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ISSUE BRIEF

Automated Renewal: Strategies to Maintain Coverage of Eligible Children in Medicaid and Child Health Plus

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In September 2008, New York State became the only state in the nation to offer publicly subsidized health insurance coverage to children with family incomes up to 400 percent of the federal poverty level (FPL).[1] This expansion was implemented despite refusal by the Centers for Medicare & Medicaid Services (CMS) to provide federal resources to support it; it is fully funded with state and local dollars. This bold step arguably creates the opportunity to reach universal coverage for children in the state for the first time. It also puts New York in an unprecedented position to shift the focus of its eligibility procedures away from a traditional public assistance model, with the primary goal of excluding ineligible individuals, to a model with the primary goal of facilitating enrollment of uninsured children into broad-based health insurance programs. Using state data systems to prospectively verify eligibility and tapping into utilization data to verify continued program participation, "automated renewal" could significantly reduce the number of uninsured children, improve health outcomes, and create greater efficiency in the administration of Medicaid and SCHIP in New York State.

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The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.

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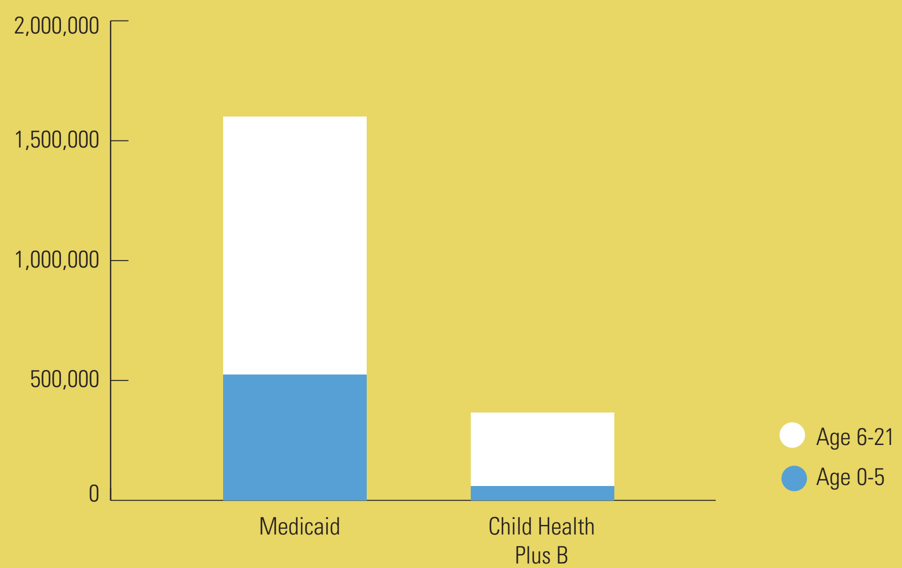
Health care is critical to children's well-being and healthy development.[2] Preventive care visits for young children provide necessary immunizations, check-ups to ensure normal growth, and an opportunity for early identification of developmental delays.[3,4] Conversely, poor health in childhood has long-lasting negative effects on physical, mental, and emotional health in adulthood, as well as on the child's educational attainment and economic status later in life.[5]

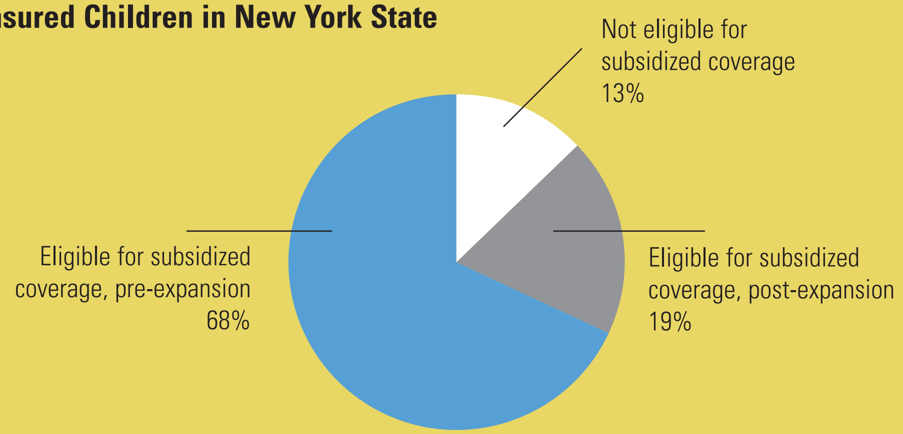
Health insurance coverage, particularly coverage under public programs, has been found to improve both access to care and health outcomes among children.[6] With this in mind, New York has invested significant resources in expanding access to public health insurance programs for children in the state. As shown in Figure 1, approximately 2 million children in New York receive health insurance coverage through Medicaid or the state's SCHIP program, Child Health Plus B (referred to as CHP throughout this paper).[7] In all, nearly half of the 4.8 million children in the state are either enrolled in or eligible for subsidized coverage.[8] Yet New York's experience illustrates that expanding eligibility levels alone does not necessarily translate into coverage. Approximately 360,000 — or nine out of ten uninsured children in the state — are currently eligible for publicly subsidized coverage but remain uninsured (Figure 2).[9,10] The remaining uninsured children may purchase coverage under CHP at full cost.

Figure 1.
Children Enrolled in New York Medicaid and Child Health Plus B Programs, as of 2008



Source: Enrollment figures provided by New York State Department of Health. Medicaid enrollment as of August 2008. CHP enrollment as of September 2008, including full pay and expansion population.

Figure 2.
Uninsured Children in New York State



N=415,000. Source: U.S. Census, Current Population Survey Estimates, three-year average for 2005-2007.

While outreach and enrollment are important to increasing program participation, New York could make significant progress by simply ensuring that children, once determined eligible for public health insurance coverage, are able to retain that coverage. Current rules, however, require annual redeterminations of eligibility for every child.[11] The purpose of annual renewal is to verify that recipients continue to meet the eligibility criteria for Medicaid or CHP,[12] including income, household size, residency, immigration status (for Medicaid), and lack of other coverage (for CHP).[13] As a practical matter, the annual renewal process also tests the family's need and desire to continue the coverage. Currently, families with children in Medicaid or CHP receive a renewal notice in the mail and are required to return the completed renewal form to their local social services district (see inset box).[14]

New York State's Renewal Process for Medicaid and Child Health Plus B

- Approximately 60-90 days before eligibility ends, renewal applications are sent to the household to complete and return by the "respond by" date — generally within 6 weeks — by mail or in person to the local department of social services (for Medicaid) or the health plan (for CHP).
- Non-responding households receive at least two additional notices before closure of a case. Those who return the form by the specified date, but who are missing information, may receive further opportunity to submit the required information.
- Most enrollees are not required to submit supporting documentation of their income, residency, resources, or child/adult care expenses at renewal. The recipient is not required to document items that remain constant, such as date of birth and identity. Documentation of new health insurance coverage or changes in immigration status is required. For CHP, the family premium contribution, if any, must be paid with renewal.
- If there is no response or the child is determined to be ineligible, the household is sent a notice of termination and informed of the right to appeal.

Sources: New York State Department of Health Administrative Directives (ADMs) 08 OHIP/ADM-4; 04 ADM-6; 03 ADM-2; and CHP ADMs 55, 53, 51, 45, 42, 41, 40, and 37.

Proving eligibility anew each year is a significant barrier to maintaining continuous coverage for children. According to the most recent estimates from the New York State Department of Health (DOH), more than one in four people receiving public health insurance lose coverage at the annual renewal process (approximately 29 percent of Medicaid recipients, and 27 percent of children enrolled in CHP).[15] At this rate, more than a half million children will lose their public health insurance coverage at renewal this year.

Very few children are disenrolled at renewal for reasons of actual ineligibility. Many families who lose coverage at renewal reapply and are reenrolled within a matter of months. These individuals remained eligible, but simply failed to successfully complete the process by the given deadline.[16] Such "churning" causes eligible children to join the ranks of the uninsured, disrupts the continuity of critical early childhood health care, and needlessly increases program administration costs.[17]

Reducing disruptions in coverage would help ensure that New York's investment in children's health is maximized while significantly reducing the number of uninsured children in the state. Historically, New York, like many states, essentially required recipients to reapply for the program at annual renewal, proving anew each eligibility requirement. In more recent years, however, in an effort to prevent eligible populations from losing coverage, New York has sought opportunities to simplify the process. This effort includes policies that prevent Medicaid workers from asking families to produce documents that are already on file and not subject to change (e.g., birth certificates), and eliminate requirements that families attend a face-to-face meeting. Today, most families are permitted to attest to their income, resources, and residence, avoiding burdensome documentation requirements and, for the first time, creating the potential for a paperless renewal process (Table 1).

In the coming year, the state plans to set up an enrollment center that will develop and operate a statewide telephone and mail-in renewal system for Medicaid, Family Health Plus, and CHP enrollees who can attest to their income and residence at renewal. The enrollment center will for the first time create a single entity with access to both Medicaid and CHP renewal information. The center is intended to "significantly advance the state's goal of enrolling all those eligible for public health insurance, reduce the number of enrollees who lose coverage at renewal, and improve transitions between project areas," such as moving children between Medicaid and CHP.[18]

Table 1.
Select Renewal Simplifications for Medicaid and Child Health Plus B in New York State

Action	Population Affected	Date Implemented
Telephone renewal	Medicaid, Family Health Plus (FHP), and CHP	Planned for 2009[19]
Self-declaration of income, residency, and some income deductions, such as child care expenses	Medicaid, FHP, and CHP (with SSN)	January 2008 for Medicaid and FHP[20]; September 2003 for CHP.[21] No documentation of address required for CHP since December 2002.[22] Self-attestation of income permitted for those with no other proof of income since April 2001 for CHP[23] and earlier for Medicaid.
Twelve months of continuous eligibility	Children under Medicaid and CHP (proposed for adults, but rejected by federal officials)[24]	January 1999 for Medicaid;[25] August 2005 for CHP[26]
Presumptive eligibility of two months if information provided at renewal is insufficient for final redetermination	CHP	September 2003[27]
Mail-in renewal allowed (face-to-face meeting not required)	Medicaid and FHP (CHP has never had such a requirement)	April 2003[28]
Simplified renewal form requesting only information subject to change since initial application	Medicaid, FHP, and CHP	April 2003 for Medicaid and FHP;[29] September 2003 for CHP[30]

With these simplifications comes implicit acknowledgement that families renewing coverage are, in fact, different from those newly applying to the program. Having already proven eligibility, and now known to the system for at least a year, they come to their annual renewal with an established record. It is neither necessary nor efficient to replicate this information.

Simplification efforts already have produced some positive results. While in the past only about half of recipients in New York's Medicaid program successfully renewed coverage, today the figure is closer to 70 percent, and higher still for CHP.[31] Renewal rates are likely to improve further with the implementation of telephone renewal and other streamlined processes.

Looking ahead, New York has an unprecedented opportunity to take this progression to the next step, by fundamentally changing the way renewal systems are organized.[32] With two million children covered by public health insurance programs and with near universal eligibility, the primary challenge at annual renewal is no longer to prevent the enrollment of the ineligible, but to sort children into the correct program and ensure proper cost-sharing for their family income level. In the past, New York placed the burden of renewal squarely on the shoulders of families, with poor results. Today, New York shares the burden by using databases to supplement information provided by families. The next step could be to eliminate the family burden, automating the renewal process and requiring families to act only to report a change in information not available through state data systems. Such a system is referred to in this report as automated renewal.

Automated Renewal: How Does It Work?

Automated renewal refers to a system in which the process of determining continued eligibility is radically streamlined by either (1) extending coverage for multiple years, referred to here as "continuous coverage"; or (2) utilizing internal state data sources to verify continued eligibility with minimal involvement from the recipient, referred to here as "administrative renewal." Automated renewal would supplement, not supplant, existing and proposed renewal options. Those who choose not to participate or are not eligible to participate in automated renewal would simply follow the normal renewal procedures (Table 2).

Continuous Coverage

Continuous coverage provides a period of guaranteed eligibility, eliminating the need to ask about or verify most eligibility criteria. Currently, federal and state laws permit continuous coverage for children in Medicaid and SCHIP for up to one year.[33] Once children have been determined eligible, they remain so for a full year regardless of changes in circumstance. Under an automated system, continuous coverage would be extended for multiple years, even extending throughout childhood. For example, renewal could be pegged to certain birthdays (for example, at ages 6, 12, and 18), or simply extended in its current form from one to multiple years.

Continuous coverage does not negate all eligibility requirements, and would not do so under an automated system. Children who move out of the state, obtain other health insurance coverage (for CHP only), or age out of the program during the continuous period would no longer be eligible. Existing data systems already automatically discontinue coverage for children who age out of coverage. Under continuous coverage, these systems would be supplemented by an annual (or more frequent) mailing to the family reminding them that a condition of the ongoing coverage is to report changes in address or health insurance status. Public education campaigns and targeted provider notices could supplement these efforts.

Extending continuous coverage beyond the current one-year limit would require the state to secure a federal waiver of the applicable Medicaid and SCHIP rules, a process typically utilized by states seeking to demonstrate new and innovative policies.[34] In the Medicaid context, this policy would need to be budget-neutral; that is, the cost of permitting children to be continuously enrolled would need to be equal to or less costly than the annual redetermination process. To bolster New York's ability to meet this standard, the state could seek an amendment to the current waiver, as budget neutrality is assessed as an aggregate across the entire waiver demonstration.[35] In the SCHIP context, a slightly different standard — "allotment neutrality" — is applied. A continuous coverage policy could be financed by federal and state dollars to the extent that there are available funds in the state's annual SCHIP allotment. Any expenditures above the allotment cap would be the responsibility of the state. It is important to note that waivers operate under the discretion of the Secretary of Health and Human Services; approval for these demonstrations thus depends on the policies and priorities of federal officials.

Table 2.
Verification at Renewal under Medicaid and Child Health Plus B

	Current New York State Policy	
	Community Medicaid for Children	**Child Health Plus B**
Renewal Process	Family returns completed renewal form and applicable documentation	Family returns completed renewal form and applicable documentation
Eligibility Criteria at Renewal		
Income and expenses	Self-attestation; state verifies with data checks[36]	Documentation not required if Social Security Number provided; state verifies with data checks[37]
Absent parent (for the purpose of pursuing medical support)	Must report information on absent parent, if applicable[38]	N/A
Residency	Self-attestation;[39] receipt of the renewal packet serves as acceptable proof[40]	Documentation not required[41]
Immigration	If status changes, send proof[44]	Report status changes[45]
Household size	Report changes[46]	Report[47]
Other insurance coverage	If new insurance has been acquired, send copy of insurance card or policy[48]	Information on other health insurance coverage required[49]
Continued desire to participate	Household returns signed renewal packet	Household returns signed renewal packet
Payment of premiums	N/A	Non-payment after 30-day grace period results in disenrollment[52]

Administrative Renewal

Administrative renewal is a process in which tasks traditionally left to the family, such as completing a renewal form and providing supporting documentation, are automated by the state. Unlike continuous coverage, recipient eligibility must be evaluated annually under administrative renewal. Several states, including Hawaii, Florida, Georgia, Illinois, and Utah, have implemented administrative renewal for targeted populations in their public health insurance programs. Typically, the state mails households a form prepopulated with the latest available eligibility information, asking that they report any changes. In the absence of a response, eligibility information for the household is presumed to remain the same, and coverage is automatically renewed. Illinois and Utah check

Proposed "Automated Renewal" Policies	
Continuous Coverage	**Administrative Renewal**
No renewal required	Family sent annual notice and asked to report only changes that affect eligibility. If no response, automatically renewed
N/A	Family asked to report if income is outside income range designated on annual notice; state verifies with data checks
N/A	Family asked to report changes
Send household notice once per year asking to report change[42]	Receipt of renewal notices serves as documentation[43]
N/A	If status changes, send proof
N/A	Report without documentation
Send household notice once per year asking to report change[50]	Same as current policy
Payment of premium or evidence of utilization	Payment of premium or evidence of utilization[51]
Non-payment after 30-day grace period results in disenrollment	Non-payment after 30-day grace period results in disenrollment

state databases to verify eligibility criteria. Sources used for data verification include state employment and wages, taxes, and motor vehicle departments. Hawaii, Illinois, and Utah also use mail returned by the U.S. postal service to identify changes in address or residency.[53]

Under administrative renewal, New York first would check databases to confirm income and residency. The state then would mail to the recipient a notice informing the household of the state's findings and the implications for the child's continued coverage. For example, the notice could include an income eligibility and cost-sharing chart and designate the income band and cost-sharing requirements that correspond to the family's income. In a change from the current mail-in process, the household would be required to respond only with corrections that indicated a change in program eligibility or cost-sharing requirements. In the absence of a response, the recipients would be automatically renewed. If the family reports a change that is less advantageous to the family (for example, a change that would require the family to pay $15 dollars per month, rather than $9), no further documentation would be requested. When the family reports an advantageous change, the state would reserve the right to request further documentation. As in the current system, families would retain their right to contest or appeal decisions with which they disagree.

Administrative renewal draws on many aspects of New York's existing renewal processes. For example, Medicaid and CHP workers currently access the state's wage and employment data systems to verify the information provided in renewal applications.[54, 55] Under an automated renewal system, the state would systematically perform these checks for all households at renewal before sending the renewal notice to the household, ensuring that the most recent data available are incorporated into the notice. The new state enrollment center will create an opportunity to centralize and systematize these data checks for all participants in administrative renewal throughout the state, alleviating the burden on local districts, health plans, and households. The state also could review motor vehicle data as a proxy for state residency, the federal SAVE database for information on changed immigration status,[56] and, potentially, IRS data for income and resource information.

Administrative renewal could be implemented under current federal rules, and would not require a federal waiver.

Supporting Automated Renewal with Utilization Data

One of the challenges in implementing either continuous coverage or administrative renewal is determining whether the family has an ongoing need for coverage. Most states, including New York, provide health insurance coverage through contracts with managed care organizations (MCOs). States paying a monthly capitated rate to an MCO understandably want to ensure that payments are not made for children who have moved away or obtained other health insurance coverage.

Currently, families indicate continued need by returning the annual renewal form. For families obligated to pay a monthly premium, the payment itself indicates the family's continued active participation in the program.[57] However, the 1.6 million children enrolled in Medicaid in New York and more than half of the 365,000 children enrolled in CHP are not obligated to pay monthly premiums (Table 3).

Table 3.
Child Health Plus B 2008 Premium Amounts by Household Income Level

Household Income by Federal Poverty Level (FPL)	CHP Premium Amount per Child per Month	Children Enrolled	Percentage of Total CHP Enrollment
≤ 160% FPL	$0	204,625	56%
≤ 222% FPL	$9 (max. $27 per family)	110,729	30%
≤ 250% FPL	$15 (max. $45 per family)	29,797	8%
≤ 300% FPL	$20 (max. $60 per family)	8,268	2%
≤ 350% FPL	$30 (max. $90 per family)	4,524	1%
≤ 400% FPL	$40 (max. $120 per family)	2,758	1%
> 400% FPL	Full premium	5,128	1%
Total CHP enrollment		365,829	100%
Children enrolled in Medicaid	$0	1.6 million	n/a

Source: Data provided by DOH. CHP enrollment data from October 2008; Medicaid enrollment data from September 2008.

An alternative approach would be to draw upon existing data sets ("utilization data") that track children's use of health care services. If utilization data indicate that a health care visit has occurred in the past year, the child would qualify for automated renewal.[58] If a child has not had a visit in the last year, the enrollee would simply revert to the current renewal process. New York already requires health plans participating in Medicaid to report monthly encounter data through the Medical Encounter Data Submission (MEDS) system,[59] and state workers currently have access to eMedNY,[60] the state's database for claims and other information. Yet utilization data have not been integrated into the renewal process. Visits with local physicians provide direct evidence that the family is still actively utilizing the program, and provide supporting information that the child continues to reside in the state.

Utilization data represent a particularly rich source of information for children because of the frequency of recommended preventive health care visits — six by the first birthday, three more by the second birthday, and annually thereafter.[61] Nine out of ten children age 0-6 enrolled in public health insurance programs in New York have at least one preventive health visit per year, and about the same proportion of children age 7-19 have a visit every two years.[62] Allowing renewal to be linked to utilization could be particularly important for sick children, who have many provider visits.

The current system for capturing utilization data is far from perfect. To date, MEDS only reflects Medicaid managed care visits, not visits under CHP.[63] However, state officials intend to expand MEDS to include CHP in the future.[64] Significant lags in visit information reported by some providers to plans, and by plans to the state,[65] also create timing challenges for automated renewal. If a visit occurs near the end of the eligibility period, it may not be reflected in MEDS until after the annual renewal date passes. Finally, the data themselves are not comprehensive, as reporting is sometimes uneven.

Yet, even with these deficiencies, utilization data provide an important source for monitoring continued family engagement and need — and there is reason to believe that they will become even more reliable. Utilization data are already used to measure health plan performance against quality indicators, which in turn are linked to enhanced reimbursement for plans. Furthermore, such data are increasingly used in audits and investigations of Medicaid payments. Indeed, the connection between automated renewal and utilization reporting could, in itself, serve as an incentive to health plans and providers to improve the quality of their data submissions.

Linking utilization to automated renewal would, for the first time, directly align the incentives of eligibility and care, while engaging providers in the renewal process in a completely new way. Providers present an important connection to families, often having the most up-to-date contact information. Providers also need families to renew coverage in order to continue to be reimbursed. Yet providers largely have been left out of the loop in renewing coverage. For their part, families and health plans currently expend enormous resources maintaining enrollment for eligible children, but so far these efforts have been focused on assembling the necessary paperwork.[66] With automated renewal linked to utilization, the energies of providers, families, and health plans would be directed towards ensuring timely and appropriate care for children. The act of obtaining care itself would support continued coverage.

Federal Audit and Compliance Considerations

Automated enrollment must be implemented in a way that balances continuous coverage for children with program integrity. Under federal rules, states must undergo two different kinds of reviews that require evidence verifying eligibility for samples of new and renewing program enrollees: the Medicaid Eligibility Quality Control (MEQC)[67] and the Payment Error Rate Management (PERM) audits.[68] Both reviews can result in states having to refund money — sometimes substantial sums — to the federal government for improper eligibility determinations.

The MEQC review provides some flexibility for states wanting to evaluate enrollment or renewal simplifications without risk of substantial federal recoveries.[69] States can freeze MEQC error rates at currently reported levels and conduct pilot projects to evaluate simplifications in lieu of their traditional eligibility audits. Under these rules, New York could propose a specific pilot project for auditing the automated renewal process to gather valuable program data and satisfy current MEQC requirements without risk to the state budget.

PERM audits offer no such flexibility. They require states to verify, using federal standards, all eligibility components of a sample of renewed enrollees, based either on current information in case files or on retroactive evidence of eligibility in the month of renewal. Automated renewal procedures, therefore, might require the state to take additional steps to collect evidence retroactively to verify a sampled individual's eligibility for the month in which they were renewed. Linking utilization to the ability to participate in an automated renewal may help to address some of the challenges involved with the audit verification process. Gathering retroactive eligibility data from the sample of enrollees is a major hurdle, as contact information is often not updated in state case files in a timely fashion.[70] Use of care data would increase the likelihood that there is updated contact information available for state workers to obtain eligibility verification for the audited sample of enrollees.

Implementation Challenges and Rollout

As any state official can attest, even the most basic changes in programs of the size, complexity, and importance of Medicaid and CHP present a host of logistical challenges. While continuous coverage and administrative renewal have the potential to vastly simplify New York's eligibility process in the long run, in the short run, they require investment in systems and commitment from various partners, including health care providers and managed care plans.

Role of the State Enrollment Center

The creation of a statewide enrollment center capable of operating a telephone and mail-in renewal system for Medicaid, Family Health Plus, and CHP (and able to facilitate transitions between Medicaid and CHP) presents an enormous opportunity for meeting the challenges inherent in implementing automated renewal. The center will perform systematic data checks to verify eligibility and will process premium payments. It could also track utilization data, providing a centralized approach to the automated renewal system. As the only renewing body in the state with access to both Medicaid and CHP renewal information, the center would be a key resource in implementing automated renewal.

Pilot-Testing the System

Even with the enrollment center, however, the challenges of implementing automated renewal are substantial. A pilot before statewide rollout would help identify and address the many logistical considerations of this initiative. In particular, the pilot could be used to evaluate the impact on coverage, care patterns, and health outcomes, as well as administrative cost and compliance issues.

A pilot study might start with a cohort of Medicaid-covered births. In 2006, approximately 99,000 births statewide were reimbursed by Medicaid.[72] This population could be further defined by geography, limiting the study to a few counties around the state. Over time, the first-year birth cohort could continue in the program and newly eligible families could enter each year upon a child's birth. Because infants require many well-baby visits, it is highly likely that children will have at least one visit at renewal. As the children age and require fewer well-care visits per year, the "look-back" period for a visit could be extended beyond twelve months. The pilot could continue through at least the child's fifth year, a crucial time in a child's development. Currently, 525,000 children under the age of 6 participate in Medicaid, and another 58,813 children are enrolled in CHP.[73]

Role of the Family

While a focus on children is particularly compelling given the recent expansion in coverage, creating different rules for children is less than ideal. Where parents or siblings are receiving coverage, the household still would need to complete the regular mail-in renewal process. Thus, any savings in program staff time, program costs, and reduced burden to the family that would be created by a streamlined process for children would be lost. An automated renewal process for some family members but not others also may create confusion, requiring more staff time and outreach to explain the different renewal procedures for different family members.

This problem could be addressed by including parents and siblings in the automated renewal process. A child's access to health care is tied to parents' coverage. Studies have demonstrated that covering low-income parents in programs such as Medicaid and CHP increases enrollment by eligible children, and that when parents have coverage, children improve their use of preventive health services.[74] For example, one study has found that having an uninsured parent decreases the likelihood that a child will have any medical provider visit by 6.5 percent, and decreases the likelihood of a well-child visit by 6.7 percent.[75] Thus, including parents in automated renewal would likely have direct benefits for children's health.

Conclusion

With nearly half of the children in the state enrolled in or eligible for coverage under Medicaid and CHP, changing the way eligibility systems are structured would have substantial benefits. Automated renewal would significantly reduce the procedural barriers that too often complicate renewals for children and their families and stand between uninsured children and the coverage for which they are eligible. Increasing the likelihood that eligible children remain covered over longer periods of time, while at the same time freeing up scarce administrative resources, would provide new opportunities to improve access to health care — allowing families, health plans, and providers to focus on the health and welfare of children.

Notes and References

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[7] About 1.6 million are covered through Medicaid, and another 365,000 through CHP. With the recent expansion, the state expects to enroll another 54,000 children in CHP, according to communication from the Office of Health Insurance Programs, State Department of Health, September 2008.

[8] Ibid.

[9] Manatt analysis of U.S. Census Current Population Survey data, three-year average 2005-2007.

[10] Holahan D, A Cook, and L Powell, New York's Eligible but Uninsured (United Hospital Fund, 2008, available at http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=675467, accessed November 17, 2008).

[11] For a description of New York's complex enrollment and renewal processes, see for example, Bachrach D, K Lipson, and K Bhandarkar, Administration of Medicaid in New York State (United Hospital Fund, 2006); Coulter Edwards B, VK Smith, and G Moody, Reforming New York's Medicaid Eligibility Process (United Hospital Fund, 2008); and Cohen A, M Dutton, K Griffin, and G Woods, Streamlining Renewal in Medicaid and SCHIP (United Hospital Fund, 2008), all available at http://www.medicaidinstitute.org/publications/.

[12] The Medicaid and SCHIP statutes only require states to establish reasonable eligibility standards. See 42 USC § 1396a(a)(17) (Medicaid); 42 USC § 1397bb(b) (SCHIP). The regulations promulgated by the U.S. Department of Health and Human Services (HHS) under the Medicaid and SCHIP statutes, however, require the redetermination of eligibility on at least an annual basis. See 42 CFR § 435.916 (Medicaid); 42 CFR § 457.320(e)(2) (SCHIP). See also 42 USC § 1302 (authorizing HHS to make regulations implementing Medicaid and SCHIP).

[13] 03 OMM/ADM-2, implementing Chapter 1 of the Laws of 2002.

[14] Ibid.

[15] Information provided by the State Department of Health via personal communication, September 2008. Recertification estimate of 71 percent is based on all Medicaid populations; a more specific recertification estimate for children was not available at time of publication.

[16] Boozang P, L Braslow, and A Fiori, Enrollment Churning in Medicaid: Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill (Manatt Health Solutions, December 2006, available at http://www.manatthealthsolutions.com/publications/articles/Enrollment_Churning.pdf, accessed November 17, 2008); Bachrach D, Costs of Churning and Source of Instability in Medicaid and SCHIP: The New York Experience, (Presentation at AcademyHealth 2003 Annual Meeting, June 2003, available at http://www.academyhealth.org/2003/presentations/bachrach.pdf, accessed November 17, 2008); Lipson K, E Fishman, P Boozang, and D Bachrach, Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Program (The Commonwealth Fund, August 2003, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221451, accessed November 17, 2008).

[17] Health plans in New York spend, on average, almost $70 in staff costs per CHP enrollee for recertification activities (Bachrach D, 2003; Boozang P, L Braslow, and A Fiori, 2006).

[18] A request for proposal (RFP) was issued for this project in October 2008; the project is expected to begin in May 2009. RFP available at http://www.health.state.ny.us/funding/rfp/0808040239/0808040239.pdf (accessed November 17, 2008).

[19] Ibid.

[20] 08 OHIP/ADM-4, implementing provisions of Chapter 58 of the Laws of 2007, allows recipients to attest to residency at renewal, even if their address has changed since the last determination. Districts were previously notified in GIS 01 MA/024 that unless they had reason to believe that a recipient no longer resided at the address specified, a recipient's receipt of the renewal form was sufficient documentation of current residence. Also, the ADM notes that "in lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the currently stored budget, or the stored budget or actual income documentation from a current Food Stamp or HEAP case."

[21] CHP ADM 45, effective September, 2003.

[22] CHP ADM 40.

[23] CHP ADM 32, April, 2001.

[24] Holahan D, A Cook, and L Powell, 2008.

[25] 99 OMM/ADM-3.

[26] CHP ADM 50.

[27] CHP ADM 41, effective September, 2003.

[28] See 03 OMM/ADM-2, implementing Chapter 1 of the Laws of 2002.

[29] Ibid.

[30] CHP ADM 41, effective September, 2003.

[31] Medicaid managed care recipients in the state have a retention rate of approximately 63 percent, according to DOH estimates. When all Medicaid is included, the figure is at 71 percent. The recertification rate for the quarter April – June 2008 was approximately 75 percent for children up to 5 years of age enrolled in CHP. This percentage is very close to the recertification rate for all children. Data provided by Office of Health Insurance Programs via email, September 25, 2008.

[32] Throughout, we use New York State to mean renewal activities of the state as well as local districts.

[33] Currently, federal and state laws permit continuous coverage under Medicaid and SCHIP for up to one year. See 42 USC § 1396a(e)(12) (permitting an individual, under 19 years old, whose Medicaid eligibility has been determined to remain eligible for benefits for up to 12 months); Implementing Regulations for the State Children's Health Insurance Program, 66 Fed. Reg. 2490, 2540, 2544 (January 11, 2001) (citing 42 USC § 2102(a)-(b) and encouraging states "to adopt continuous eligibility rules to avoid interruptions in a child's health care..."); and NY Soc. Serv. Law § 366(4)(s) (providing for continuous coverage for up to 12 months for children under 19 years old covered by Medicaid in New York State). A number of states have implemented continuous coverage in practice. See Cohen Ross D, L Cox, and C Marks, 2006. It is worth noting that New York sought federal approval to extend continuous coverage to adults but was denied (Arnold J, United Hospital Fund presentation, April 2008).

[34] The Medicaid and SCHIP statutes only require states to establish reasonable eligibility standards. See 42 USC § 1396a(a)(17) (Medicaid); 42 USC § 1397bb(b) (SCHIP). The regulations promulgated by HHS under the Medicaid and SCHIP statutes, however, require the redetermination of eligibility on at least an annual basis. See 42 CFR § 435.916 (Medicaid); 42 CFR § 457.320(e)(2) (SCHIP). See also 42 USC § 1302 (authorizing HHS to make regulations implementing Medicaid and SCHIP). Federal law empowers HHS to waive a state's obligation to comply with the Medicaid and SCHIP statutes for "any experimental, pilot, or demonstration project that promotes the objectives of [either program]," 42 USC § 1315(a). See also 42 USC § 1397gg(e)(2)(A) (expressly extending 1115 waiver authority to SCHIP). It therefore follows that HHS's waiver authority would also extend to the Medicaid and SCHIP regulations that require annual redeterminations of eligibility.

[35] The "with waiver" costs, relating to erroneous continuous coverage of ineligibles, could be approximated and monitored by the eligibility audits conducted under the MEQC and PERM programs. The "without waiver" costs, relating to disenrollment and subsequent reenrollment of eligibles (e.g., costs attributed to more costly Medicaid services utilized by eligible children due to forgone care during periods without insurance and administrative costs of reenrolling eligible children) could be assessed through existing literature or sampling.

[36] "Self-attestation" refers to a separate form completed by the household that substitutes for documentation at renewal. 08 OHIP/ADM-4, implementing provisions of Chapter 58 of the Laws of 2007, notes that "in lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the currently stored budget, or the stored budget or actual income documentation from a current Food Stamp or HEAP case."

[37] CHP ADM 32, April, 2001 allows self-attestation of income at renewal for SCHIP recipients where no other proof of income is available. CHP ADM 45, effective September, 2003, allows no documentation of income with provision of SSN for all CHP cases.

[38] 03 OMM/ADM-2, implementing Chapter 1 of the Laws of 2002.

[39] 08 OHIP/ADM-4, implementing provisions of Chapter 58 of the Laws of 2007.

[40] 08 ADM-4, GIS 01 MA/024.

[41] CHP ADM 40, effective December, 2002.

[42] Currently, 12-month continuous coverage for CHP is subject to certain exceptions, including non-residency and other health insurance coverage (CHP ADM 50). We would apply these same policies to a longer period of continuous coverage.

[43] Similar to current New York policy for Medicaid (08 ADM-4, GIS 01 MA/024). This is also allowed in Hawaii, Illinois and Utah.

[44] 03 OMM/ADM-2. For a detailed review of immigration status and Medicaid eligibility, see 04 OMM/ADM-7.

[45] Incomplete Renewal Application Guidance Sheet for CHP renewal.

[46] 03 OMM/ADM-2, implementing Chapter 1 of the Laws of 2002.

[47] Incomplete Renewal Application Guidance Sheet for CHP renewal.

[48] 03 OMM/ADM-2, implementing Chapter 1 of the Laws of 2002.

[49] Incomplete Renewal Application Guidance Sheet for CHP renewal.

[50] Currently, 12 month continuous coverage for CHP is subject to certain exceptions, including non-residency and other health insurance coverage (CHP ADM 50). We would apply these same policies to a longer period of continuous coverage.

[51] Other states, including Florida and Georgia, used premium payments as part of their administrative renewal processes. See Cohen A, M Dutton, K Griffin, and G Woods, 2008.

[52] CHP ADM 51, effective January, 2006.

[53] Cohen A, M Dutton, K Griffin, and G Woods, 2008.

[54] Verification of continued program eligibility using "behind the scenes" data checks has been used successfully in a number of public programs, including Medicare. For a discussion of how government data has been used to identify and enroll eligible individuals in a public health insurance program, see Dorn S, Eligible but not Enrolled: How SCHIP Authorization Can Help (Urban Institute, September 2007, available at http://www.urban.org/url.cfm?ID=411549, accessed November 17, 2008).

[55] CHP ADM 45, effective September, 2003. One known and significant logistical challenge related to implementing the wage database (WRS) check for child-only cases relates to Social Security Numbers (SSNs). By federal law, parents are not currently required to provide their own SSNs when applying for children. One option is to require that a parent provide an SSN in order for their child to participate in the continuous coverage or automated renewal initiative. This is done currently in New York where parents elect not to provide documentation of income at renewal.

[56] The federal database for immigration is the federal Systematic Alien Verification for Entitlements (SAVE) database. More information is available at http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=1721c2ec0c7c8110VgnVCM1000004718190aRCRD&vgnextchannel=1721c2ec0c7c8110VgnVCM1000004718190aRCRD.

[57] Florida used premium payments by families as a check under administrative renewal in its SCHIP program from 1992 to 2004. In Georgia, from 2001 to 2007 administrative renewal was available to all SCHIP enrollees, approximately 20 percent of whom did not pay premiums. See Cohen A, M Dutton, K Griffin, and G Woods, 2008.

[58] Plans currently collect encounter data from all providers, with approximately an 80 percent or higher reporting rate. Plans then report this data to the state regularly (approximately monthly) for MEDS purposes; plans also convert the data into their QARR/HEDIS software packages and report those to the state on a different timeline (once for each reporting year).

[59] New York State Medicaid Program, Managed Care Reference Guide: Encounter Data Submissions (MEDS II), available at http://www.emedny.org/ProviderManuals/ManagedCare/PDFS/ManagedCare-EncounterData.pdf, accessed November 17, 2008.

[60] RFP for DOH Enrollment Center, page 14 (available at http://www.health.state.ny.us/funding/rfp/0808040239/0808040239.pdf, accessed November 17, 2008).

[61] American Academy of Pediatrics Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Pediatric Health Care (Form RE9535), *Pediatrics* 2000, 105:645-6.

[62] New York State Department of Health, Office of Health Insurance Programs, Bureau of Program Quality Information and Evaluation, 2007 Managed Care Plan Access and Utilization Report, available at http://www.health.state.ny.us/health_care/managed_care/reports/, accessed November 17, 2008.

[63] New York State Medicaid Program, Managed Care Reference Guide: Encounter Data Submissions (MEDS II), available at http://www.emedny.org/ProviderManuals/ManagedCare/PDFS/ManagedCare-EncounterData.pdf, accessed November 17, 2008.

[64] According to the Office of Health Insurance Programs, New York State Department of Health, via personal communication, September 26, 2008.

[65] According to discussions with SDOH and select PHSP plans, while MEDS data are reported approximately monthly by managed care plans to the state, a significant number of encounters is not reported by providers to plans within a month, creating serious lags in the data reported to the state.

[66] Health plans in New York spend, on average, almost $70 in staff costs per CHP enrollee for recertification activities (Bachrach D, 2003).

[67] 42 CFR §§ 431.800–431.865.

[68] 42 CFR § 431.978.

[69] U.S. Dept. of Health and Human Services, Health Care Financing Administration, Letter to State Quality Control Directors, September 12, 2000. Available at http://www.cms.hhs.gov/smdl/downloads/smd091200.pdf (accessed November 17, 2008).

[70] Cohen A, M Dutton, K Griffin, and G Woods, 2008.

[71] RFP for DOH Enrollment Center (available at http://www.health.state.ny.us/funding/rfp/0808040239/0808040239.pdf, accessed November 17, 2008).

[72] Estimates provided by the State Department of Health, Office of Health Insurance Programs, via personal communication on September 24 and 25, 2008.

[73] Ibid.

[74] Ku L and M Broaddus, Coverage of Parents Helps Children, Too (Center on Budget and Policy Priorities, October 20, 2006, available at: http://www.cbpp.org/10-20-06health.pdf, accessed November 17, 2008); Dubay L and G Kenney, Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid, *Health Services Research*, October 2003, 38(5): 1283-98; Institute of Medicine, Committee on the Consequence of Uninsurance, *Health Insurance Is a Family Matter* (Washington, DC: National Academies Press, 2002); Davidoff, AJ, L Dubay, GM Kenney, and A Yemane, The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children, *Inquiry*, Fall 2003, 40(3): 254-68.

[75] Davidoff, AJ, L Dubay, GM Kenney, and A Yemane, 2003.