Medicaid Administration Annual Report to the Governor and Legislature

December 2019

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 for the assumption of additional functions.

In 2019, the state processed nearly 3.8 million Medicaid eligibility determinations/enrollments. 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 statewide. The chart below shows the increase in the volume of eligibility determinations/enrollments assumed by the state in 2019.

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

	2017	2018	2019
	Annually	Annually	Annually
Modified Adjusted Gross Income Applications/Renewals	2,844,000	3,213,000	3,381,000
Family Planning Benefit Program	41,900	41,900	43,480
Auto Renew Aged, Blind and Disabled	72,000	66,000	74,000
Managed Long-Term Care	209,000	237,700	271,206
Total	**3,166,900**	**3,558,600**	**3,769,686**

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*
- *Financing Medicaid Administration*
- *Delays in Medicaid Administration*
- *FY 2021 Update*

CENTRALIZED ELIGIBILITY DETERMINATIONS

NY State of Health, the state's health plan marketplace, centrally processes eligibility and enrollment for MAGI Medicaid[1], the Children's Health Insurance Program (Child Health Plus), the Basic Health 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

As of September 2019, NY State of Health has determined 3.4 million individuals eligible for Medicaid. This is an increase of 7.6 percent since 2018, driven in large part by the transition of enrollees from the Welfare Management System (WMS) to NY State of Health.

Of these 3.4 million Medicaid enrollees, 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, past enrollees who experienced a gap in coverage and enrolled as new applicants, or enrollees transitioning from WMS.

Approximately 63 percent of Medicaid enrollees are adults between the ages of 18-64 and 37 percent are children under age 18. Approximately 51 percent of the Medicaid enrollments are from New York City, 12 percent from Long Island, and the remaining 37 percent from other counties throughout the state. Compared to 2018, a higher proportion of enrollees in 2019 are from counties outside of New York City due to the transition of the MAGI population from the remaining 20 upstate counties to NY State of Health during 2019.

Medicaid enrollment in NY State of Health is diverse. About 29 percent of enrollees report they are white, 15 percent African American, 5 percent Chinese, 6 percent Asian Indian or other Asian, and 6 percent other races. Nearly 41 percent of all enrollees do not provide their race. In terms of ethnicity, 16 percent of enrollees do not provide an ethnicity. 27 percent report being Hispanic.

Until eligibility for the entire Medicaid population can be processed in a modernized eligibility system, new applications for the MAGI population will be processed by the NY State of Health and new applications for the non-MAGI population will be processed by the Local Department of Social Services in 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.

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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.

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 pursuit of payment from other health insurance (third-party liability) and processing requests for reimbursement of medical bills.

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 $7.1 billion dollars in Medicaid payments were prevented this past 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.

In 2019, the TPL unit handled approximately 50,040 requests from NY State of Health to verify third party coverage or to assess individuals for premium assistance. It has also updated several hundred thousand TPHI and Medicare records. Cost benefit analyses to reimburse group health insurance premiums have been completed for 1,898 accounts resulting in 1,615 commercial Health Insurance Premium authorizations covering 4,308 consumers. In addition, 22,969 consumers have been determined eligible for premium payment for the Medicare Part B premium.

The unit also receives an average of 1,630 phone calls per month directly from consumers inquiring about their commercial and Medicare premium payments.

Reimbursement of Medical Bills

Medicaid rules provide for reimbursement of medical bills incurred in any of the three months prior to the month of the Medicaid application, if the individual is determined eligible for Medicaid for the month in which the bill is incurred. It also reimburses out-of-pocket medical bills incurred from the date of eligibility to the receipt of a Common Benefit Identification Card.

A unit established in the Department in 2014 examines and processes reimbursement claims for individuals found eligible in NY State of Health. From October 2018 to October 2019, the unit examined 16,740 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

The transition of MAGI individuals from WMS to NY State of Health was completed in 2017 for 37 counties and in early 2019 for an additional 20 counties. The transition of

MAGI individuals from the five remaining counties (the boroughs of New York City) started in 2019 and is expected to continue into 2021

Customer Service Center

The NY State of Health customer service center continues to provide assistance to millions of consumers in need of assistance, open Monday through Friday from 8am to 8pm and on Saturday from 9am to 1pm. Since the creation of the NY State of Health customer service center in October 2013, call center representatives have fielded nearly 28 million calls from individuals and families with questions about Medicaid, Child Health Plus, the Essential Plan, Advance Premium Tax Credits, Cost-Sharing Reductions and Qualified Health Plans (QHP). In the first three quarters of 2019, this included more than 3.4 million calls requiring assistance with information about program documentation requirements and updating Marketplace accounts, identifying potential eligibility for public health insurance programs, and the provision of information about how to apply, covered benefits, current coverage status and plan enrollment. Roughly 52 percent of these calls originated in New York City, with 12 percent from Long Island, and the remaining 35 percent came from upstate consumers.

In addition to ensuring that customer service representatives are available to consumers at convenient times, New York remains committed to providing access to quality assistance for those for whom English is not their primary language. Through July 2019, more than 615,000 consumers received help in their language of choice from NY State of Health's bilingual customer service staff fluent in Spanish, Mandarin, Russian, Cantonese and Haitian Creole. Another 93,000 were assisted through three-way calls with the "language line" in 117 languages.

Community-Based Assistors

Community-based assistors have historically played a significant role in helping low-income New Yorkers apply for Medicaid. In 2019, all new MAGI applications from trained community-based assistors were submitted to NY State of Health using the online application. Community-based assistors include Navigators, Marketplace Facilitated Enrollers (health plans), Certified Application Counselors which include 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 NY State of Health as of September 30, 2019. 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. Marketplace Facilitated Enrollers are health plan employees that are trained by the state to assist individuals with the enrollment and application process. The number does not include the approximately 3,000 brokers who have been trained to provide application assistance.

Table 2: Number of Assistors by Type Listed Below Trained, Certified and Registered as of September 30, 2019

Type of Application Assistor	Total Number Trained, Certified and Registered as of 9/30/19
Navigators	476
Federally Qualified Health Centers (FQHCs)	377
Hospitals	1,412
Healthcare Providers	295
Local Departments of Social Services (LDSS)	128
Marketplace Facilitated Enrollers (FEs)	2,413
Other Organizations	552
Totals	5,653

Community-based assistors submit approximately 78 percent of all applications received by NY State of Health. As of September 30, 2019, assistors enrolled 4.1 million individuals since 2014, with Marketplace facilitated enrollers responsible for the largest number of enrollments. Medicaid enrollment accounted for approximately 71 percent of total enrollments, with Child Health Plus at nine percent and QHP enrollment at three percent. The remaining 17 percent of applications completed by assistors were enrollments in 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 37 percent 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 transitioned 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 October 2019, 765,000 individuals were enrolled in Essential Plan through NY State of Health. The program also provided approximately $1 billion in savings to the Medicaid Global Cap in State Fiscal Year 2019-20 and is projected to continue achieving savings at this level going forward.

During 2019, nearly all Essential Plan enrollees in WMS transitioned to NY State of Health. Due to systems limitations that are expected to be upgraded in 2020, a small number of Essential Plan enrollees continue to transition from New York City WMS.

MODERNIZED MEDICAID ELIGIBILITY SYSTEM

The most important factor in the state's ability to assume Medicaid administrative functions has been 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 is proceeding in parallel with the ability to automate eligibility determinations.

The eligibility system for the Individual Marketplace represents a major advancement in New York's Medicaid program. 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 NY State of Health system is that it integrates eligibility for Medicaid, Child Health Plus, 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 Child Health Plus. 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 a modernized eligibility system, these same integrated transitions will apply to non-MAGI enrollees as well.

In 2019, the eligibility system added important functionality for Medicaid. The added functionality included:

- Improving the process that checks for existing public coverage at application or account update to eliminate overlaps with LDSS WMS coverage;

- Modifying the notice for Medicaid-to-Essential Plan transitions to ensure consumes receive adequate notice;

- Automating the PARIS processing to systematically evaluate federal data on Medicaid coverage in other states and take appropriate action on NY State of Health accounts to close out Medicaid coverage for individuals who no longer reside in New York;

- Requiring MAGI eligibles aged 65 or over to apply for Medicare;

- Improving the matching process related to Client Identification Numbers (CIN) assignment to minimize possibility of duplicate coverage;
- Automating enrollment into health plans when a person renews late and moves to a new program to maintain enrollment with the same provider to ensure continuity of care;
- Automating the managed care lock-in rules for NY State of Health members;
- Enhancing the user application process to better collect and display address information;
- Updating rules related to individuals who were formerly in foster care;
- Adding ability for online users to add an authorized representative onto an account;

System improvements will continue into 2020 and 2021 to complete the Medicaid MAGI functionality, enhance system efficiency, and improve the user experience. Among the items in the pipeline:

- Improve the notices to members when documents submitted are insufficient and additional information is needed;
- Improve the functionality to process the applications for individuals who were denied public assistance;
- Track and manage email notifications to consumers within NY State of Health;
- Eligibility notice improvements;
- Improve support for eligibility determinations for the three-month retroactive period;
- Continue implementation of notices in other languages;
- Improve the assistor dashboard;
- The development of a separate path for presumptive eligibility;
- Processing eligibility changes for inmates entering or leaving Rikers Island Correctional Facility;
- Back Office enhancements to support program integrity efforts; and

- Strengthen efforts to prevent duplicate coverage by improving the CIN clearance process, enhancing the matching process and creating an interface to allow back office workers to identify and rectify duplicates.

Once the functionality for eligibility determinations and enrollments for the MAGI Medicaid population is complete, additional functionality will be added, such as enhancements to the consumer experience. The development of the non-MAGI eligibility rules will be separately procured.

STATUS OF OTHER FUNCTIONS ASSUMED BY THE STATE

Other Eligibility-Related Functions

- **Administrative Renewals for Aged, Blind and Disabled.** Administrative Medicaid renewals were completed on a monthly basis statewide for individuals whose only source of income is from the Social Security Administration (SSA). In addition, outside New York City, administrative renewals include aged, blind and disabled individuals with pensions and individuals on the Medicare Savings Program (MSP) who have income from SSA benefits and/or pensions. Individuals eligible as a Qualified Individual on the Medicare Savings Program are administratively renewed each June for the following year. 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 them of the renewal and continued coverage. In 2019, approximately 74,000 administrative renewals were completed. The expansion of administrative renewals to the New York City MSP population will be dependent on the availability of systems resources in 2020.

- **Renewal Processing for Enrollees Permitted to Attest to Income Who Have No Resource Test.** The Department has assumed responsibility for processing eligibility and renewals through New York State of Health for this population for all counties outside of NYC.

- **Processing Family Planning Benefit Program Applications and Renewals (FPBP).** Approximately 43,480 presumptive eligibility and FPBP applications have been processed by the Enrollment Center in 2019. FPBP renewals will continue to be processed through the Enrollment Center until this population is transitioned to NY State of Health.

- **Asset Verification and Real Property Resource Verification System.** The Asset Verification System (AVS) is an electronic system for use in verifying assets in banking institutions and conducting real property searches for individuals in the aged, certified blind or certified disabled category of assistance. Since the AVS queries both national and local banks and searches for real property nationwide, the AVS may identify assets and real property that might not otherwise be discovered through the eligibility determination process. Additionally, the electronic exchange of asset information provided through the AVS may assist local districts with asset documentation requirements. A web-based interface verifies currently owned assets, and assets that may have been sold or transferred during a 60-month look-back period for coverage of nursing home care. All Medicaid applications or requests for long-term care services for individuals whose eligibility is subject to a resource test may have assets verified through the AVS. The system will also verify assets for individuals renewing Medicaid eligibility. Implementation of AVS for new applications, requests for increased coverage, and for individuals renewing

Medicaid coverage was completed in November 2017 for all districts outside NYC. For NYC, AVS has been implemented for certain nursing home applications, and will be expanded to other case types in 2020.

- **Medicaid Applications for Incarcerated Individuals.**
  New Medicaid applications for MAGI individuals who are incarcerated are processed by NY State of Health. The online application process through NY State of Health improves access to Medicaid for inpatient hospital stays and provides benefits upon release. As of October 2019, there were 16,720 incarcerated Medicaid enrollees who had inpatient hospital only coverage on NY State of Health.

- **Disability Determinations.**
  Disability determinations for Medicaid within the State of New York currently occur in two venues: (1) the State Disability Review Team (SDRT), which performs disability determinations for 57 upstate local districts and the Office for People With Developmental Disabilities and (2) the disability review team from the City of New York, Human Resources Administration (HRA) and the Office of Mental Health. As part of the takeover of all the functions related to disability determination, the Medical Evidence Gathering Group was formed in 2016. By the end of 2019, all 57 upstate districts will have transitioned to the new process. Plans to include New York City will be considered in the final phases of this project.

State Assumption of County Medicaid Transportation Management

In 2011, the Department began phasing in the assumption of the management of Medicaid transportation from the counties. Management functions were consolidated into five regional contract areas. The regional models provide professional management that improves resource coordination and better ensures access to medical services – resulting in improved Medicaid transportation program accountability, enhanced quality assurance and better health care fraud and abuse prevention. These regional contracts also arrange Medicaid transportation for the Delivery System Reform Incentive Payment Program (DSRIP) networks operating under an $8.5 billion federal Medicaid redesign waiver and is therefore crucial to assisting the DSRIP networks in achieving their value-based payment goals. State administered transportation management is also a prominent feature of the Medicaid Administration Reform Initiative.

The Department contracts with two transportation management companies to arrange, prior approve, and coordinate Medicaid transportation services by assigning transports at the most cost effective, medically appropriate mode for the beneficiary. LogistiCare Solutions, a national transportation management company is the current transportation manager for the Long Island region. Medical Answering Services (MAS), a Syracuse-based non-emergency medical transportation management company, manages Medicaid transportation in all five boroughs within New York City and the three upstate regions (Finger Lakes/NNY, Hudson Valley and Western regions). Both contractors,

with Department oversight and guidance, have contributed to the development of an improved, cost effective Medicaid transportation infrastructure. This state management initiative has successfully eliminated a costly administrative mandate from the counties, provided more consistent management expertise, improved Medicaid policy accountability, and provided better transportation resource coordination.

State administrated transportation management contractors arranged 30 million trips annually, with many specialty and customer tailored transports to a wide range of medical venues, while continuing to improve service quality and provide faster responses to transportation access problems, including during natural disasters.

Management innovations include the organization of group rides, using local resources such as Volunteer Driver Agencies and Buss Pass Agencies, developing preferred provider arrangements to expedite hospital discharges, piloting the use of global positioning system (GPS) and Application Programming Interface (API) connections to preform pre and post trip verifications as a quality assurance effort in reducing fraud waste and abuse, utilizing online trip ordering capabilities with built in Medicaid rules and policies, and introducing real time adjustable transportation provider profiles that have reduced same-day trip denials and the need for trip reassignments.

Managed Long-Term Care

As of October 2019, approximately 271,206 individuals were enrolled in MLTC plans.

The expansion of MLTC enrollment reduces fee-for-service participation in programs managed by the LDSS, including the Personal Care Services Program, Personal Emergency Response Services, and the Consumer Directed Personal Assistance 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 (Maximus) enrolls and disenrolls MLTC participants and provides appropriate notices. Service authorization changes and fair hearing requests are issued by plans and monitored by the enrollment broker as well as DOH where necessary. We continue to track outcomes of Fair Hearings to inform both policy and guidance.

FUNCTIONS REMAINING WITH COUNTIES IN 2020

The implementation of the Affordable Care Act and the Medicaid Redesign Team 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 essential 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 2020 include:

- Providing in-person application assistance to MAGI applicants/enrollees, for counties that choose to retain this function;
- Continued renewal of remaining MAGI enrollees in WMS until they can be transitioned to NY State of Health (NYC only);
- 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 until this function is transitioned to the State;
- Handling eligibility for Social Security Income (SSI) cases, including separate determinations when an individual loses receipt of SSI; and
- Pursuing 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 NY 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, the administrative functions and associated costs, previously handled by counties, have been assumed by the State. The State Financial Plan assumed $139 million in reduced LDSS claims under the administrative ceiling for FY 2020.

DELAYS IN MEDICAID ADMINISTRATION

The State assumption of Medicaid administrative functions is behind schedule due to challenges with systems upgrades to WMS. In addition, extensive attention has been given to refining the MAGI eligibility and enrollment rules for NY State of Health applicants to ensure Medicaid coverage is correctly provided and continuity of care is maintained. Technical adjustments are underway to accelerate the phased New York City MAGI transition, and, functionality is expected to be added to the system in 2020 to begin processing specific MAGI populations who have not been systematically handled by NY State of Health. Efforts are underway to explore options to accelerate the completion of the remaining MAGI functionality to handle other specific populations that have not been part of the transition to date, as well as the non-MAGI functionality. Until functionality is added to a modernized eligibility system, no additional eligibility functions can be shifted from the counties to the State.

FY 2021 UPDATE

As noted throughout this report, the Department of Health continues to work collaboratively with local governments and the Division of Budget to facilitate the transition of Medicaid administrative functions and associated costs to the State. In FY 2021, the State's takeover of local Medicaid cost increases is expected to save counties $4.5 billion. Since FY 2015, the State has taken over 100 percent of State Medicaid spending growth from local governments to help them stay within their 2 percent property tax caps. The policy has cumulatively saved local governments over $20 billion.