Disaster Relief Medicaid Evaluation Project

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Background

New York State's principal health insurance programs for low-income residents—Medicaid, Family Health Plus and Child Health Plus—provide a comprehensive range of services to individuals and families who might not otherwise be able to afford health care. Eligibility is based on financial and other criteria.

In the immediate aftermath of the September 11, 2001 World Trade Center disaster, access to these needs-based programs was a serious concern. The infrastructure-supported communication with Medicaid computer systems suffered severe damage. Public transportation was disrupted. Information necessary to establish eligibility was not readily available. Faced with the likelihood of increased health care needs, and the inability to conduct business as usual, Governor Pataki's office and the New York State Department of Health collaborated with the federal government and the New York City Human Resources Administration (HRA) in the hours and days after the attacks to create a new, time-limited program called Disaster Relief Medicaid/Family Health Plus (DRM).

DRM had several unique features:

- The program used a simplified, one-page application.
- Applicants could attest to the information on their application, including income.

- Eligibility generally was determined, and a Medicaid authorization form issued, on the spot. Applicants were presumed eligible if their income met the standards for Medicaid or Family Health Plus.
- Participants received four months of coverage through traditional Medicaid providers.
- At the end of the four months, participants could transition to regular Medicaid or Family Health Plus without a gap in coverage.
- The coverage of existing Medicaid enrollees was renewed automatically.

The DRM program was unprecedented, and so was enrollment. Thousands of New Yorkers signed up between September 2001 and January 2002. Thus DRM became an unintentional laboratory for examining the consequences of a radically simplified approach to government-funded health care.

Organization of the Study

This study is a retrospective evaluation of the enrollment processes and service delivery associated with DRM. It examines this unexpected experiment and assesses the outcomes.

This report begins with an overview of the Medicaid/Family Health Plus program in September 2001, and is followed by a description of the challenges of, and responses to, the World Trade Center disaster. It then looks at how well the DRM process worked, how acces-

sible needed services were for recipients, how costs compared to costs associated with those previously enrolled in the traditional Medicaid program, and how the different eligibility/verification procedures affected program integrity. Finally, in the section "Background Information: Detailed History of Disaster Relief Medicaid," it presents a narrative timeline, detailing the decision steps by which DRM was implemented.

A team of experts in process evaluation, analysis and focus group/interview research and design was assembled from Cornell University, the University at Albany, human services practitioners, and the private sector. The team:

- Analyzed all of the information provided by the New York State Department of Health, Office of Medicaid Management (OMM), and the New York State Office of Temporary and Disability Assistance (OTDA) with regard to demographics, cost, utilization, fraud, and process.
- Conducted interviews with the authors of those reports and OMM and OTDA management to obtain additional relevant information.
- Conducted announced and unannounced site visits to eight New York City Medical Assistance Program (HRA/MAP) offices to observe work processes, workflow, accessibility, and office conditions. We were particularly interested in examining how the enhancements ("model offices") made by HRA/MAP after DRM actually affected service delivery.
- Interviewed over 200 OMM and HRA/MAP staff and members of the New York State health advocacy community to obtain their perspectives on pre-DRM Medicaid, DRM, Transitional Medicaid for former DRM recipients, and the current Medicaid/Family Health Plus programs.
- Conducted focus groups and phone call

interviews with over 275 former DRM recipients to discuss their experiences with pre-DRM Medicaid, DRM, Transitional Medicaid, and the current Medicaid/Family Health Plus programs.
- Reviewed publications and research (including focus groups and surveys conducted with DRM recipients) from the New York State health advocacy community regarding eligibility and access issues associated with health coverage for low-income New Yorkers (see Appendix H for listing of publications). We have also relied upon verbal and written information shared by recipients, HRA, New York State agency managers, staff, and advocates. Certain themes emerged and may provide some additional insight into what happened during this time.

Key Findings

Unanticipated Demand
and Program Responsiveness

- The high number of enrollees in Disaster Relief Medicaid (342,362 New Yorkers) was unanticipated and the result of a variety of factors:

  · The use of higher income eligibility levels of Family Health Plus, which were the standards used in the DRM program;

  · A recent court ruling that allowed many previously ineligible immigrants access to Medicaid;

  · Many community-organized initiatives that publicized the program, including a $1 million advertising campaign by the United Hospital Fund; and

  · Modifications to the enrollment process that led to quicker and simpler access.

- Despite the unanticipated demand, the Disaster Relief Medicaid program was responsive to the health care needs of low-income

New Yorkers and those affected by the events of September 11.

- · The DRM program began enrolling applicants within two weeks of the September 11 tragedy.
- · Applicants typically received immediate authorization for medical coverage.
- · Many MAP/HRA and DOH/OMM staff worked very long hours for months under difficult conditions to implement DRM and maintain ongoing programs.

- Providers reported discovering a number of early cancers, early-onset heart disease, and previously undetected diseases such as diabetes, asthma, and HIV among DRM recipients.

Demographic Profile of
DRM Enrollees and Subsequent Enrollment

- The surveys, focus groups, and interviews conducted by the advocacy community and Cornell University found a very diverse population enrolled in DRM, reflecting the diversity of New York City. (Data on the diversity of recipients was not collected by the DRM application process.)

- About 44 percent of the DRM population moved to regular Medicaid or Family Health Plus through the transition process, which involved making a full application for these health insurance programs. More than one-fourth of those who made the transition were found eligible for Family Health Plus. Most of the DRM recipients who did not complete the transition process had their cases closed because they failed to follow through with an application. A smaller number applied but did not meet the eligibility requirements.

- About 18 percent of DRM enrollees had previously been enrolled in the Medicaid program at some point.

Cost and Utilization Analysis

- DRM expenditures totaled approximately $670 million. The top four categories of expenditure by type of service were: (1) Inpatient ($194 million); (2) Outpatient ($166 million); (3) Dental ($125 million); and (4) Pharmacy ($121 million).

- Generally, utilization of Medicaid services by DRM enrollees was consistent with the regular Medicaid population. Exceptions were Dental ($125 million), Laboratory ($4 million), and Eye Care Services ($5.8 million), which were utilized at higher rates; and Inpatient Services ($194 million), which were utilized at a lower rate. After controlling for Inpatient Services, DRM enrollees and control groups of regular Medicaid enrollees had similar Per Member Per Month (PMPM) costs.

Program Integrity

- The NYS Department of Health monitored and evaluated the integrity of the DRM program by checking for multiple identification numbers associated with individual recipients and by investigating high volumes of claims from individual providers. Suspicious activity for dental providers appears to have been much greater than for the other providers.

- At the request of the Department of Health, the NYS Office of Temporary and Disability Assistance (OTDA) completed an independent verification of information declared by recipients on the DRM application to determine whether the simplified requirements had an impact on program integrity. A random sample of 500 cases was selected. Where possible, OTDA obtained documentation of income and other information. In those cases where documentation was avail-

able, OTDA determined that 105 cases (21 percent) were ineligible for DRM assistance, and 198 (39.6 percent) were eligible. Eligibility for the remainder of cases could not be determined.

- OTDA also evaluated eligibility decision-making by MAP staff. OTDA concluded, based solely on the information available to them on the application, that MAP workers correctly determined eligibility for 446 (89.2 percent) of the 500 reviewed applicants. There were 30 cases (6 percent) where the DRM eligibility decisions were incorrect. An additional 24 cases (4.8 percent) were unable to be evaluated by OTDA because of missing information.

- Additionally, OTDA reviewed a random sample of 250 DRM denials and 165 Transitional Medicaid cases from a total of 8,275 case files. They found 195 DRM denials (78 percent) had sufficient documentation to support the decision. Nineteen cases (7.6 percent) were found to be invalid, most because the denial notice was not in the case record maintained by MAP's Fair Hearing Division. MAP staff misapplied eligibility requirements in three cases. OTDA was unable to make a determination for 36 denials (14.4 percent) primarily because of inconsistencies between what applicants recorded on the application and what the MAP worker used on the budget worksheet.

- In interviews, some MAP and OMM staff expressed the belief that the sheer volume of applications processed by MAP staff daily and the long hours worked by staff at a fast pace contributed to the agency's error rate.

Program Observations

- The interviews and focus groups that have been conducted with DRM recipients and MAP staff have highlighted the complexity of New York State public health programs.

- The time taken to determine eligibility and then enroll clients (particularly in Family Health Plus) was a source of frustration for some former DRM recipients. The recertification process also often resulted in confusion and "Medicaid churning" of recipients' cases. There have been recent improvements, including New York City's Model Office organization, that are intended to help eligible individuals obtain and retain Medicaid.

- The interviews and focus groups confirmed that, for some people, the life circumstances that create the need for Medicaid often prevent people from obtaining the documentation required to prove eligibility.

Policy Implications

- The move to income attestation, rather than income documentation, during DRM appears to have led to enrollment errors that were much higher than usual.

    Interviews with workers and clients and the audit conducted by OTDA all suggest that significant numbers of people who applied for DRM were not truthful about their income levels. This does not mean that many of them did not need health care or that they earned enough to purchase health insurance. They earned more than they should earn to qualify for DRM. (Workers often related stories of rejecting applicants who told the truth who were slightly over the allowed eligibility levels while accepting applications from people they believed were not being truthful.)

While the idea of presumptive eligibility and reliance on after-the-fact auditing may sound like an effective argument to counter delays in processing time for those who need health coverage, DRM demonstrates how the high demand for services combined with such relaxed eligibility requirements could lead to significantly increased program expenses and significant strain on fraud detection and retroactive recovery of overpayment initiatives. Relying on income attestation would also not solve the problem of providing health coverage for those uninsured individuals who report income honestly and are just above the income limits.

It appears that efforts to increase access in New York would be better spent by continuing work on publicizing the programs, providing assistance to those confused by the complexity of the programs, working to reduce the complexity through federal and state statutory simplification, continuing to work on improving the processes and hand-offs and upgrading computer systems.

- In the event of another similar disaster, the role of the Medicaid program needs to be evaluated with the lessons learned from DRM in mind.

Public officials, in creating DRM, compassionately responded to the health care needs of New Yorkers in a time of terrible tragedy and uncertainty. They did not anticipate the program would end up addressing the pent-up demand for health care services that was demonstrated by so many New Yorkers. DRM provided a very valuable service for many with serious health care needs that were not being addressed. It also provided an opportunity for many people to access needed preventive services, including dental and pharmaceutical needs.

At the same time, DRM placed a tremendous strain on the government agencies involved and resulted in enrollment errors. Access to health care services, particularly for people without insurance, is a very serious issue. That said, it must be recognized that Medicaid recipients are not unique in a disaster. Emergency health care for those who need it should be coordinated and funded by the federal government under its emergency management protocols. This would also shield public health programs from criticism that times of disaster result in significant violations of program integrity.

Introduction

Medicaid, Family Health Plus and Child Health Plus in 2001

Medicaid is a federal, State and, in New York, locally funded program for people who meet certain income, resource, age, or disability requirements. In 2001, the income standards for Medicaid generally ranged from about half the federal poverty level (FPL) for a single individual to 200 percent FPL for a pregnant woman or an infant under the age of one year. Children ages one through five were eligible with family incomes up to 133 percent FPL; older children were eligible with family incomes up to 100 percent FPL.

Medicaid provides a full health care benefit package. A partial list of services includes: hospital inpatient and outpatient services; treatment and preventive care by doctors and dentists; medicines; laboratory and x-ray services; medical supplies and durable medical equipment; clinic services; long-term care, including nursing home, home health agency, and personal care services; treatment for mental health needs and chemical dependency; and early periodic screening, diagnosis and treatment for children under age 21.

Family Health Plus (FHPlus) was created to provide health coverage for uninsured adults ages 19-64 whose incomes are too high to qualify for Medicaid. For single individuals and childless couples, the FHPlus income limit is 100 percent FPL; for parents it was 133 percent FPL in 2001. Family Health Plus is a comprehensive managed care program that resembles employer-based plans. It covers the majority of services provided by Medicaid; however, long-term care is excluded, and there are some limits on behavioral health and chemical dependence services.

Another health care program for New Yorkers is Child Health Plus. It has two parts: Child Health Plus A, which is children's Medicaid, and Child Health Plus B, a comprehensive stand-alone program operated through participating managed care plans. Children who are uninsured and do not qualify for Medicaid may enroll in Child Health Plus B. Premiums are subsidized for families with incomes below 250 percent FPL.

As of September 2001, Medicaid covered approximately 2.85 million recipients, of whom 1.86 million were in New York City. Additionally, Child Health Plus B covered approximately half a million children statewide. The State Department of Heath, through local departments of social services, began accepting applications for Family Health Plus on September 1, 2001; enrollment in FHPlus managed care plans was to begin October 1, 2001.

Aftermath of September 11

New York State policy makers and elected officials faced tremendous challenges after the September 11, 2001, terrorist attacks. Chief among these was how to help ensure the

health and safety of New York City residents. During a traumatic time of great uncertainty, a variety of critical health-related issues were addressed including:

- Providing additional assistance to New York City with inspections of food, water, and air in the affected areas.

- Taking steps to ensure that prescription drugs were available and properly distributed to NYC residents.

- Working with the federal government to secure approval of measures designed to ensure access to health care for low-income New Yorkers after the tragedy.

- Accelerating $60 million in payments to New York City hospitals.

The effort to ensure access to health coverage for New Yorkers in need was significantly complicated by several factors. Many New Yorkers were displaced from their homes and jobs. Telecommunications as well as transportation were severely disrupted, limiting the ability to obtain personal documents and information needed to establish eligibility for needs-based programs. There was extensive loss of power and telephone lines that provided access to the computer system used to manage the New York City Medicaid program. This system, the Welfare Management System (WMS), is the client eligibility database. It was also critical in rolling out the new, expanded health program for uninsured adults that had been scheduled to begin in New York City in Fall 2001, Family Health Plus. With access interrupted, WMS could not be used to reliably determine eligibility,

Working with the federal government, Governor Pataki's Office and the New York State Department of Health (DOH) quickly created a new time-limited program, Disaster Relief Medicaid/Family Health Plus (DRM), to help meet the health care needs of low-income New Yorkers after the tragic events of September 11. Through a federal waiver, DRM became a demonstration project for presumptive eligibility.

DRM offered four months of Medicaid, through traditional fee-for-service providers. There was no managed care. A full array of benefits was provided. Nursing home coverage was excluded from DRM, and was handled separately. It should be noted that, at the time DRM was created, it was uncertain how long the program would exist because of the highly unusual and unpredictable circumstances. Thus, the State proposed the program last for four months. The application was simplified in recognition of the inability to use the normal computer systems, the difficulties people might have in obtaining documents from employers and institutions following the disaster, the short-term nature of the program, and the need to assist affected individuals quickly. Eligibility was determined manually and records transferred to the State Medicaid offices in Albany for computer entry.

U.S. Department of Health and Human Services Secretary Tommy G. Thompson was quoted in a September 19, 2001, press release from the New York State Governor's Office as saying:

> " We are happy to be able to help Governor Pataki and New York provide for those who need health care coverage during this period. These are not normal times and we will not insist on business as usual when it comes to providing coverage for needy New Yorkers. We will continue to make sure the federal government is a partner and not a barrier to Governor Pataki as he innovatively meets the health care needs of his State during this emergency. "

The press release also stated:

"The United States Department of Health and Human Services (HHS) has approved a series of requests by Governor Pataki to expedite emergency health care coverage for New York City residents, including waiving the need to document eligibility factors such as income during the next four months. This will allow the State to provide Medicaid, Child Health Plus and the new Family Health Plus program to new applicants in New York City over the next four months using an expedited program. Applicants will be able to utilize a shortened application, attesting to financial status and other relevant circumstances.

Governor Pataki also announced that the approvals granted today guarantee that New York City residents enrolled in the Child Health Plus and Medicaid programs will not lose coverage due to certification issues. Although these programs generally require participants to renew annually, any participant scheduled to recertify between September 11, 2001 and January 31, 2002, will now have that requirement waived. This will allow them to continue to receive health care coverage for an additional year."

An in-depth look at the critical decisions that needed to be made in creating what became the Disaster Relief Medicaid program and the challenges presented by the necessity of concurrently continuing to administer ongoing programs is presented in the "Background Information: Detailed History of Disaster Relief Medicaid" section of this report.

Implementation

Working with the Medical Assistance Program of New York City's Human Resources Administration, select community-based facilitated enrollment organizations and health plans, the New York City advocacy community and community-based organizations, the New York State Department of Health enrolled 342,362 New Yorkers in the resulting Disaster Relief Medicaid program.

Disaster Relief Medicaid differed from the traditional Medicaid in effect prior to September 11 in the following ways:

Table 1. Difference between Traditional Medicaid and DRM

Traditional Medicaid	DRM
Eight page application	One page application
Documentation necessary to establish eligibility	Proof of identity (social security number)
Lower income eligibility levels	Higher income standards of Family Health Plus
Resource test (limitations on resources like bank accounts	No resource test (none required for Family Health Plus)
Usually 30-90 days to confirm and establish eligibility	Same-day or within five days approval
Immigrant eligibility limited	New immigrant eligibility rules*
Health coverage for one year if no change in circumstances	Health coverage for four months

*Rules for immigrant eligibility changed as a result of the June 2001 court decision *Aliessa v. Novello*. Before *Aliessa*, only citizens and certain limited categories of "qualified" immigrants were potentially eligible for the various Medicaid programs. After *Aliessa*, most low-income immigrants (with the exception of undocumented immigrants and non-immigrants) could qualify for Medicaid or Family Health Plus regardless of when they arrived in this country. The implementation plan for Aliessa was underway in September 2001.

The DRM program began enrolling applicants within two weeks of the September 11 tragedy. In order to connect people quickly with health coverage, key modifications were made to the normal enrollment process. The Office of Medicaid Management (OMM) of the New York State Department of Health developed a one-page application form. (The previous form was eight pages long.) No financial documentation was required because of the chaotic circumstances. Attestation of financial and other relevant eligibility criteria was substituted instead.

DRM eligibility was based on only the following:

- The applicant documenting his or her identity and residence within the City of New York.

- Enumeration of, or application for, a social security number for all applicants.

- Attestation of income at or below either the Medicaid or Family Health Plus income standards.

DRM used the Family Health Plus income standards for most adults. The standard for pregnant women was the same as for Medicaid because it is higher than the Family Health Plus levels. For children, the Medicaid and DRM standards were the same. However, as part of the federal waiver, most children were enrolled temporarily in Child Health Plus B, which has higher income levels.

Applicants usually received on-the-spot or next-day eligibility determination and immediate access to medical services. There was automatic recertification for existing Medicaid enrollees.

Table 2 shows the monthly income eligibility level for Medicaid in New York City prior to September 11, 2001 compared with DRM.

Table 2. Monthly Income Eligibility Level for Medicaid vs. DRM in NYC, 2001

Family Size	Parents		Single Adults & Childless Couples		Pregnant Women & Infants	Children Aged 1–5	Children Aged 6–19
	Medicaid	DRM	Medicaid	DRM	Medicaid & DRM	Medicaid & DRM	Medicaid & DRM
1	$625.00	$953.00	$352.00	$716.00	$1,432.00	$953.00	$716.00
2	$900.00	$1,287.00	$468.50	$968.00	$1,935.00	$1,287.00	$968.00
3	$909.00	$1,622.00			$2,439.00	$1,622.00	$1,220.00
4	$917.00	$1,957.00			$2,942.00	$1,957.00	$1,471.00
5	$992.00	$2,291.00			$3,445.00	$2,291.00	$1,723.00
6	$1,134.00	$2,626.00			$3,949.00	$2,626.00	$1,975.00

Source: New York State Department of Health, Office of Medicaid Management

The United Hospital Fund organized a $1 million campaign to advertise the DRM program, and there were many community-organizing initiatives to let New Yorkers know about DRM. These efforts, combined with the higher eligibility income levels of Family Health Plus, coupled with the recent court ruling that allowed many previously ineligible immigrants access to Medicaid, resulted in an unanticipated and extremely high volume of applicants. Because of this very high demand for Medicaid coverage, HRA offices began referring applicants to 25 designated community-based facilitated enrollment organizations and health plans in late November of 2001. These sites offered assistance with enrollment to DRM applicants. The applications from these 25 sites were brought to HRA once a week, and as a result, authorizations for DRM for these applicants took two to seven days from the date of application.

Resuming the Regular Medicaid/Family Health Plus Program

Recognizing the significant logistical challenges in reestablishing standard program controls for so many DRM recipients and wanting to ensure recipients the opportunity to obtain regular Medicaid/Family Health Plus without a gap in coverage, the State and City, with federal approval, established a Transitional Medicaid program. Through the Transitional program, DRM enrollees received Medicaid Presumptive Eligibility (MPE) until they could be scheduled for and receive a regular Medicaid/Family Health Plus eligibility determination. In 2002, 307,919 individuals were transferred to the Transitional Medicaid program; extensive outreach was done with recipients to encourage them to complete the eligibility process. (Other DRM enrollees were found to

have regular Medicaid enrollment and did not need to be transitioned.)

Recertification activities for traditional Medicaid and Family Health Plus resumed in October 2002. Standard program procedures and controls were reinstated (scheduling face-to-face interviews, mailing applications, and requiring additional documentation) from March to November 2002.

Impact

OMM analyzed the services used by DRM enrollees to determine what health needs were addressed by the program. Findings included the following:

Utilization by DRM Enrollees

- The Medicaid program provided care to 272,000 DRM enrollees during the initial four months of enrollment. This represents approximately 80 percent of the 342,000 total New York DRM enrollees.

- These 272,000 individuals made nearly 650,000 visits to outpatient hospitals and free-standing clinics.

- More than 9,000 individuals utilized an inpatient service.

Health Conditions of DRM Enrollees

- Approximately 178,000 individuals sought primary and preventive care.

- More than 19,000 women sought treatment for gynecology services.

- More than 10,000 recipients had ambulatory surgery.

- Over 64,000 individuals received physician or clinic services for treatment of essential hypertension, diabetes, asthma and other respiratory conditions.

Diagnoses of DRM Enrollees Hospitalized

- Nearly 23 percent of hospital admissions were for drug and alcohol treatment.

- Diagnoses for coronary care accounted for six percent of admissions.

- Approximately four percent of admissions were for treatment of asthma and diabetes.

New York City's Health and Hospitals Corporation (HHC) also published a summary, *Experience with Enrollees of Disaster Relief Medicaid,* detailing information about services provided through April 30, 2002. HHC found that more than 75,000 DRM enrollees used its outpatient and/or hospital inpatient services. Approximately 18.5 percent of these individuals were treated for chronic and advanced illnesses that included coronary diseases, diabetes, asthma, and pulmonary tuberculosis. Nearly 3.5 percent received inpatient care. According to HHC, at least 20 percent of principal diagnoses of the individuals admitted to general medicine, general surgery, gynecology, neurobiology and urology services, or 12.6 percent of total DRM hospital discharges, were for treatment/evaluation of neoplasms/cancers.

Summary

Disaster Relief Medicaid/Family Health Plus was a time-limited program that differed dramatically from the traditional Medicaid program. There is a great deal of interest in how this process worked, how well recipients were able to access needed services, how costs compared to costs associated with those previously enrolled in the traditional Medicaid program, and how the less rigorous eligibility/verification procedures affected program integrity. This report attempts to address these issues.

Methodology

A team of experts in evaluation, process analysis and focus group/interview research and design was assembled from Cornell University, the University at Albany, human services practitioners, and the private sector. (See Appendix I: Project Team for more detail.)

Document Analysis

DOH Studies

Three documents provided by the New York State Department of Health *(Disaster Relief Medicaid: Demographic, Cost & Utilization Analysis; Disaster Relief Medicaid Interim Finding Report;* and *Disaster Relief Medicaid: Fraud & Abuse Monitoring Effort)* and two provided by the New York State Office of Temporary and Disability Assistance *(Disaster Relief Medicaid Application Monitoring;* and *Review of Negative Case Decisions)* were reviewed. In a few cases, additional information not contained in the reports was requested from and provided by the two agencies. These instances are noted in this report.

Reports by Advocacy Groups

Many advocacy organizations had a deep interest in DRM. These organizations provided many helpful reports and research summaries (see the Appendix), and the relevant findings have been noted and integrated into this report.

Interviews

Site Visits and Interviews with HRA and OMM Managers and Staff

Site visits to eight of the twenty-two HRA sites (Bellevue Hospital, the Boerum Hill Medicaid Office, Bronx Lebanon Hospital, Columbia Presbyterian Hospital, Elmhurst Hospital, Gouveneur Hospital, the Jamaica Medicaid Office, and the Staten Island Medicaid Office) were conducted in the Summer and Fall of 2003 and the Spring of 2004. These sites were suggested by OMM, HRA staff and representatives from advocacy organizations either because they had many DRM clients and/or because they were perceived as currently having some difficulties (such as processing applications in a timely manner). Follow-up phone calls were also made. General observations, including ease of application, were made; and workflow was analyzed. Interviews were also conducted with HRA managers and staff. Interviews with the Office of Medicaid Management were conducted in the Fall of 2003.

Interviews with Recipients

The Office of Medicaid Management provided a list of 3,000 former DRM recipients, randomly selected (stratified by the Center where they had applied for DRM) from a list of 22,000 former DRM recipients. This list of 22,000 had been randomly selected from the total number (342,362) of DRM recipients.

Letters were sent to all 3,000 recipients in early November 2003 inviting them to participate in focus groups during the weeks of November 17 and 24 to discuss their experience with Disaster Relief Medicaid. Two hundred seventy-one letters were returned by the U.S. Postal Service marked "undeliverable." Follow-up phone calls were made to all non-respondents, many in their native languages (since the OMM data often had information about languages spoken by recipients), inviting them to participate in the focus groups or a telephone interview. (We were unable to contact about 27 percent.)

A total of fifteen focus groups were conducted in English, Spanish, Cantonese, and Russian. (Three groups were conducted in Spanish, two in Cantonese, one in Russian, and nine in English.) Focus group participants were an ethnically and racially diverse group representing all five boroughs of New York City. Facilitators conducting the focus groups had previous knowledge and experience with the Medicaid program and several had previously conducted focus groups on DRM for the Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund.

In addition to the focus groups, telephone interviews were conducted with over 150 former DRM recipients. The results of the focus groups and telephone interviews are incorporated throughout this report and are also summarized in Appendix A.

Interviews with Advocates and Review of Advocacy Research and Reports

Interviews with advocacy organizations, including representatives from the United Hospital Fund, the Children's Defense Fund, the Children's Aid Society, and the New York State Coalition of Prepaid Health Services Plans, were held in August and September of 2003.

Profile of DRM Recipients and Utilization

Analysis of Demographic, Cost, Utilization, and Fraud Data (OMM)

The actual OMM report is included in Appendix D. The section that immediately follows provides summaries of what was found, as well as possible explanations.

The purpose of this report was to address the similarities and differences between Medicaid enrollees and those who were enrolled in the Disaster Relief Medicaid program in terms of demographics and Medicaid service utilization.

This report provides a great deal of useful demographic, cost, and utilization data regarding DRM. DOH's efforts to maintain the integrity of DRM were intensified as a result of the loss of prepayment controls and assisted by the new OMM Data Mart, which was very useful as a monitoring and targeting tool. The Data Mart was used by DOH staff for immediate turnaround on paid claims information that identified payment trends and providers who were providing services that were unusual.

We have evaluated the report methodology and found it to be sound throughout. (Minor exceptions are explained in the accompanying text.)

Enrollment Overview

The report compares basic demographic measures of DRM enrollees to the New York City Medicaid population, as it existed during the month of January 2001. It first examines the non-DRM Medicaid enrollment trend (through May of 2002) and establishes that monthly enrollment levels continued increasing slightly. A marked increase in the rate of new enrollees (see Figure 1 in Appendix D) and a sharp decline in the monthly disenrollment rate (see Figure 2 in Appendix D) were identified. A sharp spike in DRM enrollments was also noted.

The authors attribute the sharp decline in the monthly disenrollment rate to the temporary easement (through September 2002) of the federal 12-month recertification requirement of the New York City Medicaid program. This explanation is plausible since there have traditionally been significant numbers of enrollees who fail to obtain recertification due to a variety of factors (including recipients failing to show for appointments, not providing required documentation, lags in processing time by workers, and notices of recertification not reaching recipients through the mail).

Demographic Profile

A demographic profile of the DRM enrollee population was developed based on age, gender, and geography (borough/zip code) DRM enrollees during the month of January 2002 were compared to those who were enrolled in Medicaid during the month of January 2001. This group, called the "Demographic Comparison Group," represented all Medicaid eligibility groups of all ages, including the disabled and

those in long-term institutional care, as well as those enrolled in Managed Care.

It should be pointed out that DRM differed from pre-September 11, 2001, Medicaid in that higher income levels were used (Family Health Plus income guidelines), and many immigrants, as noted earlier, were now eligible because of the *Aliessa v. Novello* decision. Nonetheless, the use of the pre-DRM group for comparison, while less than ideal, still appears valid because there is no other comparison group that could be used with any degree of certainty. There is some inherent value in looking at the patterns of enrollment in the two programs, as long as their differences are kept in mind. (Trying to definitively adjust for the difference in income levels and immigration status would not be feasible.)

A. Age Comparison

OMM found the DRM enrollment rate for those over age 21 was considerably higher than in New York City Medicaid and the overall enrollment rate for DRM children much lower.

DRM had a greater proportion of adults, aged 21-64 (43.56 percent more adults) and a lower proportion of children (32.74 percent less).

This is very similar to the findings of surveys, focus groups and interviews that have been conducted. Data from focus groups, surveys, and interviews point to some possible reasons for the differences in enrollment including:

- Children generally were referred to the Child Health Plus B program, although some enrolled in DRM with their parents.

- There had been many intensive, ongoing efforts by advocacy and community-based organizations to enroll children in Child Health Plus programs.

- The higher FHPlus income levels that applied to adults, and the new eligibility status

for many immigrants, increased adult access and resulted in more adults enrolling in DRM.

- The quick access to medical coverage and the reduced documentation requirements may have made DRM more attractive to some working adults.

- There was less of a stigma attached to receiving DRM for some since it was associated more with a disaster and less with a welfare program, although applicants often had to go to welfare offices to apply.

B. Gender Comparison

When analyzing gender of enrollees, OMM found that among children there was a higher percentage of females in DRM than in the Demographic Comparison Group. It is difficult to draw definitive conclusions from the data, however, because the Demographic Comparison Group contains a large number of "unknowns." ("Unknowns" include both unknowns and unborns, who are entered as such on the client eligibility database when a Medicaid recipient reports a pregnancy. Historically, most of those categorized as unknown are unborns.)

Among adults, gender differences in enrollment are more pronounced. For the 21 to 64 age group, females comprised 53.13 percent of the total DRM enrollment, compared with 65.59 percent of the Demographic Comparison Group. Adult males comprised 46.8 percent of the total DRM enrollment, compared with 34.41 percent of the Demographic Comparison Group. In other words, females constituted just over one-half of the DRM group, but nearly two-thirds of the enrollees in regular Medicaid.

Adult DRM enrollees were more likely to be male than those in the Demographic Comparison Group (12.39 percent).

Possible explanations for this may include:

- A great deal of outreach had been done previously for mothers and children under the Prenatal Care Assistance Program (PCAP), Medicaid, and Child Health Plus programs.

- DRM made health coverage possible for many who ordinarily would have a more difficult time receiving it. The higher income eligibility levels may have meant more men, who traditionally earn more, would have become eligible.

C and D. Geographic Comparisons

OMM looked at borough and zip code of residence for DRM enrollees and the Demographic Comparison Group. For DRM, Queens ranked second in enrollment, while the Bronx ranked third. In regular Medicaid, the Bronx was second and Queens third. For both groups, Brooklyn was first in enrollment, Manhattan fourth and Staten Island fifth.

DRM had a higher proportion of Queens residents and fewer Bronx residents.

It is difficult to explain this difference. It may be due in part to employment and commuting patterns of lower Manhattan workers affected by September 11, a larger immigrant population in Queens, more people with overall higher income levels residing in Queens and/or better organization/communication about DRM. It is not possible to draw any definitive conclusions about why more Queens residents and fewer Bronx residents became DRM enrollees.

DRM enrollees were from a different group of neighborhoods than the Demographic Comparison Group.

At the zip code level there were marked differences between the DRM enrollees and the Demographic Comparison Group. This was true for DRM enrollment across the five

borough areas. DRM drew its enrollment from a different group of neighborhoods than the Demographic Comparison Group.

The individual Zip Codes with the ten highest enrollment totals for each group were compared. Only one Zip Code appears in both listings of top ten Zip Codes for DRM and the Demographic Comparison group. This comparison also suggests that a different geographic enrollment pattern was evident for the DRM Program.

Again, no definitive conclusions can be drawn about the reasons for these differences.

E. Income Comparison

The authors correlated U.S. Census Income Data for the neighborhoods. Poverty level data from the 2000 Census was used for this analysis and was broken out by New York City Community Planning District (see Table 6 in Appendix D). Each district was classified as to whether it represented either predominantly DRM or the Demographic Comparison Group or both (Table 6 in Appendix D). This classification was based on comparisons between enrollment by zip code (Maps 1 and 2 in Appendix D) and a map (not provided) of the community districts. A cumulative "Percent Below Poverty Level" for each group (DRM and Comparison) was derived by adding the individual poverty percentages of the districts in the respective groups. Collectively, the 23 community districts identified as "DRM neighborhoods" had a cumulative Percent Below Poverty Level of only 387, compared with the 22 community districts in the Demographic Comparison Group, which had a cumulative level of 626.

By this measure, the Demographic Comparison Group, called "Regular MA group" in this section of the report (we asked and were told it was the same population as the "Demographic Comparison Group") had almost twice the pov-

erty level rate as DRM neighborhoods.

DRM enrollees are from neighborhoods with lower rates of poverty.

Reasons for this are difficult to ascertain with certainty. The higher-income DRM eligibility levels may be a factor as well as the lack of stigma associated with DRM for some and the effective outreach done by a number of groups.

F. Social Security Verification

All Medicaid applicants, with few exceptions (pregnant women, unborns, infants enrolled at birth and undocumented aliens applying for coverage of an emergency medical condition) must provide a Social Security Number (SSN) or apply for one in order to be eligible for services. Because of disruption to the computer system supporting the Medicaid program in New York City, usual verification procedures could not be followed. When OMM submitted SSNs supplied by DRM enrollees to the Social Security Administration for verification, 83.46 percent were found to be valid.

There is a discrepancy listed here in the total number of DRM enrollees. Determining which names to send for a social security number match was the result of an algorithm[1] that looked at unique records that matched name, date of birth, social security number, and other factors. A few people were lost as a result of the match string. The official number of DRM enrollees is 342,362.

No figures are given for the Demographic Comparison Group. This is because the assumption is that they all would have had to have social security numbers to be eligible, with the exceptions of the instances cited above.

The DRM Social Security Number Verification rate was 83.46 percent.

Combined with the information obtained from focus groups, surveys, agency analysis of fraud, and interviews, possible explanations for the social security number verification rate include:

- Some of the 16.54 percent of applicants without valid numbers may be attributed to transposition errors by workers who had to process many applications in a short period of time and who were often under a great deal of stress themselves. The number itself may have been valid, and errors may have occurred in the actual reporting of many of the numbers.

- Some recipients may have inadvertently transposed numbers, incorrectly remembered them, or made them up.

- Some of those who applied did not have valid social security numbers, perhaps because they had not yet applied for one or because they were undocumented aliens.

G. DRM Transition to Regular Medicaid/Family Health Plus

DRM was originally intended to provide four months of health care coverage. As the program evolved, it was decided to give DRM enrollees the opportunity to obtain regular Medicaid without a gap in coverage. This opportunity became the Transition Program. Following the four-month DRM authorizations, most enrollees (about 90 percent) were granted extensions, during which they could file a full application for regular Medicaid/Family Health Plus. Their

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[1] An algorithm is defined as a logical sequence of steps for solving a problem, often written out as a flowchart that can be translated into a computer program.

coverage continued until they received a regular Medicaid determination.

Some DRM enrollees, however, were found to have active Medicaid already, and duplicate eligibility under DRM. Elimination of their DRM enrollment left them with their regular Medicaid eligibility intact. In total, 17.9 percent of the enrollees had previously had regular Medicaid eligibility.

About 18 percent of the DRM population had been enrolled in Medicaid at some prior point.

The report states that, as of February 2003, there were 150,676 DRM enrollees, or 44.3 percent, who were ultimately transitioned to regular Medicaid or Family Health Plus from DRM. Of these, 30,246 were transitioned to a prior WMS CIN Number (the Medicaid computer identification number, "Client Identification Number") directly from DRM at the conclusion of their DRM enrollment and 120,430 were transitioned to regular Medicaid and Family Health Plus after first receiving DRM Extensions. About two-thirds of those who actually applied for Medicaid or Family Health Plus immediately after DRM were found eligible.

About 44 percent of the DRM population was moved to a regular Medicaid and Family Health Plus eligibility category (27.8 percent of the total 44 percent in Family Health Plus); and

54 percent were terminated.

Focus groups, surveys, and interviews with recipients and HRA and OMM employees and managers provide some possible explanations for the high percentage (54 percent) of those who did not transition to Medicaid or Family Health Plus:

- It is very likely a significant number of enrollees applied for DRM because they had lost their jobs or had experienced a serious disruption in employment as a result of the September 11 attacks. They used the coverage, and then did not apply for regular Medicaid or Family Health Plus because their employment status had improved or they did not think they would be eligible. (The DRM application asked for income at the time of application and did not instruct applicants to come back to report changes.)

- Some recipients used DRM to take care of health care needs that had existed for a very long period of time and, once those were met, felt it would be too difficult to apply for continuing coverage or not worth the effort. Some thought they would not be eligible.

- DRM was offered as the result of a disaster and many saw it as having no stigma attached. The prospect of applying for regular Medicaid, with its close association with the welfare system, may have been unappealing to some.

- Some recipients already had some health insurance but felt the deductibles were too high. Some welcomed the opportunity to sign up for DRM and take care of health concerns, including dental services and eyeglasses, that would have cost too much under their own health care plans.

- The massive recruitment efforts brought out many people who otherwise would not have thought of applying. Some of these people were over or slightly over the income limits and justified their participation because of the unique and tragic circumstances after 9/11 or because they earned too much income to be eligible but too little to afford health insurance.

- Fear of the after effects on health status (most notably air quality) prompted some to apply. It was a traumatic, unsettling time for many Americans and many New Yorkers felt particularly vulnerable. These fears and concerns were significantly lower after the

initial DRM period.

- Some recipients did not use any services. They wanted the coverage just in case something happened and did not want to go through the more complex Medicaid eligibility process.

- Recertification rates for Medicaid are, regularly, about 50 percent statewide. (Unlike Food Stamps and some other government benefit programs, consequences for not recertifying are not always immediately felt. Recipients sometimes wait until they again need medical services. DRM recipients may have responded to these program aspects in a similar manner as regular Medicaid enrollees.)

- OMM's data does not show if DRM enrollees' medical coverage was terminated because they failed to respond to notices or did not provide documentation, although, according to OMM records, 15 percent of the "Notice to Recertify" letters were returned by the U.S. Postal Service. Failure to respond to notices or to provide documentation does not mean that a DRM recipient was not eligible or would not have been determined to be eligible. Some enrollees, including some with previous negative experiences with Medicaid, thought the process would be too complex and cumbersome. Others were concerned about providing documentation. They did not want their landlords to know of their living circumstances and/or their employers were unwilling to provide employment documentation.

Medicaid Cost and Utilization Comparison Measurements

The second section of this report examines cost and utilization. It provides a summary comparison of the Per Member Per Month

(PMPM) Medicaid cost and utilization between DRM enrollees and the control group. The full control group was defined as non-institutionalized, non-disabled, non-elderly, non-managed care Medicaid-only enrollees in New York City, who were eligible at any time during October 2000 to January 2001. A smaller "new" control group was limited to those members of the full control group who were eligible in October of 2000 but not eligible for the two preceding months of August and September of 2000. The Medicaid utilization periods are from October 2001 through January 2002 for DRM and from October 2000 through January 2001 for the control group, with a production date for the utilization data of August 12, 2002. The control data was appropriately adjusted for age weighting (by the DRM under/over 21 age ratio). Again, we would like to point out the higher income levels for DRM and the inclusion of immigrant recipients affected by the *Aliessa* decision affect the validity of the "control group" in the purest sense, but still provides useful comparison data.

Highlights of the data include:

- Total expenditures associated with DRM were approximately $670 million.

- Total expenditures of $345 million were attributed to regular DRM enrollment and $323 million were attributed to DRM transitional enrollment.

- Overall, the top four expenditure categories of service under the DRM program were: inpatient, $194 million; outpatient $166 million; dental $125 million; and pharmacy $121 million. However, for the first four months of the program (regular DRM enrollment) dental expenditures were greatest, followed by inpatient, outpatient and pharmacy.

- 61.52 percent of DRM enrollees accessed Medicaid services, compared with 71.24

percent of the control group.

- Generally, utilization of Medicaid services by DRM enrollees was consistent with the regular Medicaid population; the exceptions were dental, laboratory and eye care services, which were utilized at a higher rate under the DRM program, and inpatient services, which were utilized at a lower rate.

- After controlling for Inpatient Services, DRM enrollees and both the full and the new control groups had similar PMPM costs.

The fact that 61.52 percent of DRM enrollees accessed Medicaid services compared with 71.24 percent of the control group (a difference of 9.72 percent) may reflect the explanation given by some in interviews and focus groups that a significant number of DRM enrollees sought access to health insurance in case there might be a future need.

The higher use of dental, laboratory, and eye care services under DRM supports what was said at times in interviews and focus groups— that enrollees used DRM as an opportunity to take care of health issues such as dental, laboratory tests, and eye care, that they felt they could not afford (either because they had no insurance or high deductibles/co-pays). As indicated later in this section, there may have also been significant fraud among some providers.

Since the DRM enrollees came largely from a working age population, it seems reasonable that they would generally be healthier and require fewer in-patient services.

Overall, the DRM evaluation material in both sections of this report is thorough, detailed and comprehensive. The methodology is sound throughout. The use of the Demographic Comparison Group and the services utilization control group are justified because of the circumstances and because there is inherent value in looking at the differences resulting from enrollment in the two programs.

Profile of Providers and Fraud and Abuse

Disaster Relief Medicaid Interim Findings Report (OMM); Disaster Relief Medicaid Fraud and Abuse Monitoring Effort (OMM); Draft MEQC 2002 Project "DRM Application Monitoring," (NYS OTDA); MEQC 2002 Project "DRM Application Monitoring" Review of Negative Case Decisions (NYS OTDA)

We have summarized each report, and we provide possible explanations where appropriate. With the exception of OMM's Interim Findings, the reports themselves can be found in Appendices E and F.

   While there was recognition by policy makers of the need to make health coverage as accessible as possible to those eligible and in need, there was also a concern about the inability to verify eligibility or apply some of the up-front fraud and utilization controls used in the regular MA program. The Office of Medicaid Management, with assistance from the New York State Office of Temporary and Disability Assistance, developed a comprehensive approach to monitor and evaluate the integrity of the DRM program. (OMM and OTDA share some auditing and systems resources.) The remainder of this section details those efforts.

Introduction of Reports

OMM Reports

   The *Disaster Relief Medicaid Interim Findings Report* contains much of the same data as the *Disaster Relief Medicaid Fraud and Abuse Moni-*

toring Effort Report. The latter report, written four months later, provides updated information in the following areas:

- Social Security Number validation for DRM recipients
- Top 100 Recipients DRM Expenditures Report
- Top 25 Recipients of Outpatient Services Report
- Disaster Relief Medicaid Dental Reviews
- Other Provider Activities
- Other Recipient Activities

   In all instances, we have used the more current data in our analysis.
   The Interim Report also includes a listing of DRM monitoring activities to be completed together with a DRM follow-up interview process for reviewing recipients with the highest wages.

   We have reviewed these documents and found they follow standard auditing procedures. The questionnaire is a comprehensive auditing tool.
   The later *Disaster Relief Medicaid Fraud and Abuse Monitoring Effort Report*, in addition to providing more current data, offers future recommendations, which we will review.

OTDA Quality Control (Medicaid Eligibility Quality Control—MEQC) Review

   OMM's *Disaster Relief Medicaid Fraud and*

Abuse Monitoring Effort Report summarized the results of the OTDA Quality Control Review Interim Report.

We have obtained a copy of the more recent OTDA Draft *DRM Application* Monitoring QC Report from OMM and have summarized its findings in this section, following the discussion of the OMM reports.

We have also received a copy of the MEQC 2002 Project "*DRM Application Monitoring" Review of Negative Case Decisions (OTDA)*, pending; and its findings are also provided later in this section.

Discussion of OMM Fraud and Abuse Monitoring Reports

Both OMM reports – *Disaster Relief Medicaid Interim Findings Report* and *Disaster Relief Medicaid Fraud and Abuse Monitoring Effort Report* – offer findings in the following areas:

- Wage reporting.
- Multiple Client Identification Numbers.
- Reviews of expenditure reports.
- Other provider and recipient activity.

OMM staff also offered recommendations at the end of the *Disaster Relief Medicaid Fraud and Abuse Monitoring Effort Report*

Wage Reporting

A. Social Security Verification

Social Security Numbers (SSN) for the 331,151 recipients who had provided a SSN on the DRM application were sent to the Social Security Administration for validation. This represented 96.7 percent of the 342,362 DRM recipients. Almost 84 percent (276,723 of the 331,151) were found to be valid.

We offered possible reasons for the validity rate of DRM Social Security Numbers in the analysis of the *DRM Cost and Utilization Report.*

After Social Security Numbers were sent through the Wage Reporting System (WRS), OMM found that 101,313 individuals had wages reported during the 9/11 quarter (July, August, and September 2001), while 101,698 had wages during the post 9/11 quarter (October, November, and December 2001).

B. Investigator Case Review/Wages

OMM identified more than 13,000 recipients with Medicaid expenditures greater than $1,500 and reported wages in the third and fourth quarters of 2001. (If there were an indication of fraud, $1,500 would be the threshold for a criminal referral.)

From this group, 47 recipients with the highest wages for both quarters were selected for review. (Cornell inquired and found the annual income range projected for the 47 was from $18,000 to $100,000.) OMM investigators were able to interview 26 individuals. Fourteen could not be found and seven refused the interview. One of those interviewed was a dental practitioner who had been employed continuously but had a disruption in insurance coverage. This situation resulted in a referral to the Attorney General's Office. Five recipients were unemployed before September 11, 2001, and eleven became unemployed after September 11, 2001. The remaining nine recipients were employed at application, most in low paying or part-time positions. Each person interviewed stated they applied based on DRM eligibility information reported by the media or from conversations with family and friends. Each believed they were eligible. (The application did not instruct recipients to notify HRA of any income changes. It is possible many recipients lost their jobs or were temporarily unemployed as a result of the events of September 11, and applied while they had no income.)

A. Multiple DRM Numbers, No Active Medicaid Number

OMM reported finding 2,892 recipients with more than one DRM number, but no regular Medicaid number; 391 of these used two or more numbers concurrently. In this group, most (75 percent) received their additional DRM number in December 2001 or January 2002, thereby extending their coverage four more months.

OMM took a closer look at 301 cases where coverage overlapped for more than one day to see if there were utilization or claiming patterns that might indicate abuse. In general, diagnoses and treatment were consistent across providers, and did not indicate a pattern of abusive behavior on the part of either the recipient or the provider. For example, a diabetic recipient had a hospital admission for complications due to diabetes, follow-up care at clinics or doctor's offices, pharmacy supplies such as insulin, syringes, alcohol wipes, lancets and blood glucose test strips. A total of eight cases had patterns that warranted further investigation; and, ultimately, three individuals were referred to the Restricted Recipient program

B. Multiple DRM Numbers Coexisting with Regular Medicaid Numbers

Of the 342,362 DRM recipients, 6,836 had both DRM and regular Medicaid numbers. Of these, 2,905 used two or more numbers during overlapping time periods, 907 of whom who had inpatient services. More than 90 percent had their inpatient services billed on their regular Medicaid cards. The authors note that it is likely the hospital had a regular Medicaid number on file for these recipients and submitted the claim with that number.

OMM reviewed 145 of the recipients of inpatient services who had multiple numbers and found one recipient with three numbers who visited 24 different drug and alcohol facilities. OMM also reviewed 78 of the 1,998 who had received other than inpatient services. They found four MMTP providers (eight recipients) who had duplicate claims on the same date of service using both DRM and regular Medicaid numbers. The review of these providers was incorporated into the provider overpayment review.

In total, approximately 9,700 individuals (2.8 percent of DRM recipients) had more than one number during the DRM period, either multiple DRM numbers or regular Medicaid plus one or more DRM numbers. There are a number of possible explanations. Information from interviews with HRA and OMM staff and recipients and focus groups include these possibilities:

- Applicants became confused and applied for DRM more than once. Recipients already on Medicaid sometimes signed up for DRM as well "just to be sure" they would receive health coverage if they needed it.

- Workers mistakenly assigned more than one Client Identification Number. (This is described in more detail in the "Background Information" section.)

- There is a possibility of recipient and provider fraud, although the overall rate of multiple numbers is low. Some recipients thought they could extend their coverage by applying again late in the DRM process. Others already had Medicaid but did not like their managed care program, so they applied for DRM to have more health coverage options.

C. Multiple Billings by Providers—Referral for Collection

One consequence of multiple numbers is multiple billings. OMM reports that its review of

the Medicaid payment database identified over $1.3 million in overpayments for identical services to the same recipient, on the same day, but billed under the recipient's different Medicaid numbers. OMM states that "due to claims payment problems associated with DRM, when overpayment was denied or pended under one recipient number, the provider resubmitted the claim using the other recipient number."

This data provides some perspective on the problem of possible fraud resulting from multiple numbers. Some of this activity may be the result of using a shortcut to resolve a billing problem. Some may be deliberate duplicate billing. It is not possible to separate out fraud from the practice of resubmitting with other numbers. (New York State does not maintain overpayment statistics by any geographic region because payment is made to providers who are not limited to one geographic region. The overpayment statistics are in total, statewide, and maintained only by year.)

Reviews of Expenditure Reports

A. Top 100 Recipient Expenditures Report

OMM created and reviewed weekly a "Top 100 Recipient Expenditures Report." Claim data from the start of DRM and through August 2002, identified 572 individuals who reached the top 100 list at least once. The majority had serious illnesses that required treatment by a variety of providers. However, 18 cases were considered problematic, OMM notes that nine cases were associated with providers currently under investigation by the Attorney General's Medicaid Fraud Control Unit (MFCU) and the District Attorney's office. We inquired and found there are no statistics available to indicate a "normal" fraud rate for the regular Medicaid program for New York City. (This approach was attempted by the federal government but never successfully implemented.) There are also no statistics broken out by provider type. We were told by OMM that during the few years prior to our study, 50-75 providers were referred to the MFCU on an annual basis. We asked if there were more calls to the Fraud Hotline during DRM, and OMM stated there was no significant increase.

B. Top 25 Recipients by Expenditures for Outpatient Services

The OMM report notes that the majority of high-cost outpatient utilization was for chemotherapy and radiation. At the time of the report, two providers associated with "Top 25" recipients were either terminated from the Medicaid program (in September 2002) or under review for service provision issues unrelated to DRM. However, prior to August 2002 the terminated provider had billed $4.8 million for outpatient services under DRM.

C. DRM Dental Reviews

According to the OMM report, unusual levels of dental claims for DRM recipients were noted from the onset of the program. Reviews focused on providers who earned more than $150,000 or who were associated with the top 25 recipients by expenditure.

Suspicious activity for dental providers seems to have been much greater than for the other providers reviewed. Questionable claims identified by this review included excessive numbers of services on a single date, duplicate services claimed by more than one provider, inappropriate periodontal claims, and claims for expensive procedures that would normally require prior approval. We inquired and found that the prior approval process had been suspended for DRM because the prior approval process is dependent on WMS and the Client Identification Numbers in that system.

The report indicates that, as of March 2003, 46 of the 216 dental providers reviewed under the revised criteria (21.3 percent) were

referred to the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office. When we inquired, we learned that one of these cases was active with the Bronx District Attorney, one was settled civilly by the MFCU for $60,000, 9 had been returned to DOH for peer review by a DOH dentist, 30 were under active investigation by the MFCU and 5 were returned by the MFCU to DOH and, upon further review by DOH, it was determined there were no overpayments or other provider liability.

We also asked about the questionable claiming patterns, seeking more detail, and were told by OMM:

- 5,916 recipients received between 10-19 services per visit.
- 171 had 20-30 services per visit.
- 7 had 30 or more services per visit.

The high utilization of dental services supports the claim by many recipients in the focus groups and interviews that they used the opportunity provided by DRM to take care of longstanding needs. Recipients in interviews and focus groups indicated that some would press their dentists to provide as many services as possible at a time, in case the DRM coverage ended unexpectedly. Others said they felt their providers were "dragging the services out." A few recipients mentioned dentists complaining of the low rates they received under the Medicaid program. Perhaps some of the dentists used this to "justify" fraudulent billing activities.

D. Pharmacy

Claims for the top three recipients of pharmacy services were questionable, and the associated providers were referred to the MFCU. No patterns of fraud were found in the remaining high-cost cases. *[Note: Pharmacy utilization, though high, was not inconsistent with rates for non-DRM groups.]*

Other Provider and Recipient Activity

This investigative activity was generated from a variety of sources, including duplicate payments and complaints to the Fraud Hotline.

A total of 49 DRM provider cases have been referred to the MFCU. When the MFCU completes its investigation, the case is either prosecuted or returned to OMM for review and appropriate action, which can include termination and/or the recovery of overpayments.

HRA's BFI [Bureau of Fraud Investigation] investigated a total of 97 multiple DRM recipient cases; 24 recipients had their Medicaid cases closed and 20 were restricted. OMM restricted an additional 37 recipients, as they had become Medicaid eligible subsequent to DRM.

Recommendations

In the *Disaster Relief Medicaid Fraud and Abuse Monitoring Effort Report*, OMM staff concluded that the DRM application did not collect enough information to satisfy program integrity needs. The report recommends that any future application ask for additional information about a person's current job and employment history, household composition and residence.

The necessity of having a one-page DRM application made it more difficult to conduct subsequent investigations and the report's recommendations focus on these concerns. What it does not do is address the issue of accessibility. Consideration of this balance between accountability and accessibility is included in the "Policy Implications" section of this report.

Medicaid Eligibility Quality Control 2002 Project "Disaster Relief Medicaid Application Monitoring," draft (OTDA)

Under a Memorandum of Understanding with the Department of Health, the Bureau

of Audit and Quality Control of the New York State Office of Temporary and Disability Assistance annually conducts Medicaid Eligibility Quality Control (MEQC) reviews. These reviews meet the conditions of a federal waiver covering quality control requirements. In 2002, at the request of OMM, OTDA conducted an MEQC review of Disaster Relief Medicaid to assess the accuracy of eligibility determinations under the simplified application process.

According to the OTDA report, the purpose of the audit was to:

- Evaluate the completeness of the DRM application and validate the declared applicant information;

- Determine if MAP's eligibility decision was correct based only on the applicant reported information; and

- Determine case eligibility for DRM based on standard MEQC methodology for verifying income, residence, and household composition.

OTDA auditors reviewed a sample of 500 approved DRM applications filed between September 2001 and January 2002.

Their task was complicated by the abbreviated application. As noted earlier, the DRM application was greatly simplified in recognition of factors unique to the disaster. However, to meet the goal of having a one-page application form, some information that proved critical to quality control was deleted. This information included details about income (weekly, monthly, net, gross) and household composition. According to the OTDA report, the lack of these details made it impossible for the auditors to determine the correct household size and attribution of income.

Verification

OTDA completed an independent verification of information declared on the DRM application. The information was checked against government data files such as the Welfare Management System, Resource File Integration (RFI), Social Security, New York City Property Tax records and other databases. Client contact was initiated when data could not be obtained through existing data files. (Copies of the approved *Audit Plan, Application Monitoring Worksheet* and *QC Income Calculation Worksheet* are included in Appendix F.)

Findings: Accuracy of MAP's Eligibility Determination

The MEQC review found that, based solely on the information provided by the client and recorded on the DRM application, MAP staff correctly determined eligibility for 446 cases and made an incorrect determination for 30 cases. There were 24 cases that OTDA staff were unable to evaluate because either required information was left blank on the application or the auditors did not secure the budget calculation sheet. The auditors also noted transcription errors when entering information on the Medicaid Temporary Authorization Form.

The information in the report suggests that, under hurried and very difficult circumstances and working with the information and guidelines they were given, MAP eligibility staff correctly determined eligibility in 89.2 percent of the 500 reviewed applications.

Correct determinations:	89.2 %
Incorrect determinations:	6.0 %
Unable to evaluate:	4.8 %

Findings: Actual Case Eligibility

OTDA's independent verification of income and categorical eligibility factors yielded the following findings: based on documentation obtained, 198 of the sampled cases were found to have been eligible for DRM and 105 were found to have been ineligible. In the remaining 197 cases, OTDA was unable to verify one or more DRM eligibility factors.

The vast majority of cases determined ineligible (102 out of 105) had verified monthly income at the time of application that exceeded the income standard for the verified household size and type; 28 of these applicants listed income as $0 or left the question blank, while 74 applicants listed a lower amount of income than was actually available. Two cases did not have a Social Security Number or a notation that the individual had applied for one. One individual did not reside in New York City.

In the 197 cases where OTDA was unable to verify eligibility, staff generally needed information about source of support (income was "$0," income was "off the books," income could not be found on existing databases, etc.), residence, household composition or Social Security Number. OTDA made at least two attempts by letter to contact each of these cases. In 93 cases, the consumer failed to respond at all. In 72 cases, the consumer responded but a third party, such as an employer, did not. Seventeen consumers responded but failed to supply requested information, and 15 letters were returned by the U.S. Postal Service.

Eligible cases:	39.6 %
Ineligible cases:	21.0 %
Financially ineligible:	20.4 %
Other (SSN, residence):	.6 %
Unable to determine eligibility:	39.4 %

We reviewed all of the source documents and found the methodology employed by the OTDA auditors to be sound and consistent with standard auditing procedures. The conclusions drawn from the data were logical.

Conversations with the OTDA managers responsible for conducting the audit found they were very confident in the databases they had used to verify income. In many instances, they also contacted employers. They spent a great deal of time attempting to contact recipients and, in some instances, landlords, by phone to verify household size and type.   The authors of the report note that the DRM application did not ask for frequency of income or whether the income was net or gross. They were asked to record the "total income" for all household members. (There was an instruction sheet for HRA workers that clarified frequency of income and net/gross income. Often this information was not recorded.)

The most striking finding is that 105 cases were determined to be ineligible for DRM assistance. Review of the source documents confirms the report's conclusion that the vast majority of these cases were determined ineligible because the verified monthly income exceeded the DRM income standard for the verified household size and type. (The report states "Medicaid income standard." We checked with the authors and they used the DRM income guidelines.) When OTDA verified their actual monthly income, they found wide discrepancies; for example, 25 of the 28 cases listing income as $0 or blank had verified income of $1,000 or more per month.

In the phone calls and focus groups we conducted, a sizeable number of recipients (approximately 15 percent) also discussed the under-reporting of income. Many justified their participation in the program by stating, because of the low-income eligibility levels

required by the program, they felt they would not have been able to have their health care needs met if they had told the truth. (The levels necessarily were those of regular Medicaid/Family Health Plus.) These individuals felt they did not earn enough money to afford health insurance but earned too much to be eligible for DRM. Some HRA staff also expressed concern at what they, at times, were quite sure was client misrepresentation that led some applicants to receive benefits while others who told the truth and whose incomes were slightly over the income levels for eligibility were denied DRM coverage.

Another striking finding is OTDA's inability to determine eligibility in nearly 40 percent of the cases. This is attributable in part to the fact that applicants did not have to document most eligibility factors, including income, and in part to the brevity of the application.

It is interesting to note that a "significant number" of recipients claimed either off the books income or support by a non-legally responsible relative. It was understandably difficult for the auditors to obtain documentation to support these statements. In some instances, a landlord, tenant of record, or employer did not respond to requests for information, even though the recipient did respond to the audit. This would support information we obtained from the interviews, focus groups, and advocacy groups' reports that some recipients did not apply and/or receive Medicaid after DRM because of difficulties or anticipated difficulties obtaining documentation from landlords, other tenants, or employers.

Overall, this report was very thorough and raised some important issues that will be addressed in the "Policy Implications" section of this report.

Medicaid Eligibility Quality Control (MEQC) 2002 Project: "DRM Application Monitoring" Review of Negative Case Decisions (OTDA), pending

This is a companion piece to the OTDA report described above. OTDA auditors initiated a review of 1) denied DRM applications and, 2) terminations of Transitional Medicaid (MPE) cases because of duplicate Medicaid coverage. The OTDA review consisted of an analysis of the documentation contained in the folder maintained by MAP to ensure adequacy, appropriateness and relevancy to the stated reason for DRM denial. Staff also reviewed all relevant Welfare Management System (WMS) data to confirm the correctness of decisions to terminate Transitional Medicaid coverage. As of April 22, 2002, OTDA had counted a total of 8,275 case files. From these, they selected a random sample of 250 DRM denials and 165 Transitional Medicaid terminations for review.

Findings: DRM Denials

Decisions to deny DRM were found valid in 195 cases. In 19 cases, the decision was deemed invalid, and in 36 cases it was not possible for OTDA staff to determine validity.

According to MEQC standards, decisions by eligibility staff can be found invalid either for procedural reasons, such as paperwork or annotations missing from files, or for programmatic reasons, such as misapplication of eligibility rules. Most of the invalid decisions were procedural: failure to place a copy of the denial notice in the file maintained by MAP, or recording a denial reason on the notice that differed from the reason recorded on the application. In three instances, eligibility rules were applied incorrectly.

When OTDA staff could not determine the validity of the decision, it was attributable to data missing from the application, inconsistencies between the application and the budget sheet, or incomplete files.

Valid decisions:	78.0 %
Invalid decisions:	7.6 %
Procedural reason:	6.4 %
Programmatic reason:	1.2 %
Unable to evaluate:	14.4 %

Findings: MPE Terminations

When an individual was transferred to the Transitional Medicaid program and then found to have Medicaid coverage in another case, the Transitional (MPE) coverage was terminated before the eligibility interview.

OTDA found that 137 MPE cases were validly terminated because the recipients were members of an existing case at the time of their DRM application. In 25 cases, OTDA auditors did not find active Medicaid coverage when MPE was terminated; a number of these cases did show they had previously had Medicaid but had not recertified. In two other cases, some case members had duplicate coverage while others had no coverage. Those with no coverage were terminated incorrectly. Finally, one case had the wrong case number on the closing notice–a procedural error–and was therefore deemed an invalid termination.

Valid terminations:	83 %
Invalid terminations:	17 %

The OTDA auditors used sound methodology and standard auditing procedures. A review of the source documents found their conclusions valid.

In our review of the two reports, we noted that inaccuracy in determining eligibility for DRM cut both ways. The previous report found that MAP workers made correct determinations in 89 percent of the cases. In other words, workers followed instructions and rules correctly using the information they were provided for the majority of DRM cases. However, incorrect decisions were also made, sometimes to grant coverage or, as the second report shows, to deny or terminate coverage.

As mentioned earlier, there is a strong possibility that the very high workload and the stressful conditions affected the ability of MAP workers to consistently make accurate eligibility determinations and process recertifications, although this is impossible to quantify. It is also important to note that many of the errors were technical (e.g., invalid because the denial notice was not in the record maintained by MAP) and not substantive.

Additionally, even when MAP workers made a technically valid decision based on the information they had, in many instances that information was incorrect. OTDA auditors, with more resources and information at their disposal, found that 21 percent of the cases granted DRM were definitely *not* eligible, usually because the applicant(s) had more income than was reported on the application. And in nearly 40 percent of the cases, there was not enough information for even OTDA auditors to determine the true eligibility status.

MAP/HRA Process Analysis

In an attempt to understand and document the Medicaid eligibility process in New York City in recent years, we have:

- Reviewed documents and reports provided by the New York State Department of Health, Office of Medicaid Management (see Appendix H for listing).

- Conducted 28 announced and unannounced site visits to eight model and non-model Medical Assistance Program (MAP) offices and Human Resources Administration (HRA) offices to observe work processes, workflow, accessibility, and office conditions. We were particularly interested in examining how the enhancements HRA was making were affecting service delivery.

- Interviewed over 200 OMM and MAP staff and members of the New York State health advocacy community to obtain their perspectives on pre-DRM Medicaid, DRM, Transitional Medicaid, and the current Medicaid/Family Health Plus programs.

- Conducted focus groups and telephone interviews with over 275 former DRM recipients to discuss their experiences with pre-DRM Medicaid, DRM, Transitional Medicaid, and the current Medicaid/Family Health Plus programs.

- Reviewed publications and research (including focus groups and surveys conducted with DRM recipients) from the New York State health advocacy community regarding eligibility and access issues associated with health coverage for low-income New Yorkers (see Appendix H for listing of publications).

Pre-DRM Process

Before DRM, most people who wished to apply for Medicaid would go to a MAP community office and complete a pre-screening interview. The individual would be given an application and told what documents were required. The worker would review the applicant's household information and register the application. A face-to-face interview to complete the application process would be scheduled within five business days or at an agreed-upon time. The applicant would be expected to return for the interview with the documents identified at the pre-screening. Registration of the application would trigger Resource File Integration (RFI), the search for collateral financial information. A clearance report would be generated after the application was registered. This would show whether the person was already known to the system.

On the face-to-face interview date, the applicant would arrive at the office and wait in line. He or she would be seen by a worker who would conduct the interview using the EEDSS computer system. (EEDSS, or Electronic Eligibility Decision Support System, is a programmed series of questions pertaining

to eligibility. The worker enters the applicant's answers into the system during the interview. However, there are a number of instances when EEDSS cannot be used, and the interview would be conducted without it.) If a discrepancy arose between information provided by the applicant and RFI that could not be explained at the interview, or if the applicant did not bring all of the required documents to the interview, he or she would receive a deferral. The deferral was essentially a ten-day deadline by which the individual had to produce the documents or resolve the discrepancy with the Resource File Integration (RFI)

System. If the applicant needed more than ten days, a different deadline could be established. The applicant could either mail the necessary documents to the eligibility worker or return in person with them by the deadline. According to MAP/HRA, the eligibility decision would be rendered within the required timeframes, with the client receiving the card once the decision was made. This process required at least two visits to the community office. Some applicants came back more often if there was a deferral.

A flowchart of the former process is seen below in Figure 1.

Figure 1. Pre-DRM Workflow
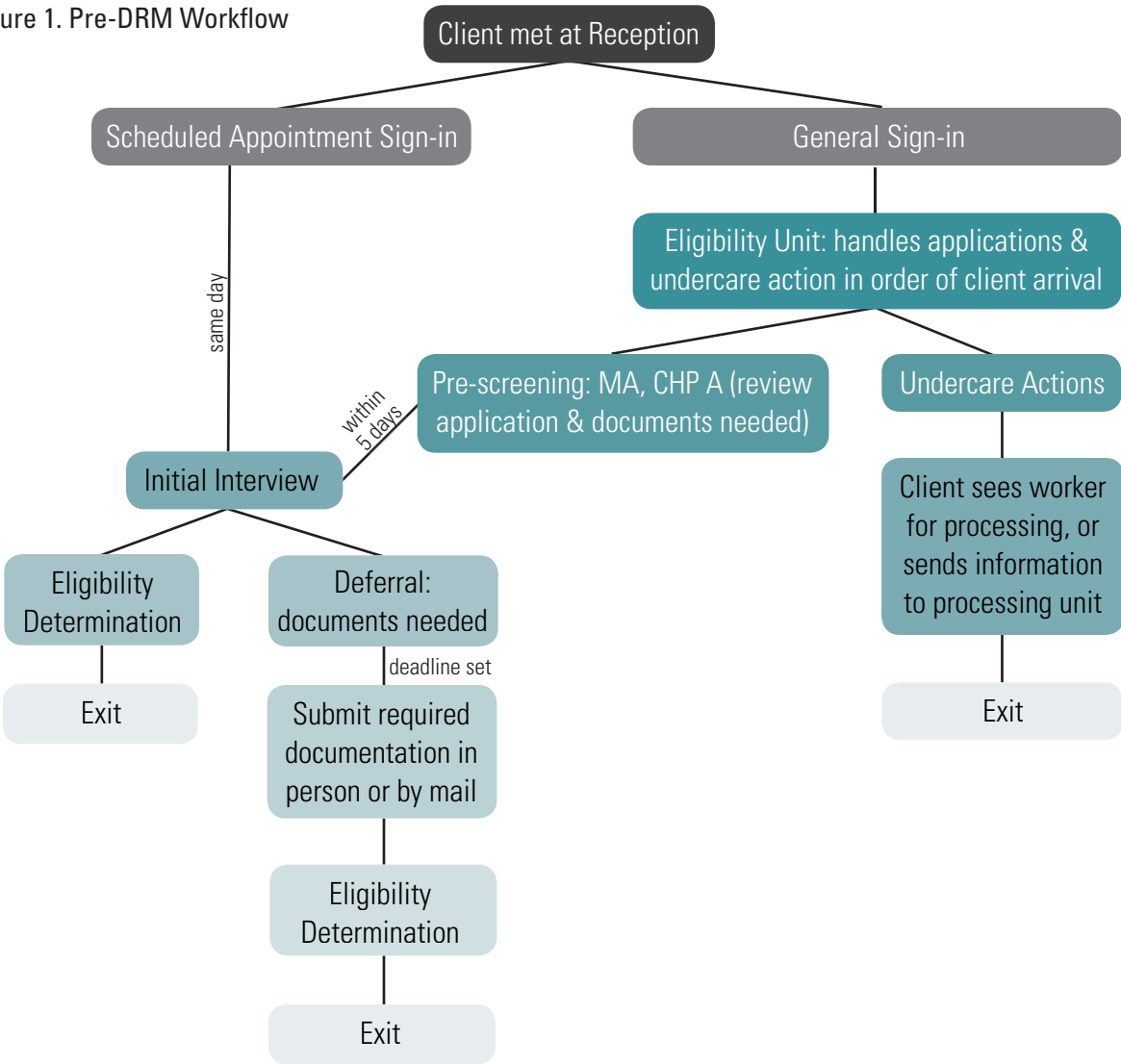
There was a general consensus among the staff, recipients and advocates we interviewed that the pre-DRM eligibility and enrollment was often characterized by long waits to apply and receive authorization, poor translation services, numerous visits, and the need to repeatedly bring the same documentation to the office at every renewal. Staff and clients were often frustrated and overwhelmed.

Renewal required in-person client interviews and documentation. Clients often missed appointments, failed to provide required documentation, or moved and could not be located. These factors also contributed to the phenomenon known as "Medicaid churning," where clients would be repeatedly dropped from the rolls for failure to complete the process, and then reinstated if the requirements were met later.

DRM Process

The key features of DRM – a one-page application, minimal documentation requirements, same-day eligibility determination and immediate access to medical care – have been described in the Introduction section of this report.

The program began enrolling applicants within two weeks of the September 11 tragedy. Initially, the number of DRM applications was consistent with projections. Medicaid applications at MAP community sites in the months just prior to the World Trade Center attack averaged about 375 per day; OMM and MAP estimated that DRM application volume would be approximately double, based on the higher Family Health Plus income levels new immigrant eligibility and disaster-related health care needs. As word spread about DRM, however, it soon became apparent that the demand for the program ("Free Medicaid" as it was described

in some of the publicity) was far exceeding what had been anticipated. Volume became extremely high and was highest (11,000/day) during the last days of DRM.

To handle this phenomenal growth, MAP hired staff and extended hours at most offices. MAP managers worked out a process to check in with all of the sites every hour, and they would adjust staffing levels and the sites applicants were sent to according to the changing demands. A more detailed description of the MAP and OMM response is found in the Background section of this report.

During DRM, applicants often waited in very long lines to apply because of the high demand, but the process was quick. The average interview took 10 minutes, about 30-45 minutes less than usual. Despite the waiting times, focus groups and interviews with DRM recipients found most were appreciative of the program and the workers' efforts. Most recipients said they were treated with courtesy and respect.

Disaster Relief Medicaid Workflow

There was some variety in the way Disaster Relief Medicaid was implemented at each site. Most sites were structured differently depending on the available space and staffing, so although the process was the same, there was some variation in procedures. For example, some sites established an "assembly line" where clients were directed to different areas to complete different stages of the application. At other sites, traffic was controlled by allowing only a certain number of clients into the interviewing area at a time. This flowchart documents the required steps of the process, recognizing that implementation in each of the sites may have varied slightly.

A flowchart of the DRM process is seen in Figure 2.

Figure 2. Disaster Relief Medicaid Workflow

Worker or client representative and client complete all sections of the one-page application including applicant's name, address, contact numbers, and the dates of birth, social security numbers, and combined household income of all those applying.

Review client's proof of identification and obtain either a social security number, the client's agreement to apply for a number, proof of application for a number, or satisfactory immigration status.

Complete eligibility determination and period of eligibility sections of the application.

If approved, read applicant the terms and rights section and obtain applicant's signature on application.

If ineligible, fill out a notice of denial in triplicate. Give original notice, application, and income calculations to applicant.

Complete temporary authorization forms for each household member with client's name, address, case number, date of birth, social security number, and dates of issue and authorization period.

Client exits

Supervisor reviews application and temporary authorization form, places CIN labels on each eligible person's line (in triplicate) on form. CINs are also handwritten on the application. Names of recipients are recorded in supervisor's log. Temporary authorization forms are signed by client/ client rep., supervisor, and worker.

Copies of documents are placed in case folder and forwarded to MAP Fair Hearing Division, 330 West 34th Street.

Copies of application and original authorization form are given to the client.

One copy of the denial notice is kept in the office and filed alphabetically.

Client exits

Original application and unseparated copies of the temporary authorization forms are forwarded to 34th Street, 5th floor.

After documents are reviewed for accuracy and screened for duplicate numbers, copies of applications and authorization forms are batched and forwarded to CSC, the State billing agent in Albany.

Transitional Medicaid Process

When DRM was initially established, it gave recipients four months of coverage, after which it was expected that recipients would have to apply for regular Medicaid/Family Health Plus if they wanted coverage to continue. A full application was necessary because DRM was based on only a few of the normal Medicaid eligibility factors. Once DRM was established, however, State and City officials became concerned about possible gaps in coverage for people who needed continuing access to care. Therefore, they created a transition program, under which recipients' coverage was extended until they could complete a Medicaid/Family Health Plus application.

Recipients were sent three separate mailings notifying them 1) that their coverage would be extended, 2) that they would receive a Medicaid card to use when they needed health care services, and 3) that they would need to keep an appointment for a face-to-face application interview. This third mailing contained the appointment time, the application, a checklist of necessary documents, and a list of facilitated enrollers who could provide application assistance.

Focus groups and interviews revealed that the transition process often was confusing to clients, perhaps in part because so m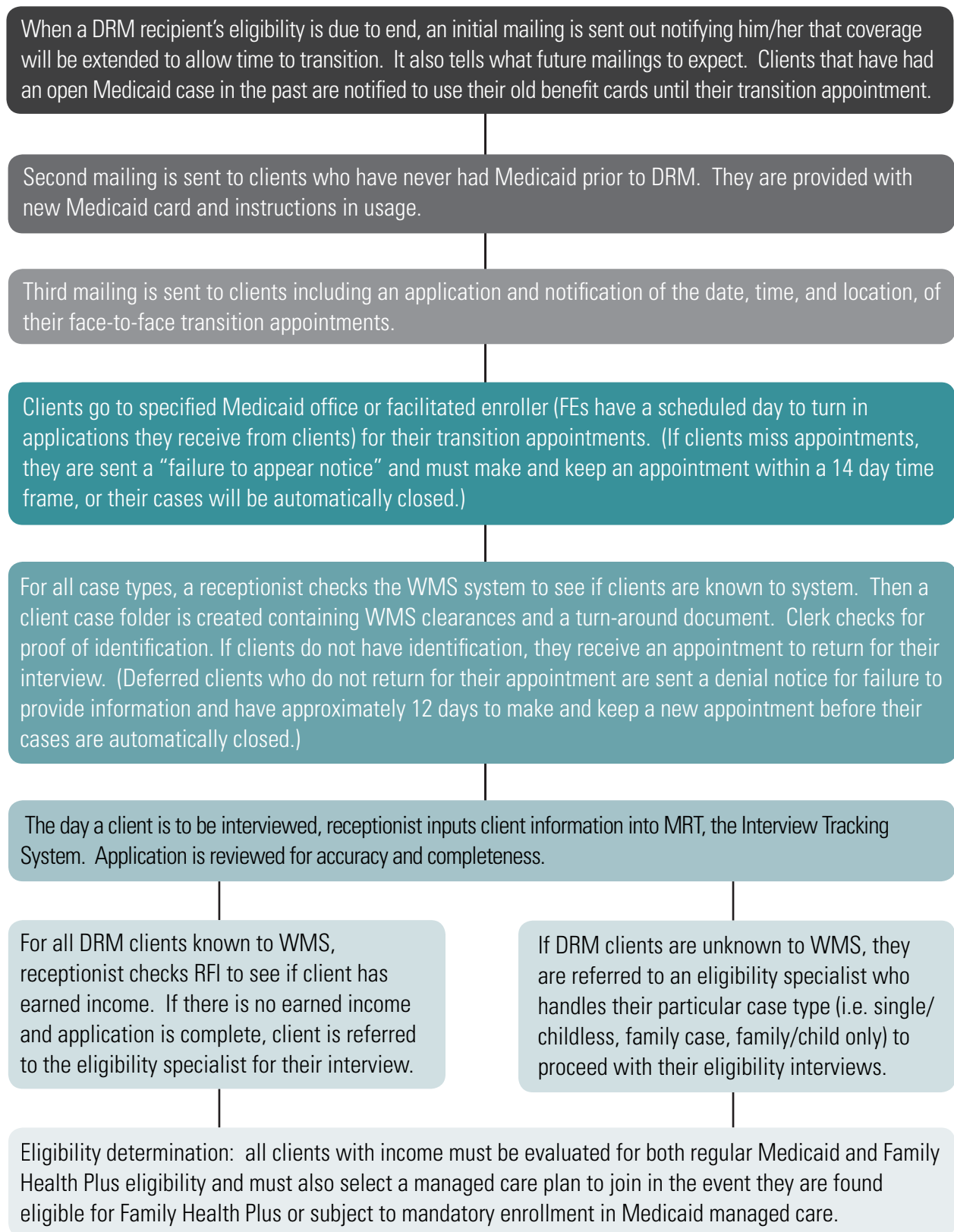any of the enrollees were unfamiliar with government processes. While applying for DRM had been extremely simple, applying for regular Medicaid/Family Health Plus required an appointment, a longer application, a longer interview, and documentation of eligibility factors.

Both MAP and the advocacy community took a number of steps to try to ensure DRM recipients were aware of how to effectively transition to Family Health Plus or Medicaid. MAP published articles in Spanish and Chinese language newspapers, conducted outreach to individuals who did not keep their application appointments through mailings and telephone calls, set up an automated phone response system in five languages through which individuals could check appointment times, and distributed flyers to other City agencies. The advocacy community wrote instructions for DRM recipients and undertook direct contact with clients.

Despite all of the outreach efforts, many DRM recipients did not return. Reasons varied, and were not limited to dislike of the application process. Some DRM recipients felt they did not need coverage at the time; others found a job and had too much income to qualify. Approximately 44 percent ultimately transitioned to Medicaid or Family Health Plus.

A flowchart of Transitional Medicaid is seen in Figure 3.

Figure 3. Transitional Medicaid Workflow

When a DRM recipient's eligibility is due to end, an initial mailing is sent out notifying him/her that coverage will be extended to allow time to transition. It also tells what future mailings to expect. Clients that have had an open Medicaid case in the past are notified to use their old benefit cards until their transition appointment.

Second mailing is sent to clients who have never had Medicaid prior to DRM. They are provided with new Medicaid card and instructions in usage.

Third mailing is sent to clients including an application and notification of the date, time, and location, of their face-to-face transition appointments.

Clients go to specified Medicaid office or facilitated enroller (FEs have a scheduled day to turn in applications they receive from clients) for their transition appointments. (If clients miss appointments, they are sent a "failure to appear notice" and must make and keep an appointment within a 14 day time frame, or their cases will be automatically closed.)

For all case types, a receptionist checks the WMS system to see if clients are known to system. Then a client case folder is created containing WMS clearances and a turn-around document. Clerk checks for proof of identification. If clients do not have identification, they receive an appointment to return for their interview. (Deferred clients who do not return for their appointment are sent a denial notice for failure to provide information and have approximately 12 days to make and keep a new appointment before their cases are automatically closed.)

The day a client is to be interviewed, receptionist inputs client information into MRT, the Interview Tracking System. Application is reviewed for accuracy and completeness.

For all DRM clients known to WMS, receptionist checks RFI to see if client has earned income. If there is no earned income and application is complete, client is referred to the eligibility specialist for their interview.

If DRM clients are unknown to WMS, they are referred to an eligibility specialist who handles their particular case type (i.e. single/childless, family case, family/child only) to proceed with their eligibility interviews.

Eligibility determination: all clients with income must be evaluated for both regular Medicaid and Family Health Plus eligibility and must also select a managed care plan to join in the event they are found eligible for Family Health Plus or subject to mandatory enrollment in Medicaid managed care.

Post-DRM Process

When MAP returned to normal operations (including the non-DRM renewal schedule), they resumed their previous efforts to streamline eligibility operations. With funding from the United Hospital Fund, the Commonwealth Fund and the New York Community Trust, MAP continued efforts with a consultant to establish Model Offices throughout New York City.

The "Model Office" concept provides:

- a one-day application process

- significantly reduced waiting times (usually 45 minutes to an hour)

- a triage process, with different lines for different needs (some workers interview applicants, others process undercare cases) so clients with specific needs that could be quickly handled usually did not have to wait for long periods of time

- the ability to not have clients repeatedly bring the same documentation with them (excluding income verification) if they are known to the system

- centralized filing systems, allowing workers and supervisors to have access to all cases, so any worker can process any case, in date order

- more clearly delineated roles for workers (greeter, processor, and interviewer responsibilities); roles are rotated on a regular basis to encourage worker understanding of and ability to handle each function

- a tracking system (while this slows work down some, it assists with accountability and tracking)

The first Model Offices began operation in June 2002, and by 2005 all offices had been converted. The Model Offices are running more efficiently and smoothly than the MAP offices were prior to the conversion.

A flowchart of the Model Office Process is seen in Figure 4.

Figure 4. Model Offices Workflow—Expanded Hours of Operation: M–F: 8–6, Sat: 9–12 (Coney Island)

Client met by Client Services Representative who determines reason for visit

MA, CHPlus, FHPlus Application: Interview conducted

Card Replacement

Quick Service Undercare Actions: Change of Name or Address, Addition of Baby/Unborn, Open Medicaid for Authorized SSI Case, Closing Case at Client Request, Re-budget Case, Add/Remove Person from Case, Informational Inquiries, & Checking Case Status, Surplus (Review Medical Bills to Offset Spenddown and Authorize Coverage)

Exit

Applicant has eligibility history; staff uses browser to locate client documents not subject to change

Applicant has no eligibility history: staff uses ALERTS match system to verify application information

Client has proof of income and residence

Client does not have proof of income and residence

Exit

Deferral: Documents Needed

Submit Required Documentation

Eligibility Determination

MA/CHP A

FHP

Exit

Specialist assists in plan selection to complete enrollment

Exit

Note: Client Tracking System: monitors client need and time spent in office

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Site visits and interviews with staff, former DRM recipients, and some advocates confirm that the Model Offices have significantly reduced wait times. The computer system improvements have also removed redundant documentation requirements for those known to the system. (Some former DRM recipients complained about the documentation that is still required. It is difficult for some of them, as described earlier, to obtain this documentation. Delays also occur, at times, because clients do not bring in the required documentation in a timely fashion.) Some former DRM recipients have expressed frustration over the income guidelines they say prevent them from accessing benefits (they feel they make too much money to qualify for Medicaid or Family Health Plus but they feel they do not make enough to afford health insurance). A few clients expressed concern over the lack of readily available translation services.

Most workers and managers we interviewed reported feeling less frustration and felt they were able to provide better services, although the pace remains hectic. Most feel the Model Office process is a significant improvement, although there is occasional confusion when reviewing cases begun by other workers. (Management is attempting to address inconsistencies in case documentation.) A significant number of the MAP staff we interviewed felt that as a result of DRM and the process of designing and implementing the Model Offices, there is now a greater tendency to ask for and implement suggestions from workers about how to improve service and working conditions.

We conducted a total of 28 announced and unannounced site visits in 2003 to eight sites selected for review by OMM and HRA. These sites were selected because they were either high DRM volume sites and/or there were concerns from advocacy organizations about how well they were providing services. The sites selected were:

- Elmhurst Hospital, Jamaica Queens
- Bellevue Hospital, Manhattan
- Boerum Hill, Brooklyn
- Staten Island Office
- Gouveneur Hospital, Manhattan
- Columbia Presbyterian Hospital, Manhattan
- Jamaica, Queens Office
- Bronx Lebanon Hospital, Bronx

During the announced visits, MAP staff were interviewed about DRM and the current and previous processes with regard to the effect on service delivery. During the announced and unannounced visits, the conditions in waiting rooms were also observed.

Two of the sites are in older buildings where lighting and ventilation were not good. All were clean, although two of the high volume sites were overcrowded. Privacy for interviews was a problem at the overcrowded sites. Six of the sites were well marked, while at two sites it was not readily apparent where one should go to apply.

Waiting times varied considerably. Those waiting to drop off documentation or who had questions were almost always seen in five to fifteen minutes. Generally clients waited from 10-45 minutes for an interview. There were a few exceptions at the busiest sites, where one couple waited four hours and twenty minutes and eight others waited between one and two hours for interviews. (These sites were in the process of conversion to Model Offices, which affected workflow.) Our observations were corroborated by what we were told by staff and applicants. We observed that clients were treated courteously, with a very few exceptions. This was confirmed in our interviews and phone calls with former DRM recipients.

Since institution of the Model Offices, MAP reports that average transaction times have been greatly reduced:

	Pre-DRM	Model Office
Application (screening, wait time, interview):	121 minutes	38 minutes*
Undercare services (e.g., change of information):	40 minutes	15 minutes
Card replacement:	40 minutes	10 minutes

*"one day, one step"

Enrollment

While applying has been made easier by the transition to the Model Offices, there were still some problems with enrollment in managed care at the time of our visits. HRA stated that they were within the timeframes for eligibility; however, clients, advocates, and some staff had voiced concerns over the length of time it could take to enroll clients in managed care plans. Clients are also sometimes confused about managed care and what the different health insurance plans offer and require.

For regular Medicaid beneficiaries, Medicaid coverage starts as soon as HRA makes a determination of eligibility. It is effective from the first day of the month of application, or up to three months retroactively if the client has medical bills for that period and would have been Medicaid-eligible at the time. Thus, a regular Medicaid beneficiary is able to access care *before* the managed care plan enrollment takes place.

Family Health Plus is different. It is a managed care-only program. People who meet the criteria for Family Health Plus are not able to access care until they are enrolled in a managed care plan. There is also no retroactive coverage. Policy and statute allow 45 days to determine eligibility and 45 days to enroll Family Health Plus applicants. This three-month timeframe, with no retroactive coverage, was a source of frustration for clients and advocates we have interviewed.

In the past, there were well-documented delays in enrolling applicants in managed care plans. These delays were exacerbated by the high volume of applicants in Family Health Plus, the loss of many MAP employees to retirement, systems problems, handoffs among three and sometimes four different organizations (HRA, facilitated enrollers, Maximus—the managed care broker—and the New York State system), and the fact that managed care rosters are established once a month. The multiple handoffs could result in inability to match clients between databases, misplaced or lost documents, failure to communicate when eligibility has been determined or enrollment completed.

Significant efforts have been made to address process and staffing issues, and several key systems problems have been eliminated. At the end of 2003, HRA stated that they were in compliance with required processing timeframes, although they acknowledged there were still exceptions at times. This was confirmed in our interviews with DRM recipients receiving Medicaid or Family Health Plus, as well as with interviews with workers. Most felt the process, while not perfect, was improving significantly.

Since our interviews, HRA has further

streamlined enrollment with a process called PCP (Primary Care Provider) One-Step. Implemented in the fall of 2004, this change allows workers to enter managed care enrollment directly into the system when the client's plan choice is recorded on the application, eliminating many of the handoffs and the problems, including delays, associated with

them. HRA also downloads information into a facilitated enrollment tracking system, so that enrollers can learn the status of applications with which they assisted.

The flowchart below (Figure 5) shows the steps in the application and enrollment process for Medicaid and Family Health Plus for both the MAP offices and the Facilitated Enrollers.

Figure 5. Steps to Eligibility and Managed Care Enrollment, New York City
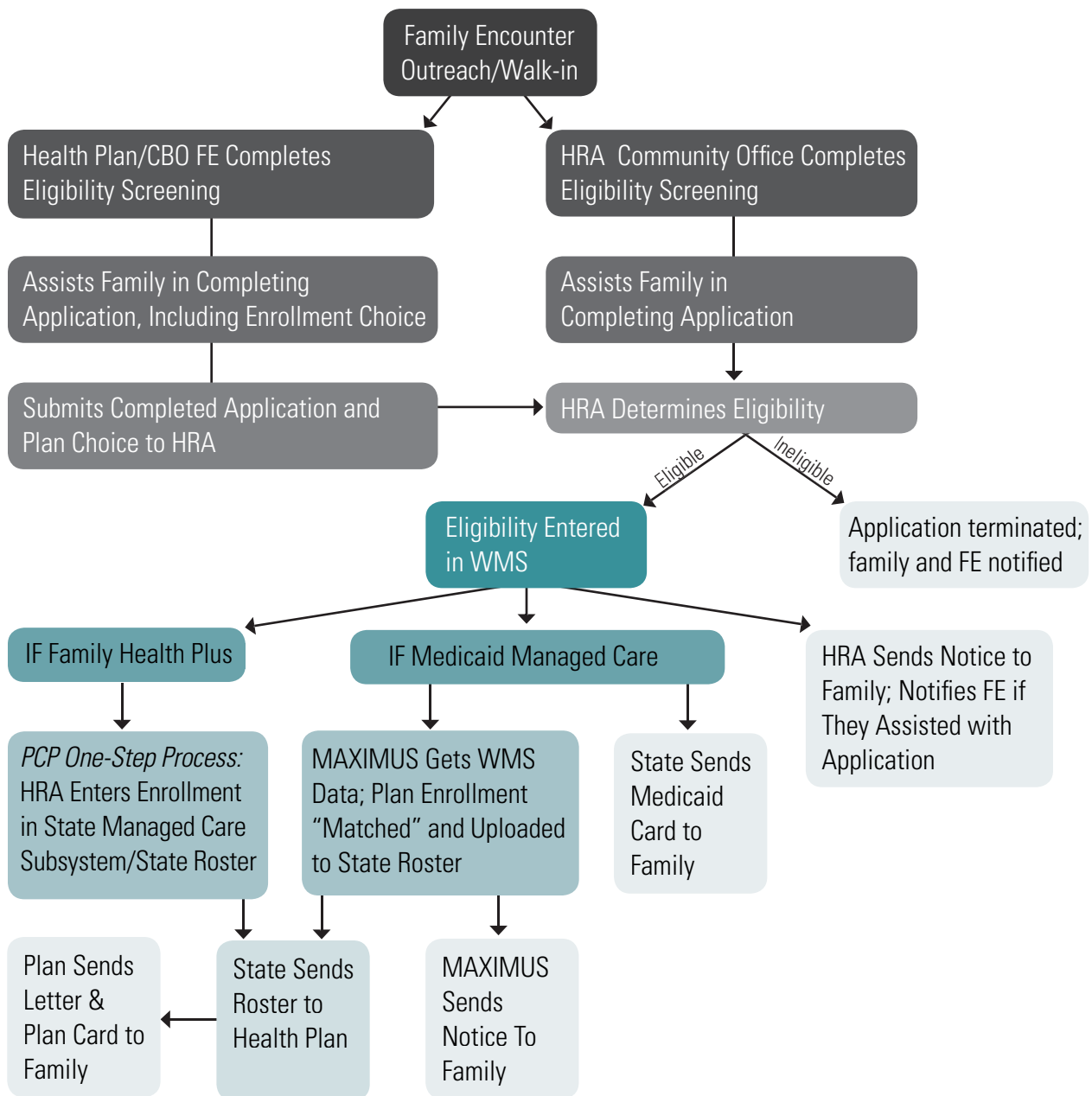
Recertification/Renewal

In Chapter 1 of the Laws of 2002, the State Legislature mandated that a face-to-face interview could not be required for Medicaid renewal. The change was enacted in response to the belief of many observers that most people who became eligible for Medicaid remained financially eligible even if they did not renew. This necessitated development of a mail-in renewal process.

New York City became the first district to implement mail-in renewal, on a pilot basis, in October 2002, as part of the reinstatement of the recertification process after the WTC attack. In this process, the client's renewal notice includes a form pre-filled with information already in the eligibility system. The client updates the form, and has the choice of mailing it back with any necessary documentation or bringing it to the local district in person. No face-to-face interview is required, nor must the client document items not subject to change. Most clients and staff we interviewed appreciated the change, despite some early difficulties in acclimating clients to the new system,

New York City's return rates for 2003 averaged 59 percent. The average return rate climbed to 66 percent in 2004, and to 80 percent in early 2005. These rates compare to 48 to 50 percent before DRM, when a face-to-face interview was required at renewal. The recent rates indicate a significant drop in "Medicaid churning," in which clients fail to renew, have their cases closed, and then come back to have them opened again when they realize they do not have coverage. Nonetheless, some problems with churning do remain. Additionally, recent experience has indicated problems with accuracy when clients are not seen face-to-face, such as a client's failure to accurately report changes in household composition. In addition inconsistencies between the client's responses and the documentation provided, which can be easily resolved when the consumer is present, now requires additional contact with the client and can delay the renewal process.

Our experience in conducting process reviews around the State also found client problems with renewal before mail-renewal was instituted statewide in April 2003. In our process review work and in interviews with former DRM recipients, we found that confusion over the forms and their purpose, language barriers, and client changes of address all contribute to problems with recertification. Another problem is the situational use of medical benefits. Clients use Medicaid when they have a specific health need. Unless they have chronic health conditions that need regular attention, they may go for months without using their Medicaid card. Unlike in other eligibility programs, such as Food Stamps, where the benefits are dispersed very regularly, clients may not pay close attention to renewal notices, and only realize they are without coverage when they attempt to access their Medicaid benefits.

There is more work to be done to reduce the number of clients who are eligible and would like to keep enrollment but fail to recertify. Listed below is a summary of the actions taken to date by HRA to increase the recertification rate.

Enhancements to Services

HRA's Medicaid Helpline is a toll-free hotline staffed by eligibility professionals providing Renewal consumers with tailored services.

Counselors can re-print a Mail Renewal notice, confirm a consumer's "respond by" date, and give specific information regarding a case status (i.e., whether the case has been processed successfully, been deferred, or is in-house being processed). The Helpline can also handle address-change requests.

The HRA Medicaid Helpline offers support in five languages—English, Spanish, Chinese Mandarin, Haitian/Creole, and Russian.

Other enhancements include the following:

- **Revised Renewal Booklet:** HRA developed, field-tested and is now using a more consumer-friendly renewal booklet, with instructions that are easier to find and follow.

- **Automated Bar Coding:** enabling HRA to scan each renewal case into the tracking system. Automating the Intake function, which is purely an administrative task, will free up eligibility staff to focus on quickly processing cases for continued eligibility.

- **Reception Reengineering:** building on the successes of HRA's Outstationed Eligibility Division (OED) Model Office program, the Office of Mail Renewal reengineered its Reception area at 34th Street to provide consumer-focused service.

- **Automated Case Status Telephone Systems:** to enable consumers to find out the status of their renewal case. This system is available in five languages: English, Spanish, Russian, Haitian/Creole, and Mandarin, and is accessible 24 hours a day.

Renewal Simplifications

These changes, many of which began in New York City, have also been instituted statewide.

- Consumers who do not need long term care can attest to Household Resources.

- Social Security numbers do not need to be documented unless the number fails a computer match with the SSA database.

- For people with regular earnings, one pay stub within the past four weeks is acceptable as proof of earned income. When the applicant cannot provide documentation, HRA accepts other verification of wages.

Policy Implications

Introduction

Disaster Relief Medicaid dramatically demonstrated the pent-up demand that existed for health care services among the previously uninsured in New York City. It reflects the national issue surrounding access to health care, as it is estimated that between 36 and 45 million Americans currently have no health insurance. At the same time, state and local governments continue to experience serious fiscal problems that are prompting some states to significantly cut their public health programs. With a $44.5 billion Medicaid program, a large number of uninsured, and, according to the Governor's Health Care Reform Working Group, "an increasing number of [hospitals]…at financial and operational risk," [2] New York faces particularly difficult challenges if it is to maintain its place as the national leader in providing public health programs for low-income people. It is also blessed with very talented and dedicated public officials, community activists, and members of the health advocacy community who are committed to working to ensure those who need public health coverage are able to obtain it.

This report on Disaster Relief Medicaid has documented how public agencies, community organizations, and advocates were able to work together at a time of great stress and uncertainty to ensure New Yorkers received needed health care. There are often differences of opinion among them, however, on how access to health care can best be achieved. The changes in eligibility policy and procedures instituted during DRM provided the opportunity to study the effects of these changes and also contribute to the dialogue regarding eligibility determination and access to health care.

Policy Implications

The interviews and focus groups that have been conducted with DRM recipients and MAP staff have highlighted the complexity of New York's public health programs.

The programs, while leading the nation in providing health coverage to low-income people, have been created or expanded incrementally over many years to address different compelling needs. Medicaid programs include regular Medicaid (with multiple eligibility categories), Child Health Plus A, Family Health Plus, the Prenatal Care Assistance Program (PCAP), the Family Planning Benefit Program, the Breast and Cervical Cancer Treatment

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[2] "Health Care Reform Working Group – Final Report"; November 17, 2004. Available on the New York State Department of Health website: www.health.state.ny.us.

Program, and the Medicaid Buy-In for Working People with Disabilities. Non-Medicaid programs include Child Health Plus B (the State' SCHIP program) and Healthy NY (an insurance program for lower income workers). The resulting complexity has several drawbacks for clients, workers and managers. Sometimes client access is affected, because clients can be confused about program types and requirements, and/or the program complexity can slow down eligibility determination and enrollment into health care plans. Workers may have difficulty sorting which rules to apply to a particular case, and managers may face challenges in organizing and training for specialized work. The enhanced use of computer systems that could assist workers in determining eligibility and in enrolling clients more quickly would help significantly, as would program consolidation and/or simplification (which would require legislation). In the interim, continued extensive training for workers and outreach to clients is needed.

The time taken to determine eligibility and then enroll clients, particularly in Family Health Plus, was a source of frustration to some former DRM recipients. The recertification process has also often resulted in confusion and "Medicaid churning" of recipients' cases.

Major efforts have been made to streamline processes and provide more effective and efficient service, including the work with the new Model Offices. Systems improvements have eliminated redundancy in providing documentation that was formerly required. HRA is determining eligibility more quickly than ever before. To address recertification issues, the State has moved to a mail-in recertification process, with more enhancements and supportive services planned for the near future.

The inclusion of three and sometimes four organizations in the enrollment process con-

tinues to be a challenge. There should be continued progress to address problems with handoffs that cause delays in enrollment. The PCP One Step Process was instituted by MAP to address this issue.

The timeframe for enrollment in Family Health Plus includes the time to complete an eligibility determination (up to 45 days, though usually shorter) and subsequently to place the individual on a health plan's roster. There is no retroactive coverage. Coverage always starts at the beginning of a month following the eligibility determination. Because plans must know who will be eligible for their services before the month begins, health plan rosters are established approximately ten days before the beginning of a month.

Clients often have been frustrated by this timeframe. Applicants have also, at times, foregone cheaper preventive services while they waited to become eligible for health interventions to treat advanced medical conditions. An analysis of the health coverage costs of those newly enrolled in Family Health Plus might be useful to determine if quicker enrollment requirements might, besides offering needed health coverage sooner, be cost effective. Alternatively, greater awareness that health care coverage is something to be obtained and maintained, even when an individual is not sick, would alleviate some of these issues.

The interviews and focus groups confirmed that, for some people, the life circumstances that create the need for Medicaid often prevent people from obtaining the documentation required to prove eligibility. However, the move to income attestation, rather than income documentation, during DRM appears to have led to serious lapses in program integrity.

Some individuals, primarily those who work "off the books," have problems in documenting employment. Others who have difficulty in-

clude seasonal workers whose previous year's returns may not reflect their current situation, workers with a variety of temporary jobs, and self-employed individuals with irregular income for multiple services. It also appears that the types of employment that do not offer health insurance are often the most difficult to document.

Further, some applicants face difficulties in obtaining proof of residence. HRA has instituted some renewal simplifications that help; for example, HRA accepts a client's receipt of Medicaid renewal notices and mailings as proof of current residency. New York City residency does not need to be redocumented when the client has not indicated a change of address. While such changes do not solve every client's problems, they do increase access for those who are eligible.

New York State recently has taken a number of steps to try to reduce the burden documentation can carry.

- The Automated Listing Requirements Tracking System (ALERTS) in the HRA Model Offices connects the eligibility worker to data sources that include employment, credit, housing, and vital statistics.

- The new mail-in renewal system described earlier requires recipients to document their income and any eligibility factors that have changed since they initially applied; they do not have to document identity, immigration status, or address if it has not changed.

- Other easements have also been implemented recently, including self-declaration of Social Security Numbers, and attestation of resources for adult Medicaid applicants who are not seeking long-term care services.

These are all developments that should increase access. Although substantive obstacles to access still remain for some New Yorkers,

and work can continue to be done incrementally to increase access, balance between access and program integrity must continue to be a major factor in these programs.

The need to maintain program integrity is evidenced by the interviews with workers and clients, some independent reports, and the audit conducted by OTDA, which all suggest that significant numbers of people who applied for DRM were not truthful about their income levels. This does not mean that many of them did not need health care or that they earned enough to purchase health insurance. They earned more than they should earn to qualify for DRM. (Workers often related stories of having to reject applicants who were slightly over the allowed eligibility levels (and told the truth about it), while having to accept applications from people they were quite sure were not being truthful.)

While the idea of presumptive eligibility and reliance on after-the-fact auditing may sound like an effective solution to delays in processing time for those who need health coverage, DRM demonstrates how the high demand for services combined with relaxed eligibility determinations could lead to significantly increased program expenses and significant strain on fraud detection and back payment collection.

In the event of another similar disaster, the role of the Medicaid program needs to be evaluated with the lessons learned from DRM in mind.

Public officials, in creating DRM, compassionately responded to the health care needs of New Yorkers in a time of terrible tragedy and uncertainty. They did not anticipate the program would end up addressing the pent-up demand for health care services that was demonstrated by so many New Yorkers. DRM provided a very valuable service for many New

Yorkers with serious health care needs that were not being addressed, as statistics described earlier demonstrated. It also provided an opportunity for many people to access needed preventive services (including dental and pharmaceutical care). At the same time, DRM placed a tremendous strain on the government agencies involved and resulted in significant lapses in program integrity.

It would probably be wise to consider following a Y2K-type plan instead. Emergency health care for those who need it should be coordinated and funded by the federal government under its emergency management protocols. This would also shield public health programs from criticism that times of disaster result in significant deviations from program standards. Should it be decided that an existing public program is the best vehicle for providing disaster-related health care, a national program such as Medicare is better suited, especially to multi-state emergencies, as its rules are federally administered and are uniform nationwide.

Background Information: Detailed History of Disaster Relief Medicaid

The tragedy of September 11, 2001, was an event unlike any other in American history. It was an incredibly difficult time and a period of great uncertainty. While those in other countries had long experienced the effects of living with terrorism, many Americans felt saddened and vulnerable in ways they had never before experienced. New Yorkers were particularly impacted. We think it important to include this background material for several reasons:

- to provide a context and a reminder of the challenging environment in which the Disaster Relief Medicaid program was created;

- to provide a closer look at how government (with assistance from community-based organizations, advocates and providers) operated and responded to a terrible tragedy;

- to provide additional information and insight into how public policy decisions critical to Disaster Relief Medicaid were made; and

> …many people would be affected by the tragedy and would need health care, including access to psychological counseling. The air quality, and its effect on residents, was also of great concern. In one day, thousands suddenly had a need for Medicaid.

- to acknowledge the efforts of those involved in creating and implementing the program. (While Disaster Relief Medicaid has subsequently helped fuel an already heated debate over eligibility requirements, it is important not to lose sight of the

remarkable accomplishments of those who worked together under very challenging conditions to deliver a complex health coverage program in a very short period of time.)

We interviewed over 200 OMM and HRA staff and members of the New York State health advocacy community to obtain their perspectives. We also reviewed the documents cited in the "Listing of Publications/Resources Consulted," which is contained in Appendix H.

September 11-19, 2001

On September 11, managers from the New York State Department of Health, Office of Medicaid Management, addressed staff protection and evacuation issues. (Some staff were in an office at 80 Maiden Lane, adjacent to the site of the attacks, and needed to be evacuated.) Employees needed to be shifted to other sites.

The extent of damage to the telephone lines and the loss of power meant the computer system used to manage the New York City Medicaid program, the Welfare Management System (WMS), was not operational, and there was no way to determine when it would be. Managers at both the New York City Human Resources

Administration, Medical Assistance Program (MAP), and New York State Office of Medicaid Management (OMM) realized the chaos and disruption following the attack in New York City was going to make it impossible for many New Yorkers who would need to obtain or retain Medicaid health coverage to verify income and provide other required documentation. They anticipated that many people would be affected by the tragedy and would need health care, including access to psychological counseling. The air quality, and its effects on residents, was also of great concern. In one day, thousands suddenly had a need for Medicaid.

By Wednesday, September 12, Kathryn Kuhmerker, DOH Deputy Commissioner and Director, Office of Medicaid Management (OMM); Sandra Pettinato, Deputy Director, OMM; Betty Rice, Director of OMM's Division of Consumer and Local District Relations; and Robert Seaman, Director of the OMM's Division of Information Technology, initiated discussions with Iris Hernandez, Executive Deputy Commissioner, New York City HRA MAP; and Mary Harper, First Assistant Deputy Commissioner, HRA MAP, regarding the status of telecommunications, the effects of the disaster on MAP staff, and the prospects of moving to a simplified medical assistance eligibility system. The State and City staff talked conceptually about a recertification waiver and a streamlined one-page application that would enable HRA to provide coverage more quickly. They also discussed the need to suspend the documentation requirements. (The severe disruption to telecommunications would make it very difficult for people to gain access to pay stubs, birth certificates,

> New York State and the federal government took a compassionate approach in responding to…September 11…there was an overriding concern that New York City residents would have serious illnesses and have no healthcare.

and other documentation normally required. None of this information could be accessed or verified by the eligibility workers through the computer system.) Everyone agreed OMM should approach Governor Pataki's office to discuss the proposed changes.

The MAP administrators felt they could continue to administer the long-term care program the way it was originally set up, as well as the Prenatal Care Assistance Program (PCAP) for pregnant women. In New York City, personal care prior authorization requirements were waived for those living below 14th Street and 24-hour care was authorized. OMM also approached Westchester, Suffolk, and Nassau counties about participating in the new program, but all declined. Some residents in the counties were affected, but not nearly as many as in New York City. Their computer systems were not so severely affected. Westchester County did accept the extension on recertifications.

In addition, OMM staff began answering questions from providers about operations. Many asked about payment checks and how they were going to provide benefits to clients. They were told to continue to provide services, and payment would be resolved. While payments were delayed a few days, OMM staff worked hard to be sure payment issues were effectively addressed.

On Friday morning, September 14, OMM officials met with the Governor's Office and the New York State Division of the Budget. The discussion included the one-page application, simplified eligibility, asking the U.S. Department of Health and Human Services for waivers and the prospect of offering the new pro-

gram for four months. A period of two months was considered. However, no one knew with any certainty how long it would take Verizon to repair telephone lines for the computer system or how long the disruption would continue in New York City. Because there was no guarantee that systems would be fully operational in two months, up to four months' duration was agreed upon. Officials did not want to have to repeat this process in two months.

The Governor's Office and the Division of the Budget agreed with the proposals. It was decided to call the program Disaster Relief Medicaid, to distinguish it from the regular Medicaid program. State requirements for financial documentation were to be suspended. Disaster Relief Medicaid eligibility was to be based on:

- The applicant documenting his or her identity and residence within the City of New York;

- Enumeration of, or application for, a social security number for all applicants; and

- Attestation of income at or below either the Medicaid or Family Health Plus income standards.

A simplified, one-page application form was agreed upon. Creating this form was a very challenging task. The original application was eight pages long. OMM and MAP had already been looking at ways to streamline the Medicaid eligibility process. (OMM had begun process reviews to streamline operations and obtain feedback from counties on removing obstacles to applying for Medicaid the previous year.) Despite these efforts, moving from an eight-page application to a one-page (two-sided) document was a challenge. The one-page application was developed the weekend of the 15th and revised again. (It was originally 8 1/2" x 14.") It was determined it needed to be 8 1/2" x 11" for a variety of reasons, including

ease of use.

The final one-page application and the accompanying worksheet for use by MAP staff were approved on September 19.

The federal government agreed to the necessary waivers of federal Medicaid rules, although it took months to work out the details. New York State received permission to implement simplified eligibility and to waive recertification for those already on Medicaid, automatically extending their enrollment for one year. (Fair hearings would not be offered.)

On September 19, the Governor's office announced, "Steps to Ensure Delivery of Quality Health Care Following [the] Attack on the World Trade Center," including the four-month DRM program. Once announced, "up to" four months of DRM became both a guaranteed four months of coverage from the date of application for each individual, and also the four-month period during which the program would accept applications. It became impossible to shorten, even though computer systems were operational and the disruptive effects of the tragedy on the ability to obtain documentation were minimal by late December. Understandably, no one wanted to be associated with shortening a program that had been offered to help New Yorkers cope with the worst disaster in their lives. Thus, individuals who applied in October 2001 received coverage through January 2002, and individuals who applied in January 2002 received coverage through April 2002.

New York State and the federal government took a compassionate approach in responding to the September 11 tragedy (see excerpts from the New York State and HHS press releases in the Introduction to this report). While there was a concern about possible fraudulent activities, there was an overriding concern that New York City residents would have serious illnesses and have no health care. Several OMM and HRA managers have indicated that if the

WMS computer system had been operational, the decision might have been delayed a little longer, to try and gauge the disruptive effects of the tragedy. Since there was no way to tell how long the computer system would be down (it was actually operational for MAP by late December), a decision was made to be proactive in addressing potentially serious health care needs. (The OMM staff did begin to work on an offline program that reported back the characteristics of recipients as well as costs.)

The challenges to the systems staff were considerable (see section on systems issues later in this case study), and work also began on systems during this time.

> The Medicaid program is very complex and involves interactions with many other organizations… OMM and HRA also met with advocacy and community-based organizations to explain the new program.

September 20—October 1, 2001

The Medicaid program is very complex and involves interactions with many other organizations. OMM staff met often with representatives of other state agencies, including the New York State Office of Temporary and Disability Assistance and the New York State Office of Children and Family Services, to coordinate efforts. OMM and HRA also met with advocacy and community-based organizations to explain the new program. Meetings with representatives from advocacy groups, providers, and other governmental agencies continued throughout DRM.

The ongoing challenges in administering a

> The ongoing challenges in administering a health insurance program for over 3 million New Yorkers did not disappear with the advent of Disaster Relief Medicaid… OMM and MAP staff worked very long hours during this time to implement DRM and maintain ongoing programs

health insurance program for over 3 million New Yorkers did not disappear with the advent of Disaster Relief Medicaid. OMM and MAP managers struggled to balance the needs of the ongoing programs and DRM. During Disaster Relief Medicaid, while some administrative tasks in New York City (such as the writing of some reports) were put on hold, none of the ongoing programmatic aspects of the work were dropped. This included the processing of pending Medicaid applications and undercare services as well as long-term care applications. (Demand for home care services also increased during this time). OMM also continued ongoing programs, including the implementation of the new Family Health Plus program upstate. (DRM in New York City used the Family Health Plus income guidelines for DRM. The program had just begun to be rolled out in New York City in early September.)

Managers continued planning the implementation of DRM during this time, and it was operational by September 24. Applications had to be printed, tracking systems developed, temporary authorization forms and Client Identification Numbers that were sequentially numbered had to be obtained (and collected from upstate counties because of a shortage), workers had to be trained in the new process, and procedures needed to be developed (See page 36). OMM and MAP

staff worked very long hours during this time to implement DRM and maintain ongoing programs.

OMM had previously contracted with the New York State Department of Taxation and Finance for a telephone system to answer questions regarding Family Health Plus. This system was used to answer questions about Disaster Relief Medicaid (see Appendix B). Extensive work had to be done to convince many providers (particularly pharmacists) to accept the new temporary "cards" (8/1/2 x 11 sheets of paper instead of the regular laminated plastic cards). Unanticipated challenges developed, such as the need for clearance from the New York State Office of General Services to allow trucks carrying paperwork to pass through tight security in New York City.

The MAP staff was involved with the details of implementation both big and small working with FEMA to offer assistance at the Family Assistance Center at Pier 94 (a site established for those directly impacted by the disaster), as well as making sure enough black pens had been ordered and distributed to avoid problems with the forms being ineffectively copied if blue pens were used. They also attempted to meet the need for additional translation services for applicants, although this continued to be a challenging issue.

The procedures for DRM were quickly developed and distributed to all of the MAP offices throughout the city. Workers were trained and the new forms sent from OMM. It took a while for new procedures to be clearly understood throughout the system. Clarification of details related to any program changes was a challenge. There was often confusion for

> …The procedures for DRM were quickly developed and distributed to all of the MAP offices throughout the city. Workers were trained and the new forms sent from OMM.

some time, particularly over the documentation requirements. Some workers were requiring applicants to produce social security cards or other documentation (only proof of identification was required). Confusion over alien status was also common. At first it appeared, in a number of sites, that anyone was eligible, including undocumented aliens. Eventually, there was much more consistency with the official policy of asking applicants to produce a social security card or number or to apply for one.

There were also problems with having to write out Client Identification Numbers by hand on the temporary authorization forms, a practice that led to illegible, transposed, and duplicate numbers (see "Systems Issues" later in this section). MAP did catch many of the duplicate numbers after the fact and notified OMM in writing so that OMM could ensure providers were paid. OMM soon produced stickers with client identification numbers on them to help eliminate this problem. There were still some problems with the stickers, particularly when the volume was very high. In multiple households, if a worker put a Client Identification Number sticker on the first page for a client, and then mistakenly put a different sticker for the same client on the second page, the client would end up with two Client Identification Numbers. These would have to be corrected by OMM and the Computer Sciences Corporation (CSC), New York State's fiscal intermediary, once the person was in the system. There were a number of authorization forms that were voided as a result of worker error. MAP was very careful to keep track of these voided authorization forms.

OMM and MAP managers had expected

some growth in the Medicaid program due to the beginning of the new Family Health Plus program, which was scheduled for rollout in New York City in Fall 2001. Increased enrollment because of changes in immigration eligibility due to the *Aliessa v. Novello* decision (described in the Introduction) was also expected. When DRM began, program managers correctly anticipated the initial heavy demand from those directly affected by the tragedy. Staff worked very long hours at both the Pier site and at the MAP administrative headquarters at 34th Street.

The demand at the other sites for DRM was not extremely high at the beginning of the initiative. Many people were unaware of the new program and its new rules. This soon changed. New York City has a very proactive, effective, and organized health advocacy community; they quickly saw the opportunity DRM would provide to offer health care to many New Yorkers who had historically needed it and not accessed services for a variety of reasons. The advocates made extensive efforts to publicize DRM throughout New York City. The United Hospital Fund organized a $1 million publicity campaign, and many community-based organizations publicized the program widely as well.

October 2001—November 2002

As word spread about DRM, it soon became apparent to OMM and MAP staff that the demand for the program ("Free Medicaid" as it was described in some of the publicity) was far exceeding what had been anticipated. Many staff had thought the program would be

used primarily by those directly affected by the events of September 11. While many people directly affected did receive DRM, many more people were signing up who had no immediate connection with the tragedy. By the end of DRM, 342,362 people had enrolled in the program.

More MAP staff was hired and OMM had to keep pace with the urgent need for more applications and cards. Many sites were overflowing and applicants often lined up as early as three hours before the offices opened. Most offices added extra hours, and staff worked very long hours (often as compulsory overtime) to try and meet the demand. Issues with childcare were common for workers. Despite all of the pressures, most workers/managers we interviewed said they felt a real sense of teamwork during this time. This was remarkable, considering the stress and pressure they were experiencing. One MAP supervisor said, "They served with integrity and with their hearts." There was also a great deal of additional input from those in lower levels of the organization, and flexible, creative approaches were attempted to meet the many challenges that arose. (In interviews we conducted, significant numbers of managers and workers stated that their experiences with DRM actually helped them be more open to and work more effectively with the Model Offices improvement initiative that was implemented after DRM.)

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The simplified process made it much easier to process the applications (the average interview took 10 minutes, about 30-45 minutes less than usual). Clients and staff, at times, had to be sent to different sites because of capacity and fire code

issues. By November, OMM and MAP allowed selected Facilitated Enrollers to accept applications throughout the city. These were batched and sent to MAP. Volume was extremely high and was highest (11,000/day) during the last days of DRM. Eventually, MAP managers worked out a process to check in with all of the sites every hour, and they would adjust staffing levels and the sites to which applicants were sent according to the changing demands. While applicants were usually respectful, there were a significant number who became angry at the wait times and some threatened workers. In some locations, security was needed to help control the flow of so many applicants. Despite the pressure, focus groups and interviews with DRM recipients found most to be very appreciative of MAP's efforts. Most recipients said they were treated with courtesy and respect.

During this time, some recipients had a difficult time finding providers who would accept DRM, despite efforts by OMM, MAP, and the advocacy community to educate the provider community. Eventually, many MAP sites posted telephone numbers of participating providers.

Transition Issues

The "Terms, Rights and Responsibilities" section of the DRM application, signed by all applicants, stated, "I understand that Disaster Relief Medicaid will give me coverage for four months only. I will not receive any notices when the coverage ends. There are no Fair Hearing or Aid Continuing rights when Disaster Relief Medicaid ends. I understand that if I want Medicaid beyond the four months of Disaster Relief, I must complete a new Medicaid applica-

tion." Nonetheless, government officials and program managers were concerned about potential gaps in coverage for people who needed continuing access to services.

Discussion of how to transition DRM recipients began in mid-October. In December, the plan formulated by the Department of Health and HRA to offer an extended transition period following the end of DRM eligibility was approved. The large volume of recipients could apply for regular Medicaid/Family Health Plus while still covered by DRM.

At the end of January, initial letters were sent to all DRM recipients whose coverage was expiring to let them know they could still use DRM and could still apply for Medicaid. Similar letters were sent in February, March and April to people whose four months of DRM was ending then. (Ten percent of these "don't worry" letters were returned by the U.S. Postal Service.) Everyone was then sent a second letter informing them that they would receive a Medicaid card in the mail. (Twenty-one percent of these letters were returned by the U.S. Postal Service.) The third letter informed them of when they would need to come in for an application face-to-face interview. (Fifteen percent of these letters were returned by the U.S. Postal Service.) [The texts of the three letters are included in Appendix C.]

In addition, MAP took a number of steps to try to ensure DRM recipients were aware of how to transition effectively to Family Health Plus or Medicaid:

- MAP used many venues to inform DRM consumers about what they needed to do to receive ongoing health coverage. MAP initiated a public awareness campaign to

> Focus groups and interviews with DRM recipients found most to be very appreciative of MAP's efforts. Most recipients said they were treated with courtesy and respect.

support their efforts, including an overview of the DRM transition process published in Spanish in the newspaper El Diario and in Chinese in the newspapers Singtao and World Journal.

- In August 2002, MAP also designed a special outreach mailing that was sent to consumers who failed to keep their scheduled transition appointments. This mailing invited consumers to call the HRA HealthStat Phoneline to reschedule their appointments.

- In August and September 2002, MAP conducted two manual telephone outreach pilots inviting consumers who had not kept their original transition appointment to schedule a new transition appointment.

- Recognizing how time-consuming and labor-intensive this manual approach was, in November MAP implemented an automated telephone outreach program.

- MAP designed and implemented an Interactive Voice Response telephone system to provide consumers with a toll-free number to access an automated message with the date, time, and location of their transition appointment. This service was available in five languages—English, Spanish, Chinese Mandarin, Haitian/Creole, and Russian.

- MAP also designed an informational flyer and distributed copies to New York City agencies as a means of spreading the DRM transition message to their joint consumers.

- MAP trained the HRA HealthStat Phoneline counselors to enable consumers to schedule DRM transition appointments, as well as provide them with general information

about the transition plan. These services were available in the same languages.

(See "DR Outreach Notification" and "MAP Outreach Notification" in Appendix G for more detail.)

Many clients expressed frustration over the requirements of the application process, perhaps because they were new to Medicaid and unfamiliar with its rules. The advocacy community attempted to help with clarification. The Children's Aid Society published, "An Advocate's Step-by-Step Guide to the DRM Transition Plan" in early February of 2002, a helpful guide that explained how the process would work for those who had received DRM between September 24, 2001 and January 31, 2002. (See Appendix H: Listing of Publications/Resources Consulted.)

> During the Transition, both recipients and MAP staff had to adjust to the change back to the standard program procedures and controls that were reinstated beginning in March 2002.

During the Transition, both recipients and MAP staff needed to adjust to the change back to the standard program procedures and controls that were reinstated beginning in March 2002. New workers often had difficulty becoming acclimated to the more complicated eligibility determinations. In the midst of the transition, New York City offered an early retirement incentive to staff. As a result, MAP was implementing these changes with a reduced workforce from August to October 2002.

Systems Issues

Systems played a key role in DRM. From a technical perspective, the computer system that supports the Medicaid program, while 25 years old, was fine. Network connections were down because the Verizon complex (and

its backup system in the same building) was destroyed. MAP had to use a manual process for DRM. A copy of the temporary Medicaid card/application was shipped to a central location from all of the centers in New York City and then brought to Computer Sciences Corporation (CSC), the existing contractor for Medicaid payments, in Albany. A separate database was created to key in this information. OMM had to create a "mini-Medicaid Management Information System" (MMIS). The contractor took the eligibility information coming in, keyed it in, and created an eligibility file for DRM. When claims came in from providers, CSC used this special database (there were special client numbers) and entered information into the system, matched and paid the claim. CSC was widely credited by OMM and HRA staff with doing an excellent job under difficult circumstances.

At the beginning of Disaster Relief Medicaid, the City established a manual register for client identification numbers. Workers used composition notebooks with the numbers. The numbers were manually entered. This led to duplicate numbers. Some were transposed and others were illegible. At times, workers did not cross out the number once they used it, and the next worker did not realize it was already used. The high volume, stress, and new process understandably led to additional mistakes of this nature. To reduce the number of duplicates, OMM had labels made of unused Client Identification Numbers (CINs) that they had pulled off of the system in Albany. The eligibility workers placed these labels on the temporary Medicaid authorization forms/temporary cards (which were in triplicate) to help reduce these errors. There were three labels for each number. One copy of the authorization form/card stayed with MAP, one went to OMM, and the other was given to the client as proof of their eligibility.

OMM also needed to create an offline program that reported back the characteristics of recipients, as well as costs. The desire was to create a reporting system that could be used by auditors. OMM had just created a large database in Oracle prior to September 11. Without the new system, only the number of applicants and total dollars spent would have been captured. The new Data Mart allowed them to create a subsystem with dozens of tables and brand-new reports that were previously unavailable or difficult to obtain. This new capability allowed auditors to be able to look at recipient and provider utilization, social security number validation, profiles of clients, and patterns of potential fraud. Auditors were able to look at unusual cases more closely. It was also necessary to correct the inconsistencies with duplicate identification numbers and a few other problems that had arisen. Dozens of tables and thousands of lines of computer code were written quickly. State workers put up the original set of tables in two weeks, and operationalized the entire system in four weeks. (Contracting out would have taken much longer and would have likely been more expensive.) Establishing the system so quickly allowed the auditors to track suspicious patterns early on in DRM.

Problems with the shortened application, as described in detail earlier, made it difficult for auditors to later verify eligibility, as key information (such as gross or net income or how frequently the income was received) was missing. While OMM developed thousands of lines of computer code to help verify social security numbers and sent demographic information to the New York State Department of Taxation and Finance to access W-2 reported incomes, they could not compensate for the lack of information about income collected on the original application. A great deal of useful information was provided by the reporting system,

however, most of it weekly (see the "Profile of DRM Recipients & Utilization" and the "Profile of Providers and Fraud and Abuse" sections of this report).

When Transitional Medicaid was planned, the OMM and HRA/MAP systems staff spent weeks on programming to manage the exceptions. For example, because of the unusual requirements of the WMS system – the DRM identification numbers could not be kept on the New York City system for the upcoming year – recipients were deliberately given two separate identification numbers while going through the transition. OMM then had to match the two numbers to be able to provide accurate reports on recipient utilization.

OMM and HRA/MAP received a great deal of cooperation and assistance from the New York State Office of Temporary and Disability Assistance. Ongoing systems work also continued during this time, as did the development of a new Medicaid payment system, eMedNY, the first phase of which became operational in November of 2002.

December 2002—December 2003

When OMM and MAP returned to normal operations after the DRM Transition Period ended in November 2002, they resumed their previous efforts to streamline eligibility operations in MAP, including continuing implementation of the Model Offices. (These efforts are described in detail in the "MAP/HRA Process Analysis" section, page 34 and following.)

OMM managers examined in detail the tremendous amount of information they had gathered about DRM from their reporting systems and issued a series of reports (described earlier and included in the Appendices).

They convened a day-long meeting in August of 2002 to review what they had learned from DRM that might be helpful in the event of another disaster. OMM also contracted for an independent evaluation of DRM (this report) to assist them in obtaining a balanced assessment of the program's outcomes.

Appendices

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Disaster Relief Medicaid Evaluation Project
Prepared for the Office of Medicaid Management,
New York State Department of Health
by Cornell University, School of Industrial and Labor Relations

Appendix A:
Supporting Materials for DRM Study

A-2

Summary of Focus Groups & Telephone Interviews with DRM Recipients

To assist with selecting members for the focus groups, the Office of Medicaid Management provided a list of 3,000 former DRM recipients, randomly selected from a list of 22,000 former DRM recipients. This list of 22,000 had been randomly selected from the total number (342,362) of DRM recipients (stratified by the Center where they had applied for DRM).

Letters were sent to all 3,000 recipients in early November 2003 inviting them to participate in focus groups during the weeks of November 17 and 24 to discuss their experiences with Disaster Relief Medicaid. (Participants were paid for their time and travel. This was done in part to help ensure objectivity—by not having participation primarily from those who wished to advance a particular point of view). Two hundred seventy-one letters were returned by the U.S. Postal Service marked "undeliverable." Since the OMM data often had information about languages spoken by recipients, follow-up phone calls were made to all non-respondents, many in their native languages, inviting them to participate in the focus groups, or a telephone interview. (We were unable to contact about 27 percent.)

A total of fifteen DRM focus groups were conducted in English, Spanish, Cantonese, and Russian. (Three groups were conducted in Spanish, two in Cantonese, one in Russian, and nine in English.) Focus group participants were an ethnically and racially diverse group representing all five boroughs of New York City. Facilitators conducting the focus groups had previous knowledge and experience with the Medicaid program and several had previously conducted focus groups on DRM for the Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund. The focus groups were held at New York Focus on Madison Avenue in Manhattan. The DRM focus group and telephone interview guides can be found in this Appendix.

A profile of the focus group participants follows:

DRM Focus Groups—Participant Profile

Total Participants: 120

Race/Ethnicity		
Hispanic	36%
African American	21%
Chinese	17%
Russian	11%
White	9%
Other	6%

Age		
45-54 Years	25%
35-44	24%
26-34	20%
55-64	16%
18-25	8%
65 and over	4%
No response	3%

Prior Medicaid Experience		
Not Enrolled Before	48%
Enrolled in Medicaid Before	37%
No response	15%

Children		
No children under 18	63%
Children under 18 years	35%
No response	2%

Employment Status		
Works full time	25%
Unemployed	20%
Works part time	19%
Homemaker	12%
Student	8%
Disabled	6%
Self Employed	5%
Retired	5%

Sex		
Female	55%
Male	45%

Marital Status		
Married	38%
Single	35%
Separated/Divorced	16%
No response	5%
Domestic Partner	3%
Widow/er	3%

Language		
English	44%
Spanish	25%
Cantonese	16%
Russian	10%
Other	5%

Length of Time in US		
Born in US	37%
More than 10 Years	31%
6-10 Years	20%
2-5 Years	8%
No response	3%
Less than 2 Years	1%

Current Health Coverage		
Family Health Plus	33%
Medicaid	27%
None	27%
Insured Through Work	9%
Medicare	3%
COBRA	1%

From November 2003 through February 2004, we also conducted phone interviews in English and Russian with 158 former DRM recipients. Of those interviewed who spoke English as a second language, 38 percent spoke either Cantonese/Mandarin or Spanish.

Those interviewed were chosen from the original OMM list of 3,000 former DRM recipients. We did not ask those who participated in the phone interviews for as extensive demographic information. A profile of those interviewed follows:

DRM Phone Interviews—Participant Profile

Total Participants: 158

Prior Medicaid Experience		
Not Enrolled Before	61%
Enrolled in Medicaid Before	29%
No response	10%

Employment Status		
Works full time	30%
Works part time	24%
Unemployed	13%
Homemaker	10%
Self Employed	8%
Student	6%
Disabled	5%
Retired	4%

Sex		
Female	31%
Male	39%

Language		
English (1st language)	39%
Spanish (English 2nd language)	24%
Cantonese (English 2nd language)	18%
Russian	16%

Current Health Coverage		
No Health Insurance	34%
Family Health Plus	30%
Medicaid	24%
Insured Through Work	9%
Medicare	3%

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Information on race/ethnicity, marital status, age, length of time in the US, and the number of children in the household was not collected during the phone interviews. Income information was purposely not collected for either group for reasons of privacy. We felt asking about enrollment in Medicaid/Family Health Plus and in employers' health insurance programs would give us much of the same information.

There are many demographic similarities between the focus groups and phone interview participants based on the information that was available. The primary differences appear to be:

- The phone interview group was less likely to have been enrolled in Medicaid before DRM (29 percent compared to 37 percent for the focus group participants).

- They were less likely to have either Medicaid or Family Health Plus at the time they were interviewed (54 percent compared to 60 percent).

- They were more likely to be employed full time (30 percent to 25 percent) and part time (24 percent compared to 19 percent).

Given the size of our samples, it is likely these differences are not statistically significant. What is significant is that both groups had very similar experiences and impressions of Disaster Relief Medicaid. Their experiences are also consistent with the findings of health care advocacy groups who also conducted focus groups and interviews with DRM recipients.

Key Findings From the Focus Grops and Phone Interviews

- **Most participants found out about DRM from family and friends.**

  The vast majority of participants (about 75 percent) found out about DRM from family and friends. About ten percent learned

about DRM from the various publicity campaigns. Others heard from their places of worship, their workplaces (particularly in the garment industry), and crisis sites. One woman, who drives an ambulette, heard about DRM from a patient she had picked up and went immediately after work to apply. Two others were walking past long DRM lines and were encouraged by others (who they did not know) waiting on line to apply.

Many stated they were initially skeptical that it could be such a simple process. A significant number (37 percent of focus group participants and 29 percent of those interviewed by phone), had been enrolled in Medicaid at some point before DRM. Their previous experiences with the more complicated and lengthy previous Medicaid process contributed to the skepticism.

- **Participants greatly appreciated the simplicity of the application process and the speed with which they were able to access benefits, as well as the peace of mind DRM offered. Some participants said they understood why more extensive documentation was required.**

  Although many of the participants had to wait in long lines to apply for DRM, they were very appreciative of the simplicity of the application process and the ability to quickly access benefits. Many were pleased about the relaxed documentation requirements. About eight percent commented on the difficulty they would normally have had in providing documentation, either because they worked "off the books" or were unable to prove residency.

  Some participants said they understood why more extensive documentation was normally required and said they observed or heard others describe fraudulent activity.

Two relayed incidents they had witnessed while waiting in line of people from New Jersey or Long Island purchasing identification cards on the street and then claiming New York City residency.

Many commented on how helpful the DRM workers had been. A significant number received assistance in filling out their applications from the workers. Some positively contrasted this to the behavior of some Medicaid workers in the past.

Many stated that DRM provided peace of mind during a time of great uncertainty.

- **There were very few complaints of difficulty in accessing translation services.**

Many of those who required translation said they were very pleased that it was so easy to access translation services. A few participants commented that when they previously applied for Medicaid, workers were impatient with them and they had to wait for lengthy periods of time for translation.

- **Participants understood DRM was created because of the events of 9/11. Some stated they felt more comfortable applying because the program was the result of a disaster. A significant number were directly affected by the disaster—financially, physically, and/or emotionally.**

Participants recognized the special, tragic circumstances that resulted in the creation of DRM. Some people felt more comfortable applying for this reason. About thirteen percent of participants stated they had lost their jobs directly as a result of 9/11. (The group included restaurant and hotel workers, airline employees, garment workers and workers in the financial industry.) Others

reported significant loss of income or intermittent employment. The Chinese participants reported the greatest impact overall, perhaps due to the proximity of Chinatown to the World Trade Center. The majority worked in factories or in restaurants where business dropped dramatically after 9/11. Several individuals who had held high paying jobs in the financial sector found themselves out of work and either uninsured or paying high COBRA payments.

Individuals working and/or living in the area near the World Trade Center expressed continuing concern about the unknown impact of the disaster on their health, particularly with regard to air quality. Several reported developing health/respiratory problems that are still affecting them. Some participants spoke of how the psychological trauma of 9/11 affected their ability to go to work in the city or to ride the trains. A few stated they lost or left their jobs as a result of the emotional impact.

- **DRM recipients were an ethnically/racially diverse group. This diversity was reflected in the focus groups and phone interviews.**

The participant profile reflects the ethnic/racial diversity of the participants. Interviews with MAP staff also confirm the diverse nature of the DRM population. (DOH did not have this data available.) A 2001 DRM enrollee survey by the United Health Fund found that 75 percent of DRM enrollees spoke a language other than English.

- **The participant groups were also economically diverse and worked in many different occupations. Many experienced frustration with the low-income eligibility levels and the high cost of health care.**

Participants worked in many different industries, including garment factories, retail sales, doctors' offices, hotel housekeeping, home health care, construction, airlines, and banking. Several participants owned small businesses, some were students, and some were retired. Twenty-nine percent of those interviewed over the phone and 37 percent of those in the focus groups were enrolled in Medicaid at the time of the disaster.

Of those with no current health coverage (34 percent of the phone interview participants and 27 percent of the focus group participants), most stated they made too much money to qualify for either Medicaid or Family Health Plus. Many also said they had made too much to legitimately qualify for DRM. They often justified the income discrepancy by stating they made too little to afford health insurance and needed the coverage. A few individuals volunteered that they were significantly over the income eligibility levels (income over $100,000), but wanted the coverage just in case health problems occurred, or they wished to avoid high deductibles.

Several other participants had lost jobs that paid very well as a result of the attacks and were eligible for DRM. While many of them were able to find similar employment with health coverage within the year, they were grateful for the health coverage while they were unemployed.

Eligibility levels was the issue that prompted the strongest reaction from most participants. Many participants expressed anger or disappointment at the low-income eligibility levels for Medicaid and Family Health Plus. While Family Health Plus allows a number of participants increased access to health care,, there were still a significant number not eligible who felt they should be eligible since their income was much too low to afford health insurance.

- **The health of DRM participants varied considerably.**

  Participants' health status varied considerably. Many of the participants felt they were in relatively good health and needed only routine preventive examinations. They had often lived with dental problems, allergies, and chronic pain without receiving treatment except in emergencies. About ten percent of the participants had chronic health conditions such as diabetes, lupus, high blood pressure, and cancer that require ongoing care. Many stated they would do "whatever they could" to purchase the medications and treatments as often as possible. Their economic situation did not allow them to have the kind of health care their medical situation warranted. Each focus group had one or two elderly participants with at least one, and often multiple, serious, chronic health care problems. They could not afford to purchase the medications and treatments that were not fully covered by Medicare (even if they were enrolled).

- **The many reasons for applying for DRM reflected participants' diverse health needs.**

  Many participants used DRM for preventive services such as check-ups, mammograms, pap smears, prostate exams, and lab tests. Dental services was mentioned most often. Receiving vision care was also a commonly used service. One participant saw a psychiatrist to help him with his reaction to 9/11.

  Those with previously diagnosed chronic health problems often enrolled to receive care they could not always afford in the

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past, including medications. Many said they signed up to receive health care services they knew they needed but could not afford.

A number of individuals had relied on emergency room visits for treatment in the past. One woman, who worked in real estate and had no health insurance, said that she discovered blood in her stool prior to DRM. She went to the emergency room several times to try to get an evaluation. Superficial exams revealed nothing, and the hospital would not conduct further tests. During DRM, she was able to undergo a more thorough evaluation, which revealed she had colon cancer. She then had surgery to remove the cancerous part of her colon.

- **Many participants related difficulty in finding quality providers that would accept DRM coverage. Overall, they spoke highly of the quality of the care they received.**

Although many reported problems in finding providers, almost all participants were able to eventually locate providers. Many were so grateful for the coverage opportunity provided by DRM that they said they were not upset about having to conduct an extensive search.

The Chinese patients reported great difficulty finding providers in Chinatown that would accept DRM. Some said Gouvernor Hospital was the only facility nearby that accepted DRM.

A few participants reported getting lists from the MAP offices of pharmacies that would accept DRM. Some participants mentioned not receiving services they required because of their lack of knowledge concerning what services were covered.

While most participants spoke highly of

the care they received under DRM, a few complained of "second class treatment" from some providers. Several participants claimed some dentists delayed services for too long. (One participant had a root canal during DRM that was never completed. It kept getting re-infected in between visits because the dentist would see him only once every two months, which was not frequently enough to prevent infections.) A few others said they pressured dentists to provide as many services as quickly as possible.

- **Some recipients were very confused about the process of transitioning to Medicaid or Family Health Plus. Some participants experienced language barriers in attempting to transition. Others believed they earned too much to qualify for these programs. Some did not want to go through what they perceived would be a complicated and lengthy process.**

While MAP took many steps to try and ensure DRM recipients would have access to the Medicaid and Family Health Plus programs, some reported being very confused. And some were still confused at the time of the interviews about how they eventually received the coverage they did have. The publicity campaign for Family Health Plus and the work done by MAP health care and community advocates to raise awareness of the program helped a number of participants realize they would be eligible.

A few participants found out through the focus groups and phone interviews that they may be eligible and were given information on how to apply. A few participants stated they chose not to apply because they assumed the process would be time consuming and complicated.

Four participants indicated they felt public

health programs were for the desperately poor, and they did not want to view themselves in that way. DRM was more palatable to them because they viewed it as a program to help New Yorkers impacted by a disaster and not for just the poor.

Chinese participants interviewed sometimes held perceptions and fears about accessing public health coverage. They worried that applying for Medicaid or Family Health Plus could have a negative impact on their sponsors or their children's chances Many (about 20 percent) said they knew they earned too much to be eligible for Medicaid or Family Health Plus, but still felt they could not afford health insurance. (Thirty-four percent of those interviewed over the phone and twenty-seven percent of focus group participants had no coverage at the time they were interviewed.)

- **Many of those who are currently enrolled and have had recent involvement with Medicaid or Family Health Plus reported improvements in their interactions with MAP offices. Concerns were often expressed about the wait times associated with Family Health Plus enrollment and the lack of retroactive coverage.**

Of those who have had involvement with MAP since DRM, most reported improvements. They mentioned the quick service, better access to translation services (although improvement is still needed), and the ability to drop off information more quickly. Several remarked they felt they were being treated more courteously by workers, although one participant described a particularly difficult interaction.

Many expressed frustration with the time required to enroll in Family Health Plus and

the lack of retroactive coverage.

Only some participants had experience with the new mail-in renewal process, as most people had not yet reached the time for renewal. The few that have received their renewal in the mail felt the process was simple and saves time. They especially appreciated that their information was pre-printed onto the forms. They were clear about the process and able to explain the process to others in the focus groups. A few individuals still brought their mail-in recertification documents into the MAP office voluntarily because they wanted to be sure their coverage continued.

- **DRM appears to have helped increase enrollment in public health programs.**

Before DRM, 29 percent of those who participated in phone interviews and 37 percent of those who participated in focus groups were enrolled in public health programs. At the time they were interviewed, 54 percent of those interviewed over the phone and 60 percent of focus group participants were enrolled in either Medicaid or Family Health Plus. While the Aliessa court decision and the higher income levels associated with DRM and Family Health Plus undoubtedly helped enrollment figures, the publicity campaigns for DRM were also a likely factor.

A significant number who had previously not been aware of the programs or that they might be eligible were successfully able to make the transition from DRM. A few cited the "lack of stigma" of the Family Health Plus program as being an incentive to apply. It is likely the extensive outreach done for Family Health Plus also contributed to the enrollment figures. Some participants reported not re-applying during the DRM

transition period and then enrolling later in either Family Health Plus or Medicaid because of the publicity or word of mouth. Several of these people said friends had encouraged them to apply again because of their more positive experiences with the revamped MAP Medicaid process.

Focus Group Invitation

October 24, 2003

NOTICE

The Office of Medicaid Management of the New York State Department of Health and Cornell University invite you to come to a meeting during the weeks of November 17, 2003 or November 24, 2003.   The purpose is to ask you and a small group of others about your experiences with the temporary Medicaid (the paper Medicaid card) eligibility that you received after 9/11/01. At the request of the New York State Department of Health, researchers from Cornell are doing a study of the Disaster Relief Medicaid program. Your experiences with that program are very important, and we would really appreciate your help. If you are currently receiving Medicaid, we would also like to find out how things are going.

Your name was picked from a list of clients who received temporary Medicaid after September 11, 2001. It is your choice whether or not to participate in this study. Your Medicaid case will not be affected in any way if you choose not to attend. If you do participate, all of your answers will remain confidential. We will summarize responses from all clients into one report and will not use your name.

You will be reimbursed $70 for your travel, any childcare, and time. Refreshments will also be provided during the session. If you can come to a meeting, please send back the stamped postcard by November 5, 2003 and check the box that says, "Yes, I am willing to attend." Please also let us know what time is better for you. We will then contact you with the date and time of the meeting, and where to go. The meeting will last up to two hours.

If you have any questions, please call Lynn Walker at 212-781-2292 or Chellie Gorgos at 518-449-4161 (collect).

Thank you for any help you may be able to provide with this project.

Sincerely,

Telephone Screening Questionnaire

Hello. This is **(CALLER'S NAME)**. I'm calling from **(FIRM'S NAME)**.
May I speak with **[NAME FROM LIST]**?

[WHEN LISTED PERSON ON THE PHONE:]
Hello. This is **(CALLER'S NAME)**. I'm calling from **(FIRM'S NAME)**. I am calling to invite you to participate in a group discussion about Disaster Relief Medicaid in Manhattan. This was the Emergency Medicaid program you applied for after 9/11 (the World Trade Center Disaster). You were given a paper Medicaid card the day you applied. I got your name from the New York State Department of Health, and we are hoping you might be interested in participating in this discussion. I do **not** work for Medicaid or the US government; this is an independent research project to learn about how this program worked for you.

The discussion group is also interested in hearing about your current experience with Medicaid, if any.

Because we want to make sure we have a good mix of people in the group I need to ask you a few questions.

[RECRUITER NOTE: IF RESPONDENT TERMINATES OR CANNOT ATTEND FOCUS GROUP SKIP TO THE NEXT PERSON ON THE LIST.]

CIRCLE ALL RESPONSES

[DO NOT ASK. ONLY RECORD GENDER. RECRUIT ENOUGH TO FILL ONE MALE, ONE FEMALE, AND ONE MIXED GENDER GROUP, IF POSSIBLE.]

> (1)   Female
> (2)   Male

1. What is your age? [READ CATEGORIES. RECORD AGE.]
      (1)   Under 18…………………….**ASK FOR PARENT/GUARDIAN**
      (2)   18 to 25………………………**CONTINUE**
      (3)   26 to 34………………………**CONTINUE**
      (4)   35 to 44………………………**CONTINUE**
      (5)   45 to 54………………………**CONTINUE**
      (6)   55 to 64………………………**CONTINUE**
      (7)   65 or older……………………...CONTINUE
      (8)   (Refused) [DON'T READ]…..TERMINATE

**[IF THE PERSON IS YOUNGER THAN 18, ASK FOR A PARENT OR GUARDIAN AND CON-
DUCT THE QUESTIONNAIRE WITH THEM INCLUDING THE INTRO.]**

2. Did you enroll for Emergency Medicaid (Disaster Relief)? To enroll for Emergency
Medicaid you would have only had to fill out a one-page form, not the regular forms and
would have received a paper eligibility card the same day.
      (1)   Yes
      (2)   No………………………………**TERMINATE**

      If yes, when? _____(The date must be between September 20, 2001
      – January 31, 2002, when Disaster Relief Medicaid was offered.)

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3. Did you use your Emergency Medicaid (Disaster Relief) card to cover medical expens-
es? [TRY TO RECRUIT A MIX, IF POSSIBLE.]
      (1)   Yes
      (2)   No

4. When the Emergency Medicaid program ended, did you enroll into regular Medicaid or
Family Health Plus? [TRY TO RECRUIT A MIX, IF POSSIBLE.]
      (1)   Yes
      (2)   I tried to enroll, but I wasn't able to
      (3)   I never tried to enroll

5. Are you currently employed?
      (1)   Full time
      (2)   Part-time
      (3)   Self-employed
      (4)   Homemaker
      (5)   Unemployed
      (6)   Retired
      (7)   Disabled
      (8)   Student

[IF QUALIFIED READ:]

I would like to invite you to participate in one of our group discussions. The groups will be held on these dates:

- **Monday, November 17** at **12:00pm**
  **Cantonese groups will also be offered on 11/17 at 6pm and 8pm

- **Tuesday, November 18 at 12:00pm, 5:30pm, or 7:30pm**

- **Wednesday, November 19 at 12:00pm, 5:30pm, or 7:30pm**

- **Tuesday, November 25 at 12:00pm or 7:30pm**
  **A Russian language group will also be offered on 11/25 at 5:30pm

**Spanish speaking groups will be offered on Monday, Nov. 24 at 4pm, 6pm, and 8pm

They will be located at New York Focus on 317 Madison Avenue and 42nd Street in Manhattan and will last for two hours. You will be paid **$70** for your participation in the group (at the time of the group) and we will provide refreshments. **[GIVE RESPONDENT CHOICE OF TIME, UNLESS GROUP IS ALREADY FILLED.]**

You must arrive no later than **[GIVE TIME 15 MINUTES BEFORE THE GROUP STARTS AS ARRIVAL TIME].**

You will receive a confirmation letter with directions to the group. Please bring some sort of photo identification card such as a driver's license. We will **not** be recording the information we just need to verify your identity. We will be reading some things so be sure to bring glasses if you need them.

The groups will last about two hours. Please arrive no later than **[GIVE TIME 15 MINUTES BE-FORE THE GROUP STARTS AS ARRIVAL TIME].**

NAME _____

STREET _____

CITY/TOWN _____

ZIP_____

DAY PHONE _____

EVENING PHONE _____

DATE _____

RECRUITER_____

[PLEASE READ TO RESPONDENTS WHO ARE SUCCESSFULLY RECRUITED:]

Thank you so much for agreeing to participate. Your help is greatly appreciated. We will look forward to seeing you on **[GIVE DATE AND TIME OF GROUP].**

Focus Group Confirmation Letter

Dear _____,

We want to thank you again for agreeing to come to the meeting about Disaster Relief Medicaid on _____ at _____.
We are very interested to hear what you have to say concerning this program and the regular Medicaid program.

The meeting will be held at **New York Focus,** which is on **317 Madison Avenue** and **42nd Street** on the **20th Floor.** Please come 15 minutes before your group is going to start. Please bring some form of photo identification with you to the meeting. The meeting will last two hours. We will have food and drinks before and during the group. We will be able to pay participants the $70 stipend when the group meeting is over.

Here are directions to New York Focus by train:

- The closest trains to New York Focus are the **4, 5, 6 and the shuttle(s)** from Times Square. The stop is 42nd street/Grand Central Station.

- The **B, D, Q** and **F trains at the 42nd Street/5th Avenue** stop is also just 2 blocks away. NY Focus is located at 317 Madison Avenue, but the **entrance is on 42nd Street** between Madison and Vanderbilt Avenues.

We look forward to meeting you!

If you have any questions, please call Lynn Walker at (212) 781-2292.

Sincerely,

Focus Group Discussion Guide

Format and some questions used by permission from Lake, Snell, & Perry Associates and the Commonwealth Fund.

LENGTH: 120 minutes

I. Introduction — 15 minutes

A. About the study

1. As most of you know, this project is about Disaster Relief Medicaid.

2. We randomly selected you from the list of people who received Disaster Relief Medicaid assistance/the Emergency Medicaid that was offered after 9/11.

3. This research is being sponsored by the Office of Medicaid, New York State Department of Health. We would like to find out what your experience with Disaster Relief Medicaid was like.

4. Another purpose of this project is to enhance the process people go through to get Medicaid. The best way to do that is to hear from people like you who have had experience with the system.

5. Thank you for helping– your experiences are important to us.

B. Taping and confidentiality

1. The room we are in is designed for groups like this.

2. Mirrors and people – monitoring my work.

3. Videotaping, microphones – We tape the group so that I don't have to take notes and can go back and watch the tapes. People working on this project will see the tapes for research purposes, and when we are done we destroy them.

4. What you say is confidential. We will only be using first names for this discussion. And no names are used in the reports. **(MODERATOR: If there are immigrants in the group note that nothing will be shared with INS.)**

5. **READ ALOUD AND HAVE THEM SIGN RELEASE FORM**

C. Guidelines

1. Talk one at a time

2. No side conversations

3. Want to hear from everyone

4. No wrong answers—if you don't understand a question, ask me to explain…

5. Might cut off if we get short on time

6. Restroom and snacks

D. Participant Intros

1. First name only

2. Family make up (adults, children, ages, etc.)

II. Context — 10 minutes

A. How are things going for you right now with your job? (full time, part time, student, unemployed, homemaker?)

1. Are you still experiencing the effects of 9/11?

B. What is your physical health status?

1. What are you doing for health care now?

C. Are you covered by any health insurance at this time?

1. What coverage do you have?

a) Medicaid?

b) Family Health Plus?

c) Private Insurance?

d) Nothing? If nothing, have you tried to apply? If not, why not?

D. Can you get health care coverage through your employer or your spouse's employer?

1. If it is available and you have not enrolled, why not?

a) Cost

b) Waiting period

c) Don't like the plan

d) Something else

III. Disaster Relief Medicaid — 35 minutes

[MODERATOR: MAKE SURE EVERYONE KNOWS WHAT DRM WAS. POINT OUT DIFFERENCES BETWEEN DRM & STANDARD MEDICAID & CLARIFY BEFORE PROCEEDING.]

A. How did you find out about Disaster Relief Medicaid?

B. How soon after September 11 did you apply for Disaster Relief Medicaid? (right away, one month, two months)

C. Did you apply more than once? If so, why?

D. Did you have a job before September 11?   ___Yes   ___No

E. Did you lose your job as a result of the events of September 11?   ___Yes   ___No

   1. If so, when?

F. Before Disaster Relief Medicaid, how did you pay for health care?

   1. What type of services did you receive?

   2. Who provided the health care?

G. If you were refused Medicaid in the past, why were you refused? Were you unable to receive Medicaid or Public insurance because you were not a United States citizen? Did you earn too much money? Did you have trouble understanding what you were supposed to do? (Was the process confusing?)

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H. Where did you apply for Disaster Relief Medicaid?

   1. Regular Medicaid Office

   2.   Hospital

   3. Community Organization

   4.   Other (please describe):

I. Did anyone give you any help before or during the application process? ___Yes   ___ No

J. Did anybody tell you how to receive benefits?   ___Yes   ___No

   1. If so, please describe what you were told:

K. Did you realize you were signing up for Medicaid?   ___Yes   ___No

L. How long did you receive Disaster Relief Medicaid?

M. During the time you received Disaster Relief Medicaid, did you know where to go for health care services such as dentists, doctors or drug stores?

N. If you were already receiving Medicaid, why did you apply for Disaster Relief Medicaid?

O. Thinking back to when you were enrolled in DRM, what health care services did you use?

    1. Did you try to see a doctor?

        a) Were you able to? If not, why not?   Were you refused services?

        b) How do you feel about the services you received?

    2. Did you try to see a dentist?

        a) Were you able to? If not, why not? Were you refused services?

        b) How do you feel about the services you received?

    3. What other services did you use or try to use while on DRM?

    4. Did you have difficulty getting follow-up appointments?

P. How has your usage of health care services changed since going off of DRM?

    1. Don't use health care services except in emergencies

    2. No change

Q. When Disaster Relief Medicaid (DRM) eligibility was ending how many of you received a letter? **[HANDCOUNT]**

R. When Disaster Relief Medicaid (DRM) eligibility was ending did anyone call you? **[HANDCOUNT]**

S. What did you find out from the call or letter?

    1. Did you understand what was in the letter or what the caller told you?

        a) Language barriers (did not speak your language)

        b) Not written in my language

        c) Letter too technical, hard to understand

    2. Did you do anything in response to the call or letter? What?

        a) Contact social services, eligibility worker?

        b) Contact Doctor?

        c) Contact legal aid?

        d) Contact someone else? Who?

T. If you did not get a letter or a call, what did you do when you realized that your Disaster Relief Medicaid (DRM) was ending?

    1. Called social services/doctor/legal aid/someone else for information about what to do?

    2. Try to find out how to keep or get new coverage?

U. If you did not do anything? Why not?

IV.   Transitioning — 25 minutes

A. Did you know that it was possible to transition from DRM to regular Medicaid? (That is to apply for regular Medicaid while you were on DRM so that you would not lose coverage.)

B. How did you find out it was possible to transition from Disaster Relief Medicaid to regular Medicaid or Family Health Plus? (In other words, how to apply for regular Medicaid while you were on DRM so that you would not lose coverage.)

C. How many of you were asked to come in for an interview to transition (change over) to regular Medicaid between March 26, 2002 and November 30, 2002?

    1. If yes, what was it like?

    2. What did you hear about transitioning? From whom?

        a) easier than if you had not been on DRM

        b) no different

        c) harder than if you had not been on DRM

D. If you did not come in for a transition interview…

    1. Why didn't you try to transition?

        a) Thought I would not qualify

        b) Having health care coverage not important

        c) Got everything taken care of that I needed to while on DRM

        d) Situation had changed and did not need Medicaid.

    2. How did it change?

        a) Worried about being hassled, them asking for too much information, looking into my personal business

b) Did not think I would be eligible.

c) Stigma of having Medicaid assistance

3. Do you believe Medicaid is just for poor people? (Is DRM different because it is about needing help after a disaster, and not the same as receiving public assistance/welfare?)

a) Too difficult to apply for regular Medicaid – how so?

b) Needed documents or information I did not have

c) Too many things required to do

d) Too time consuming to apply

e) Takes too long to find out if you are eligible

f) Moved

g) Did not think I would be eligible

E. How many of you decided to try to transition from Disaster Relief Medicaid to regular Medicaid or Family Health Plus? Why?

1. Needed benefits

2. Thought it was worth trying

3. After being on DRM I thought it might be easier to enroll in Medicaid

4. Eligibility worker suggested I try

5. Health care worker suggested I try

6. Family/friends/coworkers encouraged me to try

F. What did you have to do to transition?

G. For those who attempted to transition from DRM to Medicaid, how would you describe the recertification process?

1. Easy

2. Hard

3. Disappointing

4. Better than expected

5. Worse than expected

6. Other

Explain.

(How long did you have to wait to be seen? How many times did you have to return to the Medicaid Office before your case was opened? Did you have to return to the office with your documents?)

G. Did your experience with applying for Medicaid change how you feel about DRM?

H. For those who were turned down for regular Medicaid, how do you feel about what happened?

    1. Will you ever apply for Medicaid again?

        a) If so, under what circumstances?

        b) If not, why not?

I. What do you think was good/helpful or difficult/unhelpful about Disaster Relief Medicaid?

I. Medicaid — 15 minutes

A. Prior to applying for DRM how many of you had ever applied for regular Medicaid? **[HANDCOUNT]**

    1. How long ago did you apply for regular Medicaid coverage?

    2. What were your experiences?

    3. If so how did your memories of the Medicaid application process affect your decision of whether or not to apply for regular Medicaid this time?

B. For those who have never been enrolled in regular Medicaid, what do you think of Medicaid?

    1. For those who have been enrolled regular in Medicaid, what do you think of Medicaid?

C. What would keep you from applying for Medicaid?

    1. Don't need coverage now

    2. Need documents or information I did not have

    3. Too many things required to do

    4. Too time consuming to apply

    5. Too much of a hassle

        a) What is the hassle?

6. Takes too long to find out if I am eligible

7. Don't think I am eligible

    a) Why not?

    b) Too busy

    c) Have to work during the day.

D. What would make you more likely to apply for Medicaid?

E. After Disaster Relief Medicaid, how many of you went through the new method/Family Health Plus mail renewal process?

1. If you have, how does this renewal process compare to the previous Medicaid renewal process? Is one better than the other? If so, how?

2. How many of you have tried to apply for regular Medicaid or Family Health Plus in the last four months?

    a) If you have, what was your experience? (easy, difficult).

    b) How long did you have to wait to be seen?

    c) How many times did you have to return to the Medicaid Office before your case was opened?

        i) Did you have to return to the office with your documents?

        ii) Did you have any problems with providing documents or with the Medicaid office accepting any documents?

VI. Wrap Up —5 minutes

A. **[WRITE]** Finally, consider that you have the opportunity to point out only one thing to assist a group that is trying to make Family Health Plus and Medicaid better programs. Based on your experiences, what one thing would you tell them to do to make Family Health Plus or Medicaid better?

B. Other thoughts?

C. Thank you very much!

Telephone Call Discussion Guide

Format and some questions used by permission from Lake, Snell, & Perry Associates and the Commonwealth Fund.

I. Introduction

    A. About the study

        1. Calling from Cornell/Sent you a letter recently about Disaster Relief Medicaid.

        2. We randomly selected you from the list of people who received Disaster Relief Medicaid assistance/the Emergency Medicaid that was offered after 9/11.

        3. We would like to find out what your experience with Disaster Relief Medicaid was like.

        4. Another purpose of this project is to enhance the process people go through to get Medicaid. One good way to do that is to hear from people like you who have had experience with the system. Would you be willing to talk with us? If this isn't a good time, is there a time we can call you back?

        5. Thanks for doing this–your experiences are important to us.

    B. Confidentiality

        1. What you say is confidential. No names or identifying information will be used in the report. No information will be shared with the INS (Immigration and Naturalization Service).

    C. Guidelines

        1. No wrong answers—if you don't understand a question, ask me to explain…

        2. I am not an expert—there might be questions that I can't answer. (If client has questions about MA/FHP coverage, take down name and phone number and forward to Lynn Walker.)

II. Context

    A. How are things going for you right now with your job? (full time, part time, student, unemployed, homemaker?)

1. Are you still experiencing the effects of 9/11?

B. What is your physical health status?

1. What are you doing for health care now?

C. Are you covered by any health insurance at this time?

1. What coverage do you have?

a) Medicaid?

b) Family Health Plus?

c) Private Insurance?

d) Nothing? If nothing, have you tried to apply? If not, why not?

D. Can you get health care coverage through your employer or your spouse's employer?

III. Disaster Relief Medicaid

[MAKE SURE CLIENT KNOWS WHAT DRM WAS. POINT OUT DIFFERENCES BETWEEN DRM & STANDARD MEDICAID & CLARIFY BEFORE PROCEEDING.]

A-26

A. How did you find out about Disaster Relief Medicaid?

B. How soon after September 11 did you apply for Disaster Relief Medicaid? (right away, one month, two months)

C. Did you apply more than once? If so, why?

D. Did you have a job before September 11?   ___Yes   ___No

1. What was your job?

E. Did you lose your job as a result of the events of September 11?   ___Yes   ___No

1. If so, when?

F. Before Disaster Relief Medicaid, how did you pay for health care?

1. What type of services did you receive?

2. Who provided the health care?

G. If you were refused Medicaid in the past, why were you refused?

1. Were you unable to receive Medicaid or Public insurance because you were not a United States citizen?

2. Did you earn too much money?

3. Did you have trouble understanding what you were supposed to do? (Was the process confusing?)

H. Where did you apply for Disaster Relief Medicaid?

1. Regular Medicaid Office

2. Hospital

3. Community Organization

4. Other (please describe):

I. Did anyone give you any help before or during the application process? ___Yes ___ No

J. Did anybody tell you how to receive benefits? ___Yes ___No

1. If so, please describe what you were told:

K. Did you realize you were signing up for Medicaid? ___Yes ___No

L. How long did you receive Disaster Relief Medicaid?

M. During the time you received Disaster Relief Medicaid, did you know where to go for health care services such as dentists, doctors or drug stores? A-27

N. If you were already receiving Medicaid, why did you apply for Disaster Relief Medicaid?

O. Thinking back to when you were enrolled in DRM, what health care services did you use?

1. Did you try to see a doctor?

a) Were you able to? If not, why not? Were you refused services?

b) How do you feel about the services you received?

2. Did you try to see a dentist?

a) Were you able to? If not, why not? Were you refused services?

b) How do you feel about the services you received?

3. What other services did you use or try to use while on DRM?

4. Did you have difficulty getting follow-up appointments?

P. How has your usage of health care services changed since going off of DRM?

Q. When Disaster Relief Medicaid (DRM) eligibility was ending how many of you received a letter? ___Yes ___No

R. When Disaster Relief Medicaid (DRM) eligibility was ending did anyone call you?
___Yes ___No

S.. What did you find out from the call or letter?

    1. Did you understand what was in the letter or what the caller told you?

    2. Did you do anything in response to the call or letter? What?

        a) Contact social services, eligibility worker?

        b) Contact Doctor?

        c) Contact legal aid?

        d) Contact someone else? Who?

T. If you did not get a letter or a call, what did you do when you realized that your Disaster Relief Medicaid (DRM) was ending?

U. If you did not do anything? Why not?

IV. Transitioning

A. Did you know that it was possible to transition from DRM to regular Medicaid? (That is to apply for regular Medicaid while you were on DRM so that you would not lose coverage.)

B. How did you find out it was possible to transition from Disaster Relief Medicaid to regular Medicaid or Family Health Plus? (In other words, how to apply for regular Medicaid while you were on DRM so that you would not lose coverage.)

C. Were you asked to come in for an interview to transition (change over) to regular Medicaid between March 26, 2002 and November 30, 2002?

    1. If yes, what was it like?

    2. What did you hear about transitioning? From whom?

D. If you did not come in for a transition interview…

    1. Why didn't you try to transition?

E. Did you try to transition from Disaster Relief Medicaid to regular Medicaid or Family Health Plus? ___Yes ___No **[If response is no, skip to Section V.]** Why?

F. What did you have to do to transition?

    1. Did you have to come into office for interview?

G. If you tried to transition from DRM to Medicaid, how would you describe the recertification process?

H. Did your experience with applying for Medicaid change how you feel about DRM?

I. For those who were turned down for regular Medicaid, how do you feel about what happened?

    1. Will you ever apply for Medicaid again?

J. What do you think was good/helpful or difficult/unhelpful about Disaster Relief Medicaid?

I. Medicaid

A. Prior to applying for DRM how many of you had ever applied for regular Medicaid?

    1. How long ago did you apply for regular Medicaid coverage?

    2. What were your experiences?

    3. If so how did your memories of the Medicaid application process affect your decision of whether or not to apply for regular Medicaid this time?

B. After Disaster Relief Medicaid, did you go through the new method/MA/Family Health Plus mail renewal process?

    1. If you have, how does this renewal process compare to the previous Medicaid renewal process? Is one better than the other? If so, how?

    2. Have you tried to apply for regular Medicaid or Family Health Plus in the last four months? If you have, what was your experience? (easy, difficult)

VI. Wrap Up

A. Finally, consider that you have the opportunity to point out only one thing to assist a group that is trying to make Family Health Plus and Medicaid better programs. Based on your experiences, what one thing would you tell them to do to make Family Health Plus or Medicaid better?

B. Other thoughts?

C. Thank you very much!

Questions for New York State & HRA Managers & Employees

1. Describe what it was like to create a program like this (Disaster Relief Medicaid) from "scratch." What were the challenges and obstacles?

2. What critical decisions had to be made, and at what points?

3. What were your experiences with the host facilities?

4. How was the high volume/overcrowding managed? How were people deployed?

5. What was the impact on ongoing operations?

6. What is your perspective on the new process and the model office?

7. What is your perspective on the new mail renewal process?

8. How frustrated were the workers by the level of verification required? (Did workers feel the person across from them was telling the truth?)

9. Other thoughts:

Appendix B:
Process Documents & Reference Sheets

B-2

APPLICATION for DISASTER RELIEF MEDICAID/FHPlus

CONTACT INFORMATION   *Tell us who you are and how to contact you.*

NAME First	Middle Initial	Last

ADDRESS of the persons applying for health insurance

Street	Apt#

City	State	Zip Code	County

Phone #	Another Phone #	Primary Language Spoken

HOUSEHOLD INFORMATION   *Tell us who is applying, and how many other people live with them.*

People Who Are Applying

Last Name, First Name, Middle Initial	Date of Birth	Sex M/F	Is this person a parent of any applying child?	Is this person pregnant?	**Social Security #** Not needed for pregnant women
01			❒ Yes	❒ Yes	
02			❒ Yes	❒ Yes	
03			❒ Yes	❒ Yes	
04			❒ Yes	❒ Yes	
05			❒ Yes	❒ Yes	
06			❒ Yes	❒ Yes	

Does anyone listed above have a disability that affects their ability to work or carry out other activities?   Yes ❒   No ❒
If yes, give name:_____

Does anyone who is applying have unpaid or recently paid medical bills from the past 3 months?   Yes ❒   No ❒

Other People in Your Household
Number of people in household who are NOT applying. (Count if a parent, step-parent, or spouse of someone applying; if you wish you may also
count children under 21 related to someone applying):   None ❒   1 ❒   2 ❒   3 ❒   Other _____

INCOME   *Add together the income received by the people in your household.*

Income includes wages, salaries, Social Security benefits, unemployment payments, worker's compensation, disability payments, interest and dividends, child support payments, money from relatives or friends, and other payments you receive.

Total amount $_____

HEALTH INSURANCE   *Your family may still be eligible even if you have other health insurance.*

Does anyone who is applying already have other health insurance?   Yes ❒_____   No ❒

Name of Policy Holder:	Group/Policy #
Insurance Company Name:	Monthly Cost$
Person(s) Covered:	End Date of Coverage

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TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Disaster Relief Medicaid. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility. I understand that I may be asked for more information.

I understand that Disaster Relief Medicaid will give me coverage for four months only. I will not receive any notices when the coverage ends. There are no Fair Hearing or Aid Continuing rights when Disaster Relief Medicaid ends. I understand that if I want Medicaid beyond the four months of Disaster Relief, I must complete a new Medicaid application.

I understand that I must provide the information needed to prove my eligibility, and that workers may check the information given by me for this application. The Medicaid agency will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am on Medicaid.

I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

I understand that if I have medical bills from the 3 months preceding this application and I want to ask if Medicaid can help pay them, I will need to save the bills and bring them with me when I apply for Medicaid at the end of my Disaster Relief coverage.

I understand that my eligibility will not be affected by my race, color, or national origin. I also understand that my age, sex, or disability status may be a factor in whether or not I am eligible.

I understand that anyone who knowingly lies or hides the truth in order to receive services is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER (SSN): I understand that SSNs are required for all applicants, unless the person is pregnant or does not have satisfactory alien status. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central government Medicaid agencies to insure that proper services are made available to the recipient.

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I have read and understand the Terms, Rights and Responsibilities included in this application. By signing this application, I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____   _____ _____
SIGNATURE   DATE   SIGNATURE   DATE

Relationship to people applying_____

FOR OFFICE USE ONLY

Worker _____   *Date* _____

Determination

Name	Eligible ?	CIN# (if Yes)	Reason (if No)
_____	Yes ☐ _____	No ☐ _____	
_____	Yes ☐ _____	No ☐ _____	
_____	Yes ☐ _____	No ☐ _____	
_____	Yes ☐ _____	No ☐ _____	
_____	Yes ☐ _____	No ☐ _____	

Period of Eligibility: From: ____/____/____   To: ___/____/____
DOH/OMM/091901

Income Calculation for Disaster Relief Medicaid/FHPlus

STEP 1

Family Size* (from Household Information Section of the application)	Gross Monthly Income (from Income Section of the application)
a. # of people who are applying _____ b. # of other people not applying _____ (legally responsible parent, step-parent, or spouse of someone applying; or child under 21 related to someone applying) TOTAL _____ *Count pregnant woman as 2	Determine Family's total countable gross monthly income. (Include income received by anyone included in the Family Size. See "Reference Sheet" for income that is not included. Multiply weekly amounts by 4.333333; biweekly amounts by 2.166666) TOTAL $_____

Compare Total gross monthly income to the appropriate Monthly Income Level for the family size in the following chart. If the income is equal to, or less than the amount shown, the individual(s) is eligible. Enter the name(s) and check "yes" in the Determination Section of the application. If the income is above the amount shown, continue with **Step 2**, below.

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Family Size	1	2	3	4	5	6	Each Add'l Person Add:
Parents; Children Under age 21	$953	$1,287	$1,622	$1,957	$2,291	$2,626	+$335
Single persons; Couples without Children	$716	$968					

STEP 2

Net Monthly Income (Non-disabled adults under age 65 and children under age 21)

a. Gross Monthly Income from Step 1……..………..
$_____

b. Deductions
____# of working family members X $90/month..… $ _____
Childcare costs (actual or $200, whichever is less)
_____ # of children under 2 years X $ _____…....…. $ _____

Childcare costs (actual or $175, whichever is less)

_____ # of children over 2 years X $ _____…....…. $ _____

Adult Dependent Care costs (actual or $175, whichever is less)……………………………..…… $ _____

Health Insurance premium (allowed for parents, children, disabled adults only)………………....... $ _____
$50 from total child support received ……………… $ _____
$5.00 per day per child from income received for providing informal daycare………………..….. $ _____

TOTAL Deductions………………………..……… = ($ _____)

c: Subtract **Total Deductions** from **Monthly Income**. Enter result: . $ _____

Net Monthly Income (Adults over age 65 or disabled)

a. Monthly Income of non-SSI related spouse (if applicable)………….……………………………………… $_____
b. Minus:____# of children with no income X $275... - $ _____
c. Subtotal   = $ _____

d. Plus: Monthly Income of SSI-related person……. + $ _____
e. **Subtotal**   = $ _____

f. Deductions
$20 from unearned/earned income………….…........ $ _____

$65 from earnings from work……….…………..……… $ _____
Impairment-related work expenses……………………. $ _____
1/2 of remaining earnings from work……………..….. $ _____
Health Insurance premium………………...…….…... $ _____

TOTAL Deductions……..……………………..…… = ($ _____)

g. Subtract **Total Deductions** from **Subtotal e**. Enter result: $ _____

Compare result above to the appropriate Monthly Income Level for the family size in the following chart. If the income is equal to, or less than the amount shown, the individual(s) is eligible. Enter the name(s) and check "yes" in the Determination Section of the application. If the income is above the amount shown, the individual(s) is not eligible. Enter the name(s), check "no" and give the reason in the Determination Section of the application.

Family Size	1	2	3	4	5	6	Each Add'l Person Add:
Children under 1 year; Pregnant Women	$1432	$1935	$2439	$2942	$3445	$3949	+ $504
Children 1-5	$953	$1287	$1622	$1957	$2291	$2626	+ $335
Children 6-19 yrs	$716	$968	$1220	$1471	$1723	$1975	+$252
Children 19-20 yrs; Non-disabled adults under age 65	$625	$900	$909	$917	$992	$1134	+ $142
Elderly/disabled/blind adults	$625	$900					

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<u>REFERENCE SHEET: INCOME DISREGARDS FOR DISASTER RELIEF MEDICAID/FHPLUS</u>

For all applicants, income received from the following is not counted when determining eligibility for Medicaid or FHPlus:

Americorps/Vista
Blood Plasma Awards
Bonafide Loans
Crime Victims' Fund Payments
Disaster Relief
Earned Income of Full-Time students under the age of 21
Earned Income Tax Credit
Federal Economic Opportunity Act Loans
Federal Energy Assistance Payments
Foster Care Payments
GI Bill Deduction
Graduate/Educational Grants (for educational expenses) or Undergraduate Educational
    Grants, Scholarships or Work Study
HUD Community Block Grants
Income Tax Refunds
In-kind Maintenance (such as rent, groceries, etc.) not from a legally responsible
    relative, and not in return for goods or services rendered.
Insurance Payments
Job Corps
Job Training Partnership Act Payments
NYS Department of Labor Payments: i.e., Youth Education and Employment and
    Training Programs (**not** unemployment benefits)
Native American Payments (including Alaskan Native payments)
Persecution Payments (German/Austrian/Netherlands Reparation
    Payments, and payments to Japanese-Americans, Aleuts or Pribilof Islanders)
Preventative Housing Service Payments
Public Assistance Grants
Radiation Exposure Compensation
Relocation Assistance
Roomer or Boarder/Lodger Income (deduct $90 or actual expenses, if higher)
Supplemental Security Income (SSI)
Veterans' Payments for Aid and Attendance or Unusual Medical Expenses
Vietnam Veterans – Agent Orange Settlement Funds
Vocational Rehabilitation Payments
Volunteer Program Payments under the Domestic Volunteers Services Act
    (foster grandparents, SCORE, ACE)

B-7

FHPlus Hotline Response:
New York City Disaster Relief Medicaid/
FHPlus Health Coverage

To insure that New York City residents have access to health care coverage following the World Trade Center disaster, a special disaster relief program has been set up for people applying for Medicaid or Family Health Plus. Medicaid will be available for four months to adults who meet the Family Health Plus income levels. **This coverage is available by filing a one-page "Application for Disaster Relief Medicaid/FHPlus" at one of the City's designated Medicaid offices (see list below)… or at Pier 94 for families of disaster victims…or at 180 Water Street in Manhattan for residents below Canal Street.**

Disaster Relief Medicaid/FHPlus will be available to eligible NYC residents for four months beginning with the first day of the month in which they apply. New York City will accept applications for this coverage through January 2002. You can apply for Disaster Relief Medicaid coverage immediately at one of the City's designated Medicaid offices (see list below).

If you meet the income requirements, you will receive a numbered Temporary Medicaid Authorization form, which will be your proof of eligibility. You can take this form to a Medicaid provider and receive health care services. Providers are being instructed to accept this form. Health care services provided under Disaster Relief Medicaid are not available through managed care plans.

At this time, applications are only available at the City's designated Medicaid offices. If you let me know the borough you live in, I can help you find the Medicaid office nearest your home.

Bronx

Bronx Lebanon Hospital Healthstat Office
1276 Fulton Avenue
718-588-2997

Jacobi Hospital Healthstat Office
Pelham Pkwy. & Eastchester Rd.
(Staff House Rm 100)
718-597-4109

Lincoln Hospital Healthstat Office
234 East 149th St.(Basement-Room B-75)
718-585-3224

Morrisania Healthstat Office
1225 Gerard Avenue - Basement
718-960-2799/2752

North Central Bronx Hospital Healthstat Office
3424 Kossuth Avenue (1st Fl.- Room 1A 05)
718-290-1070

Saint Barnabas Hosp Healthstat Office
4422 Third Avenue Out-Patient Clinic Bldg. (3rd Fl)
718-960-6322/6325

Brooklyn

Boerum Hill Healthstat Office
35 4th Avenue
718-694-8722/23

East New York Healthstat Office
2094 Pitkin Avenue (Basement)
718-922-8292/8293

Bushwick Healthstat Office
737 Flushing Avenue(4th Floor)
718-963-5080/81

Kings County Hospital Healthstat Office
441 Clarkson Ave. "T" Bldg Nurses' Residence (1st Fl)
718-221-2300/2301

Coney Island Healthstat Office
30-50 West 21st Street
718-333-3000/1

Manhattan

Bellevue Hospital Healthstat Office
466 First Avenue and 27th St. "G" Link(1st Floor)
212-679-7242

Metropolitan Hospital Healthstat Office
1901 First Avenue (1st Fl. - Room 1D18)
212-423-6583/7006

Columbia Presbyterian Hospital Healthstat Office
622 West 168th St. (1st Fl) PH 040
212-342-5102/5103

Compassion Center
Pier 94 West Side Highway and 55th St.
(Families of World Trade Center Disaster Victims Only)

Gouverneur Hospital Healthstat Office
227 Madison St. (7th Fl)
212-238-7790

Twin Towers Services Center
180 Water St. 1st Floor
(Residents of World Trade Center Disaster Area Only)

Harlem Hospital Healthstat Office
6-20 West 137th St. - Old Pediatrics Bldg (Room 130)
212-281-1240

Queens

Elmhurst Hospital Healthstat Office
79-01 Broadway (Room D4-17)
718-476-5904

Far Rockaway Healthstat Office
220 Beach 87th St (Street Level)
718-318-6580/1

Queens Hospital Center Healthstat Office
82-68 164th St.(N Bldg - 1st Fl - Room 121)
718-883-3774/3773

Jamaica Healthstat Office
90-75 Sutphin Blvd. (6th Floor)
718-523-5699

Staten Island

Staten Island Healthstat Office
350 St. Mark's Place - Basement
718-270-2850/51

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Appendix C:
Transition Notices for Recipients

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

IMPORTANT

Notice of Update on Your Disaster Relief Medicaid

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Dear Disaster Relief Medicaid/Family Health Plus Recipient:

Our records show that your Disaster Relief coverage ends on January 31, 2002. You were informed at the time of your Disaster Relief application that in order to continue your coverage beyond the four months of Disaster Relief coverage, you must complete an application for Medicaid/Family Health Plus and submit documentation necessary to determine continued eligibility.

In order to assist current Disaster Relief recipients in the transition to Medicaid or Family Health Plus without a break in coverage, the State Department of Health and the Human Resources Administration are temporarily extending your Disaster Relief coverage. This will allow more time for you to complete the Medicaid/Family Health Plus application process. **You do not need to take any action at this time to continue your health coverage**.

C-3

Within the next several weeks, you will receive a letter that will tell you how you can continue to use your extended Disaster Relief coverage, and how to apply for Medicaid/Family Health Plus.

If you need medical care after your Disaster Relief coverage ends, and you have not received a letter telling you that your coverage has been extended, take this letter and your Disaster Relief Temporary Medicaid Authorization to your medical provider.

If you have not received a letter by February 15, 2002 telling you that your coverage has been extended, call 1-877-934-7587.

(Vea esta Notificación en Español a la vuelta)

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

IMPORTANTE

Aviso de Actualización de su Medicaid de Ayuda por el Desastre

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Estimado Beneficiario de Medicaid de ayuda por el desastre/Family Health Plus:

Nuestros expedientes indican que su cobertura de ayuda por el desastre termina el 31 enero, 2002. Si le informó al momento de presentar su solicitud de ayuda por el desastre que para poder continuar su cobertura después de los cuatro meses de ayuda por el desastre, usted tiene que completar una solicitud para Medicaid/Family Health Plus y presentar los documentos necesarios para determinar si sigue teniendo derecho a la cobertura.

C-4

Para poder ayudar a los beneficiarios actuales de ayuda por el desastre, en su cambio a Medicaid o Family Health Plus sin interrupción de cobertura, el Departamento Estatal de Salud y la Human Resources Administration han extendido temporalmente su cobertura de ayuda por el desastre. Esto le dará más tiempo para que complete el proceso de su solicitud de Medicaid/ Family Health Plus. **Usted no tiene que hacer nada en este momento para continuar con su cobertura**.

Dentro de las próximas semanas, usted recibirá una carta que le indicará cómo puede usar su cobertura ampliada de ayuda por el desastre y cómo solicitar Medicaid/Family Health Plus.

Si usted necesita cuido médico después que su cobertura de ayuda por el desastre se ha terminado y no ha recibido una carta indicándole que su cobertura ha sido extendida, lleve esta carta y su autorización temporaria de Medicaid para la cobertura de ayuda por el desastre a su proveedor.

Si no ha recibido una carta indicándole que su cobertura ha sido ampliada antes de 15 Febrero, 2002, llame al: 1-877-934-7587.

Medical Assistance Programs
Control Unit
GPO Box 2750
New York, NY 10017-0299

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Rev. 01/31/02

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

IMPORTANT

Notice of Update on Your Disaster Relief Medicaid

ᐁ   ↵   **NOTICE DATE: _____**

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Dear Disaster Relief Medicaid/Family Health Plus Recipient:

In order to help you in the transition to Medicaid or Family Health Plus without a break in coverage, we are temporarily extending your Disaster Relief coverage. This will allow you to complete the Medicaid/Family Health Plus application process. You do not need to take any action **at this time** to continue your health coverage.

Our records show that your Disaster Relief coverage ends on _____. Within the next several weeks, you will receive letters that will tell you how you can continue to use your extended Disaster Relief coverage, and how and when to apply for Medicaid/Family Health Plus. **You must follow the instructions in the letters you will receive, or your health insurance coverage will end.**

C-5

If you have not received a letter telling you that your coverage has been extended by the time your Disaster Relief coverage ends, call 1-877-934-7587.

(Vea esta Notificación en Español a la vuelta)

Mail Job 675

<u>The CITY of NEW YORK</u>
Human Resources Administration
<u>Medical Assistance Programs</u>

IMPORTANTE

Aviso de Actualización de su Medicaid de Ayuda por el Desastre

FECHA DEL AVISO: _____

Estimado Beneficiario de Medicaid de Ayuda por el Desastre / Family Health Plus:

Para poder ayudarlo en su cambio a Medicaid o Family Health Plus sin interrupción de cobertura, estamos extendiendo temporalmente su cobertura de Ayuda por el desastre. Esto le dará más tiempo para que complete el proceso de su solicitud de Medicaid/ Family Health Plus. Usted no tiene que hacer nada **en este momento** para continuar con su cobertura.

C-6

Nuestros expedientes indican que su cobertura de Ayuda por el desastre termina el _____. Dentro de las próximas semanas, usted recibirá cartas que le indicarán cómo usted puede continuar usando su cobertura ampliada de Ayuda por el desastre y cómo y cuándo solicitar Medicaid/Family Health Plus. **Usted deberá seguir las instrucciones de las cartas que reciba o terminará su cobertura de seguro médico**.

Si para cuando termine su cobertura de Ayuda por el desastre, usted no recibe una carta indicándole que su cobertura ha sido ampliada, llame al 1-877-934-7587.

(Turn over to see this Notification in English)

Medical Assistance Programs
Control Unit
GPO Box 2750
New York, NY 10117-0299

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Rev. 01/31/02

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

IMPORTANT

Notice of Temporary Extension of Your Disaster Relief Medicaid

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This letter is about your Disaster Relief Medicaid coverage. This coverage will automatically continue until the appointment date that we will give you.

We will send you an appointment date to meet with a worker from the Medicaid office who will see if you are eligible for Medicaid or Family Health Plus. We will also send you a new application. **You must keep your appointment and bring the documents listed on the application, or your temporary coverage will end for everyone listed below.**

Disaster Relief Medicaid coverage has been extended temporarily for:

Name	Client I.D.#
Name	Client I.D.#
Name	Client I.D.#

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Medicaid cards will be sent out for you to use during this temporary extension. If you need to see a doctor, use the Medicaid card. Some people listed above may get a new card in the mail and some may not.

Those who **will** get a new card:
- have not had Medicaid, Public Assistance or Food Stamps since 1996
- can use this new card if they need to see a doctor

Those who will **not** get a new card:
- have had Medicaid, Public Assistance or Food Stamps since 1996
- should use their old card if they need to see a doctor
- should call 1-877-472-8411 if they need a new card because they lost the old card

If you think you should get a new card and don't get one within two weeks of getting this letter, call 1-877-472-8411 to get a new card. If anyone in your family needs to see a doctor before they get a Medicaid card, take this letter with you to your doctor.

If someone who has a Public Assistance/Food Stamps benefit card gets a new Medicaid card anyway, **do not throw either card away**. Continue to use the Public Assistance/Food Stamps benefit card for Public Assistance or Food Stamps, and the Medicaid card for Medicaid.

We hope you will take the opportunity to apply for health care coverage through Medicaid or Family Health Plus.

For all other questions, please call 1-888-692-6116.

(Vea esta Notificación en Español a la vuelta)

Mail Job 677

Medical Assistance Programs
Control Unit
GPO Box 2750
New York, NY 10117-0299

MAP-0911F(E.S) reverse
Rev. 01/31/02

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

IMPORTANTE

Aviso de Ampliación Temporal de su Ayuda Medicaid por el Desastre

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Esta carta es sobre su cobertura de Ayuda Medicaid por el Desastre. Esta cobertura continuará automáticamente hasta la fecha de la cita que le haremos saber.

Le enviaremos la fecha una cita para que se reúna con un trabajador de la oficina de Medicaid, quien verá si usted tiene derecho al beneficio de Medicaid o Family Health Plus. También le enviaremos una nueva solicitud. **Usted debe venir a su cita y traer los documentos anotados en la solicitud o terminará la cobertura temporal para todas las personas indicadas abajo.**

La cobertura de Ayuda Medicaid por el desastre ha sido ampliada temporalmente para:

Nombre	Nº de Identificación del cliente
Nombre	Nº de Identificación del cliente
Nombre	Nº de Identificación del cliente

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Se enviarán tarjetas Medicaid para que las usen durante esta ampliación temporal. Si necesita ver un médico, use la tarjeta Medicaid. Es posible que algunas de las personas anotadas arriba reciban una tarjeta nueva por correo y otras no.

Aquellos que **reciban** una tarjeta nueva:
- no han tenido Medicaid, Asistencia pública ni Cupones de alimentos desde 1996
- pueden usar esta tarjeta nueva si tienen que ver al médico

Aquellos que **no** reciban una tarjeta nueva:
- han tenido Medicaid, Asistencia pública o Cupones de alimentos desde 1996
- deben usar su tarjeta vieja si tienen que ver al médico
- deben llamar al 1-877-472-8411 si necesitan una tarjeta nueva porque perdieron la tarjeta antigua

Si usted cree que debería recibir una tarjeta nueva y no la recibe a más tardar en dos semanas después de recibir esta carta, llame al 1-877-472-8411 para obtener una tarjeta. Si alguien de su familia tiene que ver al médico antes de recibir su tarjeta Medicaid, lleve esta carta a su médico.

Si alguien que tiene beneficios de Asistencia pública o Cupones de alimentos recibe de todas maneras una tarjeta Medicaid nueva, **no bote ninguna de las dos**. Siga usando la tarjeta de beneficios de Asistencia pública o Cupones de alimentos para Asistencia pública o Cupones de alimentos y la tarjeta Medicaid para Medicaid.

Esperamos que aproveche la oportunidad de solicitar la cobertura de atención médica a través de Medicaid o Family Health Plus.

Para todas las demás preguntas, por favor llame al 1-888-692-6116.

(Turn over to see this Notification in English)

Medical Assistance Programs
Control Unit
GPO Box 2750
New York, NY 10117-0299

MAP-0911G (E-S) (face)
Rev. 01/31/02

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

Notice of Application Appointment

RESP AREA: CC
LOCATION: CED/MPE
NOTICE DATE:
CASE NUMBER:
NO. OF ADULTS:
NO. OF CHILDREN:

Dear Disaster Relief Medicaid Recipient:

Our records show that you are getting Disaster Relief Medicaid coverage. In order to continue to get health care coverage, you must apply for Medicaid/Family Health Plus and complete an interview with a Medicaid worker. Your face-to-face interview has been scheduled for:

DATE: **TIME:** **AT:**

Bring this letter and all required documents to your interview. Fill out as much of the Access NY Health Care Application as you are able to before your interview.

If you do not apply for Medicaid/Family Health Plus, your Disaster Relief coverage will end under authority of State Regulation 18 NYCRR 360-2.2(f) and Section 369-ee of the Social Services Law.

PLEASE CALL US AT: 1(__)_____ IF:

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-- you need to change your appointment time or date (call no earlier than 2 weeks before your scheduled appointment date).

-- you do not want Medicaid/Family Health Plus.

IMPORTANT REMINDERS:

1. You must be interviewed. An adult family member, friend or community agency may represent you. If you have no one to do so and are unable to travel, call 1(__)_____ to request a home interview.

2. Please arrive on time. We have many people scheduled and latecomers may have to be rescheduled for another day.

3. Review your Access NY Health Care Application and documents to make sure you have all required documents with you and as much of the application completed as possible.

Bring all required papers with you to the interview.
Do not mail them to Medicaid/Family Health Plus.

For additional help with your application, see the attached list, "NYC Facilitated Enrollers."

(Vea esta Notificación en Español a la vuelta)

Medical Assistance Programs
Control Unit
GPO Box 2750
New York, NY 10117-0299

MAP-0911G (E-S) (reverse)
Rev. 01/31/02

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Programs

Aviso de Cita para Solicitud

ÁREA DE RESP: CC
UBICACIÓN: CED/MPE
FECHA DEL AVISO:
NÚMERO DE CASO:
Nº DE ADULTOS:
Nº DE NIÑOS:

Estimado Beneficiario de Ayuda Medicaid por el Desastre

Nuestros expedientes muestran que usted recibe cobertura de Ayuda Medicaid por el desastre. Para poder continuar recibiendo cobertura de atención médica, usted debe solicitar Medicaid/Family Health Plus y completar una entrevista con un trabajador de Medicaid. Esta entrevista en persona ha sido programada para el:

FECHA: **HORA:**   **EN:**

Traiga consigo esta carta y todos los documentos exigidos a su entrevista. Llene todo lo que pueda del formulario de solicitud de atención médica Access NY antes de su entrevista.

Si usted no solicita Medicaid/Family Health Plus, su cobertura de Ayuda Medicaid por el desastre terminará bajo la autoridad del Reglamento estatal 18 NYCRR 360-2.2 (f) y el artículo 369.ee de la ley de Servicios Sociales.

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POR FAVOR LLÁMENOS AL: 1(_)_____   **SI:**

-- necesita cambiar la fecha o la hora de su cita (no llame antes de 2 semanas antes de su fecha de la cita programada).

-- no desea Medicaid/Family Health Plus.

RECORDATORIOS IMPORTANTES:

1. Usted debe ser entrevistado. Puede representarlo algún adulto miembro de su familia, amigo o agencia comunitaria. Si no tiene a nadie o si no puede viajar, llame al 1(___)_____ para solicitar una entrevista en su hogar.

2. Por favor llegue a tiempo. Es posible que tengamos mucha gente citada y las citas de las personas retrasadas tendrán que ser reprogramadas para otro día.

3. Revise su solicitud de atención médica Access NY y sus documentos para asegurarse de tener consigo todos los documentos exigidos y de haber llenado todo lo posible de la solicitud.

Traiga consigo a la entrevista todos los papeles exigidos.
No los envíe por correo a Medicaid/Family Health Plus.

Si necesita ayuda adicional con su solicitud, vea la lista anexa,
"Inscriptores autorizados de NYC Facilitated Enrollers."

(Turn over to see this Notification in English)

Appendix D:
Demographic, Cost and Utilization Analysis
Disaster Relief Medicaid

December 5, 2003
Office of Medicaid Management,
Policy and Program Guidance
Knowledge Information Management Group

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Executive Summary

The purpose of this report is to address the similarities and differences between Medicaid enrollees and those who were enrolled in the Disaster Relief Medicaid Program (DRM), in terms of demographics and Medicaid service utilization. DRM was established in New York City in October 2001 to provide temporary relief in response to the disruptions caused by the September 11, 2001 attack on the World Trade Center. Due to the unique features of the DRM program (i.e., streamlined application process; attestation rather than verification for income/resources), demographic and utilization comparisons with non-DRM Medicaid enrollees may provide valuable insights that could be of future benefit to the Medicaid Program.

The **Demographic Comparison** section of this report summarizes the results of the comparison of demographic measures (e.g., Age, Gender, Geography) between DRM recipients enrolled during the month of January 2002 and the full January 2001 New York City Medicaid enrollee population. Unlike the Comparison Group, DRM enrollees had a greater proportion of adults age 21-64; were more likely to be male; had a higher tendency to live in different neighborhoods and boroughs (i.e., Queens and not the Bronx).   Also, their SSN validation rate was found to be over 80%, despite the lessened documentation requirements, and 44.3% of DRM enrollees was ultimately found to be eligible for regular Medicaid as of February 2003, with 54% terminated from Medicaid.

The **Medicaid Cost and Utilization** section of this report compares Per Member Per Month (PMPM) and other measures between DRM enrollees and a Control Group, which was comprised of non-institutionalized, non-disabled, non-elderly, non-managed care MA-Only enrollees in NYC. The Medicaid utilization periods used in this comparison were from October 2001 through January 2002 for DRM, and from October 2000 through January 2001 for the Control Group. The Control data was also adjusted for age weighting, i.e., by the "under / over 21" age ratio, to adjust for the tendency of DRM enrollees to be older. Dollars Per Eligible Month, or PMPM totals, were computed by dividing Total Dollars by Total Eligible Months and broken out by Medicaid Category of Service for each group; Units Per Eligible Month were similarly calculated. In comparison with the Control Group, cost and utilization of Medicaid services by DRM enrollees was consistent with those of the regular Medicaid population, with the exception of Dental, Laboratory and Eye Care services, which were utilized at a higher rate under the DRM Program, and Inpatient Services, which were utilized at a lower rate.

The findings also confirm that the Disaster Relief Program succeeded in providing access to the broad range of Medicaid services to a large number of enrollees at a time when there was severe disruption to New York State's ability to process Medicaid eligibility in NYC.

Introduction

New York State established the Disaster Relief Medicaid Program (DRM) in New York City in response to the September 11, 2001 attack on the World Trade Center. Under this federally funded program, a total of 342,362 DRM enrollees (see Figure 1) attested to meeting Medicaid or Family Health Plus (FHP) eligibility standards and were authorized to receive full Medicaid benefits, which have thus far totaled 338.4 million dollars. Medicaid authorization under DRM was for a duration of four months, and enrollment was confined to the period of October 2001 through January 2002. Thus, depending on the month that DRM enrollment occurred, DRM enrollments ended on January 31, 2002, February 28, 2002, March 31, 2002 or April 30, 2002. Also, some of the DRM enrollment can be attributed to the higher income limits of the Family Health Plus Program. That program represents an expansion to New York's Medicaid Program, but due to the disruption caused by the September 11 disaster, it was first introduced in NYC through the DRM Program.

As their 4-month enrollments came to an end, some DRM enrollees were given regular Medicaid authorizations, while most were transitioned under the DRM Extension Program, an administrative step to facilitate formal transition to Medicaid or FHP program enrollments for those meeting applicable eligibility standards. As displayed in Table 1, 307,910 former DRM enrollees were transitioned to the DRM Extension Program, accounting for another 232.3 million dollars in Medicaid expenditures, through September 29, 2002.

Table 1. DRM and Transitional Medicaid Enrollment
and Expenditures Through 9/29/02

Group	Expenditures (millions)	Enrollees
DRM	338.4	342,362
DRM Extension	232.3	307,919
Total	570.7	342,362

The purpose of this report is to provide a basic description of the Disaster Relief (DRM) enrollee population. In Section I of this report, basic demographic measures of DRM enrollees are compared with the existing New York City Medicaid population for comparison. In Section II, Medicaid Cost and Utilization factors are compared between the two groups: DRM; Control (selected from NYC enrollees).

Before presenting those findings, however, the overall impact that the DRM Program has had on the non-DRM Medicaid enrollment and disenrollment levels in NYC should first be examined. As depicted in Figure 1, despite the sharp spike in DRM enrollment occurring in late 2001, NYC's non-DRM Medicaid enrollment trend has remained constant, with monthly enrollment levels continuing to increase slightly in the pre and post-DRM periods (through May-02).

Changes to two dynamics (Figure 2) have contributed to the continued steady enrollment increase to NYC's regular Medicaid monthly enrollment trend since DRM enactment:

- the monthly rate of enrollment of new individuals, which shows a marked increase;

- the monthly disenrollment rate, which shows a sharp decline.

The latter dynamic is a direct result of the temporary easement (through September 2002) of the federal 12-month recertification requirement for the NYC Medicaid Program.

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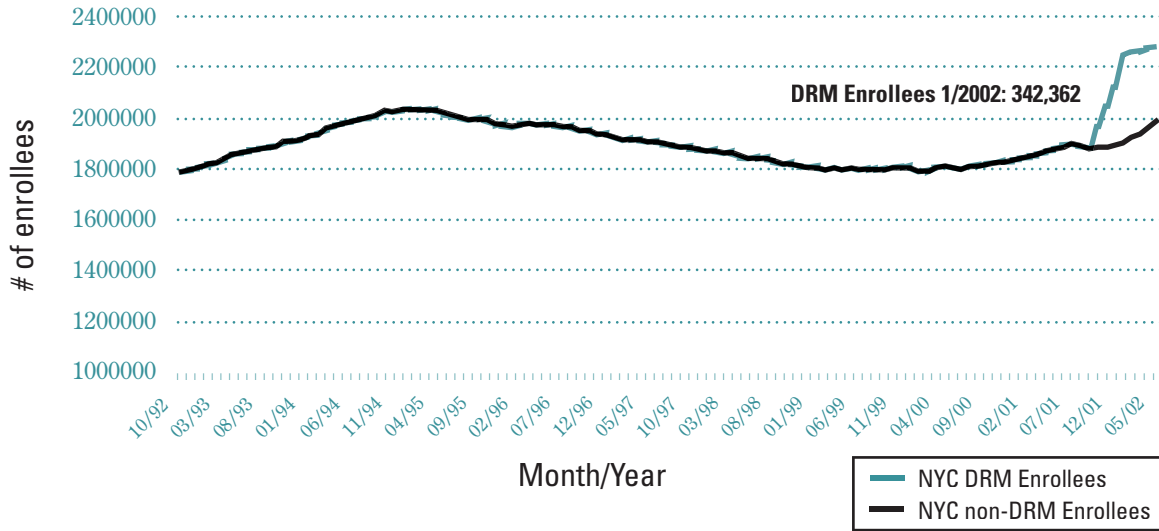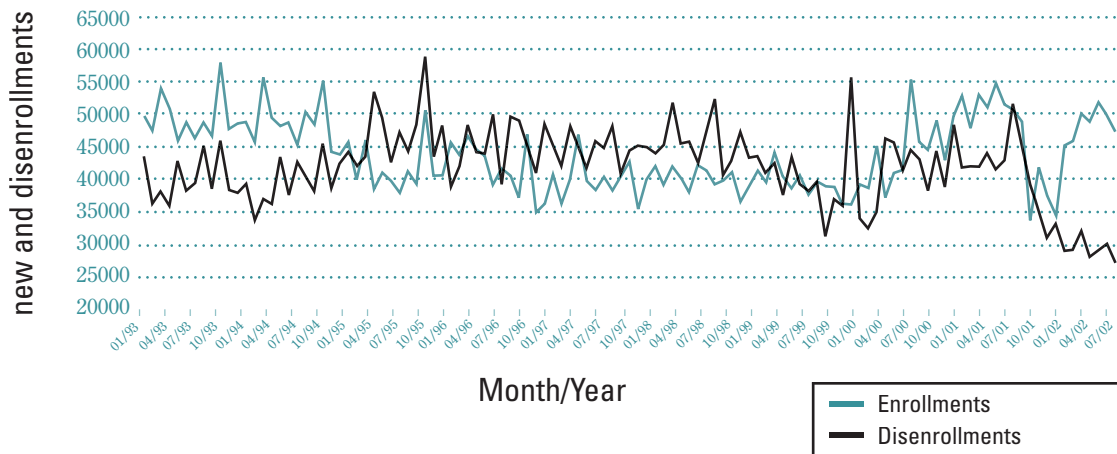Figure 1. DRM and non-DRM Monthly Enrollment in NYC 10/92–5/02

DRM Enrollees 1/2002: 342,362

NYC DRM Enrollees
NYC non-DRM Enrollees

Figure 2. NYC non-DRM Enrollments and Disenrollments 1/93–7/02

Enrollments
Disenrollments

Demographic Comparison Measures

Methodology

Data on the Disaster Relief Medicaid (DRM) enrollee population was used to develop a demographic profile based on **Age, Gender, Geography (Borough / Zip Code)**, and **Social Security Number Verification rates.** This section summarizes the results of those measures for DRM recipients enrolled in that program during the month of January 2002, and also compares those findings with those from the full New York City Medicaid enrollee population, which is referred to in this report as the **Demographic Comparison Group.** This group is limited to those who were enrolled in Medicaid during the month of January 2001, and represents all Medicaid eligibility groups of all ages, including the disabled and those in long term institutional care; Managed Care enrollees are also included.

Demographic Results

A. Age Comparison: DRM had a greater proportion of adults, 21-64.

As displayed in Table 2, the DRM enrollment rate for adults in general (i.e., over age 21) is considerably higher than in NYC Medicaid, while the overall enrollment rate for DRM children (i.e., under age 21) is much lower. In the comparison of DRM Enrollees to the Demographic Comparison Group, the age group proportions vary greatly. Only 17.91% of DRM Enrollees are in the **0 to 20** age group, compared with 50.65% for the Comparison Group. In addition, 79% of DRM Enrollees are in the **21 to 64** age group, compared with only 35.44% for the Comparison Group. However, older adults (i.e., age 65+) comprised only 3.09% of DRM enrollment, compared with a rate of 13.91% for the comparison group. Despite this, the DRM enrollment rate for adults in general (i.e., over age 21) is considerably higher than in NYC Medicaid, while the overall enrollment rate for DRM children (i.e., under age 21) is much lower.

Table 2. Age Comparison

Age Group	DRM Enrollment Total	DRM Enrollment %	Demographic Comparison Group Total	Demographic Comparison Group %
0–20	61,305	17.91	934,625	50.65
21–64	270,391	79.00	654,081	35.44
65+	10,582	3.09	256,599	13.91
Total	342,278	100.00	1,845,305	100.00

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

B. Gender Comparison: DRM enrollees were more likely to be male.

As displayed in Table 3, for the **0 to 20** age group, Females comprise 50.68% of DRM Enrollment, which is close to the rate of 47.13% for Female Enrollees in the Demographic Comparison Group. However, for the **21 to 64** age group, a larger variation was noted, with DRM Females comprising 53.13% of the total enrollment, compared with 65.59% for the Comparison Group.

Conversely, there is a higher rate of Males enrolled in DRM than in NYC Medicaid: Males of all ages comprise 46.92% of DRM enrollment, compared with an enrollment rate of 40.51% for the Demographic Comparison Group.

Table 3. Gender Comparison

Age Group	DRM Enrollees Female #	DRM Enrollees Female %	DRM Enrollees Male #	DRM Enrollees Male %	DRM Enrollees Unknown #	DRM Enrollees Unknown %	Demographic Comparison Group Female #	Demographic Comparison Group Female %	Demographic Comparison Group Male #	Demographic Comparison Group Male %	Demographic Comparison Group Unknown #	Demographic Comparison Group Unknown %
0–20	31,072	50.68	29,362	47.90	871	1.42	440,497	47.13	445,075	47.62	49,053	5.25
21–64	143,668	53.13	126,543	46.80	180	0.07	429,040	65.59	225,039	34.41	2	0.00
65+	5,895	55.71	4,681	44.23	6	0.06	179,135	69.81	77,464	30.19	0	0.00
Total	180,635	52.77	160,586	46.92	1,057	0.31	1,048,672	56.83	747,578	40.51	49,055	2.66

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

C. Geographic Comparison/ Borough: DRM had a higher proportion of Queens residents and fewer Bronx residents.

Table 4 displays the Borough ranking, by highest to lowest enrollment totals, for the DRM and the Comparison groups. Nearly identical borough rankings were found for both groups, with the exception being Queens and the Bronx, which are listed second and third for DRM Enrollment, but are in the reverse order for the Demographic Comparison Group. Overall, these findings suggest that geographic enrollment patterns are basically similar for both groups. Also, a smaller rate of enrollment outside of the 5-borough New York City area was found for DRM (0.69%), compared with the Comparison Group (2.07%), which is comprised of the existing New York City Medicaid population.

Table 4. Geographic Comparison: Borough

Borough	DRM Enrollment			Demographic Comparison Group		
	Rank	Total	%	Rank	Total	%
Brooklyn	1	125,299	36.61	1	652,549	35.36
Queens	2	85,982	25.12	2	332,861	18.04
Bronx	3	64,516	18.85	3	458,512	24.85
Manhattan	4	57,861	16.90	4	313,743	17.00
Staten Island	5	6,258	01.83	5	49,401	02.68
Other/Unknown	6	2,362	00.69	6	38,239	02.07
Totals:		342,278	100.00		1,845,305	100.00

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart
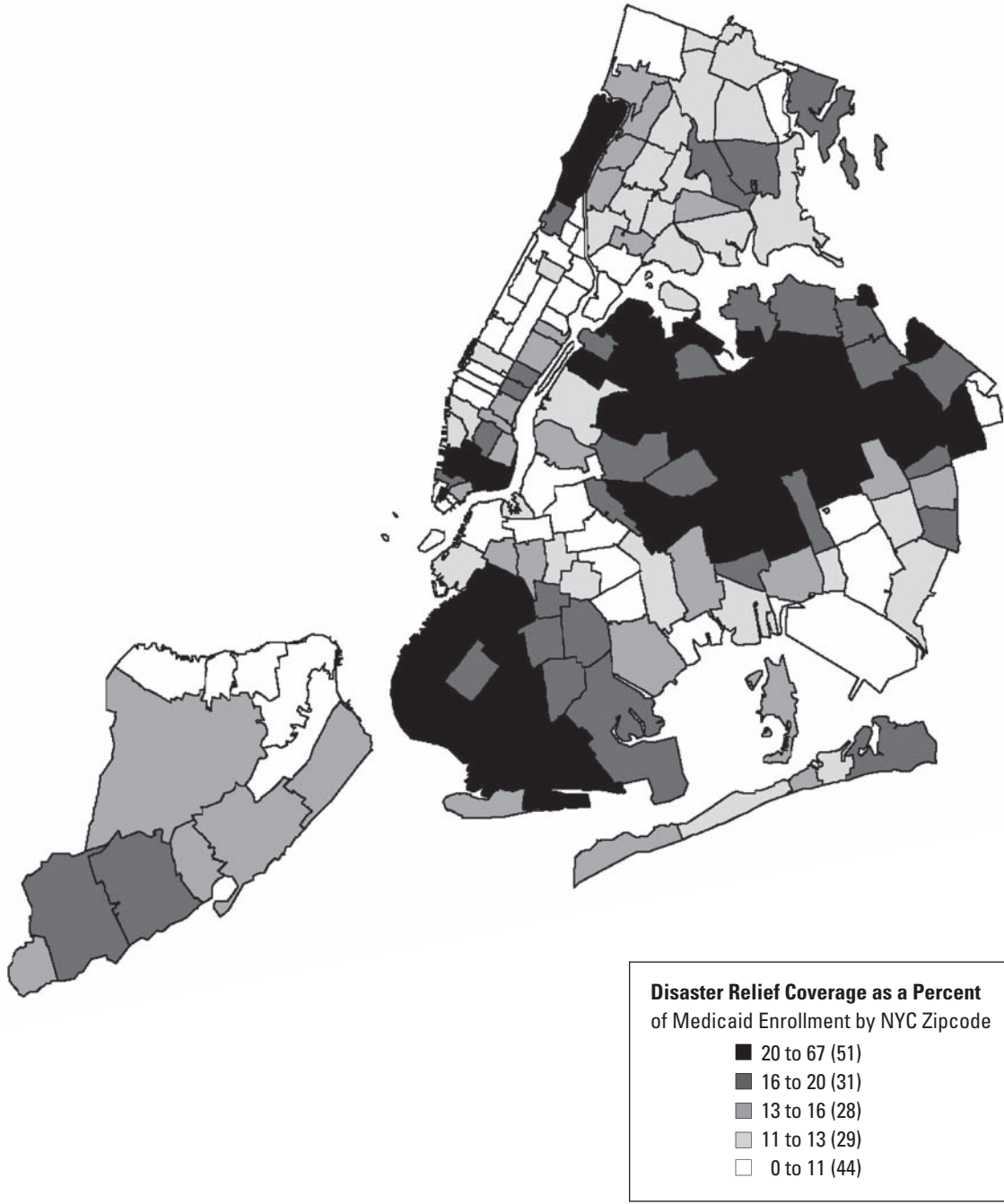
D. Geographic Comparison/ Zip Code: DRM drew its enrollees from a different group of neighborhoods.

Unlike the *borough-level* enrollment comparison in the preceding section, the enrollment comparisons at the *zip code level* show marked differences between DRM and the Demographic Comparison Group (i.e. NYC Medicaid enrollees during the month of January 2001).

There are a total of 490 individual Zip Codes representing the residences of DRM enrollees within the 5-borough area, compared with 546 for the Demographic Comparison Group. The distribution of Disaster Relief enrollees and Comparison Group enrollees by Zip Code are depicted in Maps 1 and 2, respectively, although the map displays are based on a consolidated zip code set totaling 183 discrete zip code areas. The DRM and Comparison Group distributions in the two maps represent proportions of the combined DRM and Comparison Group Medicaid enrollment total by zip code area. Each zip code area is coded with one of five shading categories. Zip areas with the highest DRM or Comparison Group enrollment rates are shaded with black, while those with the least are white. Thus, if a particular zip code area is depicted with dark shading on one map, the same zip area will have the opposite (white) shading on the other map. Such borough-by-borough zip code-level comparisons using Maps 1 and 2 will reveal how DRM enrollment patterns compare with the regular NYC Medicaid population.
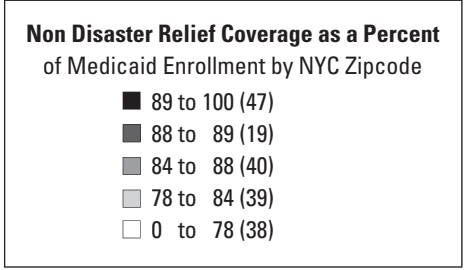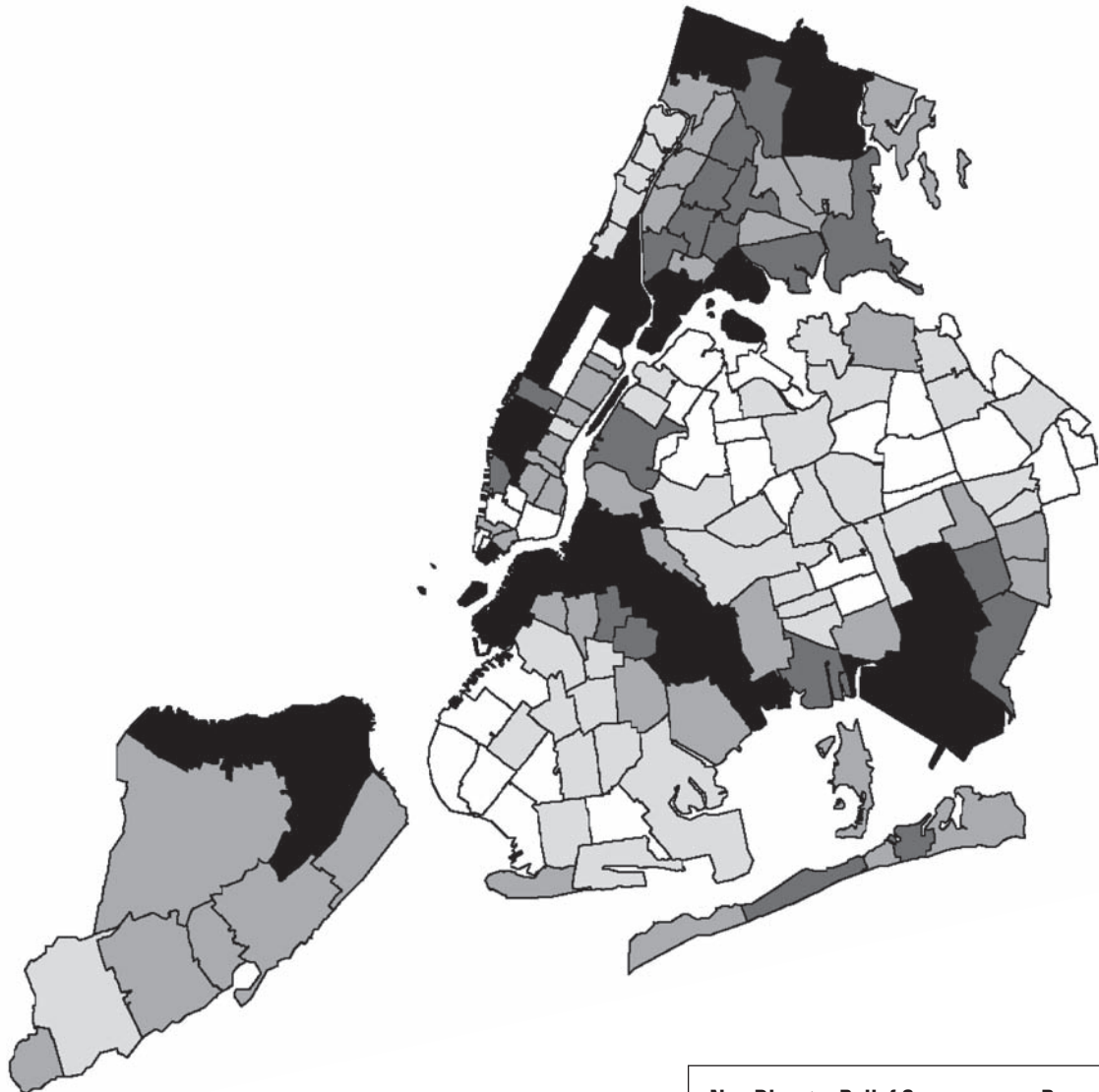
Beginning with Brooklyn, which was noted (Table 4) as having the highest proportion of both DRM and Comparison Group enrollees, it is depicted on both the DRM and NYC Medicaid maps (lower middle area) with noticeable dark-shaded areas, which signify the highest level of overall Medicaid enrollment (i.e., between 20 to 67% of most densely populated enrollment) areas. However, it is notable that this shading is located in different zip code areas of Brooklyn on each map, indicating that DRM enrollment was from predominantly different neighborhoods in Brooklyn. A similar analysis of Bronx (upper left), Manhattan (left-center), Queens (right-center) and Staten Island (lower left) also reveals divergent zip-area patterns of shading between the two maps. This comparison illustrates that the pattern of DRM enrollment across the 5-borough area differs from NYC Medicaid enrollment, suggesting that DRM drew its enrollees from a different group of neighborhoods.

Map 1: Distribution of Disaster Relief Enrollees by Zipcode

Disaster Relief Coverage as a Percent
of Medicaid Enrollment by NYC Zipcode

■ 20 to 67 (51)
■ 16 to 20 (31)
■ 13 to 16 (28)
□ 11 to 13 (29)
□ 0 to 11 (44)

Data Source: DOH/OMM Audit, Fiscal, and Program Planning Data Mart; DOIT/GIS Mapping System
Contact: Tom Fanning (518) 473-0919

Map 2: Distribution of Control Group Enrollees by Zipcode

Non Disaster Relief Coverage as a Percent
of Medicaid Enrollment by NYC Zipcode

- 89 to 100 (47)
- 88 to 89 (19)
- 84 to 88 (40)
- 78 to 84 (39)
- 0 to 78 (38)

Data Source: DOH/OMM Audit, Fiscal, and Program Planning Data Mart; DOIT/GIS Mapping System
Contact: Tom Fanning (518) 473-0919

Also, the individual Zip Codes with the ten highest enrollment totals for each group are displayed in Table 5. Interestingly, only one Zip Code appears in both listings of top ten Zip Codes for DRM and the Demographic Comparison (highlighted below). This comparison also suggests that a different geographic enrollment pattern was evident for the DRM Program.

Table 5. Geographic Comparison: Top Ten Zip Codes by Enrollment

Rank	DRM Enrollment (N=342,277)			Demographic Group (N=1,845,305)		
	Zip	# of Enrollees	Borough	Zip	# of Enrollees	Borough
1	11220	11,709	Brooklyn	10456	39,672	Bronx
2	10002	9,427	Manhattan	11211	38,258	Brooklyn
3	11373	7,511	Queens	**10453**	36,689	Bronx
4	10032	6,988	Manhattan	10457	35,102	Bronx
5	11226	6,831	Brooklyn	11207	34,398	Brooklyn
6	11214	6,158	Brooklyn	10452	33,742	Bronx
7	11368	6,133	Queens	11212	33,384	Brooklyn
8	**10453**	5,784	Bronx	10029	32,579	Manhattan
9	10033	5,638	Manhattan	11208	32,270	Brooklyn
10	11219	5,547	Brooklyn	11206	31,466	Brooklyn

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

E. Income Comparison: DRM enrollees are from neighborhoods having lower rates of poverty.

Having established (1.D) that DRM enrollees came from different neighborhoods, this section examines whether income differences could be found based on a correlation of U.S. Census income data with those neighborhoods. Poverty level data from the 2000 Census was used for this analysis, and is displayed in Table 6, broken out by NYC Community Planning District. Each district has been classified as to whether they represent either predominantly DRM or Regular Medicaid neighborhoods, or a combination of both. This classification was based on comparisons between enrollment Maps 1/2 and a map (not shown) of the community districts. The results of that analysis are summarized in the Table 6 Totals: Collectively, the 23 community districts identified as "DRM neighborhoods" had a cumulative Percent Below Poverty Level of only 387, compared with 626 for the 22 community districts considered as being "Regular MA neighborhoods." Thus, marked income differences are evident, with Regular MA neighborhoods having almost double the Poverty Level rate as DRM neighborhoods.

Table 6. Poverty Status by DRM/MA Enrollment Areas, by NYC Community District

Community District	Percent Below Poverty Level	DRM Area	Control Area	Both DRM and Contol Area
Bronx 1	45.7		o	
Bronx 2	45.0		o	
Bronx 3	45.6		o	
Bronx 4	39.7			o
Bronx 5	41.4			o
Bronx 6	45.6		o	
Bronx 7	33.0			o
Bronx 8	17.7		o	
Bronx 9	29.1			o
Bronx 10	10.7		o	
Bronx 11	17.0	o		
Bronx 12	19.6		o	
Brooklyn 1	34.7		o	
Brooklyn 2	23.5		o	
Brooklyn 3	35.1		o	
Brooklyn 4	37.8			o
Brooklyn 5	33.2		o	
Brooklyn 6	15.2			o
Brooklyn 7	24.9	o		
Brooklyn 8	27.5		o	
Brooklyn 9	24.3		o	
Brooklyn 10	14.2	o		
Brooklyn 11	19.6	o		
Brooklyn 12	28.5	o		
Brooklyn 13	29.1			o
Brooklyn 14	23.1	o		
Brooklyn 15	17.2	o		
Brooklyn 16	42.7		o	
Brooklyn 17	20.0	o		
Brooklyn 18	12.3	o		
Manhattan 1	8.8			o
Manhattan 2	10.8	o		
Manhattan 3	28.4	o		
Manhattan 4	15.3		o	
Manhattan 5	11.3		o	
Manhattan 6	7.8	o		
Manhattan 7	10.9		o	
Manhattan 8	6.5			o
Manhattan 9	31.7		o	
Manhattan 10	36.6		o	
Manhattan 11	36.9		o	
Manhattan 12	29.8	o		
Queens 1	20.1	o		
Queens 2	16.5			o
Queens 3	19.1	o		
Queens 4	19.3	o		
Queens 5	13.8	o		
Queens 6	11.2	o		
Queens 7	13.3	o		
Queens 8	10.6	o		
Queens 9	14.8	o		
Queens 10	11.4			o
Queens 11	6.6	o		
Queens 12	16.7		o	
Queens 13	7.3			o
Queens 14	22.4			o
Staten Island 1	15.7		o	
Staten Island 2	9.1			o
Staten Island 3	4.9	o		
TOTALS:		387	626	307

Sources: U.S. Census Bureau, 2000 Census; New York City Dept. of City Planning Web Site; DOH/OMM Data Mart.

F. Social Security Verification: DRM SSN validation rate was 83.46%, despite the lessened documentation requirements.

With few exceptions (i.e., undocumented aliens; pregnant women; unborns; infants enrolled at birth), all applicants of Temporary Assistance and Medicaid Only must present a Social Security Number (SSN) or apply for an initial or replacement Social Security card as a condition of eligibility. Due to the disruption to the computer system that supports Medicaid in New York City, the normal WMS case processing procedures were not available for processing DRM Medicaid cases. However, despite this disruption in regular case processing, 83.46% of DRM enrollees for whom SSN Validation was submitted to SSA for verification were found to have a validated SSN (Table 7), and the overall SSN validation rate for all DRM individuals (i.e., 342,278) was 80.85%.

Table 7. Social Security Verification

Borough	DRM Enrollment Total	# Sent for Verification	Total with Verified SSN
Bronx	64,516	—	52,486
Brooklyn	125,299	—	99,925
Manhattan	57,861	—	46,701
Queens	85,982	—	70,500
Staten Island	6,258	—	5,066
Other/Unknown	2,362	—	1,704
Total	342,278	331,151	276,723 83.46%

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart
(from SSA Verification Files)

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G. DRM Transition to Regular Medicaid/FHP: About forty-four percent of the DRM population was ultimately moved to a regular Medicaid eligibility category; fifty-four percent was terminated. Only about 18 percent of DRM enrollees had a prior WMS/MMIS ID.

A total of 339,866 "matched" individuals were enrolled in DRM for a duration of four months; these enrollees are identifiable for reporting purposed by MMIS (DE 1240) Aid Category 36. Following their 4-month DRM authorizations, some enrollees were converted directly to regular Medicaid enrollments, while most were temporarily transitioned to the Disaster Relief Extension Program (Aid Category 80), which served as an administrative step to facilitate formal transition to Medicaid or FHP program enrollments based on eligibility reviews using applicable eligibility standards for regular Medicaid. This section deals with the transition of DRM enrollees to regular Medicaid, following either DRM or DRM Extension enrollments.

Table 8 shows that, as of February 2003, more than 90 percent of DRM enrollees were given DRM Extensions (AC 80) at the conclusion of their 4-month DRM authorizations, while 9.4 percent went directly to regular Medicaid. Of the 90 percent moved to DRM Extensions, the local district reviewed 89 percent of such enrollees for a regular Medicaid eligibility determination; about 60 percent of the reviewed population was terminated from Medicaid enrollment and 40 percent was moved to a regular Medicaid eligibility category. Also, 4,880 individuals were still enrolled in Disaster Relief Extensions as of February 2003.

Of the 9.4 percent who went from DRM to a regular Medicaid eligibility category, most of these, 7.0 percent, already had an active regular Medicaid eligibility category. In other words, this group had duplicate Medicaid enrollment under DRM, and the elimination of their DRM enrollment left them with their other active Medicaid eligibility intact. The balance of those who went from DRM to regular Medicaid either had an old case reopened or a new case opened upon review by the NYC HRA eligibility staff.

Table 8 also documents that 60,704 of the 339,866 DRM enrollees, or 17.9 percent, had a previous stint of regular Medicaid eligibility. Of this previously known group, 8.2 percent were transitioned directly from DRM to regular Medicaid and 9.6 percent were moved into the DRM Extension program awaiting a regular Medicaid determination by NYC HRA staff.

Overall, there were 150,676 DRM enrollees, or 44.3 percent, who were ultimately transitioned to regular Medicaid or Family Health Plus (FHP) from DRM Medicaid. Of these, 30,246 were transitioned to a prior WMS CIN directly from DRM at the conclusion of their four-month DRM enrollment span and 120,430 were transitioned to regular Medicaid after first receiving DRM Extensions.

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Table 8. Transition Rates from Disaster Relief Medicaid to DRM Extensions and Regular MA Based on Enrollments through February 2003; includes duplicate Ids

	Enrollees	Percent
I. Total DRM (AC36) enrollees with matching WMS CIN	**339,866**	**100.0**
A. Initially transitioned to DRM Extension (Aid Category 80)	306,656	90.2
1. Still Active in Aid Category 80	4,880	1.4
2. Terminated	182,330	53.6
3. Converted to regular Medicaid	120,430	35.4
B. Initially transitioned to WMS CIN	31,914	9.4
1. Active in WMS at transition	23,719	7.0
2. Activated old WMS CIN or created new one at transition	8,195	2.4
a. Activated old WMS CIN at transition	4,295	1.3
b. Created new WMS CIN at transition	3,909	1.2
II. Total DRM (AC36) enrollees with matching WMS CIN	**339,866**	**100.0**
A. Number matched to a WMS CIN that existed prior to DRM	60,704	17.9
1. Initially transitioned to WMS CIN	28,014	8.2
2. WMS CIN not active/activated/created at transition	32,690	9.6
III. Total DRM (AC 36) enrollees transitioned to regular Medicaid/FHP	**150,676**	**44.3**
A. Aid Category 36 (DRM) prior to transition to regular MA/FHP	30,246	8.9
B. Aid Category 80 (DRM Ext.) prior to conversion to regular MA/FHP	120,430	35.4
IV. Total DRM (AC 36) enrollees transitioned to Family Health Plus	**42,292**	**28.1**

Note: Based on matching of DRM IDs to WMS CINs using SSN as one component of matching algorithm.

Source: DOH/OMM AFFP Datamart, Disaster Relief Subsystem

H. Conclusions (Sect. I):

- DRM caused a dramatic, historic jump in NYC Medicaid enrollment;

- Non-DRM dynamics show an underlying rise in enrollments and dramatic drop in disenrollments;

- DRM had a greater proportion of adults, 21-64;

- DRM enrollees were more likely to be male;

- DRM enrollees were more likely to be from Queens and less likely to reside in the Bronx;

- DRM drew its enrollees from a different group of neighborhoods;

- DRM enrollees live in neighborhoods having lower rates of poverty compared with neighborhoods of Regular Medicaid enrollees;

- DRM SSN validation rate was 83.46%, despite the lessened documentation requirements;

- Only around 18 percent of DRM enrollees had a prior WMS/MMIS ID;

- All DRM enrollees were initially moved to either regular or DRM Extension Medicaid; about 60 percent of DRM Extended enrollees were terminated upon local district review, while 40 percent were moved to regular Medicaid eligibility;

- Overall, 44.3% of DRM enrollees were eventually transitioned to regular Medicaid as of February 2003, with 54% terminated.

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Medicaid Cost and Utilization Comparison Measures

Methodology

This section contains a summary of the Per Member Per Month (PMPM) data comparisons of Medicaid cost and utilization between DRM Enrollees and the Control Group, which is defined as non-institutionalized, non-disabled, non-elderly, non-managed care MA-Only enrollees in NYC. The Medicaid utilization periods used in this comparison are from October 2001 through January 2002 for DRM, and from October 2000 through January 2001 for the Control Group, with the utilization data having a production date of August 12, 2002. The Control data was adjusted for age weighting, i.e., by the DRM under/over 21 age ratio.

Utilization Results

A. Cost Comparison Totals

As displayed in Table 9, *Total Dollars* for Medicaid costs during their respective study periods (i.e., Oct-00 to Jan-01 for Control; Oct-01 to Jan-02 for DRM) was $191,850,677 for DRM and $876,286,464 for the Control Group. The *Total Recipients Utilizing MA* column contains the number of enrollees for each group who utilized Medicaid services. Of the 342,362 individuals enrolled in DRM from October 2001 through January 2002, a total of 210,613 (61.52%) were found to have been Medicaid users during that period. Of the 416,478 Control Group individuals enrolled in Medicaid from October 2000 through January 2001, 296,696 (71.24%) were found to have been Medicaid users during that period.

The *Total Eligible Months* figures in Table 9 were calculated from the months of enrollment of all DRM and Control Group individuals enrolled during their respective study periods (i.e., Oct-00 to Jan-01 for Control; Oct-01 to Jan-02 for DRM). *Dollars Per Eligible Month*, or PMPM totals, were computed by dividing Total Dollars by Total Eligible Months for each group. When PMPM totals are compared, the Control Group is found to be more expensive ($627.02) than the DRM Group ($238.28).

Note: Although Managed Care enrollees have been excluded from the Control Group in this Cost and Utilization analysis, the PMPM data for the excluded Managed Care segment are included in Table 9 for informational purposes. As with the Control group, the Managed Care PMPM represents non-institutionalized, non-disabled, and non-elderly MA-Only enrollees in NYC; both fee-for-service and HMO expenditures are reflected.

Table 9. Cost Comparison Totals

	Total Dollars	Total Recipients Utilizing MA	Total Eligibles	Total Eligible Months	Dollars Per Eligible Month
DRM	191,850,677	210,613	342,362	805,146	238.28
Control	876,286,464	296,696	416,478	1,397,542	627.02
Managed Care	104,118,603	122,967	122,868	491,868	211.68

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

B. Cost Comparison by COS:

Table 10 displays *Total Dollars* and *Dollars Per Eligible Month* for each group, broken out by Category of Service (COS). As stated in the previous section, *Total Dollars* represents DRM and Control Group Medicaid costs during their respective study periods (i.e., Oct-00 to Jan-01 for Control; Oct-01 to Jan-02 for DRM). *Dollars Per Eligible Month*, or PMPM totals, were computed by dividing Total Dollars by Total Eligible Months for each group.

Table 10. Cost Comparison by COS

Category of Service	Control Group		DRM Group	
	Total Dollars	Dollers Per Eligible Month	Total Dollars	Dollers Per Eligible Month
Physician	$23,909,621	$17.11	$8,563,944	$10.64
Podiatrist	$5,055	$0.00	$8,844	$0.01
Psychology	$64,527	$0.05	$9,845	$0.01
Eye Care	$950,773	$0.68	$2,814,412	$3.50
Therapist	$4,340	$0.00	$15,850	$0.02
Nursing	$930,549	$0.67	$24,748	$0.03
Outpatient	$127,214,005	$91.03	$44,461,197	$55.22
Inpatient	$628,753,850	$449.90	$58,188,384	$72.27
Dental	$15,833,673	$11.33	$48,480,892	$60.21
Pharmacy	$56,291,242	$40.28	$24,530,683	$30.47
Non-Inst. Lt Care	$6,759,782	$4.84	$679,487	$0.84
Laboratories	$1,439,492	$1.03	$1,397,277	$1.74
Transportation	$1,514,294	$1.08	$376,124	$0.47
DME & Hearing Aid	$1,810,797	$1.30	$843,870	$1.05
Child Care	$2,403,135	$1.72	$0	$0.00
Referred Ambulatory	$2,327,016	$1.67	$1,169,212	$1.45
Nurse Practitioner	$22,851	$0.02	$6,305	$0.01
SSHSP	$3,219,520	$2.30	$0	$0.00
Early Intervention	$1,491,014	$1.07	$2,272	$0.00
Hospice	$194,001	$0.14	$79,009	$0.10
Community & Rehab	$439,012	$0.31	$137,703	$0.17
Case Management	$707,914	$0.51	$60,619	$0.08
TOTAL:	$876,286,464	$627.02	$191,850,677	$238.28

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

The comparison of *Dollars Per Eligible Month* data shows the following differences:

- **Inpatient Services*:** Ranked #1 for both DRM and Control groups, although the Dollars Per Eligible Month for DRM (72.27) was quite small compared to the Control (449.90);

- **Outpatient Services:** Ranked #3 for DRM (55.22), compared with a #2 ranking for the Control, which has a Dollars Per Eligible Month total of 91.03;

- **Dental Services:** Ranked #2 for DRM (60.21), but only #5 for the Control group (11.33), with DRM having a much larger Dollars Per Eligible Month total.

* Effect of Spenddown: We are unable to account for the effects of Spenddown Eligibility in the Control Group, which was not an eligibility feature of DRM. Higher Inpatient costs are an assumed result of "spenddown;" to adjust for this, we recommend that Inpatient Services be excluded from total expenditures, which would support our contention that there was little difference between the utilization patterns of the two groups.

C. Utilization Comparison by COS:

Table 11 displays Medicaid service utilization totals for each group, broken out by Category of Service (COS). *Units Per Eligible Month* is a measure that enables comparisons of service utilization, as it is based on each group's service utilization, divided by their respective "Total Eligible Months" (see Table 9) for each COS.   Overall, the DRM Units Per Eligible Month total is 3.107, compared with a somewhat lower total of 2.605 for the Control group, indicating that DRM recipients utilized Medicaid services at a higher rate than regular Medicaid recipients.

The comparison of *Units Per Eligible Month* data shows the following differences:

- **Dental Services:** Ranked # 1 for DRM, but was ranked a distant #4 for the Control group, which had a much smaller Units Per Eligible Month rate (0.984 vs. 0.212);

- **Pharmacy:** Ranked #2 for DRM, with 0.701 Units Per Month, compared with a #1 ranking for the Control, with 0.857;

- **Outpatient Services:** Ranked #3 for DRM, with 0.444 Units Per Month, compared with a #2 ranking for the Control group, with 0.734;

- **Laboratories:** The Units Per Eligible Month rate was higher for DRM (0.354) than for the Control (0.145);

- **Physician:** The Units Per Eligible Month rates were about the same for DRM (0.338) and the Control (0.383);

- **Eye Care:** The Units Per Eligible Month rate was higher for DRM (0.226) than for the Control (0.047);

- **Inpatient Services:** The Units Per Eligible Month rate was lower for DRM (0.012) than for the Control (0.072).

Table 11 also displays Medicaid *Recipients Per Month* totals, which is a measure that enables comparisons of service utilization based on the number of recipients who utilized service, divided by their respective "Total Eligible Months" (see Table 9) for each COS. Overall, the DRM *Recipients Per Month* rate is 0.262, compared with the somewhat lower total of 0.212 for the Control

group, indicating that a higher segment of DRM recipients utilized Medicaid services than regular Medicaid recipients.

The comparison of Recipients Per Month data shows the following differences:

- **Pharmacy:** Ranked #1 for DRM, with a Recipients Per Month rate of 0.158, compared with a #2 ranking for the Control, with a rate of 0.127;

- **Outpatient Services:** Ranked #2 for DRM, with a rate of 0.131, compared with a #1 ranking for the Control, with a rate of 0.149;

- **Dental Services:** Ranked #3 for DRM, with a rate of 0.127, compared with a #5 ranking for the Control, with a rate of 0.043;

- **Physician:** Ranked #4 for DRM, with a rate of 0.105, compared with a #3 ranking for the Control, with a rate of 0.097;

- **Inpatient Services:** Recipients Per Month rate was lower for DRM (0.008) than for the Control (0.047).

Table 11. Utilization Comparison by COS

Category of Service	Control Group Service Units	Control Group Units Per Eligible Month	Control Group Recipients Per Month	DRM Group Service Units	DRM Group Units Per Eligible Month	DRM Group Recipients Per Month
Physician	535,311	0.383	0.097	272,237	0.338	0.105
Podiatrist	285	0.000	0.000	542	0.001	0.000
Psychology	1,867	0.001	0.000	260	0.000	0.000
Eye Care	65,457	0.047	0.013	181,878	0.226	0.057
Therapist	319	0.000	0.000	1,177	0.001	0.000
Nursing	2,126	0.002	0.001	511	0.001	0.000
Outpatient	1,025,434	0.734	0.149	357,658	0.444	0.131
Inpatient	99,991	0.072	0.047	9,495	0.012	0.008
Dental	296,701	0.212	0.043	792,121	0.984	0.127
Pharmacy	1,197,159	0.857	0.127	564,061	0.701	0.158
Non-Inst. Lt Care	69,804	0.050	0.003	6,696	0.008	0.000
Laboratories	202,806	0.145	0.028	284,697	0.354	0.047
Transportation	37,674	0.027	0.004	7,685	0.010	0.003
DME & Hearing Aid	20,382	0.015	0.005	6,502	0.008	0.004
Child Care	16,290	0.012	0.002	0	0.000	0.000
Referred Ambulatory	27,741	0.020	0.010	14,367	0.018	0.011
Nurse Practitioner	915	0.001	0.000	376	0.000	0.000
SSHSP	8,668	0.006	0.001	0	0.000	0.000
Early Intervention	19,346	0.014	0.000	21	0.000	0.000
Hospice	44	0.000	0.000	20	0.000	0.000
Community & Rehab	3,847	0.003	0.000	822	0.001	0.000
Case Management	8,432	0.006	0.001	441	0.001	0.000
TOTAL:	3,640,598	2.605	0.212	2,501,567	3.107	0.262

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

D. Comparison of DRM Utilization to the Newly Enrolled Control Members:

In Section II.B, a cost comparison by Category of Service (COS) was done between DRM enrollees and the Control Group, with the latter having a higher Dollars per Eligible Month total ($627.02) than DRM enrollees ($238.28). This section deals with whether "newly enrolled" Control members, i.e., eligible in October 2000, but not the previous 2 months, were found to exhibit a higher utilization rate, possibly due to a pent-up need for medical services. These findings are displayed in Table 12 and were adjusted for age weighting, i.e., by the under/over 21 DRM age ratio.

The Dollars per Eligible Month total for New Control enrollees was found to be $1,278.97, compared with a total of $238.28 for the DRM group. However, when controlling for Inpatient Services, little difference was found between the New Control group ($149) and the DRM group (166.01).

The use of new Control enrollees in the COS comparison of *Dollars Per Eligible Month* shows some notable differences:

- **Inpatient Services:** Ranked #1 for New Control members, with a Dollars Per Eligible Month total of 1,129.88, far greater than the DRM total (72.27).

  Note: We deem it necessary to reiterate that the Control groups are assumed to be subject to higher Inpatient costs due to the effects of Spenddown Eligibility in the Control Group, which was not an eligibility feature of DRM. To adjust for this, we recommend that Inpatient Services be excluded from total expenditures in utilization comparisons between the groups.

- **Outpatient Services:** Ranked #2 for New Control members, which had a Dollars Per Eligible Month total of 102, compared with a total of 55.22 for DRM;

- **Dental Services:** Ranked #2 for DRM, with a Dollars Per Eligible Month total of 60.21, but was only 8.45 for New Control members;

- **Pharmacy:** New Control members have a Dollars Per Eligible Month total of 8.45, compared with a DRM total of 30.47.

Table 12. Cost Comparison by COS: New Enrollees vs. DRM

Category of Service	Control Group Total Dollars	Control Group Dollers Per Eligible Month	DRM Group Total Dollars	DRM Group Dollers Per Eligible Month
Physician	$1,450,435	$17.39	$8,563,944	$10.64
Podiatrist	$774	$0.01	$8,844	$0.01
Psychology	$0	$0.00	$9,845	$0.01
Eye Care	$43,627	$0.52	$2,814,412	$3.50
Therapist	$33	$0.00	$15,850	$0.02
Nursing	$42,895	$0.51	$24,748	$0.03
Outpatient	$8,507,644	$102.00	$44,461,197	$55.22
Inpatient	$94,242,561	$1,129.88	$58,188,384	$72.27
Dental	$705,202	$8.45	$48,480,892	$60.21
Pharmacy	$986,958	$11.83	$24,530,683	$30.47
Non-Inst. Lt Care	$176,630	$2.12	$679,487	$0.84
Laboratories	$117,297	$1.41	$1,397,277	$1.74
Transportation	$52,711	$0.63	$376,124	$0.47
DME & Hearing Aid	$53,779	$0.64	$843,870	$1.05
Child Care	$69,619	$0.83	$0	$0.00
Referred Ambulatory	$106,324	$1.27	$1,169,212	$1.45
Nurse Practitioner	$1,027	$0.01	$6,305	$0.01
SSHSP	$62,692	$0.75	$0	$0.00
Early Intervention	$37,091	$0.44	$2,272	$0.00
Hospice	$200	$0.00	$79,009	$0.10
Community & Rehab	$9	$0.00	$137,703	$0.17
Case Management	$20,213	$0.24	$60,619	$0.08
TOTAL:	$106,677,720	$1,278.97	$191,850,677	$238.28

Source: DOH/OMM Audit, Fiscal and Program Planning Data Mart

E. Conclusions (Sect. II):

- The Disaster Relief Program (DRM) was successful in providing access to the broad range of Medicaid services to a large number of enrollees;

- The DOH/OMM AFFP Datamart Disaster Relief Subsystem was successfully used to study the DRM experience during 10/01 –1/02;

- 61.52% of DRM enrollees accessed Medicaid services compared with 71.24% for the Control group;

- Generally, utilization of Medicaid services by DRM enrollees was consistent with the regular Medicaid population; the exception was Dental, Laboratory and Eye Care services, which were utilized at a higher rate under the DRM Program, and Inpatient Services, which were utilized at a lower rate;

- After controlling for Inpatient Services, DRM enrollees and both the full and the new Control groups had similar PMPM costs;

- Because DRM and both Control groups had similar costs when controlling for Inpatient Services, "pent-up demand" for services was not believed to be a factor with DRM utilization.

Appendix E:
Fraud and Abuse Monitoring Effort

Disaster Relief Medicaid

March 2003

E-2

Table of Contents

Introduction

This report summarizes the results of the Disaster Relief Medicaid (DRM) fraud and abuse monitoring during the period October 31, 2001 – December 31, 2002. It complements the DRM Monitoring Effort Report of August 2002, which described the program integrity activities that were developed for DRM.

This report deals with findings in the following areas:

- Wage reporting
- Multiple DRM numbers
- Multiple DRM/Regular Medicaid
- Report reviews
- Other provider activity
- Other recipient activity

Also, recommendations are included concerning the information that should be requested on an emergency application to address the possibility of that occurrence in the future.

No further recipients will be enrolled or provided services under DRM, and DRM cases have been converted to regular Medicaid. Therefore, the fraud and abuse monitoring has been transferred to the ongoing program integrity process within the Division of Medicaid Fraud Control and Program Integrity (MFC &PI) of New York State's Office of Medicaid Management.

The September 11, 2001 World Trade Center (WTC) Disaster altered the eligibility determination process for persons needing Medical Assistance (Medicaid). Because of the September 11 disaster, the Welfare Management System (WMS), that is, New York State's centralized client database, and supporting communication lines were unavailable for weeks. As a result, the local district Medical Assistance Program (MAP) offices could not enter the eligibility information from the application that is normally entered onto the WMS. Due to this loss of communication between the MAP and the State systems, none of the usual processing could occur. Consequently, none of the normal electronic clearances or matches on cases could be completed.

In the absence of the normal WMS processing systems, the Department initiated Disaster Relief Medicaid (DRM) to provide Medicaid to those affected by the WTC Disaster. Under the DRM program, an applicant had to complete a two-page application, including an attestation that the income reported on the form was true, rather than the normal application form. The only documentation required was to support an applicant's identity.

The DRM program permitted applications to be filed beginning in September 2001 through January 31, 2002. A total of 342,362 recipients were found eligible for DRM between September and January based on the information provided on their applications. Each person found eligible received a DSS-2831A, Temporary Medical Assistance form to use in obtaining medical assistance. Each DSS-2831A was numbered with a unique DRM client identification number. The identifier was the equivalent of the CIN assigned normally through WMS.

Each person found eligible for DRM received Medicaid coverage for four months, including coverage from the first day of the month of application. For example, a person found eligible on November 1, 2001 would have Medicaid coverage until February 28, 2002; someone found eligible on January 31, 2002 would be covered by Medicaid until April 30, 2002. Again, as the normal systems checks could not be applied to these applications, the following highlights the results of the efforts undertaken to monitor and evaluate the integrity of the program.

Statistical Summary Snapshot

The details of these statistics are explained in the narrative that follows:

Wage Reporting

- 276,723 recipients had valid social security numbers

- 101,313 recipients showed reported wages during the 9/11 quarter (July, August, September 2001)

- 101,698 recipients showed reported wages during the post 9/11 quarter (October, November, December 2001)

- 13,000 recipients with Medicaid expenditures greater than $1,500 had reported wages in the third and fourth quarters

Multiple DRM Numbers

- 2,829 unique recipients had more than one DRM number

- 361 of the 2,829 recipients (13%) never used any DRM number

- 391 of the 2,829 recipients (14%) used two or more DRM numbers concurrently for expenditures of $1,537,907

- 202 recipients received a second DRM number in December 2001 or January 2002

A. Inpatient

- 42 recipients had inpatient stays totaling $817,428

- Top 25 recipients accounted for 66% of inpatient expenditures

- 2 recipients were referred to the Recipient Restriction Program

B. Other Than Inpatient

- 259 recipients with other than inpatient-only expenditures totaling $573,841 were reviewed

- Top 60 recipients accounted for 34% of outpatient expenditures

- 1 recipient was referred to the Recipient Restriction Program

Multiple DRM Numbers/Regular Medicaid Number

- 6,836 recipients with an active DRM number and an active regular Medicaid number were identified

- 2,905 recipients (of the 6,836) were identified using more than one number concurrently. These cases were referred to NYC HRA BFI for investigative consideration.

- 1 recipient with three Medicaid numbers was referred for restriction due to numerous drug and alcohol inpatient detoxs

- 4 MMTP providers billed for duplicate services on the same date of service for 8 recipients with a DRM number and a regular Medicaid number

Report Review

A. Top 100 Recipients DRM Expenditures Report

- 572 recipients were identified between 10/12/01 and 8/22/02
- 130 recipients appeared 10 or more times
- 12 of the 130 recipients were referred
  - 9 recipients were already under investigation by the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) and/or the District Attorney's Office.
  - 3 recipients and 1 provider were referred for other medical review.

B. Top 25 Recipients of Outpatient Services Report

- 113 unique recipients appeared on the report
- 31 recipients appeared ten or more times
- While reviewing the top 25 recipients, the following providers were identified for questionable billing patterns, however they were already under investigation.
  - Second highest provider of outpatient services ($4.8 million) was terminated from Medicaid 9/15/02 for reasons unrelated to DRM.
  - CHAPS, third highest provider of outpatient services, ($4.4 million) is under MFCU review.

C. DRM Dental Reviews

- Identified 197 dental providers with earnings over $150,000
- 137 of the 197 providers have been reviewed
- Identified excessive number of dental services claimed on single date of service

- Noted inappropriate claiming of periodontal scaling and root planning
- Recognized claiming of duplicate services by single or multiple dental providers
- Identified claiming of significant number of expensive, time-consuming procedures which would normally require prior approval
- Forty-six (46) dental providers referred to MFCU
- Participation in the Medicaid Program was terminated for 3 providers

D. Top 25 Recipients of Pharmacy Services

- Providers associated with 9 Serostim recipients were already under investigation by MFCU and District Attorney's Office.
- Top 3 recipients did not have diagnosis to support pharmacy claims for Serostim. These are included and identified above.

E. Other Provider Activity

- 49 DRM cases (including the 46 dental cases referred to above) were referred to MFCU.
- Providers billing under a DRM number and a regular WMS number for the same recipient on the same date of service were identified. Total payments to 1,600 providers of $2.7 million were detected with the overpayment being $1.3 million. These overpayments are being forwarded for collection.

F. Other Recipient Activity (Restrictions)

- 37 DRM-Medicaid recipient restrictions have occurred through DOH identification of abusive behavior. In addition 20 cases, out of a total of 97 investigated by HRA BFI, were referred for restriction.

Program Integrity Activity

Wage Reporting

Social Security Numbers (SSN) for the 331,151 recipients who had provided a SSN on the DRM application were sent to the Social Security Administration for validation. This represented 96.7% of the 342,362 DRM recipients. Almost 84% (276,723 of the 331,151) were found to be valid. After being sent through the Wage Reporting System (WRS), 101,313 had reported wages during the 9/11 quarter (July, August, September 2001), while 101,698 had wages during the post 9/11 quarter (October, November, December 2001).

An analysis of the available data revealed more than 13,000 recipients with Medicaid expenditures greater than $1,500 and reported wages in the third and fourth quarters of 2001. We used $1,500 since that amount would be the threshold for a criminal referral. This population would present the most potential for fraud or abuse.

A. Investigator Case Review/Wages

Forty-seven recipients with the highest wages from both quarters were selected for review. Using the latest available address and telephone number information, OMM investigators attempted to interview each recipient.

Twenty-six interviews were conducted. One of the interviewees was a dental practitioner who has been employed continuously, but had a disruption in insurance coverage. The circumstances surrounding this situation resulted in a referral to the Attorney General's Office. Five recipients were unemployed before September 11, 2001 and eleven became unemployed after September 11, 2001. The remaining nine recipients were employed at application, most in low level jobs or in part time situations. Each recipient interviewed claimed to have applied based on DRM eligibility information reported by the media or from conversation with family and friends. Additionally, each believed they were eligible and the application process did not indicate otherwise. Fourteen recipients could not be found and seven refused to be interviewed.

B. OTDA Quality Control (QC) Review

Office of Temporary and Disability Assistance (OTDA) staff reviewed a 500 case quality control (QC) sample to ensure that case eligibility determinations were properly handled. While the final report has not been issued, findings of an October 30, 2002 interim report are as follows:

Based solely on the information provided by the client and recorded on the DRM application, MAP staff correctly determined eligibility for 245 of the 274 reviewed applications (89.45%). However, there were 13 cases (4.75%) where the DRM eligibility decision was incorrect. In several instances, MAP staff disregarded the applicant-reported income (five cases) or household size (four cases) resulting

in an incorrect DRM eligibility determination. In addition, one case correctly determined DRM eligible but not authorized for the guaranteed four-month period. In sixteen cases (5.84%) OTDA was unable to evaluate the MAP eligibility decision as either required information was left blank on the application or OTDA did not receive the complete application packet (budget calculation sheet).

- OTDA determined that 122 of the 274 approved case (44.53%) were financially and categorically eligible for assistance. A significant number of these eligible cases had sections of the application left blank or reported income and/or household size that was incorrect. In addition, transcription errors by MAP staff occurred when entering the information on the Medicaid Temporary Authorization Form. The most frequent omission was the failure to record the applicant's apartment number.

- OTDA determined that 48 of the 274 approved cases (17.52%) were financially ineligible for assistance.

- OTDA was unable to verify one or more DRM eligibility factors in 104 of the 274 cases (37.95%).

The simplified DRM application did not require the applicant to document their source of support (e.g., income) or provide the name and address of their employer or landlord. In addition, applicants were not required to provide the name, DOB or SSN for non-applying legally responsible individuals residing in the household.

Reasons for the decision of "unable to determine" are as follows:

- All eligibility factors unverified: 11 cases

- Demographic factors unverified: 2 cases

- Household Composition unverified   6 cases

- Household Income unverified: 18 cases

- Multiple factors unverified: 67 cases

OTDA's inability to verify eligibility and demographic factors was largely due to the inability to locate clients to question them and if located, a lack of client willingness to cooperate with OTDA staff.

The case folders and documentation obtained by the QC reviewers were examined for 25 of the 500 QC sample cases: 15 categorized as "Ineligible" and 10 categorized as "Unable to Determine"(UTD). The review of the QC case folders was conducted to determine if sufficient documentation was available to support a referral for investigation or, if indicated, what further work would need to be performed to reach that point. Since all the cases we reviewed have missing household, employment or residence information, to arrive at an investigative conclusion, significant additional investigative fieldwork would be required. Furthermore, the vagueness of the application presents certain evidentiary problems. For example, the application did not require detailed information regarding employment, household composition and residence, nor was supporting documentation, such as a paycheck, required.

Multiple DRM Numbers, No Active Medicaid Number

A total of 2,829 unique recipients with more than one DRM number were identified. No claims were processed for 361 of these recipients against any of the DRM numbers. The remaining 2,468 recipients had DRM claims submitted by providers of which 391 recipients used two or more DRM numbers concurrently with claims totaling $1,537,907. In 90 (of the 391) cases, the overlap in eligibility for the recipient was only a single day. It should be noted that 292 of the 391 recipients (75%) received the second DRM number in either De-

cember 2001 (62) or January 2002 (230) thus extending their eligibility period.

The more detailed review was focused on 301 recipients. These cases were further divided into inpatient and other than inpatient service categories.

A. Inpatient [Universe of 301 Individuals]

There were 42 recipients with inpatient stays covered by DRM. Expenditures for these cases totaled $817,428 or 53.1% of the total expenditure for recipients with multiple numbers. The top 25 recipients were reviewed to see if there were any patterns of abusive behavior on the part of the recipient and/or the provider of service. Expenditures for these 25 recipients represented 66% of the inpatient expenditure. In 21 of these cases, the treatment and diagnosis was consistent throughout by all providers. For example, the diabetic recipient shows admission for complications of their diabetes, follow-up care at clinics or doctor's offices, pharmacy supplies such as insulin, syringes, alcohol wipes, lancets and blood glucose test strips. In 4 cases a pattern was detected which required further investigation. Two recipients were ultimately referred for the Restricted Recipient Program and restricted; one received a two-year restriction while the second was restricted for six years. The remaining two were investigated and closed with no findings.

B. Other Than Inpatient [Universe of 301 Individuals]

The remaining 259 recipients without an inpatient stay had expenditures totaling $573,841. The top 60 recipients representing 34% ($195,318) of the expenditures were reviewed. In general, a pattern of abusive behavior was not found on the part of either the recipient or the provider. The diagnosis and treatment was consistent across providers. For example,

a cancer patient had similar diagnoses documented by all treating providers. Pharmacy and other services provided were supported by the diagnoses listed. Once again, only four (4) cases appeared problematic. Only one (1) recipient was referred to and restricted by the Recipient Restriction Program. The remaining three (3) were investigated and closed with no findings.

Multiple DRM Numbers/Regular Medicaid Numbers

As of December 2002, a total of 23,696 recipients had an active DRM number and an active WMS number. From earlier data information received, we had identified 6,836 unique recipients who had both an active DRM number and an active regular Medicaid number. Of these, 2,905 (42%) recipients used two (2) or more numbers during overlapping time periods.

Similar to the multiple DRM cases, the 2,905 recipients were divided into those with inpatient services and those receiving other than inpatient services. Of those who used the numbers concurrently, 907 recipients had inpatient services; 823 recipients had these services billed on their regular Medicaid numbers. This was most likely attributed to the fact that the recipient was known to the hospital prior to 9/11 and the hospital had the regular Medicaid number on file, which was then used to submit the claim.

A total of 145 recipients were reviewed for questionable patterns. One recipient with three numbers visited 24 different drug and alcohol facilities. This recipient has been referred to the Recipient Restriction Program.

In addition to the inpatient cases, 78 recipients receiving other than inpatient service were reviewed. This identified 4 MMTP providers (8 recipients) who had duplicate claims on the same date of service using both

the DRM and regular Medicaid number. The review of these providers was incorporated into the provider overpayment review.

Referral for Collection – Multiple Billings by Providers

The Medicaid payment database was examined to determine whether recipients with more than one Medicaid number, either DRM or regular, had bills submitted under both numbers by providers. This review identified over 1,600 providers with payments exceeding $2.7 million, of which $1.3 million was an overpayment. The overpayments were for identical services to the same recipient, on the same day, but billed under the recipient's different Medicaid numbers. Further review determined that due to claims payment problems associated with DRM, when overpayment was denied or pended under one recipient number, the provider resubmitted the claim using the other recipient number. In certain circumstances, these services wound up being paid twice for the same service to the same client. Referrals for collection of these overpayments are being made.

Report Reviews

A. Top 100 Recipient DRM Expenditures Report

The Top 100 Recipient DRM Expenditures Report was provided for review on a weekly basis and identified the top 100 recipients based on total expenditures under DRM with the exception of inpatient expenditures.

Since the beginning of DRM through August 31, 2002, 572 unique recipients appeared on this report one or more times; 130 (23%) recipients appeared 10 or more times. Each of the 572 recipients were reviewed by medical staff. The findings indicate that the majority had diagnoses and treatment from a variety of providers that supported the services rendered.

The services were continued under the new number issued after the DRM number expired. The diagnoses include, but are not limited to, cancer, renal disease, traumatic amputation, hemophilia, severe mental retardation, drug dependence, and HIV/AIDS. These are all extremely sick, and therefore, costly cases. Therefore, it is not unusual to see this recipient population represented in this report.

As a result of the review of 572 recipients, 18 cases were found to be problematic. Nine cases were associated with providers currently under investigation by the MFCU and the District Attorney's Office. Three cases were dental and the providers were included in intensive dental reviews. These were reviewed separately with possible referral to the Recipient Restriction Program following normal processes. The remaining 6 cases are currently active under regular Medicaid and are being monitored as a part of that effort.

B. Top 25 Recipients by Expenditures for Outpatient Services

This report identified the 'Top 25 Recipients by Expenditure' for outpatient services. The review revealed that the majority of the costs associated with these outpatient services were for chemotherapy and radiation. The second highest provider of outpatient services (All City) under DRM was terminated from Medicaid on 9/15/02 as a result of an investigation unrelated to DRM. This provider billed $4.8 million, 8% of the total DRM outpatient expenditures between 10/12/01-8/22/02. CHAPS, also in the top three, is under review by the MFCU for service provision issues unrelated to DRM.

C. DRM Dental Reviews

Significant Medicaid payments for dental services claimed for DRM recipients were noted from the onset. During the months of

October 2001 through December 2001, line-by-line review of each dental provider's claiming was performed. However, the volume of dental claim submissions increased rapidly.

Since the volume of dental codes was so massive, review criteria was developed that consisted of the following:

- Dental providers who have earned over $150,000.

- Dental providers who were associated with the top 25 recipients by expenditures.

As of March 2003, claims for 216 dental providers have been reviewed.

A significant number of questionable claiming patterns have been noted which include:

- Excessive number of dental services claimed on a single date of service.

- Frequent, inappropriate claiming of periodontal scaling and root planning.

- Claiming of duplicate services by one or more dental providers.

- Claiming of a significant number of expensive, time-consuming procedures, which would normally require prior approval.

Currently, 46 dental providers have been referred to the MFCU and participation in the Medicaid Program has been terminated for one.

D. Pharmacy

The top 3 recipients on this list did not have a diagnosis or services rendered by other providers that supported the need for these services. The providers associated with ordering and the pharmacies dispensing the drugs are all under active investigation by the MFCU and the District Attorney's Office.

Other Provider Activity

A total of 49 DRM cases have been referred to the MFCU. Action by the MFCU on these cases will occur over an extended period of time. Once the MFCU has completed its investigation, the case will either be prosecuted or returned to OMM for review and appropriate action. Such action could include termination and/or the recovery of overpayments through audit.

We will continue to monitor providers as part of our regular program integrity activity. This will include the review of provider Medicaid and DRM billing activity. Such activity can result in terminations or recovery of overpayments. This activity is in addition to the above referenced provider terminations and referrals to the MFCU, and the approximately 1,600 providers who were referred for collection to recover overpayments.

Other Recipient Activity

HRA BFI investigated a total of 97 multiple DRM recipient cases. Of these, most notably, 24 recipients' cases are closed or closing, and 20 clients are restricted or have restriction requested.

In addition to the 97 DRM recipient cases that HRA investigated, we restricted an additional 37 recipients' as they have become Medicaid eligible subsequent to DRM.

Furthermore, OMM investigators attempted to interview the top twenty-five recipients of combined Medicaid expenditures who had multiple DRM numbers.

No fraudulent activity was evident in the circumstances of the thirteen recipients interviewed. Eleven of the thirteen had a medical diagnosis that would substantiate the high Medicaid expenditures. Additionally, all eleven recipients had assistance with the DRM application process, mostly by the medical or social work staff of the recipient's health care service provider. Nine of the thirteen recipients interviewed are now or have been active regular Medicaid.

Two recipients were not interviewed because investigators could not accommodate a language barrier and ten recipients could not be located.

Investigators verified three of the ten recipients that could not be located had provided a fraudulent address on both their first and second application for DRM. One recipient had correctly listed his address, but he was living in homeless shelters and had moved prior to an attempt to contact. The remaining six recipients were not able to be located.

Recommendations

From a program integrity standpoint, certain deficiencies were noted in the DRM application. In the future, we recommend that any similar application include, at a minimum, questions that specifically require the applicant to provide:

- Employment information, i.e. the name of the employer, the address, the name of the supervisor, telephone number, and dates employed. The amount of salary and the specific payment period, i.e. weekly, monthly, along with a copy of a paycheck.

- The name of the landlord and/or super, as well as the telephone number and rent paid. The length of time residing at that address and whether it was temporary, resulting from the disaster, and if so, identify the relative or friend residing with.

- The name(s) of other individuals in the household, even though not applying, and the relationship to the applicant.

- Employment or benefit information pertaining to other household members.

The inclusion of these questions would assist eligibility staff in making the correct entitlement determination and also provide substantive information for investigators.

Appendix F:
Medicaid Eligibility Quality Control Audit (MECQ)

AUDIT PLAN
MEQC 1115 WAIVER PROJECT
FFY OCTOBER 2001–September 2002

PROJECT TITLE: WTC DISASTER MEDICAID: APPLICATION MONITORING

DISTRICT: NEW YORK CITY

PROJECT NUMBER: 2002-66

PURPOSE: Evaluate the completeness of the Disaster Medicaid Assistance Application
                          and validate the declared applicant information.

                          Based on the applicant-reported income, determine if the MAP income
                          eligibility decision was correct.

                          Based on QC verified income, residence and household composition,
                          determine sampled case eligibility for DRM.

SCOPE: A minimum of 500 positive cases will be reviewed from cases approved for
                          Disaster Relief Medicaid between 9/01/01 through 1/31/02.

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                          Reviews will include clearing the NYC WMS, SSA SOLQ and NYC DOF
                          Real Estate Tax database subsystems. Contact with appropriate third
                          parties (landlord; employer) and / or the applicant will be initiated as
                          necessary.

BACKGROUND: Responding to the September 11, 2001 terrorist attack on the World Trade
                          Center, and the resulting interruption of the HRA WMS computer system,
                          the NYS Department of Health, with approval from HHS Centers for
                          Medicare and Medicaid Services (CMS), established the Disaster Medicaid
                          program. The Disaster Relief Medicaid program was federally approved for
                          applications filed during the period September 11, 2001 through January
                          2002. Recipients receive four months of coverage, including the month of
                          application; therefore, coverage for January 2002 applications will end
                          4/30/02.

DOH instituted a declarative application linked to a simplified eligibility process. Applicants are not required to submit demographic documentation (e.g.: birth certificates, SSN card, etc.) or verify income, household composition or residency within New York City. By signing the application, applicants agree that they are attesting to the accuracy of the information supplied on the form.

Individuals are not entered onto the WMS database nor given a benefit card. However, they are given a temporary authorization document and certain demographic information is entered into MMIS. Income is compared to the income limits established for the appropriate Family Health Plus or Medicaid program. Eligibility decisions are to be made at the time of application and eligible applicants are immediately provided with a temporary Medicaid authorization document.

Individuals are guaranteed DRM coverage for a four-month period. To obtain further benefits, individuals must file an Medicaid application and comply with all Medicaid eligibility requirements. DRM coverage is being extended for each individual to give him/her time to apply without a break in coverage.

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Legal Authority /

Reference Material: WEB SITE: www.nysdoh/medicaid/wtc_qanda.htm
                                      www.nysdoh/medicaid/nycmedofices.htm
                                      www.nysdoh/medicaid/familyheatlh
                              Provider Letter of September 26, 2001

WORK PLAN
WTC DISASTER MEDICAID:
APPLICATION MONITORING

I PRE AUDIT PREPARATIONS

  A. Review DOH Policies & Procedures
       governing the Disaster Medicaid Program.
  B. Develop audit plan & submit for approval.
  C. Schedule & conduct staff training.
  D. Schedule & conduct entrance conference with
       HRA
  E. Develop data collection form.

II MONITORING PROCESS

  A. WMS CLEARANCE:

    1. Obtain copies of the sampled DRM application
       and income calculation sheet from CSC.

    2. Clear required recipients through WMS for present /
       past case involvement. If found, print the following screens:

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       ▪ Individual Case Involvement History
       ▪ Case composition
       ▪ RFI if system indicates unresolved RFI data exist
       ▪ If MA-Only, all MA screens for all DRM recipients*
       ▪ MAPPER or GATEWAY inquiry screens
       ▪ Budget
       ▪ If earned income budgeted, printout IM Financial
          Profiles (option 12 /13 on individual query).

  A. SOLQ CLEARNCE:

    1. Clear all recipients that do not have a current or prior
       case history on WMS through SOLQ system. SOLQ clearance
       will be done on all denied or withdrawn applications.
    2. Attach copy of SSA printouts.

*If recipient had an active MA-Only case and an active DRM authorization card at the same time, Section D question 6 is to be answered.

*If recipient has an active MA-Only case, determine if they are enrolled in Managed Care, have a spenddown or are in restricted provider program.

C. <u>DATA COMPARISON</u>

1. Compare the applying household information, as reported on
    The DRM DECLARATIVE Application, with:
    ▪ WMS Name, Date of Birth and SSN data.
    Identify non-matching information.
    ▪ SSA SOLQ name, DOB and SSN data.
    Identify non-matching information.
1. If DRM recipients have an active case
    on WMS, compare home addresses.
    Identify non-matching information.
2. Based on the date of DRM application
    determine if WMS budgets or IM Financial
    Profile Data cover the same period of time.
    If yes, determine if the DRM reported income
    matches the WMS budgeted income.
    Identify non-matching information.
3. Compare DRM application data (name, DOB, SSN)
    With MMIS/CSC file printouts to identify
    data entry errors.

F-5

C. <u>DATA VERIFICATION</u>
    Use appropriate methods to verify residence, demographic,
    data, household composition and income.

1. Clear all adult DRM recipients through
    the State RFI system.
2. Contact all identified employers via the
    "Work Number" System and or standard
    employer clearance system and obtain wage data.
3. Clear non-matching home addresses and
    no WMS history DRM applicant home addresses
    through the NYC DOF Web site. Attach printout.
4. Contact landlord or management firm to verify household
    residence, composition and income as necessary.
5. Contact recipient to verify non-matching data such as
    SSN, DOB, Employer or Landlord.

6. For Dual Coverage recipients (active MA-Only and
    DRM) obtain explanation as to why recipient obtained
    dual coverage.

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III   <u>DETERMINATIONS</u>

A. <u>MAP FINANCIAL CALCULATION</u>

1. Using DRM application information, determine if MAP correctly computed gross monthly income.
2. Determine if MAP correctly used Family Health Plus gross income limits.
3. If DRM household's gross income exceeded FH+ limits, determine if MAP correctly used budget method 2 or 3 to establish eligibility.

B. <u>ACCURACY OF DECLARATIVE APPLICANT INFORMATION</u>

1. Determine accuracy of DRM declared application data:
   - SSN
   - DOB
   - Residency
   - Household Composition
   - Income

<div style="text-align:right">F-7</div>

1. Using **QC verified income,** determine recipients financial eligibility for DRM.

2. If financially ineligible for DRM FH+, determine eligibility for MA ADC-related or SSI–related.

<u>Reference</u>

IV   <u>COMPILATION OF QC FINDINGS</u>

1. Complete worksheet
2. Update Control logs and computer systems
3. Prepare report on findings for each sample Month.

STEP 1

Family Size: Per QC verification	**Gross Monthly Income:** Per QC verification
a. # of people applying: _____ b. # of other people not applying*: _____ c. Total: _____	Total: _____

*Legally responsible parent, stepparent or spouse of someone applying; or child under 21 years of age related to someone applying.

Compare gross monthly income to the appropriate monthly income level for the family type and size in the chart below:

Family Size	1	2	3	4	5	6	Each Additional Person Add
Parents; Children Under 21	$953	$1,287	$1,622	$1,957	$2,291	$2,626	+$335
Single Persons; Couples w/o children	$716	$968					

Decision:

- Income Eligible: ☐

Or

- Go to Step 2 ☐

Step 2

MA ADC RELATED DRM (Non-disabled adults under 65 years of age and children under 21)

GROSS MONTHLY INCOME	$	
Deductions:		
_____# of Working family members x $90 pm _____	$	
Child care: Actual or $200* _____# of children x $_____	$	
Child care: Actual or $175* _____# of children x $_____	$	
Adult Dependent Care: Actual or $175 pm	$	
Health Insurance Premium	$	
$50 of total child support received	$	
$5 per day per child for providing informal day care _____# child(ren) x $5	$	
Total Deductions:		$
Net Monthly Income: (Gross – Deductions)		$

*Child Care: Cost must be verified by the provider
- For child under 2 years of age: actual up to $200 per month;
- For child over 2 years of age: actual up to $175 per month

Compare net income to chart on page 4

<u>MA SSI RELATED DRM (Adults over 65 years of age or disabled)</u>

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MONTHLY INCOME of non-SSI related spouse	$
Deduct: ————— # of children with no income x $275	$
Subtotal	$
Add: Monthly Income of SSI related Person	$
Subtotal (b)	$

Deductions:

$20 from earned / unearned income	$	
$65 from earnings from work	$	
Impairment related work expenses	$	
1/2 of the remaining earnings from work	$	
Health Insurance Premium	$	
Total Deductions		$
Net Monthly Income: (Subtotal (b)– Deductions)		$

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Compare net income to chart on page 4

Compare the net income results from Step 2 (MA ADC DRM or MA SSI DRM) to the appropriate Monthly Income Level for the family size in the following chart.

Family Size	1	2	3	4	5	6	Each additional person add:
Child under 1 year; Pregnant Woman	1432	1935	2439	2942	3445	3949	$504
Child 1-5 years	953	1287	1622	1957	2291	2626	$335
Child 6 –19 years	716	968	1220	1471	1723	1975	$252
Child 19-20 years; Non-disabled adults	625	900	909	917	992	1134	$142

under age 65							
Elderly/Disabled/ Blind Adults	625	900					

Decision:

- Income Eligible: ☐

Or

- Income Ineligible ☐

Auditor: _____   **Date:** _____

Supervisor: _____   **Date:** _____

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MEQC 2002 PROJECT
DISASTER RELIEF MEDICAID
APPLICATION MONITORING WORKSHEET

Auditor: _____   Sample (Application) Month: _____

Assignment Date: _____   Date Submitted to Supervisor: _____

I) SAMPLE DEMOGRAPHICS:

Application Serial #	
CSC Julian Date	
CSC Batch #	
CSC Box #	
QC Review #	

I) APPLICATION DEMOGRAPHICS:

Sample CIN #	
Applicant's Last Name	
Date of Application	
Number of Individuals Not Applying	
Number of Individuals Applying	Adults: Children:
Reported Household Income	$
Period of Eligibility	From: To:

F-12

III) COMPLETENESS OF DRM APPLICATION: Review application and identify those that are:

a) Incomplete (Identify section(s) not completely answered): ☐

_____

_____

_____

b) Data illegible and not corrected by MAP (Identify section): ☐

_____

_____

_____

c) Data in an incorrect format and not corrected by MAP (Identify): ☐

_____

_____

_____

Notes and Comments (For Section III):

IV) WMS CLEARANCE:

Directions: (Child is defined as any one under the age of 21.)

Clear the listed SSN for all applicants listed on the DRM application

Printout all appropriate WMS screens and complete the following sections as necessary.

a) Date WMS Clearance Completed: _____ No Record (Go to Sec. V): ☐   Hit: ☐

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b) Application (other than DRM) Denied, Rejected or Withdrawn between 8/01/01 through month of DRM application: ☐

Note: For DRM recipients with no active or closed case involvement, Section V must be completed.

Type of Assistance	Application Date	Date of Denial	Reason Code
Cash (FA, SNCA, EAF, EAA)			
NPA FS			
MA-ONLY			

c) DRM Recipient receiving other assistance during month of DRM application.
   Do not include Medicaid case type 21. ☐

Type of Assistance	Case Number	Date Opened	Current Authorization Period
Cash (FA, SNCA, EAF, EAA)			
NPA FS			
MA-ONLY			

Note: If individual, or DRM recipient household, had MA coverage during the application month, either through cash assistance or MA-Only, check characteristics that apply:

1) Has monthly Spend down: ☐

2) Enrolled in Managed Care: ☐

3) Restricted MA coverage: ☐

d) DRM Recipient Prior History: Case Currently Closed ☐

Type of Assistance	Case Number	Date Closed	Reason Code
Cash (FA, SNCA, EAF, EAA)			
NPA FS			
MA-ONLY			

e) Data Verification: Compare Name, SSN and DOB for all DRM applicants with the WMS data:
- Demographic data for all DRM applicants match WMS information: YES ☐   NO ☐

- If no match on Name, SSN or DOB, list CIN #of individual with non-match data and data element

and

- Complete Section V: SOLQ CLEARANCE FOR ALL Individuals listed on the DRM application:

_____

_____

_____

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Notes and Comments (Section IV):

V) SOLQ CLEARANCE:
Directions: If WMS clearance resulted in a "No Hit" for all applying household members, or a "Non-Match" on identifying information for some household members, submit a SOLQ (SSA) clearance to Pam Utley for a SSA clearance for all applying household members. Attach copies of SSA printouts and complete following sections as necessary:

a) Demographic data (name, DOB & SSN) for all applying individuals match SSA records:

YES: _____   NO _____

b) If no, explain: _____

Comments / Notes (Section V):

VI) PROPERTY CLEARANCE:

Directions: If WMS clearance resulted in a:

- "No Hit" **or**
- Information was on a case closed prior to 2/2001 **or**
- WMS lists a different home address

Conduct a property record search, on the DRM application address, through the NYC DOF web site. Attach copy of completed property record search form. Contact landlord or property manager (indicate date and manner of contact) and verify that at time of DRM application:

- DRM recipient address verified as correct: YES ☐ NO ☐

- DRM applicants resided in NYC : YES ☐ NO ☐

- Household Composition: _____

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- Employer's name & address for the parent of applying child(ren) per landlord records:

    _____

    _____

Comments / Notes (for Section VI):

VII) INCOME VERIFICATION

Directions: For all adults applying for DRM:

- Initiate a CINTRAK CLEARANCE for all adult applicants
- Contact, via the "Work Number" system or direct employer contact, all employers listed on the CINTRACK Clearance and or WMS (RFI, WAY-BEGIN etc.) subsystems.
- SOLQ can be used to verify SSA OR SSI INCOME.
- Contact recipient if unable to identify employer at time of DRM application.

Record all information below and attach copy of clearance:

_____

_____

_____

_____

_____

_____

VIII) **For Dual MA Coverage recipients (authorized for MA coverage and DRM at the same time):**

a) Contact recipient and ask why they applied for DRM if they already had a Medicaid Card. (record statement):

_____

_____

_____

F-16

b) Unable to determine:

Recipient did not respond
To contact letter: ☐

Unable to locate recipient: ☐

Recipient would not answer Question: ☐

Other: ☐

Comments/Notes (Section VIII)

IX) **INCOME CALCULATION AND ELIGIBILITY DETERMINATION:**

a) Based on the DRM declared applicant information determine if MAP financial determination was:

- Correct: ☐

- Incorrect: ☐
  Explain:

_____

- Unable to determine: ☐
  Explain:

F-17

MEQC 2002 PROJECT
DISASTER RELIEF MEDICAID
APPLICATION MONITORING WORKSHEET

a) Based on QC verified household income and household size, determine if applicants are eligible for DRM or potentially eligible for MA ADC-related or MA SSI-related.

Eligible FHP: DRM	
Eligible MA ADC-Related DRM	
Eligible MA SSI-Related DRM	
Ineligible: MA DRM	

c) QC unable to make an eligibility determination (check all that apply):

1. Unable to verify individual recipient demographic data (Name, SSN or DOB): ☐

2. Unable to verify NYC residency at time of DRM application: ☐

3. Unable to verify household composition: ☐

4. Unable to verify household income: ☐

5. Other (Explain): ☐

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_____

_____

_____

_____

Comments/Notes:

Supervisor Sign Off: _____ **Date:** _____

WORKING DRAFT (3/12/03)

Dear:

We have completed the Quality Control (QC) review of Disaster Relief Medical Assistance (DRM). This audit was done as part of the NYS Department of Health 1115 Medicaid Quality Control (MEQC) waiver. The audit focused on the determination of financial and categorical eligibility for DRM and reported demographic data (e.g. social security number, address and household composition).

We reviewed a sample of 500 approved DRM applications, filed between September 2001 and January 2002. The purpose of this audit was to evaluate the completeness of the DRM application and validate the declared applicant information; to determine if MAP's eligibility decision was correct based only on the applicant reported information; and to determine case eligibility for DRM based on QC verified income, residence and household composition.

We evaluated the decisions made by the MAP eligibility workers. Since the DRM application process did not allow the MAP eligibility workers to collect documentation of eligibility from the applicants, we evaluated the MAP workers' eligibility determinations based only on the information reported by the applicant. Based on these criteria we found that 6% of MAP's eligibility determinations were incorrect. Overall, MAP staff properly followed the case processing rules of the DRM program.

We also completed an independent verification of information declared on the DRM applications. QC methodology was used to verify DRM eligibility factors by clearing existing government data files such as WMS, RFI, Social Security, New York City Property Tax etc. Client contact was initiated when data could not be obtained through existing data files. This verification process resulted in finding a significant number (105 cases, 21%) of cases ineligible for assistance. We believe the large percentage of ineligible cases can be attributed to the DRM application process that did not allow MAP eligibility workers to validate client statements.

We also found that the DRM application form did not ask all of the questions necessary to make a correct eligibility decision. The form asked for the total amount of income received by people in the household, but did not ask how frequently (i.e. weekly, bi-weekly, monthly) the income was received and whether the gross or net income should be reported. The income question also did not clearly distinguish between the income of those who had to be counted as part of the Medicaid household (e.g. legally responsible relatives) and the income of those who did not have to be included in the Medicaid household. The DRM application also did not clearly identify the relationship of the non-applying people in the household to those who were applying. This made it impossible to determine the correct household size.

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We have concluded from this review that MAP eligibility workers correctly processed most of the DRM applications based on their acceptance of the eligibility information supplied by the applicants. However, the failure of the DRM process to require that the applicant's statements be substantiated combined with deficiencies in the application form resulted in a high ineligibility rate for these cases when a QC verification of actual circumstances was completed.

Attached, for your information are copies of the approved Audit Plan, Application Monitoring Worksheet and QC Income Calculation Worksheet (Refer to Attachment A through C).

DETAILED FINDINGS:

QC Evaluation of MAP DRM Eligibility Determination

We reviewed the MAP DRM eligibility determination to ensure that all reported information was properly evaluated. Based solely on the information provided by the client and recorded on the DRM application, MAP staff correctly determined eligibility for 446 (89.2%) of the 500 reviewed applications. However, there were 30 cases (6%) where the DRM eligibility decision was incorrect. In several instances, MAP staff disregarded the applicant-reported income (nine cases) or household size (14 cases) resulting in an incorrect DRM eligibility determination. In addition, we identified one case correctly determined DRM eligible but not authorized for the guaranteed four-month period (Refer to Exhibit I). In 24 cases (4.8%) we were unable to evaluate the MAP eligibility decision as either required information was left blank on the application or we did not receive the complete application packet (budget calculation sheet) (Refer to Exhibit II).

In reviewing the applications, QC noted that a significant number of the applications had sections that were either unanswered or the applicant response was illegible. These ranged from the failure of the person signing the application to identity their relationship to those applying to the MAP worker failing to sign the application and/or record their eligibility decision (Refer to Exhibit III). In addition, transcription errors by MAP staff occurred when entering the information on the Medicaid Temporary Authorization Form. The most frequent omission was the failure to record the applicant's apartment number (Refer to Exhibit IV).

QC Determined Case Eligible for DRM

One hundred ninety-eight (39.60%) of the sampled cases were found eligible for DRM benefits as QC independently verified income and categorical eligibility factors.

QC Determined Case Ineligible for DRM

QC determined that 105 cases, 21% of total sample or 34.66% of the cases with a QC eligibility determination, were ineligible for DRM assistance.

Financial Ineligibility (102 cases; 20.40% of the sample)

The vast majority of cases were determined ineligible as the verified monthly income exceeded the MA income standard for the verified household size and type. QC based the budget calculations on countable verified gross income available to the applicant at the time of application.

Twenty-eight of the applicants listed a monthly income of $0 or left the question blank but were coded eligible by MAP staff. QC verified that their actual monthly income ranged from:

- Under $999: Three cases
- $1000 to $1499: 12 cases
- $1500 to $1999: Four cases
- $2000 to $2499: Six cases
- Greater than $2500: Three cases

In 74 cases, the applicant listed an income amount that QC verified was less that the gross monthly income available at the time of application. Based on the verified gross monthly income, household size and type, QC determined these cases ineligible. It should be noted that the DRM application did not clearly indicate whether the gross or the net income should be reported. It also did not ask how frequently the income was received. The applicant was simply asked to record the "Total Income" for all household members.

Categorical Ineligible (Three cases; .60%)

The three remaining cases were determined ineligible as the applicant did not:

- Have an SSN. The application lacked the notation that an SSN had been applied for or that the individual was entitled to "PRUCOL" status (two cases).
- Reside in NYC. The applicant listed a Nassau County address on the DRM application; there was no annotation by MAP that this was a temporary living arrangement and that the applicant's permanent residence was in NYC. QC contacted the customer and verified that she was a permanent resident of Nassau County. It should be noted that the customer advised QC that she told MAP that she was not a NYC resident.

Refer to Exhibit V.

QC Unable to Make an Eligibility Determination

QC was unable to verify one or more DRM eligibility factors in 197 (39.40%) of the 500 sampled cases. The simplified DRM application did not require the applicant to document their source of self-support (e.g. income) or provide the name and address of their employer or landlord. In addition, applicants were not required to provide the name, DOB or SSN for non-applying legally responsible individuals residing in the household. As a result, contact with the customer was necessary when information could not be obtained through existing databases or there was conflicting information provided.

Customer Failed to Respond (93 Cases; 47.21%)

Customer contact was attempted via at least two mailed "Please Call Me Letters" and or telephone calls to the listed phone number. Contact was required because:

- Income and Residency / Household Composition Not Verified: 72 cases
- Residency & Household Composition Not Verified: Eight cases
- Income Not Verified: Seven cases
- SSN Problems and either Income and or Residency/Household Composition Not Verified: Six cases

Refer to Exhibit VI detailed analyses.

Customer Responded: QC Decision Remains UTD (72 cases; 36.55%)

The customer responded to our request for information but QC was still unable to verify factors of eligibility as either a landlord, tenant of record or employer did not respond to our queries for information. Also, a significant number of customers claimed either off the books income or support by a non-legally responsible relative. However, documentation was not submitted to verify these statements. Factors causing a QC decision of UTD are as follows:

- Income and Residency / Household Composition Not Verified: 34 cases
- Income Not Verified: 25 cases
- SSN Problems and either Income and or Residency/Household Composition Not Verified: Eight cases
- Residency & Household Composition Not Verified: Five cases

Refer to Exhibit VII detailed analyses.

Customer Responded but was Non-Cooperative with QC (17 cases; 8.63%)

The customer responded to either the "Call Me Letter" or telephone calls initiated by QC. However, they failed to provide the information requested or did not call back/send the information in. Breakdown of the customer actions are as follows:

- Three customers clearly stated they would not co-operate.
- Six customers never got back to QC with the requested information.
- Three customers provided information that appears to be misleading.
- Two customers would not provide information on a non-applying legally responsible spouse residing in the household.
- Three customers failed to respond to follow-up contact by QC in attempts to clarify information previously provided.

Refer to Exhibit VIII for details.

Call Me Letter Returned by Post Office (15 cases; 7.61%)

The US Post Office returned the call me letter sent to the customer and QC was unable to make contact via the telephone. Letters were returned for the following reasons:

- Attempted: Not known: Eight customers.
- "Return to Sender" Address Problem: Five customers.
- "Return to Sender" Moved Not Forwardable: One customer.
- "Return to Sender" Unclaimed: One customer.

Refer to Exhibit IX for details.

We have shared, with staff from your Office of Medicaid Management Bureau of Enforcement & Investigation, a copy of our DRM results via an ACCESS database. If you, or your staff, have any questions or need additional information please contact Alice M. Burns at 1-718-262-5079.

Thank you for your cooperation and assistance during the course of the review.

Sincerely,

Michael J. Ryan, Director
Queens Operations
Bureau of Audit and Quality Control
NY State Office of Temporary & Disability
Assistance

CC:

F-23

Re: MEQC 2002 Project:
   "DRM APPLICATION MONITORING"
   Review of Negative Case Decisions

Dear XXXXXXX:

The New York State Department of Health (NYS DOH), in response to the September 11, 2001 attacks on the World Trade Center and the resulting interruption of the New York City Human Resources Administration Welfare Management Computer System (HRA WMS), established the Disaster Relief Medicaid Program (DRM). DRM used a simplified attestation application that required minimal documentation to establish eligibility. DRM eligibility was based upon the applicant documenting his or her identity, residence within the City of New York, enumeration of, or application for, an SSN for all applicants and income at or below either the Medicaid or Family Health Plus income standards. Eligible individuals were authorized for four months of DRM coverage.

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Subsequent to the establishment of the DRM program, NYS DOH extended Medicaid coverage for DRM recipients beyond the initial four-month coverage period. These DRM cases were coded into WMS as Medicaid Presumptive Eligibility (MPE) Cases. These individuals could have MPE coverage for up to twelve months or until they were scheduled and appeared for an eligibility interview. Cases determined to meet regular Medicaid eligibility requirements were coded into WMS as regular Medicaid cases. Cases determined to be ineligible for Medicaid, or who failed to show for their scheduled Medicaid interview, had their MPE cases closed. MPE coverage was terminated prior to the eligibility interview only if, based on WMS data, it was determined that the individual had Medicaid coverage under another active case.

A&QC staff initiated a review of denied DRM applications and MPE terminations as part of the Medicaid Eligibility Quality Control (MEQC) DRM Application Monitoring review. Our review consisted of an analysis of the documentation contained in the Fair Hearing folder to ensure adequacy, appropriateness and relevancy to the stated DRM denial reason. Staff also reviewed all relevant WMS screens to confirm the correctness of the decision to terminate MPE coverage due to existing Medicaid coverage.

Per HRA Medical Assistance Program (MAP) processing procedures, case folders for the DRM denials and MPE terminations were to be forwarded to the MAP Fair Hearing Unit located at 34th Street. As of April 22, 2002, QC had counted a total of 8,275 case files. From this, we selected a random sample of 250 DRM denials and 165 MPE terminations for review.

II. SUMMARY OF FINDINGS

DRM Denials: We found that MAP staff's failure to adhere to procedures, combined with an application form and process designed for rapid granting of DRM with little emphasis on verification of statements resulted in either incorrect denials, or insufficient documentation by MAP to support the DRM denial for over 1 in 5 denied applications. We found that the DRM application form did not ask all of the questions necessary to make a correct eligibility decision. The form asked for the total amount of income received by people in the household, but did not ask how frequently (i.e. weekly, bi-weekly, monthly) the income was received and whether the gross or net income should be reported. The income question also did not clearly distinguish between the income of those who had to be counted as part of the Medicaid household (e.g. legally responsible relatives) and the income of those who did not have to be included in the Medicaid household. The DRM application also did not clearly identify the relationship of the non-applying people in the household to those who were applying. This made it impossible to determine the correct household size.
 Auditors could only clearly establish 78% of sampled cases as proper denials. For 7.6% of the DRM denials we reviewed, MAP's failure to follow processing procedures established by HRA resulted in incorrect denials. For the remaining 14.4% of the DRM denials we reviewed, data to support denials was either missing or contradictory, and auditors could not establish the validity of HRA's decision to deny DRM.

MPE terminations: Of the 165 terminations, we found 17.0% (28 cases) were incorrectly terminated. Most of these errors were the result of a failure to correctly interpret WMS data related to Medicaid expired authorization periods.

Refer to Exhibit 1 for statistical summary.

III. DETAILED FINDINGS

IV. DRM APPLICATION DENIALS

MAP procedures, detailed in MAP Procedure 01-14(R-2) issued October 12, 2001 and Procedure 01-15(R-1) issued November 20, 2001, outlined the processing procedures for DRM denied applications. Specifically, MAP staff were to complete the determination section of the DRM application, prepare the MAP 2089F "Notice of Denial of Your Disaster Relief Medicaid/FHP Application", make photocopies of the application, budget calculation sheet and notice of denial, file them in the case folder and forward the folder, with all applicable documents, to the MAP Fair Hearing Division located at 330 W. 34 St on the Third Floor.

QC reviewed the documentation supporting the decision to deny the application to ensure compliance with DRM eligibility requirements and MAP processing procedures.

Findings are:

Valid (195 denials or 78%)

Negative actions determined valid had sufficient documentation to support the decision. In addition, MAP staff properly annotated case files to explain inconsistencies in case applications, income calculation sheets and/or denial letters.

Invalid (19 cases or 7.6%)

Auditors used Medicaid Eligibility Quality Control (MEQC) procedures to determine validity of sampled denials. Under MEQC rules, if the Agency cannot provide documentation to support the negative action taken, the action is considered to be invalid. The decision to deny DRM benefits was invalid in 19 cases as the denial notice was not in the Fair Hearing Folder (12 cases), denial notice reason was not related to the reason recorded on the application (4 cases) or MAP staff misapplied eligibility requirements (3 cases). Based on these findings, we determined that 24 individuals were incorrectly denied DRM benefits. Refer to Exhibit II for case specific details.

Unable to Determine (UTD) (36 denials or 14.4%)

A determination as to the validity of the action to deny DRM benefits could not be made in 36 cases. Twenty- five of these involved inconsistencies between what applicants recorded on the application and what the MAP worker used on the budget sheet. All of these involved the number of people to be included in the household size when computing eligibility. In each instance, MAP staff did not annotate why they used a smaller household size. The remaining findings involved procedural failures in that either the budget sheet was not in the Fair Hearing Folder (6 cases), sections of the application involving eligibility were unanswered by the applicant and not completed by MAP staff (2 cases) and other reasons (3 cases). Refer to Exhibit III for case specific details.

V. MPE TERMINATIONS

Valid (137 cases or 83.03%)

The main reason for terminating an MPE case was that clients were members of an existing Medicaid case at the time of their application for DRM. We found that 137 MPE cases (83.03%) were validly terminated for this reason. The QC review found adequate documentation in the Fair Hearing case file and QC analysis of WMS established the existence of dual Medicaid coverage for all case members at the time of MPE termination.

Invalid (28 cases or 16.97%)

The QC analysis of WMS established that for 25 cases, MPE was terminated incorrectly. For these 25 cases, auditors did not find any Medicaid coverage at the time of the decision to terminate MPE due to an already existing Medicaid case. In two other cases, some case

members had no Medicaid coverage at the time of the MPE termination and therefore were terminated incorrectly.

In reviewing the various WMS screens, QC identified inconsistencies between Case History Data and the individual's Medicaid coverage data. It appears the case number would be coded as active Medicaid on WMS. However, a closer analysis of the various WMS individual inquiry screens, especially the data on MA History, revealed that the individual's Medicaid coverage period had expired well before the decision to terminate MPE coverage was made. Further analysis of the WMS data indicated that a number of the individuals had previously applied for Medicaid and been deemed eligible. For these cases, a case was opened and Medicaid coverage was authorized, but no subsequent case transactions were noted on WMS (e.g. recertification) from the date of the initial case opening. Authorization periods for the individual's Medicaid coverage had been allowed to expire. Several of the cases had the following WMS transaction note "A0275: MA Expired Authorization". As the Medicaid History screens listed a Medicaid authorization coverage end date that was prior to the decision to terminate MPE coverage, QC concluded that the individual had no Medicaid coverage.

In the remaining case, the closing notice was invalid as the case number on the notice was incorrect.
Refer to Exhibit IV for case specific details.

If you have any questions, or need additional information, please contact Alice M. Burns at 718-262-5079.

Thank you for your cooperation and assistance during the course of the review.

Sincerely,

Michael J. Ryan, Director

EXHIBIT I
DRM NEGATIVE CASE ACTION
SUMMARY OF FINDINGS

NEGATIVE CASE ACTION	QC DECISION VALID	QC DECISION UTD	QC DECISION INVALID
DRM DENIAL	195	36	19
MPE TERMINATION	137	0	28

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Appendix G:
MAP/HRA Statistics

MAP Outreach Notification IVRS
Cumulative Summary Statistics: Totals—Results for All Calls
(11/13/02–11/20/02)

Result of Call	Percent	Total
Answering Machine Detected, then Disconnected for Various Reasons	35.88%	5,996
Call Didn't Get To or Past the Language Selection	28.64%	4,787
Entire Message Played	27.26%	4,555
3 Attempts with No Answer	5.50%	919
Part of Message Played	2.72%	455
Grand Total	100.00%	16,712

DR Outreach Notification IVRS
Cumulative Summary Statistics: Totals—Results for All Calls
(3/3/03–3/10/03)

Result of Call	Percent	Total
Answering Machine Detected, then Disconnected for Various Reasons	36.68%	7,483
Entire Message Played	31.08%	6,342
Call Didn't Get To or Past the Language Selection	23.77%	4,849
3 Attempts with No Answer	5.23%	1,067
Part of Message Played	3.24%	662
Grand Total	100.00%	20,403

DR Outreach Notification
Cumulative Summary Statistics: Totals—Results for All Calls
for Part 1 (11/13/02–11/20/02) and Part 2 (3/3/03–3/10/03)

Result of Call	All Calls		Part 1: 11/13/02–11/20/02		Part 2: 3/3/03–3/10/03	
	%	Total	%	Total	%	Total
Entire Message Played	29.36%	10,897	27.26%	4,555	31.08%	6,342
Part of Message Played	3.01%	1,117	2.72%	455	3.24%	662
Call Didn't Get To or Past the Language Selection	25.96%	9,636	28.64%	4,787	23.77%	4,849
Answering Machine Detected, then Disconnected for Various Reasons	36.32%	13,479	35.88%	5,996	36.68%	7,483
3 Attempts with No Answer	5.35%	1,986	5.50%	919	5.23%	1,067
Grand Total	100.00%	37,115	100.00%	16,712	100.00%	20,403

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Client Population Indicators—February 2004

MICSA—Medical Assistance Programs
Monthly Management Report

All MA Eligibles/Borough	TOTAL= 2,423,454
Manhattan	384,903
Bronx	543,596
Queens	539,367
Brooklyn	860,853
Staten Island	68,409
Out-of-City	26,326

MA-Only Eligibles/Borough	TOTAL= 1,592,475
Manhattan	236,122
Bronx	305,156
Queens	414,705
Brooklyn	569,475
Staten Island	46,181
Out-of-City	20,836

All MA Eligibles in HMOs	TOTAL= 1,309,939

Family Health Plus Enrollment	TOTAL= 260,276

MA-Only Cases by MAP Area	TOTAL= 962,690
CED	868,429
HED	34,647
NH	39,476
CASA	20,138

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Case Volume Indicators—February 2004
MICSA—Medical Assistance Programs
Monthly Management Report

MA-Only Application Activity

New Applications Received	TOTAL= 58,024
New Applications Completed	TOTAL= 57,294
Completed within Timeframe	Percent= 98.9

MA-Only Apps Activity by Area

CED New Apps Received	TOTAL= 47,060[1]
New Applications Completed	TOTAL= 46,145[1]
Completed within Timeframe	Percent= 99.6[1]
HED New Apps Received	TOTAL= 8,743
New Applications Completed	TOTAL= 9,459
Completed within Timeframe	Percent= 99.9
NH New Apps Received	TOTAL= 2,221
New Applications Completed	TOTAL= 1,690
Completed within Timeframe	Percent= 76.9
Automated New Applications	Successful
PCAP	2,807[2]

[1] Includes FHP.
[2] Included in CED New Apps.

Case Volume Indicators—February 2004 (continued)

MA-Only Renewal Activity

Renewals Received	TOTAL= 42,443
Renewals Completed	TOTAL= 42,424
Completed within Timeframe	Percent= 99.2

MA-Only Renewal Activity by Area

CED Renewals Received	TOTAL= 41,774
Renewals Completed	TOTAL= 41,774
Completed within Timeframe	Percent=100.0
NH Renewals Received	TOTAL= 669
Renewals Completed	TOTAL= 650
Completed within Timeframe	Percent= 50.0
Automated Renewals	Successful
FFR	TOTAL= *
MRP/DAB	TOTAL= 939
Nursing Home	TOTAL= *

Medicaid Helpline

Calls Received	TOTAL= 38,974
Calls Completed	TOTAL= 28,515
Via Auto Menu	1,757
Via Counselor	26,138
Caller Error	620

Home Care Services Program

All Home Care Cases	TOTAL= 65,957
Home Attendant	45,732
Housekeeper	7,709
LTHHC	10,881
AIDS	1,635
Average Weekly Hours	42.7

*Individual automated recertification reports were not produced by New York State.

Client Population Indicators—March 2004
MICSA—Medical Assistance Programs
Monthly Management Report

All MA Eligibles/Borough	TOTAL= 2,461,699
Manhattan	389,209
Bronx	550,141
Queens	552,591
Brooklyn	873,903
Staten Island	70,475
Out-of-City	25,380

MA-Only Eligibles/Borough	TOTAL= 1,631,658
Manhattan	240,540
Bronx	311,985
Queens	428,020
Brooklyn	583,085
Staten Island	48,163
Out-of-City	19,865

All MA Eligibles in HMOs	TOTAL= 1,341,965

Family Health Plus Enrollment	TOTAL= 277,075

MA-Only Cases by MAP Area	TOTAL= 966,831
CED	864,647
HED	33,391
NH	38,928
CASA	19,865

Case Volume Indicators—March 2004

MICSA—Medical Assistance Programs
Monthly Management Report

MA-Only Application Activity

New Applications Received	TOTAL= 72,243
New Applications Completed	TOTAL= 75,841
Completed within Timeframe	Percent= 99.0

MA-Only Apps Activity by Area

CED New Apps Received	TOTAL= 59,318[1]
New Applications Completed	TOTAL= 60,775[1]
Completed within Timeframe	Percent= 100.0[1]
HED New Apps Received	TOTAL= 10,208
New Applications Completed	TOTAL= 12,226
Completed within Timeframe	Percent= 100.0
NH New Apps Received	TOTAL= 2,717
New Applications Completed	TOTAL= 2,840
Completed within Timeframe	Percent= 83.0
Automated New Applications	Successful
PCAP	3,448[2]

[1] Includes FHP.
[2] Included in CED New Apps.

MA-Only Renewal Activity

Renewals Received	TOTAL= 54,891
Renewals Completed	TOTAL= 54,473
Completed within Timeframe	Percent= 100.0

MA-Only Renewal Activity by Area

CED Renewals Received	TOTAL= 51,717
Renewals Completed	TOTAL= 51,717
Completed within Timeframe	Percent= 100.0
NH Renewals Received	TOTAL= 3,174
Renewals Completed	TOTAL= 2,756
Completed within Timeframe	Percent= 100.0
Automated Renewals	Successful
FFR	TOTAL= *
MRP/DAB	TOTAL= 1,336
Nursing Home	TOTAL= 1,919

Medicaid Helpline

Calls Received	TOTAL= 61,844
Calls Completed	TOTAL= 47,612
Via Auto Menu	2,544
Via Counselor	44,004
Caller Error	1,064

Home Care Services Program

All Home Care Cases	TOTAL= 65,847
Home Attendant	45,592
Housekeeper	7,617
LTHHC	10,960
AIDS	1,678
Average Weekly Hours	42.8

*Individual automated recertification reports were not produced by New York State.

Weekly Report from 12/24/04–12/30/04
New Applications—Community Client Activity Re-Cap Report Model Offices
WAVE I-V

Map Site	Open. bal. beginning of the week	# of applic. received	Sub-total of applic. on site	Total # of completed applic.	# of eligible	# of ineligible	Closing balance app's	# of deferred applic.	# of deferred return
Bellevue	191	98	289	109	59	50	180	30	22
B.Hill	526	270	796	194	152	42	602	38	47
Bx.Leb	177	48	225	72	48	24	153	7	11
Coney Island	448	159	607	155	100	55	452	57	60
Elmhurst	638	146	784	141	101	40	643	31	30
East NY	0	0	0	0	0	0	0	0	0
Gouverneur	129	63	192	59	49	10	133	16	6
Harlem	241	69	310	33	15	18	277	32	28
Jacobi	139	122	261	95	49	46	166	23	16
Jamaica	518	220	738	125	93	32	613	39	61
Kings County	492	155	647	45	34	11	602	39	51
Lincoln	468	117	585	103	51	52	482	19	11
Metro	257	73	330	83	65	18	60	15	12
Morris	79	48	127	67	49	18	247	7	3
Presby	272	108	380	137	90	47	243	32	33
Staten Island	180	84	264	62	38	24	202	43	19
Wdhull/Bush	190	140	330	137	95	42	193	46	4
TOTAL	4945	1920	6865	1617	1617	1088	5248	474	414

Surplus	SSI	All other services	Grand total of clients seen on site	# timely	# not timely	% timely	Interv's staff hours	Interviews per day	Process. staff hours	Process on site	Process per day
25	4	282	431	109	0	100.0%	52	12.3	52	115	14.38
43	5	421	786	194	0	100.0%	156	11.3	117.75	194	10.71
6	2	316	383	72	0	100.0%	26	12.0	26	72	18.00
29	4	426	678	155	0	100.0%	78	13.3	78	155	12.92
4	2	749	931	141	0	100.0%	78	12.2	42.25	90	13.85
0	0	0	0	0	0	#DIV/0!	0	#DIV/0!	0	0	#DIV/0!
10	0	188	267	59	0	100.0%	39	10.5	31.5	59	12.17
13	0	394	504	33	0	100.0%	35.75	12.5	14.25	27	12.32
7	4	160	309	95	0	100.0%	65	12.2	42.5	95	14.53
12	8	795	1096	125	0	100.0%	110.5	12.9	65	125	12.5
14	4	185	409	45	0	100.0%	84.5	11.9	26	45	11.25
3	3	451	585	103	0	100.0%	52	14.6	52	103	12.88
0	0	232	292	67	0	100.0%	26	12.0	32.5	67	13.4
7	1	168	252	83	0	100.0%	39	12.2	40	83	13.49
10	3	592	746	137	0	100.0%	26	12.0	32.5	67	13.4
12	3	227	345	62	0	100.0%	58.5	12.0	69	137	12.91
3	0	185	3322	137	0	100.0%	91	10.0	87.75	137	10.15
198	43	5771	8346	1617	0	100.0%	1047	11.9	828.5	1566	12.29

Aging of Applications

Map Site	45-Day Applications				DRD				ADC Families				Total Balance
	0–21	22–30	31–45	>45	0–30	31–60	61–90	>90	0–14	15–21	22–30	<30	
Bellevue	110	3	0	0	0	3	0	0	53	10	0	1	180
B.Hill	274	4	0	0	0	0	0	0	252	72	0	0	602
Bx.Leb	38	0	0	0	0	0	0	0	103	12	0	0	153
Coney Island	182	12	0	0	2	5	0	0	208	43	0	0	452
Elmhurst	230	35	21	0	1	2	0	0	183	70	101	0	643
East NY	0	0	0	0	0	0	0	0	0	0	0	0	0
Gouverneur	83	0	0	0	1	0	0	0	49	0	0	0	133
Harlem	179	5	0	0	1	0	0	0	81	11	0	0	277
Jacobi	111	6	1	0	3	1	0	0	38	4	2	0	166
Jamaica	364	0	0	0	8	0	0	0	239	2	0	0	613
Kings County	219	106	0	0	3	0	0	0	135	72	67	0	602
Lincoln	273	58	10	0	0	0	0	0	75	37	27	2	482
Metro	82	0	0	0	1	0	0	0	164	0	0	0	247
Morris	34	0	0	0	1	0	0	0	25	0	0	0	60
Presby	166	1	0	0	2	0	0	0	70	4	0	0	243
Staten Island	93	0	0	0	4	0	0	0	105	0	0	0	202
Wdhull/Bush	116	4	0	0	0	0	0	0	61	9	3	0	193
TOTAL	2554	234	32	0	27	11	0	0	1841	346	200	3	5248

51 Cases Processed Off Site
Four Day Week Holiday

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Appendix H:
Listing of Publications/Resources Consulted

Advocates' Guide to Smoothing the Transition from Disaster Relief Medicaid to Ongoing Health Coverage, February 11, 2002, The Children's Aid Society

Barriers to Enrollment in Child Health Insurance Programs, no date provided, Children's Defense Fund & New York Academy of Medicine

Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs, December 2000, New York State Coalition of Prepaid Health Services Plans

Coverage Gaps: The Problem of Enrollee Churning in Medicaid Managed Care and Child Health Plus, June 2000, New York State Coalition of Prepaid Health Services Plans

Currents: Medicaid Managed Care (Vol. 6, No. 4), Spring 2002, United Hospital Fund

Disaster Relief Medicaid (DRM) Interim Finding Report, November 2002, New York State Department of Health, Office of Medicaid Management

Disaster Relief Medicaid (DRM): Fraud and Abuse Monitoring Effort, March 2003, New York State Department of Health, Office of Medicaid Management

Disaster Relief Medicaid Enrollment in the Community Medicaid Offices: How Did It Work?, March 27, 2002, Children's Defense Fund (with support from and in collaboration with the United Hospital Fund)

Disaster Relief Medicaid: Demographic, Cost and Utilization Analysis (draft), August 7, 2003, New York State Department of Health, Office of Medicaid Management

Disaster Relief Medicaid: Lessons Learned, September 2002, Children's Defense Fund

Evaluating Disaster Relief Medicaid and Family Health Plus, January 10, 2003, New York City Human Resources Administration, Testimony of Iris R. Jimenez-Hernandez, Executive Deputy Commissioner, MAP/HRA before the Assembly Committee on Health and the City Council Committees on Health, General Welfare and Oversight and Investigations

From Application Enrollment: A Critique of New York's Public Health Insurance Maze, March 2003, New York State Coalition of Prepaid Health Services Plans

HHC's Experience with Enrollees of Disaster Relief Medicaid, 2002, New York City Health and Hospitals Corporation

Hospital Watch (Vol. 14, No. 2), June 2003, United Hospital Fund

Immigrant Child Health Project: Experiences of Immigrant Children in Public Health Insurance Programs, August 30, 2002, Children's Defense Fund—New York

Kate Lawler, Program Director, Health Care Access Program (HCAP), Children's Aid Society; Testimony before the New York State Assembly's Committee on Health and the New York City Council's Committees on Health, General Welfare, and Oversight Investigation, January 10, 2003, The Children's Aid Society

Lessons Learned from Disaster Relief Medicaid: Making Coverage Work for Children and Families; Testimony presented to the New York State Assembly Committee on Health and the New York City Council Committees on Health, General Welfare, and Oversight & Investigations, January 10, 2003, Children's Defense Fund-New York

Lost in the Medicaid Maze: Voices from the Frontlines of New York City's Public Insurance Programs, January 2003, New York City Task Force on Medicaid Managed Care

Managed Care Enrollment Trends, Summer 2003, New York State Coalition of Prepaid Health Services Plans

Medicaid Managed Care in New York: A Work in Progress, 2003, United Hospital Fund

MEQC 2002 Project "DRM Application Monitoring" (draft), May 21, 2003, New York State Office of Temporary and Disability Assistance

MEQC 2002 Project; DRM Application Monitoring; Review of Negative Case Decisions, pending, New York State Office of Temporary and Disability Assistance, Bureau of Audit and Quality Control

New York State Disaster Relief Medicaid/FHPlus Overview, June 19, 2002, New York State Department of Health

New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People, August 2002, United Hospital Fund

Radical Simplification: Disaster Relief Medicaid in New York City, January/February 2003, Health Affairs (Vol. 22, No. 1)

Reality Check: A View from the Front Lines of Public Health Insurance Enrollment, March 2003, The Children's Aid Society

Testimony of Dr. Benjamin K. Chu, President, New York City Health and Hospitals Corporation before the General Welfare, Health, and Oversight and Investigations Committees of the New York City Council on Lessons Learned from the Disaster Relief Medicaid Program and the Need for Streamlining the Application and Recertification Process for Medicaid, Child Health Plus and Family Health Plus, April 29, 2002, New York City Health and Hospitals Corporation

Appendix I:
Project Team

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Evaluation and Analysis:

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Site Visits, Focus Groups, Interviews:

Grace Chin, G.C. Global, Brooklyn (focus groups and focus group recruitment)

Rani Findlay, Findlay Associates, Brooklyn (site visits, focus groups, interviews)

Rochelle Gorgos (focus group recruitment and interviews)

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Appendix J: Acknowledgements

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George E. Pataki, Governor
Department of Health
Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner