2015

Medicaid Administration

Annual Report to the Governor and Legislature

NEW YORK STATE OF OPPORTUNITY. Department of Health

BACKGROUND

Section 6 of Part F of Chapter 56 of the Laws of 2012 authorized the State to transfer responsibility for the administration of the Medicaid program from Local Departments of Social Services (LDSS) to the Department of Health (Department). 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 annual report provides an update on 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 2015, the state processed over 2.5 million eligibility determinations/enrollments, 41 percent more than in 2014. The large volume is driven by the shift of Medicaid applications for Modified Adjusted Gross Income (MAGI) populations from the local districts to NY State of Health as of January 1, 2014. In addition to processing new applications, NY State of Health 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, pursuing third party coverage, and processing renewals. Apart from eligibility determinations, the State administration of transportation management and managed long-term care are now statewide .

The chart below shows the increase in the volume of eligibility determinations/enrollments assumed by the state in 2015.

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

	2014		2015	
	Monthly	Annually	Monthly	Annually
MAGI Applications/Renewals	111,700	1,340,000	177,400	2,129,000
Enrollment Center Renewals	26,500	318,000	22,900	275,500
Family Planning Benefit Program	3,250	39,000	2,800	33,500
Auto Renew Aged, Blind and Disabled	4,100	49,200	5,500	66,000
Managed Long Term Care	11,500	138,000	13,200	158,000
Total	**157,000**	**1,884,200**	**221,800**	**2,662,000**

The report is organized into six 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*

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

CENTRALIZED ELIGIBILITY DETERMINATIONS

New York State of Health, the state's health plan marketplace, 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. In November 2015, NY State of Health began processing applications for the Basic Health Program, branded as the Essential Plan. As of December 31, 2015, the APTC Premium Assistance Program will end. Applicants can apply online, by phone, by mail, and in-person.

Marketplace Medicaid Enrollment

In 2015, NY State of Health determined over two million individuals eligible for Medicaid. Of these, 8 percent were eligible for the newly expanded eligibility level between 100 to 138 percent of the federal poverty level. The remaining 92 percent of Medicaid enrollments were for individuals previously eligible, but not enrolled, or past enrollees who experienced a gap in coverage and enrolled as new applicants.

Approximately 70 percent of Medicaid enrollees are adults between the ages of 18-64, 29 percent are children under age 18 and less than 1 percent are adults age 65 or over. Approximately 60 percent of the Medicaid enrollments were from New York City, 10 percent from Long Island, and the remaining 30 percent from other counties throughout the state. Medicaid enrollment in NY State of Health is diverse. Of those reporting, about 27 percent are white, 20 percent Hispanic, 15 percent African American, 3 percent Chinese, and 7 percent Asian Indian or other Asian. Nearly one half of all enrollees do not provide their race/ethnicity.

Until eligibility for the entire Medicaid population can be processed in the Marketplace eligibility system, new applications for the MAGI population will be processed by the Marketplace and new applications for the non-MAGI population will be processed by the LDSS in the 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 NY State of Health website who indicate certain attributes are referred to the local district to have their eligibility for Medicaid coverage determined using non-MAGI eligibility rules.

As NY State of Health 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.

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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.

Third Party Liability (TPL)

Individuals with third party health insurance (TPHI) are eligible for Medicaid; however, Medicaid is the secondary payer to the other coverage. The Department has a Third Party Liability unit to maximize payments by other insurance. By pursuing third party health insurance, over $7.2 billion dollars in Medicaid payments are prevented per year in New York State. The Third Party Liability (TPL) unit ensures available TPHI is recorded in the claims processing system and assesses the cost benefit of paying the premiums for the TPHI. The unit supports the NY State of Health by managing the TPHI for its enrollees. The work completed by the TPL unit for NY State of Health has almost doubled between 2014 and 2015.

Since January 2015, the TPL unit has handled approximately 23,400 requests from NY State of Health to verify third party coverage and assess individuals for premium assistance. It has also updated over 73,000 TPHI records. Cost benefit analyses to reimburse group health insurance premiums have been completed for over 1,300 accounts resulting in 507 Health Insurance Premium authorizations covering 1,100 consumers. In addition, 6,052 consumers have been determined eligible for premium payment for the Medicare Part B premium.

CBIC Card Replacement

Medicaid shares a benefit card with cash assistance and the Supplemental Nutrition Assistance Program (SNAP). In a one-year period, the Department manually generated more than 80,000 CBICs. The Department continues to explore ways to streamline and/or automate the card replacement process.

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. It also reimburses out-of-pocket medical bills incurred from the date of eligibility to the receipt of a CBIC card. A unit established in DOH in 2014 examines and processes reimbursement claims for individuals found eligible in NY State of Health. In 2015, the unit has examined nearly 10,000 reimbursement claims submitted by NY State of Health applicants and enrollees. The unit also communicates with medical providers to offer assistance on correct claim submission procedures to eMedNY.

Renewals

In October 2014, the State began renewing Medicaid enrollees who had initially applied on NY State of Health. Renewals for Marketplace enrollees are first evaluated as to whether they can be administratively renewed. If information exists in the federal and state data bases to determine continued 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 are 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.

On average, one third of Medicaid enrollees can be administratively renewed. Two-thirds must return to the Marketplace to renew. Of those who can be administratively renewed, a large portion return to update their information. The low rate of administrative renewal is related to the frequency with which income fluctuates in low-income populations and the lack of current income data in the available data sources used for renewal.

Renewal of Medicaid recipients who did not enroll through NY State of Health remains with the LDSS or the Enrollment Center. However, the steadily increasing Medicaid enrollment in NY State of Health suggests that some enrollees are failing to renew at the LDSS or the Enrollment Center and then apply through the Marketplace as new applicants. The migration of enrollees in WMS to NY State of Health will continue until functionality can be built in the eligibility system to transition all of them from WMS. The Department expects the system development for the transition will be completed in 2015. In 2016, the Department can begin to phase in the transition of MAGI Medicaid enrollees in WMS to NY State of Health. The state intends to begin with a few counties to ensure the transition is successful and does not disrupt coverage. It will then expand the transition to the rest of the counties outside NYC and then finish the transition with NYC enrollees.

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. In 2015, 12,000 recipients were referred to the local districts at renewal for determination of continued Medicaid eligibility using non-MAGI rules as a result of turning age 65 or newly receiving Medicare. 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

NY State of Health has a robust Customer Service Center with locations in Albany and New York City 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, and has fielded nearly 3 million calls from January through August 2015.

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 52 percent of these calls originated in New York City, 13 percent in Long Island, and the remaining 35 percent in upstate counties.

New York remains committed to providing comprehensive assistance through the NY State of Health Customer Service Center 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. Between January and August 2015, 580,000 non-English calls were answered by the call center, about 20 percent of all calls. Multilingual NY State of Health representatives directly responded to nearly 75 percent of these consumers and the remaining callers received assistance via three-way calls with a “language line” interpreter.

Community-Based Assistors

Community-based assistors have historically played a significant role in helping low-income New Yorkers apply for Medicaid. In 2015, all new MAGI applications from trained community-based assistors were submitted to NY State of Health using the online application, including applications from In-Person Assistors/Navigators, Marketplace Facilitated Enrollers (health plans), 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, certified and registered on New York State of Health as of September 1, 2015. The number does not include the approximately 5,000 brokers who have been trained.

Table 2: Number of Assistors Trained, Certified and Registered as of September 1, 2015

Type of Application Assistor	Total Number Trained, Certified and Registered as of 9/1/15
Navigators	531
Federally Qualified Health Centers (FQHCs)	360
Hospitals	1,383
Healthcare Providers	284
Local Departments of Social Services (LDSS)	252
Marketplace Facilitated Enrollers (FEs)	2,420
Other Organizations	544
Totals	5,774

Assistors submit approximately three quarters of all applications received by NY State of Health. As of September 2015, Assistors enrolled 1.7 million individuals, with health plan facilitated enrollers and Navigators responsible for the largest number of enrollments. Medicaid enrollment accounted for 84 percent of total enrollments, with QHP enrollment at 9 percent and CHIP at 7 percent.

Implementation of the Basic Health Program (Essential Plan)

In 2015, the State implemented the Basic Health Program, branded as the Essential Plan in New York. While not a Medicaid program, the program transitions about 260,000 Medicaid enrollees to the Essential Plan and expects to provide savings to the Medicaid global cap of nearly $1 billion in State Fiscal Year 2015-16. It also transitions responsibility for the eligibility determinations, renewals, and other case management functions for the prior Medicaid enrollees from the local districts to the State.

The Essential Plan was available through NY State of Health beginning November 1, 2015 for coverage beginning January 1, 2016. The Essential Plan provides New York the opportunity to offer many consumers a lower-cost health insurance option than was previously available through NY State of Health. The Essential Plan is available to consumers under age 65, not eligible for Medicaid or the Children's Health Insurance Program (CHIP), without access to affordable minimum essential coverage, and who have income at or below 200 percent of the FPL ($23,540 for a household of one; $48,500 for a household of four in 2015). Consumers with income at or below 150 percent of the FPL ($17,655 for a household of one; $36,375 for a household of four in 2015) have no monthly premium. Those with income greater than 150 percent of the FPL, but at or below 200 percent of the FPL have a low monthly premium of $20. In accordance with federal requirements, all plans cover essential health benefits including inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others, with no annual deductible and low out-of-pocket costs. Preventive care such as routine office visits and recommended screenings have no out-of-pocket cost to enrollees.

New York began the transition to the Essential Plan on April 1, 2015. Lawfully present non-citizens with incomes at or below 138% of the Federal Poverty Level (FPL) who were enrolled in Medicaid, but not eligible for Federal Financial Participation (FFP), were transitioned to the Essential Plan. During the transition period from April 1-December 31, 2015, these individuals were permitted to remain in their Medicaid managed care plans. These individuals will be transitioned to an Essential Plan insurer on January 1, 2016 or at their renewal starting in 2016.

New Yorkers with income above the Medicaid level had the ability to enroll in the Essential Plan during the 2016 NY State of Health open enrollment period which began on November 1, 2015. For eligible consumers who were enrolled in Qualified Health Plan (QHP) coverage through NY State of Health during 2015, the Essential Plan will reduce their monthly premium costs and their out-of-pocket costs when they receive services. Enrollment in the Essential Plan is available through the NY State of Health website, by telephone with Customer Service or in-person with one of the trained and certified Marketplace assistors.

As of September 30, approximately 260,000 individuals were enrolled in the Essential Plan. This number only includes the former Medicaid enrollees who transitioned to Essential Plan, as any new enrollment among those applying during open enrollment will not be effective until January 1, 2016.

MODERNIZED MEDICAID ELIGIBILITY SYSTEM

The most important factor in the state's ability to assume Medicaid administrative functions 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.

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 that it integrates eligibility for Medicaid, CHIP, Essential Plan and tax credits for QHPs in a single system. The integrated approach allows entire families whose members may be eligible for different programs 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 who meet the MAGI definition referred from one program to another, having to begin an entirely new application. Updates and changes that result in new eligibility can occur in the system and enrollees can be transitioned to another program without gaps in coverage. Eventually, once all Medicaid enrollees are in one eligibility system, these same integrated transitions will apply to non-MAGI enrollees as well.

The eligibility system also includes "back office" functions for staff. The system provides back office screens that enable customer service representatives, 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 in the future.

In 2015, the eligibility system did not add significant new Medicaid functionality, largely as a result of the need to implement a new insurance option in the Marketplace, the Essential Plan. The work involved to launch the Essential Plan was significant, requiring changes to the eligibility rules, the online application, the creation of new notices, and the addition of new health plan choices and the corresponding changes to enrollment transactions. At the same time the Essential Plan was launched, the APTC Premium Assistance Program ended, requiring system changes to remove that program from the Marketplace. Some additional functionality was implemented in 2015 with more expected to be completed by the end of 2015. The added functionality includes:

- Periodic data matching to enable monthly verification to identify enrollees who are now deceased,

- Enhancements that fill gaps in functionality such as automating retroactive Emergency Medicaid, corrections to the treatment of Title II income, modifications to inmate suspension and reinstatement rules, improvements to the

newborn processing rules, and modifications to the rules for pregnant women and pregnant minors.

- Continued enhancements to tighten the rules to prevent duplicate coverage.
- Ensure that no one over age 65 who is not a parent or caretaker relative is enrolled in the adult group.
- Development of “read only” access to the back office and the creation of additional roles to limit access to functionality to the minimum amount necessary.
- Functionality to permit the phased transition of MAGI Medicaid enrollees from WMS to NY State of Health.
- Functionality to give consumers an opportunity to receive voter registration forms when applying for coverage through NY State of Health by including forms in eligibility determination and renewal notices.

Work remains into 2016 and 2017 to complete the Medicaid MAGI functionality, add verification sources, and improve the user experience. Among the items in the pipeline are:

- 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).
- Improvements to assessing third party coverage.
- Ability to select a Special Needs Plan.
- Ability to select a primary care provider online for Medicaid.
- 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.
- Completion of periodic verification across all eligibility factors.
- Enhanced ability to create and change enrollment transactions.
- The addition of an Equifax service through the federal hub as a verification source of current income.
- Implement absent parent functionality.
- 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.

- Processing the incarceration file from Rikers.

Once the functionality for eligibility determinations and enrollments for the MAGI Medicaid population is complete, the State can begin to 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. In addition, NY State of Health will need to be further developed and leveraged to support the planned Integrated Eligibility System which will include all the human services programs.

STATUS OF OTHER FUNCTIONS ASSUMED BY THE STATE

This section provides an update of the 8 other functions the State has assumed since 2012. The functions include other eligibility-related functions apart from MAGI determinations, Medicaid transportation management and managed long term care.

Other Eligibility-Related Functions

- **Administrative Renewals for Aged, Blind and Disabled.** Administrative Medicaid renewals are completed statewide for individuals whose only source of income is from the Social Security Administration (SSA). In addition, outside New York City, administrative renewals have expanded to include individuals with pensions and the Medicare Savings Program (MSP) population with income from SSA benefits and/or pensions. Administrative renewals eliminate 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 2015, more than 66,000 administrative renewals were completed, a 32 percent increase over the number completed in 2014.

- **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 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). Renewals may be completed by mail or by phone, with 63 percent of consumers renewing by phone. The Enrollment Center processes renewals from 36 counties, with the addition of two counties in 2015. Approximately 275,500 renewals were processed in 2015. The volume of renewals processed at the Enrollment Center has decreased in the past year. The decline is likely due to individuals failing to renew at the Enrollment Center and applying at the Marketplace as new applicants and the elimination of the Family Health Plus (FHP) program. Many former FHP enrollees have transitioned to coverage on the Marketplace.

- **Processing Family Planning Benefit Program Applications (FPBP).** During the past year, approximately 33,500 presumptive eligibility and FPBP applications have been processed by the Enrollment Center.

- **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. A web-based interface will be able to verify current assets and assets owned during 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 are subject to asset verification through the AVS system. The Department is working with PCG and several local districts, including New York City, to assist in the development and implementation of AVS. Testing of the interface has begun, in advance of

piloting the system with several local districts in 2016. All local districts will be trained on the AVS Portal prior to implementation.

- **Medicaid Applications for Incarcerated Individuals.** Incarcerated individuals continue to be eligible for Medicaid. The only restriction is on the services they may receive, as Federal rules permit payment for inpatient hospital care only. The online application process through NY State of Health improves access to Medicaid for inpatient hospital stays and benefits upon release for Medicaid eligible inmates. As of November 17, 2015, 8,700 incarcerated Medicaid enrollees had inpatient-only coverage on the Marketplace. Another 22,000 had the same coverage on WMS. The Department continues to work in partnership with the Governor's Reentry Council, other State agencies and criminal justice entities to enhance the "suspension" and reinstatement process for incarcerated individuals.

- **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. The State anticipates that system support will be in place to begin to transition medical evidence gathering for several upstate local districts beginning in early 2016.

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 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. By the end of 2015, the State will have achieved its goal of assuming transportation management in every county.

The Department contracts with two transportation management companies to coordinate Medicaid transportation statewide. LogistiCare Solutions, a national transportation management company has developed an improved, cost-effective Medicaid transportation infrastructure in New York City. As of July 1, Nassau and Suffolk Counties are included under LogistiCare's management. Medical Answering Services (MAS), a Syracuse-based non-emergency medical transportation management company, manages Medicaid transportation throughout the rest of the state. This state management initiative has successfully consolidated local administrative functions, provided more consistent management expertise and Medicaid policy oversight, and improved resource coordination.

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 more appropriate 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 was 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. By July 2015 the statewide expansion was complete. 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, are required to access services through a managed long term care (MLTC) model.

As of October 2015 more than 158,000 individuals are enrolled in MLTC plans. This represents nearly a threefold increase in MLTC enrollment since the mandatory transition was introduced.

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 plan 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 acts as the point of entry for individuals, both Medicaid and non-Medicaid, seeking CBLTC services and provides a conflict free determination. The CFEEC evaluation is completed by a Nurse Evaluator in the individual's 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.

The Department has taken a phased approach to implement the CFEEC. By July 2015 the Department had completed implementing a mandatory roll out of all the counties and the LDSS no longer had a role in evaluating a Medicaid recipient's appropriateness for MLTC participation.

FUNCTIONS REMAINING WITH COUNTIES IN 2016

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 manage the transition. Eligibility workers at the local level have been critical partners in reducing confusion and assisting enrollees in retaining coverage. In addition to assisting the state in implementing 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 2016 are the same as in 2015 and 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 NY State of Health;*
- *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 eligibility determinations for individuals enrolling in MLTC;*
- *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 2017, the Department plans to solicit the interest of counties regarding 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 costs to assume Medicaid functions. The State Financial Plan assumed $84 million in reduced LDSS claims under the administrative ceiling for FY 2016. The November 2015 Global Cap update indicates that year to date spending on administrative services is $11 million higher than initially forecasted. The shortfall can be accommodated by slower than anticipated spending on personnel and IT contracts.

DELAYS IN MEDICAID ADMINISTRATION

The Department experienced delays in its ability to assume more functions in 2015 due to the implementation of the Essential Plan and a lack of sufficient resources for system development. A priority was given to the Essential Plan over adding other Medicaid functionality based on the nearly $1 billion in savings the program is expected to generate for the Medicaid global cap in State Fiscal Year 2015-16. The Department assumed a large number of manual tasks to work around the system delays, but could not hire staff quickly enough to expand the scope of the manual activities.

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 expired on March 31, 2015. The Department anticipates releasing an RFP for the Customer Service Center in 2016 and awarding a contract in 2017. A procurement of this size and complexity typically takes more than a year 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.

State administration is also delayed by the inability to hire staff with the appropriate skills at the pace required.

2015

January 2015

- ✓ Began development of technical requirements for configuration of the AVS portal.
- ✓ Continued development of the new case management support system for disability determinations.

February 2015

- ✓ Open Enrollment closed.

April 2015

- ✓ Began the transition to the Essential Plan.

May 2015

- ✓ Released additional NY State of Health system functionality focused on closing gaps in automated rules and reducing manual work.
- ✓ Implemented automated rules to end coverage on NY State of Health when a death indicator is returned.

July 2015

- ✓ Began transportation management initiative in the Long Island Region (Nassau and Suffolk counties).
- ✓ Added a new county to Enrollment Center renewal processing.
- ✓ Mandatory transition to the Conflict Free Evaluation and Enrollment Center for Managed Long Term Care in Regions 4, 5, and 6.

August 2015

- ✓ Testing the AVS portal commenced.

September 2015

- ✓ Eligibility rules for the Essential Plan programmed into NY State of Health for renewals and open enrollment.

October 2015

- ✓ Began administrative renewals through NY State of Health.
- ✓ Expected release of procurement for Transportation Management of Hudson Valley Region counties (24 counties).

November 2015

- ✓ NY State of Health Year 3 Open Enrollment began.
- ✓ Added a new county to Enrollment Center renewal processing.

December 2015

- ✓ Released additional NY State of Health system functionality.

2016

January 2016

- ✓ Basic Health Program coverage begins for all eligibles.
- ✓ Begin transition of the Essential Plan eligibles from WMS to NY State of Health.

February 2016

- ✓ Implement AVS for non-NYC demonstration counties.

March 2016

- ✓ Begin AVS implementation in NYC.

May 2016

- ✓ Implement AVS in remaining non-NYC counties.

June 2016

- ✓ Begin to transition pre-2014 MAGI Medicaid enrollees from WMS to NY State of Health.

August 2016

- ✓ Develop plan for phasing in non-MAGI functionality into NY State of Health.

September 2016

- ✓ Add functionality to NY State of Health for next open enrollment and to improve renewals.

October 2016

- ✓ Implement administrative renewals.

November 2016

- ✓ Open Enrollment for 2017 coverage begins.

December 2016

- ✓ Add functionality to NY State of Health.

2017

- ✓ Continue the transition of MAGI Medicaid enrollees from WMS to NY State of Health at renewal.
- ✓ Implement presumptive eligibility and FPBP in NY State of Health
- ✓ Implement Riker's interface.
- ✓ Draft contract template for local districts for long-term administration of certain Medicaid functions.
- ✓ Reassess county interest in contracting with the state for Medicaid administrative functions.
- ✓ Define system requirements for non-MAGI eligibility determinations.

2018

- ✓ Continue non-MAGI development in NY State of Health
- ✓ Execute contracts with local districts, if applicable, for long-term administration of certain Medicaid functions.