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Improving Enrollment Policies While Moving Toward Long-Range "Enrollment Modernization"

Health program enrollments should be as simple, convenient, and timely as possible. Coverage should be **immediate and ongoing** for individuals who are very likely to be found eligible based on initial screening.

Consistent with these principles, MCHA helped persuade the State in 2003 to allow "deemed eligible" (DE) newborns—i.e., those whose mothers had Medi-Cal for the delivery—to enroll into Medi-Cal for 12 months over the Internet straight from the doctor's office or clinic without a Medi-Cal application. **Today, about 71,000 infants a year are being enrolled in Medi-Cal through the DE infants' pathway in the CHDP Gateway (2008 data)—that's about 27% of the newborns born to mothers with Medi-Cal each year (265,851 in 2007, the latest available data)**

Also in 2003, MCHA-sponsored SB 24 was enacted into law to allow hospitals to enroll DE newborns over the Internet, creating a Newborn Hospital Gateway. This law also allows pregnant women to apply for Medi-Cal over the Internet from prenatal care providers' offices and keep their "presumptive eligibility" (PE) benefits while the application is pending. Both the Newborn Hospital and Prenatal Gateways have yet to be implemented.

Another MCHA-sponsored measure, AB 1948, enacted in 2006, required the State Department of Health Care Services (DHCS) to conduct a "Feasibility Study Review" (FSR) for upgrading the CHDP Gateway. The upgrade would allow children to apply for Medi-Cal and Healthy Families from the provider's office *and* keep their benefits until a final eligibility determination is made. **Nearly 83% of the 519,000 children pre-enrolling each year through the CHDP Gateway whose families request an application for on-going coverage drop off in two months at most (2008 data).** This extraordinary "churning" is a huge waste of administrative resources, not to mention a major barrier to access to care.

In December 2007, the SB 24 stakeholders' group completed its work. Included in the recommendations is **an ultra-simplified Medi-Cal application consisting of 12 questions identified by DHCS as mandatory (**plus 5 optional) for pregnant applicants. **This same approach could be used for children's enrollment as well.** The AB 1948 FSR, however, issued in September 2008, recommends using Health-e-App for the CHDP Gateway follow-up application; but the children's application in Health-e-App is a replica of the existing longer and more complicated paper application.

The State has been considering "enrollment modernization" for all public programs for some time. A report commissioned by DHCS in August 2007 concluded that the SB 24 Prenatal and Newborn Hospital Gateways were necessary, reflected sound policy, and should be implemented quickly, while the State developed its longer range plan to modernize enrollment for all the programs (*see*, "Modernizing Enrollment in California's Health Programs for Pregnant Women and Children: A Blueprint for the Future" at http://www.chcf.org/topics/view.cfm?itemid=133454).

The prenatal, newborn and improved CHDP gateways lay a foundation for coordinated enrollment modernization in all health programs.

California's Health and Human Services Agency (HHSA) is moving forward with new "architecture" for enrollment modernization, or Enterpirse Enrollment Portal Planning (EEPP), for all state benefits programs. HHSA's EEPP activities are funded by The California Health Care Foundation (CHCF), which created Health-e-App and One-e-App (a program licensed to ten counties so far to screen for eligibility and/or electronically deliver completed applications). The EEPP will take many years to plan, design, and implement.

The "governance structure" for the EEPP excludes consumer representation. Requests by MCHA and other organizations working directly with low-income consumers for an opportunity to participate in the governance structure have been declined.

With HHSA's emphasis on the technology's architecture for the long run, urgently needed policy changes and federal opportunities for improving health enrollments for **large numbers of eligible but unenrolled individuals risk dropping off the radar. Improvements in enrollment *policies* would not only help families get health insurance, they would also simplify the tasks of the EEPP.**

The **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)** provides performance bonus payments for states that significantly increase their child health enrollments during the recession when families need assistance most and the federal matching rate for Medi-Cal has been significantly enhanced. In addition, **the American Recovery and Reinvestment Act of 2009 (ARRA)** creates strong financial and other incentives for pediatric, OB and other Medi-Cal providers to participate in health information exchanges and to invest in health information technology; these developments, in turn, will likely spur on enrollment modernization efforts as well.

- **Implementing the Newborn Hospital and Prenatal Gateways, improving the CHDP Gateway, and adopting the other policy recommendations outlined below are highly effective strategies for earning CHIPRA performance bonus payments that are *consistent* with California's longer range plans for enrollment modernization.**

MCHA's recommendations: We value your comments and feedback. Please let us know your thoughts about the recommendations that follow and whether you'd like to join us in continuing to pursue these goals.

Newborns and Infants

- Starting right away and until enrollment modernization is complete for health or other programs**, DHCS should let hospitals log onto the DE infants path in the CHDP Gateway to enroll up to 260,000 DE newborns directly into Medi-Cal each year *without an application* before they leave the hospital.**

    - We know this approach works: California is already enrolling about 71,000 DE infants a year without a Medi-Cal application through the DE path in the CHDP Gateway. Families who leave the hospital without insurance for their newborns may delay bringing them in for "well-baby" care at a CHDP periodic visit, or put off medical care until the baby is so sick that an emergency room visit results.

    - **By allowing hospitals to participate in the CHDP Gateway's DE infants path, California could cover a significant portion of the Medi-Cal newborns early and with very little administrative effort.** An added advantage of this approach is that a DE infant meets all of the Deficit Reduction Act of 2005 (DRA) citizenship documentation requirements *for life*. All of this would help draw down CHIPRA's performance bonus payments for increasing and retaining child health enrollments.

- **AIM and Healthy Families DE infants:** Infants whose mothers had coverage under either the Access for Infants and Mothers (AIM) program (about 12,500 a year) or Healthy Families (no estimates available) are DE for Healthy Families under California regulations that MCHA fought for. CHIPRA confirms that DE for infants applies not just in Medi-Cal but AIM and Healthy Families as well. California should now:

    - Improve its policies and procedures for DE enrollments when the mother had AIM or Healthy Families, so that infants don't fall through the cracks, especially during their first two months of life;

    - add DE AIM and Healthy Families infants to the existing CHDP Gateway infants' path so that families will not have to submit a follow up application to have their DE infants' coverage continue; and

    - allow DE infants whose mothers had AIM or Healthy Families to enroll through the Newborn Hospital Gateway without an application.

- **Health-e-App:** The State, which owns Health-e-App, should add the necessary logic to identify and immediately enroll DE infants into Medi-Cal and Healthy Families.

- **One-e-App should include the newborn enrollment forms** for Medi-Cal and Healthy Families.

Child Health and Disability Prevention Gateway

- Only 17% of the 519,000 children pre-enrolling through the CHDP Gateway each year whose families request an application for on-going coverage have the application successfully submitted. **The silver lining here is the enormous potential for California to "pick the low hanging fruit" at the CHDP Gateway to earn performance bonus payments under CHIPRA while promoting child health.**

- **State DHCS should allow families to electronically submit an application for *on-going coverage* at the time of their child's CHDP Gateway "pre-enrollment" visit**, as provided for in AB 1948. This way, likely-eligible children will keep their coverage until a complete eligibility determination is made. ***CHDP Gateway pre-enrollments no longer count against California's CHIP allotment.***

    - The children's application to be used in the CHDP Gateway should be modeled on the simplified 12-mandatory-data-element application recommended by the SB 24 stakeholders for pregnant women. Health-e-App is a valuable tool but, in its current form, is too complex for most provider settings, which is where the CHDP Gateway is used. **Creating a special path in Health-e-App for a new, simplified children's health application based on the 12-mandatory elements could be the win-win approach here.**

- DHCS should correct the screening rules used at the Single Point of Entry (SPE) that send some disabled and other children to Healthy Families, where they incur higher cost-sharing and have fewer benefits than if they were properly screened for Medi-Cal. **To address this serious problem *and* capture additional performance bonus payments, the State should use the new option in CHIPRA to screen into Medi-Cal children whose family income is 30% or more over the usual income limits.**

Accelerated Enrollment for Children Screened Eligible at the SPE for Healthy Families

Children screened eligible at the SPE for Healthy Families wait up to 20 days or more for their coverage to take effect. Healthy Families does not provide *any* retroactive coverage (except in the case of DE infants, see above) for medical bills that may be incurred during the gap between the application date and effective date of the child's health plan coverage.

- **The State should exercise the option to extend the existing "accelerated enrollment" (AE) program for children screened eligible at the SPE for Medi-Cal to children screened eligible at the SPE for Healthy Families. As with Gateway pre-enrollments noted above, *AE no longer counts against California's CHIP allotment.***

Pregnant Women

Over 260,000 women a year give birth with Medi-Cal coverage, but many of these women aren't enrolled until late in their pregnancies or after the delivery.

- **Prenatal Gateway: DHCS should use the simplified 12-data-elements Medi-Cal application for pregnant women** developed by the SB 24 stakeholders' group for women applying at a PE provider's office. Until the EEPP is implemented, the simplified application could be delivered directly to the county by secure fax or other appropriate electronic delivery mechanism (e.g., a special path in Health-e-App for provider-based enrollments for pregnant women). This way, the woman's PE will continue until a final eligibility determination is made.

- **PE for pregnant women screened eligible for Medi-Cal at the SPE:** Many pregnant women do not go to a PE provider for prenatal care before submitting their Medi-Cal applications either to the county or the SPE in Sacramento. Pregnant women who mail their applications to the SPE can experience especially long delays in getting Medi-Cal approved, since the SPE does not process the application but instead forwards it to the woman's county for an eligibility determination.

- DHCS should exercise its option, re-affirmed in CHIPRA, to **provide PE for pregnant women who send their Medi-Cal applications to the SPE.**

- Until PE becomes available for pregnant women applying via the SPE, Medi-Cal application forms (paper and Health-e-App) and screening programs (e.g., One-e-App) should:

  - instruct pregnant women **to go to a PE provider for prenatal care right away**;

  - instruct pregnant women applying for themselves alone (i.e., with no child applicant) not only to go to a PE provider for prenatal care right away but also to **submit their applications directly to the county instead of the SPE**; and

  - unless a pregnant applicant has already been enrolled in PE by a provider, require that assisted applications for pregnant women alone (i.e., with no child applicant) be mailed directly to the county, not the SPE.

- **Referrals to AIM from the SPE:** At present, Medi-Cal applications for pregnant women submitted to the SPE in Sacramento are automatically forwarded to the county, without being screened at all for income eligibility for either Medi-Cal (200% of poverty) or AIM (201% to 300%), even though AIM eligibility determinations are made in Sacramento by the Managed Risk Medical Insurance Board (MRMIB). It is only after the county finds that the pregnant woman is over the income limit for Medi-Cal that she is told to apply to AIM in Sacramento. **The current procedure results in gross administrative inefficiencies and long, unnecessary, delays in AIM eligibility determinations for pregnant women; it must change:**

  - The SPE should screen applications it receives from pregnant women, grant PE if the woman is screened eligible for either Medi-Cal or AIM (see above and below), and, when the applicant is within the income eligibility limits for AIM, **submit her application directly to AIM** instead of simply forwarding it to the county.

- **Retroactive benefits and PE for pregnant women screened eligible for AIM**: Pregnant women applying for AIM wait up to 20 days or more for their coverage to take effect. AIM will cover only up to $125 in pregnancy-related care that a woman receives during the window from 40 days before her application until the effective date of her health plan coverage.

  - **MRMIB should exercise the option, re-affirmed in CHIPRA, to provide PE to AIM applicants** to cover all medical services received between the woman's AIM application date and her effective date of coverage.

  - **MRMIB should also eliminate the cap** on reimbursement for pregnancy-related services for AIM applicants, whether the services are received during the 40 days before her application date or during the PE period between her application date and effective date of health plan coverage.

- **PE at the County for pregnant women screened eligible for Medi-Cal *or* AIM:** The State should exercise its option, also re-affirmed CHIPRA, to **designate counties as**

entities with authority to grant PE to pregnant women screened eligible for Medi-Cal *or* AIM.

- **Income counting: AIM and Medi-Cal must use the same income eligibility rules so that pregnant women no longer risk falling through the cracks between these two programs.**

    - The AIM website needs to include **clear instructions on deductions from income from sources other than a job,** such as self-employment, and post al the necessary forms for claiming deductions.

    - If a woman's income appears too low for AIM based on her prior year's tax return, **AIM must request additional information and re-evaluate** the applicant's income based on AIM's alternative income verification methods, which take into account more deductions than the federal tax form does.

    - **The income eligibility rules for AIM and Medi-Cal for pregnant women must be aligned**. Alignment must be to the least restrictive rules as between the two programs so that pregnant women will not lose eligibility-- and the State will not lose enhanced matching funds for Medi-Cal under ARRA.

Long range enrollment modernization

- **Consumer advocates' input should be solicited early and often, and consumer advocates should be included in the governance structure**, not only for the EEPP but also for screening and benefits program application delivery technology licensed to the counties, such as One-e-App, and on-line benefits program applications owned by the State, like Health-e-App.

- **The process for making policy decisions on establishing and updating the eligibility logic in the EEPP, State e-apps and e-screening products licensed to or owned by the counties for use in public benefits programs must be transparent and accessible to the public.** This is especially important for changes in eligibility rules that are necessary either because of new laws expanding eligibility or simplifying enrollment requirements or to address glitches consumer advocates discover.

- **Privacy:**

    - The simplest possible application forms and procedures should be used so that **only information strictly necessary for an eligibility determination is collected;**

    - **Consumers' private information must be strictly protected** in a manner consistent with all federal and state laws and regulations specific to the particular benefits program as well as other federal and state privacy laws, including the enhanced protections in ARRA extending HIPPA to "business associates" (e.g., Certified Application Assistors and others involved in outreach and enrollment activities who have access to consumers' private information) and providing for notice to consumers and heavier penalties in the case of HIPPA breaches;

    - **Consumer releases for information-sharing must be narrowly and carefully crafted** to authorize access only to what is needed for a specific program's eligibility

determination and only by agencies or individuals who need the information to determine eligibility or verify a condition of eligibility; and

- Procedures must be adopted to ensure that consumers, including those with limited English proficiency, give releases for use or sharing of private information only with **truly informed consent**.

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