

**MEDICAID  
INSTITUTE**  
AT UNITED HOSPITAL FUND

# Improving Enrollment and Retention in Medicaid and CHIP: Federal Options for a Changing Landscape

## **About the Medicaid Institute at United Hospital Fund**

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

## **About United Hospital Fund**

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

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# Improving Enrollment and Retention in Medicaid and CHIP: Federal Options for a Changing Landscape

PREPARED FOR THE MEDICAID INSTITUTE  
AT UNITED HOSPITAL FUND BY  
GEORGETOWN UNIVERSITY'S CENTER FOR  
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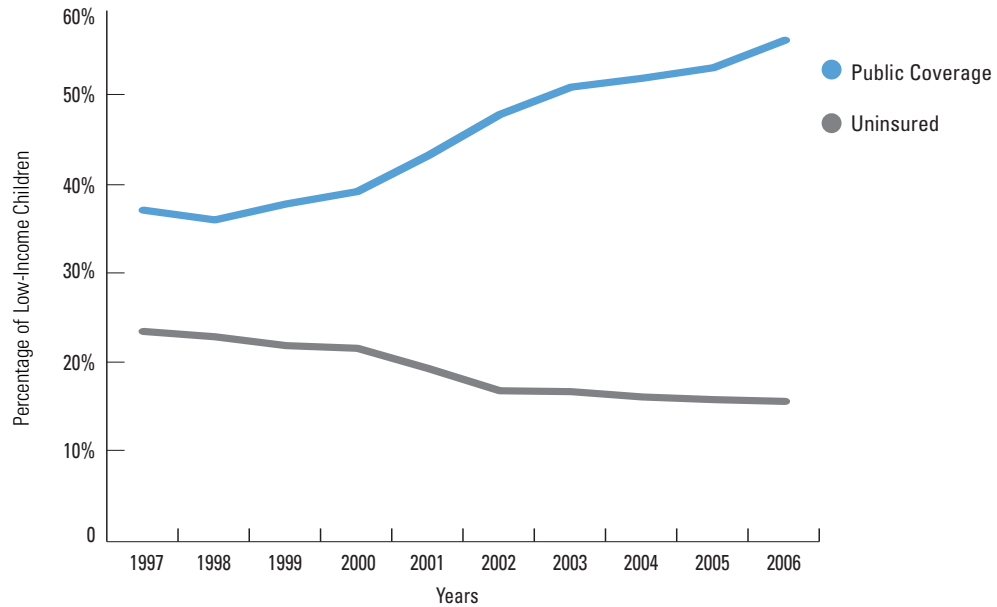


## Introduction

The enactment of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in February 2009 renewed the nation’s focus on covering uninsured children. There is also great anticipation that the potential enactment of major health reforms this year will help clear the path for all people—children as well as adults—to gain access to affordable, high-quality health coverage. A great deal can be learned from the experience of expanding coverage for children over the last decade. One of the key lessons is that the quality of the underlying eligibility and enrollment processes can be as instrumental in facilitating (or deterring) coverage as the availability of funding to support that coverage. While much of the debate over how to cover all Americans in the context of national health reform will inevitably focus on the issue of whether to impose a mandate for individuals to enroll in coverage, it is at least as important to consider how to make the underlying systems for enrolling and renewing coverage work well.

Largely as a result of enrollment growth in Medicaid and CHIP between 1997 and 2006, the uninsurance rate among low-income children dropped sharply from 23.3 percent in 1997 to 15.4 percent in 2006 (Figure 1).<sup>1</sup> It is clear from the research that this remarkable success resulted both from expansions in eligibility and improvements in the processes used to identify, enroll, and retain eligible children. After enactment of the CHIP in 1997, states expanded health coverage for children through Medicaid and separate child health programs. Program expansions were significant, but eligibility expansions were not sufficient to get the job done. A broad consensus emerged among states and others working on children’s coverage that a system redesign was needed. As a result, over the years, nearly every state adopted some improvements in program administration to remove longstanding barriers to enrollment and renewal, and many states began to take advantage of technology to make further progress. Between 2001 and 2005, participation rates for children in Medicaid and CHIP—the portion of eligible uninsured children who were enrolled in coverage—jumped from 66 to 78 percent.<sup>2</sup>

**Figure 1**  
**Decline in the Rate of Uninsured Low-Income Children Is Attributable to Enrollment in Medicaid and CHIP**



Source: Dubay L. March 1, 2008. Johns Hopkins University Bloomberg School of Public Health, analysis of the National Health Interview Survey for the Center for Children and Families. Note: data reflects low-income (<200% FPL) children.

In 2007, New York recognized the role that underlying eligibility policies and systems played in whether individuals successfully obtained and retained coverage, and embarked on a multiyear effort to reform its public health insurance programs. With coverage a top priority of the Governor, finding ways to enroll and retain those eligible for Medicaid, Family Health Plus, and Child Health Plus would cut the State’s uninsured population nearly in half. The State worked with a wide range of stakeholders and researchers to reduce administrative barriers to enrollment and identify promising strategies to maximize enrollment among those already eligible for public programs. An estimated 85 percent of eligible children are enrolled in New York’s Medicaid and CHIP programs, a rate that is well above the national average.<sup>3</sup>

Over the past two years (and three legislative sessions), New York has enacted significant reforms to expand eligibility and eliminate administrative barriers to enrollment (see accompanying text, “The New York Story”). Taken together, these reforms represent most of what can be accomplished independently at the state level. To go further requires strong federal partnership and action, either through waivers or statutory change. The State requested assistance from the United Hospital Fund’s Medicaid Institute in identifying other steps it could take to reduce enrollment barriers either on its own or in partnership with the federal government. This report emanated from that request and is being shared widely because of its relevance to all states.

More can be done nationally to boost participation and ensure continuity of care, both of which are key elements of any strategy to reach more uninsured children. Given recent program expansions, seven out of ten uninsured children are now eligible for Medicaid or CHIP coverage.<sup>4</sup> In New York, estimates suggest that 86 percent of uninsured children are now eligible for Medicaid and CHIP following the State's CHIP expansion to 400 percent of the federal poverty level (FPL).<sup>5</sup> Ensuring that all eligible children enroll in coverage will do much to reduce the number of children who have no health insurance. However, families often do not know that they are eligible or have difficulty completing the enrollment process. All too many of the children who do enroll lose coverage at the point of renewal, despite continued eligibility. Some eventually regain insurance, but only after gaps in coverage that undermine efforts to ensure that children receive regular preventive care and a consistent medical home.

With the new options in CHIPRA, a new Administration in Washington, and the potential for health care reform on the horizon, the time is right to highlight the most promising federal actions that would close these remaining coverage gaps for uninsured children and adults. This report identifies new strategies as well as some variations in concepts that have been around for many years that could help states get closer to the finish line by enrolling and retaining eligible children and families in Medicaid and CHIP. The options presented are intended to serve as a menu of federal changes—some administrative and some legislative—that would significantly improve Medicaid and CHIP enrollment and ensure greater continuity of coverage and care for children and their families. These options are particularly relevant now, given the interest in covering the uninsured, the prospects for federal action (legislative and administrative), and agreement among policymakers and stakeholders that covering eligible but uninsured children and adults is a top national priority.

## The New York Story

An estimated 2.5 million nonelderly New Yorkers were uninsured in 2006-07. Forty-four percent of these uninsured people were eligible for public coverage but not enrolled.<sup>6</sup> Furthermore, about 30 percent of New York's public program enrollees lost coverage upon renewal in 2007; many such people cycle back on after periods of uninsurance.<sup>7</sup> In light of these trends, State officials have taken a number of steps in recent years to expand coverage and to eliminate barriers to enrollment and renewal in public programs.

Specifically, New York implemented an eligibility expansion for children in CHIP to 400 percent of the FPL in 2008 and enacted an eligibility expansion for adults in its Family Health Plus (FHP) program to 200 percent of the FPL (which is contingent upon federal approval). Together, these expansions would extend eligibility to an additional 440,000 New Yorkers and would likely have even broader reach to the extent they bring in people already eligible but uninsured.<sup>8</sup>

In addition, since 2007 New York has enacted a series of streamlining reforms to ease enrollment and retention of eligible children and adults in public coverage. These include:

- Reduced documentation requirements for Medicaid and FHP at renewal;
- Presumptive eligibility for children into Medicaid;
- Elimination of vestiges of welfare, including drug and alcohol screening and finger imaging;
- Establishment of a single eligibility level for single adults and childless couples, replacing the county-specific levels;
- Elimination of the Medicaid and FHP asset test requirement;
- Elimination of the Medicaid and FHP face-to-face interview requirement; and
- Elimination of age-based eligibility distinctions (CHIP and Medicaid) and a shift to gross income test for Medicaid.<sup>9</sup>

Finally, New York is developing a centralized statewide enrollment center to process renewals for certain children and adults who are eligible for its public health insurance programs. One important goal of the enrollment center is to provide a new pathway to renewal that makes better use of technology and thereby improves public program participation and retention rates.

The combination of these reforms extends eligibility to a significant number of uninsured New Yorkers and, importantly, makes it easier for eligible people to enroll in and retain coverage.



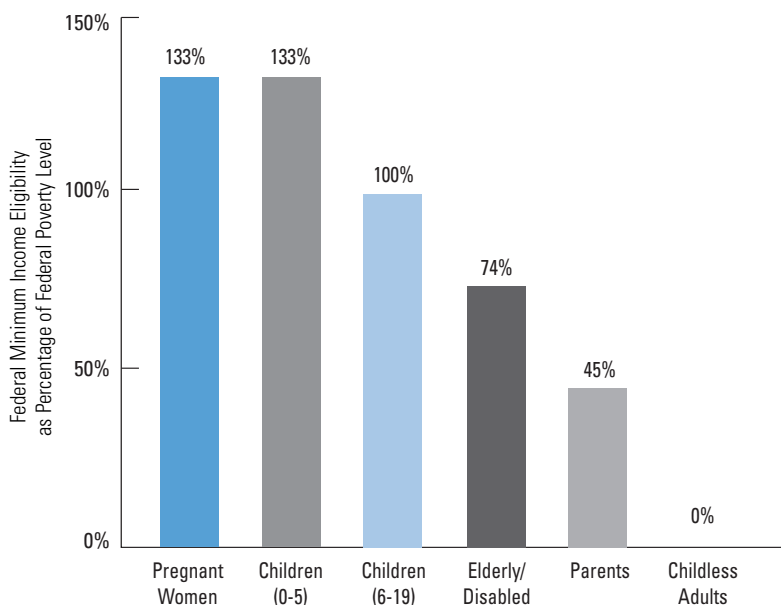
## Background: Current Rules

The Medicaid program is a unique blend of federal and state rules and options, reflecting a longstanding federal-state partnership. States have discretion to set programs' rules and procedures and to design their delivery systems within boundaries established by federal law. In some areas, the discretion is quite broad, while in other areas it is considerably more circumscribed. CHIP operates similarly, except that states have somewhat broader discretion in some areas. Before analyzing new options, rules, or guidance that the federal government could adopt to make it possible for states to do a better job enrolling and retaining eligible children and families, this section reviews some of the key federal provisions that define the boundaries of states' discretion under current Medicaid law. Unless otherwise indicated, the rules discussed below apply to both Medicaid and CHIP.

### Eligibility Rules

**Eligibility varies within families.** One of the last vestiges of Medicaid's historical association with welfare is that it serves "categories" of people at different income levels, and it does not serve some groups of people at all, no matter how poor they might be. Children and parents fall into Medicaid's eligibility categories, but federal law sets different minimum income eligibility levels for children depending on their age, and much lower minimum eligibility levels for parents. The federal minimum standard for children under age six is 133 percent of the federal poverty level (FPL), while the minimum standard for older children is set at 100 percent of the FPL. For parents, the federal minimum depends on the rules the state had in place in 1996 – the median is just 45 percent of the FPL.<sup>10</sup> Adults who are not parents, pregnant, disabled, or elderly are not eligible at any income level under Medicaid (or CHIP), except through a waiver (Figure 2).

**Figure 2**  
**Categorical Eligibility in Medicaid Leaves Coverage Gaps**



Sources: Bruen B, et al. August 1999. State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People. Washington, DC: Urban Institute. Kaiser Commission on Medicaid and the Uninsured. September 1998. Medicaid Eligibility for Families and Children. Note: The income level for parents represents the median AFDC payment level as of June 16, 1996.

**Gross versus net income.** Federal Medicaid law requires states to consider certain deductions when calculating income, but also permits states to adopt different rules for determining eligibility as long as the new rules are “less restrictive” than the federal minimum standards. Some states have been interested in simplifying eligibility by adopting a gross income standard that would expand eligibility or at least not contract it. The caveat under current law, however, is that states cannot use different rules to calculate income if any individual might lose eligibility as a result (even if on the whole, the change would not restrict eligibility and would simplify the program).<sup>11</sup> CHIP permits states to use a gross income standard, without limitation, but many states have carried over the Medicaid deductions to their CHIP programs in order to align the eligibility processes of the two programs.

### Gross and Net Income Rules in Medicaid: New York Example

New York uses a net income standard to determine if a child qualifies for Medicaid. The state first looks at gross income and then applies certain deductions (for example, up to \$200 per month in child care expenses can be deducted for each child in the family under age two). Once the deductions are applied, a child under age six is eligible if the family’s net income is below 133 percent of the FPL. Children over age six are eligible if the family’s net income is below 100 percent of the FPL. New York recently adopted a gross income standard at 160 percent of the FPL for all children and parents. Under current federal rules, the State can only implement this if it can show mathematically that it would be impossible for someone who would have been eligible under the net income calculations to be disqualified under the new rules. Otherwise, the State must operate a shadow eligibility system to continue calculating income under the previous rules to ensure that no one loses eligibility as a result of the conversion to a gross income standard.

**Asset tests are permitted.** Federal law allows states to determine eligibility without regard to a family’s assets beyond earnings and other income. Nearly all states (46) have dropped the asset test for children in their Medicaid and CHIP programs. Two additional states (Montana and Utah) have eliminated the asset test for children in CHIP but retained it for lower-income children in Medicaid.<sup>12</sup> However, fewer than half of all states—just 23—have dropped the asset test for parents, even though the income eligibility levels for parents are lower than they are for children.<sup>13</sup> New York dropped the asset tests for all adults in its recently enacted State budget.

## Enrollment and Renewal Procedures

In general, states have broad discretion as to how they design their enrollment and renewal procedures. For example, they may use mail-in or online procedures for applications and renewals, or they may require families to have a face-to-face interview at local welfare offices. Despite this broad range of options, there are some key rules and procedures that constrain states' flexibility to enroll and renew eligible children and families.

**Enrollment is not automatic.** In both Medicaid and CHIP, families must apply for coverage in their state and have their eligibility determined by the appropriate entity at the state or local level. A new option for “express lane” eligibility (ELE) for children was made available to states by the 2009 CHIP reauthorization law. ELE provides new opportunities for streamlining enrollment for children based on findings from other public programs or income tax data, but further simplifications are required to allow for full automatic enrollment of children based on their eligibility for other programs or benefits.

**States have discretion to rely on data systems, rather than documents submitted by families, to verify eligibility (except with respect to immigrant or citizenship status), but federal policies have not always been consistent in supporting streamlined, technology-based systems.** All states are required to take certain steps to verify eligibility by checking available databases (e.g., wage and bank records), but many states also require families to produce documents to verify their eligibility (e.g., several weeks' worth of pay stubs). Little has been done at the federal level to support state efforts to streamline enrollment and renewals using technology. Moreover, federal policies relating to how eligibility “error rates” are calculated have sometimes led states to err on the side of documentation instead of relying on databases.

**States must reevaluate eligibility at least every 12 months.** Federal law requires that, for both Medicaid and CHIP, eligibility must be reviewed at least every 12 months (more often at state discretion). Between renewals, changes in family circumstances (e.g., overtime pay) must be reported and may result in the loss of eligibility. However, states may elect to provide “continuous eligibility” for children, whereby children can remain enrolled without regard to fluctuations in income or other changes that might affect eligibility. The option is limited to 12 months.

**Certain Medicaid enrollment options for children are not available for parents, making family coverage more challenging.** The continuous enrollment option described above is not currently available for parents or other adults. Similarly, states can presumptively enroll children who appear to be eligible based on an application pending verification of eligibility, but this option also does not apply to parents. Finally, the new express lane enrollment option is also only available for children. These limitations make it difficult for states to take full advantage of these strategies for children who apply together with their parents and hamper state efforts to promote family-based coverage.

**States must designate a “single state agency” responsible for administering the Medicaid program, but there is no requirement for a state-level point of entry for enrollment or renewal.** States can delegate responsibility for taking applications and determining eligibility to other state agencies (e.g., welfare agencies) or to county or local agencies. In some states, families’ only available point of contact with the Medicaid program is through the local welfare office. By contrast, state CHIP programs typically have a state-level point of entry for enrollment, or enrollment and renewal is accomplished directly through the CHIP health plans themselves.

### Organization and Systems Capacity

**States design their own computer systems for processing and determining eligibility. Federal matching funds are available to help finance these systems, but the matching rate is set at the minimum 50 percent for all states.** By contrast, the federal Medicaid matching rates for improvements to and maintenance of state Medicaid claims systems are 90 percent and 75 percent, respectively. States can receive enhanced matching payments, which range from 65 percent to 85 percent, for systems improvements or maintenance related to CHIP, but these payments are subject to a cap on administrative spending. These limitations serve as a deterrent to large-scale systems redesigns that are sorely needed in many states.

## Options for a Changing Landscape

The discussion that follows lays out several approaches that could be employed to help strengthen states’ ability to enroll and retain eligible children and families in coverage. The options presented are intended to serve as a menu of administrative and legislative federal changes that could help states facilitate Medicaid and CHIP enrollment and reinforce continuity of care for children during their most critical formative years. Some of these options would allow required federal legislation to apply nationwide while others could be established administratively (e.g., through federal regulations). Almost all of the options could be tested by interested states under the Secretary of Health and Human Services (HHS) Section 1115 demonstration waiver authority.<sup>14</sup> The approaches could then be evaluated and serve as possible bases for broader program applications.

## Eligibility

A number of steps could be taken to streamline eligibility rules to make it easier for members of a family to qualify for Medicaid as a family, and to make it easier for the public to understand who is eligible and for states to administer the program. A range of options is discussed below, some of which are more likely to be undertaken in the context of broader health reform.<sup>15</sup>

**Establish eligibility rules based on income rather than categorical eligibility.** Medicaid began by making people eligible based on whether they qualified for cash assistance (AFDC or SSI). Gradually, over the years, Congress delinked Medicaid eligibility from eligibility for welfare, and established separate eligibility categories. Income eligibility levels, however, vary by category and, as noted above, some categories of people do not qualify at all, regardless of their income. In keeping with the movement to tie Medicaid eligibility to income and end “categorical” distinctions, many of the approaches for health reform currently under discussion in Congress would set a minimum eligibility level to guarantee Medicaid coverage to all people (without regard to “category”) living at or below some percentage of the federal poverty level (FPL). For example, the House “Tri-Committee” health reform legislation has proposed a mandatory minimum Medicaid eligibility level of 133 percent of the FPL (\$14,403 for an individual), a joint proposal by Families USA and PhRMA would also raise the level to 133 percent of the FPL, and the Commonwealth Fund has proposed a minimum of 150 percent of the FPL.<sup>16</sup>

Massachusetts’ health care reform effort provides an instructive example of how such a new structure might look. Massachusetts offers a menu of programs under which most individuals in the State can access insurance coverage. The State had expanded on its Medicaid/CHIP program (MassHealth) to cover children with family incomes up to 300 percent of the FPL before health reform, and with health reform, it created Commonwealth Care, which provides subsidized coverage to all adults with incomes up to 300 percent of the FPL.<sup>17</sup> The “connector” offers other coverage options to people with incomes above this level. Ending categorical exclusions and covering more people in Medicaid based on income would not only have a far-reaching impact on coverage; these steps would also go a long way toward simplifying eligibility and ensuring that parents and children are covered together as a family unit.

**Align income eligibility rules for families.** A more limited step would be to more closely align eligibility rules and enrollment procedures for parents and children. Some states have expanded Medicaid coverage for parents above the minimum federal requirements, but in most states, parent eligibility levels still lag far behind those of children—as of January 2009, the median income at which parents qualify for Medicaid was 68 percent of the FPL compared to 200 percent (through Medicaid and CHIP) for children.<sup>18</sup> Lifting the minimum eligibility standard as described above would help parents gain coverage and promote enrollment among children already eligible. A substantial body of research demonstrates that efforts to cover low-income parents in Medicaid and CHIP simultaneously increases enrollment of eligible children. In addition, when their parents are insured, children are more likely to access care, including preventive health services.<sup>19</sup> States can expand eligibility for parents without a change in law, but in the absence of a federal requirement or enhanced federal matching payment only a few states have covered parents at the same income levels as children. Congressional action is therefore needed in order to achieve meaningful advances.

**Even out eligibility levels for children.** An even more limited step would be to eliminate so-called “stair-step eligibility” rules in Medicaid and CHIP. While CHIP prompted every state to expand eligibility levels for children, almost half of the states still have Medicaid and CHIP eligibility standards that vary by age. In these states, the older children in a family are covered by CHIP, while their younger siblings are enrolled in Medicaid. This can cause confusion and extra paperwork for the family. It can also lead to children having to change health plans and perhaps providers when they turn six. In addition, the potential for coverage losses as children transfer from Medicaid to CHIP is increased, particularly when CHIP and Medicaid are not administered by the same agency and the renewal process is not aligned between the two programs.<sup>20</sup>

**Use of a gross income eligibility standard.** One of the barriers to families enrolling in Medicaid and CHIP is a lack of understanding of program eligibility rules.<sup>21</sup> Many families with modest incomes do not know that their children are eligible for coverage. Even if they are aware of published eligibility levels, those levels generally understate coverage options because in Medicaid, and in CHIP, eligibility is often measured against those levels after certain deductions are taken. A family may assume that if their gross income exceeds the published Medicaid and CHIP eligibility levels, their children do not qualify for coverage. However, once their work-related expenses are considered, the family (or the children in the family) may in fact be eligible.

The law could be revised to permit the use of other methods for calculating income eligibility (such as a gross income standard) as long as the new eligibility rules can be shown to be less restrictive for most people and achieve simplification overall. In the case of children, this change would have to be legislative, but in the case of families (parents and children), the change could be adopted by regulation.<sup>22</sup> This is not an issue for CHIP, since states are not required to apply any income deductions in CHIP and can adopt a gross income standard. Many states, however, have adopted a net income calculation in their CHIP programs to align with Medicaid.

In the context of health reform, a simplified eligibility calculation that is also aligned with the methods employed for calculating whatever subsidy or tax credit is provided to people with incomes above Medicaid or CHIP eligibility standards would be critical. Alignment would make it easier to determine whether a child or family is eligible for Medicaid, CHIP, or the subsidy without requiring separate eligibility determinations, and it would promote smooth transitions between the different components when family income changes.

**Eliminate the requirement to cooperate with medical support efforts when applying for Medicaid.** One complicating factor for Medicaid applications is that parents must agree to cooperate in identifying an absent parent for any child applying for coverage and to establish paternity and pursue child support payments to help cover the costs of medical care. This requirement goes well beyond an agreement that any insurance held by an absent parent that covers a child in the home must be the primary payer (this is also a requirement in Medicaid). The Medicaid application process is, in effect, used to initiate or potentially revisit child support obligations, a throwback to Medicaid's historical ties to welfare. An exemption is available if the parent can show that contacting the absent parent would result in harm to self or children, but some parents avoid applying for Medicaid because of this requirement (for example, they may not want to have any contact with the absent parent), and it complicates the application process. The medical support requirement does not apply to CHIP.

One option would be to eliminate the medical support cooperation requirement in Medicaid, while still retaining the third-party liability requirement (i.e., if the absent parent has insurance that could cover the child, that insurance is the primary payer). The law could also be modified to require state agencies to inform families about the services available to help them obtain child and medical support from an absent parent.

**Eliminate asset tests.** Nearly all of the states (46) have stopped using asset tests in determining eligibility for children.<sup>23</sup> However, not quite half of the states have eliminated Medicaid asset tests for parents.<sup>24</sup> A statutory change prohibiting the use of asset tests would not have much effect on eligibility (most low-income families do not have much in the way of countable assets), but it would simplify eligibility determinations for families and agencies. In the context of health reform, it would make little sense to allow an asset test for Medicaid and CHIP if such a test were not adopted for high-income people to qualify for a subsidy or tax credit.

## Enrollment

Enroll all children upon birth in U.S. hospitals. A national initiative could be established to ensure that no child born in a U.S. hospital would go home without some form of health insurance coverage. A small number of states, including California, Oklahoma, and Connecticut, are pursuing such initiatives now, and lessons learned from those efforts could be carried over into a new federal-state initiative.

The initiative could be built upon the concept of “deemed eligibility” of newborns. Under federal law, infants who are born to mothers covered by Medicaid (including emergency Medicaid) and CHIP are deemed to be eligible for coverage for one year without having to submit an application. In some states, however, this enrollment does not occur as regularly or as promptly as it should.

While most hospitals, particularly public hospitals, have someone on staff who is responsible for working with patients to facilitate Medicaid or CHIP enrollment, and states have a responsibility to “outstation” Medicaid application assistance at all disproportionate share hospitals (DSH), there is no explicit federal requirement in place to ensure that newborns have coverage. One option would be to make such a requirement a condition for hospitals to qualify for Medicaid or Medicare DSH payments.<sup>25</sup> The hospitals’ administrative costs associated with enrollment would qualify for Medicaid or CHIP administrative matching funds. Another option would be for the federal government to encourage and support automatic newborn hospital-based enrollment demonstrations through new federal outreach funding made available in CHIPRA.



## Enrolling Oklahomans Sooner Rather Than Later

The state of Oklahoma has developed a newborn enrollment initiative, known as “Electronic Newborn-1,” that allows newborns to be added to SoonerCare (the State’s Medicaid program) immediately after birth. Participating hospitals are able to enroll newborns through an Internet-based web portal in real time so that the enrollment process is completed before mother and baby are released from the hospital. Mothers choose their babies’ primary care providers at the time of enrollment in SoonerCare, eliminating the need for auto-assignment, which had been a source of member dissatisfaction in the past.

The provider receives immediate notification of eligibility and member information for the baby and can therefore immediately submit claims for services provided. The state takes an average of 3.7 days to complete the enrollment process; 94 percent of all eligible newborns are enrolled in less than 10 days. As of June 2008, 1,570 newborns had been enrolled in SoonerCare through 19 participating hospitals. Oklahoma plans to expand the system statewide during state fiscal year 2009.

Source: Oklahoma Health Care Authority. June 2008. *Service Efforts and Accomplishments: SFY 2008*. Available at <http://www.ohca.state.ok.us/WorkArea/DownloadAsset.aspx?id=9400>.

### **Consider further changes to the citizenship documentation requirement in Medicaid and**

**CHIP.** Under an amendment to federal law adopted in 2006, state Medicaid agencies no longer have the flexibility to accept an applicant’s attestation of citizenship. U.S. citizens applying for Medicaid are required to present documentation that proves their citizenship and confirms personal identity. This requirement has resulted in enrollment delays and disenrollments for tens of thousands of eligible U.S. citizen families.<sup>26</sup> CHIPRA included a new option designed to facilitate states’ efforts to confirm citizenship on behalf of applicants, and also applied the requirement to CHIP. Beginning in 2010, states will be permitted to submit Medicaid and CHIP applicants’ names and Social Security Numbers (SSNs) to the Social Security Administration (SSA) so that the agency may conduct a data match to confirm the individual’s citizenship. If the name, the SSN, or other information provided is inconsistent with the SSA’s records, the state must make a reasonable effort to address the discrepancy while providing coverage to the applicant if he or she is otherwise eligible.

One limitation of the SSA data is that citizenship can only be electronically verified for births starting in 1981. This will work for children, but will still require families to provide proof of citizenship and identity for those born before that date. Given this limitation, the Centers for Medicare and Medicaid Services (CMS) could consider eliminating the current regulatory requirement that individuals submit original documents as proof of citizenship and identity, which can be difficult and time-consuming to obtain.

This new data matching process with the SSA should be closely monitored and evaluated in order to determine its effectiveness at facilitating enrollment of otherwise eligible families. If it appears that states are not using the option, or that families are still experiencing major delays or other problems in enrollment, Congress could consider restoring states' flexibility to rely on self-attestation (under penalty of perjury).

**Streamlined enrollment demonstration for states that are covering all children regardless of immigration status.** Some states, including New York, cover children without regard to immigration status. Federal Medicaid and CHIP funds are not permitted to be used to cover undocumented children, so these states use state funds to cover these children. In addition, as discussed above, federal law requires states to document immigration and citizenship status. The rules requiring states to screen for undocumented immigrants and document immigrant and citizenship status make it difficult for states to adopt streamlined enrollment systems when they are covering all children.

A possible approach would be for CMS to develop a waiver initiative that would permit interested states that cover “all kids” to develop a streamlined enrollment process that does not identify immigration or citizenship status. Instead, the state and the federal government could determine an appropriate estimate of the proportion of children who would be enrolled, but who do not qualify for federal matching payments, based on available data. The estimate would be used to “back out” a certain portion of the state’s federal reimbursement each quarter to account for spending on ineligible individuals. There is some precedent for this concept: an HHS-approved demonstration in Los Angeles County in the mid-1990s and a more recent California family planning waiver.<sup>27</sup> The new waiver initiative for children could require an audit through a sampling process to evaluate and, if necessary, readjust the claims reduction amount.

This approach could also be tested by states interested in using eligibility information from other programs, such as school lunch or WIC programs, in the context of the new “express lane” eligibility option. Rather than complicate the eligibility process to sort out which uninsured income-eligible children enrolled in school lunch or WIC programs meet the Medicaid and CHIP immigration requirements, the state and the federal government could establish a process for not claiming federal matching payments for a portion of the children enrolled through express lane routes to account for the group of children ineligible for federal payments. Audits could be conducted on a sampling basis with a reconciliation process.

**Establish state-level point of entry for Medicaid enrollment and renewals.** Ensuring that families in all states have, as an option, a state-level point of entry and place to do ongoing business with the Medicaid program (including all aspects of the application and renewal process) could be an important step toward meeting the diverse needs of eligible families. Most separate CHIP programs handle applications and renewals in this way, but for Medicaid benefits, families in many states still ultimately deal with the local welfare office. For example, once a mail-in application is received it will be the local welfare office that follows up if more information is needed. Welfare offices typically handle eligibility renewals as well. While welfare offices provide valuable services to individuals and families and can help facilitate access to multiple benefit programs, the connection to welfare can deter some individuals from applying. It can also confuse families who apply through the mail but receive renewal information from a local welfare office with which they had no contact during the application process.<sup>28</sup>

**Align quality control and Payment Error Rate Measurement (PERM) policies with coverage goals.** The federal government appropriately reviews state eligibility determinations and claims payments to ensure that the systems are operating with minimal errors, but these reviews need to be reconsidered and modified to promote, rather than undermine, efforts to enroll and retain eligible children and families. The Medicaid eligibility quality control system (MEQC) has been operating in Medicaid for many years in different forms. More recently, an additional system has been added through a broader initiative known as PERM.<sup>29</sup>

While program integrity is certainly a shared priority for states and the federal government, the methods for measuring error rates can run counter to policies and legislation designed to facilitate and expand enrollment in Medicaid and CHIP. The way in which errors are measured and reported can have a significant impact on states' policy decisions, either supporting or hampering policies meant to enroll eligible people who would otherwise remain uninsured. In addition, states have raised concerns that the rules for PERM and the rules that remain in place for MEQC are in some cases duplicative. These new policies are prompting states to develop an unbalanced approach to program integrity out of concern that financial penalties will be levied for perceived inappropriate approvals. As one state official noted in an interview,

*"[O]ur previous approach to eligibility was designed to keep ineligible people out of the program... Caseworkers are now equally focused on ensuring that eligible people get the health benefits they need and qualify for. If PERM is implemented in a way that reverses this culture change, it will turn back the clock on ten years of hard work and progress."*<sup>30</sup>

**Experiment with efforts to establish portability for Medicaid and CHIP.** Currently, children and families are likely to experience a gap in health coverage when they move to a new state, even if they were previously enrolled in Medicaid or CHIP in their former state. These gaps in coverage can be detrimental to the health of children and parents. They can prompt families to delay necessary care and then result in extra costs in the new state once coverage is secured.

There are several ways that portability could be tried and tested. One option would be to apply the “express lane” and presumptive eligibility concepts to ensure ongoing coverage. The new state could presumptively extend coverage to a child or family based on confirmation of Medicaid enrollment in another state, pending a new application process. A somewhat more aggressive approach would be for the new state to enroll a child or other family member into coverage based on eligibility established in the former state, if the eligibility level in that state is at or above the level in the new state. For example, if a child moves from Colorado to New Mexico, which has a higher income eligibility level for children, the child could be automatically enrolled in coverage in New Mexico, perhaps with a shortened initial renewal period to allow the state to determine whether there has been any significant change in income after the move. Wisconsin, for instance, deems migrant laborer families eligible for Medicaid with proof of enrollment in another state’s Medicaid program, despite differences in program rules.<sup>31</sup> Different approaches could be tested through a Section 1115 waiver, with an evaluation to help determine what options might be most promising for states and how the concept might be applied nationwide. Portability would be somewhat easier to administer if a national eligibility floor for children (or adults) were put into place, at least for those with incomes at or below the mandatory eligibility floor.

## Continuous Coverage

One of the key problems for states, providers, and low-income families is the high rate of interruptions in health coverage that occurs within both the employer system and the public coverage programs. Among children eligible for Medicaid or CHIP, gaps often occur when a child who has been enrolled loses coverage despite ongoing eligibility. One study has found that more than one-third of all low-income eligible but uninsured children had actually been enrolled in Medicaid or CHIP at some point within the prior 12 months, but lost that coverage for procedural reasons.<sup>32</sup> Research consistently shows that children who have health insurance coverage are more likely to receive the recommended well-child care and immunizations, in addition to having fewer unmet health needs and preventable hospitalizations than those without coverage.<sup>33</sup> This in turn leads to better health outcomes overall. Indeed, without continuous coverage it is not even possible to measure outcomes

and the quality of care. Two related mechanisms that have been proven to promote enrollment and reduce the amount of churning on and off of Medicaid and CHIP are lengthening the amount of time between required eligibility renewals and ensuring continuous coverage during the periods between renewals. The options below build on these two approaches.<sup>34</sup>

**Optional two-year renewals.** Over the years, states have come to understand that scheduling renewals no more often than once a year is beneficial to the family and can reduce administrative burdens and costs to the state. The vast majority of states (46 in Medicaid, 39 in separate CHIP programs) now schedule eligibility reviews for children at 12-month intervals (the maximum permitted under current federal law).<sup>35</sup> One option is to allow states to formally renew coverage less frequently, at intervals of up to 24 months. States could check ongoing eligibility at the one-year point by consulting wage databases or other sources of information for all or a sample of cases. This approach would require a statutory change to make it an explicit option, or the federal government could test the benefits of extending the period between renewals through a demonstration waiver.

**Optional two-year continuous eligibility.** Among the states with 12-month renewals, 19 states have elected to go a step further, providing 12 months of continuous eligibility for children in both Medicaid and CHIP (New York provides 12-month continuous eligibility for children in Medicaid), meaning that changes in income or other circumstances do not affect eligibility until the point of renewal.<sup>36</sup> This option became available to states in 1997, as part of the original authorizing legislation for CHIP. States have reported that allowing 12-month continuous eligibility has greatly improved program retention and also reduced state eligibility processing costs.<sup>37</sup> In order to further test the health benefits of continuous coverage for children, Congress could increase the option for continuous eligibility from 12 to 24 months. Pending a statutory change, this approach could be tested through a Section 1115 waiver.

**Extend enrollment options to adults.** There are several options designed to facilitate enrollment for children that could be carried over to adults, or at least to parents, including 12-month continuous eligibility, presumptive eligibility, and “express lane” eligibility (ELE). While nearly 40 states rely on 12-month renewal periods for parents,<sup>38</sup> there is no formal option for states to provide continuous enrollment for parents and therefore entire families.<sup>39</sup> In 2007, New York authorized 12-month continuous eligibility for adults in Medicaid, but implementation is contingent upon federal approval. In addition, presumptive eligibility (enrolling an applicant in Medicaid or CHIP coverage based on initial income information

provided, pending the formal eligibility determination) is an option for pregnant women and for children, but it is not currently available for parents. Finally, the new authority under CHIPRA provides an option for ELE for children. The concept behind ELE is for states to utilize data and income information that has been provided to other programs or for income tax purposes to facilitate enrollment in Medicaid and CHIP. This option could similarly be extended for adults in certain circumstances. The extension of these options to parents would require explicit legislative authority, or a waiver.

Extending explicit options to families as well as children would be helpful for a number of reasons. When all members of a family are eligible for Medicaid (as is true for the lowest-income families and for families with somewhat higher incomes to the extent that parents and children in the same family are eligible for coverage), they ought to be able to apply for and renew coverage together. Having different procedures for parents and children complicates the system and tends to undermine the value of the option for the child.

Finally, in the broader context of health reform, continuous enrollment for all groups of people would be a key element to promote coverage and quality care. The concept should be applied both to public programs and to the administration of subsidies or tax credits available to those who do not qualify for Medicaid or CHIP.

**Continuous eligibility from birth to age five.** Further along the continuum would be an option to enroll young children continuously for up to five years. Research has consistently shown that children with insurance coverage are more likely to have a usual source of care, to receive the recommended course of immunizations, and to have medical and developmental needs identified earlier.<sup>40</sup> Early detection of health and developmental problems, and having a consistent medical home, are thought to promote better health outcomes and opportunities for children to achieve their full potential. Through the demonstration waiver process, CMS could offer states the opportunity to test the health benefits and evaluate the health and cost implications of providing continuous eligibility to children from birth to school age.

This type of experiment is exactly the kind of demonstration that was intended under Section 1115 waiver authority. While there would likely be increased coverage costs during the initial years of the demonstration (because children would not be churning off the program), it could be very instructive to test whether providing continuous coverage would ultimately result in fewer visits to the emergency room and improved overall health status, potentially reducing or at least stabilizing costs over time. Such an experiment could also lead to lower administrative costs for states and managed care plans due to not having to spend resources identifying and reenrolling children. In addition, the demonstration could examine the

quality implications of establishing a long-term medical home for children, allowing providers to work more effectively with families to identify and treat health care needs. It would also be useful to explore what percentage of children might otherwise have lost their eligibility during the five-year period by monitoring fluctuations in family income that may have resulted in disenrollment.

One strategy that might help allay concerns about providing coverage for children whose family incomes might have increased over the years would be to limit the demonstration to children with incomes somewhat below the upper income eligibility level for children in the state. For example, New York covers children up to 400 percent of the FPL. Continuously covering all children with incomes below 200 or 300 percent of the FPL would not likely result in enrollment of children who are not already eligible for coverage. A rigorous evaluation could test this assumption. Further steps would need to be taken to adjust premiums if family income changes over time and to ensure that any private insurance a family might obtain always serves as the primary payer.

In addition to promoting stability of coverage, this type of demonstration could also create positive new incentives for managed care organizations and other primary care case managers. Long-term relationships, particularly in risk-based capitated payment plans, offer new opportunities and incentives for keeping children healthy. States and providers participating in the demonstration could develop new quality measurement and reporting requirements in anticipation of a longer-term enrollment period. In addition to facilitating better utilization of care, regular contact with enrollees (consistent with recommended medical practice) would ensure that the children (for whom the state may be paying a capitation payment during the continuous enrollment period) are still living in the state.

## Improving Renewal Rates

State experience and research have shown the importance of the renewal process in providing continuity of coverage for eligible individuals. Many states have streamlined their renewal processes, removing the requirement for a face-to-face interview at renewal, reducing verification requirements, and, in states with separate CHIP programs, using a joint program renewal form. Despite these changes, program retention remains a problem in many states. States can make further progress within existing rules— Louisiana, for instance, has managed to reduce the loss of coverage among eligible individuals at renewals to less than 1 percent—but further changes could promote additional efficiencies.<sup>41</sup>

**Promote automated renewals.** Under current law, states are required to take several steps to independently determine ongoing eligibility for enrollees before requesting information from families or closing the case. This independent evaluation, known as the ex parte renewal process, is based on information available through accessible databases and can streamline the renewal process for states and families. Once these efforts are exhausted, if ongoing eligibility cannot be established through this process, families can be required to provide any further documentation that may be needed. Actual state practices in conducting ex parte renewals are not well documented and appear to be fairly inconsistent. CMS could help support state efforts to conduct ex parte renewals and to rely more on technology to conduct renewals. In addition, CMS could provide much needed clarification on the following:

- The use of electronic signatures is permitted for both the Medicaid and CHIP application and renewal process.
- Renewal forms are not required under federal law. States that have sufficient information on hand can renew eligibility without a renewal form, as Louisiana does for a large portion of its renewals.

**Conduct renewals based on past income or averaged income.** Tax records or wage data for the prior year can be a reliable source of information about the income of families with relatively stable earnings, but federal rules, including quality control guidelines, do not make it clear that such information can be used to renew eligibility. CMS could clarify that states are permitted to conduct eligibility renewals based on a family's income from the prior calendar year. Family members could be asked to attest to their income level and advised that their eligibility will be renewed based on this information unless they advise the agency that their circumstances have changed. Agencies could then conduct standard checks with wage databases and other sources of information to confirm the reported information as needed.

An additional simplification measure would be to explicitly allow states to average family income over a year (on a prospective basis), to avoid occasional ebbs and flows in income (due to overtime pay or seasonal work, for example) that may result in coverage gaps and program churning. Many low-income families experience variations in income from month to month or season to season, but over the year (which is now the typical eligibility period in Medicaid and CHIP), income generally stays below eligibility limits.



## Louisiana Leads the Way

Over the past decade, the Louisiana Department of Health and Hospitals has taken a series of progressive and innovative steps to reduce the number of children who lose Medicaid or CHIP (known as LaCHIP) coverage at renewal for reasons not related to eligibility. In 2008, less than 1 percent of children enrolled in Louisiana's LaCHIP program lost coverage due to procedural or administrative reasons; in other states, as many as half of enrolled children lose coverage at renewal.

In Louisiana, the great majority of children—90 percent of Medicaid children and 84 percent of CHIP children—renew coverage without renewal forms. Louisiana's process starts with administrative renewal of cases that are highly unlikely to have a change in circumstances affecting eligibility, including specific eligibility categories such as long-term care. Cases that cannot be administratively renewed are assigned to eligibility caseworkers who first conduct an ex parte review.

More than half of Louisiana Medicaid cases and one-third of CHIP cases are renewed through ex parte review, meaning that the eligibility worker is able to verify ongoing eligibility by checking these databases and sources of information. In these cases, the worker simply sends out a notice to the household informing them that their coverage has been renewed. Almost half of CHIP families (45 percent) and nearly a quarter of Medicaid families (22 percent) complete the renewal process over the phone. Before a case can be closed at renewal, a supervisor works with the eligibility worker to review the actions that have been taken to conduct an ex parte review and connect with the family. Together they brainstorm and attempt other ways to locate and reach the family. A minimum of three documented calls is required before closure, and often many more are made. Overall, the efforts have reduced administrative burdens by eliminating unnecessary forms and the tasks associated with closing and later reopening cases.

Source: Brooks T. February 2009. *The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and CHIP*. Center for Children and Families.

In the case of migrant or other types of seasonal workers, income can be fairly significant during certain months but nonexistent in others. This problem has been remedied for children in states that adopt the 12-month continuous eligibility option, but further flexibility could be made available to states that have not opted for 12-month continuous enrollment or that are hoping to stabilize coverage for adults within the family for whom the option does not currently apply. States could be permitted to allow families to provide an estimate of their average income for the coming year for purposes of determining eligibility, perhaps looking at last year's earnings as a way to verify the estimate.

## Systems Improvements

Systems improvements are a fundamental element of building a stronger and more efficient Medicaid program. These improvements are inextricably linked with states' ability to effectively rely on other data systems to identify, enroll, and retain eligible children, to keep up with eligibility changes, and to implement many of the policy options discussed in this report. Moreover, systems modernization will be key to states' ability to smoothly integrate Medicaid and CHIP with new pathways to coverage that may be included in health reform.

Many states are still using the same eligibility and claims processing systems that were developed when the Medicaid program was ramping up in the 1970s and '80s. In addition, many state Medicaid eligibility systems (including New York's) continue to be merged with Temporary Assistance for Needy Families (TANF) and food stamps programs and are actually "owned" by the TANF agency. States often lament that requests for systems changes can take as long as two years to be addressed, given the queue of needed updates for the different programs handled by the system. Allocating state funds for investing in new technology has not historically been a priority. The pendulum is beginning to shift, prompted by the interest at the state and federal levels in health information technology, but eligibility systems have not always been considered part of this area.

**Increase the matching rate for eligibility systems improvements.** Lack of available state funding is a primary barrier to states' ability to improve their systems. As noted, the federal Medicaid matching rate for eligibility systems exchanges is 50 percent.

There are currently higher matching rates—90 percent for design and development and 75 percent for operation—for Medicaid Management Information System claims processing systems. It appears that the statutory language is broad enough to permit the Secretary to carry over the 90/75 percent matching rates to eligibility systems and related activities.<sup>42</sup> Alternatively, the change could be made legislatively.

States could be permitted to use the enhanced administrative funding for activities such as:

- Medicaid eligibility system design and maintenance, including system enhancements to allow data matches with other systems to streamline enrollment, verification of eligibility, and even to help with outreach;
- Development and design of a web-based enrollment and renewal system;
- Redesigning notices and other computer-generated communications to applicants and enrollees to promote simpler, more welcoming messages, and communications in appropriate languages; and

- Information retrieval systems that would produce timely administrative data relating to outcomes of applications, renewals, reopenings, and other key case management activities. Such information could also help states and the federal government pinpoint what is and what is not working in application and renewal systems to target interventions appropriately.

To help ensure that the “enhanced” matching rate for the systems improvements translates into new practices that ultimately improve enrollment and retention, states could be required to meet certain program operation standards as a condition of receiving the enhanced match. Such standards could include:

- Ensuring through periodic audits that the state’s system is consistent with federal and state eligibility rules (thus avoiding inappropriate denials or terminations that can result when updated rules are not fully programmed into the system);
- Ensuring that the Medicaid system can “talk to” other data and eligibility systems, including CHIP, in order to promote primary reliance on data systems for eligibility verification and to promote automatic and seamless transitions in coverage for children who move between Medicaid and CHIP;
- Publicly reporting data on enrollment and retention at regular intervals; and
- Taking steps toward adoption of online/web-based enrollment and renewal systems.

**Move toward online enrollment and renewal.** The federal government could further encourage and support the use of web-based Medicaid enrollment and renewal systems. Utilizing the potential of the Internet for facilitating families’ enrollment in health coverage programs seems a logical opportunity to move these programs into the 21st century. All states currently operate websites that provide information about their Medicaid and CHIP programs, and most allow individuals to print the program application to be filled out and submitted to the state with additional documentation of income and other forms. However, only a handful of states currently offer families or community-based application assistants the opportunity to actually fill out and electronically submit Medicaid/CHIP applications directly through the state’s website. States that have adopted online application and renewal systems have found a significant and growing number of users.

There are at least two potential levels of developing web-based enrollment mechanisms that could be pursued:

- Level 1: National Eligibility Screening Tool. The federal government could develop a national web-based screening tool that could be used by the general public to learn about Medicaid and CHIP and to provide a preliminary estimation of whether individuals or families are likely to be eligible for coverage in their state. The website could include links to each state's Medicaid/CHIP website, where families could learn more about specific eligibility rules. Such a screening tool could be potentially funded as part of the \$10 million that has been allocated for a national outreach campaign through the CHIPRA legislation.
- Level 2: Online Enrollment and Renewal. States could be encouraged (with corresponding federal support and incentives) to develop and implement online enrollment and renewal systems. Under such a system, families could fill out an online application and provide an electronic signature attesting to the accuracy of the information provided. Documentation of income and other supporting materials (if required by the state) would still need to be submitted, or the state could verify eligibility through other means. States that have implemented the presumptive eligibility option could enroll those who appear to be eligible immediately, pending verification of eligibility. The underlying systems development for automated eligibility determinations potentially could be financed through CHIPRA outreach grants, or through the enhanced systems improvement matching rate discussed above. Further, the federal government could investigate ways that it could support one or more federal contractors to undertake the initial systems development, and then states could work with those contractors to adapt the system to their state rules and systems environment. The National Association of State Medicaid Directors included in their recent statement of principles on health reform a proposal to permit group purchasing among states in order to reduce costs for a variety of activities, one of which could be systems development for online enrollment.<sup>43</sup>

## Accessing Badger Care in Wisconsin—Online Enrollment

Wisconsin has implemented a web-based tool called Access that allows individuals to apply for and manage their participation in public benefits programs, including Medicaid, BadgerCare Plus (the State's CHIP program), and food stamps.

The Access system offers an electronic application that can be filled in on-screen and submitted for enrollment. The system is supported by an anonymous eligibility screener that checks potential eligibility in real time and prompts the applicant for missing information. The State also offers a toll-free number to call for additional help completing the application. Applicants can stop and restart the online application and can check the status of their application once it has been submitted. Once enrolled, individuals can use the system to monitor benefit payments and report changes.

Access includes additional tools for community-based organizations to use when assisting families in applying for benefits. Providers and certain partners are even able to complete presumptive eligibility applications online. The State also has a training site to give application assistors an opportunity to practice using the system.

As Wisconsin prepares to launch a new health insurance program for adults without dependent children—the BadgerCare Plus Core Health Plan—the Access system will continue to be upgraded. By early 2010, applicants for the new plan will complete a health assessment and list their primary care provider online. The system will then identify participating HMOs with networks that include the applicant's provider and recommend the health plan that scores the highest in treating certain chronic conditions that may have been noted on the enrollee's health assessment.

Source: Wisconsin Access, <https://access.wisconsin.gov/access/>.

## The Landscape in Context

All of these measures—some small and some bolder—are aimed at increasing Medicaid and CHIP enrollment and retention among already eligible children and families. In recent years, states have taken a number of steps to reduce barriers to enrollment and retention in public coverage. But as the New York experience demonstrates, while states can make significant strides on their own, closing the remaining coverage gap for children and adults requires more fundamental change and is only possible with a federal partner. Whether or not health care reform is adopted, measures like those described above that would significantly improve enrollment and renewal, and ensure continuity of coverage, will be needed if the systems for securing and retaining coverage are to function at optimal levels. In addition, as current health reform efforts have proposed building upon public programs to reach coverage goals, under a reformed system it will be even more critical that Medicaid and CHIP are stable and straightforward pathways to coverage. Only with such changes will we be able to make the gains in coverage that have been envisioned under CHIPRA and that will be needed to meet the goal of universal coverage under health reform.

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## Notes

- <sup>1</sup> Dubay L. March 1, 2009. Johns Hopkins University Bloomberg School of Public Health analysis of the National Health Interview Survey for the Center for Children and Families.
- <sup>2</sup> Hudson JL and TM Selden. August 16, 2007. Children's Eligibility and Coverage: Recent Trends and a Look Ahead. *Health Affairs* 26(5): w618-w629.
- <sup>3</sup> Urban Institute analysis of 2008 *Annual Social and Economic Supplement to the Current Population Survey* for the United Hospital Fund.
- <sup>4</sup> Dubay L. Johns Hopkins University Bloomberg School of Public Health analysis of March 2005 Current Population Survey using July 2004 state eligibility rules.
- <sup>5</sup> Urban Institute analysis of 2008 *Annual Social and Economic Supplement to the Current Population Survey* for the United Hospital Fund.
- <sup>6</sup> Cook A, A Williams, and D Holahan. Forthcoming. *Health Insurance Coverage in New York, 2006-2007*. United Hospital Fund.
- <sup>7</sup> New York State Department of Health, Medicaid and CHIP administrative data for 2007.
- <sup>8</sup> New York State Department of Health. March 31, 2009. Application for Extension: New York State Section 1115 Demonstration Project No. 11-W-00114/2: The Partnership Plan. Urban Institute analysis of 2008 *Annual Social and Economic Supplement to the Current Population Survey* for the United Hospital Fund.
- <sup>9</sup> The effective dates of these reforms are as follows: reduced documentation requirements for Medicaid and FHP at renewal (January 2008); presumptive eligibility for children into Medicaid (February 2008); elimination of vestiges of welfare, including drug and alcohol screening (April 2008) and finger imaging (July 2009); establishment of a single eligibility level for single adults and childless couples (April 2008); elimination of the Medicaid and FHP asset test requirement (January 2010); elimination of the Medicaid and FHP face-to-face interview requirement (April 2010); and elimination of age-based eligibility distinctions (CHIP and Medicaid) and a shift to gross income test for Medicaid (April 2010, contingent upon federal approval).
- <sup>10</sup> Kaiser Commission on Medicaid and the Uninsured. September 1998. *Medicaid Eligibility for Families and Children*.
- <sup>11</sup> See sections 1902(r)(2) and 1931(b)(2)(C) of the Social Security Act.
- <sup>12</sup> Cohen Ross D and C Marks. January 2009. *Challenges of Providing Health Coverage for Children and Parents in a Recession*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7855.cfm>.
- <sup>13</sup> Ibid.
- <sup>14</sup> Under Section 1115, the Secretary of Health and Human Services may waive certain provisions of the Medicaid statute that set the federal parameters within which states must design and operate their programs. Provisions that may be waived include certain Medicaid eligibility criteria, rules governing the services that will be offered, and the service delivery and payment methods the state uses in administering the program. For more information, see Shirk C, July 30, 2008, *Medicaid and CHIP Waivers: The Basics*, National Health Policy Forum, available at [http://www.nhpf.org/library/the-basics/Basics\\_MedicaidCHIPWaivers\\_07-30-08.pdf](http://www.nhpf.org/library/the-basics/Basics_MedicaidCHIPWaivers_07-30-08.pdf)
- <sup>15</sup> For additional information on improving enrollment, see Coulter Edwards B, VK Smith, and G Moody, May 2008, *Reforming New York's Medicaid Eligibility Process: Lessons from Other States*, United Hospital Fund, available at [http://www.uhfnyc.org/pubs-stories3220/pubs-stories\\_show.htm?doc\\_id=692383](http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=692383)
- <sup>16</sup> Note that these are all net income levels. See Georgetown University Center for Children and Families, July 2, 2009, *Key Medicaid, CHIP, and Low-Income Provisions in the House Tri-Committee Health Reform Bill*, available at <http://ccf.georgetown.edu/index/health-care-reform>; PhRMA and Families USA, April 21, 2009, PhRMA, *Families USA Jointly Promote Measures to Ensure Quality, Affordable Healthcare Coverage* (press release), available at [http://www.phrma.org/index.php?option=com\\_content&task=view&Itemid=109&id=1211](http://www.phrma.org/index.php?option=com_content&task=view&Itemid=109&id=1211); and Schoen C, K Davis, and S Collins, May/June 2008, Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance, *Health Affairs*, 27(3): 646-657.
- <sup>17</sup> For more information, see Community Catalyst, August 2008, *Massachusetts Health Reform: What's the Real Story?*, available at [http://www.communitycatalyst.org/doc\\_store/publications/mass\\_health\\_reform\\_august\\_2008.pdf](http://www.communitycatalyst.org/doc_store/publications/mass_health_reform_august_2008.pdf)
- <sup>18</sup> Cohen Ross D and C Marks. January 2009. *Challenges of Providing Health Coverage for Children and Parents in a Recession*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7855.cfm>.
- <sup>19</sup> Mann C. March 2009. *Family Coverage: Covering Parents Along with Their Children*. Center for Children and Families. Available at <http://ccf.georgetown.edu/index/family-coverage-covering-parents-along-with-their-children>.
- <sup>20</sup> Sommers B. November/December 2005. The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP. *Health Affairs* 24(6): 1611-1618.
- <sup>21</sup> Perry M and J Paradise. May 2007. *Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7640.cfm>.
- <sup>22</sup> Compare sections 1902(r)(2) and 1931(b)(2)(C) of Title XIX of the Social Security Act.
- <sup>23</sup> Ross D and C Marks. January 2009. *Challenges of Providing Health Coverage for Children and Parents in a Recession*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7855.cfm>.
- <sup>24</sup> Ibid.
- <sup>25</sup> Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment.

- <sup>26</sup> Government Accountability Office. June 2007. *Medicaid: States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*. Available at <http://www.gao.gov/new.items/d07889.pdf>.
- <sup>27</sup> Long SK and S Zuckerman. Fall 1998. Urban Health Care in Transition: Challenges Facing Los Angeles County. *Health Care Financing Review* 20(1): 45-58.
- <sup>28</sup> For more information on families' perceived barriers to recertification, see Perry M, February 2009, *Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus: Findings from Eight Focus Groups with Recently Disenrolled Individuals*, New York State Health Foundation, available at <http://www.nyshealthfoundation.org/content/article/detail/1561>.
- <sup>29</sup> Improper payments are any payments that have been made in error, including payments that should not have been made, payments that were made in an incorrect amount, and inappropriate denials of payment or services. The PERM program estimates payment errors for a sample of claims in three areas—fee for service payments, managed care payments, and program eligibility—for Medicaid and CHIP. The purpose of PERM is to estimate the number of errors states make in paying provider claims and in determining eligibility for Medicaid and CHIP. Through the PERM initiative, CMS is reporting the rate of “improper payments” in all states over a three-year period. See [www.cms.hhs.gov/perms](http://www.cms.hhs.gov/perms) for more information.
- <sup>30</sup> Wachino V and D Cohen Ross. February 2008. *Will the Payment Error Rate Measurement (PERM) Program Affect State Efforts to Facilitate Enrollment of Eligible Children and Parents in Medicaid and SCHIP?* Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7755a.cfm>.
- <sup>31</sup> The Children's Partnership. April 2009. *Express Lane Activities: States on the Move*. Available at <http://www.childrenspartnership.org>.
- <sup>32</sup> Sommers B. February 2005. From Medicaid to Uninsured: Drop-Out among Children in Public Insurance Programs. *Health Services Research* 40(1): 59-78. Available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1361126&blobtype=pdf>.
- <sup>33</sup> For example, see Institute of Medicine, February 2009, *America's Uninsured Crisis: Consequences for Health and Health Care*, February 2009, available at <http://www.iom.edu/?ID=63118>; VanLandeghem K, et al., 2006, *New York's SCHIP Program Improves Health Care Access, Continuity, and Quality*, The Child Health Insurance Research Initiative, available at <http://www.ahrq.gov/chiri/chirifind.htm>; and Dick AW, et al., September/October 2004, SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare?, *Health Affairs*, 23(5): 63-75.
- <sup>34</sup> For additional information on improving retention, see Dutton M, K Griffin, and A Cohen, December 2008, *Automated Renewal: Strategies to Maintain Coverage of Eligible Children in Medicaid and Child Health Plus*, United Hospital Fund, available at [http://www.uhfnyc.org/pubs-stories3220/pubs-stories\\_show.htm?doc\\_id=774690](http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=774690); and Cohen A, et al., 2008, *Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York*, United Hospital Fund, available at [http://www.uhfnyc.org/pubs-stories3220/pubs-stories\\_show.htm?doc\\_id=687438](http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=687438).
- <sup>35</sup> Cohen Ross D and C Marks. January 2009. *Challenges of Providing Health Coverage for Children and Parents in a Recession*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7855.cfm>. Updated by the Center for Children and Families.
- <sup>36</sup> Ibid.
- <sup>37</sup> Horner D. March 2009. *Program Design Snapshot: 12-Month Continuous Eligibility*. Center for Children and Families. Available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/ceprogram%20snapshot.pdf>.  
Dick AW, RA Allison, SG Haber, C Brach, and E Shenkman. Spring 2002. Consequences of States' Policies for SCHIP Disenrollment. *Health Care Financing Review*, 23(3): 65-88.
- <sup>38</sup> Some states require more frequent reporting of income, but only a full eligibility review annually. Cohen Ross D and C Marks. January 2009. *Challenges of Providing Health Coverage for Children and Parents in a Recession*. Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/7855.cfm>.
- <sup>39</sup> States also have the option of disregarding changes in family income between renewals in order to extend the enrollment period for adults. However, this approach is less effective than an explicit statutory option allowing continuous eligibility for groups beyond children. Few states understand that this can be done, and adopting the disregards can be complicated for states. See Centers for Medicare and Medicaid Services, August 2001, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, available at <http://www.cms.hhs.gov/schip/outreach/progress.pdf>.
- <sup>40</sup> For example, see VanLandeghem K and C Brach, November 2004, *Does SCHIP Benefit All Low-Income Children?*, Agency for Healthcare Research and Quality, available at <http://www.ahrq.gov/chiri/chiribrf4/chiribrf4.pdf>.
- <sup>41</sup> For more on Louisiana's success, see: Brooks T, February 2009, *The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP*, Center for Children and Families, available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=postcards/the%20Louisiana%20experience.pdf>.
- <sup>42</sup> Section 1903(a)(3); in regulations at 45 CFR 433.15. The Medicaid statute directs the Secretary to establish enhanced administrative matching rates for activities “attributable to... such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical and effective administration of the plan.” These matching rates are 90 percent for design and development and 75 percent for operations.
- <sup>43</sup> The National Association of State Medicaid Directors. April 2009. *2009 Health Care Reform Statement of Principles*. American Public Human Services Association. Available at [http://www.nasmd.org/home/doc/NASMD\\_reform\\_principles.pdf](http://www.nasmd.org/home/doc/NASMD_reform_principles.pdf).



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