Medicaid Administration Annual Report to the Governor and Legislature

December 2023

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 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 health emergency (PHE) 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 the FFCRA's Maintenance of Effort provisions. These federal funds totaled approximately $14.3 billion (inclusive of funding due to localities) for the period January 2020 through December 2023.

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 marketplace, automates the Medicaid application and eligibility decision, requiring little, if any, manual processes. Prior to NY State of Health's implementation an application for Medicaid eligibility took 45 days to process. It now takes about 45 minutes and that includes selection of a health plan.

As individuals throughout the State lost access to health care during the PHE, NY State of Health proved ready to handle an unanticipated increase in the volume of applications for coverage. Between January 2020 and November 2023, an additional 1.36 million people enrolled in Medicaid through NY State of Health. 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 during the PHE and decreases in enrollment once the continuous coverage period ended in New York. From March 2020 through June 2023 during the continuous coverage period Medicaid enrollment increased by 1,931,809 enrollees. However, since the ending of that period and the beginning of redeterminations Medicaid enrollment has been decreasing. The benefit of New York's fully integrated eligibility system has been significant as enrollees in need of coverage are easily transitioned within NY State of Health from Medicaid to other programs. Of the 1.1 million enrollees no longer Medicaid eligible, more than 480,000 have transitioned to other Marketplace coverage in Child Health Plus, Essential Plan and Qualified Health Plans – and a significant portion of the remaining 600,000 are expected to have transitioned to employer sponsored insurance coverage.

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

	2019	2020	2021	2022	2023**
	Annually	Annually	Annually	Annually	Annually
Modified Adjusted Gross Income	3,381,000	4,226,120	4,884,412	5,261,996	5,083,387
Family Planning Benefit Program	51481	29177	16037	19071	18209
Auto Renew Aged, Blind and Disabled	74,000	49,680*	37,196*	37,898*	41,918*
Managed Long-Term Care	271,206	274,489	281,667	300,026	329,932
Total	**3,769,686**	**4,592,865**	**5,239,374**	**5,581,093**	**5,431,528**

*The number of cases subject to the Aged, Blind and Disabled auto renewal process in 2020 through March 2023 decreased due to the systemic extension of cases during the COVID-19 public health emergency. Approximately 1,128,016 cases were systemically extended during this period.

**Medicaid redeterminations following the end of the FFCRA continuous coverage requirement and processing of new applications based on pre-PHE rules began with eligibility effective dates on or after July 1, 2023

Table 2: Month to Month Changes in Medicaid Enrollment January 2020 through November 2023

Month	Total Enrollment	Month to Month Changes
January 2020	6,109,597	-
February 2020	6,104,396	-5,201
March 2020	6,117,500	13,104

April 2020	6,224,657	107,157
May 2020	6,321,222	96,565
June 2020	6,409,528	88,306
July 2020	6,495,764	86,236
August 2020	6,569,405	73,641
September 2020	6,642,537	73,132
October 2020	6,706,847	64,310
November 2020	6,773,257	66,410
December 2020	6,866,253	92,996
January 2021	6,929,280	63,027
February 2021	6,951,316	22,036
March 2021	7,003,442	52,126
April 2021	7,047,144	43,702
May 2021	7,081,928	34,784
June 2021	7,127,264	45,336
July 2021	7,169,204	41,940
August 2021	7,204,004	34,800
September 2021	7,252,114	48,110
October 2021	7,295,509	43,395
November 2021	7,320,904	25,395
December 2021	7,372,682	51,778
January 2022	7,416,873	44,191
February 2022	7,444,964	28,091
March 2022	7,482,110	37,146
April 2022	7,495,882	13,772
May 2022	7,515,778	19,896
June 2022	7,556,142	40,364
July 2022	7,596,927	40,785
August 2022	7,630,662	33,735
September 2022	7,686,448	55,786
October 2022	7,717,314	30,866
November 2022	7,746,276	28,962
December 2022	7,793,622	47,346
January 2023	7,847,402	53,780
February 2023	7,871,504	24,102
March 2023	7,920,834	49,330
April 2023	7,951,837	31,003
May 2023	7,984,777	32,940
June 2023	8,036,205	51,428
July 2023*	7,953,349	-82,856
August 2023	7,858,179	-95,170

September 2023	7,761,720	-96,459
October 2023	7,676,525	-85,195
November 2023	7,584,758	-91,767

*****July is the first month in which eligibility redeterminations pursuant to the unwinding of the continuous coverage requirement are reflected. Comprehensive data on New York's unwinding of this provision is posted on NY State of Health's website. Medicaid data is posted monthly. Data is point in time as of November 30, 2023. It may change due to retroactive enrollment. Data is reconciled and posted on a month basis on the Departments website.

Purpose and Organization of this Report

This report describes the highlights of the State's administration of Medicaid administration during the COVID-19 Public Health Emergency (PHE) and the first six months of the unwinding of the FFCRA continuous coverage provision. It details Medicaid's ongoing response to the PHE, the significant growth in Medicaid and Essential Plan enrollment during this period, the successes of bringing assistance to consumers through a centralized customer service experience and the impact of 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 PHE Response*
- *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 PHE RESPONSE

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, NY State of Health, 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 COVID-19 pandemic. During the PHE, total Medicaid enrollment increased by nearly 2 million. To ensure local districts could meet the needs of non-MAGI Medicaid members, the State transitioned over 400,000 MAGI Medicaid members from the New York City Human Resources Administration and almost 200,000 from local districts in the Rest of the State (ROS) to the Marketplace. At the same time, in response to the PHE, and to be in compliance with the FFCRA, the Department implemented flexibilities to the Medicaid program meant to increase access, reduce barriers to obtaining Medicaid and ensure maintenance of coverage for Medicaid enrollees. These easements remained in place through June 2023

when pursuant to the Consolidated Appropriation Act (CAA), 2023's termination of the FFCRA continuous coverage period redeterminations began on a monthly basis for nearly 8 million enrollees across Medicaid, Child Health Plus and the Essential Plan.

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 ensured that no one who was in receipt of Medicaid coverage on or after March 18, 2020, lost their Medicaid coverage during the PHE continuous coverage period established by the FFCRA, unless that individual voluntarily terminated coverage, was no longer a resident of the State, or was deceased.

The CAA, 2023 signed into law on December 31, 2022, ended the FFCRA continuous coverage period on March 31, 2023. Subsequent guidance issued by the Centers for Medicare and Medicaid Services (CMS) required states to attest to compliance with federal *ex parte* processes and acceptance of renewals via multiple modalities (in person, telephone, online, mail) to receive enhanced Federal Medical Assistance Percentage (FMAP) during the unwinding of the continuous coverage requirement. States that could not attest to full compliance with the *ex parte* and multiple modality renewal submission requirements for MAGI and non-MAGI Medicaid enrollees were required to submit mitigation plans describing actions they would take to simulate an *ex parte* renewal process and/or multiple submission modalities for renewals to approximate compliance for eligibility to receive the enhanced FMAP. CMS offered waiver opportunities of section 1902(e)(14)(A) of the Social Security Act as mechanisms for mitigating non-compliance.

New York was found out of compliance for both *ex parte* renewals and multiple modalities for renewal submission for all non-MAGI cases handled by local

districts. These findings required the State to implement multiple e(14) waivers to mitigate non-compliance and secure eligibility for the enhanced FMAP offered under the CAA, 2023. New York's e(14) approvals and renewal plan are posted on NY State of Health's website. The State's mitigation strategy and ten approved e(14)s are also posted on CMS's website.

Prior to the unwind, the State initiated an intensive multi-phase multi-media outreach and marketing campaign to educate enrollees on how to maintain their health coverage when the continuous coverage period ended. A toolkit for materials is on the NY State of Health website. In addition to this work, local districts and health plans initiated address update campaigns to ensure they had the most up to date contact information for enrollees so they would receive their renewal information when it was their turn to renew. District and health plan partners also initiated multiple outreach and education campaigns to make sure their enrollees understood the redetermination requirements.

As a result of the address update mailing, Medicaid members, who have their coverage in the local department of social services (LDSS), reached out to their LDSS during the later months of 2022 and early months of 2023, and provided updated address information. The mailing also provided updated addresses for Medicaid members via returned to the LDSS; addresses were updated in the system prior to the beginning of the Unwind. For those members where there was no return address or member contact, LDSS's were instructed to try to locate a new address through the Welfare Management System in another program (ex. SNAP) or attempt to contact the member via phone number.

To minimize the number of New Yorkers at risk of losing their Medicaid, Child Health Plus or Essential Plan coverage, NY State of Health and the Office of Health Insurance Programs spent over a year working with partners, local departments of social services and other stakeholders to educate New Yorkers about important changes coming to their insurance programs. Focus and efforts include:

- The launch of a robust public education campaign, including paid advertising, specific to the Public Health Emergency (PHE) wind-down to remind enrollees how to prepare and what is needed to renew their coverage and maximize the potential for auto-renewal. Advertising and outreach efforts have been adjusted based on data in the early months of the unwind that indicate which populations have lower renewal rates.
- Ongoing efforts to get updated contact information for enrollees, such as implementing a pop-up on the NY State of Health online application to ask members to confirm their contact information.
- A robust texting campaign that allows enrollees to sign up to receive text alerts from NY State of Health that will contain important health insurance updates, including when it's time for them to renew coverage. As of December 2023, NY State of Health has sent 3 million text messages.
- Building upon our initial texting campaign, launched additional texting initiatives to reach consumers including:
    - One question text survey: send survey to consumers who did not renew their coverage to try and gain more information on why they did not return. The text is sent the month after the consumers coverage expires, with the hope that because of "late renewals" if

the text prompts someone to renew their coverage, they may be able to do so without a gap in coverage.
    - MMS Messages Sent in Consumers Preferred Language: to reach consumers via text that have a preferred language other than English or Spanish, an MMS was created that was translated in the six languages that have the largest population of outstanding renewals, Simplified Chinese, Traditional Chinese, Russian, Korean, French and Haitian Creole.
    - Customized text messages: sent out customized text messages to a small subset of consumers who had a Navigator on their account. Nearly 12,000 consumers received a text that included the phone number and name of their assistor organization.

- Meetings with federal partners to advocate for guidance that accommodates New York's concerns, and with health plans, consumer advocates, enrollment assistors, among other stakeholders about the winddown.

- Successfully secured 10 federal waivers to ease the unwind process for consumers and maximize retention.

- Preparation of multiple communication pathways to inform New Yorkers of the end of the PHE including webinars for specific stakeholders, monthly detailed dashboard reports on the unwind progress, policy guidance to local districts, social media communications, NY State of Health website updates and consumer notices.

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 5,500 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 November 30, 2023, over 4.7 million individuals were actively eligible for Medicaid in the NY State of Health. At its peak Medicaid enrollment in NYSOH exceeded 5 million due to the economic impact of the COVID-19 pandemic, but this number is now declining since eligibility redeterminations have resumed. Of these nearly 5 million Medicaid enrollees, only 8 percent, as expected, were

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

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 66 percent of Medicaid enrollees are adults between the ages of 18-64, 32 percent are children under age 18 and 2 percent are adults over the age of 65. Approximately 53 percent of Medicaid enrollments are from New York City, 11 percent from Long Island, and the remaining 36 percent from other counties throughout the State.

Medicaid enrollment in NY State of Health is diverse. Thirty one percent of enrollees report they are white, 14 percent Black/African American, 12 percent Asian/Pacific Islander and 12 percent other races. Nearly 34 percent of all enrollees do not provide their race. In addition, 28 percent of Medicaid enrollees in NY State of Health report that they are Hispanic; however, 17 percent of enrollees do not provide an ethnicity.

New applications for the MAGI population continue to be processed by the NY State of Health, while new applications for the non-MAGI[2] population are processed by the Local Department of Social Services (LDSS) using the Welfare Management System (WMS). During the PHE in an effort to avoid consumer disruption and provide additional support to local districts, individuals turning 65 or gaining Medicare who would prior to the PHE been transitioned to districts remained in NY State of Health. As part of the continuous coverage unwinding, the State requested an e(14) waiver that allows these individuals to continue receiving coverage in NY State of Health pursuant to a waiver of the non-MAGI (SSI-related) budgeting rules so their eligibility can be appropriately redetermined with coverage continuing in NY State of Health. This change allows the State to provide coverage to more than 100,000 enrollees in NY State of Health rather than transitioning their coverage to the districts.

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 continue to serve millions of consumers.

NY State of Health Customer Service Center

Throughout the PHE, the NY State of Health Customer Service Center continued to provide one stop comprehensive 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 have responded to more

[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.

than 42.5 million calls from individuals and families from across the state. Of the 14.4 million calls fielded during the PHE, roughly 56 percent of these calls originated in New York City, with 13 percent from Long Island, and the remaining 31 percent came from consumers throughout the rest of the state.

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. During the PHE over 3.3 million consumers received help in a language other than English. Eighty six percent of them were assisted by bilingual customer service specialists fluent in Spanish, Mandarin, Russian, Cantonese and Haitian Creole. The remaining 14 percent were assisted through three-way calls facilitated with the "language line" in more than 100 languages.

New York has been a leader state during the unwinding of the continuous coverage period. Despite a significant increase in call volume, the Customer Service Center average speed to answer is under one minute. In 2023, 2,337 new staff were trained in 79 classes to support the unwinding process and a new curriculum was developed to refresh existing staff. Additionally, toward the end of 2023, the Customer Service Center was engaged to help local districts reach out to consumers by phone whose renewal mailing was returned undeliverable. Customer Service staff also made a concerted effort to confirm addresses and phone numbers during calls with consumers in the months leading up to the start of the unwind.

The Customer Service Center has also enhanced its mobile application so that consumers can easily report a change in mailing address and find out if they need to submit documentation to finalize their eligibility. The app provides information about which documents are acceptable and the consumer can use the app to submit them. Consumers can also look up basic account information and will see a reminder if it is time to renew their coverage.

The Role of Certified Community Assistors

NY State of Health certified community-based assistors play 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, 2023. Navigators are community-based organizations that have grant contracts with the State to help individuals enroll in coverage. Certified Application Counselors and Marketplace Facilitated Enrollers 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, 2023

Type of Application Assistor	Total Number Trained, Certified and Registered as of 12/31/23
Navigators	433
Federally Qualified Health Centers (FQHCs)	347
Hospitals	1,525
Healthcare Providers	432
Local Departments of Social Services (LDSS)	47
Marketplace Facilitated Enrollers (FEs)	2,266
Other Organizations	537
Totals	5,587

Community-based assistors submit over 73 percent of all applications received by NY State of Health for persons determined eligible for Medicaid. During the period 2014 through 2023, assistors enrolled more than 7 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.

Assistors have been critical in meeting the needs of enrollees during the public health emergency unwind. Multiple trainings were conducted for assistors prior to the start of the unwind period. Training included an overview of rules that were suspended during the PHE, an update on changes made in NY State of Health to simplify the renewal process, an overview of the State's outreach efforts around the unwind and an overview of tools available the assistor dashboard to help with renewal efforts.

On a monthly basis, assistors are provided with a list of their consumers who are up for renewal so they can do outreach to those consumers and assist them through the process. Assistors are also provided a monthly list of consumers who fail to renew so they can outreach to them to encourage them to renew within the time period when a consumer could be reinstated without a lapse in coverage.

Other Highlights of State Administration During the PHE

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 during PHE, TPHI related activities transitioned from the LDSS to the Department included:

- Avoiding $20.87 billion dollars in Medicaid payments due to identification of TPHI liability;
- Verifying over 192,566 instances of TPHI;
- Updating more than 498,000 consumer records to correctly reflect TPHI and Medicare coverage;
- Reimbursing commercial health insurance premium for over 14,123 consumers when such reimbursement was found to be cost-effective for Medicaid;
- Determining 135,468 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 January 2020 to December 2023, the Department examined over 56,000 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 Medicaid 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 were implemented during the PHE to 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 are now processed through NY State of Health.

On January 1, 2024, the State will begin offering full health coverage through Medicaid managed care plans to undocumented individuals who are 65 and older and otherwise eligible for Medicaid. To ensure that individuals with limited Medicaid coverage for emergency services could begin receiving full coverage on January 1st, approximately 10,000 limited coverage enrollees were transitioned from New York City's Human Resources Administration (HRA) and 2,200 with limited coverage from the rest of the state were transitioned to NY State of Health. Transitions from HRA and districts throughout the state to NY State of Health will be ongoing now that this new State funded coverage is in place.

Impact of Essential Plan

The Essential Plan continues to be extremely successful and has been a critically important option for consumers during the PHE. As of December 2023, nearly 1.2 million 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 41 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 more than $1.5 billion in annual savings to the Medicaid Global Cap in State Fiscal Year 2024-25 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 and Essential Plan were also aware of their potential eligibility for the Supplemental Needs Assistance Program (SNAP). As of September 2019, following an eligibility determination for Medicaid, Child Health Plus or Essential Plan, 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. Since that time, more than 560,000 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. Since that time, more than 350,000 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 as 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, by phone or with an assistor 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 Qualified Health Plans 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.

Important functionality for Medicaid was added during the PHE and in support of the unwinding of the continuous coverage provision. 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;
- Improved the assistor search screens to help applicants and members find help in their community;
- Added support for the dual-eligible (Medicare and Medicaid) programs designed to improve access to benefits and coordination of care;
- Added the option of "X" in the sex field of the application;
- Expanded the data sources used to administratively renew individuals and increased the number of individuals eligible to be administratively renewed;
- Implemented managed care coverage for undocumented individuals ages 65 and above;
- Increased the post-partum coverage for pregnant individuals from 60 days to 12 months;
- Improved communication with consumers whose mail was returned to try to get updated contact information and reduce coverage gaps.

System improvements will continue into 2024 to complete the Medicaid MAGI functionality, enhance system efficiency, finish the unwinding of the continuous coverage provision and improve the user experience. Among the items in the pipeline:

- Making the application and member dashboard mobile friendly to streamline and simplify the application and renewal process and promote increased self-service;
- Improvements to the administrative renewal process to further expand the number of individuals eligible to be administratively renewed and ensure compliance with federal requirements;
- Develop a separate path for presumptive eligibility.

During the PHE the Department undertook significant work to document the non-MAGI eligibility rules and prepare for the development of a non-MAGI system. This work and a future system build is critical to bringing the Medicaid program into compliance with federal rules.

STATUS OF OTHER FUNCTIONS ASSUMED IN PRIOR YEARS

Other Eligibility-Related Functions

- **Administrative Renewals for the Aged, Blind and Disabled Eligibility Categories.** Prior to the PHE administrative Medicaid renewals were 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 PHE, 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. During the PHE, approximately 151,000 administrative renewals were completed.

As part of state fiscal year (SFY) 2023 budget, income eligibility for individuals in these eligibility categories was increased from the SSI level of approximately 84% of the FPL to 138% FPL to align with the MAGI income eligibility level. Effective January 1, 2023, these changes allow for much greater coverage retention for non-MAGI individuals both in the districts and in NY State of Health for individuals going through the eligibility redetermination process. Additionally, as part of New York's e(14) waiver mitigation strategy for compliance with *ex parte* renewals, the State adopted an administrative matching process with SNAP such that individuals with SNAP eligibility are automatically renewed into Medicaid. This additional automation reduces some administrative burden on local districts.

Pursuant to the SFY 2023 budget, MSP income levels were also increased for the Qualified Medicare Beneficiary (QMB) program to 138% FPL and the Qualified Individual (QI) level was increased to 186% FPL. As a result of this change and the income level increase described above individuals with MSP eligibility could not be administratively renewed since they required rebudgeting to receive a higher level of coverage.

- **Processing Family Planning Benefit Program Applications and Renewals (FPBP).** Approximately 17,624 presumptive eligibility and FPBP applications have been processed by the Enrollment Center in 2023. 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. NYC utilizes a combination of AVS and a Resource File Integration System (RFI) process.

AVS was suspended during the PHE. During the continuous coverage period unwind the asset test is waived pursuant to New York's mitigation plan. Since July 1, 2023, AVS has been utilized for new applications.

- **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 November 30, 2023, there were 13,990 incarcerated Medicaid enrollees who had inpatient hospital only coverage on NY State of Health.

- **Disability Determinations.**
  Prior to the PHE, the State Disability Review Unit (SDRU) performed disability determinations centrally for 57 local districts and the Office for People With Developmental Disabilities. In May 2023, SDRU completed work with the City of New York, Human Resources Administration (HRA) to transition HRA's workload to the State's centralized process. SDRU handled 8320 disability reviews for districts outside of New York City. The transition relieves HRA of processing more than 250 cases monthly.

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. Over the last decade, the Department contracted 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. Today, this work is accomplished by a single transportation broker. Collectively, these contractors arranged for 81 million trips from January 2020 through December 2023. The transportation mangers/brokers 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 November 2023, approximately 329,932 individuals were enrolled in MLTC plans an increase of 29,906 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 2024 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;

- 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 $122 million in reduced LDSS claims under the administrative ceiling for SFY 2024.

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 unwinding of the continuous coverage period continues the Department's ongoing priority and commitment is to ensure that all eligible New Yorkers enroll in and maintain coverage.

Technical enhancements have been implemented to expand the MAGI transition to include specific populations previously excluded due to system limitations, and functionality is expected to be added to the system in 2024 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. During the PHE extensive work was done to document the current non-MAGI eligibility rules in anticipation of transitioning this population as well. Until functionality is added to a modernized eligibility system for the remaining MAGI and entire non-MAGI population, no additional eligibility functions can be shifted from the counties to the State.