MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 20 (4/1/2018-3/31/2019)
Federal Fiscal Quarter: 1 (10/1/2018-12/31/2018)

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: First Quarter

MRT Waiver- Enrollment as of December 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	600,221	9,804	58,809
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	97,242	2,487	7,584
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	13,441	324	1,565
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	2,953	103	376
Population 5 - Safety Net Adults	403,639	12,517	50,706
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)	25,747	886	150
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	187,426	8,368	1,694

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	1,536	229	46
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	52,279	4,024	2,703

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	38,742 or an approximate 0.4% decrease from last Q

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

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.

This quarter's voluntary disenrollment showed a decline when compared to the prior quarter. Factors contributing to a decline in this quarter would include a decrease in the number recipients disenrolled due to becoming dually eligible and a decrease in the passive enrollment of a plan's HARP eligible population into the plan's HARP offspring.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	123,633 or an approximate 3.9% decrease 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.

The decline in this quarter's involuntary disenrollment is attributable to a decline in case closures. This includes both ordinary case closures and MAGI case closures where the case is closed in WMS and subsequently sent to NYSoH.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
October 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	1,041,315	20,601	3,099	17,502
Rest of State	400,392	11,769	1,186	10,583
Statewide	1,441,707	32,370	4,285	28,085
November 2018				
New York City	1,027,693	18,287	2,559	15,728
Rest of State	381,495	10,169	963	9,206
Statewide	1,409,188	28,456	3,522	24,934
December 2018				
New York City	1,004,913	19,095	2,680	16,415
Rest of State	366,457	10,643	981	9,662
Statewide	1,371,370	29,738	3,661	26,077

First Quarter	
Region	**Total Affirmative Choices**
New York City	49,645
Rest of State	29,451
Statewide	79,096

HIV SNP Plans				
October 2018				
Region	Roster Enrollment	New Enrollment	Auto-assigned	Affirmative Choices
New York City	13,189	212	0	212
Statewide	13,189	212	0	212
November 2018				
New York City	13,160	184	0	184
Statewide	13,160	184	0	184
December 2018				
New York City	13,114	161	0	161
Statewide	13,114	161	0	161
First Quarter				
Region	Total Affirmative Choices			
New York City	557			
Statewide	557			

Health and Recovery Plans Disenrollment			
FFY 19 – Q1			
	Voluntary	Involuntary	Total
October 2018	1,165	949	2,114
November 2018	946	936	1,882
December 2018	942	1,048	1,990
Total:	3,053	2,933	5,986

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (10/1/2018 – 12/31/2018) Q1 FFY 2018-2019

As of the end of the first federal fiscal quarter (end of December 2018), there were 2,543,148 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 65,919 Medicaid consumers enrolled in Health and Recovery Plans (HARP). MAXIMUS or New York Medicaid CHOICE (NYMC), the Enrollment Broker for New York State, 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 11,904 clients were educated about their enrollment options and 7,154 (60%) 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. Deficiency found is reported to MAXIMUS Field operation monthly. During the reporting period, 304 enrollment counselling sessions were evaluated which generated 304 applications for a total of 335 enrollments.

CMU Monitoring of Field Presentation Report – 1st Quarter 2019	
Enrollment Counseling - Group and One on One	**General Information**
304	820

Infractions were observed for 32 (11%) of the 304 enrollment counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA.

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

- Lock in policy
- Good Cause Transfer
- Exemptions/Exclusions
- Confirmation Letter
- Emergency Room

Of the 335 enrollments completed during informational sessions, 299 (89%) were randomly chosen and tracked for timely and correct processing. 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.

B. Auto-Assignment (AA) Outreach

Phone Enrollment			General Information (undecided)		
Regular FFS	**Nursing Home FFS**	**Total**	**Regular FFS**	**Nursing Home FFS**	**Total**
127	3	130	83	6	89

In addition to face-to-face informational sessions, FCSRs make outreach calls to Fee for Service (FFS) community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 26,821 FFS community clients was reported on the regular auto-assignment list, 3,499 (13%) clients responded to the call and 2,962 (85%) contacted made a plan selection. Of the total of 429 FFS NH clients, 366 clients and/or authorized representatives responded to the call for a total of 39 (11%) successful enrollments. The CMU monitored 219 (6%) of the 3,499 completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 130 (59%) FFS clients made voluntary phone enrollment choices for themselves and their family members, including three (3) NH clients, for a total of 147 enrollments. Infractions are described below:
  - 124 (95%) consumers were randomly chosen to track for timely and correct processing and the CMU confirmed that consumers were timely enrolled in plan;
- Undecided: 89 (41%) FFS and NH 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 31 (24%) of the 127 regular FFS AA Phone Enrollment conducted by NYMC FCSRs at HRA sites; no infractions were observed for the three (3) NH outreach calls. 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
- Helpline Number/Hours of Operation
- Emergency/Urgent Care
- Good Cause Transfer

The CMU also randomly selected 180 (1%) clients from the auto-assignment list of 26,821*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 that responded made a plan choice. CMU also confirmed that appropriate and timely notices were sent to 110 (61%) clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

C. 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 63,562 calls were received by the Helpline and 57,977 or 91% were answered. Calls answered were handled in the following languages: English: 43,440 (75%); Spanish: 8,397 (14%); Chinese: 2,724 (4%); Russian: 995 (2%); Haitian/Creole: 141 (1%); and other: 2,280 (4%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. The CMU listened to 1,802 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 1st Quarter 2019						
General Information	**Phone Enrollment**	**Plan Transfer**	**Public Calls**	**Disenrollment Call**	**Removal of Code**	**Total**
1,240 (69%)	93 (5%)	94 (5%)	351 (20%)	24 (1%)	0 (0%)	1,802

Infractions/issues were identified for 344 (19%) of the recorded calls reviewed by CMU. The following summarizes those calls:

- Process: 278 (81%) - 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: four (4) (1%) - 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: 62 (18%) - 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.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

During the first quarter (October 1, 2018 – December 31, 2018), there were no service area changes for Medicaid Managed Care Plans, HIV Special Needs Plans (HIV SNPs) or Health and Recovery Plans (HARPs).

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

During the first quarter (October 1, 2018 – December 31, 2018), New York commenced negotiation of new model contract language with the Trade Associations that represent the health plans. These negotiations were ongoing at the close of the quarter. New York anticipates submitting the new model contract to CMS during the second quarter of the federal fiscal year.

C. Health Plans/Changes to Certificates of Authority

There were no transactions requiring updates to any Certificates of Authority during the first quarter FFY2019.

D. Surveillance Activities

Surveillance activity completed during the first quarter (October 1, 2018- December 31, 2018) include the following:

Four (4) Comprehensive Operational Surveys and three (3) Targeted Operational Surveys were completed during 1st Quarter FFY 2018-2019. An SOD was issued and a POC was accepted for six (6) Plans. One (1) Plan was found in compliance.

- Empire HealthChoice HMO, Inc. (In compliance)
- Excellus Health Plan, Inc.
- HealthNow New York Inc.
- Health Plus
- Independent Health Association, Inc.
- Molina
- MVP Health Plan, Inc.

Nineteen (19) combined Access and Availability and Provider Directory Participation Surveys were completed during the 1st Quarter FFY 2018-2019. A letter of concern was issued to 19 Plans.

- Affinity Health Plan, Inc.
- Healthplus

- Amida Care, Inc.
- Capital District Physicians' Health Plan, Inc.
- Crystal Run Health Plan
- Excellus Health Plan, Inc.
- Fidelis
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan
- Molina
- MVP Health Plan, Inc.
- UnitedHealthcare of New York, Inc.
- VNS CHOICE
- WellCare of New York, Inc.
- Yourcare

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during the quarter. 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 the quarter 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 identified and implemented a policy to allow State Designated Entities to assess and link HARP enrollees to HCBS, 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 (7/1/2018-9/30/2018)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	85,835	1,063	998	1.2%
ROS	6,826	90	89	1.3%
Total	92,661	1,153	1,087	1.2%

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 (7/1/2018-9/30/2018)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,550	51	21	0.4%
ROS	3,189	29	6	0.2%
Total	8,739	80	27	0.3%

[1] Q1 data is not available and will be submitted with the next quarterly update.

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 (10/1/2018-12/31/2018)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,603,383	93.55%	13.84%
Rest of State	1,222,357	85.15%	12.18%
Statewide Total	2,825,740	89.92%	13.12%

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

HCBS Claims/Encounters 10/1/2018-12/31/2018: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	23	9
Education Support Services	44	18
Family Support and Trainings	1	1
Intensive Crisis Respite	0	0
Intensive Supported Employment	39	18
Ongoing Supported Employment	1	1
Peer Support	321	88
Pre-vocational	45	10
Provider Travel Supplements	70	37
Psychosocial Rehab	164	47
Residential Supports Services	35	10
Short-term Crisis Respite	355	61
Transitional Employment	0	0
TOTAL	1,098	244

HCBS Claims/Encounters 10/1/2018-12/31/2018: ROS

HCBS SERV GROUP	N Claims	N Recip
CPST	291	80
Education Support Services	459	178
Family Support and Trainings	38	9
Intensive Crisis Respite	0	0
Intensive Supported Employment	173	63
Ongoing Supported Employment	43	13
Peer Support	1,506	463
Pre-vocational	172	63
Provider Travel Supplements	1,008	332
Psychosocial Rehab	704	178
Residential Supports Services	555	144
Short-term Crisis Respite	70	25
Transitional Employment	17	7
TOTAL	5,036	1,022

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

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. See below for Managed Care Technical Assistance Stats during October 1, 2018- December 31, 2018

1. **Events**
   - **Total Events: 35**
   - Webinars: 17
   - In Person: 18
2. **People Served**
   - **Total Participants: 1, 128**
   - Unique Participants: 723
3. **OMH Participation**
   - **Overall: 200 of 611 (32.7%)**
   - NYC: 60 of 239 (25.1%)
   - ROS: 146 of 388 (37.6%)
4. **OASAS Participation**
   - **Overall: 180 of 543 (33.1%)**
   - NYC: 40 of 194 (20.6%)
   - ROS: 148 of 368 (40.2%)

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
- HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the HCBS workflow (Nov 2018, streamlining data collection for both HH and RCAs)
- Development of required training for HCBS providers that the State can track in a Learning Management System.
- 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.

- 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
    - DOH approval of MCO plans for incentivizing enrollment into HH (eg, Outreach Optimization)

- 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.
    - Provided technical assistance to lead HHs
- 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.

To date, 5,182 care managers in NYS have completed the required training “Understanding the Community Mental Health Assessment” and 2,059 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between October 1, 2018 and December 31, 2018, 6,743 brief eligibility assessments have been completed and 6,537 of those were found eligible for HCBS services.

Transition of School-based Health Center (SBHC) Services from Medicaid Fee-for-Service to Medicaid Managed Care:

To maintain momentum for the January 1, 2021 SBHC transition, the Department will ensure continued and documented progress on care coordination strategies to facilitate a successful transition. An internal Department meeting was held in September to discuss the next steps and the agenda for the next SBHC Stakeholder Workgroup meeting. The Department sent a letter to Health Plan Administrators and SBHCs to encourage collaboration in implementing the SBHC transition to managed care. The SBHC Stakeholder Workgroup meeting will take place on January 31, 2019.

C. Federally Qualified Health Services (FQHC) Lawsuit

No update this quarter.

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/Updates

During the October 2018 through December 2018 quarter, one Medicaid Advantage plan closed.

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 October 2018 through December 2018 quarter, post enrollment surveys were completed for nine enrollees. Seven of the eight enrollees (88%) 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 an increase in affirmative responses from 75% during the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans grew from 215,292 to 223,568 during the October 2018 through December 2018 quarter. For that period, 14,073 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a number that is relatively consistent with previous quarters and that brings the 12-month total for affirmative choice to 56,893. Monthly plan-specific enrollment for partial capitation plans during the January 2018 through December 2018 annual period is submitted as an attachment.

2. Significant Program Developments

During the October 2018 through December 2018 quarter, the Surveillance Unit conducted a Member Services survey on 28 Partial Capitation plans to provide feedback on the overall functioning of the plans' member service performance. No response was required, but when necessary the Department provided recommendations on areas of improvement. In addition:

- Review and approval of the new model notices for MLTC plans and their vendors is ongoing.
- The MLTC Ombudsman contract was renewed for the fifth and final year, and an RFA for the new Ombudsman contract has been drafted.
- The purchase of new software for the Surveillance Unit has been completed. Once customized, it is anticipated that the software will be able to identify trends easier and compile survey findings quicker.
- Staff training continues as survey processes and tools are revised.

3. Issues and Problems

There were no issues or problems to report for the October 2018 through December 2018 quarter.

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 2,990 critical incidents reported for the October 2018 through December 2018 quarter, an increase of 97% over the last quarter. The State continues to work toward identifying the reason(s) for the recent increases. An error in reporting instructions has been identified, and clarifying instructions were issued on February 6, 2019. When the number of critical incidents relating to that error is deducted from the total, there are 1,632 critical incidents remaining, an increase of 111 incidents over the last quarter.

In addition, the Department reached out to the two plans that continue to be the drivers of the increases. It was determined that they had been incorrectly reporting incidents that did not rise to the level of critical. The plans had also recently removed a data filter which skewed this quarter's results.

It appears the increase in critical incidents is due to incorrect reporting rather than an increase in the number of incidents occurring. The DLTC data team is working with the DLTC surveillance unit to begin reviewing critical incidents during surveys to ensure that plans are reporting correctly. DOH will continue to monitor critical incidents and communicate with outlier plans to ensure they understand what should be reported.

Grievances and Appeals: For the October 2018 through December 2018 quarter, the top reasons for grievances/appeals are dissatisfaction with transportation, dissatisfaction with quality of home care (other than lateness/absences), dissatisfaction with the quality of other covered services, other miscellaneous reasons, and home care aides late/absent on scheduled day of services.

Period: 10/1/2018 through 12/31/2018 **(Percentages rounded to nearest whole number)**			
Number of Recipients: 239,377	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**7,300**	**7,300**	**100%**
# Standard/Expedited	**3,843**	**3,730**	**97%**
Total for this period:	**11,143**	**11,030**	**99%**

Appeals	**1/2018-3/2018**	**4/2018-6/2018**	**7/2018-9/2018**	**10/2018-12/2018**	**Average for Four Quarters**
Average Enrollment	219,932	222,512	230,374	239,377	228,049
Total Appeals	1,643	2,451	3,084	3,742	2,730
Appeals per 1,000	7	11	13	16	12
# Decided in favor of Enrollee	264	629	637	670	550
# Decided against Enrollee	1,097	1,432	2,367	2,661	1,889
# Not decided fully in favor of Enrollee	133	143	119	165	140
# Withdrawn by Enrollee	50	67	139	121	94
# Still pending	485	684	539	559	567
Average number of days from receipt to decision	12	13	12	12	12

Grievances and Appeals per 1,000 Enrollees by Product Type October 2018-December 2018					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	220,866	6,542	30	3,032	14
Medicaid Advantage Plus (MAP) Total	12,735	3,004	236	693	54
PACE Total	5,776	1,597	276	17	3
Total for All Products:	**239,377**	**11,143**	**47**	**3,742**	**16**

Total Grievances increased 5% from 10,596 the previous quarter to 11,143 during the October 2018 through December 2018 quarter. The total number of appeals increased 21% from 3,084 during the last quarter to 3,742 during the October 2018 through December 2018 quarter.

Technical Assistance Center (TAC) Activity

During the October 2018 through December 2018 quarter, call volume decreased slightly, averaging about 170 calls per month versus the typical 200-250 calls per month. While the unit typically closes over 90% of cases within the same month, this quarter 83% of cases were closed within the same month. Case are left open due to large-scale issues, such as plan closures and service area changes. Typically, issues that affect large groups of members take longer to resolve.

Call Volume	**10/1/2018-12/31/2018**
Substantiated Complaints	79
Unsubstantiated Complaints	286
Complaints Resolved Without Investigation	41
Inquiries	98
Total Calls	**504**

The five most common types of calls for the quarter were related to:

Interdisciplinary Team	14.6%
Aide Service – Plan Not Providing Hours	14.4%
Billing – Claim Denials	8.7%
Aide Service – Agency Problems	7.1%
DME Obtaining	5.5%

The most common complaint categories are not unusual for TAC. However, the names of some of the categories have changed slightly with the new database's fuller reporting capabilities. This allows for better tracking of the types of complaints that are received. For

example, problems with aide service are now broken down into multiple categories such as "Plan Not Providing Hours" and "Agency Problems." This allows TAC to differentiate allegations against plans and vendors.

Home health care complaints are investigated based upon a member's subjective experience and do not necessarily represent neglect or abuse.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the October 2018 through December 2018 quarter, 10,979 people were evaluated, deemed eligible and enrolled into plans, a decrease of 2.1% over the previous quarter.

Referrals and 30-day assessment: For the October 2018 through December 2018 quarter, MLTC plans conducted 14,235 assessments, an increase of 18% from 12,070 the previous quarter. The total number of assessments conducted within 30 days increased 19% from 9,649 the previous quarter to 11,459 this quarter. These increases are largely attributable to plan closures and the resulting movement of enrollees.

Referrals outside enrollment broker: For the October 2018 through December 2018 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 29,885, a 20% increase from 24,880 the previous quarter. This increase most likely results from the announcement of planned closures and service area reductions.

Rebalancing Efforts	10/2018-12/2018
Enrollees from a nursing home who are transitioning to the community and are new to the plan	347
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	3,149
Individuals who are permanently placed in a nursing home and are new to plan	2,237

As of December 2018, there were 17,632 current plan enrollees who were in nursing homes as permanent placements.

VI. Evaluation of the Demonstration

The RFP to procure the Independent Evaluator for the 1115 Demonstration Waiver evaluation was released November 15, 2018 and questions were received by prospective bidders by November 20. The DOH responded to questions on December 5 and bids were received by December 21, 2018. As of the end of Quarter 1, bids were being scored and a successful bidder will be selected in Quarter 2. The contract for the Independent Evaluator is anticipated to being by August 1, 2019.

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

MMCO Product Line	Total Complaints Current Quarter 10/1/2018 to 12/31/2018	Total Complaints from Previous Quarter 7/1/2018 to 9/30/2018
Medicaid Managed Care	6,984	6,886
HARP	800	708
HIV/SNP	173	180
Total MMCO Complaints	**7,957**	**7,774**

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 7,957. This represents a 2.4% increase from the prior quarter.

This quarter's plan-reported complaint data continues a trend of increasing complaints related to HARPs over the last quarter; and is a 13% increase from the previous quarter. The enrollment for HARPs only increased by 0.5% between December 2017 and December 2018; most of the increase can be attributed to Healthfirst's doubling of their HARP – Pharmacy/Formulary complaints. The Department is reaching out to Healthfirst to determine cause and assess if the plan needs to address any systemic or access to care issue through a corrective action plan. HIV/SNP complaints decreased by -3.9 % when compared to the previous quarter.

The top 5 most frequent categories of complaints for Mainstream, HARP and HIV SNP combined, were as follows:

Description of Complaint	Top 5 Current Quarter 10/1/2018 to 12/31/2018	Previous Quarter 7/1/2018 to 9/30/2018
Pharmacy/Formulary	**36%**	**31%**
Dissatisfaction with Quality of Care	**7%**	**9%**
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	**7%**	**4%**
Difficulty with Obtaining: Dental/Orthodontia	**5%**	**4%**
Denial of Clinical Treatment	**4%**	**2%**

HARP Complaints/Action Appeals:

Of the total 7,957 complaints, MMCOs reported, 800 were associated with Health and Recovery Plans (HARPS). Healthfirst had 296 HARP related Pharmacy/Formulary complaints this quarter,

compared 157 last quarter. As indicated above, the Department is investigating the reason behind the plan's large increase of complaints in this category.

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

Pharmacy/Formulary	43%
Dissatisfaction with Quality of Care	8%
Denial of Clinical Treatment	5%
Reimbursement/Billing	5%
Dental/Orthodontia	4%

HIV/SNPS
During the quarter, Managed Care Organizations reported 173 complaints/action appeals for HIV Special Needs Plans (SNPs).

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

Dissatisfaction with Provider Services (Non-Medical) or MCO Services	23%
Pharmacy/Formulary	16%
Dental/Orthodontia	10%
Access to Non-Covered Services	9%
Personal Care	8%

Monitoring of Plan Reported Complaints
The Department is in the process of calculating the observed/expected ratio for the six-month period ending with this quarter. The observed/expected ratio is a calculation 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 in all MMCO's.

Based on the observed/expected ratio, the Department requests that MMCOs review and analyze categories of complaints where higher than expected complaint patterns persist.

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 7,957 total reported complaints/action appeals, mainstream MMCOs reported 747 complaints and action appeals from their SSI enrollees. This compares to 599 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	32
AIDS Adult Day Health Care	0
Appointment Availability - PCP	2
Appointment Availability - Specialist	4
Appointment Availability – BH HCBS	1
Balance Billing	76
Communications/Physical Barrier	3
Consumer Directed Personal Assistant	4
Denial of Behavioral Health Clinical Treatment	0
Denial of Clinical Treatment	35
Dental or Orthodontia	111
Dissatisfaction with Behavioral Health Provider Services	0
Dissatisfaction with Health Home Care Management	6
Emergency Services	5
Eye Care	7
Family Planning	0
Home Health Care	3
Mental Health/Substance Abuse Services/ Treatment	2
Non-covered Services	21
Non-Permanent Resident Health Care Facility	0
Personal Care Services	11
Personal Emergency Response System	0
Pharmacy	68
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	81
Quality of Care	114
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	70
Specialist or Hospital Services	11
Transportation	3
Waiting Time Too Long at Office	3
All Other Complaints	73
Total	**747**

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

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Quality of Care	15%
Dental or Orthodontia	15%
Provider or MCO Services (Non-Medical)	11%
Balance Billing	10%
Reimbursement/Billing Issues	9%

The Department requires 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 December 31, 2018, plans reported 27,002 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 quarter.

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
	Q1 FFY 19
AIDS Adult Day Health Care	3
Adult Day Care	0
Consumer Directed Personal Assistant	5
Home Health Care	8
Non-Permanent Residential Health Care Facility	1
Personal Care Services	37
Personal Emergency Response System	0
Private Duty Nursing	1
Total	55

Critical Incidents:
The Department requires MMCOs to report critical incidents involving enrollees in receipt of long term services and supports. There were 95 critical incidents reported for the October 1, 2018 through December 31, 2018 period. The number of critical incidents reported by MMCOs are as follows.

Critical Incidents			
Plan Name	**October 1st to December 31st 2018**	**July 1st to September 30th 2018**	**Net Change**
Mainstream Managed Care			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Crystal Run	0	0	0
Excellus Health Plan	6	1	+5
Fidelis Care	0	0	0
Healthfirst PHSP	10	1	+9
Health Insurance Plan of Greater New York	0	0	0
HealthNow	0	0	0
HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	3	-3
Molina Healthcare	1	1	0
MVP Health Plan	0	0	0
United Healthcare Plan of New York	0	0	0
Wellcare of New York	1	0	+1
YourCare Health Plan	0	0	0
Total	**18**	**6**	**+12**
Health and Recovery Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	4	-4
Fidelis Care	0	0	0
Healthfirst PHSP	73	49	+24
Health Insurance Plan of Greater New York	0	0	0

HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	1	0	+1
MVP Health Plan	0	0	0
United Healthcare Plan of New York	0	0	0
YourCare Health Plan	0	0	0
Total	**74**	**53**	**+21**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan SNP	0	0	0
VNS Choice SNP	3	4	-1
Total	**3**	**4**	**-1**
Grand Total	**95**	**63**	**+32**

Consumer Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 146 consumer complaints this quarter. This total is a slight increase from the previous quarter, which reported 138 consumer complaints.

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

Reimbursement/Billing	12%
Difficulty Obtaining Covered Home Health Care Services	12%
Difficulty with obtaining referrals or covered services for dental or orthodontia	5%
Pharmacy/Formulary	5%
Difficulty Obtaining Personal Care Services	3%

Fair Hearings
There were 317 fair hearings involving mainstream Medicaid managed care plan, HARPs, and HIV SNPs during the October 1, 2018 through December 31, 2018 period. The dispositions of these fair hearings were as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP plans)	10/1/2018-12/31/2018
In favor of Appellant	148
In favor of Plan	133
No Issue	36
Total	**317**

Fair Hearings Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP plans)	10/1/2018-12/31/2018
Less than 30 days	16
30-59	124
60-89	98
90-119	32
=>120	47
Total	**317**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 6, 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 of the results from a Medicaid Managed Care and Managed Long Term Care member satisfaction survey presented by the Division of Quality Management, Office of Quality and Patient Safety (OQPS). In addition, the Office of Health Insurance Programs Division of Health Reform and Health Insurance Exchange Integration gave an overview of the activities related to the transition from the Welfare Management System (WMS) to the New York State of Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for February 21, 2019.

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. In addition, in November, the Department provided Criteria Standards for the Authorization and Utilization Management of Harm Reduction Services to all Medicaid Managed Care (MMC) Plans. Each MMC Plan that chooses to adopt criteria for the authorization and utilization management of harm reduction services must submit the criteria (and any subsequent amendment to such criteria) electronically to the Department for review and approval prior to use. To date, there have been no significant issues with this transition process.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

In December, 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 November, the Department release to the MLTC plans, their Crude Percent Reports for the time period of January through June 2018. 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 2019 MLTC Quality Incentive.

B. Quality Measurement in Medicaid Managed Care

1. Quality Assurance Reporting Requirements (QARR)

Attachment 3 reflects the NYS overall quality results for Medicaid Managed Care for measurement year 2017 along with the national benchmarks for Medicaid, which are from NCQA's State of Health Care Quality 2018 report. National benchmarks were available for 66 measures for Medicaid. Out of the 66 measures that Medicaid plans reported, 85% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in Medicaid managed care. The NYS Medicaid, rates exceed the national benchmarks for behavioral health on adult measures (e.g., receiving a follow-up after 7 and 30 days post-hospitalization for mental illness and follow-up within 7 and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures

(e.g., prenatal and postnatal care, as well as screening for Chlamydia, and cervical cancer).

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 October through December 2018, final reports from the most recent Access Survey of Provider Availability and a Member Services Surveys were distributed to MCOs. A new High Volume PCP Ratio survey was completed, and reports drafted.

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.

Final reports from an audit of the Uniform Assessment System were distributed to MCOs. A Focused Clinical Study was conducted by IPRO, comprised of an over-read of long term care necessity determinations by a subcontractor, Maximus. Final analyses are underway with draft reports already prepared and under revision.

The 2019 QARR specifications were disseminated and a Webinar held with the MCOs to provide an overview of current requirements, highlighting changes. The child CAHPS® survey was fielded. An Access and Utilization Report was drafted and revised for public dissemination on the NYSDOH Managed Care Reports website.

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.

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 were sent a survey to evaluate their experience submitting the data and the usefulness of the data in planning quality improvement initiatives within their practice. Ten of the 40 practices responded to the survey, for a response rate of 25%. Seventy percent of respondents confirmed they viewed the slide presentation that was distributed to them with the statewide aggregate results. Eighty six percent of respondents that reviewed the slides found them helpful for interpreting practice-specific results. Ninety percent of respondents who viewed the slides agree or strongly agree that the statewide aggregate results were helpful to identify opportunities for improvement at the practice level. Eighty percent of respondents agreed that the results of the review would be used for facilitation of internal quality improvement activities in the practice.

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 were conducted in October 2018 to further delineate their 2019-2020 PIP topics. The three HIV SNP Plans submitted their 2019-2020 PIP Proposals by December 21, 2018. The PIP Proposal review process is currently underway.

The 2019-2020 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. An October 10, 2018 webinar was conducted with the HARP and HIV SNP plans to discuss the potential areas of opportunity for the PIP. On November 19, 2018 the 2019-2020 HARP PIP background document and the PIP Template was distributed to the HARP plans. The PIP Proposals were due December 21, 2018. Eight of the thirteen HARP PIP Proposals were received and five HARP plans were granted an extension to submit their Proposals in January 2019. The HARP PIP Proposals are currently under review.

The 2019-2020 Medicaid managed care PIP topic will be the KIDS Quality Agenda. NYSDOH and IPRO conducted a webinar on October 23, 2018 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. The background document is currently under development. The PIP Proposals will be due in the first quarter of 2019.

Breast Cancer Selective Contracting

The Department began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2015-2017 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as, facility-level data from the Health Facilities Information System (HFIS). A total of 223 facilities were identified as having performed at least one breast cancer surgery from 2015-2017. Preliminary facility volume designations were as follows: 115

high-volume; 21 low-volume that are allowed to perform surgeries to ensure adequate access; and, 87 low-volume restricted facilities.

Letters were drafted to notify low-volume facilities that the Department will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state fiscal year 2019-20, nor can Medicaid managed care plans contract with low-volume facilities to perform breast cancer surgeries. In addition, the letters will also include a copy of the appeal form for facilities that want to appeal the decision to be placed on the low-volume restricted list. The letters will be mailed out in January 2019.

Patient Centered Medical Home (PCMH)
As of December 2018, there were 8,750 NCQA-recognized PCMH providers in New York State. Approximately 92% (8,064) are recognized under the 2014 set of standards. No providers remain under NCQA's 2011 standards. On April 1, 2017 NCQA released their 2017 recognition standards, eliminating the leveling structure. There are 73 providers and 31 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). In the past two quarters, a continuous increase in the recognition under this new standard has been observed. There are 613 providers and 137 practices recognized. 94 providers that became recognized in December 2018 were new to the NYS PCMH program.

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 December 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 recognition: $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.

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 of 2018. 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. Final data for F-SHRP DY6 has been processed and will be submitted as soon as possible, pending the final approval of KPMG's amended contract. The State is also awaiting final approval of a timely filing waiver to allow for F-SHRP data to be re-entered into the MBES system. 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 this quarter.

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 files and will continue to work with CMS to improve the data quality of its submissions.

Attachments:
Attachment 1— MLTC Critical Incidents
Attachment 2— MLTC Partial Capitation Plan Enrollment
Attachment 3— NYS Medicaid Managed Care Statewide Rates - 2017, Compared to 2017 National Rates

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Critical Incidents
October - December 2018

Plan Name	Plan Type	Total Critical Incidents
Partical Capitation Plans		
Aetna Better Health	Partial	3
AgeWell New York ,LLC	Partial	13
AlphaCare of New York Inc.	Partial	0
Amerigroup	Partial	0
ArchCare Community Life	Partial	17
CenterLight Healthcare Select	Partial	0
Centers Plan for Healthy Living	Partial	33
Elant Choice	Partial	23
ElderServe Health, Inc.	Partial	73
Elderwood	Partial	8
Extended	Partial	131
Fallon Health Weinberg	Partial	0
FIDELIS Care New York	Partial	0
GuildNet MLTCP	Partial	93
Hamaspik Choice	Partial	0
HomeFirst MLTC, a product of Elderplan	Partial	0
I Circle	Partial	1
Independence Care Systems	Partial	16
Integra MLTC	Partial	0
Kalos, dba First Choice Health	Partial	4
Metroplus	Partial	0
Montefiore Diamond Care	Partial	1
NSLIJ Health Plan	Partial	0
Prime Health Choice, LLC	Partial	67
Senior Health Partners	Partial	1238
Senior Network Health	Partial	2
Senior Whole Health	Partial	2
United Healthcare Personal Assist	Partial	0
VillageCareMAX	Partial	136
VNA Homecare Options, LLC	Partial	88
VNSNY CHOICE MLTC	Partial	4
Wellcare	Partial	45
Total		**1998**
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	0
Fidelis Medicaid Advantage Plus	MAP	0
GuildNet GNG	MAP	7
Healthfirst CompleteCare	MAP	891
HEALTHPLUS AMERIGROUP	MAP	0
Senior Whole Health	MAP	0
VNSNY CHOICE MLTC TOTAL	MAP	36
Total		**934**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	11
Catholic Health LIFE	PACE	14
CenterLight Healthcare	PACE	8
Complete Senior Care	PACE	3
Eddy SeniorCare	PACE	10
ElderONE	PACE	0
Fallon Health Weinberg	PACE	0
Independent Living Services of CNY (PACE	PACE	12
Total Senior Care	PACE	0
Total		**58**
Grand Total		**2990**

Managed Long Term Care
Partial Capitation Plan Enrollment
January 2018 - December 2018

Plan Name	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Aetna Better Health	5,328	5,519	5,602	5,743	5,905	6,054	6,260	6,330	6,452	6,587	6,798	7,034
AgeWell New York	9,349	9,357	9,387	9,425	9,515	9,590	9,643	9,688	9,777	9,915	10,135	10,464
AlphaCare	37	14	3	5	5	3	0	0	0	0	0	0
ArchCare Community Life	3,483	3,528	3,587	3,671	3,708	3,774	3,865	3,934	3,997	4,160	4,286	4,418
Centers Plan for Healthy Living	25,276	25,801	26,363	26,996	27,726	28,275	28,938	29,427	29,980	30,606	30,978	31,716
Elant	916	912	931	942	971	973	977	995	978	966	976	975
Elderplan	12,700	12,704	12,736	12,691	12,751	12,848	12,941	12,943	13,130	13,325	13,504	13,881
Elderserve	11,626	11,751	11,893	12,032	12,155	12,289	12,399	12,380	12,453	12,738	13,071	13,654
Elderwood	203	206	227	255	271	284	305	328	353	383	414	452
Extended MLTC	3,629	3,757	3,918	4,085	4,290	4,488	4,714	4,874	4,982	5,122	5,327	5,663
Fallon Health Weinberg (TAIP)	682	678	687	706	709	716	728	742	764	788	801	810
Fidelis Care at Home	20,863	20,878	21,011	20,989	21,048	21,120	21,399	21,626	21,870	22,140	22,353	22,729
Guildnet	8,243	8,076	7,876	7,670	7,541	7,480	7,427	7,316	7,332	6,668	5,471	2,734
Hamaspik Choice	2,151	2,151	2,175	2,179	2,186	2,166	2,206	2,196	2,214	2,225	2,232	2,251
HealthPlus- Amerigroup	4,895	4,929	4,911	4,931	4,968	5,016	5,060	5,080	5,174	5,345	5,553	5,856
iCircle Services	2,342	2,384	2,441	2,485	2,556	2,600	2,647	2,691	2,769	2,862	2,981	3,067
Independence Care Systems	6,649	6,597	6,572	6,509	6,443	6,377	6,325	6,182	6,077	6,035	5,894	5,825
Integra	8,897	9,362	9,874	10,295	10,797	11,203	11,764	12,226	12,844	13,762	14,444	15,200
Kalos Health- Erie Niagara	1,265	1,254	1,235	1,252	1,276	1,294	1,291	1,309	1,318	1,324	1,350	1,367
MetroPlus MLTC	1,782	1,783	1,811	1,836	1,824	1,866	1,858	1,857	1,838	1,841	1,835	1,901
Montefiore HMO	1,460	1,462	1,464	1,474	1,495	1,507	1,519	1,520	1,526	1,540	1,553	1,592
North Shore-LIJ Health Plan	23	6	2	1	1	1	0	0	0	0	0	0
Prime Health Choice	353	354	355	360	369	373	379	383	393	392	389	397
Senior Health Partners	14,478	14,412	14,423	14,388	14,467	14,570	14,507	14,397	14,451	14,454	14,625	14,788
Senior Network Health	543	532	546	550	545	547	546	548	554	557	555	556
Senior Whole Health	13,969	13,779	13,776	13,634	13,642	13,726	13,922	13,874	13,955	14,034	14,134	14,343
United Healthcare	3,917	3,973	4,044	4,070	4,161	4,214	4,254	4,211	4,190	4,143	4,119	4,163
Village Care	9,538	9,779	9,925	10,068	10,254	10,429	10,668	10,716	10,775	10,962	11,308	11,745
VNA HomeCare Options	6,153	6,266	6,322	6,479	6,595	6,606	6,715	6,811	6,967	7,067	7,180	7,189
VNS Choice	12,934	12,899	12,806	12,788	12,743	12,749	12,758	12,651	12,699	12,861	12,929	13,184
WellCare	5,758	5,696	5,610	5,516	5,521	5,490	5,511	5,501	5,480	5,504	5,530	5,614
TOTAL	**199,442**	**200,799**	**202,513**	**204,025**	**206,438**	**208,629**	**211,526**	**212,736**	**215,292**	**218,306**	**220,725**	**223,568**

NYS Medicaid Managed Care Statewide Rates - 2017, Compared to 2017 National Rates

Domain	Measure	NYS Medicaid 2017	National 2017
Adult Health	Medication Management for People with Asthma 50% Days Covered (Ages 19-64)	69	NA
Adult Health	Medication Management for People with Asthma 75% Days Covered (Ages 19-64)	45	NA
Adult Health	Asthma Medication Ratio (Ages 19-64)	57	NA
Adult Health	Adult BMI Assessment	86	85
Adult Health	Advising Smokers to Quit	80	77
Adult Health	Persistence of Beta-Blocker Treatment	85	78
Adult Health	Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	88	81
Adult Health	Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	76	68
Adult Health	Colon Cancer Screening	62	NA
Adult Health	Controlling High Blood Pressure	61	57
Adult Health	Annual Dental Visit (Ages 19-20)	43	37
Adult Health	Monitoring Diabetes - Received All Tests	61	NA
Adult Health	Managing Diabetes Outcomes - Blood pressure controlled (lower than 140/90 mm Hg)	61	63
Adult Health	Monitoring Diabetes - Dilated Eye Exam	67	57
Adult Health	Managing Diabetes Outcomes - HbA1C Control (less than 8.0%)	59	49
Adult Health	Monitoring Diabetes - HbA1c Testing	91	88

Domain	Measure	NYS Medicaid 2017	National 2017
Adult Health	Monitoring Diabetes - Nephropathy Monitoring	93	90
Adult Health	Managing Diabetes Outcomes -Poor HbA1c Control	30	41
Adult Health	Drug Therapy for Rheumatoid Arthritis	83	74
Adult Health	Flu Shot for Adults	42	40
Adult Health	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	92	88
Adult Health	Annual Monitoring for Patients on Persistent Medications- Combined Rate	92	88
Adult Health	Annual Monitoring for Patients on Persistent Medications- Diuretics	91	88
Adult Health	Discussing Smoking Cessation Medications	59	52
Adult Health	Discussing Smoking Cessation Strategies	51	45
Adult Health	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	55	32
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Adherent	66	63
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Received	78	76
Adult Health	Statin Therapy for Patients with Diabetes - Adherent	61	59
Adult Health	Statin Therapy for Patients with Diabetes - Received	66	61
Adult Health	Viral Load Suppression	77	NA
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	66	55
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	58	45
Behavioral	Antidepressant Medication Management-	52	54

Domain	Measure	NYS Medicaid 2017	National 2017
Health	Effective Acute Phase Treatment		
Behavioral Health	Antidepressant Medication Management-Effective Continuation Phase Treatment	37	39
Behavioral Health	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	82	79
Behavioral Health	Diabetes Monitoring for People with Diabetes and Schizophrenia	81	70
Behavioral Health	Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	82	81
Behavioral Health	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days	24	18
Behavioral Health	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days	18	12
Behavioral Health	Follow-Up After Emergency Department Visit for Mental Illness Within 30 days	67	55
Behavioral Health	Follow-Up After Emergency Department Visit for Mental Illness Within 7 days	53	40
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 30 Days	78	58
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 7 Days	62	37
Behavioral Health	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67	60
Behavioral Health	Metabolic Monitoring for Children and Adolescents on Antipsychotics	42	35
Behavioral Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62	59
Child and Adolescent Health	Assessment, Counseling or Education: Alcohol and Other Drug Use	67	NA
Child and Adolescent Health	Assessment, Counseling or Education: Depression	61	NA

Domain	Measure	NYS Medicaid 2017	National 2017
Child and Adolescent Health	Assessment, Counseling or Education: Sexual Activity	65	NA
Child and Adolescent Health	Assessment, Counseling or Education: Tobacco Use	71	NA
Child and Adolescent Health	Medication Management for People with Asthma 50% Days Covered (Ages 5-18)	57	NA
Child and Adolescent Health	Medication Management for People with Asthma 75% Days Covered (Ages 5-18)	30	NA
Child and Adolescent Health	Asthma Medication Ratio (Ages 5-18)	64	NA
Child and Adolescent Health	Adolescent Well-Care Visits	68	53
Child and Adolescent Health	Adolescent Immunization Combo	84	78
Child and Adolescent Health	Adolescent Immunization (Combo2)	41	33
Child and Adolescent Health	Annual Dental Visit (Ages 2-18)	61	NA
Child and Adolescent Health	Childhood Immunization Status (Combo 3)	75	69
Child and Adolescent Health	Lead Testing	88	69
Child and Adolescent Health	Appropriate Testing for Pharyngitis	91	78
Child and	Well-Child & Preventive Care Visits in First	82	NA

Domain	Measure	NYS Medicaid 2017	National 2017
Adolescent Health	15 Months of Life (5+ Visits)		
Child and Adolescent Health	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	85	73
Child and Adolescent Health	Weight Assessment- BMI Percentile	84	73
Child and Adolescent Health	Counseling for Nutrition	83	67
Child and Adolescent Health	Counseling for Physical Activity	73	61
Provider Network	Board Certified Family Medicine	72	NA
Provider Network	Board Certified Internal Medicine	76	NA
Provider Network	Board Certified OB/GYN	77	NA
Provider Network	Board Certified Pediatrics	79	NA
Provider Network	Satisfaction with Provider Communication	91	92
Provider Network	Satisfaction with Personal Doctor	81	81
Provider Network	Satisfaction with Specialist	80	82
Satisfaction with Care	Access to Specialized Services for Children	76	NA
Satisfaction with Care	Access to Prescription Medicines for Children	91	NA
Satisfaction with Care	Coordination of Care for Children with Chronic Conditions	74	NA
Satisfaction with Care	Care Coordination	81	NA

Domain	Measure	NYS Medicaid 2017	National 2017
Satisfaction with Care	Customer Service for Children	86	NA
Satisfaction with Care	Customer Service	86	88
Satisfaction with Care	Getting Care Needed for Children	85	NA
Satisfaction with Care	Getting Care Quickly for Children	88	NA
Satisfaction with Care	Getting Care Needed	79	82
Satisfaction with Care	Getting Care Quickly	78	82
Satisfaction with Care	Getting Needed Counseling or Treatment	69	NA
Satisfaction with Care	Family-Centered Care: Personal Doctor Who Knows Child	90	NA
Satisfaction with Care	Rating of Health Plan for Children	85	NA
Satisfaction with Care	Rating of Overall Healthcare for Children	86	NA
Satisfaction with Care	Rating of Counseling or Treatment	60	NA
Satisfaction with Care	Rating of Health Plan	76	77
Satisfaction with Care	Rating of Overall Healthcare	77	75
Satisfaction with Care	Satisfaction with Personal Doctor for Children	89	NA
Satisfaction with Care	Satisfaction with Provider Communication for Children	93	NA
Satisfaction with Care	Satisfaction with Specialist for Children	83	NA
Satisfaction with Care	Shared Decision Making	80	79
Satisfaction	Shared Decision Making for Children	74	NA

Domain	Measure	NYS Medicaid 2017	National 2017
with Care			
Satisfaction with Care	Wellness Discussion	72	NA
Women's Health	Breast Cancer Screening	71	58
Women's Health	Cervical Cancer Screening	72	59
Women's Health	Chlamydia Screening (Ages 16-20)	73	54
Women's Health	Chlamydia Screening (Ages 21-24)	76	63
Women's Health	Risk-Adjusted Low Birthweight (LBW)	7	NA
Women's Health	Risk-Adjusted Primary Cesarean Delivery	14	NA
Women's Health	Postpartum Care	71	64
Women's Health	Timeliness of Prenatal Care	88	81
Women's Health	Prenatal Care in the First Trimester	75	NA
Women's Health	Vaginal Birth After Cesarean Section (VBAC)	17	NA

NA = Data Not available