MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 20 (10/1/2016 – 9/30/2017)
Federal Fiscal Quarter: 3 (4/01/2017 – 6/30/2017)

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: Third Quarter

MRT Waiver- Enrollment as of June 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	**869,699**	**8,455**	**88,826**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**118,150**	**2,652**	**8,976**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**27,599**	**372**	**13,177**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**3,952**	**121**	**838**
Population 5 - Safety Net Adults	**631,470**	**13,414**	**78,097**
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)	**32,169**	**1,515**	**157**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**195,615**	**11,395**	**1,699**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,250**	**272**	**46**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**58,720**	**3,118**	**1,598**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**41,317 or an approximate 0.3% 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 general decline in voluntary disenrollment.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**193,414 or an approximate 3% 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 declined by a small percentage when compared to the prior quarter, but case closures remain high when compared to quarters in the last fiscal year.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
April 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,296,280**	**18,289**	**2,712**	**15,577**
Rest of State	**743,026**	**13,625**	**1,493**	**12,132**
Statewide	**2,039,306**	**31,914**	**4,205**	**27,709**
May 2017				
New York City	**1,276,383**	**21,702**	**3,152**	**18,550**
Rest of State	**703,485**	**15,334**	**1,583**	**13,751**
Statewide	**1,979,686**	**37,036**	**4,735**	**32,301**
June 2017				
New York City	**1,258,608**	**20,452**	**2,701**	**17,751**
Rest of State	**667,679**	**13,541**	**1,212**	**12,329**
Statewide	**1,926,287**	**33,993**	**3,913**	**30,080**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**51,878**			
Rest of State	**38,212**			
Statewide	**90,090**			

HIV SNP Plans				
April 2017				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,400**	**128**	**0**	**128**
Statewide	**13,400**	**128**	**0**	**128**
May 2017				
New York City	**13,342**	**151**	**0**	**151**
Statewide	**13,342**	**151**	**0**	**151**
June 2017				
New York City	**13,337**	**163**	**0**	**163**
Statewide	**13,337**	**163**	**0**	**163**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**442**			
Statewide	**442**			

MRT Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
June 2017	
Plan Name	**Enrollment**
Affinity Health Plan	**3,901**
Capital District Physicians Health Plan	**2,410**
Excellus Health Plan	**5,939**
HealthFirst	**20,427**
HealthPlus	**5,584**
HIP GNY	**4,700**
Independent Health Association	**1,527**
MetroPlus	**9,852**
Molina Healthcare (name change from Today's Options)	**1,368**

MVP Health Plan	**3,841**
NYS Catholic Health Plan	**22,524**
United HealthCare	**5,428**
YourCare Health Plan	**1,445**
Total:	**88,946**

Health and Recovery Plans Disenrollment			
FFY 17 – Q3			
	Voluntary	**Involuntary**	**Total**
April 2017	**603**	**573**	**1,176**
May 2017	**778**	**617**	**1,395**
June 2017	**766**	**598**	**1,364**
Total:	**2,147**	**1,788**	**3,935**

III. Outreach/Innovative Activities

A. Outreach Activities

New York Medicaid Choice (NYMC) Field Observations

As of the end of the third federal fiscal quarter (end of June 2017), there were 2,607,694 New York City Medicaid consumers enrolled in the mainstream Medicaid managed care program (MMC) and 50,979 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 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 15,809 clients were educated about their enrollment options and 8,296 (52%) clients made an enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed a total of 2,458 presentations: 2,163 (88%) one-to-one presentations and 295 (12%) auto-assignment outreach presentations. The 2,458 presentations resulted in 757 (31%) completed managed care applications and 945 (38%) enrollments, also FCSR provided 1,701 (69%) consumers with general information. HRA's Contract Monitoring Unit (CMU) observed 2,163 one-to-one client informational sessions - 2,107 (97%) in HRA sites and 56 (3%) in nursing home facilities. CMU monitors reported the following at HRA sites:

- 1,487 (71%) clients received requested general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.

- 620 (29%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.

- Of the 620 FFS clients that selected a plan during an informational session, 221 (36%) 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, 23 (41%) residents made voluntary enrollment choice and 33 (59%) received general information.

- Infractions were observed for 78 (12%) of the 643 Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA and Nursing Home sites. Seventy-seven of the 78 (99%) infractions were observed at HRA sites and one of the 78 (1%) was observed at Nursing Home sites.

Infractions most often noted were failure to disclose or explain the following:

- Lock in policy
- Good Cause Transfer
- Emergency Room Services
- Transitional Care

<u>Auto-Assignment (AA) Outreach</u>

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients selected for plan auto-assignment. A total of 25,900 clients were reported on the auto-assignment list by NYMC. Of the 25,900 clients, 4,395 (17%) clients responded to the call. CMU monitored 295 (7%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 114 of 295 (39%) FFS clients made a voluntary phone enrollment choice for themselves and their family members.
    - Infractions were observed for 23 (20%) of the 114 AA phone enrollment. The following infractions were identified for the AA phone enrollments conducted by the FSCRs:
        - Failed to explain specialist, standing referral process
        - Use of plan ID card
        - Lock in Policy
        - Good Cause Transfer
        - Confirm Consumer Health Plan/PCP choice
- Undecided: 181 of 295 (61%) FFS clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician.

- No infractions were observed for these calls.

CMU also randomly selected 349 (1%) clients from the auto-assignment list of 25,900 clients to see if outreach calls were conducted; enrollment was chosen by consumer and notices were sent in a timely manner. CMU confirmed that appropriate notices were mailed in a timely manner to all 349 clients and clients were enrolled in their plan of choice.

NYMC HelpLine Observations

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 66,158 calls were received by the Helpline and 61,819 or 93% were answered. Calls answered were handled in the following languages -English: 45,855 (74%); Spanish: 9,845 (16%); Chinese: 2,950 (5%); Russian: 950 (2%); Haitian: 158 (0.3%); and other: 2,061 (3%).
MAXIMUS records 100% of the calls received by the NYMC Helpline. CMU listened to 2,501 recorded calls. The call observations were categorized in the following manner:

- General Information: 1504 (60%) clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 356 (14%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 376 (15%) plan enrollees requested to change their plan.
- Public Calls: 265 (11%): 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 623 (25%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 312 (50%) - 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: 118 (19%) - 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: 193 (31%) - Consumers were put on hold without an explanation or were not offered additional assistance.

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

IV. Operational/Policy Developments/Issues

A. Health Plans/Changes to Certificates of Authority

Changes to Certificates of Authority

- There were no changes to Certificates of Authority issued to Health Plans serving the Medicaid population during this period.

Plan Expansions, Withdrawals and New Plans

- On April 3, 2017, United HealthCare of New York, Inc. was approved to expand its Medicaid Managed Care and HARP Service Area to include Franklin, Orleans, Schenectady, and Yates counties.

B. Medicaid Managed Care/HIV Special Needs Plan/HARP Model Contract

- On April 11, 2017, the Department of Health received comments back from CMS regarding its review of the October 1, 2015 contract amendment. CMS identified several additional requirements that must be included in the amendment before CMS can approve it. The Department has drafted this additional contract language and submitted it for Division of Legal Affairs (DLA) review. This additional language will be transmitted to CMS after it has received DLA approval.

C. Surveillance Activities

Surveillance activity completed during the 3rd Quarter FFY 2016-2017 (04/01/2017- 06/30/1017) include the following:

Three (3) Comprehensive Operational Surveys and one (1) Targeted Operational Survey were completed during the 3rd Quarter FFY 2016-2017. An SOD was issued and a POC was accepted for each of the following four (4) Plans:

- Healthplus/Amerigroup (Targeted)
- HIP/Emblem (Comprehensive)
- NYCHP/Fidelis (Comprehensive)
- WellCare (Comprehensive)

No Focus Surveys were completed during this time.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

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

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

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

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

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

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

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

B. Benefit Changes/Other Program Changes

Transition of Behavioral Health Services into Managed Care and Development of Health and Recovery Plans (HARPs):

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

Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

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

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

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

2. **Outpatient Denial Report:** MCOs are required to submit on a quarterly basis a report to the State on ambulatory service authorization requests and denials for each behavioral health service. Submissions must include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS. Each quarterly submission contains 3 separate months of data and is due to the State 15 days on the following month after the end of the quarter being reported.

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

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

HCBS Claims/Encounters: NYC, DOS: 04/01/2017-06/30/2017

HCBS Service Type	N Claims/Encoutners	N Recip.
CPST	15	5
Education Support Services	2	1
Intensive Supported Employment	10	3
Peer Support	30	12
Pre-vocational	13	4
Provider Travel Supplement	13	6
Psychosocial Rehab	15	7
Residential Supports Services	24	7
Short-term Crisis Respite	71	13
Grand Total	193	49

HCBS Claims/Encounters: ROS, DOS: 04/01/2017-06/30/2017		
HCBS Service Type	N Claims/Encoutners	N Recip.
CPST	10	4
Education Support Services	27	7
Family Support and Training	2	1
Intensive Supported Employment	1	1
Peer Support	124	18
Pre-vocational	7	3
Provider Travel Supplement	30	2
Psychosocial Rehab	16	7
Residential Supports Services	24	3
Grand Total	241	38

The table below provides a snap shot of claims data (total, paid and denied) for the period of 04/01/2017-06/30/2017.

Mental Health (MH) & Substance Use Disorders (SUD) Claims (04/01/2017-06/30/2017)			
Region	**Total Claims**	**Paid Claims**	**Denied Claims**
New York City	1,425,906	87.56%	11.57%
Rest of State	1,208,178	83.95%	14.14%
Statewide Total	2,634,084	85.91%	12.75%

All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) have been made available to eligible HARP and HIV SNP enrollees. These services are designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery. Enrollees must undergo an assessment to determine BH HCBS eligibility. Effective January 2016 in NYC and October 2016 for the rest of the state, BH HCBS were made available to eligible individuals.

As discussed with CMS, New York experienced slower than anticipated access to BH HCBS for HARP members and has actively sought to determine the root cause for this delay. Following implementation of BH HCBS, the State and key stakeholders identified challenges, including difficulty locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process, administrative hurdles to obtain approval of BH HCBS Plans of Care, difficulty with enrolling HARP members in Health Homes (HH), difficulty finding BH HCBS providers who were ready to provide BH HCBS due to inadequate rates.

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

- Streamlining the BH HCBS assessment process

    - Effective March 7th, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Implementing low productivity rates during initial implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Developing a pathway to BH HCBS for enrollees who are not enrolled in Health Home through the use of State Designated Entities to complete assessments and develop plans of care for those not enrolled in Health Home
- 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 HH and ensure quality care management for high need SMI individuals. (HH+ expansion)
- Implementing Performance Management efforts, including developing and monitoring quality metrics to ensure HH care management is resulting in improved health outcomes
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach
- Exploring with CMS ways to utilize peers to educate and connect HARP enrollees to both Health Homes and BH HCBS earlier in the process
- The State hosted a series of Town Hall meetings for HCBS providers, Health Homes, and MCOs to provide updates/information and listen to providers' experiences with implementation. These meetings were held as outlined below:
    - March 28th, 2017: NYC
    - April 12th, 2017: Albany
    - May 23rd, 2017: Western NY
    - June 13th 2017: Long Island

As of July 31, 2017, 1,849 care managers in NYS have completed the required training for conducting BH HCBS assessments. Also, as of, July 11, 2017, 10,157 brief assessments have been completed.

DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) are continuing to meet regularly with managed care plans and behavioral health providers across the State to discuss stakeholder concerns and implementation challenges. The State plans to continue these meetings throughout the transition period. These stakeholder engagement efforts have included the following:

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

- Regional Planning Consortium (RPC) meetings for stakeholders to discuss and monitor issues related to access and availability of behavioral health services in managed care. Each RPC represents natural local patterns of access to care, and include representatives from counties, the State, consumers and families, peers and advocates, behavioral health service providers, hospitals, Health Homes and MCOs.

    - An RPC Co-Chairs Meeting occurred on June 8th, 2017 where co-chairs from each of the 11 regions across the State came together to meet with State leadership to share local impact and propose solutions related to the transition to Medicaid Managed Care.

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

In addition, the State has contracted with the Managed Care Technical Assistance Center (MCTAC) to provide technical assistance to behavioral health providers in New York State, including technical assistance around billing managed care, contracting with managed care plans, and the new BH HCBS.

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

During the 3rd Quarter of FFY 2016-2017, the New York State Department of Health, School Based Health Center (SBHC) providers, Medicaid managed care plans and other stakeholders continued to work together on the process of transitioning SBHC services from Medicaid fee-for-service to Medicaid managed care. The scheduled implementation date is July 1, 2018. During the quarter, three subgroups of the larger SBHC stakeholder workgroup (Credentialing and Contracting, Claims and Billing, and Quality Improvement, Utilization Management and Care Coordination), met to discuss implementation issues and explore possible solutions. Each subgroup is co-chaired by a Managed Care Plan representative and a School Based Health Center representative and facilitated by a Department of Health staff person. During the June 15, 2017 meeting, the full SBHC workgroup met, with the co-chairs presenting the outcomes of their respective subgroup meetings. Full workgroup and subgroup activities will continue throughout

2017. The next full SBHC workgroup meeting is set for August 25, 2017. The SBHC transition guidance document and Frequently Asked Questions are posted to the MRT 8401 page on the DOH website.

Hemophilia Blood Factor Transition from Medicaid Fee-for-service

Hemophilia blood factor products are currently carved out of the Medicaid managed care (MMC) benefit package. Reimbursement to pharmacies and hemophilia clinics, that provide blood factor to Medicaid managed care plan enrollees, takes place through Medicaid fee-for-service. The implementation date was set for July 1, 2017. The Department actively engaged in implementation discussions with stakeholders. The Clotting Factor Guidelines, the Criteria Standards for Authorization and Utilization Management, the reimbursement process for clotting factor, clotting factor FAQs, active clotting factor products by NDC and J-Code, clotting factor provider (pharmacy) and hemophilia treatment centers (HTC) were all posted to the MRT 8401 page on the DOH website. Prior to July 1, all Medicaid managed care plans had established contracts with or have entered single case agreements/letters of agreement with non-par providers for the provision of clotting factor products. The department confirmed plans and providers have coverage arrangements in place. Plans were instructed to use the next 90 days to develop person centered services plans.

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 2017 through June 2017 quarter, one MAP plan was approved for a service area expansion into four counties (Bronx, Queens, Kings and New York). There was no plan activity in terms of plan openings, closings, or service area reductions.

   New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. For the April 2017 through June 2017 quarter, post enrollment surveys were completed for ten enrollees. Seven of the ten enrollees who responded to the question (70%) 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 67% during Q2.

Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 175,654 to 181,914 during the April 2017 through June 2017 quarter. For that period, 13,412 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, bringing the 12-month total for affirmative choice to 51,741. Monthly plan-specific enrollment for the July 2016 through June 2017 annual period is submitted as an attachment.

2. Significant Program Developments

During the April 2017 through June 2017 quarter, one operational survey was finalized, with a Plan of Correction accepted. In addition:

- Redesign and revision of the MLTC Surveillance Program Policies and Procedures Manual was completed.
- A Fining Structure Program with policy and procedure is in development.
- Tools for conducting the MAP plan audits are in development.
- Staff training continues to take place on the tools that have been developed thus far, as well as review of the contract and any additional policies.

The new software system that has been targeted to go live in December 2017 is awaiting OSC and AG approvals.

3. Issues and Problems

There were no issues or problems to report for the April 2017 through June 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 274 critical incidents reported for the April 2017 through June 2017 quarter, representing a decrease from 297 incidents reported during Q2 2017. Critical incidents by plan for this quarter are attached.

Grievances and Appeals: For the April 2017 through June 2017 quarter, the top reasons for the grievance/appeal were 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 miscellaneous other reasons.

Period: 4/1/17 - 6/30/17: Percentages rounded to nearest whole number			
Number of Recipients: 193,019	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	5,392	5,392	100%
# Standard/Expedited	2,753	2,740	100%
Total for this period:	8,145	8,132	100%

Appeals	7/16-9/16	10/16-12/16	1/17-3/17	4/17-6/17	Average for Four Quarters
Average Enrollment	171,142	179,583	186,567	193,019	182,578
Total Appeals	1,267	1,055	1,506	1,433	1,316
Appeals per 1,000	7	6	8	7	7
# Decided in favor of Enrollee	393	278	287	295	313
# Decided against Enrollee	641	642	1,000	1,026	827
# Not decided fully in favor of Enrollee	116	98	126	92	108
# Withdrawn by Enrollee	15	23	29	19	22
# Still pending	272	289	371	361	322
Average number of days from receipt to decision	12	15	11	15	14

Grievances and Appeals per 1,000 Enrollees By Product Type April 2017 – June 2017					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	179,918	6,612	37	1,203	7
Medicaid Advantage Plus (MAP) Total	7,476	671	90	206	28
PACE Total	5,625	862	153	24	4
Total for All Products:	**193,019**	**8,145**	**42**	**1,433**	**7**

Total Grievances decreased slightly from 8,319 during the last quarter to 8,145 during the April 2017 through June 2017 quarter.

The total number of appeals decreased from 1,506 during the last quarter to 1,433 during the April 2017 through June 2017 quarter.

Technical Assistance Center (TAC) Activity

During the April 2017 through June 2017 quarter, the number of calls received by the TAC unit was 980, down from 1,029 last quarter. There was a spike in the number of calls related specifically to plan transfers, and this is due to two plans withdrawing from service areas. Calls related to home health care continue to be the top reason for a call.

The TAC Unit has been working on improving methods of data analysis and reporting and is also overseeing member transfers resulting from service area reductions.

Call volume:

Substantiated Complaints: 342
Unsubstantiated Complaints: 289
Complaints Resolved Without Investigation: 42
Inquiries: 245
Total Calls: 918

The five most common types of calls were related to:

Home Health Care:	16%
Billing – Claim Denials:	10%
Interdisciplinary Team:	12%
Plan Transfers:	14%
Care Increase Denials:	4%

The TAC Unit continues to turn around a majority of cases within thirty days or less.

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 2017 through June 2017 quarter, 9,936 people were evaluated, deemed eligible and enrolled into plans

Referrals and 30-day assessment: For the April 2017 through June 2017 quarter, MLTC plans conducted 10,951 assessments. The total number of assessments conducted this quarter has increased, as has the percentage of assessments conducted within the 30-day time frame which increased one percentage point to 86%. Data collection, evaluation and reporting continues to be monitored since implementing CFEEC on a statewide basis.

Referrals outside enrollment broker: During the April 2017 through June 2017 period, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 19,578, an increase from 16,524 during the previous quarter. Two plans are still in the process of withdrawing from a county, and it continues to be likely that some of their enrollees are contacting plans directly.

Rebalancing Efforts	4/17-6/17
New Enrollees to the Plan from a nursing home transitioning to the community	492
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,766
Current plan Enrollees permanently placed in a nursing home	13,052
New Enrollees permanently placed in a nursing home who remain in a nursing home	3,293

During the April 2017 through June 2017 quarter, the number of current plan enrollees permanently placed in a nursing home increased by 3,067. It has been expected that the number of plan enrollees in a nursing home would continue to grow as new nursing home patients are required to join a managed care plan.

VI. Evaluation of the Demonstration

A revised evaluation plan was submitted to CMS on May 12, 2017. Comments on revisions were received from CMS on June 15, 2017. DOH program staff are working to address questions and comments and to finalize the analytic framework and procurement of an independent evaluator. DOH is waiting for CMS to schedule a conference call with the evaluation team to discuss the draft and further questions. Revisions to the evaluation plan will be completed after clarification from the CMS evaluation team.

VII. Consumer Issues

A. All complaints

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

Category of Complaint	Number of Complaints/Action Appeals Reported	Percent of Total Complaints/Action Appeals Reported
SSI Adult	521	9%
SSI Pediatrics	51	1%
Total Long Term Services and Support	572	10%
Medicaid Managed Care (not BH or HIV/SNP)	4,879	83%
Behavioral Health-HARP Carve-in	261	4%
HIV/SNP	191	3%
Total MMCO Complaints for QTR	5,903	100%

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 5,903. This represents a 1.8% decrease from the prior quarter. The most frequent category of complaint is balanced billing disputes which represented 25 percent of the total.

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

25% Balance Billing
16% Reimbursement/Billing Issues
10% Pharmacy/Formulary
8% Dissatisfaction with Quality of Care
7% Advertising/Education/Outreach/Enrollment

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

Of the total 5,903 complaints, MMCOs reported 261 were associated with Health and Recovery Plans (HARPS). New York State added this benefit to Mainstream Managed Care in two phases. The first occurred July 1, 2015 for New York City enrollees and the second began in October 1, 2015 for the rest of the state. This is the second quarter that we are including this data as a separate subcategory to total complaints. The greatest percentage (15% or 36 complaints) was categorized as pharmacy or formulary issues.

HIV/SNPS

During the quarter, Managed Care Organizations reported 191 complaints/action appeals for HIV Special Needs Plans (SNPs). This represents a 15.8% increase in the number reported quarter over quarter. This trend will be monitored and investigated.

There are only three SNPs specifically designed to serve Medicaid beneficiaries with HIV/AIDS and their children reporting for mainstream managed care plans in New York. The greatest percentage (20% or 39 complaints) was categorized as dissatisfaction with Provider Services (Non-medical) or MCO Services.

Long Term Services and Supports

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 6,009 total reported complaints/action appeals, mainstream MMCOs reported 572 complaints and action appeals from their SSI enrollees. This compares to 558 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	33
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	6
Balance Billing	51
Communications/Physical Barrier	1
Consumer Directed Personal Assistant	0
Denial of Behavioral Health Clinical Treatment	1
Denial of Clinical Treatment	31
Dental or Orthodontia	119
Emergency Services	7
Eye Care	1
Family Planning	0
Home Health Care	3
Mental Health/Substance Abuse Services/ Treatment	2
Non-covered Services	27
Non-Permanent Resident Health Care Facility	0
Personal Care Services	3
Personal Emergency Response System	0
Pharmacy	27
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	41
Quality of Care	105
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	38
Specialist or Hospital Services	6
Transportation	12
Waiting Time Too Long at Office	2
All Other Complaints	48
Total	**572**

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

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	21%
Quality of Care	18%
Balance Billing	9%
Provider or MCO Services (Non-Medical)	7%
Reimbursement/ Billing Issues	7%

Of the 119 reported complaints in the dental or orthodontia category, one MMCO reported 96 or approximately 81%. We contacted the MMCO to determine the cause of this occurrence and if it represents a system's reporting error or actual complaints received. The plan reported that the SSI complaints were reported correctly. This information was then forwarded along to the Department's dental policy unit.

The following complaints/action appeals were reported involving difficulty with obtaining long term services and support. The Department did not identify any overall trends impacting enrollees' access to these services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	0
Home Health Care	8
Non-Permanent Residential Health Care Facility	0
Personal Care Services	8
Personal Emergency Response System	0
Private Duty Nursing	0
Total	**16**

Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 709 complaints this quarter. Of this total, 96% (679 complaints) were attributable to Medicaid Managed Care lines of business.

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on June 22, 2017. The meeting included presentations provided by state staff and discussions of the following: an

overview of the policies and status of activities related to implementation of the planned transition of School Based Health Center Services and the outpatient clotting factor products and associated services from Medicaid fee-for-service to Medicaid managed care; a discussion of current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs; an update on activities related to operationalizing Community First Choice Option (CFCO); and an update on Behavioral Health, Health and Recovery Plans (HARPs) and Health Homes. Additional agenda items were, a discussion of rate setting methodology to include explanation of CRGs, regional rates and high cost drug pool and a presentation regarding the Delivery System Reform Incentive Payment Performing Provider System Update. The next MMCARP meeting is scheduled for September 28, 2017.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

2016 Managed Long-Term Care Crude Percent Reports

2016 Managed Long-Term Care Crude Percent Reports

In May, we released Crude Percent Reports for the July through December 2016 period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each plan's July through December 2016 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month 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.

B. Quality Measurement in Medicaid Managed Care

2016 Quality Incentive for Medicaid Managed Care

2016 Quality Incentive awards were announced in June 2017. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction and efficiency (Prevention Quality Indicators). Points for issues with Compliance are subtracted from the total plan points before calculating the percentage of total points. The 2016 awards included one plan receiving the full award, fourteen plans

receiving some portion of the award, and two plans not receiving any of the award. The awards will be implemented in April 2017 capitation rates.

	MMC Quality Incentive 2016							
	Quality Points NORMALIZED to 100 based on highest score							
	March 13, 2017							
Incentive Tier	Incentive Premium Award* (%)	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)	Total Points	Percent (up to 100%)
Tier 1	2.11%	CDPHP	71.19	30	10	-2	109.19	72.80
Tier 1	2.11%	Healthfirst PHSP, Inc.	99.43	15	0	-6	108.43	72.28
Tier 1	2.11%	MetroPlus Health Plan	100.00	10	0	-6	104.00	69.33
Tier 2	1.59%	Fidelis Care New York, Inc.	84.70	10	5	-6	93.70	62.46
Tier 2	1.59%	Hudson Health Plan	54.01	20	12.5	0	86.51	57.67
Tier 2	1.59%	Excellus BlueCross BlueShield	47.87	25	12.5	-2	83.37	55.58
Tier 3	0.26%	Empire BlueCross BlueShield HealthPlus	71.19	10	0	-2	79.19	52.80
Tier 3	0.26%	UnitedHealthcare Community Plan	65.06	5	12.5	-6	76.56	51.04
Tier 3	0.26%	HealthNow New York Inc.	44.30	15	15	0	74.30	49.54
Tier 3	0.26%	MVP Health Care	35.28	25	15	-2	73.28	48.85
Tier 4	0.00%	WellCare of New York	50.33	10	0	-2	58.33	38.88
Tier 4	0.00%	Affinity Health Plan	46.64	20	0	-10	56.64	37.76
Tier 4	0.00%	Independent Health's MediSource	33.14	20	5	-2	56.14	37.43
Tier 5	0.00%	Total Care, a Today's Options of New York Health Plan	37.98	15	7.5	-8	52.48	34.98
Tier 5	0.00%	YourCare Health Plan	20.87	15	15	-2	48.87	32.58
Tier 5	0.00%	HIP (EmblemHealth)	34.37	10	0	-2	42.37	28.25

* Incentive premium awards were impacted by enacted budget actions for SFY 17-18 and may change to meet program fiscal targets

Quality Assurance Reporting Requirements (QARR)

We had 25 health plans submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2016. Data is being reviewed for completeness and accuracy and final results will be published next quarter.

External Quality Review

Over the past quarter, IPRO has worked with the DOH to develop a revised survey methodology that merges Provider Directory Survey work with the Survey of Access and Provider Availability. Plans are being made to conduct a combined survey in August (3rd quarter). Results from the plan Member Services survey were sent to DOH staff for review with the health plans.

IPRO has been working with the DOH to ensure that the new Provider Network Data Collection System (PNDS) is operational and functioning without error. Data submission is underway as of this quarter. The Provider Look Up tool was launched in May.

Throughout this quarter, IPRO conducted recurring group calls to facilitate MMC and MLTC plan completion of required Performance Improvement Projects (PIPs). Plans

began submitting proposals for the PIPs for 2017 and IPRO continued to oversee plan completion of final reports for the 2015-2016 projects. IPRO facilitated the launch of a new HARP PIP, and has been working closely with the DOH and the HARP plans to ensure a smooth start to these projects. Specific information about the MMC and HARP PIP work completed in this quarter can be found under the Performance Improvement Project description.

The Prenatal Care quality improvement project was on hold for much of the Quarter, while IPRO finalized the new platform and began piloting the application. During this quarter, a pilot study group of 3 large providers tested the system and resolved any issues prior to the initiation of a new reporting cohort later this year (3rd quarter) Data from this project will be used by the health plans to implement the common theme PIP, which will focus on perinatal care.

In this quarter IPRO finalized a contract with the National Committee for Quality Assurance (NCQA) to allow health plans to submit quality measurement data (HEDIS) directly to NCQA through its IDSS tool. EQRO quality measurement validation was completed as IPRO oversaw the collection of the health plans' Live Birth files, commercial CAHPS, and validated the plans' member level and aggregated data submissions. IPRO continues to work piloting the new Uniform Assessment System (UAS), and has also worked closely with the DOH to plan a new Focused Clinical Study examining care management within Medicaid managed care.

Planning began for a member perceptions of care survey to be administered to new HARP enrollees. IPRO is working with the Office of Mental Health (OMH) to design the survey tool and survey methodology to reach this population. This survey is expected to be in the field in the third quarter (September, 2017). IPRO began administration of the biannual MLTC satisfaction survey in the beginning of May and responses continue to come in. Responses are expected to be analyzed and the final report delivered to the DOH in the third quarter.

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

The Prenatal Care quality improvement project was on hold for much of the quarter, while IPRO finalized the new platform and began piloting the application. In April 2017 three provider practices piloted the new platform to submit medical record reviews. The 3 practices participated in a conference call to provide feedback on the ease of using the platform. Key issues were addressed and changes in processes were completed for the remaining 47 practices. The 47 practices are to begin their reviews in July 2017.

For 2015-2016, the two-year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers was implemented. Identification of MCO enrollees who are smokers was included as a major focus of the projects. Additionally, all plans were required to specifically improve access (and reduce barriers)

to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. Interventions have been implemented when the proposals were accepted in April 2015 and continued through December 2016. The MMC plans received guidance from IPRO on the due date for the Final PIP Report due to IPRO in July 2017. The PIP Final Report Template was distributed to the plans.

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic is Inpatient Care Transitions. The due date for the HARP PIP Proposal was January 23, 2017. Fifteen PIP Proposals were submitted and have been reviewed by IPRO, NYSDOH, OMH and OASAS. The fifteen PIP Proposals were finalized and interventions were initiated in April 2017. Oversight calls with IPRO and individual HARP plans and HIV SNP plans are scheduled for July 2017. Each plan will submit a written summary of progress to IPRO before the call will be conducted.

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. The due date for the Perinatal PIP was February 6, 2017. Fifteen Medicaid managed care plans have submitted their Perinatal PIP Proposals and IPRO and NYSDOH have reviewed them. The fifteen Proposals have been finalized and interventions were initiated in April 2017. The IPRO oversight calls will be conducted in August 2017. Each plan will submit a written summary of progress to IPRO before the call will be conducted. On May 11, 2017, a webinar was conducted and the March of Dimes presented on national and New York state examples of initiatives to promote the use of 17P for the prevention of preterm birth in eligible women. In addition, there was discussion of the many resources available to assist the Medicaid managed care plans in implementing their interventions, such as provider toolkits, provider surveys, 17P brochures and fact sheets. The topic of birth spacing was also addressed and a provider toolkit was presented. On June 27, 2017, a webinar by the American Congress of Obstetricians and Gynecologists (ACOG) was conducted. The presentation focused on the prevention of preterm deliveries. The epidemiology of preterm labor and risk factors to assess for were presented. The appropriate use of 17P only for eligible women was discussed. Additional interventions for other high-risk conditions, e.g. short cervix, were presented. ACOG resources were presented, including Preventing Preterm Birth Video Series, and a toolkit for enhancing access to Long-Acting Reversible Contraception (LARC) in the office setting. ACOG also presented a Perinatal Depression Toolkit that is available. Finally, ACOG presented an eToolkit for Smoking Cessation: Enhancing Early Assessment, Diagnosis and Treatment of the Casual Smoker.

Breast Cancer Selective Contracting

Staff began work on the summer review of breast cancer surgical volume and will share results and provisional volume designations with facilities' SPARCS coordinators in summer 2017. Additionally, progress was made on the evaluation of the Breast Cancer

Selective Contracting Policy and the impact of the policy on access to care, quality of care and survival rates.

Patient Centered Medical Home (PCMH)

As of June 2017, there were 6,807 NCQA-recognized PCMH providers in New York State. 141 providers that became recognized in June 2017 were new to the program and have not been recognized previously. Approximately 83% (5,672) of current PCMH providers are recognized under the newest 2014 set of standards. Between June 2016 and June 2017, the percentage shift of providers recognized under the newest standards increased from 36% to 83%. 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 17% (1,135) of recognized providers are still under the 2011 standards and the majority will expire by mid-2018. The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of June 2017, was:

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

On July 1, 2017, the incentive amounts will change, and the 2011 incentives will be eliminated. The 2014 level 2 incentive will be reduced to $3PMPM and the 2014 level 3 amount will be $7.50.

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. Currently, there are no providers that are APC recognized.

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

The December 2016 PCMH Statewide quarterly report was posted to the DOH website this past quarter. All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the MRT website, available here: http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

IX. Transition Plan Updates

No updates.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

At the end of December 2016, New York submitted an updated Specifications Manual and a draft remediation plan and timeline for the completion of the budget neutrality reconciliation process, including plans to reconcile with the CMS-64. The budget neutrality remediation efforts are nearing completion, with initial calculations for 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 has requested expedient guidance to ensure the State is able to meet the September 30, 2017 deadline for completion of this project detailed in the STCs.

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.

The State has also begun the process of identifying a contractor to complete a certified and audited final assessment of budget neutrality for the 10/1/11-3/31/16 period as detailed in STC X. This process is on track, and a contractor is expected to be identified by mid-September.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

Monthly submission of T-MSIS files is on schedule. Files for June 2017 were submitted on 7/21/2017 and have been accepted and processed by CMS.

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

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

Attachments:
Attachment 1 - MLTC Partial Capitation Plans
Attachment 2 – Critical Incidents

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Managed Long Term Care Partial Capitation Plans

July 2016-June 2017

Plan Name	Jul-16 Enrollment	Aug-16 Enrollment	Sep-16 Enrollment	Oct-16 Enrollment	Nov-16 Enrollment	Dec-16 Enrollment	Jan-17 Enrollment	Feb-17 Enrollment	Mar-17 Enrollment	Apr-17 Enrollment	May-17 Enrollment	Jun-17 Enrollment
Aetna Better Health	3,817	3,816	3,843	3,881	3,886	3,943	4,028	4,057	4,105	4,145	4,196	4,258
AgeWell New York	6,949	7,084	7,207	7,355	7,524	7,663	7,828	7,939	8,079	8,227	8,409	8,522
AlphaCare	2,920	2,977	3,041	3,154	3,263	3,347	3,428	3,528	3,627	3,735	3,856	3,951
ArchCare Community Life	2,131	2,133	2,147	2,175	2,219	2,231	2,273	2,298	2,339	2,400	2,509	2,623
CCM Select	5,428	5,402	5,215	5,135	5,099	4,969	4,819	50	53	13	1	1
Centers Plan for Healthy Living	6,602	6,978	7,331	7,829	8,373	8,950	9,587	14,711	15,147	15,777	16,345	16,881
Elant	860	856	834	829	823	826	839	852	847	843	839	847
Elderplan	11,132	11,219	11,403	11,559	11,721	11,942	12,093	12,175	12,239	12,340	12,421	12,515
Elderserve	10,921	10,921	10,966	11,033	11,037	11,072	11,084	11,113	11,158	11,207	11,196	11,231
Elderwood	24	34	40	62	74	85	88	99	103	107	116	123
Extended MLTC	1,293	1,398	1,529	1,613	1,692	1,771	1,819	1,913	1,983	2,098	2,307	2,475
Fallon Health Weinberg (TAIP)	326	376	389	419	437	459	466	483	504	521	536	563
Fidelis Care at Home	14,614	15,051	15,522	16,073	16,454	16,804	17,184	17,421	17,655	17,959	18,278	18,622
Guildnet	16,691	16,614	16,477	16,413	16,098	15,916	15,709	15,228	14,768	14,253	12,818	11,450
Hamaspik Choice	1,764	1,813	1,857	1,901	1,940	1,986	2,010	2,018	2,016	2,020	2,028	2,028
HealthPlus- Amerigroup	3,507	3,594	3,668	3,767	3,876	3,950	4,021	4,119	4,176	4,241	4,337	4,427
iCircle Services	1,374	1,432	1,474	1,534	1,577	1,625	1,668	1,719	1,725	1,760	1,789	1,854
Independence Care Systems	6,194	6,241	6,280	6,348	6,447	6,514	6,574	6,593	6,504	6,535	6,558	6,569
Integra	3,740	3,948	4,132	4,241	4,438	4,607	4,794	5,064	5,279	5,516	5,890	6,190
Kalos Health- Erie Niagara	783	805	843	874	913	936	961	978	987	1,030	1,088	1,115
MetroPlus MLTC	1,219	1,236	1,264	1,300	1,355	1,382	1,413	1,439	1,460	1,506	1,528	1,573
Montefiore HMO	1,161	1,187	1,206	1,226	1,262	1,272	1,284	1,270	1,275	1,288	1,305	1,341
North Shore-LIJ Health Plan	3,590	3,742	3,880	4,068	4,249	4,413	4,556	4,691	4,806	4,986	5,229	5,477
Prime Health Choice	189	206	209	229	230	235	244	248	263	265	275	276
Senior Health Partners	12,574	12,619	12,762	12,845	12,950	13,028	13,158	13,217	13,314	13,479	13,657	13,809
Senior Network Health	513	508	513	522	521	514	515	510	521	518	516	527
Senior Whole Health	5,405	5,663	5,909	6,163	6,483	6,696	6,912	7,162	7,373	7,599	7,981	8,303
United Healthcare	2,339	2,411	2,469	2,552	2,626	2,657	2,721	2,765	2,798	2,840	2,876	2,979
Village Care	6,390	6,518	6,609	6,773	6,986	7,190	7,304	7,455	7,466	7,667	7,906	8,102
VNA HomeCare Options	2,484	2,666	2,809	2,986	3,224	3,372	3,542	3,755	3,993	4,216	4,447	4,733
VNS Choice	13,911	13,926	13,855	13,861	13,759	13,631	13,645	13,417	13,193	13,032	12,819	12,764
WellCare	6,243	6,201	6,126	6,061	6,054	6,032	6,036	5,965	5,898	5,862	5,804	5,781
TOTAL	**157,088**	**159,575**	**161,809**	**164,781**	**167,590**	**170,018**	**172,603**	**174,252**	**175,654**	**177,985**	**179,860**	**181,914**

Critical Incidents
April - June 2017

Plan Name:	Plan Type	Total Critical Incidences
Partial Capitation Plans		
Aetna Better Health	Partial	-
AgeWell New York ,LLC	Partial	10
AlphaCare of New York Inc.	Partial	14
Amerigroup	Partial	2
ArchCare Community Life	Partial	18
CenterLight Healthcare Select	Partial	-
Centers Plan for Healthy Living	Partial	6
Elant Choice	Partial	-
ElderServe Health, Inc.	Partial	-
Elderwood	Partial	-
Extended	Partial	1
Fallon Health Weinberg	Partial	-
FIDELIS Care New York	Partial	-
GuildNet MLTCP	Partial	40
Hamaspik Choice	Partial	1
HomeFirst MLTC, a product of Elderplan	Partial	3
I Circle	Partial	-
Independence Care Systems	Partial	4
Integra MLTC	Partial	-
Kalos, dba First Choice Health	Partial	-
Metroplus	Partial	-
Montefiore Diamond Care	Partial	2
NSLIJ Health Plan	Partial	1
Prime Health Choice, LLC	Partial	21
Senior Health Partners	Partial	50
Senior Network Health	Partial	-
Senior Whole Health	Partial	-
United Healthcare Personal Assist	Partial	-
VillageCareMAX	Partial	2
VNA Homecare Options, LLC	Partial	15
VNSNY CHOICE MLTC	Partial	1
Wellcare	Partial	23
Total		**214**
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	1
Fidelis Medicaid Advantage Plus	MAP	-
GuildNet GNG	MAP	2
Healthfirst CompleteCare	MAP	14
HEALTHPLUS AMERIGROUP	MAP	-
Senior Whole Health	MAP	-
VNSNY CHOICE MLTC TOTAL	MAP	-
Total		**17**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	12
Catholic Health LIFE	PACE	11
CenterLight Healthcare	PACE	2
Complete Senior Care	PACE	4
Eddy SeniorCare	PACE	2
ElderONE	PACE	-
Fallon Health Weinberg	PACE	-
Independent Living Services of CNY (PACE CNY)	PACE	12
Total Senior Care	PACE	-
Total		**43**
Grand Total		**274**