facilitate discussion with all agencies working with medical insurance coverage for children and families.
- Improve understanding of each agencies work – needs.

✓ Improve data sharing.
- Accuracy of information.
- Interface.

✓ Location of parents.
- Improve use of FPLS.
- Include in child welfare Procedure manual.

✓ Form a Medical Support Workgroup to coordinate between Child Support and Oregon Health Plan and other Medicaid programs.
- Identify cost savings and info sharing.

Next Steps

✓ Look at Child Welfare/Child Support Groups and Child Support Medical Group.

- Do we have the right people?
- Are we communicating broadly within the organizations?
- Are there other tasks/goals that should be added?

✓ Develop tools at the line level to help workers make the connection.

Resource Issues

✓ The right people.
✓ The time.
✓ Budget.

PENNSYLVANIA

Need notes.

Goal: "improving health care coverage for children."

✓ This is more important than cost savings.
✓ Work with Medicaid and TPL.
✓ Need to understand each other's program requirements.
✓ Look at inconsistencies in federal reporting requirements.
✓ Working with counties.
✓ Online eligibility process.
✓ How to use FPLS better for permanency planning.

PUERTO RICO

Goals & Strategies

✓ Get all the concerned agencies together, working to establish a medical support order that complies with the general goal of providing good health treatment for our children.
✓ Arrange meetings with all the agencies and start talking about all the ideas I bring home from this meeting.
✓ It's very important that all the concerned agencies know the rules and legislation that apply to their own procedures.
✓ Make sure our New Employee Registry has all the information on Medical Insurance.
✓ We already had conversation with the Judicial Branch to discuss child support issues. We need to bring to that discussion the Medical Support issue.
✓ All the concerned agencies need to work together to establish a more effective way to share information.
✓ Designate specific people to work with Medical Support coordination.
✓ Be sure our automatic system has all the required information to enforce the Medical Support Order.

- ✓ Make efforts to reach agreements with other government agencies for example, Insurance Commissioner, to help us enforce medical support.
- ✓ Review our child support legislation in order to obtain the maximum of benefits on Medical Support and find out if is necessary to promote any amendments.

RHODE ISLAND

Goal: Improve Referral Process

- ✓ There is an existing automated referral of IV-E and Medicaid cases to the IV-D agency. We share portions of the same computer system and all referrals are done electronically. However, there is a need to focus on providing better and more complete information and a greater degree of communication.

IV-D/IV-E Strategies

- ✓ Review and streamline existing policy relative to referral. There may be additional exemptions to be considered.
- ✓ Training of all staff to refer more complete cases for processing
- ✓ Streamline court process to avoid duplication of DNA testing and adjudications/ exclusions
- ✓ Review and streamline paternity procedures when a case is brought against an NCP and paternity has not been adjudicated.

Medicaid Referral Strategy

- ✓ Improve process for referral of Rite Care cases regarding naming of the noncustodial party. The applications for Rite Care and Medicaid are mailed to applicants and there is no initial meeting with an eligibility worker. Accordingly, there is little or no information regarding the noncustodial party referred to the IV-D agency. A workgroup needs to be formed to study this issue.

Goal: Educate Missing Stakeholders

- ✓ IV-A, the Court, the Medicaid Manager and the budget office need to be educated as to the cost savings the State of RI may realize by collaborating more fully. RI must study and develop a cost savings analysis similar to the one developed by MA to present to the respective budget offices. We already know that RI has realized a significant cost savings by establishing cash medical orders for the past two years. For FY 2004 alone, the state collected $1.2 million in cash medical payments. The budget office must be made aware of the significant dollars collected by the IV-D program, not only for Medicaid reimbursement, but also as reimbursement to custodial parents who may provide private coverage.

The state must focus not only on increasing the amount of cash medical collected but on increasing the number of private medical orders as well. This involves the sharing of additional information from MMIS, two-way communication of information from MMIS and insurance data matching which the child support agency is in the process of procuring.

Goal: Improve Automation/Sharing of Information

- ✓ Respective legal staffs to research the issue of confidentiality.
- ✓ A meeting of IT staff from IV-E and IV-D to automate access to FPLS. This is currently being accomplished by written request to the IV-D agency.
- ✓ IT staff to discuss system enhancements of the system to communicate not only referrals but updated information such as termination of parental rights so that the order may be suspended, if circumstances warrant.
- ✓ IT staff to review data elements commonly shared by all agencies to assure there is consistency.
- ✓ IT staff to explore the possibility of additional locate tools that would assist all agencies, IV-D, IV-E and Medicaid in establishing the orders and in addition would help IV-E in locating the NCP as a possible caretaker for the child.

Goal: Cross Agency Training

- ✓ As a result of this meeting, we realized that we really do not fully understand each other's programs and all details of the referral process. We will meet to discuss setting up a training schedule for staff.

Goal: Ongoing Collaborative Meetings

- ✓ There is a need to have continuous collaboration. We will return to our respective agencies and designate staff to meet on a regular and ongoing basis as opposed to meeting when a critical issue arises.

Goal: To Develop an Idea to Apply for a Federal Grant

- ✓ Through ongoing meetings we hope to develop a collaborative idea to present for a grant proposal or to request technical assistance from OCSE to implement some system enhancements to develop best practices as presented by New York and Massachusetts.

SOUTH CAROLINA

Potential Benefits of Medicaid, SCHIP, Child Welfare, and Child Support Collaboration

- ✓ Cost containment.
- ✓ Due diligent search.

Issues or Barriers to Program Collaboration

- ✓ Quality medical support referral.
- ✓ Shared information between program areas on the child support and medical support referral.
- ✓ Competing program outcomes.
- ✓ Access to health insurance or Medicaid provider for children.
- ✓ Inconsistent feedback from child welfare staff to CSE on the status of family.

Strategies to Overcome Barriers

- ✓ Cross training between program areas (state and county level), include discussion of various program outcomes.
- ✓ State level meeting, Re: access to insurance coverage, third party liability to benefit child support, child welfare.
- ✓ Reinforce current child welfare policy of follow-up to child support enforcement.

Goals

- ✓ Cross training.

SOUTH DAKOTA

Goals and Strategies/Action Steps

- ✓ Data Integrity.
  - Improve referral info from CPS and EA.
  - Use common definitions of terms between programs.
- ✓ Increase insurance coverage for kids.
- ✓ Medicaid coverage – refer to EA.
- ✓ Private coverage.
  - Vendor matching (no hit).
  - Education of staff and employer outreach and CPS.
  - If private coverage is terminated, refer to EA to determine Medicaid eligibility.
- ✓ Inter-program common vision.
  - Top level management communications – strategic plan.
  - Common up and down to local level of goals/objectives.

Resource Issues

- ✓ IT is scarce.
- ✓ Staffing.
- ✓ Funding of Medicaid, C/B analysis.

TENNESSEE

Issues or Barriers to Program Collaboration

- ✓ Income verification, IV-E.
- ✓ Locating absent parent.
- ✓ System sharing of information.
- ✓ Identifying collections to IV-E children.
- ✓ Improper language in court order, IV-E judges.
- ✓ Medicaid (TNCare) reorganization.
- ✓ Dis-enrollment.

Strategies to Overcome Barriers

- ✓ Quarterly meetings – program, fiscal systems staff at state level.
- ✓ Follow up training.
- ✓ Follow up with best practice states.
- ✓ Explore aggressive policy for child support collections in IV-E cases.

TEXAS

- ✓ CPS Court Orders have model orders to have child support language but judges are not always using (or county/DA's not using).
- ✓ File Transfer Data Issues – identify what data is needed and how to share – how to finance database changes (currently working on this issues).
- ✓ Kinship Care cases – there will be an increase in these cases in near future – so how do we work better to provide on group child support services.
- ✓ (Solution: education for caregivers/staff/judges, training of CPS staff/DA's).
- ✓ Child Only Medicaid – what is federal guidance on requiring child support referrals on these cases.
- ✓ Third Party Resources – vs. Medicaid – how to ensure services and payments are timely so we do not lose providers and or impact permanency and length of stay in foster care.

UTAH

Goals and Strategies

- ✓ Continue to expand health insurance match.
- ✓ Medicaid/SCHIP will better learn how the match works to better assist and benefit from the process.
- ✓ Ongoing dialogue among our group members.

Action Steps

- ✓ Assemble work group with other stakeholders.
- ✓ Educate SCHIP families about the availability of child support services.
- ✓ Review overlap in SCHIP and child support cases.
- ✓ Continue work between child support and vital records to implement unified paternity registry (created through state legislation).

Resource Issues

- ✓ Prioritization of programming projects (staff time).
- ✓ Coping with surges in caseloads.
- ✓ Adding tasks to a finite number of staff.

VERMONT

Goal #1

- ✓ Develop model intra-agency protocols and procedures to increase/expedite parentage establishment and medical support establishment and enforcement.

Objective

- ✓ Finalize a written process agreement between Vermont's Office of Child Support, Economic Services Division (TANF), and Office of Vermont Health Access (Medicaid) to enhance cooperative functions for med-support establishment and enforcement.

Strategies

- ✓ Intra-agency workgroup to refine and implement cooperative procedures for enhanced intake, referral, processing, and case follow-up to establish parentage, establish/enforce sustainable medical support through private health insurers.
- ✓ Procure an information/technology contractor for ACCESS system alterations to coincide with procedural enhancements. (ACCESS is the automated eligibility, information, and payment system for both Child Support and Medicaid.)

Objective

- ✓ Enhance and expand OCS' Employer Services Unit.

Strategies

- ✓ Expedite processing of ESD referrals for medical support establishment.

- ✓ Develop functional data measures to track increases in medical support orders established and enforced.

Objective

- ✓ Provide greater child coverage flexibility via enrollment in private health insurance through parental employers and reduce Medicaid expenditures.

Strategies

- ✓ Refine and standardize intra-agency intake forms to ensure the inclusion of necessary child/medical support, assignment of rights, and referral information.
- ✓ Hire/train additional staff on assignment of rights, waivers, and referrals.
- ✓ Streamline reporting/follow-up mechanisms between intra-agency partners for mutual exchange of data on medical support court orders, child enrollment in private health insurance plans, and coverage lapses.
- ✓ Improve identification of and increase Medicaid referrals to OCS for medical support establishment/enforcement.
- ✓ Reduce Medicaid costs via increased enrollment of Medicaid-eligible children in private health insurance (cost-avoidance).
- ✓ Pursue third party reimbursement on additional cases where children are enrolled in Medicaid and private health insurance plans (cost-recovery).
- ✓ Develop functional data measures to track dollar savings.

Goal #2

- ✓ Collect and analyze data/information on medical support impacts.

Objective

- ✓ Enhance/standardize intra-agency data interfaces and establish baseline measures to evaluate goal achievement and effectiveness.

Strategies

- ✓ Enhance intra-agency decision support systems (DSSs) to process additional data, analyze and evaluate med-support trends, and incorporate OCSE-157 medical support performance standards and Medicaid savings.
- ✓ Enhance DSSs to establish caseload baseline measures.
- ✓ Use data mining (Angoss Software) to analyze demographics of customers using private versus public insurance to detect cases likely to generate savings and to develop design documents for system changes.

Objective

- ✓ Refine and implement cooperative inter-agency procedures for enhanced intake, referral, case processing, and follow-up, and to collect/analyze data regarding medical support impacts and best practices.

Strategies

- ✓ Regularly schedule workgroup and ad hoc meetings with data staff.
- ✓ Progressively select, consolidate, and format data/reports for functional analysis.
- ✓ Incorporate automated case tracking.

Goal #3

- ✓ Utilize DSS data analysis/reports to answer questions related to medical support and to determine best practices for establishment and enforcement.

Objective

- ✓ Integrate intra-agency data into OCS' decision support system for analysis and decision-making. (Strategies same as Goal 2, Objective 1 above).

Objective

- ✓ Develop, collect, analyze, format, and compile data on med-support impacts and OCSE-157 best reporting practices.

Strategies

- ✓ Regularly scheduled workgroup meetings and ad hoc sessions with data staff.
- ✓ Select and organize data and information for ongoing refinement of intra-agency med-support processes.

VIRGINIA

Initial Goal: Lay the Groundwork

- ✓ Examine state numbers.
  - Number Medicaid / SCHIP enrollees linked to IVD.
  - Medicaid / SCHIP enrollees – look at employers and potential ESI coverage available.
- ✓ Case clean up (IVD, Medicaid) – cases, insurance companies, coverage.
- ✓ Insurance company table clean up (common links between Medicaid and child support).

- ✓ Medicaid / SCHIP recognized as valid Medical Support option; changes may include
  - Legislation.
  - Courts.
  - Guidelines.
  - CMS accept payment.
  - Medicaid/SCHIP sometimes better than bad insurance policy.
- ✓ Examine referral process.
- ✓ ID current processes and systems links ("as is").
- ✓ Examine current child welfare referral process ("as is").
- ✓ Improve processes to streamline and gain efficiencies ("to be").
- ✓ Explore how health care coverage is identified for children in foster care.
  - Who collects information?

Recognize that Priorities Must be Set (Resource Needs)

- ✓ Medicaid / SCHIP - 1
- ✓ Child Welfare - 2

Future changes/Considerations

- ✓ Premiums for Medicaid / SCHIP.
- ✓ Think creatively.
- ✓ Get the right staff from agencies together – insure high-level oversight.
- ✓ Include training as appropriate – identify links.
- ✓ Identify TANF system links.
- ✓ Medicaid / SCHIP issues.
  - Feds must clarify if Medicaid can accept payments.
  - Explore options for Cash Medical.

Continue State Meetings

- ✓ Take control of your own destiny.

VIRGIN ISLANDS

- ✓ No one from child support here today.
- ✓ No discussions have happened yet – they need to lay the ground work.

WASHINGTON

Goals

- ✓ Cross Education.
  - Understanding each other's driving policies and processes.
- ✓ Regular and ongoing communications.
- ✓ Improve data sharing.

- ✓ Safer kids.
- ✓ Healthier kids.
- ✓ Cost containment.
- ✓ Widen the circle.

Strategies/Action Steps

- ✓ Pre-meeting planning.
  - Develop inventory focused on links and current business.
- ✓ Cross – administration meeting.
  - Subjects to Include
    - CA/CSD Referrals.
    - Medicaid TPL/COB + Child Support.
    - Data sharing/access.
    - Discussion of program boundaries.
    - Enhanced cost saving.
    - CA/MA Parent Locator DB.
    - Alerts/Reporting.
- ✓ Focus on key priorities.
  - Assign staff.
  - Track outcomes.

Resources

- ✓ Staff to assess priorities.
  - Action Plan presented to ELT.
- ✓ Possible legislative package.

WEST VIRGINIA

Goals

- ✓ To ensure that as many children as possible in West Virginia have access to health care coverage.
- ✓ To ensure that only children without other options receive health care paid for by state and federal funds.

Strategies

- ✓ Improving collection and exchange of data among IV-A, IV-D, IV-E, Medicaid and CHIP agencies.
- ✓ Improving education of court personnel and attorneys regarding medical support issues.
- ✓ Improving communication through regular meetings with IV-A, IV-D, IV-E, Medicaid and CHIP directors.

Indicators

- ✓ Improved establishment and enforcement of medical support on current child support federal performance standards;
- ✓ Reduction of the number of children without medical coverage, with emphasis on location of private insurance coverage;
- ✓ Reduction of the number of children covered only by state or federally funded insurance.

Action Steps

- ✓ BCSE will pursue legislation to require employers to report whether insurance is available at the time of New Hire Reporting.
- ✓ BCSE will share appropriate information on insurance coverage, orders, etc. with IV-A, IV-E and Medicaid.
- ✓ BCSE and IV-A will review which types of Medicaid cases should be referred to IV-D.
- ✓ BCSE and CHIP will review what information needs to be shared through automation.
- ✓ BCSE and CHIP will review how CHIP members will receive information about IV-D services.
- ✓ BCSE, Medicaid, IV-A, and IV-E will develop a training on medical support issues for court personnel and state bar.
- ✓ BCSE, IV-A, IV-E and CHIP will plan and implement joint training for our staff relating to joint goals, information sharing and medical support issues.

WISCONSIN

- ✓ They have the information they need. However, it's not always accessible to the people that need it.
- ✓ Child welfare staff need access to child support data screens and vice versa; to insurance provider data; to FPLS; access to Medicaid/CHIP financial information. Child support needs access to insurance information.
- ✓ Need for everyone to be kept up to date on location of various children.
- ✓ Medicaid needs to improve access to carrier (insurance info is good but are there other carriers out there that the state doesn't currently match with that would be useful?).
- ✓ Educate one another; develop working relationships; discuss impediments; update each other on status of projects. Need regular meetings among staff of all three programs.
- ✓ As part of Medicaid data match, will also be implementing a NCP contribution to premiums initiative.

WYOMING

Goals and Strategies

- ✓ Communication.
  - Referrals.
  - Policy.
  - Program knowledge.
  - Interfaces.
- ✓ Measures.
  - Reduction of bad referrals.
  - Three meetings next four months.

Actions

- ✓ Written policy for IVE referrals.
- ✓ Interface of kidcare/scholarship.
- ✓ First meeting August.

Resources

- ✓ No resources available.
- ✓ Incentives.
- ✓ Team work.
- ✓ Privatization.

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