MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 19 (4/1/2017 – 3/31/2018)
Federal Fiscal Quarter: 1 (10/01/2017 – 12/31/2017)

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: First Quarter

MRT Waiver- Enrollment as of December 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	**761,498**	**7,376**	**51,904**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**110,685**	**2,458**	**7,845**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**15,279**	**292**	**2,828**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**3,289**	**120**	**541**
Population 5 - Safety Net Adults	**537,593**	**13,306**	**47,471**
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)	**29,713**	**1,302**	**175**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**192,133**	**9,903**	**1,880**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,121**	**227**	**71**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**60,270**	**3,195**	**2,831**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**38,179 or an approximate 1.4% 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.

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	**115,546 or an approximate 34.4% decrease from last Q**

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

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

Case closures in the WMS population significantly decreased when compared to the prior quarter and quarters in the prior fiscal year (10/2016 – 09/2017).

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
October 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,196,399**	**19,186**	**2,506**	**16,680**
Rest of State	**554,071**	**13,615**	**1,173**	**12,442**
Statewide	**1,750,473**	**32,801**	**3,679**	**29,122**
November 2017				
New York City	**1,181,983**	**22,292**	**2,192**	**20,100**
Rest of State	**541,162**	**14,181**	**1,063**	**13,118**
Statewide	**1,723,145**	**36,473**	**3,255**	**33,218**
December 2017				
New York City	**1,166,525**	**20,317**	**2,384**	**17,933**
Rest of State	**532,790**	**13,028**	**1,164**	**11,864**
Statewide	**1,699,315**	**33,345**	**3,548**	**29,797**
First Quarter				
Region	**Total Affirmative Choices**			
New York City	**54,713**			
Rest of State	**37,424**			
Statewide	**92,137**			

HIV SNP Plans				
October 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,281**	**133**	**0**	**133**
Statewide	**13,281**	**133**	**0**	**133**
November 2017				
New York City	**13,294**	**191**	**0**	**191**
Statewide	**13,294**	**191**	**0**	**191**
December 2017				
New York City	**13,266**	**142**	**0**	**142**
Statewide	**13,266**	**142**	**0**	**142**
First Quarter				
Region	**Total Affirmative Choices**			
New York City	**466**			
Statewide	**466**			

Health and Recovery Plans Disenrollment			
FFY 18 – Q1			
	Voluntary	**Involuntary**	**Total**
October 2017	**876**	**788**	**1,664**
November 2017	**1,082**	**789**	**1,871**
December 2017	**999**	**847**	**1,846**
Total:	**2,957**	**2,424**	**5,381**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (10/1/2017 – 12/31/2017) Q1 FFY2017-2018

As of the end of the first federal fiscal quarter (end of December 2017), there were 2,592,350 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 54,613 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 (Medical Assistance Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 11,011 clients were educated about their enrollment options and 7,494 (68%) clients made an enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed a total of 1,937 presentations: 1,476 (76%) one-to-one presentations and 461 (24%) auto-assignment outreach presentations. The 1,937 presentations resulted in 630 (33%) completed managed care applications and generated a total of 809 enrollments. Also, FCSR provided 1,307 (67%) consumers with general information. HRA's CMU observed 1,476 one-to-one client informational sessions 1,466 (99%) in HRA sites and 10 (1%) in nursing home facilities. CMU monitors reported the following:

- At HRA sites, 1,072 (73%) clients received general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.
- 394 (27%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.
    - Of the 394 FFS clients that selected a plan during an informational session, 244 (62%) 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, eight (8) - 80% residents made voluntary enrollment choice and two (2) - 20% received general information.

Infractions were observed for 40 (10%) of the 402 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

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 27,646 clients were reported on the auto-assignment list by NYMC: 6,746 (24%) clients responded to the call and 3,946 (58%) were enrolled. CMU monitored 461 (12%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 228 (49%) FFS clients made a voluntary phone enrollment choice for themselves and their family members.
  - 69 (30%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 233 (51%) 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 28 (12%) of the 228 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
- Good Cause Transfer
- Confirm Consumer Health Plan/Primary Care Physician (PCP) choice
- Helpline Number

CMU also randomly selected 337 (1%) clients from the auto-assignment list of 27,746 clients to see if outreach calls were conducted, enrollment was chosen by consumer, and notices were sent in a timely manner. CMU confirmed that outreach calls were conducted and for clients that selected a plan on the call that appropriate notices were mailed in a timely manner. 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.

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 61,529 calls were received by the Helpline and 56,643 or 92% were answered. Calls answered were handled in the following languages - English: 41,865 (74%); Spanish: 8,706 (15%); Chinese: 3,119 (5.8%); Russian: 847 (2%); Haitian: 128 (0.2%); and other: 1978 (3%).

MAXIMUS records 100% of the calls received by the NYMC helpline. CMU listened to 2,541 recorded calls. The call observations were categorized in the following manner:

- General Information: 1,740 (68%) Clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 260 (10%) FFS clients made a voluntary phone enrollment choice.

- Plan Transfer: 398 (16%) plan enrollees requested to change their plan.
- Public Calls: 143 (6%): Callers did not have Medical Assistance (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 773 (30%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 599 (77%) - 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: 98 (13%) - 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 on a monthly basis 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 December 28, 2017, HealthNow New York, Inc. was approved to expand its Medicaid Managed Care Service Area to include Genesee and Niagara Counties.

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

On November 28, 2017 CMS issued approval of the 10/1/15 amendment to the Model Contract. On December 5, 2017, this amendment was transmitted to all contracted health plans for signature. As of the close of the quarter, 12 of the 18 health plans returned their signed amendment to the Department for processing.

C. Health Plans/Changes to Certificates of Authority

HealthNow of New York, Inc.- On December 12, 2017, the plan was approved for an expansion of their Medicaid and Child Health Plus lines of business into two additional counties: Genesee and Niagara.

D. Surveillance Activities

Surveillance activity completed during the 1st Quarter FFY 2017-2018 (10/1/2017 to 12/31/17) include the following:

No Comprehensive Operational Surveys and No Targeted Operational Surveys were completed during the 1st Quarter FFY 2017-2018. A Statement of Deficiencies (SOD) was issued and a Plan of Correction (POC) was accepted for no Plans.

Fifteen (15) Provider Directory and Provider Information Surveys were completed during the 1st Quarter FFY 2017-2018. A SOD was issued and a POC was accepted for 14 Plans. One (1) plan was found in compliance:

- Affinity Health Plan, Inc.
- AMERIGROUP New York, LLC
- Amida Care, Inc.
- Capital District Physicians' Health Plan, Inc.
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York, Inc.
- Independent Health Association, Inc. (in compliance)
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan
- New York State Catholic Health Plan, Inc.
- Today's Option of New York, Inc.
- United Health Care
- VNS CHOICE
- WellCare of New York, Inc.

Fifteen (15) PCP Ratio 1500:1 surveys were completed during the 1st Quarter FFY 2017-2018. SODs were not issued for these surveys and a Plan of Correction was not required.

- Affinity Health Plan, Inc.
- AMERIGROUP New York, LLC
- Amida Care, Inc.
- Capital District Physicians' Health Plan, Inc.
- Excellus
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York, Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MVP
- New York State Catholic Health Plan, Inc.
- Today's Option of New York, Inc.
- United Health Care
- WellCare 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, 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) 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 (10/1/2017 – 12/31/2017)**

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	50,277	717	646	1.28%
ROS	6,408	67	67	1.05%
Total	56,685	784	713	1.26%

****Note: The State is missing inpatient and outpatient submission from one plan for December 2017.**

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 (10/1/2017 – 12/31/2017)**

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	6,232	98	49	0.79%
ROS	2,416	11	7	0.29%
Total	8,648	109	56	0.65%

****Note: The State is missing inpatient and outpatient submission from one plan for December 2017.**

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2017 – 12/31/2017)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,473,869	85.19%	12.87%
Rest of State	1,137,696	81.55%	12.89%
Statewide Total	2,611,565	83.60%	12.88%

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 10/1/2017 – 12/31/2017: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	115	37
Education Support Services	41	24
Family Support and Trainings	4	3
Intensive Crisis Respite	2	1
Intensive Supported Employment	40	16
Ongoing Supported Employment	1	1
Peer Support	176	71
Pre-vocational	24	12
Provider Travel Supplements	180	87
Psychosocial Rehab	102	33
Residential Supports Services	47	17
Short-term Crisis Respite	219	36
Transitional Employment	8	1
TOTAL	959	209

HCBS Claims/Encounters 10/1/2017 – 12/31/2017: ROS

HCBS SERV GROUP	N Claims	N Recip
CPST	**113**	**24**
Education Support Services	**322**	**81**
Family Support and Trainings	**38**	**7**
Intensive Crisis Respite	**2**	**1**
Intensive Supported Employment	**144**	**23**
Peer Support	**914**	**189**
Pre-vocational	**168**	**36**
Provider Travel Supplements	**569**	**103**
Psychosocial Rehab	**285**	**72**
Residential Supports Services	**210**	**39**
Short-term Crisis Respite	**8**	**3**
Transitional Employment	**2**	**1**
TOTAL	**2,775**	**390**

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

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 7th, 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
- Submitting a proposal to CMS to develop a pathway to BH HCBS for enrollees who are not enrolled in Health Home through MCO direct contracts with State Designated Entities to perform assessments and develop plans of care for BH HCBS
- 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
- Exploring with CMS ways to utilize peers to help members understand the benefits of BH HCBS and facilitate linkage through the support of a person with lived experience.

As of January 22, 2018, 2,661 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, as of, January 15, 2018 15,352 eligibility assessments have been completed.

Transition of School-based Health Center Services from Medicaid Fee-for-Service:
The Department was notified on December 19th, that School-Based Health Centers will remain carved out of Medicaid managed care until January 1, 2021, under an agreement reached between the state Legislature and Gov. Andrew Cuomo. The Department will work with other New York State agencies involved to discuss next steps on the overall carve-in. 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
On July 1, 2017, outpatient clotting factor products and services were transitioned into the Medicaid managed care (MMC) benefit package. The DOH held two (2) calls this quarter with MMC Plans and clotting factor providers, there have been no substantive issues reported. The DOH worked with the Hemophilia Treatment Centers (HTCs), stakeholders and Plans to draft a Clotting Factor Person Centered Services Planning (PCSP) Flowchart. The group approved one flowchart for enrollees receiving care management and one flowchart for enrollees not receiving care management. These documents are posted to 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 October 2017 through December 2017 quarter, one Partial Capitation plan was approved for a service area expansion into Westchester county. By the end of December 2017, the total number of Partial Capitation plans was reduced by two, and one Medicaid Advantage plan ended operations.

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 October 2017 through December 2017 quarter, post enrollment surveys were completed for 8 enrollees. Six of the eight enrollees who responded to the question (75%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. This represents an increase in affirmative responses from 64% during the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 189,071 to 196,859 during the October 2017 through December 2017 quarter. For that period, 14,066 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 54,276. Monthly plan-specific enrollment for the January 2017 through December 2017 annual period is submitted as an attachment.

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 October 2017 through December 2017 quarter, one operational survey was finalized, with no Plans of Correction accepted. In addition:

- Processes for second round of operational and focused surveys are being refined.
- The MLTC Surveillance Unit's plan of correction process is under revision.

- The Year 2 survey process remains in redesign phase and the Year 2 survey schedule in development due to staffing changes, coupled with the anticipation of a new surveillance software system.

3. Issues and Problems

   There were no issues or problems to report for the October 2017 through December 2017 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 329 critical incidents reported for the October 2017 through December 2017 quarter, an increase of fifty-two incidents over the last quarter. Critical incidents by plan for this quarter are attached.

   Grievances and Appeals: For the October 2017 through December 2017 quarter, the top reasons for the grievance/appeal remain dissatisfaction with transportation, dissatisfaction with quality of home care, home care aides late/absent on scheduled day of services, dissatisfaction with quality of other covered services, and then miscellaneous reasons.

Period: 10/1/17 - 12/31/17 **(Percentages rounded to nearest whole number)**			
Number of Recipients: 200,869	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**5,507**	**5,507**	**100%**
# Standard/Expedited	**2,638**	**2,620**	**99%**
Total for this period:	**8,145**	**8,127**	**100%**

Appeals	**1/17-3/17**	**4/17-6/17**	**7/17-9/17**	**10/17-12/17**	**Average for Four Quarters**
Average Enrollment	186,567	193,019	200,869	209,169	197,406
Total Appeals	1,507	1,428	1,433	1,614	1,495
Appeals per 1,000	8	7	7	8	8
# Decided in favor of Enrollee	286	295	295	324	300

# Decided against Enrollee	1,000	1,021	1,021	1,158	1,050
# Not decided fully in favor of Enrollee	126	92	92	130	110
# Withdrawn by Enrollee	29	19	19	50	29
# Still pending	362	353	358	389	366
Average number of days from receipt to decision	11	15	15	12	13

Grievances and Appeals per 1,000 Enrollees By Product Type October 2017 – December 2017					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	194,529	6,660	34	1,448	7
Medicaid Advantage Plus (MAP) Total	8,903	665	75	156	18
PACE Total	5,736	820	143	10	2
Total for All Products:	**209,168**	**8,145**	**39**	**1,614**	**8**

Total Grievances decreased slightly from 8,257 the previous quarter to 8,145 during the October 2017 through December 2017 quarter. The total number of appeals increased slightly from 1,537 during the last quarter to 1,614 during the October 2017 through December 2017 quarter.

Technical Assistance Center (TAC) Activity

During the first quarter of October 2017 through December 2017, the TAC Unit took in a total of 820 cases (calls, emails, physical mail, and faxes). Ninety-one percent of the cases were resolved within the same month of receipt. The largest number of cases continue to relate to dissatisfaction with home health care or with the enrollee's interdisciplinary team at the plan. Questions from providers regarding billing, eligibility, and coverage also help to make up the majority cases. This is the third consecutive quarter in which TAC has seen a decrease in complaints, however, the amount of the decrease is negligible. TAC opened 44 less cases than the previous quarter.

Call volume:

Substantiated Complaints: 286
Unsubstantiated Complaints: 354
Complaints Resolved Without Investigation: 36
Inquiries: 173
Total Calls: 849

The five most common types of calls were related to:

Home Health Care:	18%
Interdisciplinary Team:	15%
Billing – Claim Denials:	11%
Enrollment, Eligibility Unspecified:	4%
Referral—Difficulty Obtaining DME:	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.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the October 2017 through December 2017 quarter, 10,827 people were evaluated, deemed eligible and enrolled into plans.

Referrals and 30-day assessment: For the October 2017 through December 2017 quarter, MLTC plans conducted 10,899 assessments. The total number of assessments conducted this quarter has decreased from 13,264 the previous quarter.

Referrals outside enrollment broker: During the October 2017 through December 2017 period, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 21,688, an increase from 20,805 during the previous quarter.

Rebalancing Efforts	10/17-12/17
New Enrollees to the Plan from a nursing home transitioning to the community	550
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,584
Current plan Enrollees permanently placed in a nursing home	14,639
New Enrollees permanently placed in a nursing home who remain in a nursing home	3,129

VI. Evaluation of the Demonstration

A revised evaluation plan was submitted in October to the CMS evaluation team, however questions remain regarding the specifics needed for the analytical methods as well as the process for contracting with an independent evaluator. Comments from the evaluation team were received on December 28, 2017, and program staff have worked to address the comments contained in that document. There continues to be uncertainty regarding the procurement of the independent evaluator, as well as methodological questions. A proposed conference call between program staff and the CMS evaluation team will help resolve remaining issues.

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 10/1/17 – 12/31/17
Medicaid Managed Care	**5,471**
HARP	**329**
HIV/SNP	**178**
Total MMCO Complaints	**5,978**

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 5,978. This represents a 6.3% decrease from the prior quarter. The most frequent category of complaint is balanced billing disputes which represented 22% of the total.

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

25% Balance Billing
15% Reimbursement/Billing Issues
10% Dissatisfaction with Quality of care
8% Difficulty with Obtaining: Dental or Orthodontia
7% Pharmacy/Formulary

Monitoring of Plan Reported Complaints
The Department is in the process of calculating the observed/expected ratio for the six-month period ending with this quarter. 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.

HARP Complaints/Action Appeals:
Of the total 5,978 complaints, MMCOs reported, 329 were associated with Health and Recovery Plans (HARPS).

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

20% Dissatisfaction with Quality of Care
15% Pharmacy/Formulary
11% Reimbursement/Billing
8% Balance Billing

7% Dissatisfaction with Provider Services (Non-medical) or MCO Services

During this quarter, substance use provider trade association noted protracted delays in HARP coverage of claims for physical health services provided by opioid treatment providers. The Department analyzed complaint investigations for the past two years but did not identify significant trend of substantiated complaints. The Department is continuing its investigation based on new information provided by opioid treatment providers and working with plans to confirm appropriate coverage of these services. If any deficiencies are identified, the plan will be required to take corrective action.

HIV/SNPS

During the quarter, Managed Care Organizations reported 178 complaints/action appeals for HIV Special Needs Plans (SNPs).

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

22% Dissatisfaction with Provider Services (Non-Medical) or MCO Services
21% Pharmacy/Formulary
10% Balance Billing
8% Difficulty with Obtaining: Dental/Orthodontia
7% Access to Non-Covered Services

As previously reported, Amida Care, the largest of the three HIV SNPS in New York, identified areas of concern in the areas of dental, transportation and pharmacy during the six-month period of 1/1/17-6/30/17. During the last two quarters, there has been reduction in transportation complaints with no transportation complaints reported. Pharmacy has seen a significant reduction in complaints (17% reduction) and the Dental and Orthodontia area has not materially changed.

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 5,978 total reported complaints/action appeals, mainstream MMCOs reported 585 complaints and action appeals from their SSI enrollees. This compares to 625 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	22
AIDS Adult Day Health Care	0
Appointment Availability - PCP	2
Appointment Availability - Specialist	5
Appointment Availability – BH HCBS	0
Balance Billing	69
Communications/Physical Barrier	5
Consumer Directed Personal Assistant	0
Denial of Behavioral Health Clinical Treatment	0
Denial of Clinical Treatment	26
Dental or Orthodontia	122
Dissatisfaction with Behavioral Health Provider Services	0
Dissatisfaction with Health Home Care Management	4
Emergency Services	8
Eye Care	3
Family Planning	0
Home Health Care	9
Mental Health/Substance Abuse Services/ Treatment	2
Non-covered Services	17
Non-Permanent Resident Health Care Facility	0
Personal Care Services	3
Personal Emergency Response System	0
Pharmacy	41
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	48
Quality of Care	127
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	23
Specialist or Hospital Services	13
Transportation	6
Waiting Time Too Long at Office	2
All Other Complaints	28
Total	**585**

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	21%
Balance Billing	12%
Provider or MCO Services (Non-Medical)	8%
Pharmacy	7%

The following complaints/action appeals were reported involving difficulty with obtaining long term services and supports. The Department has identified an increase in complaints involving home health care and personal care services reported, and requested plans further examine this increase and report on any identified 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	1
Home Health Care	29
Non-Permanent Residential Health Care Facility	1
Personal Care Services	16
Personal Emergency Response System	1
Private Duty Nursing	0
Total	**48**

Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 451 complaints this quarter. This is a significant drop from the previous quarter, which reported 661 complaints, but consistent with the same quarterly period in FFY 17, which reported 484 complaints. Upon analysis of reported complaints, no further trends except quarterly variations have been identified.

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 7, 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 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. An additional agenda item was, a discussion of the managed care organization financial reports. The next MMCARP meeting is scheduled for February 22, 2018.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

In November, as part of the Department's review process for the publication and public release of its annual Report on quality performance by the Managed Long-Term Care (MLTC) plans, we released the DRAFT data to the MLTC plans as an opportunity for the plans to verify their rates.

In December, the Department released to the MLTC plans, their Crude Percent Reports for the time period of January through June 2017. The Crude Percent Reports provide the plans with a distribution of their members compared to the statewide, for many of the components of the functional assessment tool.

In December, we released to the plans the methodology for the 2018 MLTC Quality Incentive.

B. Quality Measurement in Medicaid Managed Care

Quality Assurance Reporting Requirements (QARR)

Attachment 3 reflects the NYS overall quality results for Medicaid Managed Care for measurement year 2016 along with the national benchmarks for Medicaid, which are from NCQA's State of Health Care Quality 2018 report.

National benchmarks were available for 63 measures for Medicaid. Out of the 63 measures that Medicaid plans reported, 89% of measures met or exceeded national benchmarks. The NYS Medicaid rates exceed the national benchmarks for behavioral health on adult measures (receiving a follow-up after 7 and 30 days post-hospitalization for mental illness), and child measures (metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures (i.e., prenatal and postnatal care as well as screening for chlamydia, cervical cancer, and breast cancer).

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 EQR contractor 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 as well as plans that offer 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 October through December 2017, a methodology was developed to combine the existing Provider Directory Survey work with the Survey of Access and Provider Availability. New behavioral health related questions were added to the Member Services Survey to allow for assessment of accommodation of 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.

The end of the quarter coincided with a closeout of data collection for the Prenatal Care Quality Improvement project.

Regarding assessment of consumer satisfaction, IPRO facilitated completion of the 2017 adult CAHPS survey, through subcontract with DataStat, and completed administration of a MLTC satisfaction survey. In the quarter, IPRO also administered the first ever perceptions of care survey within the HAPR population. Data collection wrapped up at the end of the year, and reports will be made available in early 2018.

IPRO continues to be involved in an audit of the State's Uniform Assessment System (UAS), and is currently working with the MLTC program to plan an MLTC Focused Clinical Study to validate assessments being completed by Maximus nurse reviewers. IPRO is also helping DOH programs plan a new Managed Care Focused Clinical Study, examining care management of select conditions.

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 will be 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). Oversight calls with IPRO and individual HARP plans and HIV SNP plans were conducted in November 2017. 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.

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. The IPRO oversight calls were conducted in December 2017. Each plan submitted a written summary of progress to IPRO before the call was conducted. On October 23, 2017, a required Perinatal PIP webinar was conducted. Three Medicaid managed care plans presented their Perinatal PIP progress to the group. There are three additional webinars scheduled for the other plans to present on their PIP progress in 2018.

Breast Cancer Selective Contracting
The Department began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2014-2016 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as, facility-level data from the Health Facilities Information System (HFIS). A total of 217 facilities were identified as having performed at least one breast cancer surgery from 2014-2016. Preliminary facility volume designations were as follows: 114 high-volume; 24 low-volume that are allowed to perform surgeries to ensure adequate access; 77 low-volume restricted facilities; and, 2 recently closed facilities.

Letters were drafted to notify low-volume facilities that the Department will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state fiscal year 2018-19, nor can Medicaid managed care plans contract with low-volume facilities to perform breast cancer surgeries. In addition, the letters will also include a copy of the appeal form for facilities that want to appeal the decision to be placed on the low-volume restricted list. The letters will be mailed out in January 2018.

The Department is making progress in evaluating the Breast Cancer Selective Contracting Policy and the impact of the policy on access to care, quality of care and survival rates. The results of this evaluation will be published in a peer-reviewed manuscript.

Patient Centered Medical Home (PCMH)
As of December 2017, there were 7,819 NCQA-recognized PCMH providers in New York State. 266 providers that became recognized in December 2017 were new to the program and have not been recognized previously. Over the past year the program has consistently seen an increase in the number of new providers joining the program who have never participated before. Approximately 97% (7,609) of current PCMH providers are recognized under the newest 2014 set of standards. Between December 2016 and December 2017, the percentage shift of providers recognized under the newest standards increased from 59% to 97%. 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 3% (210) of recognized providers are still under the 2011 standards and they are expected to all expire by June 2018. On April 1, 2017 NCQA released their 2017 recognition standards, eliminating the leveling structure. There are currently no practices or providers recognized under the 2017 standards but some sites have applied. Under the new program, it can take up to one year for NCQA to grant PCMH-recognition, as opposed to the guaranteed 90-day review process NCQA offered for sites who submitted applications under all previous standards. The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of December 2017 are:

- 2011 level 2: $0 per member per month (PMPM)

- 2011 level 3: $0 PMPM
- 2014 level 2: $3 PMPM
- 2014 level 3: $7.50 PMPM
- 2017 recognition $7.50 PMPM

DSRIP requires certain practices participating in primary care transformation projects to become 2014 level 3 PCMH or Advanced Primary Care (APC) recognized by March 31, 2018. There are currently no providers recognized as APC but there are 597 providers currently enrolled in transformation.

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. Risk arrangements with practices within the ADK demonstration will differ by plan. All payments will be made to the newly approved 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. There is a quality subcommittee for this demonstration that has finalized a measure set to measure quality and performance for these sites over the next few years of participation.

The June 2017 PCMH Statewide quarterly report was posted to the DOH website this past quarter. The PCMH and ADK Initiative in NYS Medicaid annual report to the New York State Governor and Legislature was also posted to the DOH website this past quarter. Both reports 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 nearing completion, with initial calculations through DY15 and DY16 submitted on April 28, 2017 and June 29, 2017, respectively.

In early June, NYSDOH FMG uncovered an issue concerning data entry for the New Adult Group relating to reporting overlap of this MEG and Group VIII. New York State notified CMS about this issue and requested expedient guidance, which CMS provided with new deadlines for DY16 and DY17. The State submitted final Budget Neutrality calculations for DY14-DY17 Quarters 1-3 in accordance with the new project deadline of December 31, 2017. Final calculations for DY17 Quarter 4 will be submitted by March 31, 2018 as agreed to by CMS on December 5, 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.

As detailed in STC X.10, the State has identified a contractor to complete a certified and audited final assessment of budget neutrality for the 10/1/11-3/31/16 period. The audit will commence upon completion of remediation efforts and CMS approval of the audit plan.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

New York State T-MSIS is current in its submission of production files.

Attachments:
Attachment 1—MLTC Partial Capitation Plans
Attachment 2—MLTC Critical Incidents
Attachment 3—NYS MMC Statewide + National Rates 2016

State Contact:
Priscilla Smith
Medical Assistance Specialist III
Division of Program Development and Management
Office of Health Insurance Programs
priscilla.smith@health.ny.gov
Phone (518) 486-5890
Fax# (518) 473-1764

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Managed Long Term Care Partial Capitation Plans, December 2016-December 2017

Plan Name	Dec-16 Enrollment	Jan-17 Enrollment	Feb-17 Enrollment	Mar-17 Enrollment	Apr-17 Enrollment	May-17 Enrollment	Jun-17 Enrollment	Jul-17 Enrollment	Aug-17 Enrollment	Sep-17 Enrollment	Oct-17 Enrollment	Nov-17 Enrollment	Dec-17 Enrollment
Aetna Better Health	3,943	4,028	4,057	4,105	4,145	4,196	4,258	4,335	4,411	4,542	4,673	4,897	5,202
AgeWell New York	7,663	7,828	7,939	8,079	8,227	8,409	8,522	8,542	8,607	8,690	8,792	8,868	9,221
AlphaCare	3,347	3,428	3,528	3,627	3,735	3,856	3,951	4,134	4,282	4,459	4,692	4,775	4,589
ArchCare Community Life	2,231	2,273	2,298	2,339	2,400	2,509	2,623	2,695	2,783	2,871	2,993	3,187	3,294
CCM Select	4,969	4,819	50	53	13	1	1	1	0	0	0	0	0
Centers Plan for Healthy Living	8,950	9,587	14,711	15,147	15,777	16,345	16,881	17,532	18,057	18,660	19,199	20,046	24,655
Elant	826	839	852	847	843	839	847	854	853	874	879	902	909
Elderplan	11,942	12,093	12,175	12,239	12,340	12,421	12,515	12,583	12,463	12,486	12,579	12,610	12,668
Elderserve	11,072	11,084	11,113	11,158	11,207	11,196	11,231	11,248	11,265	11,277	11,354	11,390	11,497
Elderwood	85	88	99	103	107	116	123	140	151	154	171	188	197
Extended MLTC	1,771	1,819	1,913	1,983	2,098	2,307	2,475	2,660	2,800	2,895	3,110	3,320	3,481
Fallon Health Weinberg (TAIP)	459	466	483	504	521	536	563	573	584	602	627	651	670
Fidelis Care at Home	16,804	17,184	17,421	17,655	17,959	18,278	18,622	19,092	19,226	19,487	19,890	20,126	20,485
Guildnet	15,916	15,709	15,228	14,768	14,253	12,818	11,450	10,826	10,116	9,722	9,508	9,027	8,555
Hamaspik Choice	1,986	2,010	2,018	2,016	2,020	2,028	2,028	2,034	2,032	2,054	2,074	2,104	2,128
HealthPlus- Amerigroup	3,950	4,021	4,119	4,176	4,241	4,337	4,427	4,549	4,597	4,628	4,677	4,760	4,827
iCircle Services	1,625	1,668	1,719	1,725	1,760	1,789	1,854	1,915	2,000	2,054	2,147	2,212	2,257
Independence Care Systems	6,514	6,574	6,593	6,504	6,535	6,558	6,569	6,579	6,606	6,600	6,603	6,602	6,593
Integra	4,607	4,794	5,064	5,279	5,516	5,890	6,190	6,500	6,852	7,191	7,529	7,949	8,404
Kalos Health- Erie Niagara	936	961	978	987	1,030	1,088	1,115	1,151	1,169	1,210	1,252	1,248	1,264
MetroPlus MLTC	1,382	1,413	1,439	1,460	1,506	1,528	1,573	1,609	1,623	1,653	1,691	1,715	1,747
Montefiore HMO	1,272	1,284	1,270	1,275	1,288	1,305	1,341	1,380	1,393	1,404	1,432	1,447	1,465
North Shore-LIJ Health Plan	4,413	4,556	4,691	4,806	4,986	5,229	5,477	5,693	5,756	5,645	5,432	4,666	192
Prime Health Choice	235	244	248	263	265	275	276	282	295	301	308	316	334
Senior Health Partners	13,028	13,158	13,217	13,314	13,479	13,657	13,809	13,878	13,960	14,082	14,304	14,419	14,475
Senior Network Health	514	515	510	521	518	516	527	524	524	530	534	539	544
Senior Whole Health	6,696	6,912	7,162	7,373	7,599	7,981	8,303	8,561	8,826	9,141	9,359	9,440	9,575
United Healthcare	2,657	2,721	2,765	2,798	2,840	2,876	2,979	3,120	3,244	3,370	3,506	3,652	3,789
Village Care	7,190	7,304	7,455	7,466	7,667	7,906	8,102	8,328	8,525	8,713	8,924	9,105	9,276
VNA HomeCare Options	3,372	3,542	3,755	3,993	4,216	4,447	4,733	4,914	5,146	5,363	5,567	5,785	5,987
VNS Choice	13,631	13,645	13,417	13,193	13,032	12,819	12,764	12,824	12,719	12,644	12,704	12,756	12,812
WellCare	6,032	6,036	5,965	5,898	5,862	5,804	5,781	5,787	5,761	5,769	5,763	5,753	5,767
TOTAL	**170,018**	**172,603**	**174,252**	**175,654**	**177,985**	**179,860**	**181,914**	**184,843**	**186,626**	**189,071**	**192,273**	**194,455**	**196,859**

Critical Incidents, October 2017-December 2017		
Plan Name	**Plan Type**	**Total Critical Incidences**
Partical Capitation Plans		
Aetna Better Health	Partial	-
AgeWell New York ,LLC	Partial	11
AlphaCare of New York Inc.	Partial	1
Amerigroup	Partial	3
ArchCare Community Life	Partial	7
CenterLight Healthcare Select	Partial	-
Centers Plan for Healthy Living	Partial	12
Elant Choice	Partial	1
ElderServe Health, Inc.	Partial	-
Elderwood	Partial	2
Extended	Partial	36
Fallon Health Weinberg	Partial	-
FIDELIS Care New York	Partial	-
GuildNet MLTCP	Partial	31
Hamaspik Choice	Partial	-
HomeFirst MLTC, a product of Elderplan	Partial	2
I Circle	Partial	1
Independence Care Systems	Partial	1
Integra MLTC	Partial	-
Kalos, dba First Choice Health	Partial	-
Metroplus	Partial	-
Montefiore Diamond Care	Partial	2
NSLIJ Health Plan	Partial	-
Prime Health Choice, LLC	Partial	33
Senior Health Partners	Partial	51
Senior Network Health	Partial	-
Senior Whole Health	Partial	1
United Healthcare Personal Assist	Partial	-
VillageCareMAX	Partial	-
VNA Homecare Options, LLC	Partial	41
VNSNY CHOICE MLTC	Partial	1
Wellcare	Partial	22
Total Partial Capitation		**259**
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	-
Fidelis Medicaid Advantage Plus	MAP	-
GuildNet GNG	MAP	5
Healthfirst CompleteCare	MAP	20
HEALTHPLUS AMERIGROUP	MAP	-
Senior Whole Health	MAP	-
VNSNY CHOICE MLTC TOTAL	MAP	-
Total MAP		**25**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	12
Catholic Health LIFE	PACE	12
CenterLight Healthcare	PACE	1
Complete Senior Care	PACE	2
Eddy SeniorCare	PACE	6
ElderONE	PACE	-
Fallon Health Weinberg	PACE	-
Independent Living Services of CNY (PACE CNY)	PACE	12
Total Senior Care	PACE	-
Total PACE		**45**
Grand Total		**329**

NYS Medicaid Managed Care Statewide Rates - 2016, Compared to 2016 National Rates

Domain	Measure	NYS 2016	National 2016
Adult Health	Adult BMI Assessment	87	81
Adult Health	Advising Smokers to Quit	80	76
Adult Health	Annual Dental Visit (Ages 19-20)	44	36
Adult Health	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	92	88
Adult Health	Annual Monitoring for Patients on Persistent Medications- Combined Rate	92	88
Adult Health	Annual Monitoring for Patients on Persistent Medications- Digoxin	54	55
Adult Health	Annual Monitoring for Patients on Persistent Medications- Diuretics	91	88
Adult Health	Asthma Medication Ratio (Ages 19-64)	56	NA
Adult Health	Colon Cancer Screening	58	NA
Adult Health	Controlling High Blood Pressure	62	56
Adult Health	Discussing Smoking Cessation Medications	59	48
Adult Health	Discussing Smoking Cessation Strategies	51	43
Adult Health	Drug Therapy for Rheumatoid Arthritis	81	73
Adult Health	Flu Shot for Adults	40	39
Adult Health	Managing Diabetes Outcomes - Blood pressure controlled (lower than 140/90 mm Hg)	64	60
Adult Health	Managing Diabetes Outcomes - HbA1C Control (less than 8.0%)	56	47
Adult Health	Managing Diabetes Outcomes -Poor HbA1c Control	33	43
Adult Health	Medication Management for People with Asthma 50% Days Covered (Ages 19-64)	68	NA
Adult Health	Medication Management for People with Asthma 75% Days Covered (Ages 19-64)	42	NA
Adult Health	Monitoring Diabetes - Dilated Eye Exam	65	55
Adult Health	Monitoring Diabetes - HbA1c Testing	91	87

Domain	Measure	NYS 2016	National 2016
Adult Health	Monitoring Diabetes - Nephropathy Monitoring	92	90
Adult Health	Monitoring Diabetes - Received All Tests	59	NA
Adult Health	Persistence of Beta-Blocker Treatment	86	80
Adult Health	Pharmacotherapy Management of COPD Exacerbation-Bronchodilator	85	81
Adult Health	Pharmacotherapy Management of COPD Exacerbation-Corticosteroid	69	66
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Adherent:	65	61
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Received:	73	75
Adult Health	Statin Therapy for Patients with Diabetes - Adherent:	60	59
Adult Health	Statin Therapy for Patients with Diabetes - Received:	64	60
Adult Health	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	52	32
Adult Health	Viral Load Suppression	77	NA
Behavioral Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	61	59
Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	51	53
Behavioral Health	Antidepressant Medication Management-Effective Continuation Phase Treatment	36	38
Behavioral Health	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	83	78
Behavioral Health	Diabetes Monitoring for People with Diabetes and Schizophrenia	80	70
Behavioral Health	Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	82	81
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 30 Days	78	64

Domain	Measure	NYS 2016	National 2016
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 7 Days	63	46
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	68	55
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	59	44
Behavioral Health	Metabolic Monitoring for Children and Adolescents on Antipsychotics	42	33
Behavioral Health	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67	60
Child and Adolescent Health	Adolescent Immunization Combo	78	75
Child and Adolescent Health	Adolescent Well-Care Visits	68	51
Child and Adolescent Health	Annual Dental Visit (Ages 2-18)	61	NA
Child and Adolescent Health	Appropriate Testing for Pharyngitis	89	74
Child and Adolescent Health	Assessment, Counseling or Education: Alcohol and Other Drug Use	69	NA
Child and Adolescent Health	Assessment, Counseling or Education: Depression	61	NA
Child and Adolescent Health	Assessment, Counseling or Education: Sexual Activity	67	NA
Child and Adolescent Health	Assessment, Counseling or Education: Tobacco Use	73	NA
Child and Adolescent Health	Asthma Medication Ratio (Ages 5-18)	63	NA
Child and Adolescent Health	Childhood Immunization Status (Combo 3)	74	70
Child and Adolescent Health	Counseling for Nutrition	80	65
Child and Adolescent Health	Counseling for Physical Activity	69	58
Child and Adolescent Health	Lead Testing	86	68
Child and Adolescent Health	Medication Management for People with Asthma 50% Days Covered (Ages 5-18)	54	NA
Child and Adolescent Health	Medication Management for People with Asthma 75% Days Covered (Ages 5-18)	26	NA
Child and Adolescent Health	Weight Assessment- BMI Percentile	77	69

Domain	Measure	NYS 2016	National 2016
Child and Adolescent Health	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	84	72
Child and Adolescent Health	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	80	NA
Provider Network	Board Certified Family Medicine	71	NA
Provider Network	Board Certified Internal Medicine	75	NA
Provider Network	Board Certified OB/GYN	75	NA
Provider Network	Board Certified Pediatrics	78	NA
Provider Network	Satisfaction with Personal Doctor	80	80
Provider Network	Satisfaction with Provider Communication	91	91
Provider Network	Satisfaction with Specialist	80	80
Satisfaction with Care	Access to Prescription Medicines for Children	91	NA
Satisfaction with Care	Access to Specialized Services for Children	76	NA
Satisfaction with Care	Care Coordination	80	NA
Satisfaction with Care	Coordination of Care for Children with Chronic Conditions	74	NA
Satisfaction with Care	Customer Service	84	88
Satisfaction with Care	Customer Service for Children	86	NA
Satisfaction with Care	Family-Centered Care: Personal Doctor Who Knows Child	90	NA
Satisfaction with Care	Getting Care Needed	79	80
Satisfaction with Care	Getting Care Needed for Children	85	NA
Satisfaction with Care	Getting Care Quickly	80	80
Satisfaction with Care	Getting Care Quickly for Children	88	NA
Satisfaction with Care	Getting Needed Counseling or Treatment	74	NA
Satisfaction with Care	Rating of Counseling or Treatment	64	NA
Satisfaction with Care	Rating of Health Plan	76	75
Satisfaction with Care	Rating of Health Plan for Children	85	NA
Satisfaction with Care	Rating of Overall Healthcare	75	74
Satisfaction with Care	Rating of Overall Healthcare for Children	86	NA
Satisfaction with Care	Satisfaction with Personal Doctor for Children	89	NA

Domain	Measure	NYS 2016	National 2016
Satisfaction with Care	Satisfaction with Provider Communication for Children	93	NA
Satisfaction with Care	Satisfaction with Specialist for Children	83	NA
Satisfaction with Care	Shared Decision Making	79	79
Satisfaction with Care	Shared Decision Making for Children	74	NA
Satisfaction with Care	Wellness Discussion	68	NA
Women's Health	Breast Cancer Screening	71	59
Women's Health	Cervical Cancer Screening	75	58
Women's Health	Chlamydia Screening (Ages 16-20)	73	54
Women's Health	Chlamydia Screening (Ages 21-24)	76	62
Women's Health	Frequency of Ongoing Prenatal Care	67	58
Women's Health	Postpartum Care	71	64
Women's Health	Prenatal Care in the First Trimester	75	NA
Women's Health	Risk-Adjusted Low Birthweight	6	NA
Women's Health	Risk-Adjusted Primary Cesarean Delivery	14	NA
Women's Health	Timeliness of Prenatal Care	89	82
Women's Health	Vaginal Birth After Cesarean Section	17	NA

NA = Data Not available