NEW YORK STATE
OFFICE OF THE STATE COMPTROLLER

H. Carl McCall
STATE COMPTROLLER

DEPARTMENT OF HEALTH

MANAGEMENT OF CHILD HEALTH PLUS B

2000-S-28

DIVISION OF MANAGEMENT AUDIT AND STATE FINANCIAL SERVICES

H. Carl McCall
STATE COMPTROLLER

Report 2000-S-28

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our audit report on the Department of Health's management of Child Health Plus B.

The audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article II of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

May 23, 2001

Executive Summary

Department of Health
Management of Child Health Plus B

Scope of Audit

In 1991, the New York State Legislature created the Child Health Plus Program, now referred to as Child Health Plus B. Child Health Plus B, which is administered by the Department of Health (Department), provides low cost or free health insurance to children under the age of 19 who are not eligible for Child Health Plus A, formerly known as Medicaid. Projected State and Federal spending for Child Health Plus B during fiscal year 2000-01 totals approximately $735 million (including Federal funds available from prior years allocations). According to Department reports, as of October 2000 more than 530,000 children were enrolled in Child Health Plus B.

In administering Child Health Plus B, the Department contracts with 31 health insurers. The insurers are responsible for enrolling children in Child Health Plus B, providing managed care health insurance coverage to the children, and annually renewing their eligibility for Child Health Plus B. The Department also contracts with 34 facilitated enrollers, who assist in the enrollment of children and determination of a child's eligibility for Child Health Plus B.

Our audit addressed the following question about the Department's administration of Child Health Plus B for the period April 1, 1999 through December 31, 2000:

- Does the Department adequately manage Child Health Plus B to ensure that it is effectively reaching its target population and is enrolling only eligible children?

Audit Observations and Conclusions

We found that the Department has done a good job implementing new initiatives to increase enrollment and to ensure only eligible children are enrolled. We also noted additional opportunities for the Department to make further improvements in ensuring that only eligible children are enrolled and that outreach and marketing efforts reach the target population.

In our prior audit of Child Health Plus B, we found that if certain changes were not made in program rules and administration, it was unlikely that the Department would be able to use all of the Federal funding that would be available to Child Health Plus B with the passage of the Federal Balanced Budget Act of 1997. In order to fully utilize such funding, we recommended

that the Department pursue certain initiatives to increase enrollment and expand services. During our current audit, we found that the Department has implemented some initiatives we suggested in our previous audit, and has implemented additional initiatives required by law. The Department has substantially increased the number of children enrolled in Child Health Plus B,

from about 153,000 in November 1997 to more than 530,000 as of October 2000 (an increase of 250 percent). Our prior audit recommended that the Department consider expanding the health care services covered by Child Health Plus B. In 1998, legislation was passed that expanded the scope of benefits covered and expanded program income eligibility to 250 percent of the Federal poverty level. As our prior audit recommended, Child Health Plus B now includes services such as: inpatient mental health, alcohol and substance abuse services; dental, vision, and hearing care; prescription and non-prescription drugs; and durable medical equipment. We commend Department officials for effectively implementing the legislative changes. (See pp. 5-7)

In our prior audit, we found that Child Health Plus A eligible children were being enrolled in Child Health Plus B. If Child Health Plus A eligible children are incorrectly enrolled in Child Health Plus B, the Federal funds used to subsidize insurance premiums for these children could be recovered by the Federal government. In our current audit, we found the Department has undertaken a number of new initiatives to help ensure that only eligible children are enrolled, such as implementation of a new joint application for both programs and facilitated enrollment. We found that these efforts have generally been successful at directing applicants into the correct program. However, we noted several types of errors in the eligibility determination process that could lessen the effectiveness of the Department's new initiatives by potentially allowing Child Health Plus A children to be enrolled in Child Health Plus B. Our report contains recommendations to further improve the eligibility process. (See pp. 8-11)

If the Department is going to effectively enroll all uninsured populations, additional steps to enroll harder-to-reach, under-represented populations must be taken. Although the Department has increased participation in Child Health Plus B by implementing numerous and different outreach and marketing activities, there are opportunities for the Department to better coordinate its marketing and outreach activities with health insurers and facilitated enrollers and to take certain other additional steps to identify populations that are not being adequately reached. (See pp. 12-14)

Comments of Officials

Department officials generally agreed with our recommendations. The Department's complete response is attached as Appendix B.

Contents

Introduction

Background

The availability of health insurance coverage promotes the provision of the preventive and acute care that children require for healthy development. Yet many of New York's children are without such insurance. The Census Bureau's two most recent Current Population Surveys estimated that in New York State 620,000 children in 1999 and 720,000 children in 1998 under age 19 were uninsured.

Child Health Plus B (formerly known as the Child Health Plus program) is New York State's health insurance program for children under 19 years of age who are not eligible for Child Health Plus A (formerly known as Medicaid) and who do not have private health insurance. Child Health Plus B is administered by the Department of Health (Department) to provide low cost or free health care coverage to children in New York State who meet certain basic eligibility criteria. It was created in 1991 by the New York State Legislature and expanded in 1996 by the New York State Health Care Reform Act. In addition, the Federal Balanced Budget Act of 1997 created a national children's health insurance coverage initiative that is expected to provide funding for 10 years.

Child Health Plus B funding, which was initially limited to $20 million in 1991, has increased dramatically to about $556 million annually, including $305 million in Federal funding for the 2000-01 fiscal year. The Department has three years to spend the annual Federal funds allotments. For the 2000-01 fiscal year, the Department had about $179 million available from the previous years' unused Federal funds. Therefore, for the 2000-01 fiscal year, Department officials expected to have a total of about $735 million available to fund Child Health Plus B and estimated they will need about $722 million for expenses. Current law provides for increases in State funding for the next two and a half years. Total Federal allotments are set to decrease over the next three years. In addition to the annual funding, Federal law provides that if a state does not fully spend its annual allocation of Federal funds within the three-year period, the unexpended portion will be reallocated to states that have made full use of their allocations. As of October 1, 2000, Federal funding of about $2 billion had remained unexpended by 39 states after three years and, therefore, was to be reallocated to states that had made full use of their allocation. However, Congress has allowed the 39 states to retain 60 percent of the unused funds and will reallocate the remaining 40 percent to the other 11 states. Department officials told us they expect over $400 million of these unexpended funds to be reallocated to New York State this year because New York has made full use of prior years' funds. At the time of audit field work, officials also anticipated receiving $305 million in the 1999 Federal fiscal year in reallocated funding. In responding to our draft report, however, Department officials stated that in

light of incentives regarding unspent federal fiscal year allotments, no state can be assured of the amount of redistributions from these unspent allotments. As of October 2000, about 530,000 children were enrolled in Child Health Plus B.

For a child to be eligible for subsidized premiums, the gross income of the child's household cannot exceed 250 percent of the gross Federal poverty income level. If the gross income of the child's household is less than 160 percent of the Federal poverty level, the child's health insurance premium is fully subsidized by Child Health Plus B. If the gross income of the child's household is between 160 and 222 percent of the Federal poverty level, the child's family must contribute $9 per month in premium payments (with a maximum contribution of $27 per month per family). If the gross income of the child's household is between 222 and 250 percent of the Federal poverty level, the child's family must contribute $15 per month in premium payments (with a maximum contribution of $45 per month per family).

In administering Child Health Plus B, the Department contracts with 31 health insurers. The insurers are responsible for enrolling children in Child Health Plus B, providing managed care health insurance coverage to the children, and annually renewing their eligibility for Child Health Plus B. The Department also contracts with 34 facilitated enrollers. Facilitated enrollment is a $10 million joint effort between the State and community based, culturally and linguistically appropriate enrollers located in community settings such as schools, libraries, clinics and community centers to reach out and assist in the enrollment of children and determination of a child's eligibility for Child Health Plus B.

The Department is responsible for overseeing the health insurers' and facilitated enrollers' activities and performance. In addition to its own marketing and outreach effort, the Department also contracts with the New York Health Planning Association, which is an association of managed care providers, to manage an outreach campaign to encourage enrollment in Child Health Plus B. The health insurers and facilitated enrollers are also required to provide their own outreach and marketing efforts.

Audit Scope, Objectives and Methodology

We audited the Department's management of Child Health Plus B for the period April 1, 1999 through December 31, 2000. The objectives of our performance audit were to evaluate the adequacy of the Department's management of Child Health Plus B to ensure that it is effectively reaching its target population and that it is enrolling only eligible children. To accomplish these objectives, we reviewed applicable laws, rules, regulations, policies and procedures. In addition, we interviewed Department and advocacy group officials. We also reviewed contracts between the Department, the New York Health Planning Association and health insurers,

and examined other records at the Department. We visited three insurers (Empire Blue Cross Blue Shield, Health Plus, and Fingerlakes Blue Cross Blue Shield) and four facilitated enrollers (Health Plus, Onondaga Child Health Coalition, The Fulton/Montgomery Consortium on Medicaid and Child Health Plus, and The Children's Aid Society) where we interviewed officials and examined selected records.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of the Department that are included within our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to those operations which are included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records, and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are normally prepared on an "exception basis." However, this report recognizes improvements in program operation as well as areas needing improvement.

Response of Department Officials

Draft copies of this report were provided to Department officials for their review and comment. Their comments were considered in preparing this report and are included as Appendix B.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Enrollment

In our prior audit of Child Health Plus B (Report 97-S-10, issued April 27, 1998), we found that if certain changes were not made in program rules and administration, it was unlikely that the Department would be able to use all of the increased Federal funding available to Child Health Plus B. In order to fully utilize such funding, we recommended that the Department pursue certain initiatives to increase enrollment and expand the health care services covered by the program.

During our current audit, we found that the Department has implemented some initiatives we suggested in our previous audit, and has implemented some additional initiatives as required by law. Since legislation passed in 1998 expanded income eligibility to 250 percent of the Federal poverty level and expanded the scope of benefits covered, Child Health Plus B enrollment has increased substantially and health care services covered were expanded, the potential for losing Federal funding has been substantially reduced. We commend Department officials for effectively implementing legislative changes.

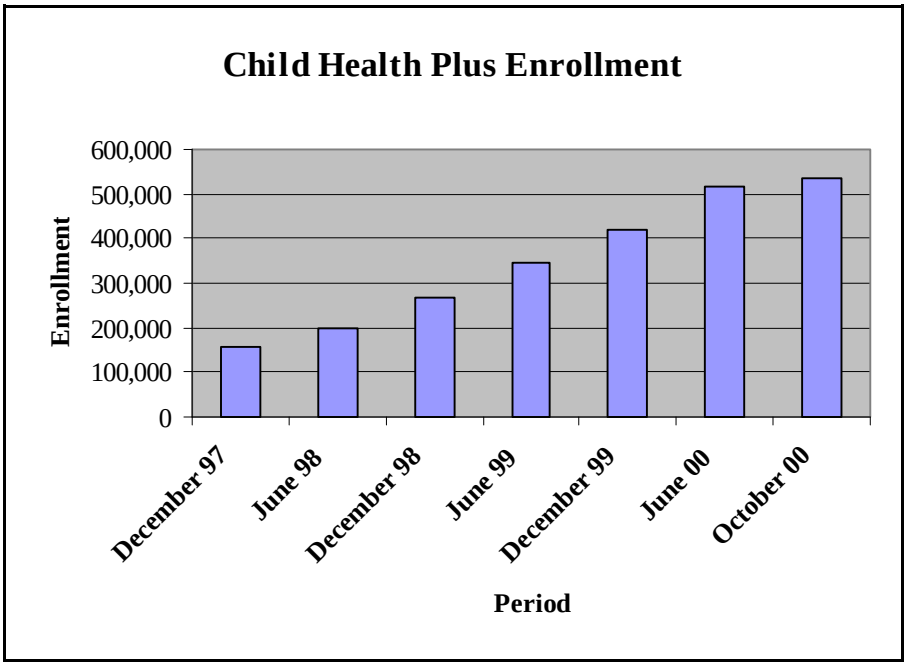
During our previous audit we found that the total State and Federal funding for Child Health Plus B could be well over $400 million a year by 2000, more than four times the amount available in 1997. At that time, according to Department data for November 1997, only 37 percent of the children eligible for subsidized premiums (153,000 of 413,000) were enrolled in Child Health Plus B. We concluded that the Department had yet to make use of available program funding, mainly because of low enrollments. Such low enrollment could be attributed in part to potential enrollee confusion as to their eligibility. However, the Department has since implemented a number of new initiatives that have increased enrollment into Child Health Plus B.

In the past, to become aware of the steps necessary to enroll in Child Health Plus B, most applicants would have to visit a local social services district or one of the Department's contracted health insurers. Additionally, a family could mail an application to a health plan to enroll in Child Health Plus B. The health insurers were responsible for evaluating whether applicants were eligible for Child Health Plus B on the basis of reliable documentation as defined by the Department and made available by the applicants. However, in most cases the applicants would have had to apply during the health insurers' normal business hours. In addition, because applicants come from diverse ethnic backgrounds, the insurers would sometimes experience difficulty

in communicating with these applicants in their own language. The Department also lacked a single application for applicants to enroll in Child Health Plus B. Rather, the contracted health insurers developed their own applications, which were unique to their plan.

In 1998, State legislation was passed that required the Department to make Child Health Plus B available through community-based organizations. For example, enrollment is now offered in the communities where potential applicants live, work and play through such facilities as schools, day care centers, libraries, clinics and community centers. In June 2000, the Department implemented a new program known as facilitated enrollment to help increase the number of children correctly enrolled in Child Health Plus B. The Department contracts with facilitated enrollers, who are culturally and linguistically appropriate individuals who work directly at the community-based organizations. Department officials indicate that facilitated enrollment services are available in 38 languages in the State. While health insurers make the actual eligibility enrollment decisions, facilitated enrollers reach out and assist in enrolling children and in determining a child's eligibility. Facilitated enrollers are available to applicants during non-traditional hours, such as nights and weekends, to assist in completing the application, to screen applicants for appropriate eligibility for Child Health Plus A or B, and to assist the family in collecting the documentation required for determining eligibility. In addition, as of September 2000, the Department requires the use of a single application by all insurers. The application has been simplified and includes a Health Insurance Eligibility Worksheet that is used to facilitate the calculation of applicant eligibility.

Department officials report that enrollment has increased from approximately 153,000 in November 1997 to more than 530,000 as of October 2000 (an increase of 250 percent), as shown in the following chart.



In our prior audit, we also recommended that the Department consider expanding the health care services covered by Child Health Plus B and subsidizing the premiums of families with higher income levels. After our field work was completed for our prior audit, the Governor proposed expanding the scope of services covered. However, the Governor's initial proposal did not fully utilize the newly-available Federal funding. At the urging of the State Comptroller and others, the Governor agreed to also extend eligibility for subsidized premiums to higher income levels. Child Health Plus B now includes services such as: inpatient mental health, alcohol and substance abuse services; dental, vision and hearing care; prescription and non-prescription drugs; and durable medical equipment.
Eligibility for subsidized insurance premiums has been increased from 222 percent to 250 percent of the Federal poverty level.

The initiatives that the Department has taken in response to our prior audit, as well as other legislative changes, have increased enrollment and expanded the health care services covered by Child Health Plus B, which, in turn, have helped preserve Federal funding for this program in addition to expanding health care services to the State's children. However, the legislative changes concerning expanded health care services and subsidizing the premiums of families with higher income levels expire on March 31, 2001, unless they are extended by the Legislature. We believe these changes should be extended. (Subsequent to the completion of our field work, the Legislature extended their provisions for an additional 90 days.)

Determining Applicant Eligibility

To be eligible for Child Health Plus B benefits, a child must be under 19 years of age, a resident of New York State, ineligible for Child Health Plus A, and have no equivalent insurance. To be eligible for State subsidized premiums, those children who meet the eligibility criteria must also live in a household with a net income at or below 250 percent of the Federal poverty level.

In our prior audit, we reported that about 41 percent of the children enrolled in Child Health Plus B as of November 1997 (63,000 of 153,000) could potentially be eligible for Child Health Plus A. If Child Health Plus A eligible children are incorrectly enrolled in Child Health Plus B, the Federal funds used to subsidize insurance premiums for these children could be recovered by the Federal government. In our prior audit, we reported that about $35 million in Federal funding used to subsidize the insurance premiums of the 63,000 children might be recovered by the Federal government, and that any funds recovered by the Federal government would likely be replaced by State funds. We therefore recommended that the Department develop procedures that would prevent the enrollment of Child Health Plus A eligible children into Child Health Plus B. At the time of our prior audit, the Department had recently assumed full responsibility for Child Health Plus A. Therefore, we stated Department officials needed to take care to ensure that a seamless process exists to enroll children into the correct program – either Child Health Plus A or B – at the point of contact when they initially apply. We also noted in the prior report that if an applicant's eligibility for insurance premium subsidies is to be accurately determined, the applicant's household income must be accurately determined. We noted the need for the Department to develop clear and specific guidelines for determining the applicants' household income.

Our current audit found that the Department has made progress in implementing our prior recommendations and therefore has improved the applicant eligibility process. Current Department estimates indicate that between 20 and 24 percent of the Child Health Plus B's enrollees (or between 105,000 and 130,000) may be eligible for Child Health Plus A, a rate that is about half of what we reported in the prior audit. The Department has undertaken a number of new initiatives that have helped to reduce this rate. To help ensure that children enroll in the correct program, a new joint application, called the Growing Up Healthy application, was implemented as of September 2000. The new application is a simplified single enrollment form for Child Health Plus B, Child Health Plus A, and the Special Supplemental Food Program for Women, Infants and Children. This single application has provided the Department with a seamless process to ensure that children are

enrolled in the correct program at the point of contact. Additionally, the Department implemented facilitated enrollment to help increase the number of children who successfully enroll and renew for Child Health Plus B and Child Health Plus A.

As part of the enrollment and renewal process, health insurers and facilitated enrollers process applications by completing the Health Insurance Eligibility Worksheet (worksheet). The worksheet is a step-by-step form used to calculate income figures for determining which program an applicant is eligible for based on information taken from completed applications and supplemental supporting documentation. The worksheets are also used to determine the premium enrollees should pay.

We evaluated the effectiveness of the Department's new initiatives by reviewing 150 randomly selected applications, comprised of 51 new enrollments and 99 renewals, at three judgmentally selected health insurers, whose eligibility began during October 2000 (the second month of implementation of the new application process). The total number of new enrollment and renewal applications processed in October 2000 by these three health insurers was 14,919. As of August 2000, enrollment at the three health insurance plans we visited accounted for approximately one third of the total enrollment in Child Health Plus B.

For each application, we reviewed the application itself, supporting documentation and the completed worksheet. Overall, we concluded that the new Growing Up Healthy application is being used and that health insurers and facilitated enrollers are generally correctly enrolling applicants into either Child Health Plus B or Child Health Plus A. Of the 150 applications reviewed, 144 contained a correct program eligibility determination. However, we identified six cases in which errors made in the worksheet income calculations led to incorrect eligibility determinations. In five of the six cases, applicants were enrolled in Child Health Plus B, rather than Child Health Plus A. In the other case, the child was eligible for Child Health Plus B but was incorrectly referred to Child Health Plus A. In our judgment, this four percent error rate may be attributable to the relative newness of this process.

Department officials have stated their belief that the new Growing Up Healthy application process, the use of facilitated enrollers, and the use of the new worksheet will continue to ensure all new and renewal applicants are enrolled in the correct program. Further Department officials have made it known that they intend to move over 100,000 current Child Health Plus B enrollees to Child Health Plus A, where they should be enrolled, within the next year.

We also identified other errors on the worksheets and/or applications that did not affect the determination of eligibility. For example, we identified four applications where Child Health Plus B children were charged an incorrect insurance premium. In addition, we noted errors on worksheets used to determine eligibility for 43 other applications we reviewed. Although these errors did not affect eligibility determinations, Department officials need to reinforce some of the application review processes to ensure such errors are kept to a minimum and do not adversely impact eligibility determinations.

We discussed with health insurer and facilitated enroller staff the reasons for the errors in the worksheet income calculations. The errors generally related to how inclusions and deductions to income were handled. We determined that the Department did not have an updated policy on one particular issue and the available guidance on a second issue was not clear. For example, the Department's Advisory Memorandum that provides instructions for transferring income from a Federal 1040 tax form to the worksheet is not up-to-date on matters relating to depreciation for self-employed persons. In addition, applicants may deduct health insurance premiums from income in certain instances. However, the worksheet instructions do not provide adequate guidance on this issue, and the Department does not have a comprehensive policy that addresses the various aspects of this issue. Department officials told us they will be issuing clarifying policy on this matter to health insurers and facilitated enrollers. We also found that the worksheet does not indicate that all income, before taxes, listed in Section D of an application is to be included on the worksheet. These are among the types of issues that the Department needs to address to limit errors in income calculations on worksheets.

Further, although the Department has held training sessions on how to properly complete the worksheet, one health insurer informed us that the sessions were inadequate and overcrowded. Department officials state they are preparing a Request For Proposal for a new training contract. Department officials also stated they have provided training upon individual requests and, to the extent possible, will continue to do so. Additionally, informational meetings are held every six months that health insurers and facilitated enrollers can take part in.

We recognize that it will take time for the Department, health insurers and facilitated enrollers to resolve various issues that arise when implementing these new initiatives. One way to address such issues is to identify best practices. For example, we identified a best practice at one health insurer we visited. To assist in supervisory review of a program application, the health insurer uses an automated system to verify that the correct eligibility determination was made. The system rechecks the income level calculation

and other eligibility criteria, such as citizenship status. When we brought this matter to the Department's attention, Department officials indicated they are in the process of developing an automated version of the worksheet.

Recommendations

1. Continue efforts to ensure that children are enrolled in the correct program.

2. Enhance training and clarify policies in areas of enrollment that are of particular difficulty, especially in calculating worksheet income.

3. Modify the worksheet, where appropriate, to facilitate the correct calculation of income. Implement the use of automated systems to review case information to ensure accurate eligibility determinations are made.

Program Outreach and Marketing

According to a publication released by the Children's Defense Fund, a well-known children's advocacy group, three out of five parents nationwide whose children lack health insurance do not know that health insurance coverage is available through Child Health Plus B or Child Health Plus A. Since a primary goal of Child Health Plus B is to reduce the number of uninsured children in the State, enrollment must continue to increase, especially in under-represented, hard-to-reach populations. To accomplish this objective, the Department must have well-planned and coordinated outreach and marketing efforts throughout the State. The Department contracts with the New York Health Planning Association, which is an association of managed care providers, to carry out the Department's marketing and outreach efforts. In addition, participating health insurers are required to annually submit marketing plans to the Department and are expected to fulfill the requirements of the submitted plans within the period of one year. Facilitated enrollers also play a key role in increasing enrollment through their own marketing and outreach in community settings.

In our prior audit, we recommended ways for the Department to strengthen outreach and marketing efforts. However, our current audit determined that some improvements are still needed.

Each health insurer participating in Child Health Plus B is required to submit a detailed plan to the Department that identifies marketing and outreach activities for the upcoming year. We examined the year 2000 marketing plans of four health insurers. We found that two of the plans were very general, while two were more detailed. For instance, one health insurer's 16-page marketing plan highlighted all marketing and outreach activities to take place during the year. The marketing plan further provided specifics about marketing goals, efforts and plans to reach under-represented populations. In contrast, the two-page marketing plan submitted by a different health insurer contained a one page general explanation of its marketing activities and a second page of non-marketing related enrollment requirements. We question the usefulness of plans that are very general.

In addition, we found that coordination and feedback in marketing and outreach between health insurers, facilitated enrollers and the Department are not consistent and need improvement. One health insurer and one facilitated enroller that we reviewed indicated that coordination of marketing and outreach information could be improved. For example, officials from one health insurer indicated that the Department rarely informs them of marketing and outreach activities that will be performed in their area. Department officials stated their belief that the State, the health insurance

plans and facilitated enrollers market different things, and therefore disagree that there is a lack of coordination. However, in our judgment, all three parties market the same program with the intent to enroll children and the tools used to do this can be shared and coordinated.

For example, we determined that marketing and outreach efforts are duplicated among health insurers and facilitated enrollers. Health insurers create their own brochures, pamphlets, posters and other marketing and outreach materials in many languages, as do facilitated enrollers. Health insurers and facilitated enrollers individually translate advertising materials into the languages of the populations served. If the marketing and outreach material that is already individually created by some facilitated enrollers and health insurers were centrally gathered and coordinated by the Department and shared among contractors, then duplication of such activities could be minimized, and these groups would have the ability to use their limited resources in more efficient ways.

Department officials indicate that they have attempted to work with health insurers and facilitated enrollers to share marketing and translated materials. However, officials state that health insurers are not eager to share marketing materials due to the competitive nature of the marketplace. In addition, Department officials stated that facilitated enrollers are interested in having their own marketing materials that are unique to their organization. However, we believe the Department has a responsibility to monitor and guide the activities of organizations they contract with.

We also found the Department has not evaluated the effectiveness of marketing and outreach efforts in reaching all targeted groups, especially harder to reach under-represented populations. Department officials explained that Child Health Plus B has been changing and they have not had time to do such an evaluation. We requested a portfolio of the demographics that comprise the target populations of those who need to be reached in order to evaluate whether the Department is reaching these target groups. Department officials stated this information is not available because they leave determinations of who needs to be reached up to health insurance plans and facilitated enrollers. However, without this information, the Department is unable to evaluate the effectiveness of marketing and outreach efforts in reaching targeted, harder-to-reach and under-represented populations.

Recommendations

4. Strengthen the outreach and marketing process by requiring more detailed marketing plans from health insurers and by coordinating and providing guidance on the marketing and outreach activities of health insurers and facilitated enrollers.

5. Evaluate the effectiveness of the marketing and outreach efforts in reaching targeted groups, especially harder to reach under-represented populations.

Major Contributors to This Report

Kevin McClune
Howard Feigenbaum
Larry Wagner
Andrea Inman
Todd Seeberger
Brian Krawiecki
Timothy Marten
Paul Bachman

Appendix A

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Dennis P. Whalen
Executive Deputy Commissioner

April 18, 2001

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2000-S-28, entitled "Management of Child Health Plus B".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix B

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2000-S-28 Entitled
"Management of Child Health Plus B"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2000-S-28 entitled "Management of Child Health Plus B".

Governor Pataki has made Child Health Plus a top priority of his administration. As a result, in the last six years Child Health Plus has grown by leaps and bounds to bring comprehensive health care coverage to more than 530,000 children in New York. Under the Governor's leadership, Child Health Plus has not only increased enrollment by more than 600 percent, but has increased benefits to include coverage for:

- Dental
- Durable Medical Equipment
- Hospitalization
- Mental Health Services
- Vision

Today, New York boasts the best and largest child health insurance program in the nation. It is through this Governor's commitment and leadership that we have been able to make Child Health Plus bigger and better and a program that is a national model for comprehensive health care coverage for our most vulnerable citizens. New York's program, and its recent expansion, is the result of the leadership of Governor Pataki and his administration's collaboration with children's advocacy organizations and health plans, rather than previous audits issued by the Comptroller's office.

The Department of Health is pleased that the most recent OSC report "Management of Child Health Plus B" recognized the efforts the Department has made to increase enrollment in children's health insurance and to expand benefits and eligibility in Child Health Plus B (CHPlusB). The report also recognizes the successful initiatives the Department has undertaken to better align CHPlusA and CHPlusB to ensure that children are enrolled in the appropriate program.

The Department's comments on the OSC report are organized into the following categories:

- Program Financing
- Enrollment
- Determining Applicant Eligibility
- Program Outreach and Marketing

1. Program Financing

New York has spent all of its federal allotments for 1998 and 1999 and most of its 2000 allotment. The OSC reports that New York can expect to receive about $400 million in additional federal funding in 2001 from the redistribution of unused 1998 allotments from other states and an additional $305 million in 2002. New York will receive $435 million in 2001 in additional federal allotments from the redistribution of 1998 allotments; however, it is too early to know how much, if any, the state can expect to receive next year.

The amount that will be redistributed to New York State from federal fiscal year (FFY) 1999 allotments cannot be well established because it depends on how much other states spend of their allotments by September 30, 2001. It is reasonable to expect other states to spend more of their FFY 1999 allotments for two reasons: 1) states are enrolling children at increasing rates and 2) states have extended coverage to other populations (e.g., parents). This increased spending should leave less unused funds to be redistributed next year.

Another factor also urges caution in counting on additional federal funding beyond the $435 million for this year. State estimates of S-CHIP spending suggest that the number of states qualifying for a redistribution may double this year, and their aggregate claims for redistribution may exceed the unspent FFY99 funds. Since the law makes no provision for this possibility, it appears that Congress would need to enact a technical amendment. That could re-open debate over the redistribution procedure and perhaps renew last year's efforts to divert some or all unspent S-CHIP funds to other purposes. In light of this uncertainty, no state can be assured of redistribution from unspent FFY99 allotments.

2. Enrollment

The OSC report demonstrates a misunderstanding of the enrollment process under CHPlusB. In the past, as currently, a family could mail an application to a health plan to enroll in CHPlusB. The family did not have to visit a local social services district or a health plan as stated on page 5 of the report. CHPlusB has no face-to-face interview requirement. While it is true that each health plan had its own application, these applications were standardized based on questions provided by the Department. In addition, health plans that serve large populations of families that do not speak English have their materials and correspondence translated into those languages. The Department also plans to employ staff that speak these languages.

* Note 1

The Department disagrees with the OSC report conclusion that facilitated enrollment and the single application is responsible for the increase in enrollment in CHPlusB. The surge in enrollment in CHPlusB is the result of successful marketing and outreach activities by the Department and health plans. The greatest increase in enrollment, as the chart on page 7 of the report shows, occurred prior to the implementation of facilitated enrollment.

* Note 2

The initiatives described on page 6 of the report - facilitated enrollment and a single application - were designed as a means for ensuring that children were enrolled in the correct program. They were also designed to simplify and increase enrollment into CHPlusA more than CHPlusB. Both efforts have been very successful.

* Note 2

3. Determining Applicant Eligibility

The Department is pleased with the OSC report finding of a 4 percent error rate in eligibility determination for CHPlusB. Given that the audit was conducted during the early implementation of the new application and new eligibility rules, a 4 percent error rate demonstrates that the Department is enrolling children into the correct program. We would expect even fewer errors as health plans gain more experience with the new rules.

The OSC audit occurred during the first few months of an effort to ensure that children were enrolled in the correct program. By aligning rules in CHPlus A and CHPlus B, at renewal some children may need to transfer to CHPlus A from CHPlus B and vice versa. At that time, the Department explained how difficult it was to estimate children who may be eligible for Medicaid because the rules for eligibility for both programs had changed. Our estimate of 105,000-130,000 children was based on information from applicants over a year ago and using old eligibility rules. It was also a number as of October 2000. Given that we have now passed the sixth month of this process, the number should be half as much today.

The Department's response to the specific recommendations in this section of the report are provided below:

Recommendation #1:

Continue efforts to ensure that children are enrolled in the correct program.

Response #1:

The OSC report confirms that the activities the Department has undertaken to ensure that children are enrolled in the correct program are working. The Department conducts audits of health plans to ensure that they are complying with program rules and that children are enrolled in the correct program. The Department will continue these efforts, including the use of the single application and eligibility worksheet.

Recommendation #2:

Enhance training and clarify policies in areas of enrollment that are of particular difficulty, especially in calculating worksheet income.

Response #2:

The Department continues to provide training to health plans and facilitated enrollees on an as-needed basis. In the next few months, we will issue a Request for Proposals to hire trainers that will be able to provide ongoing support to health plans and facilitated enrollers.

The Department recently issued a revised Manual describing enrollment and eligibility determination rules for CHPlusA and CHPlusB. The new manual clarifies policies in enrollment and in determining income, especially for the self-employed. To further convey policy changes, the Department has issued several new ADMs clarifying eligibility policies and will be issuing additional ADMs. The Department holds five meetings per year with the CHPlus Insurer Operations Workgroup and three meetings per year with all insurers to clarify program rules and discuss recommendations for changes.

Recommendation #3:

Modify the worksheet, where appropriate, to facilitate the correct calculation of income. Implement the use of automated systems to review case information to ensure accurate eligibility determinations are made.

Response #3:

As part of the new Manual, the Department has modified the eligibility worksheet to better facilitate the correct calculation of income. The new worksheet specifies the treatment of depreciation for the self-employed. We will continue to review and modify the worksheet to further ensure accurate eligibility determinations.

The Department has also developed an automated eligibility worksheet. The automated worksheet is currently being beta-tested at a facilitated enrollment lead agency. The Department plans to implement the use of the automated system after the beta-test.

4. Program Outreach and Marketing

Marketing and outreach for CHPlusB is conducted by the Department which plans and facilitates enrollees as well as through the Department's contract with the Health Plan Association. The Department's own Public Affairs Group (PAG) markets the CHPlusB program. PAG develops marketing materials as well as radio and television advertisements. The Department's response to the specific recommendations are as follows:

Recommendation #4:

Strengthen the outreach and marketing process by requiring more detailed marketing plans from health insurers and by coordinating and providing guidance on the marketing and outreach activities of health insurers and facilitated enrollers.

Response #4:

To obtain consistent information about marketing efforts of Child Health Plus health plans, the Department has drafted an ADM which includes guidance on the types of information that should be included in the annual marketing plan. In the future, marketing plans will include information about the methods of distributing marketing materials, primary marketing locations and a listing of the kinds of community events the health plan anticipates sponsoring and/or participating in during the year. This marketing plan would also include information on the cultural and linguistic characteristics of communities where the marketing efforts are taking place. This guidance will be issued shortly and will be effective with the 2002 submission. The Department will also be requiring health plans to submit information on the outcomes of the marketing activities they undertake to determine what methods are most effective. Successful marketing strategies will be shared with all health plans and facilitated enrollers.

Recommendation #5:

Evaluate the effectiveness of the marketing and outreach efforts in reaching targeted groups, especially harder to reach under-represented populations.

Response #5:

The Department collects information from our marketing contractor of which types of marketing activities are most successful. Television and radio advertisements along with "word-of-mouth", are the most successful methods of reaching the target population.

The Department does not collect information on race/ethnicity, and therefore does not know the effectiveness of marketing and outreach efforts on specific ethnic groups. Race is an optional question on the Growing Up Healthy application for the applicant. Applicants generally do not want to answer the question. As a result, most information on race is reported as "unknown." Thus, requiring the reporting of the answers to the question on race would not provide an accurate portrait of the demographics of the CHPlusB population. The Department will explore ways of obtaining information on how well we are reaching different racial/ethnic groups and which marketing activities are successful in enrolling specific groups.

Conversations with facilitated enrollers confirm that the program is reaching hard-to-reach populations. Facilitated enrollers speak 38 different languages and are enrolling large numbers of non-English speaking families.

State Comptroller's Notes

1. We modified our report to indicate that a family could mail an application to a health plan to enroll in Child Health Plus B. It should be noted that we did not state in our report that Child Health Plus B has a face-to-face interview requirement.

2. We modified our report accordingly.