MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 20 (4/1/2018-3/31/2019)
Federal Fiscal Quarter: 4 (7/1/2018 – 9/30/2018)

I. Introduction

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

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

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

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

There have been several amendments to the Partnership Plan Demonstration since its initial approval in 1997. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. A final draft evaluation report was submitted to CMS on February 11, 2015 and was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30-day public comment period. A temporary extension was granted on December 31, 2014 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 31,

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

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

II. Enrollment: Fourth Quarter

MRT Waiver- Enrollment as of September 2018

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	**651,947**	**8,221**	**60,605**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**100,109**	**2,440**	**7,490**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**14,032**	**251**	**1,701**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**3,026**	**88**	**380**
Population 5 - Safety Net Adults	**446,204**	**12,845**	**53,017**
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)	**26,762**	**846**	**145**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**188,804**	**8,579**	**1,630**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,587**	**304**	**62**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**52,896**	**5,324**	**3,588**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**38,898 or an approximate 3.9% increase from last Q**

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

WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in voluntary disenrollment.

Compared to the prior quarter, this quarter saw a further increase in the number enrollees disenrolled due to incarceration.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**128,618 or an approximate 28.0% increase from last Q**

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

WMS continues to send select closed cases to New York State of Health. Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in involuntary disenrollment.

Compared to the prior quarter, this quarter saw a further increase in the number of case closures. More than half of this increase was due to WMS's closure of MAGI cases that were subsequently sent to New York State of Health.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
July 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,087,148**	**20,402**	**2,732**	**17,670**
Rest of State	**458,767**	**11,547**	**1,229**	**10,318**
Statewide	**1,545,915**	**31,949**	**3,961**	**27,988**
August 2018				
New York City	**1,071,707**	**16,522**	**2,230**	**14,292**
Rest of State	**435,175**	**9,939**	**972**	**8,967**
Statewide	**1,506,882**	**26,461**	**3,202**	**23,259**
September 2018				
New York City	**1,054,339**	**16,909**	**2,324**	**14,585**
Rest of State	**417,868**	**10,372**	**938**	**9,434**
Statewide	**1,472,207**	**27,281**	**3,262**	**24,019**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**46,547**			
Rest of State	**28,719**			
Statewide	**75,266**			

HIV SNP Plans				
July 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,226**	**198**	**0**	**198**
Statewide	**13,226**	**198**	**0**	**198**
August 2018				
New York City	**13,182**	**152**	**0**	**152**
Statewide	**13,182**	**152**	**0**	**152**
September 2018				
New York City	**13,160**	**164**	**0**	**164**
Statewide	**13,160**	**164**	**0**	**164**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**514**			
Statewide	**514**			

Health and Recovery Plans Disenrollment			
FFY 18 – Q4			
	Voluntary	**Involuntary**	**Total**
July 2018	**1,089**	**949**	**2,038**
August 2018	**964**	**949**	**1,913**
September 2018	**1,065**	**967**	**2,032**
Total:	**3,118**	**2,865**	**5,983**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 4 (7/1/2018 – 9/30/2018) Q4 FFY 2017-2018

As of the end of the fourth federal fiscal quarter (end of September 2018), there were 2,562,130 New York City Medicaid consumers enrolled in the mainstream Medicaid managed care program and 66,001 Medicaid consumers enrolled in Health and Recovery Plans (HARP). MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted outreach in 33 HRA facilities including six (6) HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 10,996 clients were educated about their enrollment options and 6,119 (56%) clients made an enrollment choice.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that an approved presentation script is followed and required topics are explained. During the reporting period, CMU monitors observed a total of 1,161 client encounters including: 276 (24%) enrollment counselling sessions and 885 (76%) general information sessions. Enrollment counseling sessions generated 276 applications and 310 enrollments.

Infractions were observed for 29 (11%) of the 276 enrollment counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA sites. Deficiencies found are reported to MAXIMUS Field operations on a monthly basis.

Key messages most often omitted were failure to disclose or explain the following:

- Lock in policy
- Dental within plan network
- Good Cause Transfer
- Exemptions/Exclusions
- Confirmation Letter

The CMU selected 278 (90%) of the 310 enrollments to track for timely and correct processing. The CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

Auto-Assignment (AA) Outreach

In addition to face-to-face informational sessions, FCSRs make outreach calls to Fee-for-Service (FFS) clients identified for plan auto-assignment including clients in nursing homes (NH). For the 4th quarter, a total of 25,555 mandatory clients were listed on the auto-assignment file and NYMC reported that 3,812 (15%) clients responded to the call and 2,666 (70%) contacted made a plan selection. Of the 1,012 FFS clients living in a nursing home, 27 (7%) selected a plan.

The CMU monitored 218 (8%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 148 (68%) clients including 144 (97%) community clients and four (4) (3%) nursing home residents and made voluntary phone enrollment choices for themselves and their family members for a total of 171 enrollments.
  - 163 (95%) consumers were randomly chosen to track for timely and correct processing and the CMU confirmed that consumers were enrolled timely in plan.
- Undecided: 70 (32%) FFS clients did not make an enrollment choice for several reasons, including having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 25 (17%) of the 144 regular FFS AA Phone Enrollments conducted and no infractions were observed for the four (4) nursing home residents.

Key messages most often omitted were failure to disclose or explain the following:

- Medicare/Third Party Health Insurance (TPHI)
- Use of plan ID Card/Benefit Card
- Confirm Consumer Health Plan/PCP choice
- Helpline Number/Hours of Operation
- Dental (how to access services)

The CMU also randomly selected 155 (1%) clients from the auto-assignment list of 25,555 clients to see if:

- outreach calls were conducted
- the plan selected by the consumer was indicated, and
- notices were sent in a timely manner.

It was reported that 81 (52%) consumers were reached and 70 (86%) of the 81 responded made a plan choice. The CMU confirmed that outreach calls were conducted and appropriate and timely notices were mailed to clients who selected a plan on the call. The CMU also confirmed that appropriate and timely notices were sent to clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

NYMC HelpLine Observations

The CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 56,489 calls were received by the Helpline and 53,881 or 95% were answered. Calls answered were handled in the following languages: English: 39,642 (73%); Spanish: 8,175 (15%); Chinese: 3,154 (5%); Russian: 747 (2%); Haitian/Creole: 97 (1%); and other: 2,066 (4%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. The CMU listened to 1,851 recorded calls. The call observations were categorized in the following manner:

- General Information: 1,248 (67%) clients requested enrollment information and inquired about accessing plan services.
- Phone Enrollment: 98 (5%) FFS clients made a voluntary phone enrollment choice.
- Plan Disenrollment: 17 (2%) voluntary clients requested disenrollment.
- Plan Transfer: 85 (4%) plan enrollees requested to change their plan.
- Public Calls: 400 (21%): callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment or client did not want to provide CIN nor SS# to obtain non-case specific information.
- Removal of Code 90: three (3) (1%) client requested removal of code 90 to enroll in managed care.

Infractions/issues were identified for 591 (32%) of the recorded calls reviewed by theCMU. The following summarizes those calls:

- Process: 543 (92%) - 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: 13 (2%) - 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: 35 (6%) - Consumers were put on hold without an explanation or were not offered additional assistance.

Corrective Action

NYMC is advised on a monthly basis of infractions observed and is required to develop, implement and submit a corrective action plan for each infraction reported. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance. During the reporting period, CMU has reviewed and approved 54 corrective action plans completed by MAXIMUS Field Operation and 591 correction action plans completed by MAXIMUS Call Center Operation.

B. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Year (FFY) 2017-2018

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted outreach in 33 HRA facilities including six (6) HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 45,898 clients were educated about their enrollment options and 28,272 (62%) clients made an enrollment choice.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that an approved presentation script is followed and required topics are explained. During the reporting period, the CMU monitors observed a total of 5,482 client encounters including 2,004 (37%) enrollment counselling sessions and 3,478 (63%) general information sessions. Enrollment counseling sessions generated 2,004 applications and 2,446 enrollments.

Infractions were observed for 164 (12%) of the 1,345 enrollment counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA sites. Deficiencies found are reported to MAXIMUS Field operation on a monthly basis.

Key messages most often omitted were failure to disclose or explain the following:

- Lock in policy
- Dental within plan network
- Good Cause Transfer
- Exemptions/Exclusions

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients identified for plan auto-assignment including clients in nursing homes (NH). For the 4th quarter, a total of 108,801 mandatory clients were listed on the auto-assignment file and NYMC reported that 20,988 (19%) clients responded to the call and 13,475 (64%) reached made a plan selection. The CMU monitored 1,623 (8%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 807 (50%) clients made a voluntary phone enrollment choice for themselves and their family members.
    - 535 (66%) consumers were randomly chosen to track for timely and correct processing and the CMU confirmed that consumers were timely enrolled in plan selection.
- Undecided: 816 (50%) FFS clients did not make an enrollment choice for several reasons including having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 137 (17%) of the 807 regular FFS AA Phone Enrollments conducted and no infractions were observed for the four (4) nursing home residents.

Key messages most often omitted were failure to disclose or explain the following:

- Medicare/TPHI
- Use of plan ID Card/Benefit Card
- Confirm Consumer Health Plan/PCP choice
- Helpline Number/Hours of Operation
- Dental (how to access services)

The CMU also randomly selected 852 (1%) clients from the auto-assignment list of 108,801 clients to see if;

- outreach calls were conducted,
- the plan selected by the consumer was indicated, and
- notices were sent in a timely manner.

The CMU also confirmed that appropriate and timely notices were sent to clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

NYMC HelpLine Observations

The CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 236,075 calls were received by the Helpline and 219,512 or 93% were answered. Calls answered were handled in the following languages: English: 161,419 (73%); Spanish: 34,538 (16%); Chinese: 12,088 (5%); Russian: 3,242 (2%); Haitian: 425 (1%); and other: 7,800 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. The CMU listened to 8,430 recorded calls. The call observations are categorized in the following manner:

- General Information: 6,174 (73%) clients requested enrollment information and inquired about accessing plan services.
- Plan Disenrollment: 17 (1%) voluntary clients requested disenrollment.
- Phone Enrollment: 655 (7%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 658 (7%) plan enrollees requested to change their plan.
- Public Calls: 923 (11%): callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment or client did not want to provide CIN nor SS# to obtain non-case specific information.

- Removal of Code 90: three (3) (1%) client requested removal of code 90 to enroll in managed care.

Infractions/issues were identified for 2,813 (33%%) of the recorded calls reviewed by the CMU. The following summarizes those observations:

- Process: 2,293 (82%) - 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: 267 (9%) - 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: 253 (9%) - Consumers were put on hold without an explanation or were not offered additional assistance.

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

Corrective Action

NYMC is advised on a monthly basis of infractions observed and is required to develop, implement and submit a corrective action plan. Corrective actions include, but are not limited to, staff training and an increase in targeted the CSR monitoring to ensure compliance. The CMU has reviewed and approved 301 corrective action plans completed by MAXIMUS Field Operation for fiscal year 2018 and 2,813 corrective action plans completed by Call Center Operation 1/1/2018 through 9/30/2018. NYMC Call Center Operation began submitting written corrective action plans for each infraction reported 1/1/2018 through 9/30/2018.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

- During the fourth quarter (July 1, 2018 – September 30, 2018), there were no service area changes for Medicaid Managed Care Plans, HIV Special Needs Plans (HIV SNPs) or Health and Recovery Plans (HARPs).
- There were three approved plan expansions that occurred during the fiscal year:
    - On December 28, 2017, HealthNow New York, Inc. was approved to expand its Medicaid Managed Care Service Area to include Genesee and Niagara Counties.
    - On January 12, 2018, Excellus Health Plan, Inc. was approved to expand its Medicaid Managed Care and HARP Service Areas to include Erie County.

    - On June 15, 2018, Capital District Physicians' Health Plan, Inc. was approved to expand its Medicaid Managed Care and HARP Service Areas to include Clinton, Essex, Franklin and Warren Counties.
- New York Quality Healthcare Corporation was granted Article 44 Certification as an Health Maintenance Organization (HMO). They were approved to provide Medicaid Managed Care, Child Health Plus, and Health and Recovery Plan (HARP) services in all 62 counties in New York State.

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

On July 17, 2018, Centers for Medicare and Medicaid Services (CMS) issued approval for all 18 of the contract amendments that were under CMS' review. These amendments were effective October 1, 2015. This amendment included revisions related to implementation of the adult behavioral health redesign and the HARP product line, as well as new program integrity provisions and other necessary revisions related to implementation of various Medicaid Redesign Team (MRT) initiatives.

Milestone dates relative to this 10/1/2015 amendment include:

- November 18, 2016 - New York State submitted the amendment to CMS for review.
- April 11, 2017 - the Department of Health received comments back from CMS regarding its review of the amendment.
- August 9, 2017 - New York State responded to CMS comments.
- November 28, 2017 - CMS issued approval of the amendment.
- December 5, 2017 – amendments were transmitted to the Health Plans for signature.
- December 14, 2017 through February 5, 2018 – the Department of Health received signed amendments back from the Health Plans and processed them for New York State approval.
- March 5, 2018 through May 21, 2018 – New York State executed amendments were sent to CMS for final approval.
- July 7, 2018 – CMS approved all amendments.

C. Health Plans/Changes to Certificates of Authority

No updates.

D. Surveillance Activities

Surveillance activity completed during the 4th Quarter FFY 2017-2018 (July 1, 2018- September 30, 2018) include the following:

There were no Operational Surveys Completed in the 4th quarter.

There were no Focus Surveys Completed in the 4th Quarter.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during FY2018. Final reports were previously submitted for all reviews except for the one involved in an open legal matter.

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted during FY2018 due to a legal matter that is still open.

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

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

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

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

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

B. Benefit Changes/Other Program Changes

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

In October 2015 New York State began 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. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called behavioral health Home and Community Based Services (BH HCBS). For Medicaid Managed Care (MMC), all Medicaid- funded behavioral health services for adults, except for 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) began 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.

In FY 2018, New York State engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in Medicaid Managed Care. In June of 2018, HARP became an option on the New York State of Health (Exchange). This enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State implemented the State Designated Entity program and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult behavioral health Home and Community Based Services. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center.

NYS continues to monitor plan-specific data in the three key areas: 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 includes 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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (4/1/2018-6/30/2018)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	56,957	1,055	1,001	1.8%
ROS	7,240	49	46	0.6%
Total	64,197	1,104	1,047	1.6%

Note: Molina has not been included due to incomplete submissions

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 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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (4/1/2018-6/30/2018)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	6,033	58	32	0.5%
ROS	2,720	9	3	0.1%
Total	8,753	67	35	0.4%

Note: Molina has not been included due to incomplete submissions

3. **Monthly Claims Report:** Monthly, MCOs are required to submit the following for all OMH and OASAS licensed and certified services.

Mental Health (MH) & Substance Use Disorder (SUD) Claims (7/1/2018-9/30/2018)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,477,194	83.38%	15.65%
Rest of State	1,137,026	79.49%	14.01%
Statewide Total	2,614,220	81.69%	14.94%

Footnote: MCOs report monthly data. The volume of paid and denied claims could include pended claims from previous months.

[1] Q4 data is not available and will be submitted with the next quarterly update.

Annual Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2017-9/30/2018)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	5,889,256	86%	14%
Rest of State	4,626,965	81%	19%
Statewide Total	10,516,221	84%	16%

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

HCBS Claims/Encounters 7/1/2018-9/30/2018: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	46	10
Education Support Services	66	24
Family Support and Trainings	5	1
Intensive Crisis Respite	0	0
Intensive Supported Employment	56	20
Ongoing Supported Employment	4	2
Peer Support	645	119
Pre-vocational	52	15
Provider Travel Supplements	86	40
Psychosocial Rehab	238	51
Residential Supports Services	70	19
Short-term Crisis Respite	560	87
Transitional Employment	7	4
TOTAL	1,835	294

HCBS Claims/Encounters 7/1/2018-9/30/2018: ROS

HCBS SERV GROUP	N Claims	N Recip
CPST	305	72
Education Support Services	639	199
Family Support and Trainings	54	19
Intensive Crisis Respite	8	6
Intensive Supported Employment	181	65
Ongoing Supported Employment	34	10
Peer Support	1,931	551
Pre-vocational	211	66
Provider Travel Supplements	1,316	350
Psychosocial Rehab	1,098	237
Residential Supports Services	667	148
Short-term Crisis Respite	102	33
Transitional Employment	21	7
TOTAL	6,567	1,140

Note: Total of N Recip. is by unique recipient, hence, The TOTAL might be smaller than sum of rows.

The tables below represent claims data for behavioral health Home and Community Based Services in NYC and Rest of State from Quarter 1 2017- Quarter 4 2018 end of the reporting period.

Quarter 1 2017- Quarter 4 2018 BH HCBS Claims/Encounters Data
Data reported: 11/13/2018

HCBS Claims/Encounters: NYC

		N Recip.			
HCBS SERV GROUP	Annual Total Claims/Encounters	Q1: Oct 2017-Dec 2017	Q2: Jan 2018-Mar 2018	Q3: Apr 2018-Jun 2018	Q4: Jul 2018-Sep 2018
CPST	735	55	47	40	10
Education Support Services	677	56	66	60	24
Family Support and Training	37	5	2	4	1
Intensive Supported Employment	449	31	31	33	20
Ongoing Supported Employment	34	3	6	3	2
Peer Support	2,918	132	146	161	119
Pre-vocational	424	26	33	32	15
Provider Travel Supplement	841	125	43	49	40
Psychosocial Rehab	1,091	54	49	56	51
Residential Supports Services	588	41	44	41	19

Short-term Crisis Respite	**1,980**	**61**	**62**	**74**	**87**
Transitional Employment	**55**	**2**	**3**	**3**	**4**
TOTAL	**9,829**	**356**	**378**	**399**	**294**

HCBS Claims/Encounters: ROS

		N Recip.			
HCBS SERV GROUP	**Annual Total Claims/Encounters**	**Q1: Oct 2017-Dec 2017**	**Q2: Jan 2018-Mar 2018**	**Q3: Apr 2018-Jun 2018**	**Q4: Jul 2018-Sep 2018**
CPST	**1,343**	**52**	**61**	**73**	**72**
Education Support Services	**2,661**	**150**	**177**	**203**	**199**
Family Support and Training	**302**	**20**	**17**	**19**	**19**
Intensive Supported Employment	**876**	**50**	**69**	**65**	**65**
Ongoing Supported Employment	**104**	**4**	**6**	**6**	**10**
Peer Support	**7,541**	**352**	**423**	**557**	**551**
Pre-vocational	**1,131**	**77**	**66**	**75**	**66**
Provider Travel Supplement	**4,596**	**222**	**273**	**340**	**350**
Psychosocial Rehab	**4,588**	**161**	**224**	**239**	**237**
Residential Supports Services	**2,624**	**107**	**130**	**151**	**148**
Short-term Crisis Respite	**455**	**35**	**39**	**15**	**33**
Transitional Employment	**62**	**3**	**4**	**7**	**7**
TOTAL	**26,283**	**787**	**924**	**1,105**	**1,140**

Note: Total of "Number of Recipients" is by unique recipient, hence, not the sum of column; Data for past Quarters can be different than past data sent to CMS due to claim lags

Provider Technical Assistance

Managed Care Technical Assistance Center is a partnership between the McSilver Institute for Poverty Policy and Research at New York University School of Social Work and the National Center on Addiction and Substance Abuse (CASA) at Columbia University, as well as other community and State partners. It provides tools and trainings that assist providers to improve business and clinical practices as they transition to managed care.

Managed Care Technical Assistance Stats (Time Period: October 1, 2017 through September 30, 2018)

- 33 webinars

- 65 in person events throughout NYS

Participants
Overall: 5,925
Unique: 2,775

OMH Agency Participation
Overall: 429 of 611 (70.2%)
OMH NYC: 159 of 239 (66.5%)
OMH ROS: 283 of 388 (72.9%)

OASAS Agency Participation
Overall: 283 of 543 (52.1%)
OASAS NYC: 98 of 194 (50.5%)
OASAS ROS: 200 of 368 (54.3%)

Efforts to Improve Access to Behavioral Health Home and Community Based Services (BH HCBS)

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 with enrolling HARP members in Health Homes (HH); locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process; ensuring care managers have understanding of BH HCBS (including person-centered care planning) and capacity for care managers to effectively link members to rehab services; and difficulty launching BH HCBS due to low number of referrals to BH HCBS providers.

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

- Streamlining the BH HCBS assessment process
    - Effective March 7, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.

- Ongoing development of training for care managers and HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision, including developing a Health Home training guide for key core competency trainings to serving the high need SMI population
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in HH. These services are provided by State Designated Entities (SDE) through direct contracts with the MCO
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS
    - Additional efforts to support initial implementation of RCAs include
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs
        - Ongoing technical assistance.
        - Creation of statewide RCA performance dashboard.

    - The table below represents completed BH Adults HCBS Eligibility Assessments from the launch of the SDE initiative on April 1, 2018 to September 30, 2018.

BH Adults HCBS Eligibility Assessment: Unique Recipients Assessed by SDEs/RCAs

Date of Assessment: Apr. 01, 2018 - Sep. 30, 2018

NYC_ROS	
NYC	**175**
ROS	**161**
Grand Total	**336**

- Continuing efforts to increase HARP enrollment in HH including:
    - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies
    - Existing quality improvement initiative within clinics to encourage HH enrollment
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management

- Ongoing work to strengthen the capacity of HH to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
- Implementing Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach
- Implemented Quality and Infrastructure initiative to support targeted HCBS workflow processes and increase in HCBS utilization. In-person trainings completed June 2018.

As of August 9, 2018, 1,678 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between April 1, 2018 and June 30, 2018, 4503 brief eligibility assessments have been completed.

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

No activity occurred this quarter, as School Based Health Center (SBHC) services will remain carved out of the Medicaid managed care benefit package until January 1, 2021.

FFY 2017-2018: The Department was notified on December 19, 2017, that School-Based Health Centers will remain carved out of Medicaid managed care until January 1, 2021, under an agreement reached between the NYS Legislature and Governor. Andrew Cuomo. However; the Department is planning to reconvene the SBHC Stakeholder Workgroup in December 2018 to build on the work accomplished to date and to ensure continued and documented progress on care coordination strategies that will facilitate a successful transition.

C. Federally Qualified Health Services (FQHC) Lawsuit

No updates.

D. Managed Long-Term Care Program (MLTCP)

All MLTCP models provide a person-centered plan of care; integration of health care, environmental and social services; and a supportive transition from the previous fragmented FFS process to coordinated managed care.

1. Accomplishments

During the July 2018 through September 2018 quarter, one partial capitation plan was approved to withdraw from Albany, Broome, Erie, Monroe, Oneida and Onondaga counties, and one plan was approved to terminate participation in the partial capitation and MAP product lines. During the annual period of October 2017 through September 2018, the Department approved a total of five service area expansions – two for partial capitation plans, two for MAP plans, and one for a PACE. During that same annual period, the

Department approved the closing of a Medicaid Advantage plan, in addition to the above-referenced closing of one plan's partial capitation and MAP lines of business, and the above-referenced service area reduction of a partial capitation plan from six counties.

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 could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the July 2018 through September 2018 quarter, post enrollment surveys were completed for 13 enrollees. Nine of the twelve enrollees (75%) who responded to the question indicated that they continued to receive services from the same caregivers once they became members of an MLTCP (one enrollee did not respond to this question). This represents a slight decrease in affirmative responses from 77% during the previous quarter. As with previous years, the number of enrollees responding to the question varied each quarter during the period October 2017 through September 2018, but the percentage of those that continued to receive services from the same caregiver once they became members of an MLTC plan varied within a range of 4% over the course of the year, down from a variance of 11% last year.

Enrollment: Total enrollment in MLTC partial capitation plans grew from 208,629 to 215,292 during the July 2018 through September 2018 quarter. For that period, 14,109 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a number that is relatively consistent with the previous three quarters and that brings the 12-month total for affirmative choice to 56,886. Monthly plan-specific enrollment for partial capitation plans during the October 2017 through September 2018 annual period is submitted as an attachment.

2. Significant Program Developments

The Managed Long-Term Care (MLTC) Surveillance Unit was created to monitor and improve the quality of MLTC plan operations and service delivery. The ultimate purpose of these efforts is to ensure that the health and welfare of MLTC plan service recipients is protected and that the services received are fair and consistent.

During the July 2018 through September 2018 quarter, one partial capitation focused survey was finalized. In addition:

- A focused survey of plan Member Services was conducted on the 42 CFR 438 regulation changes, specifically focusing on service authorizations and the appeal and grievance processes. All surveys (29) have been finalized.
- The current MLTC ombudsman contract is set to expire on July 31, 2019; therefore, the RFA process was initiated to identify applicants for the next contract.
- New survey software still awaits final approval for purchase.
- Staff training continues as survey processes and tools are revised.

In addition to the fourth quarter activities discussed above, below is a summary of other activities that have occurred during the October 1, 2017, through September 30, 2018, annual period:

- The first round of partial capitation operational and focused surveys was completed, and all surveys have been finalized. Although all surveys in this round were initiated during the last annual period (i.e., prior to October 1, 2017), for most plans, the surveys were finalized during this annual period.

- A focused survey of all MLTC plans was conducted on the timeliness of Universal Assessment Systems (UAS) assessments. Five MLTC plans were required to submit Plans of Correction, and all surveys have now been finalized.

- Model notices for each plan were reviewed to ensure changes resulting from 42 CFR 438 had been incorporated. Plans submitted between 15 and 35 notices for each line of business, in addition to vendor notices, for Department approval.

- During the course of the year, thirty-six (36) focused reviews were conducted for educational purposes on the 42 CFR 438 regulation changes related to appeals and aid continuing. Implementation of the new service authorization, appeals and grievance processes was evaluated, and plans were required to track internal appeals and submit bi-monthly reports to the Department. The Department reviewed a sample of the associated notices for accuracy, providing feedback to plans on a bi-weekly basis.

- The Member Services survey process has been refined to include the issuance of quarterly reports to the plans to assist in improving the overall functioning of their programs.

- The second round of operational and focused surveys for partial capitation plans has been initiated.

- A new unit supervisor began in October 2017, and two staff positions have been filled, including one registered nurse position.

- With the transition to a new supervisor at the beginning of this reporting period, the entire surveillance process was reviewed. Tools, processes, topics/areas of concern, and desk guides are being developed/revised for incorporation into the process for the second round of surveys. Additionally, based on the lessons learned from the partial capitation surveys, the existing MAP survey materials are being refined, and additional materials are being created.

3. Issues and Problems

There were no issues or problems to report for the July 2018 through September 2018 quarter nor for the October 2017 through September 2018 annual 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: There were 1,521 critical incidents reported for the July 2018 through September 2018 quarter, an increase of seventy percent over the last quarter. As with the last quarter, two plans continued to drive the increase. The State has recirculated instructions for the correct reporting of critical incidents and continues to examine this issue to verify that all plans are reporting correctly. For the annual period October 2017 through September 2018, critical incidents increased significantly. Although two plans drove this increase, the State is closely monitoring this area of reporting and will be working directly with individual plans to ensure accurate reporting going forward. Critical incidents by plan for this quarter are attached.

Grievances and Appeals: For the July 2018 through September 2018 quarter, the top reasons for grievances/appeals continue to be dissatisfaction with transportation, dissatisfaction with quality of home care other than lateness/absences, dissatisfaction with the quality of other covered services, home care aides late/absent on scheduled day of services, and other miscellaneous reasons.

Period: 7/1/2018 through 9/30/2018 **(Percentages rounded to nearest whole number)**			
Number of Recipients: 230,374	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**6,831**	**6,831**	**100%**
# Standard/Expedited	**3,765**	**3,904**	**104%**
Total for this period:	**10,596**	**10,735**	**101%**

Appeals	10/2017-12/2017	1/2018-3/2018	4/2018-6/2018	7/2018-9/2018	Average for Four Quarters
Average Enrollment	209,168	219,932	222,512	230,374	220,497
Total Appeals	1,611	1,643	2,451	3,084	2,197
Appeals per 1,000	8	7	11	13	10
# Decided in favor of Enrollee	324	264	629	639	464
# Decided against Enrollee	1,159	1,097	1,432	2,368	1,514
# Not decided fully in favor of Enrollee	130	133	143	119	131
# Withdrawn by Enrollee	50	50	67	138	76
# Still pending	387	485	684	536	523
Average number of days from receipt to decision	15	12	13	12	13

Grievances and Appeals per 1,000 Enrollees by Product Type July 2018-September 2018					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	213,185	6,506	31	2,679	13
Medicaid Advantage Plus (MAP) Total	11,499	2,578	224	367	32
PACE Total	5,690	1,512	266	38	7
Total for All Products:	**230,374**	**10,596**	**46**	**3,084**	**13**

Total Grievances increased 9% from 9,724 the previous quarter to 10,596 during the July 2018 through September 2018 quarter. The total number of appeals increased 26% from 2,451 during the last quarter to 3,084 during the July 2018 through September 2018 quarter. For the annual period October 2017 through September 2018, the number of grievances grew by 30%, and the number of appeals grew by 91%. The large growth in both areas occurred after the April 1st effective date for the 42 CFR 438 requirement that the internal appeals process must be exhausted before going to a fair hearing.

Technical Assistance Center (TAC) Activity

During the July 2018 through September 2018 quarter, volume remained relatively consistent with the previous quarter. Call volumes were in the low two-hundreds. Same-month case resolution had dipped in May and June, but were back up to 92% for both July and August. September's productivity numbers are not typical because staff was working in both the new and the old databases. This is a one-time issue, and next quarter's work and data will all be from the new database.

Call Volume	7/1/2018-9/30/18	10/1/2017-9/30/2018
Substantiated Complaints	104	708
Unsubstantiated Complaints	393	1,440
Complaints Resolved Without Investigation	21	518
Inquiries	68	527
Total Calls	**591**	**3,236**

The five most common types of calls were related to:

Interdisciplinary Team	16%
Home Health Care	12%
Billing—Claim Denials	6%
DME Issues	6%
Increase of Care Denial	3%

The five most common types of calls for the year were the same as for the quarter, in the same order, except for the fifth most common type, which for the year was eligibility and coding issues.

It should be noted that home health care complaints are investigated based upon a member's subjective experience; they do not necessarily represent neglect or abuse.

During the annual period from October 2017 through September 2018, the TAC Unit took in a total of 2,731 new cases and resolved 3,236 cases. Seventy-five percent of cases were closed in the same month they were opened, an increase of four percent over last year. September's efficiency was lower than usual because staff was acclimating to new software and workflows. Removing September's efficiency as an anomaly, annual efficiency goes up to 79%.

The distribution of complaints has changed over the past year, with a higher volume of complaints unsubstantiated and more issues surrounding DME and eligibility. However, these categories make up a small percentage of total complaints, with the bulk still revolving around plan staff, home health aides, and claims.

The new database was launched mid-August. Work with the software designers is currently ongoing in an effort to maximize capabilities, including more efficiently reporting and analyzing complaint data. The category listing was updated to arrange categories by service/topic, add subcategories that highlight specific problems, and add categories to track and capture complaints related to new policies and initiatives.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the July 2018 through September 2018 quarter, 11,220 people were evaluated, deemed eligible and enrolled into

plans, a decrease of 6.2% over the previous quarter. This brings the total for the annual period October 2017 through September 2018 to 45,788.

Referrals and 30-day assessment: For the July 2018 through September 2018 quarter, MLTC plans conducted 12,070 assessments, a decrease of 5% from 12,764 the previous quarter. The total number of assessments conducted within 30 days remains relatively consistent at 9,649 versus 9,887 the previous quarter. During the annual period October 2017 through September 2018, a total of 45,409 assessments were completed, with 79% of those assessments being conducted within 30 days of the request, down 3% from the previous annual period. The Department continues to monitor data collection, evaluation and reporting of CFEEC activity.

Referrals outside enrollment broker: For the July 2018 through September 2018 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 24,880, a 10% increase from 22,572 the previous quarter. The annual period October 2017 through September 2018, saw a steady increase totaling 14%, though the increase was at a much slower pace than the previous annual period (53%).

Rebalancing Efforts	7/2018-9/2018
New Enrollees to the Plan from a nursing home transitioning to the community	955
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,418
Current plan Enrollees permanently placed in a nursing home	16,732
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,062

VI. Evaluation of the Demonstration

A revised evaluation plan was submitted in October 2017 to the CMS evaluation team, including questions regarding the specifics needed for the analytical methods as well as the process for contracting with an independent evaluator. Comments from the evaluation team were received on December 28, 2017. Program staff worked through February 2018 to address CMS comments, and administrative staff finalized questions regarding procurement of the Independent Evaluator (IE). A conference call was held on March 8, 2018 with the CMS project officer, and staff from the CMS Evaluation team, OHIP Waiver Management Unit, and OQPS Division of Performance Improvement and Patient Safety. Several outstanding issues were discussed, including the need and the process for obtaining the IE; the necessity for additional rigor in the analysis methodology; and CMS resources that are available for assistance to program staff to utilize in determining appropriate methodologies. Considerable progress was made as a result of the conference call. After several revisions, the timeline for reporting evaluation results and the evaluation period was approved on April 19, 2018. The evaluation period will run from April 1, 2016 through July 1, 2019, which allows for 3.25 years of data to evaluate. Work began on the Request for Proposals (RFP) to procure an Independent Evaluator to perform the evaluation

work. Program staff prepared a scope of work describing the activities required of the IE as well as the data sources available and the research questions to be answered. The evaluation plan was approved by the CMS evaluation team on July 3, 2018, and was incorporated into the RFP scope of work. Program staff from OQPS and the OHIP Waiver Management Unit assembled the RFP materials and began the formal procurement process. As of September 30, 2018, the RFP document was nearly completed and undergoing the Department's administrative approval process. It is anticipated that the RFP will be released for bid in November 2018.

VII. Consumer Issues

A. All complaints

Medicaid managed care organizations (MMCOs), including mainstream Medicaid managed care plans, Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV SNPs), are required to report the number and types of enrollee complaints they receive on a quarterly basis. Beginning as a "soft launch" in the third quarter, and fully implemented this quarter, the Department required MMCOs to utilize a new secure complaint reporting mechanism through New York's Health Commerce System. The new reporting software will allow the State to be more flexible in developing reporting formats, and will support future adjustments to capture plan-reported complaints that relate to MMCO enrollees in receipt of long term service and supports, as well as those with special health care needs.

The following table outlines the complaints received by category for the reporting period.

MMCO Product Line	Total Complaints FFY Q4 7/1/2018 to 9/30/2018	Total Complaints FFY 18 10/1/2017 to 9/30/2018
Medicaid Managed Care	**6,886**	**24,479**
HARP	**708**	**1,968**
HIV/SNP	**180**	**748**
Total MMCO Complaints	**7,774**	**27,195**

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 7,774. This represents a 11.1% increase from the prior quarter.

This quarter's plan-reported complaint data continues a trend of increasing complaints related to the mainstream plans and HARPs over the last four quarters; and is a 30% increase from the first quarter (10/1/2017-12/31/2017) data. While the trend for HARPs may be partially attributed to the 37% increase in enrollment between September 2017 and September 2018, the Department continues to investigate this trend for both mainstream and HARP to confirm root causes are not attributable to the recent technical change in plan reporting mechanisms. HIV/SNP complaints increased 1.1% compared to first quarter data.

The top five (5) most frequent categories of complaints for mainstream, HARP and HIV SNP combined, were as follows:

Description of Complaint	FFY18 Q4 7/1/2018 to 9/30/2018	Total Complaints FFY 18 10/1/2017 to 9/30/2018
Pharmacy/Formulary	**21%**	**13%**
Balance Billing	**17%**	**22%**
Reimbursement/Billing	**9%**	**11%**
Dissatisfaction with Quality of Care	**8%**	**9%**
Difficulty with Obtaining: Dental/Orthodontia	**6%**	**7%**

HARP Complaints/Action Appeals:
Of the total 7,774 complaints, MMCOs reported, 708 were associated with Health and Recovery Plans (HARPS).

The top five (5) most frequent categories of complaints for HARPSs were as follows:

Pharmacy/Formulary	35%
Dissatisfaction with Quality of Care	11%
Dissatisfaction with Provider Services (Non-medical) or MCO Services	6%
Reimbursement/Billing	6%
Balance Billing	6%

HIV/SNPS
During the quarter, Managed Care Organizations reported 180 complaints/action appeals for HIV Special Needs Plans (SNPs).

The top five (5) most frequent categories of complaints for HIV/SNPs were as follows:

Dissatisfaction with Provider Services (Non-Medical) or MCO Services	24%
Pharmacy/Formulary	17%
Home Health Care	10%
Access to Non-Covered Services	7%
Dental/Orthodontia	6%

Monitoring of Plan Reported Complaints
The Department engages in the following analysis to identify trends and potential problems.

The observed/expected ratio is a calculation developed for each MMCO, which represents a comparison of the number of observed complaints to the number that were expected, based on the MMCO's average enrollment for the quarter, as a portion of total enrollment among all MMCOs. For example, an observed/expected of 6.15 means that there were more than six times the number of complaints reported than were expected. An observed/expected of 0.50 means that there were only half as many complaints reported as expected.

Based on the observed/expected ratio, the Department requests that MMCOs review and analyze categories of complaints where higher than expected complaint patterns persist. During the period of January through June 2018, five plans had observed/expected ratios greater than 2.0 and include: Molina Healthcare of New York, Amida Care, YourCare Health Plan, VNS Choice, and Independent Health Association.

MMCO Outliers January 2018 – June 2018 Observed Expected Ratio Calculations

Plan	o/e All Categories Combined
Molina Healthcare of New York	18.7
Amida Care	8.7
YourCare Health Plan	2.5
VNS Choice	7.7
Independent Health Association	2.5

- **Molina Healthcare of New York:** Molina was required to respond to eight categories.
  - The denial of clinical treatment (3.6 o/e): the plan reported complaints were related to dental treatment denials in accordance with Medicaid dental coverage.** The plan did not identify any systemic or operational issues.
  - Pharmacy/Formulary (34.4 o/e): the plan reported that complaints in this area are related to the January 2018 change in Pharmacy Benefit Manager (PBM) from Express Scripts to CVS Caremark; a large number of the complaints centered on the change from Express Scripts formulary to CVS formulary and the change in Prior Authorization (PA) criteria. The plan reported implementing the following solutions:
    hired temporary staff to respond to the increase of member calls and process authorization requests and educate providers on new authorization process and new formulary; provided new CVS pharmacy fax number to providers; improved internal linkages between pharmacy and enrollment departments to address eligibility issues; hired permanent pharmacy staff; created pharmacy services option in the provider call center tree to route providers directly to the New York Pharmacy team; routed member services call center for New York to a single team who has direct access to the New York Pharmacy team to answer questions and resolve issues real time for members; streamlined member services notification of direct member communications and formulary updates so member services call center has the most current information regarding changes and notifications.
  - Problems with advertising/consumer education/outreach/enrollment (37.2 o/e): the plan did not identify any systemic or operational issues.
  - Balance Billing (6.3 o/e): the plan did not identify any systemic or operational issues. The plan reported that they posted a reminder bulletin to providers that Medicaid enrollees may not be billed.

- Dissatisfaction with provider (non-medical) or MCO services (4.8 o/e): the plan reported a trend related to cancellations or difficulty obtaining an appointment. The plan reported dedicated call center representatives assisted members in making an appointment or finding a new provider if they so choose, and resolving these issues within the first call. The plan reported sharing these member experiences with their provider relations team to outreach to the provider to advise of the complaint as well as monitor to identify if the issues are related to a particular provider.
- Difficulty obtaining specialist and hospitals (45.9 o/e); difficulty obtaining eye care (35.7); and difficulty obtaining Dental/Orthodontia (2.8 o/e): the plan reported complaints were related to members attempting to find a provider. The plan reported enhancing member services response to better educate members on the use of the plan's online provider directory.
- All Other (68.7 o/e): The plan noted a decline in this category, and reports they have New York dedicated call center representatives effective May 2018, who have become subject matter experts to properly code complaint categories.

The Department will continue to monitor Molina Healthcare corrective actions to address the systemic issues identified.

- **Amida Care:** This HIV/SNP plan was required to review higher than expected complaints in the following categories:
  - Difficulty with obtaining personal care (286.5 o/e): the plan received 12 complaints during the six-month reporting period. The plan reported that the complaints were filed against a providing agency and/or identified aides/staff. Common causes for the complaints include: aide no-shows, unprofessional behavior by the aide. The plan continues to monitor member experience with address complaints with the plan's personal care providers.
  - Dissatisfaction with provider (non-medical) or MCO services (59.1 o/e): the plan did not identify any systemic or operational issues. The plan continues to cite efforts to seek enrollee input through periodic touchpoints resulted in an increase in overall complaint filings. The plan will monitor complaints under this category for improvement opportunities through their quarterly Member Complaints Committee.
  - Difficulty obtaining dental/orthodontia (9.5 o/e): the plan reported complaints were related to the limited Medicaid dental benefit and were related to dissatisfaction with provider/staff behavior. Amida Care, through their dental vendor, HealthPlex, continues to circulate educational materials for the dental services covered under the plan. Amida Care reported enhancement of utilization management procedures and additional oversight on dental denials. Amida Care re-iterated to HealthPlex its expectations regarding treating members with dignity and respect when they are accessing care. HealthPlex re-educated all providers connected to these complaints.**
  - Pharmacy/formulary (8.1 o/e): the plan reported member concerns were primarily related to member disagreements with Amida Care or Medicaid policies; the plan did not identify any systemic or operational issues.

- Problem with advertising/consumer education/outreach/enrollment (15.6 o/e): the plan reported that 94% (15) of the complaints filed under this category were related to the Amida Care Healthy Rewards Program. In the Healthy Rewards Program members receive incentives in the form of pre-paid gift cards for completing preventative medical visits and screenings. The plan stated they re-issued approximately 4,000 gift cards due to a 2018 expiration date; generating concerns regarding replacement cards. The plan established a weekly touchpoint with their vendor, InComm, to troubleshoot and resolve issues quickly.

The Department will continue to monitor the plan's activities to address root causes of the systemic issues identified.

- **Your Care Health Plan:** Your Care responded to two categories:
  - Denial of Clinical Treatment (2.4 o/e): The plan reported complaints were related to dental treatment denials in accordance with Medicaid dental coverage.** The plan did not identify any systemic or operational issues.
  - Reimbursement/billing (17.9 o/e): The plan reported that complaints were related to enforcement of the claims timely filing limit. The timely filing limit was lifted in February 2018 to accommodate providers adjusting to new claims system and processes. The plan will issue a provider bulletin reminding providers of the timely filing limit.

  The Department will continue to monitor the plan's activities to address the systemic issues identified.

VNS Choice: VNS Choice responded to higher than expected complaints in one category:

- All Other (14.7 o/e): The plan reported that nearly all of these complaints were resolved on the same day, and that about half of those resolved the same day were related to requests for DME and/or associated supply orders. Effective 10/15/18, the plan reported establishing a pilot DME ordering platform with their DME vendor to reduce delivery errors and increase member satisfaction; if successful the ordering platform will be expanded.

The Department will continue to monitor the plan's corrective actions to address the systemic issues identified.

Independent Health Association: Independent Health Association responded to higher than expected complaints in seven categories:

- Appointment Availability – PCP (11.2 o/e): the plan received 12 complaints during the six-month reporting period, and while 7 were regarding members seeking participating providers, no systemic issues were identified.
- Dissatisfaction with quality of care (2.1 o/e): the plan did not identify any systemic or operational issues, and did not identify any trends related to a particular provider.
- Difficulty obtaining specialists and hospitals (6.1 o/e): the plan did not identify any systemic or operational issues, and did not identify any trends related to a particular provider.

- Difficulty obtaining eye care (13.9 o/e): the plan reported that complaints were related to members seeking participating providers and related to the Medicaid vision benefit; no systemic issues were identified.
- Difficulty obtaining dental/orthodontia (5.8 o/e): The plan reported complaints were related to the limited Medicaid dental benefit**, out of network requests, and related to the quality of care or service received. Through their dental vendor, HealthPlex, the plan has engaged in a monthly auditing process to review sample appeal cases to ensure compliance with regulatory requirements.
- Pharmacy/formulary (8.1 o/e): the plan reported member concerns were primarily related to member disagreements with formulary requirements and quantity limitations; the plan did not identify any systemic or operational issues.
- All other (2.1 o/e): the plan reported complaints regarding member enrollment issues from the New York State of Health outside of the plan's control and the plan's HIPAA authorization policy; the plan did not identify any systemic or operational issues.

The Department will continue to monitor the plan's activities to address root causes of the systemic issues identified, including addressing the report of members seeking assistance with finding network providers across several categories.

If no reduction is noted following several quarters of the implementation of a corrective action, an alternate or more prescriptive response will be requested to address the issue. **Note: the Department issued updated Dental policy guidance on the coverage of prosthodontics and implant services when medically necessary effective November 12, 2018, and will adjust trending and analysis of plan reported complaints related to dental services to assess the impact of these changes going forward.

Long Term Services and Supports

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 6,886 total reported complaints/action appeals, mainstream MMCOs reported 599 complaints and action appeals from their SSI enrollees. This compares to 578 SSI complaints/action appeals from last quarter.

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

Category	Number of Complaints/Action Appeals Reported for SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	17
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	1
Appointment Availability – BH HCBS	0
Balance Billing	58
Communications/Physical Barrier	8
Consumer Directed Personal Assistant	2
Denial of Behavioral Health Clinical Treatment	0
Denial of Clinical Treatment	28
Dental or Orthodontia	76
Dissatisfaction with Behavioral Health Provider Services	1
Dissatisfaction with Health Home Care Management	3
Emergency Services	6
Eye Care	2
Family Planning	0
Home Health Care	2
Mental Health/Substance Abuse Services/ Treatment	2
Non-covered Services	19
Non-Permanent Resident Health Care Facility	2
Personal Care Services	7
Personal Emergency Response System	0
Pharmacy	56
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	55
Quality of Care	141
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	36
Specialist or Hospital Services	9
Transportation	1
Waiting Time Too Long at Office	4
All Other Complaints	54
Total	**599**

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

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Quality of Care	24%
Dental or Orthodontia	13%
Balance Billing	10%
Pharmacy	9%
Provider or MCO Services (Non-Medical)	9%

As part of the complaint reporting mechanism change, beginning this quarter, the Department required MMCOs to report the number of enrollees in receipt of long term services and supports as of the last day of the quarter. As of September 30, 2018, plans reported 25,529 enrollees were in receipt of long term services and supports.

The following table describes the total complaints/action appeals that were reported by plans involving difficulty with obtaining long term services and supports for the last four quarters.

Long Term Services and Supports	Number of Complaints/Action Appeals Reported			
	Q1 FFY 18	Q2 FFY 18	Q3 FFY 18	Q4 FFY 18
AIDS Adult Day Health Care	2	0	2	0
Adult Day Care	0	0	0	0
Consumer Directed Personal Assistant	1	2	8	3
Home Health Care	29	31	31	39
Non-Permanent Residential Health Care Facility	1	3	0	7
Personal Care Services	16	14	19	16
Personal Emergency Response System	1	0	1	0
Private Duty Nursing	0	0	0	0
Total	**48**	**50**	**61**	**65**

Critical Incidents:

As part of the plan-reported complaint mechanism change, beginning this quarter, the Department required MMCOs to report critical incidents involving enrollees in receipt of long term services and supports through the new reporting platform. This change will enable the Department to enhance tracking and monitoring of critical incidents reported by MMCOs. There were 63 critical incidents reported for the July 1, 2018 through September 30, 2018 period. The number of critical incidents reported by MMCOs are as follows. These figures will serve as a basis for future trend analysis and confirmation of MMCO reporting compliance.

Critical Incidents July 1, 2018 – September 30, 2018	
Plan Name	**Total Critical Incidents**
Mainstream Managed Care	
Affinity Health Plan	0
Capital District Physicians Health Plan	0
Crystal Run	0
Excellus Health Plan	1
Fidelis Care	0
Healthfirst PHSP	1
Health Insurance Plan of Greater New York	0
HealthNow	0
HealthPlus	0
Independent Health Association	0
MetroPlus Health Plan	3
Molina Healthcare	1
MVP Health Plan	0
United Healthcare Plan of New York	0
Wellcare of New York	0
YourCare Health Plan	0
Total	6
Health and Recovery Plans	
Affinity Health Plan	0
Capital District Physicians Health Plan	0
Excellus Health Plan	4
Fidelis Care	0
Healthfirst PHSP	49
Health Insurance Plan of Greater New York	0
HealthPlus	0
Independent Health Association	0
MetroPlus Health Plan	0
Molina Healthcare	0
MVP Health Plan	0
United Healthcare Plan of New York	0
YourCare Health Plan	0
Total	53
HIV Special Needs Plans	
Amida Care	0
MetroPlus Health Plan SNP	0
VNS Choice SNP	4

Total	4
Grand Total	63

Consumer Complaints Received Directly at NYSDOH
In addition to the MMCO reported complaints, the Department directly received 138 consumer complaints this quarter. This total is a sharp decrease from the previous quarter, which reported 483 complaints.

Beginning on September 1, 2018, the Department began use of a new internal secure complaint tracking system. The new system allows the Department a sustainable platform to continue and enhance investigation of complaints, tracking, trending and analysis of reported issues.

Upon analysis of previously reported complaints, it was determined that under the previous complaint tracking system, the Department inadvertently reported inquiries not representative of a complaint, and complaints from: health care providers, third party billers, hospitals, clinics, etc.; rather than accurately reporting only consumer concerns. The 138 complaints total reported this quarter, includes an adjustment to reflect only complaints coming from consumers, including: enrollees, enrollee designees, or consumer representatives.

The top 5 most frequent categories of consumer complaints received directly at NYSDOH involving MMCOs were as follows:

Benefit Coverage Issues	19%
Reimbursement/Billing	16%
Difficulty Obtaining Covered Home Health Care Services	9%
Difficulty with obtaining referrals or covered services for dental or orthodontia	5%
Pharmacy/Formulary	5%

Annually, the Department directly received 1,769 MMC complaints. For the purposes of comparison, these annual figures represent previously reported complaints sent directly to NYSDOH, including complaints from both providers and enrollees regarding Medicaid managed care, HARP and HIV/SNPs.

MMC Complaints Received by Directly by the Department

Q1	Q2	Q3	Q4	Total FFY 18
451	469	483	366* (138 consumer; 228 provider)	1,769

*This total will be adjusted going forward to represent only complaints filed by consumers and their representatives.

Fair Hearings

Fair Hearing Decisions (includes MMC, HARP and HIV SNP plans)	7/1/18-9/30/18
In favor of Appellant	201
In favor of Plan	165
No Issue	46
Total	**412**

Fair Hearings Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP plans)	7/1/18-9/30/18
Less than 30 days	21
30-59	130
60-89	107
90-119	75
=>120	79
Total	**412**

There were 412 fair hearings involving mainstream Medicaid managed care plan, HARPs, and HIV SNPs during the July 1, 2018 through September 30, 2018 period.

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on September 28, 2018. The meeting included presentations provided by state staff and discussions of the following: current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs; an update on activities related to operationalizing Community First Choice Option (CFCO); and an update on Behavioral Health, Health and Recovery Plans (HARPs) and Health Homes. Additional agenda items included a presentation from the AIDS Institute regarding Harm Reduction Services. In addition, the Office of Health Insurance Programs gave an overview of the activities related to the Enrollment Broker Contract. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for December 6, 2018.

FFY 2017-2018: The Medicaid Managed Care Advisory Review Panel is required to meet quarterly. Meetings were held on December 7, 2017, February 22, 2018, June 21, 2018, and September 28, 2018.

C. Transition of Harm Reduction Services from Grant Funded to Medicaid Fee-for-Service & Medicaid Managed Care (MMC)

The transition of Harm Reduction Services (HRS) to Medicaid FFS and MMC occurred on July 1, 2018. The HRS guidance document, billing guidance, frequently asked questions (FAQs), list

of Syringe Exchange Providers, the template enrollee handbook language, and template member notice are posted to the MRT 8401 page on the DOH website.

FFY 2017-2018: In October 2017, the AIDS Institute (AI) began planning for the implementation of Harm Reduction Services, these services were previously offered and reimbursed through grant funds. Multiple meetings took place with AI staff to draft HRS guidance document, draft billing guidance, and draft responses to frequently asked questions (FAQs). The Department & AI staff met with stakeholders and MMC plans prior to the implementation date, to discuss the HRS guidance, and billing guidance. To date, there have been no significant issues with this transition process.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

Quality Assurance Reporting Requirements (QARR)

We had 24 Managed Care Organizations submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2018. This includes 14 of Qualified Health Plans operating through the NY 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 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.

In December, the Department released to the MLTC plans, their Crude Percent Reports for the time period of January through June 2017. 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.

In December, we released to the plans the methodology for the 2018 MLTC Quality Incentive.

2017 Managed Long-Term Care Report
The 2017 MLTC Report was publicly released in April 2018. This Report presents information on the 62 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

2017 Managed Long-Term Care Consumer Guides

The 2017 MLTC Consumer Guides were released in April 2018 on the Department's website. The Guides are also printed by Maximus, our facilitated Medicaid enroller, for inclusion in new member's packets. The Guides help new members to choose a managed long-term care plan that meets their health care needs. The Guides offer information about the quality of care offered by the different plans, and people's opinions about the care and services the plans provide.

2017 Managed Long-Term Care Crude Percent Reports

In June, we released Crude Percent Reports for the July through December 2017 time period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each plan's July through December 2017 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month time period.

The Crude Percent report provides a breakout by percentage (unless a metric is reported as an average) of each response level for most components of the Community Assessment, Functional Supplement, and Mental Health Supplement across two six-month time periods. Plans were also provided the percentages for the rest of the state with their plan excluded for comparison purposes. Plans were encouraged to review the reports, compare their results to previous data, and look at areas with changes from the previous reporting period to ensure data completeness.

2017 Quality Incentive for Managed Long-Term Care (MLTC)

2017 Quality Incentive awards were announced in April 2018. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, compliance, and efficiency. Since the MLTC is budget neutral, the bottom tier did not receive any contributed monies back, all the other tiers received back a portion or full amount of contributed monies plus additional award.

Payer	**Plan ID**	**Plan Name**	**QI Points, adjusted**	**Tier**
payer	plan_id	plan_name	points_total_adj	
partial	03549135	Extended MLTC	78.75	3
partial	03234044	ElderServe dba RiverSpring	70.00	3
partial	02104369	Senior Health Partners	68.75	3
partial	03253707	Elderplan dba Homefirst	65.00	3
MAP	03173113	Elderplan	61.25	3
partial	03420399	VillageCareMAX	60.00	3
MAP	03420808	MHI Healthfirst Complete Care	60.00	3
partial	02710185	CenterLight Select	58.75	2
partial	03522947	Hamaspik Choice	55.50	2
partial	01865329	Independence Care System	55.00	2

partial	03459881	Senior Whole Health Partial	55.00	2
PACE	03072740	Catholic Health - LIFE	54.75	2
partial	03481927	AgeWell New York	54.25	2
partial	03475427	Integra MLTC	53.75	2
PACE	01674982	Eddy Senior Care	53.00	2
partial	03506989	Centers Plan for Healthy Living	52.50	2
partial	02825230	WellCare Advocate Partial	52.50	2
partial	03594052	Montefiore MLTC	51.25	2

partial	03458546	Aetna Better Health	49.25	1
PACE	03320725	Complete Senior Care	48.93	1
PACE	04190745	Fallon Health Weinberg-PACE	48.85	1
PACE	01234037	CenterLight PACE	48.75	1
MAP	02914056	VNS CHOICE Total	45.00	1
partial	02644562	Empire BCBS HealthPlus MLTC	43.75	1
PACE	01278899	ElderONE	43.00	1
partial	03466906	MetroPlus MLTC	42.50	1
MAP	02927631	Fidelis Medicaid Advantage Plus	42.31	1
partial	01788325	Fidelis Care at Home	41.25	1
PACE	03114514	ArchCare Senior Life	41.25	1
PACE	01519162	PACE CNY	40.50	1
PACE	03056544	Total Senior Care	40.00	1

partial	03581413	Prime Health Choice	39.23	0
partial	03560441	AlphaCare of New York	38.75	0
partial	01750467	VNS CHOICE MLTC	38.75	0
MAP	02942923	GuildNet Medicaid Advantage Plus	38.00	0
partial	03466800	ArchCare Community Life	37.50	0
partial	03690851	Kalos Health	35.00	0
partial	03580307	North Shore-LIJ Health Plan	35.00	0
partial	03529059	VNA Homecare Options	35.00	0
partial	01778523	Senior Network Health	34.00	0
partial	01825947	EverCare Choice	33.75	0
partial	03439663	United Health Personal Assist	33.50	0
partial	03866960	iCircle	33.00	0
MAP	02932896	Senior Whole Health	32.69	0
partial	01827572	GuildNet	30.50	0

partial	02188296	Fallon Health Weinberg	26.00	0

C. Quality Improvement

External Quality Review

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, Part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including, performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and providing data processing and analytical support to the Department. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, FIDAs, FIDA-IIDs, HARPs, and BHOs, and include the state's Child Health Insurance Program (CHP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

During the quarter extending from July through Sept 2018, an Access Survey of Provider Availability and a Member Services Survey were completed. A new High Volume PCP Ratio survey was planned, to be initiated in the Fall.

Network changes and continued modifications were ongoing in the rebuild and rollout of the new Provider Network Data System (PNDS). IPRO has been diligent in overseeing two sub-contracts for the management of this work and has facilitated the ongoing adjustments and fixes required as new unanticipated issues arise. Data validation issues were addressed.

A Uniform Assessment System audit was completed in the quarter, and final reports drafted. DOH is currently in the process of obtaining Executive Deputy Commissioner Clearance for the reports so that they can be posted and disseminated to the plans. In addition, a Focused Clinical Study was conducted by IPRO, comprised of an over-read of long term care necessity determinations by a subcontractor, Maximus.

IPRO also ended its involvement in a second Focused Clinical Study looking at patient activation in Health Homes. DOH is completing the project in conjunction with Health Homes.

On the quality measurement front, IPRO processed QARR data submissions from plans and NCQA through patient level data (PLD) files and the IDSS, respectively. Validation of submitted IDSS data was completed using the PLD files. Plans with reporting issues were contacted by IPRO for rectification and re-submission. Meanwhile, work began on development and review of 2019 QARR specifications. Specifically, IPRO reviewed and provided a summary of changes to the HEDIS measures, and began preparation for a technical webinar, which was subsequently held in October.

Planning for a child CAHPS® was initiated late in the quarter, and a non-CAHPS® satisfaction of care survey was administered to enrollees with diabetes, to collect information on education and self-management of the disease.

IPRO conducted recurring group calls to facilitate completion of MMC, MLTC, and HARP required Performance Improvement Projects (PIPs). Specific information about the MMC and HARP PIP work completed in this quarter can be found under the Performance Improvement Project description.

Finally, IPRO concluded their work on the Prenatal Care Provider Reporting project. The NYS DOH will be handling subsequent analyses and final reports.

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

The Prenatal Care quality improvement project successfully collected medical record review data, for the birth year 2014, from 40 provider practices. The aggregate data was reported back to the participating practices to be able to compare their performance to their peers. Practices have been sent a survey to evaluate their experience submitting the data and the usefulness of the data in planning quality improvement initiatives within their practice. In addition, the 2014 birth year aggregate report has been completed.

For 2015-2016, the two-year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers was implemented. Identification of MCO enrollees who are smokers was included as a major focus of the projects. Additionally, all plans were required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. The Final PIP Reports were submitted to IPRO in July 2017. The Final Reports were reviewed and approved. A Compendium of abstracts is currently being prepared and when finalized it will be available on the public website.

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic is Inpatient Care Transitions. In January 2018 fifteen plans submitted Interim Reports summarizing their progress for the first year implementing the PIP. Oversight calls with IPRO and individual HARP plans and HIV SNP plans were conducted in March 2018 and July to August 2018. Each plan submitted a written summary of progress to IPRO before the call was conducted. There were five webinars conducted in 2018 with the participating HARP and HIV SNP plans presenting

their progress on the PIP. The webinars were held on January 23, 2018, March 19, 2018, May 4, 2018, July 13, 2018 and September 17, 2018. For each of these webinars three health plans presented their PIP progress to the group. The PIP Final Report will be due in July 2019.

For the 2017-2018 PIP for the MMC plans the selected common topic is Perinatal Care. There are four priority focus areas to be addressed in this PIP: history of prior spontaneous preterm birth; unintended pregnancy suboptimal birth spacing; maternal smoking; and maternal depression. In January 2018 fifteen plans submitted Interim Reports summarizing their progress for the first year implementing the PIP. The IPRO oversight calls were conducted in April and August 2018. Each plan submits a written summary of progress to IPRO before the call is conducted. There were five webinars conducted in 2018 with the participating MMC plans presenting their progress on the PIP. The webinars were held on January 18, 2018, April 19, 2018, May 10, 2018, June 26, 2018 and August 2, 2018. For each webinar two to three Medicaid managed care plans presented their Perinatal PIP progress to the group. The PIP Final Report will be due in July 2019.

We conducted a PIP Planning conference call with the three HIV SNP plans on September 12, 2018 with the AIDS Institute, IPRO and NYSDOH. The purpose of the call was to provide an overview of "What is a PIP?". In addition, we discussed potential topics for the 2019-2020 PIP. Follow up conference calls with the HIV SNP plans will be conducted in October 2018 to further delineate their 2019-2020 PIP topics.

The 2019-2020 HARP PIP topic is under discussion with the NYSDOH, the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and IPRO. An October 10, 2018 webinar is planned with the HARP and HIV SNP plans to further discuss the potential areas of opportunity for the PIP.

The 2019-2020 Medicaid managed care PIP topic will be the KIDS Quality Agenda. NYSDOH and IPRO are preparing for an October 23, 2018 webinar with the MMC plans to introduce the topic. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children.

Breast Cancer Selective Contracting

Staff successfully completed the Breast Cancer Selective Contracting process for contract year 2018-2019. This included: refining the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); identifying low-volume facilities for restriction; notifying restricted facilities of their status; conducting the appeals process; posting the list of restricted facilities on our website; and sharing the list of restricted facilities with staff at eMedNY to restrict Medicaid fee-for service payment, as well as, sharing the list

with Medicaid managed care health plans' Chief Executive Officers and Medical Directors.

In total, the annual review identified 255 facilities. Facility designations were as follows: 114 high-volume facilities, 25 low-volume access facilities, 76 low-volume restricted facilities, and 42 closed facilities.

Staff also completed the summer review of breast cancer surgical volume data and provisional volume designations for contract year 2019-2020 were shared with facilities' SPARCS coordinators in August 2018. 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.

The Breast Cancer Selective Contracting Policy manuscript, which provides an in-depth review of the policy's impact on access to care, quality of care and survival rates, was submitted for publication approval. The manuscript demonstrates that High-Volume facilities outperformed Low-Volume facilities on several quality of care measures, including: lower rates of readmission post-breast cancer surgery and higher rates of radiation, chemotherapy and adjuvant hormone therapy. Three-year survival rates correlated with stage of disease and patient demographics, but not facility or surgeon volume. The manuscript will be submitted to Health Services Research for publication.

Patient Centered Medical Home (PCMH)

As of September 2018, there were 8,900 NCQA-recognized PCMH providers in New York State. 21 providers that became recognized in September 2018 were new to the program and have not been recognized previously under 2011 standards. Approximately 98% (8,732) of current PCMH providers are recognized under the 2014 set of standards. Only 21 providers remain under the 2011 standards and they are expected to expire by the end of fall 2018. On April 1, 2017 NCQA released their 2017 recognition standards, eliminating the leveling structure. There are 74 providers and 26 practices recognized under the 2017 standards. On April 1, 2018 the New York State Department of Health released a new recognition program called the New York State Patient-Centered Medical Home (NYS PCMH). There are 74 providers and 23 practices recognized under the NYS PCMH standards.

Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017-recognized providers. The incentive changes were detailed in an April 2018 Medicaid Update:
https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of September 2018 are:

- 2011 level 2: $0 per member per month (PMPM)
- 2011 level 3: $0 PMPM
- 2014 level 2: $0 PMPM
- 2014 level 3: $6.00 PMPM
- 2017 recognition: $6.00 PMPM
- NYS PCMH: $6.00 PMPM

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2019 but discussions around alignment of methods for shared savings models are still not finalized.

All 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.

The number of NCQA-recognized providers in New York State has steadily increased throughout the year. As of October 2017 there were 7,258 NCQA-recognized PCMH providers in New York State. This number grew to 8,900 by the end of the fourth quarter in September 2018. From October 2017 to September 2018, the number of PCMH providers recognized under the 2014 set of standards went from 93% (6,756) to 98% (8,732). Only 21 providers (<1%) remain under the 2011 standards and they are expected to expire by the end of fall 2018. The number of NCQA-recognized PCMH practices in New York State also increased throughout the year, going from 1,658 in October 2017 to 2,423 in September 2018.

On April 1, 2018 the New York State Department of Health released a new recognition program called the New York State Patient-Centered Medical Home (NYS PCMH). The NYS PCMH Recognition Program is exclusive to New York State and seeks to establish a uniformed approach of improving primary care across New York State. The first providers and practices achieved NYS PCMH recognition in July 2018. As of September 2018, 5,012 providers and 1,270 practices have enrolled in NYS PCMH, and 74 providers and 23 practices of those enrolled have achieved NYS PCMH recognition.

There were multiple payment changes made throughout the year. Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017 recognized providers. Effective July 1, 2018, the PMPM for 2014 level 3 or 2017-recognized providers increased from $5.75 to $6.00. As of September 2018 incentive payments for 2014 level 2 standards remain discontinued and incentive

payments for 2014 level 3, 2017 standards, and NYS PCMH standards are set at $6.00 PMPM.

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 complete as of this quarter, with final calculations for DY17 quarter 4 submitted on February 16, 2018.

The state budget neutrality team is now working 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 has resumed timely quarterly expenditure reporting for 21-month lag reports and is currently working to complete all outstanding 3-month lag reports.

As detailed in STC X.10, the State has identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011 through March 31, 2016 period. The State worked with KPMG and CMS to finalize and approve an audit plan. Work on the audit was started and largely completed over the summer. Preliminary audit findings have been reported to the State and presented to Budget Neutrality contacts at CMS. A final audit report is forthcoming, pending final State approval of an amendment to KPMG's contract to cover the review of F-SHRP which was not explicitly identified as in scope in the STCs or RFP. Pending the submission of the final audit report, the State is awaiting confirmation from CMS that all corrective action requirements outlined in the STCs have been satisfied.

The State has begun to address preliminary audit findings concerning incomplete data for F-SHRP DY6 and is targeting December 31, 2018 for submission to CMS. The State will address any other findings contained within the final audit report as soon as possible once the report becomes available.

B. Designated State Health Programs

No updates.

XI. Other

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

The State sends the following files to CMS monthly:

- Eligibility
- Provider
- Managed Care
- Third Party Liability
- Inpatient Claims
- Long-Term Care Claims
- Prescription Drug Claims
- Other Types of Claims

The state is current in its submission of these claims files. Additionally, the state is working with CMS on several initiatives to improve the data quality of its submissions.

The Medicaid Data Warehouse (MDW) along with subject matter experts from Center for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) completed a data quality review of the Transformed Medicaid Statistical Information System (T-MSIS) production data, focusing on twelve high priority, cross-cutting data quality indicators that are critical to support data analytics. These are identified in the T-MSIS Data Quality Report. While most items were determined not to be data quality issues, several items required a state plan of action. This quarter the state initiated a project to fix some of the issues and address some data needs such as New Aid Category.

This quarter the state initiated a project to create an extract of the Transformed Medicaid Statistical Information System (T-MSIS) claim and encounter information for Money Follows the Person (MFP) identified claims/encounters and an extract of eligibility information for MFP members. This data will be used by the MFP unit in place of the current submissions to support a more accurate claiming of an increased federal enhanced match for MFP participants.

In the coming months, the state will work to include data elements requested by CMS via addendum B in the T-MSIS data feed. The state will continue to work with CMS to improve the data quality of its submissions.

B. 1115 Waiver Public Comment Days

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.

On November 16, 2017, the Department of Health conducted a public forum held at the Academy for Medicine, Reading Room, 1216 5th Ave, New York, NY and again on June 19, 2018 held at the Empire State Plaza, Meeting Room 6, Albany, NY.

A recording of the live webcasts, transcript, written public comments, and presentation slides from each public forum are available for viewing at the link below. To access the information, click on "MRT Public Comment Days and Written Submissions." All written public comments received are shared with program areas within the State for their consideration in shaping policy and procedures.

https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.

Attachments:
Attachment 1— MLTC Critical Incidents
Attachment 2— MLTC Partial Capitation Plan Enrollment

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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Critical Incidents July - September 2018		
Plan Name:	**Plan Type**	**Total Critical Incidences**
Partical Capitation Plans		
Aetna Better Health	Partial	-
AgeWell New York ,LLC	Partial	21
AlphaCare of New York Inc.	Partial	-
Amerigroup	Partial	1
ArchCare Community Life	Partial	19
CenterLight Healthcare Select	Partial	-
Centers Plan for Healthy Living	Partial	26
Elant Choice	Partial	1
ElderServe Health, Inc.	Partial	-
Elderwood	Partial	1
Extended	Partial	113
Fallon Health Weinberg	Partial	1
FIDELIS Care New York	Partial	-
GuildNet MLTCP	Partial	165
Hamaspik Choice	Partial	1
HomeFirst MLTC, a product of Elderplan	Partial	-
I Circle	Partial	-
Independence Care Systems	Partial	15
Integra MLTC	Partial	-
Kalos, dba First Choice Health	Partial	2
Metroplus	Partial	1
Montefiore Diamond Care	Partial	6
NSLIJ Health Plan	Partial	-
Prime Health Choice, LLC	Partial	91
Senior Health Partners	Partial	437
Senior Network Health	Partial	-
Senior Whole Health	Partial	2
United Healthcare Personal Assist	Partial	-
VillageCareMAX	Partial	95
VNA Homecare Options, LLC	Partial	85
VNSNY CHOICE MLTC	Partial	18
Wellcare	Partial	33
Total		**1,134**
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	-
Fidelis Medicaid Advantage Plus	MAP	-
GuildNet GNG	MAP	18
Healthfirst CompleteCare	MAP	291
HEALTHPLUS AMERIGROUP	MAP	-
Senior Whole Health	MAP	-
VNSNY CHOICE MLTC TOTAL	MAP	-
Total		**309**

Critical Incidents July - September 2018		
Plan Name:	**Plan Type**	**Total Critical Incidences**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	12
Catholic Health LIFE	PACE	25
CenterLight Healthcare	PACE	8
Complete Senior Care	PACE	3
Eddy SeniorCare	PACE	-
ElderONE	PACE	-
Fallon Health Weinberg	PACE	-
Independent Living Services of CNY (PACE CNY)	PACE	30
Total Senior Care	PACE	-
Total		**78**
Grand Total		**1,521**

Managed Long Term Care
Partial Capitation Plan Enrollment
October 2017 through September 2018

Plan Name	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Aetna Better Health	4,673	4,897	5,202	5,328	5,519	5,602	5,743	5,905	6,054	6,260	6,330	6,452
AgeWell New York	8,792	8,868	9,221	9,349	9,357	9,387	9,425	9,515	9,590	9,643	9,688	9,777
AlphaCare	4,692	4,775	4,589	37	14	3	5	5	3	0	0	0
ArchCare Community Life	2,993	3,187	3,294	3,483	3,528	3,587	3,671	3,708	3,774	3,865	3,934	3,997
Centers Plan for Healthy Living	19,199	20,046	24,655	25,276	25,801	26,363	26,996	27,726	28,275	28,938	29,427	29,980
Elant	879	902	909	916	912	931	942	971	973	977	995	978
Elderplan	12,579	12,610	12,668	12,700	12,704	12,736	12,691	12,751	12,848	12,941	12,943	13,130
Elderserve	11,354	11,390	11,497	11,626	11,751	11,893	12,032	12,155	12,289	12,399	12,380	12,453
Elderwood	171	188	197	203	206	227	255	271	284	305	328	353
Extended MLTC	3,110	3,320	3,481	3,629	3,757	3,918	4,085	4,290	4,488	4,714	4,874	4,982
Fallon Health Weinberg (TAIP)	627	651	670	682	678	687	706	709	716	728	742	764
Fidelis Care at Home	19,890	20,126	20,485	20,863	20,878	21,011	20,989	21,048	21,120	21,399	21,626	21,870
Guildnet	9,508	9,027	8,555	8,243	8,076	7,876	7,670	7,541	7,480	7,427	7,316	7,332
Hamaspik Choice	2,074	2,104	2,128	2,151	2,151	2,175	2,179	2,186	2,166	2,206	2,196	2,214
HealthPlus- Amerigroup	4,677	4,760	4,827	4,895	4,929	4,911	4,931	4,968	5,016	5,060	5,080	5,174
iCircle Services	2,147	2,212	2,257	2,342	2,384	2,441	2,485	2,556	2,600	2,647	2,691	2,769
Independence Care Systems	6,603	6,602	6,593	6,649	6,597	6,572	6,509	6,443	6,377	6,325	6,182	6,077
Integra	7,529	7,949	8,404	8,897	9,362	9,874	10,295	10,797	11,203	11,764	12,226	12,844
Kalos Health- Erie Niagara	1,252	1,248	1,264	1,265	1,254	1,235	1,252	1,276	1,294	1,291	1,309	1,318
MetroPlus MLTC	1,691	1,715	1,747	1,782	1,783	1,811	1,836	1,824	1,866	1,858	1,857	1,838
Montefiore HMO	1,432	1,447	1,465	1,460	1,462	1,464	1,474	1,495	1,507	1,519	1,520	1,526
North Shore-LIJ Health Plan	5,432	4,666	192	23	6	2	1	1	1	0	0	0
Prime Health Choice	308	316	334	353	354	355	360	369	373	379	383	393
Senior Health Partners	14,304	14,419	14,475	14,478	14,412	14,423	14,388	14,467	14,570	14,507	14,397	14,451
Senior Network Health	534	539	544	543	532	546	550	545	547	546	548	554
Senior Whole Health	9,359	9,440	9,575	13,969	13,779	13,776	13,634	13,642	13,726	13,922	13,874	13,955
United Healthcare	3,506	3,652	3,789	3,917	3,973	4,044	4,070	4,161	4,214	4,254	4,211	4,190
Village Care	8,924	9,105	9,276	9,538	9,779	9,925	10,068	10,254	10,429	10,668	10,716	10,775
VNA HomeCare Options	5,567	5,785	5,987	6,153	6,266	6,322	6,479	6,595	6,606	6,715	6,811	6,967
VNS Choice	12,704	12,756	12,812	12,934	12,899	12,806	12,788	12,743	12,749	12,758	12,651	12,699
WellCare	5,763	5,753	5,767	5,758	5,696	5,610	5,516	5,521	5,490	5,511	5,501	5,480
TOTAL	**192,273**	**194,455**	**196,859**	**199,442**	**200,799**	**202,513**	**204,025**	**206,438**	**208,629**	**211,526**	**212,736**	**215,292**