# Maximizing Enrollment in New York:
## Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

*A Maximizing Enrollment for Kids Diagnostic Assessment Series*

*By*

**Jodi Bitterman**

**Jennifer Edwards**

**Eileen Ellis**

Health Management Associates

February 2010

*A product of the Maximizing Enrollment for Kids program*

NATIONAL ACADEMY for STATE HEALTH POLICY

Robert Wood Johnson Foundation

*This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs, especially Medicaid and the Children's Health Insurance Program (CHIP), but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.*

## Acknowledgements

*The authors wish to thank the Robert Wood Johnson Foundation (RWJF) for its support of this report and in particular Deborah Bae, Program Officer, Brian Quinn, Program Officer, and Andrew Hyman, Team Director and Senior Program Officer. We also thank the many state Medicaid and CHIP officials in each of the eight states participating in the Maximizing Enrollment for Kids program who participated in interviews, provided extensive program data and background materials and completed detailed questionnaires and process maps that contributed to this assessment  This report could not have been completed without their participation and enthusiasm.*

*Additionally, we are indebted to the New York program staff, supervisors and managers who met with us during site visits and to state officials in public health, social services, education and other agencies, as well as advocates, providers and leaders of community-based organizations and foundations who provided their perspective and insights. In addition to the specific individuals who participated in the diagnostic assessment process listed in Appendix I, the authors would like to offer appreciation for the hard work and diligent responses of the New York Maximizing Enrollment for Kids team members, including Judith Arnold, Anne Marie Costello, and Ruchika Bajaj. The diagnostic assessment and this report benefited from the support and input of a number of individuals at NASHP including Catherine Hess, Alice Weiss, Alan Weil, Neva Kaye, Maureen Hensley-Quinn, Jennifer May and Amanda Wyatt; as well as key external advisers of the Maximizing Enrollment for Kids program.*

# TABLE OF CONTENTS

# Executive Summary

*In February 2009, New York was selected* as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) *Maximizing Enrollment for Kids* program, with the goal of helping states to improve the enrollment and retention of eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year, the National Academy for State Health Policy (NASHP), which is serving as the National Program Office on behalf of the RWJF, collaborated with Health Management Associates (HMA) to conduct a baseline assessment of each grantee state's systems, policies, and processes for enrolling and retaining children in coverage. The assessment of each state included reviewing the state's reports and policies, conducting onsite interviews with stakeholders and administrators in the children's health insurance programs, and reviewing published research about the impact of policies on coverage. This report synthesizes the information gathered, distilling the state's current strengths, challenges, and opportunities for improvement in New York's enrollment and retention of eligible children.

## *Findings*

New York has made significant progress towards achieving comprehensive health coverage for children. Approximately 91 percent of children are insured, with 40 percent of them covered by Medicaid and CHIP, which is known in New York as Child Health Plus (CHPlus). Health care reforms enacted in the past two years have included a number of expansions in coverage and enrollment simplifications, most notably expanding children's eligibility for subsidized public health insurance to 400 percent of the federal poverty level (FPL). The magnitude of New York's public health insurance programs, the shared responsibility between state and local government, the presence of separate upstate and downstate Medicaid systems and the plethora of stakeholders involved have had important influences on coverage policies and processes.

Based on site visit interviews, review of materials provided by New York, and knowledge of best practices across the states, the following themes emerged:

- **New York has shown a very strong commitment to covering uninsured children, regardless of income level or immigration status.** Multiple times over the last decade, executive and legislative branch leaders have formulated incremental policies expanding and simplifying public health insurance programs, even when the federal government limited its commitment. As a result, 91 percent of children in the State have health insurance. Of the 9 percent of children who remain uninsured, nearly 90 percent are currently eligible for free or subsidized public coverage.
- **Community-based enrollment assistance has effectively engaged eligible families.** Utilizing contracted health plans and community-based facilitated enrollers (FEs) has significantly increased children's enrollment in coverage by assisting with complex application and renewal requirements, easing transitions between Medicaid and CHPlus programs, greatly expanding advertising, and providing outreach in the communities where applicants live, work and seek health care. FEs provide services in more than 60 languages and are available at times convenient for working families including day, evening and weekend.

- **New York's forthcoming Enrollment Center offers promise in streamlining renewal.** The statewide enrollment center should streamline and simplify renewal and retention of eligible children.
- **The Department of Health gets input and assistance from several advocacy and research organizations in identifying problems and potential solutions with enrollment and retention.** New York-based foundations and advocacy groups conduct frequent studies to help understand and solve coverage problems. Advocates also assist with community monitoring and are able to identify issues in real time. DOH often works collaboratively with advocates to address these issues.

The assessment identified several challenges as well:

- **New York is a large and diverse state; each effort to understand and improve coverage is challenged by information systems, politics, inter-agency barriers, and resources.** As a result, many promising improvements are in a planning and development phase.
- **Despite many significant simplifications, including self-attestation of income, some children are losing coverage at renewal.** CHPlus disenrollment rates range from nine to 35 percent, depending on the county. Statewide Medicaid disenrollment is 30 percent overall, but 39 percent in Medicaid managed care. DOH continues to work to address renewal barriers, and the implementation of the Enrollment Center creates additional opportunities.
- **The shared state/local responsibility for enrollment and renewal has led to variability in the application of policy with some innovation, but also some perception by advocates that there are unnecessary barriers.**

Building on its notable successes, New York could further improve policies and processes to increase the number of eligible children enrolled and be more efficient in its use of limited resources. The following strategies may have the greatest payoff:

- Target outreach strategically to find large groups of eligible children, for example children who were previously enrolled but lost coverage, or by using state tax returns to electronically identify seemingly eligible children.
- Identify additional roles for facilitated enrollers.
- Improve contact information in State databases by allowing health plans and individuals to provide updated addresses.
- Promote a more seamless transition between Medicaid and CHPlus.
- Promote greater uniformity among LDSS offices.
- Strengthen data collection and analysis.
- Conduct further analyses to help prioritize new policy development.

# Introduction

*As many as five million children* in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state and a third are estimated to have been covered in the last two years. *Maximizing Enrollment for Kids*, a national program of the Robert Wood Johnson Foundation (RWJF), aims to address these problems by helping states improve the identification, enrollment and retention of eligible children. Directed by the National Academy for State Health Policy (NASHP), *Maximizing Enrollment for Kids* is a $15 million initiative that RWJF launched in June 2008. In support of enrollment and retention goals, the initiative also aims to establish and promote best practices among states.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures;
- Individualized technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. This paper reports on the diagnostic assessment of New York.

The economic and political environment at the time of this assessment (March - June 2009), provides important context for health insurance program status and the opportunities emphasized in this report. During the development of the assessment protocol in late 2008 and throughout the Spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed, two-thirds of states were facing budget shortfalls, and the outlook was for worse shortfalls for about the next three years. There was an enormous tension in most states about how to maintain access to insurance and still balance the budget.

On February 4, 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law reauthorizing the Children's Health Insurance Program (CHIP) until 2013, increasing funding for the program and outreach activities for eligible but unenrolled children and creating new financial incentives for states that increase enrollment and adopt key enrollment simplification strategies. Two weeks later on February 17, 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2008, 2009 and 2010 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels.

The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a backdrop for the state assessments.

# Methodology

*NASHP has partnered with Health Management Associates (HMA)* to complete the Diagnostic Assessment phase of the program. In consultation with NASHP, HMA designed and administered a set of data collection and interview protocols to complete an assessment of the strengths, weaknesses and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centers on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP and with Other State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-Centered Organizational Culture
- Non-Governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state was requested to provide annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process flow charts for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire covering key components of its enrollment and renewal practices and outcomes outlined in the six themes identified above.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During the visit to each state, interviews included state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover more children. The roles of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention. The names of interviewees in New York are listed in Appendix I.

The findings in this report are based on information collected from the state, a recent review of the literature,[1] and experience from our work in numerous states to distill the opportunities states have to improve enrollment and retention of children in coverage. While many opportunities were identified, this report highlights those we thought would have the greatest impact on children's coverage and also be administratively and politically feasible.

Findings across all eight state assessments are published in a separate report.

[1] Victoria Wachino and Alice M. Weiss. "Maximizing Kids' Enrollment in Medicaid and CHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children." National Academy for State Health Policy and the Robert Wood Johnson Foundation. February 2009.

# About New York's Health Insurance Programs for Children

*Despite the challenges* of a very large, diverse population, shared responsibility between state and local agencies, and significant upstate/downstate systems differences, New York has excelled in achieving broad coverage for children. Of the State's 4.7 million children, 91 percent have health coverage. An estimated 434,000 children remain uninsured, about 89 percent of whom are already eligible for free or subsidized insurance through New York's Medicaid or CHIP (Child Health Plus, or 'CHPlus') programs.[2] The eligible but uninsured are primarily school-aged, U.S. citizens, and living in low-income families where one or both parents work.[3] A combination of factors have likely contributed to enrollment gaps, including: parental misconception that working families are not eligible for coverage; low parental literacy levels; previous negative experience with a government program; parental lack of understanding of the importance of health insurance and regular primary care; language barriers; and a fear of participation in government programs (especially among immigrant families).

## *Eligibility and Enrollment in Public Health Insurance Programs*

New York implemented major eligibility expansions in 2008, which extended subsidized coverage for children to 400 percent of FPL. CHPlus was expanded to cover children in families with incomes up to 400 percent of FPL who are ineligible for Medicaid due to family income or immigration status, using state-only funds where a federal match is not available. CHPlus requires families pay a share of the premium, based on a sliding fee scale, and families with incomes above 400 percent can buy CHPlus coverage for children at the full monthly premium.

In 2009, the State enacted legislation to align the Medicaid eligibility levels of parents and children between ages 1 and 19 at 160 percent of FPL based on gross income. Medicaid eligibility will be expanded for children 6 years of age and older to 133 percent of FPL (net income) and Family Health Plus (FHP) eligibility will be expanded for parents and 19 and 20 year olds to 160 percent of FPL (based on gross income). Then all eligibility will first be evaluated with a gross income test at 160 percent of FPL. Pregnant women and infants will also move to a gross income test of 230 percent of FPL. Children aging out of foster care are now covered through the Medicaid program up to 21 years of age.

Statewide, in 2007, 40 percent of children were covered by public health programs – nearly 1.6 million in Medicaid and an additional 365,000 in CHPlus. In New York City, public insurance programs played an even larger role, insuring nearly 53 percent of children in 2007. Appendix II contains enrollment figures for the past five years.

[2] 2008 Annual and Economic Supplement to Current Population Survey, analysis by NYSDOH, 2009.

[3] New York's *Maximizing Enrollment for Kids* proposal.

## Leadership and Organizational Structure

The New York State Department of Health (DOH) is the single state agency responsible for administering the Medicaid, CHPlus and FHP programs. Prior to 2007, these programs were administered in separate offices within DOH. In 2007, DOH brought the health insurance programs and rate setting together under the Office of Health Insurance Programs (OHIP). This new office is responsible for all program policy, oversight and benefit design. Enrollment processes and data systems, however, remain separate, retaining historical divisions created under federal and state policies. The 58 Local Departments of Social Services (LDSS) are responsible for Medicaid and FHP enrollment and eligibility determinations, as well as for other public benefits such as cash assistance and Food Stamps.

By contrast, CHPlus eligibility determinations are made directly by the contracted health plans. These plans differ in their service areas, with some serving large portions of the State and others serving single counties. Created following passage of the federal CHIP legislation in 1997, CHPlus's policies have a greater consumer focus than Medicaid. Likewise, the program also benefits from newer information systems.

There are two Welfare Management System (WMS) systems – Upstate and Downstate. In addition to the separate system for CHPlus there are a total of three independent systems.

New York's gubernatorial, legislative and administrative leadership have consistently demonstrated bi-partisan commitment to comprehensive health care coverage for children. Health care reform has focused on the incremental implementation of policies that expand public health insurance programs to the point where the State has a universal coverage system for children, despite budget challenges. In one of the State's more prominent expansions, New York's leadership pushed ahead with its CHPlus expansion, funding it solely from state coffers when they were denied federal funding.[4] In its last two budgets, New York has also passed additional initiatives to expand coverage to children and make it easier for children to apply for and retain coverage.

## Applying for and Renewing Coverage

New York has unified applications, though separate processes, for Medicaid and CHPlus eligibility determinations. Families seeking Medicaid or CHPlus may use one of three available applications, depending on whether they are concurrently applying to other public assistance programs and the applicant's eligibility category.

New York is one of the last states to require a face-to-face interview when applying for Medicaid, though this requirement will be eliminated in April 2010. No interview is required at renewal. The face-to-face visit with an enroller may occur through either a LDSS or with a Facilitated Enroller (FE) – a certified, contracted entity with the ability to assist applicants in completing and submitting an application. FEs submit completed applications for determination to the LDSS for Medicaid or to the selected health plan for CHPlus. Medicaid applications are processed by the LDSS, while CHPlus applications are processed by the health plan chosen by the family.

[4] The federal government has since approved the expansion and will be providing matching funds.

Children in both Medicaid and CHPlus receive continuous eligibility for 12 months. Medicaid renewal is handled directly by the LDSS, though health plans and FEs can and do assist enrollees in completing renewals. CHPlus renewals are conducted directly by health plans and therefore aspects of the renewal process, such as the methods used and frequency of reminder notices, may vary by health plan. Health plans are required to send the recertification package 90 days prior to the end of the enrollment period. In January 2008, New York also took a significant step to simplify renewal by implementing self attestation of income, change in residency and some deductions.

The State legislature has authorized the creation of an Enrollment Center as another avenue for enrollment. The Enrollment Center is intended to improve retention and eliminate the gaps in coverage when enrollees transition between programs. New York is currently in the process of selecting a vendor and anticipates that operations will begin in mid-2010.

## *Priorities Identified by the Grantee*

In their grant application, New York identified the following priorities, which will be considered along with opportunities identified in this report, as they work with NASHP to plan the use of grant funds:

- Evaluate and streamline application and renewal policies and procedures for Medicaid and CHPlus to further eliminate barriers to health care coverage for children and teens.
- Establish an Enrollment Center to support the goal of enrolling all uninsured children. Through the Enrollment Center, New York will:
  - Centralize the processing of renewals for New York's public health insurance programs and create a telephone renewal option for consumers;
  - Create a seamless transition process for children moving between Medicaid and CHP at recertification or when moving from county to county; and
  - Create the systems necessary for the Enrollment Center to accept and process some new applications for public health insurance.
- Develop data collection tools that will allow the Office of Health Insurance Programs' Division of Coverage and Enrollment to more effectively monitor enrollment and recertification trends.
- Use data collection and analysis to better inform program policies and to formulate new initiatives.
- Increase enrollment of children and adolescents in CHPlus and Medicaid by 300,000 children.
- Increase the retention rate in CHPlus from 74 to 85 percent.
- Increase the retention rate of children in Medicaid from 70 to 80 percent.

# Findings from the Diagnostic Assessment

## 1. Enrollment and Renewal Processes and Policies

### Current Approach to Enrollment

Children apply for Medicaid and CHPlus at a wide range of locations in their communities. The State has certified and contracted with 42 Community-based Lead Agencies that include community-based organizations and health care providers to serve as Facilitated Enrollers (FEs) to assist applicants in completing and submitting an application. In addition, the contracted health plans can also act as FEs. FEs are an integral part of the New York application process – over two-thirds of CHP applicants begin the application process with these organizations, as do approximately half of Medicaid applicants. Together, CBO and health plan FEs assist approximately 30,000 families per month with Medicaid and CHPlus, which constitutes the majority of children applying for public health insurance.

Children also have the option of applying for Medicaid directly at their Local Department of Social Services (LDSS). Children seeking CHPlus insurance may alternatively apply directly at a health plan.

New York is one of the last states to require a face-to-face interview for Medicaid, and having multiple community-based enrollment options is important to ensure accessibility of the enrollment process. In April 2010, this requirement will end, thus allowing for the possibility of unassisted mail or even internet applications. The elimination of this requirement is an important simplification effort, since competing priorities often preclude potential applicants from having time to meet with an enroller – especially when it often requires multiple visits. Yet, many stakeholders report that the FEs fulfill a critical role in assisting with the complex enrollment forms and documentation and will be needed even when the face-to-face requirement is eliminated. Efforts are under way to determine how the State will continue to support applicants requiring assistance.

In the current process, an FE assists the applicant with one of the two available applications – a simplified application that may be used by pregnant women and children only (Growing Up Healthy); and the Access NY Healthcare application for health insurance that can be used by children and adults generally under the age of 65 for different programs (i.e., Medicaid, FHP and CHPlus). Individuals and families who apply directly at an LDSS for Medicaid can complete the Access NY application or the public assistance application. The benefit of having multiple applications is that it allows applicants who only want health insurance (which has less stringent eligibility requirements than some programs) to fill out a simplified application, rather than burden applicants with more lengthy applications and documentation requirements that aren't necessary to determine eligibility.

Several documents must be submitted regardless of the application type used, including documentation of date of birth, citizenship, residency and current income in the month prior to application. If applicable, dependent care costs, proof of pregnancy and documentation of other health insurance are also required. Understanding the requirements and gathering the appropriate documentation can be a challenge for applicants. Eleven percent of children applying to CHPlus in 2008 were denied due to incomplete information (Medicaid denials are not similarly tracked). New York has investigated the use of third party data in lieu of families providing documentation (described below).

The State has sought a balance between prompt handling of applications and allowing sufficient time for applicants to provide all needed documentation. The state policy is that applications need to be determined within 30 or 45 days, though additional time can be granted to produce documents.

FEs are allowed to hold a Medicaid application for up to 15 days to try to get all needed documentation before the application must be submitted to the LDSS, during which time New York requires a minimum of two outreach efforts by the FE to an applicant with incomplete information. While this time limit allows the State to meet federal mandates for timely processing of applications, even after a denial letter is issued a Medicaid or CHP applicant may still be enrolled if they provide the missing information.

Some FEs have developed their own computer-based screening program that helps preliminarily assess eligibility. Unlike LDSS offices (described below), FEs do not have access to state eligibility information nor independent sources of income, identity, or citizenship, so sometimes FEs spend time helping people who have already applied or even are already enrolled, but think they are applying for something new. Required documents are photocopied to submit with the application, along with original signatures. FEs print and submit paper applications in batches to either the LDSS (Medicaid) or the health plan chosen by the family (CHPlus). If family members are not all eligible for the same program, the application will follow both routes. Original signatures are required on each form, even if an application is sent to separate places for different family members.

The paper process is burdensome, but historically, neither CHPlus nor Medicaid has been capable of accepting the transfer of an electronic application. New York City HRA has an ongoing project to accept electronic submission of application data to the Eligibility Data and Image Transfer System (EDITS). In early 2009, three FEs became certified to use EDITS for the submission of Medicaid applications.[5] Other FEs are expected to follow.

Once a Medicaid application is received by the LDSS office, an eligibility worker reviews all required information, makes the eligibility determination and notifies the applicant. Information provided in the application is checked against the Resource File Integration (RFI), a subsystem of WMS, which includes wage, SSA and unemployment benefit data. There is no electronic citizenship or identity matching done at this time, but documents previously submitted can be accessed on an image viewer. RFI queries take approximately three to eight days and can only be performed by government eligibility staff, which creates a two-step process – the enroller requests documentation from the applicant at the time of application, and the State later uses the RFI to confirm certain pieces of information. The State noted that average processing time for April 2009 was 47 days, which falls short of the federally mandated deadline of 45 days.[6] Most counties are able to meet New York's specified timeframes for application processing, and the state is working with those counties that are over the approved time limits. Presumptive eligibility of Medicaid children is allowed through Federally Qualified Health Centers (FQHCs), who serve about 100,000 uninsured children.

[5] Hudson Health Plan, HealthPlus, and MetroPlus.
[6] 42 CFR § 435.911

CHPlus eligibility determinations are made directly by the health plan, subject to review and audit by the State. The applicant is presumptively eligible for benefits for up to 60 days while the applicant is collecting documentation needed to support the application. Of those presumptively enrolled in CHPlus, only 59 percent remain insured after the two month period. Over half of those disenrolled did not provide needed documentation.[7]

## NEW YORK CITY

While there are 58 LDSSs across the state, the Human Resources Administration (HRA) is the largest, serving the five boroughs of New York City. Approximately 65 percent of all Medicaid enrollees (adult and child) are within HRA's district. While it is recognized that New York City may not be representative of the entire State, the sheer volume of applications processed in this region, as well as its ability to readily report analytic data, offers important context for the New York Medicaid program as a whole.

Like the rest of the State, the vast majority of applicants applying for Medicaid coverage in New York City are helped by an FE (50 percent).[8] The critical function that these FEs serve is evidenced by the fact that New York City estimates that only five percent of Medicaid applications are submitted incomplete from FEs. This relatively small incompletion rate shows that FEs have been successful in following up with applicants and ensuring the complete submission of information required for eligibility determination.

For the much smaller group of applicants that apply directly at community Medicaid offices, approximately 25 to 30 percent cannot complete the application in one visit and are required to return with additional documentation. These applicants are allowed 10 days to return with the missing documentation before a denial letter is issued for failure to provide necessary documentation, and most applicants are able to return within this timeframe. As a result, final completion rates appear to be comparable to the high rates achieved with the help of FEs, though it also appears that multiple visits may be required for application completion regardless of the point of original application.

New York City reported a faster processing time for Medicaid applications than the State as a whole (30 days compared to 47 days), which meets the State's processing standard. The City attributes its processing time to a combination of the RFI time lag and staffing backlogs, and it's likely that both of these factors contribute to the prolonged statewide processing time, as well.

## MEDICAID

To begin the renewal process, the LDSS sends a renewal package to Medicaid beneficiaries whose coverage is due to expire in the next 60 to 90 days, including a list of information and documentation that the recipient must provide. Renewals must be returned approximately 30 days before the end date of coverage.

[7] Based on state data for 4th quarter 2008.
[8] Does not include applications applying concurrently to other public assistance programs.

New York rules prohibit Medicaid offices from requiring documentation that was supplied with the original application and is unlikely to change (e.g., birth certificates,). In a further simplification, most recipients have been able to self-attest to their income, change of residence, and child care expenses since January 2008.[9]

New York sends renewal forms pre-populated with all eligibility information except income. Recipients must provide new information and/or verify the accuracy of certain information since the application or last renewal. The State had originally pre-populated income information as well, but it abandoned this practice because local districts found that it was confusing to the enrollees and fewer errors were made when recipients wrote in their incomes. Some advocates affirmed that the pre-populated form has been helpful to families. Recipients may renew by mail or return forms in person to a Medicaid office. Some seek assistance from FEs in completing the process.

Upon receipt of the renewal packet, the LDSS will try to confirm reported income using the RFI. If RFI data contradict self-reported income, and the difference impacts eligibility, the LDSS must contact the enrollee to acquire documentation or resolve the discrepancy. Medicaid coverage is terminated if the completed renewal form and necessary documentation is not received by the deadline. Information about the outcome of this process was not available during the assessment. It would be valuable to know the percentage of individuals who do not return the renewal packet, the percentage who attempt to renew but are ineligible, and the percentage transferred to CHPlus.

### NEW YORK CITY MEDICAID

Returned mail is a chronic problem for most states' Medicaid programs. In New York City, where frequent moves make it particularly difficult to maintain correct addresses for Medicaid enrollees, HRA utilizes a mail-handling vendor for the Medicaid renewal package, and reports that approximately 10 percent of mail is returned for bad addresses. The mail vendor attempts to 'normalize' bad addresses on returned mail (i.e., standardize address formatting to fix common errors), but the success rate for these re-sent packages was not available. Moreover, these changes were not corrected in the Medicaid system for future mailings, nor were other attempts made to find updated addresses for enrollees with bad addresses. New York is working on new strategies to handle address changes.

New York City provides a weekly file to health plans whose Medicaid members are due to renew so that they can assist with outreach. This process allows health plans to follow up with members by mail and phone to encourage their renewal, a process that is too time-consuming for the City's limited eligibility staff to undertake. In addition, the plans often have more updated contact information for their enrollees.

New York City reports a 75 percent renewal rate for all ages. Unlike some other states interviewed for this project, neither the State nor the City was able to calculate a rate of 'renewal review' – in other words, the percent of cases up for renewal that were actually reviewed and for which eligibility status was determined. This rate, which would consequentially be higher than 75 percent, would account for those applicants whose eligibility status was reviewed but were determined no longer eligible, and would be a better assessment of the success of the State and City's renewal processes.

[9] Process differs for Surplus (spend-down) and LTC recipients.

### CHPLUS

CHPlus renewals are conducted directly by the health plans. The state establishes the timing of the initial renewal mailing, but plans differ in the amount of follow up. CHPlus recertification rates vary markedly by county (ranging from 65 to 91 percent) and health plan (ranging from 61 to 89 percent, with an average rate of 77 percent).[10] CHPlus data for the 4th quarter of 2008 showed that 27 percent of disenrolled children reenrolled after 3 months, suggesting that these children lost coverage for administrative reasons rather than eligibility.[11]

## New Initiatives

There have been several program expansions and simplifications in the past two years, and concurrent growth in enrollment and improvement in retention.

### ELIGIBILITY EXPANSION

With bi-partisan support, the legislature approved an increase in the CHPlus eligibility level to 400 percent of FPL in 2007. CMS denied federal matching funds for children above 250 percent FPL in September 2007, but implemented the change with state-only funds, which it implemented in September 2008. CMS reversed its decision in June 2009, approving and retroactively funding the expansion.

### ENROLLMENT CENTER

New York is in the process of creating a statewide Enrollment Center in an attempt to establish another enrollment pathway to specifically focus on retention, transitions between programs, and centralization of certain Medicaid programs with small enrollment and programs that interact with employers (e.g., premium assistance). A vendor will be announced during the summer of 2009 with operations to begin before the end of the year. The Enrollment Center will:

- Centralize the processing of renewals for New York's public health insurance programs and create a telephone renewal option for consumers;
- Create a seamless transition process for children moving between Medicaid and CHPlus at recertification or when moving from county to county;
- Create the systems necessary for the Enrollment Center to accept and process some new applications for specialized Medicaid programs ; and
- Over time, support other streamlining efforts.

Several additional initiatives have also been passed by the legislatures that have an impact on enrollment and renewal. These include:

- Creating one statewide Medicaid eligibility level for low-income families (as opposed to 58 different county standards of need, April 2008);

[10] Based on state data for 4th quarter 2008.
[11] CHP data is more accessible than Medicaid data due to differences in information systems.

- Simplifying Medicaid renewal by allowing self-attestation of income, change in residency and some deductions (April 2008);
- Eliminating the requirement of a face-to-face interview (April 2010);
- Allowing Federally Qualified Health Centers (FQHCs) to presumptively enroll children in Medicaid (February 2008);
- Extending Medicaid coverage to 21 years of age for children aging out of foster care (January 2008); and
- Creating the Family Health Plus (FHP) buy-in program to allow employers and unions to purchase FHP and CHPlus coverage for their workers and workers' families (April 2008 for one employer). Broader implementation will take place in 2010.

New York City has some additional improvements underway. They are developing an online renewal option which will be ready by the end of 2009. It can only be used by people eligible for self-attestation of income, have had no material change (e.g., immigration status), and are not required to provide any documentation. City staff believe FEs will still have a role in actively assisting people at renewal, even with the online option. Additionally, New York City is expanding its language capacity at renewal beyond English and Spanish. Starting in July 2009, renewal packages will now be sent in seven languages.

## Strengths

This assessment identified a number of policies and practices in New York that appear to contribute to the successful enrollment and retention of children in Medicaid and CHPlus.[12,13]

- **Breadth of coverage.** Generous eligibility levels mean that every child in New York can get insurance coverage, albeit with a premium contribution in some cases.
- **Facilitated enrollment.** Facilitated Enrollers are widely credited with having significantly increased children's enrollment in coverage, though we are not aware of any analysis that demonstrates their effect. It is, however, readily apparent that FEs add value in several ways:
  - FEs are located in many community settings where they will be seen by the target population, including in health care settings, where people may be most motivated to seek insurance. FEs are also located in schools, child care settings, shopping areas, places of worship and other community-based agencies and service providers.
  - FEs provide culturally and linguistically appropriate services in more than 60 languages at hours that meet the needs of working families – days, evenings and weekends.
  - Health plan FEs fund marketing costs such as billboards, subway signs, and materials.
  - FEs' knowledge of the programs and processes alleviate the need for families to understand the differences in applications and eligibility levels.

[12] Deborah Bachrach, National Health Reform through the Lens of New York Medicaid, July 8, 2009. (presentation for the UHF Conference on Medicaid and National Health Reform).
[13] While the strategies listed here appear to promote coverage and enhance enrollment and renewal, the impact of these strategies has not been systematically evaluated. Additional strategies that were not forthcoming in the assessment may also contribute to successful enrollment and renewal.

- FEs assist in completing applications that are believed to be too complicated for people with low health insurance literacy.
- FEs help families that are no longer income-eligible for Medicaid migrate to CHPlus.
- FEs provide follow-up to encourage complete applications.
- While all FEs are driven by their missions to provide coverage, health plan FEs are additionally driven by their bottom line, and thus commit a lot of resources to enrollment and renewal.[14]
- FEs fulfill the State's face-to-face requirement.[15]

- **Enrollment and renewal simplifications.** New York is reducing the number of steps, documents, and other barriers that may be preventing families from applying for and retaining coverage.
- **Aligned coverage for families.** Removing many of the 'stair steps' in eligibility has limited the number of families with children in two different programs.[16] Further, there is considerable evidence that parental coverage increases coverage of children, so the alignment of Medicaid and FHP eligibility offers promise for maximizing enrollment.
- **Presumptive Eligibility.** New York allows health plans to presumptively enroll CHP applicants into the program for a period of 60 days while the supporting documentation is collected. The State has also passed legislation allowing FQHCs to conduct presumptive eligibility for Medicaid, though to date this hasn't resulted in large enrollment increases. Presumptive eligibility is generally considered a positive step, and may be particularly valuable in a state like New York that is reporting 47 day processing times for Medicaid applications.[17]

## Challenges

This assessment also revealed the following programmatic challenges that are likely detracting from enrollment and retention of eligible children:

- **Losing potentially eligible children at renewal.** The State reports that churning has remained a significant problem for the Medicaid and CHPlus programs, despite efforts to simplify the renewal process.
  - Statewide Medicaid renewal rates are 70 percent and CHPlus renewal rates range from 65 to 91 percent. While some disenrollment is appropriate (e.g., recipients losing eligibility due to increases in income) and a "desirable" recertification rate is difficult to quantify, interviewees believed the churning problem in New York is significant. CHPlus data for the 4th quarter of 2008 showed that 27 percent of disenrolled children reenrolled after 3 months, suggesting that these children lost coverage for administrative reasons rather than eligibility. A recent study by New York City's Office of Citywide Health Insurance Access (OCHIA) estimated 22 percent of NYC public

[14] Also see Non-Governmental Partnerships and Outreach section for more information on the benefit of partnering with health plans.
[15] This requirement will be eliminated in April 2010.
[16] This may still occur to some extent, since infants are covered up to 230 percent of FPL.
[17] However, despite the general notion that presumptive eligibility is a worthwhile enrollment simplification, the evidence has been mixed as to whether it actually does contribute to increased enrollment. One interviewee noted that applicants who would otherwise apply for coverage right away without it may be delaying for the 60 days.

school students enrolled in Medicaid and CHP churned in a year at a cost of $14 million.[18]

- Churning may be partially the result of inaccurate contact information. While New York City's 10 percent mail return rate for renewal applications is relatively low compared to other states, it still represents a large number of enrollees; moreover, statewide mail return rates are unknown. Furthermore, health plan interviewees reported they are unable to update addresses in the State or City's system when they have more recent information. State policy requires that recipients either submit the recertification documents with a change of address or call the LDSS directly and provide information changes in writing.
- Children who are born to Medicaid mothers who are auto-enrolled at birth often lose Medicaid coverage at one year of age, either because the Medicaid income eligibility levels decrease for children over one year of age, or because their parents may not have been aware of their auto-enrollment. According to HRA officials, these children are typically still Medicaid-eligible or eligible for CHPlus, but parents often wait to re-enroll them until they're about to enter school, when immunizations are required. The gap in coverage from ages one to school-age is occurring at a time when developmental screenings and other preventive care are particularly important. The name and contact information for any child denied Medicaid due to family income is provided to a CHPlus plan for enrollment.

- **Coordinating with local districts.** The State faces a number of challenges in overseeing a Medicaid program that serves more than 4 million beneficiaries in 58 local districts, particularly given the unique structure of shared accountability and financing by the federal, state, and county for the Medicaid program and the realities of resource constraints at all levels.
  - If enrollment and renewal policies are interpreted and implemented differently in the local districts, there is a risk that the State's enrollment and simplification efforts may not benefit all families. For example, despite the policy of self-attestation, advocates report that some districts still insist on or strongly recommend income documentation in case electronic matches are not adequate and documentation is needed later. Asking for the documentation upfront can save the back and forth later, but may also be a barrier to completing the application in the first place. Another concern voiced during interviews was the variability in thresholds for application accuracy. Two different FEs reported they have had applications refused on technicalities (e.g., a missing middle initial), which requires extra work of FEs and discourages families.
  - The State has been working with local districts to figure out how to best manage ongoing, significant growth in the Medicaid program, both in terms of numbers and complexity. Some stakeholders have expressed concerns that efforts to streamline and bring more statewide consistency to the program, or to handle certain functions, like telephone renewal, through a Statewide Enrollment Center, could undermine local program control and support, or threaten local jobs. A number of others agree that

[18] Office of Citywide Health Insurance Access, May 2009. The Access to Coverage and Care Project: An Analysis of Health Insurance Enrollment and Retention by Students in Selected NYC Public Schools.

there is more "on the plate" than even the combined resources of the State and local districts are able to handle, and that it is critical to work in partnership to develop creative strategies, utilize new technologies, and seek better solutions, including emerging opportunities under federal health care reform, to address the health coverage needs of children and families.

- **Constraints on application assistance capacity and the need for adequate assistance in the future**. FEs have served a critical role in helping families navigate enrollment and to a lesser extent, renewal. New York invests $17 million in funding CBOs to serve as FEs. Combined there are 2,000 CBO and health plan FE's helping with applications and renewal. Yet despite this sizable commitment, some FEs reported resource constraints affect their ability to meet the community's needs. Several organizations noted that they were stretched to meet their existing demand, and one reported that they are booking appointments to help applicants one month in advance due to resource constraints.
  - While the elimination of the face-to-face interview is a critical component to the State's simplification efforts, it also comes with certain challenges. The application process can be quite lengthy and difficult to complete without assistance, and may discourage potential applicants from applying or increase denial rates for failure to correctly complete the application. To this end, a workgroup has been meeting to redesign the application so that is easier to complete independently. In addition, the Call Center will develop a number of customer assistance applications to meet callers' needs.
- **Lack of electronic capacity.**[19] Systems limitations hamper enrollment and renewal efforts.
  - Paper application handling is inefficient. While EDITS in New York City is starting to allow the electronic transfer of enrollment information from a few FEs, a statewide system is not currently available.
  - The RFI look up process adds days to application processing.
- **Staffing challenges.** While many successful improvements have been made over time, it was clear that program staff in OHIP are stretched very thin and that they lack the staff to keep up with all the opportunities for improvement they have identified themselves.
- **Missed enrollment and outreach opportunities.** New York's broad coverage rates mean that the remaining uninsured are often difficult to identify and further improvements in enrollment require identifying and targeting the small pockets of uninsured.
  - Many of New York's uninsured children get their care at FQHCs, and yet are slipping through the enrollment processes at the Centers. Health plan FEs have an intermittent presence in centers, but there are times and locations at which they are unavailable. Many CBO FE grantees are FQHCs, but may not have adequate processes in place that effectively target uninsured children. In 2008, the state additionally designated and authorized FQHCs to provide presumptive Medicaid coverage for children, and has a longstanding program utilizing a wide network of providers that determine presumptive Medicaid eligibility for pregnant women.

[19] Electronic capacity in general is described in detail in the "Analytic Capacity" section.

- **Complex eligibility rules for families.** As noted above, the State has taken significant strides to simplify eligibility rules, including eliminating many of the 'stair steps' in eligibility, which has limited the number of families that have children in two different programs. Two of the few remaining challenges are:
  - Documentation of income at application.
  - At changes in eligibility, families must re-apply rather than being seamlessly transferred between programs.

## 2. Interagency Coordination

### Current Approaches to Coordination

#### COORDINATION BETWEEN MEDICAID AND CHPLUS

Medicaid and CHPlus policy are centralized in the Department of Health's (DOH) Office of Health Insurance Programs (OHIP). As noted above, a joint application is used for Medicaid and CHPlus, and families can fill out a single application even if different family members are eligible for different programs. However, since eligibility determinations for Medicaid and CHPlus are made by different entities, these applications are routed in different directions – either to the LDSS for Medicaid, or the participating health plans for their CHPlus applicants.

New York has made many gains in streamlining Medicaid and CHPlus eligibility processes so that program differences are not confusing or a deterrent for families, though administrative differences become apparent for some families. When a child applies with a facilitated enroller, the applicant does not need to know which program to apply for or which application to use. The enroller directs the application to the appropriate location for processing (the LDSS or the health plan that the applicant has selected), giving the applicant the impression of a seamless program. However, when a CHPlus-eligible applicant attempts to apply at an LDSS office, they are redirected to a facilitated enroller. For these applicants, and for families with both Medicaid and CHPlus-eligible members, separate eligibility processes may become quite apparent.

The LDSSs store Medicaid data in the Welfare Management System (WMS).[20] The health plans must upload information on their CHPlus members to the State, but this information is housed in the separate Knowledge, Information and Data System (KIDS). Therefore, while a single agency has complete Medicaid and CHPlus data, they are stored in distinct systems that do not interface.

Due to the complexities of having two separate programs and entities that determine eligibility, New York has struggled to transition children between Medicaid and CHPlus. The State does have a system, known as the CHIP flip, that electronically sends Medicaid children that are over-income at renewal to CHPlus. For children enrolled in CHPlus who now are eligible for Medicaid at renewal,

health plans may temporarily enroll the children in CHPlus while the family provides the additional information needed for Medicaid. Since most health plans are FEs, they can facilitate this process. The children remain in CHPlus until their Medicaid eligibility is determined.

[20] Separate WMS' exist for New York City and the rest of the State, see next section on analytic capacity.

The problem of transitioning from CHPlus to Medicaid has been particularly salient when policy changes have required the shift of a large number of children between the two programs, which took place in 2004 and again in 2006. The State reported that the lack of coordination between the programs has resulted in a gap in coverage for many children, though because the data are housed in separate systems, the actual number of children affected is not known. The state provided 60 days of temporary CHPlus enrollment to allow time for Medicaid to process their application and to prevent gaps in coverage.

### COORDINATION BETWEEN STATE AND LOCAL GOVERNMENT

While eligibility policy is set by OHIP on a statewide level, it is implemented by staff of New York's 58 LDSSs, making it difficult to ensure uniformity. In fact, county-level data highlight some of these variations, including some differences in practices, reporting, and/or performance. An example is differences in timeliness across districts. Some districts that have a good performance on timeliness deny a lot of people because they don't keep working with the client. Other districts may exceed 45 days, but they have fewer denials because they give people more time to complete the application.

The county-based system also requires coordination between LDSSs, as a Medicaid recipient that moves from one county to another must have their Medicaid transitioned. The state reports that while this transition is not seamless, they have taken steps to streamline this process.

### COORDINATION BETWEEN HEALTH INSURANCE AND OTHER PUBLIC PROGRAMS

A universal public assistance application is available through which an applicant can apply for multiple public programs at the same time (i.e., cash assistance, Medicaid, food stamps). Applicants applying at general public assistance offices are evaluated for all services, and Medicaid determinations are made by these offices and forwarded to the Medicaid program. The Governor's Children's Cabinet (which is described in the State Leadership section below) has successfully promoted the coordination among various public programs and has helped ensure the investment of various state offices in the Governor's initiative to achieve universal health insurance coverage for children.

**Food Stamps.** Some states are using or investigating the use of Food Stamps eligibility data as a way of identifying potentially eligible but uninsured children, or even automatically enrolling Food Stamps enrollees in Medicaid, following recent Federal promotion of the concept of Express Lane Eligibility. In New York, coordination between Medicaid and Food Stamps may be possible because the data for both programs reside in WMS (though on separate 'faces', so the information is not readily exchanged). To explore the opportunity, New York's Office of Temporary and Disability Assistance (OTDA) performed a match between Food Stamps, Medicaid, and FHP and found that about 437,000 families receiving food stamps appear eligible for Medicaid or FHP but are not enrolled.[21] However, some are likely to be enrolled in private insurance or CHPlus, and a match with CHP data could not be performed because CHPlus data are not in WMS. Building on this first analysis, OHIP matched Food Stamps, Medicaid, FHP and CHPlus enrollment in a single county (Onondaga) in order to identify families with Food Stamps but not public insurance. They intend to use findings from this analysis to guide consideration of using Food Stamps data in the future.

[21] Jennifer Edwards, Rebecca Kellenberg, Caroline Davis, and Jodi Bitterman. 'Using Data Matching Strategies to Simplify Enrollment in Medicaid and CHIP', United Hospital Fund, New York, October 2009.

**New York City Public Schools.** In New York City, City staff and community-based organizations (CBOs) have worked on a variety of strategies to coordinate with the public schools to find and enroll more school-age children. New York's county-based eligibility system inherently gives each LDSS latitude in pursuing additional outreach efforts, and New York City is particularly progressive and often undertakes efforts that other LDSSs do not, with a dedicated office (Office of Citywide Health Insurance Access, or 'OCHIA') that is devoted to enrollment expansion. In two neighborhoods, OCHIA performed a match between school records and Medicaid and CHPlus eligibility data, identified uninsured children, and conducted intensive outreach. They also passed on contact information to CBO FEs in the children's neighborhood for additional outreach. However, this outreach effort did not yield significant results in terms of new applicants.

**Department of Taxation and Finance.** OHIP has tried to coordinate data sharing arrangements with the Department of Taxation and Finance (DTF) that would allow Medicaid to use tax data to administratively verify applicant-reported income information, or even eliminate the need for some applicants to report income entirely. The agencies jointly pursued legislation to permit the transfer of tax data to OHIP, but last minute changes to the legislation precluded OHIP from getting the tax data and only allowed for DTF to determine Medicaid eligibility, a system that was untenable for both Medicaid and DTF. OHIP plans to pursue further coordination efforts with DTF and the legislature to come up with a data sharing solution that will allow OHIP to maintain responsibility for eligibility determination.

**Office of Vital Records.** OHIP has likewise tried to pursue data sharing arrangements with Vital Records that would allow administrative verification of birth information, but efforts are currently on hold while other work is under way to plan and implement the work of the Enrollment Center. New York City houses its vital record information separately than the rest of the State, and matches in the city are beginning in November 2009.

## Strengths

- **Program consolidation.** State level Medicaid and CHPlus management has been consolidated into a single office (OHIP), giving staff greater opportunity to align policies and program management processes.
- **Joint application.** Moving to a single application for Medicaid and CHPlus was, according to State staff, perhaps the most significant coordination effort that has simplified enrollment for the applicant. This is particularly helpful for families with multiple children that, based on age group, may be eligible for different programs.
- **Facilitated enrollment.** Facilitated enrollment has also assisted in coordination of the programs. While the two programs have separate enrollment processes, the fact that an applicant may apply through an FE for either program gives the appearance, at least to the applicant, of a unified public insurance system.
- **Temporary renewal.** Temporary renewal has ameliorated some of the challenges in transitioning children from CHP to Medicaid by allowing children to remain in CHPlus while their Medicaid application is being processed, promoting continuity of coverage.
- **Support at the highest level in state government.** The Governor and the legislature have demonstrated their commitment to cover all children.

### Challenges

- **Data challenges.** There is not a unique identifier for children across information systems, nor much history of linking data across agencies. Technical barriers have limited New York's ability to use third party data to identify potentially eligible children. New York does use the RFI to reduce documentation burdens at renewal.
- **Transitioning children between programs.** Despite the presence of temporary enrollment in CHPlus of Medicaid eligible children at renewal, the State still struggles with seamlessly transitioning children between CHPlus and Medicaid. Because the data are housed in two different systems, children are not tracked across health insurance types (see next section on analytic capacity). Two separate mechanisms exist to address issues with Medicaid to CHPlus and CHPlus to Medicaid transitions – temporary renewal allows children to stay in CHP while their Medicaid application is being processed, and children no longer eligible for Medicaid at renewal are electronically sent to CHPlus (CHIP flip). In New York City, an analysis by OCHIA found that gaps in coverage (churning) were significantly more likely when transitioning from Medicaid to CHPlus (45 percent) than vice versa (26 percent).
- **Disparate Medicaid and CHPlus renewal processes.** Families with children in both programs have to follow different renewal processes which may confuse and deter them.
- **Complexity and size of program.** As described in the enrollment and renewal section, the sheer size and complexity of New York's programs can make it difficult to simplify and streamline processes.

## *3. Analytic Capacity for Program Management and Decision-Making*

### Current Approach

New York has three information systems that track eligibility for children. All LDSS offices with the exception of New York City use the Upstate Welfare Management System (WMS) to maintain eligibility files for those who apply for or are receiving Medicaid. New York City relies on a separate Downstate WMS system. Both the Upstate and Downstate WMS are computerized data systems that receive, maintain, and process information for the management and control of several social service programs, including Medicaid, TANF, food stamps, and supportive services. CHP data are uploaded from the health plans to the State and are housed in a separate Knowledge, Information and Data System (KIDS), which does not interface with either WMS system.

Obtaining CHPlus data from KIDS is considerably easier than obtaining Medicaid data from WMS. CHPlus staff produce regular management reports from KIDS. OHIP Medicaid staff produce monthly enrollment reports by county and eligibility as well as managed care enrollment by county and health plan. OHIP also supports a Commissioner's Dashboard that includes data on processing and caseload. Routine reports on the timeliness of application processing are also produced. A special query about CHPlus takes a day to run. A query about Medicaid can take longer, and must allow for a six month delay for all data to be considered current – this time lag is in great part due to allowing for 3 months retroactive coverage for Medicaid. NYC data is reportedly more complicated to access than the rest of the state.

Cross-sectional data that are available, including Medicaid and CHPlus enrollment, access and utilization, performance improvement and quality data and statistics, are regularly (e.g., quarterly, annually) posted to the Department of Health website. The State is able to report information on both the county and health plan level, giving them the capacity to analyze variability as a mechanism for identifying strengths and opportunities. Information about completion and abandonment rates for applications, by mode of application, assist with program decision-making.

A real limitation, though, is that these multiple systems do not share common personal identifiers, making it hard to follow children longitudinally as they move between programs. Useful data can be obtained from each system separately; however, the data are not always comparable. For this assessment, it was possible to track children who had left CHPlus and re-enrolled within 90 days, but comparable information was not available to track Medicaid churn rates.

Two NY-based foundations conduct or fund analyses that support coverage policy decisions, the United Hospital Fund and the New York State Health Foundation. These resources have given OHIP access to data and analysis that help with policy development.

## New Initiatives

The new Enrollment Center will centralize information about renewals, making it possible to track children longitudinally in the future.

State staff are working towards creating automatic reporting in WMS to support program management.

## Strengths

- **Availability of data to monitor enrollment and retention.** WMS and KIDS contain useful data to monitor most aspects of enrollment and retention. New York was able to provide more information about the status of children than were most other grantee states, including good estimates of the churning rate for the CHPlus population, as well as stratified information.

- **Public access to data.** The DOH regularly provides electronic public access to data on enrollment, access and utilization, performance improvement and quality. Consumer guides are also available. This information is used by interested stakeholders, including advocates and legislative staff.

## Challenges

- **Data systems do not easily adapt.** WMS was designed to capture data for multiple social service programs. While its connectivity to other public programs may be seen as strength, its inability to adapt quickly to the changing demands of the Medicaid program is an issue. Policy changes that would require changes to the WMS (e.g., the addition of new fields) are an onerous process in which the Medicaid program is subject to the competing priorities of the other programs. For example, adding a field to allow OHIP to match birth certificates to eligibility data requires that two fields are updated. That modification has taken a year.

- **Data systems do not interface.** The inability of the various data systems to interface has rendered it difficult to track recipients across programs. The State is unable to track children moving between Medicaid and CHPlus or ensure that recipients are not being lost in the process.

## 4. *Client-Centered Organizational Culture*

### Current Approach

OHIP has implemented policies centered on enrolling and retaining children – presumptive eligibility, enrollment simplification, and high eligibility levels all demonstrate New York's commitment to coverage that works for clients. The State's commitment is further evident in its use of state-only dollars to cover children ineligible for Medicaid due to citizenship status through its CHPlus program, and to cover children up to 400 percent FPL when CMS turned down the expansion request. The State also allows long windows for completing the application process (see enrollment approach above); and moreover does not penalize applicants for not submitting documentation within this timeframe, but rather will still re-open the case beyond that timeframe at the applicant's request.

On the other hand, the commitment and culture of each LDSS is contingent on local resources as well as the general attitude of its local policymakers, government workers, and constituent base. The State has sought to limit county resistance to State Medicaid policy by instituting a cap on the county's share of Medicaid. However, some counties fear that the cap could be lifted and county taxes would have to be raised to cover the county share of Medicaid costs. Though the State took strides to delink Medicaid from cash assistance, some stakeholders speculated that leftover 'anti-welfare' sentiment may prevail in some counties and may influence their views of the Medicaid program and increasing enrollment.

### New Initiatives

The Enrollment Center, which over time is expected to create a single, unified location for Medicaid renewal, may eliminate some of the negative consequences of the cultural and procedural differences in the current local district system.

### Strengths

- **Continuous simplifying and streamlining efforts.** The State's commitment to a client-centered approach is evident in its policies and continuous efforts to simplify and streamline enrollment and renewal processes. Funding of FEs and the redesigned joint application are evidence of this client-centered culture.
- **Uniformity through the Enrollment Center.** One of the anticipated benefits of the Enrollment Center is that it will be an opportunity to use a statewide technology platform to further automate and enhance statewide processing consistency, and to supplement and provide additional gateways for customer service (telephone, web-based assistance) to the customer service provided through LDSS offices and FEs.

- **Client-Centered orientation in some counties.** Stakeholders reported that some (but not all) LDSSs are very encouraging of a client-centered 'coverage culture'. Interviewees also noted that the orientation has improved over the last decade, as eligibility levels have risen and staff have learned more about the value of health insurance. New York City was consistently noted as a progressive county with a client-centered focus. Evidence of New York City's commitment is that New York City recognizes and rewards high performance among eligibility workers.

### Challenges

- **Variation in client-centered orientation between counties.** While the State promotes a 'coverage culture', this attitude does not prevail in all counties. Advocates report that LDSSs vary in the extent to which they actively support applicants through the process. The State's cap on the county's Medicaid share has not effectively deterred county resistance to the State's client simplification policies. Counties are extremely supportive of simplifications that ease their workload. From their perspective often client simplifications results in more work for the LDSS. This is a tension as they have limited resources.
- **Culture is influenced by county resources.** Limited county resources affects the number of eligibility staff available to process applications and conduct enrollment interviews, leaving families frustrated by long waits and slow responses to questions. Case overload in some counties may preclude a culture that focuses on increasing coverage and retention.
- **Burdensome documentation requirements.** The documentation burden is a challenge for applicants and can act as a disincentive for getting and maintaining coverage. While these may be inherently necessary to some extent, simplification efforts are limited if the State is unable to reduce some of this burden.

## *5. Non-Governmental Partnerships and Outreach*

### Current Approach

New York has many advocacy groups, provider organizations and CBOs with which it collaborates to enroll and retain children in coverage. As noted in the enrollment section above, New York has a significant partnership with 42 CBO Lead Agencies to act as facilitated enrollers. It has invested in these partnerships by providing grants to these organizations to conduct application assistance. In addition, nearly 30 health plans are authorized to act as FEs.

### Strengths

- **Good relationships with advocates.** Advocates reported a good relationship with OHIP. They have shared goals and work well together. One advocacy group reported that the long list of improvements they asked for two years ago have all been implemented.
- **Partnership with health plans.** The State has been able to capitalize on health plans' mutual interest in enrolling and retaining children by allowing them to conduct marketing and outreach campaigns. The health plans are uniquely positioned to accomplish this, since they are accountable to and heavily regulated by the State, but have a common interest in increasing

enrollment. Additionally, the health plans have name recognition, a strong community presence and more flexible staffing and budgets. Having outreach and marketing conducted by the health plans has also increased the members' connection to their health plan, so they may associate staying covered with access to care. Finally, health plans have more frequent contact with enrollees, so can help obtain contact information at renewal.

- **Facilitated enrollment.** The State's partnership with non-governmental organizations to conduct facilitated enrollment has been perhaps the biggest enhancement in enrollment procedures (see enrollment/retention section). This allows potentially eligible individuals to apply directly at the time of outreach or where they're seeking care.
- **Coordinated communication.** New York's communication with and from health plan and CBO FEs is well-coordinated by coalitions. Three health plan coalitions play an active role in shaping policy. Additionally, downstate community-based FEs are convened by Children's Defense Fund (CDF), and the two groups discuss problems and priorities. CDF advocates with OHIP or HRA in New York City on behalf of the CBO FEs.

### Challenges

- **Variance among health plan practices.** Data on retention rates by plan indicate there is variation, but we cannot tell if it relates to differences between plan enrollees or health plan renewal efforts. As noted in the renewal section above, renewal rates range from 61 to 89 percent). It may be possible to transfer more lessons among the plans to uniformly improve retention of CHP children.
- **Tight funding reduces capacity of facilitated enrollers.** New York invests $17 million in funding to CBO FEs. Nonetheless, FE's report funding is tight and that resource constraints prevent them from being able to timely handle their existing demand (see enrollment section).

## *6. State Leadership*

### Current Approach

New York's commitment to covering children has been demonstrated over time, across administrations, and by both parties. In 2001, New York chose to extend coverage to legal immigrants who did not meet the five year bar despite a federal decision to exclude them from Medicaid and CHP federal financing. In 2007 Governor Spitzer created the Children's Cabinet to unite 20 key state agencies to ensure coordinated, effective and efficient delivery of services to eligible children. Governor Paterson has continued the work of the Children's Cabinet. These agencies are mutually accountable for oversight and implementation of the health insurance expansion, which has ensured government-wide investment in the success of the governor's agenda. The FHP program was introduced in 2000, and helped reach more children when it covered parents up to 150 percent FPL (which is expected to be increased to 200 percent FPL in April 2010). And in 2007, the legislature approved an increase in the CHP eligibility level to 400 percent of FPL. Despite a denial of federal

matching funds in September 2007, New York proceeded with the expansion using state-only dollars in September 2008.[22]

### Strengths

- **State leadership support for health insurance programs.** New York enjoys a high level of support for coverage among executive and legislative branch leadership as well as across government agencies.
- **Knowledgeable and supportive legislature.** Legislative staff are very knowledgeable about health coverage issues and provide support for a coverage agenda.

### Challenges

- **Support for collaboration with other agencies is needed.** Further simplifications are needed, and further legislative or gubernatorial leadership could help. For example, OHIP has not been able to complete an income data match with the Department of Taxation and Finance, which could be very useful in finding eligible but uninsured children, as described above in the interagency coordination section. Fear about privacy of income data, which has been addressed in Maryland, New Jersey and Iowa, can be addressed in New York as well.
- **Support for unified data systems is needed.** State leadership has committed resources to an enrollment center, but not funded a unified data system for tracking all children.
- **Lack of accountability of LDSSs to OHIP.** As described in the enrollment/renewal and interagency coordination sections above, the State is challenged by lack of direct accountability of the LDSSs to State program staff, which can create differences in interpretation and implementation of state policies and can unintentionally undermine efforts of the State's leadership to increase enrollment and retention.

## *Opportunities*

New York has made tremendous progress in covering children, with nearly two million children in New York receiving publicly-funded health insurance. Based on this assessment, the following opportunities have been identified that could help reach the remaining 387,000 eligible but unenrolled children.[23]

**Target outreach strategically to find large groups of eligible children.** New York could use existing information, linkages with other data sources, and enrollment in the FHP program to find and enroll more eligible children. Ideas include:

1. Identifying previously insured children in WMS and KIDS who appear to meet eligibility criteria, and direct FEs to conduct targeted outreach to these families and help them reapply. Provide the FEs with access to eligibility information that is unlikely to change (e.g., identity,

[22] CMS reversed its decision in June 2009, approving and retroactively funding the expansion.
[23] United Hospital Fund analysis of the Current Population Survey, adjusted for program enrollment. This figure differs from the unadjusted CPS estimates displayed in Appendix II.

citizenship) to simplify reapplication. Consider testing this approach with one or two FEs and to assess the impact.

2. Promoting family coverage to capitalize on the new alignment of FHP and Medicaid income eligibility levels.
3. Working with New York's Department of Taxation and Finance (DTF) to send an outreach letter to parents of uninsured children. With the increased income standards for CHP, the buy-in option for those over 400 percent FPL, and the clear federal support for data matching, it may be more feasible this year than last to gain legislative or DTF acceptance.
4. Continuing OHIP's current assessment of the feasibility of performing express lane eligibility for children receiving food stamps.
5. Hiring and training outstationed eligibility workers at FQHCs to fill the gaps that may exist with FE coverage at FQHCs.

### Look for additional ways facilitated enrollers can contribute to enrollment and retention.

1. Allow provider-based FEs to complete a simple renewal process when children seek health care services within a determined window prior to and their renewal date.
2. Add FEs to more primary and tertiary care sites, coordinating with outstationed eligibility workers (as noted above), to ensure that enrollers are available at all times, including nights and weekends when many individuals are most likely to receive their care.
3. Adequately fund community-based FEs. The critical role that they will likely continue to play, even in the wake of changes to the enrollment and renewal processes, will require continued, and possibly additional, funding.
4. Provide access to income, birth, and citizenship documentation look-up for any FEs where confidentiality can be assured, both with KIDS and WMS. Look at protections available in hospitals for ideas of how to address privacy protection.

**Improve health plans' retention efforts.** Work with health plans to improve retention rates:

1. Include additional incentives in managed care contracts for health plans to collect information on the status of children due for renewal and to calculate a rate of 'renewal review' (e.g., at least 80 percent). By focusing the percent of cases up for renewal that were actually reviewed and for which eligibility status was determined, rather than an actual renewal rate, it may prevent selection bias that could occur if rewards were given for successful renewal rates.
2. Allow health plans to provide the state with updated contact information on enrollees.
3. Improve state oversight of health plan renewal processes, including standards for renewal.
4. Continue to work with plans on the spread of best renewal practices between plans.
5. Following New York City's example, expand the practice to other LDSSs of sending a file to health plans of their Medicaid enrollees up for renewal so that they can assist in outreach.

**Improve contact information.** Focus on ensuring that enrollee contact information is kept as up-to-date as possible.

1. Allow providers, health plans, and CBOs to update Medicaid contact information.
2. In counties utilizing a mail vendor, use the vendor and returned mail to update contact information in WMS.
3. Allow Medicaid recipients to provide updated information by phone, such as to the enrollment center or an FE.

**Promote a more seamless transition between Medicaid and CHPlus.** Create more reliable systems for a seamless transition for children between Medicaid and CHPlus, such as automatic processes that not only transfer the child the other program without reapplication, but also provide follow-up to ensure that they enrolled. OHIP may want a special eligibility code for these children to make it easier to monitor them.

**Promote greater uniformity among LDSS offices.**

1. Create a coalition of LDSSs to get together and share best practices. Creating a linkage among counties may increase commitment to a 'coverage culture', and will allow counties to benefit from peer to peer learning opportunities.
2. Consider providing incentives to LDSSs for meeting specified enrollment and retention targets.

**Strengthen data collection and analysis.**

1. The State needs a way to track children longitudinally as they transition between coverage sources. Use data more routinely to track children longitudinally; assess the impact of policy and procedure changes; and pilot test changes, using a plan-do-check-act approach.
2. Monitor rates of 'renewal review' to determine a clearer picture of lapses in the renewal process.

In order to prioritize its work in this area, New York might also consider undertaking a number of further analyses, including:

1. **Analyzing the impact of CHPlus premiums.** Measure the cancellation rate for the lowest category of premium payers compared to higher premium payers. Use these results to validate interviewees' opinions that the lowest income group to pay premiums faces great difficulty, and consider whether the data substantiates raising the income threshold at which enrollees have to pay premiums.

2. **Studying impact of eliminating face-to-face interview.** Elimination of the face-to-face interview is likely to have positive and negative consequences. As OHIP, advocates, and FEs consider simplifying the application and maintaining access to needed assistance for some, OHIP should also design a small study to assess the impact of the change.
3. **Examining the success of Medicaid presumptive eligibility at FQHCs.** While the evidence in general is inconclusive as to the success of presumptive eligibility in contributing to actual enrollment, and early evidence from New York does not suggest that Medicaid presumptive eligibility at FQHCs has substantially increased enrollment, OHIP should examine the presumptive eligibility process at FQHCs and determine if an expansion of this policy to other entities is warranted.

# Appendix I:

## *Diagnostic Assessment Interview Participants*

| Name/Title | Organization |
|---|---|
| Judith Arnold, Director, Division of Coverage and Enrollment, Office of Health Plans (OHIP) | Department of Health (DOH) |
| Anne Marie Costello, Director, Bureau of NYC Compliance and Customer Service | DOH |
| Gabrielle Armenia, Director, Bureau of CHP Enrollment | DOH |
| Kathleen Johnson, Director, Community Medicaid Unit | DOH |
| Beth Osthimer, Special Assistant, Division of Coverage and Enrollment | DOH |
| Ralph Bielefeldt, Director, Bureau of Information Management and Program Compliance | DOH |
| Bryan O'Malley, Chief of Staff | Senate Health Committee |
| Denise Soffel, Health Committee Executive Director | Senate Health Committee |
| Catherine Burch, Facilitated Enroller | Saratoga Care |
| Mary Harper, Executive Deputy Commissioner of the Medical Assistance Program | Human Resources Administration (HRA) |
| Karen Lane, Deputy Commissioner | HRA |
| Linda Hacker, Assistant Deputy Commissioner | HRA |
| Patti Boozang, Consultant | |
| Robert Fazzolari, Assistant VP, Government Affairs & Compliance | Fidelis Care New York |
| Kate Breslin, Director of Policy | Community Health Care Association of NY State (CHCANYS) |

| Name/Title | Organization |
|---|---|
| Michael Birnbaum, Director of Policy | Medicaid Institute, United Hospital Fund |
| Kinda Serafi, Consultant | Children's Defense Fund |
| Lance Goller, Assistant Program Director | Health Care Access Program, The Children's Aid Society |
| Lorraine Gonzalez, Director | Health Care Access Program, The Children's Aid Society |

# Appendix II:

## *Data on Children's Coverage*

### Table 1. 5-Year Enrollment Trends for Children

| | Number of Children | | | | |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2006 | 2007 | 2008 |
| Medicaid Enrollees | | | | | |
| Total | 1,680,000 | 1,702,000 | 1,651,000 | 1,604,000 | 1,592,000 |
| New | 43,800 | 37,700 | 37,000 | 39,700 | 37,300 |
| Disenrolled | 31,700 | 35,100 | 34,300 | 34,600 | 30,700 |
| SCHIP Enrollees | | | | | |
| Total | 356,000 | 328,100 | 371,000 | 390,300 | 364,800 |
| New | 38,700 | 24,000 | 21,500 | 26,000 | 13,000 |
| Disenrolled | 39,900 | 30,500 | 20,300 | 26,300 | 15,200 |
| Retention Rates | | | | | |
| Medicaid | NA | NA | NA | NA | NA |
| SCHIP | NA | 61% | 69% | 71% | 76% |

NA: Not available.

*SOURCE: Maximizing Enrollment for Kids* - Diagnostic Assessment Protocol (DAP) Pre-Site Visit Information Request. Average monthly enrollment and disenrollment were determined by averaging January and July data and should only be used for estimated volume. Actual enrollment can fluctuate greatly during certain months of the year based on program changes and marketing. Two examples of changes that affected enrollment are the expansion and later elimination of the increased Medicaid eligibility for children funded under Title XXI and the elimination of temporary enrollment in the Child Health Plus program.

### Table 2. 5-Year Uninsured Trends for Children

| Uninsured Children | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|
| All uninsured children | 482,604 | 354,300 | 394,747 | 415,116 | 434,481 |
| Eligible but not enrolled | 365,841 | 269,386 | 295,416 | 285,127 | 387,913* |

* Includes children eligible due to CHP expansion to 400% FPL. [Number before expansion (up to 250% FPL): 328,084.]

*SOURCE:* 2004-2008 Current Population Survey (CPS) – Calendar years 2003-2007

## Table 3. Characteristics of Children by Insurance Status and Eligibility for Public Programs

| | Number of Children | | | | |
|---|---|---|---|---|---|
| | Total Children | Total Insured | Total Uninsured | Uninsured, Eligible for Public Program** (200%) | Enrolled in Public Coverage |
| Year: 2007 | 4,722,368 | 4,287,888 | 434,481 | 387,913 | 1,901,902 |
| Age | | | | | |
| 0-5 | 1,373,820 | 1,230,889 | 142,932 | 130,754 | 549,890 |
| 6-18* | 3,348,548 | 3,056,099 | 291,549 | 257.150 | 1,352,012 |
| Race/Ethnicity | | | | | |
| African Am./Black | 802,173 | 673,453 | 128,719 | 124,224 | 423,381 |
| White, Non-Hispanic | 2,524,439 | 2,375,205 | 149,234 | 120,572 | 566,871 |
| Hispanic | 997,617 | 886,726 | 110,981 | 101,820 | 715,952 |
| Asian | 314,540 | 281,186 | 33,354 | 30,671 | 166,342 |
| Other | 83,600 | 71,318 | 12,283 | 10,624 | 29,356 |
| Poverty*** | | | | | |
| 0-100% FPL | 1,237,359 | 1,030,729 | 206,631 | 206,631 | 996,741 |
| 101%-200% FPL | 888,503 | 802,333 | 86,170 | 86,170 | 511,906 |
| 201%-300%tFPL | 728,107 | 659,144 | 68,963 | 68,963 | 207,483 |
| > 300% FPL | 1,888,399 | 1,795,682 | 72,717 | 26,149 | 185,773 |
| TOTAL | 4,722,368 | 4,287,888 | 434,481 | 387,913 | 1,901,902 |

* 2008 CPS (CY 2007) estimate.

** Medicaid & CHP total caseload unduplicated monthly average for CY 2007=1,901,902. Breakouts by age, race/ethnicity, and income derived from 2008 CPS estimated total 1.56 million children in public coverage and percentages for each category.