MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 20 (4/1/18-3/31/19)
Federal Fiscal Quarter: 3 (4/1/2018 – 6/30/2018)

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: Third Quarter

MRT Waiver- Enrollment as of June 2018

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	**705,094**	**6,809**	**46,045**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**104,334**	**2,367**	**7,132**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**14,689**	**238**	**1,526**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**3,172**	**117**	**352**
Population 5 - Safety Net Adults	**487,005**	**13,019**	**41,718**
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)	**27,794**	**975**	**162**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**189,931**	**8,514**	**1,706**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,726**	**262**	**34**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**55,471**	**5,119**	**1,803**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**37,420 or an approximate 8.6% increase 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.

WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to a general decline in voluntary disenrollment.

This quarter also saw a significant increase in the number enrollees disenrolled due to incarceration and due to becoming dually eligible and no longer eligible for the mainstream program.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**100,478 or an approximate 5.1% increase from last Q**

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

Compared to the prior quarter, there was a significant increase in the number of case closures. More than half of this increase was due to WMS's closure of MAGI cases that are subsequently sent to New York State of Health. However, the disenrollment numbers now draw on a smaller WMS population contributing to general decline in involuntary disenrollment resulting from WMS continuing to send select closed cases to New York State of Health.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
April 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,120,829**	**23,029**	**3,482**	**19,547**
Rest of State	**508,206**	**14,670**	**1,646**	**13,024**
Statewide	**1,629,035**	**37,699**	**5,128**	**32,571**
May 2018				
New York City	**1,111,708**	**17,893**	**2,266**	**15,627**
Rest of State	**503,212**	**12,098**	**960**	**11,138**
Statewide	**1,614,920**	**29,991**	**3,226**	**26,765**
June 2018				
New York City	**1,097,494**	**17,100**	**2,155**	**14,945**
Rest of State	**478,504**	**10,895**	**1,045**	**9,850**
Statewide	**1,575,998**	**27,995**	**3,200**	**24,795**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**50,119**			
Rest of State	**34,012**			
Statewide	**84,131**			

HIV SNP Plans				
April 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,298**	**192**	**0**	**192**
Statewide	**13,298**	**192**	**0**	**192**
May 2018				
New York City	**13,298**	**171**	**0**	**171**
Statewide	**13,298**	**171**	**0**	**171**
June 2018				
New York City	**13,218**	**137**	**0**	**137**
Statewide	**13,218**	**137**	**0**	**137**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**500**			
Statewide	**500**			

Health and Recovery Plans Disenrollment			
FFY 18 – Q3			
	Voluntary	**Involuntary**	**Total**
April 2018	**1,146**	**886**	**2,032**
May 2018	**877**	**866**	**1,743**
June 2018	**974**	**1,007**	**1,981**
Total:	**2,997**	**2,759**	**5,756**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 3 (4/1/2018 – 6/30/2018) Q3 FFY 2017-2018

As of the end of the third federal fiscal quarter (end of June 2018), there were 2,596,995 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 57,289 Medicaid consumers enrolled in Health and Recovery Plan (HARP). 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 six (6) HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 12,208 clients were educated about their enrollment options and 7,076 (58%) clients made an enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed a total of 1,477 presentations: 1,036 (70%) one-to-one presentations and 441 (30%) auto-assignment outreach presentations. The 1,477 presentations resulted in 462 (31%) completed managed care applications and generated a total of 558 enrollments. Also, FCSR provided 1,015 consumers with general information.

HRA's Contract Monitoring Unit (CMU) observed 1,036 one-to-one client informational sessions 1,032 (99%) in HRA sites and four (4) (1%) in nursing home facilities. CMU monitors reported the following:

- At HRA sites, 766 (74%) clients received general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.

- 266 (26%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members for a total of 329 enrollments.
    - Of the 266 FFS clients that selected a plan during an informational session, 183 (69%) 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.

- At nursing homes, two (2) (50%) residents made voluntary enrollment choice and two (2) (50**%)** received general information.

Infractions were observed for 31 (12%) of the 268 Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA and Nursing Home sites.

All infractions were observed at HRA sites and none were observed at Nursing Home sites. Key messages most often omitted were failure to disclose or explain the following:

- Lock in policy
- Dental within plan network
- Good Cause Transfer
- Exemptions/Exclusions

B. 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 23,493 clients were reported on the auto-assignment list by NYMC. 3,835 (16%) clients responded to the call and of those responding, 3,030 (79%) were enrolled. CMU monitored 441 (15%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 194 (44%) FFS clients made a voluntary phone enrollment choice for themselves and their family members for a total of 227 enrollments.
  - 137 (71%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.

- Undecided: 247 (56%) 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.

Infractions were observed for 23 (12%) of the 194 AA Phone Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA. Key messages most often omitted were failure to disclose or explain the following:

- Failed to explain specialist, standing referral process
- Medicare/TPHI
- Use of plan ID Card/Benefit Card
- Confirm Consumer Health Plan/PCP choice
- Helpline Number

CMU also randomly selected 138 (1%) clients from the auto-assignment list of 23,493 clients to see if outreach calls were conducted, the plan selected by the consumer was indicated, and notices were sent in a timely manner. CMU confirmed that outreach calls were conducted, and appropriate and timely notices were mailed to clients that selected a plan on the call. CMU also confirmed that appropriate and timely notices were sent to clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

C. 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 56,565 calls were received by the Helpline and 53,088 or 94% were answered. Calls answered were handled in the following languages: English: 38,857 (73%); Spanish: 8,590 (16%); Chinese: 2,819 (5%); Russian: 796 (2%); Haitian: 112 (1%); and other: 1,914 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 1,841 recorded calls. The call observations were categorized in the following manner:

- General Information: 1,352 (73%) Clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 161 (9%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 66 (4%) plan enrollees requested to change their plan.
- Public Calls: 262 (14%): 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 746 (41%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 614 (82%) - 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: 56 (8%) - 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: 76 (10%) - 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. Plan Expansions, Withdrawals, and New Plans

On June 15, 2018, Capital District Physicians' Health Plan, Inc. was approved to expand its Medicaid Managed Care and HARP Service Areas to include Clinton, Essex, Franklin and Warren Counties.

B. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract

On November 28, 2017, CMS issued approval of the October 1, 2015 amendment to the Model Contract. All 18 health plans have retuned their signed contract amendments. During the third quarter, the last five (5) of these amendments were executed by the New York State Office of the Comptroller. All five of these executed amendments were transmitted to CMS for final approval. As of the close of the quarter, CMS was in receipt of all 18 amendments.

Additionally, during Q3 FFY 2017-2018, New York State continued the development of the new five-year model contract. This new model contract will have an effective date of March 1, 2019. It is anticipated that this new model contract will be submitted to CMS in the late fall of 2018.

C. Health Plans/Changes to Certificates of Authority

April 20, 2018: New York Quality Healthcare Corporation was certified as an Article 44 to provide Medicaid Managed Care, Child Health Plus, Health and Recovery Plan (HARP), and Managed Long-Term Care services in all 62 counties of New York State.

June 15, 2018: Capital District Physician's Health Plan was approved to expand their Medicaid Managed Care and HARP service area to include Clinton, Essex, Franklin, and Warren counties.

D. Surveillance Activities

Surveillance activity completed during the 3rd Quarter FFY 2017-2018 (April 1, 2018- June 30, 2018) included the following:

Two (2) Comprehensive Operational Surveys and one (1) Targeted Operational Survey were completed during the 3rd Quarter FFY 2017-2018. Statement of Deficiencies (SOD) were issued and a Plan of Correction (POC) was accepted for three (3) Plans.

Comprehensive Operational Surveys:

- Metroplus Health Plan, Inc.
- Metroplus Health Plan, Inc. Special Needs Plan

Targeted Operational Survey:

- United Health Care

Eighteen (18) Member Services Surveys were completed during the 3rd Quarter FFY 2017-2018. No SOD was issued for Eighteen (18) Plans.

- Health Insurance Plan of Greater New York
- Excellus Health Plan, Inc.
- MVP Health Plan, Inc.
- Crystal Run Health Plan
- Affinity Health Plan, Inc.
- AMERIGROUP New York, LLC
- Amida Care, Inc.
- HealthFirst PHSP, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan
- UnitedHealthcare of New York, Inc.
- VNS CHOICE
- WellCare of New York, Inc.
- New York State Catholic Health Plan, Inc.
- Independent Health Association, Inc.
- Capital District Physicians' Health Plan, Inc.
- HealthNow New York Inc.
- Today's Option of New York, Inc.

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):

In October 2015 New York State began 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, except for 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) began 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. 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 includes 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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (4/1/18-6/30/18)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC				
ROS				
Total				

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 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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (4/1/18-6/30/18)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC				
ROS				
Total				

3. **Monthly Claims Report:** Monthly, MCOs are required to submit the following for all OMH and OASAS licensed and certified services.

[1] Q3 data is not available and will be submitted with the next quarterly update.

Mental Health (MH) & Substance Use Disorder (SUD) Claims (4/1/18-6/30/18)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,454,528	86.59%	10.96%
Rest of State	1,167,787	81.90%	12.31%
Statewide Total	2,622,315	84.50%	11.56%

Footnote: MCOs report monthly data. The volume of paid and denied claims could include pended claims from previous months.

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 4/1/18-6/30/18: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	119	32
Education Support Services	88	38
Family Support and Trainings	8	3
Intensive Crisis Respite	0	0
Intensive Supported Employment	37	17
Ongoing Supported Employment	5	2
Peer Support	238	88
Pre-vocational	48	18
Provider Travel Supplements	30	18
Psychosocial Rehab	71	22
Residential Supports Services	49	26
Short-term Crisis Respite	215	35
Transitional Employment	37	17
TOTAL	908	220

HCBS Claims/Encounters 4/1/18-6/30/18: ROS

HCBS SERV GROUP	N Claims	N Recip
CPST	177	45
Education Support Services	300	113
Family Support and Trainings	34	9
Intensive Crisis Respite	0	0
Intensive Supported Employment	120	46
Ongoing Supported Employment	7	2
Peer Support	820	320
Pre-vocational	147	55
Provider Travel Supplements	587	198
Psychosocial Rehab	613	165
Residential Supports Services	362	105

Short-term Crisis Respite	**23**	**11**
Transitional Employment	**6**	**3**
TOTAL	**3,196**	**727**

Note: Total of N Recip. is by unique recipient, hence, The TOTAL might be smaller than sum of rows.

Provider Technical Assistance

Managed Care Technical Assistance Center is a partnership between the McSilver Institute for Poverty Policy and Research at New York University School of Social Work and the National Center on Addiction and Substance Abuse (CASA) at Columbia University, as well as other community and State partners. It provides tools and trainings that assist providers to improve business and clinical practices as they transition to managed care.

Managed Care Technical Assistance Stats (Time Period: April 18, 2018 through June 30, 2018)

Events: MCTAC successfully executed 32 events from April 18, 2018 through June 30, 2018. 23 events were held in person and 9 events were held via webinar.

Individual Participation: 1,299 people attended/participated in our events of which 841 are unique.

OMH Agency Participation
Overall: 277 of 611 (45.3%)
NYC: 92 of 239 (38.5%)
ROS: 195 of 388 (50.3%)

OASAS Agency Participation
Overall: 187 of 543 (34.4%)
NYC: 51 of 194 (26.3%)
ROS: 142 of 368 (38.6%)

Efforts to Improve Access to Behavioral Health Home and Community Based Services (BH HCBS)

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 with enrolling HARP members in Health Homes (HH); locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process;

ensuring care managers have understanding of BH HCBS (including person-centered care planning) and capacity for care managers to effectively link members to rehab services; and difficulty launching BH HCBS due to low number of referrals to BH HCBS providers.

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 7, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Ongoing development of training for care managers and HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in HH. These services are provided by State Designated Entities through direct contracts with the MCO
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS
    - Additional efforts to support initial implementation of RCAs include
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs
        - Ongoing technical assistance.

- Continuing 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 the capacity of HH to serve high need SMI individuals and ensure their engagement in needed services through exploring the further expansion of Health Home Plus (HH+)

- Implementing Performance Management efforts, including developing and monitoring quality metrics to ensure HH care management is resulting in improved health outcomes and access to BH HCBS for HARP members
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach

As of August 9, 2018, 1,678 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between April 1, 2018 and June 30, 2018, 4503 brief eligibility assessments have been completed.

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

No activity occurred this quarter, as School Based Health Center services will remain carved out of the Medicaid managed care benefit package until January 1, 2021.

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 April 2018 through June 2018 quarter, one PACE organization and one MAP plan were approved for expansion into Westchester County and another MAP plan was approved for expansion into Richmond County.

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 could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the April 2018 through June 2018 quarter, post enrollment surveys were completed for 13 enrollees. Ten of the thirteen enrollees (77%) who responded to the question indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. This represents a slight increase in affirmative responses from 73% during the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 202,513 to 208,629 during the April 2018 through June 2018 quarter. For that period, 15,083 individuals who were being transitioned into Managed Long-Term Care made an affirmative choice, a number that is relatively consistent with the previous three quarters and that brings the 12-month total for affirmative choice to 56,758.

2. Significant Program Developments

The Managed Long-Term Care (MLTC) Surveillance Unit was created to monitor and improve the quality of MLTC Plan operations and service delivery. The ultimate purpose of these efforts is to ensure that the health and welfare of MLTC Plan service recipients is protected and the services received are fair and consistent.

During the April 2018 through June 2018 quarter:

- Six partial capitation focused surveys were finalized.
- A tentative Year 2 survey schedule has been developed and currently includes plans for 18 operational and 11 focused surveys.
- Refinement of the fining/monetary penalty/sanctions policy continues.
- Surveillance tools are being updated to reflect requirements under Regulation 438.
- Refinement of processes for the second round of operational and focused surveys is expected to be completed during August.
- The unit is still awaiting final approval for the purchase of the new survey software.

3. Issues and Problems

There were no issues or problems to report for the April 2018 through June 2018 quarter.

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 898 critical incidents reported for the April 2018 through June 2018 quarter, an increase of 514 incidents (134%) over the last quarter. The large increase is attributable to two related plans who, upon questioning, indicated that there had been a glitch in their reporting system that was just recently discovered. The two plans resubmitted prior quarters' reports, and it was determined that they had previously been underreporting the number of critical incidents. However, critical incidents as a percentage of enrollment for each plan, calculated from the revised reports, is comparable to the percentage of critical incidents reported by most other plans. Critical incidents by plan for this quarter are attached.

Grievances and Appeals: For the April 2018 through June 2018 quarter, the top reasons for the grievance/appeal were dissatisfaction with transportation, dissatisfaction with quality of

home care, dissatisfaction with the quality of other covered services, other miscellaneous reasons, and home care aides late/absent on scheduled day of services.

Period: 4/1/18 through 6/30/18 **(Percentages rounded to nearest whole number)**			
Number of Recipients: 200,869	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**6,340**	**6,340**	**100%**
# Standard/Expedited	**3,384**	**3,074**	**91%**
Total for this period:	**9,724**	**9,414**	**97%**

Appeals	**7/17-9/17**	**10/17-12/17**	**1/18-3/18**	**4/18-6/18**	**Average for Four Quarters**
Average Enrollment	200,869	209,168	219,932	222,512	213,120
Total Appeals	1,433	1,611	1,643	2,451	1,785
Appeals per 1,000	7	8	7	11	8
# Decided in favor of Enrollee	295	324	264	638	380
# Decided against Enrollee	1,021	1,159	1,097	1,441	1,180
# Not decided fully in favor of Enrollee	92	130	133	147	126
# Withdrawn by Enrollee	19	50	50	67	47
# Still pending	358	387	485	653	471
Average number of days from receipt to decision	15	12	12	13	13

Grievances and Appeals per 1,000 Enrollees **By Product Type** **April 2018-June 2018**					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	206,364	6,855	33	2,153	10
Medicaid Advantage Plus (MAP) Total	10,485	1,797	171	234	22
PACE Total	5,663	1,072	189	64	11
Total for All Products:	**222,512**	**9,724**	**44**	**2,451**	**11**

Total Grievances increased 17% from 8,327 the previous quarter to 9,724 during the April 2018 through June 2018 quarter. The reason for this increase is being investigated. The total

number of appeals also increased almost 50% from 1,637 during the last quarter to 2,451 during the April 2018 through June 2018 quarter. The increase in appeals appears to be due to the new requirement (effective May 1, 2018) that enrollees must exhaust the appeals process before filing for a fair hearing. Indeed, since May 1, the number of fair hearings has decreased between 40% and 50% from months prior to May 1.

Technical Assistance Center (TAC) Activity

During the April 2018 through June 2018 quarter, the TAC unit handled 619 cases, which is a 19% decrease from the previous quarter. The number of cases open and closed within the same month has decreased from a monthly average of 90% last quarter to a monthly average of 83.21% this quarter, partially due to some cases being more complex and, therefore, taking longer to resolve. Also, there has been a small decrease in the number of general questions and inquiries received.

Since the May 1 effectuation of the requirement that the internal appeal process must be exhausted prior to seeking a Fair Hearing, the TAC unit has been working with the Surveillance Unit in checking member notices to ensure members continue to receive fair treatment and due process rights.

The TAC unit is in the final stages of implementing a new database, having recently completed user testing and training. It is anticipated that the database will be live by August 3, after the last section of software is configured by IT.

Call volume:

Substantiated Complaints	115
Unsubstantiated Complaints	335
Complaints Resolved Without Investigation	31
Inquiries	129
Total Calls	**610**

The five most common types of calls were related to:

Interdisciplinary Team	37%
Billing—Claim Denials	10%
Home Health Care	9%
Disenrollment- Involuntary	4%
Enrollment, Eligibility Unspecified	3%

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.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the April 2018 through June 2018 quarter, 11,961 people were evaluated, deemed eligible and enrolled into plans, an increase of 12% over the previous quarter.

Referrals and 30-day assessment: For the April 2018 through June 2018 quarter, MLTC plans conducted 12,764 assessments. The total number of assessments conducted this quarter has increased from 9,676 the previous quarter.

Referrals outside enrollment broker: For the April 2018 through June 2018 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 22,572, an increase from 21,951 during the previous quarter.

Rebalancing Efforts	4/18-6/18
New Enrollees to the Plan from a nursing home transitioning to the community	453
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	3,221
Current plan Enrollees permanently placed in a nursing home	15,992
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,372

VI. Evaluation of the Demonstration

After several revisions, the timeline for reporting evaluation results and the evaluation period was approved on April 19, 2018. The evaluation period will run from April 1, 2016 through July 1, 2019, which allows for 3.25 years of data. Work has begun on the Request for Proposals (RFP) to procure an Independent Evaluator (IE) to perform the evaluation work. Program staff have prepared a scope of work describing the activities required of the IE as well as the data sources available and the research questions to be answered. The evaluation plan, which will be incorporated into the RFP scope of work, was approved by the CMS evaluation team on July 3, 2018. Program staff from OQPS and the OHIP Waiver Management Unit continue to work to assemble the RFP and begin the formal procurement process.

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.

MMCO Product Line	Total Complaints 4/1/18-6/30/18
Medicaid Managed Care	**6,314**
HARP	**498**
HIV/SNP	**185**
Total MMCO Complaints	**6,997**

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 6,997. This represents a 9% increase from the prior quarter. The most frequent category of complaint is balanced billing disputes which represented 24% of the total.

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

Balance Billing	24%
Pharmacy/Formulary	13%
Dissatisfaction with Quality of Care	9%
Reimbursement/Billing Issues	9%
Difficulty with Obtaining: Dental or Orthodontia	6%

HARP Complaints/Action Appeals:
Of the total 6,997 complaints, MMCOs reported, 498 were associated with Health and Recovery Plans (HARPS).

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

Pharmacy/Formulary	25%
Dissatisfaction with Quality of Care	14%
Dissatisfaction with Provider Services (Non-medical) or MCO Services	7%
Reimbursement/Billing	6%
Balance Billing	5%

HIV/SNPS
During the quarter, Managed Care Organizations reported 185 complaints/action appeals for HIV Special Needs Plans (SNPs).

The top 5 most frequent categories of complaints for HIV/SNPs were as follows:

Dissatisfaction with Provider Services (Non-Medical) or MCO Services	25%
Balance Billing	10%
Pharmacy/Formulary	9%

Difficulty with Obtaining: Covered Health Home Care Services	8%
Difficulty with Obtaining: Dental/Orthodontia	6%

Monitoring of Plan Reported Complaints

The Department, OMH and OASAS jointly held a July 10, 2018 call with the MMCOs to discuss the persistent behavioral health claim denial trends involving MMCOs and plan behavioral health subcontractors. This meeting marked the initiation of a root cause analysis project with all plans to determine the reasons for the persistent claim denial trends. The Department will review root cause analysis performed by each plan and monitor progress toward resolution of any identified issues.

The Department continues to calculate and analyze the observed/expected ratio for the six-month period ending with this quarter; results of this six-month analysis are to be reported in the next quarterly report. The observed/expected ratio is a calculation for each MMCO, which represents a comparison of the number of observed complaints to the number that were expected, based on the MMCO's average enrollment for the quarter as a portion of total enrollment in all MMCO's. Based on the observed/expected ratio, the Department requests that MMCOs review and analyze categories of complaints where higher than expected complaint patterns persist.

During this quarter, the Department updated the reporting software and platform for MCOs to submit complaint reports. This change will allow the Department to more efficiently make future adjustments to plan complaint categories and other related reporting as necessary to meet State and federal monitoring requirements regarding managed care plan benefits.

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 6,997 total reported complaints/action appeals, mainstream MMCOs reported 652 complaints and action appeals from their SSI enrollees. This compares to 578 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	0
Advertising/Education/Outreach/Enrollment	20
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	1
Appointment Availability – BH HCBS	0

Balance Billing	72
Communications/Physical Barrier	2
Consumer Directed Personal Assistant	0
Denial of Behavioral Health Clinical Treatment	0
Denial of Clinical Treatment	16
Dental or Orthodontia	105
Dissatisfaction with Behavioral Health Provider Services	0
Dissatisfaction with Health Home Care Management	4
Emergency Services	4
Eye Care	9
Family Planning	0
Home Health Care	4
Mental Health/Substance Abuse Services/ Treatment	3
Non-covered Services	27
Non-Permanent Resident Health Care Facility	0
Personal Care Services	6
Personal Emergency Response System	1
Pharmacy	44
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	45
Quality of Care	144
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	32
Specialist or Hospital Services	8
Transportation	5
Waiting Time Too Long at Office	4
All Other Complaints	92
Total	**652**

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

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Quality of Care	22%
Dental or Orthodontia	16%
Balance Billing	11%
Provider or MCO Services (Non-Medical)	7%
Pharmacy	7%

The following complaints/action appeals were reported involving difficulty with obtaining long term services and supports. The Department is reviewing the reported increase in complaints

involving these services as part of the six-month observed/expected ratio analysis described above to identify any trends or operational issues.

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	2
Adult Day Care	0
Consumer Directed Personal Assistant	8
Home Health Care	31
Non-Permanent Residential Health Care Facility	0
Personal Care Services	19
Personal Emergency Response System	1
Private Duty Nursing	0
Total	**61**

Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 483 complaints this quarter. This is a slight increase from the previous quarter, which reported 469 complaints.

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

Reimbursement/Billing	33%
Benefit Coverage Issues	15%
Eligibility/Application Issues	15%
Difficulty Obtaining Covered Home Health Care Services	4%
Denial of Clinical Treatment	4%

The following variations/trends have been identified during this quarter:

The Department has conducted in-depth investigations into allegations filed by consumer representatives asserting that several Medicaid Managed Care Organizations' service authorization and utilization management policies resulted in barriers to care and were not compliant with the NYS regulation governing treatment of gender dysphoria. The Department substantiated the complaint. In response, the Department issued corrective guidance to all MMCOs, created a standard for authorization and utilization review of these services, and as of September 1, 2018, required all MMCPs to obtain the Departments approval of their polices for service authorization and utilization review criteria of treatment for gender dysphoria prior to use. The Department will be issuing citations for deficiencies identified during the investigation and MMCPs will be required to take corrective action. The Department will continue to monitor the MMCPs coverage of these services and continues to work with the consumer representatives to ensure concerns have been fully addressed.

This quarter the Department has also engaged consumer representatives and other stakeholders regarding an apparent shortage of private duty nurses available to meet the needs of home-based pediatric chronic care patients throughout the State. During these discussions, six cases were brought to the Department's attention alleging failure of the MMCO to cover or arrange for needed assessments and/or to fulfill private duty nurse needs. As each complaint is investigated, the Department has worked closely with representatives to resolve to issues surrounding barriers to care for the specific child, including requiring MMCOs to take corrective action if a deficiency is identified. The Department will continue to monitor access to these services.

Fair Hearings

The Department reviews fair hearing decisions involving mainstream MMC, HARPs and HIV SNPs to ensure compliance with directives issued by the Office of Administrative Hearings, and to identify apparent trends or systemic issues warranting further investigation. No systemic plan operational issues or trends were identified this quarter. The following tables summarize fair hearing activity related to mainstream MMCs, HARPs and HIV SNPs this quarter.

Fair Hearing Decisions	**4/1/18-6/30/18**
In favor of Appellant	190
In favor of Plan	240
No Issue	46
Total	**476**

Fair Hearings Days from Request Date till Decision Date	**4/1/18-6/30/18**
Less than 30 days	32
30-59	142
60-89	175
90-119	46
=>120	81
Total	**476**

There were 476 fair hearings during the April through June 2018 period.

Since the mandatory Medicaid managed care program began under the 1115 Partnership Plan Waiver in 1997, mainstream plan enrollees had direct access to request a State Fair Hearing upon receipt of an initial adverse benefit determination from the MMCO. In compliance with 42 CFR 438 Subpart F, the Department implemented new requirements this quarter that the enrollee exhaust the MMCO's appeal process prior to requesting a State Fair Hearing. Through engagement with consumer representatives and MMCOs throughout 2017 and early 2018, new model notices were created to ensure enrollee received clear notice of their right to appeal, how to appeal, and right to State Fair Hearing upon exhaustion of the appeal process. The State held plan training webinars, worked with the Office of Administrative Hearings, updated the MMCO model handbooks, and conducted public informational webinars to announce this change. The Department is also engaged in oversight of the MMCOs to ensure compliance with the service

authorization and appeal requirements of the federal rule, including the provision, as appropriate, of continued benefits (aid to continue) during the appeal process and any subsequent State Fair Hearing.

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on June 21, 2018. The meeting included presentations provided by state staff and discussions of the following: 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. Additional agenda items included a Managed Care Rate Setting Overview by the Office of Health Insurance Programs (OHIP), Division of Finance and Rate Setting and an introduction to the Bureau of Social Determinants of Health by OHIP, Division of Program Development and Management. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for September 28, 2018.

C. Transition of Harm Reduction Services from Grant Funded to Medicaid Fee-for-Service & Medicaid Managed Care (MMC)

Effective July 1, 2018, the Medicaid Managed Care (MMC) plans will be required to cover harm reduction services (HRS) that have been recommended by a physician or other licensed professional for MMC enrollees and to reimburse HRS organizations for providing these services to plan enrollees. Harm reduction services represent a fully integrated client-oriented approach to health and wellness, which includes but is not limited to overdose prevention and response and preventing transmission of HIV, hepatitis B and C, and other illnesses in substance users, their sexual partners, and children. Department-approved harm reduction programs provide these services in accordance with a comprehensive assessment of care and an individualized service plan. MMC plans will be responsible for covering the following HRS for their enrollees: service plan development, individual supportive counseling, group supportive counseling, medication management and treatment adherence counseling, and support groups (psychoeducation). The HRS guidance document, billing guidance, frequently asked questions (FAQs), list of Syringe Exchange Providers, the template enrollee handbook language, and template member notice are posted to the MRT 8401 page on the DOH website.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

2017 Quality Incentive for Medicaid Managed Care

2017 Quality Incentive awards were announced in April 2018. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, and Prevention Quality Indicators. Points for issues with Compliance are subtracted from the total plan points before calculating the percentage of total points. Beginning this year, a plan could also earn up to 6 possible bonus points for an approved telehealth innovation plan. Plans were classified into 5 Tiers based on their total score. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and the Center for Medicare and Medicaid Services (CMS). The final results for the 2017 Incentive included one plan in Tier 1, twelve plans receiving some portion of the award (Tier 1-3), and two plans in Tier 4. There were no plans in Tier 5. The awards were implemented in April 2018 capitation rates.

MMC Quality Incentive 2017
Quality Points NORMALIZED to 100 based on highest score
February 14, 2018

Incentive Tier	Plan Name	Normalized Quality Points = Quality Points/Highest Score	Satisfaction Points (30 points possible)	PQI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Bonus Points (6 points possible)	Total Points	Percent (up to 100%)
Tier 1	Fidelis Care New York, Inc.	94.03	20	10	-2	6	128.03	85.35
Tier 2	MVP Health Care	82.09	20	12.5	-2	6	118.59	79.06
Tier 2	Healthfirst PHSP, Inc.	100.00	10	0	-2	6	114.00	76.00
Tier 2	MetroPlus Health Plan	98.51	10	0	-2	6	112.51	75.01
Tier 2	CDPHP	73.13	20	15	-2	6	112.13	74.76
Tier 3	Independent Health's MediSource	58.21	25	7.5	0	6	96.71	64.47
Tier 3	HIP (EmblemHealth)	68.66	15	0	-2	6	87.66	58.44
Tier 3	Empire BlueCross BlueShield HealthPlus	68.66	15	0	-2	6	87.66	58.44
Tier 3	HealthNow New York Inc.	52.70	20	10	-2	6	86.70	57.80
Tier 3	WellCare of New York	61.19	10	10	-2	6	85.19	56.80
Tier 3	UnitedHealthcare Community Plan	52.24	15	17.5	-6	6	84.74	56.49
Tier 3	Excellus BlueCross BlueShield	52.24	20	7.5	-2	6	83.74	55.83
Tier 3	Molina Healthcare	59.70	5	10	-4	6	76.70	51.13
Tier 4	Affinity Health Plan	43.28	15	0	-2	6	62.28	41.52
Tier 4	YourCare Health Plan	31.34	15	10	-2	6	60.34	40.23
Tier 5								

* Incentive premium awards were impacted by enacted budget actions for SFY 18-19 and may change to meet program fiscal targets

Quality Assurance Reporting Requirements (QARR)

We had 24 health plans submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2018. Data is being reviewed for completeness and accuracy and final results will be published next quarter.

B. Quality Measurement in Medicaid Managed Care

2017 Managed Long-Term Care Report

The 2017 MLTC Report was publicly released in April 2018. This Report presents information on the 62 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

2017 Managed Long-Term Care Consumer Guides

The 2017 MLTC Consumer Guides were released in April 2018 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.

2017 Managed Long-Term Care Crude Percent Reports

In June, we released Crude Percent Reports for the July through December 2017 time period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each plan's July through December 2017 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month time period.

The Crude Percent report provides a breakout by percentage (unless a metric is reported as an average) of each response level for most components of the Community Assessment, Functional Supplement, and Mental Health Supplement across two six-month time periods. Plans were also provided the percentages for the rest of the state with their plan excluded for comparison purposes. Plans were encouraged to review the reports, compare their results to previous data, and look at areas with changes from the previous reporting period to ensure data completeness.

2017 Quality Incentive for Managed Long-Term Care (MLTC)

2017 Quality Incentive awards were announced in April 2018. 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.

Payer	**Plan ID**	**Plan Name**	**QI Points, adjusted**	**Tier**
payer	plan_id	plan_name	points_total_adj	
partial	03549135	Extended MLTC	78.75	3
partial	03234044	ElderServe dba RiverSpring	70.00	3
partial	02104369	Senior Health Partners	68.75	3
partial	03253707	Elderplan dba Homefirst	65.00	3
MAP	03173113	Elderplan	61.25	3

partial	03420399	VillageCareMAX	60.00	3
MAP	03420808	MHI Healthfirst Complete Care	60.00	3
partial	02710185	CenterLight Select	58.75	2
partial	03522947	Hamaspik Choice	55.50	2
partial	01865329	Independence Care System	55.00	2
partial	03459881	Senior Whole Health Partial	55.00	2
PACE	03072740	Catholic Health - LIFE	54.75	2
partial	03481927	AgeWell New York	54.25	2
partial	03475427	Integra MLTC	53.75	2
PACE	01674982	Eddy Senior Care	53.00	2
partial	03506989	Centers Plan for Healthy Living	52.50	2
partial	02825230	WellCare Advocate Partial	52.50	2
partial	03594052	Montefiore MLTC	51.25	2
partial	03458546	Aetna Better Health	49.25	1
PACE	03320725	Complete Senior Care	48.93	1
PACE	04190745	Fallon Health Weinberg-PACE	48.85	1
PACE	01234037	CenterLight PACE	48.75	1
MAP	02914056	VNS CHOICE Total	45.00	1
partial	02644562	Empire BCBS HealthPlus MLTC	43.75	1
PACE	01278899	ElderONE	43.00	1
partial	03466906	MetroPlus MLTC	42.50	1
MAP	02927631	Fidelis Medicaid Advantage Plus	42.31	1
partial	01788325	Fidelis Care at Home	41.25	1
PACE	03114514	ArchCare Senior Life	41.25	1
PACE	01519162	PACE CNY	40.50	1
PACE	03056544	Total Senior Care	40.00	1
partial	03581413	Prime Health Choice	39.23	0
partial	03560441	AlphaCare of New York	38.75	0
partial	01750467	VNS CHOICE MLTC	38.75	0
MAP	02942923	GuildNet Medicaid Advantage Plus	38.00	0
partial	03466800	ArchCare Community Life	37.50	0
partial	03690851	Kalos Health	35.00	0
partial	03580307	North Shore-LIJ Health Plan	35.00	0
partial	03529059	VNA Homecare Options	35.00	0
partial	01778523	Senior Network Health	34.00	0

partial	01825947	EverCare Choice	33.75	0
partial	03439663	United Health Personal Assist	33.50	0
partial	03866960	iCircle	33.00	0
MAP	02932896	Senior Whole Health	32.69	0
partial	01827572	GuildNet	30.50	0
partial	02188296	Fallon Health Weinberg	26.00	0

C. Quality Improvement

External Quality Review

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, Part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including, performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and providing data processing and analytical support to the Department. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, FIDAs, FIDA-IIDs, HARPs, and BHOs, and include the state's Child Health Insurance Program (CHP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

During the quarter extending from April through June 2018, a new Access Survey of Provider Availability was administered. A new Member Services Survey was completed, incorporating questions specific to Health and Recovery Plan (HARP) populations.

Network changes and continued modifications were ongoing in the rebuild and rollout of the new Provider Network Data System (PNDS). IPRO has been diligent in overseeing two sub-contracts for the management of this work and has facilitated the ongoing adjustments and fixes required as new unanticipated issues arise. Data validation issues were addressed.

IPRO conducted recurring group calls to facilitate completion of MMC, MLTC, and HARP required Performance Improvement Projects (PIPs). Specific information about the MMC and HARP PIP work completed in this quarter can be found under the Performance Improvement Project description.

Unforeseen issues with compilation of data collected in the Prenatal Care Provider Reporting project were addressed in this quarter, as the project came to an end. IPRO continues to work closely with DOH staff to address these issues, and to produce a final report.

This quarter, IPRO completed a MLTC focused clinical study to validate assessments being completed by Maximus nurse reviewers using the Uniform Assessment System screening tool. IPRO is also facilitating a new Mainstream Managed Care Focused Clinical Study, examining patient engagement in the management of select conditions including diabetes.

IPRO also finalized MMC and MLTC Plan Technical Reports for the 2016 evaluation year. These reports are in the processes of obtaining NYSDOH executive approval for sharing publicly on the NYS DOH website.

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

The Prenatal Care quality improvement project successfully collected medical record review data, for the birth year 2014, from 40 provider practices through December 2017. The aggregate data will be reported back to the participating practices to be able to compare their performance to their peers. In addition, the 2014 birth year aggregate report has been drafted.

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. The Final PIP Reports were submitted to IPRO in July 2017. The Final Reports were reviewed and approved. A Compendium of abstracts is currently being prepared and when finalized it will be available on the public website.

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic is Inpatient Care Transitions. Fifteen PIP Proposals were submitted and have been reviewed and accepted by IPRO, NYSDOH, the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS). In January 2018 fifteen plans submitted Interim Reports summarizing their progress for the first year implementing the PIP. Oversight calls with IPRO and individual HARP plans and HIV SNP plans were conducted in March 2018 and will be conducted in July 2018. Each plan submitted a written summary of progress to IPRO before the call was conducted. There are four webinars planned for 2018 when the participating HARP and HIV SNP plans will present their progress on the PIP. One of the webinars was held on January 23, 2018, the second webinar was held on March 19, 2018 and the third was held on July 13, 2018. For each of these webinars three health plans

presented their PIP progress to the group. The final webinar will be held on September 14, 2018.

For the 2017-2018 PIP for the MMC plans the selected common topic is 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. Fifteen Medicaid managed care plans submitted their Perinatal PIP Proposals and IPRO and NYSDOH have reviewed and accepted them. In January 2018 fifteen plans submitted Interim Reports summarizing their progress for the first year implementing the PIP. The IPRO oversight calls were conducted in April 2018 and will be conducted again in August 2018. Each plan submits a written summary of progress to IPRO before the call is conducted. One of the Perinatal PIP webinars was held on January 18, 2018, the second one was held on May 10, 2018 and the third was held on June 26, 2018. The final webinar is scheduled for August 2, 2018. For each webinar three Medicaid managed care plans present their Perinatal PIP progress to the group.

Breast Cancer Selective Contracting

Staff are preparing for the summer review of breast cancer surgical volume data and will share results and provisional volume designations with facilities' SPARCS coordinators in late summer. The Breast Cancer Selective Contracting Policy manuscript, which provides an in-depth review of the policy's impact on access to care, quality of care and survival rates, was submitted for publication approval. The manuscript demonstrates that High-Volume facilities outperformed Low-Volume facilities on several quality of care measures, including: lower rates of readmission post-breast cancer surgery and higher rates of radiation, chemotherapy and adjuvant hormone therapy. Three-year survival rates correlated with stage of disease and patient demographics, but not facility or surgeon volume. The manuscript will be submitted to Health Services Research for publication.

Patient Centered Medical Home (PCMH)

As of June 2018, there were 9,092 NCQA-recognized PCMH providers in New York State. 95 providers that became recognized in June 2018 were new to the program and have not been recognized previously. Over the past year and a half, the program has consistently seen an increase in the number of new providers joining the program who have never participated before. Approximately 99% (9,043) of current PCMH providers are recognized under the 2014 set of standards. Only 7 providers remain under the 2011 standards and they are expected to expire by fall of 2018. On April 1, 2017 NCQA released their 2017 recognition standards, eliminating the leveling structure. There are 42 providers and 26 practices recognized under the 2017 standards. Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017-recognized providers. The incentive changes were detailed in an April 2018 Medicaid Update:
https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of June 2018 are:

- 2011 level 2: $0 per member per month (PMPM)
- 2011 level 3: $0 PMPM
- 2014 level 2: $0 PMPM
- 2014 level 3: $5.75 PMPM
- 2017 recognition: $5.75 PMPM

Effective July 1, 2018, the PMPM for 2014 level-3 or 2017-recognized providers will increase to $6.00.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2019 but discussions around alignment of methods for shared savings models are still not finalized.

The December 2017 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 complete as of this quarter, with final calculations for DY17 quarter 4 submitted on February 16, 2018. The State is awaiting confirmation from CMS that all corrective action requirements outlined in the STCs have been satisfied.

The state budget neutrality team is now working 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 has resumed timely quarterly

expenditure reporting for 21-month lag reports and is currently is working to complete all outstanding 3-month lag reports.

As detailed in STC X.10, the State has identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the 10/1/11-3/31/16 period. The State continues to work with KPMG and CMS to finalize an audit plan to guide KPMG's work. Upon approval of the final audit plan, work on the audit will begin.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

The State sends the following files to CMS monthly:

- Eligibility
- Provider
- Managed Care
- Third Party Liability
- Inpatient Claims
- Long-Term Care Claims
- Prescription Drug Claims
- Other Types of Claims

The state is current in its submission of these claims files. Additionally, the state is working with CMS on several initiatives to improve the data quality of its submissions.

Attachments:
Attachment 1— MLTC Critical Incidents
Attachment 2— MLTC Partial Capitation Plan Enrollment

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Submitted via email: August 29, 2018
Uploaded to PMDA: August 29, 2018

Critical Incidents April - June 2018		
Plan Name:	**Plan Type**	**Total Critical Incidents**
Partical Capitation Plans		
Aetna Better Health	Partial	-
AgeWell New York ,LLC	Partial	12
AlphaCare of New York Inc.	Partial	-
Amerigroup	Partial	7
ArchCare Community Life	Partial	4
CenterLight Healthcare Select	Partial	-
Centers Plan for Healthy Living	Partial	10
Elant Choice	Partial	-
ElderServe Health, Inc.	Partial	-
Elderwood	Partial	2
Extended	Partial	67
Fallon Health Weinberg	Partial	-
FIDELIS Care New York	Partial	-
GuildNet MLTCP	Partial	78
Hamaspik Choice	Partial	-
HomeFirst MLTC, a product of Elderplan	Partial	1
I Circle	Partial	1
Independence Care Systems	Partial	5
Integra MLTC	Partial	-
Kalos, dba First Choice Health	Partial	-
Metroplus	Partial	-
Montefiore Diamond Care	Partial	1
NSLIJ Health Plan	Partial	-
Prime Health Choice, LLC	Partial	64
Senior Health Partners	Partial	292
Senior Network Health	Partial	-
Senior Whole Health	Partial	2
United Healthcare Personal Assist	Partial	-
VillageCareMAX	Partial	-
VNA Homecare Options, LLC	Partial	84
VNSNY CHOICE MLTC	Partial	4
Wellcare	Partial	13
Total		**647**

Medicaid Advantage Plus (MAP)		
Elderplan	MAP	-
Fidelis Medicaid Advantage Plus	MAP	-
GuildNet GNG	MAP	7
Healthfirst CompleteCare	MAP	205
HEALTHPLUS AMERIGROUP	MAP	-
Senior Whole Health	MAP	-
VNSNY CHOICE MLTC TOTAL	MAP	-
Total		**212**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	2
Catholic Health LIFE	PACE	12
CenterLight Healthcare	PACE	1
Complete Senior Care	PACE	5
Eddy SeniorCare	PACE	4
ElderONE	PACE	-
Fallon Health Weinberg	PACE	-
Independent Living Services of CNY (PACE CNY)	PACE	15
Total Senior Care	PACE	-
Total		**39**
Grand Total		**898**

Managed Long Term Care Partial Capitation Plans

July 2017-June 2018

Plan Name	Jul-17 Enrollment	Aug-17 Enrollment	Sep-17 Enrollment	Oct-17 Enrollment	Nov-17 Enrollment	Dec-17 Enrollment	Jan-18 Enrollment	Feb-18 Enrollment	Mar-18 Enrollment	Apr-18 Enrollment	May-18 Enrollment	Jun-18 Enrollment
Aetna Better Health	4,335	4,411	4,542	4,673	4,897	5,202	5,328	5,519	5,602	5,743	5,905	6,054
AgeWell New York	8,542	8,607	8,690	8,792	8,868	9,221	9,349	9,357	9,387	9,425	9,515	9,590
AlphaCare	4,134	4,282	4,459	4,692	4,775	4,589	37	14	3	5	5	3
ArchCare Community Life	2,695	2,783	2,871	2,993	3,187	3,294	3,483	3,528	3,587	3,671	3,708	3,774
CCM Select	1	0	0	0	0	0	0	0	0	0	0	0
Centers Plan for Healthy Living	17,532	18,057	18,660	19,199	20,046	24,655	25,276	25,801	26,363	26,996	27,726	28,275
Elant	854	853	874	879	902	909	916	912	931	942	971	973
Elderplan	12,583	12,463	12,486	12,579	12,610	12,668	12,700	12,704	12,736	12,691	12,751	12,848
Elderserve	11,248	11,265	11,277	11,354	11,390	11,497	11,626	11,751	11,893	12,032	12,155	12,289
Elderwood	140	151	154	171	188	197	203	206	227	255	271	284
Extended MLTC	2,660	2,800	2,895	3,110	3,320	3,481	3,629	3,757	3,918	4,085	4,290	4,488
Fallon Health Weinberg (TAIP)	573	584	602	627	651	670	682	678	687	706	709	716
Fidelis Care at Home	19,092	19,226	19,487	19,890	20,126	20,485	20,863	20,878	21,011	20,989	21,048	21,120
Guildnet	10,826	10,116	9,722	9,508	9,027	8,555	8,243	8,076	7,876	7,670	7,541	7,480
Hamaspik Choice	2,034	2,032	2,054	2,074	2,104	2,128	2,151	2,151	2,175	2,179	2,186	2,166
HealthPlus- Amerigroup	4,549	4,597	4,628	4,677	4,760	4,827	4,895	4,929	4,911	4,931	4,968	5,016
iCircle Services	1,915	2,000	2,054	2,147	2,212	2,257	2,342	2,384	2,441	2,485	2,556	2,600
Independence Care Systems	6,579	6,606	6,600	6,603	6,602	6,593	6,649	6,597	6,572	6,509	6,443	6,377
Integra	6,500	6,852	7,191	7,529	7,949	8,404	8,897	9,362	9,874	10,295	10,797	11,203
Kalos Health- Erie Niagara	1,151	1,169	1,210	1,252	1,248	1,264	1,265	1,254	1,235	1,252	1,276	1,294
MetroPlus MLTC	1,609	1,623	1,653	1,691	1,715	1,747	1,782	1,783	1,811	1,836	1,824	1,866
Montefiore HMO	1,380	1,393	1,404	1,432	1,447	1,465	1,460	1,462	1,464	1,474	1,495	1,507
North Shore-LIJ Health Plan	5,693	5,756	5,645	5,432	4,666	192	23	6	2	1	1	1
Prime Health Choice	282	295	301	308	316	334	353	354	355	360	369	373
Senior Health Partners	13,878	13,960	14,082	14,304	14,419	14,475	14,478	14,412	14,423	14,388	14,467	14,570
Senior Network Health	524	524	530	534	539	544	543	532	546	550	545	547
Senior Whole Health	8,561	8,826	9,141	9,359	9,440	9,575	13,969	13,779	13,776	13,634	13,642	13,726
United Healthcare	3,120	3,244	3,370	3,506	3,652	3,789	3,917	3,973	4,044	4,070	4,161	4,214
Village Care	8,328	8,525	8,713	8,924	9,105	9,276	9,538	9,779	9,925	10,068	10,254	10,429
VNA HomeCare Options	4,914	5,146	5,363	5,567	5,785	5,987	6,153	6,266	6,322	6,479	6,595	6,606
VNS Choice	12,824	12,719	12,644	12,704	12,756	12,812	12,934	12,899	12,806	12,788	12,743	12,749
WellCare	5,787	5,761	5,769	5,763	5,753	5,767	5,758	5,696	5,610	5,516	5,521	5,490
TOTAL	**184,843**	**186,626**	**189,071**	**192,273**	**194,455**	**196,859**	**199,442**	**200,799**	**202,513**	**204,025**	**206,438**	**208,629**