

Lost in the Medicaid Maze:

**Voices From the Frontlines of New York City's
Public Insurance Programs**

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Background

Disaster Relief Medicaid (DRM) was a phenomenal success story. Although created in the wake of a disaster, the program transformed the Medicaid application and eligibility determination process from a lengthy, documentation-heavy, cumbersome, labor-intensive process to a rapid, simple, virtually paper-free process. And as a result, hundreds of thousands of New Yorkers walked into a Medicaid or facilitated enrollment office, completed streamlined paperwork, obtained a Medicaid card that very day, and with it, access to desperately needed health care services.

DRM ended on January 31, 2002. Beginning in February these newly-covered New Yorkers began to make the transition into existing public coverage programs: Medicaid, Family Health Plus and Child Health Plus. Unfortunately, the transition to ongoing coverage has not been smooth, and tens of thousands of New Yorkers are falling through the cracks. While some individuals attempting to make the transition have been found ineligible for coverage, most stumbled on at least one part of the obstacle course that is applying for public health insurance.

As the time period for making the transition from DRM into on-going coverage winds down, it is important to understand what DRM meant for people. Why are so many eligible people failing to make the transition? And what is that failure going to mean for people's lives? We need to look at what worked about the DRM process, and what that can teach us about how to reform Medicaid application procedures. It is also important to under-

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stand the obstacles that remain as people try to navigate the current Medicaid application maze. When we finally look at how many people successfully moved from DRM into ongoing coverage, and how many got lost in the transition process, it will be important to remember just how hard it is to get and keep public health insurance in New York.

Health care advocates have long recognized that the Medicaid application process acts as a barrier for people who are actually eligible for Medicaid.

The issue of streamlining and simplification of the Medicaid application has been a major emphasis of advocacy work at both the State and City levels. Reports from Medicaid offices indicated a problem stemming from a confluence of factors during the spring and summer of 2002. These included:

- Large numbers of people needing to make the transition from DRM into Medicaid/FHP (350,000 people over an 8-month period);
- Implementation of Family Health Plus. FHPlus is a new program for which there is a high demand; and even today neither clients nor workers fully understand it;

be counseled in plan selection. Further, with the implementation of FHPlus, clients need to be counseled about differences between Medicaid and FHPlus, and cases where spend-down may be a better option need to be identified.

All these developments and changes mean that at a time when the volume of clients is enormous, simultaneously workers at Medicaid offices have new responsibilities, and the process is more complicated. All of this is occurring during a time where HRA is reducing staff due to both a fiscal crisis and Medicaid's Early Retirement Initiative.

Why are so many eligible people failing to make the transition?

- The State introduced a new application for public health coverage programs, Access New York Health Care, which began to be used in New York City in the post-DRM environment;
- Medicaid workers began new counseling functions as a result of the new application and the start-up of FHPlus. The new application requires the selection of a health plan as part of the application process, and clients need to

The Project

During the summer of 2002, when the DRM transition was well underway, the New York City Task Force on Medicaid Managed Care sent survey teams out to Medicaid offices to talk to people about their experiences trying to obtain Medicaid. Over a six-week period survey teams stood outside two Medicaid offices where transition DRM applications were being handled. These teams spoke to people as they were leaving the centers and asked if they would be willing to answer a few questions about what they had just experienced inside. A total of 192 people were interviewed, about two-thirds of them at the Boerum Hill Medicaid office in Brooklyn, and the remainder at the Northern Boulevard office in Queens. About half the interviews were conducted in Spanish; 12 were conducted in Chinese and 2 in Arabic.

The survey asked about several things: health status and recent health care utilization experiences; experiences relating to the application process itself, including the number of times the individual had returned to the Medicaid office, the length of time spent in the office, and documentation problems; and finally, whether

Medicaid workers were providing counseling on differences between Medicaid and Family Health Plus, and on choosing the best health plan given an individual's specific needs.

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Findings

Many people who are trying to get coverage have significant health problems, and often go without needed health care during the application process.

Consistent with national studies on the health status of low income individuals,¹ 41% of individuals interviewed at the two Medicaid offices reported having a disability or a health condition requiring treatment. For example, 17 individuals said they had hypertension, 14 asthma, nine reported diabetes and three were pregnant. One individual had liver cancer and another had “kidney problems”.

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The survey also found that FHPlus and Medicaid enrollment barriers kept individuals who were in poor health from seeking needed medical care during the period they were transitioning from DRM or newly applying for coverage.

This is in part due to the design of the FHPlus application process, which does not provide retroactive coverage, and where coverage does not begin until eligibility determination and enrollment into a health plan have been completed, a process that can take several months. Individuals were asked about what health care they had received in recent months, as well as needed health care foregone. Some responses included: “I can’t afford it [care] so I just don’t go.” “I have to wait it out. If it’s an emergency, then I go to the hospital.” “I have to do what I can at home. I go to the hospital when I need to.” “Sometimes I go without because I can’t afford to pay.” “I just get sick a lot.”

While many individuals seeking new or on-going Medicaid and FHPlus coverage were able to access care using the DRM authorization, others were uninsured during the application process. Many uninsured individuals had sought care from hospitals and clinics in the past and feared the bills. “Hospital wants me to pay and I can’t. I suffer from severe headaches.” “I go to a city clinic but I still get bills in the mail.” “Sometimes I go to the clinic but I got a large bill so I don’t

go any more.” One respondent said that he had stopped going to a clinic where his asthma and high blood pressure was treated because it was too expensive. A number of individuals reported letting their diabetes and high blood pressure go unmonitored. One person with high blood pressure said: “I try to take care (of myself) at home when I have no medicine.” Another reported delaying needed dental work. Several people reported buying only over the counter medications when they got ill. “I buy medicine in the pharmacy, without (a) prescription.” Asthma was a common condition that individuals reported having, but not seeking care for. An asthmatic told us: “I’m afraid of the bills from the hospital because it is too much.” Another asthma sufferer said that a sister “gives me her medication (when) I can’t afford to pay.”

Many of the untreated conditions respondents reported are life-threatening. For example, one woman reported: “I have a pain in my breast and need to be seen by a doctor and have a mammogram, but I can’t pay.” Another person whose coverage had ended reported liver cancer.

Problems documenting eligibility requirements are a principle barrier to transitioning from DRM and obtaining ongoing new or ongoing Medicaid and FHPlus coverage. Problems documenting income and residence were most commonly cited.

An overwhelming number of individuals reported problems documenting Medicaid and FHPlus eligibility requirements. Nearly one-half (90) of individuals interviewed reported some sort of documentation problem. Of the 90, 72 people were returning (for the second, third, fourth, sixth or eighth time) to the Medicaid office to bring

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additional documents. Most commonly reported (26) were problems documenting income. Many individuals were asked to seek a letter from an employer stating earnings or letters of support from friends or family. Others were returning to drop off additional pay stubs. After income, problems doc-

umenting residency/home address were most commonly cited. Individuals were asked to return with a lease or other proof of their address, such as a letter from a landlord. A homeless man said that all he had was a P.O. Box. One person had been told that a Con Ed bill was not adequate and that he would have to return another day with a letter from his landlord. Two people were told that a phone bill was not sufficient and that an original lease would be required. One of these individuals was unsure whether she could locate the original lease.

For those individuals who had enrolled in DRM and were now making the transition to ongoing coverage, an even greater percentage — 58 percent — reported problems documenting eligibility requirements.

Of those whose primary language was not English (110 or 57% of total), 68 reported documentation problems, a higher percentage than the overall. Only 32 of those reporting speaking a primary language other than English said that they did not have a documentation problems, while 68 (or two thirds) did.

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Seven individuals reported problems documenting their identity. Most of these problems related to barriers to obtaining an original birth certificate. One person was asked to have her Spanish-language birth certificate translated into English, although she had a passport, which should have been sufficient to document identity. Five people reported problems documenting resources. Resources usually involved getting a letter or statement from a bank. Five individuals reported problems documenting their Social Security number, including one person who had brought the original card.

Counseling about health plan selection is not taking place, and information about Family Health Plus and the ways it is different from Medicaid, is not being provided.

Inadequate information about health plan selection portends continuity of care problems once enrolled, especially for individuals with serious illnesses and disabilities.

Only 25% of individuals interviewed were told to pick a health plan during the application and enrollment process. This is surprising given that most applications will not be processed unless a health plan selection has been made. For those who were told, they were most commonly shown a list and asked to choose a plan. When asked about health plan selection, one applicant said: “Oh, is that what that was.” She had simply written down a name from the list provided. Another said: “(I) just picked one from the list. I suppose my doctor will explain all that to me.” Another very common interviewee response was: “I wasn’t given any choices, only told to wait for a letter.” Some people did receive some additional information about health plan choice. At

times this information was not provided individually, but to a group of individuals waiting in line. Some people had tried to ask questions during these impromptu group counseling sessions, but were not given a response. One person reported that she was given information only about two different health plans.

One person did say that she was told which hospitals accept each plan and another said that he needed to consult his doctor before choosing a plan. However, this was an exceedingly rare response.

Though a very small number of people surveyed said they were told that they make too much money to qualify

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for Medicaid, it is important to note that none of these individuals were told of the differences between Medicaid spend-down and Family Health Plus. One quarter of these individuals were told only about the Family Health Plus program and another quarter were told only about Medicaid spend-down. Because counseling from Medicaid workers at this stage does not include program eligi-

bility determination, workers are required to explain that Medicaid and FHPlus do not cover the same set of benefits for those who have a choice of programs.

The physical environment at the Medicaid offices continues to act as a deterrent to coverage.

Long wait times and overall conditions at the Medicaid offices surveyed pose an unacceptable barrier to seeking and obtaining Medicaid and FHPlus coverage. Wait times, as measured by the survey instrument, were unacceptably long. According to surveys conducted by HRA staff at two of the Medicaid

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offices, about two-thirds of visits require no more than 5 minutes of time — dropping off a document, for example, or replacing a lost card.² Yet only 11 of our respondents were able to complete their visit in less than 15 minutes. An additional 14 percent had visits of less than an hour. While most clients were able to complete their business in two hours or less, one-third of the respondents reported being in the Medicaid office for over

two hours, and 2 clients reported they were there all day. Many people were scheduled for appointments during the same time frame. Lunch breaks create more delays; leaving offices apparently understaffed.

While conditions at Medicaid offices can vary greatly from one location to another, and even from one day to the next at the same location, the application and enrollment process as experienced by most beneficiaries is unpleasant at best. Notably, these conditions affect the men and women who work in these offices as much, if not more, than those people who go there to apply for coverage. One office was not air-conditioned on a 90-degree day with high humidity. Particular problems were experienced by some homeless people due to their unkempt appearance. Applicants reported rude treatment and yelling by workers, and little access to information, resulting in applicants turning to the security guards with questions. Some applicants did report good, respectful treatment from workers.

Language barriers continue to be a problem for people applying for Medicaid. As we noted, 57 percent of those we surveyed spoke a primary language other than English. While HRA is not required to provide interpreter service in Medicaid offices,

HRA is obligated to provide equal access to services regardless of national origin, and Title 6 prohibits discrimination based on national origin. A large number of HRA's clients have trouble communicating in English. Anecdotal reports from Facilitated Enrollers indicate that the vast majority of individuals applying for Disaster Relief Medicaid were non-English speakers. If language is not to act as a barrier for people trying to obtain Medicaid, a concerted effort is needed to increase the number of staff at local offices who can provide services in languages other than English.

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Implications

Barriers created by the enrollment process contributes to the large number of eligible New Yorkers who do not obtain public health coverage. The survey found that the consequences of being uninsured are severe. It corroborated existing studies that demonstrate that being without health insurance means receiving less preventive care,

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Researchers estimate that health insurance would reduce mortality rates for the uninsured by 10 percent to 15 percent. Having health insurance isn't merely a matter of making care more convenient or more affordable; people without coverage just don't get the care they need, when they need it.³

In New York City, the experience of Disaster Relief Medicaid (DRM)

brought this home to us. Although our survey did not look specifically at the relationship between application barriers and health status, it is self-evident that the challenges inherent to getting and keeping public coverage have negative health consequences for a population reporting an extremely high prevalence of illness and disability. The findings from our small survey are echoed in other sources of information about who got coverage through DRM, and what types of services they sought. According to analysis by the New York City Health and Hospitals Corporation of tens of thousands of DRM patients treated in city hospitals, nearly one-fifth suffered from chronic conditions such as heart or vascular disease, asthma, or diabetes, about 1,580 people were diagnosed and treated for a type of cancer, and over 600 women were pregnant and seeking prenatal care. The William F. Ryan Community Health Center reported the following with respect to the 1,000 DRM beneficiaries treated at that facility: breast lumps were found in 16 women, abnormal PAP test findings were found for 20 women, five patients tested positive for HIV, eight tested positive for STDs, and 23 patients were diagnosed with

iron deficiency anemia, which can be an initial presentation of colon cancer. These findings reinforce the benefits of a streamlined and efficient process for seeking and obtaining public health insurance coverage—in both economic and human terms—of providing early detection and timely treatment of health conditions.

Challenges inherent to getting and keeping public coverage have negative health consequences.

Recommendations

Before September 11th, health care advocates stressed the need to simplify and streamline the Medicaid application process. Now, as hundreds of thousands of New York City residents attempt to transition from DRM into ongoing Medicaid, Child Health Plus or Family Health Plus coverage, advocates once again worry that the process is too burdensome to complete. This study corroborates these concerns: the

The application process is tricky, and all involved, applicants and workers alike, are confused.

application process is tricky, and all involved, applicants and workers alike, are confused. Right now, this arduous transition process is complicated with the continuation of enrolling new beneficiaries into coverage, preparation to restart recertification for pre-September 11th beneficiaries (a process that had been suspended for a year in the wake of the September 11th disaster), a brand new Family Health Plus program, and a new public health insurance application form.

To fulfill their responsibility to provide people with access to benefits to

which they are entitled, the Human Resource Administration and the Department of Health of both the City and the State should enact the following recommendations:

- 1. Provide immediate Medicaid coverage to individuals while their eligibility is being determined.**
- 2. Eliminate unnecessary documentation requirements that needlessly burden applicants.**
- 3. Eliminate procedural confusions and clarify exactly what is supposed to happen in the application process.**
- 4. Immediately implement staff retraining on the importance of health plan selection, and on the differences between Medicaid and FHPlus for those who may be eligible for both programs.**
- 5. Finally, regular monitoring of all offices and staff working with applicants is essential in securing an efficient process and one that secures eligible New Yorkers' access to needed health coverage.**

Conclusion

In 2000, over 1.6 million people in New York City were uninsured—one-quarter of the City’s residents.⁴ While the tragic events of last September 11th put a short term spotlight on the uninsured and allowed for the development of Disaster Relief Medicaid, the problems of New Yorkers without health insurance haven’t diminished. In all likelihood, the situation has grown worse. Now more than ever, the issue of the uninsured must be addressed. As the economy continues to deteriorate and the number of unemployed continues to rise, the number of uninsured is also expected to grow.

Assuring coverage for eligible New Yorkers through public health insurance programs is not only the right thing to do, it is the only thing to do. The promise of Family Health Plus is illusory if people are unable to make it through the application maze. The proud history of New York’s Medicaid program, once the most generous in the nation, is lessened if people give up because it is too hard to fight the Medicaid bureaucracy. It is the government’s responsibility to preserve accessible public health insurance programs for eligible New Yorkers. This is not a question of expanding coverage,

but rather of facilitating the enrollment of people we have already agreed are eligible and SHOULD be enrolled. Research demonstrates that this is not only good public health policy, but that it is also an economically sound action.

It is the responsibility of our governmental bodies to ensure eligible people’s access to needed health care. Otherwise the legacy of DRM will be a cruel hoax, providing people with desperately needed health coverage and the access to care that it provides, only to take it away again.

The promise of Family Health Plus is illusory if people are unable to make it through the application maze.

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3 United Hospital Fund, *Health Insurance Coverage in New York, 2000*. New York: United Hospital Fund, September 2002