Medicaid Administration Annual Report to the Governor and Legislature

December 2021

Department of Health | Office of Health Insurance Programs

Department of Health

EXECUTIVE SUMMARY

Section 6 of Part F of Chapter 56 of the Laws of 2012 authorized New York State (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 and the impact of the Coronavirus pandemic on Medicaid administration. It also describes the plan for the assumption of additional functions.

Less than three months into the calendar year 2020, New York was faced with an unprecedented challenge as it became the epicenter of the Coronavirus pandemic. On January 31, 2020, the federal government declared a public emergency with State declaration following on March 7, 2020. An estimated 800,000 New Yorkers lost their health coverage when they lost their employment. Like no other time in the history of the program, Medicaid needed to respond quickly to provide a safety net for a significant number of New York families. Starting in March 2020, the number of applications for Medicaid increased rapidly, while at the same time federal rules, most notably under the Families First Coronavirus Response Act (FFCRA), necessitated immediate changes in Medicaid systems and processes to extend coverage for those already enrolled and to secure New York's ability to qualify for increased federal funds under FFCRA's Maintenance of Effort provisions. These federal funds totaled approximately $7.2 billion (inclusive of funding due to localities) for the period January 2020 through December 2021.

Foundational to the State's takeover of the administration of Medicaid, has been the Department's development and implementation of a modern eligibility system, referred to as NY State of Health. This system, built to implement the Affordable Care Act marketplaces, automates the Medicaid application and eligibility decision, requiring little, if any, manual processes. As individuals throughout the State lost access to health care, NY State of Health proved ready to handle an unanticipated increase in the volume of applications for coverage. In fact, between January and December 2021, the State processed nearly 4.9 million Medicaid eligibility determinations/enrollments through NY State of Health systems. In addition to processing new applications, NY State of Health also handled all activities associated with these enrollees, including but not limited to enrollment in health plans and processing life status updates such as changes in income or household composition. NY State of Health also stood ready to implement the requirements of the FFCRA which included automating the suspension of annual renewal requirements and other requirements as detailed in sections of this report. Table 1 below shows the increase in the volume of eligibility determinations/enrollments assumed by the state. Table 2 shows the month by month increase in Medicaid enrollment throughout 2021.

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

	2019	2020	2021
	Annually	Annually	Annually
Modified Adjusted Gross Income Applications/Renewals	3,381,000	4,226,120	4,884,412
Family Planning Benefit Program	43,480	42,576	36,099
Auto Renew Aged, Blind and Disabled	74,000	49,680*	37,196
Managed Long-Term Care	271,206	274,489	281,667
Total	**3,769,686**	**4,592,865**	**5,239,374**

*The number of cases subject to the Aged, Blind and Disabled auto renewal process in 2021 decreased due to the systemic extension of cases during the COVID-19 public health emergency. Approximately 450,000 cases were systemically extended during this period.

Table 2: Month to Month Increase in Medicaid Enrollment January through December 2021

Month	Total Enrollment	Month to Month Increase
January 2021	6,898,798	-
February 2021	6,919,755	20,957
March 2021	6,970,302	50,547
April 2021	7,012,788	42,486
May 2021	7,045,893	33,105
June 2021	7,089,512	43,619
July 2021	7,129,760	40,248
August 2021	7,162,525	32,765
September 2021	7,211,388	48,863
October 2021	7,257,180	45,792
November 2021	7,283,398	26,218
December 2021	7,333,635	50,237

Purpose and Organization of this Report

This report describes the highlights of the State's administration of Medicaid administration in 2021. It details Medicaid's ongoing response to the COVID-Public Health Emergency, the significant growth in Medicaid and Essential Plan enrollment during 2021, the successes of bringing assistance to consumers through centralized customer service and certified assistors. It also details the administrative tasks that remain with counties and the fiscal impact of state takeover on counties. It is organized into seven sections as follows:

- *Medicaid Responds to COVID-19 Public Health Emergency*
- *Centralized Eligibility Determinations*
- *Future Plans to Modernize Medicaid Eligibility Administration*
- *Status of Other Functions Assumed in Prior Years*
- *Functions Remaining with Counties*
- *Financing Medicaid Administration*
- *Delays in Medicaid Administration*

MEDICAID RESPONDS TO COVID-19 PUBLIC HEALTH EMERGENCY

Coincident with the State's takeover of Medicaid administration, the Department of Health designed, developed, and deployed a modern eligibility and enrollment system to implement the State's insurance Marketplace in accordance with the Affordable Care Act. This system, described in detail in sections below, became the foundation on which New York was able to respond to the demand on coverage that resulted as New York residents lost access to employment and health coverage as a result of the pandemic. In 2020 and 2021, Medicaid enrollment increased by nearly 1.5 million, which includes a transition of over 200,000 members from the New York City Human Resources Administration to the Marketplace. At the same time, in response to the COVID-19 Federal Public Health Emergency (PHE), and to be in compliance with the "Families First Coronavirus Response Act" (FFCRA), the Department during 2020 and 2021 implemented flexibilities to the Medicaid program meant to increase access, reduce barriers to obtaining Medicaid and ensure maintenance of coverage for Medicaid enrollees. These changes to existing policy are effective for the duration of the federal PHE, which began on March 18, 2020.

Easements to the application and renewal process included:

- Allowing attestation of all eligibility criteria, excluding U.S. Citizenship, immigration status and identity;
- Extending the reasonable opportunity period to document Citizenship, immigration status and identity;
- Suspending renewals of Medicaid eligibility, including for former SSI and Temporary Assistance recipients who require a separate Medicaid determination;

- Extending active Medicaid cases for twelve months;
- Extending cases for six months for individuals participating in the excess income program or the pay-in program who are unable to submit a bill or make a payment;
- Providing individuals in the Medicaid Buy-In Program for Working People with Disabilities, who have experienced job loss as a result of the COVID-19 emergency, with a grace period;
- Suspending referrals from NY State of Health for those individuals turning 65; and
- Suspending the requirements to apply for other benefits such as Veterans Benefits, compliance with absent parent requirements and the requirement to provide documentation of third-party health insurance.

To maintain compliance with the FFCRA these temporary changes ensure that no one who was in receipt of Medicaid coverage on or after March 18, 2020, loses their Medicaid coverage during the PHE, unless the individual voluntarily terminates coverage, is no longer a resident of the State, or is deceased.

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), and the purchase of subsidized and unsubsidized private health insurance coverage through Qualified Health Plans. Applicants can apply online through the NY State of Health web portal, by phone with a NY State of Health customer service representative, in the community with one of more than 5,100 certified application and enrollment assistors, or by mail. Less than 0.1 percent of applicants apply by mail. That NY State of Health eligibility determinations are automated and not reliant on the submission of paper applications, or staff being on site to receive and process paper, ensured that New Yorkers in need of the coverage because of the COVID-19 pandemic did not experience delays in accessing health care.

NY State of Health Medicaid Enrollment

As of December 31, 2021, NY State of Health has determined almost 4.9 million individuals eligible for Medicaid. This is an increase of over 44 percent since the COVID-19 Public Health Emergency began, driven in large part by declining income due to the COVID-19 pandemic and the requirements under the Families First Coronavirus Response Act to maintain Medicaid coverage for all individuals enrolled on or after March 18, 2020. Of these nearly 4.9 million Medicaid enrollees, only 9 percent, as expected, were eligible for the Medicaid expanded eligibility level between 100 to 138 percent of the federal poverty level as implemented under the Affordable Care Act.

Approximately 68 percent of Medicaid enrollees are adults between the ages of 18-64 and 32 percent are children under age 18. Approximately 54percent of

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

Medicaid enrollments are from New York City, 11 percent from Long Island, and the remaining 35 percent from other counties throughout the State.

Medicaid enrollment in NY State of Health is diverse. Twenty eight percent of enrollees report they are white, 14 percent Black/African American, 11 percent Asian/Pacific Islander and 6 percent other races. Nearly 43 percent of all enrollees do not provide their race. In addition, 27 percent of Medicaid enrollees in NY State of Health report that they are Hispanic; however, 19 percent of enrollees do not provide an ethnicity.

In 2021, new applications for the MAGI population were processed by the NY State of Health, while new applications for the non-MAGI[2] population were processed by the Local Department of Social Services (LDSS) using the Welfare Management System (WMS). The State has worked with the LDSS to develop a referral process for applications that originate in the wrong place to ensure eligibility is determined in a correct and timely manner. Individuals applying through NY State of Health, 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 the identification other health insurance (third-party liability).

Bringing Assistance to Consumers

A guiding principle in transitioning Medicaid administration to the Department has been the goal of bringing assistance to consumers where they are and eliminating the hurdles that make it sometimes challenging for persons to apply for or remain covered. To this end, coincident with the implementation of the NY State of Health, the Department implemented two initiatives that continued in 2021 to serve millions of consumers.

NY State of Health Customer Service Center

Throughout 2021, the NY State of Health Customer Service Center continued to provide one stop full service to consumers throughout the State. With hours of operation designed to meet the needs of consumers, the Customer Service Center is open from Monday through Friday from 8am to 8pm and on Saturday from 9am to 1pm with representatives ready to answer questions about and assist consumers with the Medicaid, Child Health Plus, Essential Plan and Qualified Health Plan application and enrollment processes. Since October 2013, customer service representatives responded to more than 36 million calls from individuals and families from across the state. Of the 3.5 million calls fielded in 2021, roughly 56 percent of these calls originated in New York City, with 12 percent from Long Island, and the remaining 32 percent came from upstate consumers.

[2] Non-MAGI refers to those populations whose eligibility is not determined based on Modified Adjusted Gross Income (MAGI) eligibility rules but rather Medicaid eligibility rules in place prior to the adoption of the MAGI rules pursuant to the federal Patient Protection and Affordable Care Act.

As part of its commitment to provide quality assistance to all NY State of Health consumers, the Department continued to aid consumers in the language of their choice. This year nearly 475,000 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 86,000 were assisted through three-way calls facilitated with the "language line" in more than 100 languages.

The Role of Certified Community Assistors

NY State of Health certified community-based assistors played a significant role in helping low-income New Yorkers apply for Medicaid. 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 shows the number of Navigators, Marketplace Facilitated Enrollers, and Certified Application Counselors trained, certified and registered on NY State of Health as of December 31, 2021. Navigators are community-based organizations that have grant contracts with the State to help individuals enroll in coverage. Certified Application Counselors receive the same training as navigators and provide the same assistance, but do not receive grant funding from the Department. Marketplace Facilitated Enrollers are health plan employees that are trained by the State to assist individuals with the enrollment and application process. All assistors must provide free and unbiased education and assistance to consumers.

Table 3: Number of Assistors by Type Listed Below Trained, Certified and Registered as of December 31, 2021

Type of Application Assistor	Total Number Trained, Certified and Registered as of 12/31/21
Navigators	439
Federally Qualified Health Centers (FQHCs)	304
Hospitals	1,554
Healthcare Providers	321
Local Departments of Social Services (LDSS)	90
Marketplace Facilitated Enrollers (FEs)	1,919
Other Organizations	510
Totals	5,137

Community-based assistors submit over 75 percent of all applications received by NY State of Health for persons determined eligible for Medicaid. During the period 2014 through 2021, assistors enrolled more than 6 million individuals in coverage through NY State of Health with Marketplace FEs responsible for the largest number of enrollments. Assistors also helped people enroll in Child Health Plus, the Essential Plan and Qualified Health Plans.

Other Highlights of State Administration in 2021

Third Party Health Insurance

Individuals with third party health insurance (TPHI) are eligible for Medicaid; however, Medicaid is the secondary payer to the other coverage including when the primary coverage is through the individual's employment or through Medicare. In the former, when cost effective, Medicaid pays the individual's cost for employer coverage. In the latter, Medicaid pays for the individual's monthly Medicare Part A and/or Part B premium. In certain instances, Medicaid also pays for services that are not covered by the primary insurer, or for out-of-pocket expenses such as deductibles and co-insurance.

Ensuring that TPHI is identified, and correctly coordinating Medicaid coverage with the TPHI coverage, saves significant Medicaid dollars while at the same time ensuring that consumers receive the benefits they are entitled to receive.

As part of the State takeover of Medicaid Administration in 2021, TPHI related activities transitioned from the LDSS to the Department included:

- Avoiding $7.5 billion dollars in Medicaid payments due to identification of TPHI liability;
- Verifying over 64,000 instances of TPHI;
- Updating more than 127,000 consumer records to correctly reflect TPHI and Medicare coverage;
- Reimbursing commercial health insurance premium for over 5,500 consumers when such reimbursement was found to be cost-effective for Medicaid;
- Determining 84,906 individual's eligibility for premium payment for the Medicare Part B premium.

Reimbursement of Medical Bills Incurred Prior to the Effective Date of Coverage

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 found to be eligible for Medicaid for the month in which the bill is incurred. Medicaid also reimburses for medical bills incurred from the date of eligibility to the date the individual receives their Common Benefit Identification Card. From October 2020 to December 2021, the Department examined 22,259 reimbursement claims submitted by NY State of Health applicants and enrollees.

Transition from WMS to NY State of Health at Renewal

Prior to the establishment of NY State of Health, Medicaid eligibility was determined through a legacy system known as WMS. The transition of MAGI individuals from WMS to NY State of Health was completed in 2017 for 37 counties of the State, and in early 2019 for an additional 20 counties. The transition of MAGI individuals from New York City was largely completed during 2021. Additional NY State of Health system changes are planned that will allow transition of any exception MAGI cases opened in WMS. With the completion of the transition in New York City, nearly all eligibility renewals for MAGI enrollees in all counties of the State will be processed through NY State of Health.

Impact of Essential Plan

The Essential Plan continues to be extremely successful and has been a critically important option for consumers during the COVID-19 public health emergency. As of December 2021, more than 947,000 individuals were enrolled in the Essential Plan through NY State of Health.

The Essential Plan, New York's Basic Health Program began in April 2015. Approximately 39 percent of the program's enrollment is composed of individuals who would have been eligible for state-funded Medicaid prior to the implementation of the Essential Plan. At the time of implementation, eligibility determinations, renewals, and other case management functions for these individuals transitioned from the LDSS to the State. During 2019, nearly all Essential Plan enrollees in WMS transitioned to NY State of Health.

The program continues to provide approximately $1.5 billion in savings to the Medicaid Global Cap in State Fiscal Year 2020-21 and is projected to continue achieving savings at this level going forward.

Partnerships to Further State Initiatives

Transitioning Medicaid eligibility determinations to the modern NY State of Health information system has allowed the Department to educate consumers about other state programs and initiatives.

Supplemental Needs Assistance Program

In 2019, recognizing the vital importance of food security, NY State of Health partnered with the Office of Temporary and Disability Assistance (OTDA) to ensure that individuals eligible for Medicaid, Child Health Plus (CHPlus) and Essential Plan (EP) were also aware of their potential eligibility for the Supplemental Needs Assistance Program (SNAP). As of September 2019, following an eligibility determination for Medicaid, CHPlus or EP, individuals who may be eligible for SNAP are provided with information about the program and offered the opportunity to provide their email address to receive application information. As of December 2021, more than 340,000 households have opted in to receive this information.

Organ Donation

Recognizing that thousands of lives could be saved by increasing the number of organ donors, State Law was amended in 2016 to add NY State of Health to the list of State Agencies offering New Yorkers the opportunity to register as donors. In April 2017, NY State of Health added this option. Like the SNAP initiative, after receiving an eligibility determination for health insurance coverage, individuals are provided with the opportunity to register with the Donate Life Registry for organ donation. As of the end of December 2021, 291,383 individuals have chosen to join the Registry to donate their organs via this Marketplace option.

FUTURE PLANS TO MODERNIZE MEDICAID ELIGIBILITY ADMINISTRATION

As described in prior sections of this Report, the most important factor in the State's ability to assume Medicaid administrative functions for the MAGI population has been the development of a modernized eligibility system that automates the verification and determination of eligibility. This system has achieved greater efficiency, reduced administrative costs, reduced paper applications/renewals and automated much of the eligibility determination process as possible.

The eligibility system for the NY State of Health Marketplace represented 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. Medicaid applications that once took up to 45 days to review and determine are now routinely processed along with the health plan enrollment the same day that the application is submitted.

Another 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 2021, the eligibility system added important functionality for Medicaid. The added functionality included:

- Major improvements to the cornerstone eligibility notice;
- Continued implementation of notices in other languages;
- Expanded use of mailing clearinghouse data to improve mailing success and address correction;
- Automated the provision of program restriction data to health plans;
- Improved the use of data matching and case closings for deceased individuals;
- Added text-messaging capability to improve member outreach.

System improvements will continue into 2022 and 2023 to complete the Medicaid MAGI functionality, enhance system efficiency, and improve the user experience. Among the items in the pipeline:

- Improve the assistor search screens to help applicants and members find help in their community;
- Support the dual-eligible (Medicare and Medicaid) programs designed to improve access to benefits and coordination of care;
- Develop a separate path for presumptive eligibility.

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

STATUS OF OTHER FUNCTIONS ASSUMED IN PRIOR YEARS

Other Eligibility-Related Functions

- **Administrative Renewals for the Aged, Blind and Disabled Eligibility Categories.** Administrative Medicaid renewals are completed monthly 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. During the COVID-19 public health emergency, many administrative Medicaid renewals were systemically extended. Additionally, individuals eligible as a Qualified Individual (QI) on the Medicare Savings Program (MSP) were administratively renewed in 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 2021, approximately 37,000 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 which have been diverted to implement initiatives necessary to maintain or extend Medicaid coverage during the COVID-19 Public Health Emergency.

- **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 20,873 presumptive eligibility and FPBP applications have been processed by the Enrollment Center in 2021. FPBP renewals will continue to be processed through the Enrollment Center until this population is transitioned to NY State of Health. Additionally, 15,226 enrollees were automatically renewed by the Department in WMS.

- **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. NYC utilizes a combination of AVS and a Resource File Integration System (RFI) process.

- **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 December 31, 2021, there were 11,631 incarcerated Medicaid enrollees who had inpatient hospital only coverage on NY State of Health.

- **Disability Determinations.**
  The State Disability Review Unit (SDRU) performs disability determinations centrally for 57 upstate local districts and the Office for People With Developmental Disabilities. SDRU is currently working with the City of New York, Human Resources Administration (HRA) to transition to a centralized process.

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 eliminating an administrative burden on counties and providing more coordination and consistency. Today, 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 member. Collectively, these contractors arranged for nearly 17 million trips in calendar year 2021. The transportation mangers implemented initiatives to improve member service, reduce unnecessary transportation costs, and reduce fraud, waste, and abuse. These included group rides, utilizing local resources such as Volunteer Driver Agencies and Bus Pass Agencies, expediting transportation for persons being discharged from the hospital, piloting the use of global positioning system (GPS) and Application Programming Interface (API) connections to perform pre and post trip verifications as a quality assurance effort to reduce fraud, waste, and abuse. The COVID-19 pandemic presented new challenges; however, the transportation contractors were able to continue operations serving consumers and ensuring that patients that need life sustaining services, such as dialysis, were safely transported to treatment.

Managed Long-Term Care (MLTC)

As of December 2021, approximately 281,667 individuals were enrolled in MLTC plans an increase of 8,935 over the prior year.

As MLTC enrollment increases, functions such as conducting assessments to determine the individual's eligibility for MLTC and developing a care plan, transitioned from the LDSS to the State through its contracted arrangements with managed long term care plans and the State conflict free assessor. With the transition of these responsibilities, the LDSS is also no longer responsible for administering the fair hearing process associated with these programs.

FUNCTIONS REMAINING WITH COUNTIES

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 if the county chooses to contract with the State to continue to administer them. The functions that will remain with the counties during 2021 include:

- Providing in-person application assistance to MAGI applicants/enrollees, for counties that choose to retain this function;
- 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 fully is transitioned to the State;

- Handling eligibility for Social Security Income (SSI) cases, including separate determinations when an individual loses receipt of SSI; and

- Legal assistance related to MA recovery for estate, personal injury, and real property liens. Additionally, counties that do not outsource MA recovery to a state-contracted vendor are also responsible for pursuing MA recovery.

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 $172 million in reduced LDSS claims under the administrative ceiling for FY 2022.

DELAYS IN MEDICAID ADMINISTRATION

The advent of COVID-19 required resources be shifted to ensuring that all available federal regulatory, waiver and state plan flexibilities were enacted so that New Yorkers could easily access and maintain coverage in Medicaid, Child Health Plus, Essential Plan and Qualified Health Plans. The State has seen unprecedented demand for Medicaid and Essential Plan coverage during the pandemic. As the public health emergency continues the Department's ongoing priority and commitment is to ensure that all eligible New Yorkers enroll in and maintain coverage.

Technical adjustments have been implemented to accelerate the phased New York City MAGI transition, and functionality is expected to be added to the system in 2022 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.