Partnership Plan
Section 1115 Quarterly and Annual Report
Demonstration Year: 18 (10/1/2015 – 9/30/2016)
Federal Fiscal Quarter: 4 (7/01/2016 – 9/30/2016)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for its Partnership Plan Medicaid Section 1115 Demonstration. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2016.

There have been 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 was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30 day public comment period. A temporary extension was granted on December 31, 2014 extending the waiver through March 31, 2015. Subsequent temporary extensions were granted through November 30, 2016.

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 2016

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	**1,106,218**	**12,762**	**60,015**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**131,639**	**3,481**	**6,843**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**65,962**	**930**	**3,591**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**5,547**	**193**	**353**
Population 5 - Safety Net Adults	**843,446**	**23,183**	**41,247**
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)	**37,332**	**5,123**	**205**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**208,965**	**26,295**	**1,799**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,639**	**443**	**32**

Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**57,091**	**4,104**	**1,009**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**76,514 or an approximate 62% increase from last Q**

Reasons for voluntary disenrollment: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**115,094 or an approximate 12% increase from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid eligibility.

WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Explanation for Voluntary and Involuntary Disenrollment:

Health and Recovery Plan (HARP) enrollment became effective in counties outside of New York City on July 1, 2016. This program change resulted in a significant increase in HARP enrollment. This increase in HARP enrollment had a direct impact on Partnership Plan disenrollment in the fourth quarter of FFY 2015. Passive enrollment into the HARP program from the parent mainstream plans grew from 4,888 in the third quarter to 34,304 in the fourth quarter of FFY 2015. This increase in passive enrollment is captured in the “Enrolled in Other Plan” category of voluntary disenrollment from the Partnership Plan program. In addition, WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Partnership Plan Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
July 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,481,918**	**18,698**	**2,722**	**15,976**
Rest of State	**1,053,818**	**16,096**	**1,721**	**14,375**
Statewide	**2,535,736**	**34,794**	**4,443**	**30,351**
August 2016				
New York City	**1,457,016**	**22,749**	**3,415**	**19,334**
Rest of State	**1,018,685**	**18,507**	**2,071**	**16,436**
Statewide	**2,475,701**	**41,256**	**5,486**	**35,770**
September 2016				
New York City	**1,439,528**	**18,817**	**2,567**	**16,250**
Rest of State	**1,005,460**	**15,111**	**1,561**	**13,550**
Statewide	**2,444,988**	**33,928**	**4,128**	**29,800**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**51,560**			
Rest of State	**44,361**			
Statewide	**95,921**			

HIV SNP Plans				
July 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,962**	**146**	**0**	**146**
Statewide	**13,962**	**146**	**0**	**146**
August 2016				
New York City	**13,896**	**155**	**0**	**155**
Statewide	**13,896**	**155**	**0**	**155**
September 2016				
New York City	**13,851**	**138**	**0**	**138**
Statewide	**13,851**	**138**	**0**	**138**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**439**			
Statewide	**439**			

Partnership Plan Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
September 2016	
Plan Name	**Enrollment**
Affinity Health Plan	**3,119**
Capital District Physicians Health Plan	**1,655**
Excellus Health Plan	**4,244**
HealthFirst	**16,317**
HealthPlus	**4,684**
HIP GNY	**4,118**
Independent Health Association	**1,183**
MetroPlus	**8,166**
MVP Health Plan	**2,914**
NYS Catholic Health Plan	**16,609**

Today's Options	**1,023**
United HealthCare	**4,195**
YourCare Health Plan	**1,059**
Total:	**69,286**

Health and Recovery Plans Disenrollment			
Q4 2016			
	Voluntary	**Involuntary**	**Total**
July 2016	**224**	**146**	**370**
August 2016	**727**	**181**	**908**
September 2016	**1,083**	**344**	**1,427**
Total:	**2,034**	**671**	**2,705**

III. Outreach/Innovative Activities

A. Managed Care Enrollment Broker

Effective September 1, 2016, Allegany County opted to utilize the assistance of Maximus, the State's contracted Enrollment Broker. There are only seven counties remaining in the state that do not use the services of the Enrollment Broker: Cattaraugus, Chautauqua, Delaware, Orleans, Seneca, Tompkins, and Wyoming.

B. Outreach Activities

NYMC Field Observations

As of the end of the fourth federal fiscal quarter (end of September 2016), there were 2,608,550 New York City Medicaid consumers enrolled in a managed care product. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted outreach in the following HRA facilities: 6 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 16,816 clients were educated about their enrollment options and that 9,101 (54%) made a voluntary enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed 1,806 one-to-one client informational sessions- 1,784 in HRA sites and 22 in nursing home facilities. CMU monitors reported the following:

- 1,220 (68%) clients received requested general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.
- 564 (31%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.
- 17 (1%) nursing home clients made voluntary enrollment choice and 5 (0.3%) received general information.

Infractions were observed for 30 (5%) of the 564 observed plan selection sessions conducted by NYMC Field Customer Service Representatives (FCSRs). Infractions most often noted were failure to disclose or explain the following:

- Good Cause Transfer;
- Preventive Care;
- How to choose a health plan; and
- Health Assessment Form.

Of the 564 FFS clients reported as making an enrollment choice during an informational session, 133 (24%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choosing and appropriate notices were mailed in a timely manner.

Auto-Assignment Outreach

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients selected for plan auto-assignment. CMU monitored 157 outreach calls conducted by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 65 (41%) FFS clients made a voluntary phone enrollment choice for themselves and their family members.
- Undecided: 92 (59%) FFS clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician.

The following infractions were identified for the outreach calls conducted by the FSCRs:

- Failed to explain specialist and standing referral processes;
- Did not restate to the client her/his health plan and/or PCP choice;
- Failed to explain how to use the plan ID card.

CMU randomly selected 216 clients auto-assigned to plans and reviewed the outreach conducted and documented by NYMC. CMU confirmed that 100% of the clients received the requisite number of 3 outreach calls and the appropriate notices were mailed in a timely manner.

NYMC HelpLine Observations

CMU monitors the NYMC HelpLine for Mainstream Medicaid managed care products only. NYMC reported that 76,683 calls were received by the Helpline and 70,128 or 91% were answered. Calls answered were handled in the following languages -English: 51,398 (73%); Spanish: 11,532 (16.4%); Chinese: 3,840 (5.4%); Russian: 1,030 (1.5%); Haitian: 106 (0.15%); and other: 2,222 (3.1%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,549 recorded calls answered for Mainstream clients by Customer Service Representatives (CSRs). The call observations were categorized in the following manner:

- General Information: 1,836 (72%) FFS clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 271 (11%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 255 (10%) plan enrollees requested to change their plan.
- Public Calls: 187 (7%): Callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment.

Infractions/issues were identified for 619 (24%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 332 (54%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 113 (18%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 174 (28%) - CSRs put consumers on hold without an explanation or did not offer additional assistance.

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 targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Health Plans

- Effective July 1, 2016, the following Medicaid Managed Care Plans commenced offering the Health and Recovery Plan (HARP) product line in all non-New York City counties within their respective service areas:
    - Affinity Health Plan, Inc.
    - Capital District Physicians Health Plan, Inc.
    - Excellus Health Plan, Inc.

- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthPlus, LLC
- Independent Health Association, Inc.
- MVP Health Plan, Inc.
- New York State Catholic Health Plan, Inc.
- Today's Options of New York
- UnitedHealthcare of New York, Inc.
- YourCare Health Plan, Inc.

Changes to Certificates of Authority (COA)

- **MVP Health Plan** – The COA was amended to reflect approval of the plan's expansion of its Medicaid Managed Care, Health and Recovery Plan, and Child Health Plus products to include Columbia, Greene, Lewis, Oneida, Putnam, and Washington counties effective September 9, 2016.

B. Surveillance Activities

Surveillance activity completed during the 4th Quarter FFY 2015-2016 (07/01/16 to 09/30/16) include the following:

- One (1) Targeted Operational Survey was completed during the 4th Quarter FFY 2015-16. A Statement of Deficiencies (SOD) was issued and a Plan of Correction (POC) was accepted for one (1) Plan:

  - Excellus Health Plan

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

Final reports have been submitted for all of the reviews except for the one involved in litigation. There are no changes from the last update.

- 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 Redeterminations 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 specialized plans that include staff with enhanced behavioral health expertise. For Medicaid Managed Care (MMC), all Medicaid-funded behavioral health services for adults, with the exception of services in Community Residences, 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) has begun phasing in enrollment of current MMC enrollees throughout New York State into HARPs beginning with adults 21 and over in New York City. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care. All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) have been made available to eligible HARP and HIV SNP enrollees. These services are designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery.

Enrollees must undergo an assessment to determine BH HCBS eligibility as well as eligibility for specific BH HCBS. Effective January 2016 in NYC and October 2016 for the rest of the state,

BH HCBS were made available to eligible individuals. DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) are continuing to meet biweekly with managed care plans and behavioral health providers across the State to discuss stakeholder concerns and implementation challenges. The State plans to continue these meetings throughout the transition period. In addition, the State has contracted with the Managed Care Technical Assistance Center (MCTAC) to provide technical assistance to behavioral health providers in New York State, including technical assistance around billing managed care, contracting with managed care plans, and the new BH HCBS. The State has also provided education to Medicaid recipients throughout New York State about the changes to behavioral health that may affect them and is continuing consumer education efforts.

During the reporting period, the State has continued to provide ongoing technical assistance across the State during the initial BH HCBS implementation period to Health Homes and Managed Care Organizations related to the completion of assessments and person-centered plans of care and delivery of the new BH HCBS. As of October 11, 2016, 1,247 care managers in NYS have completed the required training for conducting BH HCBS assessments. Also as of September 23, 2016, 3,092 brief assessments and 870 full assessments have been completed.

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

During the 4th quarter, the New York State Department of Health, School Based Health Center (SBHC) providers, managed care plans, and other stakeholders continued to work together on the process of planning the transition of SBHC services to managed care, which is scheduled effective July 1, 2017. At the September 14, 2016 meeting, the workgroup agreed upon a finalized policy paper and established three subgroups to identify implementation issues and propose solutions: Credentialing and Contracting; Claims and Billing; and Quality Improvement, Utilization Management and Care Coordination. Subgroup meetings will begin in October and November 2016, and in addition to addressing implementation issues, the subgroups will draft responses to “Frequently Asked Questions” related to the transition.

C. Federally Qualified Health Services (FQHC) Lawsuit

The Southern District of New York upheld the primary elements of DOH’s methodology for reimbursing FQHCs, and the Court of Appeals affirmed except it remanded for the purpose of determining whether DOH’s supplemental rate methodology adequately accounts for visits not paid for by the MCOs. In September 2016, the SDNY reopened discovery on the limited question of what information is included in the Managed Care Visit and Revenue Report and how DOH treats such information in calculating the FQHCs’ supplemental rates.

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 quarterly period July 2016 through September 2016, there was no plan activity in terms of plan openings, closings, mergers, or service area expansions or withdrawals. During the annual period of October 2015 through September 2016, service area expansions were approved for Total Senior Care PACE and RiverSpring at Home. In addition, Fallon Health Weinberg was approved to offer a PACE line of business. Lastly, a new health plan, Elderwood Health Plan MLTC, received approval to begin operations.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the rate at which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. For the quarterly period July 2016 through September 2016, post enrollment surveys were completed for 35 enrollees. 79% of respondents indicated they continued to receive services from the same caregivers once they became members of an MLTCP. This represents an increase in affirmative responses from 68% during Q3. Most of the reasons for not continuing to receive services from the same caregiver were a result of consumer choice rather than any particular problem.

- **Enrollment:** Total enrollment in MLTC Partial Capitation Plans grew from 154,415 to 161,809 during the quarterly period July 2016 through September 2016. For that period, 12,313 individuals who were being transitioned into Managed Long Term Care from fee for service made an affirmative choice, bringing the 12-month total for affirmative choice to 55,972. Plan-specific enrollment on a monthly basis for the annual period of October 2015 through September 2016 is submitted as an attachment.

2. Significant Program Developments

    - During the quarterly period July 2016 through September 2016, full operational audits of four MLTC partial capitation plans were completed. Statements of Deficiency (SODs) and Plans of Correction (POCs) are currently pending as a result of those surveys. Focused surveys for two MLTC partial capitation plans were also completed during this quarter. Again, SODs and POCs are pending as a result of those surveys. Focused surveys of member services were completed on all partial capitation plans during this quarter. SODs related to member services are not issued separately but are incorporated into the SODs resulting from operational or focused surveys.

    - During the annual period October 2015 through September 2016, a dedicated Managed Long Term Care (MLTC) Surveillance Unit was created to monitor and improve the quality of plan operations and service delivery. Standardized surveillance

procedures were developed and then carried out during seven operational surveys and nine focused surveys. Team members were simultaneously trained to assess, monitor and evaluate all aspects of quality assurance and improvement. Monitoring activity and processes are continually evaluated and refined. Surveillance activity during this reporting period was concentrated on Partial Capitation Plans, with training for the monitoring of Medicaid Advantage Plus (MAP) Plans in development. Routine surveillance of MAP plans is anticipated to begin during 2017.

3. Issues and Problems

    - There were no issues or problems to report for the quarterly period July 2016 through September 2016. While the annual period October 2015 through September 2016 began with enhanced support for counties new to MLTC, support was no longer needed by the end of the period. Effective October 1, 2015, the transition of the permanent nursing home population into MLTC was expanded to include voluntary option for residents who were permanently placed prior to effective date of the transition. In the past, district-specific support has been offered and provided upon request, along with a number of training sessions and educational opportunities to reinforce basic protocols. Such support and training has not been requested during the last two quarters of this period.

4. Summary of Self Directed Options

    - The transition of consumers receiving Consumer Directed Personal Assistance Service (CDPAS) was achieved during the October 2013 through September 2014 period. Self-direction is provided within the MLTCP as a consumer choice and gives individuals and families greater control over services received. Plans continue to be required to contract with a minimum of two (2) Fiscal Intermediaries in each county. The requirement continues to be monitored on a quarterly basis, and all plans are meeting that requirement.

5. Required Quarterly Reporting

    - **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. There were 230 critical incidents reported for the quarterly period July 2016 through September 2016, representing an increase from 192 incidents reported during Q3. During the annual period October 2015 through September 2016, enrollment in plans has grown, and it has been determined that the increase in critical incidents is in proportion to the increased enrollment during this period.

    - **Grievance and Appeals:** For the quarterly period July 2016 through September 2016, key areas of concern remain transportation and dissatisfaction with quality of home care.

Period: 7/01/16 - 9/30/16			
Number of Recipients: 171,142	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	5,690	5,690	100%
# Standard/Expedited	2,504	2,606	104%
Total for this period	8,194	8,296	101%

Appeals	10/15-12/15	1/16-3/16	4/16-6/16	7/16-9/16	Average for Four Quarters
Average Enrollment	146,196	154,436	162,888	171,142	158,666
Total Appeals	1,392	1,096	1,247	1,266	1,251
Appeals per 1,000	10	7	8	7	8
# Decided in favor of Enrollee	393	181	211	393	295
# Decided against Enrollee	637	514	697	640	622
# Not decided fully in favor of Enrollee	476	337	264	117	299
# Withdrawn by Enrollee	32	15	22	16	21
# Still pending	91	171	171	259	173
Average number of days from receipt to decision	13	12	11	12	12

Grievances and Appeals per 1,000 Enrollees
By Plan and Product Type
July 2016 – September 2016

Plan Name:	Plan Type	Enrollment	Total Grievances	Grievances per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plans						
Aetna Better Health	Partial	3,825	69	18	6	2
AgeWell New York ,LLC	Partial	7,080	255	36	4	1
AlphaCare of New York Inc.	Partial	2,979	290	97	21	7
Amerigroup	Partial	3,590	57	16	-	-
ArchCare Community Life	Partial	2,137	222	104	12	6
CenterLight Healthcare Select	Partial	5,348	249	47	7	1
Centers Plan for Healthy Living	Partial	6,970	188	27	24	3
Elant Choice	Partial	850	6	7	-	-
ElderServe Health, Inc.	Partial	10,936	291	27	5	-
Elderwood	Partial	33	6	184	-	-
Extended	Partial	1,407	42	30	2	1
Fallon Health Weinberg	Partial	364	3	8	-	-
FIDELIS Care New York	Partial	15,062	548	36	6	-
GuildNet MLTCP	Partial	16,594	939	57	239	14
Hamaspik Choice	Partial	1,811	21	12	15	8
HomeFirst MLTC, a product of Elderplan	Partial	11,251	1,432	127	65	6

I Circle	Partial	1,427	29	20	3	2
Independence Care Systems	Partial	6,238	188	30	119	19
Integra MLTC	Partial	3,940	37	9	15	4
Kalos, dba First Choice Health	Partial	810	16	20	-	-
Metroplus	Partial	1,240	40	32	2	2
Montefiore Diamond Care	Partial	1,185	94	79	3	3
NSLIJ Health Plan	Partial	3,737	47	13	1	-
Prime Health Choice, LLC	Partial	201	17	84	1	5
Senior Health Partners	Partial	12,652	324	26	255	20
Senior Network Health	Partial	511	17	33	-	-
Senior Whole Health	Partial	5,659	92	16	5	1
United Healthcare Personal Assist	Partial	2,406	118	49	2	1
VillageCareMAX	Partial	6,506	762	117	10	2
VNA Homecare Options, LLC	Partial	2,653	-	-	1	-
VNSNY CHOICE MLTC	Partial	13,897	725	52	321	23
Wellcare	Partial	6,190	110	18	4	1
Total:		159,491	7,234	45	1,148	7
Medicaid Advantage Plus (MAP)						
Elderplan	MAP	1,113	213	191	8	7
Fidelis Medicaid Advantage Plus	MAP	129	1	8	-	-
GuildNet GNG	MAP	660	60	91	10	15
Healthfirst CompleteCare	MAP	3,902	200	51	90	23
HEALTHPLUS AMERIGROUP	MAP	2	-	-	-	-
Senior Whole Health	MAP	117	4	34	1	9
VNSNY CHOICE MLTC TOTAL	MAP	157	-	-	1	6
Total:		6,079	478	79	110	18
Program of All-inclusive Care for the Elderly (PACE)						
ArchCare Senior Life	PACE	514	53	103	3	6
Catholic Health LIFE	PACE	223	14	63	-	-
CenterLight Healthcare	PACE	3,197	224	70	2	1
Complete Senior Care	PACE	126	14	111	-	-
Eddy SeniorCare	PACE	188	37	197	-	-
ElderONE	PACE	669	76	114	1	1
Fallon Health Weinberg	PACE	50	10	200	-	-
Independent Living Services of CNY (PACE CNY)	PACE	492	38	77	2	4
Total Senior Care	PACE	113	10	89	-	-
Total:		5,572	476	85	8	1
Total for All Products:		171,142	8,188	48	1,266	7

Total Grievances reported decreased from 9,181 during the third quarter to 8,188 during the quarterly period from July 2016 through September 2016. As mentioned last quarter, one plan's increase in enrollment, temporary discontinuation of a transportation provider, and temporary issues with the transportation provider's implementation of a new phone system had caused a

spike in complaints during Q3. Once those issues were resolved, the plan noticed a significant decrease in complaints, which is reflected in the overall number of grievances reported in Q4. For the annual period October 2015 through September 2016, the number of grievances fluctuated somewhat. As a result, grievance data will continue to be monitored closely for emerging trends.
The total number of appeals increased very slightly from 1,247 during the third quarter to 1,266 during the quarterly period of July 2016 through September 2016. Fluctuation seen in the number of appeals during the annual period October 2015 through September 2016 is thought to have normalized; however, this data will be monitored to ensure this is the case.

- **Fraud and Abuse:** For the quarterly period July 2016 through September 2016, there were 90 new potential cases of Fraud and Abuse detected, representing a decrease from Q3. The annual period October 2015 through September 2016 included a spike in the number of new potential cases detected during Q2, with a steady decrease since that time. It is reasonable to assume that fluctuation in the number of cases reported during the year represents rebalancing resulting from the Department's efforts to ensure that plans report accurate data. Since the first quarter, the Department has performed enhanced reviews designed to ensure that MLTC plans are making referrals to appropriate investigative agencies.

Fraud and Abuse Complaints	7/16-9/16
New potential cases of Fraud and Abuse detected during the reporting period	90
Open potential cases of Fraud and Abuse from previous quarter being investigated	75
Cases of Fraud and Abuse confirmed during the reporting period	24
Open potential cases of Fraud and Abuse remaining unconfirmed and still being investigated at the end of the reporting period.	105

- **Fair Hearings:**

Fair Hearing Decisions	7/16-9/16
In favor of Appellant	626
In favor of MLTC Plan	82
No Issue	10
Total	718

Fair Hearings: Days From Request To Decision	7/16–9/16
Less than 30 days	35
30 - 60 days	388
61 - 90 days	163
91 – 120 days	79
>120 days	53
Total Fair Hearing Decisions	**718**

During the annual period October 2015 through September 2016, the total number of fair hearing decisions showed some fluctuation; however, the percentage of hearings decided in favor of a plan increased from the beginning of the period.

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

    - During the annual period from October 2015 - September 2016, the TAC had an opportunity to identify areas that needed improvement, and this resulted in training and the development and/or revision of internal policies and procedures. The TAC began to see more email activity during this period; however, the majority of complaints are still received via the TAC telephone line. An increase in the number of inquiries has been noted during the third and fourth quarters, and TAC is monitoring these to determine if they are isolated cases or if a trend is developing.

    - Fourth Quarter Highlights from MLTC-TAC:
      Similar to the previous quarter, Q4 continued to see a higher number of calls pertaining to billing issues. This may be related to overall enrollment growth and an increase in questions from DOH staff and Local District Social Services staff asking for guidance and/or clarification of MLTC policies and procedures. There was also an increase in complaint investigation activity, likely the result of the TAC and Surveillance Units working together to identify cases that require further investigation. TAC will continue to monitor these situations in the next quarter.

      Complaint volume:
      - 413 substantiated complaints
      - 231 unsubstantiated complaints
      - 66 complaints resolved without investigation
      - 710 total complaints
      - 406 inquiries
      - 1116 total call volume

      Complaint investigation activity:
      - Resulted in eleven (11) targeted corrective action plan
      - Issues were related to:
        - Disenrollment due to placement

- Education - benefits explanation
- Enrollment application – not processed timely
- Enrollment - assessment, problem with plan-to-plan transfer, and non-consensual enrollment
- Grievance/complaint - notice incorrect or incomplete and denial for increase of care
- Referral – difficulty obtaining DME

➢ Impacted Regions: Broome, Chemung, Genesee, Kings, Monroe, New York, Suffolk and Wyoming counties

- **Evaluations for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the quarterly period July 2016 through September 2016, 10,158 people were evaluated, deemed eligible and enrolled into plans. The annual period October 2015 through September 2016 saw quarterly increases in the number of individuals who were evaluated, deemed eligible and enrolled into plans, with a total of 21,612 for the period.

- **Referrals and 30 day assessment:** For the quarterly period July 2016 through September 2016, 9,604 assessments were conducted by MLTC plans. The total number of assessments conducted this quarter has decreased slightly, as has the percentage of assessments conducted within the 30-day time frame, which was at 85%. During the annual period October 2015 through September 2016, a total of 39,983 assessments were conducted by plans and, on average, 83% 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 continues to be monitored.

- **Referrals outside enrollment broker:** During the quarterly period July 2016 through September 2016, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 13,571, a decrease from 14,263 in Q3. The annual period October 2015 through September 2016 saw fluctuations between a low of 11,481 in Q1 and a high of 14,263 in Q3.

- **Rebalancing efforts:**

Rebalancing Efforts	7/16-9/16
New Enrollees to the Plan from a nursing home transitioning to the community	480
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,098
Current plan Enrollees permanently placed in a nursing home	5,040
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,161

During the quarterly period July 2016 through September 2016, the number of current plan enrollees permanently placed in a nursing home increased by 1,289. During the annual period October 2015 through September 2016, an increase in membership returning to the community from nursing homes was noted. It is likely that the increase in this number related to the transition of permanently placed nursing home residents into managed care.

VI. Evaluation of the Demonstration

The evaluation of the demonstration is being reviewed and revised as part of the 1115 Renewal process.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 6,035 complaints/action appeals this quarter, a decrease of 3.1% from the previous quarter. The most frequent category of complaint/appeal was balance billing disputes, accounting for 19% of the total. There were 130 complaints/appeals reported by the HIV SNPs. The majority of these complaints (40) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 367 Medicaid managed care complaints this quarter.

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

19% Balance Billing
17% Reimbursement/Billing Issues
16% Advertising/ED/Outreach/Enrollment
9% Dissatisfaction with Quality of Care
9% Dental or Orthodontia

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	1
Consumer Directed Personal Assistant	0
Home Health Care	11
Non-Permanent Residential Health Care Facility	1
Personal Care Services	9
Personal Emergency Response System	0
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 6,035 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 614 complaints and action appeals from their SSI enrollees. This compares to 698 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	23%
Quality of Care	15%
Balance Billing	11%
Advertising/ED/Outreach/Enrollment	9%
All Other	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	1
Advertising/Education/Outreach/Enrollment	56
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	5
Balance Billing	68
Communications/Physical Barrier	3
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	29
Dental or Orthodontia	144
Emergency Services	10
Eye Care	2
Family Planning	0
Home Health Care	7
Mental Health/Substance Abuse Services/ Treatment	4
Non-covered Services	20
Non-Permanent Resident Health Care Facility	0
Personal Care Services	6
Personal Emergency Response System	0
Pharmacy	10
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	44
Quality of Care	91
Recipient Restriction Program/Plan Initiated Disenrollment	1

Reimbursement/Billing Issues	45
Specialist or Hospital Services	4
Transportation	5
Waiting Time Too Long at Office	0
All Other Complaints	56
Total:	**614**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met in person in New York City on September 29, 2016. The meeting included presentations provided by state staff and discussions of the following: a presentation of the Department's publicly available "2015 Quality Incentive for Medicaid Managed Care Plans – A Report on the Quality Incentive Program in New York State," which includes an overview of plan performance for selected measures and the quality incentive awards based on plan performance; a discussion of current auto assignment statistics and state and local district outreach and other activities aimed at reducing auto assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs, an update on activities related to operationalizing Community First Choice Option (CFCO), and efforts associated with the transition of the Nursing Home Transition and Diversion (NHTD) and the Traumatic Brain Injury (TBI) waiver programs into managed care; and updates on the integration of mental health and substance use disorder services into the mainstream Medicaid managed care benefit package, the initiation of the Health and Recovery Plan (HARP) line of business in the Rest of State (ROS) on July 1, 2016, and the upcoming availability of Behavioral Health Home and Community Based Services (BH HCBS) on October 1, 2016 for eligible enrollees in ROS; and a presentation on opportunities for and activities related addressing the opioid crisis in New York. The next MMCARP meeting is scheduled for December 1, 2016.

B. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on July 21, August 11 and September 8, 2016. The July meeting included the following: an update on the children's health and behavioral health managed care transition and Rest of State adult enrollment in Health and Recovery Plans (HARPs), and a review of New York City behavioral health claims statistics; an overview of risk adjustment and factors affecting Medicaid managed care (MMC) and Managed Long Term Care (MLTC) capitation rates; updates on MLTC and Fully Integrated Duals Advantage (FIDA) enrollment and program activities, including Conflict-Free Evaluation and Enrollment Center statistics; a review of the activities related to the scheduled transition to managed care of the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waiver programs; a status update on Community First Choice Option (CFCO) implementation activities; an update on the Delivery System Reform Incentive Payment (DSRIP) program, including timelines and access to the DSRIP Dashboard; an update on completed and scheduled Value Based Payment (VBP) boot camps; and an overview of the New York State Medicaid Incontinence Supply Management program, a Medicaid Redesign Team (MRT) initiative designed and implemented to improve

the quality of incontinence products provided to all Medicaid enrollees by establishing minimum product quality standards for adult and youth size diapers and reducing costs for incontinence products while maintaining the existing durable medical equipment and pharmacy provider network. The August meeting agenda included: an update on the April 2016 - March 2017 mainstream MMC and MLTC premium rates, including an overview of the rate methodology, rate development, current status of rates, and anticipated adjustments to the April rates; updates on MLTC and FIDA enrollment, including an overview of types and numbers of MLTC plans by county, activities of the Conflict-Free Evaluation and Enrollment Center (CFEEC), and the status of CFCO implementation; and an update on the DSRIP program. Presentations, updates and discussions at the September meeting included: a presentation on the Department's plans to include hemophilia blood factor in the Medicaid managed care benefit package and premium rates effective April 1, 2017; an overview of the HARP enrollment process and related permissible member education, and an update on the children's managed care transition; an update on health homes, including an overview of children's health home design; updates on CFCO, FIDA, MLTC, and workgroup activities related to the NHTD and TBI Waiver transition to managed care; and highlights of DSRIP activities. Managed Care Policy and Planning meetings during Federal Fiscal Year first quarter were scheduled for October 13, November 10, and December 8, 2016.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

Quality Assurance Reporting Requirements (QARR)
26 health plans submitted Quality Assurance Reporting Requirement (QARR) data on June 15, 2015. This includes 14 of Qualified Health Plans operating through the New York State of Health Marketplace with enough eligible populations to report quality data. Data has been reviewed for completeness and accuracy and final results were published this quarter on our eQARR webpages and our consumer guides data. These reports are available here
http://health.ny.gov/health_care/managed_care/reports/index.htm

B. Quality Improvement

External Quality Review
As NYS's External Quality Review Organization (EQRO), the Island Peer Review Organization IPRO conducts Medicaid managed care external quality review as required by the Balanced Budget Act of 1997, and CMS regulations. In that role, IPRO conducts Medicaid managed care external quality review activities on behalf of the state including: 1) Validation of performance improvement projects (PIPs); 2) Validation of performance measures; and 3) Review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement. In addition to these federally required activities, New

York State DOH contracts with IPRO to conduct optional external review activities including: 1) Validating encounter and functional assessment data reported by the MCOs; 2) Administering or validating consumer satisfaction surveys; 3) Calculating performance measures in addition to those conducted by the MCO; 4) Conducting focused clinical studies; and 5) Implementation of PIPs required by the State in addition to those conducted by the MCO. IPRO will continue to serve in this role for the duration of the five-year contract, ending January 31, 2020.

Over the past year, IPRO initiated the 2016 Access and Availability survey, designing the survey tool and initiating phone calls in October of 2016. They completed a 2016 Provider Directory survey and issued health plans their final 2015 and 2016 Provider Directory Survey reports. In early 2016, PCP Ratio Survey results from 2015 were issued to health plans, and IPRO coordinated collection of Corrective Action Plans. They worked closely with the DOH to address concerns risen by MMC plans related to survey methodology and resultant statements of deficiency when issues were identified. They worked on templates for the next PCP Ratio Survey and facilitated the incorporation of HARP and Nursing Home components into an online provider directory managed through a subcontract with 3M (TREO solutions).

They also began work on developing our new Provider Network Data Collection System (PNDS), complete with panel data reporting tool and data retrieval utilities. They established third party sub contracts to outsource necessary components of these projects. Meanwhile, they continued to oversee the ongoing collection of these data through the old system.

In early 2016, IPRO initiated planning and survey development for an Encounter Data validation project, which was subsequently postponed.

Throughout 2016, IPRO oversaw completion of Managed Long Term Care (MLTC) 2015 PIP final reports, and oversaw the initiation and administration of three (2016) MLTC PIPS, reviewing proposals and coordinating activities. For MMC PIPS, IPRO held ongoing conference calls and meetings with MMC plans throughout the year to discuss 2016 PIP related activities. They also developed training materials for HARP administrators who will be conducting PIPs for the first time in 2017. Additional information on MMC PIPs can be found under the Performance Improvement Project description.

Work on a Prenatal Care quality improvement project was also ongoing, with IPRO oversight of cohort identification, tool development, data collection, analysis, report generation, conference/webinar administration, and presentation of results. This time period saw completion of Cohort 1 from 2014, development of provider letters and a training for Cohort 2, and completion of a new platform for data entry.

IPRO’s oversight (external quality review) of performance measurement (QARR) included: managing revision and changes in the Data Submission System for MMC,

SNPs, and QHPs; auditing source code; providing MCOs with technical assistance, auditing data submitted by MCOs; preparing data files for the DOH; preparation of new measures for the 2016 reporting year; conducting a technical specifications webinar for MCOs; and producing Access and Utilization Reports. IPRO also assisted in development of a Care Management data collection system (CMART), and associated test files, facilitating planed onboarding of the system. Finally, IPRO facilitated, through a subcontract with DataStat, the completion of the 2015 child CAHPS survey reports (MMC member satisfaction) and administration of a 2016 adult CAHPS survey. They also prepared an audit of the state's Uniform Assessment System (UAS), piloting the project with data from a sample of Traumatic Brain Injury (TBI) centers. This work is ongoing.

In this year, IPRO worked on development and revision of 33 MLTC plan technical report drafts and 17 MMC plan and 3 HIV SNP plan PTRs, including two All Plan Summary reports, finalizing a total of 22 reports, which were subsequently made available to the public on the DOH's Medicaid managed care reports webpage.

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 Medicaid managed care (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. Interventions have been implemented when the proposals were accepted in April 2015. Individual plan specific conference calls with IPRO and the MCOs were conducted in February 2016 and June 2016. New York State Department of Health participated in these calls, with the health plans and IPRO, when there was a concern about the plans progress with implementation. A conference call was held August 11, 2016 with all of the Medicaid managed care plans, IPRO and representatives from the NYS DOH Bureau of Tobacco Control, DPIPS and the Office of Mental Health. 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. The next call for October 2016 will include four additional Medicaid managed care plans presenting on their Smoking Cessation PIP progress.

Breast Cancer Selective Contracting

Staff successfully completed the Breast Cancer Selective Contracting process for contract year 2016-2017. Inpatient and outpatient surgical data extracted from the Statewide Planning and Research Cooperative System (SPARCS) were analyzed to identify low-volume restricted, low-volume access, and high-volume facilities. In total, the annual review identified 254 facilities. Facility designations were as follows: 118 high-volume facilities, 25 low-volume access facilities, 69 low-volume restricted facilities, and 42 closed facilities. Appeals were received from 2 low-volume restricted facilities, of which both were denied.

Results were shared with the following stakeholders: restricted facilities; staff at eMedNY who ensure restricted facilities are denied Medicaid fee-for service payment; and, Medicaid managed care health plans' Chief Executive Officers and Medical Directors. Additionally, staff gave a presentation at the October Medical Directors' Meeting to update health plan leaders on policy implementation and remind them of their responsibility to send members to approved facilities.

Staff also completed the summer review of breast cancer surgical volume designations and the results were shared with facilities' SPARCS coordinators in August 2016. The release of these data will give the facilities ample time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

In addition, staff have updated computer programs to include ICD-10 codes to be used in fall 2016 to identify low-volume, restricted facilities for the 2017-2018 contract year.

Patient Centered Medical Home (PCMH)

As of September 2016, there were 6,451 NCQA-recognized PCMH providers in New York State. Approximately 43% (2,782) of current PCMH providers are recognized under the newest 2014 set of standards. Between February and September, the percentage shift of providers recognized under the newest standards increased from 0% to 43%. We expect to see a continued increase in providers recognized under the 2014 standards due to incentives encouraging practices to strive for the highest PCMH standard. The current incentive for the New York Medicaid PCMH Statewide Incentive Payment Program is:

- 2011 level 2: $2 PMPM
- 2011 level 3: $4 PMPM
- 2014 level 2=$6 PMPM
- 2014 level 3=$8 PMPM

DSRIP requires practices to become 2014 level 3 PCMH or Advanced Primary Care (APC) recognized by March 21, 2018. PCMH penetration within DSRIP is measured each quarter. As of June 2016, 13% of DSRIP PCPs met the PCMH/APC requirement. Currently, there are no providers that are APC recognized.

PCMH recognitions under the 2011 standards are phasing out. It is estimated that around 750 practices will have active recognitions under the 2011 standards after 12/31/2016, and the overwhelming majority will expire by mid-2018. Practices will need to convert to the 2014 or 2017 standards in order to continue to participate in the Medicaid Statewide incentive program.

The NYS DOH OQPS ran an analysis that showed providers with higher Medicaid patient panels are more likely to have PCMH recognition in New York State compared to providers with lower Medicaid patient panels. This is most likely due to the incentive programs described, as they only pertain to Medicaid. APC is a multi-payer initiative that may shift this trend, incentivizing practices with smaller Medicaid patient panels to adopt a more patient-centered model.

The Adirondack Medical Home demonstration (‘ADK’), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers and will continue through the end of 2016. Discussions continue to occur around continuing the demonstration post 12/31/2016 and there is a general commitment across payers and providers to continue for another three years with aligned methods for an additional incentive. In the first year, 2017, payers will continue to provider practices $7PMPM, however all payments will be made to the Adirondack Accountable Care Organization (ACO). The ACO will also be responsible for maintaining the funds and distributing among the participating practices in the region, as well as coordinating information between payers and providers. In 2018, half of the $7PMPM will be at risk. Payers and providers will share savings. Shared savings methodology is still in negotiation for 2019, although all payers besides Medicare will continue participation. Additionally, the governance committee is pursuing a new data warehouse vendor, Health Catalyst, to evaluate the demonstration. Conversations around the pay-for-performance component to the demonstration continue.

The practices participating in the Adirondack Medical Home demonstration (ADK) have committed to achieving NCQA PCMH recognition under the 2014 standards. Practices must achieve at least level 2 under these standards. Two new medical groups will be joining the demonstration in 2017 and are required to meet this goal in order to guarantee their admission into the demonstration community.

The September 2015, December 2015, and March 2016 Statewide quarterly reports were posted to the DOH website this past year. All quarterly and annual reports on

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

In June 2016 a Medicaid Update article was released clarifying which patient populations are included in the PMPM incentive payments and which patient populations should not be included in the incentive. https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-06.htm#medhome.

IX. Transition Plan Updates

No updates.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

The budget neutrality quarterly report is not available because NY is in the process of updating the specifications manual. There is an understanding with CMS that NY will work on updating the specifications manual before completing the quarterly reports; if not, the quarterly reports will be completed with inaccurate information.

B. Designated State Health Programs

No updates.

XI. Other

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

New York has been working very closely with CMS on parallel Pre-Operational Readiness Testing (PORT) and Operational Readiness Testing (ORT) for T-MSIS Release 2.0. The triage and resolution of PORT and ORT results is in process. After receiving production approval from CMS, New York will begin submitting daily files for production catchup.

B. **1115 Waiver Public Comment Day - New York City**

On May 4, 2016, DOH hosted a Public Comment Day in New York City which allowed for public comment on broad topics in the 1115 waiver, including DSRIP. A total of 39 speakers provided comment:

- 56% represented CBOs and included organized labor representatives. Concerns they expressed included: not receiving funding in a timely manner and that CBOs are being used as free consultants (they are not compensated for time and expertise)

- 11% represented PPSs as well as primary agencies. They expressed a need for capital to foster Primary Care, which is fundamental to the delivery of healthcare, as well as the need for a definition of Health Equity, Cultural Competency, and CBO diversity.
- A group of speakers raised concerns about water fluoridation. However, as the scope of the waiver does not cover this issue, NYS will seek to provide other avenues to address their concerns.

Specific issues discussed include the following:

- Workforce issues – training and retraining is not at the table; DSRIP information is being shared on a limited basis to downstream partners of the PPS
- Lack of data regarding people with disabilities; specific comments that healthcare should accommodate people with disabilities
- CBOs – Include CBOs to specifically address social determinates of health at a local level, such as to address racism, housing, and immigration. CBOs need resources for strategic planning; CBOs are not regularly included in PPS or Managed Care governance
- Need to align Medicaid, CHIP and Medicare
- Not enough time in DSRIP between DSRIP years 3-4 to make substantive corrections
- Address social determinants, gather housing data to track participants living with HIV
- Data is lost when blending services – cannot document where uninsured access care.

Several commenters provided written statements during and after the forum. These comments are archived in the following location:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/1115_mwpcd_via%20email.pdf.

C. **1115 Waiver Public Comment Day – Albany, NY**

On July 12, 2016, DOH hosted another Public Comment Day in Albany, NY which allowed for public comment on broad topics in the 1115 waiver including DSRIP. A total of 9 speakers provided comment.

- 4 speakers representing PPSs spoke about their experiences, and provided feedback from physician practices and other PPS partners.
- 2 speakers discussed the County/Public Health experience in DSRIP.
- 2 speakers raised concerns about fluoridation in water.
- 1 speaker touch on CBO funding concerns.

Specific issues discussed include the following:

- Discussed how the PPS have helped integration with physicians and identifying barriers in establishing best practices. One speaker touched on how the PPS and DSRIP is helping people with disabilities, and including Behavior Health providers in the planning process.

- Issues with state aid and county revenue for core public health services provided. Local Health Departments are not eligible for state aid regarding early intervention programs, which directly interfaces with the Medicaid population. Local Health Departments are actively involved in local PPS regarding data analysis & process contribution and have educators in communities and schools, opiate prevention, home care services & mental health clinics, maternal child home visitation, tobacco cessation, promote healthy families nutrition programs within WIC.
- Inconsistent inclusion in Governance within PPS for Nurses Association and clarity requested on patient care issues such as care management, titles, roles, personnel, training, interaction with clinical staff at acute/subacute facilities, etc.
- DSRIP funds being spent within clinical services where they should be aligned with social determinates of health. Concern with 5% cap to non-Safety Net providers, and CBOs are nontraditional partners. Feedback from CBO study indicates more CBO engagement is requested. Concerns about CBO roles.
- Bi-Annual Quarterly Reporting requested.
- Concerns Medicare rating bumps up against DSRIP initiatives. County Health perspective on staff hiring and data retrieval issues while completing daily tasks and working without reimbursement.

Several commenters provided written statements during and after the forum. These comments are archived in the following location:

http://www.health.ny.gov/health_care/medicaid/redesign/2016/docs/2016-07-02_1115waiver_written_comments.pdf

With the implementation of the Medicaid Redesign Team in 2011, New York has prioritized transparency and public engagement as a key element of developing and implementing Medicaid policies. The public comments provided at these forums has been shared with the New York teams working on these programs and has informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

Attachments:
Attachment 1 - MLTC Partial Capitation Plans

State Contact:
Priscilla Smith
Medical Assistance Specialist III
Division of Program Development and Management
Office of Health Insurance Programs

priscilla.smith@health.ny.gov
Phone (518) 486-5890
Fax# (518) 473-1764

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Managed Long Term Care
Partial Capitation Plans
October 2015-September 2016

Plan Name	Oct-15 Enrollment	Nov-15 Enrollment	Dec-15 Enrollment	Jan-16 Enrollment	Feb-16 Enrollment	Mar-16 Enrollment	Apr-16 Enrollment	May-16 Enrollment	Jun-16 Enrollment	Jul-16 Enrollment	Aug-16 Enrollment	Sep-16 Enrollment
Aetna Better Health	3,258	3,303	3,363	3,447	3,530	3,583	3,629	3,688	3,746	3,817	3,816	3,843
AgeWell New York	5,274	5,471	5,666	5,895	6,125	6,334	6,502	6,674	6,800	6,949	7,084	7,207
AlphaCare	2,025	2,082	2,176	2,230	2,347	2,490	2,634	2,765	2,856	2,920	2,977	3,041
ArchCare Community Life	1,926	1,943	1,973	2,017	2,035	2,059	2,061	2,081	2,099	2,131	2,133	2,147
CCM Select	5,732	5,745	5,652	5,590	5,571	5,556	5,521	5,490	5,452	5,428	5,402	5,215
Centers Plan for Healthy Living	3,684	3,881	4,198	4,490	4,850	5,278	5,580	5,910	6,271	6,602	6,978	7,331
Elant	866	868	860	866	861	866	880	854	851	860	856	834
Elderplan	10,667	10,666	10,599	10,647	10,711	10,742	10,780	10,861	11,007	11,132	11,219	11,403
Elderserve	10,625	10,678	10,643	10,685	10,718	10,755	10,819	10,860	10,923	10,921	10,921	10,966
Elderwood	0	0	0	0	0	0	0	6	12	24	34	40
Extended MLTC	754	821	874	915	954	999	1,042	1,086	1,191	1,293	1,398	1,529
Fallon Health Weinberg (TAIP)	198	206	225	237	249	272	257	260	304	326	376	389
Fidelis Care at Home	10,134	10,747	11,243	11,735	12,067	12,661	13,178	13,707	14,173	14,614	15,051	15,522
Guildnet	14,402	14,557	14,781	16,643	16,708	16,737	16,804	16,823	16,749	16,691	16,614	16,477
Hamaspik Choice	1,202	1,275	1,339	1,398	1,492	1,539	1,599	1,641	1,700	1,764	1,813	1,857
HealthPlus- Amerigroup	2,602	2,669	2,790	2,901	2,971	3,053	3,179	3,281	3,409	3,507	3,594	3,668
HIP of Greater New York	1,288	1,303	1,311	36	11	3	0	0	0	0	0	0
iCircle Services	682	803	883	953	1,018	1,077	1,155	1,217	1,288	1,374	1,432	1,474
Independence Care Systems	5,503	5,647	5,729	5,788	5,840	5,925	5,986	6,042	6,104	6,194	6,241	6,280
Integra	2,660	2,769	2,950	2,886	3,093	3,199	3,289	3,408	3,596	3,740	3,948	4,132
Kalos Health- Erie Niagara	481	498	524	565	604	662	693	743	743	783	805	843
MetroPlus MLTC	897	923	939	978	1,004	1,027	1,062	1,106	1,199	1,219	1,236	1,264
Montefiore HMO	609	658	691	726	771	865	947	1,054	1,123	1,161	1,187	1,206
North Shore-LIJ Health Plan	2,351	2,479	2,585	2,735	2,848	2,965	3,139	3,271	3,445	3,590	3,742	3,880
Prime Health Choice	87	99	102	108	133	149	161	175	181	189	206	209
Senior Health Partners	11,855	12,761	12,759	12,645	12,538	12,463	12,408	12,390	12,452	12,574	12,619	12,762
Senior Network Health	499	490	493	488	495	507	506	503	504	513	508	513
Senior Whole Health	3,188	3,418	3,651	3,863	4,097	4,360	4,672	4,967	5,209	5,405	5,663	5,909
United Healthcare	1,437	1,524	1,633	1,735	1,879	2,014	2,113	2,206	2,306	2,339	2,411	2,469
Village Care	4,440	4,732	4,974	5,186	5,403	5,596	5,869	6,059	6,285	6,390	6,518	6,609
VNA HomeCare Options	1,060	1,212	1,410	1,577	1,693	1,841	1,985	2,112	2,294	2,484	2,666	2,809
VNS Choice	13,278	13,418	13,555	13,732	13,762	13,824	13,913	13,908	13,871	13,911	13,926	13,855
WellCare	7,226	7,201	7,134	7,115	6,837	6,583	6,423	6,376	6,272	6,243	6,201	6,126
TOTAL	**130,890**	**134,847**	**137,705**	**140,812**	**143,215**	**145,984**	**148,786**	**151,524**	**154,415**	**157,088**	**159,575**	**161,809**