MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 20 (10/1/2016 – 9/30/2017)
Federal Fiscal Quarter: 2 (1/01/2017 – 3/31/2017)

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 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 several 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 was approved by CMS on May 24, 2016.

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 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 31,

2021. At the time of renewal, the Partnership Plan was renamed New York Medicaid Redesign Team (MRT) Waiver.

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: Second Quarter

Partnership Plan- Enrollment as of March 2017

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	947,709	9,678	91,815
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	123,425	2,379	9,615
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	39,647	454	13,307
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	4,446	72	866
Population 5 - Safety Net Adults	697,975	14,210	80,839
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)	33,913	1,165	166
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	199,896	9,965	1,593

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,387**	**299**	**29**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**58,367**	**2,939**	**1,193**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**41,161 or an approximate 22% decrease from last Q**

Reasons for voluntary disenrollment: 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.

During this quarter mainstream plans passively enrolled 7,503 of their own Health and Recovery Plan (HARP) eligibles into their own offspring HARP plan. This represents a decline from the 12,479 passively enrolled in the prior quarter. There was also a decrease in the number of enrollees with a change in program eligibility status, newly eligible Medicare recipients and incarcerations, that exclude them from further program enrollment. Both factors contributed to the current quarter's decline in 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 further contributing to a decline in voluntary disenrollment.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**199,423 or an approximate 2% increase from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid eligibility including death, plan termination, and retro-disenrollment.

As in prior quarters WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers draw on a smaller WMS population causing involuntary disenrollment to decline, but the significant increase in case closures in the WMS population that was seen in the prior quarter was carried over into this current quarter. The result being a small increase in this quarter's involuntary disenrollment.

Partnership Plan Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,352,259**	**19,265**	**2,707**	**16,558**
Rest of State	**845,094**	**14,580**	**1,618**	**12,962**
Statewide	**2,197,353**	**33,845**	**4,325**	**29,520**
February 2017				
New York City	**1,332,094**	**22,011**	**2,819**	**19,192**
Rest of State	**812,014**	**16,299**	**1,757**	**14,542**
Statewide	**2,144,108**	**38,310**	**4,576**	**33,734**
March 2017				
New York City	**1,314,804**	**20,207**	**2,396**	**17,811**
Rest of State	**779,472**	**14,673**	**1,582**	**13,091**
Statewide	**2,094,276**	**34,880**	**3,978**	**30,902**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**53,561**			
Rest of State	**40,595**			
Statewide	**94,156**			

HIV SNP Plans				
January 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	13,621	138	0	138
Statewide	13,621	138	0	138
February 2017				
New York City	13,570	174	0	174
Statewide	13,570	174	0	174
March 2017				
New York City	13,489	131	0	131
Statewide	13,489	131	0	131
First Quarter				
Region	**Total Affirmative Choices**			
New York City	443			
Statewide	443			

Partnership Plan Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
March 2017	
Plan Name	**Enrollment**
Affinity Health Plan	3,470
Capital District Physicians Health Plan	2,141
Excellus Health Plan	5,392
HealthFirst	18,943
HealthPlus	5,263
HIP GNY	4,552
Independent Health Association	1,393
MetroPlus	8,947
Molina Healthcare (name change from Today's Options)	1,258

MVP Health Plan	3,485
NYS Catholic Health Plan	20,326
Today's Options	0
United HealthCare	4,984
YourCare Health Plan	1,318
Total:	81,472

Health and Recovery Plans Disenrollment			
FFY 17 – Q2			
	Voluntary	Involuntary	Total
January 2017	697	490	1,187
February 2017	973	566	1,539
March 2017	922	579	1,501
Total:	2,592	1,635	4,227

III. Outreach/Innovative Activities

A. Outreach Activities

NYMC Field Observations

As of the end of the second federal fiscal quarter (end of March 2017), there were 2,601,259 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program. 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 throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted outreach in 33 HRA facilities including: 6 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 15,381 clients were educated about their enrollment options and 7,613 (49%) clients made an enrollment choice.

Human Resources Administration's Contract Monitoring Unit (CMU) observed a total of 1,889 presentations: 1,619 one-to-one presentations and 270 auto-assignment outreach presentations. The 1,889 presentations resulted in 543 completed managed care applications and 642 enrollments; also, FCSR provided 1,346 consumers with general information. The Contract Monitoring Unit observed 1,619 one-to-one client informational sessions- 1,598 in HRA sites and 21 in nursing home facilities.

CMU monitors reported the following:

- At HRA sites, 481 (30%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.

    - Of the 481 FFS clients that selected a plan during an informational session, 183 (38%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.
- 1,117 (69%) clients received requested general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment. At nursing homes, eight (0.5%) residents made voluntary enrollment choice and 13 (1%) received general information.

Infractions were observed for 29 (6%) of the 489 (481 FFS and 8 Nursing Home) of the one-to-one client informational sessions conducted by NYMC Field Customer Service Representatives (FCSRs). Infractions most often noted were failure to disclose or explain the following:
- Good Cause Transfer
- Health Assessment Form
- Dental
- Emergency Room Services

Auto-Assignment (AA) Outreach
In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients selected for plan auto-assignment. A total of 25,712 clients were reported on the auto-assignment list by NYMC. 4,191 clients responded to the call. CMU monitored 270 (6%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 54 (20%) FFS clients made a voluntary phone enrollment choice for themselves and their family members.
    - Infractions were observed for 16 (30%) of the 54 AA phone enrollment. The following infractions were identified for the AA phone enrollments conducted by the FSCRs:
        - Failed to explain specialist, standing referral process
        - Use of plan ID card
        - Dental
        - Good Cause Transfer
- Undecided: 216 (80%) FFS clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician.
    - No infractions were observed for these calls.

CMU also randomly selected 262 (1%) clients from the auto-assignment list of 25,712 clients to see if outreach calls were conducted; enrollment was chosen by consumer and notices were sent in a timely manner. CMU confirmed that appropriate notices were mailed in a timely manner to all 262 clients and clients were enrolled in their plan of choice.

NYMC HelpLine Observations
CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives

(CSRs) answering New York City calls every month. NYMC reported that 76,871 calls were received by the Helpline and 71,600 or 93% were answered. Calls answered were handled in the following languages -English: 53,792 (75%); Spanish: 11,201 (16%); Chinese: 3,093 (4%); Russian: 1248 (2%); Haitian: 158 (0.002%); and other: 2,108 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,010 recorded calls. The call observations were categorized in the following manner:

- General Information: 1219 (60%) Clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 339 (17%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 278 (14%) plan enrollees requested to change their plan.
- Public Calls: 174 (9%): Callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment or client did not want to provide CIN nor SS# to obtain non-case specific information.

Infractions/issues were identified for 386 (19%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 238 (62%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 90 (23%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 58 (15%) - Consumers were put on hold without an explanation or were not offered additional assistance.

NYMC is advised monthly of infractions observed and is required to develop, implement and submit a corrective action plan. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Health Plans/Changes to Certificates of Authority

1. Today's Options of New York, Inc. executed a name change 1/18/17. The new name is Molina Healthcare of New York, Inc. d/b/a Molina Healthcare.
2. MetroPlus PHSP was approved to expand their Medicaid, CHP, and HARP lines of business into Richmond County effective 1/9/17.
3. United HealthCare of New York, Inc. was approved to expand their Medicaid and HARP lines of business into Franklin, Orleans, Schenectady, and Yates counties effective 3/31/17.

B. Surveillance Activities

Surveillance activities completed during the 2nd Quarter FFY 2016-2017 (01/01/2017-3/31/1017) included the following:

One (1) Comprehensive Operational Survey and one (1) Targeted Operational Survey were completed during the 2nd Quarter FFY 2016-2017. An SOD was issued and a POC was accepted for two (2) Plans:

- Affinity Health Plan (Operational)
- Amida Care. Inc. (Targeted)

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during the quarter. Final reports were previously submitted for all reviews except for the one involved in an open legal matter.

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted during the quarter due to a legal matter that is still open.

- 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 (HARPs):

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 Supplemental 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, are 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 throughout New York State into HARPs beginning with adults 21 and over in New York City in October 2015. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care. NYS is monitoring plan-specific data in the three key areas of inpatient denials, outpatient denials, and claims payment.

NYS is monitoring plan-specific data in the three key areas of inpatient denials, outpatient denials, and claims payment. These activities assist with detecting system inadequacies as they occur, and allow the State to initiate steps in addressing identified issues as soon as possible.

1. **Inpatient Denial Report:** Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient behavioral health services based on medical necessity. The report for a calendar month will be due on the 15th day of the next calendar month. The report will include aggregated provider level data for service authorization requests and denials, whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.

2. **Outpatient Denial Report:** MCOs are required to submit on a quarterly basis a report to the State on ambulatory service authorization requests and denials for each behavioral health service. Submissions must include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS. Each quarterly

submission contains 3 separate months of data and is due to the State 15 days on the following month after the end of the quarter being reported.

3. **Biweekly Claims Report:** On a biweekly basis, MCOs are required to submit the following for all OMH and OASAS licensed and certified services, and HCBS designated services.

The tables below represent claims data for behavioral health Home and Community Based Services in NYC and Rest of State from implementation to the end of the reporting period.

HCBS Claims/Encounters: NYC, DOS: 01/01/2017-03/31/2017

HCBS Service Type	N Claims/Encoutners	N Recip.
CPST	21	6
Education Support Services	21	9
Family Support and Training	1	1
Intensive Supported Employment	10	3
On-going Supported Employme..	1	1
Peer Support	69	22
Pre-vocational	20	6
Provider Travel Supplement	18	5
Psychosocial Rehab	17	7
Residential Supports Services	53	7
Short-term Crisis Respite	61	12
Grand Total	292	66

HCBS Claims/Encounters: ROS, DOS: 01/01/2017-03/31/2017

HCBS Service Type	N Claims/Encoutners	N Recip.
Education Support Services	35	6
Peer Support	17	3
Pre-vocational	6	1
Provider Travel Supplement	3	2
Psychosocial Rehab	5	2
Residential Supports Services	14	3
Grand Total	80	13

NOTE: New York State issued a new Behavioral health claims reporting template in March 2017. Data is not available at this time and will be reported out in the next update.

All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) have been 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. Effective January 2016 in NYC and October 2016 for the rest of the state, BH HCBS were made available to eligible individuals.

As discussed with CMS, New York experienced slower than anticipated access to BH HCBS for HARP members and has actively sought to determine the root cause for this delay. Following implementation of BH HCBS, the State and key stakeholders identified challenges, including difficulty locating enrollees and keeping them engaged throughout the lengthy assessment and

Plan of Care development process, administrative hurdles to obtain approval of BH HCBS Plans of Care, difficulty with enrolling HARP members in Health Homes (HH), difficulty finding BH HCBS providers who were ready to provide BH HCBS due to inadequate rates.

NYS is continuing its efforts to ramp up utilization and improve access to BH HCBS by addressing the challenges identified. These efforts include:

- Streamlining the BH HCBS assessment process
  - Effective March 7th, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Exploring with CMS low productivity rates during initial implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Developing a pathway to BH HCBS for enrollees who are not enrolled in Health Home
- Continue efforts to increase HARP enrollment in HH including:
  - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies
  - Existing quality improvement initiative within clinics to encourage HH enrollment
  - Emphasis on warm hand-off to Health Home from ER and inpatient settings
- Ongoing work to strengthen HH and ensure quality care management for high need SMI individuals. (HH+ expansion)
- Implement Performance Management efforts, including developing and monitoring quality metrics to ensure HH care management is resulting in improved health outcomes
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach
- The State scheduled a series of Town Hall meetings for HCBS providers, Health Homes, and MCOs to provide updates/information and listen to providers' experiences with implementation. These meetings were held or will be held as outlined below:
  - March 28th, 2017: NYC
  - April 12th, 2017: Albany
  - May 23rd, 2017: Western NY

As of April 3, 2017, 1,699 care managers in NYS have completed the required training for conducting BH HCBS assessments. Also, as of May 8, 2017, 8,820 brief assessments have been completed.

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 across the State to discuss stakeholder concerns and implementation challenges. The State plans to continue these meetings throughout the transition period. These stakeholder engagement efforts have included the following:

- Bi-weekly BH Managed Care Plan/Provider Roundtables discussions in collaboration with local government to identify and resolve issues related to implementation.

- Regional Planning Consortium (RPC) meetings for stakeholders to discuss and monitor issues related to access and availability of behavioral health services in managed care. Each RPC represents natural local patterns of access to care, and include representatives from counties, the State, consumers and families, peers and advocates, behavioral health service providers, hospitals, Health Homes and MCOs.
  - An RPC Co-Chairs Meeting has been scheduled for June 8th, 2017 where co-chairs from each of the 11 regions across the State will come together to meet with State leadership to share local impact and propose solutions related to the transition to Medicaid Managed Care.

- Plan Behavioral Health Clinical Directors meetings are monthly meetings convened by the New York State (NYS) Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and DOH with New York City (NYC) and Rest of State (ROS) Managed Care Organization (MMCO) Behavioral Health (BH) Medical Directors to review clinical operations issues. Covered subject matter includes announcements and updates from NYS OMH and NYS OASAS, Clinical Transformation Goals, Utilization and Care Management, Performance Measurement and Improvement, High-Need Populations, and Training. These meetings for NYC MMCO BH Medical Directors commenced in January 2015. Meetings for ROS BH MMCO Medical Directors started in May 2016. Meeting minutes are captured and follow-up items are tracked and resolved.

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 State, including technical assistance around billing managed care, contracting with managed care plans, and the new BH HCBS.

MCTAC Trainings

January - March 2017 MCTAC #s

- 19 offerings, including webinars and in-person events
- 2,740 total attendees
- 2,059 unique/unduplicated individuals
- 406 New York State behavioral health agencies (50% of all NYS behavioral health agencies)
- 316 OMH licensed agencies (57.4% of all NYS OMH licensed agencies)

- 206 OASAS licensed agencies (49.2% of all NYS OASAS licensed agencies)

The State has also provided education to Medicaid recipients throughout New York State about the changes to behavioral health that may affect them and is continuing consumer education efforts in collaboration with the New York Association of Rehabilitation and Recovery Services (NYAPRS) and the New York City Department of Health and Mental Hygiene.

Transition of School-based Health Center Services from Medicaid Fee-for-Service:

During the 2nd Quarter of FFY 2016-2017, the New York State Department of Health, School Based Health Center (SBHC) providers, Medicaid managed care plans and other stakeholders continued to work together on the process of transitioning SBHC services from Medicaid fee-for-service to Medicaid managed care. The scheduled implementation date is now July 1, 2018, an extension from the previous implementation date of July 1, 2017. During the quarter, three subgroups of the larger SBHC stakeholder workgroup (Credentialing and Contracting, Claims and Billing, and Quality Improvement, Utilization Management and Care Coordination), met to discuss implementation issues and explore possible solutions. Each subgroup is co-chaired by a Managed Care Plan representative and a School Based Health Center representative and facilitated by a Department of Health staff person. During the March 16, 2017 meeting, the full SBHC workgroup met for the first hour, with the co-chairs presenting the outcomes of their respective subgroup meetings. During the second hour, individual subgroups met to continue working on the issues assigned to them. Full workgroup and subgroup activities will continue throughout 2017. The SBHC transition guidance document and Frequently Asked Questions are posted to the MRT 8401 page on the DOH website.

Hemophilia Blood Factor Transition from Medicaid Fee-for-service

Hemophilia blood factor products are currently carved out of the Medicaid managed care (MMC) benefit package. Reimbursement to pharmacies and hemophilia clinics that provide blood factor to Medicaid managed care plan enrollees takes place through Medicaid fee-for-service. The April 1, 2017 implementation date has been moved to July 1, 2017. Effective this date, hemophilia blood factor products will be included in the MMC benefit package and capitation rates. On the transition date, mainstream MMC plans will be required to cover medically necessary hemophilia blood factor products and associated services for plan enrollees and reimburse hemophilia blood factor providers for provision of products and services to enrollees. This change applies to all MMC plans, HIV Special Needs Plans and Health and Recovery Plans. The Department has been actively engaged in implementation discussions with stakeholders. Policy guidance was distributed to stakeholders on February 1st. A stakeholder conference call to discuss policy guidance took place on February 2nd and a follow-up stakeholder call took place on March 2nd. A template member notice was shared with MCOs on February 16th. Ongoing activities related to implementation include: CMS notification, continued stakeholder engagement, rate setting, enrollee notification, and plan and provider readiness, including network development and contracting. Additional clotting factor information is available on the MRT 8401 page on the DOH website.

C. Federally Qualified Health Services (FQHC) Lawsuit

No update this quarter.

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 quarterly period January 2017 through March 2017, two partial capitation plans were approved for service area reductions – one plan from three counties and another plan from one county. In addition, one MAP plan and one PACE plan were each approved for a service area expansion into two counties. There was no plan activity in terms of plan openings or closings.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. For the quarterly period January 2017 through March 2017, post enrollment surveys were completed for four enrollees. Two of the three enrollees who responded to the question (67%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. This represents a slight decrease in affirmative responses from 77% during Q1.

Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 170,018 to 181,237 during the quarterly period January 2017 through March 2017. For that period, 12,817 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, bringing the 12-month total for affirmative choice to 51,089. Monthly plan-specific enrollment for the annual period of April 2016 through March 2017 is submitted as an attachment.

2. Significant Program Developments

During the quarterly period January 2017 through March 2017, full operational audits of two MLTC partial capitation plans were completed, with finalized Plans of Correction accepted for each. In addition, focused surveys for three MLTC partial capitation plans were completed, with finalized Plans of Correction accepted for each of those.

Upcoming surveys will be directed to ensuring that previously identified quality improvement issues or standards are being implemented. Preparations continue for auditing the Medicaid Advantage Plus (MAP) plans, scheduled to begin in July 2017. A new software system has been identified and is targeted to go live in December 2017.

3. Issues and Problems

   There were no issues or problems to report for the quarterly period January 2017 through March 2017.

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: There were 297 critical incidents reported for the quarterly period January 2017 through March 2017, representing an increase from 247 incidents reported during Q1 2017.

   Grievances and Appeals: For the quarterly period January 2017 through March 2017, the top reasons for the grievance/appeal were related to transportation; homecare aides late; quality of home care; and quality of other covered services.

Period: 1/1/17 - 3/31/17			
Number of Recipients: 186,567	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	5,410	5,410	100%
# Standard/Expedited	2,909	2,744	94%
Total for this period:	8,319	8,154	98%

Appeals	**4/16-6/16**	**7/16-9/16**	**10/16-12/16**	**1/17-3/17**	**Average for Four Quarters**
Average Enrollment	162,888	171,142	179,583	186,567	175,045
Total Appeals	1,250	1,267	1,055	1,506	1,270
Appeals per 1,000	8	7	6	8	7
# Decided in favor of Enrollee	211	393	278	287	292
# Decided against Enrollee	697	641	642	1,000	745

# Not decided fully in favor of Enrollee	264	116	98	126	151
# Withdrawn by Enrollee	22	15	23	29	22
# Still pending	171	272	289	371	276
Average number of days from receipt to decision	11	12	15	11	13

Grievances and Appeals per 1,000 Enrollees By Product Type January 2017 – March 2017					
	Enrollment	Total Grievances	Grievances per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	174,170	7,070	41	1345	8
Medicaid Advantage Plus (MAP) Total	6,785	544	80	137	20
PACE Total	5,612	705	126	24	4
Total for All Products:	**186,567**	**8,319**	**45**	**1506**	**8**

Total Grievances reported decreased slightly from 8,397 during the last quarter to 8,319 during the quarterly period from January 2017 through March 2017.

The total number of appeals increased from 1,052 during the first quarter to 1,506 during the quarterly period of January 2017 through March 2017. One plan did have a noticeably higher number of appeals, and the Department will be following up with that plan.

Technical Assistance Center (TAC) Activity

During the quarterly period January 2017 through March 2017, the number of complaints received by the TAC unit remained relatively constant at 1,029 compared with 1,014 last quarter.

Call volume:
- Substantiated Complaints: 398
- Unsubstantiated Complaints: 286
- Complaints Resolved Without Investigation: 69
- Inquiries: 256
- Total Calls: 1029

The five most common types of calls were related to:
- Home Health Care: 19%
- Billing – Claim Denials: 11%

Interdisciplinary Team: 8%
Obtaining DME: 4%
Eligibility: 4%

It should be noted that home health care complaints are investigated based upon a member's subjective experience; they do not necessarily represent neglect or abuse.

The unit continues staff development efforts with the commencement of weekly case reviews.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the quarterly period January 2017 through March 2017, 9,670 people were evaluated, deemed eligible and enrolled into plans.

Referrals and 30-day assessment: For the quarterly period January 2017 through March 2017, MLTC plans conducted 9,275 assessments. The total number of assessments conducted this quarter has decreased, while the percentage of assessments conducted within the 30-day time frame increased one percentage point to 85%. Data collection, evaluation and reporting continues to be monitored since implementing CFEEC on a statewide basis.

Referrals outside enrollment broker: During the quarterly period January 2017 through March 2017, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 16,524, an increase from 15,151 during the previous quarter. Two plans are in the process of withdrawing from a county, and it is likely that some of their enrollees are contacting plans directly, thus the increase.

Rebalancing efforts:

Rebalancing Efforts	1/17-3/17
New Enrollees to the Plan from a nursing home transitioning to the community	377
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,605
Current plan Enrollees permanently placed in a nursing home	9,985
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,865

During the quarterly period January 2017 through March 2017, the number of current plan enrollees permanently placed in a nursing home increased by 3,770. It has been expected that the number of plan enrollees in a nursing home would continue to grow as new nursing home patients are required to join a managed care plan.

VI. Evaluation of the Demonstration

Comments on the draft evaluation plan were received from CMS on March 15, 2017. DOH program staff are working to address questions and comments and to finalize the analytic framework. DOH is waiting for CMS to schedule a conference call with the evaluation team to discuss the draft and further questions. Revisions to the evaluation plan will be completed by mid-May.

VII. Consumer Issues

A. All complaints

Medicaid managed care organizations (MMCOs) are required to report the number and types of complaints on a quarterly basis. The following table outlines the complaints received by category for the reporting period.

Category of Complaint	Number of Complaints/Action Appeals Reported	Percent of Total Complaints/Action Appeals Reported
SSI Adult	501	8%
SSI Pediatrics	57	1%
Total Long Term Services and Support	558	9%
Medicaid Managed Care (not BH or HIV/SNP)	5,071	84%
Behavioral Health-HARP Carve-in	215	4%
HIV/SNP	165	3%
Total MMCO Complaints for QTR	6,009	100%

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 6,009. This represents a 0.4% decrease from the prior quarter. The most frequent category of complaint is balanced billing disputes which represented 25 percent of the total.

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

25% Balance Billing
18% Reimbursement/Billing Issues
13% Advertising/ED/Outreach/Enrollment
7% Dissatisfaction with Quality of care
7% Dental or Orthodontia

Behavioral Health - Health and Recovery Plan Complaints/Action Appeals:

Of the total 6,009 complaints, MMCOs reported 215 were associated with Health and Recovery Plans (HARPS). New York State added this benefit to Mainstream Managed Care in two phases. The first occurred July 1, 2015 for New York City enrollees and the second began in October 1,

2015 for the rest of the state. Beginning with this report we will report and trend this data as a separate subcategory to total complaints.

HIV/SNP

During the quarter, Managed Care Organizations reported 165 complaints/action appeals for HIV SNPs. This represents an 8% increase in the number reported quarter over quarter.

Long Term Services and Supports

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 6,009 total reported complaints/action appeals, mainstream MMCOs reported 558 complaints and action appeals from their SSI enrollees. This compares to 527 SSI complaints/action appeals from last quarter.

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	26
AIDS Adult Day Health Care	0
Appointment Availability - PCP	5
Appointment Availability - Specialist	1
Balance Billing	90
Communications/Physical Barrier	3
Consumer Directed Personal Assistant	0
Denial of Behavioral Health Clinical Treatment	1
Denial of Clinical Treatment	29
Dental or Orthodontia	116
Emergency Services	6
Eye Care	2
Family Planning	0
Home Health Care	5
Mental Health/Substance Abuse Services/ Treatment	5
Non-covered Services	13
Non-Permanent Resident Health Care Facility	0
Personal Care Services	4
Personal Emergency Response System	0
Pharmacy	33

Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	39
Quality of Care	94
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	23
Specialist or Hospital Services	6
Transportation	5
Waiting Time Too Long at Office	3
All Other Complaints	48
Total	**558**

The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	21%
Quality of Care	17%
Balance Billing	16%
Provider or MCO Services (Non-Medical)	7%
Pharmacy	6%

The following complaints/action appeals were reported involving difficulty with obtaining long term services and support. The Department did not identify any overall trends impacting enrollees' access to these 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	2
Home Health Care	8
Non-Permanent Residential Health Care Facility	1
Personal Care Services	5
Personal Emergency Response System	0
Private Duty Nursing	0
Total	**16**

Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 490 Medicaid managed care complaints this quarter. This represents a 4% increase in the internal complaints received quarter over quarter.

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 23, 2017. The meeting included presentations provided by state staff and discussions of the following: an overview of the policies and status of activities related to implementation of the planned transition of School Based Health Center Services and the outpatient clotting factor products and associated services from Medicaid fee-for-service to Medicaid managed care; a discussion of current auto assignment statistics and state and local district outreach and other activities aimed at reducing auto assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs; an update on activities related to operationalizing Community First Choice Option (CFCO); and an update on Behavioral Health, Health and Recovery Plans (HARPs) and Health Homes. The next MMCARP meeting is scheduled for June 22, 2017.

C. Managed Care Policy and Planning Meetings

During the 2nd Quarter of Federal Fiscal Year 2016-2017, Managed Care Policy and Planning Meetings were held on January 12, February 9 and March 9, 2017.

The meeting has a standardized agenda consisting of updates from: Mainstream Medicaid Managed Care, HIV SNPs, the Enrollment Reconciliation and Encounter Intake System, Behavioral Health/HARPs/Health Homes, Managed Long Term Care, Delivery System Reform Incentive Payment and Value Based Payment, and a presentation regarding Medicaid managed care, HIV SNP, HARP and Managed Long Term care rates.

Managed Care Policy and Planning meetings during the 3rd Quarter of Federal Fiscal Year 2016-2017 are scheduled for April 6, May 11, and June 8, 2017.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

2016 Managed Long-Term Care Report
The 2016 MLTC Report was publicly released in February 2017. This Report presents information on the 65 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

2016 Managed Long-Term Care Consumer Guides
The 2016 MLTC Consumer Guides were released in March 2017 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.

2016 Quality Incentive for Managed Long-Term Care (MLTC)
2016 Quality Incentive awards were announced in February 2017. 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 2016 capitation rates.

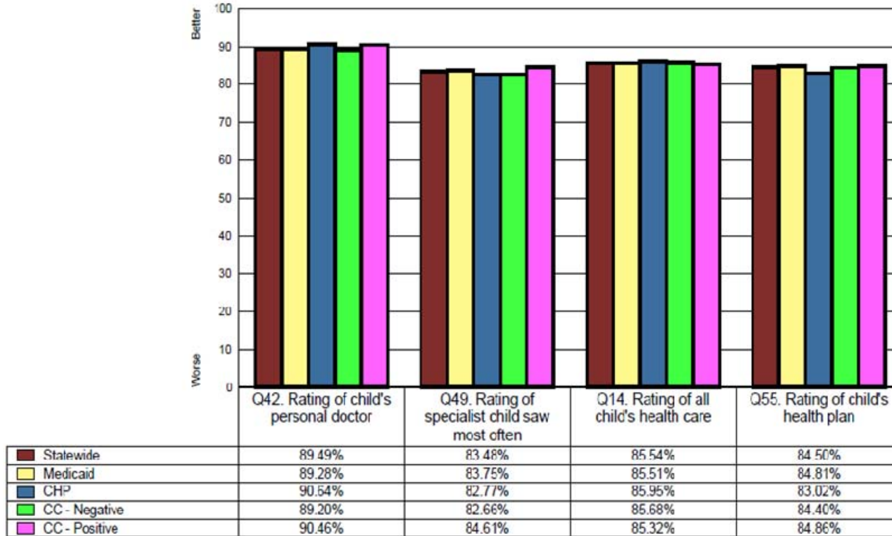
Payer	**Plan ID**	**Plan Name**	**QI Points, adjusted**	**Tier**
partial	03549135	Extended MLTC	74.4	3
partial	03234044	ElderServe dba RiverSpring	64.3	3
MAP	03173113	Elderplan	63.0	3
MAP	02942923	GuildNet Medicaid Advantage Plus	60.5	3
PACE	03072740	Catholic Health - LIFE	59.7	3
partial	03506989	Centers Plan for Healthy Living	59.2	3
PACE	01519162	PACE CNY	59.2	3
partial	02644562	Empire BCBS HealthPlus MLTC	57.9	3
partial	03420399	VillageCareMAX	57.9	3
MAP	02914056	VNS CHOICE Total	57.9	3
PACE	03320725	Complete Senior Care	57.9	3
partial	02104369	Senior Health Partners	54.6	2
MAP	03420808	MHI Healthfirst Complete Care	54.6	2
partial	03253707	Elderplan dba Homefirst	54.1	2

PACE	01234037	CenterLight PACE	54.1	2
partial	03481927	AgeWell New York	52.0	2
partial	01865329	Independence Care System	51.5	2
partial	03580307	North Shore-LIJ Health Plan	51.5	2
PACE	01674982	Eddy Senior Care	50.4	2
MAP	02927631	Fidelis Medicaid Advantage Plus	50.3	2
partial	03458546	Aetna Better Health	49.5	2
partial	03459881	Senior Whole Health Partial	49.0	2
MAP	02932896	Senior Whole Health	48.4	2
partial	01778523	Senior Network Health	47.7	2
PACE	03114514	ArchCare Senior Life	46.4	2
partial	02825230	WellCare Advocate Partial	43.9	1
PACE	01278899	ElderONE	43.9	1
partial	03475427	Integra MLTC	41.3	1
partial	01750467	VNS CHOICE MLTC	41.3	1
partial	03594052	Montefiore MLTC	39.3	1
partial	01825947	EverCare Choice	38.8	1
partial	01827572	GuildNet	38.8	1
partial	03529059	VNA Homecare Options	38.8	1
partial	01788325	Fidelis Care at Home	37.5	1
partial	03439663	United Health Personal Assist	36.7	0
partial	03690851	Kalos Health	36.5	0
partial	03581413	Prime Health Choice	35.3	0
partial	02710185	CenterLight Select	33.7	0
partial	03466906	MetroPlus MLTC	33.7	0
partial	3466800	ArchCare Community Life	31.1	0
partial	03522947	Hamaspik Choice	30.6	0
partial	03866960	iCircle	28.6	0
partial	03560441	AlphaCare of New York	26.5	0
PACE	03056544	Total Senior Care	25.4	0
partial	02188296	Fallon Health Weinberg	17.5	0

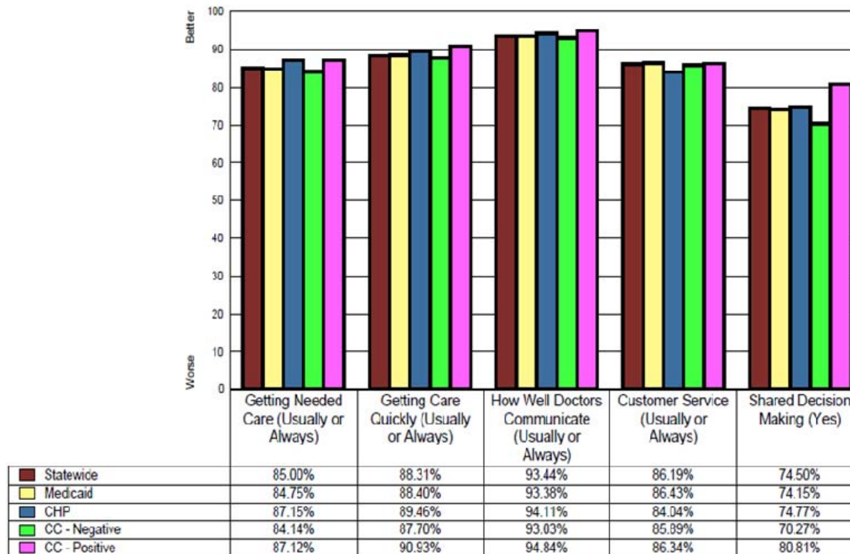
Figure 1

Overall Rating Questions by Sub-Population

(Percent of Responses Rating 8, 9, or 10)

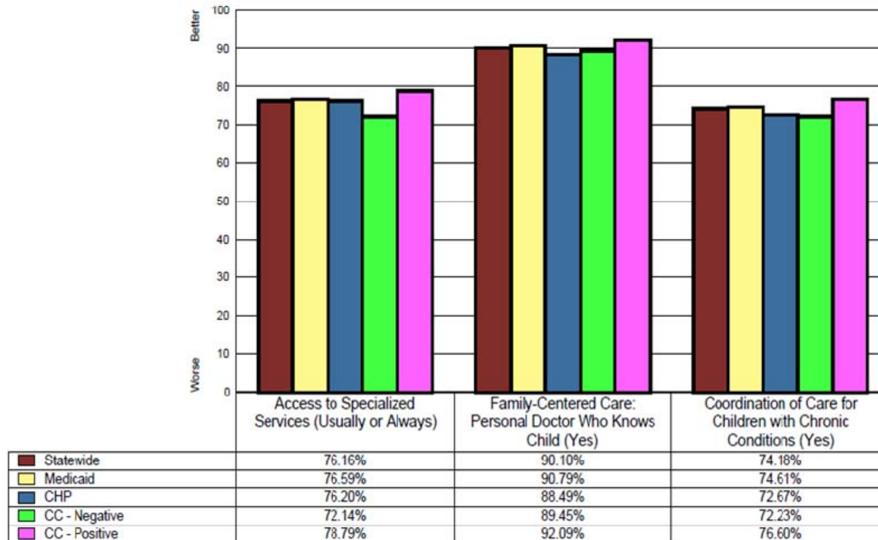


Standard Composites by Sub-Population



CCC Composites by Sub-Population

(related to care for chronic conditions)



	Access to Specialized Services (Usually or Always)	Family-Centered Care: Personal Doctor Who Knows Child (Yes)	Coordination of Care for Children with Chronic Conditions (Yes)
Statewide	76.16%	90.10%	74.18%
Medicaid	76.59%	90.79%	74.61%
CHP	76.20%	88.49%	72.67%
CC - Negative	72.14%	89.45%	72.23%
CC - Positive	78.79%	92.09%	76.60%

B. Quality Improvement

External Quality Review

As NYS's External Quality Review Organization (EQRO), the Island Peer Review Organization IPRO conducts Medicaid managed care external quality review as required by the Balanced Budget Act of 1997, and CMS regulations. 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. IPRO will continue to serve in this role for the duration of the five-year contract, ending January 31, 2020.

Over the past Quarter, IPRO compiled final reports on the most recent Access and Availability survey. The reports have been shared with the MMC plans, who subsequently worked with IPRO to address discrepancies and any issues. IPRO has also been working with the DOH to develop a revised survey methodology that merges

Provider Directory Survey work with the Survey of Access and Provider Availability. Plans are being made to conduct a combined survey in the late Summer of this year.

IPRO has been working with the DOH to ensure that the new Provider Network Data Collection System (PNDS) is operational and functioning without error. Data submission is underway. The Provider Look Up tool was developed in this quarter and final quality assurance checks are underway prior to an anticipated May launch. Third party sub contracts continued to be leveraged to outsource necessary components of these projects. Meanwhile, IPRO continues to oversee the ongoing collection of these data through the old system, which will be closed out at the end of April.

Throughout the Quarter, IPRO conducted recurring group calls to facilitate MMC and MLTC plan completion of required Performance Improvement Projects (PIPs). They discussed planning and implementation of PIPs for 2017 and are overseeing completion of final reports for the 2015-2016 projects. They facilitated the launch of a new HARP PIP, and have been working closely with the DOH and HARPs to ensure a smooth start to these projects. Additional information on the MMC and HARP PIP work completed can be found under the Performance Improvement Project description below.

The Prenatal Care quality improvement project was on hold for much of the Quarter, while IPRO finalized the new platform and began piloting the application. They are working with several MMC plans to test the system and resolve any issues prior to initiating a new cohort later this year.

IPRO's oversight (external quality review) of performance measurement (QARR) during the quarter was largely limited to oversight of the completion of the 2016 Child CAHPS survey, and negotiating a new contract for health plans to submit quality measurement data directly to NCQA though an IDSS submission. The CAHPS survey was completed, and the contract with NCQA finalized. They also continue work piloting the new Uniform Assessment System (UAS), and have been working closely with the DOH to plan a new Focused Clinical Study.

In this quarter, IPRO finalized MLTC, SNP, and MMC plan technical report drafts, which are updated annually and posted to the DOH Website.

Performance Improvement Projects (PIPs) for Medicaid Managed Care Plans (MMC)

For 2015-2016, the two-year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers was implemented. Identification of MCO enrollees who are smokers was included as a major focus of the projects. Additionally, all plans were required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. Interventions have been implemented when the proposals were

accepted in April 2015 and continued through December 2016. The MMC plans received guidance from IPRO on the due date for the Final PIP Report due to IPRO in July 2017. The PIP Final Report Template was distributed to the plans.

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic is Inpatient Care Transitions. A HARP PIP Training Webinar occurred on October 26, 2016 to review the PIP requirements and the process. In addition, the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS) provided a brief background on the common topic. IPRO provided an overview of PIP requirements and the process for developing, implementing and evaluation of a PIP. On November 14, 2016, a Kick-Off Conference Call was held with the HARP plans, IPRO, OMH, OASAS and NYSDOH. The purpose of this call was to provide all the materials necessary for the plans to be able to draft their PIP Proposal. A background document was provided on Care Transitions and a guest speaker from OMH spoke on potential evidence based interventions to consider. The due date for the HARP PIP Proposal was January 23, 2017. Fifteen PIP Proposals were submitted and have been reviewed by IPRO, NYSDOH, OMH and OASAS. A summary of comments was provided to the HARP or HIV SNP and individual health plan conference calls were conducted with all the plans to discuss the Proposal and comments. The Proposals are currently under revision and are in the process of being finalized.

For the 2017-2018 PIP for the MMC plans the selected common topic is Perinatal Care. On December 19, 2016, a Kick-Off Conference Call was held with the MMC plans, IPRO and NYSDOH to provide all the materials necessary for the plans to be able to draft their PIP Proposal. A background document was provided on Perinatal Care. There are four priority focus areas to be addressed in this PIP: history of prior spontaneous preterm birth; unintended pregnancy suboptimal birth spacing; maternal smoking; and maternal depression. On January 30, 2017, a conference call with all the MMC plans was conducted to review the required common measures for the PIP. The due date for the Perinatal PIP was February 6, 2017. Fifteen Medicaid managed care plans have submitted their PIP Proposals and IPRO and NYSDOH have reviewed them. A summary of comments was provided to the MMC plans and individual health plan conference calls were conducted with all the plans to discuss the Proposal and comments. The Proposals are currently under revision and are in the process of being finalized.

Breast Cancer Selective Contracting

The Department completed its ninth annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2013-2015 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 255 facilities were designated as follows: 115 high-volume facilities, 26 low-volume unrestricted facilities, 73 low-volume restricted facilities, and 41 closed facilities.

Six facilities appealed the decision to be placed on the low-volume restricted list, and only one of the appeals was approved. Administrators at these facilities were notified via mail of their denial or approval. In addition, letters regarding final volume designation for state fiscal year 2017 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 2017 March Medicaid Update.

Patient Centered Medical Home (PCMH)

As of March 2017, there were 6,601 NCQA-recognized PCMH providers in New York State. Approximately 74% (4,887) of current PCMH providers are recognized under the newest 2014 set of standards. Between February 2016 and March 2017, the percentage shift of providers recognized under the newest standards increased from 0% to 74%. We expect to see a continued increase in providers recognized under the 2014 standards due to incentives encouraging practices to strive for the highest PCMH standard. About 26% (1,714) of recognized providers are still under the 2011 standards and the majority will expire by mid-2018. The current incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program is:

- 2011 level 2: $2 per member per month (PMPM)
- 2011 level 3: $4PMPM
- 2014 level 2: $6PMPM
- 2014 level 3: $8PMPM

DSRIP requires practices to become 2014 level 3 PCMH or Advanced Primary Care (APC) recognized by March 31, 2018. PCMH penetration within DSRIP is measured each quarter. As of December 2016, 17% of DSRIP PCPs met the PCMH/APC requirement. Currently, there are no providers that are APC recognized.

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 letter of intent (LOI) was sent to all payers and providers stating that the demonstration will continue business as usual through June 30, 2017. There is a commitment across payers and providers to continue through 2019 but discussions around alignment of methods for shared savings models are still not finalized. All payments will be made to the Adirondack Accountable Care Organization (ACO) under the new participation agreement. The ACO will also be responsible for maintaining the funds and distributing among the participating practices in the region, as well as coordinating information between payers and providers. The Adirondack Health Institute (AHI) is working with the new data analytics vendor, Health Catalyst, and the payers to get all data use agreements signed.

The September 2016 PCMH Statewide quarterly report was posted to the DOH website this past quarter. All 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.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

At the end of December 2016, New York submitted an updated Specifications Manual and a draft remediation plan and timeline for the completion of the budget neutrality reconciliation process, including plans to reconcile with the CMS-64. The budget neutrality remediation efforts are underway and NY is on track to meet the September 30, 2017 deadline for completion of this project detailed in the STCs. The first deliverable comprising the complete initial budget neutrality calculations for Demonstration Year 14 was submitted to CMS for review on February 28, 2017.

New York remains in regular contact with CMS regarding the progress of this project. At this time, the state budget neutrality team is entirely focused on the remediation effort and on the development and implementation of the internal processes necessary to ensure New York remains in compliance with Quarterly Expenditure Reporting requirements going forward. The state expects to resume timely quarterly expenditure reporting once the reconciliation process is complete.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

New York State T-MSIS completed the submission of its twenty months of production catch-up files. New York State T-MSIS is current in its submission of production files.

B. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (No updates this quarter)

On November 18, 2016, New York State submitted to CMS an amendment to the March 1, 2014 Medicaid Managed Care/Family Health Plus/HIV Special Needs Model Contract. This contract amendment includes revisions related to implementation of the adult behavioral health redesign and the Health and Recovery Plan (HARP) product line, as well as new program integrity provisions and other necessary revisions related to implementation of various Medicaid Redesign Team (MRT) initiatives.

Attachments:
Attachment 1 - MLTC Partial Capitation Plans

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Uploaded to PMDA: May 25, 2017

Managed Long Term Care - Partial Capitation Plans

April 2016-March 2017

Plan Name	Apr-16 Enrollment	May-16 Enrollment	Jun-16 Enrollment	Jul-16 Enrollment	Aug-16 Enrollment	Sep-16 Enrollment	Oct-16 Enrollment	Nov-16 Enrollment	Dec-16 Enrollment	Jan-17 Enrollment	Feb-17 Enrollment	Mar-17 Enrollment
Aetna Better Health	3,629	3,688	3,746	3,817	3,816	3,843	3,881	3,886	3,943	4,028	4,057	4,105
AgeWell New York	6,502	6,674	6,800	6,949	7,084	7,207	7,355	7,524	7,663	7,828	7,939	8,079
AlphaCare	2,634	2,765	2,856	2,920	2,977	3,041	3,154	3,263	3,347	3,428	3,528	3,627
ArchCare Community Life	2,061	2,081	2,099	2,131	2,133	2,147	2,175	2,219	2,231	2,273	2,298	2,339
CCM Select	5,521	5,490	5,452	5,428	5,402	5,215	5,135	5,099	4,969	4,819	50	53
Centers Plan for Healthy Living	5,580	5,910	6,271	6,602	6,978	7,331	7,829	8,373	8,950	9,587	14,711	15,147
Elant	880	854	851	860	856	834	829	823	826	839	852	847
Elderplan	10,780	10,861	11,007	11,132	11,219	11,403	11,559	11,721	11,942	12,093	12,175	12,239
Elderserve	10,819	10,860	10,923	10,921	10,921	10,966	11,033	11,037	11,072	11,084	11,113	11,158
Elderwood	0	6	12	24	34	40	62	74	85	88	99	103
Extended MLTC	1,042	1,086	1,191	1,293	1,398	1,529	1,613	1,692	1,771	1,819	1,913	1,983
Fallon Health Weinberg (TAIP)	257	260	304	326	376	389	419	437	459	466	483	504
Fidelis Care at Home	13,178	13,707	14,173	14,614	15,051	15,522	16,073	16,454	16,804	17,184	17,421	17,655
Guildnet	16,804	16,823	16,749	16,691	16,614	16,477	16,413	16,098	15,916	15,709	15,228	14,768
Hamaspik Choice	1,599	1,641	1,700	1,764	1,813	1,857	1,901	1,940	1,986	2,010	2,018	2,016
HealthPlus- Amerigroup	3,179	3,281	3,409	3,507	3,594	3,668	3,767	3,876	3,950	4,021	4,119	4,176
iCircle Services	1,155	1,217	1,288	1,374	1,432	1,474	1,534	1,577	1,625	1,668	1,719	1,725
Independence Care Systems	5,986	6,042	6,104	6,194	6,241	6,280	6,348	6,447	6,514	6,574	6,593	6,504
Integra	3,289	3,408	3,596	3,740	3,948	4,132	4,241	4,438	4,607	4,794	5,064	5,279
Kalos Health- Erie Niagara	693	743	743	783	805	843	874	913	936	961	978	987
MetroPlus MLTC	1,062	1,106	1,199	1,219	1,236	1,264	1,300	1,355	1,382	1,413	1,439	1,460
Montefiore HMO	947	1,054	1,123	1,161	1,187	1,206	1,226	1,262	1,272	1,284	1,270	1,275
North Shore-LIJ Health Plan	3,139	3,271	3,445	3,590	3,742	3,880	4,068	4,249	4,413	4,556	4,691	4,806
Prime Health Choice	161	175	181	189	206	209	229	230	235	244	248	263
Senior Health Partners	12,408	12,390	12,452	12,574	12,619	12,762	12,845	12,950	13,028	13,158	13,217	13,314
Senior Network Health	506	503	504	513	508	513	522	521	514	515	510	521
Senior Whole Health	4,672	4,967	5,209	5,405	5,663	5,909	6,163	6,483	6,696	6,912	7,162	7,373
United Healthcare	2,113	2,206	2,306	2,339	2,411	2,469	2,552	2,626	2,657	2,721	2,765	2,798
Village Care	5,869	6,059	6,285	6,390	6,518	6,609	6,773	6,986	7,190	7,304	7,455	7,466
VNA HomeCare Options	1,985	2,112	2,294	2,484	2,666	2,809	2,986	3,224	3,372	3,542	3,755	3,993
VNS Choice	13,913	13,908	13,871	13,911	13,926	13,855	13,861	13,759	13,631	13,645	13,417	13,193
WellCare	6,423	6,376	6,272	6,243	6,201	6,126	6,061	6,054	6,032	6,036	5,965	5,898
TOTAL	**148,786**	**151,524**	**154,415**	**157,088**	**159,575**	**161,809**	**170,530**	**173,259**	**175,662**	**178,260**	**179,849**	**181,237**