# STATE OF NEW YORK
# DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 00 OMM/ADM-2

**DIVISION:** Office of Medicaid Management

**TO:** **Commissioners of Social Services**

**DATE:** May 4, 2000

**SUBJECT:** Facilitated Enrollment of Children into Medicaid, Child Health Plus and WIC

**SUGGESTED DISTRIBUTION:**

Commissioners
Medicaid Directors
Medicaid Staff
Managed Care Staff
Staff Development Coordinators

**CONTACT PERSON:**

Medicaid Local District Liaison: (518) 474-9130
New York City Representative: (212) 268-6855
Managed Care County Relations Staff: (518) 473-1134

**ATTACHMENTS:**

Attachment I: DOH-4133 (Growing Up Healthy Application)
Attachment II: DOH-4134 (Growing Up Healthy Documentation Checklist)
Attachment III: Statewide List of Facilitated Enrollers

(None are available on-line

**FILING REFERENCES**

| Previous ADMs/INFs | Releases Cancelled | Dept. Regs | Soc. Serv. Law & Other Legal Ref. | Manual Ref. | Misc. Ref. |
|---|---|---|---|---|---|
| 98 OMM/ADM-3<br>91 ADM-28<br>91 ADM-18 | 98 OMM/ADM-3 | 360-2.1<br>360-2.2<br>360-2.4 | PL 105-33<br>Public Health Law Section 2511(9) | | |

## I. PURPOSE:

The purpose of this Office of Medicaid Management/Administrative Directive (OMM/ADM) is to:

- advise local social services districts (LDSS) of the requirement to coordinate their application processes with approved community-based organizations contracting with the Department to provide "facilitated enrollment" assistance to families in applying for Medicaid, Child Health Plus (CHPlus) and the Special Supplemental Food Program for Women, Infants, and Children (WIC) for their eligible children; and,

- introduce the revised DOH-4133, Growing Up Healthy Application.

## II. BACKGROUND:

In 1997, the U.S. Congress passed the Balanced Budget Act (BBA), Public Law 105-33, which contains several provisions relating to children's health care coverage. These provisions, including the newly created Title XXI of the Social Security Act, contain the framework for states to establish State Child Health Insurance Plans (SCHIPs), to vastly expand outreach and enrollment efforts for both Medicaid and the new SCHIPs, and to foster close coordination between the two programs. Enhanced federal financial participation is available for these efforts.

New York State has had its own children's health insurance program since 1990. This program, Child Health Plus (CHPlus), contracts with private insurers to supply low-cost or free health insurance to low income children. The BBA recognized New York's CHPlus program, which was previously funded with State-only money, as an acceptable SCHIP program.

In New York State, Chapter 2 of the Laws of 1998 was enacted to provide authority for the Department to implement the BBA. Chapter 2 requires the Department to implement locally-tailored public education, outreach and facilitated enrollment strategies targeted to children who may be eligible for benefits under CHPlus and Medicaid. In response, the Department released a Request for Proposals (RFP) in March 1999, to solicit proposals from community-based organizations to facilitate enrollment in CHPlus and Medicaid. As a result, 34 "lead organizations" (also called lead agencies) were selected to coordinate facilitated enrollment in community-based settings. Many of them have sub-contracted with other community-based organizations to which they will provide oversight. CHPlus insurers have also been given an opportunity to facilitate enrollment in these programs.

Additionally, the State has revised the Growing Up Healthy application (DOH-4133, Attachment I) which has been in use in pilot sites as a joint application for CHPlus, Medicaid and WIC. This application, which includes a documentation checklist, will be used by facilitators to assist children in accessing the appropriate program(s).

## II. PROGRAM IMPLICATIONS:

Facilitators will be placed in various locations in the community, such as hospitals, clinics, day care centers, and community centers. Chapter 2 of the Laws of 1998 requires facilitators to be available evenings and weekends.

Facilitators will assist families in applying for Medicaid or CHPlus and WIC. This assistance will include screening the applicant for the appropriate program, completing the application, collecting the required documentation, submitting the completed application and necessary documentation to the appropriate program, and follow-up with families to ensure they complete the application process. Local districts may delegate to the facilitator the authority to conduct the Medicaid face-to-face interview with the applying family, or they may require the facilitator to act as the family's authorized representative during the face-to-face interview at the LDSS. The family cannot be required to come into the LDSS for the face-to-face interview. The facilitator will also assist families in choosing a health plan for CHPlus. For Medicaid, facilitators may assist families in pre-selecting a health plan, at the families' option.

The goal of facilitated enrollment is to maximize the enrollment of eligible children in the appropriate program and ultimately, demonstrate improved access to care and health outcomes. The role of the LDSS is critical to the success of facilitated enrollment. Some LDSS have already been involved in the development of facilitated enrollment proposals with organizations in their communities, while others may not have had a direct role. In either event, LDSSs are responsible for working with approved organizations in the facilitated enrollment process. Districts, in conjunction with the lead organizations, may design processes/procedures which meet local needs while accommodating applications received from facilitators.

## IV. REQUIRED ACTION:

### A. Local District Responsibilities

The LDSS must coordinate the application process with the approved facilitated enrollment organizations working in their communities. It is also anticipated that recipients who enroll in Medicaid through a facilitator will be assisted in the recertification process by such facilitator. Attachment II provides a Statewide listing of approved lead agencies. The responsibilities of the LDSS in the facilitated enrollment process include the following:

1. Work with the lead organizations to develop protocols for the receipt and processing of applications and recertifications. This includes developing processes for notifying the lead organization and the applicant when additional documentation is required and of

the final eligibility determination. Such procedure must allow for the submission of the DOH-4133 by the lead organizations.

2. When needed, provide information to lead organizations to assist facilitators in determining a health care provider's participation in Medicaid Managed Care, as described in Section B of this directive.

3. Accept completed applications (DOH-4133) from the lead organizations and process applications in a timely manner, but in no event later than 30 days from the date of application. Districts must also provide notice of the results of the eligibility determination to the applicant, and the lead organization and/or health plan.

4. Accept Medicaid Managed Care enrollment forms from the facilitators, pending the enrollment until eligibility has been established and managed care enrollment can be completed in the PCP subsystem.

5. Provide prompt feedback to the lead organization on incomplete or incorrect applications, so that problems can be addressed in a timely fashion.

6. Delegate the Medicaid face-to-face interview to the facilitators, **or** establish procedures which allow the lead organization to act as the authorized representative for the applicant, for purposes of the face-to-face interview with LDSS staff.

   Where the LDSS agrees to delegate the face-to-face interview to a facilitator, the facilitator is responsible for informing the applicant of his/her rights and responsibilities, as required by 18 NYCRR 360-2.2(f). Where the LDSS retains responsibility for the face-to-face interview, interviews with staff from the lead organizations should be scheduled in such a manner that several interviews may be conducted during one appointment.

   The date that the application is completed and signed with the facilitator is considered the date of application for Medicaid purposes. Applications may be signed by the applicant, or anyone the applicant designates to represent him/her in the application process.

   **NOTE: If there is a delay in the receipt of a completed application from a lead organization such that the thirty day timeframe for the Medicaid determination is compromised, local districts are advised to document this circumstance in the case record. This will serve to hold the district harmless in the event of an audit or other administrative review.**

The lead organizations and the LDSS must describe the above procedures, in writing, and such procedures will be made a part of the lead organization's contract with the Department. These procedures may include any standards of performance and/or quality control measures agreed to by both parties, and actions to be taken by the district to correct performance that does not meet the agreed upon standards.

Children who apply and are found fully eligible for Medicaid through the facilitated enrollment process will be authorized for no less than 12 months of Medicaid coverage, or through the end of the month in which their 19th birthday occurs, whichever is earlier. Upon being notified of the need to recertify eligibility, such children will have the option of recertifying with the LDSS or they may return to the facilitator to recertify, using the DOH-4133. (See Systems Implications for instructions for identification of these cases.)

**NOTE:** Pregnant women may also apply for Medicaid using the DOH-4133. Generally, such pregnant women are provided coverage only until the end of the 60 day post-partum period and are required to recertify in order for coverage to continue beyond such period. Procedures for authorizing coverage for pregnant women are not changing under the facilitated enrollment process. It is recommended that a separate case be maintained for the pregnant woman in order to ensure recertification at the appropriate time.

It is anticipated that a significant number of adults may be identified as potentially eligible for Medicaid by facilitators. Such individuals cannot complete the application with a facilitator and should be referred by the facilitator to the LDSS to initiate the application process. It is recommended that districts establish procedures to coordinate the processing of such adult applications with the applications received from the lead organizations for their children.

B. Managed Care Implications

Facilitators may be assisting Medicaid applicants in choosing a Medicaid Managed Care plan, when appropriate. In doing so, they will be inquiring about existing provider relationships, in an effort to identify health plans in which a child's current provider participates. The facilitator will be responsible for providing complete and impartial information about all participating insurers, to allow a family to make an informed choice of which plan will meet its needs. A primary goal is to retain the child's current relationship with a primary care provider, if one exists.

Districts must be prepared to assist lead organizations to set up procedures for access to information regarding the most current managed care plan provider network. Where a family has chosen a plan, the enrollment will be forwarded to the LDSS, using the prescribed SDOH enrollment form (DOH-4175 or DOH-4097), along with the DOH-4133. Districts must have a written process in place, approved by the Office of Managed Care,to pend the enrollment until such time as the child is determined eligible for Medicaid. (In New York City, managed care enrollments will be forwarded to Maximus and processed only after Medicaid eligibility has been established.)
Districts' written procedures must include provision for monitoring the education process of the lead organizations to ensure the following:

- In mandatory counties, the education process must ensure the enrollee has sufficient information to make an informed choice and understand the provisions of mandatory enrollment. This may include dissemination by the facilitator of the county's enrollment packet or other educational materials as agreed upon in the lead agency/LDSS protocol.

**Note:** 1115 counties must make assurances that all terms and conditions mandated by the Health Care Financing Administration will be adhered to.

- In voluntary counties, the education process must ensure informed choice, as well as convey the voluntary nature of the program.

- All counties must have a protocol for follow-up in instances of biased marketing, incomplete, or incorrect information disseminated by facilitators.

In situations when an applicant does not choose a Managed Care plan during the interaction with the facilitator, the district's existing processes for enrolling the individual in a managed care plan upon establishment of eligibility are followed.

C. Transition of Medicaid Eligible Children from CHPlus

Title XXI prohibits Medicaid eligible children from being enrolled in CHPlus. Under the Department's approved Title XXI State Plan, the State is required to ensure efficient and effective coordination between the Medicaid and CHPlus programs. Districts were notified in 98 OMM/ADM-3, "Medicaid Referrals from the Child Health Plus Program," of procedures whereby CHPlus insurers screen families at the time of application and yearly recertification and, where it appears the family income is below the Medicaid standard, refer the family to the LDSS. As an interim process, monthly lists of families so referred have been provided to the districts. Districts were then required to forward Medicaid application packages to each family on the list. With the implementation of facilitated enrollment, these processes will change.

CHPlus plans will identify children who appear to be Medicaid eligible based on the previous year's income. At least 60 days prior to the child's annual recertification for CHPlus, the family will be instructed via a letter from their CHPlus insurer that, unless the family income has increased, the child must apply for Medicaid prior to the recertification due date. Further, the family will be informed that failure to apply for Medicaid will result in disenrollment from CHPlus. The recertification packets will include a list of facilitated enrollment locations and the documentation requirements for Medicaid. Facilitators will complete the Medicaid application process with the family (including the face-to-face interview, when the authority has been delegated by the LDSS), provide information on all available Medicaid Managed Care plans the applicant may choose from, and complete the state-prescribed managed care enrollment form, when appropriate. The application package will then be forwarded to the LDSS for the eligibility determination.

A similar process will be followed for new CHPlus applications mailed directly to CHPlus insurers, when the child appears Medicaid eligible.

Districts are required to provide a copy of the Medicaid decision notice to the facilitator and/or CHPlus insurer. It is necessary for the LDSS to notify the facilitators and the CHPlus insurers of the results of the Medicaid determination, to enable them to follow up with applicants who have not submitted all required documentation and to

disenroll from CHPlus children who have become Medicaid eligible, and children whose families have failed to comply with the application process.

The joint application has a specific consent provision to share applicants' Medicaid status with CHPlus insurers. Districts are permitted to release information to facilitators under the provisions of Social Services Law, Section 136, which allows disclosure to an authorized representative. The lead organizations are under contract with the Department, and are subject to (and have been trained on) the same standards of confidentiality as LDSS staff.

D. Revised DOH-4133

The DOH-4133, "Growing Up Healthy Application," which was provided to districts in 99 OMM/ADM-1, has undergone substantial revisions as a result of recommendations from the pilot sites. These revisions are primarily a reordering of the existing questions. However, there are several notable changes:

- The shelter information includes questions regarding whether the housing payment includes heat, and if not, the type of heat. Completion of these questions is optional on the part of the applicant. However, when answered, it will allow LDSS staff to determine eligibility using Low Income Family (LIF) budgeting. If the questions are not answered, eligibility is determined using the appropriate poverty level budgeting methodology.

- The question requesting information about absent parents has been removed from the application. Instead, applicants will be given information regarding the availability of child support services and the benefits to their children of establishing paternity and/or pursuing cash/medical support from the absent parent.

- Information for non-citizens has been expanded.

The revised DOH-4133 is included in this Directive as Attachment I. It will eventually replace the DSS-2921-P. Local districts should accept both applications until further notice.

E. Revised DOH-4175 and DOH-4097

The DOH-4097, "Medicaid Managed Care Program Enrollment Form" and DOH-4175, "Medicaid Managed Care Enrollment Form (Voluntary Counties)" are the prescribed enrollment forms for use in the Medicaid Managed Care Program in voluntary and mandatory counties. For voluntary counties, use of the DOH-4175 will negate the need for a separate client attestation, as previously required with the plan specific enrollment forms.

## V. SYSTEMS IMPLICATIONS:

A. Upstate:

As discussed in Section IV of this directive, children who apply and are found eligible for Medicaid through the facilitated enrollment process will be given the option of recertifying with the LDSS, or with a facilitator, using the DOH-4133. A new recert call in letter and

reason code is under development for the Client Notices System (CNS) which will advise the recipient of the need to recertify, and will include the DOH-4133 and language explaining the recertification process. In order to ensure such cases are appropriately identified, a unique identifier must be entered in the Welfare Management System (WMS) for these cases.

Districts should assign their own identifier. This may be either a unique Unit Identifier or Worker Identifier. Whichever option is used, districts should be aware of the hierarchy of the sort order of the Recertification Report (WINR 4133). Creating a new Unit Identifier will cause all cases with that identifier to appear together, regardless of the worker assigned to the case. Creating a new Worker Identifier will designate facilitated enrollment cases by worker, and integrate these cases into the existing unit to which the worker is assigned. Creation of new Unit/Worker Identifiers requires districts to update their CNS Contact Data, so that the recert call in letter will print the proper Unit/Worker information.

B. New York City:

New York City procedures for identifying cases which enter the agency through facilitated enrollment will be transmitted under separate cover.

**VI. EFFECTIVE DATE:**

Districts will be notified to begin processing applications from the approved agencies once the contract between the Department and the agency has been signed by both parties and approved by the Office of the State Comptroller.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management