

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

“Revisioning” Medicaid as Part of New York’s Coverage Continuum

About the Medicaid Institute at United Hospital Fund

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

About United Hospital Fund

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, health centers, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

Medicaid Institute at United Hospital Fund

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Introduction: A New Vision for Medicaid in New York

Medicaid provides health insurance coverage for 4.8 million New Yorkers, more than 25 percent of people residing in the state.¹ With the implementation of federal reform in 2014, perhaps as many as 1 million additional New Yorkers will secure coverage through Medicaid.² By any measure, Medicaid is an important building block of health insurance coverage in New York State.

New York's commitment to maximizing coverage through government insurance programs is long-standing, and the State has made steady progress over the last decade in both reducing the numbers of uninsured New Yorkers and filling the gaps in eroding employer-sponsored coverage. New York is one of only five states in the country that provide Medicaid coverage to childless adults and the *only* state to subsidize coverage for children in families with incomes up to 400 percent of the federal poverty level (FPL). Building on the facilitated enrollment program³ initiated in 2000, New York began a multi-year effort in 2007 to reach and enroll New Yorkers eligible for Medicaid, Family Health Plus (Medicaid for adults with incomes just above traditional Medicaid levels), and the Children's Health Insurance Program. Despite these efforts, 1 million uninsured New Yorkers are eligible for public health insurance programs but not enrolled.⁴ Even with streamlining eligibility and enrollment rules for Medicaid and redoubling outreach efforts, New York has not been able to fully extricate it from its welfare roots or eliminate perceived and actual barriers to obtaining and maintaining coverage.

Now, with the Affordable Care Act of 2010 (ACA), a new vision for health insurance coverage in the United States is being advanced, bolstered by significant funding to implement that vision. National health care reform is predicated on the principle that health insurance be accessible, affordable, and stable for all Americans.

To achieve near-universal coverage, the ACA lays out the parameters of a new health insurance infrastructure for low- and moderate-income Americans, those least likely to have employer-sponsored coverage. At the core of that infrastructure are seamless and transparent processes for determining consumers' eligibility for coverage subsidies—a full subsidy funded by Medicaid or partial subsidy funded by federal tax credits—and for enrolling them in health insurance coverage.⁵

¹ Birnbaum M. December 2010. *Medicaid in New York: Current Roles, Recent Experience, and Future Challenges*. New York: United Hospital Fund.

² Birnbaum 2010.

³ Facilitated enrollment was authorized by New York State statute in 1998 to allow community-based organizations and health plans to assist consumers in completing the Medicaid application. Today, over 60 percent of all Medicaid applications in the state come through the facilitated enrollment program.

⁴ Cook A, E Lawton, and D Holahan. June 2010. *Health Insurance Coverage in New York, 2008*. New York: United Hospital Fund.

⁵ The lowest-income Medicaid beneficiaries may be eligible for additional benefits, including cash assistance and food stamps. While an electronic interface between Medicaid and these programs is ultimately desirable, the interface between Medicaid and other health insurance is a federal mandate at the heart of health care reform's coverage goals. Accordingly, this paper focuses on the latter, which must be New York's first priority.

New York's implementation of federal health care reform—together with the State's own plan to centralize Medicaid administration—provides an unprecedented opportunity to “re-vision” Medicaid as another source of health insurance, part of a continuum of coverage vehicles for New Yorkers. The challenge is to take advantage of this opportunity.

Under New York State legislation passed shortly after Congress enacted the ACA, the State Department of Health is authorized to assume administration of Medicaid, including eligibility and enrollment decisions, from county and New York City governments that currently administer the program. In crafting the transition plan, the Commissioner of Health is directed by statute to coordinate that assumption of Medicaid responsibility with the ACA's requirements.

Those requirements call for a new eligibility and enrollment system that will be accessible, simple, technology-enabled, and consumer-centric. As a result of the State's Medicaid administration legislation, the system will also be statewide. The result is that consumers will be able to apply for coverage using a simplified application, whether on-line, over the telephone, in person, or by mail. Documentation of eligibility, long a stumbling block for consumers seeking public health insurance, will be replaced with electronic verification through connectivity to state and federal databases.

Most consumers with family incomes up to 400 percent FPL will be eligible for some level of subsidy. Through Medicaid, the state and federal governments will subsidize coverage for individuals with incomes up to 138 percent FPL. For most people with incomes above the maximum Medicaid eligibility level, up to 400 percent FPL, federal subsidies for the cost of private coverage will be in the form of tax credits. Regardless of the underlying coverage funding source or mechanism, consumers' ability to receive a subsidy—the processes for applying for, enrolling in, maintaining, and using health insurance coverage—will be the same. In fact, the goal of this post-reform, post-statewide-administration world is that eligibility for Medicaid and subsidized private coverage will be coordinated with the Health Insurance Exchange that will be created, and New Yorkers will have easy access to continuous coverage even as their incomes fluctuate.

The ACA and the State's centralization of Medicaid administration build on decades of efforts to expand insurance coverage to more New Yorkers. That these new federal and state mandates will advance Medicaid as part of New York's continuum of coverage—a precondition for continuity of health care—will buoy New York's efforts to reform the larger health care delivery system and monitor and improve patient outcomes across all payers.

Implementing the Vision: Mandates, Opportunities and Challenges

Over the past fifteen years, federal rules have gradually transformed Medicaid into a major health insurance program. This transformation began in 1996, when Medicaid eligibility was delinked from cash assistance, and continued in 1997 when federal legislation required states to coordinate eligibility and enrollment for Medicaid and the Children’s Health Insurance Program (CHIP). When CHIP was reauthorized in 2009, states were given new tools to expedite enrollment in both CHIP and Medicaid. With the ACA’s passage in 2010, Medicaid is firmly established as the foundation for the nation’s coverage strategy. For New York State, indeed for every state, the challenge is to turn the ACA mandate into an on-the-ground reality. The Centers for Medicare & Medicaid Services (CMS) has been clear as to its expectations:

“States [will] need to apply new rules to adjudicate eligibility for the program; enroll millions of newly eligible individuals through multiple channels; renew eligibility for existing enrollees; operate seamlessly with newly authorized Health Insurance Exchanges...; participate in a system to verify information from applicants electronically; incorporate a streamlined application used to apply for multiple sources of coverage and health insurance assistance; and produce notices and communications to applicants and beneficiaries....”⁶

Importantly, New York is better positioned to respond to the ACA requirements because of its 2010 legislation directing the State Department of Health, the single state Medicaid agency in New York, to plan and implement a transition to statewide Medicaid administration from the local governments of New York City and the fifty-seven non-City counties. In short, the ACA envisions and State legislation supports a consumer-centric and simplified approach to health insurance enrollment for low- and moderate-income people that requires New York to implement a streamlined and coordinated application and eligibility process for Medicaid, CHIP, and premium subsidies.

The Affordable Care Act

The ACA expands Medicaid by creating a national income threshold for the program while at the same time simplifying eligibility rules, application procedures, and eligibility data verification processes. In addition to the new income standard for Medicaid and CHIP means testing, the ACA applies the same income definition for determining eligibility for premium subsidies.

For New York, that means the State will be required to abandon the income-counting methodology now used for the majority of Medicaid and CHIP beneficiaries: a complex formula that “disregards” certain types of income, in a host of specific categories, and allows applicants to deduct various expenses, such as child care costs, that they report and document.

⁶ CMS Notice of Proposed Rulemaking, November 8, 2010. *Federal Register*.

Instead, as of 2014, the State will be required to adopt a single federal income standard, articulated in tax law: modified adjusted gross income, or MAGI.⁷ This simpler standard consists of adjusted gross income, as defined in the tax code, plus foreign income and tax-exempt interest.⁸ The new MAGI formula eliminates the need for most Medicaid applicants to report and provide paper verification of expenses as part of the Medicaid eligibility determination process.

The ACA also eliminates the limits on assets that are now in effect for many Medicaid applicants.⁹ But individuals who are elderly, disabled, medically needy, or eligible for Medicaid through other programs, such as cash assistance, will continue to be subject to the asset test and have their income calculated according to the traditional Medicaid formula.^{10,11} As such, New York will need to continue to provide eligibility determinations and enroll non-MAGI populations, while developing and implementing a centralized, coordinated information technology platform to facilitate access to public and private coverage options through the Exchange.

In addition to instituting new income-counting rules and aligning those rules across Medicaid, CHIP, and the tax subsidies for premium costs, the ACA requires states to create an array of consumer access points—often referred to as “no wrong door”—for those programs. These access points would facilitate on-line, telephone, in-person, and mail enrollment and renewal, as well as eligibility data exchange and electronic verification to create a paperless eligibility system for all subsidy programs.

Simplifying procedures. New York’s current eligibility and enrollment process for Medicaid and CHIP meets few of the ACA’s requirements. As a result, the State must evaluate the byzantine web of rules that currently drives its public insurance application, eligibility, and enrollment processes and requirements, and align those rules with the new imperatives of simplicity and transparency.

The ACA requires New York to either substantially revise its application for Medicaid coverage, eliminating unnecessary questions about income and expense deductions and associated documentation requirements, or adopt a simplified application developed by the federal Department of Health and Human Services (HHS). New York’s current Medicaid application is a complex, eight-page paper form that consumers must mail or submit in person to a county Medicaid office. Recent consumer testing demonstrated that most individuals cannot correctly complete the application without assistance from a facilitated enroller or local district case worker. Even after a recent revision of the application to improve its user-friendliness, many applicants remain unable to independently navigate the complex form.¹²

⁷ Affordable Care Act (ACA), Sec. 2002.

⁸ Internal Revenue Code (IRC) of 1986, 36B(d)(2).

⁹ ACA, Sec. 2002.

¹⁰ ACA, Sec. 2002(a)(D).

¹¹ New York has never had an asset test in its CHIP program and the State eliminated the test for all Medicaid beneficiaries in 2010, except for those applying for long-term care, and those in the aged, blind, and disabled eligibility categories. Thus, this change under the ACA will not alter the State’s existing eligibility and enrollment process.

¹² Children’s Defense Fund of New York, Coalition of New York State Public Health Plans, and Community Service Society. Medicaid Application Redesign, United Hospital Fund grant-supported project, 2009-2010.

New York's application remains cumbersome in part because it includes a series of questions—such as the applicant's veteran's status, housing expenses, and mother's maiden name—that will be either unnecessary or prohibited once the ACA is implemented. Some of these questions are included to compensate for New York's inadequate information systems, while others—used to refer beneficiaries to other programs—will be obviated by data matching with federal agencies.

Yet despite its complexity, the paper application is currently one of the few standardized aspects of New York's public health insurance application and enrollment process. Many features and functions of Medicaid and CHIP eligibility and enrollment in New York vary at the operational level, often by county and program. The fifty-eight local governments that administer the program use, in many cases, their own unique processes and procedures.¹³ The State maintains two separate and unconnected Medicaid eligibility systems (one for New York City and the other for the rest of the state), and yet another system for its CHIP program (health plans are primarily responsible for CHIP eligibility and enrollment).

The transition to MAGI and the requirement for electronic data matching also necessitate extensive eligibility system reprogramming (or appropriate programming for the new statewide eligibility system). New York's use of electronic data matching to external federal and State databases to help automate eligibility determinations is currently extremely limited. The State has begun to match Social Security numbers provided by Medicaid, Family Health Plus, and CHIP applicants with the Social Security Administration database to verify citizenship status and identity, which is an important step forward in automating eligibility determinations. New York City employs data matching to the City's Vital Statistics database in a limited number of cases, to verify that an applicant was born in New York City and is therefore a citizen. While ultimately effective for this subset of citizens, the Vital Statistics match requires multiple questions on the Medicaid application, adding to its complexity and length. And New York's Medicaid program matches income data to certain third-party databases, including the Wage Reporting System. But such electronic matching does not currently replace paper documentation of income, as envisioned by the ACA; the State still requires paper documentation of most eligibility factors that require verification, including income, residency, and certain expenses.

Resolving conflicting requirements. Notably, New York's ability to reform Medicaid and integrate it into the health insurance market will be inextricably linked to the federal government's resolution of four significant issues.

- The transition to the MAGI income standard is a significant departure from how New York calculates income for Medicaid, with both household size and types of countable income differing from the current Medicaid standard. While the ACA directs states to use MAGI to

¹³ Dutton M, W Bernstein, K Bhandarkar, and S Ingargiola. August 2009. *The Role of Local Government in Administering Medicaid in New York*. New York: United Hospital Fund.

determine Medicaid eligibility for non-elderly and nondisabled populations, the law also says that the use of MAGI shall not affect or limit the continued application of Medicaid’s traditional definition of “sources of countable income.”¹⁴ New York requires early and detailed guidance from CMS on how Medicaid will apply the MAGI definition—specifically the sources of income that “count” and how family size should be calculated in 2014—and the systems changes necessary to effectuate the new definition.

- While the ACA clearly contemplates that states use tax return data to determine eligibility for Medicaid, CHIP, and premium tax credits and cost-sharing reductions, the law also preserves states’ obligation to determine individuals’ income at the point in time at which they apply for Medicaid. Tax data are generally a year old, and in some cases older. To simplify income verification through tax data matching, New York requires guidance or a waiver from CMS that will allow it to use less-than-current tax data to meet Medicaid’s point-in-time income requirement.
- Federal statute compels New York to ask all Medicaid applicants for information regarding parents or spouses who might be legally responsible for providing financial “medical support” to applicants.¹⁵ Given the new mandate that all individuals obtain insurance for themselves and dependents, this medical support requirement seems obsolete. Allowing states to apply the ACA health insurance framework in lieu of medical support enforcement provisions will require HHS-issued guidance or, absent that, sponsorship of an amendment to the federal statute to eliminate these requirements.
- Although the ACA outlines a uniform national Medicaid income threshold and streamlined eligibility rules and procedures, issues related to states’ ability to claim receipt of an enhanced federal match remain unresolved. To claim the appropriate enhanced federal match, states will need to demonstrate whether an individual is eligible under new Medicaid rules or those in effect in December 2009. To avoid having states determine eligibility under both the old and new rules, negating the goal of simplification, the states will need guidance from CMS that will allow them to use a sampling methodology to reconcile these federal matching issues.

While the ACA offers a significant opportunity to radically streamline New York’s Medicaid eligibility and enrollment procedures, implementing these changes will require substantial work by State officials, as well as resolution of outstanding issues with the federal government. These reforms are essential, however, to increasing eligible individuals’ participation in Medicaid and allowing seamless coordination with subsidized coverage through the Exchange.

¹⁴ ACA, Sec. 2002.

¹⁵ 42 USC 1396k, 42 CFR § 433.147.

Transitioning to Statewide Administrative Responsibility

The transformation of Medicaid from a welfare program for the impoverished to a health insurance program for lower-income New Yorkers has also been facilitated by changes in how the State administers the program. From 1967 until 1997, responsibility was vested in the State Department of Social Services. In 1997, administration of Medicaid was transferred to the Department of Health; ten years later, the Office of Health Insurance Programs was established within the Department and vested with responsibility for the major operations of Medicaid. Throughout this forty-year period, however, day-to-day operational responsibility has remained with the counties and New York City.

New York is one of twenty states in the country that delegate responsibility for several key Medicaid functions—including eligibility determinations—to local governments.¹⁶ Stemming from both Medicaid’s roots in the welfare system and a history of partial local financing of Medicaid costs, local departments of social services currently serve as gatekeepers to New York’s Medicaid program, responsible for determining initial and ongoing eligibility of applicants and beneficiaries residing in their localities. This structure has not been without controversy, characterized by both a history of county complaints about escalating local Medicaid costs due to eligibility expansions imposed by the State, and State policymakers’ concerns about the diffusion of administrative responsibility and oversight for the \$50 billion program. Legislation, in 2006, capping local Medicaid contributions opened the door to a broader re-examination of the localities’ administrative role; a 2009 study of the current structure concluded that “while local governments shoulder significant administrative and financial responsibility for the implementation of Medicaid in New York, the distribution of core programmatic functions across 58 local governmental entities contributes to fractured governance, diffuse authority, and a disjointed operational infrastructure within the program.”¹⁷

Acting on that assessment, New York State’s Enacted SFY 2010-11 Budget mandated that the Commissioner of Health create and implement a five-year plan for the State’s assumption of Medicaid administrative responsibilities now being performed by local social services districts, to begin April 1, 2011, with full implementation by April 1, 2016. A first report, which has been described by Department of Health officials as “a plan to plan,” was released on November 30, 2010,¹⁸ based on a series of roundtable meetings with providers, plans, consumers, counties, and New York City, and a survey of local governments seeking input on transition priorities.

Written by the staff of the New York State Department of Health, the report describes the current administration of Medicaid in New York and makes short- and long-term recommendations for developing and implementing a final plan for the State takeover over the course of the next five years. Noting that variation among local districts in enrollment procedures, systems, and attitudes has led to

¹⁶ National Association of Counties, in conversation with M Dutton. September 10, 2010.

¹⁷ Dutton, Bernstein, Bhandarkar, and Ingargiola 2009.

¹⁸ New York State Department of Health. November 2010. New York State Medicaid Administration November 2010 Report. Accessed at http://www.health.ny.gov/health_care/docs/2010-11_medicaid_admin_report.pdf

variation in program outcomes, the report cites greater uniformity and consistency in the determination of eligibility as one of the major goals—indeed, a critical aspect—of centralizing Medicaid administration, and highlights immediate opportunities to transition components of the program.

Recognizing the importance of consolidation in light of federal health reform, the report notes that “the [S]tate, 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.... Implementation of the phases described above would transition the majority of eligibility determinations to the [S]tate, leaving the local social services districts primarily responsible for eligibility determinations for the elderly and individuals with disabilities.” It also presents a preliminary implementation timeline for the transition (see box).

New York State Department of Health Preliminary Implementation Timeline: Excerpt of Eligibility Provisions

April 2011	Statewide enrollment center becomes operational, consolidating consumer help lines and implementing telephone renewals. The Department begins stakeholder process for eligibility determination functions.
December 2011	Statewide enrollment center assumes responsibility for disability determinations, cross-county eligibility reviews, and low-volume programs.
June 2012	Statewide enrollment center assumes responsibility for applications from facilitated enrollments.
December 2012	The Department begins stakeholder process for eligibility determinations for elderly/disabled individuals.
January 2014	Concurrent with implementation of federal health care reform, the Department assumes responsibility for eligibility determinations for non-elderly and nondisabled persons under federal MAGI rules.
June 2015	The Department assumes responsibility for eligibility determinations for elderly/disabled individuals.

While the initial announcement of the State Medicaid administration bill was positioned primarily as an administrative cost-saving measure,¹⁹ the statute also specifies that the plan must include “coordination of state assumption of medical assistance administrative responsibilities with the requirements of the [ACA].”²⁰ The law reflects a growing consensus that the continued delegation of eligibility responsibilities to local government is challenging, if not impractical, in light of the ACA requirements for a streamlined and coordinated application system across Medicaid and the Exchange.

Such coordination between the Exchange and the fifty-eight local administrative offices would create significant challenges and burdens for the still-emerging Exchange, including issues of process requirements and information systems. For example, the Medicaid agency and the Exchange will have to establish procedures to share application information collected by either entity to permit eligibility

¹⁹ Office of Assembly Speaker Sheldon Silver. March 25, 2010. Silver, Farrell Detail Proposal for State Pickup of County Share of Medicaid Administration Costs: Plan Would Save Hundreds of Millions in Taxpayer Dollars by Consolidating Operations, Reducing Costs and Establishing Statewide Uniformity (press release).

²⁰ Chapter 58 of the Laws of 2010, Section 47-b.

determinations for all state subsidy programs—Medicaid, CHIP, and subsidized coverage through the Exchange. And while Medicaid eligibility in New York is supported by the state’s Welfare Management System, local governments have developed their own systems and information technology (IT) tools to supplement this infrastructure. Integrating these subsystems into a statewide patchwork would add enormous cost and complexity to the already daunting systems task before the State. Federal officials have acknowledged such challenges, noting in recent proposed rules that they will “scrutinize carefully any proposed investments in sub-State systems...performing essentially the same functions within the same state,” when reviewing states’ requests for enhanced funding for Medicaid eligibility and enrollment activities.²¹

Maintaining a county-run eligibility structure in the post-reform world also would bring new challenges and burdens to local governments themselves. The ACA “no wrong door” requirements apply equally to Medicaid just as to the Exchange. This would, presumably, require local governments to take on new responsibilities, including screening a significantly increased number of applicants for Medicaid and, for those persons found to be ineligible, either determining their eligibility for Exchange subsidies and enrolling them into that coverage or developing electronic interfaces to share relevant application information with the Exchange.

Local governments have already been straining under the escalating volume and complexity of their eligibility responsibilities in recent years, as the state has expanded eligibility through targeted coverage programs and the downturn in the economy has increased demand. Federal health reform will further expand Medicaid eligibility to approximately 100,000 previously ineligible uninsured New Yorkers,²² and is also expected to stimulate enrollment among the nearly 1 million New Yorkers already eligible for Medicaid but not enrolled. Combined with the estimated 1 million people becoming newly eligible for subsidized coverage, the demand for eligibility determinations could quickly overwhelm local social services eligibility staff and systems.

Information Systems: Enabling Timely and Accessible Coverage

CMS has provided substantial guidance on the standards that state electronic eligibility systems must meet to assure that consumers are able to seamlessly obtain and maintain the full range of health insurance options, including Medicaid and CHIP. In September, HHS Secretary Sebelius adopted the recommendations of the Health Information Technology Policy and the Standards Committees’ Enrollment Workgroup, established pursuant to ACA Section 1561 to develop interoperable and secure standards and protocols to facilitate electronic enrollment and renewal in federal and state subsidy programs. Key recommendations include:²³

²¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Part 433 [CMS-2346-P] RIN 0938-AQ53. Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.

²² Holahan D. October 2010. *Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and Opportunities in Health Reform*. New York: United Hospital Fund.

²³ Section 1561 standards, adopted by Secretary Sebelius on September 17, 2010. Note that these standards use the term “State” to include counties or local governments in states that delegate such authority.

- Federal and state agencies should use National Information Exchange Model guidelines to support exchange of data elements between programs and states, and should express “business rules” using a consistent, “technology-neutral” standard format that allows different systems to communicate with each other;
- A federal “reference software model” should be developed to be used by states to verify eligibility information; and
- Consumers should have timely, electronic access to their eligibility and enrollment data, knowledge of how it will be used, the ability to request corrections or updates of such data, and the ability to grant third-party access to their data.

In November 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) and CMS issued joint guidance to states outlining principles for exchange and Medicaid information technology systems architecture to promote an eligibility and enrollment process that offers seamless integration between public and private insurance options. Among other things, federal guidance requires state systems that allow consumers to apply for and renew benefits on line; provide superior consumer service, including real-time transactions; allow third parties to assist consumers in enrolling and maintaining coverage; and provide seamless integration among health insurance options.²⁴

An accessible, simple, technology-enabled, and consumer-centric eligibility and enrollment system requires modern information systems that can accommodate a high volume of applicants with varied technical skills, languages, and literacy levels. In such a system, consumers will interface with a user-friendly “front end” to apply for coverage and submit minimal, if any, proof of eligibility. Eligibility information will be verified on the “back end” through behind-the-scenes electronic matches with federal and state databases. Consumers will receive an eligibility determination through their preferred mode of communication, including e-mail or text message. Every step of the eligibility determination and enrollment process must be automated as far as possible.

New York’s existing Medicaid eligibility and enrollment systems do not meet these standards. Instead, they rely upon a 1970s legacy information system, which is antiquated and cumbersome and run by the State’s Office of Temporary and Disability Assistance. To meet the ACA’s coverage goals and its vision for Medicaid enrollment, New York will, ideally, build a new information technology system—but there are challenges to making this vision a reality. First is the expected cost of systems development, which is particularly challenging in a period of multiple-year budget deficits. Second is the time required to build a new system, exacerbated by the constraints of the state procurement process. The ACA requires states to have modernized eligibility and enrollment systems up and running by 2014, but getting from here to there will require significant time, work, and resources.

²⁴ Section 1561 standards, Appendix A, and the November 3, 2010, Guidance for Exchange and Medicaid Information Technology Systems.

HHS is helping states address these challenges through significant federal financial support and by facilitating information and technology sharing among states and between the federal government and states. To ease and expedite the process, HHS indicates that resources such as software and a federal business rules repository will be made available to states and to systems developers working with them. The Department also outlines the need to standardize common data elements, develop technology-neutral processes, and ease data sharing between state and federal agencies.

The OCIO-CMS joint guidance to states for exchange and Medicaid information technology systems, described as “Version 1.0,” outlines principles for systems architecture needed for exchanges and to achieve interoperability between the exchanges and Medicaid/CHIP. States seeking federal financial support for systems development are required to comply with this guidance, which reiterates the goals and philosophy outlined in the Section 1561 enrollment standards above. These include the use of common systems and a coordinated set of rules for Medicaid, CHIP, and exchange subsidy eligibility determination; compliance with widely used standards, including those stemming from Section 1561 and others for HIPAA transactions; and use of open architecture standards for ease of information exchange.

These standards will be coupled with technical assistance and substantial federal dollars (described below) to enable states to design, develop, implement, and operate the systems required by the ACA. This federal support places a new Medicaid eligibility system within reach for New York.

Funding

HHS has announced significant funding that will support the planning and implementation required to realize the new vision for New York’s, and other states’, Medicaid programs. While distinct funding opportunities target planning and implementation of systems for Medicaid and for state health insurance exchanges, they share a common mandate to integrate eligibility and enrollment systems.

Medicaid Systems Development

On November 3, 2010, HHS issued a proposed rule that, if approved, would make enhanced federal Medicaid matching funds available to support development of upgraded state eligibility IT systems.²⁵ A 90 percent federal Medicaid matching rate would be available for the design, development, and installation of modernized systems through calendar year 2015, and a 75 percent match would be available thereafter for maintaining and operating those upgraded systems, as long as specified

²⁵ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. November 3, 2010. Notice of Proposed Rulemaking: Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Accessed at <http://www.federalregister.gov/articles/2010/11/08/2010-27971/medicaid-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>.

conditions continued to be met. This represents a significant increase from the 50 percent matching rate currently available under Medicaid for such activities. The Notice of Proposed Rule Making notes the need for “systems transformation” in most states to fulfill ACA requirements, including new eligibility rules, electronic verification of information, a streamlined application for multiple sources of coverage, and seamless interfacing with the health insurance exchanges.²⁶

Exchange Planning and Implementation

HHS is also making funding available to support planning and implementation of state health insurance exchanges that are compatible with Medicaid and CHIP. Recognizing that states will need significant technical assistance to develop modernized IT systems, HHS announced its support for the development of models upon which other states can build, with a goal of realizing efficiencies in both time and costs.²⁷ These model systems would likely include the decision rules needed to determine eligibility for both Medicaid and premium subsidies, based on uniform federal income limits and citizenship and immigration status verification requirements. Two-year grants will be made to five “early innovator” states, or coalitions of states, to build IT systems for state exchanges. To ensure that *all* states benefit from this investment, HHS will promote significant sharing, between innovator and non-innovator states, of software, code, and other information needed to upgrade systems and support coordination between exchanges and Medicaid/CHIP. The federal solicitation notes that “systems must be interoperable and integrated with State Medicaid/[CHIP] programs and be able to interface with HHS and/or other Federal agencies and data sources in order to verify and acquire data as needed.”²⁸

These innovator grants are the second wave of funding for exchange planning and/or implementation activities. The first exchange grants were awarded in September 2010, with each applicant state receiving \$1 million to support planning efforts. A third round of grants will be available to all states in early 2011 to assist them in establishing their exchanges.²⁹ To date, no state matching funds have been required to access exchange planning or implementation funds. While all three phases of this funding are earmarked for exchange-related activities, not Medicaid-related projects, funding guidance reinforces the statutory mandate to ensure that exchange eligibility and enrollment functions are well coordinated with Medicaid’s and CHIP’s.

This support offers New York an unprecedented opportunity to develop the modernized information systems that will be needed to meet the vision for a fully accessible Medicaid program and to meet the ACA’s enrollment challenges.

²⁶ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. November 3, 2010.

²⁷ U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight. October 29, 2010. Cooperative Agreements to Support Innovative Exchange Information Technology Systems.

²⁸ U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight. October 29, 2010. Funding Opportunity Announcement: Cooperative Agreement to Support Innovative Exchange Information Technology Systems, CDFA 93.525.

²⁹ U.S. Department of Health and Human Services. October 29, 2010.

Conclusion

The goals of Medicaid—the largest health insurer in New York State and the largest single item in the New York State budget—are to ensure that eligible New Yorkers are able to obtain and maintain health insurance coverage, and that cost-effective, high-quality care is purchased for its 4.8 million beneficiaries. Despite the importance of this mission, the magnitude of the State’s investment, and the number of individuals who rely on the program for coverage and care, Medicaid’s infrastructure is old, unstable, and not up to the task of supporting the state’s largest health insurer and integrating with other payers. New York’s legislation centralizing Medicaid administration, coupled with the ACA’s mandates and technical and financial support, holds the promise of a vastly improved infrastructure—one capable of supporting the centerpiece of health insurance coverage in New York State.

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