



Children's Defense Fund[®]

Disaster Relief Medicaid: Lessons Learned

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Children's Defense Fund Mission Statement

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In 1992 the Children's Defense Fund opened an office in New York City. CDF-NY has since added offices in Albany and Long Island, expanding our efforts statewide. Our unique approach to improving conditions for children by combining research, public education, policy development, community organizing, and advocacy activities has made CDF-NY an innovative and tireless leader for New York's children.

CDF began in 1973 and is a private, nonprofit organization supported by foundation and corporate grants and individual donations. We have never taken government funds.

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Executive Summary

In the aftermath of the September 11th tragedy, the computer system used to manage the New York City Medicaid program suffered extensive damage, adversely affecting New York's ability to enroll new Medicaid beneficiaries and to roll out the new Family Health Plus (FHPlus) program for uninsured adults. In order to help ensure ongoing access to health care coverage for low-income individuals and families in New York City and to provide assistance to the thousands of New Yorkers affected by the tragedy, Disaster Relief Medicaid (DRM) was established. Authorized and implemented virtually overnight, DRM was designed to be a temporary mechanism to replace regular Medicaid, and to substitute for FHPlus, for most new applicants in New York City.

DRM has been widely heralded for its success in enrolling New Yorkers eligible for, but not enrolled in, public health insurance programs. DRM utilized a streamlined enrollment process and provided immediate coverage to eligible applicants. Between September 2001 and the close of the enrollment window on January 31, 2002, over 340,000 individuals were enrolled through DRM.

This report presents the findings from surveys with 701 DRM applicants at Medicaid offices during the last month of enrollment. Interviews were conducted in English, Spanish, Cantonese and Mandarin. Applicants were asked about their motives for applying, their past experience with the Medicaid program, their experiences applying for DRM and their plans for coverage after DRM's expiration.

Findings from our applicant interviews show that DRM applicants were largely uninsured adults with unmet health care needs. Despite the fact that many appeared to have been eligible for Medicaid before September 11, the vast majority (63%) had not previously applied. Four of the five top reasons reported by DRM applicants for their decision to apply after September 11 centered on the combination of a significant, underlying need for health care and an easier, faster enrollment process.

Based on the survey data, it appears that the combination of reduced paperwork requirements and faster access to needed health care, overlaid with existing, significant need among these uninsured adults for health care, all contributed to the overwhelming response to DRM.

Introduction

In the aftermath of the September 11th tragedy, the computer system used to manage the New York City Medicaid program suffered extensive damage, adversely affecting New York's ability to enroll new Medicaid beneficiaries and to roll out the new Family Health Plus (FHPlus) program for uninsured adults¹. In order to help ensure ongoing access to health care coverage for low-income individuals and families in New York City and to provide assistance to the thousands of New Yorkers affected by the tragedy, Disaster Relief Medicaid (DRM) was established. Authorized and implemented virtually overnight, DRM was designed to be a temporary mechanism to replace regular Medicaid, and to substitute for FHPlus, for most new applicants in New York City.

DRM replaced the lengthy and burdensome Medicaid application process with a drastically streamlined system. Through DRM, uninsured New York City residents with an annual family income of less than \$24,000 for a family of four, and who met immigration related eligibility criteria were allowed to fill out a one page application, show proof of identity, attest to their income, complete a short interview and immediately receive 4 months of fee-for-service Medicaid coverage.² Individuals could apply for the program at local Medicaid offices, Department of Health offices, and select community based facilitated enrollment sites and health plans.

Between September 2001 and the close of the enrollment window on January 31, 2002, over 340,000 individuals were enrolled through DRM,³ ten times the rate of normal enrollment.⁴ Prior to DRM it had been estimated that 600,000 uninsured New Yorkers were potentially eligible for, but not enrolled in, public health insurance programs.⁵

The success of DRM comes on the heels of a multi-year effort by multiple public, private, national, state and local players to increase participation in publicly funded health insurance programs by eligible children, and more recently, adults. While

¹ FHPlus is a New York State Medicaid expansion program which offers managed care coverage for adults earning up to 133% of the federal poverty level (FPL) if they are parents or 100% FPL if they are childless. In NYC enrollment into the program was slated to begin September 1, 2001, but was derailed by the events of September 11.

² Income eligibility varied, depending on whether a single adult, parent or child was applying. DRM was only available to those categories of immigrants eligible under the Medicaid and FHPlus programs.

³ Enrollment figures provided by the Human Resources Administration, July 2002.

⁴ Medicaid enrollment in NYC increased by an average of 6,885 cases per month between 1/2001 and 8/2001. Medicaid enrollment under DRM jumped to a monthly average of 81,300 cases between 9/01 and 12/01- a more than ten-fold increase.

⁵ There are approximately 1.6 million uninsured individuals in New York City (81% adults); it is estimated that about 30% of the adults, and 70% of the children are potentially eligible for Medicaid, Child Health Plus A, Child Health Plus B or Family Health Plus. *Health Insurance Coverage in New York 2000*; United Hospital Fund, August 2002.

these efforts have resulted in higher enrollment,⁶ and likely are responsible at least in part for the recent reduction in the number of uninsured children,⁷ their successes are dwarfed by the overwhelming response to DRM. Thus, DRM provides an important opportunity to better understand what caused this unprecedented number of “eligible uninsured” New Yorkers to apply.

Methodology

CDF-NY recruited 12 linguistically diverse college and graduate students to observe operations and conduct on-site surveys with DRM applicants at the 22 Medicaid offices throughout New York City where DRM enrollment was being conducted. Using research instruments developed in collaboration with the United Hospital Fund and other health care advocates, each site was visited 3 times between January 11 and January 31, 2001 (the end of the DRM enrollment period). Students arrived at each site before opening, observed the site’s enrollment activities for three to four hours, and left by noon. The students documented their observations of each site’s systems and procedures, referral practices, volume, atmosphere and clientele. In all, 67 site observations were conducted, and the results from these observations are contained in a companion report.⁸

This report presents the findings from the DRM applicant surveys completed during the site visits. During each site visit, the students asked DRM applicants leaving the Medicaid offices if they would complete a short interview. The interview protocol was available in English and Spanish, and the student translators were also able to conduct interviews in Cantonese and Mandarin. A total of 701 interviews were completed and analyzed for this report. Applicants were asked a series of questions to determine why and for whom they were applying, the applicant’s past experience with the Medicaid program, how the DRM enrollment worked, and whether applicants would seek ongoing coverage in the future. Questions were open-ended and multiple responses were recorded.

Background on New York State Health Insurance Programs

New York State has a complex system of public health insurance programs that predates the creation of DRM. Just prior to September 11, these programs were

⁶ In September 1997 when SCHIP was signed into law there were 1,2390,095 children covered by Medicaid in New York State, and 146,924 by Child Health Plus. As of June, 2002 Medicaid (now known as CHPlus A) enrollment stood at 1,427,659 and CHPlus B at 526,204. The combined enrollment of 1,953,863 was a 36% increase since September 1997.

⁷ The US Census Bureau reports that in 1997 the percentage of uninsured children in New York stood at 15.5%. By 2000 that number had dropped to 10.5%, although it is important to note that verification questions were added to the CPS in 2000 which resulted in lower numbers of uninsured children being reported.

⁸ *Disaster Relief Medicaid Enrollment in the Community Medicaid Offices: How Did it Work?* Children’s Defense Fund, March, 2002.

undergoing dramatic changes, including the addition of a major new adult insurance initiative, and a court decision significantly expanding coverage of immigrants. The mosaic of programs includes Medicaid, Family Health Plus (FHPlus), Child Health Plus A (CHPlus A), Child Health Plus B (CHPlus B), and the Prenatal Care Assistance Program (PCAP). While providing important avenues for access to needed medical care, the fragmentation and differing program rules add layers of complexity to the enrollment process, and make it much harder to disseminate a clear, consistent message to the public about the availability of coverage.

New York's health insurance programs have divergent, though overlapping, eligibility requirements, enrollment procedures, and different mechanisms for accessing care. Program eligibility requirements vary with respect to the age, immigration status, family structure and income eligibility of participants, as well as the amount of documentation needed to qualify. Brief descriptions of the various health insurance programs in New York follow.

Prenatal Care Assistance Program. PCAP is a Medicaid program covering prenatal care, delivery, and postpartum care, available to all pregnant women up to 200% of the federal poverty line (FPL) regardless of their immigration status.⁹ Services are available immediately and without documentation to women applying through specially designated PCAP providers. However, women must provide documents proving identity, state residency, income and pregnancy within 60 days of application to receive ongoing coverage.

Child Health Plus. There are two health insurance programs for children. *CHPlus A* (formerly Children's Medicaid), is a comprehensive insurance program for children under age 19 with income up to 133% FPL (infants under age 1 are eligible up to 200% FPL). CHPlus A has certain immigration restrictions, which are aligned with the Medicaid requirements (see below). Some children under CHPlus A access care through the "fee-for-service" Medicaid program, from doctors who accept Medicaid. Others must be enrolled in a health plan.

CHPlus B provides free or low cost managed care coverage for children under 19 who are ineligible for CHPlus A. Children are eligible on a sliding fee scale basis regardless of their immigration status. Families with incomes over 250% FPL are required to cover the full cost of the coverage.¹⁰

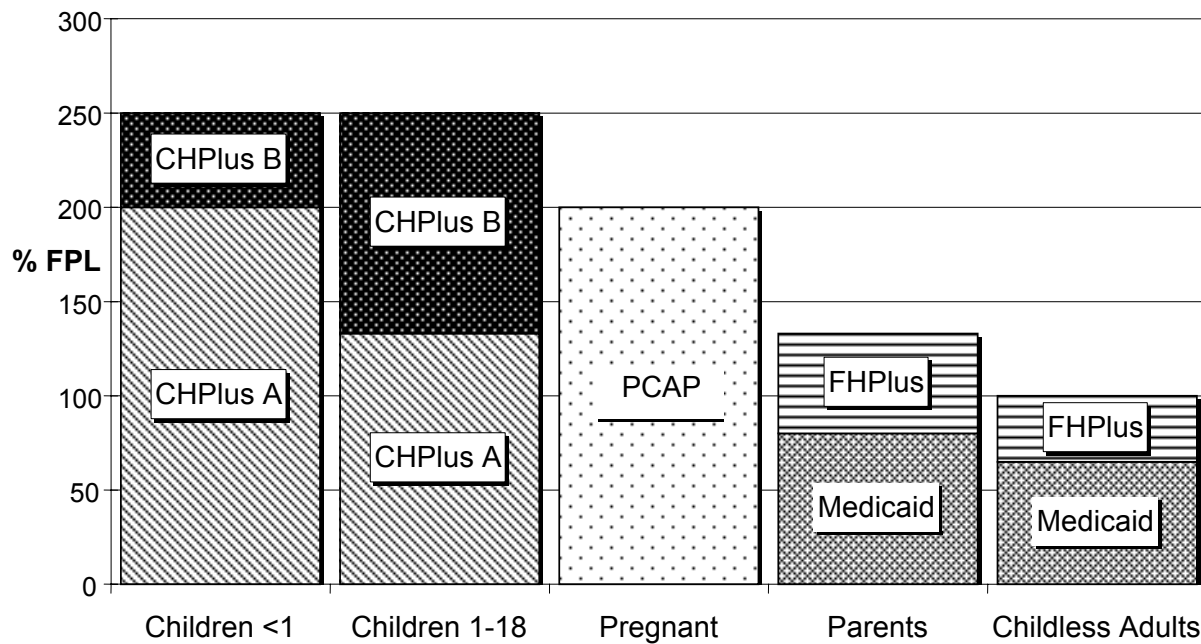
Both CHPlus A and B require that families provide documents proving identity, residency, age, income, and in some circumstances, immigration status to receive ongoing coverage. CHPlus A also requires proof of certain

⁹ Although a 2001 New York State appellate court decision in Lewis v. Perales barred the use of federal funds to provide PCAP coverage to undocumented women, state funds are still used to cover all women who are eligible based on income.

¹⁰ The CHPlus B program is not part of the Medicaid system and enrollment was not effected by September 11th. The program continued to enroll children in NYC alongside the DRM program.

expenses, such as health insurance and child care costs. Eligible applicants for both programs may be temporarily enrolled in a CHPlus B health plan for up to two months while the family is gathering the required documentation.¹¹ Temporary enrollment is not immediate, however, taking between one and five weeks to activate. Regular enrollment in CHPlus A can take up to 30 days after submitting the completed documentation, and from one to five weeks in CHPlus B.

Figure 1: State Health Insurance Programs in New York



Medicaid. The Medicaid program has traditionally been available for very low-income individuals. Parents of children up to age 19 and those who are elderly or disabled can qualify for Medicaid at slightly higher income levels than single adults or childless couples. Eligibility requirements related to the applicant’s immigration status were recently expanded, so that most documented immigrants are now eligible for New York’s Medicaid program.¹²

¹¹ New York Social Services Law § 364-i(4).

¹² The rules and procedures with respect to the categories of immigrants who are eligible for particular programs, and for proving immigration status, have changed considerably since the major overhaul of the welfare laws in 1996. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), 8 U.S.C. Sec. 1601 *et seq.* These rules became even more complex in New York last year, with the June, 2001 court decision in Aliessa v Novello. Prior to Aliessa, only citizens and certain limited categories of “qualified” immigrants were potentially eligible for Medicaid, FHPlus and CHPlus A. Legal immigrants

Care under the Medicaid program is accessed either on a “fee-for-service” basis, or through health plans. Adult applicants for Medicaid, have to provide all of the documentation required for CHPlus A, along with proof of their resources.¹³ Unlike PCAP and CHPlus, there is no temporary coverage. Enrollment in Medicaid occurs 45 days after application (90 days for disabled individuals.)¹⁴

Family Health Plus. The Family Health Plus (FHPlus) program is New York State’s newly established managed care health insurance program for low-income adults age 19-64 who are not eligible for Medicaid because of their income or resources. The FHPlus documentation requirements are similar to the Medicaid rules for CHPlus A. Enrollment for FHPlus began in New York City in September 2001, just days before the September 11 disaster. It currently takes several months for adults to be enrolled in FHPlus, and there is no temporary or retroactive coverage available under this program.

Enrollment into DRM offered several advantages over the regular enrollment process. New York State’s combined application for its public health insurance programs requires four pages of information, along with a number of supporting documents proving various aspects of eligibility. These documentation requirements are burdensome to applicants and workers alike, and have been shown to deter otherwise eligible individuals and families from applying and/or completing the process.^{15,16,17} Applicants often must make multiple trips to an enrollment office, and wait weeks or months before gaining coverage and, with it, access to needed medical care. The documentation requirements, combined with the delays before obtaining access to actual health care, operate to discourage working individuals and people with immediate health problems from even applying.

were also barred from Medicaid for up to five years after their arrival in this country. After Aliessa, most low-income immigrants, except for undocumented individuals, could potentially qualify for Medicaid or FHPlus, regardless of their arrival date. State officials were still in the process of finalizing the implementation plan for Aliessa when the tragedy of September 11 occurred.

¹³ Recent legislation mandates the elimination of the resource documentation requirement for many Medicaid applicants by April, 2003. This provision has not yet been implemented in New York City. New York Social Services Law § 366-a (2)(b).

¹⁴ However, once found eligible, Medicaid will pay for medical expense incurred by an applicant up to three months prior to date of application.

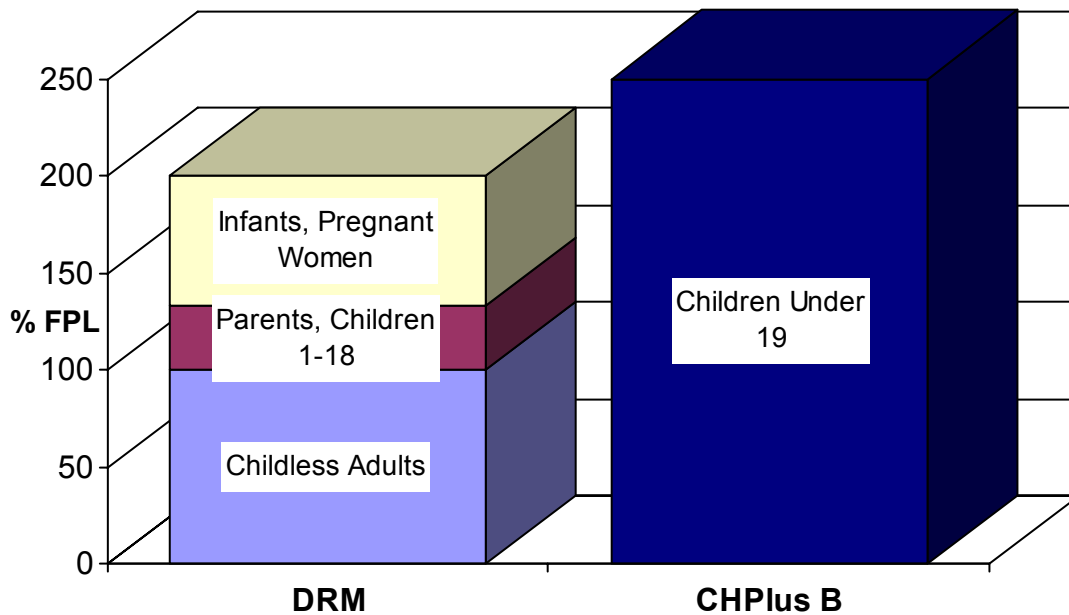
¹⁵ Research has shown that the documentation requirements present a formidable barrier for otherwise eligible children and adults. See Perry, M., Kannel, S., Valdez, R., Chang, C. *Medicaid and Children: Overcoming Barriers to Enrollment: Findings from a National Survey*. Kaiser Commission on Medicaid and the Uninsured, January, 2000.

¹⁶ Fairbrother, G., Dutton, M., Stuber, J., Scheinmann, R., and Cooper, R. *Barriers to Enrollment in Child Health Insurance Programs*. Children’s Defense Fund-NY & New York Academy of Medicine, June, 2002.

¹⁷ Thorpe K and Florence C, *Medicaid Eligible but Uninsured: The New York State Experience*. United Hospital Fund, October, 2000.

The Disaster Relief Medicaid program turned the traditional approach on its head. DRM streamlined the application process by offering a one-page application,¹⁸ minimal documentation requirements, and perhaps most importantly, the ability to receive immediate coverage at, or within days of, the time of application. Eligible applicants were able to complete the application, provide proof of identification, have a brief meeting with an enroller, and leave with an authorization form that provided access to services at any Medicaid provider that same day.¹⁹ The simplified process both attracted more eligible applicants and improved worker efficiency, thereby enabling the program to provide hundreds of thousands of eligible individuals with insurance, and with access to health care, within a highly compressed timeframe.

Figure 2: Coverage Levels Under DRM



¹⁸ The application itself asked for the name, birth date, sex, and social security number of all applying household members; whether any of the applicants were pregnant, parenting, disabled or already covered by health insurance; for the family's address, contact information and total household income; and for the number of people in the household not applying.

¹⁹ Program rules on the forms of identification needed to apply for DRM underwent several changes during the early days of the program. The final rules required the individual applying on behalf of his or her family to show valid picture identification or two forms of other identification to apply for DRM. MAP Procedure 01-14 (R2), October 12, 2001.

Findings

How Applicants Heard about DRM

Other studies have found that a lack of knowledge about publicly funded health insurance programs among potentially eligible populations is a key factor contributing to the programs' under-utilization by children and families.^{20,21} In contrast, within four and a half months and with only modest publicity of the program's availability, over 340,000 New Yorkers were enrolled in DRM. Given the short life span of the program and the overwhelming response, it is important to understand how people heard about DRM.

By far, word of mouth was the most important tool in informing people about the availability of DRM as a free health insurance program available at local community Medicaid offices. Two-thirds (67%) of all applicants stated that they had heard about DRM from a neighbor, friend or relative. This finding reflects the DRM "buzz" that spread throughout New York's communities, itself a measure of the program's popularity with applicants.²²

The second most cited source of information about the program (18%) was Advertisement/Media, which included any ads, newspaper articles, or TV or radio reports. The United Hospital Fund, which provided support for this research project, sponsored an advertising campaign informing people about the availability of DRM. The campaign carried a short message that emphasized both the simplicity of the application process and the immediacy of the coverage. While advertisements were placed in a wide range of venues, the advertising period itself was relatively brief, lasting only a few months.

Health Care Providers were also an important source of information (12%), followed by the Medicaid Office (8%), and other governmental offices, such as the unemployment office (4%). Health care providers were the target of an education campaign by both government and private actors to ensure that they would recognize and accept the paper DRM authorization forms as legitimate proof of coverage. It appears that many providers also took it upon themselves to advise their uninsured patients to seek coverage through DRM.

It is likely that the simplicity of the program helped fuel the DRM message. DRM was a program that people could explain to their friends and relatives, that doctors could describe in the course of an office visit, and that could be captured well in advertising. Without the need for lengthy explanations or written materials to make the system comprehensible to the average New Yorker, word of DRM was

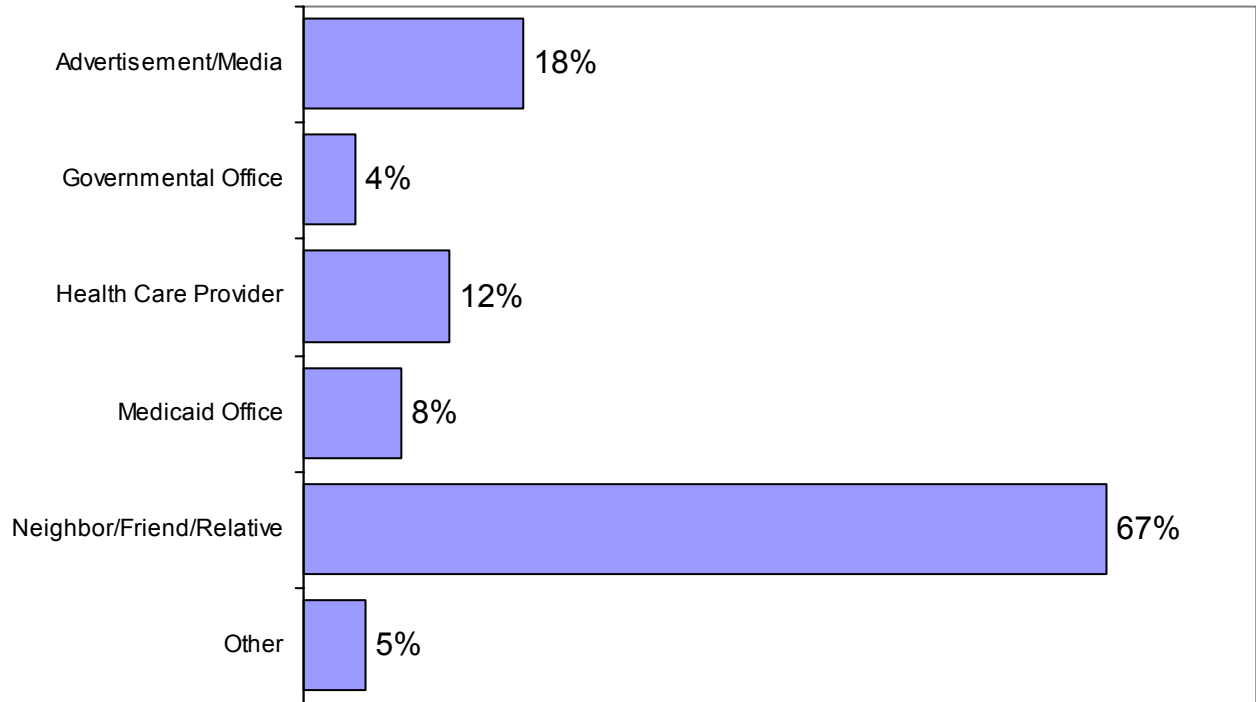
²⁰ See fn 15, supra.

²¹ Kenney, G. and J. Haley. *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* Urban Institute, *Assessing the New Federalism* Policy Brief. May 2001.

²² Perry, M. *New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People*. Kaiser Commission on Medicaid and the Uninsured in collaboration with the United Hospital Fund, August, 2002.

able to filter into families through their most trusted sources, influencing them to take action.

Figure 3: How Did You Hear About DRM

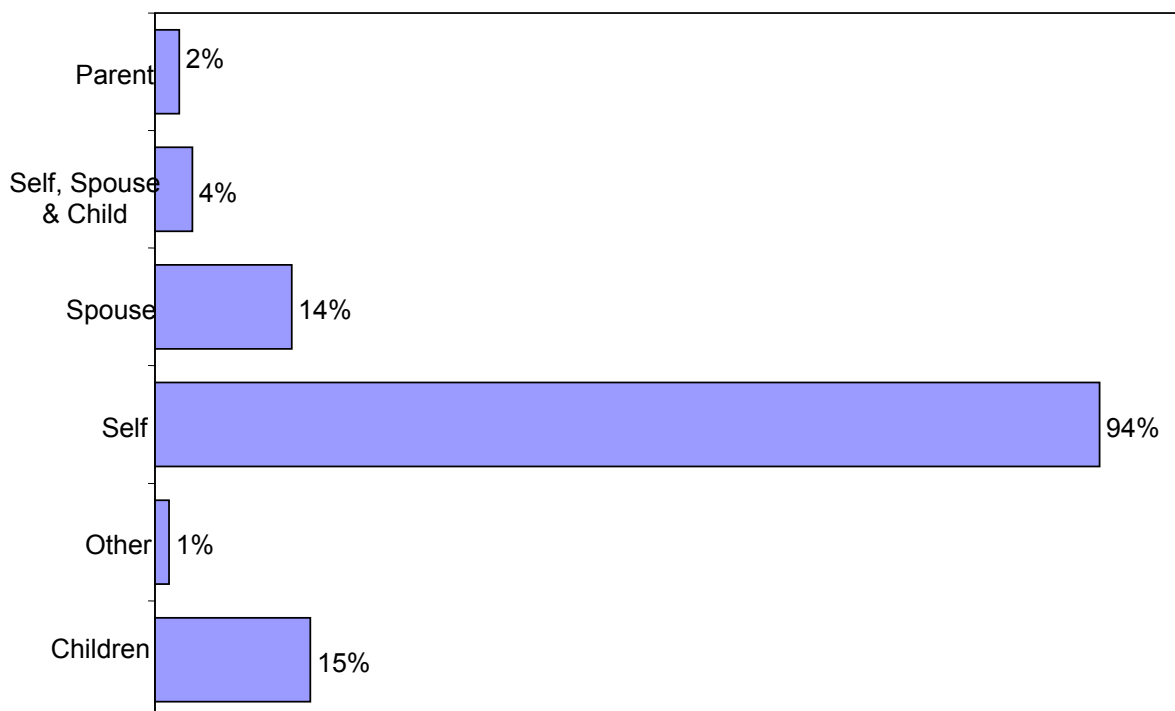


Who Applied For DRM

Enrollment into DRM was largely an adult phenomenon. Of the 701 adults interviewed for this study, 656 or 94% were applying for coverage for themselves, 14% for their spouse, and only 15% on behalf of a child. These numbers correspond with preliminary analysis done by HRA of DRM recipients which found that 81% of the recipients were adults 21 and over²³. This is in sharp contrast to the typical NYC Medicaid rolls in which adults comprise about half of all recipients.²⁴ The high concentration of adults is at least in part attributable to a policy change which encouraged CHPlus A eligible children to enroll in CHPlus B temporarily. Since CHPlus A is reliant on the Medicaid computer system, children could not be enrolled into the program. Families were therefore encouraged to enroll their children into CHPlus B instead of DRM because it ensured children one year of coverage instead of only four months.

²³ Data provided by the Human Resource Administration, July, 2002.

²⁴ Enrollment numbers provided by New York State Health Department.

Figure 4: Who Are You Applying For

New York City is one of the most diverse cities in the world with immigrants from every part of the globe calling it home. As with the United States as a whole, the immigration patterns of the last decade have shifted and immigrants from Latin America and Asia now account for the majority of foreign-born New Yorkers.²⁵ With the changes in immigration, the overall racial composition of the city has changed with Non-Hispanic Whites now accounting for 35% of the population, Hispanics 27%, Non-Hispanic Blacks 24.5%, and Asians and Pacific Islanders 9.8%²⁶.

While ethnic breakdowns of those applying for DRM were not directly collected, this study attempted to create a proxy for this by asking applicants about their primary language.²⁷ The mix of primary languages spoken shows that the sample interviewed for this survey was diverse, and reflects the diversity of the city. While 44% of applicants speak English as their primary language, the majority speak some other language. Reflecting the large Hispanic population in the city, 28% of

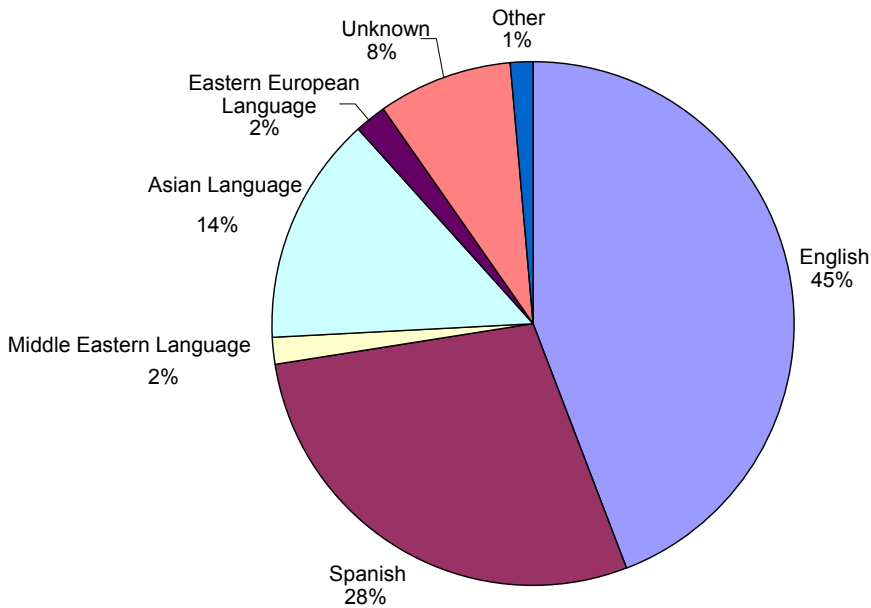
²⁵ According to Census 2000, 53% of Foreign-Born New Yorkers are from Latin America (which includes the Caribbean), 24% from Asia, and 19% from Europe.

²⁶ Census 2000.

²⁷ See *Disaster Relief Medicaid Enrollment in the Community Medicaid Offices: How did it Work?* for a discussion on the ethnic diversity observed at each community Medicaid office.

participants list Spanish as their first language, although presumably many second and third generation Hispanics actually use English as their primary language. Asians, including South Asians, are the fastest growing group in New York, and they were well represented in our sample with 14% speaking an Asian language (this includes Mandarin, Cantonese, Urdu, and others). An additional 2% of those surveyed spoke an Eastern European language, for example Russian, and 2% a Middle Eastern language, such as Arabic; unfortunately the primary language is unknown for 8% of the sample. This diversity is particularly striking given that the language capacity of our interviewers did not fully match the diversity of applicants (7 interviewers spoke Spanish, 3 Cantonese, 2 Mandarin, 2 French, 1 Konkani, and 1 Tamil), and therefore it is likely that our sample over-represents English speaking applicants. It is clear that knowledge of the DRM program filtered out to various ethnic communities around the city, and that the program had a wide appeal.

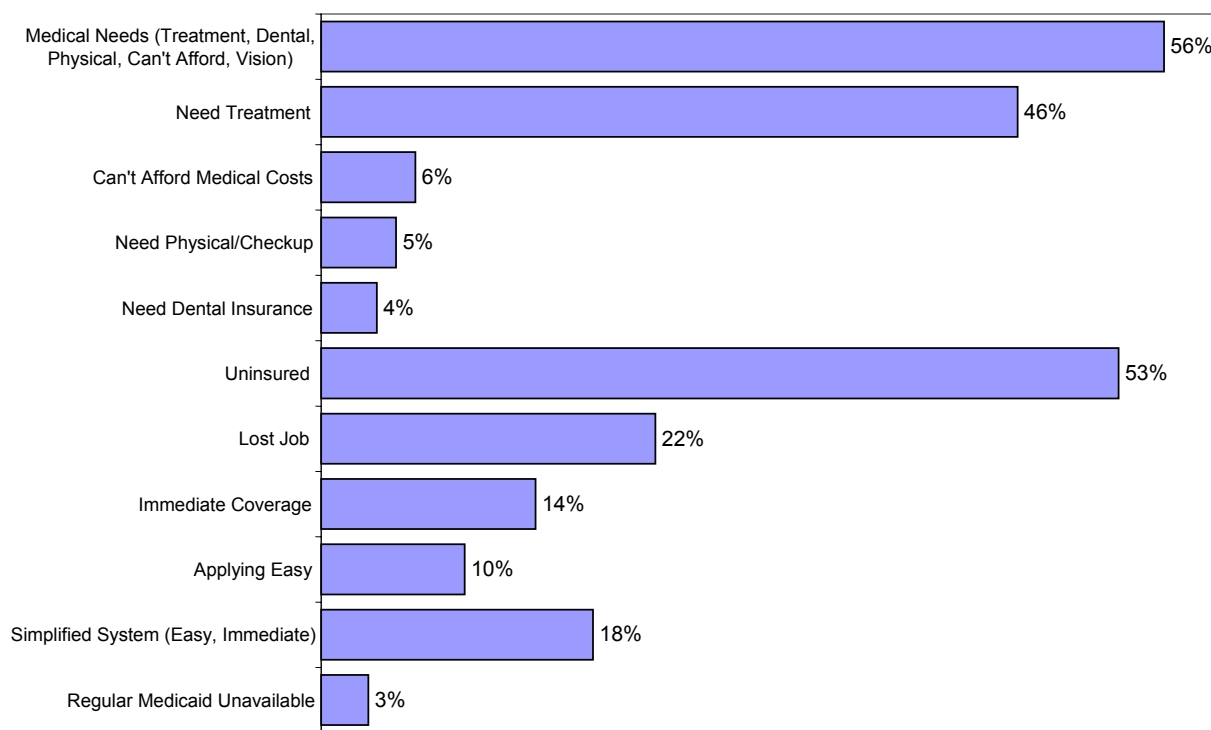
Figure 5: Primary Language Spoken by Applicant



Why People Applied for DRM

The DRM program was instituted in the wake of a tragic and unprecedented event that had far reaching consequences, including the sudden loss of over 100,000 jobs in New York City. Understanding the reasons why so many Medicaid and FHPlus-eligible adults applied for DRM is of critical importance in assessing the lessons learned from the program’s vastly simplified and expedited process, and the impact such a program might have under more normal circumstances.

Figure 6: Why Are You Applying for DRM



While 22% of all applicants surveyed stated that they or a family member recently lost their job, the majority of applicants did not mention a change in income which would suggest that many, if not most, had been financially eligible for the regular Medicaid/FHPlus program before September 11th.²⁸ This is especially significant because only 3% of respondents said that they were applying for DRM because the regular Medicaid program was not available, and out of 701 participants interviewed only 2 mentioned that they had been waiting for FHPlus to begin. These findings suggest that while the vast majority of applicants may have been eligible for either Medicaid or FHPlus, they only attempted to apply once DRM was instituted.

While the reason most often given for applying for DRM was being uninsured and needing health insurance (53%), it was closely followed by having a health condition that needs treatment (46%).²⁹ Other health needs mentioned as reasons for applying included: cannot afford their medical costs on their own (6%), need a

²⁸ Pending receipt of more complete administrative data from the DRM transition process, it is difficult to estimate how many of these individuals and families may have been previously eligible for Medicaid versus CHPlus B or FHPlus.

²⁹ When people's first response to this question is analyzed, Need Treatment is the most common answer with 37% and being Uninsured following at 36%.

physical or checkup (5%), and need dental coverage (4%). When these “need” categories are combined (need treatment, dental, physical, cannot afford, vision), 56% of respondents identified a medical need as a reason for applying. The findings seem to indicate that there were a large number of uninsured New Yorkers with unmet medical needs who applied for DRM as soon as it became available. The nature of the need bridged a wide spectrum, from the dramatic to the routine. One applicant had just suffered a heart attack, heard about DRM at the clinic that treated him, and was applying so he could access follow-up care. Many others noted that it had been years since they had seen a doctor and were anxious to access basic health services.

Although only about 18% of the survey participants specifically cited the simplified aspects of DRM (easy to apply and immediate coverage) as the reason why they applied, it was clearly the major reason after medical need and the loss of a job. The immediate coverage, which allowed applicants to leave the Medicaid office and go directly to a healthcare provider for services, was especially valued (14% of those interviewed gave this as the reason that they were applying).

Why DRM Applicants Didn't Apply for Medicaid Before September 11?

Despite the high levels of medical need reported by DRM applicants, and even though DRM eligibility requirements were virtually unchanged from those already in existence for other public coverage programs on September 11, 63% of DRM applicants reported that they had never applied for Medicaid in the past.³⁰

This number is higher than HRA estimates finding 45% of DRM recipients new to the system.³¹ There are two possible explanations for this disparity. First, it is possible that the timing of our survey, which was in the last weeks of DRM enrollment, tapped into a group of applicants less likely to have applied for Medicaid in the past. Second, and even more compelling, the HRA estimate is based on those recipients who kept their appointment to transition to regular Medicaid or FHPlus coverage.³² The DRM recipients who attempted to transition to regular coverage are likely to be very different from those who chose not to. Those who chose not to complete the transition process are more likely to have either been temporarily unemployed and quickly found a new job offering insurance, or be

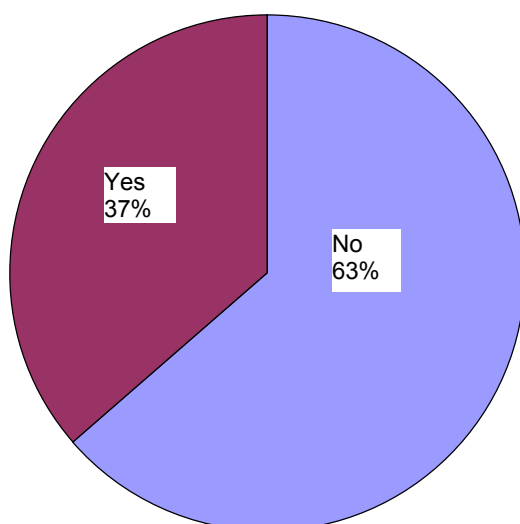
³⁰ It is unknown how many applicants were newly eligible based on the higher FHPlus income levels or because of the Aliessa decision. As previously stated the FHPlus program was on the verge of being initiated in New York City when the computer systems were damaged, and the Aliessa expansions were just going into effect.

³¹ Figure provided by Human Resource Administration, July, 2002.

³² In order to allow DRM recipients the opportunity to apply for the 12 months of coverage that the Medicaid and FHPlus programs provide, city officials created a transition system. All DRM recipients received a series of letters informing them that their coverage was being extended until a face-to-face interview with an HRA enroller could be held; at the time of the interview the client would then complete the regular application procedure. If the DRM recipient did not keep their transition appointment, their coverage was automatically terminated.

unwilling to go through the much more burdensome application process. Even using the more limited estimates from HRA, it is clear that the DRM program attracted a large pool of people who had never before accessed publicly funded health insurance programs.

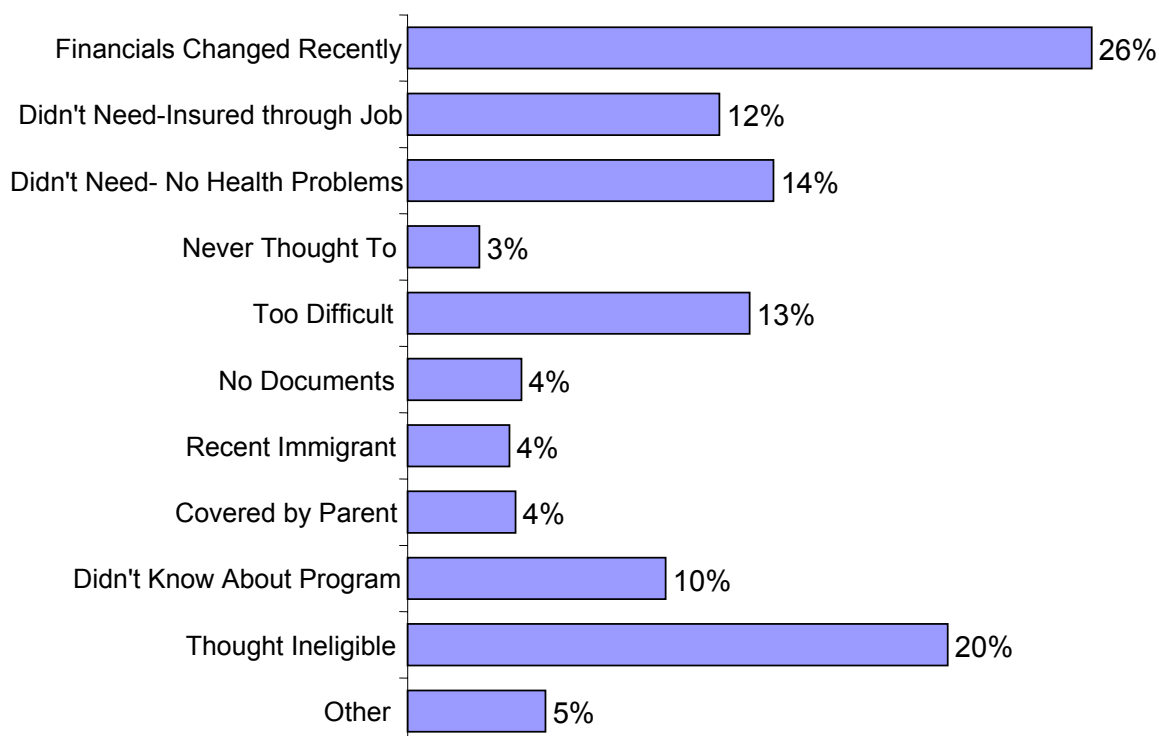
Figure 7: Applied For Medicaid in Past



The reasons people gave for why they had never applied for Medicaid before varied. Reflecting in part the economic fallout of the September 11th tragedy, 26% of people said that they were applying now because their financial situation recently changed, and 12% said that they had not previously needed it because they were insured through their job. Somewhat surprisingly, 14% of people reported that they had not needed Medicaid before because they did not have any health problems. This finding suggests that a group of the uninsured apply for coverage only out of urgent medical need and not with the view of accessing preventative services.

Although people's changing circumstances help to explain why they applied for DRM but not for Medicaid, confusion about eligibility requirements and the difficulty of applying were also major reasons. 20% of respondents said that they had never applied for Medicaid because they did not think they were eligible, and 10% said that they did not know about the program. And although they were likely eligible prior to DRM, 4% said that they had not applied because they were recent immigrants. Finally, negotiating the Medicaid enrollment process was a major deterrent for many people with 13% saying it was too difficult and time consuming to apply, and 4% saying that they did not have all of the required documents.³³

³³ Interestingly, of those applicants who reported having received Medicaid in the past, 23% stated that they lost their Medicaid coverage because they failed to recertify. The recertification process requires the same levels of extensive document production and

Figure 8: Why Have You Not Applied for Medicaid in the Past

How the DRM Process Worked

While the process varied slightly by application site, in general the DRM application and enrollment procedure was very simple and worked well in serving the needs of applicants.³⁴ When an applicant arrived at the Medicaid office they were given the one page DRM application to fill out and then waited to see an enroller or, if demand in the site was high, to get a referral to another site.³⁵ While there was a great deal of variation by site, 79% of applicants were processed by the Medicaid offices, and only 21% received a referral. Despite very heavy volumes at most locations, the process moved quickly and 71% of applicants who were not referred waited less than 2 hours before meeting with an enroller.

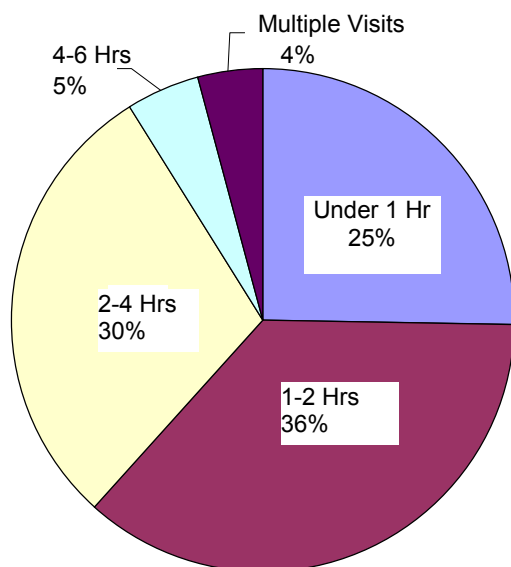
verification as the regular Medicaid application process, however recent legislation mandates that the recertification process be simplified by April, 2003. Health Care Reform Act of 2002.

³⁴ See fn 8, supra.

³⁵ Because of the tremendous volume of people applying for DRM at certain sites, the city established a system referring some clients to authorized facilitated enrollers located at community based organizations, health plans, and Department of Health offices throughout the city. The referral process was an important tool in the city's DRM effort and more than 50,000 applicants were processed by a referral site. Enrollment numbers provided by the Human Resources Administration, March, 2002.

Once with the enroller, the application was double checked, identification was viewed, and income eligibility calculated based on the client’s sworn statement (called a self-attestation.) If the applicant was found to be eligible, the enroller completed a Temporary Medicaid Authorization Form which the client could use immediately to begin accessing care. The process was quick and efficient, and of the study participants who met with an enroller, 96% spent less than 20 minutes in the interview.

Figure 9: Total Time to Receive DRM



In contrast to the traditional Medicaid application process which can take multiple visits by a family during workday hours and weeks or months of waiting, applying for DRM was a simple and efficient process. Of people who received an Authorization form, 62% walked out of the Medicaid office with access to care in 2 hours or less, and another 30% completed the process in less than 4 hours. Ironically, some of those who waited the longest may have been some of the earliest to arrive to apply for DRM. Applicants were observed lining up at DRM enrollment sites in the early morning hours, sometimes over three hours before the offices opened.³⁶ For most applicants, however, DRM provided an easy application and immediate coverage.

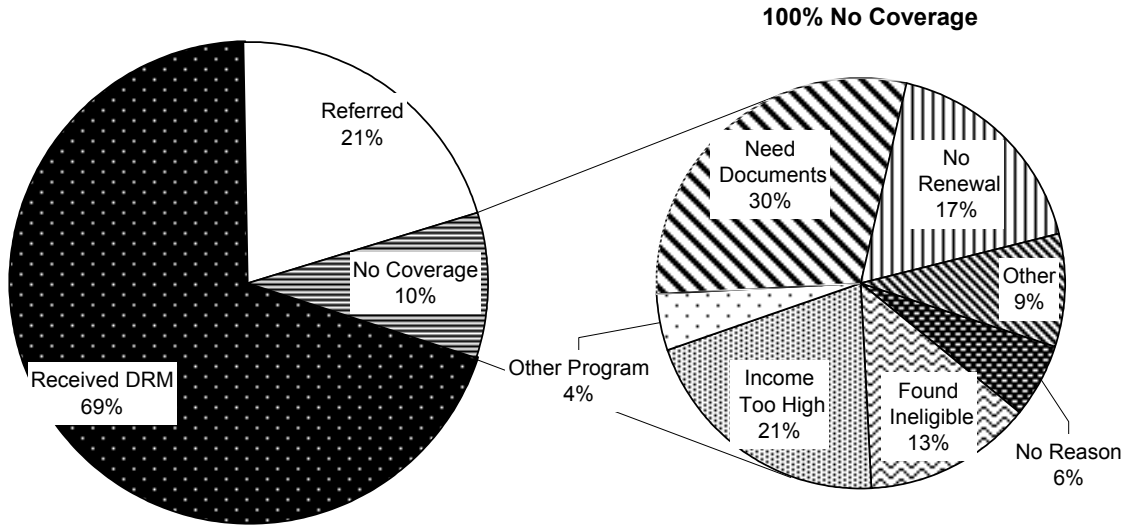
Did Everyone Who Applied for DRM Get Approved?

DRM was far from an “automatic” approval process, despite the streamlined nature of the program. Nearly 10% of applicants were denied coverage, for a variety of

³⁶ See fn 8, supra..

reasons, including income that exceeded the program guidelines. Of the 21% of the clients who were referred to another location to complete the application process, there is no way of knowing how many of them were successful in obtaining DRM coverage.

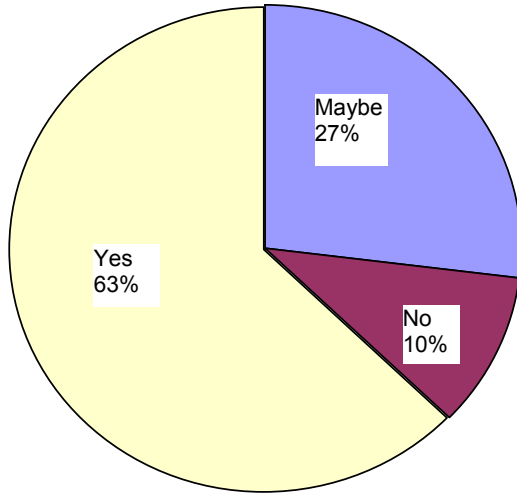
Figure 10: Why Did You Not Get Coverage



Would DRM Applicants Reapply for the Program?

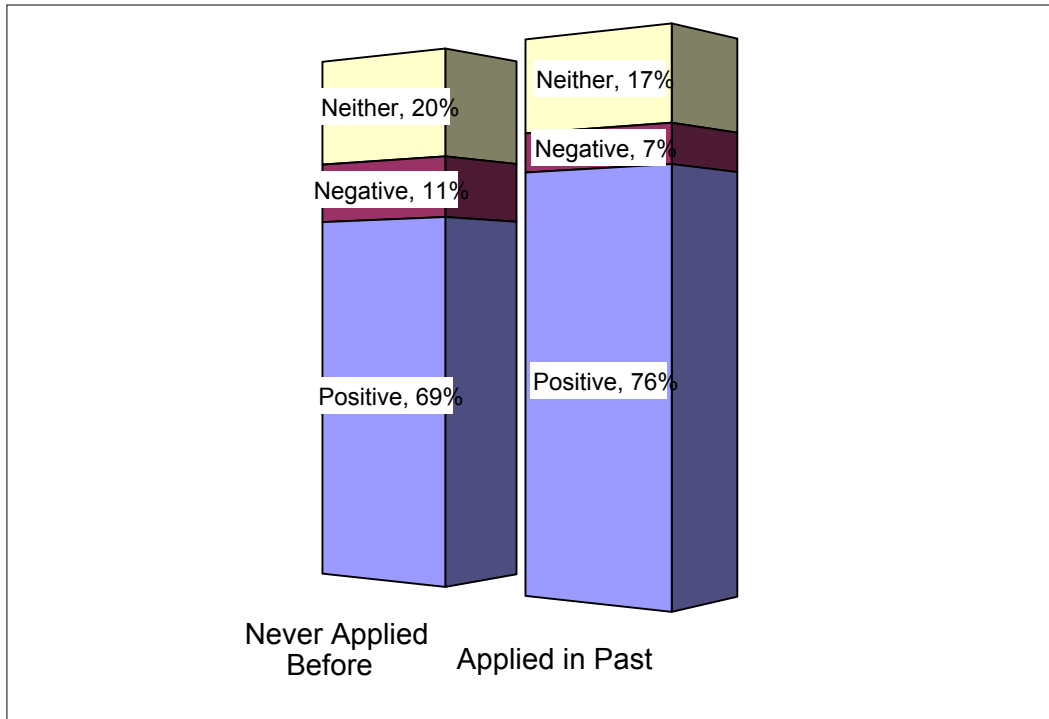
The overwhelming majority of DRM applicants (63%) reported that they would reapply for the program, even if the process took longer and more documents were required. This likely reflects the high levels of unmet medical need among these largely uninsured adults. Similarly, the majority of applicants (71%) rated their experience with DRM as “positive.”

Figure 11: Willingness to Reapply for Medicaid



It is also noteworthy that a larger percentage of those applicants who had previously applied for Medicaid rated the DRM process favorably (76%), as compared to those who had never before applied (69%). This suggests that applicants with direct experience with the slower, more burdensome and bureaucratic Medicaid system were even more favorably impressed with the streamlined DRM process than those who had previously been uninsured, or insured through their employer.

Figure 12: Rating of DRM by Past Experience



Lessons Learned from the DRM Experience

The events of September 11 touched every aspect of New Yorker's lives. There can be no doubt they also impacted the experience of DRM in ways too subtle to detect. However, the 701 interviews conducted with DRM applicants are notable in that they so clearly echo the larger challenges faced by New York's eligible uninsured.

A Good Program Generates Good Outreach

DRM demonstrated that a simple enrollment process that results in relatively quick access to care, results in a "credentialing" process, where favorable reports about the program spread quickly among families, neighbors and communities. The positive "buzz" on DRM, and the fact that there was a lot of "buzz" (67% of applicants heard about it from a neighbor, friend or relative) seemed to differentiate DRM from the myriad of other existing health programs. In addition, DRM lent itself to a simple, straightforward message, largely communicated from person to person: "You need to see a doctor? No hassles, no long delay, no cost!" The simplicity of the message, together with the ease and speed of the process, contributed to the unprecedented response.

DRM Enrollment Reflects Underlying Health Needs

Applicants for DRM were overwhelmingly new to the system, previously eligible and in need of health care. They are precisely the population that public health insurance programs should seek to enroll.^{37,38} While complete utilization data is not yet available from the New York State Department of Health, it may be that the pent up health needs of the applicants will be reflected in increased rates of health care utilization by DRM recipients.³⁹ It would be a mistake, in any event, to view DRM utilization as a burden. Without access to ongoing primary and preventive care the uninsured develop more complex health needs, which are more expensive to treat and more likely to impact a person's ability to work, care for a family and lead a productive life. Analysis by the New York City Health and Hospitals Corporation of the health care needs of DRM recipients detected and treated during the course of this short lived program revealed significant numbers of early cancers, early-onset heart disease, and previously undetected asthma, diabetes,

³⁷ *The NewsHour with Jim Lehrer*, Kaiser Family Foundation, *National Survey on the Uninsured*; April 2000.

³⁸ Dubay and Kenney G. *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*. The Urban Institute, October 2001.

³⁹ Interestingly, however, such increased utilization was not revealed in a recent analysis of DRM utilization by the New York City Health and Hospitals Corporation (HHC), which found only 100,000 visits for approximately 75,000 individuals between 9/11/01 and 4/30/02. *HHC's Experience with Enrollees of Disaster Relief Medicaid*, New York City Health and Hospitals Corporation, August 7, 2002.

and HIV.⁴⁰ Such early detection and treatment saves lives and avoids more expensive, later-stage care. The impact reverberates far beyond the personal, taxing public health resources and raising health costs for all consumers. Because public health insurance programs are funded jointly by local, state and federal governments,⁴¹ providing public health insurance coverage brings a broader base of resources to the health care table.

Enrollment Simplification Increased Access to Coverage

The positive response of DRM applicants to the reduced paperwork requirements underscores the critical importance of streamlining the existing public health insurance programs, most notably, by eliminating unnecessary documentation requirements. Asking for documents to prove the balance in a low-income family's bank account, or the value of their car, or for the production of original birth certificates, are all requirements that keep eligible individuals and families out of needed health care programs. They are not necessary for eligibility determinations and are not required by the federal government. Furthermore, some states have found that reducing documentation requirements actually reduces administrative burdens, thereby improving worker efficiency and reducing administrative costs.⁴²

Moreover, the time period between initial application and the ability to access care in existing health coverage programs should be significantly shortened. This is particularly important in light of the significant existing medical needs of many DRM applicants.⁴³ Waiting weeks or months after application to start utilizing healthcare undermines the purpose of the program and compromises the health of recipients. Simplification itself could contribute to expediting enrollment. However, fundamental changes would be needed to achieve the immediate coverage provided in DRM to existing health insurance programs for adults, particularly FHPlus.

Simplification Can be Done Responsibly

For some policy makers, the burdens of our enrollment procedures are viewed as legitimate means for preserving program integrity. The experience of DRM creates an important opportunity to re-examine this assumption. DRM was a paper driven system, lacking mechanisms traditionally employed to protect against fraud and the

⁴⁰ HHC's *Experience with Enrollees of Disaster Relief Medicaid*, New York City Health and Hospitals Corporation, August 7, 2002.

⁴¹ New York's Medicaid, Child Health Plus A, PCAP and FHPlus programs are financed by approximately 25% local funds, 25% state funds, and 50% federal funds. CHPlus B is funded by approximately 35% state funds and 65% federal funds. There is no local share for CHPlus B.

⁴² E. Hill. *A Model for Health Coverage of Low-Income Families*. California Legislative Analyst's Office. June, 1999.

⁴³ Testimony of Maria Lugo, Director of Patient Services, William F. Ryan Community Health Center, before the General Welfare, Health and Oversight Committees of the New York City Council, April 29, 2002.

enrollment of those persons who do not meet the eligibility requirements. The program was entirely reliant on the honesty of applicants. And yet 10% of the applicants we interviewed were denied coverage.⁴⁴

Other states have found that a public health coverage program based on the applicant's attestation of income and other eligibility factors can and does result in higher enrollment and better health care access, without compromising program integrity.^{45/46} In fact, New York's health insurance programs already employ sophisticated tools, such as searching state data bases for earned and unearned income of applicants, to ensure the integrity of our public health insurance programs. This type of "paperless verification," unavailable in the course of the DRM program, is a more effective means for ensuring that only eligible New Yorkers are enrolled while preserving access to the programs.

Conclusion

In the aftermath of the September 11 attack, local, state and federal officials rushed to meet the needs of New Yorkers in crisis. DRM was an unprecedented action for an unprecedented moment. Yet, as is often the case in times of tragedy, DRM offers some important lessons about what is possible. Programs that on September 10 were viewed as so large and complex as to be almost immune to change turned on a dime. Uninsured New Yorkers, the healthy and the sick, from every background and speaking every language, poured into Medicaid offices, many for the first time in their lives. By any measure, DRM must be deemed a success in seeing New Yorkers through our darkest moments. It would be a mistake, however, to view DRM only in its historical context. The lessons of DRM can and should be applied to ensure appropriate, cost-effective and timely access to needed health care, brightening the future of New York's uninsured families.

⁴⁴ Some additional number of applicants who were referred to another site to complete their DRM applications were likely determined ineligible.

⁴⁵ Cox, L. *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*. Center on Budget and Policy Priorities, December, 2001.

⁴⁶ Smith, V., Ellis, E., and C. Chang. *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*. Kaiser Commission on Medicaid and the Uninsured, April, 2001.