**Partnership Plan**
**Section 1115 Quarterly Report and Annual Report**
**Demonstration Year: 17 (10/1/2014 – 9/30/2015)**
**Federal Fiscal Quarter: 4 (7/01/2015 – 9/30/2015)**

# 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. In implementing the Partnership Plan Demonstration, it is 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 initial 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 2014.

There have been a number of 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 is awaiting acknowledgement from CMS that the report has been accepted.

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 February 29, 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.

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: Fourth Quarter

**Partnership Plan- Enrollment as of September 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** | **1,301,611** | **12,478** | **61,602** |
| **Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06** | **153,839** | **2,431** | **8,154** |
| **Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)** | **76,388** | **960** | **4,006** |
| **Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)** | **6,569** | **124** | **539** |
| **Population 5 - Safety Net Adults** | **1,051,509** | **15,476** | **36,381** |
| **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)** | **49,788** | **662** | **259** |
| **Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)** | **248,367** | **5,558** | **2,027** |

| | | | |
|---|---|---|---|
| **Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)** | **3,099** | **421** | **43** |
| **Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)** | **53,355** | **3,632** | **1,051** |

## Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

| **Voluntary Disenrollments** | |
|---|---|
| **Total # Voluntary Disenrollments in Current Demonstration Year** | **41,742 or an approximate 4.66% decrease over last Q** |

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** | **114,062 or an approximate 9.25% decrease over last Q** |

Reasons for involuntary disenrollments include: loss of Medicaid eligibility.

## Partnership Plan Waiver –Affirmative Choices

| **Mainstream Medicaid Managed Care** | | | | |
|---|---|---|---|---|
| **July 2015** | | | | |
| **Region** | **Roster Enrollment** | **New Enrollment** | **Auto-assigned** | **Affirmative Choices** |
| **New York City** | **1,803,034** | **18,177** | **2,556** | **15,621** |
| **Rest of State** | **1,217,249** | **18,303** | **1,740** | **16,563** |
| **Statewide** | **3,020,283** | **36,480** | **4,296** | **32,184** |
| **August 2015** | | | | |
| **New York City** | **1,773,893** | **16,964** | **2,690** | **14,274** |
| **Rest of State** | **1,205,066** | **18,647** | **1,582** | **17,065** |

| | | | | |
|---|---|---|---|---|
| **Statewide** | **2,978,959** | **35,611** | **4,272** | **31,339** |
| **September 2015** | | | | |
| **New York City** | **1,744,523** | **21,590** | **3,576** | **18,014** |
| **Rest of State** | **1,185,283** | **21,651** | **2,134** | **19,517** |
| **Statewide** | **2,929,806** | **43,241** | **5,710** | **37,531** |
| **Fourth Quarter** | | | | |
| **Region** | **Total Affirmative Choices** | | | |
| **New York City** | **47,909** | | | |
| **Rest of State** | **53,145** | | | |
| **Statewide** | **101,054** | | | |

| **HIV SNP Plans** | | | | |
|---|---|---|---|---|
| **July 2015** | | | | |
| **Region** | **Roster Enrollment** | **New Enrollment** | **Auto-assigned** | **Affirmative Choices** |
| **New York City** | **14,875** | **160** | **0** | **160** |
| **Statewide** | **14,875** | **160** | **0** | **160** |
| **August 2015** | | | | |
| **New York City** | **14,806** | **122** | **0** | **122** |
| **Statewide** | **14,806** | **122** | **0** | **122** |
| **September 2015** | | | | |
| **New York City** | **14,719** | **149** | **0** | **149** |
| **Statewide** | **14,719** | **149** | **0** | **149** |
| **Fourth Quarter** | | | | |
| **Region** | **Total Affirmative Choices** | | | |
| **New York City** | **431** | | | |
| **Statewide** | **431** | | | |

# III. Outreach/Innovative Activities

Outreach Activities

Field

There are 2,819,473 New York City Medicaid (NYMC) consumers successfully enrolled into a managed care product as of the end of the 4th quarter (end of September 2015) for 2015. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC) conducted in-person outreach and enrollment activities throughout the five boroughs of NYC within Human Resources Administration (HRA) facilities-- 7 HIV/AIDS Services Administration (HASA) sites, 11 Community Medicaid Offices (MA Only) and 17 Job Centers (Public Assistance).

For the reporting period, NYMC reported that 15,562 consumers were educated about their enrollment options. MAXIMUS reported that that 9,589 (62%) of these consumers made a voluntary enrollment choice.

Human Resources Administration's (HRA) Contract Monitoring Unit (CMU) observed 1,593 individual consumer informational sessions conducted within its facilities. CMU reported that 608 (38%) of these consumers chose to make a plan selection for themselves and their family members; and 985 (62%) were either not enrolled and did not make a choice or were enrolled and made inquiries, such as plan transfers. Infractions were observed for 5% of the sessions where the Field Client Service Representative (FCSR) did not disclose or explain the following:

- Advise consumers selected for auto-assignment of remaining days left to make a voluntary choice
- Good cause transfer
- Transitional care
- Preventive care

NYC Mainstream Calls Answered

During the reporting period, NYMC reported that 88,310 calls were received and 71,022 or 80% were answered: English: 49,157 (69%), Spanish: 13,464 (19%), Chinese: 3,983 (5.6%), Russian: 1,292 (1.8%), Haitian: 171 (1.8%).

The Contract Monitoring Unit (CMU) listened to 2,868 recorded calls answered by the NYMC Call Center Representatives (CSR). The consumer calls were categorized in the following manner:

- General Information, 2,105 (73%): Medicaid consumers (enrolled and not enrolled) requesting information that dealt with how to navigate/access services in a plan.
- Phone Enrollment, 333 (12%).

- Public calls, 153 (5%): Callers did not have MA eligibility and were inquiring on how to apply for coverage and plan enrollment.
- Transfer Plan, 277 (10%).

Issues related to process, failure to disclose critical information and customer service were identified with 450 (16%) of the recorded calls reviewed. The following summarizes those issues:

- Process, 300 (67%): The CSR did not correctly document or did not document the issue presented; did not provide correct information; and/or, did not repeat the issue presented by the caller to ensure the information conveyed by the caller was accurately captured.
- Key Messages, 85 (19%): Information, considered as a point in how to navigate a managed care plan were omitted - use of emergency room, explanation of PCP and referrals for specialists.
- Customer Service, 65 (14%): consumers were put on hold without an explanation.

All infractions are reported monthly to NYMC for corrective actions to be prepared and implemented. Corrective actions include, but are not limited to, staff training and an increase in monitoring to ensure compliance.

# IV. Operational/Policy Developments/Issues

### A. Health Plans

On September 4, 2015, the State processed a name change in the Statewide Financial System officially changing the name of Univera Community Health, Inc. to YourCare Health Plan, Inc.

Changes to Certificates of Authority (COA)

- Crystal Run Health Plan was granted an Article 44 Certificate of Authority to provide Commercial, Medicaid, and Child Health Plus services in Orange and Sullivan Counties effective 8/1/15.
- Healthfirst PHSP- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in the five boroughs of New York City on 8/14/15.
- Metroplus- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in Bronx, Kings, New York, and Queens Counties on 8/14/15.
- Amerigroup- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in the five boroughs of New York City on 8/14/15.
- New York State Catholic Health Plan- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in the five boroughs of New York City on 8/14/15.
- United Healthcare- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in the five boroughs of New York City on 8/14/15.

- Emblem Health- Amended Certificate of Authority (COA) to include the Health and Recovery Plan (HARP) line of business in the five boroughs of New York City on 8/14/15.
- Univera Healthcare changed their name to YourCare effective 8/1/15.
- Total Care of CNY- Address change effective 8/20/15.

B. Surveillance Activities

Surveillance activity for 4th Quarter FFY 2014-2015 (07/01/15 to 09/30/15) included the following:

- Two Targeted Operational Surveys were completed during the 4th Quarter FFY 2014-15. Both plans were found to be in compliance.

    - Health Insurance Plan of Greater New York
    - United Healthcare of New York

- Member Services Focus Surveys were completed on fifteen (15) Medicaid Managed Care Plans during the 4th Quarter FFY 2014-15. One plan, Empire Health Choice HMO was issued a Statement of Deficiency, for which the plan submitted an acceptable Plan of Correction.
    - Hudson Health Plan, Inc.
    - Amida Care, Inc.
    - Affinity Health Plan, Inc.
    - Empire Health Choice HMO
    - Health Insurance Plan of Greater New York
    - MetroPlus Health Plan, Inc. Special Needs Plan
    - New York State Catholic Health Plan, Inc.
    - VNS CHOICE
    - HealthFirst PHSP, Inc.
    - AMERIGROUP New York, LLC
    - UnitedHealthcare of New York, Inc.
    - WellCare of New York, Inc.
    - HealthNow New York Inc.
    - MVP Health Plan, Inc.
    - Independent Health Association, Inc.

# 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
  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:**

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 Social Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are Special Needs Plans that include specialized staff with behavioral health expertise. For Medicaid Managed Care (MMC), all Medicaid funded behavioral health services, with the exception of services in Community Residences, will become 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) will also begin phasing in enrollment of current MMC enrollees into Health and Recovery Plans (HARPs) beginning with adults 21 and over in New York City. This transition will then expand to the rest of the state in July 2016. HARPs will provide all covered services available through Medicaid Managed Care, in addition to an enhanced benefit package that includes Behavioral Health

Home and Community Based Services (BH HCBS) for eligible enrollees. These services are designed to provide the enrollee with specialized supports to remain in the community and assist with recovery. Enrollees must undergo an assessment to determine BH HCBS eligibility, and if eligible, the specific BH HCBS for which they are eligible. In addition, all HARP enrollees are eligible for individualized care management.

DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) have convened biweekly meetings with managed care plans and behavioral health providers to discuss stakeholder concerns and implementation issues. The State plans to continue these meetings throughout the transition period. 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 City, including technical assistance around billing managed care, contracting with managed care plans, and new BH HCBS. The State has also provided education to Medicaid consumers in New York City about the changes to behavioral health that may affect them. The State will mirror these efforts in the rest of the state closer to the statewide implementation.

***Transition of Nursing Home Benefit and Population into Managed Care:*** Phase 3 of the Nursing Home Transition began as scheduled, with Medicaid Managed Care Plans (MMCPs) assuming responsibility effective July 1, 2015 for covering long term placement in a nursing home for eligible beneficiaries age 21 and over in the rest of state. The transition in New York City took place on February 1, 2015 (Phase1), and in Nassau, Suffolk and Westchester Counties on April 1, 2015 (Phase 2). DOH continues to convene joint meetings on a monthly basis with MMCPs and nursing home providers to discuss stakeholder concerns, and the Department plans to continue to hold such meetings throughout the transition period. Prior to the July 1, 2015 Phase 3 transition date and also during this quarter, DOH convened statewide conference calls with the Phase 3 counties to address implementation issues. Also during this period, DOH provided ongoing technical assistance to Phase 1 and Phase 2 local districts. On July 21, 2015, at the New York Public Welfare Association's Annual Summer Conference, DOH staff discussed the nursing home transition in the context of larger presentation on the evolving long term care environment in managed care. Finally, to address new questions from affected stakeholders, DOH continues to update the Frequently Asked Questions (FAQ) document which is posted on the DOH website.

**Transition of School Based Health Center Services from Medicaid Fee-for-Service to Medicaid Managed Care:** As a result of the 2015-2016 Legislative Budget process, the date for transitioning School Based Health Center (SBHC) services from Medicaid Fee-for-Service (MFFS) to Medicaid Managed Care (MMC) has been extended from July 1, 2015 to July 1, 2016 to allow SBHC providers additional time to contract with MMC plans and to appropriately address outstanding operational issues. DOH continues to work with a stakeholder workgroup to facilitate the transition of SBHC Services from Medicaid Fee-for-Service to Medicaid Managed Care.

C. Federally Qualified Health Services (FQHC) Lawsuit

There hasn't been a ruling to date on the CHACNYS issues that were returned to the trial court. No change since last update.

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 July 2015 through September 2015, expanded MLTCP availability by approving four service area expansions. For the annual period of October 2014 through September 2015, eight different MLTC plans were approved for service area expansions. Two of those plans, VNA Options and Fidelis Care at Home, received approval for multiple service area expansions. In addition, one new certificate of authority was approved. Statewide MLTC capacity was achieved during June 2015.

- New York's Enrollment Broker, NYMC, conducts 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 July 2015 through September 2015 post enrollment surveys were completed for 88 enrollees. The target group of consumers was refined to focus exclusively on consumers who were receiving home care services on a fee for service basis prior to enrollment. 75% of respondents indicated they continued to receive services from the same caregivers once they became members of an MLTCP. Throughout the annual period October 2014 to September 2015, the percentage of respondents who indicated continuity of agency/worker fell to 66% and 64%. During Q2, 50 % of respondents indicated they were not receiving in home services at all prior to enrollment. These disparities were addressed by refining the survey questions to better capture intent, along with ensuring that the target group of members was appropriate. While affirmative responses increased to 75% during Q4, DOH will pursue additional review to identify any trends.

- At the conclusion of Q3, statewide mandatory MLTC was achieved. During Q4, MLTC aligned with the statewide transition of the permanent nursing home population into managed care. During the annual period October 2014 through September 2015, the expansion of mandatory MLTC was incrementally achieved as follows:

    - October 2014: Niagara, Madison, and Oswego
    - November 2014: Chenango, Cortland, Livingston, Ontario, Steuben, Tioga, Tompkins, and Wayne
    - December 2014: Genesee, Orleans, Otsego, Wyoming
    - February 2015: Cattaraugus
    - June 2015 – Phase 1: Chautauqua, Chemung, Essex, Hamilton, Seneca, Schuyler, and Yates

- June 2015 – Phase 2: Allegany, Clinton, Franklin, Jefferson, Lewis, and St. Lawrence

- **Enrollment.** Total enrollment in MLTC Partial Capitation Plans for the period July through September 2015 is 131,280. For that quarterly period, 8,740 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 annual period of October 2014 through September 2015 is submitted as attachment 1 to this report. MLTC enrollment grew from 122,921 to 131,280 during that time period and the annual total of affirmative choice is 30,459.

2. Significant Program Developments

- During the period October 2014 through September 2015, the Conflict Free Evaluation and Enrollment Center (CFEEC) was established and then successfully expanded to include operations on a statewide basis. This expansion aligned with expansion of mandatory MLTC, and statewide CFEEC operations were completed by the end of Q3. The Independent Consumer Support Program, commonly referred to as "ICAN," was implemented initially during December 2014 in the New York City region and continued expansion to achieve statewide operations during May 2015.

- During the period October 2014 through September 2015, focus audit findings for Fidelis Care at Home were released, a corrective action plan was received and accepted. During Q4, based on identification of care management concerns, commenced a focused audit of Integra. During the preliminary stages of review the plan acknowledged that they had already begun implementing corrective strategies to address areas of concern. Conclusions and recommendations and/or corrective actions will be formulated during Q1.

- During the period July 2015 through September 2015, research began to develop a comprehensive operational survey tool to address the components of managed care and program integrity with a particular focus on the care management component of MLTC. Additional development efforts are underway to create companion focus audits to respond to areas of deficiency identified through either the operational survey or via data trends. It is anticipated that formal structured survey activities will be launched during the upcoming federal fiscal year.

- During the period July 2015 through September 2015, the 'secret shopper' process was conducted across all MLTC products. Findings were varied; survey questions and approaches required significant refinement to account for many variables including plan type. Next steps will be to utilize data from Enrollment Broker experiences with plan communications to formulate more successful strategies. Findings will inform development of plan training which will be conducted prior to roll out of refined 'secret shopper' outreach activity.

3. Issues and Problems

A number of Managed Long Term Care Plans experienced significant service area expansion during the annual period of October 2014 through September 2015 and much of this growth aligned with expansion of mandatory MLTC to new counties. Initial efforts were made to ensure appropriate communication mechanisms were in place between local district staff and MLTCPs, and protocols continue to be reinforced on an ongoing basis. Transition of the permanent nursing home population into MLTC also occurred during this period with a number of training sessions and educational opportunities which also provided a platform to reinforce basic protocols.

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. All plans are in compliance.

5. Required Quarterly Reporting

- **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. There were 196 critical incidences reported for the period July 2015 through September 2015. For the period October 2014 through September 2015 reporting of critical incidents was consistent except for a spike to 287 during Q3. Investigation revealed increased reporting was isolated to one plan; staff covering during a maternity leave had misinterpreted the requirement.

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

- **Grievance and Appeals:** For the period July 2015 through September 2015, key areas of concern remain transportation and dissatisfaction with quality of home care.

| **Total Grievances for this period:** | **7/15-9/15** |
|---|---|
| Recipients | 140,873 |
| # Same Day | 5,506 |
| # Standard/Expedited | 1,953 |
| **Total** | 7,459 |

| **Period: 07/01/15 – 09/30/2015** | | | |
|---|---|---|---|
| **Total Grievances for this period:** | | **Resolved** | **Resolved %** |
| # Same Day | 5506 | 5506 | 100% |
| # Standard/Expedited | 1953 | 1609 | 82% |

| | | | |
|---|---|---|---|
| **Total for this period:** | **7459** | **7115** | **95%** |

| **Appeals** | **10/14-12/14** | **1/15-3/15** | **4/15-6/15** | **7/15-9/15** | **Total for 4 Qtrs** |
|---|---|---|---|---|---|
| Avg Quarterly Enrollment | 137,978 | 139,353 | 137,182 | 140,873 | 555,387 |
| Total Appeals for the period | 1,248 | 1,662 | 2,446 | 1,593 | 6,949 |
| Appeals per 1,000 | 9 | 12 | 18 | 11 | 13 |
| # Decided in favor of Enrollee | *N/A | *N/A | *N/A | 943 | *N/A |
| # Decided against Enrollee | *N/A | *N/A | *N/A | 876 | *N/A |
| # Not decided fully in favor of Enrollee | *N/A | *N/A | *N/A | 230 | *N/A |
| # Withdrawn by Enrollee | *N/A | *N/A | *N/A | 20 | *N/A |
| # Still pending | *N/A | *N/A | *N/A | 224 | *N/A |
| Avg days to decision (total number of days from request to decision) | *N/A | *N/A | *N/A | 14 | *N/A |

**Appeals** *categories were added to reporting effective July 2015

For the annual period of October 2014 through September 2015, there was a notable increase in appeals during Q3. A number of plans had implemented enhanced quality improvement processes that resulted in a proposed reduction of services, and a corresponding increase in request for appeals. Remainder of quarterly data otherwise consistent.

| **Grievances and Appeals per 1,000 Enrollees By Plan and Product Type 7/15-9/15** | | | | | | |
|---|---|---|---|---|---|---|
| **Plan Name:** | **Plan Type** | **Enrollment** | **Total Grievances** | **Grievances per 1,000** | **Total Appeals** | **Appeals per 1,000** |
| **Partial Capitation Plans** | | | | | | |
| AETNA BETTER HEALTH MLTC | Partial | 3,170 | 35 | 11 | 29 | 9 |
| AgeWell New York, LLC | Partial | 4,956 | 275 | 55 | 7 | 1 |
| AlphaCare of New York Inc. | Partial | 1,918 | 238 | 124 | 8 | 4 |
| Amerigroup | Partial | 2,580 | 43 | 17 | 0 | 0 |
| ArchCare Community Life | Partial | 1,905 | 385 | 202 | 12 | 6 |
| CenterLight Healthcare Select | Partial | 5,853 | 257 | 44 | 26 | 4 |
| Centers Plan for Healthy Living | Partial | 3,222 | 61 | 19 | 7 | 2 |
| Elant Choice | Partial | 857 | 15 | 18 | 0 | 0 |

| Grievances and Appeals per 1,000 Enrollees<br>By Plan and Product Type<br>7/15-9/15 | | | | | | |
|---|---|---|---|---|---|---|
| **Plan Name:** | **Plan Type** | **Enrollment** | **Total Grievances** | **Grievances per 1,000** | **Total Appeals** | **Appeals per 1,000** |
| ElderServe Health, Inc. | Partial | 10,486 | 186 | 18 | 11 | 1 |
| EmblemHealth | Partial | 1,278 | 38 | 30 | 3 | 2 |
| Extended | Partial | 622 | 27 | 43 | 1 | 2 |
| Fallon Health Weinberg | Partial | 177 | 12 | 68 | 0 | 0 |
| FIDELIS Care New York | Partial | 9,721 | 53 | 5 | 53 | 5 |
| GuildNet MLTCP | Partial | 14,146 | 1067 | 75 | 92 | 7 |
| Hamaspik Choice | Partial | 1,047 | 29 | 28 | 1 | 1 |
| HomeFirst MLTC, a product of Elderplan | Partial | 10,826 | 443 | 41 | 64 | 6 |
| I Circle | Partial | 426 | 10 | 23 | 0 | 0 |
| Independence Care Systems | Partial | 5,402 | 408 | 76 | 53 | 10 |
| Integra MLTC | Partial | 2,485 | 26 | 10 | 6 | 2 |
| Kalos, dba First Choice Health | Partial | 408 | 18 | 44 | 0 | 0 |
| Metroplus | Partial | 878 | 48 | 55 | 1 | 1 |
| Montefiore Diamond Care | Partial | 589 | 36 | 61 | 1 | 2 |
| NSLIJ Health Plan | Partial | 2,138 | 60 | 28 | 1 | 0 |
| Prime Health Choice, LLC | Partial | 74 | 3 | 41 | 0 | 0 |
| Senior Health Partners | Partial | 13,716 | 530 | 39 | 524 | 38 |
| Senior Network Health | Partial | 486 | 6 | 12 | 0 | 0 |
| Senior Whole Health | Partial | 2,880 | 36 | 12 | 3 | 1 |
| United Healthcare Personal Assist | Partial | 1,351 | 6 | 4 | 1 | 1 |
| VillageCareMAX | Partial | 4,064 | 551 | 136 | 6 | 1 |
| VNA Homecare Options, LLC | Partial | 822 | 68 | 83 | 2 | 2 |
| VNSNY CHOICE MLTC | Partial | 13,572 | 1477 | 109 | 607 | 45 |
| Wellcare | Partial | 7,192 | 115 | 16 | 12 | 2 |
| **Total** | | **129,248** | **6,562** | | **1,531** | |
| **Medicaid Advantage Plus (MAP)** | | | | | | |
| Elderplan | MAP | 849 | 35 | 41 | 4 | 5 |
| EmblemHealth | MAP | 599 | 32 | 53 | 2 | 3 |
| Fidelis Medicaid Advantage Plus | MAP | 158 | 1 | 6 | 3 | 19 |
| GuildNet GNG | MAP | 661 | 106 | 160 | 4 | 6 |
| Healthfirst CompleteCare | MAP | 3,679 | 19 | 5 | 28 | 8 |
| HEALTHPLUS AMERIGROUP | MAP | 1 | 0 | 0 | 0 | 0 |
| Senior Whole Health | MAP | 92 | 3 | 33 | 0 | 0 |

| Grievances and Appeals per 1,000 Enrollees<br>By Plan and Product Type<br>7/15-9/15 | | | | | | |
|---|---|---|---|---|---|---|
| **Plan Name:** | **Plan Type** | **Enrollment** | **Total Grievances** | **Grievances per 1,000** | **Total Appeals** | **Appeals per 1,000** |
| VNSNY CHOICE MLTC TOTAL | MAP | 90 | 0 | 0 | 0 | 0 |
| **Total** | | **6,129** | **196** | | **41** | |
| **Program of All-inclusive Care for the Elderly (PACE)** | | | | | | |
| ArchCare Senior Life | PACE | 426 | 39 | 92 | 0 | 0 |
| Catholic Health LIFE | PACE | 196 | 19 | 97 | 3 | 15 |
| CenterLight Healthcare | PACE | 3,320 | 481 | 145 | 8 | 2 |
| Complete Senior Care | PACE | 120 | 23 | 191 | 3 | 25 |
| Eddy SeniorCare | PACE | 163 | 59 | 361 | 0 | 0 |
| ElderONE | PACE | 669 | 43 | 64 | 3 | 4 |
| Independent Living Services of CNY (PACE CNY) | PACE | 494 | 26 | 53 | 4 | 8 |
| Total Senior Care | PACE | 109 | 11 | 101 | 0 | 0 |
| **Total** | | **5,497** | **701** | | **21** | |
| **Grand total MLTC Partial, PACE and MAP** | | | | | | |
| **Grand Total Enrollment** | | **140,873** | **7,459** | | **1,593** | |

- **Fraud and Abuse:** For the period July 2015 through September 2015, there were 59 Fraud and Abuse complaints reported. This represents a slight increase over Q3. Enhanced reporting requirements were implemented effective 7/1/15, designed to provide detailed identification of potential versus confirmed cases. Those new elements are reflected in Q4 data. For the annual period of October 2014 through September 2015, Fraud and Abuse complaints were consistent.

| **Fraud and Abuse Complaints Reported During Quarter** | **7/15-9/15** |
|---|---|
| New potential cases of Fraud and Abuse detected during the reporting period | 59 |
| Open potential cases of Fraud and Abuse from previous quarter being investigated | 24 |
| Cases of Fraud and Abuse confirmed during the reporting period | 8 |
| Open potential cases of Fraud and Abuse remaining unconfirmed and still being investigated at the end of the reporting period. | 63 |

- **Fair Hearings:**

| Fair Hearing Decisions | 7/15-9/15 |
|---|---|
| **Total** | 428 |
| In favor of Appellant | 375 |
| In favor of MLTC Plan | 30 |
| No Issue | 23 |

| Fair Hearings<br>Days from Request Date till Decision Date | 7/15-9/15 |
|---|---|
| **Total** | 27 |
| less than 30 Days | 291 |
| 30-60 | 77 |
| 61-90 | 19 |
| 91-120 | 14 |
| >120 | 428 |

There was a significant increase in Fair Hearings during the July – September 2015 period. New requirements were implemented effective the July 1, 2015, allowing members to request a fair hearing without exhausting the internal plan appeals process. This resulted in a dramatic increase in Fair Hearings, and it is anticipated that this trend will continue.

The annual period October 2014 through September 2015 also reflected a spike in Q3, relating to an increase relating to plan implementation of quality initiatives that resulted in a proposed reduction of hours.

- **Technical Assistance Center (TAC) Activity**

During the annual period of October 2014 through September 2015, the TAC unit continued to grow, increasing staff in preparation for the addition of Nursing Home Transition complaints. The TAC unit also increased training protocols to educate staff regarding the changes in population. Additional quality protocols were added to increase the consistency of complaint investigation and resolution. Policies and procedures were added and adapted to existing TAC policy to reflect the changes in trends identified by TAC staff. The majority of the complaints still come through the TAC phone line; however, the email address has proven to be an effective resource for both complaints and inquires.

<u>Fourth Quarter Highlights from MLTC-TAC:</u>

**Technical Assistance Center Activity:** During Q4 there was a significant decrease in Grievance/Complaint-internal appeals, which was down approximately 88%. This can be linked to the change in policy which allows the consumer to go directly to Fair Hearing rather than

exhausting internal appeal option. The unit also saw a decrease of 82% in complaints regarding referrals-difficulty obtaining DME. The main categories for complaints are related to Home Health/PCA Services, Billing and Enrollment Issues.

- **Complaint Volume:**
  - **Substantiated Complaints = 338**
  - **Unsubstantiated Complaints = 256**
  - **Total Complaints = 594**
  - **Inquiries = 177**
  - **Total Call Volume = 771**
- **Complaint investigation Activity:**
  - **Resulted in 2 targeted corrective action plans**
  - **Issues: Enrollment Plan did not take Services and Grievance/Complaint-Fair Hearing.**
  - **Impacted Regions: Kings & Queens Counties**

- **Assessments for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were incrementally expanded to additional regions during the 2nd quarter. CFEEC was not fully implemented statewide until June 30, 2015. For the period July 2015 through September 2015; 3,274 people were evaluated, deemed eligible and enrolled into plans. For the annual period 10/1/2014 to 9/30/2015, there were 25,859 people evaluated, deemed eligible and enrolled into plans.

- **Referrals and 30 day assessment:** For the period July 2015 through September 2015, total assessments conducted by the MLTC plans during the period were 19,279. There was significant MLTC expansion during Q4, along with achieving statewide capacity. 84% were conducted within the 30 day time frame. During the annual period of October 2014 through September 2015, a total of 40,614 assessments were conducted by plans and on average 85% were conducted within the 30 day time frame. Due to the implementation of CFEEC on a statewide basis, data collection, evaluation and reporting for this element will be reviewed and refined for Q1.

- **Referrals outside enrollment broker:** The CFEEC began during October 2014. This data element will be evolving to coincide with the rollout of CFEEC process. During the period October 2014 through September 2015, the number of people not referred by the enrollment broker and contacting the plan directly rose from Q1 - 8,939, Q2- 6,883, Q3 - 9,340, to Q4 - 12,696. The dramatic spike during Q4 would coincide with significant MLTC plan service area expansion which included achieving statewide capacity.

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

| **Rebalancing Efforts** | **7/15-9/15** |
|---|---|

| | |
|---|---|
| New Enrollees to the Plan from a nursing home transitioning to the community | **235** |
| Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community | **1458** |
| Current plan Enrollees permanently placed in a nursing home | **1959** |
| New Enrollees permanently placed in a nursing home who remain in a nursing home. | **207** |

Effective July 1, 2015, there was a change to the reporting regarding rebalancing, which may have resulted in misinterpretation of the number of current plan enrollees permanently placed in a nursing home. However, based on the large increase, there may have been misinterpretation, and this number could reflect all current plan enrollees who are permanently placed. This will be investigated and clarified.

# VI. Evaluation of the Demonstration

**Currently under review and discussion with CMS.**

# VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 5,658 complaints/action appeals this quarter, an increase of 1.3% from the previous quarter. Of these complaints/appeals 29 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 27% of the total. There were 144 complaints/appeals reported by the HIV SNPs. The majority of these complaints (35) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 458 Medicaid managed care complaints this quarter.

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

27% Balance Billing
13% Reimbursement/Billing Issues
10% Provider or MCO Services (Non-Medical)
9% Dental or Orthodontia
8% 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 | 3 |
| Home Health Care | 13 |
| Non-Permanent Residential Health Care Facility | 0 |
| Personal Care Services | 5 |
| Personal Emergency Response System | 1 |
| Private Duty Nursing | 1 |
| Total | 23 |

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 5,658 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 791 complaints and action appeals from their SSI enrollees. This compares to 742 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 | 26% |
| Quality of Care | 23% |
| All other | 21% |
| Balance Billing | 18% |
| Provider or MCO Services (Non-Medical) | 12% |

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 | 24 |
| AIDS Adult Day Health Care | 0 |
| Appointment Availability - PCP | 4 |
| Appointment Availability - Specialist | 4 |
| Balance Billing | 87 |
| Communications/Physical Barrier | 3 |
| Consumer Directed Personal Assistant | 1 |
| Denial of Clinical Treatment | 33 |
| Dental or Orthodontia | 123 |
| Emergency Services | 13 |
| Eye Care | 11 |
| Family Planning | 0 |
| Home Health Care | 6 |
| Mental Health or Substance Abuse Services/ Treatment | 54 |
| Non-covered Services | 34 |

| | |
|---|---|
| Non-Permanent Residential Health Care Facility | 0 |
| Personal Care Services | 2 |
| Personal Emergency Response System | 0 |
| Pharmacy | 24 |
| Private Duty Nursing | 0 |
| Provider or MCO Services (Non-Medical) | 59 |
| Quality of Care | 108 |
| Recipient Restriction Program/Plan Initiated Disenrollment | 4 |
| Reimbursement/Billing Issues | 55 |
| Specialist or Hospital Services | 17 |
| Transportation | 10 |
| Waiting Time Too Long at Office | 13 |
| All Other Complaints | 102 |
| Total | **791** |

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

MMCARP met on September 24, 2015. The meeting included presentations provided by State staff and discussions of the following: an overview and discussion by Office of Quality and Patient Safety staff regarding Quality Assurance Reporting Requirements (QARR) and CAHPS 2014 Measurement Year Results for Medicaid and Child Health Plus; an update on the status of the Managed Long Term Care (MLTC), the Fully Integrated Duals Advantage (FIDA) programs, and CFEEC; a brief update on Delivery System Reform Incentive Payment Program (DSRIP) project deliverables and timeline; and an update on the implementation of Medicaid behavioral health reform in New York, including a review of the behavioral health managed care timeline, an update on the status of the HARP enrollment process, an discussion of general principles and standards surrounding the behavioral health network, and an overview of behavioral health expenditure tracking, behavioral health expenditure target, and HARP Medical Loss Ratio.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on July 9, August 13, and September 10, 2015. The July meeting included the following presentations: a status update on DSRIP and the Value Based Payment roadmap; updates on FIDA MLTC and an overview of CFEEC activity; a status update on MLTC and Mainstream Medicaid Managed Care capitation rates; and an update on activities related to the implementation of adult behavioral health in managed care. The August meeting agenda included: MMC and MLTC finance and rate development overview; a discussion of DSRIP and Value Based Payment/Quality Improvement Program with respect to the roles and responsibilities of Managed Care Organizations, Performing Provider Systems, facilities, and DOH, and an overview of the

VBP/QIP timeline and managed care premium methodology; an overview of changes to the Medical Home payment process (Patient Centered Medical Home and Adirondack Medical Home); a status update on the implementation of the FIDA program, MLTC enrollment and CFEEC activity; and a behavioral health transition update, with emphasis on provider claims testing, member notification of the transition and the Rest of State Request for Qualifications process. Presentations, updates and discussions at the September meeting included: an update on DSRIP; a finance and rate development update; MLTC, FIDA and CFEEC update; an update on health benefit exchange 834 issues; an overview of the Basic Health Program/Essential Plan; a behavioral health transition and HARP status update; and a presentation on billing and reimbursement for managed care plans related to integrated services provided by clinics licensed by more than one agency (DOH, OMH and/or OASAS).

# VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

1. Quality Assurance Reporting Requirements (QARR)

28 health plans submitted QARR data on June 15, 2015. This includes 11 of the 18 Qualified Health Plans operating through the NY State of Health Marketplace with enough eligible populations to report quality data. Data is being reviewed for completeness and accuracy and final results will be published next quarter.

Sixteen Medicaid managed care plans and three Medicaid HIV Special Needs plans submitted 2014 Measurement Year QARR data in June 2015. All plan data was audited by NCQA licensed audit organizations prior to submission. The following table reflects the overall results for the two products for the measurement year.

National benchmarks for Medicaid are from NCQA's State of HealthCare Quality 2015 report. Of the 35 measures included here with national comparison, NYS Medicaid average exceeds the national average for 29 measures (green highlight), is consistent with the national average for 2 measures (yellow highlight), and is below the national average for 4 measures (red highlight). National benchmarks for HIV SNP plans are not available.

| Measure | Medicaid MC | HIV SNP | National Medicaid Average |
|---|---|---|---|
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 61 | 57 | 60 |
| Adolescent Well-Care Visits | 65 | 41 | 50 |
| Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs | 92 | 99 | 87 |

| Measure | Medicaid MC | HIV SNP | National Medicaid Average |
|---|---|---|---|
| Annual Monitoring for Patients on Persistent Medications-Digoxin | 54 | | 54 |
| Annual Monitoring for Patients on Persistent Medications-Diuretics | 91 | 99 | 87 |
| Annual Monitoring for Patients on Persistent Medications-Combined Rate | 92 | 99 | 87 |
| Antidepressant Medication Management-Effective Acute Phase Treatment | 50 | 52 | 52 |
| Antidepressant Medication Management-Effective Continuation Phase Treatment | 35 | 38 | 37 |
| Appropriate Testing for Pharyngitis | 88 | | 70 |
| Appropriate Treatment for Upper Respiratory Infection (URI) | 93 | 93 | 87 |
| Asthma Medication Ratio (Ages 5-64) | 57 | 32 | 59 |
| Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis | 28 | | 29 |
| Breast Cancer Screening | 71 | 70 | 59 |
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia | 78 | | 76 |
| Cervical Cancer Screening | 75 | 82 | 60 |
| Chlamydia Screening (Ages 16-24) | 72 | 78 | 55 |
| Comprehensive Care for Persons with HIV/AIDS Engaged in Care | 81 | 85 | NA |
| Comprehensive Care for Persons with HIV/AIDS Syphilis Screening | 73 | 83 | NA |
| Comprehensive Care for Persons with HIV/AIDS Viral Load Monitoring | 71 | 80 | NA |
| Controlling High Blood Pressure | 65 | 54 | 57 |
| Diabetes Monitoring for People with Diabetes and Schizophrenia | 78 | 89 | 69 |
| Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds | 82 | 99 | 80 |
| Drug Therapy for Rheumatoid Arthritis | 81 | | 70 |
| Follow-Up After Hospitalization for Mental Illness Within 30 Days | 78 | 61 | 63 |
| Follow-Up After Hospitalization for Mental Illness Within 7 Days | 63 | 43 | 44 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase | 67 | | 48 |

| Measure | Medicaid MC | HIV SNP | National Medicaid Average |
|---|---|---|---|
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase | 58 | | 40 |
| Frequency of Ongoing Prenatal Care | 70 | 45 | 55 |
| Medication Management for People with Asthma 50% Days Covered (Ages 5-64) | 58 | 77 | NA |
| Medication Management for People with Asthma 75% Days Covered (Ages 5-64) | 32 | 58 | 31 |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (Ages 1-17) | 37 | | NA |
| Non-Recommended Cervical Cancer Screening | 4 | | 4 |
| Persistence of Beta-Blocker Treatment | 86 | | 83 |
| Pharmacotherapy Management of COPD Exacerbation-Bronchodilator | 88 | 91 | 79 |
| Pharmacotherapy Management of COPD Exacerbation-Corticosteroid | 75 | 64 | 65 |
| Postpartum Care | 69 | 40 | 62 |
| Timeliness of Prenatal Care | 88 | 69 | 82 |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1-17) | 65 | | NA |
| Use of Imaging Studies for Low Back Pain | 77 | 74 | 75 |
| Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Ages 1-17) | 3 | | NA |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 53 | 23 | 31 |
| Well-Child & Preventive Care Visits in First 15 Months of Life (6 or more Visits) | 66 | 60 | 59 |
| Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life | 84 | 70 | 72 |

NA = Not available

2. Managed Long Term Care (MLTC)

MLTC Quality Data

In July, the MLTC Quality Incentive work group met to review methodological changes for the 2015 MLTC Quality Incentive.

A draft version of the 2014 Managed Long Term Care report was released to the MLTC plans in September. The report will be posted on the public website once approval is complete. Sharing the report with the plans will allow them to review information and prioritize areas for improvement activities. The report is organized in four sections 1) Quality of life and care based on the Uniform Assessment System for New York (UAS-NY) data from January – June 2014; 2) Quality performance over time; 3) enrollee satisfaction with care from the 2013 satisfaction survey; and 4) potentially avoidable hospitalizations (based on inpatient hospitalizations during 2013).

Highlights of the report:
Quality performance

- 75% of enrollees received the recommended annual influenza vaccination. Plan results ranged from 65% to 93%.
- 54% of enrollees age 65 or older received a pneumococcal vaccination in the last five years or after age 65. Plan results ranged from 41% to 85%.
- 95% of enrollees had no falls that resulted in medical intervention in the past 90 days.
- 94% of enrollees did not have severe daily pain.
- 88% of enrollees were not lonely and distressed.

Utilization

- 3% of enrollees were admitted to a nursing home and of that group, 13% were admitted for long-term placement.
- 14% of enrollees were admitted to the hospital. The most common reasons for admission were: respiratory problems (20%), falls (12%), urinary tract infection (7%), congestive heart failure (7%), and scheduled surgical procedure (8%).
- 10% of enrollees visited an emergency room, 15% were for respiratory and 9% were for cardiac problems

Enrollee Satisfaction

- 84% of respondents rated their health plan as good or excellent.
- 90% would recommend their plan to a friend.
- 86% rated their care manager and home health aide/personal care aide as good or excellent.

Potentially Avoidable Hospitalizations

- The overall rate of PAH for all MLTC plans was 3.66 potentially avoidable hospitalizations per 10,000 days enrolled in the plan.
- Plan results ranged from 0 to 13 potentially avoidable hospitalizations per 10,000 days enrolled in the plan.

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. The previous EQR contract with IPRO, expired on November 30, 2014. A two-month extension to that contract was approved through January 31, 2015. As the External Quality Review Organization (EQRO), IPRO conducts Medicaid Managed Care (MMC) external quality review as required by the Balanced Budget Act of 1997 and CMS regulations for the duration of the five-year contract, February 1, 2015 through January 31, 2020.
In April, the External Quality Review Organization (EQRO) prepared the All Plan Summary Report for New York State Medicaid Managed Care Organizations. The EQRO prepared and released its annual technical evaluation of the Managed Long-Term Care Plans (MLTC) in June. The EQRO reviewed the Medicaid managed care plan's 2013- 2014 final Performance Improvement Project (PIPs) reports that were due in July 2015. In August the EQRO completed compilation of the individual Plan Technical Reports for the Medicaid managed care organizations and the three HIV SNP plans.

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 submitted final PIP reports to IPRO in July 2015. A compendium of 2013-2014 PIP abstracts is currently being drafted.

For 2015-2016, the two year common-themed PIP to address smoking cessation among MMC enrolled smokers is being implemented. Identification of MCO enrollees who are smokers is included as a major focus of the projects. Additionally, all plans are 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 and they have all been reviewed and accepted as final. Interventions have been implemented when the proposals were accepted in April 2015. Individual plan specific conference calls with IPRO, DOH and the MCOs are scheduled for November 2015 for the plans to report on their PIP progress. A conference call was held October 19, 2015 with all of the Medicaid managed care plans, IPRO and representatives from the DOH Bureau of Tobacco Control and DPIPS, as well as OMH. Three Medicaid managed care plans presented on their progress on the respective Smoking Cessation PIPs including: the project aim, performance indicators, interventions, preliminary data, barriers experienced, lessons learned and next steps. A summary chart of the MMC Smoking Cessation PIPs was distributed to all of the call participants. The summary chart includes the MMC plans' primary Smoking Cessation PIP staff persons' contact information for each plan to encourage collaboration among the plans. DOH is planning a second call for January 2016 when four additional MMC plans will present on their Smoking Cessation PIP progress.

Breast Cancer Selective Contracting

Staff successfully completed the Breast Cancer Selective Contracting process for contract year 2015-2016. This included: refining the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); identifying low-volume facilities for restriction; notifying restricted facilities of their status; conducting the appeals process and notifying facilities about appeal decisions; sharing the list of restricted facilities with staff at eMedNY to restrict Medicaid fee-for-service payment, as well as, sharing the list with Medicaid managed care health plans' Chief Executive Officers and Medical Directors.

In total, the 2015-2016 annual review of breast cancer surgical volume identified 214 facilities. Facility designations were as follows: 121 high-volume facilities, 27 low-volume access facilities, and 66 low-volume restricted facilities. Appeals were received from 6 low-volume facilities, of which 3 were approved and 3 were denied.

In addition, volume designations as of August 2015, were released to provide facilities with their projected status for the 2016-2017 contract year. Release of projected status allows facilities time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

Staff also updated the protocols and computer programs that will be used in the fall of 2015 to identify low-volume, restricted facilities for the 2016-2017 contract year.

Patient Centered Medical Home (PCMH)

On April 1, 2015, incentive payments for providers recognized as a PCMH by the National Committee for Quality Assurance (NCQA) under the 2008 standards concluded. The NY Statewide Medicaid PCMH program will continue to provide incentive payments for providers recognized as a level 2 or level 3 PCMH by the NCQA under the 2011 or 2014 standards. Providers recognized as a level 1 under any NCQA PCMH standard year are not eligible for incentive payments through this program.

As of January 1, 2015, level 2 and 3 providers are given the same incentive payment regardless of their standard year achievement. On January 1, 2016 incentives for providers recognized under the 2014 standards will be increased, while incentives for providers recognized under the 2011 standards will decrease (detailed on pages 23-24 of the March 2015 Medicaid Update, which can be found here: http://www.health.ny.gov/health_care/medicaid/program/update/main.htm).

As of September 30th, there were 149 providers recognized under NCQA's 2014 standards. This number is expected to increase exponentially over the next year, potentially due to the upcoming change in incentive payments, but also due to the requirement for DSRIP. Some of the anticipated recognized providers under the 2014 standards will be new to the program but it is

also expected that a large majority will be providers currently recognized under the 2011 standards that plan to renew their certification under the 2014 standards.

Quarterly reports on NYS PCMH program growth can be found on the MRT website, available here: http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

The multi-payer medical home demonstration in the Adirondack region, also referred to as 'ADK', was slated to conclude on December 31, 2014 but was extended through December 31, 2016.

A report to the Legislature detailing the background, evaluation, and findings of the ADK was sent in August 2015 and was posted to the public Medicaid Redesign Team website on August 28, 2015. The report can be found here: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014_pcmh_initiative.pdf.

# IX. Transition Plan Updates

No updates for this quarter.

# 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 – finalized edits to 7 of 8 claiming protocols. Still working through the General Public Health Work (GPHW) protocol with CMS and DOH program staff in order to finalize List 2. Once List 2 is completed, NY will move back to List 3 to complete protocols for state operations and rate-based programs.

C. Clinic Uncompensated Care

An amendment request has been submitted to CMS.

D. Hospital-Medical Home Demonstration

The H-MH Program expired on December 31, 2014. A draft evaluation report was submitted to CMS on April 30, 2015.

# XI. Other

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

On August 25, 2015, CMS approved five of the eighteen March 1, 2014 – February 28, 2019 Medicaid Managed Care/Family Health Plus/HIV SNP contracts. At the close of the quarter, the other thirteen contracts were under CMS review for final approval.

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

New York has been working very closely with CMS as a front running state. New York is in Pre-Operational Readiness Testing (PORT) for T-MSIS Release 1.X. There have been issues with processing New York's large volume files in T-MSIS Release 1.X. New York has been engaged with Loretta Schickner, Director, Division of Medicaid and CHIP Information Systems (DMCIS), and is currently onboarding for T-MSIS 2.0 State Beta Testing, which is expected to begin November 16th. New York also submitted T-MSIS claim files in June as a vehicle to demonstrate New York's end-to-end ICD-10 processing capability.

**Attachments:**

**Attachment 1 - MLTC Partial Capitation Plans**
**Attachment 2 - Q3 DOH Responses**

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