Partnership Plan
Section 1115 Quarterly Report
Demonstration Year: 17 (10/1/2014 – 9/30/2015)
Federal Fiscal Quarter: 3 (4/01/2015 – 6/30/2015)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS), for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times. The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care. There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997.

CMS had approved an extension on September 29, 2006 of New York's 1115 Partnership Plan Waiver for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT).

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. In accordance with the April 1, 2011 Special Terms and Conditions (STC) Number 50, a final report for the F-SHRP demonstration was submitted to CMS on June 30, 2014. The Department of Health (the Department) has contracted with Rockefeller Institute of Government (RIG) to evaluate the F-SHRP demonstration and develop a final evaluation report. A final draft evaluation report was submitted to CMS on February 11, 2015. The Department is awaiting acknowledgement from CMS that the report has been accepted.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30 day public comment period. A temporary extension was granted on December 31, 2014 extending the waiver through March 31, 2015. Subsequent temporary extensions were granted through September 30, 2015. Approval of the renewal request will extend the Demonstration until December 31, 2019, thus allowing New York to reinvest federal savings generated by the MRT reform initiatives, and to reinvest in the state's health care system currently authorized by the Partnership Plan.

II. Enrollment: Second Quarter

Partnership Plan- Enrollment as of March 2015

Demonstration Populations (as hard coded in the	**Current Enrollees (to date)**	**# Voluntary Disenrolled in Current Quarter**	**# Involuntary Disenrolled in Current Quarter**

CMS 64)			
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	**1,355,743**	**13,979**	**52,836**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**166,605**	**2,970**	**9,182**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**79,352**	**1,010**	**3,458**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**7,257**	**188**	**628**
Population 5 - Safety Net Adults	**1,115,572**	**16,624**	**34,931**
Population 6 - Family Health Plus Adults with Children	**0**	**0**	**0**
Population 7 - Family Health Plus Adults without Children	**0**	**0**	**0**
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	**51,320**	**797**	**276**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**249,983**	**6,132**	**1,928**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**3,151**	**212**	**58**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**51,939**	**1,870**	**1,110**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**43,782 or an approximate 5.28% decrease over last Q**

Reasons for voluntary disenrollments include: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**104,407 or an approximate 17% decrease over last Q**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility.

III. Outreach/Innovative Activities

Outreach Activities

2,806,517 New York City (NYC) Medicaid consumers were enrolled into a managed care product as of the end of June 2015. Approximately 958,572 or 34% were enrolled through New York State of Health (NYSoH).

During the third quarter, the New York Medicaid Choice program (NYMC) Field Customer Service Representatives (FCSRs) conducted outreach and enrollment activities within the NYC Human Resources Administration (HRA) field offices. This outreach was specifically performed at 5 HIV/AIDS Services Administration (HASA) sites, 12 Medicaid offices and 19 Job Centers using scheduled presentations and the Education and Enrollment Driven Referral (EED) process developed by HRA in concert with the NYMC program.

MAXIMUS reported that a total of 2,694 presentations were conducted by NYMC program. Of these, 577 or 21% were observed by HRA's Contract Monitoring Unit (CMU) to ensure that consumers were given accurate and full disclosure of their managed care enrollment choices. As a result of the EED process, 14,051 consumers received personal consultation by a FCSR regarding their enrollment choices and 8,525 made voluntary enrollment choices.

IV. Operational/Policy Developments/Issues

A. Health Plans

Changes to Certificates of Authority (COA):

- **Amida Care, Inc.-**COA updated to reflect a change of address to 14 Penn Plaza, 2nd Floor, New York, New York 10122.

- **Empire Healthchoice HMO, Inc.-**COA updated to reflect the withdrawal from the CHP line of business in all NYS. This change was effective December 31, 2014 with the exception of Putnam County which was April 1, 2015.

- **Amerigroup New York, LLC d/b/a HealthPlus, an Amerigroup Company**-COA updated to reflect a service area expansion for CHP in Putnam County April 1, 2015.

B. Surveillance Activities

Surveillance activity for 3rd Quarter FFY 2014-2015 (April 1, 2015 to June 30, 2015) included the following:

- One Targeted Operational Survey was completed during the 3rd Quarter FFY 2014-15.
    - Today's Options New York
        - Statement of Deficiency was issued and an Acceptable Plan of Correction received.

- Member Services Focus Surveys were completed on seven (7) Managed Care Plans during the 3rd Quarter FFY 2014-15.
    - Health Insurance Plan of Greater New York
    - New York State Catholic Health Plan, Inc.
    - MetroPlus Health Plan, Inc. – Special Needs Plan
    - MetroPlus Health Plan, Inc.
    - HealthFirst PHSP, Inc.
    - Affinity Health Plan, Inc.
    - AMERIGROUP New York, LLC
        - Statements of Deficiency and Acceptable Plans of Correction were received for all seven plans.

- Provider Participation Directory / Information survey was completed on one (1) plan during the 3rd Quarter FFY 2014-15.
    - Independent Health Association
        - Statement of Deficiency was issued and an Acceptable Plan of Correction was received.

- One Full Operational Survey was completed during the 3rd Quarter FFY 2014-15.
    - Excellus Health Plan
        - Statement of Deficiency was issued and an Acceptable Plan of Correction was received.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

- MEQC 2008 – Applications forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted during the quarter. The review is involved in litigation.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance
  The final summary report was forwarded to the regional CMS office and CMS Central Office on July 1, 2015.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability
  The final summary report was forwarded to the regional CMS office on January 31, 2014 and CMS Central Office on December 3, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations
  The final summary report was forwarded to the regional CMS office on June 28, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications
  The final summary report was forwarded to the regional CMS office on July 25, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding
  The final summary report was forwarded to the regional CMS office on August 1, 2014 and CMS Central Office on December 3, 2014.

B. Benefit Changes/Other Program Changes

Transition of Nursing Home Benefit and Population into Managed Care: Phase 2 of the Nursing Home Transition began as scheduled, with Medicaid Managed Care Plans (MMCPs) assuming responsibility effective April 1, 2015 for covering long term placement in a nursing home for eligible beneficiaries age 21 and over in Nassau, Suffolk and Westchester Counties. The Department has convened joint meetings with MMCPs and nursing home providers to discuss stakeholder concerns at least monthly prior to and subsequent to the transition dates. The Department plans to continue to hold such meetings throughout the transition period. On May 18 and 19, 2015, the Department participated in trainings hosted by the New York City Human Resources Administration (HRA) to provide guidance to managed care plans and providers regarding processes specific to the Nursing Home Transition in New York City. Prior to the April 1, 2015 Phase 2 transition date, the Department convened individual conference calls with each of the Phase 2 counties, and subsequent to this transition date, the Department conducted follow-up calls with the individual counties to discuss implementation issues. The Department continues to be available to provide technical assistance to Phase 1 and Phase 2 local districts. The Department provided training and technical assistance to Phase 3 counties during the June 18, 2015 Medicaid - Technical Assistance Group (M-TAG) meeting. In addition to convening meetings, conference calls and trainings, the Department has developed and posted to the Department website a Frequently Asked Questions (FAQ) document to address questions from affected stakeholders. The FAQ document is updated periodically as new questions are received. The Department also issued a Nursing Home Administrative Directive (15OHIP/ADM-01) dated April 1, 2015.

Transition of School Based Health Center Services from Medicaid Fee-for-Service to Medicaid Managed Care: As a result of the 2015-2016 Legislative Budget process, the date for transitioning School Based Health Center (SBHC) services from Medicaid Fee-for-Service (MFFS) to Medicaid Managed Care (MMC) has been extended from July 1, 2015 to July 1, 2016 to allow SBHC providers additional time to contract with MMC plans and to appropriately address outstanding operational issues. The Department continues to work with

a stakeholder workgroup to facilitate the transition of SBHC Services from Medicaid Fee-for-Service to Medicaid Managed Care.

C. Federally Qualified Health Services (FQHC) Lawsuit

No updates this quarter; please see first quarter report, demonstration year 17 for most recent updates.

D. Managed Long Term Care Program (MLTCP)

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services and a supportive transition from the previous, fragmented, FFS process to coordinated managed care.

1. Accomplishments

- During the period April 2015 through June 2015, significantly expanded MLTCP availability by approving three service area expansions and achieving statewide capacity.

- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period April 2015 through June 2015 post enrollment surveys were completed for 526 enrollees. 46% of respondents indicated they were not receiving home care services prior to enrollment in the MLTCP. 70% of respondents who were receiving home care services prior to enrollment indicated they continued to receive services from the same caregivers once they became members of an MLTCP. Target group of consumers surveyed will be adjusted for Q4 to focus exclusively on consumers who were receiving home care services prior to enrollment.

- Achieved statewide mandatory MLTC at conclusion of Q3.

    - June 2015 – Phase 1 - expanded to Chautauqua, Chemung, Essex, Hamilton, Seneca, Schuyler, and Yates.
    - June 2015 – Phase 2 – expanded to Allegany, Clinton, Franklin, Jefferson, Lewis, and St. Lawrence.

<u>Enrollment</u>

- Total enrollment in MLTC Partial Capitation Plans for the period April 2015 through June 2015 is 128,397. For that quarterly period, 8,814 individuals who were being transitioned into Managed Long Term Care from fee for service made an affirmative choice. Plan specific enrollment on a monthly basis for the period July 2014 through June 2015 is submitted as attachment 2 of this report. Total affirmative choice for that period is 29,728.

2. Significant Program Developments

- During the period April 2015 through June 2015 the Conflict Free Evaluation and Enrollment Center (CFEEC) was successfully expanded to include operations on a statewide basis. This expansion aligned with expansion of mandatory MLTC.

- During the period April 2015 through June 2015 focus audit findings for Fidelis Care at Home were released, a corrective action plan was received and accepted. An additional focus audit has been formulated, and release is anticipated during Q3.

- During Q3 the Independent Consumer Support Program, commonly referred to as "ICAN", continued expansion and achieved statewide operations during May 2015.

- During the period April 2015 through June 2015 the 'secret shopper' process was launched.

3. Issues and Problems

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

4. Summary of Self Directed Options

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

5. Required Quarterly Reporting

- **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. For the period April 2015 through June 2015, 287 Critical Incidents were reported, representing a large increase over the previous quarter. It appears the increase predominately relates to one plan, this will be investigated and incorrect reporting is suspected.

- **Grievance and Appeals Annual Summary:** Key areas of concern remain dissatisfaction with quality of home care and transportation.

- **Grievance and appeals:** For the period April 2015 through June 2015 key areas of concern remain transportation and dissatisfaction with quality of home care. The Department will report on conclusions of analysis of this quarter data within the next quarterly report.

Total Grievances for this period:	**4/15-6/15**
Average recipients for the period	137,182
# Same Day	6,717
# Standard	1,876
# Expedited	**8,593**

Period: 04/01/15 – 06/30/2015		
Total Grievances for this period:	**Resolved**	**Resolved %**

# Same Day	6717	6717	100%
# Standard/Expedited	1876	1185	63%
Total for this period:	8593	7902	92%

Appeals	7/14-9/14	10/14-12/14	1/15-3/15	4/15-6/15	Total for 4 Qtrs
Avg Quarterly Enrollment	133,619	137,978	139,353	137,182	548,132
Total Appeals for the period	1,344	1,248	1,662	2,445	6,699
ii. Appeals per 1,000	10	9	12	18	12

April and May show a decline of enrollment for partial cap plans but June was an increase above all other months.

There was an increase in Appeals this quarter, targeted within a small group of plans. This will be reviewed to determine circumstances.

Grievances and Appeals per 1,000 Enrollees By Plan and Product Type 4/15-6/15					
Plan Name:	**Enrollment**	**Total Grievances**	**Grievances rate per 1,000**	**Total Appeals**	**Appeals rate per 1,000**
Aetna Better Health (Partial)	3,066	15	5	54	18
AgeWell New York ,LLC (Partial)	4,471	316	71	6	1
AlphaCare of New York Inc. (Partial)	1,738	259	149	8	5
Amerigroup (Partial)	2,558	40	16	0	0
Amerigroup (MAP)	1	0	0	0	0
Archare Senior Life (PACE)	388	31	80	0	0
ArchCare Community Life (Partial)	1,883	431	229	27	14
Catholic Health LIFE (PACE)	191	16	84	1	5
CenterLight Healthcare (PACE)	3,370	306	91	20	6
CenterLight Healthcare Select (Partial)	6,247	188	30	362	58
Centers Plan for Healthy Living (Partial)	2,592	110	42	16	6

Grievances and Appeals per 1,000 Enrollees By Plan and Product Type 4/15-6/15					
Plan Name:	**Enrollment**	**Total Grievances**	**Grievances rate per 1,000**	**Total Appeals**	**Appeals rate per 1,000**
Complete Senior Care (PACE)	117	25	214	0	0
Eddy SeniorCare (PACE)	162	36	222	1	6
Elant Choice (Partial)	854	13	15	0	0
ElderONE (PACE)	661	88	133	1	2
Elderplan (MAP)	831	48	58	17	20
ElderServe Health, Inc. (Partial)	10,462	300	29	28	3
EmblemHealth (Partial)	1,270	43	34	2	2
EmblemHealth (MAP)	621	21	34	1	2
Kalos, dba First Choice Health (Partial)	324	23	71	0	0
Extended MLTC (Partial)	410	41	100	2	5
Fallon Health Weinberg (Partial)	154	16	104	0	0
Fidelis Care New York (Partial)	9,282	60	6	129	14
Fidelis Medicaid Advantage Plus (MAP)	166	1	6	0	0
GuildNet GNG (MAP)	696	95	137	8	11
GuildNet MLTCP (Partial)	13,951	1193	86	94	7
Hamaspik Choice (Partial)	825	21	25	5	6
Healthfirst CompleteCare (MAP)	3,561	21	6	121	34
HomeFirst MLTC, a product of Elderplan (Partial)	10,688	321	30	132	12
I Circle (Partial)	137	4	29	0	0
Independence Care System (Partial)	5,174	374	72	35	7
Independent Living Services of CNY (PACE)	478	28	59	3	6
Integra MLTC (Partial)	2,325	26	11	5	2
Metroplus (Partial)	871	42	48	0	0
Montefiore Diamond Care (Partial)	534	53	99	0	0
NSLIJ Health Plan (Partial)	1,819	64	35	3	2

Grievances and Appeals per 1,000 Enrollees By Plan and Product Type 4/15-6/15					
Plan Name:	**Enrollment**	**Total Grievances**	**Grievances rate per 1,000**	**Total Appeals**	**Appeals rate per 1,000**
Prime Health Choice, LLC (Partial)	47	5	107	0	0
Senior Health Partners (Partial)	13,763	810	59	680	49
Senior Network Health (Partial)	488	15	31	0	0
Senior Whole Health (MAP)	72	4	56	0	0
Senior Whole Health (Partial)	2,459	57	23	0	0
Total Senior Care (PACE)	101	11	109	1	10
United Healthcare (Partial)	1,262	22	17	0	0
VillageCareMAX (Partial)	3,670	537	146	12	3
VNA Homecare Options, LLC (Partial)	668	84	126	3	4
VNSNY CHOICE MLTC (Partial)	14,668	2234	152	658	45
VNSNY CHOICE MLTC TOTAL (MAP)	146	1	7	3	21
Wellcare (Partial)	6,959	144	21	7	1
Total	**137,181**	**8593**		**2445**	

- **Fraud and Abuse:**

Fraud and Abuse Complaints Reported during Quarter	**4/15-6/15**
Fraud and Abuse Complaints Reported during Quarter	52

- **Fair Hearings:**

Fair Hearing decisions	**4/15-6/15**
Total	**147**
In favor of Appellant	108
In favor of MLTC Plan	33
No Issue	6

Days from Request Date till Decision Date	**4/15-6/15**

Total	147
less than 30 Days	16
30-60	69
61-90	35
91-120	7
>120	20

There was an increase in Fair Hearings this quarter. This will be reviewed to identify trends.

- **Technical Assistance Center Activity:** During Q3 - 19% of the calls received through the Technical Assistance Center (TAC) were not specifically related to a plan, an increase over the previous quarter. Three main categories are evident: seeking assistance in obtaining MLTC information and education, coding and systems problems, and general inquiries regarding MLTC enrollment and appeals procedures. The TAC was successful with investigating codes/systems concerns, highlighting areas to target for systemic enhancements.

    - Complaint Volume:
        - Substantiated Complaints = 422
        - Unsubstantiated Complaints = 198
        - Total Complaints = 620
        - Inquires = 292
        - Total Call Volume = 912
    - CFEEC Complaints: 9
    - Complaint Investigation Activity:
        - Resulted in 3 targeted corrective action plans
            - Issues: Authorization for Provider, Dissatisfaction with Home Health Care, and Difficulty Obtaining DME.
            - Impacted Regions: Nassau, Suffolk, Westchester
            - This was a decrease of 50% from the previous quarter in corrective action plans required as a result of TAC complaint investigations

- **Assessments for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were incrementally expanded to additional regions during the 2nd quarter. For the period April 2015 through June 2015 the total number of CFEEC assessments that resulted in MLTC enrollment was 7,634. During this quarter 1,180 assessments for enrollment were conducted by MLTC plans, as CFEEC was not fully implemented statewide until June 30, 2015.

- **Referrals and 30 day assessment:** For the period April 2015 through June 2015, total assessments conducted by MLTC plans during the period is 9,386. 86% were conducted within the 30 day time frame. Data collection, evaluation and reporting for this element will be refined with the expansion of the CFEEC.

- **Referrals outside enrollment broker:** The Conflict Free Evaluation and Enrollment Center began during October 2014. This data element will be evolving to coincide with the rollout of

CFEEC process. During the period April through June 2015, 9,340 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Rebalancing efforts:** Quarterly reporting of Rebalancing Efforts has been implemented, effective with fourth quarter 2013 data submission. Previous data reported was based on a semi-annual data collection cycle.

Rebalancing Efforts	
Period: 4/01/16 - 6/30/15	
Number of Individuals enrolled in the plan from a nursing home	**269**
Number of Enrollees admitted to a nursing home but returned to the community	**1029**
Number of Enrollees permanently admitted to a nursing home	**1343**

VI. Evaluation of the Demonstration

Currently under review and discussion with CMS.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 5,587 complaints/action appeals this quarter, an increase of 7.8% from the previous quarter. Of these complaints/appeals 40 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 23% of the total. There were 132 complaints/appeals reported by the HIV SNPs. The majority of these complaints (36) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 499 Medicaid managed care complaints this quarter.

The top 5 most frequent categories of complaints were as follows:

23% Balance Billing
11% Reimbursement/Billing Issues
10% Provider or MCO Services (Non-Medical)
10% Dental or Orthodontia
9% Quality of Care

This quarter, mainstream Medicaid managed care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0

Consumer Directed Personal Assistant	0
Home Health Care	10
Non-Permanent Residential Health Care Facility	3
Personal Care Services	17
Personal Emergency Response System	1
Private Duty Nursing	1
Total	32

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 5,587 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 742 complaints and action appeals from their SSI enrollees. This compares to 589 SSI complaints/action appeals from last quarter. The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	20%
Balance Billing	15%
Quality of Care	10%
Reimbursement/Billing Issues	9%
Provider or MCO Services (Non-Medical)	9%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	30
AIDS Adult Day Health Care	0
Appointment Availability - PCP	4
Appointment Availability - Specialist	2
Balance Billing	64
Communications/Physical Barrier	1
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	38
Dental or Orthodontia	150
Emergency Services	27
Eye Care	6
Family Planning	0
Home Health Care	3
Mental Health or Substance Abuse Services/ Treatment	32
Non-covered Services	24
Non-Permanent Residential Health Care Facility	2

Personal Care Services	8
Personal Emergency Response System	0
Pharmacy	23
Private Duty Nursing	1
Provider or MCO Services (Non-Medical)	64
Quality of Care	109
Recipient Restriction Program/Plan Initiated Disenrollment	2
Reimbursement/Billing Issues	38
Specialist or Hospital Services	24
Transportation	11
Waiting Time Too Long at Office	2
All Other Complaints	77
Total	**742**

B. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on June 25, 2015. The meeting included presentations provided by state staff and discussions of the following: an update on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs and the Conflict Free Evaluation and Enrollment Center (CFEEC); an update on Delivery System Reform Incentive Payment Program (DSRIP) project deliverables and timeline; an overview of the implementation of Medicaid behavioral health reform in New York, including an update on the following items: behavioral health managed care timeline, plan designation status, state plan and Home and Community Based Services, provider technical assistance, and consumer outreach; and an update and discussion of auto-assignment of enrollees.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on April 23, May 14, and June 11, 2015. The April meeting included the following presentations: a status update on Delivery System Reform Incentive Payment (DSRIP) and a discussion of the DSRIP opt-out consent process; Managed Long Term Care (MLTC), Fully Integrated Dual Advantage (FIDA) and Conflict Free Evaluation and Enrollment Center (CFEEC) update; a status update on MLTC and FIDA capitation rates and Nursing Home Transition rates; an overview of and update on Basic Health Program Phase 2 rate development; an actuarial report overview, including the 30 day budget requirement; an overview of transgender related care and services, including the associated State regulation and coverage criteria and requirements; a discussion of New York State's End of AIDS plan and related activities; an update on activities related to the implementation of adult behavioral health in managed care; and a review of contract modifications related to facilitated enrollment from the March 1, 2014 managed care contract. The May meeting agenda included: a DSRIP update; MMC and MLTC finance and rate development overview; a status update on the implementation of the FIDA program, MLTC enrollment and Conflict-Free Evaluation and Enrollment Center (CFEEC) activity; a presentation on Statewide pharmacy supplemental rebates and direct contracting; an overview of the New York State All Payer Database (APD) Encounter Intake System; and a

behavioral health transition update. Presentations, updates and discussions at the June meeting included: an update on DSRIP; a finance and rate development update; MLTC, FIDA and CFEEC update; discussion of health benefit exchange 834 issues; and behavioral health transition/Health and Recovery Plan (HARP) status update.

VIII. Quality Assurance/Monitoring

A. Quality Measurement

Quality Assurance Reporting Requirements (QARR)

Twenty-eight health plans submitted Quality Assurance Reporting Requirement (QARR) data on June 15, 2015. This includes 11 of the 18 Qualified Health Plans operating through the New York State of Health Marketplace with enough eligible populations to report quality data. Data is being reviewed for completeness and accuracy and final results will be published next quarter.

Care Management Annual Reporting Tool (CMART)

Medicaid managed care and HIV SNP plans reported the annual CMART files in April 2015 for care management services provided in calendar year 2014

Plan-administered care management is defined as a comprehensive assessment of a member's needs with an individualized care plan carried out through specific interventions designed to provide coordinated, efficient, quality care to achieve the care plan goals and optimize health outcomes for people with complex health issues. For the HIV SNP plans, the cases in the CMART were limited to those with active medical management and did not include cases with routine assessment and monitoring only. The following table summarizes the cases submitted by plans for the past four years and the percentage enrolled in care management.

Plan	**Submitted 2012**	**Submitted 2013**	**Submitted 2014**	**Submitted 2015**
Affinity Health Plan	4,432	4,608	5,647	2,268
Health Plus/AmeriGroup	5,855	19,288	11,752	11,582
CDPHP	2,392	5,058	3,258	2,576
HIP	5,576	5,709	11,438	15,262
Excellus	5,541	6,623	6,968	4,655
Fidelis Care New York	31,175	24,998	16,824	6,108
HealthFirst*	35,114	38,007	45,214	40,671
HealthNow	901	910	1,284	665
Hudson Health Plan	310	548	768	1,028
Independent Health	3,019	3,129	3,578	3,538
MetroPlus	4,730	5,600	7,233	9,222
MVP	3,585	3,531	5,532	2,967
Total Care	372	315	370	27

UnitedHealthCare of New York	2,663	5,177	4,187	6,492
Univera Community Health	3,363	3,369	2,672	3,503
WellCare	2,257	1,684	2,182	1,517
MMC Total	111,285	128,554	128,907	112,081
Amida Care			335	407
MetroPlus SNP			2,815	2,822
VNSNY Choice Select Health			5,020	5,430
HIV SNP Total			8,170	8,659
Overall Percent Enrolled in Plan Care Management	37%	31%	36%	43%

* Includes Neighborhood Health Provider data for 2011 and 2012.

Managed Long-Term Care (MLTC)

In April, the 2014 Managed Long-Term Care Performance dataset was released on the Department's HealthData NY website. Here is the link: https://health.data.ny.gov/browse?tags=mltc. This link provides access to the Managed Long-Term Care Performance dataset and nine chart.

B. Quality Improvement

External Quality Review

The Island Peer Review Organization (IPRO) was the successful bidder of the Medicaid External Quality Review, Utilization Review, Quality Improvement and AIDS Intervention Management System Activities in New York State RFP. The term of the five-year contract is February 1, 2015 through January 31, 2020. IPRO is conducting Medicaid managed care external quality review, as required by the Balanced Budget Act of 1997, and CMS regulations.

In April, the External Quality Review Organization (EQRO) prepared the All Plan Summary Report for New York State Medicaid Managed Care Organizations. The EQRO prepared and released its annual technical evaluation of the Managed Long-Term Care Plans (MLTC), in June. The EQRO is reviewing the Medicaid managed care plan's 2013- 2014 final Performance Improvement Project (PIPs) reports, due July 2015.

Performance Improvement Projects (PIPs)

For the 2013-2014 PIP, Part 2 focused on implementing interventions to improve care in one of the four clinical areas: diabetes prevention, diabetes management, hypertension and smoking cessation. All plans are aware that the final PIP report is due to IPRO in July 2015.

For 2015-2016, there will be a two year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers. While the smoking cessation theme will be common to all Managed Care Organizations (MCOs), they may choose to focus on specific populations and will develop unique interventions based on analysis of barriers specific to their enrollees and providers. Identification of MCO enrollees who are smokers will be included as a major focus of the projects. Additionally, all plans will be required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. All MMC plans have submitted smoking cessation PIP proposals and they have all been reviewed and accepted as final. Interventions have been implemented when the proposals were accepted in April 2015. Individual plan specific conference calls with IPRO, New York State Department of Health and the MCOs are scheduled for July 2015 for the plans to report on their PIP progress.

Breast Cancer Selective Contracting

Since 2009, the Department no longer pays for mastectomy or lumpectomy procedures performed at hospital and ambulatory surgery centers averaging fewer than 30 surgeries over a three-year period. Now in the project's seventh year, we are evaluating the impact of this policy on where Medicaid recipients are going for breast cancer surgery.

Discharge data from the Statewide Planning and Research Cooperative System (SPARCS) were linked to Medicaid claim and encounter data to determine how many breast cancer surgeries from 2009-2014 were performed at each of the following facility-level categories: high-volume facilities, low-volume restricted facilities, and low-volume appeal approved facilities. Our analyses indicate that a small proportion of surgeries in State Fiscal Year 2014-2015 were performed at low-volume restricted facilities among the non-dual Medicaid population (2% of Medicaid fee-for-service surgeries and 3% of Medicaid managed care surgeries). Results will be shared with Medicaid managed care plans this summer.

Patient Centered Medical Home (PCMH)

Effective April 1, 2015, providers in practices recognized as PCMHs under the National Committee for Quality Assurance's (NCQA's) 2008 standards are no longer eligible to receive PCMH incentive payments from New York State Medicaid. Additional changes to the incentive program will go into effect on January 1, 2016 (detailed on pages 23-24 of the March 2015 Medicaid Update).

A report to the Legislature detailing the background, evaluation, and findings of the Adirondack multi-payer medical home demonstration will soon be available on the Medicaid Redesign website, along with quarterly reports monitoring of the continued growth of the PCMH program in New York State:
https://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm

IX. Transition Plan Updates

Please see Attachment 1.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

Budget Neutrality report forthcoming.

B. Designated State Health Programs

List 2 DSHP's – finalized edits to 6 of 8 claiming protocols. Awaiting final version of the newborn screening program protocol from CMS. Still working through the GPHW protocol with CMS and the Department program staff in order to finalize List 2. Once List 2 is completed, NY will move back to List 3 to complete protocols for state operations and rate-based programs.

C. Clinic Uncompensated Care

The Department is still working to get the Federal match to the State's share of $54.5 million.

D. Hospital-Medical Home Demonstration

The H-MH Program expired on December 31, 2015. A draft evaluation report was submitted to CMS on April 30, 2015.

XI. Other

A. Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract

All 18 of the March 1, 2014 – February 28, 2019 Medicaid Managed Care/Family Health Plus/HIV SNP contracts were approved by the Office of the State Comptroller, and copies of 17 of these contracts were forwarded during the 3rd quarter to CMS for final approval.

B. Delivery System Reform Incentive Payment Program (DSRIP)

DSRIP is the main mechanism by which the Department will implement the MRT Waiver Amendment. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Up to $6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health. The DSRIP quarterly report is forthcoming.

Attachments:
Attachment 1 – Transition Plan
Attachment 2 – MLTC Partial Capitation Plans

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