

MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 20 (10/1/2016 – 9/30/2017)
Federal Fiscal Quarter: 1 (10/01/2016 – 12/31/2016)

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 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 30,

2021. At the time of renewal, the Partnership Plan was renamed New York Medicaid Redesign Team (MRT) Waiver.

New York is well positioned to lead the nation in Medicaid reform. Governor Cuomo’s Medicaid Redesign Team (MRT) has developed a multi-year action plan ([A Plan to Transform the Empire State’s Medicaid Program](#)) that when fully implemented will not only improve health outcomes for more than five million New Yorkers but also bend the state’s Medicaid cost curve. Significant federal savings have already been realized through New York’s MRT process and substantial savings will also accrue as part of the 1115 waiver.

II. Enrollment: Fourth Quarter

Partnership Plan- Enrollment as of December 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	1,022,928	12,597	93,880
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	126,974	2,897	9,051
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	51,624	668	15,414
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	4,818	109	1,128
Population 5 - Safety Net Adults	763,169	17,402	72,383
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)	35,196	1,938	191
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	202,704	13,746	1,673

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	2,536	295	25
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	57,721	3,414	1,346

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	53,066 or an approximate 31% decrease from last Q

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

During the 1st quarter of FFY 2016 the mainstream plans passively enrolled 12,479 of their own Health and Recovery Plan (HARP) eligible enrollees into their own offspring HARP plan. This represents a significant decline from the 34,304 HARP eligible enrollees passively enrolled during the 4th quarter of FFY 2015. This decline in passive enrollment created a decline in the 1st quarter FFY 2016 mainstream plan voluntary disenrollment, when compared to the prior quarter, since passive enrollment is included in the “Enrolled in Other Plan” category of voluntary disenrollment. In addition, WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers now draw on a smaller WMS population further contributing to a decline in voluntary disenrollment.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	195,091 or an approximate 41% increase from last Q

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

As in prior Quarters WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers draw on a smaller WMS population causing involuntary disenrollment to decline, but in the 1st Quarter of FFY 2016 there was also a significant increase in case closures in the WMS population giving an overall increase in involuntary disenrollment.

Partnership Plan Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
October 2016				
Region	Roster Enrollment	New Enrollment	Auto-assigned	Affirmative Choices
New York City	1,412,967	18,178	2,636	15,542
Rest of State	975,912	15,865	1,722	14,143
Statewide	2,388,879	34,043	4,358	29,685
November 2016				
New York City	1,389,999	22,146	2,883	19,263
Rest of State	924,629	18,290	2,030	16,260
Statewide	2,314,628	40,436	4,913	35,523
December 2016				
New York City	1,370,820	17,200	2,513	14,687
Rest of State	883,227	14,773	1,722	13,051
Statewide	2,254,047	31,973	4,235	27,738
Fourth Quarter				
Region	Total Affirmative Choices			
New York City	49,492			
Rest of State	43,454			
Statewide	92,946			

HIV SNP Plans				
October 2016				
Region	Roster Enrollment	New Enrollment	Auto-assigned	Affirmative Choices
New York City	13,738	128	0	128
Statewide	13,738	128	0	128
November 2016				
New York City	13,675	134	0	134
Statewide	13,675	134	0	134
December 2016				
New York City	13,623	150	0	412
Statewide	13,623	150	0	412
Fourth Quarter				
Region	Total Affirmative Choices			
New York City	412			
Statewide	412			

Partnership Plan Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
December 2016	
Plan Name	Enrollment
Affinity Health Plan	3,360
Capital District Physicians Health Plan	2,084
Excellus Health Plan	5,312
HealthFirst	17,194
HealthPlus	4,890
HIP GNY	4,307
Independent Health Association	1,375
MetroPlus	8,433
MVP Health Plan	3,467
NYS Catholic Health Plan	19,272

Today's Options	1,262
United HealthCare	4,781
YourCare Health Plan	1,317
Total:	77,054

Health and Recovery Plans Disenrollment			
FFY 16 - Q1			
	Voluntary	Involuntary	Total
October 2016	729	415	1,144
November 2016	1,040	449	1,489
December 2016	884	544	1,428
Total:	2,653	1,408	4,061

III. Outreach/Innovative Activities

A. Outreach Activities

NYMC Field Observations

As of the end of the first federal fiscal quarter (end of December 2016), there were 2,603,851 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program. 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 15,802 clients were educated about their enrollment options and that 8,325 (53%) made a voluntary enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed 1,860 one-to-one client informational sessions - 1,832 in HRA sites and 28 in nursing home facilities. CMU monitors reported the following:

- 1,265 (68%) clients received requested general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.
- 567(30%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.
- 19 (1%) nursing home clients made voluntary enrollment choice and 9 (0.5%) received general information.

Infractions were observed for 39 (7%) of the 586 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; or
- Health Assessment Form.

Of the 567 FFS clients reported as making an enrollment choice during an informational session, 240 (42%) 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 (AA) Outreach

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients selected for plan auto-assignment. CMU monitored 274 outreach calls conducted by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 65 (24%) FFS clients made a voluntary phone enrollment choice for themselves and their family members.
- Undecided: 209 (76%) FFS clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician.

Infractions were observed for 14 (5%) of the 274 AA outreach calls. The following infractions were identified for the outreach calls conducted by the FCSRs:

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

CMU randomly selected 360 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 72,493 calls were received by the Helpline and 67,920 or 94% were answered. Calls answered were handled in the following languages - English: 50,858 (75%); Spanish: 10,469 (15%); Chinese: 3,304 (5%); Russian: 962 (1%); Haitian: 117 (.2%); and other: 2,210 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,473 recorded calls answered for Mainstream clients by Customer Service Representatives (CSRs). The call observations were categorized in the following manner:

- General Information: 1,676 (68%) FFS clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 283 (11%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 322 (13%) plan enrollees requested to change their plan.
- Public Calls: 192 (8%): Callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment.

Infractions/issues were identified for 597 (24%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 374 (63%) - 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: 132 (22%) - 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: 91(15%) – 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

Changes to Certificates of Authority (COA)

- There were no changes to Certificates of Authority (COA) during the 1st Quarter of FFY 2016-2017 (10/1/16 to 12/31/16).

Plan Expansions, Withdrawals and New Plans

- During the period October 1, 2016 through December 31, 2016, there were no service area changes for Medicaid Managed Care plans, HIV Special Needs Plans (HIV SNPs) or Health and Recovery Plan (HARPs).

B. Surveillance Activities

Surveillance activity completed during the 1st Quarter of FFY 2016-2017 (10/1/16 to 12/31/16) includes the following:

- One (1) Comprehensive Operational Survey and two (2) Targeted Operational Surveys were completed during the 1st Quarter. One (1) Plan was found in compliance. A Statement of Deficiencies (SOD) was issued and a Plan of Correction (POC) was accepted for two (2) Plans.
 - MVP Targeted (in compliance)
 - IHA Comprehensive
 - CDPHP Targeted

- Eighteen (18) Provider Directory and Provider Information Surveys were completed during the 1st Quarter. Two (2) Plans were found in compliance. An SOD was issued and a POC was accepted for sixteen (16) Plans.
 - Independent Health Association, Inc. (in compliance)
 - Today's Options of New York, Inc. (in compliance)
 - Affinity Health Plan, Inc.
 - AMERIGROUP New York, LLC
 - Amida Care, Inc.
 - Capital District Physicians' Health Plan, Inc.
 - Excellus Health Plan, Inc.
 - Health Insurance Plan of Greater New York
 - HealthFirst PHSP, Inc.
 - HealthNow New York Inc.
 - MetroPlus Health Plan, Inc.
 - MetroPlus Health Plan, Inc. Special Needs Plan
 - MVP Health Plan, Inc.
 - New York State Catholic Health Plan, Inc.
 - UnitedHealthcare of New York, Inc.
 - VNS CHOICE
 - WellCare of New York, Inc.
 - YourCare Health Plan, Inc.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

- 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.

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

B. Benefit Changes/Other Program Changes

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

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

As part of the transition, the New York State Department of Health (DOH) has begun phasing in enrollment of current MMC enrollees throughout New York State into HARPs beginning with adults 21 and over in New York City in October 2015. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered

services available through Medicaid Managed Care. NYS is monitoring plan-specific data in the three key areas of inpatient denials, outpatient denials, and claims payment.

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

1. **Inpatient Denial Report:** Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient behavioral health services based on medical necessity. The report for a calendar month will be due on the 15th day of the next calendar month. The report will include aggregated provider level data for service authorization requests and denials, whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.
2. **Outpatient Denial Report:** MCOs are required to submit on a quarterly basis a report to the State on ambulatory service authorization requests and denials for each behavioral health service. Submissions must include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS. Each quarterly submission contains 3 separate months of data and is due to the State 15 days on the following month after the end of the quarter being reported.
3. **Biweekly Claims Report:** On a biweekly basis, MCOs are required to submit the following for all OMH and OASAS licensed and certified services, and HCBS designated services.

The table below represents claims data for behavioral health services in NYC and Rest of State from implementation to the end of the reporting period.

New York City and Rest of State Mental Health (MH) & Substance Use Disorders (SUD) Claims Stats			
Region	Total Claims	Total Paid Claims	Total Denied Claims
New York City: (10/01/2015-12/19/2016)	6,141,158	83.6%	15.8%
Rest of State: (07/01/2016-12/19/2016)	1,366,021	82.1%	16.7%

Note: This is Plan reported information.

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

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

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

- Streamlining the BH HCBS assessment process
- Increasing the assessment rates pending CMS approval
- Exploring with CMS low productivity rates during initial implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Developing a pathway to BH HCBS for enrollees who are not enrolled in Health Home
- Continue efforts to increase HARP enrollment in HH including:
 - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies
 - Existing quality improvement initiative within clinics to encourage HH enrollment
 - Emphasis on warm hand-off to Health Home from ER and inpatient settings
- Ongoing work to strengthen HH and ensure quality care management for high need SMI individuals. (HH+ expansion)
- Implement Performance Management efforts, including developing and monitoring quality metrics to ensure HH care management is resulting in improved health outcomes
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach

HCBS Claims from MDW (OMH View) as of 01/06/17		
	Claims Vol.	Unique Recipients
HCBS Service	842	137
Provider Travel Supplement	1	1
Transitional Employment	2	2
On-going Supported Employment	4	1
Intensive Supported Employment	13	4
Pre-vocational	27	8
Education Support Services	30	13
Psychosocial Rehab	39	9
Residential Supports Services	51	5
Peer Support	70	14
Short-term Crisis Respite	605	80

As of January 9, 2017, 1,529 care managers in NYS have completed the required training for conducting BH HCBS assessments. Also, as of January 3, 2017, 3,733 brief assessments and 1,034 full assessments have been completed.

DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) are continuing to meet 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. These stakeholder engagement efforts have included the following:

- Bi-weekly BH Managed Care Plan/Provider Roundtables discussions in collaboration with local government to identify and resolve issues related to implementation.
- Regional Planning Consortium meetings for stakeholders to discuss and monitor issues related to access and availability of behavioral health services in managed care. Each RPC represents natural local patterns of access to care, and include representatives from counties, the State, consumers and families, peers and advocates, behavioral health service providers, hospitals, Health Homes and MCOs.
- Plan Behavioral Health Clinical Directors meetings are monthly meetings convened by the New York State (NYS) Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and DOH with New York City (NYC) and Rest of State (ROS) Managed Care Organization (MMCO) Behavioral Health (BH) Medical Directors to review clinical operations issues. Covered subject matter includes announcements and updates from NYS OMH and NYS OASAS, Clinical Transformation Goals, Utilization and Care Management, Performance Measurement and Improvement, High-Need Populations, and Training. These meetings for NYC MMCO BH Medical Directors commenced in January 2015. Meetings for ROS BH MMCO Medical Directors started in May 2016. Meeting minutes are captured and follow-up items are tracked and resolved.

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

MCTAC Trainings

April - December 2016

1. 68 MCTAC training offerings, including live webinars and in-person events
2. 9,247 total attendees
3. 4,557 unique/unduplicated individuals
4. 504 New York State behavioral health agencies (62% of all NYS BH agencies)
5. 378 OMH licensed agencies (69% of all NYS OMH licensed agencies)
6. 250 OASAS licensed agencies (60% of all NYS OASAS certified agencies)

*OMH vs. OASAS is not mutually exclusive as agencies can be dually licensed/certified.

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 in collaboration with the New York Association of Rehabilitation and Recovery Services (NYAPRS) and the New York City Department of Health and Mental Hygiene.

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

During the 1st Quarter of FFY 2016-2017, the New York State Department of Health, School Based Health Center (SBHC) providers, Medicaid managed care plans and other stakeholders continued to work together on the process of planning the transition of SBHC services from Medicaid fee-for-service to Medicaid managed care. The scheduled implementation date is July 1, 2017. During the quarter, three subgroups of the larger SBHC stakeholder workgroup (Credentialing and Contracting, Claims and Billing, and Quality Improvement, Utilization Management and Care Coordination) met to discuss implementation issues and explore possible solutions. In addition to addressing implementation issues, the subgroups began developing responses to “Frequently Asked Questions” related to the transition. Each subgroup is co-chaired by a Managed Care Plan representative and a School Based Health Center representative and facilitated by a Department of Health staff person. During the December 15, 2016 full SBHC workgroup, the co-chairs presented the outcomes of their respective subgroup meetings. Full workgroup and subgroup activities will continue throughout 2017.

Hemophilia Blood Factor Transition from Medicaid Fee-for-service

Hemophilia blood factor products are currently carved out of the Medicaid managed care (MMC) benefit package and reimbursement to pharmacies and hemophilia clinics that provide blood factor to Medicaid managed care plan enrollees takes place through Medicaid fee-for-service. Effective April 1, 2017, hemophilia blood factor products will be included in the MMC benefit package and capitation rates. On the transition date, mainstream MMC plans will be required to cover medically necessary hemophilia blood factor products and associated services for plan enrollees and reimburse hemophilia blood factor providers for provision of products and services to enrollees. This change applies to all MMC plans, HIV Special Needs Plans and Health and Recovery Plans. The Department of Health presented an overview of the guiding principles of the carve-in to Medicaid managed care plans at the September 9, 2016 Managed Care Policy and Planning meeting and convened a conference call on November 9, 2016 to discuss the transition with providers and patient advocates. Development of written policy guidance, rate setting, notification to plans, providers and enrollees, and plan readiness activities are ongoing and will continue throughout the 2nd Quarter as well.

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 October 2016 through December 2016, one plan withdrew from three counties, and another plan is scheduled to expand their service area to those same three counties beginning January 1, 2017. Otherwise, there was no plan activity in terms of plan openings, closings, or mergers.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. For the quarterly period October 2016 through December 2016, post enrollment surveys were completed for 22 enrollees. 77% of respondents indicated they continued to receive services from the same caregivers once they became members of an MLTCP. This represents a slight decrease in affirmative responses from 79% during Q4. Most of the negative responses to the question about this topic are because the question is not applicable to the consumer's particular situation – for example, the consumer was not receiving home care services with the original plan.

Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 161,809 to 170,018 during the quarterly period October 2016 through December 2016. For that period, 13,199 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 50,517. Plan-specific enrollment on a monthly basis for the annual period of January 2016 through December 2016 is submitted as an attachment.

2. Significant Program Developments

During the quarterly period October 2016 through December 2016, full operational audits of two MLTC partial capitation plans were completed, with finalized Plans of Correction accepted for each. Also during this quarter, three new staff were added to the MLTC surveillance team in preparation for the added responsibility of auditing the Medicaid Advantage Plus (MAP) plans, scheduled to begin in May 2017. In addition to training and other preparations for the MAP audits, time and effort continues to be directed toward the development, testing and refinement of surveillance tools. New software system options are being explored to assure the appropriate management of the vast amount and complexity of data collected during surveys.

3. Issues and Problems

There were no issues or problems to report for the quarterly period October 2016 through December 2016.

4. Summary of Self Directed Options

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

5. Required Quarterly Reporting

Critical incidents: There were 247 critical incidents reported for the quarterly period October 2016 through December 2016, representing an increase from 230 incidents reported during Q4 2016. Critical incidents as a percentage of enrollment remains fairly constant, ranging from .11% to .14%; therefore, it is likely the increase in critical incidents is the result of increased enrollment.

Grievances and Appeals: For the quarterly period October 2016 through December 2016, the top five reasons for the event were related to transportation; homecare aides late or absent on a scheduled day; and dissatisfaction with the quality of home care, member services and plan operations, or the quality of other covered services.

Period: 10/01/16 - 12/31/16			
Number of Recipients: 179,583	Grievances	Resolved	Percent Resolved
# Same Day	5,982	5,982	100%
# Standard/Expedited	2,353	2,689	114%
Total for this period:	8,335	8,671	104%

Appeals	1/16-3/16	4/16-6/16	7/16-9/16	10/16-12/16	Average for Four Quarters
Average Enrollment	154,436	162,888	171,142	179,583	167,013
Total Appeals	1,096	1,250	1,267	1,055	1,167
Appeals per 1,000	7	8	7	6	7
# Decided in favor of Enrollee	181	211	393	278	266
# Decided against Enrollee	514	697	641	641	623
# Not decided fully in favor of	337	264	116	98	204

Enrollee					
# Withdrawn by Enrollee	15	22	15	23	19
# Still pending	171	171	272	290	226
Average number of days from receipt to decision	12	11	12	15	13

Grievances and Appeals per 1,000 Enrollees By Product Type October 2016 – December 2016					
	Enrollment	Total Grievances	Grievances per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	167,463	7,455	45	939	6
Medicaid Advantage Plus (MAP) Total	6,433	458	71	98	15
PACE Total	5,687	422	74	18	3
Total for All Products:	179,583	8,335	46	1,055	6

Total Grievances reported increased slightly from 8,188 during the last quarter to 8,397 during the quarterly period from October 2016 through December 2016.

The total number of appeals decreased from 1,266 during the fourth quarter to 1,052 during the quarterly period of October 2016 through December 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 is being monitored to ensure this is the case.

Technical Assistance Center (TAC) Activity

During the quarterly period October 2016 through December 2016, the TAC unit saw a slight decrease in complaints from 1,116 during the last quarter to 1,014 this quarter. Such a decrease is typical for the holiday period. The five most common types of complaints were:

Home Health Care:	21%
Billing – Claim Denials:	9%
Interdisciplinary Team:	7%
Obtaining DME:	5%
Eligibility:	4%

It should be noted that, while the largest proportion of complaints are related to home health aide service, these complaints are investigated based upon a member’s subjective experience; they do not necessarily represent neglect or abuse.

The TAC unit recently updated its billing policy to help staff provide better communication with plans and providers regarding billing issues, the second most common complaint type.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the quarterly period October 2016 through December 2016, 8,975 people were evaluated, deemed eligible and enrolled into plans.

Referrals and 30-day assessment: For the quarterly period October 2016 through December 2016, 11,197 assessments were conducted by MLTC plans. The total number of assessments conducted this quarter has increased, while the percentage of assessments conducted within the 30-day time frame decreased one percentage point to 84%. Data collection, evaluation and reporting continues to be monitored since implementing CFEEC on a statewide basis.

Referrals outside enrollment broker: During the quarterly period October 2016 through December 2016, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 15,151, an increase from 13,571 during the previous quarter. It is believed that this is the result of Mainstream Managed Care enrollees contacting MLTC plans directly to transfer. Plan managers are looking into the situation and will follow up with plans if needed.

Rebalancing efforts:

Rebalancing Efforts	10/16-12/16
New Enrollees to the Plan from a nursing home transitioning to the community	461
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,110
Current plan Enrollees permanently placed in a nursing home	6,215
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,754

During the quarterly period October 2016 through December 2016, the number of current plan enrollees permanently placed in a nursing home increased by 1,175. It is expected that the number of plan enrollees in a nursing home will continue to grow as new nursing home patients are required to join a managed care plan.

VI. Evaluation of the Demonstration

The evaluation plan for the demonstration has been updated incorporating subject matter expertise from program, analytical and evaluation staff. A draft has been submitted to CMS for comment. DOH is waiting for CMS to schedule a conference call to discuss the draft and answer questions from the CMS evaluation team.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 6,126 complaints/action appeals during the 1st quarter (October 1, 2016 through December 31, 2016), an increase of 1.5% from the previous quarter. The most frequent category of complaint/appeal was balance billing disputes, accounting for 22% of the total. There were 91 complaints/appeals reported by the HIV SNPs. The majority of these complaints (25) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 354 Medicaid managed care complaints this quarter.

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

- 22% Balance Billing
- 17% Reimbursement/Billing Issues
- 13% Advertising/ED/Outreach/Enrollment
- 8% Dissatisfaction with Quality of care
- 8% 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	0
Consumer Directed Personal Assistant	2
Home Health Care	8
Non-Permanent Residential Health Care Facility	1
Personal Care Services	17
Personal Emergency Response System	0
Private Duty Nursing	1
Total	29

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 6,126

total reported complaints/action appeals, mainstream Medicaid managed care plans reported 527 complaints and action appeals from their SSI enrollees. This compares to 614 SSI complaints/action appeals from last quarter. The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	20%
Quality of Care	16%
Balance Billing	12%
Provider or MCO Services (Non-Medical)	9%
Advertising/ED/Outreach/Enrollment	9%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	47
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	2
Balance Billing	64
Communications/Physical Barrier	2
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	28
Dental or Orthodontia	104
Emergency Services	8
Eye Care	2
Family Planning	0
Home Health Care	2
Mental Health/Substance Abuse Services/ Treatment	6
Non-covered Services	23
Non-Permanent Resident Health Care Facility	0
Personal Care Services	5
Personal Emergency Response System	0
Pharmacy	15
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	49
Quality of Care	84
Recipient Restriction Program/Plan Initiated	0

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Disenrollment	
Reimbursement/Billing Issues	22
Specialist or Hospital Services	6
Transportation	6
Waiting Time Too Long at Office	3
All Other Complaints	46
Total	527

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 1, 2016. The meeting included presentations provided by state staff and discussions of the following: an overview of the policies and status of activities related to implementation of the planned transition of School Based Health Center Services from Medicaid fee-for-service to Medicaid managed care; a discussion of current auto assignment statistics and state and local district outreach and other activities aimed at reducing auto assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs, including the Department of Health’s commitment to extending the FIDA demonstration through December 2019; an update on activities related to operationalizing Community First Choice Option (CFCO); and an update on Health and Recovery Plan (HARP) implementation, focusing on HARP enrollment and opt-out data and claims monitoring data. The next MMCARP meeting is scheduled for February 23, 2017.

C. Managed Care Policy and Planning Meetings

During the 1st Quarter of Federal Fiscal Year 2016-2017, Managed Care Policy and Planning Meetings were held on October 13, November 10 and December 8, 2016.

The October meeting included the following: a discussion of Medicaid recertification and churn, and an overview of the enrollment reconciliation project; an update on the children’s health and behavioral health managed care transition and a review of adult behavioral health claims statistics; discussion of July 2016 Medicaid managed care (MMC) capitation rates; updates on Managed Long Term Care (MLTC) and Fully Integrated Duals Advantage (FIDA) statewide enrollment and Conflict-Free Evaluation and Enrollment Center (CFEEC) activity; an update on the scheduled transition to managed care of the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waiver programs; an update on Community First Choice Option (CFCO) implementation activities; and a on the Delivery System Reform Incentive Payment (DSRIP) program update which focused on highlights, timeline and key benchmarks, midpoint assessment activities, dashboard access status, data sharing guidance, managed care rosters of Performing Provider System attributed members, Value Based Payment (VBP) boot camps, and data sharing opt-out process; and a review of VBP policy implementation timelines.

The November meeting agenda included: an update on the enrollment reconciliation project; an adult behavioral health managed care transition update, with a focus on steps being taken to address issues related to HARP enrollment; an overview of children's behavioral health design and related standards for Managed Care Organizations; a presentation by contractor 3M™ on the features and functionality of the 3M™ Clinical Risk Groups (CRG) Version 2.0; a discussion of the Hospital Quality Pool and Hospital Sole Community Pool established by the State Fiscal Year 2015-2106 Budget, its impact on managed care plan premiums, and next steps for implementation; a discussion of minimum wage guidelines and minimum wage rate setting and reconciliation relative to MLTC capitation rates; a presentation on new federal notice requirements under 45 CFR 92 for outreach materials and communication, including the inclusion of a non-discrimination statement and taglines that are published in languages other than English; a presentation on the role of MMC plans in ending the HIV epidemic; an update on MLTC, FIDA and CFCO; an update on the DSRIP program's current status, key highlights and timeline of activities; and a presentation on the Advanced Primary Care model.

Presentations, updates and discussions at the December meeting included: an overview of the timeline for transitioning Welfare Management System (WMS) enrollment data from rosters to 834s; an update on the enrollment reconciliation project; a discussion of the behavioral health managed care transition, including a status update on health homes designated to serve children, an update on the children's plan qualification process, a discussion of adult behavioral health claims, and an update on the establishment of an MCO/State workgroup to address HARP enrollment issues; a discussion of July 2016 Mainstream MMC premium rate adjustments and MLTC rate status and timeline; updates related to MLTC, FIDA, and CFCO policies and activities; and an overview of DSRIP activities.

Managed Care Policy and Planning meetings during the 2nd Quarter of Federal Fiscal Year 2016-2017 are scheduled for January 12, February 9, and March 9, 2017.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

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

Also in November, the Department released to the MLTC plans, their Crude Percent Reports for the time period of January through June 2016. The Crude Percent Reports provide the plans with a distribution of their members compared to the statewide, for many of the components of the functional assessment tool.

Child CAHPS with Chronic Care Condition (CCC) Module

DataStat administered a CAHPS® 5.0H Medicaid Child with CCC module survey to parents/guardians of children enrolled in Medicaid and Child Health Plus managed care plans. The survey was in the field between September and December 2016. Reports are being prepared for managed care plans with anticipated distribution in February 2017.

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 Quarter, IPRO initiated and conducted an Access and Availability survey, completing the survey, initiating quality assurance validations, and producing preliminary rates. The activity should be completed this Quarter. They also completed the 2016 Provider Directory survey, issuing final reports to MCOs, collecting plans of correction, and addressing identified issues with the plans. In response to concerns that were raised

by MMC plans regarding the methodology used in the annual PCP Ratio Survey conducted earlier in 2016, IPRO worked with the DOH to address specific issues.

They also began collecting data through the newly built Provider Network Data Collection System (PNDS). The system came on-line this Quarter, complete with panel data reporting tool, and data retrieval utilities. Edits were ongoing to the data system's processing and functionality as tests were conducted. Third party sub contracts continued to be leveraged to outsource necessary components of these projects. Meanwhile, they continued to oversee the ongoing collection of these data through the old system.

Throughout the Quarter, IPRO conducted recurring group calls to discuss conduct and completion of Managed Long Term Care (MLTC) PIPs for 2016. Late in the Quarter, IPRO began facilitating discussion and planning for the roll out of 2017 PIPs. A 2017 MLTC PIP training was designed by IPRO and will be completed in January 2017. IPRO also oversaw MMC PIPs, and the design and planning for a new HARP PIP. Additional information on the MMC and HARP PIP work completed can be found under the Performance Improvement Project description below.

Work on a Prenatal Care quality improvement project was on hold for much of the Quarter, as IPRO worked closely with the DOH to reassign many (non-EQR) activities to DOH staff, in an effort to increase efficiencies and save money. Some testing was conducted on the new data collection platform.

IPRO's oversight (external quality review) of performance measurement (QARR) included providing a training to all MCOs on the new specifications and reporting requirements for QARR 2017. IPRO also worked closely with the department and NCQA to develop and execute a contract that will allow for IDSS submission directly to NCQA in the upcoming measurement year. IPRO also facilitated, through a subcontract with DataStat, the administration of the 2016 adult CAHPS survey. They 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 Quarter 1, IPRO continued work on development and revision of MLTC, SNP, and MMC plan technical report drafts, which are updated annually and posted to the DOH Website.

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

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 and continued through December 2016. 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 October 13, 2016 with all of the Medicaid managed care plans, IPRO and representatives from the NYSDOH Bureau of Tobacco Control, DPIPS and the Office of Mental Health. Four 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. All of the Medicaid managed care plans received guidance from IPRO on the due date for the Final PIP Report due to IPRO in July 2017. The PIP Final Report Template was distributed to the plans.

For the 2017-2018 Health and Recovery Plan (HARP) Performance Improvement Project the selected common topic is Care Transitions. A HARP PIP Training Webinar occurred on October 26, 2016 to review the PIP requirements and the process. In addition, the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS) provided a brief background on the common topic. IPRO provided an overview of PIP requirements and the process for developing, implementing and evaluation of a PIP. On November 14, 2016 a Kick-Off Conference Call was held with the HARP plans, IPRO, OMH, OASAS and NYSDOH. The purpose of this call was to provide all of the materials necessary for the plans to be able to draft their PIP Proposal. A background document was provided on Care Transitions and a guest speaker from OMH spoke on potential evidence based interventions to consider. The due date for the HARP PIP Proposal is January 23, 2017.

For the 2017-2018 Medicaid managed care plans, the selected common topic is Perinatal Care. On December 19, 2016 a Kick-Off Conference Call was held with the Medicaid managed care plans, IPRO and NYSDOH to provide all of the materials necessary for the plans to be able to draft their PIP Proposal. A background document was provided on Perinatal Care. There are four priority focus areas to be addressed in this PIP: history of prior spontaneous preterm birth; unintended pregnancy suboptimal birth spacing; maternal smoking; and maternal depression. The due date for the Perinatal PIP is February 6, 2017.

Breast Cancer Selective Contracting

The Department began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2013-2015 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as, facility-level data from the Health Facilities Information System (HFIS). A

total of 255 facilities were identified as having performed at least one breast cancer surgery from 2013-2015. Preliminary facility volume designations were as follows: 116 high-volume; 25 low-volume that are allowed to perform surgeries to ensure adequate access; 73 low-volume restricted facilities; and, 41 recently closed facilities.

Letters were drafted to notify low-volume facilities that the Department will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state fiscal year 2017-18, nor can Medicaid managed care plans contract with low-volume facilities to perform breast cancer surgeries. In addition, the letters will also include a copy of the appeal form for facilities that want to appeal the decision to be placed on the low-volume restricted list. The letters will be mailed out in January 2017.

Patient Centered Medical Home (PCMH)

As of December 2016, there were 6,317 NCQA-recognized PCMH providers in New York State. Approximately 59% (3,710) of current PCMH providers are recognized under the newest 2014 set of standards. Between February and December, the percentage shift of providers recognized under the newest standards increased from 0% to 59%. 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. There has been a decrease in the total number of PCMH recognized providers since the previous report (6,471). This is most likely due to recognitions expiring under the 2011 standards and practices not being able to achieve 2014 recognition in time to prevent a lapse of recognition. We anticipate most practices in this situation will apply for 2014 recognition to maintain their incentive payments. It is estimated that around 750 practices will have active recognitions under the 2011 standards after 12/31/2016, and the majority will expire by mid-2018. The current incentives for the New York Medicaid PCMH Statewide Incentive Payment Program is:

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

DSRIP requires practices to become 2014 level 3 PCMH or Advanced Primary Care (APC) recognized by March 31, 2018. PCMH penetration within DSRIP is measured each quarter. As of September 2016, 15% of DSRIP PCPs met the PCMH/APC requirement. Currently, there are no providers that are APC recognized.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers and will continue through the end of 2016. A letter of intent (LOI) was sent to all payers and providers stating that the demonstration will continue business as usual through June 30, 2017. There is a commitment across payers and providers to

continue through 2019 but discussions around alignment of methods for shared savings models are not finalized. All payments will be made to the Adirondack Accountable Care Organization (ACO) under the new participation agreement. The ACO will also be responsible for maintaining the funds and distributing among the participating practices in the region, as well as coordinating information between payers and providers. The Adirondack Health Institute (AHI) is working with the new data analytics vendor, Health Catalyst, and the payers to get all data use agreements signed. Currently 5 of 7 payers have signed the agreement. The pay for performance program in the ADK will not continue. The last cycle covered dates of service 6/1/14-12/31/14 and the final payment calculations will be finalized in 2017.

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

IX. Transition Plan Updates

No updates.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

At the end of December 2016, New York submitted an updated Specifications Manual and a draft remediation plan and timeline for the completion of the budget neutrality reconciliation process, including plans to reconcile with the CMS-64. The budget neutrality remediation efforts are underway and NY is on track to meet the September 30, 2017 deadline for completion of this project detailed in the STCs.

New York remains in regular contact with CMS regarding the progress of this project. At this time, the state budget neutrality team is entirely focused on the remediation effort and on the development and implementation of the internal processes necessary to ensure New York remains in compliance with Quarterly Expenditure Reporting requirements going forward. The state expects to resume timely quarterly expenditure reporting once the reconciliation process is complete.

B. Designated State Health Programs

No updates.

XI. Other

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

New York State T-MSIS entered production and sent its first production files on 12/27/2016 to CMS based on the draft timeline, the target date is approximately 3/6/2017 to complete submission of twenty months of production catch-up files.

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

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

Attachments:

Attachment 1 - MLTC Partial Capitation Plans

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MLTC Enrollment - Partial Capitation Plans

January 2016-December 2016

Plan Name	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	Oct-16 Enrollment	Nov-16 Enrollment	Dec-16 Enrollment
Aetna Better Health	3,447	3,530	3,583	3,629	3,688	3,746	3,817	3,816	3,843	3,881	3,886	3,943
AgeWell New York	5,895	6,125	6,334	6,502	6,674	6,800	6,949	7,084	7,207	7,355	7,524	7,663
AlphaCare	2,230	2,347	2,490	2,634	2,765	2,856	2,920	2,977	3,041	3,154	3,263	3,347
ArchCare Community Life	2,017	2,035	2,059	2,061	2,081	2,099	2,131	2,133	2,147	2,175	2,219	2,231
CCM Select	5,590	5,571	5,556	5,521	5,490	5,452	5,428	5,402	5,215	5,135	5,099	4,969
Centers Plan for Healthy Living	4,490	4,850	5,278	5,580	5,910	6,271	6,602	6,978	7,331	7,829	8,373	8,950
Elant	866	861	866	880	854	851	860	856	834	829	823	826
Elderplan	10,647	10,711	10,742	10,780	10,861	11,007	11,132	11,219	11,403	11,559	11,721	11,942
Elderserve	10,685	10,718	10,755	10,819	10,860	10,923	10,921	10,921	10,966	11,033	11,037	11,072
Elderwood	0	0	0	0	6	12	24	34	40	62	74	85
Extended MLTC	915	954	999	1,042	1,086	1,191	1,293	1,398	1,529	1,613	1,692	1,771
Fallon Health Weinberg (TAIP)	237	249	272	257	260	304	326	376	389	419	437	459
Fidelis Care at Home	11,735	12,067	12,661	13,178	13,707	14,173	14,614	15,051	15,522	16,073	16,454	16,804
Guildnet	16,643	16,708	16,737	16,804	16,823	16,749	16,691	16,614	16,477	16,413	16,098	15,916
Hamaspik Choice	1,398	1,492	1,539	1,599	1,641	1,700	1,764	1,813	1,857	1,901	1,940	1,986
HealthPlus- Amerigroup	2,901	2,971	3,053	3,179	3,281	3,409	3,507	3,594	3,668	3,767	3,876	3,950
HIP of Greater New York	36	11	3	0	0	0	0	0	0	0	0	0
iCircle Services	953	1,018	1,077	1,155	1,217	1,288	1,374	1,432	1,474	1,534	1,577	1,625
Independence Care Systems	5,788	5,840	5,925	5,986	6,042	6,104	6,194	6,241	6,280	6,348	6,447	6,514
Integra	2,886	3,093	3,199	3,289	3,408	3,596	3,740	3,948	4,132	4,241	4,438	4,607
Kalos Health- Erie Niagara	565	604	662	693	743	743	783	805	843	874	913	936
MetroPlus MLTC	978	1,004	1,027	1,062	1,106	1,199	1,219	1,236	1,264	1,300	1,355	1,382
Montefiore HMO	726	771	865	947	1,054	1,123	1,161	1,187	1,206	1,226	1,262	1,272
North Shore-LIJ Health Plan	2,735	2,848	2,965	3,139	3,271	3,445	3,590	3,742	3,880	4,068	4,249	4,413
Prime Health Choice	108	133	149	161	175	181	189	206	209	229	230	235
Senior Health Partners	12,645	12,538	12,463	12,408	12,390	12,452	12,574	12,619	12,762	12,845	12,950	13,028
Senior Network Health	488	495	507	506	503	504	513	508	513	522	521	514
Senior Whole Health	3,863	4,097	4,360	4,672	4,967	5,209	5,405	5,663	5,909	6,163	6,483	6,696
United Healthcare	1,735	1,879	2,014	2,113	2,206	2,306	2,339	2,411	2,469	2,552	2,626	2,657
Village Care	5,186	5,403	5,596	5,869	6,059	6,285	6,390	6,518	6,609	6,773	6,986	7,190
VNA HomeCare Options	1,577	1,693	1,841	1,985	2,112	2,294	2,484	2,666	2,809	2,986	3,224	3,372
VNS Choice	13,732	13,762	13,824	13,913	13,908	13,871	13,911	13,926	13,855	13,861	13,759	13,631
WellCare	7,115	6,837	6,583	6,423	6,376	6,272	6,243	6,201	6,126	6,061	6,054	6,032
TOTAL	140,812	143,215	145,984	148,786	151,524	154,415	157,088	159,575	161,809	164,781	167,590	170,018