



CREATING A SEAMLESS HEALTH INSURANCE SYSTEM FOR NEW YORK'S CHILDREN

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EXECUTIVE SUMMARY

Passage of the federal State Children's Health Insurance Program (CHIP) in 1997 created many opportunities for states to provide uninsured children with health care coverage. With money allocated from the program, the states moved forward with their individualized plans to increase child coverage. State CHIP plans have ranged in eligibility and services: some states have used their allocations to expand their Medicaid program; some have expanded or created new programs for children above and beyond their current Medicaid program; and some have combined both these options. New York State chose to expand and improve both its Medicaid program and its preexisting Child Health Plus program.

New York's Child Health Plus program was instituted in 1991 to complement the state Medicaid program. Historically, however, the programs have operated separately, with different administrative systems, financing mechanisms, program rules, and benefit delivery systems. Medicaid—the older and larger program—has been administered largely as a by-product of the cash assistance welfare system. While Medicaid benefits are more expansive and the program is free, entering the system has been burdensome and participation poor. Child Health Plus, on the other hand, has benefited from its perception as a private health insurance program implemented with public funds. Despite their separate histories, the two programs share a single mission, and the failure to integrate their function has resulted in a fragmented safety net for New York's uninsured children.

A seamless child health insurance system is one that allows children to easily enroll and remain in a program without experiencing disruption in their care because of changes in family circumstances. With the influx of federal dollars, New York has taken several steps to move their two disparate programs into a more seamless health insurance system for children. The first step occurred in 1998, when state lawmakers passed the children's health insurance expansion. The legislation mandated several specific changes:

- The Child Health Plus benefits package was expanded to resemble more closely Medicaid managed care.
- Health plans participating in Medicaid managed care were allowed to become Child Health Plus providers without engaging in a competitive bidding process. This change was intended as a step in creating a single network of providers.

- Child Health Plus was made more affordable by expanding its eligibility thresholds for subsidized coverage, reducing the family's share of premiums, and eliminating copayments.
- Medicaid's eligibility guidelines were expanded to eliminate age-based distinctions among children.
- Medicaid was made more accessible by guaranteeing year-long certification and mandating "presumptive eligibility"—whereby a child is presumed eligible for health coverage based on a completed application form while the family gathers the necessary supporting documentation.
- Locally tailored public education, outreach, and facilitated enrollment strategies were implemented to target children eligible for both Medicaid and Child Health Plus.

More recently, New York has brought Medicaid and Child Health Plus under one umbrella, renaming both programs Child Health Plus A and B, respectively. Through these initiatives, the two programs have become more compatible. However, more work remains before they are truly seamless.

This paper takes a comprehensive look at both programs as they exist today in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

Public Education

Medicaid and Child Health Plus have very different funds dedicated to public education. While Child Health Plus has a \$4 million mass media budget, Medicaid has no money devoted to advertising. With the recent decision by the state to incorporate both programs under the Child Health Plus name, it will be easier to educate families about the availability of health insurance for children. But New York has many more possibilities for making public education about the programs more equitable:

- Develop clear marketing messages that convey the arrival of a new health insurance program for all of New York's uninsured children.
- Develop educational materials for families that explain the new unified program and the benefits and eligibility requirements for both components.

- Change the Medicaid card for child-only cases to reflect the Child Health Plus name.
- Develop public education materials for health care providers that explain the reasoning behind the change and the practical implications for providers and patients.
- Change Medicaid notices to families and providers for child-only cases to reflect the Child Health Plus name.

Enrollment Rules

While Medicaid and Child Health Plus have in the past had very different methods of enrolling families, the advent of “facilitated enrollment” has created an opportunity for families to apply for both programs through a single, community-based, and family-friendly application process. The state also has made very concrete changes in enrollment policies that have made Medicaid and Child Health Plus more compatible. Nevertheless, many disparities remain. The following recommended changes would further unify the enrollment process for Medicaid and Child Health Plus.

- Ensure that all children applying for Medicaid or Child Health Plus are directly linked to enrollment for both programs.
- Standardize income disregards for Medicaid, much as they are currently for Child Health Plus.
- Eliminate age-based eligibility rules for Medicaid by implementing the second phase of the Medicaid expansion, so that all children ages 1 to 18 with incomes below 133 percent of the poverty level will be eligible for Medicaid.
- Eliminate the face-to-face interview requirement for the Medicaid program.
- Implement presumptive eligibility for Medicaid immediately. Institute changes to allow children enrolling presumptively in Child Health Plus to gain immediate coverage and to be deemed presumptively eligible by the same entities as in the Medicaid program.
- Allow for immediate Child Health Plus coverage upon birth of a child.

- Eliminate the Medicaid rule that requires all family members to enroll in the same managed care plan.
- Issue special policies for Medicaid cases regarding pursuit of absent parents that meet the requirements of federal rules without serving as a deterrent to eligible families.
- Create a single database to track enrollment of children across the Medicaid and Child Health Plus programs.
- Eliminate questions regarding applicants' housing costs and veteran status on the single application, which are optional for Medicaid applicants and unrelated to Child Health Plus.
- To the extent allowed by federal law, do not require those applying for Medicaid or Child Health Plus to provide third-party documents to verify information on the application. At the very least, to make the two programs consistent, do not require Medicaid applicants to provide third-party documents to verify the child's Social Security number and citizenship status.

Program Transfers and Recertification

Program transfers and recertification are the processes whereby children move between the Medicaid and Child Health Plus programs while maintaining eligibility. Transfers refer to the one-time movement of Medicaid-eligible children from Child Health Plus to Medicaid. Recertification refers to the continuous coverage between programs for children as their family circumstances change.

New York faces a unique challenge in transferring children. Federal law prohibits children from enrolling in a state CHIP program if they are eligible for Medicaid. Prior to the 1997 CHIP law, nearly 150,000 children in New York benefited from Child Health Plus. Approximately 41 percent of these children appeared to be eligible for Medicaid. The state is now in the process of moving Medicaid-eligible children from Child Health Plus into Medicaid. The state has taken steps to ensure that there are safeguards in place before children are moved in order to minimize the risk of children losing coverage. The following recommendations would boost these safeguards:

- Eliminate the face-to-face interview requirement currently in place for children transferring from Child Health Plus to Medicaid.

- Fund specialized “facilitated enrollers” to help with the transfer of children. Agencies engaged in facilitated enrollment should receive increased funding to hire staff specifically for the transition process.
- Streamline documentation requirements. At the very least, families should not be required to document their child’s age and home address.

Recertification occurs when children have a change in their family situation that triggers a change in eligibility. For Medicaid, recertification takes place annually, regardless of changes in family income. For Child Health Plus, recertification occurs annually or whenever there is a change in family circumstance. Creating seamlessness between the programs throughout the recertification process can be addressed through the following recommendations.

- Adopt guaranteed year-long coverage for Child Health Plus.
- Eliminate the personal interview requirement for Medicaid recertification.
- Use a simplified, joint recertification form for all children enrolled in Child Health Plus and for all child-only Medicaid cases.
- Clarify, minimize, and unify documentation requirements across and within programs.
- Ensure that every child recertified for either program is directly linked to enrollment in the other program.

Providers and Benefits Utilization

Important disparities exist in the benefits utilization systems for Medicaid and Child Health Plus. First, Medicaid and Child Health Plus each have health care providers and health plans that do not participate in the other program. Second, although the 1998 child health insurance expansion added many benefits to the Child Health Plus benefits package to make it more complete, Medicaid still offers a more comprehensive package of benefits for children. Medicaid essentially guarantees any service that is medically necessary to treat a “defect” or health condition. Finally, the two programs differ in the way services are delivered: Medicaid benefits are available in a fee-for-service and a managed care system, while Child Health Plus is available only as a managed care program. Some of the recommendations to address these differences are as follows:

- Halt all new enrollment in Child Health Plus health plans that do not participate in Medicaid managed care, except in those counties where no plans participate in both programs. Develop strategies to address providers' reluctance to enter both markets, including addressing payment rate differentials between programs.
- Ideally, both Child Health Plus and Medicaid would have an identical, comprehensive benefits package. But at the very least, necessary benefits should be added to the Child Health Plus benefits package and formal structures created to ensure that children with special health needs receive assistance in connecting with other programs that can provide appropriate benefits not available through Child Health Plus.
- Educate families about the different benefits available outside the health plan when families enroll or transition into Medicaid.

Program Financing and Administration

Underlying all these issues is the challenge of bringing together two programs with disparate financing mechanisms that are administered by different staff within the New York State Department of Health. Table ES-1 outlines some of the major areas of disparity between Medicaid and Child Health Plus and the recommended solutions. The chart also includes the highest level of authority that would need change in order to achieve the recommended solution: state administrative policy, state regulation, state statute, federal administrative policy, federal regulation, or federal statute.

Table ES-1
Summary Disparities, Recommendations, and Legal Authority

ISSUE	MEDICAID POLICY	CHILD HEALTH PLUS POLICY	SOLUTION	LEVEL OF CHANGE NEEDED*
Conditions of Eligibility				
Income disregards	Itemized deductions for expenses related to child care, employment, other health insurance, etc.	Standardized	Standardize.	Change state statute. ¹
Age	Income eligibility test linked to age of child	All children under 19 treated the same	Treat all children under 19 the same (except infants, who retain the higher eligibility levels tied to pregnant women).	Change state statute ² OR gain permission from federal officials to require only children ages 6–18 living at 100%–133% of the federal poverty level to join Medicaid managed care. ³
Existing Health Coverage	Not condition of eligibility	Precludes eligibility	Do not require as condition of eligibility for either program.	Change federal statute. ⁴

* The chart refers to the highest level of change necessary to achieve the recommended policy. The terms used to describe the level of change needed are defined below.

State administrative policy. State officials can make the recommended change without any change in state regulation or statute, and without requiring a change in federal administrative policy, federal regulation or federal statute.

State regulation. State regulation(s) must be amended to achieve the recommended change. No change in state statute, and no change in federal administrative policy, federal regulation or federal statute is necessary.

State statute. The state statute must be amended to achieve the recommended change. No change in federal administrative policy, federal regulation or federal statute is necessary.

Federal administrative policy. Federal officials can make the recommended change without any change in federal regulation or federal statute.

Federal regulation. Federal regulations must be amended to achieve the recommended change. No change in federal statute is necessary.

Federal statute. The federal statute must be amended to achieve the recommended change.

ISSUE	MEDICAID POLICY	CHILD HEALTH PLUS POLICY	SOLUTION	LEVEL OF CHANGE NEEDED
Enrollment Procedures				
Face-to-face meeting in application process	Required	Not required	Do not require for either program.	Change state administrative policy; determine that telephone conversation between enroller and person applying on child's behalf meets statutory requirement for a "personal interview" for Medicaid applications. OR Change state statute to eliminate personal interview requirement. ⁵
Presumptive eligibility	Not allowed currently, but will be when state implements changes in Medicaid's age-based eligibility rules (see above)	Allowed, but coverage is still prospective	Presumptive eligibility should be allowed for both programs.	Change state statute to allow presumptive eligibility for children immediately, without the preconditions outlined in current law. ⁶
—When coverage begins	Immediately	Prospective at next enrollment cycle	Coverage should be immediate for both programs.	Change state administrative policy. ⁷
—Who decides	A range of entities, including health care providers authorized to receive Medicaid, and organizations authorized to perform eligibility determinations for Head Start; Women, Infants and Children; and Child Care Development Block Grants	Only Child Health Plus health plan	The range of entities authorized under Medicaid law should be permitted to make presumptive eligibility decisions.	Change state administrative policy. ⁸

ISSUE	MEDICAID POLICY	CHILD HEALTH PLUS POLICY	SOLUTION	LEVEL OF CHANGE NEEDED
Enrollment Procedures (continued)				
Allowing children from the same family to enroll into different health plans	Not allowed	Allowed	Allow families flexibility in making their personal health care choices.	Change state administrative policy. ⁹
Pursuit of absent parents against the caretaker's wishes	Allowed, unless the parent can show good cause	Not allowed	Prohibit the pursuit of absent parents without the caretaker's consent. OR Create new state policies that seek to minimize burden on parents while maintaining compliance with federal rules.	Change federal administrative policy. ¹⁰ Change state regulation. ¹¹
Application Questions				
Crowd-out	Not required	Required	Eliminate the question.	Change federal administrative policy. ¹²
Housing costs	Optional	Not required	Eliminate the question.	Change state administrative policy.
Veteran status	Desired	Not required	Eliminate the question.	Change state administrative policy.
Social Security number of child	Required	Not required	Do not require.	Change federal regulation. ¹³

ISSUE	MEDICAID POLICY	CHILD HEALTH PLUS POLICY	SOLUTION	LEVEL OF CHANGE NEEDED
Documentation Requirements				
Social Security number of child	Must be documented	Need not be documented	Do not require documentation.	Change state administrative policy. ¹⁴
Itemized disregards	Documentation required to get the disregard	None	Do not require documentation. OR Standardize disregard.	Change state administrative policy. ¹⁵ OR Change state statute. ¹⁶
Immigration status	Must be documented for all children, even citizens	Documentation required only when child is (1) not a citizen, and (2) in one of the immigrant categories qualified for federal financing ¹⁷	Do not require documentation for Medicaid for children who are U.S. citizens. ¹⁸	Change state administrative policy. ¹⁹
Recertification				
Year-long coverage	Guaranteed	Not guaranteed	Adopt year-long guaranteed coverage under Child Health Plus.	Change state statute. ²⁰
Face-to-face interview	Required	Not required	Do not require.	Change state regulation. ²¹
Providers and Benefits Utilization				
Benefits package	Comprehensive	Generous, but not comprehensive	Make comprehensive.	Change state statute. ²²
Providers	Some health plans only participate in Medicaid Managed Care	Some health plans participate only in Child Health Plus Plans	Freeze new enrollment in Child Health Plus health plans that do not participate in Medicaid managed care.	Change state administrative policy.

CREATING A SEAMLESS HEALTH INSURANCE SYSTEM FOR NEW YORK'S CHILDREN

I. INTRODUCTION

New York currently has two publicly funded health insurance programs for children: Medicaid and Child Health Plus. Historically, these programs have existed separately, with different administrative systems, financing mechanisms, program rules, and benefit delivery systems. Medicaid—the older and larger program—has been implemented largely as a by-product of the cash assistance welfare system. The program is financed jointly by federal, state, and local governments. While Medicaid benefits are free and more expansive than those offered under Child Health Plus, enrollment procedures are widely considered burdensome and participation is poor.

Child Health Plus, on the other hand, has benefited from its perception as a private health insurance program implemented with public funds. Until recently, Child Health Plus was funded entirely by state resources. It now uses federal funds as well. Since its inception, the state has promoted enrollment in the program through advertising in the mass media. The enrollment system is streamlined, and the program is perceived as accessible. Despite their separate histories, Child Health Plus and Medicaid have shared a single mission, and the failure to integrate their function has resulted in a fragmented safety net for New York's uninsured children.

In 1998, New York State lawmakers took the first step toward integrating the two programs. Using an influx of new funding from the federal State Children's Health Insurance Program (CHIP),²³ New York passed legislation that built upon the best of both programs and improved their coordination.²⁴ The 1998 children's health insurance expansion accomplished the following:

- Expanded the Child Health Plus benefits package to more closely resemble Medicaid managed care.
- Allowed health plans providing Medicaid managed care to become Child Health Plus providers without engaging in a competitive bidding process, in a move toward establishing a single network of health care providers.
- Made Child Health Plus more affordable by expanding the program's eligibility thresholds for subsidized coverage, reducing the family's share of premiums, and eliminating copayments. (Medicaid is free for children.)

- Expanded Medicaid eligibility guidelines to nearly eliminate age-based distinctions among children. (Child Health Plus has no such age-based distinctions.)
- Increased the accessibility of Medicaid by guaranteeing year-long certification and mandating presumptive eligibility. (Child Health Plus already had presumptive eligibility.)
- Mandated locally tailored public education, outreach, and facilitated enrollment strategies targeted to children eligible for both Medicaid and Child Health Plus, including workers authorized to do the face-to-face interview for Medicaid.

The work, however, is far from complete. The process of knitting these two programs into a single system that maximizes the resources available and capitalizes on the strengths of each program is painstaking and long. It requires understanding the systems as they are mandated in law, as they are understood by administrators, and as they are practiced in the communities they serve.

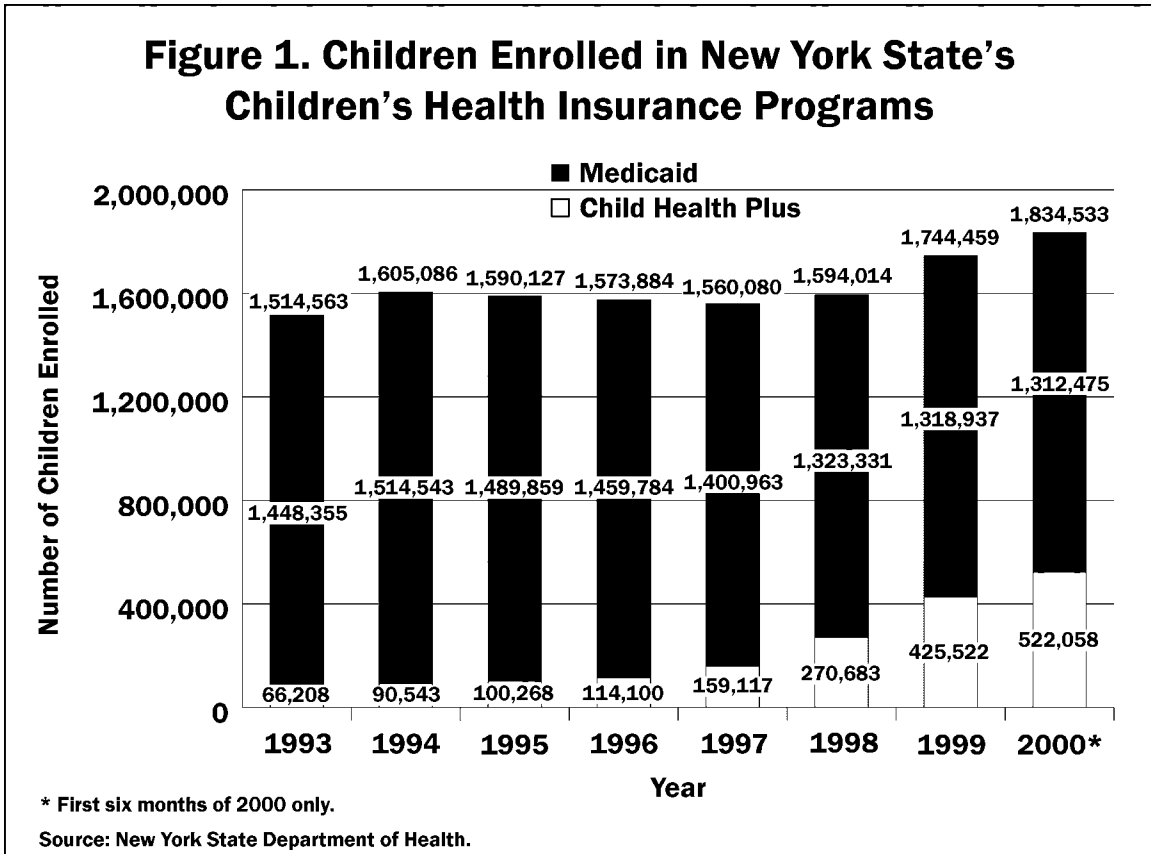
On August 17, 2000, the Children’s Defense Fund–New York (CDF–NY) called together a small group of policymakers, health care providers, and advocates with the knowledge and experience to begin to chart the next steps.²⁵ The meeting, called the Seamlessness Summit, produced a vigorous and productive dialogue and identified several key areas of consensus. The following paper is a product of both these discussions and CDF–NY’s broader work to create a comprehensive, accessible, and seamless health insurance system for children. While the paper draws on these discussions, the recommendations of this paper represent the position of CDF–NY alone.

II. WHY IS A SEAMLESS SYSTEM DESIRABLE?

The creation of Child Health Plus in 1991 placed New York at the forefront of the national movement to expand health insurance coverage for children. Today, there can be no question that the program has benefited the state’s children. Child Health Plus provides health insurance coverage to more than 539,000 children across New York²⁶ (Figure 1). While Medicaid roles were plummeting,²⁷ Child Health Plus served to challenge ideas of what enrollment in a publicly subsidized health insurance program can achieve, increasing its enrollment at a rate of roughly 12,500 children per month.²⁸

Medicaid, for its part, has continued its role as the primary health insurance program for children in the state, covering 1.2 million children.²⁹ Its benefits package is comprehensive and tailored to the needs of children.³⁰ And while Child Health Plus has

prompted reexamination of various aspects of the Medicaid program, Medicaid has exerted a similar force on Child Health Plus, prompting the recent expansion in benefits and improvements in affordability. While each program individually can boast success, maintenance of two separate health insurance programs for children is not the ideal.³¹ A single, coordinated system can improve upon existing success.



A seamless system would make it easier for eligible families to obtain and keep health insurance for their children. Without coordinated enrollment, parents must either understand the complex eligibility rules that determine for which program their child is eligible, or maneuver between two separate enrollment systems. Other parents must transfer their children between programs as family circumstances change, often resulting in a disruption of health coverage. With a coordinated system, families would be less likely to fall through the cracks.

Program coordination also is important to maintain continuity in relationships between children and their health care providers. At present, parents who must transfer their child between programs cannot be assured that the child will be able to continue to see the same doctor—or even stay with the same health plan. The purpose of these health insurance programs is to provide children access to a consistent and reliable medical home. Disruptions in provider relationships undermine that goal.

A unified child health insurance program would be easier for state officials to monitor and maintain, as it would ensure consistency in policies and coordination of efforts. It would reduce overall administrative costs, allowing the state to devote more resources to covering eligible children. Coordination would also help ensure that the programs are being administered fairly and equitably to all families.

Finally, a unified system is important to maintain the integrity of both programs and to insure all of New York's children. State and federal law stipulates that only children ineligible for Medicaid may be eligible for Child Health Plus.^{32,33} Medicaid, an entitlement program, guarantees coverage for all eligible children. Child Health Plus's federal funding stream is capped. For the 2000 fiscal year, the program will draw down a maximum of \$286 million in federal funding.³⁴ After these funds are expended, federal financing stops. Yet if all children in need of publicly funded health insurance were covered through Child Health Plus alone, it would cost \$2.8 billion per year.³⁵ New York clearly needs federal Medicaid financing to cover all of its eligible children.

III. PUBLIC EDUCATION

Public education refers to the outreach activities that are used to shape public perceptions of health insurance programs for children. Medicaid and Child Health Plus offer starkly different experiences in this regard.

Child Health Plus currently benefits from a \$4 million mass media advertising campaign. Advertisements for the program feature the Governor and the Commissioner of the New York State Department of Health urging families to apply, describing Child Health Plus as the "best" program New York can offer.³⁶ Television and radio ads, billboards, and other media promote a statewide telephone hotline through which families can learn about the program and receive direction on how to apply. Small prizes, such as Frisbees, refrigerator magnets, hats, and tee shirts, are distributed to families as promotions. The state has even purchased a miniature blimp that is taken to state fairs and other events to call attention to the program. Department of Health staff also have engaged in extensive mailing and public-speaking efforts, targeting social service and health care providers as well as schools, to educate families about Child Health Plus.

Medicaid, on the other hand, does not have an advertising campaign or other similar outreach activities. Approximately half the children enrolled in Medicaid receive benefits through the welfare system,³⁷ which is known more for deterring, rather than encouraging, new enrollment. Confusion about Medicaid eligibility rules and fear of

unwelcoming application procedures have been major obstacles to enrollment of eligible families.^{38,39,40}

Recently, the New York State Department of Health announced its intention to unify children's health insurance programs under the Child Health Plus name. This change is the clearest way to convey to the public that health coverage programs are available for children. Of course, this change is not without risks. Some fear that families who unwittingly sign up for Medicaid may have a negative experience with the program that will color their view of Child Health Plus or engender distrust of the enrollment system. There is also potential for confusion, especially for those families in which parents are participating in Medicaid along with their children.

Details have yet to emerge about what steps New York will take to ensure the success of this change. Certainly, there are some immediate changes the state could make to bring children's Medicaid under the Child Health Plus banner. These include:

- Developing clear marketing messages that convey the arrival of a new health insurance program for all of New York's uninsured children.
- Creating public education materials that explain the new unified program, including the eligibility rules and benefits packages for the two component programs.
- Changing the Medicaid card for child-only cases to reflect the Child Health Plus name.
- Developing materials for health care providers that explain the reasoning behind the policy change and the practical implications for them and their patients.
- Changing Medicaid notices to families and providers to reflect the Child Health Plus name.

Changing the program name for families in which both child and adult are enrolled in Medicaid raises additional challenges that must be addressed separately. In these cases, the child would be covered under the Child Health Plus name and the parent under the Medicaid name; in reality, though, both would be enrolled in the same program. For families still struggling to understand how Medicaid managed care works, this situation is potentially problematic. To help lessen potential confusion, children who receive

Medicaid as part of a family application should continue to receive notices and insurance cards with the Medicaid name. Further study is necessary to find ways to bring the benefits of the newly unified program to these children without causing undue confusion for families.

IV. ENROLLMENT

This section examines the recent progress made in creating a seamless enrollment process for children's health insurance in New York State and discusses the challenges that still remain. Historically, the Medicaid and Child Health Plus enrollment systems have been completely separate, with different application forms, eligibility criteria, documentation requirements, and administrative oversight. There has been little communication between the two programs. Even though low-income families not eligible for Medicaid are virtually guaranteed to be eligible for Child Health Plus, a reliable referral system between the two systems has not existed.

The Medicaid and Child Health Plus programs also have differed significantly in their level of accessibility. Many families have described Medicaid's application process as lengthy and burdensome.⁴¹ Until very recently, families applying for Medicaid were required to appear in person at the local social services office for an interview. Many offices, however, do not accept appointments and are open only during traditional work hours, requiring applicants to take off time from work. With the enrollment process generally taking two to three separate visits, applicants frequently cite missed work—along with unfriendly treatment by office staff—as significant barriers to completing the enrollment process. Families applying for both Medicaid and cash assistance have experienced even greater barriers, as new policies aimed at decreasing the welfare rolls have made it even harder to obtain coverage.

In contrast, families with Child Health Plus describe it as an easily accessible program. Applications can be submitted to the contracted managed care plan either in person or through the mail—a feature that is accommodating to working families. Child Health Plus managed care plans themselves are responsible for outreach and enrollment of eligible children, and receive funding for this purpose in their capitation rate. These health plans are highly motivated to increase their enrollment and engage in extensive marketing and community-based recruitment activities.

A. Creating a Single Enrollment Pathway

In 1998, state legislation required a streamlining of the application process for the Medicaid and Child Health Plus programs.⁴² Implementation of this law resulted in the

creation of a system called facilitated enrollment.⁴³ Under facilitated enrollment, the New York State Department of Health contracts with broad coalitions comprising community-based organizations, child advocacy organizations, health care providers, school-based health centers, and local government agencies to hire staff authorized to enroll children into the two insurance programs. Facilitated enrollers are located in community settings that are geographically accessible to large numbers of eligible children, and they must be present during evening and weekend hours to accommodate working families.

Facilitated enrollers help families fill out the application form, gather necessary documentation, and assist with managed care plan selection to ensure continuity of existing provider relationships. These workers are authorized to conduct the personal interviews required for the Medicaid application, thus eliminating the need for applying families to go to the local social services office to complete the application process. Currently, 33 lead agencies have been contracted and trained to enroll children as part of the facilitated enrollment initiative. Combined, these agencies will employ the equivalent of 223 full-time staff to engage in enrollment.⁴⁴ As of January 17, 2001, 36,290 children have applied for health insurance, and 19,375 have been enrolled during the first seven months this system has been in operation.⁴⁵

In addition to creating the community-based facilitated enrollment system, the state is giving managed care plans that enroll children into Child Health Plus the option to become facilitated enrollers for Medicaid as well. Currently, 18 plans statewide are authorized to act as facilitated enrollers, 13 of them in New York City.⁴⁶ As of January 11, 2001, approximately 26,000 children have been enrolled in Medicaid through plan-based facilitated enrollers.

Under facilitated enrollment, families apply for Medicaid and Child Health Plus through a single application process with a single point of entry. The facilitated enroller makes a preliminary decision based on the information in the completed application as to which program the child is eligible. The enroller then sends the completed application and all necessary documentation to the local department of social services (for Medicaid) or to the managed care plan (for Child Health Plus) for a final eligibility decision and activation of benefits.

Despite the great progress made with the creation of facilitated enrollment, Child Health Plus and Medicaid enrollment pathways are not fully integrated. Many children still apply for both programs in settings that are not a part of facilitated enrollment and therefore are not given the opportunity to be screened for and enrolled in both programs.

Integrating Medicaid into All Child Health Plus Enrollment Opportunities

Families that apply for Child Health Plus through a health plan that has not opted to become a facilitated enroller will not be able to apply for Medicaid with that plan. Instead, the family will be screened for Medicaid eligibility and referred to a facilitated enrollment site. This referral is not enough for families to bridge the potential “disconnect” in the application process. At the very least, these health plans should be required to follow detailed protocols for the transfer of Medicaid-eligible applicants to facilitated enrollers. These protocols should require the plan to provide the enroller with all information—including any completed or partially completed application and supporting documentation—to the facilitated enroller for follow-up. While the family should be informed of the transfer and given the new contact information, the burden should not be on the family to contact the enroller. Adequate resources to accommodate these families in a timely way should be provided to the enrollers.

Even health plans that are participating as facilitated enrollers will likely have some staff who are enrolling families only into Child Health Plus. Presumably, it is in the interest of these plans to develop systems to ensure that Medicaid-eligible children are connected with their own facilitated enrollers. However, it is important that this new process be monitored to ensure that such systems are in fact working for families.

Integrating Child Health Plus into All Medicaid Enrollment Opportunities

Children may apply for Medicaid through multiple avenues that do not offer the opportunity for Child Health Plus enrollment. Nearly half (44%) of children in Medicaid are enrolled in conjunction with an application for cash assistance under Temporary Assistance for Needy Families (TANF).⁴⁷ These children are enrolled at a traditional welfare office administered by the local department of social services. Most of the remaining children are enrolled through the local Medicaid office, also run by the local social services department. A small group of children are enrolled through a limited number of health care providers that have been given permission by the local Medicaid program to assist in enrollment of eligible children and adults, a process sometimes referred to as “outstationed” enrollment or community enrollment. Families seeking Medicaid coverage for their children through all these pathways are not part of a single application process. If found ineligible for Medicaid, these children are not enrolled in Child Health Plus. At best, they are referred to the state hotline for more information about children’s health insurance programs.

It is crucial that these other enrollment pathways are integrated into a system that ensures Medicaid-ineligible children of coverage under Child Health Plus without the

need to submit a new application or start over with a different enrollment process. The New York City Human Resources Administration recently announced plans to train workers in nine Medicaid application sites to conduct onsite enrollment for Child Health Plus. This effort could serve as a model for replication at other Medicaid application sites staffed by local departments throughout the state. In addition, formal systems should be put in place to ensure that Medicaid-ineligible children encountered through the TANF program and in community Medicaid sites are similarly screened for Child Health Plus and, if eligible, enrolled.

Extending the Single Enrollment Pathway to Adults

Many children live in households where a parent or other adult is eligible for Medicaid. The current system offers opportunities for these families to apply together as a unit for Medicaid. However, there is no single application pathway for adult Medicaid, children's Medicaid, and Child Health Plus. It is possible for families to have individual members eligible for each of these programs. It is even more common that these families will not know for which, if any, of the programs they are eligible. Yet by design the current system requires families to engage in at least two separate enrollment pathways.

With passage of Family Health Plus, state policymakers are beginning the process of mapping a coordinated enrollment system for children and families, as well as single adults. It is in the interest of children that a streamlined and simplified application pathway exist for children and adults potentially eligible for Medicaid, Child Health Plus, or Family Health Plus. This process is complicated by differences in the law and in practice regarding the treatment of children and adults within the Medicaid program. No one wants to see the progress made toward improving children's access to Medicaid compromised, and the process of integrating the systems should be guided by the effort to preserve that progress. It is clear, however, that many uninsured children in New York live with eligible adults, and the ability to enroll as a family increases the likelihood that these children will be insured.

B. Conditions of Eligibility

This section discusses recent policy changes and remaining disparities in rules related to an applicant's eligibility for health insurance under Medicaid or Child Health Plus.

Recent Changes

In order to promote seamlessness, several changes were made in how various conditions of eligibility are interpreted. Table 1 outlines some of the changes that have been implemented thus far.

Table 1
Recent Changes in Conditions of Eligibility

Eligibility Criteria	Previous Child Health Plus Policy	Previous Medicaid Policy	Policy Adopted ⁴⁸	Program Policy Adopted
Household Size	<p>Must count all family members living together.</p> <p>Pregnant women count as one person.</p>	<p>Must count legally responsible relatives⁴⁹ and applying siblings.</p> <p>Never count people receiving Supplemental Security Income (SSI) or public assistance (PA), or foster children.⁵⁰</p> <p>Pregnant women count as two people.⁵¹</p>	<p>Must count legally responsible relatives and applying siblings, with the option of adding nonapplying siblings and other related children.</p> <p>Never count people receiving SSI or PA, or foster children.</p> <p>“Grandfather” Child Health Plus households where premium payment affected negatively by new rule.</p> <p>Pregnant women count as two people.</p>	Combination
Countable Income	All household income counts.	Exclusions exist for income of full-time students under age 21, ⁵² educational grants and loans for undergraduates, ⁵³ in-kind maintenance, ⁵⁴ loans from persons not legally liable. ⁵⁵	Exclusions exist for income of full-time students under age 21, educational grants and loans for undergraduates, in-kind maintenance, loans from household members.	Medicaid
Teenagers Applying Alone	<p>Can apply on their own if married, parenting, or emancipated.</p> <p>If living with parents, must show their income.</p>	<p>Can apply on their own if pregnant, married, parenting, or emancipated.⁵⁶</p> <p>If living with parents and not pregnant, must show their income.⁵⁷</p>	<p>Can apply on their own if pregnant, married, parenting, or emancipated.</p> <p>If living with parents and not pregnant, must show their income.</p>	Medicaid

Definition of Household. Throughout their histories, Child Health Plus and Medicaid have used different standards to determine who is counted as a member of the applying child's household. Household size determines family income eligibility guidelines (the larger the household, the higher the income test), and the income of individuals considered to be part of the household generally must be counted when determining the child's eligibility. Child Health Plus formerly counted all household members, regardless of their relationship to the child. Medicaid counted only certain categories of household members.⁵⁸ These differences made it extremely difficult to calculate eligibility for any given family and raised concerns about fairness. In an effort to address these concerns, the New York State Department of Health created a single definition of household for both programs to maximize coverage for children while maintaining compliance with state and federal law.

Countable Income. In the past, Child Health Plus and Medicaid employed different rules about what kinds of income are to be considered when determining eligibility. Child Health Plus generally considered all income received by any household member. Medicaid, on the other hand, allowed certain kinds of income to be ignored, including income of a full-time student under age 21,⁵⁹ educational grants and loans for undergraduates,⁶⁰ in-kind maintenance,⁶¹ and loans from persons not legally liable.⁶² To achieve consistency, the more generous Medicaid rules were adopted for both programs.

Teenagers Applying Alone. Medicaid and Child Health Plus had different rules about when teenagers could apply on their own behalf and whose income would be counted toward their application. Child Health Plus allowed teens to apply on their own behalf if they were married, if they were parents, or if they were emancipated. Medicaid allowed teens to apply on their own in those circumstances, and also if they were pregnant. Child Health Plus required counting the parents' income toward the eligibility decision in all cases where the teen lived with the parent. Medicaid only counted parents' income when the teen was living with the parent and the teen was not pregnant. Again, the more expansive Medicaid rules were adopted in both cases.

Remaining Disparities

Despite progress made, some disparities still exist in the rules governing program eligibility. Table 2 outlines some of the program eligibility rules that remain different for the two programs.

Table 2
Remaining Disparities in Conditions of Eligibility

	Current Child Health Plus Policy	Current Medicaid Policy
Income Disregards	<p>Standardized</p> <p>Net income of 133% FPL = 160% FPL</p> <p>Net income of 185% FPL = 222% FPL</p> <p>Net income of 208% FPL = 250% FPL⁶³</p>	<p>Itemized</p> <p>Deductions are allowed for some categories of actual expenses, including:</p> <ul style="list-style-type: none"> • child care expenses up to \$200 per month for children under age 2 and \$175 per month for children 2 and older;⁶⁴ • health insurance premiums;⁶⁵ • the first \$90 of earned income per working adult;⁶⁶ and • the first \$50 of child support per household.⁶⁷
Immigration Status	Immigration status is not a condition of eligibility.	Immigration status is a condition of eligibility. ⁶⁸
Age	All children under 19 treated the same.	<p>Income eligibility test is linked to child's age.</p> <p>Children under age 1 are eligible if household income is below 185% FPL.</p> <p>Children ages 1 to 5 are eligible if household income is less than 133% FPL.</p> <p>Children ages 6 to 18 are eligible if household income is less than 100% FPL (to be increased to 133% FPL).</p>
Other Insurance	Condition of eligibility	Not condition of eligibility

Income Disregards. Both Medicaid and Child Health Plus determine program eligibility on the basis of families' net income. Both programs "disregard"—that is, do not count—some gross income. However, the methods by which the two programs derive net family income are very different. Medicaid uses an "itemized" disregard system, under which families are allowed to deduct certain actual expenses. Examples of deductible expenses include child care expenses up to a capped amount, health insurance premiums paid by the family, the first \$50 of child support payments received by the family, and \$90 for each working family member. Additional deductions are available for families

transitioning from TANF. This itemized method stems from traditional budgeting methodology employed in the welfare program and is mandated by state law.⁶⁹

Child Health Plus, on the other hand, takes a “standard” deduction for every family. The Child Health Plus statute provides net income eligibility guidelines and then permits the Department of Health to determine the gross equivalent.⁷⁰ Traditionally, the gross equivalent has been set at 20 percent higher than the net amount provided in statute. Thus, while the statute caps subsidized participation for families at the gross equivalent of 208 percent of the federal poverty level (FPL), the program actually offers subsidized coverage for families living at up to 250 percent of FPL. From a practical perspective, families and eligibility workers know only about the gross numbers and have no need to bother with taking any disregard at the individual level.

Maintenance of these two separate methodologies for determining net income is an obvious source of confusion in the current application process. Because every family must be screened for Medicaid eligibility first, workers are forced to engage in the more complex Medicaid calculation for virtually every application. If the family is not eligible for Medicaid, the workers must remember to go back to the gross number, before the Medicaid deductions, when determining eligibility for Child Health Plus. Both the math involved and the different income calculations raise the risk of worker error and render it nearly impossible for families to determine likely eligibility without assistance. Families who are eligible for Medicaid also must prove each disregard, adding to their documentation requirements.

The Child Health Plus standardized method, with its absence of math and extra documentation, is the best method for determining net income. Standardization for both programs is possible with federal permission and a change in state law.⁷¹ Massachusetts and Oregon both use such gross income tests for their Medicaid and CHIP programs.⁷² Recently, New York adopted a gross income standard for the Family Health Plus program, eliminating the need for itemized disregards in that Medicaid-financed program.⁷³ It is possible without any changes in the law to change rules in Child Health Plus to require the itemized deductions currently used by the Medicaid program.⁷⁴ However, the extra burden placed on families by the need to prove each disregard and its more complex methodology makes this a poor choice.

Immigration Status. Federal law prohibits federal financing through Medicaid⁷⁵ or Child Health Plus⁷⁶ of all but certain categories of immigrant children. State funding is available under Child Health Plus for children who are not qualified for federally funded

coverage due to their immigration status. For families, this means that immigration status is a factor in determining eligibility for Medicaid, but not for Child Health Plus. Congress recently rejected a change in federal law that would have allowed federal financing for more categories of immigrant children. However, even this change would not have covered all children currently covered by Child Health Plus. Thus, while this is a technical point of difference between the programs, it is a desirable difference, as it leads to coverage for all uninsured children.

Age-Based Eligibility. Medicaid eligibility is dependent on the child's age as well as other factors. Child Health Plus's eligibility rules do not include this distinction. The 1998 children's health insurance expansion provides for gradually phasing out Medicaid eligibility distinctions based on age for all but infants, who retain the higher eligibility levels tied to pregnant women. However, the second phase of this expansion—placing eligibility for all children ages 1 to 18 at 133 percent of FPL—has not yet taken effect. The 1998 legislation provides that the expansion must occur either (1) upon receipt of federal permission to enroll all children, with expanded eligibility into Medicaid managed care; or (2) upon reaching 50 percent statewide enrollment of Medicaid children in a managed care program. Neither condition has been met thus far.

Delay in implementing this change to the current system ensures that serious problems will continue, including split eligibility of children in the same family, instances where children must be transferred between programs, and family confusion over eligibility criteria. This is especially problematic in areas where Child Health Plus and Medicaid utilize different managed care plans, which can lead to disruptions in provider relationships as well as coverage. (Such disruptions may also occur when families are transferred from Child Health Plus to Medicaid as a result of the increase in eligibility, but this problem can be addressed through transition systems, described later in this paper.⁷⁷)

The state should implement the second phase of the Medicaid expansion immediately. While implementation could be achieved by obtaining federal permission to require all expansion children to enroll in a managed care plan, this condition would result in its own discontinuity within the Medicaid program. In areas of the state where managed care is voluntary, expansion children would be treated differently than their neighbors—even their siblings—who are also enrolled in Medicaid. This provision also requires that the enrollment system be altered to identify this group of children and single them out for differential treatment. Instead, lawmakers should amend New York statute to eliminate the conditions on the second phase of the expansion.

Other Insurance. Federal law stipulates that children covered by private health insurance are ineligible for Child Health Plus, though not for Medicaid. Medicaid families who have other insurance must use their private coverage as the first payer, with Medicaid acting as a “back up” to pay for uncovered costs or services.

Ideally, all children would have Child Health Plus or Medicaid as a backup to inadequate private policies. With such a policy, families would be less likely to drop their other health coverage for Child Health Plus, thus reducing the risk of “crowding out” private insurance. But such a system would be possible only through a change in federal law, or through the use of state-only resources to purchase coverage for these children. Modification of federal law, however, is unlikely in the immediate future. And before a recommendation can be made regarding the use of state-only dollars to fund these underinsured children, more information is needed about the potential costs of such an approach, well as the needs of affected children.

C. Enrollment Procedures

In addition to differences in the rules governing a child’s eligibility for Medicaid and Child Health Plus, many disparities remain in the actual process of applying for Medicaid and Child Health Plus. Table 3 lists some enrollment policies and procedures that remain different for Medicaid and Child Health Plus.

Table 3
Remaining Procedural Disparities in
Medicaid and Child Health Plus Enrollment

	Current Child Health Plus Policy	Current Medicaid Policy
Face-to-face meeting	Not required	Required ⁷⁸
Presumptive eligibility	Allowed, but coverage still prospective	Not allowed currently, but will be at a future date. When implemented, coverage will be immediate.
Locus of eligibility determinations	Child Health Plus health plan	Local department of social services.
Date of initiation of coverage	Prospective	Retroactive
Choosing a managed care plan at the time of enrollment	Required	Not required
Enrolling children from the same family into different health plans	Allowed	Not allowed
Third-party collection and absent parents	None	Required ⁷⁹
Central database of enrolled children	None	Exists as part of the larger Medicaid program

Face-to-Face Meeting

State law requires a “personal interview” for Medicaid applications, a provision that has been interpreted by Medicaid officials as a face-to-face meeting.⁸⁰ (No such requirement exists for Child Health Plus.) The interview is a significant deterrent for enrollment of eligible children, and is especially burdensome for working families and families in rural areas, who often must travel long distances in order to comply. In a recent national study by the Kaiser Commission, half of parents of Medicaid-enrolled children and 60 percent of parents of eligible but uninsured children reported that the ability to mail in the application would make them much more likely to enroll their sons and daughters.⁸¹

Federal law does not require a personal interview as a condition of eligibility for Medicaid or Child Health Plus. In fact, 39 states have eliminated the interview requirement for parents enrolling their children in Medicaid, as well as in the separate CHIP program, where one exists.⁸² In New York, the Child Health Plus program has operated since its inception without requiring interviews—and, notably, without any indication of fraud or abuse as a result.

The New York State Department of Health should immediately use its administrative power to define “personal interview” as a telephone conversation under state Medicaid law. In addition, the statute should be amended to eliminate any reference to a personal interview and to explicitly allow mail-in applications.

Presumptive Eligibility

Currently, there is great disparity, as well as some confusion, regarding presumptive eligibility for Medicaid and Child Health Plus. Traditionally, presumptive eligibility refers to a feature in the Medicaid program whereby pregnant women who appear eligible may immediately begin accessing health care services upon completion of an application.⁸³ The applicant has approximately 60 days to gather supporting documents and complete the application process. Under traditional presumptive eligibility practices, enrollment usually occurs at the site of the health care provider. The provider declares the applicant presumptively eligible and is immediately able to provide services. That relationship serves as an anchor throughout the rest of the application process. Health care providers supplying services to applicants who are ultimately declared ineligible are still reimbursed.

The 1998 children’s health insurance expansion authorized this kind of presumptive eligibility for children. The provision made it possible for the state to allow not just health care providers, but the full range of entities permitted under federal law, to declare a child presumptively eligible. When fully implemented, it is possible that all of the

following could be authorized to declare a child presumptively eligible for Medicaid: health care providers, including health clinics, health departments, doctors, hospitals, and schools; organizations that make eligibility determinations for Head Start, the Special Nutrition Program for Women, Infants and Children (WIC), and the Child Care and Development Block Grants (CCDBG);⁸⁴ elementary and secondary schools; emergency food and shelter programs operating under the Stewart B. McKinney Homelessness Assistance Act; eligibility offices for public or assisted housing; and additional entities determined by state and approved by federal officials.⁸⁵ Presumptive eligibility for children in the Medicaid program will be implemented at the same time the second phase of New York's Medicaid expansion for children is begun.

Presumptive eligibility under Child Health Plus functions very differently. Enrollment is not immediate, but occurs at the next scheduled enrollment cycle. Only health plans—not health care providers—are permitted to declare a child presumptively eligible. But as is the case with Medicaid, families in Child Health Plus may receive health services for approximately 60 days while they gather supporting documentation and complete the enrollment process.

Finally, state law provides for a third, hybrid form of presumptive eligibility. This hybrid provision, sometimes called temporary enrollment, is in effect until presumptive eligibility for Medicaid is implemented.⁸⁶ Under the provision, children who appear to be eligible for Medicaid may be enrolled in Child Health Plus on a temporary basis. Like Child Health Plus, presumptive eligibility coverage begins at the start of the next enrollment cycle. The family is informed that the child appears to be Medicaid-eligible and is instructed to meet with a facilitated enroller. The family has 60 days to submit the Medicaid application and comply with other application procedures, such as attending the personal interview and providing supporting documentation. Throughout this time, the child remains covered by Child Health Plus. The child is then transferred into Medicaid at the time of the final Medicaid determination. Because families are bounced between programs within weeks of their initial enrollment, this interim system creates great opportunities for confusion and disruption.

Presumptive eligibility is an important tool for enrolling eligible children in health insurance programs, and New York has gone too long without it. New York statute should be amended to allow presumptive eligibility for children applying for Medicaid immediately, without the preconditions outlined in current law. Until this can happen, every effort should be made to meet the preconditions for presumptive eligibility under Medicaid. The interim hybrid provision that allows children to be enrolled presumptively

in Child Health Plus does more harm than good and should be eliminated immediately. Finally, temporary enrollment under Child Health Plus should be changed to operate like presumptive eligibility for Medicaid. This would require expanding the number of entities empowered under Child Health Plus to make the presumptive determination. It would also require allowing immediate coverage under Child Health Plus, rather than delaying presumptive coverage until the next enrollment cycle.

Locus of Eligibility Determination

Eligibility determinations are ultimately made by separate entities. For the Medicaid program, federal law prohibits delegation of eligibility determination beyond the local department of social services. For Child Health Plus, state law gives authority to the health plans participating in that program.⁸⁷ The state has attempted thus far to bridge this difference through the use of facilitated enrollment. However, some have observed that this dual system creates duplicative bureaucracy and red tape.

Some states have created a single entity for determining eligibility for both the Medicaid and the CHIP programs.⁸⁸ In New York, this would require major restructuring of Child Health Plus. Such a change would seem unwise at this point, as it is too early to tell whether facilitated enrollment will be adequate to bridge the gap between the programs.

Date of Initiation of Coverage

Medicaid coverage for children generally is retroactive to the first day of the month in which the application for assistance was submitted. In some circumstances, coverage is available three months prior to the application date. Child Health Plus coverage, in contrast, is prospective based on a monthly schedule. For applications submitted before the 20th day of the month, the child is enrolled on the first day of the following month. For applications submitted after the 20th, the child is not enrolled until the first of the month after the following month. This system has been problematic for families with immediate health needs, including those with newborn infants.

The changes recommended for Child Health Plus presumptive eligibility would seem to resolve some of the practical problems related to this disparity. However, they would not help newborns and other children whose families applied outside the presumptive process. The programmatic changes to allow payments for services received prior to the date of the application would be difficult to implement, given that there is no fee-for-service payment option and it is unlikely that providers utilized prior to enrollment

would be in the health plan's network. At the very least, payment mechanisms need to be designed to ensure coverage of all newborns, for whom earlier enrollment is not an option.

Choosing a Managed Care Plan at the Time of Enrollment

Because Child Health Plus has no fee-for-service option, applicants must choose a health plan when enrolling. Medicaid applicants, on the other hand, have the option of enrolling in fee-for-service or in managed care, though some are required to join a managed care plan at a later date.⁸⁹ This difference between the two programs is extremely confusing for families and their advocates involved in the enrollment process.

Enrolling Children from the Same Family into Different Health Plans

There is nothing in state or federal law that dictates whether children in the same family must be enrolled in the same health plan. However, New York's Medicaid managed care program has maintained an administrative rule that enrolled family members must participate in the same plan, except in limited circumstances.⁹⁰ In the interest of consistency—and to provide families with maximum flexibility in making their personal health care choices—the state should rescind this requirement.

Third-Party Collection and Absent Parents

Under state and federal law, no child may be denied access to health insurance because of the custodial parent's refusal to provide information about the child's absent parent.⁹¹ However, federal officials have interpreted federal law to require pursuit of medical support from absent parents even without such cooperation, except in cases where the parent can show good cause for the state not to pursue.⁹² Child Health Plus has no such provision in federal or state law. Local departments of social services vary considerably in their collection practices. But where pursuit is the norm, it often serves as a strong disincentive for participation in the Medicaid program.

All parents have the opportunity to avail themselves of government assistance in pursuing medical or other support from an absent parent.⁹³ The difference between families enrolled in Child Health Plus and those enrolled in Medicaid is that the former must seek out, or at the very least consent to, pursuit. Under current practice, families with children enrolled in Medicaid are not afforded this option. The practice forces many parents to choose between access to health care for their children and involving the state in their personal relationships. Many families, especially those from upstate counties with a history of aggressive collection practices, will not participate in such a system.

The practice of pursuing these absent parents without their active and voluntary consent should be prohibited. Unfortunately, this would take a change in federal policy—an unlikely development in the immediate future.⁹⁴ As long as federal requirements remain the same, New York should take steps to ensure that child support services are implemented in the way that is least threatening for families. The state should develop specific guidelines regarding support enforcement provisions for child-only Medicaid cases to ensure they are as “family friendly” as possible. Standards for granting a good-cause exemption should be broadened beyond existing regulations, which define the exemption very narrowly and impose onerous procedures for obtaining it.⁹⁵ Families need to be presented with information about collection as a service: they should be informed in plain and friendly language that their responses or participation will not affect their child's eligibility, and they should be informed of their rights to request a good-cause exemption. Top priority should be given for collection in cases where the parent is actively seeking support, and lowest priority should be given in cases where the parent has expressed a desire to avoid pursuit. Finally, the state should be diligent in ensuring that the proper guidelines are being followed and that support enforcement is never used as a tool to scare families away from getting health coverage for their eligible children.

Database of Enrolled Children

One very practical challenge under the new enrollment system is the lack of a central database for tracking enrollment of children into Child Health Plus. Because program enrollment occurs within individual health plans, there has not been a need to maintain such information systems. With the expansion of Child Health Plus and the merging of the enrollment process with Medicaid, it is now important to create systems for monitoring the enrollment of children in both programs on a live basis.

D. Creating a Single Application Form

Historically, families applied for Medicaid and Child Health Plus on separate application forms. In addition, each Child Health Plus insurer had its own unique form. In April 2000, the New York State Department of Health released a colorful, family-friendly joint application form for children under age 19 applying for Medicaid and Child Health Plus. This new common form integrates the information needed for both programs. Table 4 lists some of the policies that were changed to enable the creation of the single application. Table 5 lists some of the questions that remain on the single application even though they apply to only one program.

Table 4
Policy Changes in Creating the Single Application

	Previous Child Health Plus Application	Previous Medicaid Application	Resolution
Social Security number of parent	Requested	Not requested	Not requested
Immigration status	Historically, not requested, though now required for some categories of immigrant children	Required ⁹⁶	The application was designed to request minimal information, and only from those groups mandated by federal law.
Absent-parent information	Not requested	Requested, but not required ⁹⁷	Not requested

Table 5
Outstanding Issues on the Single Application

Question	Child Health Plus	Medicaid
Crowd-out	Required	Not required
Housing costs	Not required	Possibly required
Veteran status	Not required	Desired
Social Security number of child	Not required	Required

Crowd-Out Question

The current application contains a series of questions for determining whether families are dropping existing health insurance to participate in Child Health Plus. Federal law requires monitoring to ensure that this phenomenon, known as “crowd-out,” is not occurring in significant numbers. New York law provides that if crowd-out is found to be occurring at a certain rate (determined by federal officials), then the state will employ waiting periods for families who drop existing coverage to participate in the Child Health Plus program. This is a condition of receiving federal financing for Child Health Plus; eliminating it would require a change in federal administrative policy.⁹⁸

Housing Costs Question

The application includes an optional question about the applicant's housing and heating costs. State officials included this provision because they thought it necessary to determine whether a small subgroup of applicants could be eligible for continued Medicaid coverage despite increases in income. Federal officials have noted that other states do not include such a question, and that it was not included in the model application produced by federal officials charged with monitoring the CHIP program. It seems unlikely that children will benefit from its inclusion, given the extremely small number children who are potentially eligible and the current low utilization of transitional benefits among eligible families. Given its limited usefulness, the question should be removed from the application.

Veteran Question

The application asks whether any household members are military veterans. The question was retained from the old Medicaid application because of a historical desire to track the number of veterans on Medicaid. It does not affect eligibility for either Medicaid or Child Health Plus. While it is tempting to include questions that tell us more about families, each additional question adds to the time that each family must spend on the application. Since the question does not contribute to the eligibility determination, it should be removed.

Social Security Number of Child

The application asks for the Social Security number of the applying child, "if available." Federal law mandates provision of the Social Security number for a child applying for Medicaid only.⁹⁹ No such state or federal requirement exists for Child Health Plus, although families are permitted to provide the number at their option, as it often proves useful in record-keeping. It is worth having a disparity between the programs in order to keep this option open for Child Health Plus.

E. Application Verification

Extensive changes have been made in the past year to clarify and unify the verification, or documentation, requirements for both Medicaid and Child Health Plus. For example, a driver's license was not accepted as documentation to prove the address of applicants under the Child Health Plus program, but was acceptable for Medicaid. Under the new unified program, a recently issued license is acceptable for both programs. Not all policies were unified. Table 6 lists some of the outstanding differences between the programs.

Table 6
Unifying Documentation Requirements: Outstanding Differences

	Current Child Health Plus Policy	Current Medicaid Policy	Comments
Social Security number of child	Need not be documented	Must be documented	Federal law does not require documentation for either program. ¹⁰⁰
Documentation of itemized disregards (e.g., child care expenses)	None	Documentation required to get the disregard ¹⁰¹	Standardization of disregard would eliminate this documentation for Medicaid. Alternatively, the state could allow disregards without requiring documentation.
Immigration status	Documentation required only when child is (1) not a citizen and (2) for one of the immigrant categories qualified for federal financing ¹⁰²	Documentation required of all children, even citizens	The only change allowed under federal law is to <i>not</i> require documentation for a citizen child under Medicaid. ¹⁰³

Coordination of the verification requirements has led to an evolving process of rule-making regarding which documents are acceptable for verifying various eligibility factors. Despite the best efforts of program administrators to develop clear yet flexible guidelines, each daily interaction with real families produces new questions—and a growing body of increasingly nuanced rules. Clearly, the resources needed to develop and maintain these rules could be better spent on providing health care to children.

Federal law requires states to verify information on the application by conducting data exchanges with various agencies, such as the Social Security Administration. Federal law does not require families to provide any documentation to verify eligibility, except proof of a child’s immigration status if the child is not a citizen. States are permitted to rely on applicants’ statements to establish other eligibility factors, including income, identity, age, and residency.¹⁰⁴ Ten states allow families to self-declare income for children applying for Medicaid and the state CHIP program, if there is one.¹⁰⁵ New York is not among them. Studies in two of these states found either no rise in errors or only small errors that generally did not affect eligibility.¹⁰⁶ New York should take advantage of this opportunity to significantly reduce, if not eliminate, documentation requirements for applying children.

V. PROGRAM TRANSFERS AND RECERTIFICATION

This section discusses the two processes whereby children are moved between Medicaid and Child Health Plus. Transfers refer to the current effort under way to move Medicaid-eligible children enrolled in Child Health Plus into correct programs. Recertification, or “renewal,” refers to the movement of children between the two programs as family circumstances change.

A. Transfer of Children from Child Health Plus to Medicaid

Federal CHIP legislation conditions a child’s eligibility on his or her ineligibility for the state Medicaid program. This provision was included to prevent states from using the CHIP program, which offers more generous federal financing and more state flexibility in program implementation, to supplant the existing Medicaid programs. Without this provision, it was feared, states could simply shift children from Medicaid to CHIP, without increasing the number of children covered.

This provision poses unique challenges for New York. At the time of CHIP’s passage in 1997, New York covered nearly 150,000 children in its Child Health Plus program.¹⁰⁷ A report issued by the state’s comptroller in April 1998 found that approximately 41 percent of children enrolled in Child Health Plus statewide appeared to meet the financial requirements for Medicaid.¹⁰⁸ While New York law conditions Child Health Plus eligibility on Medicaid ineligibility, for a variety of important reasons, the provision has not been strictly enforced. Advocates and others feared that to do so without first crafting a more accessible Medicaid program would restrict access for the poorest children, if not all children. Facilitated enrollment was, in large part, created to ensure that children eligible for Medicaid are enrolled in the correct program at the time their families apply.

Now that a single application pathway has been established, state officials are turning their attention to those Medicaid-eligible children who are currently enrolled in Child Health Plus. Although reliable estimates of the number of these children are not available, the New York State Department of Health has estimated that approximately 30 percent of children—nearly 160,000—may be eligible for Medicaid. These children must be transferred from Child Health Plus to Medicaid.

More families enrolled in Child Health Plus will qualify for Medicaid when Medicaid eligibility levels are increased to 133 percent of the poverty level for all children. While this will help improve the seamlessness of the enrollment process, it also will result in the need for additional children who are now enrolled in Child Health Plus to move

into Medicaid. Only children ages 6 to 18 who are enrolled in Child Health Plus and who live at 100 to 133 percent of FPL will be affected. The state health department has estimated that 55,000 children fall into this category.

The stakes are high. By transferring these children, the state runs the risk of losing them in the process. Failure to transfer children, on the other hand, puts federal financing under CHIP at risk. State officials have attempted to design a transfer system that minimizes both risks.

As of June 2000, the health department's transfer plan requires Child Health Plus health plans to review their records monthly for families who appear to be eligible for Medicaid based on income.¹⁰⁹ Eligible families will be given an opportunity to update their income and immigration information so that plans can determine whether they remain Medicaid-eligible. Families that do appear to be eligible will be sent a letter 60 days prior to their recertification date for Child Health Plus informing them that they must initiate the Medicaid enrollment process or be disenrolled from Child Health Plus. These families will be referred to facilitated enrollers for assistance in completing this process. In addition, they will receive several letters reminding them to comply or risk termination of Child Health Plus coverage. Parents who file a Medicaid application before their recertification date will be permitted to remain in Child Health Plus until they are found eligible for Medicaid.

By permitting health plans to be facilitated enrollers, the state hopes that plans will be able to retain those Child Health Plus children who are transferring to Medicaid. Families enrolled in plans that do not wish to become facilitated enrollers will be identified by the state, which will in turn assign a community-based enroller to help ensure a smooth transition for these families.

Despite this planning, several challenges remain. First, children in plans that do not participate in Medicaid managed care will likely experience a disruption in provider relationships at the time of transfer. While precise figures do not exist, based on current enrollment data, it has been estimated that over 35,000 transfer children will be required to change plans at the time of transfer.¹¹⁰ Second, health plans that do not elect to become facilitated enrollers will be referring families to another entity for enrollment assistance. Families may be less likely to initiate the Medicaid enrollment process if they must go somewhere new and unfamiliar to apply. Third, families found to be eligible for Medicaid must have a face-to-face interview with an enroller to apply. This changes their recertification process from a mail-in system to one that requires travel. Finally, some

families may be reluctant, or even unwilling, to participate in Medicaid because of concerns about the program's link to the welfare system.

While the state has worked hard to craft a seamless transfer system, experience shows that more can be done. In addition to eliminating the requirement for a face-to-face interview, the state should increase funding for agencies engaged in facilitated enrollment to enable them to hire staff devoted specifically to the transition process. Adequate funding would enable agencies to dedicate the amount of time necessary to reach out to families and help them through the process, while still accommodating new families who are entering the program for the first time. Finally, the transition time offers an ideal opportunity to test some of the streamlining strategies for documentation. At the very least, families should not be asked to document their child's age and home address: after all, the child's birth date is already established at the time of the initial Child Health Plus application, and the family's receipt of the recertification notice from the health plan should be adequate for verifying place of residence.

B. Recertification of Children Due to Changes in Eligibility

The second kind of transfer that must be addressed is that which occurs when a change in a family's situation triggers a change in the child's eligibility. This transfer happens at the time of recertification, or renewal.

In the past, the processes for recertification for Medicaid and Child Health Plus had been as separate as those for enrollment. Both Medicaid and Child Health Plus recertification occurred annually or at the time the family reported a change in circumstance. For Medicaid, families recertified in person at their local department of social services using the eight-page application form. In New York City, all recertifications occurred at the Medicaid agency's central office in midtown Manhattan. Child Health Plus recertification took place through the mail using the health plan's own form. Both programs required documentation, although exact requirements often varied between social services departments and health plans.

Children involved in both processes were not connected to the other program in any significant way. A child found ineligible for Medicaid might have received, at most, a referral, and more often, no information about Child Health Plus. Both programs have reported high dropout rates at the time of recertification. While experiences vary, some health plans have estimated that 25 to 50 percent of children are disenrolled because of parents' failure to recertify.¹¹¹

The 1998 children's health insurance legislation changed recertification in two ways. First, it includes year-long coverage for all children in the Medicaid program.¹¹² Thus, once enrolled, children are entitled to stay in the Medicaid program for a full year, regardless of changes in family income. A similar provision was not included in the law for Child Health Plus. The 1998 legislation also mandated that recertification for both programs be available in community-based enrollment sites.¹¹³

Children should not suffer gaps in their health coverage when their family's circumstances change. Mechanisms must be created to allow shifting between programs without any added burden for families. Several specific changes are necessary to make the recertification rules for both programs the same. If one program has more stringent enrollment requirements, families moving to that program are more likely to be lost in the transition. Consistent rules make the systems easier to understand, as well as more fair.

In this vein, state law should be amended to provide year-long certification for Child Health Plus. In addition, state regulation should be revised to eliminate the personal interview requirement for Medicaid recertification and instead allow mail-in recertification, just as Child Health Plus does.¹¹⁴ State lawmakers indicated they are receptive to such a change by passing legislation that allows mail-in recertification for the new Family Health Plus program, which is financed through Medicaid.¹¹⁵ All child-only cases should be recertified using a simplified joint form for both programs; state officials have already expressed a willingness to develop such a form for children who are enrolled through the facilitated enrollment system. Also, documentation rules for both programs should be clarified, minimized, and unified across and within the Medicaid and Child Health Plus programs.

Finally, it is crucial that all children undergoing recertification be evaluated for both programs. It is not enough to ensure that children enrolled through the joint system are part of a unified recertification process. Every child who is determined ineligible for Child Health Plus because a change in circumstance renders him or her eligible for Medicaid should be seamlessly transferred to the Medicaid program. And every child who loses Medicaid eligibility should similarly be transitioned into Child Health Plus.

These changes, along with those outlined for the enrollment system, would make great strides toward achieving seamless transfers between programs for children with changing eligibility.

VI. PROVIDERS AND BENEFITS UTILIZATION

While the 1998 health insurance expansion attempted to create more consistency within the Child Health Plus and Medicaid benefits and delivery systems, many differences remain.

A. Different Providers

Perhaps the most serious disparity between the Child Health Plus and Medicaid programs can be found in the participating health plans that are available. The potential for disruptions in children's health care is astounding:

- Statewide, approximately 130,000 children are enrolled in Medicaid managed care plans that do not participate in Child Health Plus in the family's county of residence.¹¹⁶
- Another 157,000 children statewide are enrolled in Child Health Plus plans that do not participate in Medicaid managed care in the family's county. About 90 percent of these children are enrolled in one of the Blue Cross Blue Shield (BCBS) affiliates.¹¹⁷ In New York City alone, 43,000 children are enrolled in Child Health Plus through Empire BCBS.¹¹⁸ Empire BCBS does not participate in Medicaid managed care.
- Families seeking health insurance for their children in 21 upstate counties do not have any plans that participate in both Child Health Plus and Medicaid managed care. More than 26,000 children are enrolled in Child Health Plus in these 21 counties alone.¹¹⁹

The 1998 children's health insurance expansion took one step toward reducing this disparity by authorizing the state to contract with Medicaid managed care providers to become Child Health Plus providers without a competitive bidding process. To date, nine Medicaid managed care plans have taken advantage of this option and now offer Child Health Plus.¹²⁰

The larger crisis exists in the mirror image of this solution. It has been estimated that over 35,000 children enrolled in Child Health Plus plans that do not accept Medicaid will be required to change plans at the time of their next recertification.¹²¹ Many of these children will experience a disruption in physician relationships. All of these families will experience a disruption in their relationship with their managed care plan during recertification—a time when families are particularly vulnerable to being dropped from coverage.

It is crucial that state policymakers craft both long- and short-term solutions to this problem. In the long term, only providers that accept both Child Health Plus and Medicaid should be permitted to participate in either program. This is the only way to ensure continuity in the health care provided to enrolled children. To implement this reform immediately, however, would require a massive transfer of the nearly 300,000 children statewide in health plans that do not participate in both programs. Instead, the state should create a plan for a time-limited transition toward this goal.

The first step in the transition plan should be an immediate halt to new enrollment in Child Health Plus plans that do not participate in Medicaid managed care, except in cases where doing so would effectively close new enrollment in the county. Continuing to enroll new children in Child Health Plus plans that do not accept Medicaid only compounds the existing disparity and places those newly enrolled children at risk of future disruptions in care. At the same time, children in counties that do not have physicians that accept both programs, or in counties lacking the capacity to accept new enrollment, should not be denied access to the program.

In addition, it is important to take a hard look at the reasons behind health plans' failure to participate in Medicaid managed care and enact program changes accordingly. Further analysis is necessary regarding rates paid and administrative systems used for payment and reporting in Medicaid versus Child Health Plus. Over the years, Child Health Plus has offered health plans more generous payment rates than Medicaid managed care—a practice that is antithetical to a seamless health insurance system. Finally, further study is needed on the capacity of provider networks with and without Child Health Plus-only plans to help formulate a comprehensive response to this problem.

Where managed care plans do participate in both Medicaid and Child Health Plus, it is important to ensure that their provider networks are identical. While little evidence exists of large disparities, a more comprehensive analysis of provider networks, including but not limited to primary care physicians, is necessary.

B. Covered Benefits

Medicaid offers the most comprehensive package of benefits for children. Federal law mandates that all children enrolled in the Medicaid program have access to a full range of health services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).¹²² In essence, the law not only entitles children to regular preventive care but provides a legal guarantee to any service considered medically necessary to treat any

“defect” or health condition. This provision has been interpreted as requiring payment for a wide range of child health care services.¹²³

Child Health Plus does not have any similar provision in law. Instead, the program offers a defined package of benefits modeled on private insurance. When Child Health Plus was created in 1990, this package was very limited. Covered services included well-child visits; immunizations; x-ray and laboratory tests; outpatient surgery; diagnosis and treatment of accident; injury or illness; emergency care; prescription drugs; limited treatment for alcoholism and substance abuse; and some short-term therapeutic services.¹²⁴ The 1996 New York Health Care Reform Act expanded coverage to include inpatient care.¹²⁵ The 1998 children’s health insurance expansion added even more benefits in an attempt to make the Child Health Plus benefits package more like that provided by Medicaid managed care plans. Benefits added included nonprescription drugs; durable medical equipment; dental care; vision care (including eyeglasses); speech and hearing services; outpatient mental health; and inpatient mental health, alcohol abuse, and substance abuse services.¹²⁶ While the Child Health Plus benefits package today is far more generous than it was—indeed, more generous than many private health insurance policies—it is still not as comprehensive as the package guaranteed by Medicaid.

What, if any, further changes should be made to bring the Child Health Plus package closer to Medicaid-covered services has been the subject of considerable debate. Opponents to further expansion raise the concern that it would be costly, leaving less money for covering additional children. They note that other programs exist to serve children with special health care needs that cannot be met through Child Health Plus, such as the Medicaid waiver program, the Physically Handicapped Children’s Program (PHCP), and the Early Intervention Program. But children’s advocates point out that these other programs do not offer a comprehensive solution. Some services serve only children with a particular diagnosis (e.g., Medicaid waiver) or of a certain age (e.g., Early Intervention). Many of the services are oversubscribed or unevenly implemented (e.g., PHCP).¹²⁷

Differences in benefits packages create several problems. They create confusion for families as to which services are covered and which are not, particularly when there are no coordinated materials to convey these differences clearly at the time of transitions. Differences between the programs’ benefits also raise questions about fairness. Most importantly, the more limited coverage leaves gaps in health coverage for some children.

Widespread agreement exists that the fragmentation of health coverage for services for children with special health needs has created a patchwork system that is not fully meeting the needs of these vulnerable children. In the past, the Children’s Defense Fund–NY has recommended the provision of the full range of services guaranteed through the Medicaid program for children enrolled in Child Health Plus, as well. That remains the ideal. At the very least, the Child Health Plus benefits package should be amended to include specific benefits that are important to the health of children. In addition, Child Health Plus should have a formalized structure for connecting families with greater health needs to existing programs for children with special health needs. One way to achieve this would be to add specialized care coordination services for children with special health needs to the Child Health Plus benefits package.

C. Benefit Delivery Systems

All children participating in Child Health Plus receive services through managed care plans. Children enrolled in Medicaid may receive services either through a managed care system or through the traditional fee-for-service program. In some areas of the state, participation in Medicaid managed care is optional. In others, it is mandatory for most people. As mentioned earlier, this variance is a source of considerable confusion for families enrolling into a health insurance program.

There are also differences in utilization of services between Medicaid managed care and the managed care system for Child Health Plus. The existence of a fee-for-service option in Medicaid means that several services are available on a “wrap-around” basis. For example, while children may be able to receive only 60 outpatient mental health visits within the Medicaid managed care plan, children in need of more services can obtain them outside the plan on a fee-for-service basis. Child Health Plus has no such wrap-around option.

Other services are carved out of the Medicaid managed care benefits package. Prescription drugs, for example, are always obtained outside the Medicaid managed care plan. They are received within the plan, however, in the Child Health Plus program. Other services, such as dental care, are provided by some Medicaid managed care plans, but carved out for others. Finally, family planning services are available both within Medicaid managed care plans and on a fee-for-service basis, while Child Health Plus offers them only in-plan. Understanding such complex and finely detailed distinctions between the programs can be extremely difficult for families.

VII. PROGRAM FINANCING AND ADMINISTRATION

Underlying and overarching all of the issues discussed in this paper are program financing and administration.

A. Program Financing

Medicaid and Child Health plus use different financing mechanisms. Medicaid is a joint federal, state, and local program. The federal government pays 50 percent of program costs, while the state and local governments pay 25 percent each. Because Medicaid is an entitlement program, as long as the state is complying with federal requirements, federal financing is guaranteed for every eligible child. Child Health Plus began as a wholly state-funded program. However, after passage of the federal CHIP program in 1997, New York began to apply federal CHIP dollars toward Child Health Plus. CHIP is not an entitlement program. In the 2000 fiscal year, New York can draw down a maximum of \$286 million dollars; when these funds are exhausted, the state is not guaranteed additional resources until the next fiscal year.¹²⁸ Like the Medicaid program, New York must spend state dollars to secure federal CHIP financing. The matching rate, however, is more generous, with New York's share at 35 percent and the federal share at 65 percent. Since passage of CHIP, New York has allocated far more than required to receive its full federal match.

The different financing mechanisms for both programs certainly influence the choices made by responsible policymakers during implementation. But the differences are not, themselves, problematic. Instead, they provide a framework for programmatic planning to ensure resources are maximized for eligible children.

B. Program Administration

Medicaid and Child Health Plus are administered by different staff within the New York State Department of Health. Medicaid itself is further divided between the Office of Medicaid Managed Care and the Office of Medicaid Management, which is responsible for all issues other than managed care. In the past year, the Medicaid and Child Health Plus programs have successfully worked together to design the single enrollment system. However, it has often proved challenging to coordinate the various and sometimes competing programmatic needs in order to achieve policy improvements for children's health insurance programs.

A second, equally important layer of program administration for children's health insurance is local government. Under the direction of the state health department, the Medicaid program is implemented at the county or city level by the local department of

social services, which is charged with making final Medicaid eligibility determinations for all applicants. In addition, the local department of social services conducts most administrative tasks related to children's continued enrollment: sending notices, monitoring for program integrity, and conducting recertification. This role is in part linked to the requirement that the local government pay 25 percent of the costs of residents enrolled in Medicaid.

Some counties have welcomed the state's new initiative to enroll all eligible children, seizing the opportunity to provide health care to their local uninsured children. Indeed, two local departments of social services have been awarded contracts to be facilitated enrollment sites, and have achieved great success. In other counties, local governments, fearful of the financial burden resulting from increased Medicaid enrollment, have not embraced New York's effort. In some counties, the social services department has actively fought implementation of facilitated enrollment.

Crucial to the success of children's health insurance programs is that local government entities charged with managing the Medicaid program embrace the mission of covering the state's uninsured, much as the state has done in its Child Health Plus program. Some have suggested shifting program oversight responsibilities from the local department of social services, whose relationship with Medicaid has historically been through the welfare system, to the local health department, which often has a broader vision for public health. Others have suggested that the counties be relieved of their financial stake by having the state pay their share—thus removing the primary obstacle to obtaining the full support of local governments. Short of these steps, the New York State Department of Health must provide clear guidelines for acceptable standards of practice for counties implementing children's Medicaid. It must also closely monitor those counties that would hamper the state's mission of making health insurance accessible to all eligible children.

In the end, New York's children need a coordinated and comprehensive health insurance system that is accessible to their families and effective in delivering care. The individuals charged with implementing this goal must enthusiastically pursue it on all fronts if they are to succeed. Program loyalty or past practices should never be allowed obscure the real focus: developing strategies to make New York's children healthier.

VIII. THE FUTURE OF CHILDREN'S HEALTH INSURANCE PROGRAMS IN NEW YORK STATE

It is impossible not to be struck by the amount of time and effort expended—and the additional time and effort still needed—to integrate the Child Health Plus and Medicaid programs into a seamless health insurance system for children. Certainly the participants in the Seamlessness Summit agreed that the resources spent on sorting children into the appropriate program box, and tweaking program rules to instill a sense of reason and fairness, would be better spent finding and enrolling uninsured children and providing them with the health services they need.

The only explanation for the current complex, bifurcated system is history. That is not reason enough to maintain what all agree is a cumbersome and wasteful system. Yet moving beyond the present system is not as simple as it should be. Both Medicaid and Child Health Plus are burdened with layer upon layer of laws, rules, and conventions. Furthermore, many of these layers are themselves entwined with the complex rules and customs of related programs, such as Medicaid for adults, and even cash assistance. The process of stitching the programs together presents an inherent risk: Will the progress achieved in one program be diminished by the limitations in the other?

The 1998 children's health insurance expansion made several incremental changes toward one integrated program. Yet it stopped short of the greater notion of a seamless system. The health insurance programs offered to New York's families through the New York State Department of Health should be viewed not individually as Medicaid, Child Health Plus, and Family Health Plus. And they should not be viewed against the backdrop of welfare. Rather, they should be viewed as a single health insurance program. Like any insurance program, the state may offer different riders—one rider, for example, may entitle the participant to richer benefits or lower costs. The whole of the program, however, must be coherent and cohesive, and crafted purely around the common goal of providing health coverage for all eligible New Yorkers.

This paper has attempted to list some of the many detailed changes that currently stand between what exists today and our goal for a truly seamless health insurance system for children. It offers concrete recommendations that will take New York incrementally closer toward that goal. As Table 7 illustrates, most of these changes are within the power of state officials to change. The next step is to integrate this level of detail within the broader vision of seamless, comprehensive, and accessible health insurance for all New Yorkers.

Table 7
Summary Disparities, with State Remedies

ISSUE, DISPARITY, AND PROPOSED REMEDY	LEVEL OF CHANGE NEEDED
Conditions of Eligibility	
<i>Standardize Income Disregards:</i> Use gross income test for Medicaid.	Change state statute. ¹²⁹
<i>Age:</i> Eliminate age-based eligibility for Medicaid.	Change state statute. ¹³⁰
Enrollment Procedures	
<i>Face-to-Face Meeting:</i> Eliminate for Medicaid.	Change state administrative policy OR Change state statute to eliminate the “personal interview” requirement. ¹³¹
<i>Presumptive Eligibility:</i> Allow for Medicaid.	Change state statute.
<ul style="list-style-type: none"> • When coverage begins. Enable Child Health Plus coverage to begin immediately. 	Change state administrative policy. ¹³²
<ul style="list-style-type: none"> • Who decides. Allow a range of entities to determine presumptive eligibility for Child Health Plus. 	Change state administrative policy. ¹³³
<i>Allowing Children from the Same Family to Enroll in Different Health Plans:</i> Allow families this option in Medicaid.	Change state administrative policy. ¹³⁴
Application Questions	
<i>Housing Costs:</i> Do not ask on application.	Change state administrative policy.
<i>Veteran Status:</i> Do not ask on application.	Change state administrative policy.
Documentation Requirements	
<i>Social Security Number of the Child:</i> Do not require documentation for Medicaid.	Change state administrative policy. ¹³⁵
<i>Itemized Disregards:</i> Do not require documentation for Medicaid.	Change state administrative policy. ¹³⁶
<i>Immigration Status:</i> Do not require for U.S. citizens for Medicaid.	Change state administrative policy. ¹³⁷
Recertification	
<i>Year-Long Coverage:</i> Allow for Child Health Plus.	Change state statute. ¹³⁸
<i>Face-to-Face Meeting:</i> Do not require for Medicaid.	Change state regulation. ¹³⁹
Providers and Benefits Utilization	
<i>Benefits Package:</i> Expand for Child Health Plus.	Change state statute. ¹⁴⁰
<i>Providers:</i> Halt enrollment in health plans not participating in both programs.	Change state administrative policy.

GLOSSARY OF TERMS

Crowd-out: Crowd-out refers to the potential problem of families already covered by private health insurance electing to drop that coverage for publicly funded programs or having their employers drop coverage.

Income disregard: Income disregard refers to the difference between the net and gross income of families applying for publicly funded health insurance programs. Both programs consider net income for the purposes of determining eligibility. Both programs “disregard” a portion of the gross income to determine the net amount, for example, expenses to cover child care, transportation, other work-related expenses, or basic living expenses. However, the two programs have different mechanisms for deriving the net from the gross income.

Presumptive eligibility: Presumptive eligibility refers to a feature that allows an applicant to be presumed eligible for health insurance based on the information provided on a completed application and nothing more. The applicant deemed presumptively eligible for health insurance is able to obtain coverage while the applicant gathers supporting documentation and supplies other information necessary to complete a full eligibility determination.

ENDNOTES

- ¹ New York Social Services Law § 366(4)(m)-(q).
- ² Ibid.
- ³ New York Social Services Law § 366(4)(t)(4).
- ⁴ 42 USC § 1397aa(1999).
- ⁵ New York Social Services Law § 366-a(1).
- ⁶ New York Social Services Law § 364-l(4).
- ⁷ New York Public Health Law § 2510(6).
- ⁸ State statute does not specifically rule out the possibility that entities other than the health plan could determine presumptive eligibility. See New York Public Health Law § 2511 (9)(b)(iv). See also § 2511(5-a) and § 2511 (7)(a)(iii).
- ⁹ New York State Department of Health, Partnership Program Operational Protocol § 12-6, September 8, 1999.
- ¹⁰ Health Care Financing Administration, Fact Sheet: CHIP and Child Support Enforcement (CSE), January 12, 1999. Available at www.hcfa.gov/init/chfscse.htm
- ¹¹ 18 NYCRR § 360-3.2(a)-(i).
- ¹² Health Care Financing Administration, New York Title XXI Program Second Plan Amendment Fact Sheet, Approved September 24, 1999. Available at www.hcfa.gov/init/chpafsnny.htm.
- ¹³ 42 CFR § 435.910(a)(1999).
- ¹⁴ New York State Department of Health Medicaid Reference Guide (MRG), Revised August 1999, Sixth Edition, p.494.
- ¹⁵ Ibid. at 162–165.
- ¹⁶ Supra note 1.
- ¹⁷ 42 CFR § 457.320 (c). See also letter from Sally Richardson, Director, Health Care Financing Administration, to State Health Officials, dated September 10, 1998. Available at www.hcfa.gov
- ¹⁸ Ibid. and HCFA State Medicaid Manual Chapter III, Section 3212, January 29, 1997. Available at www.hcfa.gov. See also 18 NYCRR § 351.1(b)(2)(ii).
- ¹⁹ Ibid.
- ²⁰ New York Public Health Law § 2511(4-a) and (5-a).
- ²¹ 18 NYCRR § 351.20(b)(3).
- ²² New York Public Health Law § 2510(7).
- ²³ Supra note 2.
- ²⁴ S.7843/A.10767B § 18-a (New York 1998).
- ²⁵ Meeting participants included representatives of the New York State Department of Health's Medicaid and Child Health Plus programs; New York Academy of Medicine Child Health Forum; Bronx Health Plan; HealthSource/Hudson Health Plan; Mothers and Babies Perinatal Network of South Central New York, Inc.; Greater New York Hospital Association; Greater Upstate Law Project; New York City Medical Assistance Program; Hinman, Straub (on behalf of the Blue Cross Blue Shield affiliates); Health Plan Association; Mohawk Valley Perinatal Network;

Westchester County Department of Social Services; Children's Aid Society; Community Service Society; Statewide Youth Advocacy, Inc.; Metro Plus; Univera Healthcare; The Commonwealth Fund; Healthy Capital District Initiative; Kalkines, Arky, Zall and Bernstien (on behalf of the PHSP Coalition); and Syracuse PHSP (Total Care).

²⁶ New York State Department of Health, *Child Health Plus Enrollment by County as of September 2000*. Available at www.health.state.ny.us/nysdoh/Child Health Plus/childrenr.htm.

²⁷ New York State Department of Health, *Monthly Average of Medicaid-Eligibles by Category of Eligibility by Social Service District*, January 2000. Available at www.health.state.ny.us/nysdoh/medstat/medicaid.htm#table1.

²⁸ New York State Department of Health, *Child Health Plus Enrollment by County as of June 2000*. Available at www.health.state.ny.us/nysdoh/Child Health Plus/childrenr.htm. Figures based on data from October 1998 through October 1999.

²⁹ Supra note 27.

³⁰ See e.g. Perkins J., and S. Zinn, *Toward a Healthy Future – Early and Periodic Screening, Diagnosis, and Treatment for Poor Children*. Prepared by the National Health Law Program and the Texas Rural Legal Aid, April 1995.

³¹ Mann C., D. Cohen-Ross and L. Cox, *Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children*, Center on Budget and Policy Priorities, February 2000. Available at www.cbpp.org/2-1-00health.htm.

³² New York Public Health Law § 2511(2)(b).

³³ 42 USC § 1397bb. 42 CFR § 457.350 (2001). See also letter from Nancy-Ann Min DeParle, Administrator and Claude Earl Fox, Acting Administrator, Health Care Financing Administration, to State Health Officials dated January 23, 1998 and Letter from Sally K. Richardson, Director, Health Care Financing Administration, to State Health Officials dated November 23, 1998. Available at www.hcfa.gov.

³⁴ Federal Register, Vol. 65, No. 101, Wednesday, May 24, 2000, p 33643, HCFA 2067-N. Available at www.hcfa.gov.

³⁵ According to New York State Department of Health data compiled by the Children's Defense Fund, approximate cost per child per month under Child Health Plus is \$107. Adding the children covered by Medicaid (1.2 million), those covered by Child Health Plus (500,000) and the uninsured eligible for subsidy under either program (540,000), approximately 2.2 million children are in need of publicly subsidized coverage. Coverage of all of these children under Child Health Plus would cost approximately \$2.8 billion per year.

³⁶ Funding estimates for the mass media campaign were given by the New York State Department of Health to be between \$4 and \$5 million.

³⁷ Supra note 27.

³⁸ Feld, Peter and Courtney Matlok, *Insuring the Children of New York City's Low-Income Families*, prepared by Global Strategies Group, Inc. for the Commonwealth Fund, New York, New York, December 1998.

³⁹ Perry M., et al., *Medicaid and Children: Overcoming Barriers to Enrollment*, prepared for the Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, January 2000.

⁴⁰ Andrulis D., et al., *Voices for Children's Health in New York State*, New York Forum for Child Health, February 1999.

⁴¹ Stoakley D and J Wessler, *Medicaid Barriers: A Qualitative View of the Need for Change*, Children's Defense Fund/New York Child Health Project, January 1994.

⁴² Supra note 24.

⁴³ New York State Department of Health, *Request for Proposals, Child Health Plus and Medicaid Facilitated Enrollment*, March 1999.

⁴⁴ New York State Department of Health July 31, 2000.

⁴⁵ New York State Department of Health January 17, 2001.

⁴⁶ New York State Department of Health. Unpublished list of plans authorized to engage in facilitated enrollment, October 2000.

⁴⁷ As of May 2000, approximately 525,000 children were receiving Medicaid along with a cash assistance grant under TANF or the Safety Net Program. Approximately 674,000 children were receiving Medicaid alone, without cash assistance. New York State Department of Health, *Medicaid-Eligibles by Category of Eligibility by Social Service District, May 2000*. Available at www.health.state.ny.us/nysdoh/medstat/may00el.xls.

⁴⁸ New York State Department of Health, *New York State Facilitated Enrollment Training Manual*, March 2000.

⁴⁹ Supra note 48.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Supra note 14, p.135.

⁵³ Ibid., p.136.

⁵⁴ Ibid., p.129.

⁵⁵ Ibid.

⁵⁶ Ibid., p.433.

⁵⁷ Ibid., pps. 424, 444.

⁵⁸ New York Social Services Law § 366(1)(a). See also 18 NYCRR § 360-4.2.

⁵⁹ Supra note 14, p.135. See also New York Social Services Law § 366(2).

⁶⁰ Ibid., p.136.

⁶¹ Ibid., p.129.

⁶² Ibid.

⁶³ Supra note 64.

⁶⁴ New York Social Services Law § 366(4)(m)-(q) and 18 NYCRR § 360-4.6(a).

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Supra note 69.

⁶⁹ Supra note 1.

- ⁷⁰ New York Public Health Law §§ 2510(9) and 2511(2).
- ⁷¹ Ku L., et al., *What Counts? Determining Medicaid and CHIP Eligibility for Children*, Urban Institute, May 1999.
- ⁷² Cox L., and D. Cohen Ross, *Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50 State Survey*, Center on Budget and Policy Priorities, October 2000.
- ⁷³ New York Social Services Law § 369-ee(2)(v).
- ⁷⁴ Supra note 64.
- ⁷⁵ 42 USC § 1611(a)(1999).
- ⁷⁶ Ibid. See also 42 CFR § 457.320(b)(6)(2001). Letter from Sally Richardson, Director and Claude Earl Fox, Acting Administrator, Health Care Financing Administration, to State Health Officials dated January 14, 1998. Available at www.hcfa.gov.
- ⁷⁷ New York statute provides that federal permission will be sought to allow children already enrolled in Child Health Plus who become newly eligible for Medicaid due to the Medicaid expansion to be allowed to maintain Child Health Plus eligibility. New York Social Services Law § 366(4)(t)(5). However, the expansion is not contingent on this permission being granted, and federal officials have indicated that they will not approve such a request.
- ⁷⁸ Supra note 14., p. 367.
- ⁷⁹ Supra note 10.
- ⁸⁰ Supra note 5.
- ⁸¹ Supra note 39.
- ⁸² Supra note 66.
- ⁸³ New York Public Health Law § 2529.
- ⁸⁴ Families USA, *Promising Ideas in Children's Health Insurance: Presumptive Eligibility for Children*, April 2000. Available at www.familiesusa.org/pubs/prelig.htm.
- ⁸⁵ Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000.
- ⁸⁶ New York Public Health Law § 2511(2)(g).
- ⁸⁷ New York Public Health Law § 2511(5-a).
- ⁸⁸ Massachusetts and Oregon are two states that have combined their Medicaid and Child Health Programs under one program name. Both programs, MassHealth and the Oregon Health Plan use their CHIP funds to cover children who are not eligible for Medicaid and one agency determines eligibility for the Medicaid and CHIP parts of the program. Some states, such as Connecticut and New Jersey also use one name, but separate entities determine eligibility, so there is still a distinction between programs. Supra note 31.
- ⁸⁹ Supra note 53., p.65.
- ⁹⁰ Supra note 9.
- ⁹¹ Supra note 10.
- ⁹² Supra note 10.
- ⁹³ 42 USC § 654.

- ⁹⁴ The Medical Child Support Working Group, *21 Million Children's Health: Our Shared Responsibility*, June 2000.
- ⁹⁵ 18 NYCRR § 360-3.2(f).
- ⁹⁶ HCFA State Medicaid Manual, Chapter III, Section 3212, January 29, 1997. Available at www.hcfa.gov.
- ⁹⁷ 42 USC § 1396k(a)(1)(B) (1998).
- ⁹⁸ Supra note 12.
- ⁹⁹ Supra note 13.
- ¹⁰⁰ Ibid.
- ¹⁰¹ Supra note 14, p.162-165.
- ¹⁰² Supra note 18.
- ¹⁰³ Ibid.
- ¹⁰⁴ Supra note 66.
- ¹⁰⁵ Ibid.
- ¹⁰⁶ Ibid.
- ¹⁰⁷ New York State Department of Health, *Child Health Plus Enrollment Data 1992-2000*.
- ¹⁰⁸ New York State Department of Health, *Management of Child Health Plus Program*, Report 97-S-10, Office of the State Comptroller Division of Management Audit and State Financial Services, April 27, 1998.
- ¹⁰⁹ New York State Department of Health, New York State Child Health Plus Advisory Memorandum No. A-26, March 31, 2000.
- ¹¹⁰ This number was derived by the Children's Defense Fund based on enrollment figures compiled from New York State Department of Health files by Anthony Tassi of Kalkines Arky, Zall and Berstien working on behalf of the New York State Coalition of Prepaid Health Services Plans.
- ¹¹¹ Bachrach D., et al., *Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs*, New York State Coalition of PHSPs, December 2000.
- ¹¹² New York Social Services Law § 366(4)(s).
- ¹¹³ New York Public Health Law § 2511(9)(a)(iv).
- ¹¹⁴ Supra note 21.
- ¹¹⁵ New York Social Services Law § 369-ee(5)(a).
- ¹¹⁶ Supra note 110.
- ¹¹⁷ Ibid.
- ¹¹⁸ Ibid.
- ¹¹⁹ Ibid.
- ¹²⁰ New York State Department of Health.
- ¹²¹ Supra note 110.
- ¹²² Supra note 30.

¹²³ Ibid.

¹²⁴ Szilagyi, Peter G., et al., *Evaluation of Child Health Plus in New York State*, The Rochester Child Health Studies Group, April 1996.

¹²⁵ Supra note 108, pps. 1-2, 8-10.

¹²⁶ Supra note 24.

¹²⁷ The New York Academy of Medicine's Forum for Child Health is currently host to a benefits work group that is analyzing the Child Health Plus benefits package so that health care providers, advocates, and policymakers can pinpoint more clearly where gaps exist.

¹²⁸ On December 15, 2000, Congress passed the Medicare, Medicaid and CHIP Benefits Improvement and Protection Act, which provided that states that exhaust their federal allocation under CHIP may share in a designated pool of funds left over from those states that have not used their CHIP allotments. New York could receive over \$400 million under this reallocation plan.

¹²⁹ Supra note 1.

¹³⁰ Supra note 2.

¹³¹ Supra note 5.

¹³² Supra note 7.

¹³³ Supra note 8.

¹³⁴ Supra note 9.

¹³⁵ Supra note 14.

¹³⁶ Supra note 15.

¹³⁷ Supra note 18.

¹³⁸ Supra note 20.

¹³⁹ Supra note 21.

¹⁴⁰ Supra note 22.

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