

BARRIERS TO MEDICAID

Challenges & Opportunities
for New York

Prepared by
Care for the Homeless

In Collaboration with
Greater Upstate Law Project
Commission on the Public's Health System

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EXECUTIVE SUMMARY

In 1965, Congress enacted Title XIX of the Social Security Act, which created Medicaid, a joint federal and state health insurance program for low-income single-parent families with children, low-income persons over the age of 65, and the disabled. In addition to those persons covered under the federal program, New York State subsequently extended the coverage to include low-income childless adults.

A study of federal law and numerous directives from the Health Care Financing Administration (HCFA), the federal agency with oversight of the Medicaid program, reveals that federal intent was to design a straightforward program with a simple application process. Federal law requires few of the administrative complexities characteristic in New York State's application and enrollment process. In addition, over the years, HCFA has set forth directives to state Medicaid agencies, encouraging greater simplification of the Medicaid application process.

This report identifies areas where New York State and local practices exceed or counter federal regulations and, in doing so, create barriers to accessing Medicaid. This causes Medicaid-eligible New Yorkers to not apply, to give up during the application process, or to be found ineligible due to inadequate documentation.

These problematic areas include:

- < a long and poorly designed application form
- < extensive and repetitive documentation requirements
- < an asset test
- < a personal interview
- < language-appropriate materials and translation services that do not meet federal standards
- < finger-imaging and drug screening requirements
- < local practices which delay or impede attempts to apply for Medicaid
- < extended time periods before eligibility determination
- < frequent and extensive recertification requirements
- < re-application requirements for beneficiaries who move from county to county

These are burdens placed on the shoulders of low-income New Yorkers instead of the New York State Medicaid Agency, as federal law mandates. This report makes the following recommendations in order to simplify the Medicaid application process and assure that eligible New Yorkers have access to health care coverage.

RECOMMENDATIONS

Simplified Application Form and Documentation Requirements

- < New York State should require the State Medicaid agency to re-design and use a shorter, simpler, user-friendly application form for Medicaid-only applicants pending the approval of Family Health Plus and the development of a single Medicaid/Family Health Plus/Child Health Plus application form within a specified time frame. The application form should request only the minimal information that is essential to determining Medicaid eligibility. As noted in a January 23, 1998, HCFA letter to State Medicaid

Directors, federal funds may be used to achieve this goal. In addition, the State should re-design the joint Medicaid/Food Stamps/cash assistance application form in order to make it shorter, simpler, and easier to use.

- < The task of verifying information should be placed on the State Medicaid agency and not on the applicant, by cross-matching computer files and automated clearances with federal, state, and local government records. The State should rely on its own resources, not on applicants, to validate eligibility.
- < New York State should mandate Medicaid applicants and recertifying beneficiaries to submit only those eligibility-verifying documents that are required by federal law; i.e., documents verifying an immigrant applicant's qualified immigration status.
- < New York State should eliminate the Medicaid program's asset test, making it consistent with New York's other health care coverage programs.

Removal of Appointment and Screening Requirements

- < New York State should permit Medicaid applicants and recertifying beneficiaries to submit their applications and recertification papers by mail.
- < New York State should eliminate personal interview requirements for both Medicaid applicants and recertifying beneficiaries.
- < New York State should repeal its finger-imaging requirements for Medicaid applicants and beneficiaries.
- < New York State should eliminate the drug and alcohol screening and treatment requirement as a condition of Medicaid eligibility.

Consistent and Appropriate Local Practices

- < New York State should mandate the availability of language-appropriate application forms and interpreter services appropriate to the neighborhood of Local Departments of Social Service offices and other locations that interact with Medicaid applicants and beneficiaries.
- < New York State should mandate regular intensive training, including customer service, of all Local Departments of Social Service workers, and should routinely screen local district offices' compliance with legal application and enrollment requirements.
- < New York State should mandate that local district workers provide all Medicaid applicants and recertifying beneficiaries with help and assistance in completing their applications and recertification documents.
- < New York State should require appropriate staffing levels to accommodate the two previous recommendations.

- < New York State should provide for presumptive Medicaid eligibility for all applicants whose Medicaid eligibility is not determined within legal time limits.

Simplified Recertification Process and Simple Re-Application Requirements for Beneficiaries Who Move

- < New York State should amend the state Medicaid law to require adult Medicaid beneficiaries, including those in receipt of other public assistance, to recertify no more than once a year, or when circumstances affecting eligibility change.
- < New York State should direct the State Medicaid agency to design and use a simple, easy to complete Medicaid-only recertification form, different than the initial application form. The revised form should eliminate requests for information already in the possession of the local districts, and omit questions unrelated to continuous eligibility for Medicaid. Federal Medicaid funds may be used for this purpose.
- < New York State should prohibit the Medicaid agency from requiring Medicaid beneficiarys to re-apply for Medicaid when they move from one local district within New York State to another. Once the information about the change in residence is reported, the local district should be obligated to conduct, at most, a limited redetermination of Medicaid eligibility based on the new information, and to notify the beneficiary of the change in the local district responsible for ongoing Medicaid eligibility.

These recommendations are intended to simplify the application process and assure that Medicaid beneficiaries are able to maintain access to health care. The bottom line, as one professional assisting Medicaid applicants stated, is that low-income New Yorkers “should not need an advocate” to get the benefits for which they are eligible.

With the advent of Family Health Plus, New York has a remarkable opportunity to link the application process of its three health programs (Medicaid, Child Health Plus, and Family Health Plus) by simplifying their application process. In order for these three health programs to be congruous, New York State must remove the formidable Medicaid application barriers. Federal law creates the opportunity to simplify this process through its directives and resources. New York should take advantage of these directives and resources to create a user-friendly application process for all low-income New Yorkers.

PREFACE

In 1965, Congress enacted Title XIX of the Social Security Act, which created Medicaid, a joint federal and state health insurance program for low-income single-parent families with children, low-income persons over the age of 65, and the disabled. In addition to those persons covered under the federal program, New York State subsequently extended the coverage to include low-income childless adults.

While the intent of the Medicaid program is to serve as the safety net for health care coverage, over the years the actual practice of the application process has become a barrier to many who appear to meet program eligibility standards. This analysis compares federal law and regulations, state law and regulations, and local New York City practices. The report identifies areas where state law and local practices exceed or counter federal regulations, and, in doing so, create barriers to Medicaid access. The analysis underscores the federal guidance, reiterated in several directives, to make the eligibility process accessible, and documents instances where local practice diverges from this standard.

The goal in preparing this report is to improve the existing system so that those persons who are entitled to Medicaid can gain access to this important benefit. This report has been prepared by staff of Care for the Homeless, in collaboration with the Commission on the Public's Health System, and the Greater Upstate Law Project under a grant from the United Hospital Fund.

Many thanks are due to everyone who worked on this project from conception to completion:

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Barbara Lowe who facilitated the focus groups and Raul Gonzalez who translated groups into Spanish;

Ellen Yacknin, Greater Upstate Law Project, who analyzed Title XIX of the Social Security Act and State Medicaid laws and regulations;

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Finally, special thanks to Ellie Tinto-Poitier and Kirsten Aspengren, who observed the process in Medicaid offices, interviewed clients, and prepared the report.

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INTRODUCTION

The consequences of being without health insurance are severe and well-documented. These include less access to health care, a lower chance of successful treatment, and severe financial burden. Living without medical insurance can be a terrifying experience, creating feelings of vulnerability and powerlessness. Uninsured individuals and families are susceptible to huge financial burdens from the slightest of illnesses. In response to this, the federal government created the Medicaid program as a safety net for the low-income uninsured by enacting Title XIX of the Social Security Act. The federal Medicaid program expressly discourages the use of complicated application and verification procedures that hinder applicants' access to Medicaid. Instead, virtually all of New York State's Medicaid application process barriers identified in this report are the creation of New York State itself. In practice, the underlying foundation of New York's Medicaid application process is one that focuses on keeping the error rate of wrongly approved applications down, requiring the applicant to prove they are not ineligible. This foundation places the Medicaid worker in the position of disproving applicants' eligibility, as opposed to helping applicants enroll in Medicaid. This prevailing attitude of assumed ineligibility, coupled with the confusing and complex Medicaid application process, increases barriers to accessing to medical coverage.

This report is unique in that it combines an analysis of Title XIX of the Social Security Act and State Medicaid laws and regulations with the experiences of actual Medicaid applicants. As described below, Medicaid applicants in New York State encounter many obstacles as they attempt to gain and maintain medical coverage for themselves and their families. These difficulties generally arise from eleven areas in the New York Medicaid application process, each of which is explored in this report from three viewpoints. First, each area is reviewed according to the federal Medicaid program and Health Care Financing Administration (HCFA) regulations and directives. Second, the federal Medicaid program and HCFA directives are compared to New York State Medicaid laws, New York State Medicaid agency regulations, and actual procedures. Personal examples are used to illustrate the barriers that these laws or procedures create in accessing medical coverage. Finally, recommendations are suggested for removing these barriers.

BACKGROUND

The federal government does not require states to participate in the Medicaid program, but any state that elects to participate must comply with the requirements of federal Medicaid program rules. In return, the state receives substantial federal Medicaid funds.¹ In 2001, all 50 states, The District of Columbia, and United States territories participate in the federal Medicaid program. New York State has participated in the federal Medicaid program since 1966.² In general, federal funds pay for 50% of the cost of New York's Medicaid program. In addition, and in conjunction with New York's 1997 Medicaid Managed Care Waiver, New York's Medicaid program provides federally funded health care coverage for financially eligible childless adults.

The Federal Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services reviews and supervises states' compliance with federal Medicaid program rules. The rules governing the federal Medicaid program are set forth primarily in Title

¹ See 42 U.S.C. §1396a *et seq.*

² See N.Y. Soc. Serv. Law §363 *et seq.*

XIX of the Social Security Act, federal Medicaid regulations,³ and HCFA's State Medicaid Manual. Additionally, on occasion, HCFA distributes directives, known as State Medicaid Director Letters, to state Medicaid programs to clarify federal Medicaid program policy and requirements. These program and policy materials set forth the federal requirements with respect to Medicaid application, verification, and recertification procedures.

In 1965, family-based federal Medicaid was directed to families that were eligible for Aid to Families with Dependent Children (AFDC), the joint federal and state program that provided cash assistance to single-parent families. In the late 1980s and early 1990s, however, Congress, wanting to broaden the reach of Medicaid, began to de-link families' eligibility for Medicaid from eligibility for cash assistance. This de-linking process began with the creation of programs that provide Medicaid for children and pregnant women at higher income levels. These programs were created without the restrictive resource rules that existed in the general Medicaid program, and were called federal "poverty level" Medicaid programs.

In 1996, Congress completely separated the federal Medicaid program eligibility rules from the federal AFDC program rules with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Under Section 1931 of PRWORA,⁴ states were given the opportunity, within certain parameters, to adopt more liberal and more expansive federal Medicaid eligibility rules, even if the eligibility rules for the new federal cash assistance program, christened the Temporary Assistance for Needy Families program, were not similarly changed.

One year later, in 1997, Congress adopted the federal State Child Health Insurance Program (SCHIP) that permitted states to implement new health care coverage programs for children, to expand their Medicaid programs for children, or to do both. Six years before SCHIP, New York had created a state-funded Child Health Plus program to provide basic medical coverage to a limited number of children who were ineligible for Medicaid coverage. In 1998, to take advantage of SCHIP's federal dollars, New York greatly expanded its Child Health Plus program and increased its Medicaid income levels for children. In 1999, New York adopted the Family Health Plus program to provide, when approved by HCFA, health care coverage to thousands of uninsured adults who do not qualify for federally funded or state-funded Medicaid.

New York State demonstrated its awareness of the need to minimize barriers to health care access that occur with multiple application procedures by expanding Child Health Plus and adopting Family Health Plus. In doing so, the State directed the development and use of a joint "simplified application form" for Child Health Plus, Medicaid for children, and Medicaid for pregnant women.⁵ Similarly, the law directed the development and use of "an application form for services under [Family Health Plus and Medicaid] that is easy to understand and complete."⁶

Clearly, in devising Child Health Plus and Family Health Plus, policymakers understood that simple, understandable, uniform application procedures are essential to ensuring access to health

³ See C.F.R. §§430-456.

⁴ See 42 U.S.C. §1396u-1.

⁵ See N.Y. Public Health Law §§2511(9)(b)(iii), 2511(16).

⁶ N.Y. Soc. Serv. Law §369-ee(4)(b)(iii).

care coverage for eligible New Yorkers. However, the new law did not simplify the application and eligibility procedures for the adult Medicaid program, which is the oldest health care program in New York, and was originally created for the neediest New Yorkers. Consequently, as this report shows, despite the State's intent to make health coverage more accessible, obtaining Medicaid continues to be a cumbersome and difficult process.

Furthermore, the Medicaid program's application and eligibility procedures contradict legislative intent and have an adverse impact on accessibility to Child Health Plus and, when implemented, Family Health Plus. To be eligible for Family Health Plus, an adult cannot be eligible for Medicaid. Accordingly, preliminary planning for Family Health Plus calls for a family to provide all the information necessary to determine whether the family is eligible for conventional Medicaid, even though much of the information is irrelevant to Family Health Plus eligibility.

Few of the application and eligibility procedures which impede access to health care coverage are required by federal law. In fact, as discussed below, several of the access barriers in New York's Medicaid application procedures are not even required by state law; rather, they are procedures implemented by the State Department of Health. Nevertheless, to ensure the elimination of these access barriers and to further the legislative goal of easy access to health care coverage for all New Yorkers, legislative amendments to the State laws regarding the Medicaid program will be the most effective step.

THE STUDY

The access barriers discussed in this report were identified through a project funded by the United Hospital Fund and conducted by Care for the Homeless, the Commission on the Public's Health System (CPHS), and the Greater Upstate Law Project (GULP).

DATA COLLECTION

Researchers collected data in a variety of ways. Six focus groups were facilitated across New York City. They were comprised of people who had applied (successfully or not) for Medicaid benefits within the last year. In addition, in-depth interviews were conducted with eleven recent Medicaid applicants and eight professionals from community-based sites where assistance is provided to individuals applying for Medicaid. Researchers conducted a final focus group of six other professionals who assist Medicaid applicants in gathering required documentation and often accompany them to Human Resources Administration (HRA) offices. (HRA is the agency which administers the Medicaid application process in New York City.)

A professional facilitator, with expertise conducting focus groups of this type, worked with researchers to design the process, develop materials, facilitate the Medicaid applicant groups, and provide written reports of each applicant focus group. Focus groups included recent Medicaid applicants associated with a community health center, a homeless women's shelter, a homeless family shelter, a community-based assistance organization, and two hospitals where people apply for Medicaid. Facilities in each borough, except for Staten Island, provided study participants. Study participants represented the experiences of Medicaid applicants from nearly every eligibility category. All categories are federally mandated except singles and childless couples, which New York State's Medicaid law covers. Project staff worked to assure that the

study represented geographic and demographic diversity of Medicaid beneficiaries in New York City. Two groups were conducted with Latino participants (one entirely in Spanish), while others included Caribbean and Middle Eastern immigrants, and one of the in-depth interviews was conducted in Chinese through an interpreter. To capture the broadest range of experiences, the study included single men and women, families, domiciled and homeless people, and people with chronic physical and behavioral health conditions.

The professional interviews and focus group consisted of directors of programs which provide application assistance in the community, homeless shelter case workers, a private hospital social service director, and community health center and other community-based organization staff who are responsible for helping clients navigate the Medicaid application process.

Finally, the Greater Upstate Law Project completed an analysis of Title XIX of the Social Security Act and New York State Medicaid laws and regulations corresponding to the experiences of the actual Medicaid applicants in this study.

THE MEDICAID APPLICATION PROCESS

Under federal rules, each state designates a “single state agency” which is responsible for administering the Medicaid program. In New York that agency is the New York State Department of Health (NYS DOH). This state Medicaid agency then delegates responsibility to Local Departments of Social Service (LDSS). In New York City, HRA is responsible for accepting applications and approving eligibility for Medicaid benefits in New York City. HRA operates Medicaid-only offices and Income Support Centers (also known as Job Centers and formerly known as Income Maintenance Centers) where people can apply for all three public benefits: Medicaid, Public Assistance, and Food Stamps. People seeking applications for Medicaid-only at Income Support Centers are directed by HRA staff to the closest Medicaid-only office.

A single application form exists for all three benefits mentioned above. This form is sometimes included with an application packet. Materials included in the application packet (e.g., application form, instructions, supplemental forms, and guidance) differ from office to office. Applicants can either take the application form out of the office for completion at a later time or can complete the form on-site for review that day by an HRA worker. This application form, also known as “the blue form,” is an eight-page document requiring extensive information on all household members. Once completed, the application form must be submitted in person at a Medicaid-only office or an Income Support Center. The applicant must wait to speak with an HRA worker, who reviews the application form and informs the applicant of the supporting documentation required for the next appointment: the “face-to-face” personal interview. This interview is required even if the applicant has all necessary supporting documentation with them at the time the application is turned in. The process of approving the application does not officially begin until the applicant satisfies the HRA worker that each piece of required documentation has been provided. Notification of either approval or denial, by federal law, must occur within 45 days for non-disabled applicants and 90 days for disabled applicants.

Project staff attempted to confine the scope of this study to people who apply for Medicaid-only due to findings that “as many as 70 percent of people who receive Medicaid no longer get cash

assistance.”⁷ However, because some study participants applied for all three public benefits, and de-linking is still being implemented, participants’ impressions of the process occasionally were intertwined with their experience of applying for and maintaining Public Assistance and Food Stamp benefits. As much as possible, clarifying questions were included to identify Public Assistance and Food Stamp access barriers, and to elicit the elements solely associated with the Medicaid application.

FINDINGS

The study revealed tremendous inconsistencies in practices and an alarming lack of uniformity in New York City’s Medicaid application process. These irregularities are the direct result of an unduly complicated system which makes demands on the applicant, often contrary to Title XIX of the Social Security Act. It is this anachronistic system of requirements that erects formidable barriers to health care access for millions of low-income New Yorkers. Although the examples given below are from individuals, each participant expressed common themes of frustration and confusion. Outlined below are the eleven greatest barriers in New York’s Medicaid application process.

New York State’s Medicaid application form requires more information than federal law requires.

FEDERAL LAW AND HCFA DIRECTIVES FOR APPLICATION FORM REQUIREMENTS

Federal law requires Medicaid applicants to provide only limited, basic information on a written form. Specifically, federal law requires the written application form to solicit only: (1) applicants’ Social Security numbers⁸ (2) information about applicants’ citizenship or lawful immigration status⁹; and (3) information about potential alternative sources of payment for applicants’ medical coverage.¹⁰ Federal law also requires the applicant to assign any rights he or she may have to legal support from a third party (typically a spouse or ex-spouse) to the state Medicaid agency.¹¹ Finally, federal law requires the applicant to sign a statement attesting to the truth of the information on the application form.¹²

⁷ See Jennifer Steinhauer, “For Poor, Health Benefits Are Easier to Have Than to Hold,” *New York Times* (December 31, 2000).

⁸ See 42 C.F.R. §435.910.

⁹ See HCFA State Medicaid Manual, §3212; U.S. Department of Justice, “Interim Guidance on Verification of Citizenship, Qualified Alien Status, and Eligibility,” 62 Fed.Reg. 61344 (November 17, 1997); *proposed* 8 C.F.R. Part 104, 63 Fed.Reg. 41662 (August 4, 1998).

¹⁰ See 42 C.F.R. §433.148.

¹¹ See 42 C.F.R. §433.145.

¹² See 42 C.F.R. §435.907.

Rather than relying on the information provided by a Medicaid applicant in the application form, federal law encourages primary reliance on a state Medicaid agency's information verification systems to establish and verify eligibility factors. Specifically, Title XIX of the Social Security Act requires every state to create and use a sophisticated and computerized "Income and Eligibility Verification System." This system relies on the applicant's Social Security number to obtain and exchange detailed information about applicant eligibility and income from a wide array of state and federal agencies.¹³ Additionally, federal Medicaid regulations require every state Medicaid agency to request specified information from the designated agencies about each applicant, using his or her Social Security number, for the purpose of "verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant."¹⁴ To verify information about potential third-party sources of medical support, a state Medicaid agency must use the data collection and processing systems described in federal Medicaid regulations.¹⁵ To verify applicants' lawful immigration status, a state Medicaid agency has the option to access the federal "Systematic Alien Verification for Entitlements" system.¹⁶

Consistent with the principles underlying these requirements – that the Medicaid application process should be as user-friendly as possible, and that the state Medicaid agency should carry the burden of verifying applicants' eligibility for Medicaid – HCFA wrote to State Medicaid Directors on January 23, 1998, and again on September 10, 1998, urging them to simplify their Medicaid application procedures by, among other things, simplifying the application form. In its letter, HCFA observed:

"One barrier to enrollment in Medicaid is the complexity of the application. We encourage States to develop strategies to simplify these processes by: preparing a simplified Medicaid application for the eligibility groups that include most children; . . . [and] shortening the Medicaid application form generally. [Medicaid administrative funds can be used]"¹⁷

Attached to HCFA's September 10th State Medicaid Director Letter is a three-page revised Model Application Form that the Administration urged Medicaid agencies to use "as is," or with minimal modifications. Although the Model Application Form is drafted as a joint Child Health Plus and Medicaid application form for children, HCFA suggests that it can also be used as a Medicaid application form for adults with few changes.¹⁸ Similarly, the Washington, D.C. Medicaid application form for adults has only two pages of questions, with an additional question for non-citizen applicants.

¹³ See 42 C.F.R. §§435.910; 42 U.S.C. §§1320b-7; §136a(a)(46).

¹⁴ See 42 C.F.R. §435.948.

¹⁵ See 42 C.F.R. §433.138.

¹⁶ See 8 C.F.R. §100.2; *proposed* 8 C.F.R. Part 104, Subpart C, 63 Fed. Reg. at 41682.

¹⁷ HCFA State Medicaid Director Letter, January 23, 1998 at 4 (Available at <http://www.hcfa.gov/init/chourtrch>).

¹⁸ See HCFA State Medicaid Director Letter, September 10, 1998, pp. 5-6 (Available at <http://www.hcfa.gov/init/chpelig>).

THE NEW YORK STATE MEDICAID APPLICATION FORM

Study participants criticized the Medicaid application form, stating that it was too long, confusing, and poorly designed with very small print, and that it contained redundant questions. In fact, some participants said that the most difficult aspect of applying for Medicaid is the application form itself and that it is not uncommon to spend hours completing this application form. One participant stated, “*They ask you everything but your bra size.*”

As mentioned earlier, New York’s Medicaid application form for adults is a joint application for Medicaid, Public Assistance, and Food Stamps. The joint application form has two pages of instructions and six pages of questions, divided into 20 sections, that must be answered. Because it is a joint application form, it requests information for all three New York public benefit programs. While the information needed for these three programs overlaps to some extent, the joint form requests information that is entirely unnecessary to obtain from Medicaid-only applicants.

New York’s joint application form enables an applicant for Public Assistance and/or Food Stamps to apply, on the same form, for Medicaid. However, less information is needed from persons applying only for Medicaid. This application undermines the federal goal of making the Medicaid application process as simple as possible for Medicaid-only applicants. In addition, study participants reported being confused about the services for which they were applying, e.g., Medicaid, Public Assistance, or Food Stamps. Participants thought that the application was for all three benefits and many did not realize that they could apply for Medicaid alone.

New York State’s joint application form does not contain a completely discrete section for Medicaid-only applicants. Instead, the joint form requires all applicants to provide nearly all the requested information, even if the information is not necessary for Medicaid purposes. For example, although federal law bars the state from soliciting the citizenship and/or immigration status of non-applying household members,¹⁹ New York State’s joint application form makes no such distinction with respect to this requested information. In fact, study participants were specifically critical of being required to provide information about other household members. Other objectionable required information on the application form was the provision of directions to the applicant’s home and questions about whether applicants could cook where they lived.

Examples in this report illustrate that New York State’s Medicaid application form is not user-friendly. In fact, the numerous, sometimes confusing, and unnecessary questions often discourage eligible applicants from completing the form. The two-page instruction sheet, which is labeled, “**READ THE IMPORTANT INFORMATION BELOW,**” is filled with densely written and compressed information in small, difficult to read 8-point type (8-point type). At least one federal court has concluded that notices in smaller than 12-point type are unreadable, and ordered the use of 12-point or larger type for Medicare notices and Medicare managed care

¹⁹ See U.S. Department of Justice, “Interim Guidance on Verification of Citizenship, Qualified Alien Status, and Eligibility,” 62 Fed.Reg. at 61347.

plans.²⁰ Since errors in completing the forms can cause rejection of the application form, study participants voiced concern that the design and content of the form increases the likelihood of making errors and therefore impedes application approval.

New York's Child Health Plus/Poverty Level Medicaid application form is written in simple, user-friendly language and is easy to understand. No federal or state laws or regulations prevent the New York State Medicaid agency from immediately creating and using a simplified, easy-to-use application form for adults who wish to apply only for Medicaid and not for Public Assistance or Food Stamps. Indeed, as part of the Family Health Plus Act, the State must create and use a single Medicaid/Family Health Plus application form "that is easy to understand and complete,"²¹ especially due to findings that "as many as 70 percent of people who receive Medicaid no longer get cash assistance."²²

RECOMMENDATIONS

1. **New York State should require the State Medicaid agency to re-design and use, within a specified time frame, a shorter, simpler, user-friendly application form for Medicaid-only applicants pending the approval of Family Health Plus and the development of a single Medicaid/Family Health Plus application form. The application form should request only the minimal information that is essential to determining Medicaid eligibility. As noted above in the January 23, 1998 HCFA letter to State Medicaid Directors, federal funds may be used to achieve this goal.**
2. **New York State should require the State Medicaid agency to re-design, within a specified time frame, the joint Medicaid/Public Assistance/Food Stamps application form in order to make it shorter, simpler, and easier to use.**

New York's verification and documentation requirements are more stringent than federal law requires.

FEDERAL LAW AND HCFA DIRECTIVES FOR VERIFICATION AND DOCUMENTATION REQUIREMENTS

As a general rule, federal law imposes few information and documentation verification obligations on a Medicaid applicant. With few exceptions, federal law does not require applicants to furnish documentation to prove the information on the application form. HCFA has repeatedly clarified and emphasized that federal law requires minimal verification and documentation for Medicaid applications or re-determinations. According to HCFA:

²⁰ See Grijalva v. Shalala, 946 F.Supp. 747,761 (D. Az. 1996); HCFA National Marketing Guidelines for Medicaid Managed Care Organizations (Aug. 8, 1997); CCH Medicare and Medicaid Guide ¶45,699.

²¹ N.Y. Soc. Serv. Law §369-ee(4)(b)(iii).

²² See Jennifer Steinhauer, "For Poor, Health Benefits Are Easier to Have Than to Hold," New York Times (December 31, 2000).

[T]here are few verification requirements under Federal law that are mandatory. While it is important to maintain program integrity by verifying

*income, excessive requirements can deter families from completing the application process. (Emphasis added)*²³

Specifically, federal law *only* requires Medicaid applicants and beneficiaries to submit evidence of a qualified immigrant applicant's immigration status.²⁴ As long as the State has established fair, nondiscriminatory procedures for doing so, states are permitted to accept a self-declaration of one's status as a U.S. national, including one's status as a U.S. citizen.²⁵

To ensure that all Medicaid beneficiaries are, in fact, eligible, federal law attempts to place the burden on state Medicaid agencies, rather than on applicants, to verify all the essential information. Federal law mandates state Medicaid agencies to develop and use specific, comprehensive systemic information verification systems to verify applicants' and beneficiaries' eligibility for Medicaid. According to HCFA, rather than requiring Medicaid applicants to submit documented evidence of their income and resources, a state Medicaid agency can, if it chooses, conduct all mandated information verification through its own data verification systems.

In its September 10, 1998 State Medicaid Director Letter, HCFA emphasized the availability, and promoted the use, of this option:

[U]nder Medicaid, with the exception of obtaining documentation of immigration status for qualified alien applicants and the applicants' Social Security numbers, States have flexibility to determine documentation requirements, *including self-declaration of income and assets. The current application and enrollment requirements for Medicaid . . . do not call for families to provide extensive amounts of documentation and information in order to file for benefits. (Emphasis added)*²⁶

Accordingly, HCFA's Letter urges states to "allow self-reporting of income by the family with follow-up verification by the State," and to "reduce verification/documentation requirements

²³ HCFA State Medicaid Director Letter, January 23 1998 at 4 (Available at <http://www.hcfa.gov/init/choutrch>).

²⁴ See HCFA State Medicaid Director Letter, September 10, 1998 at 3 (Available at <http://www.hcfa.gov/init/choutrch>); HCFA State Medicaid Manual, §3212; U.S. Department of Justice, "Interim Guidance on Verification of Citizenship, Qualified Alien Status, and Eligibility," 62 Fed.Reg. 61344 (November 17, 1997); *proposed* 8 C.F.R. Part 104, 63 Fed.Reg. 41662 (August 4, 1998).

²⁵ See HCFA Summary of final 42 C.F.R. §457.320(c), 66 Fed.Reg. 2489, 2542 (January 11, 2001)(note: implementation of these regulations was halted on 1/20/91 pending further review); *proposed* 8 C.F.R. Part 104, 63 Fed.Reg. at 41669-70; HCFA State Medicaid director Letter, September 10, 1998 at 3, (Available at <http://www.hcfa.gov/init/chpelig>).

²⁶ HCFA State Medicaid Director Letter, September 10, 1998 at 2 (Available at <http://www.hcfa.gov/init/chpelig>).

that go beyond Federal regulation.”²⁷

Concerns that eliminating documentation submission requirements lead to enrolling significant numbers of Medicaid beneficiaries who are actually ineligible for coverage are unsubstantiated. The experience of other states that have eliminated documentation submission requirements is that no significant upswings in fraud or error rates have occurred.²⁸ Directly addressing this concern, HCFA advised State Medicaid Directors:

[W]e have strongly encouraged States to simplify application and enrollment processes to remove barriers to the enrollment of children and families in Medicaid and children in your State Children’s Health Insurance Program (SCHIP). However, some States have voiced concern that the Federal Medicaid Eligibility Quality Control (MEQC) program is a barrier to their simplification efforts. *However, there is no indication that States’ simplification procedures have contributed to an increase in errors.* (Emphasis added)²⁹

NEW YORK STATE’S MEDICAID LAW AND REGULATIONS FOR VERIFICATION AND DOCUMENTATION REQUIREMENTS

Like federal law, New York State Medicaid law does not require applicants to submit documented proof of information provided in the application form. (Upon receipt of a Medicaid application form, the social services official must, “if necessary . . . verify the conditions of such eligibility . . . [and] promptly cause an investigation to be made”).³⁰ In addition, State Medicaid law permits (but does not mandate) the verification of information through the use of the State’s systematic information and data collection systems.³¹

Graphically illustrated throughout this report, New York’s extensive Medicaid documentation requirements are a major, and legally unnecessary, barrier to Medicaid coverage. When asked which documentation requirement is the most challenging, one professional stated, “*Every last one [documentation requirement] is a barrier. . . . It depends on the person’s situation as to which one is the barrier that makes them say ‘no more of this’.*”

State Medicaid regulations, however, impose substantial documentation submission requirements on both Medicaid applicants and recertifying beneficiaries.³² Applicants can be

²⁷ HCFA State Medicaid Director Letter, September 10, 1998 at 1 (Available at <http://www.hcfa.gov/init/chourrch>).

²⁸ See Kalkines, Arky, Zall & Bernstein, “Closing Coverage Gaps: Improving Retention Rates in new York’s Medicaid and Child Health Plus Programs,” pp. 24-25 (December 2000).

²⁹ HCFA State Medicaid Director Letter, September 12, 2000 at 1 (Available at <http://www.hcfa.gov/medicaid/smd91200>).

³⁰ See N.Y. Soc. Serv. Law §366-a(2).

³¹ See N.Y. Soc. Serv. Law §366-1(8).

³² See 18 N.Y.C.R.R. §360-2.3.

required, as in New York City, to provide extensive documented proof of more than twenty factors, including documents proving identity, citizenship, marital status, residence, household composition, income, and assets.³³ If the requested documentation is not supplied, Medicaid eligibility is denied or terminated. Gathering all of the required documents can take an excessive amount of time and can be a financial burden for low-income people. Most participants find it necessary to obtain letters from family members, friends or community-based organizations (CBOs) to prove information on the application form. This requires travel around the city, which can be challenging without money for transportation and without child care. Many applicants reported traveling to as many as five different places. Even making phone calls to track down documents can be difficult. Many applicants do not have a phone, do not have money to use pay phones, and must rely on the use of family members, friends, and client advocates' phones. New York State regulations require all Medicaid applicants and beneficiaries to submit:

documentation of wages received by all employed family members who are included in the application and by all legally responsible relatives living with the applicant. . . . If the applicant's income varies, the documentation must show all wages earned in the past four weeks. . . . All other income also must be documented. . . .³⁴

This documentation requirement is particularly frustrating for Medicaid applicants who know that financial checks are already being done with their Social Security numbers regardless of whether they supply documentation of income or assets. In many instances, this documentation is extremely cumbersome to obtain. Study participants described the following barriers to providing documentation:

- < When applicants are self-employed (e.g., selling merchandise on the street), it is difficult to prove not only how much money they make, but also where and what they sell. One professional assisted a self-employed applicant in obtaining letters from customers. Although this was accepted by Medicaid, the cumbersome task of obtaining the letters illustrates the difficulties confronted by applicants to pull together necessary documents without professional assistance.
- < Providing income documentation is a barrier for some employed individuals. For example, seasonal workers often earn more than the monthly Medicaid income level during periods of employment. Yet their yearly income may still fall well below the annual Medicaid income level. Due to documentation requirements of "wages earned in the past four weeks", many workers cannot apply for medical benefits during employed seasons.

New York State regulations also require applicants and beneficiaries to provide documented proof that potentially available income and resources are not available:

If any income or resources are unavailable, the applicant/beneficiary must

³³ See NYS Medicaid Reference Guide; Documentation Requirements Chart, DSS-2642, Attachment 1.

³⁴ 18 N.Y.C.R.R. §360-2.3(c)(2).

submit documentation establishing the unavailability.³⁵

Unemployed study participants also reported being required to prove that they had no income by applying for Unemployment Insurance and by presenting a letter of denial from the Unemployment Insurance office to Medicaid before determining eligibility. Other participants were required to obtain letters from previous employers, even from jobs held five years previously.

New York State regulations also require that:

The applicant/beneficiary must satisfactorily explain and/or document how current living expenses are being met.³⁶

HRA workers communicate this requirement during personal interviews. One unemployed study participant reported that an HRA worker requested documentation of how often she had dinner at her sister's because she was told that it "*could be over the amount that is allowed.*" Another participant claimed an HRA worker scrutinized the monetary value of her coat, which she received from the homeless shelter where she resided. The worker even summoned her supervisor to see the coat, while they both aggressively questioned the applicant about how she could afford such a nice coat.

Finally, Medicaid applicants who have assets, such as savings accounts, reported that documenting these accounts is time-consuming and burdensome. Banks are slow and charge by the page for three years of required statements.

Proof of residence can also be complicated for many reasons. "*In a city where we have real housing problems. . . this kind of thing is a real barrier. A simple thing, like proving your address, is not a simple thing for many of the people we serve . . . and proof of address is the easiest one [of the eligibility documentation requirements to prove],*" said one professional interviewed. For example:

- < Medicaid applicants may live in domestic violence shelters or homeless shelters. This has been reported as the easiest proof of residence. But, for families at the Emergency Assistance Unit (EAU), it encompasses long waiting periods for a letter verifying resident status from shelter staff.
- < Medicaid applicants may live with friends or family members doubled-up in apartments where they are technically not allowed to stay and cannot receive mail. In these cases, HRA workers require a bill in the name of the friend or family member who is the primary tenant. This friend or family member may not be willing to write a letter stating that the applicant is residing in the apartment. In some instances, the landlord does not allow doubling up and the tenant fears eviction. Also, primary tenants currently receiving public benefits, such as SSI, may worry that monthly allowances will be decreased if the

³⁵ 18 N.Y.C.R.R. §360-2.3(c)(4).

³⁶ 18 N.Y.C.R.R. §360-2.3(c)(5).

benefit agency suspects unreported household income. Finally, because Medicaid has not been completely de-linked from welfare, the stigma attached to Medicaid often creates resistance. Friends and family members have concerns about their names or addresses being associated with “welfare.”

- < Medicaid applicants who reside in their own apartments sometimes are not able to satisfactorily prove residence. For example, a widow with the lease and most household bills in her deceased husband’s name claimed that a telephone bill in her name was not accepted as verification of residence. *“This is proof but it isn’t proof enough,”* said the HRA worker who insisted that the participant document residence with a letter from her landlord, in addition to the telephone bill. In fact, it was not uncommon for participants to report the requirement of letters from landlords even after providing a lease or bills. Another participant was in a tenant-landlord dispute with a landlord who refused to cooperate. She was not receiving mail at her apartment due to this dispute. However, she had a Con Edison bill mailed to her Post Office box. The HRA worker required more documentation. The applicant said, *“In the end you probably wind up . . . with a minimum of four proofs of your address.”*

Applicants must also provide original birth certificates. If they do not have them, they must purchase a certified copy, which in New York City costs \$15. Typically, for those born in New York State, obtaining the certified copy necessitates a trip to the New York City Department of Health. If applicants have access to an application for a birth certificate, they can mail this, along with a check or money order; however, the cost of a money order can be more than the travel costs. In addition, mailing requires time. It is cheaper and quicker to visit the New York City Department of Health to receive a certified copy of a New York birth certificate that day. (Local practices impeding even the use of original documents verifying age and identity will be discussed in greater detail on page 22).

While policymakers may be concerned about program integrity, the State has adequate resources (i.e., computerized data and information systems) to verify applicants’ statements.

RECOMMENDATIONS

3. **The task of verifying information should be placed on the New York State Medicaid agency through the use of its computerized data and information systems and not upon the applicant. The State should rely on its own resources, not on applicants’, to validate their statements.**
4. **New York State should mandate Medicaid applicants and recertifying beneficiaries to submit only those eligibility-verifying documents that are required by federal law: i.e., documents verifying an immigrant applicant’s qualified immigration status. The State should verify other eligibility elements by cross-matching computer files and automated clearances with federal, state, and local government records.**

New York State requires an asset test although federal law does not.**FEDERAL LAW AND HCFA DIRECTIVES FOR ASSET TEST REQUIREMENTS³⁷**

Since the adoption of PRWORA in 1996, the federal Medicaid program no longer requires states to have an asset test for Medicaid eligibility. Indeed, because one of the largest barriers to Medicaid coverage is the asset test, HCFA has strongly encouraged states to eliminate Medicaid assets requirements.³⁸ According to an analysis by the Greater Upstate Law Project as of March 2001, at least 13 states and the District of Columbia do not have any assets limits in their Medicaid programs.³⁹ In a forthcoming report by The Henry J. Kaiser Family Foundation, states that have eliminated their asset test have found that it creates administrative ease.⁴⁰

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR ASSET TEST REQUIREMENTS

Questions about Medicaid applicants' assets consume nearly a page of the Medicaid application form. However, because of the burdensome nature of this requirement, New York State has removed asset tests from its "poverty level" Medicaid programs for pregnant women, children and infants, its Child Health Plus program, and its Family Health Plus program. Information on assets can be difficult to prove or provide. Still, New York State Medicaid law retains a restrictive, arduous asset test that prevents many impoverished and uninsured New Yorkers from obtaining Medicaid.⁴¹

Study participants regarded questions about resources as irrelevant. They felt that questions about bank accounts, possessions, car value, life insurance, and bonds were inappropriate because they, as benefit applicants, were poor and had few resources. Assets which applicants may have are typically not available or not financially adequate to pay for commercial health insurance.

RECOMMENDATION

- 5. New York State should eliminate the Medicaid program's asset test, making it consistent with New York's other health care coverage programs and ensuring the broadest access possible to low-income, uninsured New Yorkers.**

³⁷ Resources or assets include saving accounts, stocks, checking accounts, bonds, trust funds and real estate.

³⁸ See HCFA State Medicaid Director Letters, January 23 1998 (Available at <http://www.hcfa.gov/init/choutrch>), and September 10, 1998 (Available at <http://www.hcfa.gov/init/chpelig>).

³⁹ Information compiled by Kristin Brown, Greater Upstate Law Project.

⁴⁰ See The Kaiser Commission on Medicaid and the Uninsured, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," February 2001.

⁴¹ See N.Y. Soc. Serv. Law §366(2)(a)(7).

New York State requires a personal interview where federal law does not.

FEDERAL LAW AND HCFA DIRECTIVES FOR PERSONAL INTERVIEW REQUIREMENTS

Federal law does not require applicants to attend personal, “face-to-face” interviews with Medicaid workers to receive Medicaid benefits. In fact, Federal law permits Medicaid applicants and recertifying beneficiaries to submit applications and recertification paperwork by mail. Personal, “face-to-face” interviews are not required. In fact, HCFA recognizes that personal interviews to determine Medicaid eligibility are both a major barrier to access to Medicaid coverage and are unnecessary:

One option that allows States to ease the enrollment process is the use of mail-in applications. Mail-in applications, especially for Medicaid, can significantly reduce the barriers to enrollment that may occur with requiring in-person applications. Transportation costs are eliminated, the stigma of going to a social services office is removed, parents will not have to miss work, and community groups like PTAs and church organizations can assist in distributing applications and information regarding Medicaid and CHIP. *Many, but not all, States use this option in Medicaid today. We encourage all states to adopt this option.* (Emphasis added)⁴²

As of January 23, 1998, twenty-four states did not require personal interviews for Medicaid applicants or recertifying beneficiaries.⁴³

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR PERSONAL INTERVIEW REQUIREMENTS

New York State Medicaid law, unlike federal law, requires Medicaid applicants to have a personal, “face-to-face” interview with an HRA worker to be eligible for Medicaid.⁴⁴ In addition, participants reported that all “face-to-face” interviews are scheduled for the opening time of the Medicaid-only office or Income Support Center. However, applicants must wait hours, often all day, to visit an HRA worker. Reports of re-scheduling these appointments after a full day of waiting were not uncommon. Therefore, the requirement of a personal interview often leads to serial appointments for the Medicaid applicant. Taking the day or several days off work, and finding and paying for child care and transportation are burdens for Medicaid applicants.

⁴² HCFA State Medicaid Director Letter, January 23, 1998 at 3-4 (Available at <http://www.hcfa.gov/init/chourtrch>).

⁴³ HCFA State Medicaid Director Letter, January 23, 1998 at 6-7 (Available at <http://www.hcfa.gov/init/chourtrch>).

⁴⁴ See N.Y. Soc. Serv. Law §366-a(1).

New York State Medicaid law does not require Medicaid beneficiaries to have a personal interview when they recertify for continuing Medicaid.⁴⁵ Nevertheless, New York State's Medicaid Agency regulations require Medicaid beneficiaries to have a personal, "face-to-face" interview when they first apply for Medicaid and every time they recertify for ongoing Medicaid eligibility.⁴⁶

RECOMMENDATIONS

6. **New York State should permit Medicaid applicants and recertifying beneficiaries to submit their applications and recertification papers by mail.**
7. **New York State should eliminate mandatory personal interview requirements for both Medicaid applicants and recertifying beneficiaries.**

New York State's language-appropriate Medicaid applications, assistance, and personal interviews do not meet federal standards.

FEDERAL LAW AND HCFA DIRECTIVES FOR REQUIREMENTS FOR LANGUAGE-APPROPRIATE MATERIALS

The lack of language-appropriate application forms and assistance for Medicaid applicants with limited proficiency in English has long been a federal concern. On August 30, 2000, the United States Department of Health and Human Services, acknowledging this problem throughout the United States, issued specific mandatory guidelines that require state Medicaid agencies to ensure the availability of language-appropriate application forms and language translation services to assist applicants throughout the application and recertification process.⁴⁷

NEW YORK STATE'S PROVISION OF LANGUAGE-APPROPRIATE MATERIALS

The New York State's Medicaid agency's provision of language-appropriate applications and translation services remains deficient, although New York has a large number of Limited English Proficiency (LEP) applicants. Many study participants were unable to obtain language-appropriate Medicaid application forms and adequate translation services for help in completing their forms and for their personal interviews when applying for Medicaid.

Upon entering a Medicaid-only office or an Income Support Center, even the most proficient

⁴⁵ See N.Y. Soc. Serv. Law §§366a(1), (5).

⁴⁶ See N.Y.C.R.R. §366-2.2(f).

⁴⁷ See U.S. Dep't of Health and Human Services, Policy Guidance, 65 Fed. Reg. 52762-74 (August 30, 2000).

English speaker can be confused about where to go and what to do. When unable to ask questions due to limited English proficiency, this confusion becomes overwhelming. Most offices lack bi-lingual capacity, and bi-lingual workers are not readily available for questions about the process. Many posted signs contain convoluted, hand-written instructions, often only in English. A sign posted with a set of single-line instructions, in as many as ten different languages, directs non-English speaking applicants for assistance. However, in most offices, these are in obscure places, not likely to be seen immediately upon entry, if at all.

One woman said that her first visit to a Medicaid office was “scary. *The first time is very difficult for me. . . . [An HRA worker] asks me to ‘sit there.’ And I want to ask him to bring a Chinese person to me but there wasn’t any. I sit down and wait and wait and wait until everyone is gone. It is a long time but still there is no one. And then I saw a little young girl who came into the office. So I asked her to help me and she explained. And then they gave me a form to fill and I don’t know what it is. I don’t know how to fill it. She explains it to me, but still, I don’t know.*”

Similarly, HRA workers in a Bronx Income Support Center were open about their inability to assist Spanish-speaking applicants. One study participant reported that she was told to go home to get someone who spoke English to help her apply. Another Medicaid-only office in a Spanish-speaking neighborhood had only one HRA worker and this worker did not speak Spanish. Applicants who visit this site and need assistance in Spanish must call the Main Medicaid office in Manhattan. Spanish speakers are told over the phone about the documentation they must bring and are given an appointment at the Main Medicaid office for their “face-to-face” interview.

RECOMMENDATION

8. **New York State should mandate the availability of language-appropriate application forms and interpreter services appropriate to the neighborhood of Local Department of Social Service offices and other locations that interact with Medicaid applicants and beneficiaries.**

New York State’s Medicaid finger-imaging requirements are counter-productive and legally dubious.

FEDERAL LAW AND HCFA DIRECTIVES FOR FINGER-IMAGING REQUIREMENTS

Federal law does not address the issue of finger-imaging. However, when New York announced the implementation of its Medicaid finger-imaging procedures, HCFA expressed concern about its legality under federal law.⁴⁸

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR FINGER-IMAGING REQUIREMENTS

⁴⁸ See Nina Bernstein, “Experts Cast Doubt on Worth of New York Plan to Fingerprint for Medicaid,” New York Times (August 30, 2000).

As part of its Welfare Reform Act of 1997, the New York State Legislature required most applicants⁴⁹ for Public Assistance programs, including Medicaid, to be “finger imaged” as an eligibility requirement.⁵⁰ On December 1, 1999, New York State began to require most adult

Medicaid beneficiaries to be “finger imaged” as a prerequisite for obtaining Medicaid coverage.⁵¹ The State has implemented this regulation despite an evaluation finding that the policy had little, if any, efficacy in reducing fraud.⁵²

Most study participants did not understand finger-imaging but were too intimidated to ask any questions. The participants bold enough to question this procedure were told it was for “fraud purposes,” further obscuring the reason for finger-imaging. Some participants assumed that it was to protect them from fraud, in other words, to keep other people from using their benefit cards. *“And I’m trying to figure what part of fraud they are talking about because my husband can take my card and go to the store and take cash out and they don’t question him.”* Applicants often do not understand that it is to examine their own background.

Participants who assumed that their backgrounds would be examined were fearful of the procedure, even though they had never been arrested. Participants claimed that it made them feel as if asking for help was a crime. *“This is not jail. But that’s what it feels like. They have total control over your life.”* Finger-imaging intensifies feelings of powerlessness. Applicants, needing medical and other benefits, do not feel they have the right to question anything that is asked of them. Another participant expressed that finger-imaging was unnecessary and an invasion of her privacy. However, she did counter, *“the reason why I went through the system is because I have a child to support, so I have to do . . . whatever I have to do for my child.”*

RECOMMENDATION

9. **New York State should repeal its finger-imaging requirements for Medicaid applicants and beneficiaries.**

New York State’s Medicaid alcohol and drug screening and treatment requirements are not mandated by federal law.

FEDERAL LAW AND HCFA DIRECTIVES FOR ALCOHOL AND DRUG SCREENING REQUIREMENTS

⁴⁹ Exempt categories of Medicaid beneficiaries from the finger-imaging requirements include children living with caretaker relatives, supplemental Security Income beneficiaries, and homebound or institutionalized Medicaid beneficiaries.

⁵⁰ See N.Y. Soc. Serv. Law §139-a; 18 N.Y.C.R.R. §360-3.2(m).

⁵¹ 99 Administrative Directive 9 (December 21, 1999).

⁵² See Nina Bernstein, “Experts Cast Doubt on Worth of New York Plan to Fingerprint for Medicaid,” *New York Times* (August 30, 2000).

Federal law neither requires nor addresses alcohol and drug screening as a prerequisite for benefit eligibility.

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR ALCOHOL AND DRUG SCREENING REQUIREMENTS

As part of its Welfare Reform Act of 1997, New York State required applicants for Public Assistance programs, including Medicaid, to be screened for alcohol or drug abuse and, if the screening was positive, to participate in treatment programs as a prerequisite for eligibility.⁵³ The State Medicaid agency alcohol and drug abuse requirements apply to all non-disabled, non-pregnant childless adults under age 65, husbands or boyfriends of pregnant women with their own children in the household where the birth parents also live.⁵⁴ If a Medicaid beneficiary fails to comply with the treatment requirements, or leaves a treatment program, he or she is not eligible for Medicaid until he or she returns to an appropriate treatment program.⁵⁵

Several compelling reasons support extending Medicaid coverage to persons who do not participate in, or drop out of, a treatment program. First, qualified treatment programs often have long waiting lists before someone can participate. Second, it is well-established that a drug or alcohol abuser will often relapse several times during treatment, and that such relapses are considered a normal part of the treatment process. In addition, if the drug or alcohol abuser is in need of medical care while not in treatment, he or she cannot obtain medical care without Medicaid, except from a hospital emergency room or community health center that may be ill-equipped to cover the costs. Finally, without Medicaid, it is unlikely substance users will be able to get into a treatment program.

RECOMMENDATION

- 10. New York State should eliminate the drug and alcohol screening and treatment requirement as a condition of Medicaid eligibility.**

New York City's local ad hoc actions delay or impede a person's attempt to apply for Medicaid.

FEDERAL LAW AND HCFA DIRECTIVES FOR PROCEDURAL REQUIREMENTS OF STATE MEDICAID AGENCIES

Federal law permits, and indeed encourages, state Medicaid agencies to use an application and

⁵³ See N.Y. Soc. Serv. Law §132.

⁵⁴ See 97 Office of Medicaid Management/Administrative Directive 2 (December 3, 1997); New York State Department of Health, Medicaid reference Guide, pp. 383-85 (August 1999); General Information System Message 00 MA/005 (4/29/00).

⁵⁵ See 97 Office of Medicaid Management/Administrative Directive 2 (December 3, 1997); New York State Department of Health, Medicaid reference Guide, pp. 384-85 (August 1999).

recertification process that is as simple and user-friendly as possible. Generally, these goals of simplicity and easy accessibility are inherent in the federal Medicaid program's application, recertification, and information verification requirements. Federal law requires a state Medicaid agency to create and administer a Medicaid program that is easy and simple for applicants and beneficiaries to access and use. Under federal law, a state Medicaid agency must:

ensure that eligibility is determined in a manner consistent with simplicity of administration and *the best interest of the applicant*. (Emphasis added)⁵⁶

Specifically:

The Federal requirements for the application and enrollment process for Medicaid . . . provide a great deal of flexibility to states to design an application and enrollment process that is streamlined and simple, and avoids burdensome requirements for families that apply for benefits.⁵⁷

Federal law requires a state Medicaid agency to provide Medicaid coverage “with reasonable promptness”⁵⁸ and “without any delay caused by the agency’s administrative procedures.”⁵⁹ Additionally, the state Medicaid agency must permit everyone wishing to do so “to apply for Medicaid without delay.”⁶⁰

NEW YORK STATE’S MEDICAID PROCEDURES

In sharp contrast to federal law, New York State’s Medicaid eligibility determination and re-determination procedures include several cumbersome requirements not mandated by federal law. Many of New York State’s procedures, discussed below, effectively discourage eligible New Yorkers from obtaining Medicaid. Indeed, precisely because many of the application procedures used by New York State unnecessarily prevent eligible households from obtaining Medicaid, the federal Medicaid program explicitly discourages the use of them.

New York State regulations require local district workers to provide help and assistance to applicants for benefit programs in several specific situations.⁶¹ Unfortunately, there are no

⁵⁶ 42 C.F.R. §435.902; See 42 U.S.C. §1396a(19).

⁵⁷ HCFA State Medicaid Director Letter, September 10, 1998 (Available at <http://www.hcfh.gov/init/chpelig>).

⁵⁸ 42 U.S.C. §1396a(a)(8).

⁵⁹ 42 C.F.R. §435.930(a).

⁶⁰ 42 C.F.R. §435.906.

⁶¹ For Food Stamp applicants see 18 N.Y.C.R.R. §387.14(a)(4)(i)(a); for adolescents applying for services and Public Assistance see 18 N.Y.C.R.R. §361.10(a); for Public Assistance applicants who appear to qualify for Supplemental Security Income but who are physically or emotionally unable to complete the application see 18 N.Y.C.R.R. §§352.30(f), 369.2(h). In addition, a local district must conduct an “appropriate collateral investigation” where a recertifying Public Assistance beneficiary is “unable to secure documentation” of continued eligibility factors, 18

similar requirements to provide help and assistance to Medicaid applicants and recertifying beneficiaries, except for Medicaid applicants who claim a “good cause” reason for not cooperating with the support requirements. Here, assistance must be provided to obtain documents to support their claim.⁶²

Inconsistencies in General HRA Practice

An unduly complex system leads to inconsistent practices by HRA workers. These inconsistencies delay the application process or prevent an applicant from applying for Medicaid. Individuals attempting to apply for Medicaid and project staff reported the following:

- < HRA workers claim that the only people who can apply only for Medicaid at an Income Support Center are those who first apply for Public Assistance and are “rejected or withdraw their application.” HRA workers tell all Medicaid-only applicants that they must visit a Medicaid-only office. Still, applicants denied eligibility for Public Assistance and Food Stamps are often not informed that they may be eligible for Medicaid and can apply just for Medicaid. Since Medicaid has been de-linked from welfare, it is troublesome that applicants apparently do not have Medicaid eligibility determined simultaneously and separately.
- < HRA workers require applicants to close benefit cases opened in other New York City offices. One study participant reported that the HRA worker told the applicant to close her Food Stamp case in Queens before proceeding with her Medicaid and Public Assistance application in Manhattan, where she was residing in a domestic violence shelter. The worker dismissed her Medicaid and Public Assistance application until she visited the Food Stamp Office in the Queens neighborhood of her abuser and personally closed the Food Stamp case. She then began the entire application process again in Manhattan.
- < HRA workers incorrectly turn away Medicaid applicants due to income. A homeless applicant reported telling an HRA worker that she generated an income of \$50 per week from babysitting. The HRA worker told the applicant that she would not be eligible for Medicaid and encouraged her to apply for Public Assistance, even though the applicant said she did not want cash assistance.
- < HRA workers incorrectly turn away Medicaid applicants because of no income. A homeless applicant reported being told that he needed to have an income to receive Medicaid. He obtained work, making \$40 per week, to meet the supposed income requirement. When he re-applied, the HRA worker told him that his income of \$40 per week exceeded the income eligibility level, and again denied his Medicaid application. The HRA worker encouraged him to apply for Public Assistance in order to receive Medicaid.

N.Y.C.R.R. §351.20(b)(4).

⁶² See 18 N.Y.C.R.R. §360-3.2(f)(1)(vii)(e)(2).

- < HRA workers incorrectly turn away Medicaid applicants in drug treatment programs. A pregnant study participant in a methadone program applied for Medicaid. The HRA workers at the hospital-based Medicaid-only office turned her away because she was a methadone clinic patient. She was also encouraged to apply for Public Assistance in order to receive Medicaid.
- < HRA workers incorrectly turn away pregnant Medicaid applicants in their first trimester. Several women from the Bronx reported the custom at local offices of telling women that they must wait until they are six months pregnant before applying for Medicaid.
- < HRA workers incorrectly turn away Medicaid applicants due to resources that fell under the required limit. A professional described a client who was turned away by an HRA worker because the client had \$1500 in a savings account, an amount which is below the resource limit for eligibility.
- < HRA incorrectly deters applicants from applying for benefits due to immigration status. A professional reported cases at Food Stamp offices where the applicants were found ineligible for benefits due to immigration status. However, they did have citizen children who may have been eligible for Food Stamps. The HRA workers told the parents that if they pursued assistance for their eligible, citizen children, they would report the family to the Immigration and Naturalization Service (INS). Although other study participants did not report that this happened in Medicaid-only offices, the negative impact on community sentiment toward government agencies and all public benefits is immense. Families told by Food Stamp workers that they will be reported to INS do not feel safe applying for medical benefits, even for eligible children. Applicant families, especially immigrants, often turn to networks in their community, families in similar situations, and word of mouth advice to learn where it is safe to apply for assistance. These cases illustrate the HRA benefit offices' pervasive negative attitude which perpetuates a feeling of terror for immigrant families in need of and eligible for medical and other benefits.

Inconsistent Documentation Requirements

Practices which restrict acceptable documentation verification compound application delays and denials. Professionals recognize the vast documentation requirements when applying for Medicaid and provide the assistance required of local district workers. They have Social Security card applications and New York State Birth Certificate applications on site. Applicants *“need help getting their documentation together,”* one professional stated. *“We have the forms because we don’t want the family to give up.”* This assistance sharply contrasts the situation at Medicaid-only offices and Income Support Centers. Numerous study participants reported that they followed the instructions given and submitted their application form with specified documents, only to be told that more information or documentation was needed. Here are a few examples:

- < A Medicaid-only office rejected a baptismal certificate because it was not the applicant’s birth certificate. The applicant was told, *“It is not on our list [of accepted documents].”* However, a baptismal certificate *is* one of the documents listed as acceptable on the DSS-2642, the HRA form listing acceptable documentation.

- < A participant reported seeking help from a shelter worker in getting a new birth certificate from Illinois because her HRA worker would not accept the original, but worn, birth certificate she had.
- < An HRA worker refused to accept a child's original South Carolina birth certificate. The mother stated that South Carolina's standard birth certificates are summarized versions of what is kept at the hospital and are the size of a Social Security card. The mother had to argue, beg and plead not to be sent away with instructions to obtain a different birth certificate. The worker finally called South Carolina to confirm that the mother was telling the truth.

Environmental Barriers

Finally, the social and physical environment of Medicaid-only offices and Income Support Centers impede the benefit application process, delaying necessary medical services. The obvious lack of uniformity among centers in both the application process and acceptable documentation, as described above, is monumental, bewildering, and frustrating to applicants and professionals alike.

HRA staffing levels in Medicaid-only offices and Income Support Centers are not adequate to accommodate the number of applicants and all the application requirements. Workers are rarely available or approachable to provide assistance or to answer questions about the lengthy application form or the confusing procedures. Workers apply the rules differently and applicants receive no clear enrollment instructions or guidance when they do ask questions. Medicaid-only offices and Income Support Centers are only open during daytime business hours, which is a deterrent to working applicants. This deterrent is compounded when applicants learn from either experience or word of mouth that applying for benefits is a two- to three-day, all-day process. Working applicants, therefore, know that three days spent applying for benefits equals up to 24 unpaid hours.

Excessive waiting periods are common. Medicaid applicants spend hours waiting, often with their children, to speak with an HRA worker for fifteen minutes. The application process is extremely time-consuming, requiring applicants to literally spend days sitting in uncomfortable waiting areas waiting for their names to be called. Applicants often wait in a Medicaid-only office or Income Support Center for hours before even receiving the application paperwork. In fact, one woman waited three hours at a Medicaid office before she was scheduled for an appointment to return another day and pick up the application form.

Requiring numerous appointments adds undue stress to the Medicaid application process. Many of these appointments are the result of an obvious lack of uniform procedures in the benefit application process. A participant reported, *"It totally wore me out. My blood pressure was up. . . . I stopped eating. . . . I was looking at myself saying, 'What's wrong with me?' That is how bad it was going back and forth. I couldn't sleep at night. I was crying all the time."* This system serves as a deterrent for people to complete the application process or reapply when benefit cases are closed. Another participant expressed her frustration, *"They put you through so much stress. I thought I was going to have a heart attack."*

One of the numerous appointments often required for Medicaid applicants is an Eligibility Verification Review (EVR) appointment. Here, applicants must again present all documentation to a different worker for eligibility verification. These appointments are varied and, apparently,

randomly scheduled. Some participants reported their HRA workers scheduled their EVR appointments at the EVR Office in Brooklyn. In some cases, EVR workers make home visits. Some participants reported that their HRA workers scheduled this appointment. Some reported a phone call from an EVR worker scheduling a home visit for the following day. Still others reported the EVR team arriving at their home unannounced, looking through cupboards, and questioning sleeping arrangements, prescription medication, and other household purchases. A study participant relayed that one EVR worker asked to use the bathroom, then demanded to know the purpose of each medication in the participant's medicine cabinet, and forced her to disclose all of her health problems.

RECOMMENDATIONS

11. **New York State should mandate regular intensive training, including customer service, of all Local Department of Social Service workers, and should routinely screen local district offices' compliance with legal application and enrollment requirements.**
12. **New York State should mandate that local district workers provide all Medicaid applicants and recertifying beneficiaries with help and assistance in completing their applications and recertification documents.**
13. **New York State should require appropriate staffing levels to accommodate the first two recommendations.**

New York State Medicaid eligibility determination is too often not within federal mandated time limits.

FEDERAL LAW AND HCFA DIRECTIVES FOR ELIGIBILITY DETERMINATION TIME FRAMES

Federal law requires Medicaid eligibility determinations to be made no more than 90 days from the date of application for all disability-based applications, and no more than 45 days from the date of application for all other applications. While federal law permits occasional exceptions to the time limits in extremely unusual specified circumstances,⁶³ the Agency's failure to make a determination within the time limits is not a legitimate reason to deny eligibility.⁶⁴

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR ELIGIBILITY DETERMINATION TIME FRAMES

New York State Medicaid regulations impose the same time frames as federal law for making

⁶³ See 42 C.F.R. §§435.911(a), (b).

⁶⁴ See 42 C.F.R. §§435.911(c), (e).

eligibility decisions.⁶⁵ However, researchers were frequently told that eligibility determination exceeded federal time limit mandates. Unfortunately, there is no hard data available to document the extent of the problem. Applicants reported often waiting up to several months before they received notice of their eligibility for Medicaid and were able to access benefits. In fact, two study participants applied for Medicaid during pregnancy and waited for benefits for more than five months.

RECOMMENDATION

- 14. New York State should provide presumptive Medicaid eligibility for all applicants whose Medicaid eligibility is not determined within legal time limits.**

New York requires Medicaid recertification more frequently than federal law.

FEDERAL LAW AND HCFA DIRECTIVES FOR RECERTIFICATION REQUIREMENTS

Federal law requires Medicaid beneficiaries to recertify their Medicaid eligibility at least once every twelve months.⁶⁶ Significantly, at recertification, state Medicaid agencies are required to re-evaluate only those “circumstances that may change.”⁶⁷ Federal law does *not* require recertifying beneficiaries to submit completely new Medicaid applications. In fact, HCFA has advised state Medicaid agencies that recertification procedures that parallel initial Medicaid application procedures are improper:

Pursuant to Federal regulations (42 CFR 435.902 and 435.916), States must limit the scope of re-determinations to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and residency. *States cannot require individuals to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.* (emphasis added)⁶⁸

⁶⁵ See 18 N.Y.C.R.R. §360-2.4.

⁶⁶ See 42 C.F.R. §§435.916(a).

⁶⁷ 42 C.F.R. §435.916(a).

⁶⁸ HCFA State Medicaid Director Letter, April 7, 2000 at 4 (Available at <http://www.hcfa.gov/medicaid/smd40700>).

Finally, when a beneficiary's circumstances change and the beneficiary notifies the state Medicaid agency of this change, the agency must re-evaluate eligibility base only upon the new information.⁶⁹

NEW YORK STATE MEDICAID LAW REGULATIONS FOR RECERTIFICATION REQUIREMENTS

New York State Medicaid law only requires Medicaid beneficiaries to recertify their eligibility “from time to time, or as frequently as may be required by the regulations of the department.”⁷⁰ Like federal law, State Medicaid regulations require beneficiaries to complete a formal recertification process at least once every twelve months.⁷¹ But, the State Medicaid agency gives the Local Department of Social Service considerable latitude and, indeed, encourages districts to require Medicaid beneficiaries to complete full application procedures. This process includes personal interviews, at the annual recertification and whenever their circumstances change,⁷² instead of only re-evaluating “circumstances that may change.”

The local Department of Social Service often imposes more rigorous recertification requirements on Medicaid beneficiaries who also receive Public Assistance than on Medicaid-only beneficiaries. Local districts must recertify Public Assistance beneficiaries every three or six months, depending upon their eligibility category.⁷³ State regulations give local districts the authority to recertify Medicaid beneficiaries more frequently than once a year, and no state law, regulation, or directive prohibits local districts from discontinuing a Public Assistance beneficiary's Medicaid if he or she fails to recertify more frequently than once a year for Medicaid. Contrary to federal law, local districts often discontinue Medicaid of Public Assistance beneficiaries who do not comply with the more stringent Public Assistance recertification requirements.

New York State recognized that this loss of medical coverage is problematic. In 1998, with the major changes in New York State's Child Health Plus program, New York State mandated that children be permitted to retain their Medicaid benefits for one year, regardless of changes in their circumstances.⁷⁴

RECOMMENDATIONS

- 15. New York State should amend the State Medicaid law to require that adult Medicaid beneficiaries, including those receiving other public benefits, be required to recertify no more than once a year, or when circumstances affecting eligibility change.**

⁶⁹ See 42 C.F.R. §435.916(c).

⁷⁰ See N.Y. Soc. Serv. Law §366-a(5).

⁷¹ See 18 N.Y.C.R.R. §360-2.2(e).

⁷² See N.Y.S. Medicaid Reference Guide, pp. 372-73 (August 1999).

⁷³ See 18 N.Y.C.R.R. §351.21.

⁷⁴ See N.Y. Soc. Serv. Law 366(s).

16. **New York State should direct the State Medicaid agency to design and use a simple, easy to complete Medicaid-only Recertification form, separate and different from the initial application form. The revised form should eliminate requests for information already in the possession of the local districts and omit questions unrelated to continuous eligibility for Medicaid. Federal Medicaid funds may be used for this purpose.**

New York State's re-application requirements for beneficiaries who move from one district to another counter federal law.

FEDERAL LAW AND HCFA DIRECTIVES FOR BENEFICIARIES WHO MOVE

Federal law requires states to designate a “single state agency” to administer or supervise the administration of the Medicaid program.⁷⁵ Federal regulations prohibit:

other State or local agencies or offices [that] perform services for the Medicaid agency . . . to change or disapprove any administrative decision of that agency, or otherwise substitute their judgement for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.⁷⁶

Under federal law, therefore, a local district’s Medicaid eligibility determination is, by law, a decision of the “single state agency”. Moreover, no federal or state Medicaid law or regulation authorizes different eligibility rules depending upon a beneficiary’s district of residence. For these reasons, although a change in residency from one district to another must be reported to the state Medicaid agency, it will generally not be a change in circumstances that affects the beneficiary’s eligibility.⁷⁷ The decision that an applicant is eligible for Medicaid within one local district should be upheld in another local district without re-application.

HCFA clarified this legal requirement in a State Medicaid Director Letter issued December 4, 2000. In unequivocal language, HCFA stated:

We have learned that, in some states, counties terminate Medicaid when a family moves from one county to another within the state and require the family to reapply in the new county of residence. These terminations are not permitted under Federal law.⁷⁸

⁷⁵ 42 U.S.C. §1396a(a)(5); 42 C.F.R. §431.10(a)

⁷⁶ 42 C.F.R. §431.10(e)(ii)(3).

⁷⁷ See 42 C.F.R. §§435.916(a), (c).

⁷⁸ HCFA State Medicaid Director Letter, December 4, 2000 at 1 (Available at <http://www.hcfa.gov/medicaid.smd12400.htm>).

In addition, according to HCFA:

In a county-administered program, when a family moves within the state, the state and the counties are responsible for transferring the case record from the old county of residence to the new county of residence so that Medicaid can continue without interruption. The State cannot require the family to reapply

for Medicaid or comply with a Medicaid redetermination solely based upon a move to a new county.⁷⁹

NEW YORK STATE MEDICAID LAW AND REGULATIONS FOR BENEFICIARIES WHO MOVE

Medicaid eligibility decisions are made on behalf the New York State Medicaid agency by each county's Local Social Service District.⁸⁰ The State Medicaid agency requires Medicaid beneficiaries who move from one local district within New York State to another to complete a new application before receiving medical services in their new local district. This results in an interruption of benefits.

In New York City, the beneficiary must first visit the Main Medicaid office in Manhattan and request that their case be closed due to relocation. They must say that the closing date cannot wait until their recertification date and that they need an official closing letter. They can then present this closing letter to the new local district office. This letter will override anything in the system that may say the beneficiary has an open Medicaid case in another local district.

If the beneficiary has already moved and/or cannot visit the Main Medicaid office in New York City, they must write to the Correspondents Unit requesting that their case be closed and that an official closing letter be mailed to the beneficiary. This will take up to 30 days.

If the beneficiary needs medical attention (e.g., for pregnancy), they can request an expedited process due to medical need to re-establish a Medicaid case in a new local district and an official closing letter to be faxed and mailed. The beneficiary must provide medical statements verifying medical emergency.

The beneficiary must then submit a new Medicaid application to the new local district.⁸¹ When notified of the beneficiary's new residence in a different district, the local district does not undertake either a complete or limited Medicaid redetermination based on the new information (i.e., the beneficiaries' new residence in a different district). Rather, contrary to federal law:

“The former district [must] inform the beneficiary of his/her need to apply for Medicaid in his/her new district of residence, if s/he wants to continue

⁷⁹ HCFA State Medicaid Director Letter, December 4, 2000 at 1 (Available at <http://www.hcfa.gov/medicaid/smd12400.htm>).

⁸⁰ See 28 N.Y.C.R.R. §360-2.2.

⁸¹ See New York State department of Health, Medicaid Reference Guide, p. 404 (August 1999).

receiving Medicaid. The client must complete the full eligibility process in the new local district.”⁸²

RECOMMENDATION

- 17. New York State should prohibit the State Medicaid agency from requiring Medicaid beneficiaries to reapply for Medicaid when they move from one local district within New York State to another. Once the information about the change in residence is reported, the local district should be obligated to conduct, at most, a limited redetermination of Medicaid eligibility based on the new information, and to notify the beneficiary of the change in the local district responsible for ongoing Medicaid eligibility.**

CONCLUSION

With the advent of Family Health Plus, New York has a remarkable opportunity to link the application process of its three health programs (Medicaid, Child Health Plus, and Family Health Plus) by simplifying their application process. In order for these three health programs to be congruous, New York State must remove the formidable Medicaid application barriers. Federal law creates the opportunity to simplify this process through its directives and resources. New York should take advantage of these directives and resources to create a user-friendly application process for all low-income New Yorkers.

⁸² New York State department of Health, Medicadi Reference Guide, p. 404 (August 1999).

SUMMARY OF FEDERAL AND NEW YORK STATE MEDICAID REQUIREMENTS

	Federal Medicaid Law	New York State Medicaid Law	NYS Medicaid Agency Regulations
Number of Questions on A Medicaid Application	3	---	20
Number of Documentation Requirements	1	1	20
Asset Test for Medicaid Eligibility	NO	YES	YES
Personal Interview for a New Application	NO	YES	YES
Personal Interview for Recertification	NO	NO	YES*
Alcohol and Drug Screening Requirements	NO	YES	YES
Eligibility Determination Time Frames	Maximum 45 days for all non-disabled applicants	Maximum 45 days for all non-disabled applicants	Up to 150 days
Recertify Every 12 Months	YES	YES	YES
Recertification Required for Beneficiaries with Information Changes	NO	YES	YES
Recertification Procedures Parallel Original Medicaid Application Process	NO	YES	YES
Requirements to Re-Apply when Applicant Moves from Local District to Local District	NO	YES	YES

**Except Aid to the Blind/Aid to the Disabled*

Care for the Homeless

Care for the Homeless coordinates the New York City's largest program of health and dental care services for homeless people. We contract with licensed health facilities to send teams of doctors, physician's assistants, nurse practitioners, nurses, health educators and social workers into shelters, soup kitchens and drop-in centers in four boroughs. The Brooklyn team is from the Bedford Stuyvesant Family Health Center; the Manhattan team, from the Institute for Urban Family Health; the Bronx team, from Montefiore Medical Center; and the Queens team, from New York Hospital Medical Center of Queens and the Visiting Nurse Service of New York.

We also provide counseling and social services for homeless people with HIV/AIDS; substance abuse and mental health services for homeless families and adults; and education and advocacy on a wide range of issues, including Medicaid managed care.

The Greater Upstate Law Project

The Greater Upstate Law Project (GULP) is a not-for-profit statewide legal services support center. From its offices in Rochester, Albany and White Plains, GULP provides legal expertise and assistance to legal services programs throughout the state. GULP undertakes research and policy analysis and engages in legislative and administrative advocacy in targeted areas of poverty law. As a public interest law firm, GULP pursues individual and impact litigation to help protect, defend and improve the legal rights of poor and low income New York residents.

Commission on the Public's Health System

The Commission on the Public's Health System (CPHS) is a community-based, city-wide membership health advocacy organization formed in 1991 to fight the privatization of the public hospital system. CPHS and its membership works with community organizations, health advocates and health workers to fight privatization and to work to strengthen the public health system whose mission is to provide services to everyone regardless of the ability to pay. In the long term, we are working to mobilize residents and community-based organizations to fight to maintain and strengthen the public system and to expand health insurance coverage for more uninsured residents.

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