MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 19 (4/1/2017 – 3/31/2018)
Federal Fiscal Quarter: 2 (1/1/2018 – 3/31/2018)

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: Second Quarter

MRT Waiver- Enrollment as of March 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	**736,681**	**6,686**	**40,559**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**108,359**	**2,236**	**7,747**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**15,175**	**244**	**1,541**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**3,295**	**97**	**379**
Population 5 - Safety Net Adults	**514,760**	**12,412**	**39,076**
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)	**28,809**	**810**	**161**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**190,871**	**7,984**	**1,684**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,894**	**217**	**161**

Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**57,589**	**3,507**	**4,017**

Mainstream Disenrollment (January 2018 to March 2018) – Voluntary and Involuntary

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**34,193 or an approximate 10% 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 a general decline in voluntary disenrollment.

In addition, the plans' passive enrollment of its own HARP eligible enrollment into its offspring HARP plan declined during this quarter when compared to the prior quarter thus significantly contributing to this quarter's overall decline.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**95,325 or an approximate 17.5% 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 general decline in involuntary disenrollment.

For the third consecutive quarter case closures in the WMS population significantly decreased when compared to the prior quarter. This occurred even though WMS's closure of MAGI cases contributed to this quarter's count of case closures.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,153,899**	**20,509**	**2,586**	**17,923**
Rest of State	**527,003**	**13,247**	**1,139**	**12,108**
Statewide	**1,680,902**	**33,756**	**3,725**	**30,031**
February 2018				
New York City	**1,140,617**	**21,366**	**3,065**	**18,301**
Rest of State	**520,177**	**14,044**	**1,325**	**12,719**
Statewide	**1,660,794**	**35,410**	**4,390**	**31,020**
March 2018				
New York City	**1,130,264**	**20,497**	**2,532**	**17,965**
Rest of State	**513,903**	**13,332**	**1,173**	**12,159**
Statewide	**1,644,167**	**33,829**	**3,705**	**30,124**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**54,189**			
Rest of State	**36,986**			
Statewide	**91,175**			

HIV SNP Plans				
January 2018				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,259**	**153**	**0**	**153**
Statewide	**13,259**	**153**	**0**	**153**
February 2018				
New York City	**13,242**	**164**	**0**	**164**
Statewide	**13,242**	**164**	**0**	**164**
March 2018				
New York City	**13,266**	**189**	**0**	**189**
Statewide	**13,266**	**189**	**0**	**189**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**506**			
Statewide	**506**			

Health and Recovery Plans Disenrollment			
FFY 18 – Q2			
	Voluntary	**Involuntary**	**Total**
January 2018	**914**	**857**	**1,771**
February 2018	**997**	**827**	**1,824**
March 2018	**1,028**	**876**	**1,904**
Total:	**2,939**	**2,560**	**5,499**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (01/01/2018 – 03/30/2018) Q2 FFY 2017-2018

As of the end of the second federal fiscal quarter (end of March 2018), there were 2,603,306 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 56,043 Medicaid consumers enrolled in Health and Recovery Plan (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 11,683 clients were educated about their enrollment options and 7,583 (65%) clients made an enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed a total of 1,880 presentations: 1,377 (73%) one-to-one presentations and 503 (27%) auto-assignment outreach presentations. The 1,880 presentations resulted in 636 (34%) completed managed care applications and generated a total of 769 enrollments. Also, FCSR provided 1,244 (66%) consumers with general information. HRA's Contract Monitoring Unit (CMU) observed 1,377 one-to-one client informational sessions 1,368 (99%) in HRA sites and nine (9) (1%) in nursing home facilities. CMU monitors reported the following:

- At HRA sites, 974 (71%) clients received general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment;
- 394 (29%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members for a total of 473 enrollments;
    - Of the 394 FFS clients that selected a plan during an informational session, 217 (55%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner;
- At nursing homes, five (5) (56%) residents made voluntary enrollment choice and four (4) (44**%)** received general information.

Infractions were observed for 64 (16%) of the 399 Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA and Nursing Home sites. All infractions were observed at HRA sites and none were observed at Nursing Home sites. Key messages most often omitted were failure to disclose or explain the following:

- Lock in policy;
- Dental within plan network;
- Good Cause Transfer; and

- Exemptions.

B. Auto-Assignment (AA) Outreach

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS clients selected for plan auto-assignment. A total of 32,107 clients were reported on the auto-assignment list by NYMC. A total of 6,595 (21%) clients responded to the call and of those responding, 3,833 (58%) were enrolled. CMU monitored 503 (8%) completed outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 237 (47%) FFS clients made a voluntary phone enrollment choice for themselves and their family members for a total of 291 enrollment;
  - 166 (70%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely;
- Undecided: 266 (53%) FFS clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 61 (25%) of the 237 AA Phone Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA. Key messages most often omitted were failure to disclose or explain the following:

- Failed to explain specialist, standing referral process;
- Medicare/TPHI;
- Use of plan ID Card/Benefit Card;
- Confirm Consumer Health Plan/PCP choice; and
- Helpline Number.

CMU also randomly selected 222 (1%) clients from the auto-assignment list of 27,746 clients to see if outreach calls were conducted, the plan selected by the consumer was indicated, and notices were sent in a timely manner. CMU confirmed that outreach calls were conducted and appropriate and timely notices were mailed to clients that selected a plan on the call. 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.

C. NYMC HelpLine Observations

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 61,492 calls were received by the Helpline and 55,900 or 91% were answered. Calls answered were handled in the following languages -English: 41,055 (73%); Spanish: 9,067 (16%); Chinese: 2,996 (5%); Russian: 852 (2%); Haitian: 88 (0.2%); and other: 1842 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,197 recorded calls. The call observations were categorized in the following manner:

- General Information: 1834 (84%) Clients requested enrollment information and inquired about accessing plan services;
- Phone Enrollment: 136 (6%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 109 (5%) plan enrollees requested to change their plan;
- Public Calls: 118 (5%): 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.

Infractions/issues were identified for 703 (32%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 537 (77%) - 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: 100 (13%) - 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: 66 (10%) - 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

On January 12, 2018, Excellus Health Plan, Inc. was approved to expand its Medicaid Managed Care and HARP Service Areas to include Erie County.

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

On November 28, 2017 CMS issued approval of the 10/1/15 amendment to the Model Contract. All 18 health plans have retuned their signed contract amendments. During the second quarter, 13 of these amendments were executed by the New York State Office of the Comptroller. Of these 13 executed amendments, eight (8) were transmitted to CMS for final approval.

Additionally, during Q2 FFY 2017-2018, New York State initiated the development of the new five-year model contract. This new model contract will have an effective date of March 1, 2019. It is anticipated that this new model contract will be submitted to CMS in the fall of 2018.

A. Health Plans/Changes to Certificates of Authority

- The COA for HealthPlus Health Plan was updated February 6, 2018 to update an error whereby an incorrect name was contained within the body of the COA.
- Excellus Health Plan was approved on January 12, 2018 to expand their Medicaid, CHP, and HARP lines of business into Erie County.

B. Surveillance Activities

Surveillance activity completed during Q2 FFY 2017-2018 include the following:

- Four (4) Comprehensive Operational Surveys and one (1) Targeted Operational Survey were completed during the Q2 FFY 2017-2018. An SOD was issued and a POC was accepted for five (5) Plans.

Comprehensive Operational Surveys:

- Amida Care, Inc.,
- Capital District Physicians Health Plan, Inc.,
- Crystal Run Health Plan, and
- Yourcare.

Targeted Operational Surveys:

- Healthfirst PHSP, Inc.

Seven (7) Provider Directory and Provider Information Surveys were completed during the Q2 FFY 2017-2018. An SOD was issued and a POC was accepted for seven (7) Plans:

- AMERIGROUP New York, LLC (verified POC accepted 1/17/18),
- Crystal Run Health Plan,
- Excellus Health Plan,
- HealthFirst PHSP, Inc. (verified POC accepted 1/25/18),
- MVP Health Plan, Inc.,
- Molina, and
- Yourcare.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews – no new updates this quarter

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. For Medicaid Managed Care (MMC), all Medicaid- funded behavioral health services for adults, with the exception of services in Community Residences, are part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) 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.

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

1. **Inpatient Denial Report:** Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient behavioral health services based on medical necessity. The report 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 (1/1/18-3/31/18)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	58,300	848	780	1.34%
ROS	6,670	59	50	0.75%
Total	64,970	907	830	1.28%

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 (1/1/18-3/31/18)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	7,332	85	45	0.61%
ROS	3,031	2	0	0.00%
Total	10,363	87	45	0.43%

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

[1]Note: Report from one MCO is not included in this data.

[2]Note: Report from one MCO is not included in this data.

Mental Health (MH) & Substance Use Disorder (SUD) Claims (1/1/18-3/31/18)[3]

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,483,665	89.45%	11.27%
Rest of State	1,184,456	80.39%	12.95%
Statewide Total	2,668,121	85.43%	12.02%

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 Encounters 1/1/18-3/31/18: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	144	37
Education Support Services	99	41
Family Support and Trainings	2	1
Intensive Supported Employment	60	24
Ongoing Supported Employment	10	5
Peer Support	398	109
Pre-vocational	50	19
Provider Travel Supplements	28	15
Psychosocial Rehab	156	38
Residential Supports Services	94	26
Short-term Crisis Respite	245	38
Transitional Employment	9	1
TOTAL	1,295	258

HCBS Claims/Encounters 1/1/18-3/31/18: ROS[4]

HCBS SERV GROUP	N Claims	N Recip
CPST	279	43
Education Support Services	394	119
Family Support and Trainings	46	11
Intensive Supported Employment	162	36
On-going Supported Employment	20	4
Peer Support	1,387	248
Pre-vocational	183	40
Provider Travel Supplements	583	113
Psychosocial Rehab	739	143
Residential Supports Services	420	81
Short-term Crisis Respite	154	28
Transitional Employment	11	4
TOTAL	4,378	598

[3] Footnote: MCOs report monthly data. The volume of paid and denied claims could include pended claims from previous months. Number may exceed 100% due to adjudication of pended claims over a one month period.
[4] Note: Total of N Recip. is by unique recipient, hence, The TOTAL might be smaller than sum of rows.

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 7th, 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
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes
- Ongoing Technical Assistance efforts for BH HCBS providers including workforce development and training
- On April 1, 2018 implemented State Designated Entity/ Recovery Coordination Agency for enrollees who are not enrolled in Health Homes to perform assessments and develop plans of care for BH HCBS
- Implemented a Quality and Infrastructure program for MCOs and providers to improve infrastructure and to increase utilization and access of BH HCBS
- 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
    - Leveraging State Designated Entity to increase Health Home enrollment
- On May 1, 2018 implemented Health Home Plus to strengthen the capacity of HH to serve high need SMI individuals and ensure their engagement in needed services

- Implementing Performance Management efforts, including developing and monitoring quality metrics to ensure HH care management is resulting in improved health outcomes and access to BH HCBS for HARP members.
    - Developing a compliance letter to Health Homes reiterating State and MCO requirement that all HARP members must be assessed for BH HCBS
- Disseminated Consumer Education materials to improve understanding of the benefits of BH HCBS and educated peer advocates to perform outreach
- Submitted concept paper to CMS considering a waiver amendment to move rehabilitation services from BH HCBS to rehabilitation demonstration under HARP

As of May 11, 2018, 2,690 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 2018 and March 2018, 3,616 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 services will remain carved out of the Medicaid managed care benefit package until January 1, 2021.

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

   During the January 2018 through March 2018 quarter, one partial capitation plan was approved for a service area expansion into Monroe County.

   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 January 2018 through March 2018 quarter, post enrollment surveys were completed for 11 enrollees. Eight of the eleven enrollees (73%) who responded to the question indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. This represents a slight decrease in affirmative responses from 75% during the previous quarter.

   Enrollment: Total enrollment in MLTC Partial Capitation Plans grew from 196,859 to 202,513 during the January 2018 through March 2018 quarter. For that period, 13,628 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 55,087.

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 the services received are fair and consistent.

During the January 2018 through March 2018 quarter, one partial capitation focused survey was finalized, and Plans of Correction were accepted for nine partial capitation plans. In addition:

- A tentative Year 2 survey schedule has been developed, and it is anticipated that these surveys will begin in May.
- Processes for second round of operational and focused surveys are being refined.
- Evaluation of the plan of correction process determined that the current process did not require modification.
- The fining/monetary penalty/sanctions policy is being refined.
- Providers were trained about Part 438 regulatory changes pertinent to notices, and surveillance tools are being updated to reflect the 438 regulatory requirements.
- Surveillance staff attended Value Based Payment training.
- The unit is awaiting approval to purchase survey software that will allow more efficient documentation of survey results and more expeditious issuance of findings.

3. Issues and Problems

There were no issues or problems to report for the January 2018 through March 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 384 critical incidents reported for the January 2018 through March 2018 quarter, an increase of fifty-five incidents over the last quarter. Critical incidents by plan for this quarter are attached.

Grievances and Appeals: For the January 2018 through March 2018 quarter, the top reasons for the grievance/appeal were dissatisfaction with the quality of other covered services, dissatisfaction with quality of home care, dissatisfaction with transportation, home care aides late/absent on scheduled day of services, and other miscellaneous reasons.

Period: 1/1/18 through 3/31/18 (Percentages rounded to nearest whole number)			
Number of Recipients: 219,932	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**5,371**	**5,371**	**100%**
# Standard/Expedited	**2,956**	**2,897**	**98%**
Total for this period:	**8,327**	**8,268**	**99%**

Appeals	4/17-6/17	7/17-9/17	10/17-12/17	1/18–3/18	Average for Four Quarters
Average Enrollment	**193,019**	**200,869**	**209,168**	**219,932**	**205,747**
Total Appeals	**1,428**	**1,433**	**1,611**	**1,637**	**1,527**
Appeals per 1,000	**7**	**7**	**8**	**7**	**7**
# Decided in favor of Enrollee	**295**	**295**	**324**	**263**	**294**
# Decided against Enrollee	**1,021**	**1,021**	**1,159**	**1,094**	**1,074**
# Not decided fully in favor of Enrollee	**92**	**92**	**130**	**132**	**112**
# Withdrawn by Enrollee	**19**	**19**	**50**	**51**	**35**
# Still pending	**353**	**358**	**387**	**468**	**392**
Average number of days from receipt to decision	**15**	**15**	**12**	**11**	**13**

Grievances and Appeals per 1,000 Enrollees by Product Type January 2018-March 2018

	Enrollment	Total Grievances	Grievances per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	**204,719**	**6,452**	**32**	**1,391**	**7**
Medicaid Advantage Plus (MAP) Total	**9,517**	**1,049**	**110**	**227**	**24**
PACE Total	**5,696**	**826**	**145**	**19**	**3**
Total for All Products:	**219,932**	**8,327**	**38**	**1,637**	**7**

Total Grievances increased slightly from 8,145 the previous quarter to 8,327 during the January 2018 through March 2018 quarter. The total number of appeals also increased slightly from 1,614 during the last quarter to 1,637 during the January 2018 through March 2018 quarter.

Technical Assistance Center (TAC) Activity

During the January 2018 through March 2018 quarter, the TAC unit averaged 256 cases monthly, which is typical. Most complaints again revolve around home health aide quality and billing issues. The unit continues to close an average of over 90% of cases within one month of receipt.

TAC is also designing and testing a new database which is expected to be in place this summer. The new database will enable more accurately documented cases, better organization, and increased efficiencies in data analysis and reporting. A new peer review system has also been put into place to increase the quality of casework. In addition, the unit is conducting training with newly hired staff.

Call volume:

Substantiated Complaints:	203
Unsubstantiated Complaints:	358
Complaints Resolved Without Investigation:	25
Inquiries:	157
Total Calls:	743

The five most common types of calls were related to:

Interdisciplinary Team	21%
Home Health Care	16%
Billing—Claim Denials	8%
Referral—Difficulty Obtaining DME	4%
Enrollment, Eligibility Unspecified	3%

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.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the January 2018 through March 2018 quarter, 10,673 people were evaluated, deemed eligible and enrolled into plans.

Referrals and 30-day assessment: For the January 2018 through March 2018 quarter, MLTC plans conducted 9,676 assessments. The total number of assessments conducted this quarter has decreased from 10,899 the previous quarter.

Referrals outside enrollment broker: For the January 2018 through March 2018 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 21,951, an increase from 21,688 during the previous quarter.

Rebalancing Efforts	1/18–3/18
New Enrollees to the Plan from a nursing home transitioning to the community	453
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,655
Current plan Enrollees permanently placed in a nursing home	14,362
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,732

VI. Evaluation of the Demonstration

Comments from the CMS evaluation team regarding the revised 1115 Demonstration evaluation plan were received by the DOH on December 28, 2017. In this quarter, program staff worked to address these comments, and administrative staff addressed 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. Significant progress was made as a result of the conference call however, questions remain about the process for obtaining the IE as well as finalizing the timeline for reporting the evaluation results.

VII. Consumer Issues

A. All complaints

Plan Reported Complaints
Medicaid managed care organizations (MMCOs) are required to report the number and types of enrollee complaints they receive on a quarterly basis. The Department requires plans to include both complaints and enrollee appeals related to benefits, referrals and administrative denials in one report to capture the full range of consumer issues filed with the plan. Enrollee appeals related to medical necessity denials and provider complaints are not included in this report. The following table outlines the total enrollee complaints reported by plan type by category for the current quarter.

MMCO Product Line	Total Complaints 1/1/18 – 3/31/18
Medicaid Managed Care	**5,808**
HARP	**433**
HIV/SNP	**205**
Total MMCO Complaints	**6,446**

As described in the table, total MMCOs complaints reported for the quarter equal 6,446. This represents a 7.8% increase from the prior quarter. The most frequent category of complaint is balance billing disputes which represented 24% of the total.

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

Balance Billing	24%
Reimbursement/Billing Issues	11%
Dissatisfaction with Quality of Care	10%
Pharmacy/Formulary	9%
Difficulty with Obtaining: Dental or Orthodontia	7%

- **HARP Complaints**

Of the total 6,446 complaints MMCOs reported, 433 were associated with Health and Recovery Plans (HARPS).

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

Pharmacy/Formulary	19%
Dissatisfaction with Quality of Care	15%
Dissatisfaction with Provider Services (Non-medical) or MCO Services	15%
Reimbursement/Billing	7%
Balance Billing	5%

- **HIV/SNPS**

During the quarter, Managed Care Organizations reported 205 complaints 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	18%
Pharmacy/Formulary	18%
Access to Non-Covered Services	12%
Balance Billing	9%
Difficulty with Obtaining: Dental/Orthodontia	8%

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 a higher than expected complaint pattern persists to identify and address any trend or systemic operational issue that may be a contributing cause of the complaints. During the period of July through December 2017, four plans had observed/expected ratios greater than 2.0: Amida Care, Inc., Molina Healthcare of New York, Inc., Univera Community Health, Inc, and VNS Choice.

MMCO Outliers July 2017-December 2017 Observed Expected Ratio Calculations

Plan	o/e All Categories Combined
Amida Care, Inc.	9.5
Molina Healthcare of New York, Inc	16.2
Univera Community Health, Inc,	5.0
VNS Choice	9.2

- **Amida Care Inc.:** This HIV SNP was required to review higher than expected complaints in the following categories:
    - Dissatisfaction with quality of care (7.5 o/e): the plan did not identify any systemic operational issues. Amida Care noted a downward trend in this category and will continue to monitor for improvement opportunities.
    - Dissatisfaction with provider or MCO services (50.8 o/e): the plan did not identify any trend or systemic operational issue, but noted that enhanced enrollee engagement strategies are implemented by the plan to seek out enrollee feedback on MCO and provider services as part of the HIV SNP's overall approach to serving their unique, high needs population. These additional enrollee touchpoints may contribute to complaints, which are responded to timely by the plan and used to identify improvement opportunities.
    - Difficulty obtaining dental/orthodontia (15.0 o/e): the plan reported denials persist due to enrollee lack of education regarding the limited Medicaid dental benefit. The plan's dental vendor, HealthPlex, will circulate educational materials for the dental services covered under the plan and continue providing enrollee education via town hall meetings, mailing and during enrollee calls.
    - Pharmacy/formulary (21.3 o/e): the plan did not identify any trends or systemic operational issues.
    - Advertising/consumer education/outreach/enrollment (12.1 o/e): the plan, noting a downward trend, reported 5 of these complaints were related to an inadvertent confidential information breach previously reported to the Department and corrected.

  The Department will continue to monitor the plan's complaint trends, and impact of the corrective actions described.

- **Molina Healthcare of New York, Inc:** Molina was required to review higher than expected complaints in the following categories:
    - Denial of clinical treatment (6.3 o/e): the plan reported no system operational issues was identified. Th plan noted a downward trend for the last three quarters.
    - Pharmacy/formulary (12.5 o/e): the plan reported complaints in this category were the result of change in pharmacy benefit managers on January 1, 2018, which changed the plan's drug formulary and prior authorization requirements. In response, the plan hired additional staff to respond promptly to these concerns and educate prescribers on the changes; and provided a new 1-800 fax number for providers to contact the pharmacy manager.
    - Advertising and outreach (25.1 o/e): the plan attributed a spike in complaints to a system issue resulting in the failure of ID cards being issued timely over a two-week period. Once identified, the system issue was resolved and all ID cards were immediately issued. This accounted for 46% of Amida Care's complaints in this category in the 3rd and 4th quarter of 2017.
    - Difficulty obtaining specialist or hospital services (30.5 o/e): upon review, the plan identified that call center staff required additional training in navigating the plan's provider search tool and how to assist members with navigating the plan's on-line provider directory.

- Balance billing (3.8 o/e): upon review, the plan identified certain provider offices in need of reeducation regarding billing Medicaid enrollees; provider relations staff have begun this outreach.
- Dissatisfaction with quality of care (2.4 o/e): The plan reported a new system of tracking complaints began in the fall of 2017, and call center staff were miscoding complaints in this category. The plan has begun retraining of staff and improving internal policies for more consistent and accurate reporting.
- All Other (95.6 o/e): The plan reported a new system of tracking complaints began in the fall of 2017, and call center were overusing this complaint category. The plan has begun retraining of staff and improving internal policies for more consistent and accurate reporting.

The Department will continue to monitor the plan's complaint trends, and impact of the corrective actions described.

- **Univera Community Health, Inc.:** Univera Community Health was required to review higher than expected complaints in two categories:
  - Denial of Clinical Treatment (8.4 o/e): Upon review, the plan reported that most of the Denial of Clinical Treatment complaints were incorrectly coded and were related to pharmacy or dental issues. Staff were re-educated on appropriate coding of complaints.
  - Reimbursement/billing (28.7 o/e): Upon review, the plan reported the increase was related to provider complaints regarding claims payment that were mistakenly included in the enrollee complaint report. The Department instructed the plan to initiate corrections to their complaint data and reporting processes.

The Department will continue to monitor the plan's complaint trends, and impact of the corrective actions described.

- **VNS Choice.:** this HIV SNP was required to review higher than expected complaints in two categories:
  - Dissatisfaction of providers or MCO services (35.4 o/e): the plan reported that no trends or systemic operational issues were identified.
  - pharmacy/formulary (36.4 o/e): the plan reported that no trends or systemic operational issues were identified.

The Department will continue to monitor the plan's complaint trends to determine if further action is required.

If no reduction is noted following several quarters of the implementation of the corrective action, an alternate or more prescriptive response will be requested to address the issues. The Department is committed to identifying trends and to ensure MMCOs take corrective action as appropriate.

Long Term Services and Supports

As SSI enrollees typically access long term services and supports, the Department monitors complaints filed by this population with managed care plans. Of the 6,446 total reported complaints, mainstream MMCOs reported 578 complaints from their SSI enrollees. This compares to 585 SSI complaints from last quarter.

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

Category	Number of Complaints Reported for SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	16
AIDS Adult Day Health Care	0
Appointment Availability - PCP	3
Appointment Availability - Specialist	4
Appointment Availability – BH HCBS	1
Balance Billing	55
Communications/Physical Barrier	3
Consumer Directed Personal Assistant	0
Denial of Behavioral Health Clinical Treatment	0
Denial of Clinical Treatment	19
Dental or Orthodontia	83
Dissatisfaction with Behavioral Health Provider Services	1
Dissatisfaction with Health Home Care Management	4
Emergency Services	6
Eye Care	2
Family Planning	0
Home Health Care	3
Mental Health/Substance Abuse Services/ Treatment	2
Non-covered Services	29
Non-Permanent Resident Health Care Facility	0
Personal Care Services	3
Personal Emergency Response System	0
Pharmacy	38
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	54
Quality of Care	145
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	49
Specialist or Hospital Services	9
Transportation	1
Waiting Time Too Long at Office	4
All Other Complaints	44
Total:	578

The top 5 categories of SSI complaints reported were:

Category	Percent of Total Complaints Reported for SSI Enrollees
Quality of Care	25%
Dental or Orthodontia	14%
Balance Billing	10%
Provider or MCO Services (Non-Medical)	9%
Reimbursement/Billing Issues	8%

The following complaints/action appeals were reported involving difficulty with obtaining long term services and support. The 50 complaints received this quarter are consistent with the 48 complaints received last quarter.

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	2
Home Health Care	31
Non-Permanent Residential Health Care Facility	3
Personal Care Services	14
Personal Emergency Response System	0
Private Duty Nursing	0
Total	**50**

Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 469 complaints this quarter. This is a slight increase from the previous quarter, which reported 451 complaints.

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

Reimbursement/Billing	31%
Eligibility/Application Issues	18%
Benefit Coverage Issues	13%
Pharmacy/Formulary	5%
Difficulty Obtaining Covered Home Health Care Services	4%

This quarter, the Department and the Office of Alcoholism and Substance Abuse Services confirmed a persistent issue among complaints filed directly with the State regarding payment for physical health exams at Opioid Treatment Programs (OTPs). Physical health exams are a required service at the OTP. Multiple HARPs subcontract with Beacon Health Options (Beacon) for the management of the behavioral health benefit. Beacon combines two behavioral health companies, Beacon Health Strategies and ValueOptions. Preliminary findings show that Value Options has stopped paying for the physical exams at OTPs for the following plans' enrollees:

- Affinity Health Plan, Inc.
- Amida Care, Inc.
- MetroPlus Health Plan, Inc. (largest payer of these claims)

The Department is working with each plan/Beacon relationship to ensure there is a mechanism in place to pay the physical health claim in the OTP setting or route the claim to the plan for payment. The department will require a plan of correction and monitor its implementation where a deficiency in the plan operations and/or plan oversight of its vendor has been substantiated.

Fair Hearings
The Department reviews fair hearing decisions involving mainstream MMC, HARPs and HIV SNPs to ensure compliance with directives issued by the Office of Administrative Hearings, and to identify apparent trends or systemic issues warranting further investigation. No systemic plan operational issues or trends were identified this quarter. The following tables summarize fair hearing activity related to mainstream MMCs, HARPs and HIV SNPs this quarter.

Fair Hearing Decisions MMC, HARP and HIV SNP	1/1/18-3/31/18
In favor of Appellant	145
In favor of Plan	197
No Issue	35
Total	**377**

Fair Hearings Days from Request Date till Decision Date MMC, HARP and HIV SNP	1/1/18-3/31/18
Less than 30 days	12
30-59	102
60-89	124
90-119	74
=>120	65
Total	**377**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 22, 2018. The meeting included presentations provided by state staff and discussions of the following: a discussion of current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs; an update on activities related to operationalizing Community First Choice Option (CFCO); and an update on Behavioral Health, Health and Recovery Plans (HARPs) and Health Homes. An additional agenda item was a discussion of the managed care organization financial reports which was a follow-up on a request from the prior meeting on December 7, 2017. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for June 21, 2018.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

The Department conducted a satisfaction survey with adults enrolled in Medicaid managed care in the fall of 2017. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 Adult survey was administered to adults, ages 18 to 64, enrolled in Medicaid. The administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The overall response rate was 24% (with a range of 20% to 26% for response rates by plan). The findings demonstrate that adults have generally

high levels of satisfaction with care. Consistent performance in discussion of preventive activities or reducing risk behaviors. However, providers are less likely to address depression, smoking and alcohol use than diet, exercise and stress.

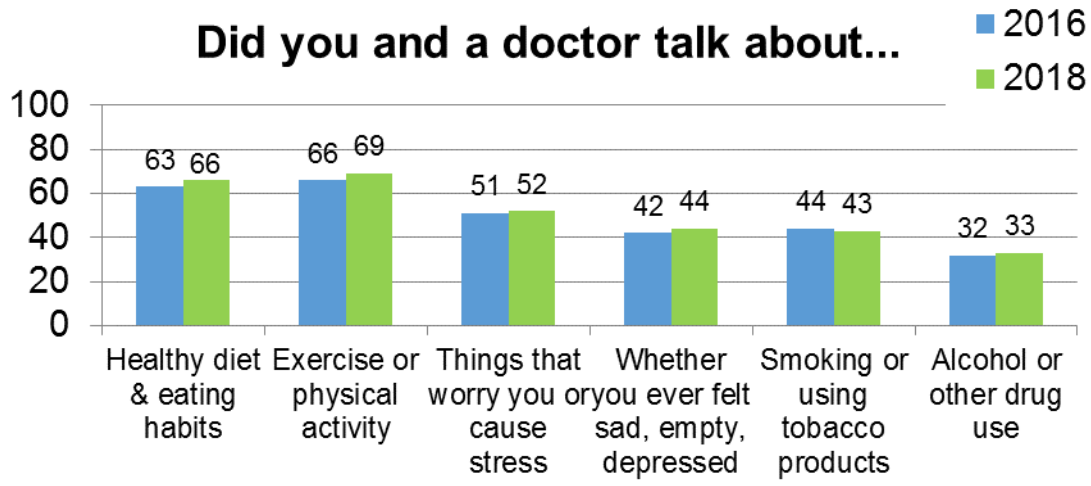
- Ratings of providers, health plans, and overall healthcare was similar or increased from 2016 (Percent rating 8, 9, or 10 with scale 0 - worst to 10 - best)

	2016 result	2018 result	2016 National Average[5]
Personal Doctor	80%	81%	80%
Specialist seen most often	80%	80%	80%
Health plan	76%	76%	75%
Overall healthcare	75%	77%	74%

- Similar or improved access to care, doctor communication and customer service from 2016
- Decreased rates of getting care quickly (Percent Usually or Always)

	2016 result	2018 result	2016 National Average[6]
Getting care quickly	79%	79%	80%
Doctors communicate well	80%	78%	80%
Customer Service	91%	91%	91%
Getting care needed	84%	86%	88%

Health promotion activities discussed (Percent 'Yes')



[5]Note: National average is from NCQA's State of Healthcare Quality report which uses 2016 CAHPS survey data (latest available)

[6]Note: National average is from NCQA's State of Healthcare Quality report which uses 2016 CAHPS survey data (latest available)

B. Quality Measurement in Managed Long-Term Care

No updates to report.

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 January through March 2018, a new Access Survey of Provider Availability was approved and initiated. A new Member Services Survey was also fielded, incorporating questions specific to Health and Recovery Plan (HARP) populations. Data collection for that Member Services Survey is ongoing. Plans of Corrections were processed for MCO's failing components of the PCP High Volume Survey, conducted at the end of 2017.

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.

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.

Unforeseen issues with compilation of data collected in the Prenatal Care Provider Reporting project were addressed in this quarter, as the project came to an end. IPRO continues to work closely with DOH staff to address these issues, and to produce a final report.

Regarding assessment of consumer satisfaction, IPRO oversaw a subcontract with DataStat to complete final reports for the 2017 adult CAHPS survey. They also completed final reports for a HARP perceptions of care survey.

This quarter, IPRO launched a new MLTC focused clinical study to validate assessments being completed by Maximus nurse reviewers using the Uniform Assessment System screening tool. IPRO is also facilitating a new Mainstream Managed Care Focused Clinical Study, examining patient engagement in the management of select conditions including diabetes.

Finally, IPRO has been working closely with DOH staff to obtain and compile relevant information for inclusion in MMC and MLTC Plan Technical 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 through December 2017. The aggregate data will be reported back to the participating practices to be able to compare their performance to their peers. In addition, the 2014 birth year aggregate report will be drafted.

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

For 2015-2016, the two-year common-themed PIP to address smoking cessation among Medicaid managed care (MMC) enrolled smokers 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. Fifteen PIP Proposals were submitted and have been reviewed and accepted by IPRO, NYSDOH, the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS). 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. Each plan submitted a written summary of progress to IPRO before the call was conducted. There are four webinars planned for 2018 when the participating HARP and HIV SNP plans will present their progress on the PIP. One of the webinars was held on January 23, 2018 and the second webinar was held on March 19, 2018. For each of these webinars three health plans presented their PIP progress to the group.

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. Fifteen Medicaid managed care plans submitted their Perinatal PIP

Proposals and IPRO and NYSDOH have reviewed and accepted them. In January 2018 fifteen plans submitted Interim Reports summarizing their progress for the first year implementing the PIP. The IPRO oversight calls will be conducted in April 2018. Each plan will submit a written summary of progress to IPRO before the call is conducted. On January 18, 2018, a required Perinatal PIP webinar was conducted. Three Medicaid managed care plans presented their Perinatal PIP progress to the group. There are three additional webinars scheduled for the other plans to present on their PIP progress in 2018.

Breast Cancer Selective Contracting

The Department completed its tenth annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2014-2016 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 257 facilities were designated as follows: 114 high-volume facilities, 25 low-volume unrestricted facilities, 76 low-volume restricted facilities, and 42 closed facilities.

Letters regarding final volume designation for state fiscal year 2018 were sent to health plan chief executive officers, and health plan trade organizations. The list of low-volume restricted facilities was posted on the Department's website and included in the 2018 March Medicaid Update.

Patient Centered Medical Home (PCMH)

As of March 2018, there were 8,711 NCQA-recognized PCMH providers in New York State. 193 providers that became recognized in March 2018 were new to the program and have not been recognized previously. Over the past year and a half, the program has consistently seen an increase in the number of new providers joining the program who have never participated before. Approximately 99% (8,642) of current PCMH providers are recognized under the 2014 set of standards. Between March 2017 and March 2018, the percentage shift of providers recognized under the newest standards increased from 74% to 99%. Less than 1% (49) of recognized providers are still under the 2011 standards and they are expected to all expire by June 2018. On April 1, 2017 NCQA released their 2017 recognition standards, eliminating the leveling structure. There are 20 providers and 15 practices recognized under the latest 2017 standards. Under this new program, it can take up to one year for NCQA to grant PCMH-recognition, as opposed to the guaranteed 90-day review process NCQA offered for sites who submitted applications under all previous standards. The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of March 2018 are:

- 2011 level 2: $0 per member per month (PMPM)
- 2011 level 3: $0 PMPM
- 2014 level 2: $3 PMPM
- 2014 level 3: $7.50 PMPM
- 2017 recognition: $7.50 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. Risk arrangements with practices within the ADK demonstration will differ by plan. All payments will be made to the newly approved Adirondack Accountable Care Organization (ACO) under the new participation agreement. The ACO will also be responsible for maintaining the funds and distributing among the participating practices in the region, as well as coordinating information between payers and providers. There is a quality subcommittee for this demonstration that has finalized a measure set to measure quality and performance for these sites over the next few years of participation.

The September 2017 PCMH Statewide quarterly report was posted to the DOH website this past quarter. All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the MRT website, available here: http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

IX. Transition Plan Updates

No updates.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

At the end of December 2016, New York submitted an updated Specifications Manual and a draft remediation plan and timeline for the completion of the budget neutrality reconciliation process, including plans to reconcile with the CMS-64. The budget neutrality remediation efforts are complete as of this quarter, with final calculations for DY17 quarter 4 submitted on February 16, 2018. The State is awaiting confirmation from CMS that all corrective action requirements outlined in the STCs have been satisfied.

The state budget neutrality team is now working on the 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 is 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 10/1/11-3/31/16 period. The State continues to work with KPMG and CMS to finalize an audit plan to guide KPMG's work. Upon approval of the final audit plan, work on the audit will begin.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

Monthly submission of T-MSIS files is on schedule. Several projects have been completed to improve the data quality of the monthly file submissions.

Attachments:
Attachment 1—MLTC Partial Capitation Plans
Attachment 2—MLTC Critical Incidents

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Submitted via email: May 24, 2018
Uploaded to PMDA: May 24, 2018

MLTC Partial Capitation Plan Enrollment April 2017 - March 2018

Plan Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Aetna Better Health	4,145	4,196	4,258	4,335	4,411	4,542	4,673	4,897	5,202	5,328	5,519	5,602
AgeWell New York	8,227	8,409	8,522	8,542	8,607	8,690	8,792	8,868	9,221	9,349	9,357	9,387
AlphaCare	3,735	3,856	3,951	4,134	4,282	4,459	4,692	4,775	4,589	37	14	3
ArchCare Community Life	2,400	2,509	2,623	2,695	2,783	2,871	2,993	3,187	3,294	3,483	3,528	3,587
CCM Select	13	1	1	1	0	0	0	0	0	0	0	0
Centers Plan for Healthy Living	15,777	16,345	16,881	17,532	18,057	18,660	19,199	20,046	24,655	25,276	25,801	26,363
Elant	843	839	847	854	853	874	879	902	909	916	912	931
Elderplan	12,340	12,421	12,515	12,583	12,463	12,486	12,579	12,610	12,668	12,700	12,704	12,736
Elderserve	11,207	11,196	11,231	11,248	11,265	11,277	11,354	11,390	11,497	11,626	11,751	11,893
Elderwood	107	116	123	140	151	154	171	188	197	203	206	227
Extended MLTC	2,098	2,307	2,475	2,660	2,800	2,895	3,110	3,320	3,481	3,629	3,757	3,918
Fallon Health Weinberg (TAIP)	521	536	563	573	584	602	627	651	670	682	678	687
Fidelis Care at Home	17,959	18,278	18,622	19,092	19,226	19,487	19,890	20,126	20,485	20,863	20,878	21,011
Guildnet	14,253	12,818	11,450	10,826	10,116	9,722	9,508	9,027	8,555	8,243	8,076	7,876
Hamaspik Choice	2,020	2,028	2,028	2,034	2,032	2,054	2,074	2,104	2,128	2,151	2,151	2,175
HealthPlus- Amerigroup	4,241	4,337	4,427	4,549	4,597	4,628	4,677	4,760	4,827	4,895	4,929	4,911
iCircle Services	1,760	1,789	1,854	1,915	2,000	2,054	2,147	2,212	2,257	2,342	2,384	2,441
Independence Care Systems	6,535	6,558	6,569	6,579	6,606	6,600	6,603	6,602	6,593	6,649	6,597	6,572
Integra	5,516	5,890	6,190	6,500	6,852	7,191	7,529	7,949	8,404	8,897	9,362	9,874
Kalos Health- Erie Niagara	1,030	1,088	1,115	1,151	1,169	1,210	1,252	1,248	1,264	1,265	1,254	1,235
MetroPlus MLTC	1,506	1,528	1,573	1,609	1,623	1,653	1,691	1,715	1,747	1,782	1,783	1,811
Montefiore HMO	1,288	1,305	1,341	1,380	1,393	1,404	1,432	1,447	1,465	1,460	1,462	1,464
North Shore-LIJ Health Plan	4,986	5,229	5,477	5,693	5,756	5,645	5,432	4,666	192	23	6	2
Prime Health Choice	265	275	276	282	295	301	308	316	334	353	354	355
Senior Health Partners	13,479	13,657	13,809	13,878	13,960	14,082	14,304	14,419	14,475	14,478	14,412	14,423
Senior Network Health	518	516	527	524	524	530	534	539	544	543	532	546
Senior Whole Health	7,599	7,981	8,303	8,561	8,826	9,141	9,359	9,440	9,575	13,969	13,779	13,776
United Healthcare	2,840	2,876	2,979	3,120	3,244	3,370	3,506	3,652	3,789	3,917	3,973	4,044
Village Care	7,667	7,906	8,102	8,328	8,525	8,713	8,924	9,105	9,276	9,538	9,779	9,925
VNA HomeCare Options	4,216	4,447	4,733	4,914	5,146	5,363	5,567	5,785	5,987	6,153	6,266	6,322
VNS Choice	13,032	12,819	12,764	12,824	12,719	12,644	12,704	12,756	12,812	12,934	12,899	12,806
WellCare	5,862	5,804	5,781	5,787	5,761	5,769	5,763	5,753	5,767	5,758	5,696	5,610
TOTAL	**177,985**	**179,860**	**181,914**	**184,843**	**186,626**	**189,071**	**192,273**	**194,455**	**196,859**	**199,442**	**200,799**	**202,513**

FFQ2 Critical Incidents by Plan		
Plan Name	**Plan Type**	**Total Critical Incidents**
Partical Capitation Plans		
Aetna Better Health	Partial	0
AgeWell New York ,LLC	Partial	See new Form
AlphaCare of New York Inc.	Partial	0
Amerigroup	Partial	0
ArchCare Community Life	Partial	7
CenterLight Healthcare Select	Partial	0
Centers Plan for Healthy Living	Partial	10
Elant Choice	Partial	0
ElderServe Health, Inc.	Partial	0
Elderwood	Partial	2
Extended	Partial	41
Fallon Health Weinberg	Partial	0
FIDELIS Care New York	Partial	0
GuildNet MLTCP	Partial	25
Hamaspik Choice	Partial	2
HomeFirst MLTC, a product of Elderplan	Partial	0
I Circle	Partial	0
Independence Care Systems	Partial	3
Integra MLTC	Partial	0
Kalos, dba First Choice Health	Partial	0
Metroplus	Partial	0
Montefiore Diamond Care	Partial	0
NSLIJ Health Plan	Partial	0
Prime Health Choice, LLC	Partial	63
Senior Health Partners	Partial	69
Senior Network Health	Partial	0
Senior Whole Health	Partial	2
United Healthcare Personal Assist	Partial	0
VillageCareMAX	Partial	0
VNA Homecare Options, LLC	Partial	64
VNSNY CHOICE MLTC	Partial	1
Wellcare	Partial	14
Total		303
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	1
Fidelis Medicaid Advantage Plus	MAP	0
GuildNet GNG	MAP	3
Healthfirst CompleteCare	MAP	27
HEALTHPLUS AMERIGROUP	MAP	0
Senior Whole Health	MAP	0
VNSNY CHOICE MLTC TOTAL	MAP	0
Total		31

FFQ2 Critical Incidents by Plan		
Plan Name	**Plan Type**	**Total Critical Incidents**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	7
Catholic Health LIFE	PACE	13
CenterLight Healthcare	PACE	1
Complete Senior Care	PACE	2
Eddy SeniorCare	PACE	8
ElderONE	PACE	0
Fallon Health Weinberg	PACE	0
Independent Living Services of CNY (PACE CNY)	PACE	19
Total Senior Care	PACE	0
Total		50
Grand Total		**384**