Partnership Plan
Section 1115 Quarterly Report
Demonstration Year: 18 (10/1/2015 – 9/30/2016)
Federal Fiscal Quarter: 2 (1/01/2016 – 3/31/2016)

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. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 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 2016.

There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997. 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). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

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. A final draft evaluation report was submitted to CMS on February 11, 2015 and 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 May 31, 2016. Approval of the renewal request will extend the Demonstration until March 31, 2020, 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.

New York is well positioned to lead the nation in Medicaid reform. Governor Cuomo´s Medicaid Redesign Team (MRT) has developed a multi-year action plan (A Plan to Transform the Empire State´s Medicaid Program) that when fully implemented will not only improve health outcomes for more than five million New Yorkers but also bend the state´s Medicaid cost curve. Significant federal savings have already been realized through New York´s MRT process and substantial savings will also accrue as part of the 1115 waiver.

II. Enrollment: First Quarter

Partnership Plan- Enrollment as of March 2016

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	**1,205,105**	**17,314**	**57,267**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**140,476**	**3,170**	**7,937**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**70,747**	**967**	**4,482**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**6,034**	**132**	**540**
Population 5 - Safety Net Adults	**949,923**	**18,354**	**29,316**
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)	**43,987**	**1,268**	**252**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**225,680**	**6,485**	**1,883**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,880**	**365**	**29**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**54,974**	**3,327**	**946**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**51,382 or an approximate 37% decrease from last Q**

Reasons for voluntary disenrollment: In the 1st quarter of FFY 2015 the mainstream plans began the passive enrollment of its own HARP eligible enrollment into their own HARP subsidiary plan. This passive enrollment of 38,214 enrollees was captured in the "Enrolled in Another Plan" category of voluntary disenrollment in the 1st quarter. During the 2nd quarter of FFY 2015 this passive enrollment dropped to 322 enrollees and created a sharp decline in the 2nd quarter voluntary disenrollment. In addition, WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**102,652 or an approximate 10% decrease from last Q**

Reasons for involuntary disenrollment: WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Partnership Plan Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,607,243**	**21,338**	**3,034**	**18,304**
Rest of State	**1,126,375**	**27,733**	**1,940**	**25,793**

Statewide	**2,733,618**	**49,071**	**4,974**	**44,097**
February 2016				
New York City	**1,591,774**	**29,522**	**5,309**	**24,213**
Rest of State	**1,118,501**	**21,954**	**2,268**	**19,677**
Statewide	**2,710,275**	**51,467**	**7,577**	**43,890**
March 2016				
New York City	**1,575,783**	**23,333**	**3,130**	**20,203**
Rest of State	**1,109,763**	**19,700**	**1,874**	**17,853**
Statewide	**2,685,546**	**43,033**	**4,977**	**38,056**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**62,720**			
Rest of State	**63,323**			
Statewide	**126,043**			

HIV SNP Plans				
January 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**14,407**	**144**	**0**	**144**
Statewide	**14,407**	**144**	**0**	**144**
February 2016				
New York City	**14,347**	**165**	**0**	**165**
Statewide	**14,347**	**165**	**0**	**165**
March 2016				
New York City	**14,307**	**148**	**0**	**148**
Statewide	**14,307**	**148**	**0**	**148**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**457**			
Statewide	**457**			

Partnership Plan Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
December 2015	
Plan Name	**Enrollment**
HealthFirst	**13,551**
HealthPlus	**4,024**
HIP GNY	**2,869**
MetroPlus	**7,375**
NYS Catholic Health Plan	**5,635**
United HealthCare	**1,895**
Total:	**35,349**

Health and Recovery Plans Disenrollment			
Q2 2016			
	Voluntary	**Involuntary**	**Total**
January 2016	**617**	**119**	**736**
February 2016	**447**	**104**	**551**
March 2016	**348**	**73**	**421**
Total:	**1,412**	**296**	**1,708**

III. Outreach/Innovative Activities

Outreach Activities

NYMC Field Observations

As of the end of the second federal fiscal quarter (end of March 2016), there were 2,633,421 New York City Medicaid consumers enrolled in a managed care product. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities located throughout the five (5) boroughs of New York City.

During the reporting period, MAXIMUS conducted outreach in the following HRA facilities: 7 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 18 Job Centers (Public Assistance). MAXIMUS reported that 15,383 clients were educated about their enrollment options and that 8,522 (55%) made a voluntary enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed 2,128 one-to-one client informational sessions conducted within its facilities. CMU monitors reported the following:

- 1,392 (65%) clients request general information. General information includes, and is not limited to plan transfer, enrollment options, and mandatory enrollment.
- 736 (35%) Fee-For-Service (FFS) clients made a voluntary plan enrollment choice for themselves and eligible family members.

Infractions were cited for 44 (6%) of the 736 voluntary plan enrollment/education sessions conducted by NYMC Field Customer Service Representatives (FCSR). Infractions most often included failure to disclose information for one or more of the following:

- Good Cause Transfer;
- Preventive Care;
- HARPs;
- Prescriptions; and
- Emergency Services.

NYMC HelpLine Observations

CMU monitors the NYMC HelpLine for Mainstream Medicaid Managed Care products only. During the reporting period, NYMC reported that 83,146 calls were received by the HelpLine and 78,576 or 95% were answered. Calls answered were handled in the following languages - English: 56,676 (72.1%); Spanish: 13,596 (17.3%); Chinese: 4,127 (5.3%); Russian: 1,645 (2.1%); Haitian: 188 (0.2%); and "other": 2,251 (2.9%).
MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,651 Mainstream recorded calls answered by the NYMC HelpLine Customer Service Representatives (CSRs). The call observations were categorized in the following manner:

- General Information: 2,002 (76%) FFS clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 212 (8%) FFS clients voluntarily made a plan enrollment choice.
- Plan Transfer: 316 (12%) plan enrollees requested to change their plan.
- Public Calls: 115 (4%) of callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment.

Infractions/issues were identified for 709 (27%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 373 (53%) - CSRs did not correctly document or failed to document the issue presented; did not provide correct information; and/or did summarize the concern presented to ensure the information conveyed was accurately captured or correct.
- Key Messages: 149 (21%) - CSRs inaccurately explained and/or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 187 (26%) - Consumers were put on hold without an explanation.

All infractions are reported monthly to NYMC for corrective actions to be prepared and implemented. Corrective actions include, but are not limited to: staff training and an increase in monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Health Plans

Effective January 1, 2016, Hudson Health Plan's Medicaid Managed Care enrollees in Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester Counties were migrated to MVP Health Plan or, if selected by the affected enrollee, to another plan operating in the service area in which the enrollee resided.

Effective January 1, 2016, Independent Health Association withdrew from Medicaid Managed Care in Niagara County.

Effective January 1, 2016, MVP Health Plan expanded its Medicaid Managed Care service area to include Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester Counties.

Effective January 1, 2016, UnitedHealthcare of New York expanded its Medicaid Managed Care service area to include Dutchess, Erie, Greene, Livingston and Wyoming Counties.

Effective January 1, 2016, WellCare of New York expanded its Medicaid Managed Care service area to include Nassau, Niagara, Schenectady, Schuyler and Steuben Counties.

Effective March 1, 2016, YourCare Health Plan expanded its Medicaid Managed Care service area to include Monroe, Ontario and Wyoming Counties.

Effective March 1, 2016, Crystal Run Health Plan commenced accepting enrollments in Orange and Sullivan Counties.

Changes to Certificates of Authority (COA)

- MVP Health Plan-Expansion of Medicaid and CHPlus into Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester Counties effective 1/1/16. MVP's COA was updated to reflect the expansion Counties. Hudson Health Plan- transitioned its Medicaid and CHPlus membership to MVP and discontinued its Medicaid managed care operations in Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester Counties effective 1/1/16. Hudson Health Plan's COA was adjusted to reflect "run off" and closed out activities only.
- YourCare-Medicaid and Child Health Plus expansion into Monroe, Ontario, and Wyoming Counties was approved effective 2/1/16. The COA was updated to reflect the expansion Counties.
- Wellcare of New York-Expansion of Medicaid and CHP into Nassau, Niagara, Schenectady, Schuyler and Steuben Counties effective 1/1/16
- United Healthcare-Expansion of Medicaid into Dutchess, Erie, Greene, Livingston and Wyoming Counties effective 1/1/16.
- United Healthcare expansion of CHP into Lewis, Ontario, Seneca, and Wayne Counties effective 1/1/16.

B. Surveillance Activities

Surveillance activity completed during the 2nd Quarter FFY 2015-2016 (01/01/16 to 03/31/16) include the following:

- Three (3) Full Operational Surveys were completed during the 2nd Quarter FFY 2015-16. An SOD was issued and a POC was accepted.

- MVP Health Plan, Inc.
- Empire HealthChoice HMO, Inc.
- Amida Care, Inc.

- One (1) Targeted Operational Survey was completed during the 2nd Quarter FFY 2015-16. An SOD was issued and a POC was accepted for:

  - YourCare Health Plan, Inc.

- Member Services Focus Surveys were completed on one (1) Managed Care Plan during the 2nd Quarter FFY 2015-16. SODs was issued and an Acceptable POC was received for:

  - Affintiy Health Plan, Inc.

- Provider Participation Directory / Information survey was completed on two (2) plans during the 2nd Quarter FFY 2015-16. SODs were issued and Acceptable POCs were received for the following plans:

  - UnitedHealthcare of New York, Inc.
  - Excellus Health Plan, Inc.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

Final reports have been submitted for all of the reviews except for the one involved in litigation. There are no changes from the last update.

- 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 Behavioral Health Services into Managed Care and Development of Health and Recovery Plans:

New York State is transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and substance use disorder) and physical health service system that provides comprehensive, accessible, and recovery oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Social Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are specialized plans that include staff with enhanced behavioral health expertise. For Medicaid Managed Care (MMC), all Medicaid-funded behavioral health services for adults, with the exception of services in Community Residences, will become part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) has begun phasing in enrollment of current MMC enrollees into HARPs beginning with adults 21 and over in New York City. This transition will then expand to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) will provide all covered services available through Medicaid Managed Care. All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) will be made available to eligible HARP and HIV SNP enrollees. These services are designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery. Enrollees must undergo an assessment to determine BH HCBS eligibility as well as eligibility for specific BH HCBS. Effective January 2016 in NYC, BH HCBS were made available to eligible individuals. BH HCBS implementation will begin October 2016 for all regions outside of NYC.

DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) are continuing to meet biweekly with managed care plans and behavioral health providers to discuss stakeholder concerns and implementation challenges. The State plans to continue these meetings throughout the transition

period. In addition, the State has contracted with the Managed Care Technical Assistance Center (MCTAC) to provide technical assistance to behavioral health providers in New York City, including technical assistance around billing managed care, contracting with managed care plans, and the new BH HCBS. The State has also provided education to Medicaid recipients in New York City about the changes to behavioral health that may affect them. The State is mirroring these efforts in the rest of the state for statewide implementation.

During the reporting period, the State has continued to provide ongoing technical assistance during the initial BH HCBS implementation period in NYC to Health Homes and Managed Care Organizations related to the completion of assessments and person-centered plans of care and delivery of the new BH HCBS. The State has begun to focus efforts on educating Health Home care managers in the rest of the state on the training requirements for administering the assessment tools for HARP enrollees. As of March 28, 2016, 538 care managers in NYS have completed the required training. Also during the reporting period, the State and MCTAC have been replicating NYC training related to the behavioral health transition in the rest of the state in preparation for the July 2016 statewide transition.

Transition of Nursing Home Benefit and Population into Managed Care: Effective October 1, 2015, any eligible individual residing in a nursing home who is in fee-for-service Medicaid will be permitted to enroll in a Managed Care Organization on a voluntary basis. This population will no longer be excluded, but exempt from mandatory enrollment into mainstream Medicaid managed care and MLTC. DOH continues to convene joint meetings on a monthly basis with MMCPs and nursing home providers to discuss stakeholder concerns. Most of the questions and concerns brought up on calls during this quarter relate to billing and reimbursement issues.

C. Federally Qualified Health Services (FQHC) Lawsuit

No updates. Decision on wrap calculation is still pending.

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

- <u>During the period January 2016 through March 2016</u>, expanded PACE availability by approving one new plan and two service area expansions.

  New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the rate at which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. <u>For the period January 2016 through March 2016</u> post enrollment surveys were completed for 32 enrollees. 81% of respondents indicated

they continued to receive services from the same caregivers once they became members of an MLTCP. This represents an increase in affirmative responses from 80% during Q1.

- **Enrollment:** Total enrollment in MLTC Partial Capitation Plans grew from 137,705 to 145,984 during the period January 2016 through March 2016. For that quarterly period, 12,245 individuals who were being transitioned into Managed Long Term Care from fee for service made an affirmative choice, bringing the 12-month total for affirmative choice to 39,713. Plan specific enrollment on a monthly basis for the annual period of April 2015 through March 2016 is submitted as an attachment.

2. Significant Program Developments

- During the period January 2016 through March 2016, the focused audit review of Integra concluded. Conclusions and recommendations were released and corrective actions are under review. One new focused audit and one full operational audit have commenced. Release of conclusions and recommendations for these new audits is anticipated during Q3.

- During the period January 2016 through March 2016, design of the focused audit and the comprehensive operational survey tool continued to be refined. Survey staffing and training activities also continued.

- During the period January 2016 through March 2016, efforts to review data that will inform refinement of the 'secret shopper' process continued. Data is also being incorporated into the survey process.

3. Issues and Problems

- During the period January 2016 through March 2016 continued to provide enhanced support to counties new to MLTC. Effective October 1, 2015, the transition of the permanent nursing home population into MLTC was expanded to include voluntary option for residents who were permanently placed prior to effective date of the transition. District specific support was offered and provided upon request, along with a number of training sessions and educational opportunities to reinforce basic protocols.

4. Summary of Self Directed Options

- The transition of consumers receiving Consumer Directed Personal Assistance Service (CDPAS) was achieved during the October 2013 through September 2014 period. Self-direction is provided within the MLTCP as a consumer choice, and gives individuals and families greater control over services received. Plans continue to be required to contract with a minimum of two (2) Fiscal Intermediaries in each county. The requirement continues to be monitored on a quarterly basis, and all plans are meeting that requirement.

5. Required Quarterly Reporting

- **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. There were 179 critical incidents reported for the period January 2016 through March 2016. This increase from 117 incidents reported during Q1 is largely due to one plan's underreporting in Q1, which has subsequently been corrected and captured in Q2.

- **Grievance and Appeals:** For the period January 2016 through March 2016, key areas of concern remain transportation and dissatisfaction with quality of home care.

Period: 1/01/16 - 3/31/16			
Number of Recipients: 154,436	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	5,239	5,239	100%
# Standard/Expedited	2,061	1,866	91%
Total for this period	7,300	7,105	97%

Appeals	**4/15-6/15**	**7/15-9/15**	**10/15-12/15**	**1/16-3/16**	**Average for Four Quarters**
Average Enrollment	137,182	140,873	146,196	154,436	144,672
Total Appeals	2,446	1,593	1,392	1,099	1,633
Appeals per 1,000	18	11	10	7	11
# Decided in favor of Enrollee	N/A*	944	393	181	N/A*
# Decided against Enrollee	N/A*	875	637	513	N/A*
# Not decided fully in favor of Enrollee	N/A*	228	476	337	N/A*
# Withdrawn by Enrollee	N/A*	20	32	15	N/A*
# Still pending	N/A*	208	91	155	N/A*
Average number of days from receipt to decision	N/A*	13	13	12	N/A*

*Appeals subcategories were added to reporting effective July 2015.

Grievances and Appeals per 1,000 Enrollees
By Plan and Product Type
January 2016 – March 2016

Plan Name:	**Plan Type**	**Enrollment**	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plans						
Aetna Better Health	Partial	3,520	38	11	15	4
AgeWell New York ,LLC	Partial	6,118	216	35	6	1
AlphaCare of New York Inc.	Partial	2,356	190	81	8	3
Amerigroup	Partial	2,975	34	11	-	-
ArchCare Community Life	Partial	2,037	314	154	9	4
CenterLight Healthcare Select	Partial	5,572	190	34	4	1
Centers Plan for Healthy Living	Partial	4,873	143	29	16	3

Elant Choice	Partial	864	18	21	-	-
ElderServe Health, Inc.	Partial	10,719	158	15	13	1
EmblemHealth	Partial	17	-	-	-	-
Extended	Partial	956	36	38	2	2
Fallon Health Weinberg	Partial	253	1	4	-	-
FIDELIS Care New York	Partial	12,154	222	18	4	0
GuildNet MLTCP	Partial	16,696	993	59	125	7
Hamaspik Choice	Partial	1,476	11	7	-	-
HomeFirst MLTC, a product of Elderplan	Partial	10,700	849	79	77	7
I Circle	Partial	1,016	11	11	-	-
Independence Care Systems		5,851	370	63	46	8
Integra MLTC	Partial	3,059	47	15	11	4
Kalos, dba First Choice Health	Partial	610	16	26	-	-
Metroplus	Partial	1,003	46	46	1	1
Montefiore Diamond Care	Partial	787	70	89	1	1
NSLIJ Health Plan	Partial	2,849	68	24	1	0
Prime Health Choice, LLC	Partial	130	7	54	-	-
Senior Health Partners	Partial	12,549	482	38	441	35
Senior Network Health	Partial	497	7	14	-	-
Senior Whole Health	Partial	4,107	161	39	3	1
United Healthcare Personal Assist	Partial	1,876	11	6	5	3
VillageCareMAX	Partial	5,395	467	87	11	2
VNA Homecare Options, LLC	Partial	1,704	-	-	3	2
VNSNY CHOICE MLTC	Partial	13,773	1,371	100	56	4
Wellcare	Partial	6,845	72	11	2	0
Total		143,337	6,619	46	860	6
Medicaid Advantage Plus (MAP)						
Elderplan	MAP	902	91	101	7	8
EmblemHealth	MAP	5	-	-	-	-
Fidelis Medicaid Advantage Plus	MAP	144	1	7	-	-
GuildNet GNG	MAP	613	52	85	7	11
Healthfirst CompleteCare	MAP	3,748	40	11	213	57
HEALTHPLUS AMERIGROUP	MAP	4	-	-	-	-
Senior Whole Health	MAP	120	3	25	2	17
VNSNY CHOICE MLTC TOTAL	MAP	84	1	12	-	-
Total:		5,620	188	33	229	41
Program of All-inclusive Care for the Elderly (PACE)						
ArchCare Senior Life	PACE	468	35	75	-	-
Catholic Health LIFE	PACE	208	19	91	1	5
CenterLight Healthcare	PACE	3,243	273	84	1	0
Complete Senior Care	PACE	122	9	74	3	25
Eddy SeniorCare	PACE	179	50	280	1	6
ElderONE	PACE	669	56	84	-	-
Independent Living Services of CNY (PACE CNY)	PACE	485	31	64	1	2

Total Senior Care	PACE	106	20	188	-	-
Total:		5,480	493	90	7	1
Grand Total:		154,436	7,300	47	1,096	7

Total Grievances reported decreased from 8,542 during Q1 to 7,300 during the Q2 period of January 2016 through March 2016.

Total number of appeals also decreased from 1,394 during Q1 to 1,096 during the Q2 period of January 2016 through March 2016.

- **Fraud and Abuse:** For the period January 2016 through March 2016, there were 165 new potential cases of Fraud and Abuse detected, representing an increase over Q1. However, enhanced reviews of reported fraud and abuse began during Q1 to ensure that referrals to appropriate investigative agencies were being made by MLTC plans. While these efforts are likely reflected in Q2 results, outreach and continued review of reported cases will be conducted to ensure appropriate reporting.

Fraud and Abuse Complaints Reported During Quarter	1/16 - 3/16
New potential cases of Fraud and Abuse detected during the reporting period	165
Open potential cases of Fraud and Abuse from previous quarter being investigated	33
Cases of Fraud and Abuse confirmed during the reporting period	18
Open potential cases of Fraud and Abuse remaining unconfirmed and still being investigated at the end of the reporting period.	47

- **Fair Hearings:**

Fair Hearing Decisions	1/16-3/16
In favor of Appellant	552
In favor of MLTC Plan	97
No Issue	5
Total	654

Fair Hearings: Days From Request To Decision	1/16 – 3/16
Less than 30 days	50

30 - 60 days	403
61 - 90 days	121
91 – 120 days	45
>120 days	35
Total Fair Hearing Decisions	**654**

- **Technical Assistance Center (TAC) Activity**

    - During the Quarterly Period from January 2016 - March 2016, the TAC unit continued to face database problems, with the completion of repairs anticipated for April 2016. Staff have been retrained on the appropriate procedures for working with the new database. TAC staff continue with the work-around that was put in place the previous quarter. Preliminary testing of the new database indicates the complaint process will be more efficient.

    - Second Quarter Highlights from MLTC-TAC: During Q2, there was a noticeable reduction in delayed enrollments caused by CFEEC evaluations not being completed timely. This improvement resulted from a discussion with Maximus about the trending issue and an agreement to hire and train more staff. Overall, however, there was an increase in enrollment issues. The TAC Unit also noticed an increase in billing issues related to claims denied in error. Most of the billing issues involve only a few providers, but the TAC will continue to monitor this issue to determine if it is more widespread.

        Complaint volume:
        - 357 substantiated complaints
        - 292 unsubstantiated complaints
        - 679 total complaints
        - 144 inquiries
        - 844 total call volume

        Complaint investigation activity:
        - Resulted in one (1) targeted corrective action plan
        - Issue: Enrollment-Assessment/Application-Not Timely
        - Impacted Regions: New York, Dutchess, Suffolk

    - **Evaluations for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the period January 2016 through March 2016, 3,830 people were evaluated, deemed eligible and enrolled into plans.

    - **Referrals and 30 day assessment:** For the period January 2016 through March 2016, total reported assessments conducted by the MLTC plans during the period were 10,302. The total number of assessments conducted this quarter has increased, as has

the percentage of assessments conducted within the 30-day time frame, which was at 83%. Due to the implementation of CFEEC on a statewide basis, data collection, evaluation and reporting for this element will continue to be monitored.

- **Referrals outside enrollment broker:** During the period January 2016 through March 2016, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 13,359. This is an increase from 11,481 in Q1.

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

Rebalancing Efforts	1/16 - 3/16
New Enrollees to the Plan from a nursing home transitioning to the community	398
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	1,898
Current plan Enrollees permanently placed in a nursing home	3,432
New Enrollees permanently placed in a nursing home who remain in a nursing home	1,682

During Q4, plans reported 1,959 enrollees permanently placed in a nursing home. Subsequent outreach to plans indicated misinterpretation of data instructions. The correct number for the period was 1,584. Q1 data reflected a significant increase over Q4, and outreach to plans continued. Q2 likely represents more accurate data as plans have now had the opportunity to realign data reporting with the data instructions. However, follow up will be conducted with those plans that reported the largest increases in order to ensure accurate reporting.

VI. Evaluation of the Demonstration

Currently under review and discussion with CMS.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 5,521 complaints/action appeals this quarter, an increase of 6.4% from the previous quarter. The most frequent category of complaint/appeal was balance billing disputes, accounting for 25% of the total. There were 190 complaints/appeals reported by the HIV SNPs. The majority of these complaints (48) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 435 Medicaid managed care complaints this quarter.

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

25% Balance Billing
16% Advertising/ED/Outreach/Enrollment
12% Dental or Orthodontia
9% Reimbursement/Billing Issues
7% All other

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	1
Consumer Directed Personal Assistant	0
Home Health Care	6
Non-Permanent Residential Health Care Facility	4
Personal Care Services	9
Personal Emergency Response System	0
Private Duty Nursing	1
Total:	21

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 5,521 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 628 complaints and action appeals from their SSI enrollees. This compares to 736 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	31%
Quality of Care	21%
All other	17%
Balance Billing	17%
Advertising/ED/Outreach/Enrollment	15%

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	1

Advertising/Education/Outreach/Enrollment	56
AIDS Adult Day Health Care	0
Appointment Availability - PCP	0
Appointment Availability - Specialist	3
Balance Billing	65
Communications/Physical Barrier	6
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	16
Dental or Orthodontia	119
Emergency Services	14
Eye Care	2
Family Planning	0
Home Health Care	6
Mental Health/Substance Abuse Services/ Treatment	33
Non-covered Services	31
Non-Permanent Resident Health Care Facility	2
Personal Care Services	6
Personal Emergency Response System	0
Pharmacy	27
Private Duty Nursing	1
Provider or MCO Services (Non-Medical)	42
Quality of Care	79
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	33
Specialist or Hospital Services	10
Transportation	2
Waiting Time Too Long at Office	7
All Other Complaints	66
Total:	**628**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 25, 2016. The meeting included presentations provided by state staff and discussions of the following: a presentation on the Medicaid budget and Medicaid Global Cap; an update on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs, including Conflict Free Evaluation and Enrollment Center (CFEEC) activity, and an overview of financial monitoring for MLTC plans; a presentation on the Medicaid managed care auto assignment process, including criteria for auto assignment, the auto assignment algorithm, and a discussion of state and local district outreach and other activities aimed at reducing auto assignment; and an update on the behavioral health

managed care transition, with discussion of Health and Recovery Plan (HARP) enrollment and ongoing and planned monitoring and oversight activities related to implementation.

B. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on January 21, February 11, and March 10, 2016. The January meeting included the following: a discussion of the National Diabetes Prevention Program (NDPP) by representatives from the New York State Health Foundation, including the costs and benefits of the NDPP program; an update on Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) capitation rates; a discussion of 2016-2017 Executive Budget proposals affecting managed care; a discussion of Value Based Payment (VBP) data; a status update on Delivery System Reform Incentive Payment (DSRIP) activities; a brief update on the behavioral health transition and HARP implementation; updates on MLTC and Fully Integrated Dual Advantage (FIDA) program activities; and a presentation from staff of "God's Love We Deliver" regarding their medically tailored home-delivered meal program for eligible managed care enrollees. The February meeting agenda included: an overview of mainstream MMC and MLTC finance and rate development; a brief discussion of Hepatitis C and high cost drugs; an overview of the Fair Labor Standards Act and its impact on managed care plans; a DSRIP update; updates on FIDA and MLTC enrollment, activities of the Conflict-Free Evaluation and Enrollment Center (CFEEC), and Community First Choice Option; an overview of the planned transition of School Based Health Center services to Medicaid Managed Care, including an update on the progress of the carve-in, summaries of draft SBHC policy guidance and draft policy regarding confidentiality for minors, and a discussion of the carve-in process and timeline; updates on managed care enrollment issues; and a discussion of the behavioral health transition and HARP implementation, including an update on the children's managed care transition. Presentations, updates and discussions at the March meeting included: an overview of MMC and MLTC rate development and status, and discussions of base data and risk adjustment; an update on DSRIP status and related activities; updates on FIDA, MLTC, and the workgroup activities related to the Nursing Home Transition and Diversion and Traumatic Brain Injury Waiver transition to managed care; an update on 2014 access and availability surveys; and a discussion of 834 reports and roster reconciliation process.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

1. <u>2015 Quality Incentive for Medicaid Managed Care</u>

2015 Quality Incentive awards were announced in March 2016. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction and efficiency (Prevention Quality Indicators). Points for issues with Compliance are subtracted from the total plan points before calculating the percentage of total points. The 2015 awards included one plan receiving all of the

award, fourteen plans receiving some portion of the award, and two plans not receiving any of the award. The awards will be implemented in April 2016 capitation rates.

Quality Incentive 2015
Quality Points NORMALIZED to 100 based on highest score
April 1st, 2016

Incentive Premium Award (%)	Plan Name	Normalized Quality Points = Quality Points/High Score (100 points possible)	Satisfaction Points (30 points possible)	PQI/PDI Points (20 points possible)	Compliance Points (18 points possibly subtracted)	Total Points	Percent of Total Points (up to 100%)
100%	Healthfirst PHSP, Inc.	100.0	20	0	-2	118.0	79
75%	Fidelis Care New York, Inc.	88.6	15	0	-4	99.6	66
75%	CDPHP	65.2	25	5	-2	93.2	62
75%	Hudson Health Plan	53.0	25	15	-2	91.0	61
50%	HealthPlus, an Amerigroup Company	81.8	10	0	-6	85.8	57
50%	Affinity Health Plan	72.0	15	0	-6	81.0	54
50%	MetroPlus Health Plan	68.9	15	0	-6	77.9	52
50%	UnitedHealthcare Community Plan	53.8	15	10	-2	76.8	51
50%	WellCare of New York	56.8	5	15	-2	74.8	50
50%	MVP Health Care	43.0	15	15	-2	71.0	47
50%	HealthNow New York Inc.	42.5	20	12.5	-6	69.0	46
25%	Excellus Blue Cross BlueShield	26.5	15	20	-2	59.5	40
25%	Independent Health	30.3	25	5	-2	58.3	39
25%	Univera Community Health	29.2	20	7.5	-6	50.7	34
0%	HIP (EmblemHealth)	40.2	10	0	-6	44.2	29
0%	Total Care, A Today's Options of New York Health Plan	20.5	10	5	-6	29.5	20

2. Quality Measurement in Managed Long-Term Care (MLTC)

<u>2015 Managed Long-Term Care Consumer Guides</u>
The 2015 MLTC Consumer Guides were released in January 2016 on the Department's website. The Guides are also printed by Maximus, our facilitated Medicaid enroller, for inclusion in new member's packets. The Guides help new members to choose a managed long-term care plan that meets their health care needs. The Guides offer information about the quality of care offered by the different plans, and people's opinions about the care and services the plans provide.

<u>2015 Managed Long-Term Care Report</u>
The 2015 MLTC Report was publically released in March of 2016. This Report presents information on the 69 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

<u>2015 Quality Incentive for Managed Long-Term Care (MLTC)</u>
2015 Quality Incentive awards were announced in February 2016. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, compliance, and efficiency. Since the MLTC is budget neutral, the bottom tier did not receive any contributed monies back, all the other tiers

received back a portion or full amount of contributed monies plus additional award. The awards are retroactive to the April 2015 capitation rates.

Payer	Plan ID	Plan Name	QI Points,
PACE	03072740	Catholic Health - LIFE	71.3
partial	03234044	ElderServe dba RiverSpring	70.0
partial	03549135	Extended MLTC	66.7
partial	02644562	HealthPlus MLTC	62.5
MAP	02942923	GuildNet Medicaid Advantage Plus	62.5
partial	02825230	WellCare Advocate Partial	58.8
partial	02188296	Fallon Health Weinberg	57.7
PACE	03114514	ArchCare Senior Life	57.5
PACE	01519162	PACE CNY	57.5
partial	03560441	AlphaCare of New York	56.3
partial	03580307	North Shore-LIJ Health Plan	56.3
partial	03594052	Montefiore MLTC	55.4
partial	01827572	GuildNet	55.0
PACE	03320725	Complete Senior Care	55.0
MAP	03173113	Elderplan	55.0
MAP	03420808	MHI Healthfirst Complete Care	53.8
partial	02104369	Senior Health Partners	51.3
partial	01778523	Senior Network Health	51.3
PACE	01234037	CenterLight PACE	51.3
partial	03458546	Aetna Better Health	48.8
partial	03481927	AgeWell New York	48.8
PACE	01278899	ElderOne	48.8
MAP	02927631	Fidelis Medicaid Advantage Plus	48.5
partial	01825947	Evercare Choice	46.3
partial	01865329	Independence Care System	46.3
MAP	02914056	VNS Choice Plus MAP	45.0
partial	03690851	Kalos Health	44.2
partial	03466906	MetroPlus MLTC	42.5
partial	03420399	VillageCareMAX	42.5
partial	03253707	Elderplan dba Homefirst	41.3
partial	01750467	VNS Choice Partial	41.3
PACE	03056544	Total Senior Care	40.4
partial	03466800	ArchCare Community Life	40.0
partial	03506989	Centers Plan for Healthy Living	40.0
partial	03459881	Senior Whole Health Partial	40.0
partial	03475427	Integra MLTC	37.5
partial	02710185	CenterLight Select	36.3

partial	01788325	Fidelis Care at Home	35.0
partial	03522947	Hamaspik Choice	34.6
partial	03439663	United Health Personal Assist	30.0
partial	03529059	VNA Homecare Options	30.0
MAP	03239801	Health Insurance Plan	28.8
partial	03416231	HIP MLTC	27.5
PACE	01674982	Eddy Senior Care	26.9

B. Quality Improvement

External Quality Review

The Island Peer Review Organization (IPRO) was awarded a 5 year contract in 2015 to continue to serve as New York State's External Quality Review Organization (EQRO). In that role, IPRO conducts Medicaid managed care external quality review activities on behalf of the state including: 1) Validation of performance improvement projects (PIPs); 2) Validation of performance measures; and 3) Review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement. In addition to these federally required activities, New York State DOH contracts with IPRO to conduct optional external review activities including: 1) Validating encounter and functional assessment data reported by the MCOs; 2) Administering or validating consumer satisfaction surveys; 3) Calculating performance measures in addition to those conducted by the MCO; 4) Conducting focused clinical studies; and 5) Implementation of PIPs required by the State in addition to those conducted by the MCO.

In this period, IPRO finalized reports on Managed Care Organizations (MCOs) Access and Availability, Member Services, and Provider Directory surveys. They worked closely with the DOH to address concerns risen by MMC plans related to survey methodology and resultant statements of deficiency when issues were identified. They worked on templates for the next PCP Ratio Survey and facilitated the incorporation of HARP and Nursing Home components into an online provider directory managed through a subcontract with 3M (TREO solutions). They also continued to work on developing a new Panel Data reporting system for the Department, and provided the DOH with a proposal for rebuilding the state's Provider Network Data System (PNDS), facilitating ascertainment of third party vendors for select components of required work.

IPRO also began review of the Managed Long Term Care (MLTC) 2015 PIP final reports, and started review of the MLTC PIP proposals for 2016. They facilitated conference calls and meetings with MLTC plans to coordinate PIP activities and address issues encountered with reports or proposals. For MMC PIPS, IPRO compiled and worked with DOH to finalize the 2013/2014 PIP summary compendium. They collected and began review of 2015 PIP interim reports. They held ongoing conference calls and meetings with MMC plans throughout the quarter to discuss PIP related activities.

Additional information on MMC PIPs can be found under the Performance Improvement Project description.

In this quarter, IPRO drafted templates for 2014 MMC plan technical reports and developed plan correspondence documentation. They also worked on development and revision of 36 MLTC plan technical report drafts.

Plans for an audit of the state's Uniform Assessment System (UAS) were in development this quarter. IPRO assisted the DOH in creating a validation tool, incorporating a Traumatic Brain Injury (TBI) component.

Work on a Prenatal Care quality improvement project was ongoing with IPRO oversight of the Cohort identification, tool development, data collection, analysis, report generation, conference/webinar administration, and presentation of results. This time period saw the rollout of Cohort 1 from 2014, and planning for a validation project to roll out in late spring 2016.

IPRO's oversight (external quality review) of performance measurement (QARR) included managing revision and changes in the Data Submission System for MMC, SNPs, and QHPs. The finalized DSS was approved for dissemination to plans at the end of the quarter. IPRO also assisted in development of a Care Management data collection system (CMART), and associated test files, facilitating plan onboarding of the system. Finally, IPRO facilitated, through a subcontract with DataStat, the completion of the CAHPS survey reports (MMC member satisfaction) for the survey administered in the fall of 2015.

Performance Improvement Projects (PIPs)

For the 2013-2014 Performance Improvement Project (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 submitted final PIP reports to IPRO in July 2015. A compendium of 2013-2014 PIP abstracts has been completed and is posted on the NYSDOH public website.

For 2015-2016, the two year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers is being implemented. Identification of MCO enrollees who are smokers is included as a major focus of the projects. Additionally, all plans are required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. Individual plan specific conference calls with IPRO and the MCOs were completed for March 2016 for the plans to report on their PIP progress. A conference call was held January 6, 2016 and March 29, 2016 with all of the Medicaid managed care plans, IPRO and representatives from the NYSDOH Bureau of Tobacco Control and DPIPS, as well as the Office of Mental Health. Seven Medicaid managed care plans presented on their progress on the respective Smoking Cessation PIPs including: the

project aim, performance indicators, interventions, preliminary data, barriers experienced, lessons learned and next steps. Additional handouts distributed to the MMC plans included: Recovery from Nicotine Dependence: A Counselor Manual to Help People with HIV Quit Smoking, a brochure Live Smoke Free, designed for people with HIV who smoke. In addition, the International Classification of Diseases (ICD)-10 Codes for Tobacco/Nicotine Dependence, and Secondhand Smoke Exposure, Effective October 1, 2015, was distributed to the MMC plans. All MMC plans submitted smoking cessation PIP Interim Reports which were due January 15, 2016 to summarize their first year progress on their PIP. All of the Interim PIP Reports have been accepted as final.

Breast Cancer Selective Contracting

The Department completed its eighth annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2012-2014 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 254 facilities were designated as follows: 118 high-volume facilities, 25 low-volume unrestricted facilities, 69 low-volume restricted facilities, and 42 closed facilities.

Two facilities appealed the decision to be placed on the low-volume restricted list; both appeals were denied. Administrators at these facilities were notified via mail of their denials. In addition, letters regarding final volume designation for state fiscal year 2016 were sent to health plan chief executive officers, and health plan trade organizations. The list of low-volume restricted facilities was posted on the Department's website and included in the March Medicaid Update.

Patient Centered Medical Home (PCMH)

As of March 31, 2016, there were approximately 6,800 NCQA-recognized PCMH providers in New York State. Approximately 1,600 (24%) of these providers are recognized under the newest (2014) set of standards. Changes to the PCMH payment structure, which reduced the incentive amount for those recognized under 2011 standards and increased the incentive for those recognized under 2014 standards, went into effect on January 1, 2016. PCMH staff continue to work with plans and providers to explain payment changes.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. A recent multi-payer quality analysis showed several positive outcomes for patients receiving care from ADK practices compared to patients in a comparison group, particularly on pediatric measures in 2014 and 2015.

Quarterly and annual reports on NYS PCMH and ADK program growth can be found on the MRT website, available here: http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

IX. Transition Plan Updates

No updates for this quarter.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

The budget neutrality quarterly report is not available, because NY is in the process of updating the specifications manual. There is an understanding with CMS that NY will work on updating the specifications manual before completing the quarterly reports; if not, the quarterly reports will be completed with inaccurate information.

B. Designated State Health Programs

No Updates for this quarter.

C. Clinic Uncompensated Care

No updates for this quarter.

XI. Other

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

During the second quarter, CMS approved the remaining four out of eighteen March 1, 2014 – February 28, 2019 Medicaid Managed Care/Family Health Plus/HIV SNP contracts.

On January 20, 2016, CMS approved the Medicaid Managed Care contract with Crystal Run Health Plan. This contract has effective dates of August 1, 2015 – February 28, 2019.

B. Transformed Medicaid Statistical Information Systems (T-MSIS)

New York has been working very closely with CMS as a front running state. New York is in Pre-Operational Readiness Testing (PORT) for T-MSIS Release 2.0. New York is submitting test files for all eight file types, reviewing results through the Operations Dashboard, entering issues/defects through JIRA and using HipChat for real-time communications with the T-MSIS support team.

Attachments:

Attachment 1 - MLTC Partial Capitation Plans

State Contact:

Priscilla Smith
Medical Assistance Specialist III
Division of Program Development and Management
Office of Health Insurance Programs

priscilla.smith@health.ny.gov
Phone (518) 486-5890
Fax# (518) 473-1764

Uploaded to PMDA: May 25, 2016

Attachment 1

Managed Long Term Care
Partial Capitation Plans
April 2015- March 2016

Plan Name	Apr-15 Enrollment	May-15 Enrollment	Jun-15 Enrollment	Jul-15 Enrollment	Aug-15 Enrollment	Sep-15 Enrollment	Oct-15 Enrollment	Nov-15 Enrollment	Dec-15 Enrollment	Jan-16 Enrollment	Feb-16 Enrollment	Mar-16 Enrollment
Aetna Better Health	3,034	3,028	3,137	3,147	3,154	3,210	3,258	3,303	3,363	3,447	3,530	3,583
AgeWell New York	4,303	4,452	4,659	4,814	4,931	5,124	5,274	5,471	5,666	5,895	6,125	6,334
AlphaCare	1,652	1,725	1,836	1,869	1,919	1,967	2,025	2,082	2,176	2,230	2,347	2,490
Amerigroup	2,530	2,545	2,600	2,589	2,563	2,589	2,602	2,669	2,790	2,901	2,971	3,053
ArchCare Community Life	1,875	1,877	1,898	1,899	1,894	1,923	1,926	1,943	1,973	2,017	2,035	2,059
CCM Select	6,297	6,243	6,202	5,978	5,771	5,810	5,732	5,745	5,652	5,590	5,571	5,556
Centers Plan for Healthy Living	2,405	2,575	2,795	3,011	3,192	3,462	3,684	3,881	4,198	4,490	4,850	5,278
Elant	844	857	861	857	861	853	866	868	860	866	861	866
Elderplan	10,539	10,684	10,842	10,809	10,848	10,821	10,667	10,666	10,599	10,647	10,711	10,742
Elderserve	10,421	10,381	10,583	10,456	10,412	10,590	10,625	10,678	10,643	10,685	10,718	10,755
ErieNiagara MLTCP (Kalos Health	307	323	342	373	405	445	481	498	524	565	604	662
Extended MLTC	371	398	461	556	615	694	754	821	874	915	954	999
Fidelis Care at Home	9,147	9,203	9,495	9,490	9,626	10,048	10,134	10,747	11,243	11,735	12,067	12,661
Guildnet	13,809	13,888	14,157	14,064	14,102	14,271	14,402	14,557	14,781	16,643	16,708	16,737
Hamaspik Choice	772	821	883	969	1,042	1,131	1,202	1,275	1,339	1,398	1,492	1,539
HIP of Greater New York	1,255	1,268	1,286	1,279	1,263	1,293	1,288	1,303	1,311	36	11	3
iCircle Services	78	117	215	319	398	562	682	803	883	953	1,018	1,077
Independence Care Systems	5,059	5,128	5,335	5,377	5,356	5,473	5,503	5,647	5,729	5,788	5,840	5,925
Integra	2,257	2,319	2,399	2,440	2,458	2,556	2,660	2,769	2,950	2,886	3,093	3,199
MetroPlus MLTC	847	873	893	883	874	876	897	923	939	978	1,004	1,027
Montefiore HMO	524	535	544	568	590	608	609	658	691	726	771	865
North Shore-LIJ Health Plan	1,693	1,797	1,968	2,048	2,113	2,254	2,351	2,479	2,585	2,735	2,848	2,965
Prime Health Choice	41	45	54	67	71	84	87	99	102	108	133	149
Senior Health Partners	13,524	13,767	13,997	13,808	13,583	13,758	11,855	12,761	12,759	12,645	12,538	12,463
Senior Network Health	491	489	485	481	483	494	499	490	493	488	495	507
Senior Whole Health	2,295	2,471	2,610	2,756	2,846	3,039	3,188	3,418	3,651	3,863	4,097	4,360
Fallon Health Weinberg (TAIP)	149	155	158	169	173	189	198	206	225	237	249	272
United Healthcare	1,226	1,261	1,300	1,324	1,336	1,394	1,437	1,524	1,633	1,735	1,879	2,014
Village Care	3,551	3,641	3,818	3,878	4,040	4,273	4,440	4,732	4,974	5,186	5,403	5,596
VNA HomeCare Options	650	666	689	713	800	952	1,060	1,212	1,410	1,577	1,693	1,841
VNS Choice	14,807	14,495	14,701	14,037	13,372	13,306	13,278	13,418	13,555	13,732	13,762	13,824
WellCare	6,769	6,914	7,194	7,137	7,207	7,231	7,226	7,201	7,134	7,115	6,837	6,583
TOTAL	**123,522**	**124,941**	**128,397**	**128,165**	**128,298**	**131,280**	**130,890**	**134,847**	**137,705**	**140,812**	**143,215**	**145,984**

Mandatory County Transition by month			Allegany, Chuautaqua, Chemung, Clinton,Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence, Schuyler,Seneca, Yates									
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
MLTC Product	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Partial Cap	123,522	124,941	128,397	128,165	128,298	131,280	130,890	134,847	137,705	140,812	143,215	145,984
PACE	5,451	5,464	5,491	5,473	5,516	5,502	5,493	5,481	5,491	5,464	5,467	5,508
MAP	6,055	6,074	6,152	6,148	6,098	6,140	6,210	6,231	6,240	5,625	5,573	5,661
TOTAL	**135,028**	**136,479**	**140,040**	**139,786**	**139,912**	**142,922**	**142,593**	**146,559**	**149,436**	**151,901**	**154,255**	**157,153**