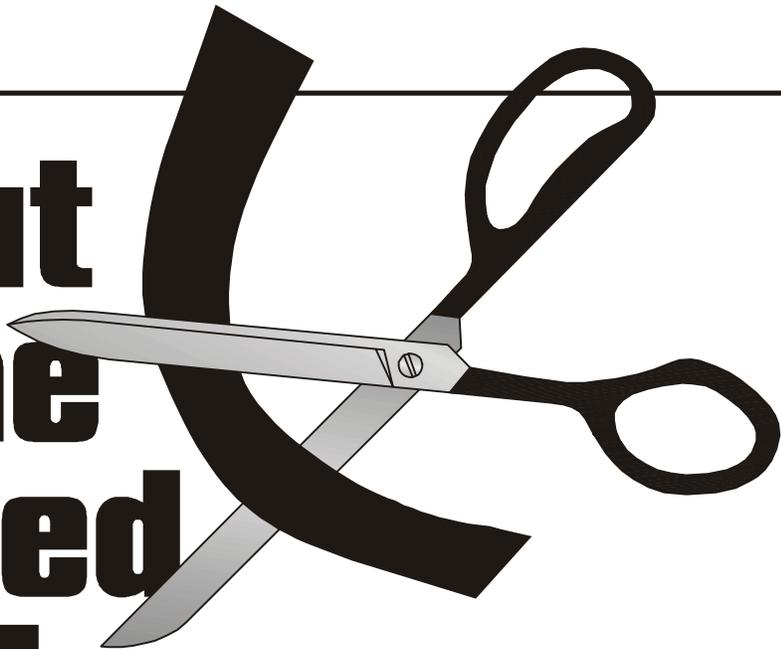


Cut The Red Tape



Simplifying Applications for Medicaid and Other Publicly Funded Health Insurance Programs



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Background:

Approximately 1.7 million New York City residents are uninsured. Of this number, roughly 900,000 are eligible for one of the State's publicly funded health insurance programs – Medicaid, Child Health Plus A (“CHPlus A”), Child Health Plus B (“CHPlus B”)¹ and Family Health Plus (“FHP”) – but are not enrolled. A major reason so many eligible people remain uninsured is that the state-mandated rules for these programs, particularly Medicaid, make enrolling extremely difficult, especially for non-English-speaking applicants. Eligibility criteria are highly technical and confusing and applications call for onerous amounts of back-up documentation. These administrative hurdles discourage eligible individuals and families from completing the application process and result in mistaken eligibility denials based on applicants' inability to provide all the documentation required. In fact, according to a report by the United Hospital Fund, “[s]tudies in several states indicate that most eligibility denials are the result of failure to meet procedural requirements and not failure to meet eligibility standards.”²

The human costs of this enrollment shortfall are substantial. For people without insurance, routine check-ups and preventative services become a luxury, resulting in health problems that often go untreated until they require hospitalization. For example, 58% of uninsured women in New York City aged 50 or older did not receive a breast examination in the past year, as compared with 36% of the insured. Among New York City men aged 50 and older, 74% of the uninsured did not have a prostate examination in the past year, compared with 44% of the insured.³ Indeed, in New York City, 69% of the uninsured have no regular doctor, as compared with 23% of the insured. Numerous studies have found that uninsured babies are less likely to survive to their first birthdays than those with insurance and that uninsured adults have a significantly higher mortality rate over time.⁴ Moreover, the problems associated with lack of insurance may have implications for worker productivity and ultimately the City's economy since seventy-four percent of uninsured adults in New York City work either full time (64%) or part-time (10%).⁵

¹ The State uses the term "Child Health Plus" (CHPlus) to refer to two distinct programs for children. What used to be known simply as CHPlus is now called CHPlus B and is administered directly by the State Health Department. CHPlus A is another term for Medicaid for Children and is administered by local social services districts such as HRA. Children who are not eligible for Medicaid for Children (CHPlus A) are often eligible for Child Health B, which has different requirements.

² Megan Toohey and Kathryn Haslanger, *Medicaid Eligibility and Welfare Reform in New York City*, United Hospital Fund Report, 2000, p. 13.

³ The Commonwealth Fund, *Survey of Health Care in New York City*, March 1998.

⁴ The Kaiser Commission on Medicaid and the Uninsured, “Sicker and Poorer: The Consequences of Being Uninsured,” May 2002, pp. 5-7.

⁵ United Hospital Fund tabulations of data from March 2001, *Current Population Survey*, prepared by Kenneth E. Thorpe and Curtis Florence.

The large number of uninsured New Yorkers also has ramifications for the City's public hospital system. In fiscal year 2001, New York City's Health and Hospitals Corporation ("HHC") estimates that it cared for approximately 545,000 uninsured patients, most of whom did not pay for their care. The City's FY 03 adopted budget projects operating losses for HHC of \$251 million in FY 03, \$244 million in FY 04, \$329 million in FY 05, and \$429 million in FY 06, attributable in large part to the cost of treating so many uninsured patients.⁶ An increase in insurance enrollment among HHC's eligible uninsured patient population would go far toward reducing these deficits. Indeed, HHC has estimated that it can generate as much as \$30 million in additional revenue for every 10,000 of its uninsured patients who enroll in FHP alone.

Many of the bureaucratic obstacles to enrollment in New York's publicly funded health insurance programs were temporarily removed last fall. In the aftermath of the World Trade Center disaster, the City and State moved quickly to establish Disaster Relief Medicaid: a greatly simplified program for temporarily enrolling New York City residents in "community Medicaid"⁷ (including CHPlus A) and FHP. A simple one-page application was used instead of the complicated, multi-page form normally required. Applicants stated their address, income, and other insurance coverage, but were not asked for documentation other than a photo identification. They did not have to wait two or three months for the Medicaid application to be approved, as was normally the case, nor were they required to return several times with missing documents. Instead, they were granted immediate coverage on the spot, but were warned that the factual information they provided would be verified independently later.

This temporary program was open to everyone who met the relevant income guidelines and not just those directly affected by the attack on the World Trade Center. In a four-month period, over 340,000 people enrolled in Disaster Relief Medicaid, which represented ten times the number of people normally enrolling in these programs during a comparable period.⁸ By April 30, 2002, HHC had provided outpatient services covered by Disaster Relief Medicaid to 75,339 people,⁹ many of whom presumably would not have had other coverage. Nearly one fifth of the Disaster Relief Medicaid enrollees who were seen at HHC clinics had serious or chronic health problems, such as heart disease, diabetes, asthma and untreated tuberculosis.¹⁰

The City is now trying to help Disaster Relief Medicaid recipients enroll in regular Medicaid or FHP.

⁶ HHC carried a cash reserve of approximately \$339 million, accumulated over several years, from FY 02 into FY 03, which is large enough to offset the projected FY 03 operating loss. Based on the projections in the City's financial plan, however, HHC will have to balance its budget in other ways in future years or its accumulated cash reserve will be exhausted.

⁷ "Community Medicaid" covers Medicaid recipients not living in an institution, such as a nursing home. The eligibility issues for enrolling nursing home residents are somewhat different from the ones addressed in this report.

⁸ Benjamin Chu, President, New York City Health and Hospitals Corporation, Testimony before the New York City Council Committees on General Welfare and Health, April 29, 2002.

⁹ New York City Health and Hospitals Corporation, *Disaster Relief Medicaid (DRM) Clinic Visits: 9/11/2001 through 4/30/2002* (May 2002 internal analysis by HHC planning department).

¹⁰ *Ibid.*

However, this effort may be undercut because the enrollees now have to overcome the same administrative obstacles they faced before the disaster. The health plans that serve these patients estimate that at most 50 percent of Disaster Relief Medicaid beneficiaries will fail to complete the transition process, even though many are eligible for coverage.¹¹

Existing Bureaucratic Obstacles:

It is often difficult for eligible patients to enroll in or to recertify for publicly funded health insurance programs because of the complexity of the application process and the sheer quantity of documentation required. For example, upon application and annual recertification,¹² prospective Medicaid enrollees must complete a detailed eight-page form that calls for a broad range of personal and financial information about the applicant and all other members of the household. The form requires complex calculations for establishing household size, household income and the value of household resources¹³ and calls for back-up documentation for more than 20 categories of information – including name, address, social security number, age and the value of almost every asset. Much of this documentation concerns information the government already possesses. For instance, if a child has Medicaid coverage and her parents later apply for coverage for themselves, they must supply Medicaid officials with a copy of her Medicaid card before their own applications can be considered complete. Applicants also must document close to 30 different types of income, despite the fact that the government can verify much of this information from existing food stamps, TANF and other records.

Not surprisingly, the Human Resources Administration reports that, under normal circumstances, half of its “Medicaid-only” clients (on Medicaid, but not welfare) fail to recertify, as compared with a 90% recertification rate for the food stamp program.¹⁴ Most of these people lost their coverage for reasons unrelated to their underlying eligibility, such as filling out a form incorrectly, missing a recertification interview or failing to produce some of the required documentation.¹⁵ The other publicly funded insurance programs have similar problems. Indeed, HHC’s managed care plan reports that since February 2002, roughly 20% of the applications it processed for Medicaid, CHPlus A, CHPlus B and FHP were missing documentation.

The State Has Authority to Streamline the Application and Recertification Process:

Unfortunately, New York’s experience is not unique. Recognizing the complex administrative

¹¹ Deborah Bachrach, Counsel to the New York State Coalition of Prepaid Health Services Plans, Testimony Before the New York City Council Committee on General Welfare and Committee on Health, April 29, 2002.

¹² Most applicants must recertify annually.

¹³ For instance, the value of a car is counted as a resource, but only if it is worth more than \$4,650 and there is no child in the household.

¹⁴ City of New York, Office of the Mayor, Office of the Director of State Legislative Affairs, Memorandum in Support of A.7909 by Members of Assembly Gottfried, Grannis, Glick. et al., June, 11, 2001.

¹⁵ The New York State Coalition of Prepaid Health Services Plans came to the same conclusion in a study of children enrolled in managed care plans. The coalition found that about half of the enrollees due for recertification each month were disenrolled due to failure to complete the recertification process, yet the vast majority remained eligible.

requirements many states have imposed on applicants for publicly funded insurance, the Federal Government has encouraged states to simplify their programs to boost enrollment and recertification rates. According to guidelines issued by the U.S. Department of Health and Human Services, the federal agency that oversees Medicaid, CHPlus A, CHPlus B, FHP and other programs that grew out of Medicaid:

“Federal law requires that Medicaid eligibility be determined in a manner consistent with simplicity of administration and in the best interests of recipients...[A] leading reason why eligible families fail to successfully enroll in Medicaid is that the families do not supply State required documentation [not mandated by federal law]. Federal law imposes only one documentation requirement for Medicaid: individuals seeking coverage who are not citizens or nationals of the United States must provide . . . reasonable evidence of satisfactory immigration status.”¹⁶

The overwhelming majority of New York State’s existing application and documentation requirements are based on its own regulations and laws, so it can simplify these requirements without running afoul of federal mandates. New York already uses a simple application for a program for the elderly, the Elderly Pharmaceutical Insurance Coverage Program (EPIC), which can serve as a model, along with Disaster Relief Medicaid. EPIC uses a simple one-page application and allows applicants to simply state their income without bringing documentary proof of this information.

Other jurisdictions that have simplified their programs, including those allowing self-attestation of income, have not documented an increase in fraud.¹⁷ In a recent study, the Department of Health and Human Services reported:

“We see no evidence that State simplification procedures have contributed to an increase in errors and, indeed, simplifications can reduce erroneous denials and terminations ... [P]rogram integrity is not limited to accurate eligibility determinations and payments but also includes ensuring that eligible individuals and families receive the benefits to which they are entitled.”¹⁸

Recommendations:

1. New York State Should Not Wait To Implement The January 2002 Reforms

On January 25, 2002, the Governor signed legislation amending the Health Care Reform Act of 2000 (“HCRA”), which, among other things, began the important process of easing the administrative burdens on New York State’s eligible uninsured. The key streamlining provisions of the HCRA

¹⁶ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage,” pp. 1-2.

¹⁷ Megan Toohey and Kathryn Haslanger, *Medicaid Eligibility and Welfare Reform in New York City*, United Hospital Fund Report, 2000, p. 13.

¹⁸ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, p. 35.

amendments:

- Allow self-attestation of resources (but not income) during application and recertification for Medicaid (excluding long-term care coverage);
- Eliminate the face-to-face interview requirement for Medicaid recertification;
- Implement a new and simpler form for recertification for Medicaid, CHPlus A, CHPlus B and FHP;
- Allow self-attestation of income during recertification for CHPlus B; and
- Establish a two-month grace period at recertification if a CHPlus B enrollee continues to appear eligible for CHPlus B coverage.

These reforms are not scheduled to go into effect until April 1, 2003. However, there is no compelling reason to wait until next year to implement these measures. The City has requested authority from the State to implement these changes as quickly and aggressively as possible. Specifically, the City plans to fully revise the recertification process to both simplify the process for recipients and achieve administrative efficiencies.¹⁹ That request is still pending.

2. New York State Should Harmonize Standards and Procedures

A major area for further reform is in harmonizing the documentation and application requirements for the various programs. Medicaid, CHPlus A, CHPlus B and FHP do not, but should, have consistent requirements and be equally free of unnecessary bureaucratic obstacles. There are illogical and confusing differences between the programs based in state law and/or state regulations in terms of income guidelines, the amount of documentation required and other administrative hurdles. The State Health Department has made progress in this regard by developing a common application form, although there is still far to go. For example:

- Asset test. People who are eligible for Medicaid have lower incomes than those who are eligible for FHP or CHPlus B. However, only in the Medicaid program are the family's assets taken into account (e.g., bank account, car, cash value of life insurance). At least 14 other states have already eliminated consideration of assets for eligibility for community Medicaid, having found that once someone is poor enough to meet the income criteria for community Medicaid their assets generally do not affect the eligibility determination.²⁰ New York State should go beyond allowing self-attestation of assets as provided in the HCRA amendments and eliminate consideration of assets altogether.

¹⁹ Linda Hacker, Deputy Director of the Mayor's Office of Health Insurance Access, Testimony Before the New York City Council Committee on General Welfare and Committee on Health, April 29, 2002.

²⁰ Kaiser Commission on Community based Medicaid and the Uninsured, "Eliminating the Community based Medicaid Asset Test for families: A Review of State Experiences" (April 2001). The authors surveyed Medicaid officials in states that had eliminated the asset test. "The surveyed states generally found that, despite being cumbersome for agency staff to administer and onerous for applicants to document, an asset test actually kept few families from meeting Community based Medicaid eligibility requirements and may have prevented some from completing the application process."

- Self-Attestation of Income: According to the U.S. Department of Health and Human Services, states can allow applicants to simply state their income when they apply for insurance coverage, without bringing documents to prove those statements. “[S]tates can verify financial eligibility through employers, banks and other collateral contacts,”²¹ as well as by using information from other government programs, such as food stamps, TANF records, and state child care and child support files.²²

Under the HCRA amendments, CHPlus B families will no longer have to document their income upon recertification. Each family will simply state its income and provide a social security number for each parent or guardian, which the Health Department will use to verify the income statements. Self-attestation of income should be extended to the Medicaid, CHPlus A and FHP programs as well.

- Face-to-Face Interview. New York State law requires a “personal interview” for Medicaid applications. New York Medicaid officials have not allowed applicants to satisfy this requirement via telephone interviews, mandating face-to-face meetings instead. This interpretation of state law makes applying for coverage unnecessarily demanding for eligible uninsured people who work, have childcare responsibilities, or have other obligations that make it difficult to appear personally.²³ Under the HCRA amendments, face-to-face meetings will no longer be required for Medicaid recipients who apply for recertification after April 2003, but it will still be required for new applicants for Medicaid, including CHPlus A. There is no such requirement for CHPlus B.

Federal law does not require a personal interview for enrollment in Medicaid. Indeed, as of February 2001, 39 states had already eliminated that requirement for parents enrolling their children in Medicaid.²⁴ New York State Health Department regulations should be clarified to eliminate face-to-face interviews altogether.

- Complexity of the Income Guidelines: Applicants must provide more information on their income and expenses if they apply for Medicaid than if they apply for CHPlus B or FHP. Both programs start with the family’s total income. But the Medicaid program also requires information on family income and expenses that the other programs do not require – for example, costs of housing and heating fuel. Some kinds of income and expenses can be deducted from the family’s income, but the rules are very complex (for instance, the first \$20 of monthly Social Security Disability payments are deductible for

²¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, p. 3.

²² U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, pp. 11, 13-15.

²³ Melinda Dutton, Kimberly Chin, and Cheryl Hunter-Grant, *Creating A Seamless Health Insurance System For New York’s Children*. New York: The Commonwealth Fund, February 2001, p. 16.

²⁴ *Ibid.*

single adults and childless couples, but not for couples with children).

CHPlus B and FHP also allow for deductions, but they do so in a much simpler way. The difference is similar to the difference between completing a tax return by itemizing deductions and by taking a standard deduction. Under CHPlus B and FHP, a standard deduction is built into the income guidelines. By contrast, in New York, Medicaid uses an approach that is more like itemizing a tax return, which is more complicated and which requires more documentation. Federal law permits States to utilize a simple gross income standard for Medicaid.²⁵ This standard should be implemented for Medicaid in New York.

- Requirements Not Relating to Federally-Mandated Eligibility Criteria: Under State law, single adults and childless couples who apply for Medicaid have to answer questions about their use of alcohol and drugs and have to be fingerprinted, even though neither requirement is related to federally-mandated eligibility standards. However, if a child applies for CHPlus A or CHPlus B coverage or a parent applies for herself under Medicaid or FHP, these requirements do not apply. Medicaid for single adults and childless couples should be made more consistent with CHPlus A, CHPlus B, Medicaid for parents and FHP by eliminating alcohol and drug screening and fingerprinting from the application process.

3. New York State Should Make Further Reductions in Documentation Requirements

The HCRA Amendments do not go far enough in reducing the amount of documentation required to receive or recertify for publicly funded insurance. The Department of Health and Human Services instructs:²⁶

“States must rely on information already available to the State before contacting the family or individual.... [In so doing, the State] can reduce the risk that an eligible family or individual will not complete the renewal process and thus be denied continued coverage even when the information establishing eligibility is available to the agency.”

Applicants should not be required to submit documentation not mandated by the Federal government to corroborate information that the State can verify on its own through government databases. States can allow applicants to state their citizenship, income, resources, date of birth, residency, and social security number when they apply, without providing documentation, subject to later verification to guard against fraud.²⁷ Indeed, many other states already use wage reporting systems and other computerized state and federal databases to verify information provided by applicants to reduce the

²⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, p. 29.

²⁶ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, p. 14.

²⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *op. cit.*, p. 3 and *passim*.

administrative burdens on people seeking coverage.²⁸

Elimination of unnecessary documentation requirements would have the greatest impact with respect to proof of income, which remains the greatest administrative hurdle to Medicaid coverage.²⁹ Currently, to receive Medicaid and remain in the program, most beneficiaries have to submit detailed proof of every element of household income for each year, including income from other government programs. Among other things, they may have to provide pay stubs for four consecutive weeks, records of any self-employment earnings and expenses, unemployment award certificates, letters from court or former spouses documenting child support payments, statements from landlords who pay rent, and letters from family members who provide food, housing or other forms of in-kind support.

Accordingly, in addition to the documentation requirements that were already eliminated as of April 2003, New York also should eliminate the following requirements:

- Documentation of income at application and recertification for Medicaid and FHP;
- Documentation of residence and social security number³⁰ for all three programs;
- Documentation of age for all three programs.

4. The Federal Government Should Adjust Its Medicaid Funding Formulas

The Federal government pays 50 percent of Medicaid and FHP costs for New York City residents with the City and the State each paying another 25 percent.³¹ New York State's federal reimbursement rate is among the lowest in the country; nationally the Federal government pays an average of 61 percent of these costs.³² New York is at a disadvantage because the current reimbursement formula is based on a per capita income index, without taking into account state poverty levels and regional cost differentials.

On July 31, 2002, the Senate passed S. 812, which included a proposal to temporarily increase the amount of federal Medicaid money available to the states. The House is currently considering a similar measure. If passed, this legislation could bring some relief to New York City, which in FY 02 incurred costs from increased enrollment through Disaster Relief Medicaid of roughly \$110 million. In FY 03, these costs could reach an estimated \$130 million per year if half of Disaster Relief Medicaid enrollees transition into Medicaid and FHP. A temporary infusion of money may

²⁸ In these systems, "[t]he family is asked for documentation only if the data match reveals a conflict between government records and the reported information or the information furnished by the family appears to be incomplete or inconsistent." Kalkines, Arky, Zall and Bernstein, LLP, *Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs*, December 2000, p. 24.

²⁹ City of New York, Office of the Mayor, *op cit*.

³⁰ The State Health Department had planned to eliminate the requirement that Medicaid and FHP applicants document their social security numbers by July 2002, but it has not yet done so. The requirement has already been eliminated for CHPlus B applicants.

³¹ The Federal Government pays 65 percent of the funding for CHPlus, with the remainder paid by the State.

³² The reimbursement rates for the nation range from 50 to 83 percent.

provide short term fiscal relief to the City, but it will not address the larger problem. The Federal government should permanently adjust its funding formulas to ensure that it pays an equitable share of the Medicaid costs of New York City and State, commensurate with the needs of New York residents.

Conclusion

The streamlining recommendations discussed above should be implemented as soon as possible, both to help eligible people obtain the insurance to which they are entitled and to assure the continued well-being of New York City's public hospital system. Medicaid, CHPlus and FHP should be evaluated using the same standards applied to most other government programs. In most cases, a government program would not be considered effective if it failed to deliver the services for which it was established, particularly if the failure was largely attributable to unnecessary bureaucratic obstacles.³³ By this standard, New York's publicly funded health insurance programs are in desperate need of reform since more than half the uninsured New York City residents who are eligible for coverage are not enrolled.

³³ Indeed, it is striking that the greatest administrative hurdles are imposed on Medicaid applicants, since Medicaid clients are poorer than participants in the other programs. This phenomenon may be the result of Medicaid's historical linkage with welfare. Although Medicaid and welfare were separated in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, many Medicaid procedures are still influenced by welfare policy and practices to the extent that they seem primarily designed to identify applicants who may not qualify for coverage rather than covering everyone who is eligible. State laws and regulations should be changed to more clearly reflect the program's primary goal of enrolling as many eligible people as possible.