Partnership Plan
Section 1115 Quarterly Report
Demonstration Year: 17 (10/1/2014 – 9/30/2015)
Federal Fiscal Quarter: 2 (1/01/2015 – 3/31/2015)

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. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times. The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care. There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997.

CMS had approved an extension on September 29, 2006 of New York's 1115 Partnership Plan Waiver 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 2014. 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).

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. In accordance with the April 1, 2011 Special Terms and Conditions (STC) Number 50, a final report for the F-SHRP demonstration was submitted to CMS on June 30, 2014. The Department of Health (the Department) has contracted with Rockefeller Institute of Government (RIG) to evaluate the F-SHRP demonstration and develop a final evaluation report. A final draft evaluation report was submitted to CMS on February 11, 2015. The Department is awaiting acknowledgement from CMS that the report has been accepted.

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who had access to cost-effective ESHI were required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees got all FHPlus benefits. FHPlus expired on December 31, 2013 and became a state-only program, federal matching funding for state expenditures for FHPlus were available as a designated state health program through December 31, 2014. The FHPlus program was phased-out entirely by December 31, 2014, and there is no remaining enrollment.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30 day public comment period. A temporary extension was granted on December 31, 2014 extending the waiver through March 31,

2015. Subsequent temporary extensions were granted through May 31, 2015. Approval of the renewal request will extend the Demonstration until December 31, 2019, thus allowing New York to reinvest federal savings generated by the MRT reform initiatives, and to reinvest in the state's health care system currently authorized by the Partnership Plan.

II. Enrollment: Second Quarter

Partnership Plan- Enrollment as of March 2015

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	1,399,536	13,673	60,653
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	196,023	3,890	15,248
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	81,155	994	3,513
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	8,157	348	1,217
Population 5 - Safety Net Adults	1,155,696	17,103	34,125
Population 6 - Family Health Plus Adults with Children	0	379	8,494
Population 7 - Family Health Plus Adults without Children	0	0	57
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	52,626	932	251
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	249,095	6,709	1,797
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	3,200	194	37
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	50,340	2,001	871

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Total # Voluntary Disenrollments in Current Demonstration Year	**46,223 or an approximate decrease over last Q 15%**

Reasons for voluntary disenrollments include: 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.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**126,263 or an approximate 23% decrease over last Q**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility.

III. Outreach/Innovative Activities

No updates this quarter; please see first quarter report, demonstration year 17 for most recent updates.

A. Mandatory Managed Care Expansion

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

B. Outreach Activities

2,755,184 New York City (NYC) Medicaid consumers were enrolled into a managed care product as of the end of March 2015. Approximately 828,812 or 30% were enrolled through New York State of Health (NYSoH).

During the first quarter of 2015, the New York Medicaid Choice program (NYMC) Field Customer Service Representatives (FCSRs) conducted outreach and enrollment activities within the NYC Human Resources Administration (HRA) field offices. This outreach was specifically performed at 5 HIV/AIDS Services Administration (HASA) sites, 12 Medicaid offices and 19 Job Centers using scheduled presentations and the Education and Enrollment Driven Referral (EED) process developed by HRA in concert with the NYMC program.

A total of 2,502 presentations were conducted by NYMC program. Of these, 527 or 21% were observed by HRA's Contract Monitoring Unit (CMU) to ensure that consumers were given accurate and full disclosure of their managed care enrollment choices. As a result of the EED process, 12,627 consumers received personal consultation by a FCSR regarding their enrollment choices and 7,088 made enrollment choices.

IV. Operational/Policy Developments/Issues

A. Health Plans

Changes to Certificates of Authority (COA):

No changes to Medicaid Plan Certificates of Authority.

B. Surveillance Activities

Surveillance activity for 2nd Quarter FFY 2014-2015 (01/01/15 to 03/31/15) included the following:

- Targeted Operational Surveys were completed on three (3) Managed Care Plans. Health First, Amerigroup and NYS Catholic Health Plan were found to be in compliance.

- Member Services Focus Surveys were completed on two (2) Managed Care Plans during the 2nd Quarter FFY 2014-15. Statements of Deficiency were issued to and Acceptable Plans of Correction were received from both VNS Choice and United Healthcare of New York, Inc.

- Provider Directory/Information Focus Surveys were completed on two (2) Managed Care Plans during the 2nd Quarter FFY 2014-15.

  - Today's Options New York was determined to be in compliance.

  - Affinity Health Plan was issued a Statement of Deficiency in September 2014 and their Plan of Correction was accepted February 2, 2015.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

- MEQC 2008 – Applications forwarded to LDSS Offices by Enrollment Facilitators

  No activities were conducted during the quarter. The review is involved in litigation.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance With CMS approval, the Pacific Health Policy Group (PHPG), the contractor hired to assist the New York State Department of Health with multiple MEQC reviews, implemented an alternate approach for generating the necessary universes of cases. A revised approach was necessary because the availability of DOH system staff continued to be limited due to other system priorities (i.e., system work related to ACA and the NY State of Health Marketplace). Implementation of the revised approach began in September 2013. The process continued for several quarters because the alternate universe identification process was labor intensive and very time consuming.

During the quarter, steps continued to be taken to provide preliminary findings to the appropriate local district offices and evaluate the comments/information received in response. It is expected that the findings resolution process will be completed during the next quarter. Upon completion, next steps include analyzing the final results and drafting a summary report.

- 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 Nursing Home Benefit and Population into Managed Care: Beginning February 1, 2015, all eligible beneficiaries age 21 and over, in need of long term placement in a nursing facility, as defined by §1919(a)(1)(C) or 42 U.S.C. 1396r, requirements for nursing facilities, will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP), following the "Nursing Home Transition Phase-in Schedule" in the table below. All current long term placed beneficiaries in a Medicaid certified skilled nursing facility (NH) prior to February 1, 2015 for Phase 1, April 1, 2015 for Phase 2, and July 1, 2015 for the upstate phase-in will remain in fee-for-service Medicaid and will not be required to enroll in a Managed Care Organization (MCO). As of October 1, 2015, the State will allow any eligible individual residing in a nursing home to enroll in a managed care organization on a voluntary basis. This population will no longer be excluded, but exempt from mandatory enrollment into mainstream Medicaid managed care and MLTC.

In addition, beneficiaries currently enrolled in a MMCP will not be disenrolled if they need long term placement in a nursing facility. Effective February 1, 2015, the MMCP is responsible for covering this benefit in the Phase I counties. MLTCs are currently responsible for covering this benefit and will continue to do so. No individual is required to change nursing homes resulting from this transition; however, new placements will be based upon the MCO's contractual arrangements and the needs of the individual. MCOs must evaluate and ensure that individuals are placed in the least restrictive setting with needed community supports.

Nursing Home Transition Phase-In Schedule	
Month	**County**
February 1, 2015 **Phase 1**	New York City – Bronx, Kings, New York, Queens, Richmond
April 1, 2015 **Phase 2**	Nassau, Suffolk, Westchester
July 1, 2015 **Phase 3**	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Wayne, Washington, Wyoming, Yates
October 1, 2015	Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

MCOs are required to pay the NH the current fee-for service (Benchmark) rate or a negotiated rate, acceptable to both plans and nursing homes, for 3 years after a county has been phased in. If the MCO had previously negotiated agreements with NHs which reflect a different level of reimbursement, the MCO is required to pay the benchmark rate during this transition unless another arrangement is agreed to for this specific transition period. After the transition period, NHs and MCOs will negotiate a rate of payment for services.

The steps toward this transition require that each party – MCOs, providers and the state – assure that individuals in need of long term care services receive care in the most integrated and least restrictive setting. The ultimate goal is to foster a care delivery model that promotes transitional planning across the health care delivery system with the focus on providing services in the community whenever possible.

C. Federally Qualified Health Services (FQHC) Lawsuit

No updates this quarter; please see first quarter report, demonstration year 17 for most recent updates.

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 period January 2015 through March 2015, expanded MLTCP availability by approving one service area expansion.

- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period January 2015 through March 2015 post enrollment surveys were completed for 504 enrollees and 64% of respondents indicated they were receiving services from the same caregivers. Close to 50% of respondents indicated they were not receiving in home services prior to enrollment, therefore an additional review of the pool of consumers surveyed will be conducted to ensure target group is accurate. Further enhancements to the survey will also be explored.

- Activity for the period January 2015 through March 2015. With CMS approval, successfully expanded to Cattaraugus County. Transition plan for the remaining 13 counties is under review. Subject to CMS approval, anticipate achieving remainder of State transition during 3rd quarter 2015. Remaining counties:

    - Chautauqua, Chemung, Seneca, Schuyler, Yates, Allegany, Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence.

<u>Enrollment</u>

- Enrollment. Total enrollment in MLTC Partial Capitation Plans for the period January 2015 through March 2015 is 128,243. For that quarterly period, 6,621 individuals who were being transitioned into Managed Long Term Care from fee for service made an affirmative choice. Plan specific enrollment on a monthly basis for the period April 2014 through March 2015 is submitted as attachment 2. Total affirmative choice for that period is 28,919.

2. Significant Program Developments

- During the period January 2015 through March 2015 the Conflict Free Evaluation and Enrollment Center (CFEEC) was successfully expanded beyond the initial operations in New York City and Nassau County. CFEEC became operational in the following regions: East Hudson (Columbia, Dutchess, Putnam); Catskill (Rockland, Orange, Ulster, Greene, Sullivan); Capital (Warren, Washington, Saratoga, Fulton, Montgomery, Schoharie, Schenectady, Albany, Rensselaer); and Western/Central (Erie, Monroe, Onondaga). This expansion addressed the majority population areas of the State. Completion of remaining regions are anticipated during 3rd quarter, and will align with expansion of mandatory MLTC.

- During the period January 2015 through March 2015 initial focus audit findings were released, a corrective action plan was received and is under review. Additional focus audit release is pending further analysis of data trends, and anticipate expansion of scope. As a direct result of Technical Assistance Center (TAC) investigations in response to substantiated complaints, 6 targeted corrective action plans were commissioned and approved. These areas

of concern are monitored to identify trends, poised to inform creation of larger focus audit activity.

- During the period January 2015 through March 2015 the Independent Consumer Support Program, commonly referred to as "ICAN", was expanded each month on a regional basis. The expansion provides the "ICAN" in all regions of the State except for the Hudson Valley (Sullivan, Ulster, Dutchess, Orange, Rockland). Statewide operation is expected to be achieved during 3rd quarter.

- During the period January 2015 through March 2015 further refinements were made to the 'secret shopper' process and preparations finalized to launch the survey during 3rd quarter.

3. Issues and Problems

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

4. Summary of Self Directed Options

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

5. Required Quarterly Reporting

- **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. For the period January 2015 through March 2015, 176 Critical Incidents were reported, representing a decrease of 22 incidents over the previous quarter.

- **Grievance and Appeals Annual Summary:** Key areas of concern remain dissatisfaction with quality of home care and transportation.

- **Grievance and appeals:** For the period January 2015 through March 2015 key areas of concern remain transportation and dissatisfaction with quality of home care. Homecare aides late/absent on scheduled day of service has become a notable area of concern.

Total Grievances for this period:	1/15-3/15
i. Average recipients for the period	139,353
# Same Day	6,814
# Standard	1,703
# Expedited	8,517

Period: 01/01/15 – 03/31/2015			
Total Grievances for this period:		**Resolved**	**Resolved %**
# Same Day	6,814	6,814	100%
# Standard/Expedited	1,703	1,185	70%
Total for this period:	8,517	7,999	94%

Appeals	4/14-6/14	7/14-9/14	10/14-12/14	1/15-3/15	4 Qtrs
Total Appeals for the period	1,767	1,344	1,248	1,662	6,021
ii. Appeals per 1,000	14	10	9	12	45

** VNS was including provider appeals in with the participant appeals for Denial in whole or part of payment for service. In 7/17-9/14 reporting period this was corrected and thus a decrease in appeals

Plan Name:	Avg Beneficiaries for Quarter	Total Grievances	Grievances per 1,000	Total Appeals	Appeals per 1,000
Aetna Better Health	3,045	6	2	9	3
AgeWell New York ,LLC	4,188	230	55	1	0
AlphaCare of New York Inc.	1,571	192	122	3	2
Amerigroup	2,770	0	0	0	0
AMERIGROUP HEALTHPLUS	4	80	18,462	0	0
Archcare Senior Life	371	20	54	0	0
ArchCare Community Life	1,922	582	303	14	7
Catholic Health LIFE	185	12	65	1	5
CenterLight Healthcare PACE	3,444	67	19	5	1
CenterLight Healthcare Select	7,047	216	31	432	61
Centers Plan for Healthy Living	2,188	93	43	14	6
Complete Senior Care	116	20	172	1	9
Eddy SeniorCare	161	53	329	0	0
Elant Choice	818	27	33	0	0
ElderONE	658	87	132	0	0
Elderplan, MAP	817	23	28	7	9
ElderServe Health, Inc.	10,456	136	13	17	2
EmblemHealth	1,311	78	59	5	4
EmblemHealth	640	49	77	2	3
Erie Niagara MLTC	245	17	69	0	0
Extended MLTC	349	28	80	2	6

Fallon Health Weinberg	146	30	206	0	0
FIDELIS Care New York	9,710	34	4	232	24
Fidelis Medicaid Advantage Plus	174	0	0	0	0
GuildNet GNG	737	92	125	2	3
GuildNet MLTCP	14,287	1,127	79	62	4
Hamaspik Choice	696	23	33	2	3
Healthfirst – CompleteCare (MAP)	3,410	12	4	3	1
HomeFirst MLTC, a product of Elderplan	10,693	350	33	110	10
I Circle	22	2	91	0	0
Independence Care System	5,334	326	61	29	5
Independent Living Services of CNY (PACE CNY)	477	28	59	0	0
Integra MLTC	2,284	83	36	4	2
Metroplus	841	45	54	0	0
Montefiore Diamond Care (MLTC)	520	54	104	0	0
NSLIJ Health Plan	1,569	56	36	5	3
Prime Health Choice, LLC	30	7	236	0	0
Senior Health Partners	14,240	1,041	73	146	10
Senior Network Health	491	16	33	0	0
Senior Whole Health-MAP	2,057	2	1	0	0
Senior Whole Health-MLTC	54	31	574	0	0
Total Senior Care	102	17	167	0	0
United Healthcare	1,183	21	18	2	2
VillageCareMAX	3,570	479	134	19	5
VNA Homecare Options, LLC	592	105	177	0	0
VNSNY CHOICE MLTC	16,597	2,379	143	266	16
VNSNY CHOICE MLTC TOTAL	200	1	5	1	5
Wellcare	7,032	140	20	266	38
Total	**139,352**	**8,517**		**1,662**	

- **Fraud and Abuse:** Fraud and Abuse cases were higher than average and will be investigated. Conclusions will be reported third quarter.

Fraud and Abuse Complaints Reported during Quarter	1/15-3/15
Fraud and Abuse Complaints Reported during Quarter	72

- **Fair Hearings:**

Fair Hearing decisions	1/15-3/15
a. Total	74
b. In favor of Appellant	47
c. In favor of MLTC Plan	19
c. No Issue*	8

Fair Hearings: Average Days till resolution	1/15-3/15
Days from Request Date till Decision Date **	
less than 30 Days	13
30-60	36
61-90	13
91-120	1
>120	11
Total	74

- **Technical Assistance Center Complaints:** For the period January 2015 through March 2015 - 21% of the calls received through the Technical Assistance Center (TAC) were not specifically related to a plan, an increase over the previous quarter. Three main categories are evident: seeking assistance in obtaining MLTC information and education, coding and systems problems, and general inquiries regarding MLTC enrollment and appeals procedures. The TAC was successful with investigating codes/systems concerns, highlighting areas to target for systemic enhancements.

- **Assessments for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were incrementally expanded to additional regions during the 2nd quarter. For the period January through March of 2015 the total number of CFEEC assessments that resulted in MLTC enrollment was 5,638. 983 assessments for enrollment were conducted by MLTC plans, as CFEEC has not reached Statewide operations yet.

- **Referrals and 30 day assessment:** For the period January 2015 through March 2015, total assessments conducted by MLTC plans during the period was 4,822. 79% were conducted within the 30 day time frame. Data collection, evaluation and reporting for this element will be refined with the expansion of the CFEEC.

- **Referrals outside enrollment broker:** The Conflict Free Evaluation and Enrollment Center began during October 2014. This data element will be evolving to coincide with the rollout of CFEEC process. During the period January through March 2015, 6,883 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

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

Period: 1/01/15-3/31/15	
Rebalancing Efforts	
Number of Individuals enrolled in the plan from a nursing home	143
Number of Enrollees admitted to a nursing home but returned to the community	1,260
Number of Enrollees permanently admitted to a nursing home	1,067

VI. Evaluation of the Demonstration

Currently under review and discussion with CMS.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 5,182 complaints/action appeals this quarter, a decrease of 9.8% from the previous quarter. Of these complaints/appeals 82 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 33% of the total. There were 132 complaints/appeals reported by the HIV SNPs. The majority of these complaints (67) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 270 Medicaid managed care complaints and 2 Medicaid Advantage complaints this quarter.

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

33% Balance Billing
14% Reimbursement/Billing Issues
8% Provider or MCO Services (Non-Medical)
7% Dental or Orthodontia
6% Quality of Care

This quarter, mainstream Medicaid managed care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	1
Home Health Care	5
Non-Permanent Residential Health Care Facility	2
Personal Care Services	17
Personal Emergency Response System	0
Private Duty Nursing	0
Total	24

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 5,182 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 589 complaints and action appeals from their SSI enrollees. This compares to 650 SSI complaints/action appeals from last quarter. The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	20%
Balance Billing	14%
Quality of Care	12%
Reimbursement/Billing Issues	10%
Provider or MCO Services (Non-Medical)	9%

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	16
AIDS Adult Day Health Care	0
Appointment Availability - PCP	5
Appointment Availability - Specialist	5
Balance Billing	85
Communications/Physical Barrier	0
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	22
Dental or Orthodontia	115

Emergency Services	44
Eye Care	3
Family Planning	0
Home Health Care	2
Mental Health or Substance Abuse Services/ Treatment	13
Non-covered Services	14
Non-Permanent Residential Health Care Facility	1
Personal Care Services	7
Personal Emergency Response System	0
Pharmacy	19
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	53
Quality of Care	70
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	56
Specialist or Hospital Services	5
Transportation	3
Waiting Time Too Long at Office	1
All Other Complaints	49
Total	**650**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 26, 2015. The meeting included presentations provided by state staff and discussions of the following: a brief update on the status of the transition of the nursing home benefit and population to managed care; an overview of the Delivery System Reform Incentive Payment Program (DSRIP) and an update on the project deliverables and timeline; and an update and discussion of auto-assignment of enrollees.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on January 8, February 12, and March 12, 2015. The January meeting included the following presentations: a status update on Delivery System Reform Incentive Payment (DSRIP) and Performing Provider Systems (PPS); Managed Long Term Care (MLTC), Fully Integrated Dual Advantage (FIDA) and Health Home update; overview and discussion of State Fiscal Year (SFY) 2015-16 Medicaid Managed Care (MMC) and HIV Special Needs Plan (HIV SNP) base rate development; a timeline and status update on mainstream managed care and MLTC capitation rates; an update on Patient Centered Medical Home (PCMH); an overview of key elements of the Basic Health Program and related implementation activities and milestones; an update on activities related to the implementation of adult behavioral health in managed care; and an overview of the Division of Health Plan Contracting and Oversight's areas of responsibility. The February meeting agenda included: a presentation on proposed state regulations related

to transgender related care and services; a status update on the implementation of the FIDA program, MLTC enrollment and Conflict-Free Evaluation and Enrollment Center (CFEEC) activity; finance and rate development overview; SFY 2015-16 Executive Budget and global cap update; a presentation on rollout of the Medicaid Analytics Performance Portal (MAPP) for the health home program; a behavioral health transition update; a presentation by the Consumer Directed Personal Assistance Association of New York (CDPAANYS) on peer mentoring in the Consumer Directed Personal Assistance Program; and an overview of the Office of Quality and Patient Safety's mission and functional areas. Presentations, updates and discussions at the March meeting included: an update regarding key SFY 2015-16 budget proposals; a status update on MAPP, including implementation timeline, new functionality and a demonstration; an update by the Office for People with Developmental Disabilities (OPWDD) on the progress of the development of Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs); a discussion of SFY 2015-16 MMC and HIV SNP premium development; an overview of MMC and HIV SNP Operating Report (MMCOR and HIV SNPOR) changes for 2015; an update on DSRIP; MLTC and FIDA update; and behavioral health/Health and Recovery Plan (HARP) status.

VIII. Quality Assurance/Monitoring

A. Quality Measurement

Child CAHPS with Chronic Care Condition (CCC) Module

DataStat administered a CAHPS® 5.0 Medicaid Child with CCC module survey to parents/guardians of children enrolled in Medicaid and Child Health Plus managed care plans. The survey was in the field between September and December 2014. The results indicated continued satisfaction with health care and health plans. In general, families with children with (self-reported) chronic conditions were more satisfied than families with children without chronic conditions, which is an improvement from the 2012 survey that showed opposite results. Figures 1-3 provide results for the overall responses and stratifications of Medicaid/Child Health Plus, and if screened positive or negative for chronic conditions.

Figure 1

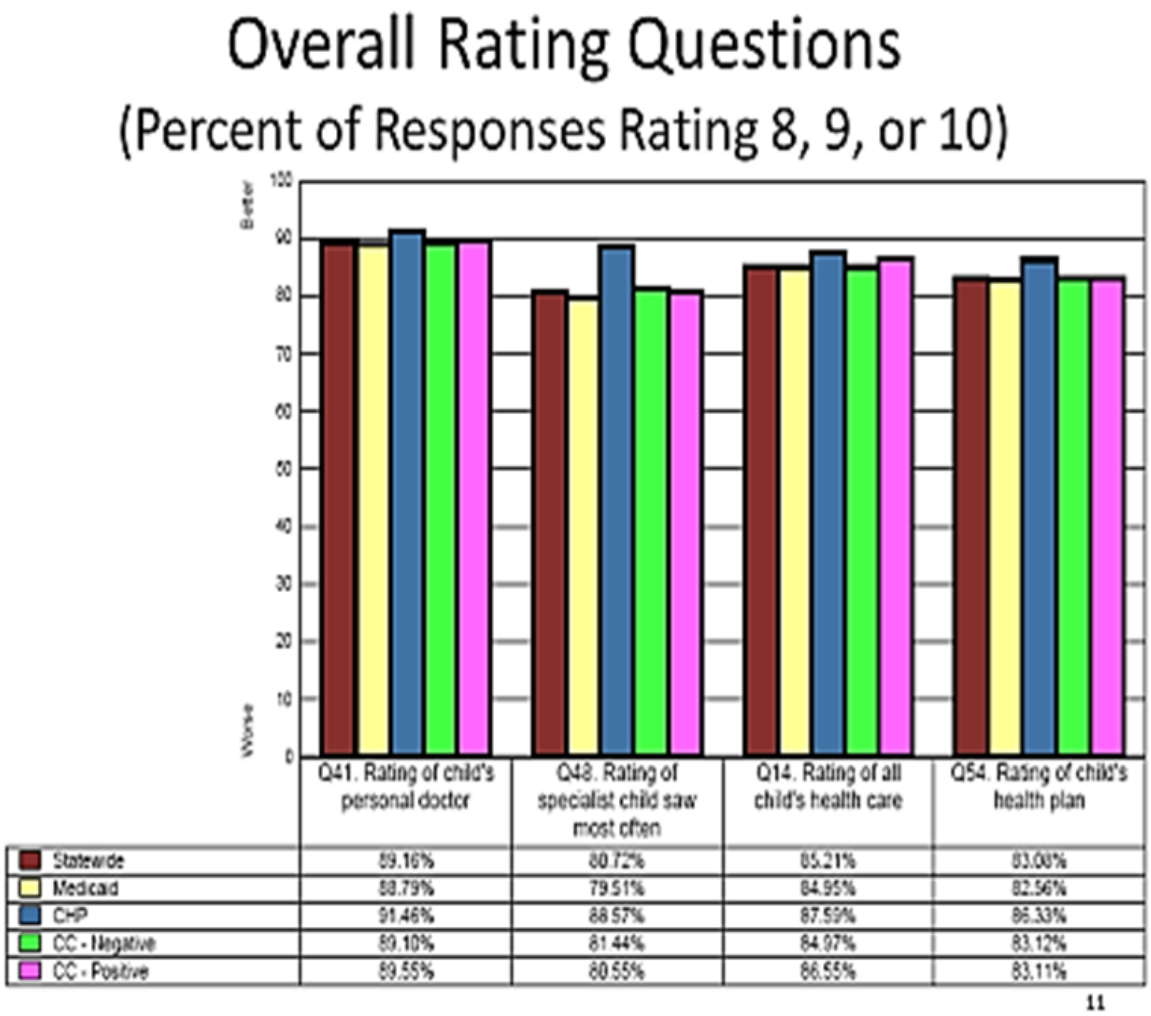
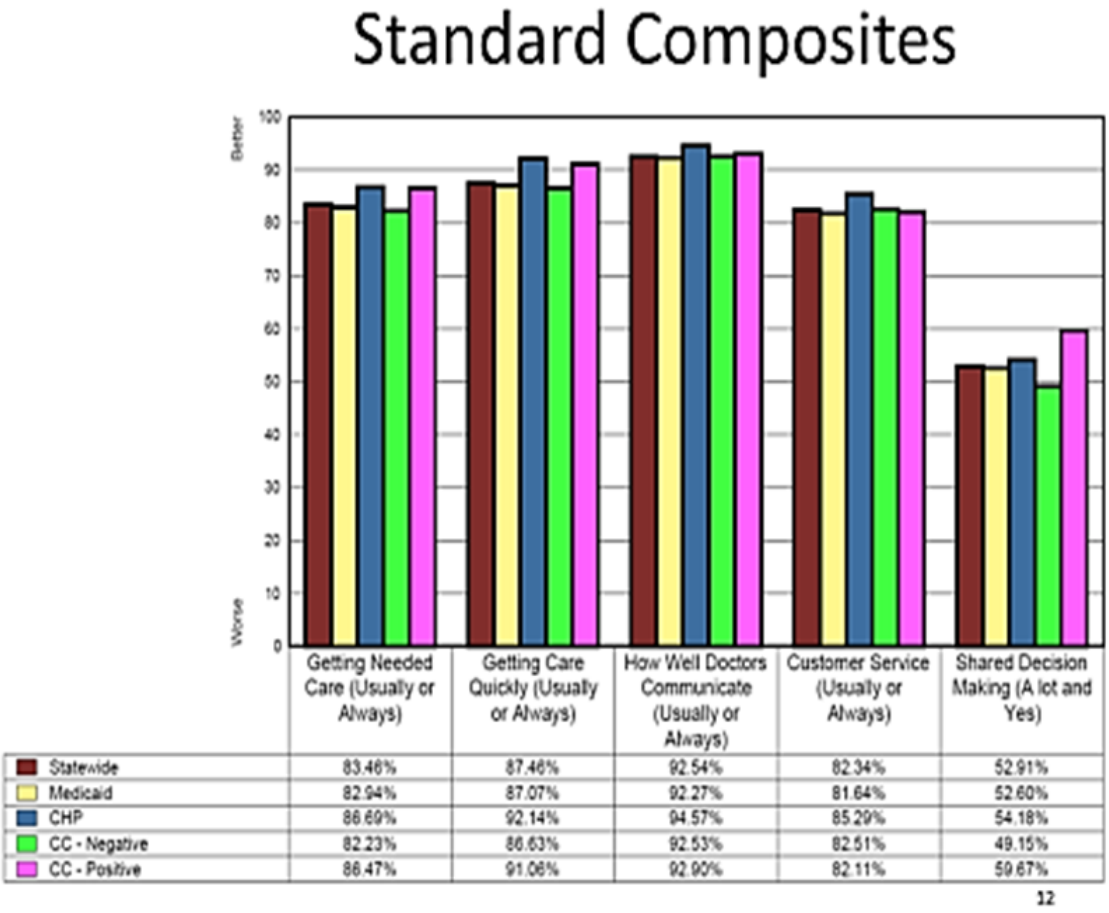

Overall Rating Questions
(Percent of Responses Rating 8, 9, or 10)
Better
Worse
100
90
80
70
60
50
40
30
20
10
0
Q41. Rating of child's personal doctor
Q48. Rating of specialist child saw most often
Q14. Rating of all child's health care
Q54. Rating of child's health plan
Statewide 89.16% 80.72% 85.21% 83.08%
Medicaid 88.79% 79.51% 84.95% 82.56%
CHP 91.46% 88.57% 87.59% 86.33%
CC - Negative 89.10% 81.44% 84.97% 83.12%
CC - Positive 89.55% 80.55% 86.55% 83.11%
11

Figure 2



	Getting Needed Care (Usually or Always)	Getting Care Quickly (Usually or Always)	How Well Doctors Communicate (Usually or Always)	Customer Service (Usually or Always)	Shared Decision Making (A lot and Yes)
Statewide	83.46%	87.46%	92.54%	82.34%	52.91%
Medicaid	82.94%	87.07%	92.27%	81.64%	52.60%
CHP	86.69%	92.14%	94.57%	85.29%	54.18%
CC - Negative	82.23%	86.63%	92.53%	82.51%	49.15%
CC - Positive	86.47%	91.06%	92.90%	82.11%	59.67%

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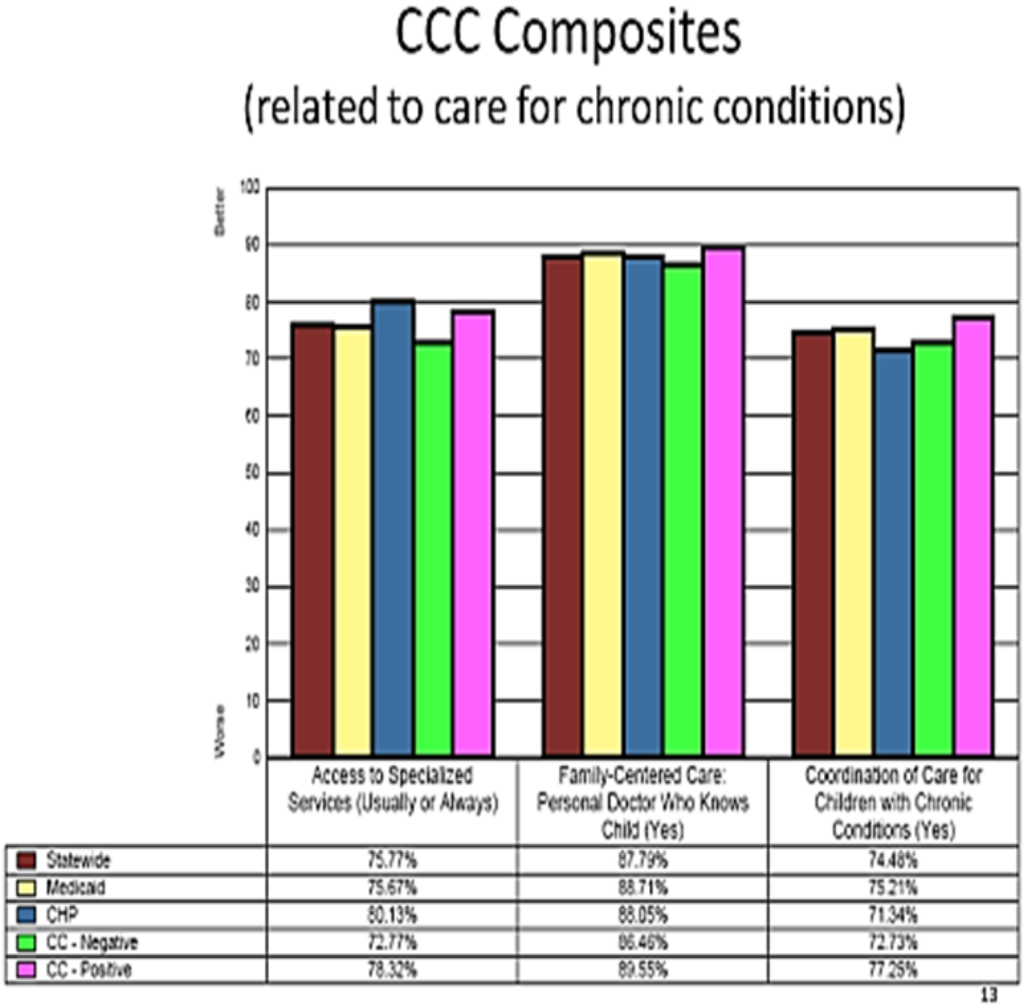
Figure 3



2014 Quality Incentive for Medicaid Managed Care

2014 Quality Incentive awards were announced in March 2015. 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 2014 awards included one plan receiving all of the award, thirteen plans receiving some portion of the award, and two plans not receiving any of the award. The awards will be implemented in April 2015 capitation rates.

Quality Incentive 2014 Quality Points NORMALIZED to 100 based on highest score March 18, 2015							
Incentive Premium Award (%)	Plan Name	Quality Points (100 points possible)	Satisfaction Points (30 points possible)	PQI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Total Points	Percent (up to 100%)
100%	Hudson Health Plan	96.351	30	10	-4	132.4	88
75%	Healthfirst PHSP, Inc.	100	10	9.25	-6	113.3	76
75%	MetroPlus Health Plan	97.297	10	9	-6	110.3	74
50%	WellCare of New York	68.919	15	17.25	-6	95.2	63
50%	HealthPlus, an Amerigroup Company	81.081	15	2.5	-6	92.6	62
50%	UnitedHealthcare Community Plan	68.919	15	9.5	-6	87.4	58
25%	Fidelis Care New York, Inc.	70.27	15	1.5	-6	80.8	54
25%	Univera Community Health	54.459	20	4.75	-4	75.2	50
25%	Independent Health	48.649	20	11.5	-6	74.1	49
25%	Total Care, A Today's Options of New York Health Plan	60.045	10	3.75	-4	69.8	47
15%	HIP (EmblemHealth)	55.405	10	7.25	-6	66.7	44
15%	MVP Health Care	50.27	20	0	-4	66.3	44
15%	Excellus Blue Cross BlueShield	47.297	20	4.75	-6	66	44
15%	CDPHP	39.189	20	7.5	-2	64.7	43
0%	Affinity Health Plan	41.892	15	3.5	-6	54.4	36
0%	HealthNow New York Inc.	33.784	10	8	-8	43.8	29

Managed Long Term Care (MLTC) Quality Incentive

In March, the Department calculated the 2014 Long Term Care Incentive results. The MLTC Quality Incentive includes points for quality, satisfaction and compliance. The pool of available funds is anticipated to be about $95 million, with plans able to receive full, two levels of partial, or none of the incentive funds. The 2014 incentive awards have eight plans receiving the top tier, 20 plans receiving partial awards in the middle two tiers and 16 plans not receiving any of the incentive funds.

B. Quality Improvement

External Quality Review

The Island Peer Review Organization (IPRO) was selected as the successful bidder of the Medicaid External Quality Review, Utilization Review, Quality Improvement and AIDS Intervention Management System Activities in New York State RFP, issued in April 2014. IPRO will conduct Medicaid managed care external quality review, as required by the Balanced Budget Act of 1997, and CMS regulations. The term of the five year contract is February 1, 2015 through January 31, 2020.

Performance Improvement Projects (PIPs)

For the 2013-2014 Performance Improvement Project (PIP), Part 2 focused on implementing interventions to improve care in one of the four clinical areas: diabetes prevention, diabetes management, hypertension and smoking cessation. All plans are aware that the final PIP report is due to IPRO in July 2015.

For 2015-2016, there will be a two year common-themed PIP to address smoking cessation among Medicaid Managed Care (MMC) enrolled smokers. While the smoking cessation theme will be common to all Managed Care Organizations (MCOs), they may choose to focus on specific populations and will develop unique interventions based on analysis of barriers specific to their enrollees and providers. Identification of MCO enrollees who are smokers will be included as a major focus of the projects. Additionally, all plans will be required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. All MMC plans have submitted smoking cessation PIP proposals. They are currently under review and in the process of being finalized. Interventions will begin to be implemented once the proposals are accepted in April 2015.

Breast Cancer Selective Contracting

The Department completed its seventh annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data for 2011-2013 to identify low-volume facilities (with a three year average of fewer than 30 surgeries per year). Two hundred and twenty-one facilities designated as follows were identified: 121 high-volume facilities, 27 low-volume unrestricted facilities, 66 low-volume restricted facilities, and seven closed facilities.

Seven facilities appealed the decision to be placed on the low-volume restriction list, and five of the appeals were approved. Approved letters were sent out to administrators of the low-volume facilities who appealed, health plan chief executive officers and health plan trade organizations. The list of low-volume restricted facilities was posted on the Department website and was included in the March Medicaid Update.

Patient Centered Medical Home (PCMH)

New York State has announced plans to alter the PCMH payment structure to provide a greater incentive to providers recognized as level 2 or 3 under the National Committee for Quality Assurance's (NCQA) 2014 standards beginning on January 1, 2016. Simultaneously, providers recognized as level 2 or 3 under NCQA's 2011 will be eligible for a reduced incentive. The number of providers recognized under 2014 standards is expected to grow substantially in 2015. Providers recognized under 2008 standards will no longer be eligible for PCMH incentive payments effective April 1, 2015. Quarterly reports monitoring of the continued growth of the PCMH program in New York State are posted to the Medicaid Redesign website, available here:
https://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm

The multi-payer medical home demonstration in the Adirondack region was slated to conclude on December 31, 2014, but has been extended through December 31, 2016.

IX. Transition Plan Updates

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

Budget Neutrality report forthcoming.

B. Designated State Health Programs

List 2 DSHP's - received edits from CMS on 7 of the 8 programs in List 2, moving forward with completing List 2. Once List 2 is completed, NY will move to List 3.

C. Clinic Uncompensated Care

No updates this quarter; please see fourth quarter/annual report, demonstration year 16 for most recent updates.

D. Hospital-Medical Home Demonstration

All hospitals submitted final reports including narrative and data on their selected projects. These were reviewed by the team and feedback letters were provided to each hospital. Four hospitals, Erie County Medical Center, Good Samaratian Hospital, Peconic Bay, and Brookhaven, were penalized from 5-20% of their expected final payment allocated for Year 2, Quarter 4 due to performance. All others received their full payment. A resident survey on PCMH was sent to all participants and analyzed showing overall favorable attitudes toward and good knowledge of PCMH principles. A final Hospital Medical Home conference was held in New York City on March 19, 2015, attended by approximately 250 hospital, residency program and clinic participants. It included a summary of program results from the DOH, speakers on primary care and DSRIP as well as from the Institute of Medicine, as well as hospital and residency program leadership. Residents presented 30 research posters that had been selected in a competitive process. Programs also participated in a hospital showcase demonstrating their projects through videos, brochures and posters. The conference was recorded and is posted on the Hospital Medical Home website https://hospitalmedicalhome.ipro.org which will be available through the end of the year. Two papers for publication on the project were also completed. One has been published in the New York State Academy of Family Medicine Family Doctor Journal and the other has been accepted and scheduled for June publication in the Journal of Graduate Medical Education. A draft final report for CMS has been completed and submitted and we are awaiting feedback.

XI. Other

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

The Department distributed the CMS-approved March 1, 2014 – February 28, 2019 Medicaid Managed Care/Family Health Plus/HIV SNP contract to participating MCOs during January 2015 for MCO signature and forwarded signed contracts to the State Attorney General's Office and the Office of the State Comptroller's office for approval.

B. Delivery System Reform Incentive Payment Program (DSRIP)

DSRIP is the main mechanism by which the Department will implement the MRT Waiver Amendment. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Up to $6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health. The DSRIP quarterly report is attached as attachment 1 to this document.

Attachments:

Attachment 1 – DSRIP Quarterly Report
Attachment 2 – MLTC Partial Capitation Plans

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