NEW YORK STATE

Medicaid Administration
November 2010 Report

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Section 1: Introduction

In June 2010, legislation was enacted to transfer administrative responsibilities of New York State Medicaid to state government. An excerpt from the enacted legislation follows:

> *§ 47-b. 1. The commissioner of health shall create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts. 2. In developing such a plan, the commissioner of health shall, in consultation with each social services district: (i) define the scope of administrative services performed by social services districts and expenditures related thereto; (ii) require social services districts to provide any information necessary to determine the scope of services currently provided and expenditures related thereto; (iii) review administrative processes and make determinations necessary for the state to assume responsibility for such services; and (iv) establish a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016.*

The law (Exhibit A-1) instructs the Commissioner of Health (Commissioner), in consultation with the local social services districts, to develop a plan that: (1) defines the scope of administrative services performed by local social services districts and expenditures related thereto; (2) requires local social services districts to provide any information necessary to determine the scope of the services currently provided and expenditures related thereto; (3) reviews administrative processes and makes determinations necessary for the state to assume responsibility for such services, and (4) establishes a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016. The legislation further requires that the Commissioner prepare a report by November 30, 2010, on the anticipated implementation of such plan, its elements, a timeline for such implementation and any recommendations for legislative actions and such other matters as may be pertinent.

This report is the first step in developing a plan for state administration of Medicaid. It describes in varying levels of detail the current administration of New York Medicaid and makes short-term and long-term recommendations for the steps that must be taken over the next five years to develop and implement a final plan. It was written by the staff of the New York State Department of Health (Department). Stakeholder input, as required by the statute, was obtained in collaboration with the Medicaid Institute of the United Hospital Fund which surveyed local social services commissioners with the assistance and advice of the New York Public Welfare Association (NYPWA). The survey and a summary of responses are attached as Exhibits C and D.

The Department reviewed the report issued by the New York State Association of Counties (NYSAC) entitled, "Administering Medicaid in New York State: The County Perspective" issued in September 2010. A meeting was held with NYSAC on November 12, 2010. Input was also obtained from consumer representatives and associations representing health plans and the providers that deliver services to Medicaid beneficiaries. Exhibit B lists the stakeholder groups that were consulted in developing this report.

The Department appreciates the advice and cooperation extended by these organizations in the development of this report.

Guiding Principles

As the Department continues to plan for state assumption of Medicaid administration, the following principles should guide the development:

Continue to Reduce the Number of Uninsured New Yorkers

Significant strides have been made in recent years to simplify and eliminate the barriers that keep eligible people from enrolling in and retaining health insurance coverage. Nevertheless, an estimated 1.1 million New Yorkers remain eligible for but not enrolled in Medicaid, Family Health Plus (FHP) or Child Health Plus (CHPlus). Changes in Medicaid administration should accelerate, not impede the goal of enrolling eligible New Yorkers.

Involve Stakeholders

Administration of Medicaid has far-reaching impact on government agencies, workers, health care providers and consumers. The development of the plan must be informed by stakeholders and fully recognize the implications of a shift in administration of the program. The timeline included in this report includes quarterly meetings with stakeholders, although more frequent input will be gathered informally throughout the process.

Prepare New York for Implementation of Federal Health Care Reform

Federal heath care reform will expand Medicaid to 133 percent of the federal poverty level on January 1, 2014, making an estimated 90,000 New Yorkers newly eligible for Medicaid. Coincident with the expansion are new requirements for determining eligibility using modified adjusted gross income and interfacing with the insurance exchange which will provide subsidies for individuals up to 400 percent of the federal poverty level. Medicaid administration must prepare New York for the administrative infrastructure that will be required in 2014 under federal health care reform. In addition, there are provisions that directly impact on long-term care services that must be considered in the context of Medicaid administration.

Ensure that Medicaid Administration Meets the Needs of Consumers

At its heart, Medicaid is health insurance for low-income New Yorkers. It covers some of the state's most vulnerable citizens. Care must be taken to ensure that changes in the administration of the program ensure that consumers have access to consumer friendly, linguistically and culturally appropriate points of contact to apply, recertify and navigate the enrollment process and to obtain needed services.

Promote Uniformity and Consistency in Administrative Process and Decision Making

Administrative changes must optimize the opportunity to create uniform, statewide processes that ensure consistency across geographic areas of the state. These include the process and procedures for applying for coverage and the processes for arranging and approving services once an individual is enrolled.

Improve Accountability and Transparency

Entities responsible for administering Medicaid must be held accountable for performance. Processes and rules must be clearly stated and interested parties educated about such processes.

Improve Efficiency

Consolidation of administrative functions should be designed to realize economies of scale and opportunities to reduce costs through efficiency.

Recognize the Role of Medicaid in New York's Health Care Delivery System

As the largest insurer in the state and payer of 28 percent of health care services delivered in the state, including one-half of the births in the state, and over 73 percent of nursing home stays, the plan must recognize the impact that administrative process has on the operations and financial viability of health care providers.

Ensure Program Integrity

As steps in the plan are implemented, consideration must be given to protecting and improving the integrity of the program. Improved systems and greater uniformity should ensure program integrity.

Section 2: Background

New York Medicaid provides essential health insurance coverage to over 4.7 million New Yorkers including 1.8 million beneficiaries age 18 and under, 1.8 million adults without disabilities age 19 to 64 and 400,000 elderly and 700,000 disabled individuals. Enrollment by county is shown in Exhibit E. In 2010-11, Medicaid spending will exceed $52 billion including state, federal and local funds, or about one-third of the state's all funds budget. Exhibit F details Medicaid spending by category of service for 2009. Additionally, New York's Child Health Plus program, which is administered by the state, covers an additional 400,000 children up to 400 percent of the federal poverty level.

- 400,000 elderly
- 700,000 disabled individuals
- 1.8 million beneficiaries age 18 and under
- 1.8 million adults without disabilities age 19 to 64
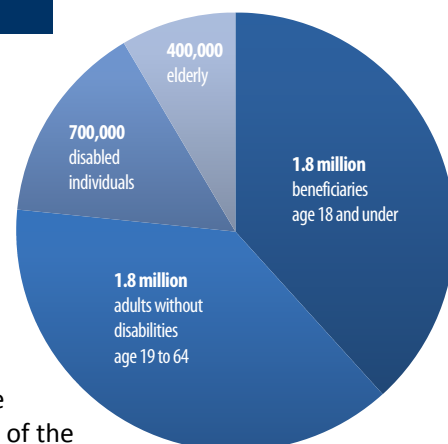
Administration of New York Medicaid is a shared responsibility. The federal government, through the Centers for Medicare and Medicaid Services (CMS) plays a vital role in program policy. Through promulgation of rules, issuance of State Medicaid Director Letters, the State Plan approval process and waivers, CMS oversees the program from both its central and regional offices. The Department of Health, as the single state agency, is responsible for policy development, ensuring compliance with federal requirements and day-to-day administration of New York Medicaid. The Department delegates certain responsibilities for special needs services to other state agencies including the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) and the Office of People with Developmental Disabilities (OPWDD). Also, since a portion of Medicaid beneficiaries receive other human services such as public assistance or food stamps, the Department must also work closely with the Office for Temporary Disability Assistance (OTDA). In fact, the OTDA is responsible for the system that maintains eligibility for Medicaid.

Most relevant to this report are the significant duties the Department delegates to 57 county local social services offices and the Human Resources Administration in the five counties representing New York City (referred to in this report as counties, local social services districts and local social services commissioners). These critical responsibilities include processing applications and conducting initial eligibility determinations and recertifications; enrolling persons into Medicaid managed care; authorizing use of select services such as private duty nursing, non-emergency transportation and personal care, among others.

In addition to sharing administration of New York Medicaid, the state and local governments share in program costs not paid for by the federal government. New York is one of 28 states that require some form and level of local contribution for Medicaid.[1] Legislation in 2005, effective with calendar year 2006, fixed the amount the local governments contribute towards Medicaid. Referred to as the local Medicaid cap, this law fundamentally changed the way Medicaid costs are shared between the state and local governments. It did not, however, change the day-to-day administration of the program nor the duties delegated to the local districts. The Medicaid cap is discussed in detail in Section 6 of this report.

The passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, will require every state to examine its policies and processes for determining Medicaid eligibility and create a new responsibility to coordinate with a state- or federally-administered Insurance Exchange. A number of states currently operate their Medicaid programs through a combination of state and local administrative roles and responsibilities. Counties in 20 states contribute to Medicaid administrative costs and/or perform eligibility determinations for various local, state and federal means-tested programs.[2]

For example, California and Wisconsin combine centralized statewide administration with local administration. Both states currently conduct some Medicaid determinations through a centralized, statewide, web-based and mail-in process (including some telephone assistance). Wisconsin estimates that about 50 percent of its Medicaid determinations are currently handled at the local/county level, while the other half are processed through the statewide on-line system. California operates a statewide "single point of entry" for processing mail-in applications for children and pregnant women, enrolling eligible individuals in the CHP program, and forwarding Medicaid applications to local districts for processing.[3] New York plans to begin some statewide processing of certain Medicaid renewals via mail and telephone in 2011.

New York has been a leader in covering eligible persons; nevertheless, federal health care reform will increase the number of New Yorkers eligible for Medicaid and create a new set of tasks. The impact of federal health care reform on administration of New York Medicaid is discussed later in this report.

[1] Data collected from National Association of Counties, 2010.
[2] National Association of Counties, 2010.
[3] NASMD presentation: November 2010.

Section 3: **Alternative Options**

Section 47-b of the 2010-11 State Budget requires the Commissioner to define the scope of administrative services performed by local social services districts and, indeed, the tasks are broad ranging and critical. The sections that follow describe by function the role of the district and present options for alternative administration of such functions. In some instances, a specific action is recommended. In other instances, transition of the function is far more complex, and a recommendation is made for a process to further examine the issue.

While some stakeholders have suggested that the phase-in of state assumption of Medicaid administration should occur on a county by county basis referred to by some as a "holistic approach" with either "pilot" counties (Monroe) or counties with poor performance being transitioned first, this report recommends an initial phasing that is more task-specific and builds upon the efforts and capacity already in place or planned at the state level. For the state to assume all the functions in one local district, it would need to develop the capacity and technology to administer the full complement of functions performed by the county. Once that had been accomplished, only assuming the functions for a few districts would be inefficient and duplicative. Instead, the Department recommends phasing by function to ensure that the capacity is in place to assume the function and then taking statewide responsibility for it.

This approach recognizes that transition of certain administrative functions, most notably some tasks related to eligibility and authorization of long-term care services, must occur coincident with the adoption of new technology and implementation of federal health care reform. At the same time, it takes advantage of more immediate opportunities to improve efficiency, uniformity and service to members through earlier transition of certain administrative elements of the program.

Medicaid Eligibility

Medicaid is not just one program; it is comprised of many different programs with coverage that varies by population, income level and benefits. Eligibility rules vary by population, making it an extraordinarily complex and multi-faceted program. In addition, there are several different application pathways that can lead to enrollment (e.g., direct applications, Supplemental Security Income (SSI) coverage through the federal State Data Exchange (SDX) system, separate determinations for Temporary Assistance for Needy Families (TANF) applicants).

Of the 4.7 million people enrolled in New York Medicaid, three-quarters (3.6 million) are non-disabled children and adults under age 64. The remaining enrollees are elderly or disabled (1.1 million). Even within those broad population groups, there are many different eligibility categories with their own rules and benefits. For example, adults could fall into one of several different eligibility groups depending on their income level, whether or not they have children, their age and their health status.

Families, the elderly and individuals with disabilities, whose income exceeds their Medicaid eligibility level, can become Medicaid eligible if they pay the difference between their income and their Medicaid eligibility level or incur medical bills at least equal to this difference. This is an important benefit for those above Medicaid eligibility levels with recurring health needs. Medicaid also contains service-specific programs such as the Family Planning Benefit Program, programs for individuals diagnosed with certain types of cancer, emergency services for otherwise eligible immigrants who do not have satisfactory immigration status and programs for people with AIDS. Medicaid also acts as a supplemental payer for low income individuals with private health insurance and Medicare. Exhibit G depicts the complexity of Medicaid eligibility. The bars represent the eligibility levels for the different Medicaid groups or programs, and the shading reflects variations in the Medicaid benefit package.

The multiple programs within Medicaid lend themselves to phasing the state assumption of the eligibility determination process. Several respondents suggested centralization of certain enrollment/eligibility processes. For example, children and most adults could be phased in separately from the elderly and disabled, who tend to be handled by specialized workers within the local departments of social services. Similarly, programs with small volumes in any one local district, such as the Medicaid Buy-in Program for Working People with Disabilities, lend themselves to centralization.

Programs or populations that cross local district boundaries would also benefit from early centralization. For example, many facilitated enrollment entities assist applicants in multiple counties. These facilitated enrollers must learn and navigate different procedures for each local district which can slow down enrollment. The same occurs with individuals being released from prison since the county where the prison is located is rarely the county where the prisoners will live after they are released. A more complete discussion of suggested phasing is provided later in this section.

Functions Performed by Local Districts

Medicaid eligibility and enrollment is largely a manual process, although some of the larger districts (New York City, Westchester) have automated some aspects of the process. This section describes the many functions that encompass enrollment, renewal and ongoing maintenance of enrollee eligibility. The plan for state administration of the myriad eligibility functions needs to consider areas where these largely manual functions can be automated, as well as ensure that all functions are accounted for in the final plan. Some functions may lend themselves to earlier transition to the state than others. Exhibits H and I illustrate the process flow for applications and renewals. The major functions include:

- **New applications -** Local departments of social services accept new applications from individuals directly, as well as from various community and provider partners. The functions include, but are not limited to, providing applications and associated informational materials; assisting with applications; arranging for assistance to those with limited English proficiency and/or disabilities; registering an application including Client Identification Number (CIN) selection; tracking applications and required documentation; calculating and storing budgets; determining eligibility; and resolving inconsistent information received from third-party databases such as new hires, wage reporting, banks, unemployment and Social Security. In addition, eligibility workers have to identify whether there is any other source of health insurance to defray Medicaid costs, ensure that appropriate notices are sent to the applicant, educate and enroll certain enrollees in managed care, make child support referrals, conduct disability reviews and/or compile disability review packets, image documents and expedite the process for individuals who have medical emergencies. For enrollees seeking nursing home services, workers have responsibility for more extensive financial reviews including identifying transfers and reviewing trusts and promissory notes. Additionally, for certain individuals applying for participation in a home and community-based waiver program, eligibility must be coordinated with the acceptance into the waiver program. Finally, they authorize coverage, if eligible, or determine reason for ineligibility.

- **Renewals -** Many local departments of social services manually identify cases that do not need to be renewed (e.g., those in managed care guarantee periods) and trigger the mailing of renewals through the Medicaid Renewal Tracking System (MRT) in New York City and the Client Notices System (CNS) in the rest of the state. They track returned renewals, close cases for which the renewal has not been returned and determine eligibility for those that have been returned. In addition, as with new applications, the workers reconcile inconsistencies with third party information, follow-up on other health insurance, send out appropriate notices, add new people who have come into the family or subtract family members, conduct disability reviews and/or compile disability review packets and make IVD referrals.

- **Ongoing management -** Though most Medicaid enrollees renew their coverage once a year, local districts perform a large number of manual functions during the year for certain groups of enrollees and to monitor program integrity:

  > **Spend down -** About 150,000 Medicaid enrollees receive Medicaid only after they meet a "spend down" amount, which is the amount their monthly income is above the Medicaid income level. Individuals can meet their spend down by paying in or by applying paid or unpaid medical bills. Managing the spend down program is manual with people either mailing in or coming into the local district every month to bring in their medical bills or spend down amounts to maintain their Medicaid coverage.

  > **Third-party coverage -** One percent of the Medicaid population, including Family Health Plus, is enrolled in cost-effective group health insurance in which Medicaid pays the cost of the premiums and cost sharing. Local districts are required to obtain information needed to assess the benefits and cost of the policy prior to authorizing payments. Payments are currently completed manually in WMS via the Benefit Issuance Control System (BICS) program. Staff must also enter the policy information into the Third Party subsystem in eMedNY in order to ensure that Medicaid does not pay claims for services provided by third-party insurance.

  > **Program integrity -** Some information (e.g., data from financial institutions) from third-party databases is only available after someone is enrolled in Medicaid and can take months to provide a complete picture of the person's finances. Local district workers have to monitor this information and take action if information surfaces that raises questions about the person's eligibility. In addition, the state conducts data runs to improve program integrity and provides lists of problem cases to the local districts for follow-up (e.g., duplicate CINs, identification of deceased individuals through vital records, identification of coverage in another state through Public Assistance Reporting Information System (PARIS), cases with missing SSNs). Given the manual nature of this follow-up, there is wide variation across the state in the resolution of the information. Additionally, local districts must retrieve records for audits performed by federal, state and local agencies.

  > **Process changes -** Local district workers process changes throughout the year. This includes processing changes in demographics, address and household composition. It may also require conducting a disability review and/or compiling disability review packets, reactivating an inmate's Medicaid upon release from prison, redetermining eligibility for former SSI and TANF cash recipients, handling county-to-county moves and converting unborns to newborns.

  > **Fair hearings -** Local district eligibility workers represent the local agency at fair hearings and implement compliance decisions.

One of the major goals of centralizing administration is to create greater uniformity and consistency in the Medicaid eligibility determination process. The premise is simple: the county in which a person resides should not impact how and whether they are enrolled in Medicaid nor the services they are able to receive. Today, variation exists in the administration of the program in terms of enrollment procedures, systems and local district attitudes and that variation has led to different outcomes.

Procedures

While the federal and state governments establish the policy that governs Medicaid eligibility, local departments of social services have latitude in how those policies are implemented. The complexity of the program and increasing volume also affects its administration as rules can be inadvertently applied to populations and programs incorrectly. A common error is to apply the rules for cash assistance to the Medicaid program. Some local districts embrace a culture of coverage and have initiated local outreach, data matching and other activities to increase the enrollment of the eligible uninsured. Other counties view Medicaid as a welfare program and increases in enrollment more negatively. Some counties add forms and documents that are not required by the state. Frequent requests for additional information result in people giving up on their application and remaining uninsured. Similarly, some local districts have embraced facilitated enrollers as an extension of their own staff while others distrust them and are suspicious of applications submitted by them. Long-term care providers report wide variation in the implementation of rules and regulations among the local districts, often creating confusion for providers and audit liability. Tracking such local practices and working to eliminate those that are contrary to federal and state policy is labor intensive. Timeliness in processing applications and renewals also varies across the state. Most counties complete community Medicaid applications in less than 45 days, but a few routinely exceed 60 days. In the area of long-term care, delays in determining eligibility can be even longer, with reports in some local districts of delays exceeding six months.

Systems

The Medicaid eligibility determination and enrollment process is largely manual and there is no one statewide system for any part of eligibility. As will be discussed in more detail in the technology section, there are two separate WMS systems that contain the eligibility records (New York City and Rest of State). These systems do not communicate well with each other due to different field lengths and edits. There are multiple imaging systems across the state and documents cannot be shared easily across districts. New York City has made the most progress in developing technological solutions to enrollment with EDITS, their automated renewal process, and various tracking systems. However, despite these advances, there is still no automation of the eligibility determination itself in any county.

Notices

The limitations of the Client Notices System (CNS) have led many local districts to create their own manual notices. The use of these varies across New York State. It also makes it difficult to track whether an appropriate notice was sent in a timely manner.

The Imperative for a Modern Eligibility System

While centralized administration of Medicaid will help to eliminate some of this variation, overall success will require an investment in a new health insurance eligibility system that meets the needs of the Medicaid program envisioned in the Affordable Care Act (ACA) in 2014. The new system must be statewide and it must automate the eligibility logic so that it can be a true system for eligibility determination and not merely a repository of enrollment information. The limitations of the current systems and the characteristics of a new system are described below.

Welfare Management System

The Welfare Management System (WMS) is maintained by the Office of Temporary and Disability Assistance (OTDA) and consists of two separate systems. There is a separate WMS for New York City and one for the rest of the state. WMS is the eligibility system of record for TANF, Food Stamps, the Office of Children and Family Services programs and Medicaid. For Medicaid alone, WMS maintains 4.7 million records across the two systems. None of the other programs supported by WMS comprise even half the volume of Medicaid. Five subsystems within WMS support Medicaid eligibility and enrollment processing:

- **MBL (Medicaid Budget Logic)** uses the income, household composition, and, if applicable, resources to determine program eligibility.
- **CNS (Client Notices System)** produces notices for each transaction (enrollment, denial, closing, renewal, etc.).
- **RFI (Resource File Integration)** displays information from third-party databases to verify eligibility such as wage reporting, unemployment benefits and social security information. Eligibility workers must manually reconcile RFI "hits" with information reported on the application.
- **Prepaid Capitation Plan Subsystem (PCP)** effectuates enrollment in managed care plans.
- **Restriction/Exception Subsystem** further refines the eligible coverage and services based on an individual's specific needs.
- **Principal Provider Subsystem** uses worker entered income from the eligibility budget to offset Medicaid payments made toward the cost of a recipient's inpatient care (primary nursing home care).

WMS is over 30 years old and programmed in a code that is now obsolete. It lacks the capacity of current technology to flexibly respond to policy changes. Over time, workarounds have been created to the extent that the system is now too complex and cumbersome to modify and maintain. Often the limitations of WMS drive how policy will be implemented with less than optimal results. WMS is not designed to produce the data needed to inform policy decisions. Moreover, WMS has not been able to keep up with the rapid policy changes to Medicaid which will become even more critical as the state implements the ACA.

The eligibility determination process is almost entirely manual. WMS is a record of eligibility determinations, not a system that automates these determinations. Information from applications is entered into WMS, but as it has no decision logic programmed into it, workers are responsible for computing budgets and effectuating the eligibility determination. While MBL computes an eligibility budget based on some of the information entered, it does not have adequate fields to capture all the relevant information (sources of income and deductions), does not produce multiple budgets often needed in Medicaid eligibility and has no capacity to store prior budgets.

As such, much of the budget work for an eligibility worker is manual with only the final result entered into MBL. Similarly, coding the final eligibility determination is all manual and must be derived from a stack of codes, four inches high. Despite TANF, Food Stamps, OCFS Services and Medicaid sharing a system, cross program eligibility determinations are largely manual. For example, an applicant for cash assistance and Medicaid who is found ineligible for cash assistance must have a separate Medicaid eligibility determination.

In addition to the eligibility determination process being almost entirely manual, the enrollment process is a paper one. Managing a program with nearly 5 million people and increasing enrollment means that over 10,000 applications or renewals enter the system every day, or looked at another way, this represents about 200,000 individual application pages with supporting documentation. Eligibility workers need to review all the paper, enter the data into WMS, determine if any documents are missing and manually determine eligibility. The volume, coupled with the complexity of the rules, can create backlogs in eligibility determinations, leading applicants to wait months for an eligibility determination, and even longer for more complex long-term care eligibility. The paper driven enrollment system and manual eligibility determinations lead to errors, lost paperwork and delays in enrollment.

Medicaid policy changes can take 12-18 months to become effective because WMS has 3 system change migrations a year and Medicaid changes must compete for programming staff time with TANF, Food Stamps and OCFS Services. Moreover, since WMS is hard-coded rather than table driven, changes need to be made in multiple parts of the system and take a long time to program and test. This time frame is completely at odds with the fluid policy environment of the Medicaid program in recent years and with the ACA.

The operation of two separate systems results in the separate creation of identifiers that are unique within each system, but not statewide, making it more difficult to prevent duplicate enrollments. The differences between the two systems in terms of edits and field lengths make it difficult to seamlessly enroll an eligible person who moves between NYC and any other county. The systems are not identical because they each contain unique fields and edits; as such, every policy change must be designed and programmed twice – once for NYC WMS and once for the WMS used in the rest of the state. This creates huge inefficiencies at a time of declining staff resources.

Despite the fact that all eligibility determinations are contained within one of two systems, information needed to manage the program and determine whether policy changes are needed is not readily available through WMS. Information on the characteristics of enrollees, common deductions, churning, movement between programs, etc., is either unavailable or requires special computer programming that can be time consuming and often provide incomplete information. The lack of budget history in MBL makes answering questions about fluctuations in income impossible. Because the NYC WMS is not integrated with the WMS used in the rest of the state, it can be difficult to obtain accurate statewide data.

Third-party data validation through the Request for Information (RFI) subsystem is incomplete and inefficient. The RFI subsystem displays all "hits" from the third-party databases in its system whether they are material to eligibility or not. As such, a local district worker must manually cull through wage reporting, bank account information and other data to determine whether any of it is material to eligibility and reconcile any material differences. RFI would be much more effective if it had embedded logic that only displayed information material to eligibility. In addition, RFI lacks some important sources of information, and available information can be dated.

For example, it does not contain any data on property, and the bank account data is not available for applicants. In addition, it takes thirteen weeks to complete the full match with financial institutions, and some bank account data can be five months old. Wage reporting system data can also be as old as five months. The data lags require workers to constantly check RFI on existing enrollees or else miss information that may render someone ineligible.

The Client Notices System (CNS) does not meet broader needs for applicant and enrollee communication. CNS generates notices that communicate the legal requirements for the applicant/enrollee and the state. They contain the requisite information relating to the appeals and fair hearing process. However, they could be greatly improved or supplemented as broader communication tools and in appearance, organization and length. The limitations of system generated notices built on an antiquated system means that they cannot take advantage of the use of different font sizes, color and other more modern means of highlighting parts of the communication.

In addition, the limitations of CNS have led to an increasing number of notices being manually generated. CNS as it is today cannot meet the notice requirements under the ACA for Medicaid or the subsidies in the Exchange.

The most critical investment to ensure that the state can assume responsibility for Medicaid administration and successfully implement the ACA is to build a new health insurance eligibility system. Neither state assumption of Medicaid administration nor implementation of federal health care reform can succeed without it. The new federal imperatives in the ACA demand a new system:

- **Large volume increases -** The state needs an on-line real-time system to support eligibility determinations for 25 percent more Medicaid enrollees and another 1 million enrolled through the Exchange, 700,000 of whom will be subsidized.
- **Compressed enrollment time -** Exchange enrollment occurs during open enrollment times which will generate higher volumes of Medicaid enrollment during the same period. Business processes must support compressed enrollment periods.
- **Seamlessly integrated -** The state needs a single, integrated eligibility process for health insurance provided through Medicaid and the Exchange. It needs to communicate in real time with the federal information portal and needs to improve integration with the social service eligibility process.
- **Ready in three years -** The new system must be operational in mid 2013.
- **Meet federal interoperability standards -** Depending on federal guidance to be issued on required interoperability of health information technology enrollment systems, the new system may have to enable an individual consumer to enroll, renew, update and/or check on the status of their enrollment from various locations, including their home computer.

To meet the imperative of the ACA, the state needs to invest in one statewide health insurance eligibility system that supports online enrollment and renewal. The new eligibility system must automate all elements of eligibility determination to reduce errors, achieve statewide uniformity and increase the number and speed of determinations. It must accommodate Medicaid, Family Health Plus, Child Health Plus and Exchange subsidies and create more seamless transitions as people move between programs. The entry way must accommodate online enrollment as well as by phone, mail and in person. To meet the requirements of the ACA by 2013, the system should be built first for the health insurance programs, but it should be able to accommodate the other social services programs over time.

A federal notice of proposed rulemaking issued on November 3, 2010, makes it feasible for states to develop and build new health insurance eligibility systems to support Medicare, CHIP and the Exchange. The proposed regulations provide 90 percent federal financial participation for the design and implementation of the new system through 2015, provided it meets certain conditions in support of the ACA.[4]

The new eligibility system must be linked with Medicaid claims payment systems and adhere to the requirements in the Medicaid Information Technology Architecture initiative (MITA). As described in the Joint OCIIO/CMS Guidance for Exchange and Medicaid Information Technology (IT) Systems, the IT systems are required to support a first-class customer experience as well as be simple and seamless in identifying people who qualify for tax credits, cost-sharing reductions, Medicaid and CHIP.

Recommendations

Implementation of the Statewide Enrollment Center

The complexity and diversity of the Medicaid program lends itself to a phased approach to the state assuming responsibility for the administration of eligibility. The phased approach also has to be developed in concert with the state's new requirements under the ACA. As part of an effort to ease the workload burden at local departments of social services and to establish greater uniformity in the application of Medicaid rules, the state had already begun to assume some enrollment functions through the plan for a Statewide Enrollment Center. The Enrollment Center is expected to be operational in Spring 2011 and will:

- **Establish a consolidated call center for public health insurance programs:** Currently the state operates three separate call centers for enrollees and prospective enrollees seeking information about Medicaid, Family Health Plus and Child Health Plus. The Enrollment Center will consolidate these call centers into one and provide a high level of customer service in providing program information, assisting with applications and resolving enrollee complaints. The call center will have integrated voice recognition (IVR) capabilities offering services 24 hours a day as well as language capacity for those with limited English proficiency.

- **Telephone renewals:** The Enrollment Center will assume responsibility for renewals outside New York City for those who can self-attest to income and residency. It will provide a telephone renewal option in addition to mail-in renewals using a tool developed by the Department called Healthcare Eligibility Assessment and Renewal Tool (HEART). This will move 440,000 renewals (not individuals) from 57 local districts to the state (two-thirds of all renewals in those counties). New York City renewals assumed by the Enrollment Center are likely to focus on the elderly and disabled populations representing a volume of 51,000. State staff will be co-located at the Enrollment Center to oversee the renewal decisions.

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[4] Proposed regulation: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities (CMS–2346-P) http://edocket.access.gpo.gov/2010/pdf/2010-27971.pdf

The Enrollment Center may be a private contractor, comprised entirely of state staff, or more likely a combination of the two. Following this initial implementation phase, the Enrollment Center should assume responsibilities for select eligibility functions currently performed by the local social services district. These tasks were anticipated in the scope and design of the Enrollment Center:

- **Programs or populations that cross county lines:** (e.g., prisoner re-entry, FHP Employer Buy-In administration). In these cases, one entity (the prison or the employer) has applicants from many different counties. It is difficult and labor intensive for these entities to develop procedures in multiple counties. It would be more efficient for the state to assume these enrollments.

- **Programs with small volume in any one county:** Including the Medicaid Buy-In Program for Working People with Disabilities and the Premium Assistance Program which have a small volume and unique rules or populations. Given the nature of these programs, the volume at any one local district is not sufficient for workers to develop an expertise in the program which can result in errors or inefficiencies. For example, individuals seeking the Medicaid Buy-In for People with Disabilities are often told by local workers that the program does not exist or they are enrolled in spend down instead. In New York City enrollment in this program is far below levels anticipated, largely because the overall volume in New York City makes it especially difficult for workers to track and manage smaller programs.

- **Medicare Savings Program:** Individuals who receive Medicare may apply for Medicaid to pay the Medicare premium, coinsurance and deductible amounts. For individuals who apply for the Medicare Savings Program (MSP) only, a simplified one-page application form is completed. There is no resource test and many of the eligibility requirements do not apply to participation in this program, thus making it unique and less complex. Renewals are processed using the same simplified form. As of January 2010, the state also began receiving MSP applications from the Social Security Administration on behalf of individuals who apply for a Low Income Subsidy to help pay Medicare Part D costs. These applications are currently forwarded to the local districts for a determination of MSP eligibility which has resulted in an additional and somewhat unexpected workload at the local social services offices. Applications and renewals could be processed centrally at the Enrollment Center.

- **Facilitated Enrollment Applications:** 41 Community Based Organizations and 15 Health Plans serve as facilitated enrollers (FEs). FEs provide application assistance to those seeking Medicaid, Family Health Plus or Child Health Plus and account for over 430,000 applications submitted annually. FEs provide assistance in 60 languages. Over half of FE organizations assist people in multiple counties. These FEs report an increased burden in coordinating with multiple local districts in terms of the different rules, different forms and additional documentation required in some counties but not others. For example, one country requires 12 additional forms. Instead, all FE applications could be processed through the Enrollment Center once the Department eligibility tool is able to process new applications.

- **Disability Reviews:** Currently, the Department handles the disability reviews and continuing disability reviews for 34 upstate local districts. Additionally, the state performs all disability determinations for applicants over the age of 65 who are applying for Medicaid with a pooled trust and all applicants/recipients for the Medicaid Buy-In for Working People with Disabilities program. The state monitors and provides policy guidance to 23 upstate local Disability Review Teams, the City of New York and the OMH. The state reviews are done by 14 nurse consultants and a consultant supervisor. Oversight of the reviews is provided by one State staff and one physician who signs off on the cases (14 hours/month). The State Disability Review Team performed 4,665 determinations for 2009, nearly 30 percent of the determinations made statewide. Feedback from advocates seeking disability reviews on behalf of clients is that the Department reviews occur much more timely than reviews at the local districts. Many local districts that (in the 1980s) originally elected to maintain their own disability review team, have requested to be relieved of the obligation, citing staffing burdens on the district and the lack of qualified medical consultants to head the team. It would be more efficient for the Department or a vendor to assume responsibility for all disability reviews throughout the state. This would require 24 additional nurse reviewers, one additional state staff to provide oversight, an increase of physician hours to two days a week and a clerical staff person.

Preparing New York for Federal Health Care Reform

The next logical step in the transition plan is for the state to assume responsibility for the eligibility determinations for those Medicaid populations affected by the ACA that must interact seamlessly with the Exchange. The ACA eliminates categorical eligibility and requires a seamless bridge with private coverage. It establishes a national Medicaid eligibility level of 133 percent of poverty, raised to 138 percent with a uniform 5 percent disregard of income by 2014. It also provides subsidies for uninsured persons up to 400 percent of poverty to purchase health insurance through an Exchange. For many populations (e.g., children and most adults) eligibility rules for Medicaid change and align with the Exchange; income eligibility will be based on Modified Adjusted Gross Income (MAGI) with no asset test.

Estimates suggest that an additional 1.2 million New Yorkers will be eligible for Medicaid (either already eligible, but not enrolled or newly eligible), 700,000 will be eligible for subsidies through the Exchange and 340,000 will be eligible for Exchange coverage without subsidies. The groups affected by the transition to MAGI are principally parents and children and childless adults under age 64. The Exchange whether operated by New York or by the federal government, is required to enroll applicants into the appropriate program (Medicaid, CHIP, Exchange coverage) and/or subsidy level. For the first time, an entity outside the Medicaid agency or the local districts will be enrolling people in Medicaid. Similarly, the Medicaid agency is required to enroll individuals into Exchange coverage.

The requirements under the ACA for entry to health insurance (online, phone, mail, in-person), "screen and enroll" for all programs, closer to "real time" enrollment are not easily supported if enrollment is distributed across 57 local departments of social services and the Human Resources Administration in New York City.

By January 2013, the state must demonstrate that it will be ready to operate an Exchange by mid 2013 or the federal government will assume responsibility for Exchange functions in the state. Regardless of whether the state or the federal government operates New York's Exchange, the state, either through the Exchange or within the Department, should assume the responsibility for eligibility determination and enrollment for Exchange coverage for at least the MAGI Medicaid populations (those groups most readily aligned). This aspect should be accomplished in conjunction with the new health insurance eligibility system described above.

Remaining Populations

Implementation of the phases described above would transition the majority of eligibility determinations to the state, leaving the local social services districts primarily responsible for eligibility determinations for the elderly and individuals with disabilities. These individuals are among the most medically fragile Medicaid enrollees. Though they may seek coverage through an Exchange, these individuals are more likely to continue to seek, and to qualify for, public coverage through existing, traditional Medicaid pathways. The eligibility rules for the elderly and individuals with disabilities are linked to the Supplemental Security Income program and the disability rules must follow those established by the federal Social Security Administration.

For aged and disabled individuals requiring long-term care services, the eligibility determination is perhaps the most complex. When an individual needs certain long-term care services, resources must be documented to ensure that assets have not been transferred during the five-year look-back period for less than fair market value. Such reviews require an understanding of various financial instruments such as trusts, life estates and annuities. Special spousal impoverishment rules are also triggered when an individual becomes institutionalized or requires home and community based waiver services. In the area of long-term care, unlike community Medicaid, local districts must use judgment in determining the reasonableness of individual circumstances and actions. This creates differences among districts in areas such as undue hardship, what transfers are reviewed and the cases pursued for spousal support.

In a recent report on administration of Medicaid, the Nelson A. Rockefeller Institute of Government found variation in county approaches used to collect required eligibility-related paperwork with some counties requiring a wider range of documents than others, use of different codes in the Medicaid database to indicate when an individual had been denied for eligibility due to asset transfer, variations in county administrative capacity both in terms of case load and stability and experience of the workforce, use of different standards for determining when an investigation of an asset transfer might be warranted and significant variations in where nursing home care applications may come from.[5] Given the complexity of these requirements, many of these individuals will need more personal and hands-on assistance.

Applications are often filed by a legal representative hired by the family or a provider representing the individual. The legal resources required to process long-term care cases also impose a significant burden on social services districts. Reviewing trust documents and other planning devices used by elder law attorneys to shelter assets is time consuming and requires a certain degree of experience in Medicaid law. Local districts vary in the extent they have the legal expertise on staff to conduct these reviews. It would be more efficient and uniform for the state to centralize the resource reviews for long-term care applications and provide the necessary legal support. To do this, however, the state would need additional legal and other staff.

The eligibility rules for long-term care services are more complex with wide variation in case-specific circumstances requiring specialized handling. It may be more complex to automate the various pathways required to support "non-MAGI" eligibility determinations. For this reason, phasing should first focus on centralized eligibility determinations for the MAGI populations. During that time analysis on the actual steps for non-MAGI eligibility will be developed so that the automated system for MAGI can be extended to the 1.1 million elderly and disabled populations. By the end of 2012, the Department will convene stakeholders and prepare a detailed timeline for state administration of the eligibility process for the elderly and persons with disabilities.

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[5] Courtney Burke with Barbara Stubblebrine and Kelly Stengel, Room for Interpretation Cause of Variation in County Medicaid Asset Transfer Rates and Opportunities for Cost Reduction, The Nelson A. Rockefeller Institute of Govt. , University at Albany, August 2010.

Assistance at the Local Level

It is important to note that even after transition to a more centralized, statewide administration of the Medicaid program, some applicants and/or enrollees will continue to require more "hands on" help, in order to select, enroll in and navigate their health coverage and care. Such in-person assistance must necessarily be provided at the local level. A "face to face" encounter is often helpful, particularly for individuals with complex or special needs. Many persons with disabilities, elderly or medically fragile individuals, very low income families also in need of cash or other forms of assistance in addition to medical coverage, persons with diverse linguistic and cultural needs and individuals who require personalized assessments for home and community based services, often benefit greatly from in-person consumer assistance.

In recognition of the need for local presence, the ACA requires states to provide such an "in person" option, or doorway, in addition to telephone, mail and web options, for all eligibility determinations and enrollment offered through state-based Exchanges. In other words, an individual seeking to enroll in Medicaid, CHIP, or in a subsidized, private insurance option through an Exchange must be given the choice of getting in-person help with the process. The ACA also mandates that federally funded consumer assistance, available prior to implementation of the health benefits Exchanges, must provide a "walk-in" access option. By 2014, Exchanges will be required to fund health "navigators," who will be charged with assisting enrollees in securing coverage and appropriately accessing care. These navigators will be mandated to provide culturally and linguistically appropriate assistance to health care consumers seeking to enroll through one of the Exchange "doorways" (mail, telephone, in-person, Web).

Both as a practical matter and in light of the various ACA mandates, it is clear that a robust local presence will continue to be critical to New York's success in providing needed health coverage and care for millions of adults and children in this state. The exact form and configuration of that local presence- likely some combination of county workers, state workers in local offices, facilitated enrollers, health care providers, non-profit organizations and other "navigators"- has yet to be determined, and will be the subject of ongoing dialogue. What is clear, however, is that New Yorkers will need access to ongoing help, in the local communities where they live and work, to learn about their health insurance options, complete applications, make appointments with providers, access needed care and to address a wide range of critical health and human service needs.

Administering Managed Care Programs

Medicaid Managed Care and Family Health Plus

New York covers nearly 69 percent of Medicaid beneficiaries through a managed care delivery system. Medicaid managed care began in New York on a voluntary basis in the 1988. In 2007, following passage of state law authorizing the mandatory enrollment of certain beneficiaries into managed care plans, the CMS (at the time the Health Care Financing Administration) approved New York's request for waiver under Section 1115 of the Social Security Act. The goals of the waiver, called the Partnership Plan, were to:

- **Improve access to health care for the Medicaid population;**
- **Provide beneficiaries with a medical home;**
- **Improve the quality of health services delivered; and**
- **Expand coverage to additional low income New Yorkers with resources generated by managed care efficiencies.**

In October 2007, mandatory managed care began in five upstate counties. Implementation of Medicaid managed care began in New York City in August 1999. Today, mandatory managed care operates in 44 counties and all areas of New York City. Voluntary managed care programs operate in 12 additional counties including Chemung, Chenango, Clinton, Delaware, Franklin, Jefferson, Lewis, St. Lawrence, Schuyler, Steuben, Tioga and Warren. Over 2.8 million Medicaid beneficiaries are enrolled in a managed care plan.

In May 2001, the Partnership Plan waiver was amended to allow for the implementation of Family Health Plus (FHP), New York's Medicaid expansion which covers parents up to 150 percent of the federal poverty level and childless adults up to 100 percent of the federal poverty level. Nearly 300,000 low income adults are currently enrolled in FHP.

The implementation and expansion of Medicaid managed care, and the subsequent enactment of FHP, added to the work of the local social services districts in two significant ways: it placed new responsibilities on the local district for enrolling eligible persons into managed care plans and, initially, it required them to maintain contractual relationships with health plans that serve persons in their districts.

Health Plan Enrollment

With the implementation of Medicaid managed care and FHP, local districts assumed new responsibilities for managing the health plan enrollment process. This included determining whether an individual was required to join a managed care plan; processing managed care exemptions consistent with state law when appropriate; educating beneficiaries about their choice of health plans; executing health plan enrollment transactions; contracting with multiple health plans; and, in the case of Medicaid beneficiaries who did not choose a health plan in the specified timeframe, assigning them to a health plan. Additionally, since FHP is delivered exclusively through managed care plans, even those districts that did not operate a Medicaid managed care program at the time FHP was enacted had to assume responsibility for health plan education and enrollment activities.

As managed care was implemented, federal regulations and consumer advocates alike kept close watch on auto-assignment rates as a proxy for the effectiveness of state and local efforts to educate and counsel enrollees on plan choice. As mandatory enrollment rolled out through the state, there were variances in the rate of auto-assignment which required corrective action from time to time.

Anticipating the new administrative responsibilities associated with a managed care enrollment and the importance of educating consumers, state social services law permitted the Commissioner of Health to contract with one or more independent organizations to provide enrollment counseling and enrollment services for each social services district requesting such service.[6] The law required that such organization be selected by competitive procurement and, in April 1998, Maximus operating as New York Medicaid Choice, began acting as the enrollment broker for New York Medicaid managed care first serving New York City and then expanding to other districts. The primary role of New York Medicaid Choice is to educate and counsel potential eligibles and enrollees in making a choice of health care plans through the use of field enrollment counselors on site at the districts and through a call center located in New York City.

Today, 19 local districts and New York City, representing over 82 percent of all managed care enrollments, have opted to use New York Medicaid Choice to assist in the administration of Medicaid managed care in their districts. Exhibit J lists these counties and their managed care enrollment as of September 2010. In these counties, the enrollment broker assumes a significant portion of the health plan enrollment related work that would otherwise be performed by the local district. New York Medicaid Choice educates beneficiaries on site about the program and plan choice; sends mailings and multiple follow-up reminders to beneficiaries advising them that they must select a health plan; processes applicant requests for exclusion or exemption from mandatory managed care enrollment; processes auto-assignments for those individuals who do not select a plan within the required timeframe; electronically processes health plan enrollments submitted by health plans and community-based facilitated enrollers; processes health plan enrollments by mail or telephone; makes presentations in the community about the program; and submits required reports to the Department.

To carry out its duties, the enrollment broker uses a priority information system that interacts with the WMS and allows for tracking of calls and contracts with consumers. Local districts remain responsible for certain tasks including reconciling health plan member rosters and retroactive disenrollment of members who can not longer be enrolled in a health plan such as persons who enter a nursing home. Each month, New York Medicaid Choice processes an average of 42,000 health plan enrollments, 88,000 calls and 35,000 mandatory enrollment notices. For the period, October 2010 through September 2011, contract costs are an estimated $48 million; however, because of the local Medicaid cap, local districts that opt to use enrollment broker services are not charged for the cost of the contract.

Health Plan Contracting

Federal rules set forth the requirements that must be included in the contracts with health plans that serve Medicaid beneficiaries. Contracts are subject to CMS approval and must include such provisions as the respective responsibilities of the parties, contractor performance requirements, consumer protections and compensation which, in the case of health plan contracts is the monthly premium (or capitation) rate set by the Department and certified as actuarially sound by an independent actuary. Social services law initially specified that the local social services district would hold the contract with health plans.

[6] New York State: SSL 364-j.

Since federal rules generally require a choice of health plan in a county in order to operate a mandatory managed care program, that meant that each local social services district would enter into contracts with two or more health plans. Health plans, in turn, were required to negotiate a contract with each and every county in which they participated even though the contracts were for the most part identical. To illustrate, a health plan that had been approved by the Department to operate in four counties would have entered into five contracts: one with each local district for Medicaid and one with the Department for Family Health Plus. At its highest number, the Medicaid managed care program was governed by 129 individual contracts between plans and counties plus an additional 26 contracts between the state and the same health plans for FHP.

Recognizing the administrative complexity, unnecessary cost and administrative burden associated with this many contracts, social services law section 364-j (5) (d) was amended in 2004 to authorize the Commissioner of Health to contract with health plans, with the notable exception of a local social services district in a city with a population over two million, that is, New York City. The New York City Department of Health and Mental Hygiene (NYCDOHM) administers health plan contracts on behalf of New York City. The contract is the same as the model contract with the state, except it includes general New York City specific clauses as Appendix R and an Appendix N which includes New York City specific contracting requirements related to compensation for public health services, coordination with NYCDOHMH on public health initiatives, additional reporting requirements, quality management, marketing guidelines, member services and retention , enrollment and disenrollment guidelines and transportation policies. In addition, the NYCDHMH staff assists with surveillance of health plans in the areas of marketing, oversight of the enrollment broker and ensuring the adequacy of health plan networks.

Recommendations

New York Medicaid has sufficient positive experience, as do other states, in using the services of an independent enrollment broker to educate consumers about Medicaid managed care and effectuate enrollment in managed care plans. State law should be amended to require all counties to utilize the enrollment broker(s) selected by the Commissioner. This will ensure administrative efficiencies and a consistent level of service to beneficiaries across the state. The current enrollment broker contract expires in December 2011. The Request for Proposal that will be issued by the Department in late 2010 should procure services on a statewide basis for use by all local districts in early 2012.

While the 2004 change in state law greatly simplified the health plan contracting process, further simplification could be achieved through an amendment to SSL 364-j to allow the Commissioner to hold the contracts for all counties and New York City. This would reduce the total number of health plan contracts by 10 without affecting service to enrollees. The Department and the NYCDOHMH should jointly review to the New York City specific contract provisions.

Arranging/Managing Transportation Services

Access to health care for Medicaid enrollees requires both ensuring access to appropriate numbers and types of medical professionals, and necessary modes of transportation to the services they provide. Medicaid enrollees use transportation to gain access to nearly all Medicaid-funded services, including local primary care practitioners. Especially in rural regions, enrollees may use transportation for long-distance trips to inpatient and outpatient tertiary care facilities. Transportation also serves enrollees needing routine, scheduled transit, such as regular visits to adult day centers, day habilitation, or renal dialysis centers.

New York Medicaid covers transportation provided via ambulance, ambulette, taxi, public transit and personal vehicle. Transportation services are reimbursed in a number of ways. Transportation provider fees are established locally by the counties and New York City, and then approved by the Department. In some counties and in New York City, the cost of transportation services is included in the health plan capitation rate and the health plan is responsible for arranging services. In some cases, such as adult day care, transportation is included in the facility rate, with that entity being responsible for arranging the necessary transportation and reimbursing the transportation provider. New York, like other states, has struggled to continue to provide safe, reliable and cost-efficient non-emergency medical transportation for their Medicaid enrollees in an era of growing enrollment and severe fiscal constraint. In State Fiscal Year 2010-11, New York's spending for transportation is projected to be $446 million.

Historically, the responsibility for managing transportation services, including prior authorization of transports and recommending fees to the Department, has rested with the local districts. To assist in this responsibility, 31 local districts have contracted with external transportation managers. Chapter 109 of the Laws of 2010, enacted on June 8, 2010, amended Section 365-h of the Social Services Law (see Exhibit A-2) to also give the Commissioner of Health the authority to contract for the management of transportation services. This new authority will allow the Department to develop multi-county, regional or statewide contractual arrangements; eliminate the often time consuming and costly local request for proposal contracting process; and serve to attract nationally recognized managers with proven performance records.

In November 2010, the Department in collaboration with local social services, released the first regional solicitation to select one or more contractors to provide management and coordination of non-emergency medical transportation for Medicaid fee-for-service enrollees in the Hudson Valley region. This region includes, but is not limited to, Albany, Columbia, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, Washington and Westchester Counties.

Recommendation

While New York's counties are diverse geographically and demographically, there are sufficient similarities among groups of counties to support the development of regional Medicaid transportation management contracts. Regional transportation management would allow consolidation of administrative functions, such as screening and prior approval operations, thereby increasing economies of scale and helping to ensure the availability of appropriate modes of transportation in rural areas.

Regional transportation management would also centralize expertise, allowing for more consistent and transparent application of transportation regulations and guidance, and serve to attract nationally recognized managers with proven performance records. It would also eliminate the often time consuming, costly local request for proposal procurement process and burden of administering transportation management contracts.

Strong support for this concept was voiced by one survey respondent, describing this function as the "easiest component" to centralize. Additionally, the survey respondent supported transitioning this function in phases, beginning with a regional approach, and remarking that some vendors already contract with multiple counties and centralization would lead to organization on a larger and more coordinated scale.

In a report released this month (November 2010), the Medicaid Institute of the United Hospital Fund compared different approaches for administering transportation benefits. The report found that when compared to the current administrative structure, state contracts for regional transportation management offer the opportunity for improved oversight; more consistent application of quality assurance and surveillance systems; reduced administrative redundancies; the benefits of economies of scale; and consistent application of management approach and policy. On the downside, the report found that state contracted regional transportation management could result in disruption to beneficiaries, providers and staff; loss of local knowledge, geographic proximity and personal connection; and reduced county flexibility.[7] Care will be needed in the planning and contracting process to ensure that these risks are mitigated to the greatest extent possible, and opportunities to improve consistency and achieve administrative efficiencies are optimized.

Over the next three years, the Department should phase in regional transportation management throughout state and in New York City. The Department should work in collaboration with local social services districts and care should be taken to coordinate the phase-in with districts that have already contracted for these services. Exhibit K presents a detailed timeline, by region, for implementation of transportation management.

[7] Medicaid Transportation in New York: Background and Options, Medicaid Institute at the United Hospital Fund, November 2010.

Reviewing Requests for Dental Services

New York Medicaid covers dental services including preventive care, restoration and, in certain circumstances, orthodontic services. In general, the Department has established a process to prior authorize certain dental procedures before payment is made. These efforts ensure that services are medically appropriate and result in significant cost avoidance for the program.

Orthodontic care is covered when provided for severely handicapping malocclusions. In these instances, the orthodontic services are covered for a maximum of three years of active orthodontic care, plus one year of retention care. Cleft palate or approved orthodontic related surgical cases may be approved for additional treatment. Orthodontic care requires prior approval in order to qualify for reimbursement. With the exception of New York City, the responsibility for review and determination of medical appropriateness for the provision of orthodontic services for beneficiaries, resides with the Department.

In New York City, screening and determination for orthodontic treatment for New York City beneficiaries are the responsibility of the Physically Handicapped Children's Program (PHCP), administered by the NYCDOHMH, Division of Health Care Access and Improvement. New York Medicaid accesses these review services through a memorandum of understanding between OTDA and New York City. Beneficiaries are screened and authorized to seek treatments from enrolled orthodontic providers under arrangements by the PHCP, using common PHCP/Medicaid criteria. Community orthodontists refer children directly to one of three screening centers in New York City (NYU Dental Center, Columbia University Health Care and Montefiore Medical Center). If a case is approved, the beneficiary is assigned to an orthodontist for treatment. In the event that a request for service is denied, New York City must notify the beneficiary of their Fair Hearing rights and defend the case at Fair Hearing. New York City screens approximately 65,000 orthodontic treatment requests per year, as compared to the total upstate volume of 21,000. The Orthodontic Program Intra-City Budget identified 13 staff for the 2011-12, and 2012-13 New York City fiscal years at a personnel budget of $1,095,365 and $1,128226, respectively.

Recommendation

To improve uniformity in review of orthodontic services, review of New York City requests for service should be consolidated with reviews conducted for beneficiaries from other parts of the state. This will ensure uniform delivery of the benefit throughout the state through centralized decision making on the medical necessity of all orthodontic treatment requests. Consolidation could be accomplished in a number of ways. Orthodontic reviews could be centralized within the Department. Based on the relative volume of requests, the Department would require additional staff including 3 orthodontists, 4.5 hygienists and 5.5 support staff. Alternatively, review of all orthodontia requests throughout the state could be centralized with a dental benefits manager selected through a competitive process or by one or more of the State University dental schools through a memorandum of understanding. The advantages and disadvantages of each approach as well as the cost-effectiveness of each option should be assessed to determine how reviews should be consolidated.

Long-Term Care Program and Services

Medicaid is the largest payer of long-term care services in the state. Some long-term care services, most notably personal care services, are covered under New York Medicaid's State Plan, while others, often referred to as long-term care programs are generally operated through one of a variety of federal waivers. While different in design and population, there is significant overlap in the services provided and each is intended to enable elderly and disabled beneficiaries to remain safely in their homes in the community as opposed to institutional placement.

In 2009, New York Medicaid spent approximately $23.1 billion on long-term care services accounting for 46 percent of total spending. While spending continues to grow at a significant rate, the total number of Medicaid recipients receiving long-term are services has remained flat. The average cost of services per recipient has increased from $30,769 in 2003 to $38,839 in 2009. This increase is noted to point out the importance of a uniform and consistent administration of one of the largest and fastest growing Medicaid expenditure categories.

The local district role in administering Medicaid can be characterized by two major activities: determining beneficiaries' eligibility and need for long-term care services; and authorizing coverage and payment of long-term care services. The extent of the local district role varies by service and program type. However, local districts point out that administration of long-term care services is inextricably linked to the county's role in adult protective services.

Perhaps most notable among all long-term care services is the significant role of the local social services district in administering personal care services to over 75,000 beneficiaries statewide in 2009 at a cost of $2.2 billion. Among these tasks, local social services districts conduct intake, perform social and clinical assessments to determine level of care required including Personal Emergency Response Systems, design a plan of care, enter service authorizations into the Department's claims payment system, notice beneficiaries of decision, conduct annual reassessments, ensure that individuals receiving personal care have access to all needed services and monitor quality. In several counties, these tasks are conducted by Community Alternative Services Agencies (CASAs) which employ case managers and nurses who are responsible for program referrals, conducting assessments and developing plans of care for individuals in need of personal care services. New York City, due to its size, has multiple CASAs.

In addition, local districts also play a somewhat unique role in contracting with personal care providers. Generally, providers who wish to serve Medicaid patients enroll in Medicaid through a centralized provider enrollment process administered by the Department. Personal care providers, however, are contracted by the local social services district through a competitive request for proposal process or other selection mechanism conducted by the district. Among districts, New York City is further unique in that it is the only district that sets reimbursement rates for personal care agencies under an exemption to the cost based rate methodology requested by New York City and approved by the Department and the State Division of the Budget in 1996 and authorized in 515.14 (h)(7)(v) of Title 18 of regulations. The Department sets reimbursement rates for personal care services for all other districts in the state. Local social services districts also play a role in the administration of consumer assisted personal care services. For this program, local districts authorize services and contract with fiscal intermediaries.

Private Duty Nursing

NYCRR Title 10 and Title 18 contain regulations for the provision of Medicaid coverage of private duty nursing services in the patient's home or in a school. Private duty nursing services may be provided when a written assessment from a Certified Home Health Agency, local Social Services department or recognized agent of a local Social Services department indicates that the patient is in need of either continuous nursing services which are beyond the scope of care available from a certified home health agency, or intermittent nursing services which are normally provided by the Certified Home Health Agency but which are unavailable. Providers of private duty nursing services are limited to home care service agencies licensed in accordance with the provisions of Part 765 and to private practicing licensed practical nurses and registered professional nurses. Providers must be enrolled in the New York State Medicaid Program prior to the start of service.

Prior approval by New York Medicaid or the local designee is required for private duty nursing services. Prior approval requests identify the private duty provider; the informal support caregiver; a statement from the ordering practitioner that the informal support caregiver is trained and capable to meet all of the skilled and unskilled needs of the patient; and a written physician's order including diagnoses, medications, treatments, prognoses and other pertinent patient information. Initial approval of private duty nursing services is for a period not to exceed three months with required recertification every six months thereafter. Determinations for continued care beyond the initial three months must be approved by the Medicaid program local designee. When, at any time, the Medicaid program or the local designee determines that private duty nursing services are no longer clinically appropriate or safe, and the beneficiary continues to request nursing care, the beneficiary is advised of the determination and of their due process rights. Under state regulation, requests for prior approval must be completed within 21 days.

Annually, the Department reviews approximately 6,100 requests for private duty nursing services. In 2009, $49 million in savings resulted from the Department's private duty nursing prior authorization activities. The Department is currently responsible for reviewing all requests for private duty nursing with the exception of the following five counties: Westchester, Oneida, Schenectady, Chemung and Tompkins. In these counties, prior approval is performed by local district staff utilizing the Medicaid management information system, eMedNY, to manage work and document prior approval decisions.

Long-Term Care Waiver Programs

New York has a number of Home and Community Based Services (HCBS) waiver programs under section 1915 (c) of the Social Security Act. HCBS waiver programs serve both elderly and disabled populations.

The Long-Term Home Health Care Program (LTHHCP), including the AIDS Home Care Program (AHCP), serves people older than 65 years of age and individuals of all ages who have physical disabilities. Eligible individuals must be in need of nursing home level of care and have needs that can safely be met in the community. LTHHCP offers both medical and nonmedical support services to assist an individual in improving or maintaining their health and daily functioning. While the Department has the lead in managing these waivers, local social services districts also play an important role in the day-to-day administration of the waiver. The local social services district receives referrals and visits the recipient's home to conduct an assessment and determine level of care needed in collaboration with providers. The local district authorizes participation in the program and approves expenditures for services projected to be within a cap which is set at 75 percent of the cost of nursing home care in the region, with certain exceptions which allow a cap of 100 percent.

The Traumatic Brain Injury (TBI) waiver serves Medicaid eligible individuals who have an acquired traumatic brain injury, are in need of nursing home level of care and have needs that can safely be met in the community. The waiver enrolls individuals between the ages of 18 and 64. The program provides supports and services in the most community integrated setting and strongly encourages maximum participant choice.

The Nursing Home Transition and Diversion (NHTD) waiver serves Medicaid eligible individuals 18 to 64 years of age who have a physical disability, and seniors 65 and older, who require nursing home level of care and have needs that can safely be met in the community. The program emphasizes community services and supports to transition or divert individuals from nursing home placement. For the Traumatic Brain Injury and Nursing Home Diversion waivers, Regional Resource Development Centers (RRDC), not-for-profit, community based organizations that contract with the Department to manage the waiver programs on a regional basis statewide, conduct assessments and approve plans of care to authorize services. The local social service districts retain responsibility for approval and authorization of state plan services.

The Care At Home (CAH) I/II waiver serves individuals under age 18, who are physically disabled, require a skilled nursing facility or hospital level of care and can be safely cared for in the community. Children who are Medicaid eligible based on their parents income and if applicable, resources, as well as children who are ineligible for Medicaid based on their parents' income and/or resources, may apply for enrollment in the waiver. This waiver serves children with a physical disability, allowing them to live in the community. Local districts review initial assessments and reassessments, make eligibility determination for the Care at Home waivers and authorize coverage of waiver and state plan services.

Managed Long-Term Care

New York Medicaid's Managed Long-Term Care (MLTC) program is designed for Medicaid beneficiaries who are chronically ill or have disabilities and need health and long-term care services such as home care or adult day care. The goal of the program is to allow beneficiaries to stay in their homes in the community as long as possible. Managed long-term care plans arrange and pay for a wide range of health and social services. There are three basic models of managed long-term care in New York State: Programs of All-inclusive Care for the Elderly (PACE), Managed Long-Term Care Plans and Medicaid Advantage Plus (MAP).

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis). PACE members are required to use PACE physicians and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member. The PACE is approved by CMS.

Managed Long-Term Care Plans provide long-term care services (like home health and nursing home care) and ancillary and ambulatory services (including dentistry and medical equipment), and receive Medicaid payment. Members get services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare cards. Members must be eligible for nursing home admission. While several plans in New York State enroll younger members, most managed long-term care plan enrollees must be at least age 65.

MAP plans participate in both Medicaid and Medicare. They cover a broad range of services including Medicare and Medicaid covered acute care and Medicaid covered long-term care services. New York City has the greatest concentration of Managed Long-Term Care Plans and members at present. Ten partially capitated plans serve approximately 26,000 members, seven MAPs serve 450 members and two PACE serve 2,400 members.

The local districts' role in the managed long-term care program is somewhat more complex than in the mainstream managed care program. In addition to determining the individual's eligibility for Medicaid as described earlier in this report, the districts also reviews health plans' completion of the state required assessment tool to ensure that the applicant is in need of a nursing home level of care and that the care plan developed by the managed long-term care plan will allow the applicant to remain safely in the community.

In response to health plan provider concerns that local districts were not timely in their processing of managed long-term care applications, state law was changed in 2006 to require that complete enrollment applications received at the local social services district by the 20th day of the month be processed for enrollment in the managed long-term care plan by the 1st day of the following month.[8] As managed long-term care has rolled out to other counties in the state, local social service districts have taken on new responsibilities for program administration. During the period 2003 though 2009, managed long-term care enrollment grew by over 175 percent, adding to the workload of the local district. For some districts, the managed long-term care program and working with managed long-term care providers was a new activity.

[8] Chapter 57 of the Laws of 2006.

As managed long-term care enrollment continues to grow both in geographic coverage and number of enrollees, it is unclear that local social services districts can keep up with the new and increasing demand. Unlike the mainstream managed care program, currently there is not an enrollment broker to assist in the processing of health plan applications.

Recommendations

Administration of long-term care benefits is complex, therefore significant planning is needed to transition administrative functions. Similar to administration of eligibility, the transition of administrative responsibilities related to long-term care lends itself to a phased approach. Shorter-term actions include the following:

- To improve uniformity in decision making and efficiencies, responsibility for reviewing prior approval requests for private duty nursing in the five remaining counties should be consolidated with the Department. Centralization will not only lessen the work load at the local districts, it will also eliminate the need for the Department to separately monitor activity for the five counties. The transfer process would best be accommodated by scheduling a phase-in that would allow five months for the transfer of cases from the lower volume counties of Chemung, Oneida, Schenectady, Tompkins, and, due to the high volume, a separate three-month transition of the Westchester cases with the goal of beginning the transition in December 2010 and completing it by July 30, 2011. Transfer to the Department will require 1.5 additional nurse reviewers.

- Managed long-term enrollment is expected to grow both geographically and in terms of the total number of people enrolled. The capacity to handle this increasing enrollment is dependent on uniform and timely processing of applications. The upcoming resolicitation of the enrollment broker services, described in the Managed Care section of this report, provides an opportunity to consolidate on a statewide basis enrollment into the Managed Long-Term Care program.

Longer term, the Department should work over the next 12 months internally and with multiple stakeholders to identify opportunities to streamline and transition administration of long-term care services. Critical to this objective is the development of a uniform assessment tool to improve and standardize assessments, care planning and case management. This need was echoed by several local district survey respondents who noted that such a tool would provide uniformity in individual assessments for all personal care services and consistency in the way that such services are authorized. The Department took an important step towards reaching this goal in August 2010 when it released a Request for Proposals to identify a vendor to implement the requirements for a uniform long-term care assessment tool for use across Medicaid long-term care programs. A contract award is expected in late 2010 with a contract launch date of March 2011.

Other critical components of the plan include exploration of a regional approach to assessment, care planning and case management functions similar to the functions to be performed by the long-term care assessment centers authorized in state law and planned for the mid-Hudson region and Brooklyn. As part of the plan, the provider contracting function currently performed by local social services districts should be transitioned to align with the Department's enrollment process used for other types of providers.

By the end of 2012, the Department should convene internal and external stakeholders to make recommendations on a "point of entry" approach for access to all long-term care services. Many states have such a system and many in New York have called for such a system. The recommendations should address issues such as capacity, exact function and effect on the discharge practices in the acute care systems. While there is no doubt that the current collection of long-term care services is complex and confusing, care must be taken to facilitate early access to appropriate services.

As the planning process continues, attention should be given to the numerous opportunities provided in the ACA to encourage home and community based services and reward states through increased federal match, including the following:

■ **STATE BALANCING INCENTIVE PROGRAMS** - *IMPLEMENTATION PERIOD: 2011-2015*
Competitively awarded temporary increase to federal matching percentage to rebalance from institutional care to home and community based services to 50 percent of expenditures. Requires maintenance of effort, conflict-free case management, no wrong door and standardized assessment within 6 months of application.

■ **COMMUNITY FIRST CHOICE OPTION** - *IMPLEMENTATION DATE: OCTOBER 2011*
Option to provide home and community based services and supports through state plan amendment rather than waivers. Allows new services such as skills acquisition, training for managing attendants, one months rent, utility deposits, furnishings, alternative to agency staffing (vouchers, cash, fiscal agents), implementation in consultation with consumer council and covers both those in need of a nursing home level of care and those financially eligible for Medicaid. This option increases the federal matching percentage by 6 percent.

■ **REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY BASED SERVICES -** *IMPLEMENTATION DATE: OCTOBER 2010*
Provides states with an option under 1915(i) that allows hybrid between existing 1915 waivers and state plan optional services to broaden scope of services, allow specific targeted populations and services that differ in amount, duration and scope.

Program Integrity Activities

At the end of 2006, the state established the Office of the Medicaid Inspector General (OMIG) as an independent entity to tackle the issues of fraud, waste and abuse in New York's Medicaid program. The OMIG is charged with coordination to the greatest extent possible of activities to prevent, detect and investigate medical assistance program fraud and abuse.[9] Local social services districts are some of the partners with which the OMIG coordinates. While program integrity is imbedded in every aspect of Medicaid administration, from determining eligibility to authorizing services, local social services districts also carryout certain discrete tasks related to program integrity. Three of these tasks are described below.

County Demonstration Project Audits

Under the Medicaid Fraud Waste and Abuse County Demonstration Projects, counties and local social services districts partner with the state in an effort to identify and reduce fraud through audits of providers who bill Medicaid. Sixteen counties hold Memorandum of Understanding with the OMIG of which twelve (Albany, Broome, Chautauqua, Dutchess, Monroe, Nassau, New York City, Niagara, Rennselaer, Rockland, Suffolk and Westchester) are actively conducting audits. Some counties use exclusively contracted services to conduct these audits, while others use employed staff or a combination of employed and contracted services. Counties are responsible for conducting the audits and the OMIG reviews and approves the audits prior to their release. The non-federal share of any recoupments, after the expense of conducting the audit, is shared equally between the local social district and the state. Since its inception, county demonstration projects have identified $14.1 million in findings, with over $11.2 million recovered to date. In 2009, county demonstration projects yielded approximately $8 million in findings and $5 million in recoveries. In total 441 audits have been initiated to date.[10]

2009 County Demonstration Project Audits by Region

Region	Intitiated	Finalized	Findings	Recoveries
Downstate	102	20	$6,138,889	$3,473,297
Upstate	32	50	$2,335,228	$1,280,133
Western	6	22	$352,782	$918,355
Statewide	140	92	$8,826,899	$5,671,785

Medicaid Recovery Activities

Local districts have historically played a significant role in estate and casualty third-party liability recoveries. Effective April 1, 2008, a new subdivision was added to social services law providing that Medicaid recovery activities including estate recoveries, personal injury liens[11] and recoveries from spouses who refuse to provide medical support can be undertaken by the Department. The legislation did not remove the recovery function from social services districts, but simply made it clear that the Department has concurrent authority to pursue its own recovery activities. To effectuate this change in law, the OMIG is currently working with select counties to create a centralized program which can be leveraged to other counties to increase savings. In responding to the survey, some local social services districts included these tasks in their recommendations for prioritizing the transfer of activities.

[9] New York State Office of the Medicaid Inspector General , 2009 Annual Report.
[10] New York State Office of the Medicaid Inspector General , 2009 Annual Report.
[11] Section 71-a of Part C of Chapter 58 of the Laws of 2008.

Recommendation

One of the guiding principles of transitioning administration of Medicaid to the state from the local social services districts is to protect and, where possible, improve program integrity.
To ensure this goal is met, an advisory group including local representatives, the Department and the OMIG should be formed to identify all of the tasks performed by the counties, the local relationships that exist related to identification and recovery of overpayments and fraud for the purpose of informing the Commissioner's transition plan.

Section 4:
Summary of Survey of Local Departments of Social Services

State law requires the Commissioner to consult with each local social services district in the development of the plan to transition Medicaid administration to the state from counties. Given the relatively short time frame between enactment of the legislation in June 2010 and this report, an initial survey of local districts focused on certain administrative functions was undertaken as a first step in meeting this requirement. The sections that follow describe the goal of the survey and the process used and provides a high-level summary of the many thoughtful responses received from local social services districts. Exhibit (C) contains a copy of the survey tool and Exhibit (D) is the presentation of the survey results.

Goal of Survey

To inform the development of the New York State Department of Health's Department report to the State Legislature on planning the implementation of state takeover of New York State Medicaid administration, the Department developed and administered a survey of all local departments of social services (LDSS) to gather feedback on how Medicaid related tasks and responsibilities can be transitioned to the State. The Department collaborated with the Medicaid Institute at United Hospital Fund (UHF); Manatt, Phelps & Phillips (Manatt) and the New York State Public Welfare Association (NYPWA). Survey development and analysis were provided by the UHF and Manatt. The administration of this survey is an essential first step in the State's comprehensive plan to gather information and insight from all local departments of social services. NYPWA supported the development of the survey content and did outreach to local districts to encourage a robust response.

Process

The survey was distributed through a web-based tool to all 58 local departments of social services in early October. They were given 2 weeks to complete the survey. Forty-eight local departments of social services responded, resulting in an 83 percent response rate. All major metropolitan areas of the state responded to the survey.

Questions included those that focused on:

- Description of tasks and responsibilities within each major focus area (e.g. eligibility, personal care, transportation) that should be given priority by the state during the transition and rationale.
- Implementation steps and challenges associated with transition of each task.
- Level of coordination with local agencies on Medicaid-related tasks.
- Medicaid-related tasks that require a physical local presence.
- Local information systems devised to assist in Medicaid administration.

Questions were followed by open-ended text boxes to encourage detailed feedback. Subsequent to the survey, the Department held meetings with the following groups to solicit additional feedback: Commissioners of local departments of social services, NYPWA, the New York City Mayor's Office, the New York State Association of Counties (NYSAC), the Coalition of Public Health Plans, the Health Plan Association, provider associations that included the Greater New York Hospital Association, the Healthcare Association of New York State, the Home Care Association of New York State, the Community Health Center Association of New York State and key consumer groups.

Characterization of Responses

Survey responses revealed that local district views of what should make a task a "priority" for state administration varied significantly, producing sometimes contradictory results. The results were highly dependent on the perspective of the respondent in defining the term priority with respect to state administration. The respondents' prioritization criteria can be grouped into three basic categories.

- **Local Departments of Social Services Burden.** These tasks were prioritized because they were viewed as particularly difficult or burdensome for local districts.

- **Temporal.** These tasks were prioritized because they could most immediately or readily be transferred to the state, often due to the fact that they were viewed as severable from other local tasks or more likely to be successfully managed at the state level.

- **State Challenge.** These tasks were thought to present the greatest challenge in the overall context of a transfer, requiring the most attention or work, frequently because of their large scope or interconnectedness with local district functions.

Summary of Findings

Local districts provided a wealth of feedback on the tasks and responsibilities that should be transferred to the state and implementation steps that would facilitate such a transfer. A high level summary of their responses include:

- Counties are concerned about delays and disruptions of services as tasks are transferred to the state.

- Counties are concerned about the severability of administrative tasks, both from other aspects of Medicaid administration and from other local social services functions. Many emphasized the need to ensure coordination between the state and local districts throughout the transfer process. Some recommended a one-time transfer of tasks to the state, rather than a phased-in approach.

- Challenging tasks identified by counties included customer assistance, relationship building with local providers and referral to local services. Counties highlighted the importance of maintaining a local presence in the transition of these responsibilities.

■ Keys to successful task transfer, as recommended by counties, include:

- Adequate training of staff assuming transferred tasks.
- Maintenance of local presence to assist and drive distinct functions, mostly related to long-term care beneficiaries.
- Strong, working relationships with local providers and knowledge of community-based resources.
- Standardization of key processes, rules and services to ensure efficiency and accountability.
- Delineation and communication of clear roles among state and local districts during and after transition to state takeover.
- Detailed procedures to meet emergency needs of Medicaid beneficiaries during transition of tasks to state.
- Ongoing education to beneficiaries and local providers during and after transition of tasks.

Section 5: Employee/Labor Implications

Local District Staffing

In State Fiscal year 2009-10, counties reported that a total of 5,582 staff worked on Medicaid. This was a 13 percent increase over the 4,948 staff allocated to Medicaid related tasks in 2005, the year on which the Medicaid cap is based. The vast majority of workers were allocated to Medicaid eligibility and authorization tasks as opposed to policy.

	Eligibility and Authorization	Policy	Total
2005			
Total	4747	202	4948
NYC	2285	42	2327
Rest of State	2462	160	2622
2009-10			
Total	5383	199	5582
NYC	2435	40	2475
Rest of State	2948	159	3107

Other than the broad categorization of staff into eligibility and authorization or policy, no detail is reported about the specific duties of the staff allocated to Medicaid. Based on data reported by the counties, statewide, the staff allocated to Medicaid constitutes 14.2 percent of the total staff working on all programs administered by the local districts. The percentage reported by New York City is lower, at 10.9 percent, and higher in upstate counties at 18.5 percent of total staff.

Shared Administration of Human Services Programs

One of the major complexities in the state assuming administrative responsibilities for Medicaid is that local social services districts also administer other human services programs, such as food stamps and cash assistance. Over time, the percent of Medicaid beneficiaries who receive cash assistance has dramatically declined. As of July 2010, only 28 percent of individuals on Medicaid also received cash assistance. About 2 million Medicaid enrollees also receive other human services programs, the vast majority (1.8 million) in receipt of food stamps. There is also overlapping eligibility between Medicaid and other human services, such as heating assistance (HEAP) although data was not available to quantify the number of people.

Throughout the stakeholder engagement process, concerns were raised about the need to recognize the cross-program needs of individuals applying for Medicaid. Many local district survey responses described the importance of recognizing that clients depend on programs other than Medicaid for their needs, such as food stamps and cash assistance. One survey respondent commented that local district workers make referrals for many types of services and clients are sometimes unaware of what information must be provided and how these programs interface.

Consumer representatives also raised the issue of "cross-program" eligibility, but questioned the extent of a statewide uniform and systematic approach to ensure this happens in the current administrative structure. For example, unlike years ago when individuals went to the local social services district to apply for Medicaid, today, most Medicaid applications are initiated by community-based or health plan FEs. These enrollers are not responsible for determining an individual's eligibility for other human services programs nor are they responsible for submitting such applications. As an approach to addressing this issue, one concerned party suggested that the role of facilitated enrollers could be expanded. Others suggested technology solutions perhaps similar to a system that New York City plans to implement in the near future to exchange information among human services programs within existing privacy laws. Notwithstanding the approach, facilitating efficient cross-program eligibility is an important goal and the clear message is that the plan to transition Medicaid administration to the state from the counties, while ideally advancing this goal, should at a minimum not result in lost ground.

Employee Relations Considerations

Generally, all local district staff, with the exception of the Local Social Services Commissioner, are unionized. Except for Monroe and Suffolk and the counties of New York City, local government employees are generally members of the Civil Service Employees Association (CSEA). Local government employees in New York City are represented by District Council 37 (DC37). In Monroe County they are represented by a local affiliate of Industrial Union of Engineers (IEU), a union under the umbrella of the national AFL-CIO, and in Suffolk County they are members of an independent local union known as the Suffolk County Association of Municipal Employees.[12]

Civil Services Law (see Exhibit A-3) anticipates situations in which transfers of functions will occur between government agencies including transfer of functions from counties, described in the law as civil divisions of the state, to state agencies or departments. More specifically, the law provides a process for the transfer of necessary officers and employees who are "substantially engaged" in the performance of the function to be transferred. That process requires the head of the department or agency from which the function is to be transferred, in this case the county, to certify to the state department to which the function is to be transferred, in this case the Department a list of names and titles of those employees substantially engaged in the performance of the functions. The list is publicly posted in the county office and employees are given the opportunity object to their inclusion in or exclusion from the list with the final determination to be made by the agency to which the function is to be transferred. Employees on the final list are transferred without further examination or qualification and retain their civil service classification status.

Recommendation

Identifying and addressing the labor and personnel issues related to transitioning Medicaid administration from the county level to the state is one of the most critical and sensitive aspects of developing the plan to transition Medicaid administration from the counties to the state. Detailed information about the employees in the counties who perform Medicaid functions will need to be collected. This information may include, but not be limited to, employee names, titles and grades, salary, location, negotiating unit, length of employment in Medicaid functions, primary and secondary job functions with time spent on each, reporting relationships and supervisory responsibilities.

[12] Medicaid Institute Report: The Role of Local Gov't in Administering Medicaid in New York, August 2009. http://www.medicaidinstitute.org/publications/880597)

An advisory group comprising representatives from the Department, the State Department of Civil Service, the Governor's Office of Employee Relations, counties including personnel officers and local social services commissioners and representatives of labor should be formed to identify the issues and inform the development of the Commissioner's plan. Among its tasks, the advisory group would assist the Commissioner in defining "substantially engaged" as it relates to Medicaid administration and provide input into the information that would be needed from the counties.

Section 6: State/County Financial Impact

Medicaid Funding

New York Medicaid is funded by the state, federal and local governments. Historically, the federal government paid for 50 percent of most Medicaid costs in New York. The passage of the federal American Recovery and Reinvestment Act (ARRA) provided states with temporary fiscal relief and increased the federal matching rate for period starting October 2008 and ending in July 2011.

Since the inception of New York Medicaid in 1966, state law has required counties to contribute to the non-federal cost of Medicaid for their residents. New York is one of 28 states that require some level and type of county contribution toward the non-federal share of Medicaid costs for their residents.[13] With some exceptions, such as long-term care services, counties historically paid 50 percent of the non-federal share of Medicaid. Thus, counties would generally be responsible for 25 percent of the total cost of most services.

Implementation of FHPlus in September 2001 for all areas other than New York City, and in New York City in February 2002, expanded the number of people eligible for Medicaid and increased county costs. In 2004, state law was changed to require the state to pay for the full non-federal share of FHPlus. More sweeping changes in Medicaid funding occurred in 2005, when the legislature passed Part C of Chapter 58 of the Laws of 2005 capping each county's share of Medicaid effective January 1, 2006. The cap limits each county's Medicaid liability to 2005 Medicaid expenditures, including county administrative costs, increased by uncompounded trend factors set in statute as follows: 3.5 percent in 2006; 3.25 percent in 2007; and 3 percent each year thereafter. In years 2008 and beyond, counties also had the option of contributing a fixed percentage of their local sales tax, as opposed to paying the cap amount. Only one county, Monroe, has elected this option.

In state fiscal year 2009-10, the Medicaid cap statute limited the total county contribution to Medicaid to $6.7 billion. Without the cap, counties would have contributed $7.6 billion in that same year. In addition to the $914 million in savings that accrued to counties in 2009-10 as a result of the cap legislation, counties also received a $1.3 billion benefit from the increased Federal Medical Assistance Percentages (FMAP). Exhibit L shows county costs of Medicaid, the impact of the statutory cap and the county benefit of the enhanced FMAP for the state fiscal years 2005-06 through 2009-10.

The Medicaid cap statute fixes county costs and makes amounts over and above the cap the fiscal responsibility of the state regardless of the cause of the increase in costs (e.g. more eligible people, medical cost inflation, changes in benefit design, provider fee increases, additional staff needs, etc.) Despite this paradigm change in the financing of the program, some local districts have expressed reluctance to hire additional staff needed to meet the increasing workload for a variety of reasons; including perceptions about increasing the size of the county workforce, physical plant limitations and pension costs.

[13] National Associations of Counties.
   Other states include AZ, CA,CO,FL,HI,IA,ID,IL,IN,MI,MN,MT,NC,ND,NH,NJ,NM,NV,OH,OR,PA,SC,SD,TX,UT,WA,WI.

Local Cost of Administering Medicaid

Overall, state and local costs of administering Medicaid represent 2 percent of the total costs of Medicaid which compares favorably with the administrative costs of private insurance in New York in 2009. In 2009-10, the cost of county administration of Medicaid was $1 billion, a steady increase from total reported costs of $764 million in 2005. The only detail available about these costs is a broad characterization of costs into eligibility and authorization functions which account for 92 percent of total cost and policy functions which account for the remaining 8 percent of total costs.

County Reported Cost of Administering Medicaid *(2005 COMPARED TO 2009-10)*

	2005	2009-10	Percent Change
Total Cost	**$764,474,907**	**$1,016,655, 759**	**33%**
NYC	$476,250,020	$642,038,787	35%
Rest of Sate	$288,224,887	$374,616,972	30%

Data available to the Department does not provide detailed information about the counties' cost of performing specific administrative functions. However, the data only broadly identifies direct and indirect costs, such as information technology (WMS) and general county overhead costs.

Absent more detailed information about county administrative costs, available data was used to conduct two high-level analyses for the purposes of this report. As stated earlier, counties report that the number of staff assigned to Medicaid administration comprise 14.2 percent of the total number of staff working on all human services programs administered by the county. Yet, the total cost of administering Medicaid is a much higher percentage, 23 percent of total costs reported by the counties for administering all human services programs. While not conclusive, this suggests that Medicaid contributes a disproportionate share of county administrative costs relative to the number of staff assigned to Medicaid related tasks.

A recent report issued by NYSAC concluded that, "of most concern is the fact that New York provides NO reimbursement to counties for Food Assistance, Safety Net, Food Stamps and Home Energy Assistance Program." [14] This statement is misleading. While the state has eliminated State General Fund support for some of these programs, counties continue to receive federal administrative funding. Nevertheless, administrative functions do overlap across human services programs (e.g., intake) and existing information is insufficient to delineate the functions and their related costs. The State must undertake a more detailed analysis of the functions and their component costs in order to transfer the Medicaid functions and related funding to the State.

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[14] *Time for Change, Administering Medicaid in New York State:* The County Perspective, New York State Associations of Counties Presidential Commission on the State Takeover of Medicaid, September 2010. http://www.nysac.org/documents/NYSACTimeforChangeReportWEB.pdf

In a second analysis, staffing and administrative cost data reported by the counties was used to separately calculate for New York City and the rest of the state an average administration cost per staff allocated to Medicaid functions. In 2009-10, New York City reported total Medicaid administration costs of $642 million and total staff of 2,476, for an average administration cost per assigned staff of $259,000. For the rest of the state, county Medicaid administration costs in 2009-10 were reported at $374 million and total staff at 3,107, for an average administration cost per assigned staff of over $120,000. The disparity between New York City and the rest of the state needs to be further analyzed to determine if this is an accounting artifact or an indication of relative efficiency.

Recommendation

While this report presents a very high level of analysis of county reported data on the cost of administering Medicaid, clearly more detailed information is needed from counties to facilitate the development of the fiscal elements of a plan to transition Medicaid administration to the State. In order to collect this information, the Department should engage the services of an independent accounting firm to collect detailed county expenditures for Medicaid administration. The scope of the review and the data to be analyzed by the accounting firm should be developed by the Department with the advice of the counties.

Section 7: Implementation Timeline

New York State Department of Health Preliminary Implementation Timeline

As this report demonstrates, planning the transition of Medicaid administration to the state from local social service districts requires a coordinated and comprehensive effort, along with thoughtful planning. The following timeline for a five-year implementation of a state assumption of administrative services, required by the June 2010 legislation, was developed with consideration of the guiding principles detailed at the beginning of this report and feedback provided by stakeholders.

NOVEMBER 2010:
- ▶ The Department releases first report required by legislation.
- ▶ The Department releases solicitation for Transportation Manager in Hudson Valley region.
- ▶ The Department releases solicitation for Transportation Manager in New York City.
- ▶ Prior approval of private duty nursing services for the remaining five counties begins to transition to the Department.

DECEMBER 2010:
- ▶ The Department releases Request for Proposal for Managed Care Enrollment Broker Services.
- ▶ Contract award expected for vendor to implement requirements for a long-term care assessment tool for use across Medicaid long-term care programs.

FEBRUARY 2011:
- ▶ Transportation Management-Hudson Valley implementation for Albany, Columbia, Greene, Orange, Rockland, Sullivan and Ulster.
- ▶ The Department to begin development of guidelines for review of county Medicaid administration costs with advice from counties.

MARCH 2011:
- ▶ Contract start date anticipated for vendor to implement requirements for a uniform long-term care assessment tool for use across Medicaid long-term care programs.

New York State Department of Health Preliminary Implementation Timeline

(continued)

APRIL 2011:

▶ Statewide enrollment center becomes operational consolidating consumer help lines and implementing telephone renewals.

▶ The Department assumes responsibility for contracts with health plans serving enrollees in New York City.

▶ The Department begins stakeholder process to prepare detailed plan for transition of tasks related to long-term care services.

▶ The Department begins stakeholder process for eligibility determination functions.

▶ The Department convenes advisory group to explore employee and labor issues and develop recommendations for the Commissioner.

▶ Transportation Management-Hudson Valley implementation for Westchester and Putnam counties.

▶ Transportation Management–NYC implementation for Brooklyn borough.

▶ The Department hosts quarterly stakeholder meeting.

▶ The Department to engage services of an independent accounting firm to collect detailed county expenditures for Medicaid administration using guidelines developed by the Department with advice from counties.

MAY 2011:

▶ Transportation Management-Hudson Valley implementation for Fulton, Montgomery, Washington and Warren counties.

JUNE 2011:

▶ Transition of prior approval of private duty nursing services completed.

▶ The Department hosts quarterly stakeholder meeting.

▶ Recommendation finalized for prior authorization of orthodontic services.

JULY 2011:

▶ Transportation management – New York City implementation for Queens and Staten Island boroughs.

New York State Department of Health
Preliminary Implementation Timeline

(continued)

TIMELINE COLOR KEY
▶ Law/Federal Reform
▶ Transportation
▶ Managed Care
▶ Eligibility
▶ Dental
▶ Long-Term Care

SEPTEMBER 2011: ▶ The Department hosts quarterly stakeholder meeting.

OCTOBER 2011: ▶ Transportation management– New York City implementation for Manhattan and Bronx boroughs.

▶ The Department presented with results of review of county expenditures on Medicaid administration by contracted independent accounting firm.

DECEMBER 2011: ▶ Statewide enrollment center assumes responsibility for disability determinations, cross county eligibility reviews and low volume programs.

▶ The Department releases solicitation for transportation manager in the 4 rest-of-state regions: Long Island, Western, Central and Northern.

▶ The Department hosts quarterly stakeholder meeting.

▶ Advisory group on employee and labor relations submits recommendations to Commissioner.

JANUARY 2012: ▶ Enrollment broker assumes responsibility for managed care outreach and education for all counties.

APRIL 2012: ▶ The Department hosts quarterly stakeholder meeting.

JUNE 2012: ▶ Statewide enrollment center assumes responsibility for applications from FEs.

▶ Transportation management implementation for Long Island region (Nassau and Suffolk counties).

▶ The Department hosts quarterly stakeholder meeting.

New York State Department of Health
Preliminary Implementation Timeline

(continued)

SEPTEMBER 2012:
▶ Transportation management implementation for Western Region (Erie, Chautauqua, Cattaraugus, Genesee, Niagara, Orleans, Allegany, Monroe, Wayne, Wyoming, Yates, Livingston and Steuben counties).

▶ The Department hosts quarterly stakeholder meeting.

OCTOBER-NOV 2012:
▶ Transportation management implementation for Central region (Oneida, Onondaga, Otsego, Oswego, Cayuga, Tompkins, Seneca, Schuyler, Jefferson, Herkimer, Broome, Schoharie, Cortland, Chemung, Chenango, Tioga, Madison and Delaware counties).

DECEMBER 2012:
▶ The Department begins stakeholder process for eligibility determinations for elderly/disabled.
▶ The Department should convene stakeholders to make recommendations on "point of entry" for all long-term services.
▶ Transportation management implementation for Northern region (Franklin, Clinton, St. Lawrence, Essex, Ontario, Lewis, and Hamilton counties).
▶ The Department hosts quarterly stakeholder meeting.

JANUARY 2013:
▶ States must demonstrate to Health and Human Services Secretary readiness to operate Exchange Insurance.

MID 2013:
▶ ACA requires that new on-line real-time system is operational in mid-2013.

JANUARY 2014:
▶ Concurrent with implementation of federal health care reform, the Department assumes responsibility for eligibility determinations for non-elderly and non-disabled persons under federal MAGI rules.

JUNE 2015:
▶ The Department assumes responsibility for eligibility determinations for elderly/disabled.

APRIL 2016:
▶ The Department assumes responsibility for tasks related to long-term care services.
▶ The Department hosts quarterly stakeholder meeting.

EXHIBITS

A. Relevant Sections of Law

    1. Chapter 58 of the Laws of 2010, Section 47-b

    2. Social Services Law Section 365-h

    3. Civil Service Law Section 70

B. Schedule of Stakeholder Meetings

C. Survey of Local Districts of Social Services on Local Roles in Medicaid Administration

D. Medicaid Institute at United Hospital Fund Presentation on Survey Responses

E. New York State Medicaid Eligibles as of December 2009

F. New York State Medicaid Utilization by Category of Service for Calendar Year 2009

G. New York State Medicaid Programs

H. New York State Medicaid Application Process Diagram

I. New York State Medicaid Renewal Process Diagram

J. Mandatory Medicaid Managed Care Enrollment

K. New York State Medicaid Transportation Management Initiative Roll-out Plan Schedule

L. Local Share of Medicaid Worksheet

§ 47-b.1. The commissioner of health shall create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts.

2. In developing such plan, the commissioner of health shall, in consultation with each social services district: (i) define the scope of administrative services performed by social services districts and expenditures related thereto; (ii) require social services districts to provide any information necessary to determine the scope of services currently provided and expenditures related thereto; (iii) review administrative processes and make determinations necessary for the state to assume responsibility for such services; and (iv) establish a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016.

3. Such plan developed by the commissioner of health shall include, but is not limited to: (i) a definition of administrative services; (ii)a cost analysis related to the delivery of such administrative services; (iii) operational objectives that create efficiency in administrative functions; (iv) standards that provide greater uniformity in eligibility criteria and continued enrollment; (v) a plan to transition social services district employees to state employment and to ensure that such transition shall not interfere with existing collective bargaining contracts; (vi) a statewide informational system that facilitates and monitors enrollment and promotes efficient transfer of information; (vii) a streamlined approach to communicating medical assistance policy changes; (viii) coordination of state assumption of medical assistance administrative responsibilities with the requirements of the federal Patient Protection and Affordable Care Act; (ix) a plan, consistent with subdivision 6 of this section and including any recommendations for legislative action, for state assumption of expenditures related to the costs of administering the medical assistance program; (x) recognition of the unique circumstances of the counties including, but not limited to: population size, demographics, geography and existing program infrastructure; and (xi) other critical issues as determined by the commissioner of health to increase efficiency in administration of the medical assistance program.

4. The commissioner of health shall submit a report to the governor, temporary president of the senate and speaker of the assembly by November 30, 2010, on the anticipated implementation of such plan, its elements, a timeline for such implementation, any recommendations for legislative action, and such other matters as may be pertinent.

5. The commissioner of health is authorized to promulgate regulations addressing the elements described in subdivision 3 of this section.

6. Subject to the approval of the director of the budget, beginning state fiscal year April 1, 2011, reimbursement for expenditures made on or after such date, by or on behalf of social services districts for medical assistance pursuant to section 368-a of the social services law and chapter 58 of the laws of 2005 shall be adjusted to reflect the state assumption of local administrative functions and the expenditures thereto pursuant to this section.

SOCIAL SERVICES LAW SECTION 365-h

* § 365-h. Provision and reimbursement of transportation costs. 1. The local social services official and, subject to the provisions of subdivision four of this section, the commissioner of health shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official and, as appropriate, the commissioner of health shall:

(a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

(b) maintain quality assurance mechanisms in order to ensure that (i)only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided; (ii) no expenditures for taxi or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons; and (iii)transportation services are provided in a safe, timely, and reliable manner by providers that comply with state and local regulatory requirements and meet consumer satisfaction criteria approved by the commissioner of health.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning

SOCIAL SERVICES LAW SECTION 365-h

tracking system reporting requirements and service verification
mechanisms. Any and all reimbursement rates developed by transportation
managers under this subdivision shall be subject to the review and approval
of the commissioner. Notwithstanding any inconsistent provision of sections
one hundred twelve and one hundred sixty-three of the state finance law, or
section one hundred forty-two of the economic development law, or any other
law, the commissioner is authorized to enter into a contract or contracts
under this subdivision without a competitive bid or request for proposal
process, provided, however, that:
(a) the department shall post on its website, for a period of no less than
thirty days:
(i) a description of the proposed services to be provided pursuant to the
contract or contracts;
(ii) the criteria for selection of a contractor or contractors;
(iii) the period of time during which a prospective contractor may
seek selection, which shall be no less than thirty days after such
information is first posted on the website; and
(iv) the manner by which a prospective contractor may seek such
selection, which may include submission by electronic means;
(b) all reasonable and responsive submissions that are received from
prospective contractors in timely fashion shall be reviewed by the
commissioner; and
(c) the commissioner shall select such contractor or contractors that, in
his or her discretion, are best suited to serve the purposes of this
section.
* NB Effective until 4 years after the date the contract entered into
pursuant this section (365-h) is executed.
* § 365-h. Provision and reimbursement of transportation costs. 1. The local
social services official shall have responsibility for prior authorizing
transportation of eligible persons and for limiting the provision of such
transportation to those recipients and circumstances where such
transportation is essential, medically necessary and appropriate to obtain
medical care, services or supplies otherwise available under this title.
2. In exercising this responsibility, the local social services
official shall:
(a) make appropriate and economical use of transportation resources
available in the district in meeting the anticipated demand for
transportation within the district, including, but not limited to:
transportation generally available free-of-charge to the general public or
specific segments of the general public, public transportation, promotion of
group rides, county vehicles, coordinated transportation, and direct
purchase of services; and
(b) maintain quality assurance mechanisms in order to ensure that (i)only
such transportation as is essential, medically necessary and
appropriate to obtain medical care, services or supplies otherwise
available under this title is provided and (ii) no expenditures for taxi or
livery transportation are made when public transportation or lower cost
transportation is reasonably available to eligible persons.
3. In the event that coordination or other such cost savings measures
are implemented, the commissioner shall assure compliance with
applicable standards governing the safety and quality of transportation of
the population served.
* NB Effective 4 years after the date the contract entered into pursuant
this section (365-h) is executed.

CIVIL SERVICE LAW SECTION 70

§ 70. Transfers. 1. General provisions. Except as provided in subdivisions four and six of this section no employee shall be transferred to a position for which there is required by this chapter or the rules established hereunder an examination involving essential tests or qualifications different from or higher than those required for the position held by such employee. The state and municipal commissions may adopt rules governing transfers between positions in their respective jurisdictions and may also adopt reciprocal rules providing for the transfer of employees from one governmental jurisdiction to another. No employee shall be transferred without his or her consent except as provided in subdivision six of this section or upon the transfer of functions as provided in subdivision two of this section.

2. Transfer of personnel upon transfer of functions. Upon the transfer of a function (a) from one department or agency of the state to another department or agency of the state, or (b) from one department or agency of a civil division of the state to another department or agency of such civil division, or (c) from one civil division of the state to another civil division of the state, or (d) from a civil division of the state to the state, or vice versa, provision shall be made for the transfer of necessary officers and employees who are substantially engaged in the performance of the function to be transferred. As soon as practicable after the adoption of a law, rule, order or other action directing such a transfer of function, but not less than twenty days prior to the effective date of such transfer, the head of the department or agency from which such function is to be transferred shall certify to the head of the department or agency to which such function is to be transferred a list of the names and titles of those employees substantially engaged in the performance of the function to be transferred, and shall cause copies of such certified list to be publicly and conspicuously posted in the offices of the department or agency from which such function is to be transferred, along with copies of this subdivision. Any employee of the department or agency from which such function is to be transferred may, prior to the effective date of such transfer, protest his or her inclusion in or exclusion from such list by giving notice of such protest in writing addressed to the heads of the respective departments or agencies from which and to which transfer is to be made, which notice shall state the reasons for the protest. The head of the department or agency to which such function is to be transferred shall review the protest and after consultation with the head of the department or agency from which such function is to be transferred notify the protestor within ten days from the receipt of such protest of the determination with respect to such protest. Such determination shall be a final administrative determination. Failure to make such protest shall be deemed to constitute consent to inclusion in or exclusion from, as the case may be, the certified list of employees engaged in the function to be transferred. Officers and employees so transferred shall be transferred without further examination or qualification, and shall retain their respective civil service classifications and status. For the purpose of determining the officers and employees holding permanent appointments in competitive class positions to be transferred, such officers and employees shall be selected within each grade of each class of positions in the order of their original appointment, with due regard to the right of preference in retention of disabled and non-disabled veterans. Any employee who fails to respond to or accept a written offer of transfer from the department or agency to which such function is to be transferred within ten days after receipt of such offer shall be deemed to have waived entitlement to such transfer.

CIVIL SERVICE LAW SECTION 70

All officers and employees so transferred shall, thereafter, be subject to the rules of the civil service commission having jurisdiction over the agency to which transfer is made. Officers and employees holding permanent appointments in competitive class positions who are not so transferred shall have their names entered upon an appropriate preferred list for reinstatement to the same or similar positions in the service of the governmental jurisdiction from which transfer is made and in the office or agency to which such function is transferred. Officers and employees transferred to another governmental jurisdiction pursuant to the provisions of this subdivision shall be entitled to full seniority credit for all purposes for service rendered prior to such transfer in the governmental jurisdiction from which transfer is made. Except where such transferred officers and employees are entitled, pursuant to a special law or a rule adopted pursuant to law, to credit upon transfer for their unused vacation or annual leave and sick leave, the officer or body having authority to adopt provisions governing vacation or annual leave and sick leave applicable to the department or agency to which transfer is made may, after giving due consideration to the similarities and differences between the provisions governing vacation or annual leave and sick leave in the respective jurisdictions from which and to which transfer is made, allow employees transferred hereunder credit for all or part of the unused vacation or annual leave and sick leave standing to their credit at the time of transfer, as may be determined equitable, but not in excess of the maximum accumulation permitted in the jurisdiction to which transfer is made. Unused vacation or annual leave not credited by the jurisdiction to which transfer is made may be compensated for to the extent, if any, such compensation is authorized by other law.

4. Transfer and change of title. Notwithstanding the provisions of subdivision one of this section or any other provision of law, any permanent employee in the competitive class who meets all of the requirements for a competitive examination, and is otherwise qualified as determined by the state civil service commission or the municipal civil service commission, as the case may be, shall be eligible for participation in a non-competitive examination in a different position classification, provided, however, that such employee is holding a position in a similar grade.

5. (a) Where, because of economy, consolidation or abolition of functions, curtailment of activities or otherwise, a police department of any county, city, town, village, district, commission, authority or public benefit corporation is dissolved or abolished and the functions of such department are assumed by another police agency by contractual agreement or payment or taxation therefore, the provisions of this section shall apply.

(b) For the purposes of this subdivision:

(1) The term "police agency" shall mean any agency or department of a county, city, town, village, district, commission, authority or public benefit corporation having responsibility for enforcing the criminal laws of the state.

(2) The term "police agency" or "police department" shall not be construed to include the police department of a city of one million or more persons, the police department of a housing authority of a city of one million or more persons, or the police department established pursuant to the provisions of section one thousand two hundred four of the public authorities law.

(Exhibit B)

STATE ADMINISTRATION OF MEDICAID SCHEDULE OF STAKEHOLDER MEETINGS

October 1, 2010 Survey sent to local social services Commissioners.

October 20, 2010 Meetings with associations representing health plans
Attendees: Health Plan Association, Prepaid Health Services Plan Coalition, Blue Cross Plans, United Hospital Fund.

October 28, 2010 Meeting with hospital and long-term care provider associations
Attendees: Hospital Association of NYS (HANYS), Community Health Care Association of NYS (CHCANYS), NYSHFA (NYS Health Facilities Association), NYSHSA (NY Association of Homes and Services for the Aging), HCA (Home Care Association of NYS), HCP (NYS Association of Health Care Providers), GNYHA (Greater NY Hospital Assn.), Iroquois Healthcare Alliance.

October 29, 2010 Meeting with consumer representatives
Attendees: Medicaid Matters NY, Empire Justice, Legal Aid, Center for the Independence of the Disabled in NY, Community Service Society of NY, Children's Defense Fund-NY, New Yorkers for Accessible Health Coverage, Commission on the Public's Health System, NY Immigration Coalition, Self Help Community Services, Inc., Health and Welfare Council of Long Island, Consumer Directed Choices, Inc., United Hospital Fund.

November 4, 2010 Conference call with NYPWA/local social services Commissioner to discuss survey results
Attendees: Local Social Services Commissioners.

November 12, 2010 Meeting with New York State Association of Counties
Attendees: NYSAC Presidential Commission, NYSAC, United Hospital Fund.

(Exhibit C)

SURVEY OF LOCAL DISTRICTS OF SOCIAL SERVICES ON LOCAL ROLES IN MEDICAID ADMINISTRATION

Purpose of Survey:

As you may know, New York State recently enacted legislation to transfer administrative responsibilities of Medicaid to State government. An excerpt from the enacted legislation is below:

> § 47-b. 1. The commissioner of health shall create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts. 2. In developing such a plan, the commissioner of health shall, in consultation with each social services district: (i) define the scope of administrative services performed by social services districts and expenditures related thereto; (ii) require social services districts to provide any information necessary to determine the scope of services currently provided and expenditures related thereto; (iii) review administrative processes and make determinations necessary for the state to assume responsibility for such services; and (iv) establish a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016.

As part of the process of transitioning these responsibilities, the New York State Department of Health is conducting a survey with assistance from the New York State Public Welfare Association of all local departments of social services (LDSS) to gather feedback on how Medicaid related tasks and responsibilities can be transitioned to the State. The Medicaid Institute at the United Hospital Fund and Manatt, Phelps & Phillips are assisting the Department of Health in this effort.

Critical to implementation of the legislative mandate requiring state takeover of Medicaid administration is information gathering. The administration of this survey is an essential first step in the state's comprehensive plan to gather information and insight from all LDSS. This survey focuses on the functions of Medicaid administration (e.g., eligibility, transportation, long-term care, etc.); issues of staffing, logistics, and financing are not part of this survey but will be addressed later in the process.

Your immediate attention to this survey is greatly appreciated. Please submit your completed responses by Friday, October 15th at 5:00 PM.

Name: _____   Title: _____

Name of Agency: _____   County: _____

KEY LDSS ROLES IN MEDICAID ADMINISTRATION

1.) Please provide responses to the questions below for tasks/responsibilities held by your local department of social services (LDSS). Please be specific in your responses.

I. ELIGIBILITY/RENEWAL (COMMUNITY MEDICAID)

2.) Describe the tasks or responsibilities within eligibility/renewal for community Medicaid which should be given priority in the transition to state administration and why.

3.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

4.) Which tasks/responsibilities within eligibility/renewal for community Medicaid present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

5.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency? ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

6.) Task: _____   Type of Agency: _____

7.) Task: _____   Type of Agency: _____

8.) Task: _____   Type of Agency: _____

9.) Task: _____   Type of Agency: _____

II. ELIGIBILITY/RENEWAL (LONG TERM CARE MEDICAID)

10.) Describe the tasks or responsibilities within eligibility/renewal for long term care Medicaid which should be given priority in the transition to state administration and why.

11.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

12.) Which tasks/responsibilities within eligibility/renewal for long term care Medicaid present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

13.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency?   ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

14.) Task: _____ Type of Agency: _____

15.) Task: _____ Type of Agency: _____

16.)Task: _____ Type of Agency: _____

17.) Task: _____ Type of Agency: _____

III. TRANSPORTATION

18.) Describe the tasks or responsibilities within transportation which should be given priority in the transition to state administration and why.

19.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

20.) Which tasks/responsibilities within transportation present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

21.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency?   ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

22.) Task: _____ Type of Agency: _____

23.) Task: _____ Type of Agency: _____

24.) Task: _____ Type of Agency: _____

25.) Task: _____ Type of Agency: _____

IV. PERSONAL CARE AND OTHER COMMUNITY-BASED LTC SERVICES/PROGRAMS

26.) Describe the tasks or responsibilities within personal care and other community-based LTC services which should be given priority in the transition to state administration and why.

27.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

28.) Which tasks/responsibilities within personal care and other community-based LTC services present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

29.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency?   ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

30.) Task: _____   Type of Agency: _____

31.) Task: _____   Type of Agency: _____

32.) Task: _____   Type of Agency: _____

33.) Task: _____   Type of Agency: _____

V. SERVICE DELIVERY (E.G. CASE MANAGEMENT)

34.) Describe the tasks or responsibilities within different areas of service delivery which should be given priority in the transition to state administration and why.

35.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

36.) Which tasks/responsibilities within service delivery present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

37.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency? ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

38.) Task: _____   Type of Agency: _____

39.) Task: _____   Type of Agency: _____

40.) Task: _____   Type of Agency: _____

41.) Task: _____   Type of Agency: _____

VI. RECOVERIES (E.G. THIRD PARTY, ESTATE)

42.) Describe the tasks or responsibilities within recoveries which should be given priority in the transition to state administration and why.

43.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

44.) Which tasks/responsibilities within recoveries present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

45.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency?   ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

46.) Task: _____   Type of Agency: _____

47.) Task: _____   Type of Agency: _____

48.) Task: _____   Type of Agency: _____

49.) Task: _____   Type of Agency: _____

VII. FRAUD AND ABUSE

50.) Describe the tasks or responsibilities within fraud and abuse which should be given priority in the transition to state administration and why.

51.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

52.) Which tasks/responsibilities within fraud and abuse present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

53.) (a) Are any tasks/responsibilities in this program area fully or partially performed by entities outside of your agency?   ( ) Yes   ( ) No

Please list which tasks are handled and by what type of agency.

54.) Task: _____   Type of Agency: _____

55.) Task: _____   Type of Agency: _____

56.) Task: _____   Type of Agency: _____

57.) Task: _____   Type of Agency: _____

VIII. OTHER

58.) Are there other areas of responsibility held by your LDSS related to administration of Medicaid? (You will be able to list up to five.) ( ) Yes   ( ) No

(a) Responsibility (*Describe*)

59.) Describe the tasks or responsibilities within this program area which should be given priority in the transition to state administration and why.

60.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

61.) Which tasks/responsibilities within this program area present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

62.) (b) Responsibility (*Describe*)

63.) Describe the tasks or responsibilities within this program area which should be given priority in the transition to state administration and why.

64.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

65.) Which tasks/responsibilities within this program area present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

66.) (c) Responsibility (*Describe*)

67.) Describe the tasks or responsibilities within this program area which should be given priority in the transition to state administration and why.

68.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

69.) Which tasks/responsibilities within this program area present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

70.) (d) Responsibility (*Describe*)

71.) Describe the tasks or responsibilities within this program area which should be given priority in the transition to state administration and why.

72.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

73.) Which tasks/responsibilities within this program area present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

74.) (e) Responsibility (*Describe*)

75.) Describe the tasks or responsibilities within this program area which should be given priority in the transition to state administration and why.

76.) What implementation steps do you see as key to ensuring the successful transfer of responsibilities described above?

77.) Which tasks/responsibilities within this program area present the most challenges for the state to assume? Please describe implementation steps that may help mitigate these challenges.

2. Describe tasks/responsibilities that require a physical local presence for their effective implementation.

78.) i. Task

79.) Rationale for Physical Local Presence

80.) ii. Task

81.) Rationale for Physical Local Presence

82.) iii. Task

83.) Rationale for Physical Local Presence

84.) iv. Task

85.) Rationale for Physical Local Presence

86.) v. Task

87.) Rationale for Physical Local Presence

Coordination with Other Local Agencies

88.) **3. Does your LDSS collaborate with other local agencies on Medicaid-related tasks (e.g. local Developmental Disabilities Services Organizations, local child care agencies)? (You will be able to list up to five.)** ( ) Yes   ( ) No

List the agency(ies) and describe the nature of the collaboration.

89.) i. Name/Type of Agency

90.) Nature of Collaboration (*Describe*)

91.) How, if at all, would collaboration with other local agencies be affected by the state takeover of Medicaid? (*Describe*)

92.) ii. Name/Type of Agency

93.) Nature of Collaboration (*Describe*)

94.) How, if at all, would collaboration with other local agencies be affected by the state takeover of Medicaid? (*Describe*)

95.) iii. Name/Type of Agency

96.) Nature of Collaboration (*Describe*)

97.) How, if at all, would collaboration with other local agencies be affected by the state takeover of Medicaid? (*Describe*)

98.) iv. Name/Type of Agency

99.) Nature of Collaboration (*Describe*)

100.) How, if at all, would collaboration with other local agencies be affected by the state takeover of Medicaid? (*Describe*)

101.) v. Name/Type of Agency

102.) Nature of Collaboration (*Describe*)

103.) How, if at all, would collaboration with other local agencies be affected by the state takeover of Medicaid? (*Describe*)

Systems Design/Information Technology

4. Describe the information technology systems that facilitate administration of Medicaid that were developed specifically by and/or for your LDSS. (You will be able to list up to five.)

104.) i. Name of System

105.) Relevant Administrative Tasks (e.g. Eligibility/Renewal, etc.)

106.) Key Function(s) of System

107.) Principal Benefit of this System

108.) Principal Challenge of this System

109.) ii. Name of System

110.) Relevant Administrative Tasks (e.g. Eligibility/Renewal, etc.)

111.) Key Function(s) of System

112.) Principal Benefit of this System

113.) Principal Challenge of this System

114.) iii. Name of System

115.) Relevant Administrative Tasks (e.g. Eligibility/Renewal, etc.)

116.) Key Function(s) of System

117.) Principal Benefit of this System

118.) Principal Challenge of this System

119.) iv. Name of System

120.) Relevant Administrative Tasks (e.g. Eligibility/Renewal, etc.)

121.) Key Function(s) of System

122.) Principal Benefit of this System

123.) Principal Challenge of this System

124.) v. Name of System

125.) Relevant Administrative Tasks (e.g. Eligibility/Renewal, etc.)

126.) Key Function(s) of System

127.) Principal Benefit of this System

128.) Principal Challenge of this System

Additional Feedback

129.) Please provide any additional feedback.

Thank you for taking our survey.
Your responses are valuable to this process.

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND
PRESENTATION ON SURVEY RESPONSES

Slide 1

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND

State Takeover of NYS Medicaid Administration:
Findings from a Survey of Departments of Social Services

Melinda Dutton
Manatt, Phelps and Phillips, LLP

Presentation for Findings to NYSDOH
November 15, 2010

Slide 2

Overview

- **Background and Purpose**
- **SDOH Plan and Approach**
- **LDSS Survey Findings**
  - Community Medicaid
  - Long-Term Care Medicaid
  - Personal Care and Community-Based Long-Term Care
- **Appendix**
  - Transportation, Recoveries, Fraud and Abuse
  - Other Medicaid-Related Tasks
  - Coordination with Local Agencies
  - Locally-Derived Technology Systems

Slide 3

Background and Purpose
Statute Mandating State Takeover of Medicaid Administration

Through the Enacted SFY 2010-11 Budget, New York State Legislature mandated that NYS takeover Medicaid administration over a five year period

§ 47-b. 1. The commissioner of health shall create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts.

2. In developing such plan, the commissioner of health shall, in consultation with each social services district:

(i) define the scope of administrative services performed by social services districts and expenditures related thereto;

(ii) require social services districts to provide any information necessary to determine the scope of services currently provided and expenditures related thereto;

(iii) review administrative processes and make determinations necessary for the state to assume responsibility for such services; and

(iv) establish a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016.

Slide 4

SDOH Plan and Approach
Information Gathering and Planning

First Phase

1. Gather and analyze information from local departments of social services (LDSS) on how Medicaid-related tasks and responsibilities can be transitioned to the state
   - Survey distributed via web-based tool to every LDSS
   - Surveys submitted and completed in October 2010
   - Analysis conducted by Manatt, Phelps and Phillips
   - Feedback from discussions with LDSS, NYPWA, NYSAC and other key stakeholders will be integrated into an updated presentation for SDOH

2. Hold meetings with LDSS, NYSAC, NYC Mayor's Office and key stakeholders to gather further input

3. Present initial report to Legislature on November 30 addressing a) overall plan and timeline for implementation of state takeover; and b) any legislation needed to enable transition of responsibilities

Next Phases

1. Compile detailed analysis of finance and staffing issues related to transfer of administrative responsibilities to the state

Throughout the planning process, collaboration with all LDSS, county executives, the NYC Mayor's Office, and key stakeholders will remain a priority

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Slide 5

SDOH-Administered Survey of LDSS
Survey Overview

48 / 58 LDSS responded to survey (83% response rate)

Questions

- Description of tasks and responsibilities within each major focus area (e.g. eligibility, renewal, personal care, transportation) that should be given priority by the state during the transition and rationale
- Implementation steps and challenges associated with transition of each task
- Level of coordination with local agencies on Medicaid-related tasks
- Medicaid-related tasks that require a physical local presence
- Local information systems devised to assist in Medicaid administration

Format

- Open-ended text boxes to encourage detailed feedback

Slide 6

LDSS Survey Findings
Characterization of Responses

Survey responses revealed variation in what made a task a "priority"

1. **LDSS Burden:** tasks that were particularly difficult or burdensome for local districts.

2. **Temporal:** tasks that could most immediately or readily be transferred to the state because they are severable from other local tasks or more likely to be successfully managed at the state level.

3. **State Challenge:** tasks that present the greatest challenge in the overall context of a transfer, frequently because of their large scope or interconnectedness with local district functions.

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND
PRESENTATION ON SURVEY RESPONSES

Community Medicaid
Priority LDSS Tasks to Transition to State Administration

- **Direct Application Assistance (n=19)**: Counties prioritized transfer of direct application assistance and general customer service to state. Coordination with Facilitated Enrollers also listed as key.
  - Four counties suggested focusing on transfer of most time-consuming community Medicaid-related tasks to the state.
  - Four counties noted importance of streamlining and standardizing the eligibility process, including improving coordination between SDOH and OTDA for beneficiaries also receiving public assistance.
  - Two counties expressed strong sentiment for the shift of all Community Medicaid responsibilities at once to the state, rather than a phased task transfer.
  - One county stated that no tasks related to Community Medicaid should be transferred to the state.

Several counties cited concerns about potential disruptions in coverage during task transfer.

Community Medicaid
Priority LDSS Tasks to Transition to State Administration

- **Application Assistance and Management for Special Populations (n=9)** LDSS report that Spend-Down applicants/beneficiaries as well as Medicaid-SSI enrollees should be transferred to the state, due to their time-consuming nature.
- **Applications for Discrete Programs (n=11):** Applications including those for Medicare Savings, Family Planning Benefit Program, Family Health Plus Premium Assistance, Prenatal Care Assistance Program suggested as high priority.
  - Five counties recommended the transfer of application assistance / processing for the discrete programs listed above because they are simpler and more likely to be successfully completed at the state level.
  - Two counties noted application assistance for discrete programs such as Medicare Savings, Family Planning Benefit Program, and Medicaid Buy-In for Working Disabled are more time-consuming and distract staff from general Community Medicaid responsibilities, and thus should be transferred.
  - Coordination with public assistance programs cited by three counties as imperative to successful task transfer.

Community Medicaid
Priority LDSS Tasks to Transition to State Administration

- **Documentation Checking and Income Verification (n=10)**: Documentation checking and income verification prioritized, noting significant challenges, given its time-consuming nature and complexity.
- **Recertification (n=10)**: Counties noted recertification should be a task assumed by the state.
- **Case Transfers (n=8)**: Tasks including transfers from Medicaid to Child Health Plus, fee for service to managed care, and county to county transfers, were prioritized, with some noting they could easily be assumed by the state.
- **Undercare (n=4)**: Counties prioritized assumption of overall undercare for transfer, including a particular focus on SSI enrollees.

Community Medicaid
Recommended Implementation Steps to Aid Transfer

General Feedback
- Delineate clear roles and responsibilities among state and LDSS (n=9)
- Notify applicants and providers of process changes (n=7)
- Ensure adequately trained staff (n=6)
- Maintain local presence for discrete tasks e.g. communication for applicants without access to phone / email, assistance for Spend-Down enrollees (n=5)
- Phase in assumption of tasks by geographic area (n=2)
- Designate an LDSS contact person in each county to assist in planning / task transfer (n=1)
- Maximize use of electronic systems for task completion (n=1)

Task-Specific Recommendations
- Streamline eligibility / recertification process and documentation requirements (n=5)
- Align documentation / verification requirements between Medicaid and public assistance requirements and ensure concrete communication and procedure guidelines regarding Medicaid beneficiaries that also receive public assistance (n=1)
- Standardized training of outstation workers (n=1)

Community Medicaid
Most Challenging Tasks to Transfer

- Customer service / follow up on incomplete applications (n=15)
  - *Recommendations*
    - *Maintain local presence for this function*
    - *Standardized training to outreach workers across the state*
    - *Ensure language assistance is available to applicants / beneficiaries*
- Management of / payment collections from Spend-Down enrollees (n=10)
  - *Recommendation: Develop specific staff expertise and knowledge of procedures related to these tasks*
- Issuing temporary / replacement Medicaid cards (n=4)
  - *Recommendation: Maintain local presence for this function*
- Follow up on late renewals (n=3)
  - *Recommendation: Maintain local presence for this function*

Community Medicaid
Most Challenging Tasks to Transfer

- Child support assistance (n=3)
  - *Recommendation: Maintain local presence for this function*
- Referrals to local services (ongoing and in emergency situations) (n=2)
  - *Recommendation: Maintain local presence for this function*
- Income verification (n=2)
  - *Recommendation: Ensure access to electronic income verification tools*
- Language assistance to beneficiaries (n=2)
  - *Recommendation: Maintain local presence for this function*

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND PRESENTATION ON SURVEY RESPONSES

Long-Term Care Medicaid
Priority LDSS Tasks to Transition to State Administration

- ***Income / Asset Verification and Eligibility Determination (n=25)***: Counties prioritized transfer this task to the state, often due to its time-consuming nature.
  - Six counties noted that state takeover presented an opportunity to standardize long-term care eligibility determination and develop procedures through which beneficiaries can "seamlessly" transition across programs and provider settings, when needed.
  - Three counties expressed strong sentiment that all tasks related to long-term care Medicaid should be transferred altogether, rather than through a phased-in approach.
  - Two counties stated that no long-term care Medicaid tasks should be transferred to the state.
  - Two counties stressed that one case worker should be wholly responsible for one case, as opposed to multiple staff handling the same case.

Long-Term Care Medicaid
Priority LDSS Tasks to Transition to State Administration

- ***Application Assistance for Beneficiaries (n=19)***: Districts cited communication with beneficiaries regarding programs and direct provision of application assistance should be a priority.
  - Two counties suggested particular attention be paid to those that do not have health care proxies.
  - One county recommended that the state develop agreements with local providers to deliver direct application assistance to long-term care Medicaid applicants, in lieu of the state or LDSS.
- ***Recertification (n=8)***: Eight LDSS prioritized recertification for assumption by the state.
- ***Handling Spousal Refusal Cases (n=4)***: Counties noted the time-consuming nature of this task renders it a high priority for transfer to the state.

Long-Term Care Medicaid
Recommended Implementation Steps to Aid Transfer

General Feedback
- Establish close working relationship with hospitals, nursing homes, and community-based organizations during and after task transfer (n=23)
- Ensure adequately trained staff, with specific expertise in budgeting and resource verification (n=13)
- Maintain local presence for discrete tasks e.g. to ensure accessibility for target population (n=8)
- Delineate clear and well-communicated roles and responsibilities among state and LDSS (n=8)

Task-Specific Recommendations
- Standardize application process across state (n=6)
- Maintain strong legal support (at state and/or local level) (n=2)

Long-Term Care Medicaid
Most Challenging Tasks to Transfer

- Eligibility determination and full resource verification (n=19)
- *Recommendations*
  - *Maintain local presence for this function*
  - *Increase electronic access to financial institutional information*
  - *Build relationships with local nursing homes*
  - *Ensure adequately trained staff that can develop relationships with local providers*
  - *Maintain working relationship with NY Connects*
- Provision of application assistance to elderly and the disabled (n=10)
  - *Recommendations: Maintain local presence for this function*

Several counties raised that local presence is critical to supporting application assistance and meeting emergency and safety needs of Long-Term Care Medicaid enrollees

Long-Term Care Medicaid
Most Challenging Tasks to Transfer

- Establishing relationships with local long-term care providers (n=7)
- Gathering required documentation (n=5)
- Establishing working relationships with local attorneys (n=4)
- Calculating penalty rate for asset transfers (n=2)
  - *Recommendation: Develop one statewide penalty rate*
- Participation in local fair hearings (n=2)

Personal Care
Priority LDSS Tasks to Transition to State Administration

- ***Assessments and Approvals (n=24)***: Counties prioritized transfer of medical and social assessments and approvals for personal care, Long Term Home Health Care Program, Assisted Living Program and private duty nursing to state. Included in these tasks are obtaining physicians' orders.
  - Seven counties recommend that the state standardize the assessment process to triage beneficiaries and assign them to the appropriate program e.g. personal care, Managed Long-Term Care, Assisted Living Programs, etc.
  - Four counties expect no efficiency gains in the transfer of personal care and community-based long-term care functions to the state.
  - Three counties stressed the importance of devising protocols for the state to evaluate quality and outcomes of care delivered to this population.
  - Three counties suggested that tracking mechanisms be set up statewide to monitor the transition of beneficiaries across programs.

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND PRESENTATION ON SURVEY RESPONSES

Personal Care
Priority LDSS Tasks to Transition to State Administration

- **Home Visits, Case Management and Monitoring Safety of Clients (n=9)**: Many counties stated that a local presence was needed for these functions.
  - Knowledge of community-based resources and providers cited as essential to the successful handling of these tasks.
- **Contracting / Coordination with Providers (n=7)**: Some counties indicated that this function could be transferred to the state relatively seamlessly.
- **Referrals (n=4)**: This was viewed as interconnected to contracting and provider coordination role.
- **Coordinate / Advance Participation in Consumer-Directed Personal Assistance Program (CDPAP) (n=3)**: Counties cited a need to develop specific regulations related to the CDPAP program to enable access to this program.

Personal Care
Recommended Implementation Steps to Aid Transfer

General Feedback
- Maintain a local presence to assist in these tasks (n=7)
- Ensure adequately trained staff (n=6)
- Designate an LDSS contact person in each county to assist in planning / task transfer (n=4)

Task-Specific Recommendations
- Deliver staff training on coordination of personal care assessments (n=1)

Personal Care
Most Challenging Tasks to Transfer

- Coordinating personal care assessments (n=9)
- Initial and ongoing home visits / level of care changes (n=6)
- Case management for personal care recipients (n=5)
- Addressing adult protective / safety issues (n=2)
- Maintaining knowledge of / working relationship with local providers (n=4)

Limited implementation steps recommended by LDSS to mitigate challenges of task transfers related to personal care.

Summary

- Counties are concerned about delays and disruptions of services as tasks are transferred to the state.
- Counties are concerned about the severability of administrative tasks, both from other aspects of Medicaid administration and from other local social services functions.
  - Many emphasized the need to ensure coordination between the state and local districts throughout the transfer process.
  - Some recommended a one-time transfer of tasks to the state, rather than a phased-in approach.
- Challenging tasks identified by counties included customer assistance, relationship building with local providers, and referral to local services.
  - Counties highlighted the importance of maintaining a local presence in the transition of these responsibilities.
- Keys to successful task transfer, as recommended by counties, include:
  - Adequate training of staff assuming transferred tasks
  - Maintenance of local presence to assist and drive distinct functions, mostly related to long-term care beneficiaries
  - Strong, working relationships with local providers and knowledge of community-based resources
  - Standardization of key processes to ensure efficiency and accountability
  - Delineation and communication of clear roles among state and local districts during and after transition to state takeover
  - Detailed procedures to meet emergency needs of Medicaid beneficiaries during transition of tasks to state
  - Ongoing education to beneficiaries and local providers during and after transition of tasks

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Appendix

Additional Summary Information

Transportation
Priority LDSS Tasks to Transition to State Administration

Significant Support
- Prior approval / scheduling of transportation services (n=29)
- Contracting with local providers (n=7)
- Rate setting (n=5)

Additional Recommendations
- Coordinating non-emergency transportation and transportation for special populations (e.g. dialysis patients, TBI patients) (n=4)
- Reimbursement of beneficiaries for out of pocket expenses (n=4)
- Coordinating volunteer drivers (n=3)

Several counties noted that the "localness" of these tasks may hamper the successful transfer of transportation-related responsibilities to the state.

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND
PRESENTATION ON SURVEY RESPONSES

Transportation
Recommended Implementation Steps to Aid Transfer

General Feedback
- Manage vendor contracts (n=7)
- Educate enrollees and families of process changes e.g. state takeover of tasks (n=6)
- Standardize transportation request policies statewide (n=4)
- Build relationships with local health care providers and educate them on process changes (n=4)
- Develop specific knowledge of local transportation options and routes (n=3)
- Develop specific policies and procedures to coordinate transportation for individuals that cross counties (n=3)
- Ensure local presence / coordination (n=3)

Task-Specific Recommendations
- Delegate more authority to providers to approve transportation services (n=1)
- Develop standardized rate for non-emergency transportation across populations (n=1)

Transportation
Most Challenging Tasks to Transfer

- Prior approval of transportation services (n=13)
  - *Recommendations*
    - *Ensure continuous local involvement during the transition of tasks*
    - *Standardize request forms and procedures across the state*
    - *Contract directly with vendors*
    - *Automate prior approval process*
- Knowledge of local resources / Relationships with local providers (n=8)
  - *Recommendations*
    - *Build strong relationships and communicate regularly with local providers*
    - *Designate local liaison*
- Determining most cost-effective method of local transportation (n=6)
- Vendor fraud prevention (n=5)

Recoveries

Recommendations for Priority Transfer of Tasks
- Estate recoveries (n=12)
- Property liens (n=10)
- Personal injury lawsuits (n=8)
- Third party health insurance payment recovery (n=6)
- Spousal refusal legal actions (n=3)
- Information retrieval from local Surrogate Courts (n=3)

Recommended Implementation Steps to Aid Transfer
- Coordinate with local Surrogate Courts to obtain information to aid estate recoveries (n=4)
- Regularly research death notices of Medicaid recipients (n=4)
- Coordinate with local attorneys (n=3)
- Use electronic systems to update and finalize liens and track lien statuses (n=3)
- Build relationships with local nursing homes (n=3)

Recoveries

Most Challenging Tasks to Transfer
- Timely information retrieval from public sources, courts, and providers to aid all tasks e.g. estate recoveries, liens, etc. (n=21)
  - *Recommendations*
    - *Build working relationships with local providers to assist in information retrieval*
    - *Ensure communication mechanisms to retrieve timely information from local Surrogate Courts*
- Third party health insurance payment retrieval (n=2)

Fraud and Abuse

Recommendations for Priority Transfer of Tasks
- Preventing and investigating beneficiary fraud (n=7)
- Providing referrals of suspected fraud cases to the Office of the Medicaid Inspector General (OMIG) (n=3)
- Investigating provider fraud and handling complaints (n=1)

Recommended Implementation Steps to Aid Transfer
- Ensure adequate staff and training (n=3)
- Develop relationships with local law enforcement / District Attorneys (n=3)
- Maintain local presence to ensure coordination of resources (n=3)

Fraud and Abuse

Most Challenging Tasks to Transfer
- Investigation of fraud and abuse (n=6)
  - *Recommendations*
    - *Ensure adequately trained staff*
    - *Build working relationship with local law enforcement*
- Ensuring timeliness of referrals and investigation (n=5)
  - *Recommendations*
    - *Build working relationship with local law enforcement*
    - *Educate public officials and providers on fraud and abuse issues*
- Obtaining necessary case information (n=4)
  - *Recommendation*
    - *Build working relationship with local law enforcement and providers*

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND
PRESENTATION ON SURVEY RESPONSES

Service Delivery

Recommendations for Priority Transfer of Tasks
- Coordination of support services e.g. mental health, housing (n=3)
- Case management services for long-term care recipients (n=3)
- Oversight / contract with case management agencies (n=3)

Recommended Implementation Steps to Aid Transfer
- Ensure local presence and trained staff knowledgeable of key service needs of beneficiaries (n=5)
- Build relationships with local providers and ensure clear communication to prevent disruption in services (n=3)

Most Challenging Tasks to Transfer
- Case management (n=4)
  - *Recommendation: Early identification of cases that require early intervention / service coordination*

Other Medicaid-Related Tasks
Priority LDSS Tasks to Transition to State Administration

- Fair hearing participation (n=5)
- Education on managed care (n=4)
- Determining cost effectiveness for Family Health Plus Premium Assistance Program participation (n=1)
- Resolving billing problems with local providers (n=1)
- Disability determination reviews (n=1)
- Management of duplicate Client Identification Numbers (n=1)

Tasks Requiring a Physical Local Presence
Tasks and Rationale

- Application assistance / General customer service (n=16)
- Assessments for long-term care recipients (n=8)
- Assistance for enrollees of Medicaid Spend-Down program (n=8)
- Fraud and abuse prevention / investigation (n=4)
- Issuance of temporary / replacement Medicaid cards (n=10)
- Fair hearing participation (n=9)
- Undercare (n=4)
- Processing emergency Medicaid applications / meeting emergency needs of Medicaid beneficiaries (n=4)
- Oversight of managed care plan marketing (n=2)
- Maintaining working relationships with local providers (n=2)

Community Medicaid
Tasks Handled by Outside Agency

Task	Type of Agency
Application Assistance	• *Facilitated Enrollers through* Community-based organizations and Managed Care plans • Planned Parenthood Clinics • Prenatal Care Assistance Program (PCAP) sites • Hospitals, Federally qualified health centers (Outstation workers) • Office for Aging • ARC (Medicaid HCBS Waivers)
Managed Care Education	• Local agencies • Enrollment broker
Fair Hearing Representations	Legal services agency

Long-Term Care Medicaid
Tasks Handled by Outside Agency

Task	Type of Agency
Application Assistance	• County Department of Aging • Nursing homes • Local community-based agencies • Licensed Home Care Services Agency (LHCSA) • Certified Home Health Agency (CHHA)
Home Visits / Casework	• Adult Protective Services • County Public Health Department • Office of the Aging
Assessments	• CHHAs / LHCSAs • Hospitals
Spend-Down Payment Collection	Hospitals
Referrals	Office of Aging
Case Management	Community-based agencies
Burial Application / Assistance	Local funeral homes

Personal Care
Tasks Handled by Outside Agency

Task	Type of Agency
Assessments for Personal Care and Long Term Home Health Care Program	• Certified Home Health Agencies • CASAs • County Health Departments • Local hospitals • Local community-based agencies
Case Management	Hospitals
Coordination of PERS	Local agency
Training / Background Check of Personal Care Aides	Certified Home Health Agencies Licensed Home Care Services Agency

MEDICAID INSTITUTE AT UNITED HOSPITAL FUND
PRESENTATION ON SURVEY RESPONSES

Transportation
Tasks Handled by Outside Agency

Task	Type of Agency
Prior Approval	• Local agencies • Local health care providers
Management / Coordination of Transportation Services	• Third party broker
Transportation Services for Special Populations	• County VA services (Veterans) • Managed care clients (Managed care plans) • Scheduling (County call center) • Seriously mentally ill patients (County Department of Health)

Service Delivery
Tasks Handled by Outside Agency

Task	Type of Agency
Case Management (including eligibility)	• County Health Department • Local hospitals • Local agencies
Traumatic Brain Injury / Nursing Home Transition and Diversion Waiver Screening / Service Coordination	• Local Regional Resource Development Centers (RRDCs)
Residence cleaning / pest examination	• Adult Protective Services

Recoveries
Tasks Handled by Outside Agency

Task	Type of Agency
Recoveries	• Legal services
Information Retrieval on Personal Injury and Malpractice Claims	• Local comptrollers' office • Local public hospital

Fraud and Abuse
Tasks Handled by Outside Agency

Task	Type of Agency
Investigation	• County Sheriff • District Attorneys • Local agencies
Self-Employment Cases	• Local agencies
Provider Audits	• IPRO • OMIG

Coordination with Local Agencies
Types of Agencies and Nature of Collaboration

Task	Type of Agency
Application Assistance	• Hospitals • Nursing Homes • Federally-Qualified Health Centers • Community-Based Organizations • Office for Aging
Referrals	• Developmental Disabilities Services Organizations (DDSOs)
Coordination of Services for Foster Care Children, Early Intervention Program	• Local government agencies
Coordination of Services for Mentally Ill Patients	• County Health Departments • Local Agencies • Local Substance Abuse and Mental Health Clinics
Monitoring Safety Issues	• Adult Protective Services
Enrollment / Service Coordination of Nursing Home Transition and Diversion and TBI Waivers	• Regional Resource Development Centers

Coordination with Local Agencies
Types of Agencies and Nature of Collaboration

Task	Type of Agency
Long Term Care Enrollment / Placement	• CASA
Presumptive Eligibility for Children	• Federally-Qualified Health Centers
Burials and Related Billings	• Local funeral homes
Training and Monitoring Managed Care Plans	• County Public Health Departments
Advocacy for Disabled Individuals	• Legal Services

(Exhibit E)

NEW YORK STATE MEDICAID ELIGIBLES AS OF DECEMBER 2009

Source: NYS/DOH/OHIP Data Mart (claims paid through 09/10)

County code	County	Eligibles
	Total:	4,639,412
01	ALBANY	42,978
02	ALLEGANY	9,177
03	BROOME	39,049
04	CATTARAUGUS	15,218
05	CAYUGA	13,523
06	CHAUTAUQUA	30,595
07	CHEMUNG	19,705
08	CHENANGO	11,140
09	CLINTON	15,692
10	COLUMBIA	8,942
11	CORTLAND	9,754
12	DELAWARE	8,075
13	DUTCHESS	29,122
14	ERIE	165,696
15	ESSEX	6,016
16	FRANKLIN	9,448
17	FULTON	13,050
18	GENESEE	8,738
19	GREENE	8,150
20	HAMILTON	583
21	HERKIMER	12,925
22	JEFFERSON	19,316
23	LEWIS	4,754
24	LIVINGSTON	8,587
25	MADISON	10,823
26	MONROE	132,676
27	MONTGOMERY	11,709
28	NASSAU	124,146
29	NIAGARA	38,427
30	ONEIDA	48,837

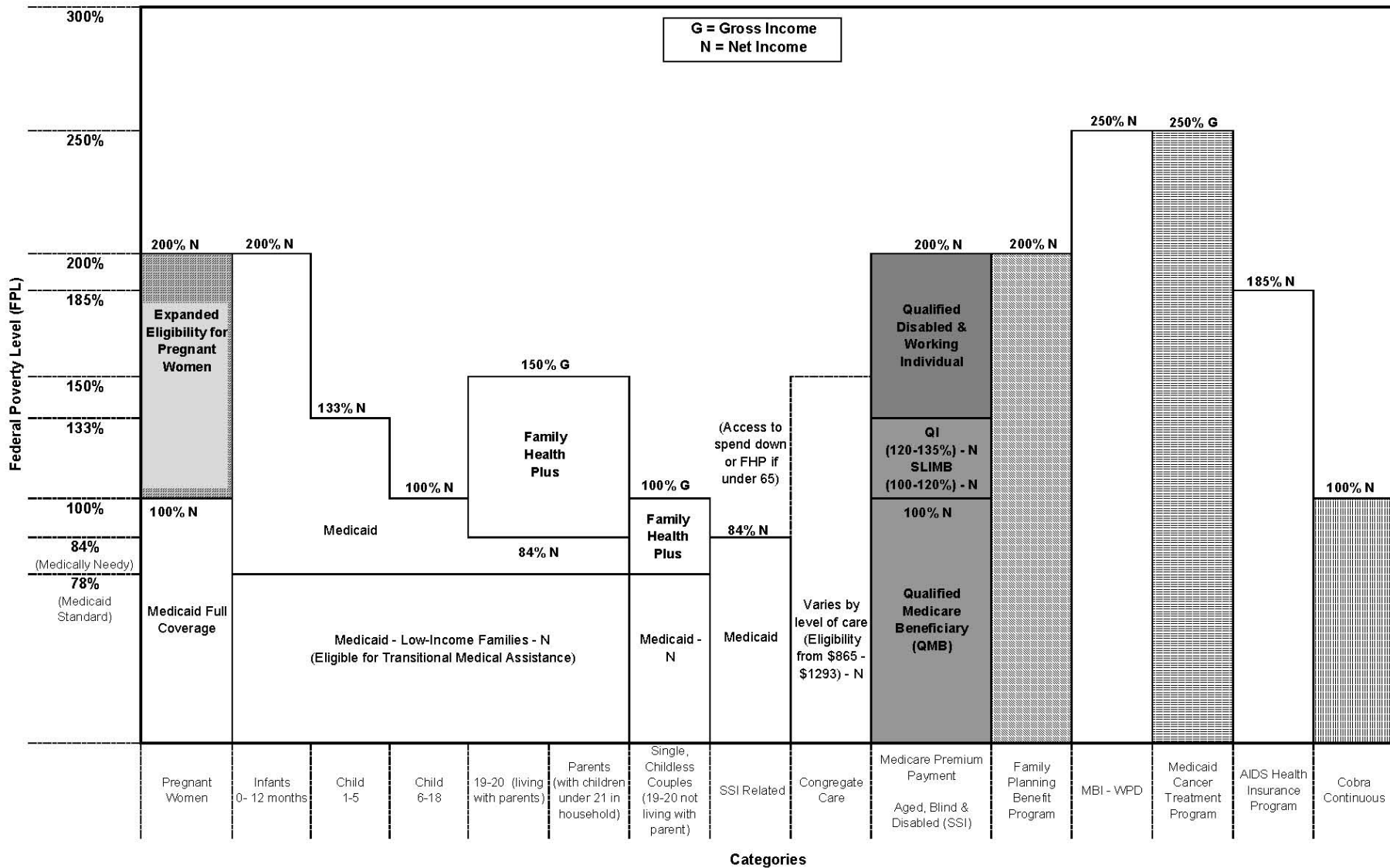| County code	County	Eligibles
31	ONONDAGA	78,824
32	ONTARIO	13,200
33	ORANGE	59,683
34	ORLEANS	8,042
35	OSWEGO	25,565
36	OTSEGO	9,528
37	PUTNAM	5,586
38	RENSSELAER	24,277
39	ROCKLAND	57,785
40	SAINT LAWRENCE	21,941
41	SARATOGA	20,836
42	SCHENECTADY	25,823
43	SCHOHARIE	5,011
44	SCHUYLER	3,464
45	SENECA	5,116
46	STEUBEN	17,883
47	SUFFOLK	160,201
48	SULLIVAN	14,974
49	TIOGA	8,431
50	TOMPKINS	11,789
51	ULSTER	25,244
52	WARREN	9,373
53	WASHINGTON	10,451
54	WAYNE	13,347
55	WESTCHESTER	117,273
56	WYOMING	5,242
57	YATES	4,218
66	NEW YORK CITY	2,978,284
97	NYS OMH	4,229
98	NYS OMR	12,564
99	NYS DOH	2
00	NO COUNTY CODE	4,375

(Exhibit F)

New York State Medicaid Utilization by Category of Service: Calendar Year 2009

Source: NYS/DOH/OHIP Data Mart (claims paid through 09/10)

Category of service	Dollars	Claims	Recipients
Total:	**$46,324,617,163**	**216,795,462**	**4,902,518**
Physicians	389,288,277	16,210,339	1,105,014
Psychology	19,344,038	435,350	27,665
Eye Care	16,285,947	930,227	230,130
Nursing Services	181,710,213	793,484	9,621
OPD Clinics	1,335,227,605	7,903,127	1,089,205
ER	201,293,820	960,678	1,769,488
FS Clinics	1,428,858,459	12,006,873	915,771
OMH Clinics	56,376,850	172,035	8,007
OMR Clinics	1,293,052	14,867	2,868
SSHSP	140,173,188	625,987	65,333
Early Intervention	293,005,758	3,259,369	45,825
Inpatient	5,948,410,411	3,910,633	660,671
OMH Inpatient	242,706,169	245,833	2,533
OMR Inpatient	2,413,554,324	669,025	2,062
SNF	6,395,372,830	29,857,504	130,539
RTF	100,450,208	484,608	2,788
Dental	453,863,993	5,575,522	910,546
Pharmacy	4,377,146,034	59,708,493	3,448,782
Non-Institutional LTC	4,389,895,676	32,517,423	169,281
Personal Care	2,235,042,783	16,886,266	75,095
Home Health Care	1,362,219,772	7,782,036	86,722
LTHHC	701,605,151	6,925,159	26,659
ALP	86,826,549	767,370	4,751
PERS Device	4,201,420	156,592	17,099
Laboratories	39,312,028	2,975,126	360,431
Transportation	378,345,776	7,024,874	339,694
HMO	8,393,235,316	30,385,888	3,281,397
CTHP	26,095,026	542,722	198,555
DME and Hearing Aid	200,076,274	3,380,578	292,428
Child Care	121,907,611	6,848,375	30,195
FHP	1,071,238,242	4,760,986	615,417
Referred Ambulatory	108,575,464	1,110,972	276,670
ICF-DD	961,800,905	2,382,550	8,939
Hospice	119,388,980	35,965	8,144
Community/Rehab Services	5,729,707,383	11,944,524	88,429
Case Management	462,090,794	2,545,193	171,388

(Exhibit G)
New York State Medicaid Programs

New York State Medicaid Application Process

NEW YORK STATE MEDICAID APPLICATION PROCESS

- APP Received screened
  - FE
  - QE
  - PCAP Provider
  - Client Rep
  - Consumer at Medicaid office
- Case assigned by Caseload or Supervisor
- Clerk/ES/Examiner Register Application TAD & Clearance Report generated Triggers RFI
- Case file prepared
- ES/Examiner reviews clearance report for current/prior WMS involvement and reviews application &supporting documentation
- Missing documents
  - No → Response from RFI (3 days) Review and Resolve RFI if necessary → Calculate + Store budget → ES/Examiner determines eligibility
  - Yes → Defer case deferral notice sent/ documentation check list given (10-14 days to respond) → Documents returned?
    - Yes → (back to ES/Examiner reviews clearance report)
    - NO → Case rejected Notice generated/sent → Appropriate case Documents filed/Imaged (Imaging takes 7 days)

- If appropriate ES/Examiner annotates TAD + Manual notice prepared (if necessary)
- ES/Examiner prepares docs/files for supervisor review
- Supervisor reviews case
- Supervisory sign off?
  - No → Return back to worker for correction → Worker makes correction → (back to Supervisor reviews case)
  - Yes → Data entry If required → Batch Transmission → Success in Host Processing? (Overnight)
    - No → WMS error report Back to worker for error correction → ES/Examiner makes corrections → (back to Data entry)
    - Yes → Consumer eligible?
      - No → Case rejected Notice generated/sent
      - Yes → Notice generated/sent Coverage authorized for 12 months Card issued** → If TPHI, enter In EMEDNY → Appropriate case Documents filed/Imaged (Imaging takes 7 days)

Legend:
- Start & outcomes
- Steps in process
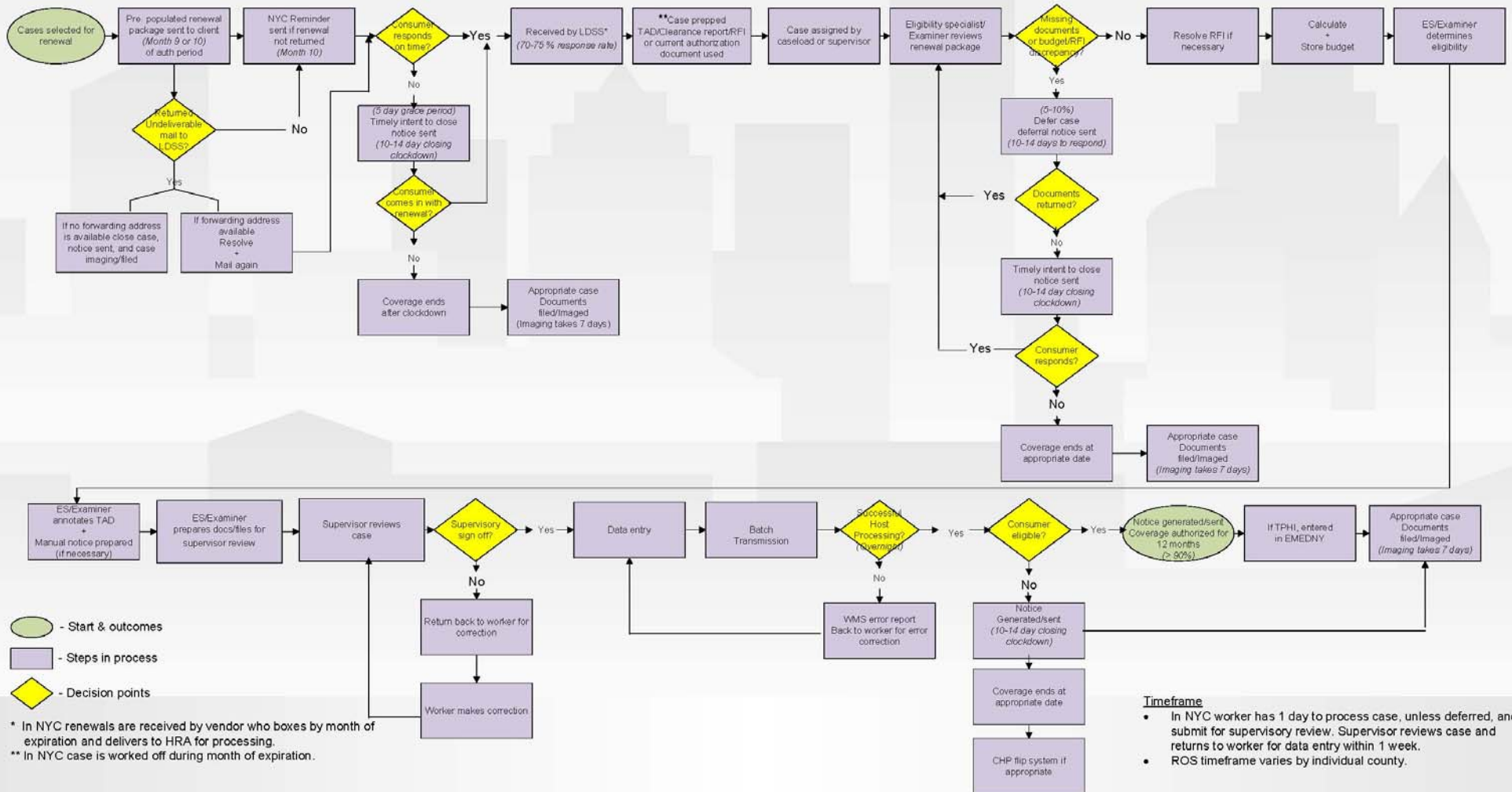- Decision points

* 30 days allowed to make determination
**If in mandatory or voluntary county referred for managed care enrollment

(Exhibit I)
New York State Medicaid Renewal Process

NEW YORK STATE MEDICAID RENEWAL PROCESS

(Exhibit J)

MANDATORY MEDICAID MANAGED CARE ENROLLMENT – SEPTEMBER 2010

Counties Using Enrollment Broker

COUNTY	MEDICAID	FHPLUS	TOTAL
Albany	23,904	2,870	26,774
Cayuga	1,003	1,008	2,111
Dutchess	16,025	2,481	18,506
Fulton	7,212	1,052	8,264
Madison	702	935	1,637
Montgomery	7,231	1,111	8,342
Nassau	70,014	14,209	84,223
Orange	38,209	4,051	42,260
Otsego	4,641	861	5,502
Putnam	2,283	488	2,771
Schenectady	14,270	1,724	15,994
Schoharie	470	527	997
Suffolk	90,101	16,532	106,633
Sullivan	8,518	1,331	9,849
Tompkins	3,937	722	4,659
Ulster	13,637	2,339	15,976
Washington	5,137	810	5,947
Wayne	4,228	1,087	5,315
Westchester	68,379	9,839	78,218
New York City	1,956,687	253,042	2,209,729
TOTALS	**2,336,821**	**318,080**	**2,655,001**
STATEWIDE TOTAL	**2,817,384**	**386,220**	**3,203,704**

(Exhibit K)

MEDICAID TRANSPORTATION MANAGEMENT INITIATIVE ROLL-OUT PLAN SCHEDULE

HUDSON VALLEY REGION

November 2010 Hudson Valley Funding Availability Solicitation procurement document is posted on Department Web site to solicit offers from transportation management companies.

December 2010 Proposals are due to the Department.

January 2011 The contractor(s), will be selected after all responses have been reviewed.

February 2011 Albany, Colombia, Greene, Orange, Rockland, Sullivan and Ulster counties.

April 2011 Westchester and Putnam counties.

May 2011 Fulton, Montgomery, Washington and Warren counties.

NEW YORK CITY

November 2010 New York City Funding Availability Solicitation procurement document is posted on the Department Web site to solicit offers from transportation management companies.

January 2011 Proposals are due to the Department.

February 2011 The contractor(s), will be selected after all responses have been reviewed.

April 2011 Full transportation management in Borough of Brooklyn. The transportation manager implements a call center and begins call center operation, assesses current processes of large volume orderers of Medicaid transportation, identifies inefficient transactions, conveys policy expectations and simultaneously creates infrastructure necessary to implement efficiencies.

July 2011 Full transportation management in Boroughs of Queens and Staten Island.

October 2011 Full transportation management in Boroughs of Manhattan and Bronx.

MEDICAID TRANSPORTATION MANAGEMENT INITIATIVE ROLL-OUT PLAN SCHEDULE

REST OF STATE

July 2011

All counties in the four regions, including those currently under contract with a county transportation manager, will be canvassed concerning their interest in participating in a state regional transportation management initiative.

December 2011

A Funding Availability Solicitation will be posted on the Department Web site to procure a transportation manager or managers for the four regions. Solicitation will invite proposals to manage any or all of the four regions.

February 2012

Proposals are due to the Department from interested transportation management companies.

April 2012

The contractor(s), for the four regions will be selected after all responses to the procurement offering have been carefully reviewed.

(Exhibit L)
Local Share of Medicaid Worksheet

LOCAL SHARE OF MEDICAID 2005 - 2010

LOCAL SHARE WITH STATUTORY CAPS

		FISCAL YEAR				
		2005-06 (a)	2006-07	2007-08 (b)	2008-09 (c)	2009-10 (c)
	TOTAL	6,132,541,731	$6,348,620,940	$6,503,012,386	$6,562,361,814	6,740,525,483
	NYC	4,319,780,220	$4,472,686,303	$4,609,359,162	4,737,992,441	4,866,625,720
	ROS	1,812,761,518	$1,875,934,637	$1,893,653,224	$1,824,369,373	1,873,899,763

LOCAL SHARE WITHOUT STATUTORY CAPS

		FISCAL YEAR				
		2005-06	2006-07	2007-08 (b)	2008-09 (c)	2009-10 (c)
WITHOUT FMAP	TOTAL	6,114,199,180	$6,546,401,220	$6,628,633,512	$6,676,164,241	7,655,152,657
	NYC	4,309,436,012	$4,565,367,572	$4,652,206,326	4,706,725,538	5,382,159,189
	ROS	1,804,763,174	$1,981,033,648	$1,976,427,187	$1,969,438,704	2,272,993,467

LOCAL SAVINGS RESULTING FROM CAP

		FISCAL YEAR				
		2005-06 (a)	2006-07	2007-08 (b)	2008-09 (c)	2009-10 (c)
	TOTAL	3,259,174	198,386,855	127,902,035	147,542,110	
	NYC	0	92,681,269	42,847,164	0	515,533,470
	ROS	3,259,174	105,705,586	85,054,872	147,542,110	399,093,704

COUNTY BENEFIT FROM ENHANCED FMAP

		FISCAL YEAR				
		2005-06	2006-07	2007-08 (b)	2008-09	2009-10
FMAP EARNED	TOTAL	N/A	N/A	N/A	526,695,137	1,378,194,771
	NYC				365,006,820	967,397,937
	ROS				161,688,317	410,796,834

FOOTNOTES:

(a) LOCAL SHARE CAP WAS STARTED JAN 1, 2006.

(b) MONROE CO. ELECTED THE SALES TAX INTERCEPT OPTION EFFECTIVE JAN. 1, 2008. MONROE IS ONLY RECONCILED FOR APR.-DEC. IN SFY 07-08 AND DOES NOT RECEIVE A CAP RECONCILIATION THEREAFTER.

(c) NOT INCLUDING MONROE CO.

(d) MONROE CO. DOES RECEIVE AN FMAP BENEFIT.

(e) DETAIL MAY NOT ADD TO TOTAL DUE TO ROUNDING.