NEW YORK STATE OF OPPORTUNITY. Department of Health

Medicaid Administration

Annual Report to the Governor and Legislature
December 2014

NEW YORK STATE OF OPPORTUNITY. 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 (Department) 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. This third annual report will update the status of the activities the state has undertaken to assume Medicaid administrative functions. It will also describe the plan and timeline for the assumption of additional functions.

In 2014 the state processed nearly two million eligibility determinations/enrollments, three and a half times the number in 2013. The large volume is driven by the shift of Medicaid applications for Modified Adjusted Gross Income (MAGI) populations from the local districts to New York State of Health
(NYSOH) as of January 1, 2014. In addition to processing new applications, NYSOH also handled all activities associated with these enrollees, including enrollment in health plans, processing life status updates and changes, reimbursing for medical bills, replacing benefit cards, and pursuing third party coverage. The

state also increased the number of counties for which it processed disability determinations, managed transportation services and completed managed long-term care enrollments.

The chart below shows the increase in the volume of eligibility determinations/enrollments assumed by the state in 2014.

Table 1: Volume of Eligibility Determinations/Enrollments Processed by the State

	2013		2014	
	Monthly	Annually	Monthly	Annually
New MAGI Applications	19,000	47,000	111,700	1,340,000
Enrollment Center Renewals	25,000	300,000	26,500	318,000
Family Planning Benefit Program	2,500	30,000	3,250	39,000
Auto Renew Aged, Blind and Disabled	3,000	36,000	4,100	49,200
Managed Long Term Care	10,000	121,000	11,500	138,000
Total	**59,500**	**534,000**	**157,000**	**1,884,200**

The report is organized into seven sections:

- *Centralized Eligibility Determinations*
- *Modernized Medicaid Eligibility System*
- *Status of Administrative Functions Assumed in Prior Years*
- *Functions Remaining with Counties in 2015*
- *Financing Medicaid Administration*
- *Delays in Medicaid Administration*
- *Need for Additional Legislation*

Finally, the report concludes with a timeline for State Administration of Medicaid.

CENTRALIZED ELIGIBILITY DETERMINATIONS

New York State of Health (NYSOH) centrally processes eligibility and enrollment for MAGI Medicaid[1], the Children's Health Insurance Program, Advance Premium Tax Credits (APTC), Cost-Sharing Reductions, the APTC Premium Payment Program, and unsubsidized purchases of Qualified Health Plans. Applicants can apply online, by phone, by mail, and in-person.

Beginning January 1, 2014 most Medicaid applications for the MAGI population (pregnant women, children, parents/caretakers, and adults under age 65) were processed by the state through NYSOH and not by the LDSS. Eligibility determinations for about 65 percent of all new Medicaid applications shifted from the counties to the state. New applications taken by local districts declined by two-thirds in 2014 from 109,000 in December of 2013 to 35,000 in September 2014. Local districts in 25 counties and New York City continue to process renewals for MAGI Medicaid enrollees continuously covered as of December 2013. Renewals in the remaining 32 counties are processed by the Enrollment Center.

Marketplace Medicaid Enrollment

In 2014, the Marketplace determined over one million individuals eligible for Medicaid. Of these, 10 percent are eligible for the newly expanded eligibility level between 100 to 138 percent of the federal poverty level. The remaining 90 percent of Medicaid enrollments are for individuals previously eligible, but not enrolled, or enrollees who experienced a gap in coverage and enrolled as new applicants. Approximately 76 percent of Medicaid enrollments are adults between the ages of 18-64, 23 percent are children under age 18 and 1 percent are adults age 65 or over.

More than 60 percent of the Medicaid enrollments were from New York City, 9 percent from Long Island, and the remaining 31 percent from other counties throughout the state. Medicaid enrollment in NYSOH is diverse. Of those reporting, about 28 percent are white, 24 percent Hispanic, 18 percent African American, 7 percent Chinese, and 6 percent Asian Indian or other Asian. One-third of enrollees do not provide their race/ethnicity.

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[1] MAGI refers to those populations whose eligibility is determined based on Modified Adjusted Gross Income (MAGI) household size and income rules.

Nearly all Marketplace applications are submitted online, with 60 percent of applications completed with assistance from either a Navigator, Marketplace Facilitated Enroller, Certified Application Counselor or the Customer Service Center. Those individuals in need of financial assistance are more likely to seek help with the application process than those purchasing a Qualified Health Plan (QHP) at full-price.

Until eligibility for the entire Medicaid population can be processed in the NYSOH eligibility system, new applications for the MAGI population will be processed by NYSOH and new applications for the non-MAGI population will be processed by the LDSS in Welfare Management System (WMS). The state has worked with the counties to develop a referral process for applications that originate in the wrong place to ensure the eligibility is determined in a correct and timely manner. Individuals applying on the NYSOH website who indicate certain attributes are referred to the local district to have their eligibility for Medicaid coverage determined using non-MAGI eligibility rules. In 2014, 84,000 referrals were made to the counties. The majority of referrals were for requests for retroactive eligibility for payment of medical bills. NYSOH added the ability to determine eligibility for retroactive Medicaid coverage in April 2014, which decreased the referrals to the local districts by 90 percent. A small number of referrals to LDSS occur on a case-by-case basis if long term care services are needed.

As NYSOH assumed responsibility for the application intake, eligibility determinations and renewals, it also assumed responsibility for processing changes in circumstances and several post-eligibility functions previously performed by local districts, such as pursuing other health insurance (third-party liability), Common Benefit Issuance Card (CBIC) replacement and processing requests for reimbursement of medical bills.

Third Party Liability (TPL)

The Third Party Liability (TPL) unit has created and maintains a process to receive, research, update and respond to requests for information to verify Third Party Health Insurance (TPHI), update third party records and process requests for Premium Assistance. Since January 2014, the TPL unit has handled approximately 17,500 direct requests from NYSOH and have updated over 40,000 TPHI records in total. To date, a Cost Effectiveness Analysis to reimburse group health insurance premiums has been completed on over 900 accounts resulting in 194 Health Insurance Premium Payments (HIPP) covering 296 consumers. In addition, 381 consumers have been determined eligible for premium payment of the Medicare Part B premium. The TPL unit also works closely with the state Third Party contractor and with Medicaid managed care plans to identify and verify TPHI and to ensure consumers are appropriately enrolled in Medicaid Managed Care or Medicaid fee-for-service.

The TPL unit is working closely with Cornell University on a pilot project to enhance the students' health care plans by supplementing them with Medicaid for those students who qualify for Medicaid. Students enrolled in Medicaid alone have historically had a difficult time finding adequate care with a limited number of providers and specialists who accept Medicaid near some colleges. This project, administered centrally by the Department, works as an added benefit to both the college and the students by enhancing access to providers while paying premiums for students. To date, 220 students from across New York State are participating in this pilot.

CBIC Card Replacement

Medicaid shares a benefit card with cash assistance and the Supplemental Nutrition Assistance Program (SNAP). The policy of the Office of Temporary and Disability Assistance (OTDA) is that individuals are not issued new benefit cards if they had ever been in receipt of benefits in the past. Many individuals that enrolled in Medicaid through NYSOH had not had Medicaid for many years and no longer had their original card. An unexpected workload occurred, requiring manual issuance of replacement CBIC cards. In 2014, DOH issued 4,800 new cards a month. The Department is exploring changes to this policy with OTDA and considering contracting for a separate, less expensive Medicaid card.

Reimbursement of Medical Bills

Medicaid rules provide for reimbursement of medical bills incurred in any or all of the three months prior to being found Medicaid eligible as long as the individual was eligible for Medicaid in those months. A unit has been established in DOH to examine and process reimbursement claims for individuals found eligible in NYSOH. In 2014, the unit has examined nearly 13,000 reimbursement claims submitted by NYSOH applicants and enrollees. The unit also communicates with medical providers to offer assistance on correct claim submission procedures from the provider to eMedNY.

Renewals

In October 2014, NYSOH began renewing Medicaid enrollees with coverage ending at the end of the year. Medicaid enrollees may be renewed with family members in QHPs during open enrollment or three months prior to the month their coverage ends. Renewals for Marketplace enrollees are administrative, meaning that, to the extent information exists in the federal and state data bases to determine eligibility, enrollees receive a notice informing them of their eligibility for the next year and whether they can remain in their health plan or need to return to select a new plan. Individuals will be required to select a plan for the next year if their program eligibility changes or if their plan is no longer available. If individuals are satisfied that the administrative renewal reflects their current circumstances, they do not have to take any action and will be administratively renewed into the same plan. Individuals whose eligibility cannot be determined from federal and state data bases will be asked to return to the Marketplace to update their account information (demographics, income, etc.) for coverage to continue for another year.

Renewal of non-NYSOH Medicaid enrollees will remain with the local districts or the Enrollment Center for most of 2015. However, the steadily increasing Medicaid enrollment in NYSOH suggests that some enrollees are failing to renew at the local district and then apply through the Marketplace as new applicants. The migration of enrollees in WMS to NYSOH will continue until functionality can be built in the eligibility system to transition all of them from WMS. The Department expects the system development will be completed in 2015 to begin to phase in the transition of MAGI Medicaid enrollees in WMS to NYSOH. The state intends to begin with a few counties, increase it to the rest of the counties outside NYC and then finish the transition with NYC enrollees in 2016.

Until NYSOH builds the eligibility rules to determine eligibility for non-MAGI individuals, at renewal, certain individuals who are no longer eligible under a MAGI category will be transitioned to the district for a determination of eligibility on a non-MAGI basis. Individuals with certain long-term care service needs such as managed long-term care are also being referred to the local district.

Customer Service Center

NYSOH has a robust Customer Service Center with locations in Albany and New York City staffed by state staff and Maximus staff to answer general consumer questions, provide assistance with applications started online, take applications over the phone, and assist with plan selection and enrollment. Customer Service is available Monday through Friday from 8am to 8pm and on Saturday from 9am to 1pm. From January through October 2014, call center representatives have answered over 2.2 million calls from across the state.

When responding to consumer calls, customer service representatives spent about 70 percent of their time providing telephone or online application assistance. Other assistance includes responding to a variety of general inquiries ranging from the availability of health plans (and their premium rates) to requests for basic information about the Advanced Premium Tax Credit and Cost Sharing Reductions. Overall, about 46 percent of these calls originated in New York City, 10 percent in Long Island, and the remaining 44 percent of calls came from consumers residing in other counties throughout the state.

The NYSOH Customer Service Center continued and expanded New York's commitment to providing assistance to consumers for whom English is not their primary language. While all callers have always had access to translation services through the traditional Medicaid helpline, customer service center staff now includes representatives that speak Cantonese, Haitian-Creole, Mandarin, Russian and Spanish. In 2014, more than 500,000 non-English calls came into the call center. Multilingual NYSOH representatives directly responded to nearly 80 percent of these consumers and the remaining callers received assistance via three-way calls with a "language line" interpreter.

A Spanish version of the online Marketplace application was available beginning November 2014. Since the start of open enrollment, the web site had over 1,200 active users on the Spanish application. In addition, NYSOH fact sheets and some informational material have been translated into 17 languages. A few of the notices sent to consumers are available in Spanish with more to be added by the end of the year.

Since January 2014, the Call Center has answered over 2.2 million calls.

Community-Based Assistors

In 2014 over 5,000 Assistors helped consumers complete applications for health insurance.

Community-based assistors have historically played a significant role in helping low-income New Yorkers apply for Medicaid, with over 50 percent of new Medicaid applications in some counties submitted by facilitated enrollers and other community-based assistors. In 2014, all new MAGI applications from trained community-based assistors were submitted to NYSOH using the online application, including applications from In-Person Assistors/Navigators, Marketplace Facilitated Enrollers (health plans) and Certified Application Counselors, which encompass federally qualified health centers, hospitals, local departments of social services, and other community-based organizations, and Brokers.

The chart below lists the number of Navigators, Marketplace Facilitated Enrollers, and Certified Application Counselors trained as of November 2014. The number does not include the nearly 4,000 brokers who have been trained.

Table 2: Number of Assistors Trained in 2014

Type of Application Assistor	Total Number Trained as of 11/14
Navigators	585
Federally Qualified Health Centers (FQHCs)	282
Hospitals	1,702
Local Departments of Social Services (LDSS)	238
Marketplace Facilitated Enrollers (FEs)	2,144
Other Organizations	404
Totals	5,355

Individuals that were enrolled is shown below along with the ratio of enrollments to determinations.

Table 3: Ratio of Enrollments of Eligibility Determinations

Type of Assistor	Total Determinations (Cumulative)	Total Enrollments (Cumulative)	Ratio of Enrollments to Determinations (Cumulative)
Navigators	202,728	158,904	78%
Marketplace FEs	817,769	673,441	82%
FQHCs	34,884	27,047	78%
Hospitals	102,845	84,627	82%
Healthcare Providers	13,117	10,588	81%
LDSS	17,603	14,475	82%
Other	98,682	57,086	85%
ALL Assistors	**1,287,628**	**1,026,168**	**80%**

The percentage of completed enrollments by program type is shown below.

Table 4: Assistor Enrollments by program

Assistor Type	Medicaid	CHP	QHP
Navigators	74%	8%	18%
Marketplace FEs	73%	12%	15%
FQHCs	84%	5%	11%
Hospitals	93%	4%	3%
Healthcare Providers	86%	5%	9%
LDSS	94%	4%	2%
Other	83%	6%	11%
All Assistors	**86%**	**6%**	**8%**

MODERNIZED 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. 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 Marketplace, a major component of which is an online, automated eligibility system for the Individual Marketplace. The Individual Marketplace serves most non-elderly individuals and families seeking health insurance with or without financial assistance.

The eligibility system for the Individual Marketplace represents a major advance in New York's Medicaid program. For the first time in the program's history, individuals can apply online or by phone and receive an eligibility determination in real time if their information can be verified through federal and state databases. The eligibility system automates the determination, enabling consistency and reducing errors. Consumers can also select and enroll in health plans and receive electronic communication about their eligibility and plan enrollment.

A major advantage of the new system is it integrates eligibility for Medicaid, CHIP, and tax credits for QHPs in a single system. The integrated approach allows entire families with different eligibility results to apply on a single application and through one system. For example, nearly every family eligible for tax credits will have children eligible for Medicaid or CHIP. The integrated system also facilitates transitions between programs as circumstances change. No longer are families referred from one program to another and having to begin an entirely new application. Updates and changes that result in new eligibility can occur in the system and enrollees can be seamlessly transitioned to another program without gaps in coverage.

The eligibility system also includes "back office" functions for staff. The system provides back office screens that enable customer service representatives, state Department employees, and appeals specialists to perform necessary assistance, determinations and quality assurance functions.

The system has established interfaces with a wide range of state and federal systems, with more planned for 2015. In addition to verification data sources, some of the other interfaces support functionality needed for Medicaid program administration. For example, the Medicaid plan roster is being replaced with secure electronic enrollment transactions (834s) as Medicaid enrollees transition from WMS to NYSOH. Additional Medicaid system functions include auto assignment into plans, preventing duplicate coverage, generating client identification numbers, issuing and replacing benefit cards, processing newborn enrollments, referring non-MAGI individuals to local districts, and various post-eligibility activities including Medicaid suspension and reinstatement based on incarceration and release, supporting restrictions, exceptions and exemptions, an automated force closing process for individuals who receive cash benefits, third party coverage determinations and administration of premium payment programs including the APTC Premium Payment Program. The system also provides data for Medicaid reporting and claiming.

To meet the federal requirement to open on October 1, 2013, much functionality was deferred to 2014 and later. By focusing on essential operational functionality, New York was able to avoid the very serious problems that were encountered by many states and the federal government in the first months of the program, and earned a national reputation as achieving successful implementation under difficult circumstances. The decision to phase-in functionality proved effective given the successful launch of NYSOH. At the same time, it created some difficulties as new functionality needed to be built into an existing system without the luxury of planning ahead for how all the pieces would interact with each other. The project also experienced a six month delay in securing approval for a contract amendment to add resources. The lack of adequate resources for nearly all of 2014 significantly reduced the amount of system development that could be accomplished and resulted in the deferral of a large amount of urgent and high priority functionality.

NYSOH is successfully processing applications and plan enrollments without many of the problems plaguing the Federal and some other state Marketplaces. However, the system still needs to add significant functionality during 2015 and after to fulfill the requirements of the Affordable Care Act (ACA) and to replace WMS.

New Functionality for 2014

In 2014, the state deployed additional functionality in the following areas affecting the Medicaid program:

- Determine eligibility for Medicaid retroactive coverage.
- Enhancements to prevent gaps in coverage and ease transitions in coverage.
- Functionality to provide inpatient only Medicaid coverage when an eligible individual is incarcerated and to convert that coverage to full Medicaid coverage when the individual is released. The addition of a question on the application to self-identify as being incarcerated when the incarceration is not found in the federal or state data bases.
- Improvements to the self-employment income screens and to other income screens to capture both annual projected income and current income.
- Improvements to capturing immigration data to match the immigration codes received from the federal hub.
- Implemented automated closing of Medicaid enrollments in the Marketplace that are opened in WMS for Medicaid of greater or equal coverage.
- Expanded reasons for referral to the LDSS for non-MAGI eligibility determinations.
- Developed the interface to the new federal immigration verification service.
- Modifications to address new federal rules released after the launch of NYSOH.

- Tightened rules to prevent duplicate coverage.
- Launch of an online Spanish application.
- Consolidated the eligibility notice into one for the entire family even if individuals are eligible for different programs. Streamlined the enrollment notice to list all household members enrolled into coverage, regardless of their eligibility, the plan they are enrolled in, or end date of coverage, in a single notice.
- Enhanced functionality that allows for correction to eligibility and/or enrollment dates including the ability to reprocess transactions sent to the plans and eMedNY.
- Improved transparency of data captured in the application and visibility of historical application data.
- Implemented administrative renewal functionality for all programs.
- Transitioned Medicaid enrollees at renewal to LDSS if no longer MAGI.

Planned Functionality for 2015

In 2015, the state plans to add the following functionality:

- Implementation of the Basic Health Program.
- Periodic data matching to enable monthly verification of eligibility factors such as death, other health insurance, and continued New York residency.
- The addition of an Equifax service through the federal hub as a verification source of current income.
- Support for overlapping and more complex paths for eligibility and enrollment including, but not limited to, the ability of consumers to move between programs seamlessly as their eligibility changes at renewal, during special enrollment periods, or when they reach a milestone age (e.g., age 19 or age 65).
- Enhancements that fill gaps in functionality such as automating retroactive Emergency Medicaid, improvements to the newborn processing rules, and modifications to the rules for pregnant women and pregnant minors.
- Improvements to assessing third party coverage.
- Ability to select a primary care provider online for Medicaid.
- Continued enhancements to tighten the rules to prevent duplicate coverage.

- Development of "read only" access to the back office and different roles to limit access to functionality to the minimum amount necessary.
- Transition of MAGI Medicaid enrollees from WMS to NYSOH.
- Completion of Spanish notices and translation and development of notices in other languages.
- Ensure that notices are available in alternative formats for the visually impaired.
- Addition of third-party health insurance processing tools and notices.
- Enhanced ability to create and change enrollment transactions.
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- Implement enhancements in the enrollment transactions with insurers.
- Greater visibility into information provided from data source returns.
- The development of a separate path for presumptive eligibility for pregnant women, the family planning benefit program, and the implementation of hospital presumptive eligibility.
- Addition of processing the incarceration file from Rikers.

Eligibility System Planning for 2016

By the end of 2015, the Department anticipates that the functionality for eligibility determinations and enrollments for the MAGI Medicaid population will be largely complete. In 2016, the state can focus on important deferred functionality such as the implementation of eligibility rules for non-MAGI Medicaid, improvements to the eligibility worker interfaces and improving the consumer experience. The areas of focus for 2016 include:

- *Non-MAGI.* The non-MAGI populations include individuals whose Medicaid eligibility is based on their being elderly, blind or disabled, those eligible for spend-down, the Medicare Savings Program, the Medicaid Buy-In for Persons with Disabilities, the Cancer Services Program, and foster care youth. For each of these populations, the system requirements need to be developed including the consumer facing screens, notices, the eligibility rules engine, and plan enrollment, if applicable, as well as the accompanying back end functionality for the eligibility staff.
- *Improvements to Back Office Interfaces.* Includes the archiving and identification of documentation type submitted to verify factors of eligibility, ability to make updates to consumer accounts without having to proceed through all application screens, improvements to the paper application process to allow the collection of missing information through the online application, and enhancements to the notice process for re-generation and mailing of notices, creation of ad-hoc notices and the suppression of notices.
- *Enhance the consumer experience* by asking certain questions at the household level rather than the individual level to make the application process faster for consumers, by improving the application design to create a smoother process for consumers and by displaying all the data elements to the consumer in the application summary/dashboard.

- *Improvements to Assistor Interfaces.* The Broker, Navigator and Certified Application Counselor (CAC) portal requires upgrades and enhancements to make it easier and more efficient for assistors to track the status of applications in process and submitted. Assistors also want the ability to more efficiently enter updates and changes to applications. Navigators and CAC lead agencies, in particular, need functionality to monitor the performance of their employees and subcontractors.

- *Reporting Capabilities.* NYSOH has identified a number of reports that will be produced to regularly monitor enrollment, system performance, and for other program management and oversight needs. While a number of reports are in production, some still need to be programmed and generated in 2016. In addition to defined reports, there is a need for accessible query capabilities for Department staff.

STATUS OF ADMINISTRATIVE FUNCTIONS ASSUMED IN PRIOR YEARS

Administrative Renewals for Aged, Blind and Disabled

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). 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. In 2014, nearly 50,000 administrative renewals were completed, a 37 percent increase over the number completed in 2013.

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

The Department currently processes renewals for enrollees in New York's Medicaid, Family Health Plus, and Family Planning Benefit Programs who are allowed to attest to changes in income at renewal and who have no resource test (non-Aged, Blind or Disabled). These renewals include enrollees who have not yet transitioned to NYSOH and they 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. Renewals may be completed by mail or by phone, with 61 percent of consumers renewing by phone. The Enrollment Center processes renewals from 35 counties. In 2014, 318,000 renewals were processed. No new counties are being added to the Enrollment Center as these renewals will all transition to NYSOH as soon as the functionality can be built to transition the MAGI enrollees from WMS to NYSOH.

Processing Family Planning Benefit Program Applications

Effective November 2012, New York State included a presumptive eligibility (PE) option and transportation services for the Family Planning Benefit Program (FPBP) in its Medicaid State Plan. With this change, individuals 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 provides eligible individuals with immediate access to FPBP-covered services. The Department transitioned the responsibility for all FPBP application processing from local districts, including NYC HRA, to New York Health Options. During the past year, approximately 39,000 presumptive eligibility and FPBP applications have been processed by New York Health Options. The Department oversees the contract with New

York Health Options and retains responsibility for approving the final eligibility determination for coverage.

Asset Verification and Real Property Resource Verification System

In November, 2014, the Department executed a contract with Public Consulting Group, Inc. (PCG), to customize an Asset Verification and Real Property Resource Verification System. This system, the AVS, will identify assets and real property that might not otherwise be discovered through the eligibility determination process and will assist local districts with asset documentation requirements by providing verification results in a timely manner. The Asset Verification System Portal will consolidate Accuity's financial institution and LexisNexis' property data into a web-based application interface through which verification requests will be made, processed and results returned. The interface will be able to verify assets for a one month request or a 60-month look-back period for nursing home eligibility. All Medicaid applications or requests for long-term care services made by an individual in the aged, certified blind or certified disabled category of assistance will have assets verified through the AVS system. The Department began working with PCG in November 2014 and will develop requirements of the project through two work groups, one for New York City and one for the rest of the state. This will allow for critical input from the relevant stakeholders specific to how eligibility is processed in their counties. All local districts will be trained on the AVS Portal prior to implementation.

Medicaid Applications for Inmates/Coverage for Inpatient Hospital Care

In June 2014, NYSOH modified the online application to expand Medicaid suspensions by accepting applications from incarcerated individuals who are Medicaid eligible. This initiative will improve access to Medicaid for inpatient hospital stays and benefits upon release. As of October 2014, 2,200 incarcerated Medicaid enrollees have been approved for inpatient-only coverage through NYSOH.

Disability Determinations

The State Disability Review Team (SDRT) performs disability determinations for Medicaid eligibility purposes for all local districts outside New York City and the Office for People with Developmental Disabilities. Medical evidence gathering and New York City disability determinations will be transitioned to the SDRT when a new disability determinations system and all resources necessary to perform the function are in place.

Reassessing Eligibility when a Household Member is Deceased

The Department has been centralizing the resolution of reported deaths by the Social Security Administration since January 2013. 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 or exceptions from the automated process are handled by the 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 investigating and resolving exceptions from the automated process, including closing coverage for a person in a multi-person household and contacting the district to re-budget the remaining family members. The Department began phasing in the centralization on January 1, 2013 in a few counties. The Department added 14 counties in 2013 and added the remaining non-NYC counties in the early part of 2014. 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. The statewide assumption of this function will be completed in 2015.

Family Health Plus Premium Assistance Program

Approximately 9,000 Family Health Plus enrollees who were identified as also having TPHI according to state data systems were contacted to confirm the accuracy of the TPHI information and appropriate enrollment in FHP. Individuals with active TPHI were disenrolled from FHP and offered premium assistance, where appropriate. The FHP program will be discontinued at the end of 2014 as most enrollees have been transitioned to Medicaid.

State Assumption of County Medicaid Transportation Management

Since 2011, the Department has been phasing in the assumption of the management of Medicaid transportation 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. The initiative created 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 (MAS), a Syracuse-based non-emergency medical transportation management company. This state management initiative, now expanded to 24 counties and includes 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 were included under LogistiCare's transportation management as of January 1, 2013 – representing a total of 3.1 million Medicaid enrollees, the largest Medicaid transportation management project in the nation.

In November 2012, the Department offered a procurement for 24 counties in the Finger Lakes and Northern New York regions. The contract was awarded to MAS, and by August 2013 all of the counties in the two regions were being managed by MAS. In August 2013, another procurement was offered for the seven-county Western New York region that includes Erie County. The contract was awarded to MAS, and as of September 2014, all of the counties in the Western New York region were under state management. Beginning January 1, 2015, all managed care enrollees throughout the Western New York Region counties will be included under MAS' management. A procurement for the Long Island region comprising Nassau and Suffolk counties was issued in September 2014, and responding proposals are being reviewed for the contract award. With this procurement, state administration of Medicaid transportation will have been achieved in every county.

The transportation management initiatives have met the Medicaid Redesign Team's ongoing $30 million transportation state share savings target. 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. In addition, state administration has improved service quality, provided faster responses to transportation access problems, including during natural disasters, and has resulted in better fraud and abuse identification and prevention.

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 (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 September 2012, and as of November 2014 more than 138, 200 individuals are enrolled in MLTC plans. This represents a 138% increase in MLTC enrollment since the mandatory transition was introduced. In March 2013 mandatory enrollment was initiated in Nassau, Suffolk, and Westchester counties; September 2013 saw expansion of mandatory MLTC enrollment in Orange and Rockland counties. December 1, 2013 increased the mandated MLTC enrollment in Albany, Erie, Monroe and Onondaga counties. In 2014, mandatory enrollment has continued to expand to 18 additional counties (Dutchess, Montgomery, Broome, Fulton, Schoharie, Delaware, Warren, Niagara, Madison, Oswego, Chenango, Cortland, Livingston, Ontario, Steuben, Tioga, Tompkins, and Wayne). Other counties will transition in 2015 to complete the statewide expansion of MLTC.

The expansion of MLTC enrollment reduces the participation in programs managed by the LDSS, including the Personal Care Services Program, Personal Emergency Response Services, Consumer Directed Personal Assistance Program and the Long Term Home Health Care Program. The responsibility for the LDSS to assess the need for community based long term care 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.

The LDSS staff is not required to enroll and disenroll MLTC participants nor are they responsible for sending appropriate notice to the MLTC enrollees; this responsibility has been assumed by the state's enrollment broker, New York Medicaid Choice. Any change in service authorization, particularly reductions, resulting in fair hearing requests are also handled by the MLTC and the state's enrollment broker rather than LDSS staff. Additionally, the LDSS staff role in the prior approval of placements into the Assisted Living Program is no longer required but post placement review of admission is solely at LDSS option.

The New York State Terms and Conditions for the 1115 waiver also required the state to implement a conflict free evaluation and enrollment center for Medicaid recipients newly seeking MLTC enrollment. Therefore, on October 1, 2014, the Department began implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC). Our contractor, Maximus (New York Medicaid Choice), is responsible for conducting an evaluation to determine if an individual is eligible for Community Based Long Term Care (CBLTC) for 120 days or more. The CFEEC will act as the point of entry for individuals, both Medicaid and non-Medicaid, seeking CBLTC services and provide a conflict free determination. The CFEEC evaluation is completed by a Nurse Evaluator in the individuals' home and the single evaluation instrument, the Uniform Assessment System, is administered. Following the evaluation, Maximus staff provides education to the individual on benefits and available MLTC plans in their district.

MAXIMUS has taken a phased approach to implement the CFEEC. MAXIMUS is implementing a mandatory roll out schedule for the CFEEC contingent upon the timing of the counties becoming mandatory for MLTC enrollments. This roll-out will ensures that all Fully Integrated Dual Advantage (FIDA) regions have an independent assessor in place prior to operationalizing.

LDSS will no longer have a role in evaluating a Medicaid recipient's appropriateness for MLTC participation as the CFEEC will evaluate.

FUNCTIONS REMAINING WITH COUNTIES IN 2015

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 to 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 during 2015 include:

- *Providing in-person application assistance to MAGI applicants/enrollees, for counties that choose to retain this function;*
- *Continued renewal of MAGI enrollees in WMS until they can be transitioned to NYSOH;*
- *Assisting those who are denied TANF to apply for Medicaid and conduct separate determinations for non-MAGI applicants;*
- *Administering the spend down program;*
- *Processing applications and renewals for individuals who are aged, blind, or disabled;*
- *Medicare Savings Program (MSP) application processing;*
- *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; and*
- *Provide legal assistance with recoveries.*

The state will work with counties to determine the appropriate phase-in of the non-MAGI population to the state. Those counties that wish to retain responsibility for the eligibility determinations for certain non-MAGI populations for the long-term will need to enter into contracts with the state. In 2015, the Department plans to solicit the interest of counties in which functions of the Medicaid program they want to retain under contract with the state. County interest may have changed since the initial survey conducted in 2012.

FINANCING MEDICAID ADMINISTRATION

Part F of Chapter 56 of the Laws of 2012 established a cap on county Medicaid administrative costs at State Fiscal Year 2011-12 appropriated levels. The savings from the cap were used to fund the state staff to assume Medicaid functions and the State Financial Plan assumed $121 million in reduced LDSS claims under this ceiling in FY 2015. The August 2014 Global Cap update indicates that year to date spending on administrative services is $5 million higher than initially forecasted, though spending is likely to decrease as State Takeover progresses.

As the state assumes additional functions, local district claiming for Medicaid administrative costs is expected to decline. The state anticipates reductions below the 2011 levels beginning in 2015 as 65 percent of new Medicaid applications are processed centrally through the NYSOH Health Plan Marketplace. The Department recognizes that three million current MAGI enrollees still need to be transitioned from the counties to NYSOH during 2015 and 2016, and counties will retain responsibility for the eligibility determinations for the non-MAGI population, a population requiring more work than the MAGI population. Any future reductions in the administrative ceiling will reflect the volume that remains with the counties, as well as the uneven workload relief provided to specific counties as the state phases in Medicaid administration functions.

DELAYS IN MEDICAID ADMINISTRATION

The Department experienced delays in its ability to assume more functions in 2014 due to the complexity of eligibility rules for the MAGI population, changing federal guidance requiring a shift in priorities, and a lack of sufficient resources for system development throughout 2014. The Department had expected to complete full functionality for the MAGI population in 2014 and begin to develop the requirements for the non-MAGI population in 2015. The entire project schedule has been delayed by one year. The project experienced a setback with a six-month delay in securing a contract amendment to add resources to the Systems Integrator contract. This caused significant delays implementing high priority functionality. In addition, delays with some of our interface partners, such as WMS also deferred essential functionality. The Department assumed a large number of manual tasks to work around these system delays, but could not hire staff quickly enough to keep up with the manual work load. Typically, the process for establishing new positions for state takeover is 6-9 months.

Part F of Chapter 56 of the Laws of 2012 provided flexibility in hiring and contracting for the Department to implement the assumption of Medicaid administration. The contracting flexibility expires on March 31, 2015. The Department anticipates releasing an RFP for the Customer Service Center in 2015 and awarding a contract in 2017. A procurement of this size and complexity typically takes two years from the release of the RFP to contract execution. Until a new contract can be executed, the current Customer Service Center will operate under its contract amendment.

The Department will continue to identify and assess other barriers that affect the ability to meet projected timelines for the transition.

State Medicaid Administration Timeline

2014

January 2014

- ✓ All new Medicaid applications for individuals in MAGI eligibility categories begin being processed by NYSOH
- ✓ Continue to train CACs

March 2014

- ✓ Release additional NYSOH system functionality
- ✓ Add counties to state centralization of reassessing eligibility for families with deceased members

April 2014

- ✓ Retroactive eligibility for MAGI categories processed in NYSOH
- ✓ Begin transportation management initiative in the seven-county Western Region
- ✓ Expected release of procurement for Transportation Management of Long Island (Nassau and Suffolk counties)

June 2014

- ✓ Release additional NYSOH system functionality

October 2014

- ✓ Begin processing administrative renewals through NYSOH

November 2014

- ✓ Contract for the Asset Verification System (AVS)
- ✓ NYSOH Year 2 Open Enrollment begins
- ✓ Released new consolidated eligibility notices
- ✓ Launched online application in Spanish

December 2014

- ✓ Mandatory transition to the Conflict Free Evaluation and Enrollment Center for Managed Long Term Care in Regions 1&2 (New York City and Nassau).
- ✓ Submit Annual State Administration Report to Governor and Legislature

State Medicaid Administration Timeline

2015

February 2015

- ✓ Open Enrollment closes

March 2015

- ✓ Release additional NYSOH system functionality focused on closing gaps in automated rules and reducing manual work
- ✓ Implement AVS with one upstate demonstration county

April 2015

- ✓ Move some Medicaid enrollees into the Basic Health Program

June 2015

- ✓ Roll-out AVS implementation to non-NYC counties.
- ✓ Begin AVS implementation in NYC
- ✓ Release additional NYSOH system functionality
- ✓ Begin to transition pre-2014 MAGI Medicaid and CHIP enrollees to NYSOH at renewal

September 2015

- ✓ Processing administrative renewals through NYSOH
- ✓ Eligibility rules for the Basic Health Program programmed into NYSOH for renewals

October 2015

- ✓ NYSOH Year 2 Open Enrollment begins

December 2015

- ✓ Reassess county interest in contracting with the state for Medicaid administrative functions
- ✓ Implement presumptive eligibility in NYSOH
- ✓ Mandatory transition to the Conflict Free Evaluation and Enrollment Center for Managed Long Term Care in Regions 4, 5, and 6.
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2016

- ✓ Basic Health Program coverage begins for all eligibles.
- ✓ Transition MAGI Medicaid enrollees in NYC from WMS to NYSOH at renewal
- ✓ Define requirements for Phase 1 of transitioning non-MAGI eligibility determinations to NYSOH
- ✓ Develop Plan for Automating Non-MAGI eligibility determinations
- ✓ Draft contract template for local districts for long-term administration of certain Medicaid functions
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2017

- ✓ Complete system development for non-MAGI eligibility determinations in NYSOH.
- ✓ Execute contracts with local districts, if applicable, for long-term administration of certain Medicaid functions.
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2018

- ✓ Complete transition of non-MAGI populations to NYSOH
- ✓ Submit Annual State Administration Report to Governor and Legislature