MEDICAID ADMINISTRATION

Annual Report to the Governor and Legislature

December 2012

NEW YORK
state department of
HEALTH

BACKGROUND

In April 2012, the Legislature enacted Section 6 of Part F of Chapter 56 of the laws of 2012 authorizing the Department of Health to transfer responsibility for the administration of the Medicaid program from Local Departments of Social Services (LDSS) over a period of six years by March 31, 2018. The Department may accomplish the assumption of administrative responsibilities with State staff, contracted entities, and contracts with counties.

The legislation requires the Department to submit an annual report to the Governor and Legislature beginning December 2012 and continuing until the year after full implementation. The annual report will describe the activities the State has undertaken in the past year to assume Medicaid administrative functions, and the plan and timeline for the assumption of additional functions. The report will also describe how the State has coordinated the implementation of the Federal Affordable Care Act (ACA) with the State Administration of Medicaid.

The first annual report was prepared by Department of Health staff. The Department benefited from input from stakeholders, principally the Medicaid Redesign Team Work Group on Program Streamlining and State/Local Responsibilities. The Department also collaborated with Local Departments of Social Services through a work group of Commissioners that met monthly to plan for the State assumption of Medicaid administrative functions.

The report is organized into eight sections:

- *Guiding Principles*
- *Functions Assumed by the State in 2012*
- *Functions Planned for Transition in 2013*
- *Implementation of the Affordable Care Act*
- *Functions Remaining with Counties After 2014*
- *Statement of Interest Results*
- *Post-ACA Implementation: Non-MAGI Administration Functions*
- *Financing Medicaid Administration*
- *Need for Additional Legislation*

Finally, the report concludes with a five-year timeline for State administration of Medicaid. Appendices include the authorizing Legislation, the Statement of Interest, the Inmate Solicitation of Interest, and the Medicaid Redesign Team Work Plan for the Program Streamlining and State/Local Responsibilities Work Group.

GUIDING PRINCIPLES

The Medicaid Redesign Team Work Group on Program Streamlining and State/Local Responsibilities developed a set of principles to guide the multi-year State assumption of Medicaid administrative functions:

Build on Success. State administration should build on the best practices of Medicaid administration and streamlined eligibility and enrollment throughout the State.

Reduce the Number of Uninsured New Yorkers. Approximately 2.7 million New Yorkers lack health insurance. Changes in Medicaid administration should accelerate the enrollment of eligible New Yorkers.

Ensure Robust Performance Accountability for Customer Service. Care must be taken to ensure that changes in the administration of the program ensure that consumers have access to consumer friendly, linguistically and culturally appropriate points of contact to apply, recertify and navigate the enrollment process to obtain needed services.

Maximize Automation. The eligibility determination process must be automated to the greatest extent possible to streamline enrollment and to allow more time to be spent with vulnerable populations who need greater in-person assistance.

Improve Efficiency. Consolidation of administrative functions should be designed to realize economies of scale and opportunities to reduce costs through efficiencies.

Promote Uniformity and Consistency in Administrative Process and Decision Making. Administrative changes must optimize the opportunity to create uniform, statewide processes that ensure consistency across geographic areas of the state. These include the processes and procedures for applying for coverage and the processes for arranging and approving services once an individual is enrolled.

Involve Stakeholders. The Administration of Medicaid has far-reaching impact on government agencies, workers, health care providers and consumers. The assumption of functions by the State must be informed by stakeholders and fully recognize the implications of a shift in administration of the program.

FUNCTIONS ASSUMED BY THE STATE IN 2012

The State assumed responsibility for several Medicaid administrative functions in 2012. Priorities identified by the Medicaid Redesign Team Work Group on Program Streamlining and State/Local Responsibilities and the Department's readiness for implementation were among the factors considered when identifying which functions would be transitioned. Over the past year, the State has implemented changes to automate renewals for Medicaid enrollees with stable income outside New York City, expanded the number of counties for whom the Enrollment Center processed renewals, centralized the processing of applications from family planning providers outside New York City for the Family Planning Benefit Program, initiated a project to consolidate and expand the prisoner suspension program, started transitioning responsibility for disability determinations for additional counties, centralized transportation management, and started transitioning adults in need of community-based long term care services to mandatory managed long term care. Each of these functions is described below. Implementation of these initiatives was staggered throughout the year and, while none of the initiatives were implemented statewide in 2012, for some, the rest of the state will be added in 2013.

Administrative Renewals for Aged, Blind and Disabled Individuals

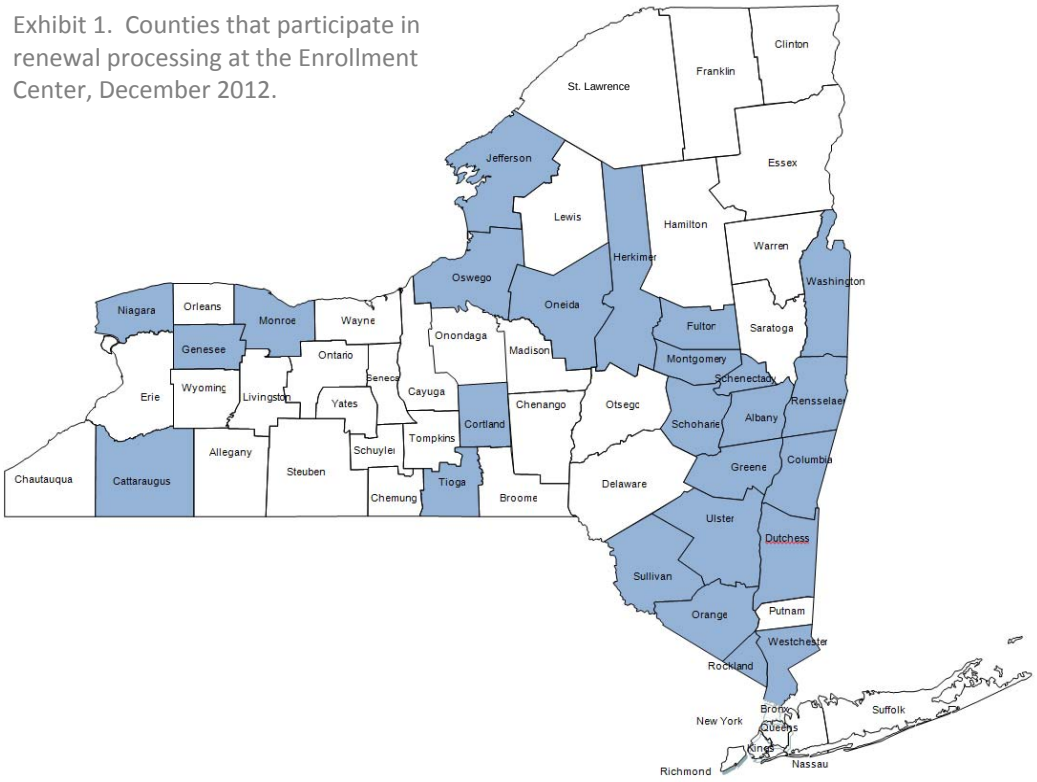
Administrative Medicaid renewals began in January 2012 for individuals who are Aged, Blind and Disabled and whose only source of income is from the Social Security Administration (SSA). To qualify for an administrative renewal, resources must be 10 percent below the Medicaid resource level and there can be no unresolved match with State data systems. The Administrative renewal eliminates the need for the recipient to fill out a paper renewal application. The renewal is completed in an automated fashion and a notice is sent to the recipient informing him/her of the renewal and continued coverage.

Approximately 1,000 automated renewals for this group are processed in counties outside New York City each month. In June 2012, automated renewals were expanded to include recipients in the Medicare Savings Program (MSP) who have income only from SSA benefits. For counties outside New York City, between 700 and 1,000 recipients have their MSP eligibility renewed each month. Two expansions of automated renewal are planned for 2013. First, New York City will begin automated renewals for both the Aged, Blind and Disabled and the MSP populations. Second, in October 2013, recipients with income from a pension will be included in automated renewal for counties outside New York City. These expansions will more than double the number of monthly renewals that are processed through this process.

Renewal Processing for Enrollees Permitted to Attest to Income Who Have No Resource Test

In June 2011, the Department began to assume responsibility for processing renewals for a subset of enrollees in New York's Medicaid, Family Health Plus, and Family Planning Benefit Programs—those who are allowed to attest to changes in income at renewal and who have no resource test (non-Aged, Blind or Disabled). These renewals are processed at New York's centralized Enrollment Center. The Enrollment Center, operating under the name *New York Health Options*, is implemented through a contract with MAXIMUS.

Exhibit 1. Counties that participate in renewal processing at the Enrollment Center, December 2012.



From January 2012 to August 2012, an average of 12,000 renewals per month from 12 counties were directed to the Enrollment Center for processing. Six counties were added in September 2012 and seven more counties were added in December 2012, bringing the average number of renewals directed to the Enrollment Center to over 20,000 per month from 25 counties.

With the implementation of renewal processing at the Enrollment Center, New York introduced a new option for Medicaid recipients to renew their coverage by telephone. Recipients who choose to renew by telephone call the Enrollment Center and a telephone renewal interview is conducted by Enrollment Center staff. Recipients who choose to renew by mail send their completed renewal forms back to the Enrollment Center for processing. The updated information provided by recipients at renewal is entered into a software program developed by the Department that interfaces with the Welfare Management System (WMS) to make the eligibility determination. The final eligibility determination is made by State staff.

The Department initially limited the telephone renewal option in order to build experience and refine the process so that consumers would have a positive experience. The option was gradually expanded to more counties and by July 2012, recipients in all 12 participating counties were allowed to renew by telephone. As new counties are added, recipients from all of those counties are offered the telephone renewal option.

The Enrollment Center is open Monday through Friday from 8am to 8pm and Saturdays from 9am to 1pm, providing recipients with the option to renew during evening and weekend hours. With telephone renewals, the need for additional client outreach has been reduced, as the renewal assistant can ask clarifying questions while the recipient is on the phone. Data from the last six months show that nearly 50 percent of recipients choose to renew their coverage by telephone. Processing a telephone renewal takes more actual staff time than processing a mail-in renewal because of the renewal interview, however, phone renewals reduce the need for applications to be pended for missing information. All required renewal application information is provided on the phone for 96 percent of phone renewals compared to 78 percent of renewals received by mail on the paper application. Moreover, applicants renewing by phone submit supporting documents (e.g., proof of income and citizenship) more often and more timely than those renewing by mail. The more complete application and more timely return of verification documents results in phone renewals being processed, on average, in 30 percent less time than those received by mail.

> The telephone renewal option has improved the consumer experience and the efficiency of renewals.

The Department will continue to gradually expand renewal processing at the Enrollment Center in 2013. Another expansion to add approximately 4,700 renewals is planned for March 2013. The Department is assessing its capacity for additional county transitions of renewal processing in 2013 vis a vis the resources that will be needed to prepare for implementation of MAGI Medicaid eligibility rules under the ACA, but hopes to be able to transition additional counties between May and September of 2013. Local Social Services Commissioners were asked to identify during which phase of the expansion their county would be interested in transitioning renewals to the Enrollment Center. This information has assisted the Department with preparing the roll-out schedule.

The Department has gained valuable experience with the development of the software program for processing renewals and the centralization of renewal processing at the Enrollment Center and is using that experience to inform planning efforts for New York's Health Benefit Exchange. Department staff will continue to dialogue with county staff through a monthly Enrollment Center Workgroup to identify opportunities for improvement and to assist with planning for the transition of renewal processing to the Health Benefit Exchange in the coming year.

Processing Family Planning Benefit Program Applications

Effective November 2012, New York State included a presumptive eligibility (PE) option for the Family Planning Benefit Program (FPBP) in its Medicaid State Plan. With this change, individuals will have the opportunity to be screened presumptively eligible for the FPBP at a Medicaid-enrolled and trained family planning provider who has signed a Memorandum of Understanding (MOU) with the Department. The PE option will provide eligible individuals with immediate access to FPBP-covered services.

With the implementation of the new PE option, the Department is transitioning the responsibility for processing all FPBP applications submitted by family planning providers from Local Departments of Social Services (LDSS) to New York Health Options.

Many family planning providers had previously signed MOUs with LDSS's that allowed them to submit applications for the FPBP directly to the LDSS on behalf of their clients. These MOUs will be replaced with a new MOU between the family planning providers and the Department that will permit the provider to screen clients for PE, and to submit both PE screening forms and full FPBP applications to New York Health Options on behalf of their clients.

The State, will have the capacity to process over 250,000 presumptive eligibility and full FPBP applications in calendar year 2013.

New York Health Options will process both presumptive eligibility screenings and full applications for FPBP benefits that are submitted by providers who have signed an MOU with the Department. The final eligibility determination for FPBP will be made by State staff. The LDSS will continue to process FPBP applications submitted by individuals. The first MOUs were executed in December 2012 and application processing started outside New York City shortly thereafter. Implementation of the new PE option was delayed by one month to accommodate additional testing of WMS systems changes needed to support application processing. New York City implementation was delayed further due to Hurricane Sandy as staff time was redirected to programming required to preserve coverage for those unable to renew or submit documents due to the storm. New York Health Options, in conjunction with the State, will have the capacity to process over 250,000 presumptive eligibility and full FPBP applications in calendar year 2013.

Medicaid Applications for Inmates/Coverage for Inpatient Hospital Care

The Department has been working with the Division of Budget (DOB) and the Department of Corrections and Community Supervision (DOCCS) to develop a consolidated process for expanding Medicaid suspensions by reviewing applications for individuals who are incarcerated in State prisons. This initiative will improve access to Medicaid for inpatient hospital stays and benefits upon release. The Department intends to select a small number of Local Departments of Social Services to process inmate Medicaid applications statewide.

A Solicitation of Interest was sent to all counties (Attachment B) in September 2012. Counties only needed to respond if they were interested in participating in the initiative. The Department received responses from seven counties and the Human Resources Administration in New York City. The Department is following up with these counties to provide further information regarding anticipated volume, the terms and conditions of participation and reimbursement. Following these discussions, contracts are expected to be developed with selected counties in early 2013.

In addition, the Department is working to create a new coverage code in WMS to authorize reimbursement for hospital care only. All inmates with suspended Medicaid coverage will receive this new coverage code, so that claiming for inpatient hospital care can be done electronically through eMedNY. Currently, these claims are being paid through a manual retroactive process. The new coverage code is expected to be available in February 2013.

Disability Determinations

The State Disability Review Team (SDRT) performs disability determinations for Medicaid eligibility purposes for 41 local districts and for the Office of Persons with Developmental Disabilities. Beginning in December 2012, a staged transition of disability determinations for the remaining counties will begin and continue through 2013 and into 2014. It is estimated that disability determinations for all upstate districts will be performed by the SDRT by the end of 2013 and disability determinations for the Office of Mental Health and for New York City will be phased in during 2014. Districts will continue to be responsible for collecting the documentation necessary to perform a disability determination, until such time as the State can assume this responsibility.

State Assumption of County Medicaid Transportation Management

Prior to the State's development of initiatives aimed at achieving mandate relief for Local Departments of Social Services, the administration of Medicaid transportation by the counties was a costly local mandate that reduced the State's ability to ensure uniform compliance with policy directives, did not take advantage of potential regional efficiencies, and had not been effective in reducing costs. The Medicaid Redesign Team (MRT) led a reform effort to address these problems with the resulting impact of reducing transportation costs and providing work load relief to counties.

The first step towards achieving reform and mandate relief came when the 2010-11 State Budget amended Section 365-h of the Social Services Law to give the Commissioner of Health the new authority to assume the management of Medicaid transportation in any county, and to select a contractor at his discretion for this purpose. The intent of the law was to improve the quality of transportation services, reduce the local burden of administering transportation services and local management contracts, and achieve projected budgeted Medicaid savings.

Early indications are that the Department has realized significant reductions in the cost of transportatio per user when compared to the same months in the year prior to state management.

The authority given the Commissioner makes possible the centerpiece of the MRT#29 Medicaid Non-emergency Transportation Management Initiative which creates several regions based on common medical marketing areas. These new regional models were created to consolidate local administrative functions, centralize specialized management expertise, and improve resource coordination – resulting in a more seamless, cost efficient, and quality oriented delivery of transportation services to Medicaid beneficiaries.

In May 2011, the Department of Health awarded a Hudson Valley Region contract to Medical Answering Services, a Syracuse-based non-emergency medical transportation management company. This state management initiative, now expanded to 24 counties and including managed care recipients, has successfully consolidated local administrative functions, provided more consistent management expertise and Medicaid policy oversight, and improved resource coordination.

State assumption of transportation management has become an important step in relieving local districts of the responsibility for administering a major service of the Medicaid program. Not only are the districts no longer responsible for arranging and prior authorizing transports for Medicaid enrollees, but they are also no longer responsible for the administrative tasks associated with reimbursing enrollees and non-enrolled transportation providers for certain off line transportation associated expenses. The state assumption of this particular function provides relief in two ways: county staffs are no longer responsible for the many tasks associated with the administration of Medicaid transportation, and county budgets no longer have to provide for the upfront costs of funding off line transportation reimbursements.

Building on the success of the Hudson Valley initiative, the Department has procured LogistiCare Solutions, a national transportation management company, to develop an improved, cost effective Medicaid transportation infrastructure in New York City. This project began with transportation management in Brooklyn on May 1, 2012 and by October was expanded to all five City boroughs. All Managed Care enrollees throughout the City will be included under LogistiCare's transportation management effective January 1, 2013 – representing a total of 3.2 million Medicaid enrollees when fully implemented the largest Medicaid transportation management project in the nation.

This past November, the Department offered procurements for 24 counties in the Finger Lakes and Northern New York regions. Procurements for the Western New York and Long Island regions will follow later in 2013 to complete the transportation management initiative statewide.

The transportation management initiatives are on track to achieve the Medicaid Redesign Team's $30 million transportation state share savings when fully implemented. Early indications are that the Department has realized significant reductions in the cost of transportation per user when compared to the same months in the year prior to state management. This savings trend generally results from a decrease in the number of higher cost trips in favor of lower cost modes such as livery, or public transportation, and other targeted efficiency efforts such a group rides.

Managed Long-Term Care

One of the most significant reforms recommended by the MRT is the plan to migrate long-term care services to a managed care environment. In August 2012, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to require certain Medicaid consumers to enroll in managed long-term care plans. Over a several year period, the Managed Long-term Care (MLTC) program will expand statewide and the majority of community-based long-term care service recipients will be enrolled in plans. Under the expansion, all dual eligible individuals (persons in receipt of both Medicare and Medicaid) aged 21 or older and in need of community based long-term care services for more than 120 days, will be required to access services through a managed long-term care (MLTC) model.

The transition to mandatory managed long-term care began in New York City in the summer of 2012, and as of November over 69,000 individuals were enrolled in 36 MLTC plans**.** In January 2013 mandatory enrollment will begin in Nassau, Suffolk, and Westchester counties. In the second half of 2013 mandated MLTC enrollment is anticipated to be expanded to six additional counties, including Albany, Erie, Monroe, Onondaga, Orange, and Rockland. Other counties will transition in 2014 and after, based on the availability and capacity of managed long-term care plans in the county.

The expansion of MLTC enrollment reduces the participation in programs managed by the LDSS, including the Personal Care Services Program, Personal Emergency Response Services, and Consumer Directed Personal Assistance Program. In addition, once federal approval is given on additional waiver amendments, the Long-Term Home Health Care Program will be transitioned. While the need for the LDSS to assess the need for services and authorize the level and duration of services declines as enrollment in managed long term care increases and the health plan assumes responsibility for managing the care, district resources are needed alert consumers and personal care vendors of the practical implications of transition, to ensure that sufficient prospective authorization is in place for the transition process, to conduct outreach and education to those who delay selecting a plan in order to minimize auto assignment, and to address environmental and social issues that might interfere with the transition process. LDSS retains reassessment and reauthorization responsibilities for community based long term care services for those under 21 or not Medicare eligible. In an unrelated action, the LDSS role in the prior approval of placements into the Assisted Living Program was eliminated in the enacted budget, though the county may still do a post-placement review.

Centralization of Casualty and Estate Recovery

The Office of Medicaid Inspector General (OMIG) administers the MRT initiative to centralize the management and reporting of Medicaid casualty and estate recovery. OMIG requires Local Departments of Social Services (LDSS), at a minimum, to use the HMS Maestro Case Management System to administer these recovery programs. Prior to assuming such responsibility from a social services district and in consultation with the district, OMIG/HMS will define the scope of services the district will be required to perform on behalf of the Department of Health. Additional services and assistance are available from OMIG/HMS including full outsourcing of estate, casualty and lien recovery efforts.

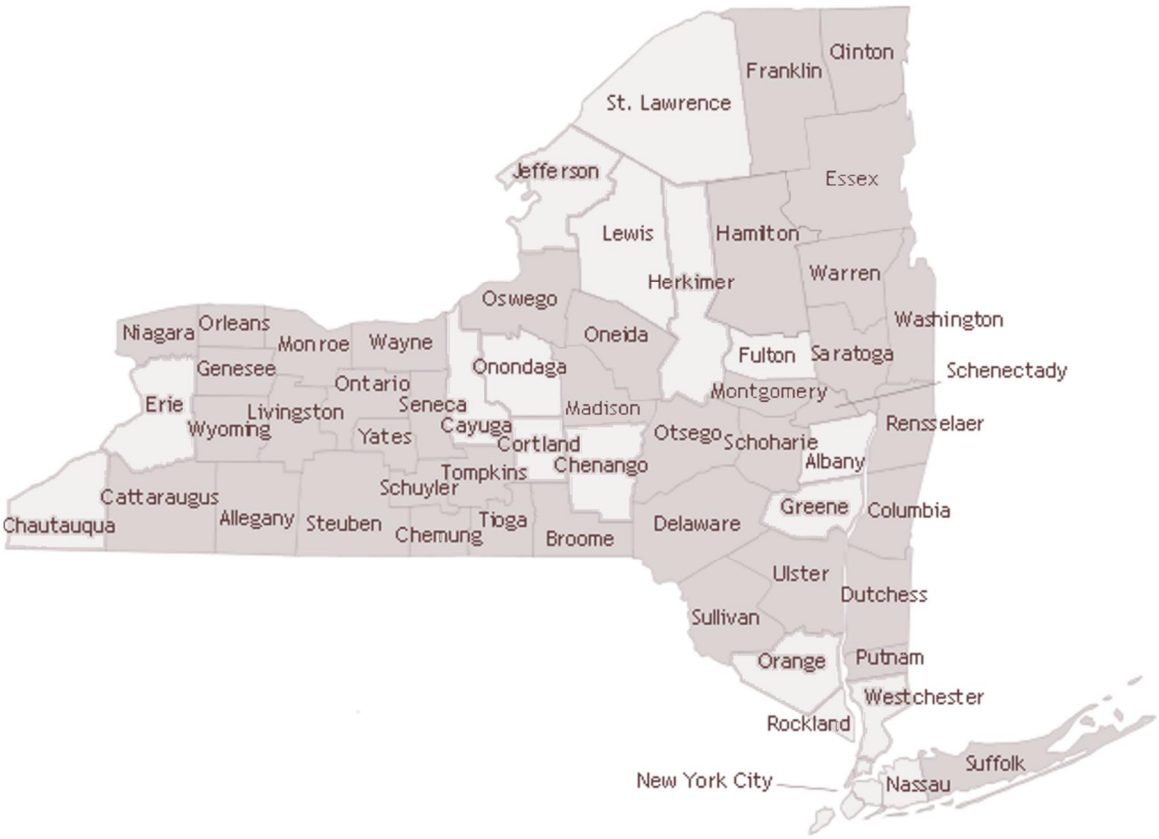
LDSS may choose from the assistance options described below:

- *Case Management Option - LDSS would have access to all of HMS intake and referral networks and use Maestro and Image Now to manage all LDSS cases.*
- *Overflow Option - this second option expands on the first solution to create a "hybrid" solution that includes full case management system support and direct HMS assistance with "case overflow." With this solution, LDSS would be able to continue working a caseload that is manageable and tap into HMS resources for added value and enhancement of the caseload.*
- *Full Outsourcing Option – this is our third and most comprehensive solution which is a (near) full utilization of HMS services. This solution includes the case management and referrals network solution, case overflow assistance, additional case identification and full case management by HMS caseworkers for all cases, both those identified by NYC and those identified by HMS. With this solution, LDSS direct involvement in casework would be limited to situation where only the county has the legal authority to take an action. On these cases, HMS would provide consultation to facilitate the work.*

As of December 2012, eighteen New York counties have been implemented through the MRT 102 Medicaid Centralization efforts including New York City's Casualty Recovery Program (HRA-IREA).

Of the 18 counties implemented to date, 15 have fully outsourced their estate and casualty recovery work to OMIG/HMS, two have a shared work/hybrid option and New York City maintains their casualty casework in-house while using a customized version of the Maestro Case Management System with over flow and front end assistance from OMIG/HMS.

Implementations for Monroe County, Suffolk County and New York City (HRA-OLA) are currently in progress along with several smaller counties throughout New York State.



FUNCTIONS PLANNED FOR TRANSITION IN 2013

The Department's highest priority for 2013 is to complete work on the development of a new eligibility and enrollment system for the population that can obtain coverage through the New York Health Benefit Exchange in time for open enrollment in October 2013 and to modify the Medicaid categories and rules to align with the new eligibility rules based on Modified Adjusted Gross Income required by the ACA. These efforts will be described below in the section on implementation of the ACA.

As described earlier, in 2013, the Department will expand centralization of many of the functions initiated in 2012. These include expanding the number of cases that qualify for administrative renewal, increasing the number of counties that participate in renewal processing at the Enrollment Center, expanding the transportation management initiative statewide and expanding mandatory managed long term care enrollment to more counties. The additional initiatives planned for implementation in 2013 include procurement of an Asset Verification System, automated spend down, evaluating Family Health Plus cases for potential Premium Assistance Program eligibility, processing paper Medicaid Savings Program (MSP) applications, and reassessing household eligibility when data matching reports a death.

Asset Verification System

The Department intends to contract for an Asset Verification System (AVS) in 2013. Section 1940 of the federal Social Security Act requires all states to implement an electronic system for verifying the assets of aged, blind or disabled (SSI-related) applicants for and recipients of Medicaid. The Local Departments of Social Services currently perform this function. Assets are currently verified through the Resource File Integration (RFI) process, but much of the process is manually performed by analyzing information brought in by the applicant or by reaching out to the financial institutions for banking records. This process is labor-intensive, inefficient and not timely.

The Department intends to contract with a vendor with access to data from financial institutions to automate the verification of assets. This will reduce a significant portion of the work currently being performed by the LDSS and improve the timeliness of eligibility determinations. The AVS will augment the role of the LDSS by providing comprehensive verification and account reporting of Medicaid applicants' and recipients' resources by:

- *Verifying the assets of the population applying for or receiving Medicaid on the categorical basis of being aged, blind or disabled;*
- *Providing flexibility, security and automation that allows the LDSS to manage and act upon verification results in a timely manner; and*
- *Improving program integrity.*

The Department anticipates that the verification of real (instead of personal) property will be included in the information provided by the contractor, providing access to information that is difficult to obtain electronically today.

Automated Spend Down

The spend down program allows certain individuals to obtain Medicaid coverage if they have medical expenses that exceed the difference between their net income or resources and the Medicaid income/resource eligibility levels. Currently, recipients must submit their medical bills to the LDSS, who track the amount of bills and, when the spend down amount is reached, give the individual Medicaid coverage.

Automated spend down will relieve district workers of manually tracking bills and changing coverage codes in WMS every month.

Tracking whether individuals have met the spend down is a cumbersome and largely manual process that occurs on a monthly basis. The Department is building an interface between WMS and eMedNY (the bill payment system for Medicaid) to enable eMedNY to identify individuals with a spend down and the dollar amount of the spend down. The eMedNY system will then track medical bills submitted by Medicaid providers and apply the bills towards an individual's spend down. Medicaid payment of claims submitted will occur once the spend down is met. Automated spend down will relieve district workers of manually tracking bills and changing coverage codes in WMS every month. Design specifications for this project have been completed, however, given the complexity of the project, the expected implementation date is July 2013. The date is likely to be further delayed as WMS system resources are shifted to support the WMS interfaces required for interaction with the new Exchange eligibility system.

Family Health Plus Premium Assistance Program

The Family Health Plus Premium Assistance Program (FHP-PAP) was established in 2007 with the intent of allowing New York State to cover individuals' premiums for qualified employer-sponsored insurance in lieu of capitation payments to Family Health Plus (FHP) managed care plans, when that employer-sponsored insurance is cost-effective. Prior to the implementation of FHP-PAP, most individuals enrolled in employer-sponsored insurance were ineligible for FHP. No statutory mechanism existed to pay a cost-effective premium as allowed for individuals eligible for Medicaid. Therefore individuals who were income-eligible for FHP either dropped the employer coverage to enroll in FHP, or continued to pay premiums on the employer coverage, an often large expense for low-income working households.

Individuals who are already enrolled in FHP and later found to be enrolled in employer-sponsored insurance must be evaluated for FHP-PAP, however the volume of cases and the complexity of the cost-effectiveness evaluation process has been a burden on resources at the New York City Human Resources Administration. The Department will transition to New York Health Options the responsibility for evaluating New York City FHP cases for potential FHP-PAP eligibility. New York Health Options will request documentation from recipients enrolled in FHP that are identified as having other health insurance in order to evaluate whether the case should be converted to FHP-PAP, continued as FHP, or discontinued when the insurance is not cost-effective and qualified.

Originally planned for December 2012, the implementation has been moved to April 2013 to allow for sufficient staff training and systems changes necessary to ensure that WMS is fully capable of processing the transactions and notices necessary for FHP-PAP. New York Health Options, in conjunction with the State, will process the current New York City caseload of 9,000 FHP individuals who also have third-party insurance identified in eMedNY and then, on an ongoing basis, any FHP cases later found with third-party insurance.

Medicare Savings Program

The Medicare Savings Program (MSP) is a Medicaid benefit which pays the Medicare premiums for low income individuals. On a yearly basis, 13,000 paper applications for this benefit are received statewide. These applications are currently received and processed by the LDSS. The Department plans to assume the responsibility for determining eligibility for this program. By the end of 2013 paper applications for the MSP for residents of New York City will be directed to New York Health Options. The State, in conjunction with New York Health Options, will be responsible for reviewing the applications, determining eligibility, and sending written notification to applicants. After New York City applications have been transitioned, the centralized processing of paper MSP applications will be incrementally expanded to Upstate counties.

Reassessing Eligibility when a Household Member is Deceased

The Department intends to centralize the resolution of reported deaths by the Social Security Administration. In order to reduce Medicaid (especially managed care) payments for deceased individuals, a monthly auto-close procedure for single individual Medicaid cases identified from a match with the Social Security Administration has been in place since 2007. These cases are closed automatically after proper notice is provided. Cases with multiple individuals are handled by the Local Departments of Social Services (LDSS). Once an individual's death is confirmed, coverage for that individual is discontinued, the information for the remaining members is updated, and the eligibility for the remaining individuals is re-determined due to the change in household size. Client notices are then sent to inform the remaining individuals of their eligibility status.

The Department is going to assume the re-determinations of eligibility where there are multiple individuals on the case, thereby eliminating this function for the LDSS. The Department will phase in the centralization in a few counties commencing January 1, 2013 and expand it to all the counties except New York City once the State is confident that the new process is working. Once the non-NYC districts are complete, the Department will work with the Human Resources Administration (HRA) to set up a similar process for the State to assume this function for NYC.

IMPLEMENTATION OF THE AFFORDABLE CARE ACT

The implementation of the ACA is connected to the State assumption of Medicaid functions in two important ways. First, the ACA provides new options for health coverage and aligns the eligibility rules across a continuum of Insurance Affordability Programs (IAPs) which include Medicaid, CHIP, Premium Tax Credits, and Cost-Sharing reductions. Consumers must be able to apply for IAPs on one application through one process.

Approximately 1 million New Yorkers are expected to receive coverage through the Exchange, with an additional 500,000 receiving Medicaid coverage. To implement the requirements of program integration of the ACA, the Department intends to centralize eligibility and enrollment for all IAPs through the Health Benefit Exchange.

Second, the ACA provided generous support to states to upgrade their eligibility systems to meet the requirement for an online application pathway with electronic verification and automated eligibility decision support. The Department intends to replace the decades old Welfare Management Systems (NYC and Rest of State) with a single statewide eligibility and enrollment system for all IAPs, and eventually the remaining Medicaid populations and programs. The State assumption of eligibility functions from the counties is dependent on the development of automated decision support for verifying and determining eligibility.

Exchanges must establish online application processes with automated eligibility determinations for those whose eligibility can be determined based on Modified Adjusted Gross Income (MAGI).

Centralized Eligibility Determinations for the MAGI Population

The ACA requires the creation of Health Benefit Exchanges as a marketplace for more affordable and more understandable health insurance options. Qualified individuals may directly purchase insurance from the Exchange or apply for financial assistance to determine if they are eligible for an Insurance Affordability Program. IAPs are available to certain individuals with household incomes below 400 percent of the federal poverty level ($92,000 for a family of four) and include Medicaid, Child Health Plus, Advance Premium Tax Credits (APTC) (a reduction in the monthly premium for families with income above Medicaid eligibility but below 400% of FPL), cost-sharing reductions (CSR) (for those below 250% of FPL or 300% for Native Americans/Alaskan Natives) and the Basic Health Plan (if the state chooses to adopt it).

Exchanges must establish online application processes with automated eligibility determinations for those whose eligibility can be determined based on Modified Adjusted Gross Income (MAGI). MAGI-based eligibility applies to all IAPs and includes children, pregnant women, parents/caretakers, and non-elderly adults. The MAGI eligibility rules use Internal Revenue Service definitions of household size and income. In the case of Medicaid, the MAGI eligibility rules replace current Medicaid rules for the affected populations to better align eligibility across all IAPs. It creates a bifurcation in the Medicaid program of populations whose eligibility is based on MAGI and those whose eligibility is based on current rules (Non-MAGI). In addition to online application processes, Exchange applicants must also be able to apply by telephone, mail and in person.

Governor Cuomo's Executive Order No. 42 established the New York Health Benefit Exchange in the Department of Health. The Department intends to centralize MAGI eligibility determinations for Medicaid, CHIP, and APTCs/CSRs while preserving local presence for in-person application assistance.

The Department is establishing a centralized customer service center comprised of state staff and vendor (MAXIMUS) staff to:

- *Operate a Customer Service Contact Center expanding on the New York Health Options Call Center to provide information on all IAPs, non-MAGI Medicaid, direct purchase of Qualified Health Plans (QHP), and for the Small Business Health Options Program (SHOP).*
- *Provide customer service assistance to applicants/enrollees who apply/renew online for IAPs, QHP purchase, and SHOP. The services will include assistance completing the application online through click to chat and co-browsing as well as following up on missing information if the eligibility determination cannot be completed online due to a failure to verify an eligibility component (e.g., citizenship).*
- *Link missing information and verification documentation to applications/renewals in the online eligibility system.*
- *Accept applications/renewals by telephone and process them in the new eligibility system*
- *Receive and scan paper applications/renewals in a manner that allows them to be processed in the automated eligibility system*
- *Accept complaints from consumers and resolve those that can be resolved by customer service representatives and refer others to regulatory agencies for follow up (e.g., DOH, Department of Financial Services (DFS)).*
- *Participate in consumer appeals adjudicated by state staff.*
- *Provide appropriate language access for those seeking to apply for/renew coverage.*

The populations that are eligible under new MAGI rules will be phased into the Exchange eligibility system:

- *October 2013: Open enrollment for Qualified Health Plans including direct purchase and purchase with tax credits/cost-sharing reductions. MAGI rules only apply to individuals eligible for tax credits and cost-sharing reductions. Medicaid and CHIP eligibility are based on current rules.*
- *January 2014: MAGI rules apply to new applications for Medicaid and CHIP*
- *April 2014: MAGI rules apply to renewals for Medicaid and CHIP. Existing Medicaid and CHIP enrollees will be transitioned to MAGI over a twelve-month period.*

The Customer Service Contact Center will have two sites at open enrollment in October 2013 and may expand to other sites over time. The sites will be in Albany and New York City. The New York City site will allow the State to take advantage of the rich diversity of the population to better provide language access and culturally appropriate customer service. Both sites will employ both State staff and MAXIMUS staff.

In addition, the Human Resources Administration plans to play a role in renewals for the Medicaid MAGI population that resides in New York City. As the Medicaid rules transition from the current rules to the MAGI eligibility rules on April 1, 2014, all renewals will be treated similarly to new MAGI applications (in that new rules apply and different information is needed regarding factors of eligibility such as household composition and income), and will be processed in the new eligibility system. Other counties may also assist with the transition of current Medicaid enrollment on WMS to MAGI enrollment on the Exchange eligibility system to the extent additional resources are needed.

Counties that no longer directly enroll or renew the MAGI Medicaid population will continue to have two important roles with respect to MAGI. Some counties will provide in-person assistance to individuals seeking financial assistance through an IAP. These counties will no longer be permitted to provide assistance only to Medicaid applicants, but must assist applicants for all IAP programs. They will be able to enter the information into the new online application and the eligibility will be processed in the centralized customer service center. Counties may want to install computers in local district waiting areas for applicants to enroll online with assistance from local district workers.

Counties will continue to provide assistance to applicants for cash assistance (TANF) and food assistance (SNAP). TANF enrollees are defined as non-MAGI, but many will become MAGI if they lose eligibility for TANF. Counties will need to assist those who lose TANF eligibility or are denied TANF in applying for Medicaid under MAGI rules.

Counties that retain eligibility determination functions for the MAGI population will be required to meet performance standards. The performance standards will be included in the State Plan and subject to further federal guidance. The recently issued federal Medicaid regulations include a number of provisions regarding timeliness and performance standards. At a minimum, the county is expected to adhere to federal timelines for eligibility determinations. Entities delegated by the State to determine eligibility will be required to have contracts and adhere to performance standards on timeliness, accountability, and high quality consumer experience. Plans of correction will be required for patterns of incorrect, inconsistent or delayed determinations.

The most important factor in the State's ability to assume Medicaid administrative functions by 2018 is the development of a modernized eligibility system that automates the verification and determination of eligibility.

Progress on the New Medicaid Eligibility System

The most important factor in the State's ability to assume Medicaid administrative functions by 2018 is the development of a modernized eligibility system that automates the verification and determination of eligibility. Today, eligibility determinations are largely a manual process with applications and supporting documents submitted by paper. The only way to achieve greater efficiency and reduce administrative costs is to significantly reduce paper applications/renewals and automate as much of the eligibility determination process as possible. The State assumption of Medicaid eligibility functions will proceed in parallel with the ability to automate eligibility determinations.

In June 2012, the Department entered into a contract with Computer Sciences Corporation to design and develop the Information Technology Systems for the Exchange, one of which includes the eligibility system. The other components of the IT solution include SHOP, the financial accounting system, customer service, and the ability to provide health plan comparisons on the Exchange.

The eligibility system component includes an online application portal for those applying for financial assistance and for those who seek to purchase a Qualified Health Plan without financial assistance. Financial assistance includes providing access to IAPs including Medicaid, CHIP, Advance Premium Tax Credits, and Cost-Sharing Reductions for those whose eligibility can be determined based on Modified Adjusted Gross Income (MAGI) including children, pregnant women, parents/caretakers, and non-elderly adults. Once the eligibility system is completed for the MAGI population, the remainder of the Medicaid

population will be included in the new system, thereby replacing the Welfare Management System for the Medicaid population. In a third phase, the human services programs (e.g., SNAP, TANF) will be integrated into the new system.

The Eligibility and Enrollment System for the MAGI population (Phase 1 of the total Eligibility System Replacement) is scheduled to be delivered in two releases with five builds. The builds are described below:

Build 1: Eligibility and enrollment for purchasers of Qualified Health Plans without financial assistance. The functionality included in this build is contact information, household composition (demographic information on family members, legal/insurable relationships), social security number verification, citizenship verification, residency, incarceration verification, immigration verification, eligibility determination of ability to purchase, plan selection, and plan enrollment.

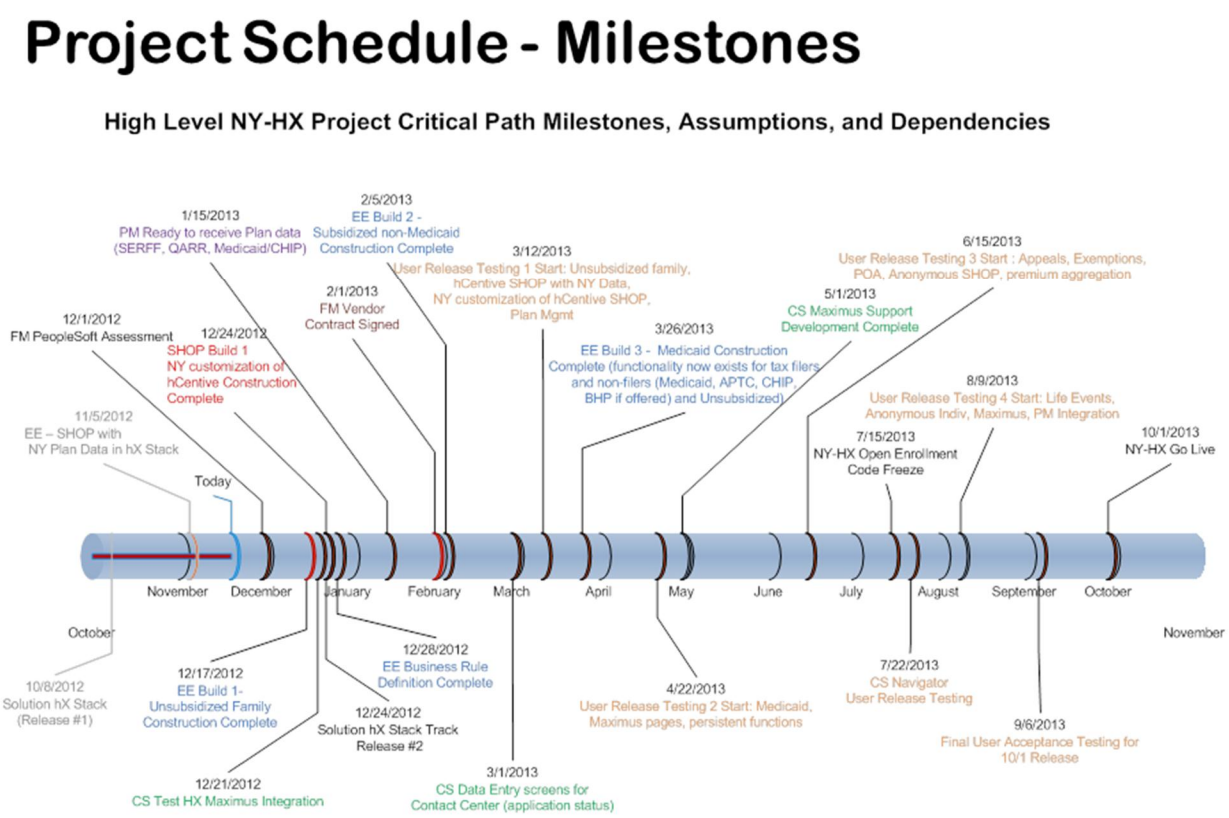
Build 2: Eligibility and enrollment for tax filers seeking financial assistance through plan enrollment for APTC and CHIP eligibles. This build includes all the functionality in Build 1 and adds: account creation, identity proofing, household composition (tax filer household), MAGI income construction, MEC/ESI reporting and verification for public MEC, SHOP, and NYSHIP, tax filer eligibility determination for Medicaid, CHIP, APTC/Cost-sharing Reductions, QHP selection and enrollment for APTC eligibles, CHIP plan selection and enrollment for CHIP eligibles, and junctures for notices.

Build 3: Eligibility and enrollment for non-tax filers and completion of Medicaid and CHIP-specific eligibility factors. The additional functionality in this build includes: income construction for non-tax filers, household composition for non-tax filers, eligibility determination for non-tax filers (Medicaid/CHIP only), Medicaid eligibility determination for incarcerated persons for immediate suspension, Medicaid eligibility for immigrants, Medicaid third party health insurance, CHIP specific immigration rules, CHIP state-employee rules and crowd out, Medicaid plan selection and enrollment, and additional junctures for appropriate notices.

Build 4: Renewals, updates, notices, appeals, and mandate exemptions. This build includes functionality for administrative renewals, processing changes in circumstances (e.g, income, household composition), production of notices, filing and tracking appeals, report generation, and consumer exemption from the coverage mandate.

Build 5: Completion of all eligibility and enrollment functionality including: anonymous shopping, help functions, glossary of terms, website user functionality, options for consumers to change the look of the online application (e.g., font size), keyword search, designation of authorized representatives, persistent features, click to chat with a customer service representative, and displaying news about the Exchange.

The eligibility system will also be able to process applications received by mail and by phone using efficient customer service interfaces. The project schedule below shows the components of the Exchange IT solution, including eligibility and enrollment.



Those wanting more information about the Exchange IT solution for Eligibility and Enrollment or any of the other tracks can review the Exchange Blueprint document at: http://www.healthbenefitexchange.ny.gov/news/state-submits-blueprint-application-hhs

FUNCTIONS REMAINING WITH COUNTIES AFTER 2014

The implementation of the Affordable Care Act and the MRT initiatives, along with the transition of functions from counties to the State represents significant change to Medicaid enrollees. The significance and speed of change requires a close partnership between the State and counties to ensure a smooth transition. Eligibility workers at the local level will be critical partners in reducing confusion and assisting enrollees in retaining coverage. In addition to assisting the State implement these changes with the least disruption to coverage and services, counties will retain responsibility for many functions until the State has developed more automated processes to support assuming the functions on a large scale, or for a longer period of time if the county chooses to contract with the State to continue to administer them. The functions that will remain with the counties for a period of time post-2014 include:

- *Providing in-person application assistance to MAGI applicants/enrollees, for counties that choose to retain this function;*
- *Assisting those who are denied TANF apply for Medicaid and conduct separate determinations for non-MAGI applicants;*
- *Administering spend down for the pay-in population;*
- *Processing applications and renewals for individuals who are aged, blind, or disabled;*
- *Conducting chronic care (nursing home) and alternate-levels-of-care eligibility determinations and renewals;*

- *Processing applications and renewals for the Medicaid buy-in for Working Persons with Disabilities program;*
- *Collecting documentation for disability determinations;*
- *Handling eligibility for SSI cases, including separate determinations when an individual loses receipt of SSI;*
- *Assisting individuals obtain health care in emergency situations;*
- *Provide legal assistance with recoveries.*

STATEMENT OF INTEREST RESULTS

Section 6 of Part F of Chapter 56 of the laws of 2012 required the Department to send a Statement of Interest (SOI) to counties to elicit their interest and capacity to contract with the Department to perform certain Medicaid administrative functions.

To fulfill this requirement, the Department sent a cover letter and survey to the chief elected official in each county in July 2012 (see Appendix C). The survey document included an overview of the purpose of the survey, and described the Department's authority to assume administrative responsibility using state staff, contracted entities, and contracts with counties. The survey also recognized the changes in Medicaid eligibility rules as a result of the ACA and the need for the State to build the capacity to manage eligibility determinations under the new rules. The Department also acknowledged a need to create the infrastructure to assume responsibility for each function before initiating the transition.

The survey results were intended to inform the development of a timeline for the transition of specific functions from counties to the state, and county interest in exploring individual or regional contract arrangements. For specific functions, counties were asked to indicate whether they did not want to retain responsibility (i.e., they wanted the State to assume responsibility as soon as the State has the capacity to do so), or whether they were willing to retain responsibility for the short or long-term (beyond 2018). The survey indicated that expressing an interest in retaining responsibility for the long-term suggested that the county would be interested in contracting with the Department to continue to perform the function.

Survey Results

Formal survey responses were received from 56 of 58 counties. Responses to the surveys were analyzed to inform the process and projected timing for the state assumption of specific functions, and the potential for individual or regional contract arrangements. Follow-up phone calls were conducted with counties to clarify specific responses. Two counties declined to respond to the survey. As stated in the survey cover letter, the Department assumed that counties that did not respond to the survey wanted the State to assume responsibility for all of their Medicaid administrative functions. Responses were considered non-binding.

The survey asked counties to respond with their interest in retaining responsibility for the following specific functions:

- *Conducting MAGI renewals until the State can fully centralize*
- *Providing in-person application assistance to MAGI applicants/enrollees*
- *Processing applications and renewals for individuals who are aged, blind, or disabled*
- *Conducting chronic care (nursing home) and alternate-levels-of-care eligibility determinations and renewals*
- *Processing applications and renewals for the Medicaid Buy-in for Working Persons with Disabilities program*
- *Conducting disability determinations*
- *Handling eligibility for SSI cases, including separate determinations when an individual loses receipt of SSI*

Counties were also offered the opportunity to provide information regarding their preferences for Medicaid administrative functions that were not specifically identified in the survey.

Responses are summarized in the table below.

Table 1: Responses to County Statement of Interest Survey

Tasks related to the MAGI Population	***MAGI renewals***	**Yes: 38 (66%)**	**-**	**No: 20 (34%)**
	In-Person Application Assistance	Yes: 48 (83%)	-	No: 10 (17%)
Tasks related to the Non-MAGI Population	*Apps and Renewals: Aged, Blind, Disabled*	LT: 34 (59%)	ST: 14 (24%)	No: 10 (17%)
	Apps and Renewals: Chronic Care	LT: 40 (69%)	ST: 10 (17%)	No: 8 (14%)
	Apps and Renewals: Medicaid Buy-In Program	LT: 27 (46.5%)	ST: 16 (27.5%)	No: 15 (26%)
	Disability Determinations	LT: 14 (24%)	ST: 4 (7%)	No: 40 (69%)
	SSI Cases	LT: 30 (52%)	ST: 13 (22%)	No: 15 (26%)

(Short term = ST, Long-Term = LT)

Discussion

In general, most counties are willing to retain responsibility for administering the Medicaid program until the State can build the capacity to handle the work. Nine counties expressed an interest in having the State assume responsibility for most, if not all, of the listed functions as soon as possible. Several counties included comments in their responses conveying the need for more detailed information before actual commitments could be made.

The survey responses and follow-up conversations with several county Commissioners and staff indicated variation in the interpretation of some of the questions. For example, some counties expressed an interest in continuing to conduct disability determinations, even though the State has already assumed responsibility for that work. Calls were made to counties to clarify responses as needed. In the case of disability determinations, no county intended for the State to return that function to the local district. Some Commissioners reported that they did not intend for a response of "willing to continue the function long-term" to be an indication of an interest in contracting with the State, but rather an indication that they wanted to be one of the last counties to transition that responsibility to the State.

Several counties indicated their willingness to continue to provide certain functions was contingent on adequate funding and indemnification from liability. One county expressed an interest in contracting with the State as a Regional Center to support the Health Benefit Exchange. Survey responses and follow-up conversations with Commissioners made it clear that counties are concerned about their most vulnerable populations and want to ensure that proper support is provided to these clients if and when responsibility for these clients is transitioned from the LDSS to the State.

The survey results reinforce the need for continued communication between the counties and the Department on the timeline for the transition of Medicaid administrative functions. In general, counties requested that the transition of functions to the State be clearly defined, communicated to counties in a timely manner, and respectful of staff and clients. Counties were reluctant to respond about their willingness to contract with the State without additional details. Furthermore, county responses may change in the coming years. At this time, however, the Department plans to use the survey results to identify counties that have an interest in transitioning specific functions earlier in the transition timeline. The survey results also help to identify counties with whom the Department may want to dialogue about establishing a contract.

POST-ACA IMPLEMENTATION: NON-MAGI ADMINISTRATION FUNCTIONS

The State will begin work to build the non-MAGI eligibility rules into the new eligibility and enrollment system once the eligibility determinations for the MAGI population have been fully automated and transitioned from WMS to the new system. At the same time, the State will work with counties to determine the appropriate phase-in of the non-MAGI population to the State and to develop contracts with those counties that wish to retain responsibility for the eligibility determinations for certain non-MAGI populations for the long-term. Counties have indicated that any contract must indemnify them from damages if they are complying with state and federal rules.

The non-MAGI population includes a wide array of eligibility pathways and is the most difficult to automate. The variety of eligibility pathways requires the automation to be phased. Through the work to automate eligibility determinations for the MAGI populations, the Department has identified some early candidates for phasing in the non-MAGI populations. These include the ability to automate the transfer of TANF application information to the new system after a TANF denial or the loss of eligibility for TANF, the ability to automate the eligibility for mixed MAGI/non-MAGI households, and those eligible on the basis of foster care who age out and will have expanded eligibility up to age 26 for Medicaid regardless of income. In addition, automating the eligibility for the Medicare Savings Program has always been a high priority among the non-MAGI populations. The Department will work closely with the stakeholder groups, especially the local departments of social services, to prioritize the phase-in of the automation of the non-MAGI populations.

FINANCING MEDICAID ADMINISTRATION

Part F of Chapter 56 of the Laws of 2012 established a cap on county Medicaid administrative costs at 2011 levels. The savings from the cap were used to fund the State staff to assume Medicaid functions and $5 million was directed to the State Financial Plan. The October 2012 Global Cap update indicates that year to date spending on administrative services is $35 million lower than initially forecast, though spending is likely to increase once reimbursements for the full year are completed.

NEED FOR ADDITIONAL LEGISLATION

Part F of Chapter 56 of the Laws of 2012 provided adequate flexibility in hiring and contracting for the Department to implement the assumption of Medicaid administration. The barriers to more rapid implementation of Medicaid administrative functions included the delay in completing the contract with Computer Sciences Corporation for the modernized eligibility system, delays in WMS system changes to accommodate certain initiatives due to other priorities and Hurricane Sandy, and the cumbersome personnel process for hiring new staff even with enhanced flexibility to hire existing county staff.

At this time, the Department does not require additional legislation to continue to assume Medicaid administrative functions beyond the hiring and contracting flexibility granted in 2012. The priority legislative changes for 2013 include enacting ACA conforming legislation to recognize the MAGI eligibility groups and rules.

State Medicaid Administration Timeline

2012

June 2012

- ✓ Executed CSC Contract
- ✓ Executed MAXIMUS Contract Amendment
- ✓ Expanded administrative renewals to MSP population

July 2012

- ✓ Statement of Interest Sent to Counties
- ✓ Executed MAXIMUS Contract Amendment
- ✓ Expanded administrative renewals to MSP population

August 2012

- ✓ Began Mandatory MLTC Enrollment in NYC

September 2012

- ✓ Added Six Counties to Enrollment Center renewal processing
- ✓ Inmate Solicitation of Interest Sent to Counties

November 2012

- ✓ Released procurement for Transportation Management in 24 counties in Finger Lakes and Northern NY

December 2012

- ✓ Added Seven Counties to Enrollment Center renewal processing
- ✓ Began Processing FPBP applications
- ✓ Added One County to the State Disability Review Team Disability Reviews
- ✓ Submitted Annual State Administration Report to Governor and Legislature
- ✓ Received Conditional Certification from HHS to Operate State Exchange.

State Medicaid Administration Timeline

2013

January 2013

- ✓ Transportation Management fully implemented in NYC
- ✓ Centralize resolution of reported deaths in selected counties
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Contract with Selected Counties for Inmate Eligibility Determination
- ✓ Mandatory MLTC Enrollment in Nassau, Suffolk, and Westchester Counties
- ✓ Add counties to centralized recovery

February 2013

- ✓ Automate inpatient claiming for inmates through eMedNY
- ✓ Add Two Counties to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

March 2013

- ✓ Add Additional Counties to Enrollment Center renewal processing
- ✓ Add Two Counties to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

April 2013

- ✓ Process FHP-PAP for New York City
- ✓ Add counties to centralized recovery

May 2013

- ✓ Execute contract for Asset Verification System
- ✓ Complete First Release of New Eligibility System
- ✓ Complete training material on MAGI application and eligibility processing
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

June 2013

- ✓ Mandatory MLTC Enrollment in Rockland and Orange Counties
- ✓ Add counties to centralized recovery

State Medicaid Administration Timeline

2013 (continued)

July 2013

- ✓ Begin Training of eligibility workers
- ✓ Receive pre-open enrollment certification from HHS
- ✓ Automate Spend Down
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Automate renewals in NYC for aged, blind and disabled and MSP populations with SSA income.
- ✓ Add counties to centralized recovery

August 2013

- ✓ Conduct Regional meetings for LDSS/NYC on new rules, new system
- ✓ Train LDSS, Navigators, Application Assistors on Eligibility Processing in new system with MAGI rules
- ✓ Complete Second Release of New Eligibility System
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

September 2013

- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

October 2013

- ✓ Start of open enrollment in New York's Health Insurance Exchange
- ✓ Release procurement for Transportation Management in Western NY and Long Island
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Auto-renew Aged, Blind, Disabled and MSP with pension income
- ✓ Add counties to centralized recovery

December 2013

- ✓ Mandatory MLTC Enrollment in four additional counties
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Process MSP applications for NYC
- ✓ Add counties to centralized recovery
- ✓ Submit Annual State Administration Report to Governor and Legislature

State Medicaid Administration Timeline

2014

January 2014

- ✓ MAGI eligibility rules effective for new Medicaid applicants

April 2014

- ✓ Transition existing MAGI Medicaid enrollees to Exchange System

June 2014

- ✓ Reassess county interest in contracting with the State for Medicaid administrative functions

September 2014

- ✓ Develop Plan for Automating Non-MAGI eligibility determinations
- ✓ Draft contract template for local districts for long-term administration of certain Medicaid functions

December 2014

- ✓ Define requirements for Phase 1 of transitioning non-MAGI eligibility determinations to the Exchange System
- ✓ Submit Annual State Administration Report to Governor and Legislature

State Medicaid Administration Timeline

2015

- ✓ Complete phase 1 of transitioning non-MAGI eligibility determinations to the Exchange System.
- ✓ Execute contracts with local districts for long-term administration of certain Medicaid functions.
- ✓ Define requirements for remaining non-MAGI automation.
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2016

- ✓ Complete transitioning non-MAGI eligibility determinations to the Exchange System.
- ✓ Develop requirements for integrating other human service programs into the Exchange System.
- ✓ Submit Annual State Administration Report to Governor and Legislature.

APPENDICES

Legislation (Appendix A)

Solicitation of Interest for Inmates (Appendix B)

Statement of Interest (Appendix C)

MRT Work Plan (Appendix D)

PART F

Section 1. Section 1 of part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, is amended by adding a new subdivision (c-1) to read as follows:

(c-1) Notwithstanding any provisions of subdivision (c) of this section to the contrary, effective April 1, 2013, for the period January 1, 2013 through December 31, 2013 and for each calendar year thereafter, the medical assistance expenditure amount for the social services district for such period shall be equal to the previous calendar year's medical assistance expenditure amount, except that:

(1) for the period January 1, 2013 through December 31, 2013, the previous calendar year medical assistance expenditure amount will be increased by 2%;

(2) for the period January 1, 2014 through December 31, 2014, the previous calendar year medical assistance expenditure amount will be increased by 1%.

§ 2. Paragraph (iii) of subdivision (g) of section 1 of part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, as amended by section 59 of part A of chapter 57 of the laws of 2006, is amended to read as follows:

(iii) During each state fiscal year subject to the provisions of this section **and prior to state fiscal year 2015-16**, the commissioner shall maintain an accounting, for each social services district, of the net amounts that would have been expended by, or on behalf of, such district had the social services district medical assistance shares provisions in

effect on January 1, 2005 been applied to such district. For purposes of this paragraph, fifty percent of the payments made by New York State to the secretary of the federal department of health and human services pursuant to section 1935(c) of the social security act shall be deemed to be payments made on behalf of social services districts; such fifty percent share shall be apportioned to each district in the same ratio as the number of "full-benefit dual eligible individuals," as that term is defined in section 1935(c)(6) of such act, for whom such district has fiscal responsibility pursuant to section 365 of the social services law, relates to the total of such individuals for whom districts have fiscal responsibility. As soon as practicable after the conclusion of each such fiscal year, but in no event later than six months after the conclusion of each such fiscal year, the commissioner shall reconcile such net amounts with such fiscal year's social services district expenditure cap amount. Such reconciliation shall be based on actual expenditures made by or on behalf of social services districts, and revenues received by social services districts, during such fiscal year and shall be made without regard to expenditures made, and revenues received, outside such fiscal year that are related to services provided during, or prior to, such fiscal year. The commissioner shall pay to each social services district the amount, if any, by which such district's expenditure cap amount exceeds such net amount.

§ 3. Paragraph (i) of subdivision (b) of section 2 of part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, is amended and a new paragraph (iii) is added to read as follows:

(i) A social services district shall exercise the option described in this section through the adoption of a resolution by its local legisla-

tive body, in the form set forth in subparagraph (ii) of this paragraph, to elect the medical assistance reimbursement methodology set forth in paragraph (a) of this section and to elect the tax intercept methodology set forth in subdivision (f) of section 1261 of the tax law or subdivi-

sion (g) of section 1261 and subdivision (h) of section 1313 of the tax law, as applicable. A social services district, acting through its local legislative body, is hereby authorized to adopt such a resolution. Such a resolution shall be effective only if it is adopted exactly as set forth in subparagraph (ii) of this paragraph no later than September 30, 2007, and a certified copy of such resolution is mailed to the commissioner of health by certified mail by such date. The commissioner of health shall, no later than October 31, 2007, certify to the commissioner of taxation and finance a list of those social services districts which have elected the option described in this section. A social services district [~~**shall have no authority to rescind the exercise of**~~] **that elected** the option described in this section**, acting through its local legislative body, may repeal that election by adopting a resolution exactly as set forth in paragraph (iii) of this subdivision and mailing a certified copy of such repeal resolution to the commissioner of health no later than January 1, 2013. The commissioner of health shall, within two weeks of receiving any such copy of a certified repeal resolution by certified mail from a social services district, certify in writing to the commissioner of taxation and finance the name of any such social services district that adopted such a resolution to repeal its election. Upon receiving such written certification, the commissioner of taxation and finance shall no longer calculate the Medicaid amount of such county under subdivision (f) of section 1261 of the tax law, and**

the amount due such county under subdivision (c) of such section 1261 shall no longer be reduced by such Medicaid amount, effective the first day of the month next commencing at least 10 days after the commissioner of taxation and finance has received such written certification. If every social service district that elected such option repeals its election and the commissioner of health certifies in writing to the commissioner of taxation and finance that every such social services district has repealed its election, then subdivisions (f) and (g) of section 1261 and subdivision (h) of section 1313 of the tax law tax shall be repealed and the phrase "or a tax revenue intercept amount calculated pursuant to subdivision (f) or (g) of section 1261 of the tax law" in section four of this act shall be deleted, effective the first day of the month next commencing at least 10 days after the date on which the commissioner of taxation and finance receives such written certification from the commissioner of health. At the same time that the commissioner of health makes such certification to the commissioner of taxation and finance that every county has repealed its election, the commissioner of health shall also notify the legislative bill drafting commission that every social service district that elected such option has repealed its election in order that the legislative bill drafting commission may maintain an accurate and timely data base of the official text of the laws of the state of New York in furtherance of effecting the provisions of section 44 of the legislative law and section 70-b of the public officers law.

(iii) Form of resolution.

Be it enacted by the (county) of (insert county's name) as follows:

Section one. The (county) of (insert county's name) hereby repeals its election in 2007 of the medical assistance reimbursement option and revenue intercept for Medicaid purposes described in section 2 of chapter 58 of the laws of 2005.

Section 2. This resolution shall take effect immediately.

§ 4. Part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts

for medical assistance for needy persons and the administration thereof, is amended by adding a new section 4-a to read as follows:

§ 4-a. (a) For state fiscal year 2012-13, and for each state fiscal year thereafter, a social services district will be reimbursed by the state for the full non-federal share of expenditures by the district for the administration of the medical assistance program, not to exceed the administrative cap amount determined in accordance with subdivision (b) of this section. Any portion of the non-federal share of such expenditures in excess of the administrative cap amount shall be the responsibility of the social services district and shall be in addition to the medical assistance expenditure amount calculated in accordance with subdivisions (b), (c), (c-1), and (d) of section one of this act. Beginning in state fiscal year 2013-14, no reimbursement will be made for administrative expenditures in excess of such cap.

(b) The administrative cap amount for a social services district shall be equal to a percentage of the amount included in the state fiscal year 2011-12 enacted budget for the non-federal share of medical assistance administrative costs pursuant to this section. Each social services district's percentage shall be equal to the percentage of medical assistance administrative costs claimed by such district in the 2011 calendar year in relation to all other social services districts.

(c) Notwithstanding the provisions of subdivision (b) of this section, the commissioner of health may, at his or her sole discretion, reduce a social services district's administrative cap amount to account for a reduction in the scope or volume of the district's administrative responsibilities, including but not limited to such a reduction result-

ing from the process of converting the medical assistance program to a department-administered program pursuant to section 365-n of the social services law.

(d) If, for state fiscal year 2012-13 and for any state fiscal year thereafter, the aggregate amount of administrative costs claimed or projected to be claimed by all social services districts is less than the non-federal financial plan appropriation for the administration of the medical assistance program for that fiscal year, the difference between such aggregate amount of claims or projected claims and such appropriation shall be used for reimbursement to those districts determined by the commissioner, with the approval of the director of the budget, to have claims or projected claims for reasonable administrative costs which exceed or are projected to exceed the administrative cap amount as established pursuant to subdivision (b) of this section. Such reimbursement shall be accomplished by allocating proportionally among such districts the aggregate amount of such excess.

§ 5. Section 91 of part H of chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates is amended to read as follows:

§ 91. **1.** Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds Medicaid spending shall not exceed the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years.

2. Except as provided in subdivision three of this section, for state fiscal year 2013-14 and for each fiscal year thereafter, the spending limit calculated pursuant to subdivision one of this section shall be increased by an amount equal to the difference between the total social

services district medical assistance expenditure amounts calculated for such period in conformance with subdivisions (b), (c), (c-1), and (d) of section 1 of part C of chapter 58 of the laws of 2005 and the total social services district medical expenditure amounts that would have resulted if the provisions of subdivision (c-1) of such section had not been applied.

3. With respect to a social services district that rescinds the exercise of the option provided in paragraph (i) of subdivision (b) of section 2 of part C of chapter 58 of the laws of 2005, for state fiscal year 2013-14 and for each fiscal year thereafter, the spending limit calculated pursuant to subdivision one of this section shall be reduced by the amount of the medical assistance expenditure amount calculated for such district for such period.

§ 6. The social services law is amended by adding a new section 365-n to read as follows:

§ 365-n. Department of health assumption of program administration.

1. Notwithstanding the provisions of title two of article three of this chapter or of section three hundred sixty-five of this title or of any other law to the contrary, the commissioner of health (commissioner) is authorized to take actions explicitly authorized by this section that are necessary to transfer responsibility for the administration of the medical assistance program from local social services districts to the department of health (department) by March thirty-first, two thousand eighteen.

2. For purposes of this section, the administration of the medical assistance program includes: processing applications for benefits and services available under this title and title eleven-D of this article; making determinations of initial and ongoing eligibility for such benefits and services; making coverage determinations with respect to bene-

fits and services requiring prior authorization; notifying applicants and recipients of these determinations and of their rights and responsibilities, authorizing benefits and services for persons found eligible; exercising subrogation rights with respect to amounts received from insurance carriers or other liable third parties; imposing liens and pursuing recoveries; and any other such tasks and functions identified by the commissioner.

3. Notwithstanding sections sixty-one, sixty-three, seventy, seventy-eight, seventy-nine, eighty-one and eight-one-a of the civil service law or any provisions to the contrary contained in any general, special, or local laws, all lawful appointees of a county performing the functions established in subdivision two of this section as of the effective date of this section will be eligible for voluntary transfer to appropriate positions, in the department, that are classified to perform such functions without further examination, qualification, or probationary period; and, upon such transfer, will have all the rights and privileges of the jurisdictional classification to which such positions are allocated in the classified service of the state.

4. Within one hundred twenty days of the effective date of this section, the department shall develop and implement a local department of social services statement of interest. The statement of interest will elicit from local departments of social services their interest in and capacity to contract with the department to perform the functions established in subdivision two of this section. To the extent practicable and in the best interest of the medical assistance program, the department shall contract with local social services districts to perform all or a portion of the functions described in subdivision two of this section.

In no event, however, shall the department, by means of such a contract,

delegate its authority to exercise administrative discretion in the administration or supervision of the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or to issue policies, rules, and regulations on program matters nor may any contracted entity be given the authority to change or disapprove any administrative decision of the department, or otherwise substitute such entity's judgment for that of the department with respect to the application of policies, rules, and regulations issued by the department. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, the commissioner is authorized to enter into a contract with local departments of social services without a competitive bid or request for proposal process.

5. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, the commissioner is authorized to amend the terms of contracts awarded prior to the effective date of this section, including a contract entered into pursuant to subdivision twenty-four of section two hundred six of the public health law, as added by section thirty-nine of part C of chapter fifty-eight of the laws of two thousand eight, without a competitive bid or request for proposal process, upon a determination that the existing contractor is qualified to provide assistance with one or more functions established in subdivision two of this section. Such amendments shall be limited to implementation of: (i) automation enhancements, including but not limited to, the Medicare savings program and the family planning benefit program; (ii) processes for verification of third party insurance and

processing enrollment in medical assistance with third party health insurance; (iii) procedures that will increase efficiencies at enrollment centers; (iv) an asset verification system; and (v) processes to comply with federal law, including, but not limited to, the use of modified adjusted gross income in eligibility determinations.

6. The commissioner shall submit an annual report to the governor, temporary president of the senate, speaker of the assembly, the chair of the senate health committee and the chair of the assembly health committee by December thirty-first, beginning in two thousand twelve and for each year thereafter until the year following full implementation. The initial report shall consist of modifications to the plan developed pursuant to section forty-seven-b of part B of chapter fifty-eight of the laws of two thousand ten, and shall include anticipated implementation of the revised plan, its elements, a timeline for such implementation, recommendations for legislative action, and such other matters as may be pertinent.

The report shall include a plan and timeline for the state to: (i) assume specific functions related to the administration of the medical assistance program; (ii) coordinate the implementation of provisions of federal law with the assumption of the administration of the medical assistance program; and (iii) address the financing of the medical assistance program administration and any associated administrative cost relief to local social services districts. The report shall also indicate any function that the state intends to enter into a contract with a public and/or private entity to perform, and the date in which the state anticipates entering into any such contract. In addi-

tion, reports shall, at a minimum, indicate: (i) any progress the department has made regarding its proposed timeline, including a summary

of all functions assumed by the state during the previous year; (ii) any anticipated and/or actual delay from the proposed timeline; (iii) the reason for any such delay; and (iv) actions the department has undertaken to mitigate any such delay.

7. The commissioner shall promulgate such regulations that are necessary to carry out the provisions of this section. In addition, the commissioner shall make any amendments to the state plan for medical assistance, or develop and submit an application for any waiver or approval under the federal social security act, that are necessary and required to carry out the provisions of this section.

§ 7. Subdivision 7 of section 369 of the social services law, as added by section 71-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

7. Notwithstanding any provision of law to the contrary, the department [~~may commence~~] **shall, when it determines necessary program features are in place, assume sole responsibility for commencing** actions or proceedings in accordance with the provisions of this section, sections one hundred one, one hundred four, one hundred four-b, paragraph (a) of subdivision three of section three hundred sixty-six, subparagraph one of paragraph (h) of subdivision four of section three hundred sixty-six, and paragraph (b) of subdivision two of section three hundred sixty-seven-a of this chapter, to recover the cost of medical assistance furnished pursuant to this title and title eleven-D of this article. The department is authorized to contract with an entity that shall conduct activities on behalf of the department pursuant to this subdivision. **Prior to assuming such responsibility from a social services district, the department of health shall, in consultation with the district, define the scope of the services the district will be required to perform on behalf of the department of health pursuant to this subdivision.**

§ 8. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

§ 9. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

§ 10. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 11. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2012, provided that:

1. section one of this act shall take effect April 1, 2013;

2. any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

3. this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act;

4. the commissioner of health and the superintendent of financial services and any appropriate council may take any steps necessary to implement this act prior to its effective date;

5. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of financial services and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

6. the amendment to section 91 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, made by section five of this act shall take effect on the same date and in the same manner as such section takes effect;

7. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act;

8. subdivision 5 of section 365-n of the social services law, as added by section six of this act shall expire and be deemed repealed March 31, 2015.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

August 24, 2012

Dear Chief Elected Official:

I am writing to solicit your County's interest in contracting with the State to process Medicaid eligibility determinations for individuals incarcerated in a New York State or local correctional facility. Currently, Medicaid coverage is suspended only for individuals who have coverage immediately prior to incarceration. Suspended coverage allows Medicaid payment of any inpatient hospital services provided off the grounds of a correctional facility and for reinstated benefits immediately following release. To improve access to Medicaid for inpatient hospital stays and benefits upon release, this initiative will expand Medicaid suspended coverage to individuals determined to be Medicaid eligible incarcerated individuals.

Under this initiative, enrollment will be centralized with one or more county. Participating counties will receive completed Medicaid applications, review and make eligibility determinations, authorize a Medicaid case for eligible individuals, send notices of decision and notify the State on the disposition of applications. This initiative will involve the processing of Medicaid applications for individuals that may not be residents of your county. The county of fiscal responsibility immediately prior to incarceration will remain responsible for any inpatient hospital claims paid while an individual is incarcerated and for reinstated Medicaid benefits provided upon release.

Section 6 of Part F of chapter 56 of the laws of 2012 authorizes the State to contract with localities to perform certain administrative functions, including initial and ongoing coverage determinations, during the transition to a full State assumption of administrative functions by March 31, 2018. The legislation further authorizes a streamlined contracting process with local social service districts.

Responses to this solicitation should be returned to the Department no later than September 21, 2012. The results received from this solicitation will be used by the State for planning purposes. A response is not binding on either the County or the Department. **Any county that does not respond will be assumed to be not interested in participating and will not be contacted further regarding this initiative.**

The attached document contains additional background information on this initiative as well as instructions for signifying county interest in participating. Questions about the initiative or responding to this solicitation can be directed to Kim Ciraulo at 518-474-8887 or kmc15@health.state.ny.us.

Thank you for your cooperation.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Attachment

cc: Local Social Service Commissioner
Stephen Acquario, New York State Association of Counties
Sheila Harrigan, New York Public Welfare Association

Centralized Medicaid Enrollment for State Inmates
Solicitation of Interest

Background

It is estimated that only 8,000 ï or 14 percent ï of the Stateôs 56,000 prison inmates have access to Medicaid coverage, although most inmates may be eligible for program benefits. To significantly improve this rate will take a concerted effort of the State and local governments to encourage eligible inmates to apply for Medicaid benefits, to review and validate eligibility and enroll them into the program. This will offset the State and local costs of providing health care coverage of inpatient hospital services provided outside of the local jail/State prison and have a longer term benefit of reducing recidivism rates by connecting inmates with health care coverage upon release.

The percentage of State inmates enrolled in Medicaid has increased marginally over time due to the automated Medicaid suspension and reinstatement program. Local jails currently do not provide any information on the Medicaid status of their inmates to DCJS.

Changes in the 2012-13 Budget, will serve to reduce barriers to localities and present a unique opportunity for the State to partner with localities to enroll eligible inmates in the Medicaid suspension program. These changes include the State takeover of administration over five years that will ultimately relieve counties of the administrative burden of enrolling recipients in Medicaid and the three year State takeover of local Medicaid growth (beginning in 2013-14) that will relieve the counties of annual cost increases. Further, most if not all counties are benefiting from the Local Medicaid Cap, enacted in 2005, that limits their fiscal exposure to the growth in Medicaid costs.

Initiative

The State Department of Corrections and Community Supervision (DOCCS) will identify potentially eligible inmates and gather necessary information from inmates to file an Access NY Health Care (Medicaid Only) application. State inmate participation will be voluntary.

DOCCS will make efforts to transmit this information electronically. However, until the functionality is developed, completed paper Medicaid application packets will be submitted by mail.

The State will contract with one or more counties to receive the completed applications from DOCCS and determine Medicaid eligibility. Specifically, the county contractors will be required to:

1. Register the application on the Welfare Management System (WMS);

2. If the individual has active Medicaid and benefits have not yet been suspended, notify the county of origin to place the individualôs Medicaid benefits in suspended status (this should be infrequent due to the current suspension process for active Medicaid recipients);

3. Determine Medicaid eligibility;

4. If Medicaid eligible, authorize the individualôs Medicaid benefits in suspended status and issue eligibility determination notice to inmate at DOCCS facility. If Medicaid ineligible, deny the Medicaid application and issue appropriate eligibility determination notice to inmate at DOCCS facility and

5. Participate in a weekly or monthly report of applications received, processed or rejected and other applicable data on the initiative. In addition, report quarterly to the State, in a format to be determined, on the disposition of each application. If an application is rejected, the county will be asked to provide the reason for rejection.

6. Work with the State to develop an electronic interface to receive applications as either form-based and/or data stream.

Further, the State may also consider taking applications from local jails using this centralized process as a second phase of this initiative. This will be determined based upon the success of the initial phase at enrolling State inmates.

Funding

The State will reimburse participating counties, in accordance with contract terms, for their increased Medicaid administrative costs to determine Medicaid eligibility for State inmates. These local administrative costs will not count against the cap on local Medicaid administration expenses.

Participating counties will be required to process applications within the prescribed federal time frames. Participation in this initiative is in addition to (and not a substitution for) a countyôs regular Medicaid administration workload.

The State may consider offering a performance-based financial incentive to participating counties, based upon responses received from interested counties.

Instructions for Interested Counties

Interested counties should respond in writing indicating their interest in participating in this initiative and responding to the following questions:

1. Explain your current local social service district Medicaid administration operation:
    a. How many Medicaid applications currently processed a month?
    b. How many full time equivalents (FTE) employees review these applications?
    c. How long does it take on average to process one application?
    d. What are your current costs to process one application?
    e. Do you have existing relationships with the State prison system or local jails?

2. Explain how your current operation will change to meet this new Medicaid administrative function?
    a. Create a separate unit or use existing process?
    b. How many staff will be devoted?
    c. Would staff be full time employees, part-time employees or a combination (please explain)?

3. How many additional applications could the local social service district process?

4. What would be the cost of processing the additional applications? Can we assume that the cost would be less since the application would generally be completed?

5. Would you participate in this initiative without a financial incentive (assuming full costs are covered by State)?

6. What types of financial incentives would be most appealing to you?

    a. Per application processing payment
    b. Performance based on timeliness of approval
    c. Performance based on number of approved Medicaid applications
    d. Other (please explain)

The responses from interested counties will be used by the State for planning purposes and to determine contracting options. **A response is non-binding on either the county or the Department.** The Department recognizes it will need to develop and negotiate a contract with the county and that process may result in a change in the interest of the county contracting with the State.

While no assurances are able to be made regarding indemnifying counties, it is expected that language identifying indemnification clauses will be included in any contractual relationship.

Responses to this solicitation of interest are due back to the Department by September 21, 2012.

Completed responses should be returned to:

Kim Ciraulo
Division of Health Reform and Health Insurance Exchange Integration
New York State Department of Health
Office of Health Insurance Programs
Corning Tower OCP 826
Albany, N.Y. 12237
kmc15@health.state.ny.us

Questions about the initiative or responding to this solicitation can be directed to Kim Ciraulo at 518-474-8887 or kmc15@health.state.ny.us.

Any county that does not respond will be assumed to be not interested in participating and will not be contacted further regarding this initiative.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

July 9, 2012

Dear Chief Elected Official:

I am writing to obtain your County's interest in contracting with the State to continue to administer certain Medicaid administrative functions as part of the State assumption of Medicaid administration.

Section 6 of Part F of Chapter 56 of the laws of 2012 authorizes the Department of Health (Department) to transfer responsibility for the administration of the Medicaid program from local social services districts over a period of six years (by March 31, 2018). The Department will accomplish the assumption of administrative responsibilities with state staff, contracted entities, and contracts with counties.

The legislation requires the Department to send a Statement of Interest to counties to elicit their interest and capacity to contract with the Department to perform Medicaid administrative functions. Results from the Statement of Interest questionnaire will be used to guide the State in planning the transition of Medicaid administrative functions.

The Department will determine the timing of the assumption of administrative functions based upon when the necessary infrastructure has been created to take on the function. A timeline for assuming functions will be published once the results of the Statement of Interest have been analyzed. Counties should maintain the capacity to perform Medicaid administration until the State has assumed the function from the county.

Completed Statements of Interest should be returned to the Department no later than September 10, 2012. Submitting a response in favor of contracting with the State is informational and will be used for planning purposes only. It is not binding on either the county or the Department. **Any county that does not respond to the Statement of Interest will be assumed to want the State to assume all Medicaid administrative functions.**

The attached document contains additional background information on the State assumption of Medicaid administration, including functions the state intends to centralize, functions counties will continue to perform, as well as instructions for completing the Statement of Interest. Questions about completing the Statement of Interest questionnaire can be directed to Judy Arnold at 518-474-0180 or jaa01@health.state.ny.us.

Thank you for your cooperation.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Attachment
Cc: Local Social Services Commissioner
Stephen Acquario, New York State Association of Counties
Sheila Harrigan, New York Public Welfare Association

STATEMENT OF INTEREST

BACKGROUND

Section 6 of Part F of Chapter 56 of the laws of 2012 authorizes the Department of Health (Department) to transfer responsibility for the administration of the Medicaid program from local social services districts over a period of six years (by March 31, 2018). The Department may accomplish the assumption of administrative responsibilities with state staff, contracted entities, and contracts with counties. The legislation requires the Department to send a Statement of Interest to counties to elicit their interest and capacity to contract with the Department to perform Medicaid administrative functions. The Department will determine the timing of the assumption of functions. The timing will be based on when the Department has created the infrastructure (staff and systems) to take on the function. The Department will publish a timeline for assuming functions once the results of the Statement of Interest have been analyzed. The timeline will be updated each year until 2018 or when full State assumption of Medicaid functions has been achieved.

The State has begun to assume some functions (e.g., transportation, selected county renewals, managed long term care) and has started defining the requirements for a modernized eligibility system. The capacity to assume a large portion of eligibility determinations from the counties will take a minimum of two to three years. Counties should maintain the capacity to perform Medicaid administration until the State has assumed the function from the county.

FUNDING

In completing the questionnaire in the Statement of Interest, counties should assume that they will receive no more funding than they currently receive under the Medicaid administrative cap.

IMPLEMENTATION OF FEDERAL HEALTH CARE REFORM (AFFORDABLE CARE ACT)

The Affordable Care Act requires the creation of Health Benefit Exchanges as a marketplace for more affordable and more understandable health insurance options. Individuals may directly purchase insurance from the Exchange or apply for financial assistance for an Insurance Affordability Program. Insurance Affordability Programs are available to individuals with household incomes below 400 percent of the federal poverty level and include Medicaid, Child Health Plus, Advanced Premium Tax Credits (a reduction in the monthly premium for families with income above Medicaid eligibility but below 400% of FPL), and the Basic Health Plan (if the state chooses to adopt it).

Exchanges must establish online application processes with automated eligibility determinations for MAGI (Modified Adjusted Gross Income) Medicaid, the Children's Health Insurance Program (CHIP), and Advance Premium Tax Credits (APTCs), in addition to telephone, mail, and in-person application pathways. MAGI Medicaid includes those Medicaid applicants/enrollees eligible on the basis of new eligibility rules using income tax definitions of household size and income (Modified Adjusted Gross Income without deductions) and includes children, pregnant women, and adults under age 65 not in receipt of Medicare.

Governor Cuomo's Executive Order No. 42 established the State's Health Benefit Exchange in the Department of Health. The Department intends to centralize MAGI eligibility determinations for Medicaid, CHIP, and APTCs while preserving local presence for in-person application assistance. Given the short time period before open enrollment for the Exchange, the Department intends to

phase-in the centralization of MAGI eligibility and may even contract with some counties for this function for a longer period of time. Regardless of whether the State or the county is responsible for MAGI eligibility determinations, all determinations will be completed through a new eligibility system being developed for the Exchange, not through WMS. The new eligibility system will be Web-based, requiring internet access by county eligibility workers.

Counties that choose to contract with the State to determine/re-determine eligibility for MAGI Medicaid will also be required to assess eligibility for CHIP and APTCs, and electronically transmit the assessment to the CHIP program and the Exchange, respectively, for enrollment in those programs. Additional funding may be available to counties for the CHIP and APTC functions.

Counties will also be required to meet performance standards for the MAGI eligibility determinations. The performance standards will be included in the State Plan and subject to further federal guidance. The recently issued Medicaid regulations include a number of provisions regarding timeliness and performance standards. At a minimum, the county is expected to adhere to federal timelines for eligibility determinations. Entities delegated by the State to determine eligibility will be required to have contracts and adhere to performance standards on timeliness, accountability, and high quality consumer experience. Plans of correction will be required for patterns of incorrect, inconsistent or delayed determinations. Counties will be subject to monetary penalties for unmet performance measures.

FUNCTIONS THE STATE INTENDS TO CENTRALIZE WITHOUT A COUNTY CONTRACTING OPTION

A number of functions are in the process of being centralized by the State by 2018. There is no county option to continue to perform the functions beyond 2018. The functions include:

- Eligibility determinations for MAGI applications (i.e., Community Medicaid under age 65) and renewals (except renewals in NYC)
- Transportation management
- Assessment for Managed Long-Term Care Services
- Medicare Savings Program application/renewal processing
- Family Planning Benefit Program (FPBP) application processing for applications submitted by family planning providers and renewal processing.
- Third Party Health Insurance (payment of premiums if cost effective).

FUNCTIONS COUNTIES WILL CONTINUE TO PERFORM LONG-TERM

- Provide assistance with Medicaid eligibility for those who walk in to apply for other social services programs or who have a medical emergency.

- Assisting individuals obtain health care in emergency situations.

- Medicaid eligibility for individuals with a Spend-down. In 2013, eMedNY will calculate spend down amounts as claims are submitted, however, some worker data entry to establish the spend-down amount and review medical bills that cannot be paid by Medicaid will still be required.

- Provide legal assistance with recoveries. The Office of the Medicaid Inspector General is centralizing recoveries. However, OMIG relies on local legal support when the recoveries are taken to court.

INSTRUCTIONS FOR COMPLETING THE STATEMENT OF INTEREST

The questions to follow are organized by function and are multiple-choice. For most functions, a county has three choices:

- No – The County does not want to retain responsibility for the function and prefers the State assume responsibility as soon as the State has the staff and systems in place to assume the function. A county that indicates it does not want to retain the function will still be required to do so until the State is able to assume the function.

- Short-term – The County wants to retain responsibility for the function for some period of time, at least as long as it takes the State to develop the infrastructure to assume the function. This option would not involve contracting with the State. While the answer of "no and short-term" may have the same effect, the counties that respond "short term" meaning they want to retain the function at least until the Department has the capacity to assume the function, will inform the phase-in schedule of counties.

- Long-term – The County wants to retain responsibility for the function for the long term (i.e., beyond 2018) and is interested in contracting with the State.

Please check the box that best reflects the county's election for each of the following functions. Space has been provided for comments if you choose to elaborate on your answers.

How Will the Department Use the Statement of Interest?

The Department will analyze the responses to the questions and use them in three ways:

- To develop a plan with a timeline for the phase-in of the centralization of some functions
- To determine which counties the Department should begin the process of contract discussions for specific functions
- To determine whether a regional approach to contracting may be preferable for certain functions.

A response in favor of contracting with the State is informational and will be used for planning. **It is not binding on either the county or the Department.** The Department recognizes it will need to develop and negotiate a contract with the county and that process may result in a change in the interest of the county in contracting with the State. While no assurances are able to be made regarding indemnifying counties, it is expected that language identifying indemnification clauses will be included in any contractual relationship.

Statements of Interest are due back to the Department by September 10, 2012.

Completed Statements of Interest should be returned to:

Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration
New York State Department of Health
Office of Health Insurance Programs
Corning Tower OCP 826
Albany, NY 12237
jaa01@health.state.ny.us

Questions about completing the survey can be directed to: Wendy Butz, Director, Bureau of Medicaid Enrollment and Exchange Integration, wlb01@health.state.ny.us, 518-474-8887.

Any county that does not respond will be assumed to want the State to assume all Medicaid administrative functions. However, Counties must continue to perform the functions until the State is able to assume them from the county.

MAGI ELIGIBILITY DETERMINATIONS (PHONE, ONLINE, MAIL)

MAGI Eligibility Determinations include all new applications and renewals for children, pregnant women, and non-elderly/non-Medicare adults for Medicaid, CHIP, and Advanced Premium Tax Credits (APTCs). APTCs reduce the premium contribution required for insurance for households with incomes above Medicaid eligibility levels and below 400% of FPL. All under-care changes are also included. MAGI eligibility also includes determining Medicaid/CHIP and APTC eligibility when a recipient loses eligibility for Temporary Assistance.

The State intends to centralize new MAGI applications statewide using a new Web-based eligibility system. Renewals will likely be processed centrally and by some local districts.

Question	*Yes*	*No*
Is the County interested in conducting MAGI renewals until State can fully centralize? By April 2014, the State intends to centralize MAGI renewals outside New York City. In the event state staffing is not in place to manage the volume anticipated, some counties outside New York City may be asked to assist with MAGI renewal processing for a period of time. In order to develop a phase in-plan in the best interests of the counties and the State, we would like input as to which counties may be interested in assisting with MAGI renewals until the State can fully centralize that function. Counties will know whether or not they will be needed to process MAGI renewals no later than May 2013, in time for completing their 2014 budgets.		
Does the county want to provide in-person application assistance to MAGI applicants/enrollees? Centralized back end processing of MAGI applications/renewals assumes a continued local presence for in-person application assistance. This entails assisting applicants/enrollees complete the application/renewal and entering the information into the online portal. Assistance must be provided for all Insurance Affordability Programs, including MAGI Medicaid, CHIP, and APTCs. Additional funding may be available to counties for the CHIP and APTC functions. Counties should assume they will continue to provide assistance with Medicaid eligibility for those who walk in to apply for other social services programs or who have a medical emergency.		
Comments, if any, on MAGI Eligibility Determinations		

NON-MAGI ELIGIBILITY DETERMINATIONS : NON-MAGI REFERS TO APPLICANTS OVER AGE 65, ON MEDICARE, CATEGORICALLY ELIGIBLE FOR MEDICAID BASED ON ANOTHER PROGRAM (E.G., TA, FOSTER CARE, SSI), AND THOSE WHOSE ELIGIBILITY IS BASED ON CHRONIC CARE BUDGETING

Question	*No*	*Short-Term*	*Long-Term*
Process applications and renewals for aged, blind, disabled individuals, excluding automated renewals.			
Chronic care (nursing home) and alternate levels of care eligibility determinations and renewals. The State anticipates providing counties with access to an Asset Verification System to provide an electronic verification source for resources, including bank accounts and real property.			
Process applications and renewals for the Medicaid Buy-in for Working Persons with Disabilities program.			
Conducting Disability determinations.			
SSI cases, including separate determinations when an individual loses receipt of SSI.			
Other Medicaid functions the county currently performs that were not listed in the questions. For each one you list, provide the county's election regarding the county's role in administering the function. (No Role, Short-Term Role, or Long-Term Role).			
Comments, if any, on Non-MAGI Eligibility Determinations			

Thank you for completing the survey!

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
					Program Streamlining and State/Local Responsibilities Work Group		
5001					**Project Name: Develop and Implement Core Exchange Business Processes** **Division Lead: Exchange Staff** **Team Lead:**		
					Tasks to be implemented by Exchange Staff.		
5002					**Project Name: Restructure Medicaid Financing** **Division Lead: Division of Health Reform and Health Insurance Exchange Integration** **Team Lead: Judy Arnold** **Additional Staff: DOB** **Description: Develop and implement a plan for more sustainable Medicaid financing that phases out reliance on local taxes (e.g., property taxes) and includes the examination of financing structures in other states.**		
	4/1/12	✓	✓	✓	Fiscal Relief Enacted in Budget		
	4/1/12	✓	✓	✓	Administrative cap enacted in budget		
	~~11/1/12~~ 10/1/14	⊙	⊙	⊙	Examine impact of county administrative cap		
5003					**Project Name: Transition Medicaid Administration from Counties to the State** **Division Lead: Division of Health Reform and Health Insurance Exchange Integration** **Team Lead: Judy Arnold** **Additional Staff: Wendy Butz, Ralph Bielefeldt, Beth Osthimer** **Description:** **5003A: Secure Legislative Authority and Resources** **5003B: Identify Functions for Early State Administration and Implement** **5003C: Centralize MAGI Eligibility Determinations**		
5003A					**Project Name: Transition Medicaid Administration from Counties to the State: Secure Legislative Authority and Resources** **Team Lead: Judy Arnold** **Additional Staff: Ralph Bielefeldt** **Description:**		
	4/1/12	✓	✓	✓	Legislation Enacted		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	4/20/12	✓	✓	✓	Develop staffing plan and contracting plan		
	4/20/12	✓	✓	✓	Identify vacant items and submit waivers to fill positions		
	4/30/12	✓	✓	✓	Develop process for streamlined contract amendments		
	5/1/12	✓	✓	✓	Request Lists from Civil Service and canvass		
	5/29/12	✓	✓	✓	Start recruiting/hiring staff		
	6/30/12	✓	✓	✓	Develop new eligibility worker title and submit package to Civil Service		
	12/31/12	⊙	⊙	⊙	Complete hiring		
5003B					**Project Name: Transition Medicaid Administration from Counties to the State: Identify Functions for Early State Administration and Implement** **Team Lead: Judy Arnold** **Additional Staff: Wendy Butz, Ann Volpel, Rita Zink, Peggy Williams** **Description:** **5003B1 FPBP Applications** **5003B2 Add Counties to Enrollment Center** **5003B3 Resolve Death Matches** **5003B4 Process Third Party Health Insurance** **5003B5 Disability Determinations**		
	3/15/12	✓	✓	✓	Identify functions the State can assume in 2012		
	4/30/12	✓	✓	✓	Identify contract amendments required to implement		
	5/1/12	✓	✓	✓	Develop separate work plans for each function identified		
5003B1					**FPBP Applications**		
	7/1/12	✓	✓	✓	Develop tool to receive and track applications from providers		
	10/1/12	✓	✓	✓	Hire and train staff		
	~~11/1/2012~~ 12/10/12	⊙	⊙	⊙	Begin processing FPBP applications		
	12/31/12	⊙	⊙	⊙	Hire and train staff		
					Systems Updates - CNS/WMS		
	6/30/12	✓	✓	✓	Submit System Change Request for Central location and interfaces		
	7/30/12	✓	✓	✓	Submit CNS Renewal Notice Changes		
	9/1/12	✓	✓	✓	Finalize System Change Requests		
	~~11/1/2012~~ 12/10/12	⊙	⊙	⊙	Begin processing FPBP applications		
5003B2					**Add Counties to Enrollment Center**		
	8/15/12	✓	✓	✓	Confirm HEART functionality to process increased volume		
	9/1/12	✓	✓	✓	Add 4700 monthly renewals for Enrollment Center processing		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	10/1/12	✓	✓	✓	Hire new staff		
	10/15/12	✓	✓	✓	Complete new staff training		
	11/20/12	✓	✓	✓	Hire new staff		
	12/1/12	✓	✓	✓	Add 4700 monthly renewals for Enrollment Center processing		
	12/10/12	⊙	⊙	⊙	Complete new staff training		
	3/1/13	⊙	⊙	⊙	Add 4700 monthly renewals for Enrollment Center processing		
5003B3					**Resolve Death Matches**		
	6/1/12	✓	✓	✓	Preliminary review of policy issues		
	6/1/12	✓	✓	✓	Evaluate effectiveness of current automated closing process		
	7/1/12	✓	✓	✓	Explore advantages / disadvantages of using NYS Vital Statistics data for automated closing process.		
	8/1/12	✓	✓	✓	Explore changes to current matching process		
	~~10/1/2012~~ ~~11/15/12~~ ~~12/1/12~~ 12/31/12	⊙	⊙	⊙	Hire new workers to close death match cases		
	~~11/1/12~~ ~~12/1/12~~ 12/15/12	⊙	⊙	⊙	Finalize policy changes - if any		
	~~11/1/20~~ ~~12/1/12~~ 12/15/12	⊙	⊙	⊙	Submit draft GIS for clearance		
	~~12/1/2012~~ 12/15/12	⊙	⊙	⊙	Develop training module for new hires		
	~~12/1/12~~ ~~12/15/12~~ 1/15/13	⊙	⊙	⊙	Train new workers in correct closing process		
	~~12/1/12~~ ~~12/15/12~~ 12/28/12	⊙	⊙	⊙	Issue GIS		
	1/2/13	⊙	⊙	⊙	Begin resolution of death match case in some upstate counties		
5003B4					**Process Third Party Health Insurance**		
	04/30/12	✓	✓	✓	Define approach for state assumption of function		
	~~10/1/2012~~ 12/31/12	⊙	⊙	⊙	Hire and train staff		
	~~11/30/2012~~ 2/22/13	⊙	⊙	⊙	Execute contract amendment		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	03/01/13	⊙	⊙	⊙	Begin processing TPHI for NYC (Applications with TPHI-FHP Premium Assistance Program)		
					Downstate System Updates - CNS, WMS		
	08/15/12	✓	✓	✓	Submit System Change Request - Central location ID/Issue Interfaces		
	~~10/31/2012~~ ~~11/30/12~~ 1/7/13	⊙	⊙	⊙	Submit CNS Notice Changes		
	~~10/31/2012~~ ~~11/30/12~~ 1/15/13	⊙	⊙	⊙	Finalize System Change Requests		
5003B5					**Disability Determinations: Staged transition of disability determinations to the State Disability Review Team (SDRT)**		
	6/30/12	✓	✓	✓	Submit amendment to increase physician T contracts to $49,000 for life of contract (currently at $39,000)		
	6/30/12	✓	✓	✓	Hire 2 new state staff		
	9/30/12	✓	✓	✓	First half of training complete		
	11/30/12	✓	✓	✓	Second half of training complete.		
	12/1/12	✓	✓	✓	Increase physician hours per amended T contracts		
	12/1/12	✓	✓	✓	Begin adding other county reviews (up to 200 additional cases/month)		
5003C					**Project Name: Transition Medicaid Administration from Counties to the State: Centralize MAGI Eligbility Determinations** **Team Lead: Judy Arnold** **Additional Staff: Beth Osthimer, Wendy Butz** **Description:**		
	3/15/12	✓	✓	✓	Obtain staff and contract/hiring flexibility in enacted Executive Budget		
	~~10/1/2012~~ 12/15/12	⊙	⊙	⊙	Execute contract amendments		
	11/1/12	✓	✓	✓	Complete policy decisions		
	12/30/12	⊙	⊙	⊙	Determine local districts that will continue to ~~process~~ assist with MAGI applications and for how long		
	7/1/13	⊙	⊙	⊙	Hire staff for central processing unit		
	7/1/13	⊙	⊙	⊙	New eligibility system with MAGI rules engine is operationally ready		
	8/1/13	⊙	⊙	⊙	Complete business processes for application processing, referrrals, special handling, etc		
	9/30/13	⊙	⊙	⊙	Complete staff training		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	10/1/13	⊙	⊙	⊙	Begin processing MAGI applications		
5004					**Project Name: Long Term Care Recommendations** **Division Lead: Division of Coverage and Enrollment** **Team Lead: Judy Arnold** **Additional Staff:** **Description:** **5004A: Centralize and automate eligibility and enrollment processes for the Medicare Savings Programs.** **5004B: Expand Aged, Blind, and Disabled Automated Renewals** **5004C: Asset Verification System (AVS)** **5004D: Automate Spend Down** **5004E: Address Vulnerable Population Consumer Assistance Needs** **5004F: Long Term Care Work Group**		
5004A					**Project Name: Centralize and automate eligibility and enrollment processes for the Medicare Savings Programs.** **Division Lead: Division of Health Reform and Health Insurance Exchange Integration** **Team Lead: Wendy Butz** **Additional Staff: Rita Zink, Margaret Williams** **Description: Centralize and automate eligibility and enrollment processes for the Medicare Savings Programs by January 2014.**		
Phase 1					**Phase I - Expand MSP Renewals to Include Pension Income**		
					Policy and Procedure		
	5/31/12	✓	✓	✓	Meet with contractor - exceptions to MSP Auto renewal		
Step					**Downstate - Systems Updates - CNS, WMS, MBL, Local District Interface**		
	4/11/12	✓	✓	✓	Submit System Change Request for Mass rebudgeting		
	6/1/12	✓	✓	✓	Submit Systems Change Request for Auto Renewal Process		
	~~11/17/12~~ 2/28/13	⊙	⊙	⊙	Finalize SA for Mass Rebudgeting		
	3/15/13	⊙	⊙	⊙	Finalize SA for Auto Renewal Process		
	~~1/30/13~~ 5/1/13	⊙	⊙	⊙	CNS - Development/coding changes		
	~~2/1/13~~ 5/1/13	⊙	⊙	⊙	Finalize systems change ~~requirements~~ WMS, MBL		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	~~2/13/13~~ 6/15/13	⊙	⊙	⊙	Finalize testing complete WMS, MBL, and CNS		
	~~2/25/13~~ 6/15/13	⊙	⊙	⊙	User acceptance		
	~~6/1/13~~ 7/1/13	⊙	⊙	⊙	Implementation - / Auto Renewals QMB/SLIMB		
	~~6/1/13~~ 7/1/13	⊙	⊙	⊙	Implementation Contractor process exceptions to auto renewal		
	~~6/1/13~~ 7/1/13	⊙	⊙	⊙	Implementation - Auto renewals QI 1		
Step					**Upstate Systems Updates - CNS, WMS, MBL, Local District Interface**		
	4/11/12	✓	✓	✓	Submit System Change Request for Mass rebudgeting		
	6/1/12	✓	✓	✓	Submit Systems Change Request for Auto Renewal Process		
	2/15/13	⊙	⊙	⊙	Finalize SA for Auto Process Renewal		
	3/31/13	⊙	⊙	⊙	CNS - Development/coding changes		
	3/31/13	⊙	⊙	⊙	Finalize systems changes WMS, MBL		
	5/20/13	⊙	⊙	⊙	Finalize testing complete WMS, MBL CNS		
	5/25/13	⊙	⊙	⊙	User acceptance		
	6/1/13	⊙	⊙	⊙	Implementation - Auto Renewals QMB/SLIMB		
	6/1/13	⊙	⊙	⊙	Implementation Contractor process exceptions to auto renewal		
	6/08/13	⊙	⊙	⊙	Implementation - Auto renewals QI 1		
Phase 1A					**Phase IA - Expand MSP Renewals to Include those with a Spenddown**		
	9/01/13	⊙	⊙	⊙	**Policy and Procedure** GIS Released		
Step					**Downstate Systems Updates - CNS, WMS, MBL, Local District Interface**		
	4/11/12	✓	✓	✓	Submit System Change Request for Mass rebudgeting		
	6/1/12	✓	✓	✓	Submit Systems Change Request for Auto Renewal Process		
	6/30/12	✓	✓	✓	Submit CNS Mass Redbudgeting Notice Changes		
	4/30/13	⊙	⊙	⊙	Finalize/Submit SA for Auto Re-budgeting/renewal process		
	4/30/13	⊙	⊙	⊙	Finalize/Submit SA for CNS renewal notice changes		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	~~4/01/13~~ 9/1/13	⊙	⊙	⊙	Submit SA for CNS - Development/coding changes		
	~~5/01/13~~ 10/1/13	⊙	⊙	⊙	Finalize systems changes for Auto Renewal requirements WMS, MBL		
	2/10/14	⊙	⊙	⊙	Complete Testing for CNS renewal notices		
	2/10/14	⊙	⊙	⊙	Complete Testing for Mass Rebudgeting		
	2/10/14	⊙	⊙	⊙	Complete Testing for Auto Renewal process		
	~~5/25/13~~ 2/15/14	⊙	⊙	⊙	User acceptance		
	~~6/13/13~~	~~⊙~~	~~⊙~~	~~⊙~~	~~Finalize testing complete WMS, MBL, and CNS~~		
	~~10/05/13~~ 3/1/14	⊙	⊙	⊙	Implementation - / Auto Renewals QMB/SLIMB		
	~~6/8/14~~ 3/1/14	⊙	⊙	⊙	Implementation - Auto renewals Ql 1		
					UpstateSystems Updates - CNS, WMS, MBL, Local District Interface		
	4/11/12	✓	✓	✓	Submit System Change Request for Mass rebudgeting		
	6/1/12	✓	✓	✓	Submit Systems Change Request for Auto Renewal Process		
	6/30/12	✓	✓	✓	Submit CNS Mass Rebudgeting Notice Changes		
	4/01/13	⊙	⊙	⊙	Submit SA for CNS - Development/coding changes		
	4/30/13	⊙	⊙	⊙	Finalize/Submit SA for Auto Re-budget/renewal Process		
	6/15/13	⊙	⊙	⊙	Finalize systems changes for Auto Re-budget/renewal		
	6/30/13	⊙	⊙	⊙	Finalize CNS renewal notice changes		
	10/1/13	⊙	⊙	⊙	Complete testing		
	10/1/13	⊙	⊙	⊙	Complete testing for Mass Rebudgeting		
	10/1/13	⊙	⊙	⊙	Complete testing for Auto Renewal Process		
	10/4/13	⊙	⊙	⊙	User acceptance		
	10/5/13	⊙	⊙	⊙	Implementation - / Auto Renewals QMB/SLIMB		
	6/8/14	⊙	⊙	⊙	Implementation - Auto renewals Ql 1		
Phase II					**Phase II - Automate MSP MIPPA Applications**		
Step					**Policy and Procedure**		
	5/15/13	⊙	⊙	⊙	ADM Issued		
Step					**Downstate Systems Updates - CNS, WMS, MBL, Local District Interface**		
	7/31/12	✓	✓	✓	Submit Systems Change Request		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	~~9/30/12~~ 12/31/12	⊙	⊙	⊙	Submit Evolution Project Request (eMedNY) Hold Pending Phase I, IA and II		
	~~10/30/12~~ ~~12/31/12~~ 2/28/13	⊙	⊙	⊙	Finalize/Submit SA for CNS renewal notice changes		
	~~12/31/12~~ 2/15/13	⊙	⊙	⊙	Finalize/Submit SA for WMS/MBL changes		
	2/8/13	⊙	⊙	⊙	Identify & resolve outstanding application issues (LIS app info)		
	4/30/13	⊙	⊙	⊙	CNS - Development/coding changes		
	5/1/13	⊙	⊙	⊙	~~Finalize systems change requirements WMS, MBL~~ WMS/MBL/Development/Coding changes complete		
	5/20/13	⊙	⊙	⊙	Complete testing for CNS renewal notices		
	5/20/13	⊙	⊙	⊙	~~Finalized testing~~ Complete testing for WMS/ MBL		
	5/30/13	⊙	⊙	⊙	User Acceptance		
	6/2/13	⊙	⊙	⊙	Implementation		
					Upstate Systems Updates - CNS, WMS, MBL, Local District Interface		
	7/31/12	✓	✓	✓	Submit Systems Change Request		
	12/31/12	⊙	⊙	⊙	Submit Evolution Project Request (eMedNY) Hold Pending Phase I, IA and II		
	2/8/13	⊙	⊙	⊙	Identify and resolve outstanding appication issues (LIS app info)		
	2/15/13	⊙	⊙	⊙	Finalize/Submit SA for CNS renewal notice changes		
	2/15/13	⊙	⊙	⊙	Finalize/Submit SA for WMS/MBL changes		
	4/20/13	⊙	⊙	⊙	CNS - Development/coding changes complete		
	4/20/13	⊙	⊙	⊙	WMS/ MBL - Development/coding changes complete		
	5/20/13	⊙	⊙	⊙	Complete testing for CNS renewal notices		
	5/20/13	⊙	⊙	⊙	Complete testing for WMS/MBL changes		
	5/30/13	⊙	⊙	⊙	User acceptance		
	6/2/13	⊙	⊙	⊙	Implementation		
Phase III					**Phase III - Centralize MSP Eligibility Determinations**		
Step					**Administrative**		
	5/14/12	✓	✓	✓	Meet with Contractor		
	8/1/12	✓	✓	✓	Execute Contract Amendment		
	10/1/12	✓	✓	✓	Identify/hire staff for oversight of Contractor process		
	12/31/12	⊙	⊙	⊙	Hire and train staff for oversight process		
					Policy and Procedures		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	1/1/13	⊙	⊙	⊙	Policy and Procedures for Maximus/state staff completed		
	1/1/13	⊙	⊙	⊙	Maximus staff training complete		
					Downstate Systems Updates - CNS, WMS, MBL, Local District Interface		
	7/30/12	✓	✓	✓	Submit Systems Change Request		
	~~9/30/12~~ 2/1/13	⊙	⊙	⊙	Finalize/Submit SA for CNS notice changes		
	~~11/1/12~~ 2/1/13	⊙	⊙	⊙	Finalize/Submit WMS System Changes ~~Requests~~		
	3/30/13	⊙	⊙	⊙	Complete coding of CNS notice changes		
	4/30/13	⊙	⊙	⊙	Complete coding of WMS/MBL changes		
	4/15/13	⊙	⊙	⊙	Complete testing of CNS notice changes		
	5/15/13	⊙	⊙	⊙	Complete testing of WMS/MBL changes		
	~~3/1/13~~ 5/30/13	⊙	⊙	⊙	Implementation MSP Applications NYC		
	6/1/13	⊙	⊙	⊙	MIPPA Exceptions Report goes to Contractor for manual processing		
					Upstate System Updates - CNS, WMS, MBL, Local District Interface		
	7/30/12	✓	✓	✓	Submit Systems Change Request		
	2/1/13	⊙	⊙	⊙	Finalize/Submit SA for CNS notice changes		
	2/1/13	⊙	⊙	⊙	Finalize/Submit WMS System Changes		
	3/30/13	⊙	⊙	⊙	Complete coding of CNS notice changes		
	4/30/13	⊙	⊙	⊙	Complete coding of WMS/MBL changes		
	5/30/13	⊙	⊙	⊙	Complete testing of CNS notice changes		
	7/31/13	⊙	⊙	⊙	Complete testing of WMS/MBL changes		
	10/1/13	⊙	⊙	⊙	Implementation MSP Applications Upstate (Rollout of districts to be determined)		
Phase IIIA					**Expand MSP Renewals - Exceptions to Auto Renewals**		
	12/31/12 ~~10/1/12~~	⊙	⊙	⊙	Identify/hire staff for oversight of contractor process Hold Pending Phase I,IA,II		
	2/15/13	⊙	⊙	⊙	ADM issued		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
5004B					**Project Name: Expand Aged, Blind, and Disabled Automated Renewals** **Division Lead: Division of Health Care Reform and Health Insurance Exchange Integration** **Team Lead: Ralph Bielefeldt** **Additional Staff: Wendy Butz** **Description: Expand Aged, Blind, and Disabled Automated Renewals to Include Pension Income and Spenddown Cases**		
					Policy and Procedure		
	9/15/13	⊙	⊙	⊙	ADM issued		
					Systems Updates - CNS, WMS, MBL, Local District Interface		
	3/1/13	⊙	⊙	⊙	Submit Systems Change Request		
	3/15/13	⊙	⊙	⊙	Submit SA for WMS/MBL and CNS renewal notice changes		
	8/15/13	⊙	⊙	⊙	Complete CNS - Development/coding changes		
	9/1/13	⊙	⊙	⊙	Finalize systems change ~~requirements~~ WMS, MBL		
	~~9/15/13~~ 10/20/13	⊙	⊙	⊙	~~Finalized~~WMS/MBL testing complete ~~WMS, MBL, and CNS~~		
	~~9/30/2013~~ 10/20/13	⊙	⊙	⊙	User acceptance		
	~~10/6/2013~~ 10/22/13	⊙	⊙	⊙	Implementation		
5004C					**Project Name: Asset Verification System (AVS)** **Division Lead: Division of Health Care Reform and Health Insurance Exchange Integration** **Team Lead: Ralph Bielefeldt** **Additional Staff: Wendy Butz** **Description: The State should invest in an Asset Verification System (AVS) to permit the electronic verification of assets (including assets in the 5 year look back period) for determining eligibility for aged, blind, and disabled Medicaid applicants and recipients. AVS should be deployed as soon as possible in existing systems and this functionality should also exist in any new eligibility system.**		
	6/1/12	✓	✓	✓	Analyze Requirements		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	~~11/1/12~~ ~~12/1/12~~ 2/15/13	⊙	⊙	⊙	Meet with systems staff and LDSS representatives on process and data flow		
	~~11/1/12~~ ~~12/1/12~~ 2/15/13	⊙	⊙	⊙	Determine and develop system requirements		
	~~11/1/12~~ ~~12/1/12~~ 2/15/13	⊙	⊙	⊙	Select a contractor		
	~~11/15/12~~ ~~12/15/12~~ 2/15/13	⊙	⊙	⊙	B1184 funding justification submitted to DOB for approval		
	~~12/1/12~~ ~~1/1/13~~ 3/15/13	⊙	⊙	⊙	Negotiate contract and deliverables		
	~~12/1/12~~ ~~1/1/13~~ 3/15/13	⊙	⊙	⊙	Write SA for system changes		
	~~1/1/13~~ ~~2/1/13~~ 4/1/13	⊙	⊙	⊙	Contract approved		
	~~1/1/13~~ ~~2/1/13~~ 4/1/13	⊙	⊙	⊙	Develop programming specifications and deliverables		
	4/1/13	⊙	⊙	⊙	Develop LDSS training requirements		
	~~2/1/13~~ 4/1/13	⊙	⊙	⊙	Test programming		
	~~4/1/13~~ 6/1/13	⊙	⊙	⊙	ADM Issued		
	~~5/15/2013~~ 7/15/13	⊙	⊙	⊙	Train LDSS staff		
	~~8/1/2013~~ 10/1/13	⊙	⊙	⊙	Implement AVS program		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
5004D					**Project Name: Automate Spend Down** **Division Lead: Division of Health Reform and Health Insurance Exchange Integration** **Team Lead: Wendy Butz** **Additional Staff: David Bacheldor** **Description: Automate spend down by linking eMedNY to WMS and using provider billing to track spend down similarly to an insurance deductible. In addition to streamlining spend down eligibility, the automation ensures that Medicaid is correctly paid. This spend down automation function should be deployed as soon as possible in existing systems and this functionality should also exist in any new eligibility system.**		
					Policy and Procedure		
5004D	5/31/12	✓	✓	✓	Complete review of policy issues		
	3/13/13 ~~9/30/12~~	⊙	⊙	⊙	Submit draft ADM for clearance		
	~~11/7/12~~ 5/30/13	⊙	⊙	⊙	M-TAG call for LDSS		
	~~12/1/12~~ 5/1/13	⊙	⊙	⊙	Submit Medicaid Update article for clearance		
	~~12/10/12~~ 6/1/13	⊙	⊙	⊙	Issue ADM		
	~~2/1/13~~ 6/1/13	⊙	⊙	⊙	Issue Medicaid Update article		
	~~2/1/13~~ 6/1/13	⊙	⊙	⊙	Policy Manual and DOH website changes completed		
	~~2/1/13~~ 6/1/13	⊙	⊙	⊙	Information to Call Center (Qs&As) completed		
Step					**Systems Update - CNS, WMS, MBL, Local District Interface**		
	3/31/12	✓	✓	✓	Submit Systems Change Request		
	4/12/12	✓	✓	✓	Submit Evolution Project request (eMedNY)		
	~~9/28/12~~ 3/28/13	⊙	⊙	⊙	Submit CNS notice changes		
	~~9/28/12~~ 2/28/13	⊙	⊙	⊙	DOH sign off Evolution Project Request		
	~~2/17/13~~ 6/17/13	⊙	⊙	⊙	Migrate system changes (WMS)		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	~~3/1/13~~ 7/1/13	⊙	⊙	⊙	Roll out system changes to eMedNY		
	~~3/1/13~~ 7/1/13	⊙	⊙	⊙	Implementation Revised date pending eMed NY assessment		
5004E					**Project Name: Address Vulnerable Population Consumer Assistance Needs** **Division Lead: Division of Health Reform and Health Insurance Exchange Integration** **Team Lead: Gabrielle Armenia** **Additional Staff: Wendy Butz** **Description: Disabled and elderly New Yorkers in need of long term care services should have the same access to enrollment and eligibility assistance as other applicants for Medicaid.**		
	6/1/12	✓	✓	✓	Submit B1184 for Approval		
	~~9/20/12~~ 12/28/12	✓	✓	✓	Receive approval for B1184		
	10/29/12	✓	✓	✓	Draft RFP		
	10/29/12	✓	✓	✓	Develop selection criteria for RFP		
	12/28/12	⊙	⊙	⊙	Obtain InternalExecutive clearance for release of RFP		
	1/7/13	⊙	⊙	⊙	Post RFP on DOH website		
	2/11/13	⊙	⊙	⊙	Post reponses to questions		
	3/18/13	⊙	⊙	⊙	Proposal due date		
	4/29/13	⊙	⊙	⊙	Review and score proposals		
	6/3/13	⊙	⊙	⊙	Select successful contractor and obtain Executive Deputy Clearance approval		
	6/7/13	⊙	⊙	⊙	Notify successful and unsuccessful bidders		
	6/28/13	⊙	⊙	⊙	Negotiate contract with successful bidder		
	7/1/13	⊙	⊙	⊙	Effective date for contract with successful bidder		
					Project Name: Improve Access to Emergency Medicaid **Division Lead: DCE** **Team Lead: Kathleen Johnson** **Description: Improve Access to Emergency Medicaid**		
					PART 1		
5005					**Clarify Emergency Medicaid Application Procedures**		
					Policy and Procedure		
	4/2/12	✓	✓	✓	Complete preliminary review of policy issues		
	11/30/12	✓	✓	✓	Update Training Materials		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
	11/30/12	✓	✓	✓	Draft Medicaid Update Article for clearance		
	11/30/12	✓	✓	✓	Draft Fact Sheet for Website for clearance		
	12/30/12	⊙	⊙	⊙	Submit draft Administrative Directive (ADM) for clearance		
	1/15/13	⊙	⊙	⊙	Issue Medicaid Update Article		
	2/1/13	⊙	⊙	⊙	Issue ADM		
	2/15/13	⊙	⊙	⊙	Issue Fact Sheet on Website		
					Website		
	2/15/13	⊙	⊙	⊙	Post information about Emergency Medicaid		
					PART 2		
					Pre-Qualify Medicaid Financial Eligibility		
					Policy and Procedure		
	4/2/12	✓	✓	✓	Complete preliminary review of policy issues		
	4/3/12	✓	✓	✓	Explore the need for regulatory changes		
	11/30/12	✓	✓	✓	Update Training Materials		
	11/30/12	✓	✓	✓	Draft Medicaid Update Article for clearance		
	11/30/12	✓	✓	✓	Draft Fact Sheet for Website for clearance		
	12/30/12	⊙	⊙	⊙	Submit draft Administrative Directive (ADM) for clearance		
	1/15/13	⊙	⊙	⊙	Issue Medicaid Update Article		
	1/15/13	⊙	⊙	⊙	Issue Fact Sheet on Website		
	2/1/13	⊙	⊙	⊙	Issue ADM		
	3/1/13	⊙	⊙	⊙	Implement Changes		
					System Updates		
					WMS/HEART		
	3/1/12	✓	✓	✓	Explore necessary system changes		
	4/2/12	✓	✓	✓	Submit System Change Request Form		
	4/27/12	✓	✓	✓	Finalize system change requirements		
	5/4/12	✓	✓	✓	Finalize System Action Request		
	12/14/12	⊙	⊙	⊙	Development/coding changes		
	2/8/13	⊙	⊙	⊙	Unit testing		
	2/13/13	⊙	⊙	⊙	User Acceptance		
					eMedNY		
	7/1/12	✓	✓	✓	Explore need for emedNY evolution project to strengthen edits on emergency claims		
	7/1/12	✓	✓	✓	Submit eMedNY evolution project (if necessary) Not necessary		
	7/1/12	✓	✓	✓	Finalize eMedNY evolution project (if necessary) Not necessary		

MRT Project #	Date	Schedule	Budget	Risk	Project/Task Description	State Savings 2012-13 ($millions)	Information for Team Leads
Key					**Completed, On Track, Caution, Alert**		
					CNS		
	7/1/12	✓	✓	✓	Explore CNS Notice Issues		
	10/15/12	✓	✓	✓	Finalize and submit CNS notices (if necessary)		
	~~10/29/12~~ 12/1/12	✓	✓	✓	Finalize System Action Request		
	12/14/12	⊙	⊙	⊙	Development/coding changes (if necessary)		
	2/8/13	⊙	⊙	⊙	Unit testing (if necessary)		
	2/13/13	⊙	⊙	⊙	User Acceptance (if necessary)		
					PART 3		
					Implement 12 month Certification Period for Certain Conditions		
					Policy and Procedure		
	4/2/12	✓	✓	✓	Complete preliminary review of policy issues		
	4/3/12	✓	✓	✓	Explore the need for regulatory changes		
	4/19/12	✓	✓	✓	Explore Federal requirements for statement from treating physician		
	11/30/12	✓	✓	✓	Submit draft Medicaid Update article for clearance		
	12/30/12	⊙	⊙	⊙	Submit draft Administrative Directive (ADM) for clearance		
	1/15/13	⊙	⊙	⊙	Issue Medicaid Update Article		
	2/1/13	⊙	⊙	⊙	Issue ADM		
	2/15/13	⊙	⊙	⊙	Revise online Emergency Medicaid training for LDSS staff		
					System Updates		
					WMS/HEART		
	3/1/12	✓	✓	✓	Explore necessary system changes		
	4/2/12	✓	✓	✓	Submit System Change Request Form		
	4/27/12	✓	✓	✓	Finalize system change requirements		
	5/4/12	✓	✓	✓	Finalize System Action Request		
	12/14/12	✓	✓	✓	Development/coding changes		
	2/8/13	✓	✓	✓	Unit testing		
	2/13/13	⊙	⊙	⊙	User Acceptance		
	2/18/13	⊙	⊙	⊙	Migrate system change		
					eMedNY		
	7/1/12	✓	✓	✓	Explore need for emedNY evolution project to strengthen edits on emergency claims		
	7/1/12	✓	✓	✓	Submit eMedNY evolution project (if necessary)		
	7/1/12	✓	✓	✓	Finalize eMedNY evolution project (if necessary)		