Medicaid Administration

Annual Report to the Governor and Legislature
December 2016

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 2016, the state processed over 3.3 million eligibility determinations/enrollments across all programs. 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 2016.

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

	2014	2015	2016
	Annually	Annually	Annually
Modified Adjusted Gross Income Applications/Renewals	1,340,000	2,129,000	2,837,000
Enrollment Center Renewals	318,000	275,500	142,000
Family Planning Benefit Program	39,000	33,500	35,000
Auto Renew Aged, Blind and Disabled	49,200	66,000	73,000
Managed Long Term Care	138,000	158,000	170,000
Total	**221,800**	**2,662,000**	**3,257,000**

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.

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, Essential Plan, Advance Premium Tax Credits (APTC), Cost-Sharing Reductions, and unsubsidized purchases of Qualified Health Plans. Applicants can apply online, by phone, by mail, and in-person.

Marketplace Medicaid Enrollment

From January 1, 2014 to September 2016, NY State of Health determined 2.3 million individuals eligible for Medicaid. Of these, 9 percent were eligible for the newly expanded eligibility level between 100 to 138 percent of the federal poverty level. The remaining 91 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 68 percent of Medicaid enrollees are adults between the ages of 18-64 and 32 percent are children under age 18. 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 enrollees reporting, about 27 percent are white, 21 percent Hispanic, 16 percent African American, 6 percent Chinese, and 7 percent Asian Indian or other Asian. Nearly 40 percent 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 payment from other health insurance (third-party liability) and processing requests for reimbursement of medical bills. In 2016, the state also began to transfer MAGI Medicaid enrollees from WMS to NY State of Health.

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 NY State of Health by managing the TPHI for its enrollees.

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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.

In 2016, the TPL unit handled approximately 29,057 requests from NY State of Health to verify third party coverage or to assess individuals for premium assistance. It has also updated over 124,000 TPHI records. Cost benefit analyses to reimburse group health insurance premiums have been completed for 510 accounts resulting in 299 Health Insurance Premium authorizations covering 6500 consumers. In addition, 4,788 consumers have been determined eligible for premium payment for the Medicare Part B premium.

Reimbursement of Medical Bills

Medicaid rules provide for reimbursement of medical bills incurred in any or all of the three months prior to Medicaid eligibility determination 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 2016, the unit has examined nearly 14,000 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.

Transition from WMS to NY State of Health at Renewal

MAGI individuals who enrolled in Medicaid prior to January 1, 2014, Medicaid eligibility determinations were renewed by the local districts instead of being transitioned to NY State of Health. Beginning July 2016, MAGI individuals in WMS began to transition to NY State of Health at their renewal. The transition will be phased in by county, beginning with counties that have had their renewals processed by the Enrollment Center. The renewal volume transitioning from WMS to NY State of Health is 20,000 per month through the end of 2016.

Customer Service Center

Since the creation of the NY State of Health customer service center in October 2013, call center representatives have fielded more than 10 million calls from individuals and families with questions about Medicaid, Child Health Plus, the Essential Plan (EP), Advance Premium Tax Credits (APTC), Cost-Sharing Reductions and Qualified Health Plans. In the first six months of 2016 alone, representatives responded to more than 3 million calls requiring the provision of assistance with updating consumer Marketplace accounts and details about program documentation requirements, the assessment of potential eligibility for public health insurance programs, and the provision of information about covered benefits, current coverage status and plan enrollment. Overall, about 53 percent of these calls originated in New York City, 13 percent in Long Island, and the remaining 34 percent in upstate counties.

To ensure adequate access for consumers in need of assistance, the NY State of Health customer service center is open Monday through Friday from 8am to 8pm and on Saturday from 9am to 1pm. Additionally, New York remains committed to providing access to quality assistance for those for whom English is not their primary language – nearly 650,000 consumers received help in their language of choice in the first half of 2016. For more than 70% of these calls, consumers were served by the NY State of Health's bilingual customer service staff which are able to communicate in Cantonese, Haitian-Creole, Mandarin, Russian and Spanish. For the other 30% of foreign language calls, consumers have the opportunity to communicate via three-way call with a "language line" interpreter and a NY State of Health representative.

Community-Based Assistors

Community-based assistors have historically played a significant role in helping low-income New Yorkers apply for Medicaid. In 2016, 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 July 1, 2016. Navigators are community-based organizations that have contracts with the state to help individuals enroll in coverage. Certified Application counselors are trained by the state to assist individuals enroll, but do not have contracts with the state. The number does not include the approximately 5,000 brokers who have been trained.

Table 2: Number of Assistors by Type Listed Below Trained, Certified and Registered as of July 1, 2016

Type of Application Assistor	Total Number Trained, Certified and Registered as of 7/1/16
Navigators	497
Federally Qualified Health Centers (FQHCs)	316
Hospitals	1,537
Healthcare Providers	227
Local Departments of Social Services (LDSS)	176
Marketplace Facilitated Enrollers (FEs)	1,972
Other Organizations	468
Totals	5,193

Assistors submit approximately three quarters of all applications received by NY State of Health. As of July 2016, assistors enrolled 2.2 million individuals, with health plan facilitated enrollers and Navigators responsible for the largest number of enrollments. Medicaid enrollment accounted for 78 percent of total enrollments, with QHP enrollment at 4 percent and CHP at 6 percent. The remaining 12 percent of enrollments by assistors were in the newly established Essential Plan.

Impact of Essential Plan

In 2015, the State implemented the Basic Health Program, branded as the Essential Plan in New York. While not a Medicaid program, about half of the program's enrollment is comprised of individuals who would have been eligible for Medicaid prior to the implementation of the Essential Plan. 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.

Essential Plan has been extremely successful. As of September 2016, 570,000 individuals were enrolled in Essential Plan through NY State of Health. The program also provided $1 billion in savings to the Medicaid Global Cap in State Fiscal Year 2015-16.

Beginning January 2016, the Essential Plan population in WMS began to transition to NY State of Health at their renewal. All Essential Plan enrollees will be in NY State of Health by June 2017.

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, CHP, 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 or Essential Plan will have children eligible for Medicaid or CHP. 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.

In 2016, the eligibility system added important functionality for Medicaid. The added functionality includes:

- Transition of MAGI Medicaid enrollees from WMS to NY State of Health.
- Administrative renewals and auto-enrollment across Medicaid, EP and CHP.
- Eligibility verification simplifications.
- Medicare and other third party health insurance confirmation.
- Ability to select a Medicaid Special Needs Plan.
- Availability of notices in alternative formats for the visually impaired.
- Improve referrals to Local Departments of Social Services
- Enhanced ability to create and change enrollment transactions.
- Address validation

Work remains into 2017 and 2018 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).
- Improve system efficiency to assure the surge in volume from the WMS transition can be managed
- Automate coverage initiation for newborns
- Stop using federal incarceration data base due to incorrect returns and instead rely on State incarceration data
- Allow choice between QHP/EP and Medicaid for pregnant women
- Add access to DMV information to verify identity proofing
- Automate appeals
- Ability to select a primary care provider online for Medicaid.
- Completion of Spanish automated notices and translation and development of notices in other languages.
- 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 eligibility changes for inmates entering or leaving Rikers Island Correctional Facility.

Once the functionality for eligibility determinations and enrollments for the MAGI Medicaid population is complete, additional functionality will be added, such as the implementation of eligibility rules for non-MAGI Medicaid, improvements to the eligibility worker interfaces and improving the consumer experience.

STATUS OF OTHER FUNCTIONS ASSUMED BY THE STATE

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 2016, approximately 73,000 administrative renewals were completed. The Department plans to further expand administrative renewals to the New York City MSP population in 2017.

- **Renewal Processing for Enrollees Permitted to Attest to Income Who Have No Resource Test.** The Department continued processing renewals for enrollees in New York's Medicaid and Family Planning Benefit Programs from 36 counties through the Enrollment Center. During the year, Medicaid enrollees who previously had their coverage renewed through the Enrollment Center started to transition to New York State of Health.

- **Processing Family Planning Benefit Program Applications and Renewals (FPBP).** During the past year, approximately 35,000 presumptive eligibility and FPBP applications have been processed by the Enrollment Center. FPBP renewals will continue to be processed through the Enrollment Center until this population is transitioned to New York State of Health.

- **Asset Verification and Real Property Resource Verification System.** In November 2014, the Department began to develop an Asset Verification and Real Property Resource Verification System (AVS). 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 long term care 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. A pilot of the system began in early 2016 with several upstate local districts. The rest of the upstate local districts will be phased in starting in September of 2016. New York City will begin a pilot in February 2017.

- **Medicaid Applications for Incarcerated Individuals.** New Medicaid applications for incarcerated individuals are now processed by NY State of Health. Improvements to the system will allow for more timely processing of coverage changes for individuals leaving state prison facilities.

- **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 also be transitioned to the SDRT beginning in 2016.

State Assumption of County Medicaid Transportation Management

In 2011, the Department began phasing in the assumption of the management of Medicaid transportation, and consolidated management functions into 6 regions. The regional models 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.

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 and Long Island. 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.

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

As of September 2016 more than 170,000 individuals are enrolled in MLTC plans. This represents a significant 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 state's Medicaid managed care enrollment broker, New York Medicaid Choice enrolls and disenrolls MLTC participants and provides appropriate notices. Service authorization changes and fair hearing requests have been migrated from LDSS' to MLTC plans and the state's enrollment broker. LDSS' no longer authorize Assisted Living Program benefits, but may opt to continue placement reviews.

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 2017 are the same as in 2016 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 Temporary Assistance for Needy Families (TANF) to apply for Medicaid and conducting 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 long term 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 Social Security Income (SSI) cases, including separate determinations when an individual loses receipt of SSI; and*
- *Pursue recovery of Medicaid payments for recipients found to be ineligible.*

The state will work with counties to phase-in the non-MAGI population to the New York State of Health. Counties may opt to contract with the state to retain responsibility for eligibility determinations for certain non-MAGI populations.

FINANCING MEDICAID ADMINISTRATION

Part F of Chapter 56 of the Laws of 2012 established a cap on county Medicaid administrative costs at State Fiscal Year 2011-12 appropriated levels. As outlined in this report, administrative functions associated costs previously handled by counties have been assumed by the State. The State Financial Plan assumed $118 million in reduced LDSS claims under the administrative ceiling for FY 2017.

State Medicaid Administration Timeline

2016

January 2016

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

February 2016

- ✓ Open Enrollment Closed

March 2016

- ✓ Implement AVS for non-NYC demonstration counties (Albany, Schoharie, Suffolk)

June 2016

- ✓ Release of procurement for Transportation Management of New York City
- ✓ Implement system enhancements including adding Special Needs Plans, acting on third party health insurance information, and the ability to receive notices in alternative formats for the visually impaired

July 2016

- ✓ Begin to transition pre-2014 MAGI Medicaid enrollees from WMS to NY State of Health with 12 counties.
- ✓ Added 4 counties to AVS

August 2016

- ✓ 25 additional counties were added to the transition from WMS to NYSOH

September 2016

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

October 2016

- ✓ Implement administrative renewals
- ✓ Added 8 counties to AVS and began AVS in NYC with a small number of chronic care applications

November 2016

- ✓ Open Enrollment for 2017 coverage begins
- ✓ Added 8 counties to AVS
- ✓ Changed and expanded force close process for Medicaid enrollees on NY State of Health when coverage opens on WMS

December 2016

- ✓ Add functionality to NY State of Health.

2017

January 2017

- ✓ Add 9 counties to AVS

February 2017

- ✓ Add 9 counties to AVS
- ✓ Open Enrollment Ends

March 2017

- ✓ Add 13 counties to AVS
- ✓ Continue the transition of MAGI Medicaid enrollees from WMS to NY State of Health at renewal
- ✓ Add functionality to NY State of Health

May 2017

- ✓ Renewals for all counties except NYC

June 2017

- ✓ Develop plan for phasing in non-MAGI functionality into NY State of Health.
- ✓ Begin to define the system requirements for non-MAGI eligibility determinations
- ✓ Reinstate coverage for justice involved individuals 30 days prior to release

September 2017

- ✓ Add functionality to NY State of Health for open enrollment

November 2017

- ✓ Open Enrollment Begins

December 2017

- ✓ Add functionality to NY State of Health

2018

- ✓ 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.
- ✓ Complete system requirements for non-MAGI eligibility determinations.

2019

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