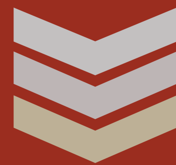
Medicaid Administration



Annual Report to the Governor and Legislature
December 2013

BACKGROUND

In April 2012, the Legislature enacted Section 6 of Part F of Chapter 56 of the laws of 2012 authorizing the Department of Health to transfer responsibility for the administration of the Medicaid program from Local Departments of Social Services (LDSS) over a period of six years by March 31, 2018. 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 second annual report will update the status of the activities the state has undertaken to assume Medicaid administrative functions, and the plan and timeline for the assumption of additional functions. The report will also describe the major work undertaken in 2013 to coordinate the implementation of the Federal Affordable Care Act (ACA) with the State Administration of Medicaid.

The report is organized into seven sections:

- *Status of Functions Assumed by the State*
- *Implementation of the Affordable Care Act*
- *Additional Functions Planned for 2014 and 2015*
- *Functions Remaining with Counties After 2014*
- *Post-ACA Implementation: Non-MAGI Administration Functions*
- *Financing Medicaid Administration*
- *Need for Additional Legislation*

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

STATUS OF FUNCTIONS ASSUMED BY THE STATE

In 2013 the state processed nearly two-thirds more eligibility determinations than in 2012. It also added counties to state administered disability determinations, transportation management, and managed long-term care, as well as made progress in implementing other functions. Over the past year, the state expanded its administration of the following functions:

- *Automated renewals for Medicaid enrollees with stable income;*
- *Renewals processed by the Enrollment Center;*
- *Applications from family planning providers for the Family Planning Benefit Program;*
- *Inmate suspension program;*
- *Disability determinations;*
- *Reassessing eligibility when a household member is deceased;*
- *Determining eligibility for the Family Health Plus Premium Assistance Program;*
- *Transportation management;*
- *Mandatory managed long term care; and*
- *Centralization of casualty and estate recovery.*

The chart below shows the increase in volume of eligibility determinations assumed by the state in 2013.

	2012		2013	
	Monthly	Annually	Monthly	Annually
Auto Renew Aged, Blind and Disabled	1,000	12,000	3,000	36,000
Enrollment Center Renewals	20,000	240,000	25,000	300,000
Family Planning Benefit Program	0	0	2,500	30,000
New MAGI Applications	0	0	19,000	47,000
Managed Long Term Care	6,942	83,300	10,000	121,000
Total	**27,942**	**335,300**	**59,500**	**534,000**

Each of these functions is described below.

Administrative Renewals for Aged, Blind and Disabled Individuals

Administrative Medicaid renewals began in January 2012 for individuals who are Aged, Blind and Disabled and whose only source of income is from the Social Security Administration (SSA). To qualify for an administrative renewal, resources must be 10 percent below the Medicaid resource level and there can be no unresolved match with state data systems.

The Administrative renewal eliminates the need for the recipient to fill out a paper renewal application. The renewal is completed in an automated fashion and a notice is sent to the recipient informing him/her of the renewal and continued coverage.

Administrative Medicaid renewals for individuals who are Aged, Blind and Disabled with income only from the Social Security Administration was expanded in June, 2013 to include New York City recipients. Additionally, automated renewals for Aged, Blind and Disabled and Medicare Savings Program recipients outside New York City were expanded to include recipients with a pension. For the combined groups, approximately 3,000 automated renewals are processed statewide each month; almost three times the number processed in 2012. Future expansions of automated renewals will be done through the New York State of Health.

Renewal Processing for Enrollees Permitted to Attest to Income Who Have No Resource Test

In June 2011, the Department began to assume responsibility for processing renewals for a subset of enrollees in New York's Medicaid, Family Health Plus, and Family Planning Benefit Programs – those who are allowed to attest to changes in income at renewal and who have no resource test (non-Aged, Blind or Disabled). These renewals are processed at New York's centralized Enrollment Center. The Enrollment Center, operating under the name *New York Health Options*, is implemented through a contract with MAXIMUS.

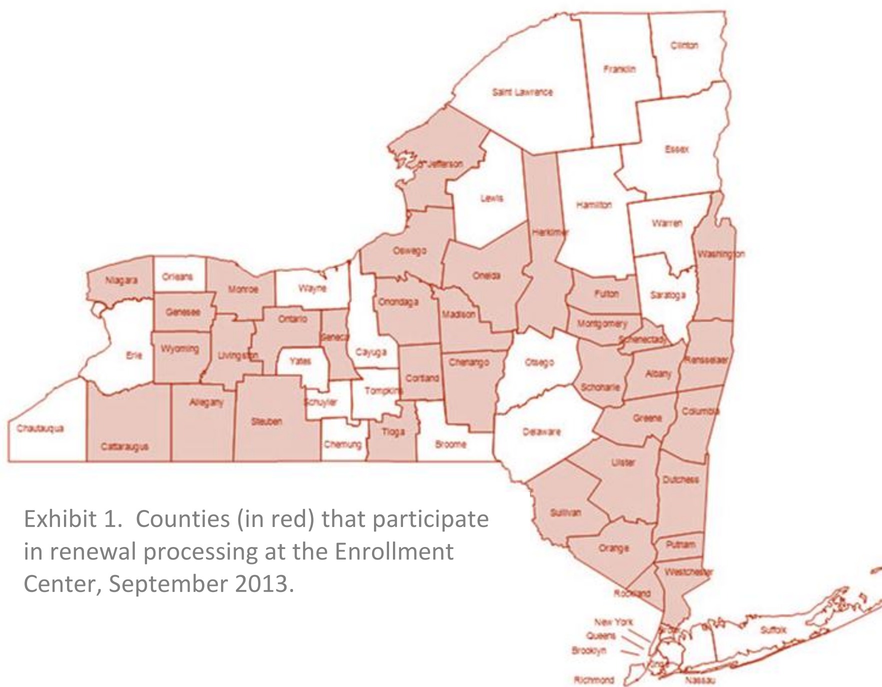


Exhibit 1. Counties (in red) that participate in renewal processing at the Enrollment Center, September 2013.

With the implementation of renewal processing at the Enrollment Center, New York introduced a new option for Medicaid recipients to renew their coverage by telephone. Recipients who choose to renew by telephone call the Enrollment Center and a telephone renewal interview is conducted by Enrollment Center staff. Recipients who choose to renew by mail send their completed renewal forms back to the Enrollment Center for processing. The Enrollment Center is open Monday through Friday from 8am to 8pm and Saturdays from 9am to 1pm, providing recipients with the option to renew during evening and weekend hours.

> *Renewals are centrally processed in 35 counties for most enrollees.*

Offering telephone renewal has been beneficial and has decreased the need for additional client outreach, as the renewal assistant can ask clarifying questions while the recipient is on the phone. Telephone renewal has proven to be a popular option as consistently 50 percent of renewals by the Enrollment Center each month are telephone renewals. Data show that 95 percent of the time the Enrollment Center can collect all the information it needs for processing the renewal during the telephone interview, as opposed to 79 percent of the time for a mail-in-renewal. [1]

As of January 2013, renewals from 25 counties were directed to the Enrollment Center for processing. Seven counties were added in March 2013 and three more were added in September 2013, bringing the number of monthly renewals directed to the Enrollment Center to over 25,000. The roll-out schedule for 2013 was based on input from the Local Social Services Commissioners about which counties were interested in transitioning their renewals to the Enrollment Center.

Processing Family Planning Benefit Program Applications

Effective November 2012, New York State included a presumptive eligibility (PE) option and transportation services for the Family Planning Benefit Program (FPBP) in its Medicaid State Plan. With this change, individuals have the opportunity to be screened presumptively eligible for the FPBP at a Medicaid-enrolled and trained family planning provider who has signed a Memorandum of Understanding (MOU) with the Department. The PE option will provide eligible individuals with immediate access to FPBP-covered services.

With the implementation of the new PE option, and throughout the past year, the Department transitioned the responsibility for processing all FPBP applications submitted by family planning providers from Local Departments of Social Services (LDSS), including NYC HRA, to New York Health Options.

All Family Planning Benefit Program applications submitted by providers are processed centrally.

Many family planning providers had previously signed MOUs with LDSS's that allowed them to submit applications for the FPBP directly to the LDSS on behalf of their clients. These MOUs have been replaced with a new MOU between the family planning providers and the Department that permits the provider to screen clients for PE, and to submit both PE screening forms and full FPBP applications to New York Health Options on behalf of their clients.

The first state DOH MOUs were executed in December 2012, and application processing started shortly thereafter. New York City implementation was delayed due to Hurricane Sandy, as staff time was redirected to programming required to preserve coverage for those unable to renew or submit documents due to the storm. In March 2013, New York City-based providers began submitting applications to New York Health Options.

As of November 2013, DOH holds MOUs with 50 providers who deliver services at 322 family planning sites throughout the state. During the past year, approximately 30,000 presumptive

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[1] These statistics do not reflect that documentation of certain eligibility factors may be necessary, regardless of whether the recipient renewed by phone or by mail.

eligibility and FPBP applications have been processed by New York Health Options for Family Planning coverage. The Department oversees the contract with New York Health Options and retains responsibility for approving the final eligibility determination for coverage.

Medicaid Applications for Inmates/Coverage for Inpatient Hospital Care

The Department, in partnership with the Division of Budget (DOB) and the Department of Corrections and Community Supervision (DOCCS), has developed a consolidated process for expanding Medicaid suspensions by reviewing applications for individuals who are incarcerated in state prisons. This initiative will improve access to Medicaid for inpatient hospital stays and benefits upon release.

The Department has selected Clinton County to process inmate Medicaid applications statewide (except for New York City, which is on a different computer system), based on their response to the Solicitation of Interest that was sent to all counties in September 2012. This pilot program began in September 2013.

In addition, the Department has created a new coverage code in WMS to authorize Medicaid payment for inpatient hospitalizations provided off the grounds of the New York State or local correctional facility. Most inmates with suspended Medicaid coverage will receive this new coverage code, so that claiming for inpatient hospital care can be done electronically through eMedNY. Until this time, these claims were being paid through a manual retroactive process. The new coverage code was available as of July 1, 2013.

Disability Determinations

The State Disability Review Team (SDRT) performs disability determinations for Medicaid eligibility purposes for 52 local districts and for the Office of Persons with Developmental Disabilities. The staged transfer of disability determinations from local disability review teams to the State Medicaid Disability Review Team began in December 2012 and proceeded according to schedule through November 2013, with eleven additional districts transitioning disability determinations to the State team. Five upstate districts are slated for transition in the first quarter of 2014. At that time, all disability determinations outside New York City will be performed by the State Medicaid DRT. New York City disability determinations will be transferred to the State DRT after a new disability determinations system is in place. Districts will continue to be responsible for collecting the documentation necessary to perform a disability determination until such time as the state team can assume this responsibility.

The state performs disability determinations for 52 counties.

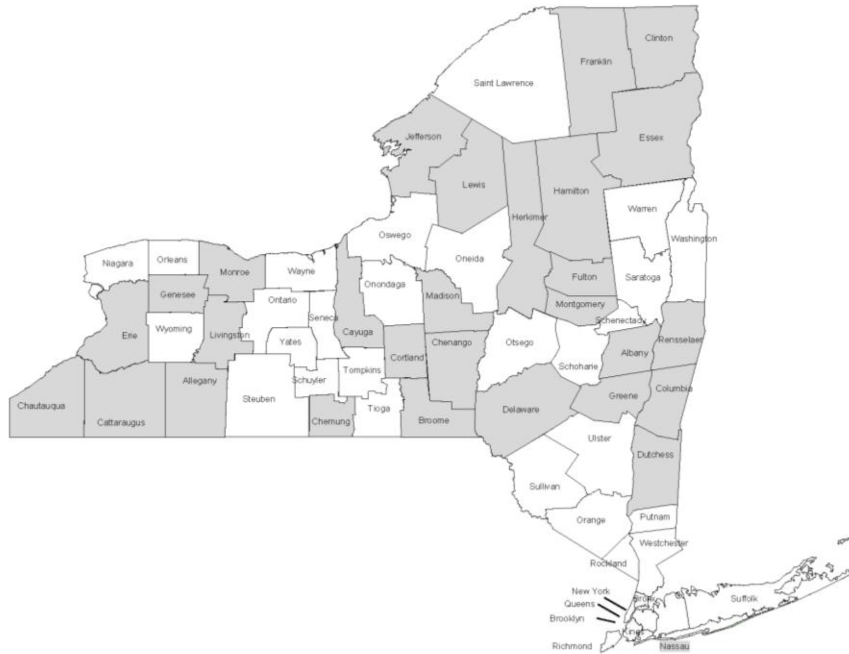
Reassessing Eligibility when a Household Member is Deceased

The Department is centralizing the resolution of reported deaths by the Social Security Administration. In order to reduce Medicaid (especially managed care) payments for deceased individuals, a monthly auto-close procedure for single individual Medicaid cases identified from a match with the Social Security Administration has been in place since 2007. These cases are closed automatically after proper notice is provided. Cases with multiple individuals or exceptions from the automated process are handled by the LDSS. Once an individual's death is confirmed, coverage for that individual is discontinued, the information for the remaining members is updated, and the eligibility for the remaining individuals is redetermined due to the change in household size. Client notices are then sent to inform the remaining individuals of their eligibility status.

The Department is investigating and resolving exceptions from the automated process, including closing coverage for a person in a multi-person household and contacting the district to rebudget the remaining family members. The Department began phasing in the centralization on January 1, 2013 in a few counties. The Department added 14 counties effective with the December 2013 report bringing the count up to 29 counties.

The Department intends to add the remaining non-NYC counties in the early part of 2014 and once the non-NYC districts are complete, the Department will work with the Human Resources Administration (HRA) to set up a similar process for the state to assume this function for NYC. The statewide assumption of this function will be completed by the end of 2014.

The 29 counties (in grey) where the Department is currently handling the closing of cases for those enrollees who are identified as deceased are:



Family Health Plus Premium Assistance Program

The Family Health Plus Premium Assistance Program (FHP-PAP) was established in 2007, and began enrollment in January 2008. Applicants determined eligible for FHP who have access to Third Party Health Insurance (TPHI) are required to take this coverage if it is qualified and cost-effective compared to enrolling in traditional FHP with managed care. FHP-PAP will pay or reimburse the employee share of the TPHI insurance premium, and reimburse any deductibles, coinsurance, co-payments and cost-sharing above the FHP levels. The program can also provide wrap around services to the TPHI plan for any FHP benefits not included in the TPHI plan.

Prior to the implementation of FHP-PAP, most individuals enrolled in employer-sponsored insurance were ineligible for FHP. No statutory mechanism existed to pay a cost-effective premium, as allowed for individuals eligible for Medicaid. Therefore individuals who were income eligible for FHP either dropped the employer coverage to enroll in FHP, or continued to pay premiums on the employer coverage, an often large expense for low-income working households.

Individuals who are already enrolled in FHP and later found to be enrolled in employer sponsored insurance must be evaluated for FHP-PAP.

The volume of cases and the complexity of the cost-effectiveness evaluation process has been a burden on resources at the New York City Human Resources Administration (HRA). In response, in June 2013, The Department transitioned to New York Health Options the responsibility for evaluating New York City FHP cases for potential FHP-PAP eligibility. Through an outreach letter campaign New York Health Options requested documentation from recipients enrolled in FHP that are identified on eMedNY as having other health insurance in order to evaluate whether the case should be converted to FHP-PAP, continued as FHP, or discontinued when the insurance is not cost-effective and qualified.

Approximately 9,000 FHP individuals were identified as also having third-party insurance (TPHI) in state data systems. New York Health Options has been conducting staggered outreach to these members to determine whether they continue to have TPHI and can be converted to FHP-PAP or whether they no longer have TPHI. As of November 2013, 1,623 recipients were found not to have TPHI and retained on FHP, and 123 individuals were converted, or are scheduled to be converted, from FHP to FHP-PAP. Some consumers were disenrolled from FHP for failure to respond to the request for information and the remainder is still in process. On an ongoing basis, any FHP cases later found to have TPHI will be reviewed for FHP-PAP eligibility until the program is phased out at the end of 2014.

State Assumption of County Medicaid Transportation Management

Prior to the state's development of initiatives aimed at achieving mandate relief for Local Departments of Social Services, the administration of Medicaid transportation by the counties was a costly local mandate that reduced the state's ability to ensure uniform compliance with policy directives, did not take advantage of potential regional efficiencies, and had not been effective in reducing costs. The Medicaid Redesign Team (MRT) led a reform effort to address these problems with the resulting impact of reducing transportation costs and providing work load relief to counties.

The first step towards achieving reform and mandate relief came when the 2010-11 State Budget amended Section 365-h of the Social Services Law to give the Commissioner of Health the new authority to assume the management of Medicaid transportation in any county, and to select a contractor at his discretion for this purpose. The intent of the law was to improve the quality of transportation services, reduce the local burden of administering transportation services and local management contracts, and achieve projected budgeted Medicaid savings.

The authority given the Commissioner makes possible the centerpiece of the MRT#29 Medicaid Non-emergency Transportation Management Initiative which creates several regions based on common medical marketing areas. These new regional models were created to consolidate local administrative functions, centralize specialized management expertise, and improve resource coordination – resulting in a more seamless, cost efficient, and quality oriented delivery of transportation services to Medicaid beneficiaries.

In May 2011, the Department of Health awarded a Hudson Valley Region contract to Medical Answering Services, a Syracuse-based non-emergency medical transportation management company. This state management initiative, now expanded to 24 counties and including managed care recipients, has successfully consolidated local administrative functions, provided more consistent management expertise and Medicaid policy oversight, and improved resource coordination.

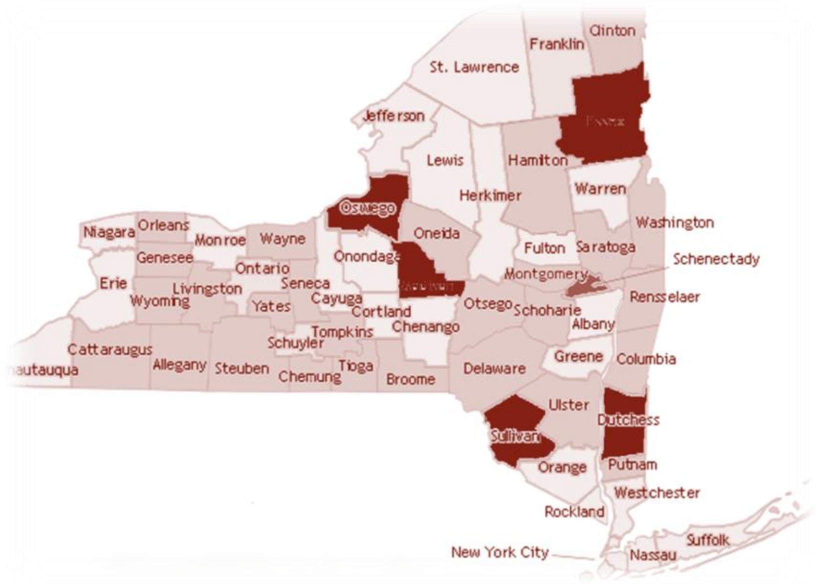
State assumption of transportation management has become an important step in relieving local districts of the responsibility for administering a major service of the Medicaid program. Not only are the districts no longer responsible for arranging and prior authorizing transports for Medicaid enrollees, but they are also no longer responsible for the administrative tasks associated with reimbursing enrollees and non-enrolled transportation providers for certain off line transportation associated expenses. The state assumption of this particular function provides relief in two ways: county staffs are no longer responsible for the many tasks associated with the administration of Medicaid transportation, and county budgets no longer have to provide for the upfront costs of funding off line transportation reimbursements.

Building on the success of the Hudson Valley initiative, the Department has procured LogistiCare Solutions, a national transportation management company, to develop an improved, cost effective Medicaid transportation infrastructure in New York City. This project began with transportation management in Brooklyn on May 1, 2012 and by October was expanded to all five City boroughs. All Managed Care enrollees throughout the City are included under LogistiCare's transportation management as of January 1, 2013 – representing a total of 3.1 million Medicaid enrollees, the largest Medicaid transportation management project in the nation.

In November 2012, the Department offered a procurement for 24 counties in the Finger Lakes and Northern New York regions. The contract was awarded to Medical Answering Services, and as of October 2013 all of the counties in the Finger Lakes and Northern New York regions are being managed by Medical Answering Services. In August 2013, another procurement was offered for the seven county Western New York region that includes Erie county, for which the responding proposals are being considered for a contract award. A procurement for the Long Island region comprising Nassau and Suffolk counties is expected to be issued in 2014, thereby completing the Department's assumption of transportation management statewide.

The transportation management initiatives are on track to achieve the Medicaid Redesign Team's $30 million transportation state share savings when fully implemented. Early indications are that the Department has realized significant reductions in the cost of transportation per user when compared to the same months in the year prior to state management. This savings trend generally results from a decrease in the number of higher cost trips in favor of lower cost modes such as livery, or public transportation, and other targeted efficiency efforts such a group rides.

Managed Long-Term Care



One of the most significant reforms recommended by the MRT is the plan to migrate long term care services to a managed care environment. In August 2012, the Department received approval from the Centers for Medicare and Medicaid (CMS) to require certain Medicaid consumers to enroll in managed long term care plans. Over a several year period, the Managed Long Term Care (MLTC) program will expand statewide and the majority of community-based long-term care service recipients will be enrolled in plans. Under the expansion, all dual eligible individuals (persons in receipt of both Medicare and Medicaid) aged 21 or older and in need of community based long-term care services for more than 120 days, will be required to access services through a managed long term care (MLTC) model.

The transition to mandatory managed long-term care began in New York City in September 2012, and as of November 2013 more than over 120, 800 individuals are enrolled in MLTC plans. This represents a 45% increase in MLTC enrollment since the mandatory transition was introduced. In March 2013 mandatory enrollment was initiated in Nassau, Suffolk, and Westchester counties; September 2013 saw expansion of mandatory MLTC enrollment in Orange and Rockland counties. December 1, 2013 will see the mandated MLTC enrollment expand to four additional counties, including Albany, Erie, Monroe and Onondaga. Other counties will transition in 2014 and after, based on the availability and capacity of managed long term care plans in the county.

The expansion of MLTC enrollment reduces the participation in programs managed by the LDSS, including the Personal Care Services Program, Personal Emergency Response Services, Consumer Directed Personal Assistance Program and the Long Term Home Health Care Program. The responsibility for the LDSS to assess the need for community based long term care services and authorize the level and duration of services declines as enrollment in managed long term care increases and the health plan assumes responsibility for managing the care.

The LDSS staff is not required to enroll and disenroll MLTC participants nor be responsible for appropriate notice to the MLTC enrollees; this responsibility has been assumed by the state's enrollment broker, Medicaid Choice. Any change in service authorization, particularly reductions, resulting in fair hearing requests are also handled by the MLTC and the state's enrollment broker rather than LDSS staff. Additionally, the LDSS staff role in the prior approval of placements into the Assisted Living Program is no longer required but post placement review of admission is solely at LDSS option.

Centralization of Casualty and Estate Recovery

The Office of Medicaid Inspector General (OMIG) administers the MRT initiative to centralize the management and reporting of Medicaid casualty and estate recovery. OMIG requires Local Departments of Social Services (LDSS), at a minimum, to use the HMS Maestro Case Management System to administer these recovery programs. Prior to assuming such responsibility from a social services district and in consultation with the district, OMIG/HMS will define the scope of services the district will be required to perform on behalf of the Department of Health. Additional services and assistance are available from OMIG/HMS including full outsourcing of estate, casualty and lien recovery efforts.

LDSS may choose from the assistance options described below:

- *Case Management Option - LDSS would have access to all of HMS intake and referral networks and use Maestro and Image Now to manage all LDSS cases.*

- *Overflow Option - this second option expands on the first solution to create a "hybrid" solution that includes full case management system support and direct HMS assistance with "case overflow." With this solution, LDSS would be able to continue working a caseload that is manageable and tap into HMS resources for added value and enhancement of the caseload.*

- *Full Outsourcing Option – this is our third and most comprehensive solution which is a (near) full utilization of HMS services. This solution includes the case management and referrals network solution, case overflow assistance, additional case identification and full case management by HMS caseworkers for all cases, both those identified by NYC and those identified by HMS. With this solution, LDSS direct involvement in casework would be limited to situation where only the county has the legal authority to take an action. On these cases, HMS would provide consultation to facilitate the work.*

As of December 2013, twenty five New York counties have been implemented through the MRT 102 Medicaid Centralization efforts including New York City's Casualty Recovery Program (HRA-IREA). Of the 25 counties implemented to date, 20 have fully outsourced their estate and casualty recovery work to OMIG/HMS, five have a shared work/hybrid option and New York City maintains their casualty casework in-house while using a customized version of the Maestro Case Management System with over flow and front end assistance from OMIG/HMS. Implementations for Essex County, Sullivan County and New York City (HRA-OLA) are currently in progress along with several smaller counties throughout New York State.

IMPLEMENTATION OF THE AFFORDABLE CARE ACT

On October 1, 2013, New York State of Health, the Official Health Plan Marketplace, began accepting applications for coverage effective January 1, 2014. The significance of the Marketplace for the State Administration of Medicaid is, beginning January 1, 2014, most Medicaid applications for the MAGI populations (pregnant women, children, parents/caretakers, and adults under age 65) will be processed by the Marketplace and not by the LDSS. The applications will be processed using a new, modernized eligibility system with electronic verification and automated eligibility decision support. Moreover, applications for MAGI populations from community-based assistors (e.g., facilitated enrollers, in-person assistors/navigators, health plans, hospitals, and other providers) will be sent to the Marketplace electronically instead of by paper to the counties. Eligibility determinations for about 65 percent of new applications are shifting from the counties to the state.

Centralized Eligibility Determinations for the MAGI Population

New York State of Health (NYSOH) centrally processes eligibility and enrollment for Medicaid MAGI populations, the Children's Health Insurance Program, Advance Premium Tax Credits, Cost-Sharing Reductions, the APTC Premium Payment Program, and unsubsidized purchases of Qualified Health Plans. Applicants can apply online, by phone, by mail, and in-person.

NYSOH also has a Customer Service Center with locations in Albany and New York City staffed by state staff and Maximus staff to answer general consumer questions, provide assistance with applications started online, take applications over the phone, and to respond to myriad other consumer inquiries. Customer Service is available Monday through Friday from 8am to 8pm and on Saturday from 9am to 1pm. Extended hours were available in December to ensure applicants were able to be enrolled in a plan by January 1, 2014. Since launching the NYSOH Customer Service Center in October 2013, call center representatives have answered over 300,000 calls from across the state. This is in addition to the 90,000 calls already handled by the traditional Medicaid helpline on a monthly basis.

Of those calls coming into NYSOH in the first two months of operation, call center representatives provided telephone or online application assistance 45 percent of the time. Other calls included a variety of general inquiries ranging from the availability of health plans (and their premium rates) to requests for basic information about the Advanced Premium Tax Credit and Cost Sharing Reductions. Overall, nearly 30 percent of these calls originated in New York City, 10 percent in Long Island and the remaining 60 percent of calls came from consumers residing in other counties throughout the state.

Since October 1, the Call Center has answered over 300,000 calls.

During the first two months of operations, calls were answered quickly, within 35 seconds, on average. Recently, the wait time at the call center has increased, bringing the average since October 1 to 3.5 minutes. Call volume surged in the month leading up to December 23, the last day to select a plan for January 1 enrollment. The average call length has also increased to over 12 minutes as more consumers are calling for assistance in completing the application, selecting a health plan, and understanding any verification documents they may owe. The call center is adding resources to bring the call wait times back down to earlier levels.

As an alternative to speaking with call center representatives to obtain answers to their questions, thousands of callers opted to obtain their answers through the NYSOH Integrated Voice Response system (IVR). For example, by making selections using their telephone keypad, nearly 20,000 callers retrieved the contact information for a navigator that could provide them with in-person application assistance. In another example, 3,600 callers listened to the Frequently Asked Questions and Answers about the Marketplace.

Since October 1 the Marketplace enrolled 47,000 individuals in Medicaid, 30% who are newly eligible.

Finally, creation of the NYSOH Customer Service Center continued and expanded New York's commitment to providing assistance to consumers for whom English is not their primary language. While all callers have always had access to translation services through the traditional Medicaid helpline, customer service center staff now includes representatives that speak Cantonese, Haitian-Creole, Mandarin, Russian and Spanish. These are the top five languages selected by callers choosing a language other than English in the IVR system. In October and November, more than 42,000 non-English calls came into the call center. Of those, NYSOH representatives directly responded to over 29,000 and the remaining callers received assistance via three-way call with a "language line" interpreter.

Between October 1 and December 20, 2013, the Marketplace determined 47,000 individuals eligible for Medicaid. Nearly 30 percent of Medicaid enrollments through the Marketplace are for adults in the newly expanded eligibility level between100 to 138 percent of the federal poverty level. The remaining 70 percent of Medicaid enrollments are for individuals previously eligible, but not enrolled. Approximately 85 percent of Medicaid enrollments are adults between the ages of 21-64 and 11 percent are children under age 19. More than half of the new Medicaid enrollments were from New York City (37%) or Long Island (15%), with the remaining 48 percent from other counties throughout the state.

Coverage for Medicaid enrollment through the Marketplace is effective January 1, 2014. As such, individuals were encouraged to apply at their LDSS through December 31, 2013 after which New York State of Health would process new Medicaid applications for the MAGI population. As demonstrated by the nearly 50,000 individuals enrolled in Medicaid through the Marketplace, many individuals were newly eligible or decided to apply anyway and wait for coverage to begin on January 1. Some individuals applied in both places and their eligibility was cancelled on the Marketplace if found on WMS.

The October-November period gives us a unique opportunity to examine differences between new applicants who were determined eligible by the LDSS and those determined eligible by the Marketplace. During this period, more than twice as many Medicaid eligibility determinations were made by the LDSS as the Marketplace. The percentage of new Medicaid enrollment in the Marketplace from New York City (37%) is lower than historical patterns and lower than the percentage that applied through HRA in October and November (54%). A possible explanation for the lower than expected enrollment from New York City is that applications from facilitated enrollers were submitted to local districts until the end of 2013 and these applications account for a high percentage of HRA's volume. Another explanation is that New York City has historically had high enrollment levels among the uninsured compared to other counties across the state.

75 percent of applications are submitted online.

Marketplace enrollment from individuals living on Long Island and in counties throughout the rest of the state was slightly higher than those determined eligible at local districts in those areas. About 11 percent of Medicaid determinations in October and November were made by the LDSS in Long Island compared to 15 percent on the Marketplace. For counties outside NYC and Long Island, 44 percent were determined by local districts and 48 percent were determined by the Marketplace. The Marketplace accounted for a higher percent of eligibility determinations for adults (85% compared to 50% at LDSS). Local districts processed eligibility for twice as many children as the Marketplace.

New Yorkers embraced the ability to apply for health insurance online much faster than anticipated given the manual, paper process that existed for public programs prior to the launching of NYSOH. Since the Marketplace began taking applications on October 1, the vast majority have been submitted online (75 percent). The next highest application channel has been in-person assistors at 18 percent, followed by phone applications at 6 percent and mail at less than 1 percent. Those individuals seeking financial assistance are more likely to apply with an assistor (24%) or by phone (8%) than those not seeking financial assistance. The distribution is expected to change in January when most new applications for the MAGI Medicaid population will be processed by NYSOH instead of the LDSS. Until consumers get used to the change, some may continue to mail paper applications to the local districts, which will be referred to NYSOH, increasing the paper application processing numbers in NYSOH.

Until eligibility for the entire Medicaid population can be processed in the NYSOH eligibility system, new applications for the MAGI population will be processed by NYSOH and new applications for the non-MAGI population will be processed by the LDSS in WMS. The bifurcation of eligibility will require good coordination and communication between NYSOH and the local districts.

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 NYSOH website who indicate certain attributes are referred to the local district to have their eligibility for Medicaid coverage determined using non-MAGI eligibility rules.

While completing the NYSOH application, individuals are notified via immediate screen text and subsequent mailed notice that a referral has been made to their local district office for potential eligibility for a non-MAGI category. The following applicant populations are referred to the local district to complete the application process for Medicaid coverage:

- *Aged, Blind, Disabled and Chronically ill persons who are not eligible for Medicaid under MAGI methodologies.*
- *Individuals who indicate they were in Foster Care in New York State or receiving an Adoption subsidy at age 18.*
- *Individuals who exceed income for Medicaid and indicate they would like to have their MA eligibility determined for the Excess Income Program (spend down). This option is not available to single/childless individuals age 19-64.*
- *Individuals applying for Medicaid coverage for nursing home care, Care at Home Waiver services, or Managed Long-Term Care.*
- *Individuals applying for retroactive coverage for medical expenses incurred in the three months prior to application until March 31, 2014 when NYSOH will process retroactive coverage for the MAGI population. Individuals whose income exceeds the MAGI income level may continue to be referred to the local district for a determination of eligibility for the spend down program.*

Between October 1 and December 9, 2013, nearly 20,000 referrals were made to the counties, about 7,000 to the Human Resources Administration (HRA) in New York City and 13,000 to local departments of social services in non-NYC counties. Nearly 90 percent of the referrals were for retroactive coverage for medical bills or non-MAGI eligibility determinations for the aged, blind or disabled. Counties have indicated a low percentage of individuals following up with the district for coverage in the retroactive period or under the spend down program. Many individuals being referred are already known to the district and have income over the applicable Medicaid income level.

A similar process will be in place at the local districts beginning January 2014 for those MAGI applicants that first apply at the district. Applicants who are; pregnant, under age 19, parent/caretaker relative of a dependent child under age 19, and those who are age 19-64 and not eligible for Medicare Part A or B who mail in an application will be referred by the local district to NYSOH for a determination of Medicaid eligibility. Nearly 70 percent of the counties have decided to have staff certified as application counselors so they will be able to assist individuals in a MAGI eligibility category file their applications with NYSOH if they come into the local district to apply in person. Nineteen local districts decided not to designate any staff as Certified Application Counselors including Broome, Chemung, Chenango, Clinton, Columbia, Greene, Herkimer, Jefferson, Livingston, Monroe, Nassau, Niagara, Putnam, Onondaga, Otsego, Saratoga, Seneca, Tioga, and Westchester.

Renewals of current Medicaid enrollees will remain with the local districts or the Enrollment Center in 2014. Given the complexity of the eligibility system development, the short time for adequately testing all the eligibility permutations and the data services available through the Federal Hub, and the reality that functionality will continue to be added six to nine months after open enrollment, the state has decided to focus its resources on providing coverage starting January 1, 2014 to new Medicaid applicants, and delay the transition of current Medicaid enrollees to minimize possible disruptions in coverage.

To maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Local districts will be able to determine MAGI eligibility using the current legacy system for those individuals renewing coverage.

Local districts will continue to renew existing enrollees using MAGI rules in the legacy system until at least October 2014 or until the new eligibility system is fully automated and is stable enough to handle the transition of over 3 million current recipients. The MAGI rules built into the legacy system will include:

- *No longer counting child support as income;*
- *Not applying income disregards/deductions;*
- *Increased federal poverty levels to comply with ACA income levels;*
- *New AID categories for claiming; and*
- *Revised client notices.*

In addition to renewals, local districts will continue to process eligibility determinations for MAGI populations who are denied eligibility for cash assistance (TANF) and need a separate determination for Medicaid and presumptive eligibility for pregnant women and children.

Modernized Medicaid Eligibility System

The most important factor in the state's ability to assume Medicaid administrative functions by 2018 is the development of a modernized eligibility system that automates the verification and determination of eligibility. The only way to achieve greater efficiency and reduce administrative costs is to significantly reduce paper applications/renewals and automate as much of the eligibility determination process as possible. The state assumption of Medicaid eligibility functions will proceed in parallel with the ability to automate eligibility determinations.

In June 2012, the Department entered into a contract with Computer Sciences Corporation to design and develop the Information Technology Systems for the Marketplace, one of which includes the eligibility system. The other components of the IT solution include the Small Business Marketplace, the financial accounting system, customer service, and the ability to provide health plan comparisons on the online Marketplace.

The current functionality of the eligibility and enrollment system accepts application data and updates and changes from consumers and a wide range of community-based assistors. The system verifies the information with electronic sources, determines eligibility or pends eligibility for documentation, allows the consumer to select and enroll in health plans, and generates electronic communications as well as notices to consumers.

The new system provides both "front end" and "back end" functionalities needed to support the eligibility and enrollment process from end to end. The system provides back office screens that enable customer service representatives, state DOH employees, and appeals specialists to perform necessary assistance, determination and quality assurance functions, with further enhancements planned for 2014.

The system has established interfaces with a wide range of state and federal systems, with more planned for 2014. In addition to verification data sources, some of the other interfaces support functionality needed for Medicaid program administration. For example, the Medicaid plan roster is being replaced with secure electronic enrollment transactions (834s) as Medicaid enrollees transition from WMS to NYSOH. Additional Medicaid system functions include auto assignment into plans, preventing duplicate coverage, generating client identification numbers, issuing and replacing benefit cards, processing newborn enrollments, referring non-MAGI individuals to local districts, and various post eligibility activities including Medicaid suspension based on incarceration, third party coverage determinations and administration of premium payment programs including the APTC Premium Payment Program. The system also provides data for Medicaid reporting and claiming.

To meet the ACA deadline of October 1 for accepting applications, determining eligibility using the MAGI methodology and processing health plan enrollments for new applicants, by necessity, some functionality needed to be deferred. The state phased in the development of the modernized eligibility system and established priorities based on when the functionality was or will be needed. The decision to phase-in functionality proved effective given the successful launch of NYSOH.

The Marketplace is successfully processing applications and plan enrollments without many of the problems plaguing the Federal and some other state Marketplaces. However, it also means that the system still needs to add significant functionality during 2014 and after to meet the full requirements of the ACA and to replace WMS for the Medicaid population.

In 2014, the state will deploy additional functionality in the following areas:

- **Additional Required Functionality:** The functionality to be added in 2014 includes continuing to automate and refine processes that are still manual, rework to accommodate revised regulations from HHS/IRS that affect eligibility rules, inclusion of a path for presumptive eligibility, more streamlined changes and updates functionality, the ability to process retroactive eligibility for Medicaid, redesign to support administrative renewal and the ability to move current MAGI Medicaid enrollees from WMS to the new system. Inherent in the added functionality is the need to support overlapping and more complex paths for eligibility and enrollment including, but not limited to, the ability of consumers to move between programs seamlessly as their eligibility changes at renewal, during special enrollment periods, or when they reach a milestone age (e.g., age 19 or age 65).

- **Improvements to the Consumer Interface:** The consumer online experience will be enhanced in several areas. One enhancement is to tailor the application to ask certain program-specific questions once a consumer's program eligibility is established based on his/her income eligibility results. Assisting consumers to better navigate plan choices is another area for improvement. The online application will also be provided in other languages, beginning with Spanish in late 2014. Notices will also be provided in seven languages as well as in alternate formats for the visually impaired.

- **Improvements to the Eligibility Worker Interface:** NYSOH includes "back end" worker screens that enable eligibility specialists to troubleshoot consumer problems. They also permit quality assurance reviews of the eligibility determinations for program integrity and to ensure the system is operating correctly. Next year, more robust functionality will be added to the "back end" screens as well as a fully automated appeals function.

- **Improvements to Assistor Interfaces:** The Broker, Navigator and Certified Application Counselor (CAC) portal requires upgrades and enhancements to make it easier and more efficient for assistors to track the status of applications in process and submitted. Assistors also want the ability to more efficiently enter updates and changes to applications. Navigators and CAC lead agencies, in particular, need functionality to monitor the performance of their employees and subcontractors. In the short-term, some immediate enhancements include adding functionality to sort applications by the date the application was taken to better track the progress and status of applications. A field for case notes is also planned for the dashboard so that assistors can easily see what information is outstanding. In the long-term, functionality will be added to allow assistors to review and track the work of their employees and contractors.

- **Additional Data Matching:** NYSOH includes robust electronic verification for the initial eligibility determination. Slated for automation in 2014 is the ability to verify continued eligibility by running post eligibility data matches with existing data sources and the addition of others such as the PARIS match through the Federal Hub. In addition, NYSOH needs to be able to connect with added federal interfaces including a new version of the existing required immigration verification service and the TALX service for more current income verification. NYSOH is also planning to add state data sources to strengthen verification such as New Hire data, NYSHIP, and DMV.

- **Enhanced Program Integrity:** The NYSOH modernized eligibility system enhances program integrity through robust identity proofing of applicants, the use of electronic verification sources, including tax data, and for Medicaid, the ability to check for an existing Client Identification Number (CIN) across both the upstate and downstate WMS and NYSOH, before assigning a new one. Enhancements for 2014 include periodic data matches to ensure continued program eligibility, a universal CIN clearance process to detect and eliminate duplicate CINs, and address validation.

- **Reporting Capabilities:** NYSOH has identified a number of reports that will be produced regularly to monitor enrollment, system performance, and for other program management and oversight needs. Most of the reports still need to be programmed and generated in 2014. In addition to defined reports, there is a need for accessible query capabilities for DOH.

Eligibility System Planning for 2015

The state will build the non-MAGI eligibility rules into the new eligibility and enrollment system in 2015. The non-MAGI populations include individuals whose Medicaid eligibility is based on their being elderly, blind or disabled, those eligible for spend-down, Medicare Savings Program, Medicaid Buy-In for Persons with Disabilities, the Cancer Services Program, and foster care youth. For each of these populations, the system requirements need to be developed including the consumer facing screens, notices, the eligibility rules engine, and plan enrollment, if applicable as well as the accompanying back end functionality for the eligibility workers.

Incorporating the non-MAGI population requires the development of a wide array of eligibility pathways and is the most difficult to automate. The variety of eligibility pathways requires the automation to be phased. Through the work to automate eligibility determinations for the MAGI populations, the Department has identified some early candidates for phasing in the non-MAGI populations. These include the ability to automate the transfer of TANF application information to

the new system after a TANF denial or the loss of eligibility for TANF, spend down, and those eligible on the basis of foster care who age out and will have expanded eligibility up to age 26 for Medicaid regardless of income. In addition, automating the eligibility for the Medicare Savings Program has always been a high priority among the non-MAGI populations. The Department will work closely with the stakeholder groups, especially the local departments of social services, to prioritize the phase-in of the automation of the non-MAGI populations.

Community-Based Assistors

Community-based assistors have historically played a significant role in helping low-income New Yorkers obtain Medicaid. In some counties, over 50 percent of new Medicaid applications were submitted by facilitated enrollers and other community-based assistors. Beginning January 1, 2014, all new MAGI applications from trained community-based assistors will be submitted to NYSOH using the online application, including applications from In-Person Assistors/Navigators and Certified Application Counselors, which encompass federally qualified health centers, health plans, hospitals, local departments of social services, and other community-based organizations, and Brokers.

3,600 navigators and CACs were trained in 2013.

- **In-Person Assistors/Navigators:** The ACA requires Marketplaces to provide grants to organizations to serve as in-person assistors/Navigators. Navigators are individuals that have been trained and certified to provide application assistance to individuals and small businesses applying for health insurance coverage. This includes individuals applying for Medicaid, Child Health Plus and Qualified Health Plans with or without an advance premium tax credit or cost sharing reduction. Through a competitive procurement, New York awarded navigator grants to 48 organizations throughout the state. These organizations have subcontract agreements in place with an additional 96 organizations to provide navigator services. Every county, except one, has at least two navigator agencies available to assist consumers. Navigators provide application assistance in approximately 48 different languages. Navigators must provide unbiased assistance and cannot charge consumers for their services. The program is funded at approximately $27 million per year.

- **Certified Application Counselors (CACs):** CACs are organizations, staff and volunteers who will help individuals apply for coverage through the Marketplace. CACs must also be trained and certified but are not compensated for their services by the Marketplace. Some CACs are funded by Medicaid as out-stationed workers or to provide assistance to Medicaid applicants. HHS broadened this role through the creation of CACs to enable traditional Medicaid providers to assist applicants across all Insurance Affordability Programs. We expect that the types of organizations in New York that will be CACs include Federally Qualified Health Centers, hospitals, health plans, Local Departments of Social Services, and other organizations that currently assist Medicaid applicants. CAC organizations may train their staff using the training material provided by the state. In order to use the train the trainer option, organizations must enter into an agreement with the state.

- **Brokers:** State licensed insurance brokers are available to assist individuals, in addition to small businesses, apply for coverage through the Marketplace. Although brokers cannot receive any commission for assisting Medicaid or CHIP enrollments, if they participate in the Individual Marketplace, they must assist all applicants regardless of the program for which they may be eligible. The Marketplace entered into agreements with licensed brokers who have completed a specialty designed Continuing Education Course for the Marketplace. Nearly 3,700 brokers are credentialed to assist consumers.

The chart below lists the number of Navigators and Certified Application Counselors trained primarily by DOH contractors in 2013. The numbers below do not fully reflect the estimated number of individuals who were trained using the train-the-trainer option described above. It also does not include the nearly 4,000 brokers who have been trained.

Type of Application Assistor	Total Number Trained as of 12/31/13
Navigators	656
Federally Qualified Health Centers	230
Hospitals	534*
Local Departments of Social Services	410
Health Plans	1,735
Other Organizations	88
Totals	3,653

*Does not include hospital representative trained by Greater New York Hospital Association (GNYHA)

ADDITIONAL FUNCTIONS PLANNED FOR 2014 AND 2015

In addition to the continued work to move the entire MAGI Medicaid population into NYSOH, the state will assume some additional functions in 2014 and 2015 as described below.

Asset Verification System

The Department intends to contract for an Asset Verification System (AVS) in 2014. Section 1940 of the federal Social Security Act requires all states to implement an electronic system for verifying the assets of aged, blind or disabled (SSI-related) applicants for and recipients of Medicaid. The Local Departments of Social Services currently perform this function. Assets are currently verified through the Resource File Integration (RFI) process, but much of the process is manually performed by analyzing information brought in by the applicant or by reaching out to the financial institutions for banking records. This process is labor intensive, inefficient and not timely.

The Department intends to contract with a vendor with access to data from financial institutions to automate the verification of assets. This will reduce a significant portion of the work currently being performed by the LDSS and improve the timeliness of eligibility determinations. The AVS will augment the role of the LDSS by providing comprehensive verification and account reporting of Medicaid applicants' and recipients' resources by:

- *Verifying the assets of the population applying for or receiving Medicaid on the categorical basis of being aged, blind or disabled;*
- *Providing flexibility, security and automation that allows the LDSS to manage and act upon verification results in a timely manner; and*
- *Improving program integrity.*

The Department anticipates that the verification of real (instead of personal) property will be included in the information provided by the contractor, providing access to information that is difficult to obtain electronically today.

The Department has taken steps to secure a contractor to perform this function and intends to enter into a contract in early 2014. The Department will then work with the contractor and the LDSS to provide the information to the LDSS in the most efficient manner to ease the workload of the LDSS. The electronic process of identifying assets will be transitioned to NYSOH once the determination of long term care eligibility is assumed by the state and is centrally completed through the marketplace.

Automated Spend Down

To address the cumbersome and largely manual process that occurs each month to collect medical bills and give coverage when a Medicaid spend down is met, the Department designed specifications for an interface between WMS and eMedNY (the bill payment system for Medicaid) to enable eMedNY to identify individuals with a spend down and the dollar amount of the spend down. The eMedNY system would then track medical bills submitted by Medicaid providers and apply the bills towards an individual's spend down. Medicaid payment of claims submitted would occur once the spend down is met. Implementation of the project was delayed when systems resources were required to shift to the WMS interfaces required for interaction with NYSOH. With the transition of the Medicaid population to NYSOH, the specifications for the automated spend down project will be redesigned to an interface between NYSOH and eMedNY. Phase 2 of NYSOH will include eligibility determinations and enrollment for individuals not based on MAGI. The automated spend down project will be needed in the initial build of Phase 2 which is expected in 2015.

Medicare Savings Program

The Medicare Savings Program (MSP) is a Medicaid benefit which pays the Medicare premiums for low income individuals. On a yearly basis, 13,000 paper applications for this benefit are received statewide. These applications are currently received and processed by the LDSS. The Department originally planned to assume the responsibility for determining eligibility for this program by the end of 2013 by directing applications for MSP to New York Health Options. Instead, NYSOH will be responsible for receiving the applications, determining eligibility, and sending written notification to applicants at the time the NYSOH eligibility system is programmed to accommodate these cases in 2015. MSP applications from all regions of the state will then be processed centrally.

FUNCTIONS REMAINING WITH COUNTIES AFTER 2014

The implementation of the Affordable Care Act and the MRT initiatives, along with the transition of functions from counties to the state represents significant change to Medicaid enrollees. The significance and speed of change requires a close partnership between the state and counties to ensure a smooth transition. Eligibility workers at the local level will be critical partners in reducing confusion and assisting enrollees in retaining coverage. In addition to assisting the state to implement 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 for a period of time post-2014 include:

- *Providing in-person application assistance to MAGI applicants/enrollees, for counties that choose to retain this function;*
- *Assisting those who are denied TANF apply for Medicaid and conduct separate determinations for non-MAGI applicants;*
- *Administering the spend down program;*
- *Processing applications and renewals for individuals who are aged, blind, or disabled;*
- *MSP application processing;*
- *Conducting chronic care (nursing home) and alternate-levels-of-care eligibility determinations and renewals;*
- *Processing applications and renewals for the Medicaid buy-in for Working Persons with Disabilities program;*
- *Collecting documentation for disability determinations;*
- *Handling eligibility for SSI cases, including separate determinations when an individual loses receipt of SSI;*
- *Provide legal assistance with recoveries; and*
- *Transitioning MAGI Medicaid enrollees from WMS to NYSOH.*

POST-ACA IMPLEMENTATION: NON-MAGI ADMINISTRATION FUNCTIONS

The state will work with counties to determine the appropriate phase-in of the non-MAGI population to the state. Those counties that wish to retain responsibility for the eligibility determinations for certain non-MAGI populations for the long-term will need to enter into contracts with the state.

As the state began centralizing Medicaid administrative functions, the counties began expressing the need to be indemnified from damages resulting from State errors as well as errors made by county workers if they are complying with State and federal rules.

Counties have no liability for the eligibility determinations made by the State, either in the new eligibility system or in WMS. Counties also have no liability for decisions with respect to services for Medicaid enrollees they had no part in making, such as those made by the Transportation Manager or the Managed Care Plan. As the state assumes responsibility for eligibility determinations for additional populations beyond MAGI, and transfers additional populations into managed care, a greater share of current county liability will shift to the state.

With respect to Medicaid functions that have not been assumed by the State, the counties remain responsible for performing those functions pursuant to Social Services Law §§ 62(1), 77(1), and 365(1). The Department cannot provide blanket indemnification to any county, thereby holding them harmless for the accuracy of the eligibility determinations and service authorizations performed by its staff.

If a county chooses to contract with the Department for functions related to the non-MAGI population over the long-term, the county will be the State's contractor, which changes the nature of the current relationship with the county. The county will be agreeing to perform specific functions for defined reimbursement. The contract, similar to all contracts entered into by the Department, will not provide wholesale indemnification of errors made by county staff. Department contracts typically include performance measures with financial penalties for failing to meet performance targets. The Department will work with the counties to develop acceptable contract terms and performance measures.

FINANCING MEDICAID ADMINISTRATION

Part F of Chapter 56 of the Laws of 2012 established a cap on county Medicaid administrative costs at State Fiscal Year 2011-12 appropriated levels. The savings from the cap were used to fund the state staff to assume Medicaid functions and the State Financial Plan assumed $5 million in reduced LDSS claims under this ceiling. The September 2013 Global Cap update indicates that year to date spending on administrative services is $20 million lower than initially forecast, though spending is likely to increase once reimbursements for the full year are completed.

As the state assumes additional functions, local district claiming for Medicaid administrative costs is expected to decline. The State anticipates reductions below the 2011 levels beginning in 2015 as 65 percent of new Medicaid applications are processed centrally through New York State of Health. The Department recognizes that the three million current MAGI enrollees still need to be transitioned from the counties to NYSOH during 2015 and counties will retain responsibility for the eligibility determinations for the non-MAGI population, a population requiring more work than the MAGI population. Any future reductions in the administrative ceiling will reflect the volume that remains with the counties as well as the uneven workload relief provided to specific counties as the state has phased in Medicaid administration functions.

NEED FOR ADDITIONAL LEGISLATION

Part F of Chapter 56 of the Laws of 2012 provided flexibility in hiring and contracting for the Department to implement the assumption of Medicaid administration. The barriers to more rapid implementation of Medicaid administrative functions included the complexity of the development of the modernized eligibility system, delays in WMS system changes to accommodate certain initiatives due to other priorities and the cumbersome and rigid personnel process for hiring new staff even with enhanced flexibility to hire existing county staff.

The Department will not complete the hiring of its staffing allocation this year due to delays in obtaining Civil Service approval of the positions and difficulty hiring staff with the skills required to meet position requirements. The Department is interested in pursuing a legislative amendment to provide greater flexibility in hiring individuals from the local departments of social services with the skills to best meet the job requirements.

The Department will continue to identify and assess other barriers that affect the ability to meet projected timelines for the transition.

State Medicaid Administration Timeline

2013

January 2013

- ✓ Transportation Management fully implemented in NYC
- ✓ Centralize resolution of reported deaths in selected counties
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Mandatory MLTC Enrollment in Nassau, Suffolk, and Westchester Counties
- ✓ Add counties to centralized recovery

February 2013

- ✓ Add Two Counties to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

March 2013

- ✓ Add Additional Counties to Enrollment Center renewal processing
- ✓ Add Two Counties to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery
- ✓ Family planning benefit program application processing in New York City

April 2013

- ✓ Add counties to centralized recovery

May 2013

- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery

June 2013

- ✓ Mandatory MLTC Enrollment in Rockland and Orange Counties
- ✓ Add counties to centralized recovery
- ✓ Process FHP-PAP in New York City

July 2013

- ✓ Receive pre-open enrollment certification from HHS
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Automate renewals in NYC for aged, blind and disabled and MSP populations with SSA income.
- ✓ Add counties to centralized recovery
- ✓ Executed Transportation Management Contract for Finger Lakes and Northern NY counties
- ✓ MOU with Clinton county for inmate eligibility decisions
- ✓ Automate inpatient claiming for inmates through eMedNY

State Medicaid Administration Timeline

2013 (continued)

August 2013

- ✓ Train in person assistors/Navigators on Eligibility Processing in new system with MAGI rules
- ✓ Complete Second Release of New Eligibility System
- ✓ Add One County to the State Disability Review Team Disability Reviews
- ✓ Add counties to centralized recovery
- ✓ Released procurement for Transportation Management of 7 counties in Western NY

September 2013

- ✓ HHS Approval to open New York State of Health
- ✓ Continue to train in person assistors/Navigators on Eligibility Processing in new system with MAGI rules and expand to include CACs
- ✓ Eligibility determinations for inmates begins
- ✓ Added counties to Enrollment Center renewal processing
- ✓ Added One County to the State Disability Review Team Disability Reviews
- ✓ Added 13 counties to State centralization of reassessing eligibility for families with deceased members
- ✓ Add counties to centralized recovery

October 2013

- ✓ Start of open enrollment in New York State of Health
- ✓ Conduct regional meetings for LDSS/NYC on new rules, new system
- ✓ Continue to train in person assistors/Navigators and CACs
- ✓ Added One County to the State Disability Review Team Disability Reviews
- ✓ Auto-renew Aged, Blind, Disabled and MSP with pension income
- ✓ Added counties to centralized recovery

December 2013

- ✓ Release additional NYSOH system functionality for Medicaid enrollment
- ✓ Mandatory MLTC Enrollment in four additional counties
- ✓ Conduct regional meetings for LDSS/NYC on new rules, new system
- ✓ Added One County to the State Disability Review Team Disability Reviews
- ✓ Added 14 counties to State centralization of reassessing eligibility for families with deceased members
- ✓ Add counties to centralized recovery
- ✓ Submit Annual State Administration Report to Governor and Legislature

State Medicaid Administration Timeline

2014

January 2014

- ✓ All new Medicaid applications for individuals in MAGI eligibility categories begin being processed by NYSOH
- ✓ Continue to train CACs

March 2014

- ✓ Release additional NYSOH system functionality
- ✓ Contract for the Asset Verification System (AVS)
- ✓ Add counties to State centralization of reassessing eligibility for families with deceased members

April 2014

- ✓ Retroactive eligibility for MAGI categories processed in NYSOH
- ✓ Begin transportation management initiative in the seven-county Western Region
- ✓ Expected release of procurement for Transportation Management of Long Island (Nassau and Suffolk counties)

June 2014

- ✓ Release additional NYSOH system functionality
- ✓ Define requirements for Phase 1 of transitioning non-MAGI eligibility determinations to NYSOH

September 2014

- ✓ Develop Plan for Automating Non-MAGI eligibility determinations
- ✓ Release additional NYSOH system functionality

October 2014

- ✓ Begin to transition current MAGI Medicaid and CHIP enrollees to NYSOH at renewal

December 2014

- ✓ Reassess county interest in contracting with the State for Medicaid administrative functions
- ✓ Test AVS with selected counties
- ✓ Submit Annual State Administration Report to Governor and Legislature

State Medicaid Administration Timeline

2015

- ✓ Complete development of system requirements for non-MAGI eligibility determinations in NYSOH.
- ✓ Transition some non-MAGI populations to NYSOH
- ✓ Draft contract template for local districts for long-term administration of certain Medicaid functions
- ✓ Define requirements for remaining non-MAGI automation.
- ✓ Implement AVS statewide
- ✓ Complete transition of current MAGI population from WMS to NYSOH
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2016

- ✓ Complete system development for non-MAGI eligibility determinations in NYSOH.
- ✓ Execute contracts with local districts, if applicable, for long-term administration of certain Medicaid functions.
- ✓ Develop requirements for integrating other human service programs into the Exchange System.
- ✓ Submit Annual State Administration Report to Governor and Legislature.

2017

- ✓ Complete transition of non-MAGI populations to NYSOH
- ✓ Submit Annual State Administration Report to Governor and Legislature