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Policy Research

CHIPRA Express Lane Eligibility Evaluation

Case Study of New York's Telephone Renewal in Medicaid

Final Report

October 30, 2013

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Health Management Associates

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EXECUTIVE SUMMARY

In September 2011, the New York Health Options enrollment center (Enrollment Center) established by the New York Department of Health (DOH) began renewing health insurance benefits by telephone for certain Medicaid, Family Health Plus, and Family Planning Benefit recipients in four counties. By October 2013, the telephone renewal option had expanded to 35 of the state's 62 counties (New York City, which has about two-thirds of the state's renewals, does not use telephone renewal). Table ES.1 highlights some key information about the telephone renewal process.

Table ES.1. Key Facts About New York's Telephone Renewal Policy

Policy simplification adopted?	Telephone renewal for children, parents, pregnant women (not aged, blind, disabled, or dual eligible)
Policy adopted in Medicaid, CHIP, or both?	Medicaid
Processes affected?	Renewal
Implementation date?	September 2011 in 4 counties, expanded to 35 counties by October 2013
Is the simplified process different from the perspective of the enrollee/applicant?	Yes. Client may renew Medicaid coverage on the telephone with state Enrollment Center staff.
Any time savings for enrollees/applicants?	Telephone renewal is generally faster and more likely to obtain all needed information than paper renewal.
Any time savings for the state?	Staff report spending more time on the telephone to complete a renewal than they would spend initially reviewing a mailed renewal form, but they issue fewer notices to applicants requesting additional information before renewal can be completed.
Estimated cost to implement?	Data not available.
Estimated savings?	Staff assume the process saves money, but data are not available to estimate savings.
Other benefits for applicants?	• Immediately extends coverage from the time of the call until a final eligibility determination is made. • Staff answer questions and clarify documentation requirements, reducing iterations necessary to complete renewal.

In addition to handling telephone renewals, the Enrollment Center, also processes mail-in renewals for these 35 counties and operates a statewide call center for all of New York's publicly financed health insurance programs. The Enrollment Center as a whole, and telephone renewals specifically, faced implementation challenges related to early technical, communication, and procedural difficulties. These included lack of alignment between mail renewal forms and the Enrollment Center's new online data entry system for phone renewal (the Health Eligibility and Renewal Tool, or HEART), and interface problems between the new system and the state eligibility system. Over time, these issues were addressed, and at the time of our site visit, stakeholders agreed that the telephone renewal process runs smoothly.

Though only limited data on the effectiveness of telephone renewals were available at the time of this case study, stakeholders cited many perceived advantages compared to the mail-in renewal process, including: convenience and client satisfaction; a higher proportion of families able to complete renewals during initial contact with the state; less processing time, resulting in faster

renewal decisions; presumably less churn because clients who call at the end of the month can be granted last-minute coverage extensions and avoid losing coverage; and reduction in case loads for county caseworkers who were no longer responsible for renewal processing and were able to redirect their time to other casework. This last benefit is a result of the shift of both mail and telephone renewals to the state-level Enrollment Center in participating counties (not including New York City, which accounts for about two-thirds of the renewals in the State). Counties retain responsibility for enrollment, and continue to maintain case files for enrollees who renew their coverage through the Enrollment Center. While some county workers initially had concerns about losing control of the renewal process, the shift was generally perceived by counties as reducing caseloads that were excessive. The state reported that there has been a decrease in county-level staff (that they have not yet quantified), though this was primarily related to some counties deciding to not fill positions when losing a staff person due to resignation or retirement.

Because the Affordable Care Act requires telephone enrollment as an option for Medicaid, CHIP, and premium subsidy applications, New York's experience with telephone renewal offers several lessons for health reform implementation. For example, the telephone process is more effective than the mail-in process at acquiring all necessary eligibility information quickly, which lessens the burden on the client and reduces the time needed to make eligibility decisions. New York found that its phased-in approach allowed the state to test out scripts, technologies, and protocols and make necessary adjustments before expanding the program. However, the gradual approach also made it impractical for the state to launch major public campaigns to educate beneficiaries about the new telephone option because few people were included in each phase of phone renewal implementation. New York's experience also illustrates the importance of clear and ongoing communication between state and county/community-based workers, particularly when there is a shift in responsibilities. For example, when at first counties struggled with the state Enrollment Center "takeover" of renewals, the state eased tensions through regular meetings to inform county caseworkers about the new process and to give them opportunities to ask questions and have an ongoing dialogue.

1. Introduction

The Children's Health Insurance Program (CHIP), a landmark legislative initiative passed in 1997 to help close the health insurance coverage gap for low-income children, was reauthorized with bipartisan support in 2009. Although CHIP had helped to fuel a substantial increase in health insurance coverage among children, Congress remained concerned about the many children—estimated at 4.4 million in 2010—who are eligible for but not enrolled in coverage (Kenney et al. 2012). In the CHIP Reauthorization Act (CHIPRA) of 2009, Congress gave states new tools to address enrollment and retention shortfalls, along with new incentives to do so.

One of these new options is a policy called Express Lane Eligibility (ELE). With ELE, a state's Medicaid and/or CHIP program can rely on another agency's eligibility findings to qualify children for public health insurance coverage, even when programs use different methods to assess income or otherwise determine eligibility. ELE thus gives states another way to try to identify, enroll, and retain children who are eligible for Medicaid or CHIP but who remain uninsured. The concept of using data from existing government databases and other means-tested programs to expedite and simplify enrollment in CHIP and Medicaid has been promoted for more than a decade; before CHIPRA, however, federal law limited state reliance on information from other agencies by requiring such information to be cross-walked into the Medicaid and CHIP eligibility methodologies (Families USA 2010; The Children's Partnership n.d.). To promote adoption of ELE, Congress made it one of the eight simplifications states could implement to qualify for performance bonus payments. These were new funds available to states that implemented five of the eight named simplifications and which also increased Medicaid enrollment (CHIPRA Section 104).

Federal and state policymakers are keenly interested in understanding the full implications of ELE as a route to enrolling children, or keeping them enrolled, in public coverage. To that end, Congress mandated an evaluation of ELE in the CHIPRA legislation. In addition to reviewing states that implemented ELE, the evaluation provides an opportunity to study other methods of simplified or streamlined enrollment or renewal (termed "non-ELE strategies") that states have pursued, and to assess the benefits and potential costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand and assess the value of ELE and related strategies.

This report summarizes findings from a case study of a non-ELE simplification: New York's telephone renewal for Medicaid beneficiaries. The telephone renewal process merited inclusion in the evaluation as a non-ELE simplification strategy because telephone enrollment is required under the ACA, and because the goals of telephone renewal align well with the goals of ELE to simplify the application or renewal process for families. New York also implemented ELE statewide in June 2012. Under its ELE model, CHIP determines eligibility for Medicaid at renewal and automatically transitions children who qualify to Medicaid without a new application. Because of the focus on the phone renewal process, we did not focus on ELE for this case study; however, we summarize the ELE process and early results and lessons in Appendix A.

To learn about New York's telephone renewal processes, staff from Health Management Associates conducted a site visit in June 2013, interviewing 12 key informants over a two-day visit to the state capital and by telephone. Staff from Mathematica Policy Research conducted a focus group with parents of children whose Medicaid coverage was renewed by telephone. Three parents shared their experiences with the telephone renewal process.

2. State Context: Why Pursue Telephone Renewals for Medicaid?

The state had two goals in developing a centralized enrollment center, called New York Health Options (referred to as the 'Enrollment Center' in this report): to consolidate separate state-level call centers for Medicaid, Child Health Plus (New York's separate CHIP program) and Family Health Plus (New York's waiver program for parents with income above Medicaid eligibility and childless adults); and to implement telephone renewal for Medicaid to help reduce churning. State officials also hoped that the Enrollment Center would help standardize renewal practices, which were decentralized and therefore varied among counties outside New York City. [1] Table 1 summarizes key facts about Medicaid and CHIP in New York.

Table 1. Key Facts About New York Medicaid and CHIP

Name of Medicaid and Medicaid Expansion CHIP Program for Children	Medicaid	
Name of separate CHIP program	Child Health Plus	
Medicaid upper income limit for children	200% of FPL for ages 0–1 133% of FPL for ages 1–6 100% of FPL for ages 6-19	
CHIP program type and upper income limits	Combination Program	
	Medicaid expansion CHIP (Medicaid): 101%-133% of FPL for ages 6-19	Separate CHIP (Child Health Plus): 201%-400% of FPL for children ages 0-1 134%-400% of FPL for ages 1-19 Higher income families may buy into CHIP
Delivery system	100% of children in CHIP are in managed care; 13% of children in Medicaid are in fee-for-service and 87% are in managed care.	
12 months continuous elig1bility?	Yes	
Presumptive eligibility for children?	Yes	
In-person interview required?	No	
Asset Test?	No	
Joint Medicaid and CHIP application and renewal forms?	No, but new CHIP ELE renewal process determines Medicaid eligibility and enrolls Medicaid-eligible children without a separate application.	
Premium support program?	Available for adults in Family Health Plus, New York's waiver program for parents with income above Medicaid eligibility and childless adults.	
Adult coverage?	Childless adults with incomes up to 78% of FPL are eligible for the Medicaid (Home Relief) waiver program, and parents up to 150% FPL and childless adults up to 100% FPL are eligible for Family Health Plus.	
Renewal processes	Medicaid enrollees are mailed a renewal form when coverage is due to expire within 90 days. In counties that participate in telephone renewal, the notice alerts enrollees to this option, and if a client calls the Enrollment Center for any reason, staff also check whether they are eligible to renew. CHIP renewal notices are sent by the managed care plans.	

Sources: Kaiser Commission on Medicaid and the Uninsured, March 2013; site visit interviews.
ELE=Express lane eligibility; FPL = federal poverty level

[1] New York City could not participate in centralization and telephone renewals because its eligibility system or Welfare Management System (WMS) is specific to the city and functions entirely separately from the legacy system that operates in the rest of the state. Therefore, recipients who live in the five boroughs of New York City, who constitute about two-thirds of Medicaid renewals in the state, continue to renew with the New York City Human Resources Administration (HRA). The New York City system has more automation than the state system but does not conduct telephone renewals at this time.

In 2008, when New York first started exploring simplified renewal options, the state estimated that about 30,000 eligible people were losing Medicaid coverage every month because they did not complete the renewal process, often churning back into coverage within a few months. In developing the Enrollment Center, the state explored barriers to renewal by conducting focus groups with English-, Spanish- and Chinese-speaking participants who had lost coverage despite being eligible. Participants thought telephone renewal would be a valuable addition to the mail-in and in-person renewals that had historically been offered, and they preferred it to the option of online renewal because of concerns about privacy.

Telephone renewal also aligned well with a concurrent New York initiative to shift Medicaid administration to the state level. Technological advances had led the state to question the rationale for conducting eligibility and enrollment at the county level, since it is increasingly feasible to automate and streamline these processes, and New York does not require an in-person interview as part of the eligibility process. The 2010-11 New York State Budget included language requiring the State to develop a plan to take over administration of Medicaid from counties. In early 2011, after Governor Andrew M. Cuomo came into office, the DOH developed a more detailed plan. The Division of the Budget also suggested that imminent implementation of nationwide health reform enacted by the Affordable Care Act meant that the time was right to seriously consider the shift. As a result, the budget enacted in 2012 included a timeline that would gradually transition responsibility for Medicaid administration to the state level by 2018.[2]

3. Planning and Design: What Was Needed To Develop Policy?

The policy planning process for telephone renewal required neither federal approval nor a Medicaid waiver, making it relatively easy to implement. The DOH, however, communicated with CMS about the planned policy, providing a short summary of the proposed approach and responded to questions from CMS, which related primarily to the role of the Enrollment Center contractor. Under the proposed approach, the Enrollment Center would take responsibility for the renewal process for Medicaid enrollees who are not aged, blind, or disabled, though the DOH must still make the final eligibility determinations. This design required a division of responsibilities and coordination between the Enrollment Center, the DOH, and counties, which are still responsible for enrollment and continue to maintain case files on enrollees who are renewed through the Enrollment Center. The state decided to phase in use of the Enrollment Center gradually because it involved substantial changes in how renewals are processed and required developing and refining a new online system. The state notified the counties in writing that the Enrollment Center would be implemented about 18 months to two years in advance, and held calls with the counties to discuss the upcoming changes.

New York launched the Enrollment Center with mail-in renewals only in order to test the systems and coordination with the DOH and counties, then introduced phone renewal gradually. The first counties to transition to the Enrollment Center were chosen from a group that had

[2] The budget also required an annual report on progress and provided for up to 1,200 staff for state-level Medicaid administration to be phased in. County-level Medicaid administrative costs were capped during the transition, which meant the state would need to get involved to help the counties reduce their administrative role. This spending cap led to an additional enrollment simplification in 2012, the implementation of administrative renewal for aged, blind and disabled enrollees.

volunteered to participate in a planning workgroup for the Enrollment Center, and the DOH then selected those that would transition to phone renewal first.

The DOH released a request for proposals for a contractor to establish and operate an enrollment center in October 2008. After receiving proposals in February 2009, the DOH signed a contract with an administrative services organization in August 2010. The scope of the contract included a statewide call center to answer questions about Medicaid, Family Health Plus, Child Health Plus, and the state's Family Planning program (launched in December 2010), and to process renewals for Medicaid enrollees who are not aged, blind, or disabled. The DOH began developing policies and procedures with the contractor in October 2010, and launched the Enrollment Center in June 2011 with mail-in renewals; telephone renewals were implemented in September 2011 (Table 2).

Table 2. Time Line: Telephone Renewal and Related Events

Date	Activity
2008	The Department of Health (DOH) examines telephone renewal as a potential approach to reduce churn.
October 2008	DOH releases a request for proposals for a contractor to establish and operate the Enrollment Center, including telephone renewal as an option.
February 2009	Potential vendors submit proposals.
August 2010	State contracts with administrative services organization to operate the Enrollment Center.
Fall-Winter 2010	DOH develops policies and procedures for Enrollment Center operations with contractor.
June 2011	The Enrollment Center, called NY Health Options, begins mail-in renewals for 11 counties.
September 2011	The Enrollment Center begins telephone renewals in 4 counties.
December 2011	Some counties that had been using mail-in renewal suspend their participation in the Enrollment Center.
September 2012	Counties re-join the Enrollment Center and additional counties are added; more counties begin telephone renewal.
October 2013	35 counties are using telephone and mail-in renewals.

Because the Enrollment Center was an entirely new entity, training for the contractor staff who conduct telephone renewals as part of their responsibilities, and DOH staff who conduct the final eligibility determinations, was an important component of state planning. Appropriate training for telephone interview processes was required because the telephone interview process involves an entirely different set of customer service skills than processing mail-in applications (which began prior to telephone renewals). For example, telephone renewals occur in real time; and workers must follow scripts to capture a standard set of information and also respond to questions from each caller to explain eligibility requirements and any documentation needs. Enrollment Center workers needed extensive practice and had to be prepared to "hear the unexpected."

Initially about 10 DOH state staff processed renewals that are sent to the state by the Enrollment Center; that number since has grown to 30. Though some of these staff had county-level experience, most were newly hired and lacked Medicaid experience, so comprehensive training on eligibility policies and procedures was necessary.

Leading up to the implementation of the Enrollment Center and telephone renewal option, the DOH held frequent conference calls with participating counties to discuss such topics as how the new systems would work, which cases the state would take responsibility for renewing, and the

content of cover letters for renewals and for documentation sent to the state. The conference calls, open to all participating counties, have been reduced to one hour about every other month, with most counties participating.

The state did not conduct broad consumer outreach to advertise the availability of telephone renewal because of the gradual phase-in of telephone renewal both within and across counties. However, New York has a facilitated enroller program involving partnerships with community-based organizations and health plans. The state notified facilitated enrollers by letter that the Enrollment Center would be implemented, providing a list of counties that would use it and an initial implementation schedule. DOH then held a conference call with the community organizations to explain the new process and made a presentation to explain the role of facilitated enrollers and counties, emphasizing that renewal forms needed to be returned to the Enrollment Center rather than to counties, and that telephone renewal would be an option.[3]

4. Implementation: What Happened?

The Enrollment Center was designed to include telephone and mail-in Medicaid renewals so that both types could be processed in one place. It does not conduct new enrollments except when individuals are added to an existing household during the renewal process. The Enrollment Center began phasing in mail-in renewal in 11 upstate counties in June 2011, starting with counties that had volunteered to participate in the planning effort. Telephone renewal was added to mail-in renewal gradually, starting with four counties in September 2011. As of March 2013, 32 out of the state's 62 counties used the Enrollment Center for telephone and mail-in renewals. Three more counties began using the Enrollment Center in September 2013 for both mail-in and phone renewals. About 48 Enrollment Center staff conduct telephone renewals as part of their responsibilities, which also include following up with enrollees about missing documentation.

DOH reviews and monitors Enrollment Center operations, including worker training materials, recordings of calls to identify potential needs for changes to the scripts, the Enrollment Center's quality control processes, and weekly reports on operations to identify backlogs or issues that need to be addressed.

Telephone Renewal Process

In counties that use the Enrollment Center for renewals, each month the state identifies households whose Medicaid coverage will end within 90 days. Aged, blind and disabled (ABD) enrollees are renewed administratively, so the population served by the Enrollment Center consists mostly of pregnant women, children, and adults enrolled in Family Health Plus. A paper renewal notice with pre-populated contact information is mailed to the family, with instructions that they may mail back the signed form and information to the Enrollment Center or call the toll-free Enrollment Center telephone number to renew by telephone. The telephone renewal policy is also designed to ensure that any time an individual enrolled in Medicaid calls the Enrollment Center for

[3] The DOH intended for the Enrollment Center to notify facilitated enrollers of eligibility determinations, though this policy took time to become fully operational after implementation. Facilitated enrollers needed this information to fulfill their requirement to report to the state on the outcomes of their cases.

any reason, the worker checks the person's name against a monthly list of non-ABD enrollees due for renewal; if the name is listed, the worker asks whether the individual would like to complete the renewal process by telephone.

All telephone renewals are conducted by the Enrollment Center staff according to a script developed by the DOH, and conversations are recorded. Enrollment Center staff first verify callers' identity using their Social Security number, Medicaid ID number, and date of birth. Next, callers are asked to confirm that they understand they will be renewing their coverage by telephone and are asked to agree to the terms of renewal. The Enrollment Center worker proceeds with a series of questions that correspond with items in the renewal form and enters the responses into the online Health Eligibility and Renewal Tool (HEART), which was built specifically for telephone renewals (but is accessible only to Enrollment Center and DOH staff; beneficiaries cannot access it online). The worker simultaneously enters other substantive information required for renewal determination into the contractor's workflow system, MAXe, which is able to collect case notes. These two systems share information with each other so that duplicate entry is not needed. HEART also interfaces with the state's legacy eligibility system. Telephone renewal conversations typically last 10 to 15 minutes.

Callers may self-attest to their residency and income and may add children to their household or self-attest to another change in household composition such as marriage. They may also self-attest to their child care or adult care expenses. One adult in the household "signs" the renewal form over the telephone by verbal agreement, and is told that their coverage will continue until their eligibility is verified, and they will be notified of the final eligibility determination by mail.

Through the HEART system, Enrollment Center workers can access quarterly wage data, Department of Labor and monthly Social Security Administration information, and checking and savings account information (though there is no asset test in New York State). During the renewal call, the Enrollment Center worker checks whether the available data matches the caller's self-attestation. If income appears to exceed eligibility or there is another discrepancy that would affect eligibility, the worker asks for documentation. The Enrollment Center worker also makes a follow-up call about needed documentation, and then sends a letter detailing what information is needed. If requested information is not returned after 15 days, the case is re-processed based on the information the state has been able to confirm, and if their eligibility cannot be confirmed, they are disenrolled.

New York has a "financial maintenance" policy that requires enrollees to show how they meet their financial needs, measured primarily by how much of their income they spend on housing. If these costs are less than 60 percent of their income, the state considers them able to meet their financial needs and proceeds with the renewal process. If housing expenses are more than 60 percent of income, enrollees are asked to itemize how they meet basic needs like food, utilizes, and transportation, so that eligibility staff can determine whether they have another source of financial support. If enrollees fail to account for how they meet their expenses or identify additional sources of income, they may be considered ineligible for Medicaid and disenrolled. The state reported that applicants have found this policy confusing in the past. When enrollees use the Enrollment Center telephone option for renewal, the worker is able to explain the policy, making it more likely that the applicant will successfully provide the needed information. More applicants than anticipated—the state estimates one third—end up needing to detail how they meet their financial needs because their housing expenses exceed 60 percent of income. The state does not track how many disenrollments result from this requirement.

When all required information is submitted, the contractor completes a quality control process to check internal consistency before the renewal is sent to the state through HEART for an official redetermination decision. The HEART system displays a recommended renewal determination, and DOH staff confirm the decision based on the information or investigate further as needed. Coverage is extended until the determination is made, which typically takes 25 to 30 days to process. The state's goal is to complete the determination by the time coverage would have ended. The state legacy eligibility system automatically generates a notice to the household. If coverage is renewed, the notice says that coverage has been extended by a year (or 60 days post-partum for pregnant women). If coverage is not renewed, families are notified that if they disagree with the decision they can call the DOH to request a hearing.

Most enrollees are in a managed care plan with coverage renewed in the same health plan. If the renewal is still being processed when coverage was scheduled to end, the state notifies the managed care organization that it needs to provide prospective coverage while the renewal is being processed.

Non-Telephone Renewal Processes

As with telephone renewal, when the Enrollment Center receives renewals by mail, staff enter the data into the HEART and MAXe systems. If information is missing or there is a discrepancy between reported information and what appears in HEART on prior records, the Enrollment Center sends a letter requesting the missing information or documentation, and uses the same follow-up process as occurs in telephone renewal.

In upstate counties that do not use the Enrollment Center but that continue to process renewals themselves, the state legacy eligibility system generates a renewal form with the head of household's basic information (name and address) pre-populated, which is mailed to the family prior to the end of the current eligibility period. The enrollee completes and mails back the form to the county office, the county worker processes information received, and the county sends out a document checklist for any missing information. This correspondence continues until the necessary documents are received.

Implementation Challenges

The Enrollment Center as a whole, and telephone renewals specifically, faced several implementation challenges. First, the development of telephone renewals took longer than anticipated. Originally scheduled to begin concurrently with mail-in renewals in June 2011, telephone renewal was delayed because the HEART system was still being refined and the contractor needed more time to test telephone scripts. Second, processing of early mail-in renewals was difficult; Enrollment Center staff processed the mail-in forms using HEART, which had been designed for telephone renewal, so the screens were not fully aligned with the paper forms. This resulted in errors when workers transferred information from paper renewal forms to the HEART system. There were also interface problems between HEART and the state eligibility system; initially, about 60 percent of paper applications entered into HEART received error messages. The state had to dedicate substantial staff time to resolving these technical problems for seven to eight months. Enrollees were not dropped from coverage as a result of these errors; rather, the state extended coverage for each case until the technical issue was resolved. Nevertheless, counties saw the errors in the eligibility system and were critical of the high failure rate of the new, centralized process.

Once telephone renewals began, when enrollees called to renew at the end of the month when their coverage was about to expire, some disenrollments occurred even though coverage was supposed to continue while the renewal was being processed. The Enrollment Center's policies and procedures needed to be changed to prevent this from happening. For example, the state needed to ensure that the managed care organization covering the client was notified quickly and provided prospective coverage while the renewal was being processed. The state also worked to ensure that clients received their renewal letters at least one month before their coverage was due to end.

Initially, the amount of information shared between the Enrollment Center and participating counties was also an area of negotiation. County workers who previously had responsibility for renewal were now informed that a renewal decision had taken place for households in their caseload, but they did not have access to renewal case notes or other detailed information from the renewal process. Some clients continued to call or visit county offices asking about their renewal status, but the county case workers were unable to answer their questions. Many county workers felt they lacked complete information even though they continued maintaining the cases after renewal.

In response, the state and contractor built a "case file" in which HEART data is posted to the electronic document management system that is part of the legacy eligibility system. This allows county caseworkers to see all renewal information and letters sent during the renewal process. The DOH and the contractor held on-site orientations about the new process in counties. Also, the Enrollment Center contractor assigned a county liaison for each participating county, providing a point person for county staff to call with any questions or problems. Both county and Enrollment Center staff find this strategy helpful.

Some counties were enthusiastic about joining the Enrollment Center, while others were more reluctant, and by late 2011, 26 counties were using the Enrollment Center for renewals, four of which had implemented phone renewals in addition to mail-in. However, some of the early technical challenges led to a backlog in processing cases, resulting in about half of participating counties deciding, with permission from the state, to stop participating in December 2011. Once the backlog, technical, and communication issues had been addressed, most of these counties returned during the Fall of 2012, and additional counties joined in 2013. The four counties that had initially launched phone renewal never stopped using it, and other counties adopted the phone renewal option over the course of 2012, so that by 2013 all Enrollment Center counties had both mail-in and phone renewals in place.

As the contractor and the state gained experience using the HEART system, they identified and implemented a number of additional improvements to the telephone renewal process. One involved creating a grid for missing information, which helps workers more easily identify documentation needs. Another eliminated an early process of inserting case notes into multiple locations; because the HEART and contractor systems interface, notes can be entered in one system and automatically shared with the other. A recent improvement allows the Enrollment Center, rather than counties, to reactivate recently discontinued coverage.

In addition to conducting general training for new staff, the Enrollment Center contractor conducts ongoing training on rule changes from the state and process or technical improvements. One-on-one coaching is used if Quality Control staff identify a particular problematic worker based on their review of renewals before the files are sent to the DOH.

5. Outcomes: What are the Observed Outcomes?

As of June 2013, the Division of Coverage and Enrollment at the DOH was just beginning an evaluation of the Enrollment Center, supported with a grant from the Health Resources and Services Administration.[4] The evaluation would compare the Enrollment Center's impact on enrollment, renewal, and retention relative to non-participating counties' enrollment and renewal experience. There is limited information available to date, and there are challenges to comparisons because the HEART system used by the Enrollment Center and the legacy eligibility system used by the counties do not track identical data. The state expected to complete the evaluation at the end of 2013.

Despite the delays and early complaints from counties, DOH and Enrollment Center staff believe that implementation issues have been addressed and telephone renewal has been a success. The observed outcomes support the state's argument that phone renewal is a successful strategy:

- **Substantial volume.** Even as new counties have been added, consistently about half of Enrollment Center renewals are conducted by telephone, which the state believes shows strong consumer interest in using this option. Table 3 shows the number and percentage of telephone and mail-in or fax renewals in the participating counties from October 2012 through March 2013.[5]

Table 3. Renewals by Source in Counties Where Phone Renewal is an Option, October 2012 – March 2013

Month	Number of Counties Where Telephone Renewal is an Option	Total Number of Renewals in These Counties	Number of Telephone Renewals	Proportion of Telephone Renewals (%)	Proportion of Mail In/Fax Renewals (%)
Oct. 2012	18	11,907	6,115	49	51
Nov. 2012	18	11,764	6,200	47	53
Dec. 2012	25	11,594	6,110	47	53
Jan. 2013	25	18,493	9,681	48	52
Feb. 2013	25	16,677	8,450	49	51
Mar. 2013	32	16,733	8,309	50	50

Source: New York Department of Health, 2013.

Note: New York City operates its own eligibility system covering its five boroughs and is therefore excluded from participation in the phone renewal option. Medicaid recipients from New York City's five boroughs constitute about two thirds of all Medicaid renewals in the state.

[4] For more information see State Health Access Program, http://www.hrsa.gov/communitiesofpractice/ataglance/statehealthaccess.pdf.

[5] Upstate counties represent about one-third of all cases (New York City has two-thirds), and about half of upstate renewals are conducted through the Enrollment Center.

- **Convenience and client satisfaction**. Enrollment Center staff report that feedback from clients about telephone renewal has been positive, and DOH has not received complaints about telephone renewal from consumers or advocates. Parents who participated in focus groups also reported positive experiences with telephone renewal, as well as with access to providers, though some experienced long waits for some specialists. Benefits identified by staff and focus group participants included that telephone renewal allows enrollees to reach an actual person, and ask questions in real time; that families do not have to worry that their case was lost in the mail; that families do not have to deal with filling out or making copies of forms or documents; and that the phone renewal option is available anytime from 8 a.m. to 8 p.m., beyond the hours that county offices would be open. Enrollment Center staff report that clients seem pleased but surprised when they call the Enrollment Center for other reasons and are told they can renew right then on the telephone.

Focus Groups Findings: Phone Renewal Easier and More Convenient, but Still Wait for Decision

We asked focus group members, all recruited because they had a child's Medicaid coverage renewed through the telephone process, about their experience. Parents reported that phone renewal is easier and more convenient than paper renewals, and they felt comfortable sharing information by phone, noting that the state already had their information. They appreciated the temporary coverage, but would like to receive the final renewal decision sooner.

Right now, I kind of have something similar to carpel tunnel system, so right now it would be so much easier for me to call and not have to write and fill out forms. It's so much easier.

When you mail it back, you have to make copies. There is a lot of stuff [to] run around to do. It's so much easier to do it by phone.

[Regarding whether phone renewal was confusing]. No, they even said that you would be covered until you got the letter –even if you [didn't] get approved. They gave you a cut-off date.

It goes smoothly; it's just a long wait from the point when you renew until the point when you know he is covered for another year. They won't tell you anything even if you call. You have to wait for the form letter. They don't tell you anything.

- **Completed renewal forms**. Telephone renewal forms are more likely to be complete than forms sent by mail and they require less follow up. All required renewal information can be collected on the telephone for 95 percent of telephone renewals, while only 78 percent of renewal forms received by mail contain all required information. The telephone worker clarifies and answers questions immediately, including explaining exactly what documentation may be needed and why. The rate of return of needed documents is higher for telephone renewals than for mail renewals as well. The Enrollment Center contractor reported that telephone renewals reach a determination decision in 36 percent less time, on average, than mail-in renewals.

- **Quick processing time for the state**. The HEART system (used for both telephone and mail renewals by the Enrollment Center) facilitates fast processing by state workers because it displays a recommended eligibility determination; in most cases state workers can quickly and easily confirm that the recommended decision is correct based on the information submitted.

- **Last-minute coverage extension reduces churn**. Telephone renewals are particularly helpful at the end of the month when a client is about to lose coverage; a telephone renewal—even if additional documentation is required—allows the state to extend coverage until the renewal decision is made.

- **Relief to counties**. Regarding the Enrollment Center overall, there is a "sense of relief" at the county level because the Enrollment Center took over 80 percent of their renewals, significantly reducing county staff caseloads. Some workers went from 80 to 90 cases initially, to five cases after the change occurred. Though numerous implementation issues initially damaged some county relationships with the Enrollment Center, the system has improved. County meetings with state and Enrollment Center staff helped ease the transition and counties have reached a "truce" with the Enrollment Center. Counties were able to decrease staff time dedicated to family cases, increasing resources available to serve the chronically disabled population. Some counties reported that the speed of other tasks has improved because of the caseload reduction. The state reported that there was a decrease in county-level staff needed, but could not quantify how many, and noted that the reductions are primarily from counties deciding to not fill positions when workers left. Counties are in close contact with the state to plan for the broader transition of Medicaid administration to the state level in coming years, and are asking questions in order to plan for anticipated reductions in county-level staff at that time.

Focus Groups Findings: Overall Good Quality of Care, with Mixed Experience on Access

Parents reported good quality and access to care overall, though some have struggled to find doctors' offices without long wait times, and others are willing to wait to see providers they like.

My son has his own doctor…last year, I used his Medicaid card because he had surgery…And Medicaid was not a problem. They paid the surgeon, the anesthesiologist. They paid for everything. It was a godsend.

The first doctor that he had, I had to change. The doctor was ok, but the receptionist was horrible. She'd make an appointment at 1, but we won't be seen still at 4. I tried another doctor, same thing. But then I finally found a doctor who would see us at our appointment time, would see us immediately. Very happy with the doctor.

I also have to wait a lot, but she's one of the best doctors in the area, so I won't change her.

[My son's] doctor is open until 8 – otherwise the doctor will call from where she is and say if he needs to go to the emergency room or not.

[My son's] doctor closes at 5, but she has an answering service. They always have doctors on call – no matter what time of the day or night. If it's pertaining to his surgery [his doctor] will call back herself.

The one [specialist] that my doctor chose was kind of far – that's my only complaint. But if he was a good doctor – that's OK.

Last time we went to the doctor, [my son] was referred to a specialist, but they won't give him an appointment until October. We just went in July, so I think that is quite a long wait.

My son did use a physical therapist, but it was part of the hospital [care] actually. His neurologist found him. It was easy [to get an appointment]. It was excellent care, it was in the best facility in the state. It was awesome.

6. Looking Forward: Future Prospects for Using Telephone Renewals

The main purpose of the Enrollment Center was to streamline renewals, but the center was also a laboratory for implementing health reform. State officials say New York's current policies have prepared them to implement Affordable Care Act provisions, including telephone enrollment as one

application option in the state's new Health Insurance Marketplace. The DOH will be operating the state's Marketplace, which will be integrated with Medicaid, thereby facilitating seamless transitions between the Marketplace and Medicaid coverage.

The flexibility of the Enrollment Center contract will allow it to expand its role to develop and conduct "back-end operations" for the Marketplace, including processing telephone applications, uploading documentation, and verification.

Based on experience to date with telephone renewals, state administrators anticipate that a caller's initial contact with an enrollment worker for telephone enrollment through the Marketplace will typically take longer than filling out a paper application, but the overall time that applicants and enrollment workers spend on enrollment, as well as the time to the enrollment decision, will be shorter than the current time spent for phone renewals. This is because the workers will be able to capture more complete information during that first interaction and will also be able to explain the specific need for other documentation.

The Marketplace will use a new online screening system rather than HEART, which was built to support telephone renewals. State officials view their telephone renewal history as giving them valuable experience in thinking through the renewal process and making it more efficient for Enrollment Center workers and applicants. Workers have experience using state data sources and comparing existing data on applicants with self-attested information in real time. This will be helpful when they interact with the federal data hub for enrollment through the Marketplace.

Telephone renewal is expected to be available statewide, and for all coverage programs the state offers once the new Marketplace customer service center is fully operational as part of health reform. In the meantime, after three counties join in September 2013, no additional counties will transition to the Enrollment Center for mail-in or telephone renewal until the Marketplace is "stable."

7. Lessons Learned

Several lessons emerged from this case study that are salient for health reform implementation and for New York's continuing centralization of Medicaid administration. First, telephone renewals offer advantages over mail-in renewals by making it possible to clarify information and address discrepancies in real time. New York's Enrollment Center telephone renewals require fewer iterations of contact with families than mail-in renewals because well-trained telephone staff are generally able to obtain all the information they need during the initial phone conversation, reducing the burden on families and shortening the time from renewal notice to eligibility decision. Mail-in renewals are more likely to have incomplete information, which lengthens the time to eligibility decision.

Second, there are tradeoffs involved in phasing in a new process and gradually adding populations and counties rather than implementing the new program statewide at once. Most key informants felt that the decision to phase in telephone renewals was correct: it allowed the state to test out scripts, technologies and protocols, and make necessary adjustments. For example, administrators judged that it was a good decision to delay implementation of telephone renewals until they could adequately test the automated system interfaces and scripts. They felt it was critical to take four to six months to work with and test systems, including "scenario testing" to help prepare for unexpected situations. Despite this testing, systems issues still emerged during implementation, although they usually did not negatively affect enrollees' continuity of coverage.

Also, New York needed to make adjustments to improve efficiency in its system interfaces. For example, they made changes to ensure that the state's renewal application system interfaces with the vendor's workflow system to eliminate double data entry and reduce errors. Officials also learned the importance of aligning paper renewal forms with the telephone application protocol to reduce errors and time spent entering information; they made adjustments along the way.

However, the phased-in approach made it impractical for the state to launch major public education campaigns about the new telephone option, because the option was made newly available only to small numbers of beneficiaries at a time. Interviewees said that more outreach to introduce and describe the new telephone renewal option—even a very targeted approach such as additional explanation in the renewal form that is mailed to enrollees—would have made the transition easier and smoother for beneficiaries. Also, some key informants felt that because some clients may be wary of giving out information over the telephone, county social services offices could have helped educate enrollees about the privacy protections and advantages of the telephone renewal option.

Third, New York's experience illustrates that good communication among state and county and community-based workers is essential, particularly when there is a shift in responsibilities. Counties initially struggled with the state Enrollment Center "takeover" of renewals. It was helpful for the state to hold regular meetings with counties to help ensure that county caseworkers were well-informed of the new process and had opportunities to ask questions and have an ongoing dialogue. After caseworkers expressed initial concerns, the state added the capability for caseworkers to see all information collected and all letters sent to the client during the renewal process, in order to keep caseworkers fully informed on the status of each renewal. Like counties, facilitated enrollers might have benefited from more sharing of information on the status of renewals. One facilitated enroller said it would have been helpful to have more information about telephone renewals and better communication between the Enrollment Center and facilitated enrollment organizations on an ongoing basis.

Fourth, telephone enrollment/renewal requires particular training and quality improvement strategies. The Enrollment Center needed to adapt its training specifically for telephone interactions: workers had to learn unique aspects of the telephone process and how to interact with people by telephone most effectively; telephone communication with enrollees required a completely different skill set than processing paper applications. Also, the Enrollment Center managers felt they should have begun recording all calls sooner and reviewing the recordings earlier to refine scripts. They found that when an issue emerges, it typically comes up multiple times; reviewing the call recordings is an important way to identify issues and design solutions quickly. As other states implement the required phone application capabilities, they should anticipate substantial call center staff hiring and training needs and establish systems to gather information on how the implementation process is unfolding, in order to make adjustments as issues emerge and ensure that enrollees are not negatively affected as the new systems are implemented.

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APPENDIX A

EXPRESS LANE ELIGIBILITY: NEW YORK'S EARLY EXPERIENCE

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When New York State expanded Medicaid eligibility for children aged 6 through 18 from 100% to 133% of the federal poverty level (FPL) in November 2011, DOH officials knew this would shift a large number of children from Child Health Plus, the separate CHIP program, to Medicaid. During prior eligibility changes, clients often did not apply for the other program and lost coverage. In an effort to create a more seamless transition for the 5,000 to 7,000 children who would be transferred each month, officials chose to implement an express lane eligibility (ELE) model statewide in June 2012, whereby CHIP renewal could determine eligibility for Medicaid and automatically transition a child to Medicaid without requiring the family to fill out a new application. ELE was built into New York City's automated system, and a paper ELE process was developed for the rest of the state.

ELE Process: All CHIP-eligible individuals are enrolled in managed care plans, which conduct renewals for their members. The CHIP application and renewal forms include a screening process for Medicaid (to comply with screen and enroll rules). Prior to ELE, health plan workers would instruct families to apply for Medicaid if a child appeared to be Medicaid-eligible during the CHIP renewal process. If the health plan was a facilitated enroller, as most plans are, the worker could assist the family, but they would have to complete an entirely new, different Medicaid application.

With ELE, the family does not need to fill out a new Medicaid application or provide new documentation. The health plan makes the initial determination that the child is eligible for Medicaid, and the child receives 60-day temporary CHIP coverage until Medicaid enrollment is fully processed. Once the county makes the final Medicaid eligibility determination, it sends the family a notice of Medicaid coverage, and if necessary a new Medicaid ID card. Then during a monthly Medicaid-CHIP match, if a child is listed as Medicaid-enrolled, the child is removed from CHIP.

ELE Approval and Implementation: DOH submitted a Medicaid state plan amendment (SPA) before implementing ELE. The CMS approval process was somewhat lengthy, in part because CMS did not understand why New York officials thought they needed the SPA, since CHIP was not a typical ELE partner organization. However, DOH thought the SPA was required in order to use CHIP self-attested income (with back-end verification) rather than the Medicaid income documentation required for Medicaid enrollment.

During the implementation process, DOH informed counties, health plans, and facilitated enrollers about ELE. The state shared drafts of the administrative directive delineating changes with three health plans before the final directive was issued to counties. DOH held regular calls with counties, additional calls as needed, and quarterly meetings with health plans. The state grappled with technical difficulties related to getting the CHIP and Medicaid systems to communicate with each other that caused delays. In addition, DOH held many meetings and communicated with New York City's Medicaid agency, the Health Resources Administration, to address technical challenges in adapting ELE to its automated system.

ELE required a "mind set" change at the county level, where workers were not used to giving health plans such a significant role in Medicaid determinations. There was resistance among some county staff who believed that attempted fraud was common. This was addressed and overcome through several meetings with the DOH and counties to explain the new policy and its rationale.

Early Results and Lessons: Though ELE has not been formally evaluated, DOH officials said that ELE resulted in administrative savings for the local counties that normally conduct Medicaid eligibility determinations. ELE also saves time for families by eliminating the Medicaid application process. Because of the state's change in eligibility rules (expanding Medicaid for children ages 6 to

19 from an upper income limit of 100 percent of FPL to 133% of the FPL), DOH moved more than 100,000 children from CHIP to Medicaid; they don't know how many were transferred through ELE but are pleased that there have been no complaints about the shift or reports of children losing coverage.

New York's ELE experience underscores the importance of a state including counties and health plans in the planning process, including holding frequent meetings before, during, and after roll out to explain the new process and its rationale and to clarify rules when issues arise. Further, as with telephone renewal, early technical difficulties with ELE taught DOH to not underestimate system challenges, a lesson that they will carry forward in implementing the Health Insurance Marketplace. According to one official, "It was hard enough with two programs within the same agency. It will be even more difficult integrating programs across agencies [under the new Marketplace]."

Looking Ahead: Some state officials believe that New York will not need ELE once the integrated eligibility system is fully implemented because the system will move people across health programs. After January 2014, enrollees will be told at renewal that they need to renew via the Marketplace. New York is not likely to consider ELE using SNAP or other programs in the near term, because the DOH is focused on Affordable Care Act deadlines and getting the Marketplace up and running smoothly. However, every state will be required to make the same expansion of Medicaid eligibility for children 6 to 19 up to 133 percent of the FPL (if they were below that threshold) under Affordable Care Act rules. ELE may be a valuable tool for helping states make this transition.

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