MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 20 (4/1/2018-3/31/2019)
Federal Fiscal Quarter: 2 (1/1/2019-3/31/2019)

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 2019

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	562,780	8,902	48,710
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	93,426	2,315	7,276
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	12,899	210	1,435
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	2,771	106	373
Population 5 - Safety Net Adults	374,929	13,007	39,518
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)	24,779	843	142
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	184,990	8,744	1,761

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,436**	**215**	**43**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**50,444**	**4,279**	**2,428**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**38,621 or an approximate 0.3% 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.

Compared to the prior quarter there was a slight decline in voluntary disenrollment. This is due to the significant decrease in disenrollment due to incarcerations being largely offset by the significant increase in the passive enrollment of the plan's HARP eligible enrollment into the plan's HARP offspring.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**101,686 or an approximate 17.8% 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.

This quarter's involuntary disenrollment showed a significant decline from the previous quarter. The decline was due to a significant decline in case closures. About one third of the decline in total case closures was due to a decline in MAGI case closures which are subsequently sent over to NYSoH for redetermination.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2019				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**991,885**	**22,081**	**3,046**	**19,035**
Rest of State	**349,288**	**11,833**	**1,433**	**10,400**
Statewide	**1,341,173**	**33,914**	**4,479**	**29,435**
February 2019				
New York City	**979,160**	**16,661**	**2,266**	**14,395**
Rest of State	**338,543**	**9,479**	**1,044**	**8,435**
Statewide	**1,317,703**	**26,140**	**3,310**	**22,830**
March 2019				
New York City	**969,903**	**18,451**	**2,493**	**15,958**
Rest of State	**325,471**	**9,726**	**921**	**8,805**
Statewide	**1,295,374**	**28,177**	**3,414**	**24,763**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**49,388**			
Rest of State	**27,640**			
Statewide	**77,028**			

HIV SNP Plans				
January 2019				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,103**	**205**	**0**	**205**
Statewide	**13,103**	**205**	**0**	**205**
February 2019				
New York City	**13,059**	**177**	**0**	**177**
Statewide	**13,059**	**177**	**0**	**177**
March 2019				
New York City	**13,080**	**166**	**0**	**166**
Statewide	**13,080**	**166**	**0**	**166**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**548**			
Statewide	**548**			

Health and Recovery Plans Disenrollment			
FFY 19 – Q2			
	Voluntary	**Involuntary**	**Total**
January 2019	**1,217**	**934**	**2,151**
February 2019	**942**	**976**	**1,918**
March 2019	**1,016**	**1,064**	**2,080**
Total:	**3,175**	**2,974**	**6,149**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2019-3/31/2019) Q2 FFY 2018-2019

As of the end of the second federal fiscal quarter (end of March 2019), there were 2,527,727 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 66,786 Medicaid consumers enrolled in Health and Recovery Plan (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 (FCSR) conducted outreach in 32 HRA facilities including six (6) HIV/AIDS Services Administration (HASA) sites, nine (9) Community Medicaid (MA) Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 13,108 clients were educated about their enrollment options and 7,934 (61%) clients made an enrollment choice.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSR to ensure that an approved presentation script is followed and required topics are explained. Any deficiencies found are reported to MAXIMUS field operation monthly. During the reporting period, 348 enrollment counselling sessions were evaluated which generated 348 applications for a total of 410 enrollments.

CMU Monitoring of Field Presentation Report – 2nd Quarter 2019	
Enrollment Counseling - One on One	**General Information**
348	993

Infractions were observed for 66 (19%) of the 348 Enrollment Counselling sessions conducted by NYMC FCSR 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
- Confirmation Letter
- Dental within plan network

Of the 410 enrollments completed during informational sessions, 401 (98%) were randomly chosen to track for timely and correct processing. The CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

B. Auto-Assignment (AA) Outreach

Phone Enrollment			General Information (undecided)		
Regular FFS	**Nursing Home FFS**	**Total**	**Regular FFS**	**Nursing Home FFS**	**Total**
161	17	178	81	9	90

In addition to face-to-face informational sessions, FCSR make outreach calls to Fee for Service (FFS) community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 27,417 FFS clients were reported on the auto-assignment list; 4,107 (15%) clients responded to the call including 3,630 community clients and 477 nursing home residents, resulting in 3,417 over the phone (83%) plan enrollments. A total of 3,368 (93%) community clients and 49 (13%) nursing home clients reached made a plan selection. CMU monitored 268 (7%) of the 4,107 completed outreach calls by FCSR in HRA facilities. The following captures those observations:

- Phone Enrollment: 178 (66%) FFS clients made a voluntary enrollment choice for themselves and their family members, including 17 NH clients for a total of 234 enrollments. Infractions are described below.
    - 212 (91%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 90 (34%) FFS and NH clients did not make an enrollment choice for several reasons that included having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 23 (14%) of the 161 regular FFS AA Phone Enrollment conducted by NYMC FCSR at HRA sites and none were observed for the 17 NH outreach calls. Key messages most often omitted were failure to disclose or explain the following:

- Medicare/TPHI
- Use of plan ID Card/Benefit Card
- Dental (how to access services) Good Cause Transfer

The CMU also randomly selected 124 (1%) clients from the auto-assignment list of 27,417 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 63 (51%) consumers were reached and 57 (90%) of the 63 that responded made a plan choice. The CMU also confirmed that appropriate and timely notices were sent to the 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 (CSR) answering New York City calls every month. NYMC reported that 61,304 calls were received by the Helpline and 55,950 or 91% were answered. Calls answered were handled in the following languages: English: 42,632 (76%); Spanish: 7,987 (14%); Chinese: 2,527 (5%); Russian: 818 (1%); Haitian/Creole: 99 (1%); and other: 1,887 (3%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 1,906 recorded calls. The call observations are categorized in the following manner:

CMU Monitoring of Call Center Report – 2nd Quarter 2019						
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Plan Disenrollment**	**Removal of Restriction**	**Total**
1,314 (69%)	79 (4%)	102 (5%)	397 (21%)	14 (1%)	0 (0%)	1,906

Infractions/issues were identified for 767 (40%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 716 (93%) - CSR 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: 16 (2%) - CSR incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 35 (5%) - 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 March 12, 2019, WellCare of New York, Inc. was approved to expand its Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) service areas to include Broome, Richmond, and Suffolk counties. On March 15, 2019, HealthFirst PHSP, Inc. was approved to expand its MMC and HARP service areas to include Westchester County.

On February 11, 2019, Partners Health Plan, Inc. was issued a contract to operate a Medicaid Managed Care product to coincide with the updating of their Certificate of Authority. At the close of the quarter, this contract was in the internal state approval process and will be sent to CMS for approval upon receiving all necessary state approvals.

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

During the second quarter, New York continued negotiation of new model contract language with the Trade Associations that represent the health plans. These negotiations were almost concluded at the close of the quarter. New York anticipates submitting the new model contract to CMS during the first week of April 2019.

C. Health Plans/Changes to Certificates of Authority

During the second quarter (January 1, 2019 – March 31, 2019), there were four (4) transactions requiring updates to Certificates of Authority.

- WellCare of New York, Inc.
- MVP Health Plan, Inc.
- Partners Health Plan, Inc.
- HealthFirst PHSP, Inc.

D. CMS Certifications Processed

During the second quarter (January 1, 2019 – March 31, 2019), there were five (5) Medicare Advantage State Certification requests processed.

- HealthFirst PHSP, Inc.
- United Health Care of New York, Inc.
- Wellcare of New York, Inc.
- Empire Health Choice HMO, Inc.
- Capital District Health Plan, Inc.

E. Surveillance Activities

Surveillance activity completed during the second quarter FFY 2018-2019 (January 1, 2019 - March 31, 2019) include the following:

One (1) Comprehensive Operational Survey and one (1) Targeted Operational Survey were completed during second quarter FFY 2018-2019. A Statement of Deficiency (SOD) was issued and a POC was accepted for one (1) Plan. One (1) Plan was found in compliance.

- Capital District Physicians' Health Plan, Inc. (In compliance)

- New York Quality HealthCare Corporation dba Fidelis Care New York

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

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	53,818	1,121	1,060	2.0%
ROS	5,091	62	61	1.2%
Total	58,909	1,182	1,120	1.9%

Note: MVP has been excluded due to non-submission of data.

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

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,699	59	30	0.5%
ROS	2,101	19	14	0.7%
Total	7,800	78	44	0.6%

Note: MVP has been excluded due to non-submission of data

[1] Q2 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 (1/1/2019-3/31/2019)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,393,045	92.12%	13.47%
Rest of State	1,123,921	94.15%	12.75%
Statewide Total	2,516,966	93.03%	13.15%

Note:

1. **MCOs report monthly data. The volume of paid and denied claims could include pended claims from previous months.**
2. **United and Emblem (CMO)'s March 2019 data have been excluded due to non-submission of data.**

HCBS Claims/Encounters 1/1/2019-3/31/2019: NYC

HCBS SERV GROUP	N Claims	N Recip
CPST	34	14
Education Support Services	27	14
Family Support and Trainings	0	0
Intensive Crisis Respite	0	0
Intensive Supported Employment	39	16
Ongoing Supported Employment	2	1
Peer Support	380	106
Pre-vocational	53	17
Provider Travel Supplements	92	41
Psychosocial Rehab	138	36
Residential Supports Services	40	12
Short-term Crisis Respite	356	52
Transitional Employment	0	0
TOTAL	1,161	257

HCBS Claims/Encounters 1/1/2019-3/31/2019: ROS

HCBS SERV GROUP	N Claims	N Recip
CPST	**316**	**82**
Education Support Services	**415**	**158**
Family Support and Trainings	**46**	**26**
Intensive Crisis Respite	**0**	**0**
Intensive Supported Employment	**186**	**73**
Ongoing Supported Employment	**41**	**12**
Peer Support	**1,217**	**440**
Pre-vocational	**129**	**60**
Provider Travel Supplements	**1,157**	**420**
Psychosocial Rehab	**721**	**206**
Residential Supports Services	**522**	**152**
Short-term Crisis Respite	**81**	**37**
Transitional Employment	**14**	**5**
TOTAL	**4,845**	**1,115**

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.

Time Period: 1/1/2019-3/31/2019

Events: MCTAC successfully executed 27 events from 1/1/2019- 3/31/2019. 13 events were held in person and 14 events were held via webinar.

1. Individual Participation: 1,777 people attended/participated in our events of which 932 are unique
    - OMH Agency Participation
        1. Overall: 248 of 611 (40.6%)
        2. NYC: 76 of 239 (31.8%)
        3. ROS: 181 of 388 (46.7%)

    - OASAS Agency Participation
        1. Overall: 195 of 543 (35.9%)
        2. NYC: 46 of 194 (23.7%)
        3. ROS: 157 of 368 (42.7%)

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)
- Developed 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.
        - Enhancing HCBS dashboard to include RCA and Health Home data

- 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
    - NYS Office of Mental Health has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for Medicaid Managed Care Health and Recovery Plans (HARPs) and Adult Behavioral Health (BH) Home and Community Based Services (BH HCBS).
        - NYAPRS conducts outreach in two ways:
            - Through 45-90-minute training presentations delivered by peers
                - OMH approves the PowerPoint before significant changes are made
            - Through direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers)

- Implemented Quality and Infrastructure initiative to support targeted HCBS workflow processes and increase in HCBS utilization. In-person trainings completed June 2018.

To date, 5,187 care managers in NYS have completed the required training "Understanding the Community Mental Health Assessment" and 2,246 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2019 and March 31, 2019, 7,218 brief eligibility assessments have been completed.

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

On January 31, 2019, the Department reconvened the workgroup developed for the transition of SBHC services into Medicaid Managed Care (MMC). The Department encouraged the MMC plans and SBHCs to proceed with contracting and gap reporting efforts. The MMC plans and SBHCs were provided a copy of a gap report template, instructions for completing the gap reporting, and frequently asked questions (FAQs) related to the transition of services into MMC. These documents are also posted on the Department's MRT 8401 web page. Follow-up meetings will be convened as needed, to continue the momentum for the January 1, 2021 implementation date.

C. Federally Qualified Health Services (FQHC) Lawsuit

On February 19, 2019, Community Health Care Association of New York, *et al*. v. DOH, Daines concluded through a settlement agreement that dismissed the remaining claims in this action and resolved outstanding issues.

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 January 2019 through March 2019 quarter, one Medicaid Advantage Plus plan opened for enrollment.

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 2019 through March 2019 quarter, post enrollment surveys were completed for sixteen enrollees. Twelve of the fifteen enrollees (80%) who responded to the question indicated that they continued to receive services from the same caregivers once they became members of an MLTCP (one enrollee did not respond

to this question). This represents a slight decrease in affirmative responses from 88% during the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans grew from 223,568 to 227,731 during the January 2019 through March 2019 quarter, a 1.9% increase over the last quarter. For that period, 14,691 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a 4% increase over the previous quarter. This brings the 12-month total for affirmative choices to 57,956, a 1.9% increase over the previous 12-month period. Monthly plan-specific enrollment for partial capitation plans during the April 2018 through March 2019 annual period is submitted as an attachment.

2. Significant Program Developments

During the January 2019 through March 2019 quarter:

- Member Services surveys continued. These surveys are conducted each quarter to provide feedback on the overall functioning of plans' member services performance. No response is required, but when necessary the department will provide recommendations on areas of improvement. This quarter, such surveys were conducted on 27 Partial Capitation plans.

- Operational Surveys remain in process for three (3) Partial Capitation plans.

- The review and approval of the new model notices for the MLTC plans and their vendors is an ongoing task.

- The draft RFA for a new MLTC Ombudsman Contract is in the review and approval process awaiting final approvals.

- The Surveillance tools are continually updated to reflect process changes including HCBS Final Rule requirements.

- New survey software awaits customization. The vendor provided initial training on March 28th and 29th which will allow staff to begin customizing the software. Further software training is scheduled to take place April 10th – 12th.

3. Issues and Problems

There were no issues or problems to report for the January 2019 through March 2019 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within the MLTCP as a consumer choice and gives individuals and families greater control over services received. Plans continue to be required to contract with

a minimum of two (2) Fiscal Intermediaries in each county. The requirement continues to be monitored on a quarterly basis, and all plans are meeting that requirement.

5. Required Quarterly Reporting

Critical incidents: There were 1,298 critical incidents reported for the January 2019 through March 2019 quarter, a decrease of 57% over the last quarter. This decrease was anticipated given that clarification to the reporting instructions was issued in February and that the Department met with the two plans that were driving past large increases to review the reporting instructions. It is anticipated that it will take several quarters to determine a new baseline for critical incidents given plans' better understanding of the reporting requirements.

Grievances and Appeals: For the January 2019 through March 2019 quarter, the top reasons for grievances/appeals remained the same as last quarter: 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: 1/1/2019 through 3/31/2019 **(Percentages rounded to nearest whole number)**			
Number of Recipients: 246,521	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	**6,378**	**6,378**	**100%**
# Standard/Expedited	**4,698**	**4,727**	**101%**
Total for this period:	**11,076**	**11,105**	**100%**

Appeals	**4/2018-6/2018**	**7/2018-9/2018**	**10/2018-12/2018**	**1/2019-3/2019**	**Average for Four Quarters**
Average Enrollment	222,512	230,374	239,377	246,521	234,696
Total Appeals	2,451	3,084	3,495	4,151	3,295
Appeals per 1,000	11	13	15	17	14
# Decided in favor of Enrollee	629	637	617	815	675
# Decided against Enrollee	1,432	2,367	2,542	3,031	2,343
# Not decided fully in favor of Enrollee	143	119	148	184	149
# Withdrawn by Enrollee	67	139	110	106	106
# Still pending	684	539	500	580	576
Average number of days from receipt to decision	13	12	12	8	11

Grievances and Appeals per 1,000 Enrollees by Product Type January-March 2019					
	Enrollment	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	226,313	7,094	31	3,642	16
Medicaid Advantage Plus (MAP) Total	14,405	2,488	173	491	34
PACE Total	5,803	1,494	257	18	3
Total for All Products:	**246,521**	**11,076**	**45**	**4,151**	**17**

Total Grievances decreased slightly from 11,143 the previous quarter to 11,076 during the January 2019 through March 2019 quarter. The total number of appeals increased 11% from 3,742 during the last quarter to 4,151 during the January 2019 through March 2019 quarter. This increase continues to reflect the 2018 implementation of the requirement that internal appeals must be exhausted prior to seeking a fair hearing.

Technical Assistance Center (TAC) Activity

During the January 2019 through March 2019 quarter, call volume increased significantly, averaging about 321 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 55% of cases were closed within the same month.

During February, the unit also saw a significant increase in the number of cases that came into the TAC unit. The bulk of those calls were referred to the appropriate subject matter expert to assist the member. Such cases for February were reviewed, and there does not seem to be one specific cause for these types of calls.

Call Volume	**1/1/2019- 3/31/2019**
Substantiated Complaints	116
Unsubstantiated Complaints	467
Complaints Resolved Without Investigation	44
Inquiries	333
Total Calls	**960**

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

General-other	10%
IDT Dissatisfaction	10%
Aide Services- Agency Problems	7%
Aide Services- Plan Not Providing Hours	7%
DME Obtaining	5%

The top five categories of calls are, for the most part, consistent with previous quarters with the exception that Billing – Denied claims was not in the top five this quarter, but General – Other was in the top five. The unit saw an increase in these general questions and inquiries during the month of February.

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 January 2019 through March 2019 quarter, 11,755 people were evaluated, deemed eligible and enrolled into plans, an increase of 7.1% over the previous quarter.

Referrals and 30-day assessment: For the January 2019 through March 2019 quarter, MLTC plans conducted 14,128 assessments, a very slight decrease of .8% from 14,235 the previous quarter. The total number of assessments conducted within 30 days decreased 6% from 11,459 the previous quarter to 10,805 this quarter.

Referrals outside enrollment broker: For the January 2019 through March 2019 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 25,576, a 14% decrease from 29,885 the previous quarter. This decrease is likely a normalization after the increase resulting from the announcement of planned closures and service area reductions last quarter.

Rebalancing Efforts	1/2019-3/2019
Enrollees from a nursing home who are transitioning to the community and are new to the plan	296
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	2,967
Individuals who are permanently placed in a nursing home and are new to plan	2,709

As of March 2019, there were 17,852 current plan enrollees who were in nursing homes as permanent placements.

VI. Evaluation of the Demonstration

The contract for the independent evaluation is pending New York State approval. The anticipated contract start date is August 1, 2019.

VII. Consumer Issues

A. All complaints

Medicaid managed care organizations (MMCOs), including mainstream managed care plans (MMCs), 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 1/1/2019 to 3/31/2019	Total Complaints from Previous Quarter 10/1/2018 to 12/31/2018
Medicaid Managed Care	7,826	6,984
HARP	764	800
HIV/SNP	215	173
Total MMCO Complaints	**8,805**	**7,957**

As described in the table, total MMCOs complaints/action appeals reported for the quarter equal 8,805. This represents an 11% increase from the prior quarter. This change is attributed to a slight increase coming from three plans: Affinity, MetroPlus and VNS Choice.

This quarter's plan-reported complaint data shows an increase of 12% for MMCs and a decrease of 4.5% for HARPs over the last quarter. HIV/SNP complaints increased by 24.3% 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 1/1/2019 to 3/31/2019	Previous Quarter 10/1/2018 to 12/31/2018
Pharmacy/Formulary	**29%**	**36%**
Balance Billing	**18%**	**3%**
Reimbursement/Billing	**8%**	**4%**
Difficulty with Obtaining: Dental/Orthodontia	**8%**	**5%**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	**7%**	**9%**

HARP Complaints/Action Appeals:
Of the total 8,805 complaints MMCOs reported, 764 were associated with HARPs.

The top 6 most frequent categories of complaints for HARPSs were as follows:

Pharmacy/Formulary	52%
Dissatisfaction with Quality of Care	8%
Dental/Orthodontia	6%
Dissatisfied with Provider Services (Non-Medical or MCO Services)	5%
Reimbursement/Billing	4%
Balance Billing	4%

As the Pharmacy/Formulary category is elevated at 52% (21% increase from the prior quarter), DOH researched for any trend. It was found that HealthFirst continues to report an increased number of complaints for HARP Pharmacy (344, or 16% increase from the prior quarter) and a root cause analysis was requested from HealthFirst. HealthFirst responded that the increase was largely due to complaints and action appeals regarding new generic versions for Ventolin and Suboxone Film coming to market. DOH continues to investigate this trend and will closely monitor this category for improvement.

HIV/SNPS Complaints/Action Appeals:
During the quarter, MMCOs reported 215 complaints/action appeals for HIV/SNPs.

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

Pharmacy/Formulary	17%
Dissatisfied with Provider Services (Non-Medical or MCO Services)	17%
Balance Billing	9%
Dental/Orthodontia	8%
Problems with Advertising/Consumer Education/Outreach/Enrollment	7%

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

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

MMCO Outliers July 2018-December 2018 Observed Expected Ratio Calculations

Plan	o/e All Categories Combined
Amida Care, Inc.	6.3
Molina Healthcare of New York, Inc	21.3
Your Care Health Plan	2.6
VNS Choice	15.6

All plans have submitted written explanations of any surges or changes in reporting and what corrective steps they will implement to address any trends or issues identified.

- **Amida Care, Inc.:** This plan reported higher than expected complaints in three (3) categories in the 2nd half of 2018.
    - Dissatisfaction with Provider Services (Non-Medical) or MCO Services (43.1 o/e)*:* the plan reports a decrease in the o/e ratio over the 1st half of 2018. The plan identified two limited trends in this category. First, there were complaints related to outpatient appointments and services and access to DME. Though there were no patterns related to a specific provider or site, the plan has the following monitoring process: if a provider or site receives more than 2 complaints in a quarter for the same issue, the Provider Services team will conduct a site visit/conference call to review systems/workflows to ensure this issue is addressed. Second, there were complaints related to MCO customer services. Amida Care reported that their quarterly complaints committee, a subcommittee of the Quality Management Committee, met in January 2019, where department leaders were presented with complaint data illustrating where customer service expectations were not met, to review each complaint and identify opportunities for process improvement and coaching/training for staff. The plan anticipates follow up, and will take corrective action if necessary, at the next quarterly complaints committee meeting.
    - Difficulty with obtaining Dental/Orthodontia (11.5 o/e): the plan reports an increase in the o/e ratio over the 1st half of 2018. Amida Care reported that the complaints continue to be related to the limitations in the Medicaid benefit package for Dental/Orthodontia services. In addition, the plan also reported an increase in complaints regarding poor service at network facilities. Based on this trend, Amida determined in late 2018 to identify a new dental vendor that could meet the plan's required performance and customer service expectations. Once a final vendor is selected, Amida Care will work closely with the selected vendor's

leadership to ensure their network is educated as to Amida Care's service level requirements.

- Pharmacy/Formulary (2.7 o/e): The plan reported a significant decrease in the o/e ratio from the 1st half of 2018. The plan reported that most complaints this quarter involve network pharmacies not fulfilling their contractual obligations, and the plan is determining if network changes are necessary to address the needs of members.

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

- **Molina Healthcare of New York, Inc:** This plan reported higher than expected complaints in ten (10) categories in 2nd half 2018.
  - All Categories Combined (21.3 o/e): The plan reports an increase in the o/e ratio over 1st half 2018. The plan identified an issue with call center teams coding complaints. To remedy this, Molina will continue to offer additional training as needed and review internal policies to assist with more consistent and accurate reporting; the most recent training was conducted with the call center representatives in 4th quarter 2018. The plan will continue to monitor the results of their training initiatives and report.
  - Denial of Clinical Treatment (5.8 o/e): Molina reports that all complaints are related to the limitation of the Medicaid dental benefit. The plan did not identify any systemic or operational issues.
  - Dissatisfaction with Provider Services (Non-Medical*)* (6.4 o/e): The plan reports an increase in their o/e ratio over 1st half 2018. Molina indicates that the trend for this category continues to be related to cancellations or difficulty in obtaining an appointment. While continuing to dedicate call center representatives to assist enrollees in contacting providers, scheduling appointments or finding a new provider; the plan's provider relations team is also tracking, monitoring these complaints and discussing any recurring issues with providers, including a physician to physician discussion, if needed.
  - Difficulty with obtaining services (Specialist and Hospital (80.2 o/e) and obtaining Eye Care (39.7 o/e). The plan reports that a trend for these types of complaints stemming from educating enrollees on how to find a participating provider. The plan reports they believe their provider network provides very sufficient coverage and is comparable to networks of other Medicaid managed care plans. The plan reports call center representatives continue to educate enrollees on how to search for participating providers through the Molina Online Directory. If a need to add a specialty provider to the network is identified through the plan's Provider Contracting and Provider Relations team's monthly tracking process, the plan will conduct appropriate outreach and contracting efforts.
  - Difficulty with obtaining Dental/Orthodontia (8.1 o/e): the plan reports the majority were from enrollees calling to make an appointment with a dentist and the call representative being unable to complete that request on the initial call.

The incidents reported included enrollees calling after hours when offices were closed, enrollees with incorrect information in Molina's database, enrollees calling about waiting on prior authorizations, etc. Molina is working with its dental vendor to make sure the call center has the most current information and resources to educate and respond to enrollee inquires.

- Pharmacy/Formulary (12.8 o/e): This category shows a significant decrease from 1st half 2018. The plan reported most complaints were due to the enrollee's provider not sending in a prior authorization request when a medication rejected at point of sale. The next most common complaint was reportedly due to the formulary change to True Metrix glucometer and test strips, though enrollees did acknowledge receiving the timely notification of this change. The plan also reported a trend related to expiring authorizations; in response, the plan is developing a mechanism to notify enrollees and providers 30 days prior to an active authorization expiring.
- Problems with Advertising/Consumer Education/Outreach (64.6): This category saw an increase over 1st half 2018. The plan identified a trend in complaints related to Molina's enrollment information. As a result, Molina began a remediation project to review all enrollment processes and implemented changes to address gaps in procedures.
- All Other (92.9 o/e): This category saw an increase between the two reporting periods in 2018. The plan continues to work with their representatives in reporting specific categories. Molina identified in 3rd quarter 2018 that the call center representatives were incorrectly defining complaints which caused an inappropriate inflation of reported totals. Additional training was conducted with the call center representatives in 4th quarter 2018.
- Balanced Billing (9.6 o/e) This category saw an increase between the reporting periods. Molina implemented a more stringent process in early 2019 to review monthly reporting of repeated "offenses" by providers and having designated provider relations representatives reach out to the providers and will reminding providers of billing prohibitions as part of the regular visits conducted by the provider relations team.

The Department will continue to monitor the plan's activities to address root causes of the systemic issues identified, including, given the continuation of complaints related to access issues in several areas, cross analysis with the results of the State's routine surveillance activity related to network adequacy and appointment availability to assess capacity of the plan's network. Where a deficiency is identified and cited, the plan will be required to implement a corrective action plan, after which the State will reassess to determine effectiveness of the corrective action.

- **Your Care Health Plan:** This plan reported higher than expected complaints in two (2) categories in 2nd half 2018.
    - Denial of Clinical Treatment (21.6 o/e): This category increased between the two reporting periods. The plan identified two trends: 1) action appeals related to a change in Pharmacy Benefit Manager (Optum) resulting in a new formulary and

generating pharmacy authorization denials. The plan reports these appeals stabilized in late 2018; and 2) complaints related to limited Medicaid coverage of dental services; in response the plan will include an explanation of dental benefit coverage in their member newsletter in Q2 2019 and monitor trending for appeals/grievances received.

- Reimbursement/Billing (13.7 o/e): This category declined since first half of 2018. According to the plan, data shows that several participating providers use out of state billing facilities to manage claims reimbursements. Plan initiated corrective action includes utilizing their provider relations team to educate billers, specifically out of state billers, on appropriate billing practices for Medicaid Managed Care Enrollees.

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

- **VNS Choice:** VNS was required to respond to seven (7) categories in this reporting period.
    - All categories combined (15.6 o/e) and All other (28.4): VNS reports that most of these complaints continued the trend related to DME and/or the associated supply orders processed by their DMEPOS Benefit Management Vendor. To address this issue, effective 10/15/2018, VNS implemented a new pilot DME ordering platform. Use of the new platform has reduced the number of DME equipment and associated supplies delivery errors. VNS reports that they are expanding the pilot program.
    - Dissatisfaction with Provider Services (Non-Medical) (35.9 o/e): The plan did not identify any systemic or operational issues.
    - Difficulty with Obtaining Home Health Care (426.9 o/e) The plan reports a trend in complaints regarding enrollee requests for an increase in services beyond their assessed needs and in the case of consumer directed personal assistant services (CDPAS) requests, enrollee misunderstanding of CDPAS roles and responsibilities, and requirements of Fiscal Intermediaries. Although all new enrollees receive CDPAS information, the Plan is reviewing CDPAS related communications for improvement, including potential development of a "reminder" flyer.
    - Difficulty with obtaining Dental/Orthodontia (16.8 o/e): The plan identified two trends. First, complaints involved enrollees seeking treatment from out of network providers for their Dental needs. Second, complaints were related to misunderstanding the Medicaid dental benefit. In an effort to reinforce/remind enrollees about their dental coverage, the plan providing a one-time mailing to . This flyer will also be added to the new enrollee Welcome Kit and will be posted to the VNS website.
    - Pharmacy/Formulary (12.5 o/e): The plan did not identify any systemic or operational issues.

- Balanced Billing: (6.9 o/e) the plan reported that a majority of complaints were related to hospitals incorrectly billing enrollees. The plan conducted outreach to each facility to remind them of balance billing prohibitions.

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

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 8,805 total reported complaints/action appeals, mainstream MMCOs reported 845 complaints and action appeals from their SSI enrollees. This compares to 747 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	15
AIDS Adult Day Health Care	0
Appointment Availability - PCP	1
Appointment Availability - Specialist	4
Appointment Availability – BH HCBS	0
Balance Billing	80
Communications/Physical Barrier	5
Consumer Directed Personal Assistant	5
Denial of Behavioral Health Clinical Treatment	2
Denial of Clinical Treatment	54
Dental or Orthodontia	170
Dissatisfaction with Behavioral Health Provider Services	4
Dissatisfaction with Health Home Care Management	18
Emergency Services	7
Eye Care	1
Family Planning	0
Home Health Care	19
Mental Health/Substance Abuse Services/ Treatment	1
Non-covered Services	42
Non-Permanent Resident Health Care Facility	3

Personal Care Services	23
Personal Emergency Response System	0
Pharmacy	55
Private Duty Nursing	1
Provider or MCO Services (Non-Medical)	102
Quality of Care	146
Recipient Restriction Program/Plan Initiated Disenrollment	4
Reimbursement/Billing Issues	37
Specialist or Hospital Services	18
Transportation	1
Waiting Time Too Long at Office	4
All Other Complaints	23
Total	**845**

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

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental/Orthodontia	20%
Dissatisfied with Quality of Care	17%
Provider or MCO Services (Non-Medical)	12%
Balance Billing	9%
Pharmacy/Formulary	7%

The Department requires MMCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. As of March 31, 2019, plans reported 26,892 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 LTSS for the last quarter.

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
	Q2 FFY 19
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	5
Home Health Care	19
Non-Permanent Residential Health Care Facility	0
Personal Care Services	10

Personal Emergency Response System	0
Private Duty Nursing	1
Total	35

Critical Incidents:
The Department requires MMCOs to report critical incidents involving enrollees in receipt of LTSS. There were 62 critical incidents reported for the January 1, 2019 through March 31, 2019 period. The number of critical incidents reported by MMCOs are as follows.

Critical Incidents			
Plan Name	**January 1st to March 31st 2019**	**October 1st to December 31st 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	1	6	-5
Fidelis Care	0	0	0
Healthfirst PHSP	8	10	-2
Health Insurance Plan of Greater New York	0	0	0
HealthNow	0	0	0
HealthPlus	3	0	+3
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	1	1	0
MVP Health Plan	0	0	0
United Healthcare Plan of New York	0	0	0
Wellcare of New York	0	1	-1
YourCare Health Plan	4	0	+4
Total	**17**	**18**	**-1**
Health and Recovery Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	1	0	+1
Fidelis Care	0	0	0
Healthfirst PHSP	42	73	-31

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	0	1	-1
MVP Health Plan	0	0	0
United Healthcare Plan of New York	0	0	0
YourCare Health Plan	0	0	0
Total	**43**	**74**	**-31**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan SNP	0	0	0
VNS Choice SNP	2	3	-1
Total	**2**	**3**	**-1**
Grand Total	**62**	**95**	**-33**

Consumer Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 101 consumer complaints this quarter. This total is a 31% decrease from the previous quarter, which reported 146 consumer complaints

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

Pharmacy/Formulary	10%
Reimbursement/billing disputes	9%
Difficulty obtaining covered Home Health Care Services	9%
Difficulty obtaining Personal Care Services	8%
Difficulty obtaining referrals or covered services	7%

Fair Hearings
There were 322 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2019 through March 31, 2019. The dispositions of these fair hearings were as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP plans)	1/1/2019-3/31/2019
In favor of Appellant	117
In favor of Plan	164
No Issue	41
Total	**322**

Fair Hearings Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP plans)	1/1/2019-3/31/2019
Less than 30 days	14
30-59	130
60-89	86
90-119	45
=>120	47
Total	**322**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 21, 2019. 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 (HARP) and Health Homes. An additional agenda item included a presentation of the results from a 2017-2018 Perception of Care Survey for Health and Recovery Plan Members in New York State presented by the New York State Office of Mental Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for June 20, 2019.

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

To date, there have been no significant issues with this transition process. No updates to report this quarter.

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 January to March 2019, Final reports from the most recent High Volume PCP Ratio survey were distributed to MCOs. Planning for a new Access Survey of Provider Availability and Member Services Department survey was underway, with revision to some of the survey questions.

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.

Plan proposals for the 2019/2020 Managed Long Term Care Performance Improvement Projects (PIPs) were obtained and revised based on the oversight of the EQRO. An MLTC Satisfaction Survey was planned, with the first round of administration in April. Encounter Data Validation was planned.

Final reports from a Focused Clinical Study (FCS) looking at necessity of long-term care were revised. New FCSs on MLTC Frailty, HARP Intensive Care Management (ICM), and MMC Maternal Sepsis were developed for implementation next quarter.

Fielding of the child CAHPS® survey was completed and final reports revised. Contracting with NCQA for plan submission of QARR data was established, and planning for the 2018 measurement year reporting cycle finalized. The fielding of a Diabetes Self-Management Education (DSME) survey was completed and analysis plan finalized. A HARP perceptions of care survey was also designed/revised based on previous surveys, and fielded late in the quarter.

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.

EQRO Technical Reports were developed, revised, and finalized.

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. Internal discussions are underway regarding next steps for the data analysis.

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 was 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 was Perinatal Care. There were four priority focus areas 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.

The three HIV SNP Plans submitted their 2019-2020 PIP Proposals by December 21, 2018. The submitted PIP Proposals were reviewed by IPRO and NYSDOH. A summary of comments was provided to the HIV SNPs and individual health plan conference calls were conducted with all the plans to discuss the Proposal and comments. The revised PIP Proposals were received, reviewed and approved. One of the three HIV SNP's will participate in the HARP PIP topic. The other two HIV SNPs are each conducting separate PIP topic areas.

The 2019-2020 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. 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. All PIP Proposals have been received and underwent review by IPRO, NYSDOH and partners (including OASAS and OMH). A summary of comments was provided to the HARPs. Individual health plan conference calls were conducted with all the plans to discuss the Proposal and comments. All the revised PIP Proposals were received, reviewed and approved, except one which is in final review.

The 2019-2020 Medicaid managed care (MMC) PIP topic is related to the Medicaid KIDS Quality Agenda. 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 was distributed to the plans on February 4th. The PIP Proposals were due in the first quarter of 2019. The Proposals were received and are under review by IPRO and NYSDOH. A summary of comments was provided to the MMC plans and individual health plan conference calls were conducted with all the plans to discuss the Proposal and comments. A webinar was conducted with the plans on February 19, 2019 to provide more details on the Lead Focus Area and answer questions from the plans.

An FAQ document for the Feb. 19 webinar was created and distributed to the MMC plans. A Guide to the Plan-Specific Member Level File for Lead Testing results was sent to the plans on February 13, 2019. The Plan- Specific Member Level File was sent to the plans on March 29, 2019 and April 3, 2019.

A Webinar on the Hearing Screening Focus Area will be conducted on April 29, 2019. The PowerPoint presentation is being prepared by EHDI, OQPS, and OHIP. A Guide to the Plan Specific Member Level File for Hearing Screening Focus Area is being prepared by NYSDOH. A webinar will also be scheduled with the Plans to discuss and provide more details about the Developmental Screening Focus Area.

Breast Cancer Selective Contracting
The Department completed its annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2015-2017 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 262 facilities were designated as follows: 117 high-volume facilities, 22 low-volume unrestricted facilities, 84 low-volume restricted facilities, and 39 closed facilities.

Eight facilities appealed the decision to be placed on the low-volume restricted list; and two of the appeals were approved. Administrators at these facilities were notified via mail of their decisions. In addition, letters regarding final volume designation for state fiscal year 2019-20 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 2019 March Medicaid Update.

Patient Centered Medical Home (PCMH)
As of March 2019, there were 9,116 NCQA-recognized PCMH providers in New York State. Approximately 83% (7,585) 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 77 providers and 35 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 1,454 providers and 305 practices recognized. 27 providers that became recognized in March 2019 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 March 2019 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

The transition is complete and there will not be another update.

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. Additionally, New York state is working closely with CMS's analytics vendors to improve the data quality of its submissions. A recent communication from one of these vendors provided positive feedback regarding New York's efforts and communications to improve the quality of its Medicaid data 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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Uploaded to PMDA: May 29, 2019

January 2019-March 2019 Critical Incidents		
	Plan Type	**Critical**
Partical Capitation Plans		
Aetna Better Health	Partial	4
AgeWell New York ,LLC	Partial	19
AlphaCare of New York Inc.	Partial	0
Amerigroup	Partial	0
ArchCare Community Life	Partial	14
CenterLight Healthcare Select	Partial	0
Centers Plan for Healthy Living	Partial	30
Elant Choice	Partial	28
ElderServe Health, Inc.	Partial	98
Elderwood	Partial	2
Extended	Partial	99
Fallon Health Weinberg	Partial	1
FIDELIS Care New York	Partial	1
GuildNet MLTCP	Partial	0
Hamaspik Choice	Partial	16
HomeFirst MLTC, a product of Elderplan	Partial	0
I Circle	Partial	0
Independence Care Systems	Partial	1
Integra MLTC	Partial	0
Kalos, dba First Choice Health	Partial	6
Metroplus	Partial	0
Montefiore Diamond Care	Partial	3
NSLIJ Health Plan	Partial	0
Prime Health Choice, LLC	Partial	94
Senior Health Partners	Partial	225
Senior Network Health	Partial	5
Senior Whole Health	Partial	3
United Healthcare Personal Assist	Partial	1
VillageCareMAX	Partial	186
VNA Homecare Options, LLC	Partial	126
VNSNY CHOICE MLTC	Partial	29
Wellcare	Partial	38
Total		**1029**
Medicaid Advantage Plus (MAP)		
Elderplan	MAP	0
Fidelis Medicaid Advantage Plus	MAP	0
GuildNet GNG	MAP	0
Healthfirst CompleteCare	MAP	220
HEALTHPLUS AMERIGROUP	MAP	0
Senior Whole Health	MAP	0
VNSNY CHOICE MLTC TOTAL	MAP	1
Total		**221**
Program of All-inclusive Care for the Elderly (PACE)		
ArchCare Senior Life	PACE	7
Catholic Health LIFE	PACE	17
CenterLight Healthcare	PACE	0
Complete Senior Care	PACE	3
Eddy SeniorCare	PACE	6
ElderONE	PACE	0
Fallon Health Weinberg	PACE	0
Independent Living Services of CNY (PACE CNY)	PACE	15
Total Senior Care	PACE	0
Total		**48**
Grand Total		**1298**

Managed Long Term Care Partial Capitation Plan Enrollment
April 2018- March 2019

Plan Name	April	May	June	July	August	September	October	November	December	January	February	March
Aetna Better Health	5,743	5,905	6,054	6,260	6,330	6,452	6,587	6,798	7,034	7,265	7,370	7,417
AgeWell New York	9,425	9,515	9,590	9,643	9,688	9,777	9,915	10,135	10,464	10,824	11,022	11,187
AlphaCare	5	5	3	0	0	0	0	0	0	0	0	0
ArchCare Community Life	3,671	3,708	3,774	3,865	3,934	3,997	4,160	4,286	4,418	4,513	4,545	4,578
Centers Plan for Healthy Living	26,996	27,726	28,275	28,938	29,427	29,980	30,606	30,978	31,716	32,212	32,550	33,006
Elant	942	971	973	977	995	978	966	976	975	952	953	954
Elderplan	12,691	12,751	12,848	12,941	12,943	13,130	13,325	13,504	13,881	14,125	14,129	14,070
Elderserve	12,032	12,155	12,289	12,399	12,380	12,453	12,738	13,071	13,654	14,053	14,271	14,429
Elderwood	255	271	284	305	328	353	383	414	452	496	591	617
Extended MLTC	4,085	4,290	4,488	4,714	4,874	4,982	5,122	5,327	5,663	5,995	6,155	6,322
Fallon Health Weinberg (TAIP)	706	709	716	728	742	764	788	801	810	827	843	862
Fidelis Care at Home	20,989	21,048	21,120	21,399	21,626	21,870	22,140	22,353	22,729	23,107	23,331	23,412
Guildnet	7,670	7,541	7,480	7,427	7,316	7,332	6,668	5,471	2,734	23	11	2
Hamaspik Choice	2,179	2,186	2,166	2,206	2,196	2,214	2,225	2,232	2,251	2,252	2,266	2,287
HealthPlus- Amerigroup	4,931	4,968	5,016	5,060	5,080	5,174	5,345	5,553	5,856	6,111	6,208	6,247
iCircle Services	2,485	2,556	2,600	2,647	2,691	2,769	2,862	2,981	3,067	3,165	3,420	3,495
Independence Care Systems	6,509	6,443	6,377	6,325	6,182	6,077	6,035	5,894	5,825	5,761	5,632	5,252
Integra	10,295	10,797	11,203	11,764	12,226	12,844	13,762	14,444	15,200	15,821	16,388	17,037
Kalos Health- Erie Niagara	1,252	1,276	1,294	1,291	1,309	1,318	1,324	1,350	1,367	1,386	1,381	1,416

MetroPlus MLTC	1,836	1,824	1,866	1,858	1,857	1,838	1,841	1,835	1,901	1,991	1,978	1,962
Montefiore HMO	1,474	1,495	1,507	1,519	1,520	1,526	1,540	1,553	1,592	1,615	1,619	1,648
North Shore-LIJ Health Plan	1	1	1	0	0	0	0	0	0	0	0	0
Prime Health Choice	360	369	373	379	383	393	392	389	397	429	455	456
Senior Health Partners	14,388	14,467	14,570	14,507	14,397	14,451	14,454	14,625	14,788	15,086	15,169	15,104
Senior Network Health	550	545	547	546	548	554	557	555	556	557	584	573
Senior Whole Health	13,634	13,642	13,726	13,922	13,874	13,955	14,034	14,134	14,343	14,497	14,581	14,635
United Healthcare	4,070	4,161	4,214	4,254	4,211	4,190	4,143	4,119	4,163	3,861	2,988	3,003
Village Care	10,068	10,254	10,429	10,668	10,716	10,775	10,962	11,308	11,745	11,800	11,515	11,308
VNA HomeCare Options	6,479	6,595	6,606	6,715	6,811	6,967	7,067	7,180	7,189	7,289	7,535	7,564
VNS Choice	12,788	12,743	12,749	12,758	12,651	12,699	12,861	12,929	13,184	13,224	13,207	13,214
WellCare	5,516	5,521	5,490	5,511	5,501	5,480	5,504	5,530	5,614	5,620	5,655	5,674
TOTAL	**204,025**	**206,438**	**208,629**	**211,526**	**212,736**	**215,292**	**218,306**	**220,725**	**223,568**	**224,857**	**226,352**	**227,731**

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
Adult	Monitoring Diabetes - Nephropathy	93	90

Domain	Measure	NYS Medicaid 2017	National 2017
Health	Monitoring		
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 Health	Antidepressant Medication Management-Effective Acute Phase Treatment	52	54

Domain	Measure	NYS Medicaid 2017	National 2017
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
Child and	Assessment, Counseling or Education: Sexual	65	NA

Domain	Measure	NYS Medicaid 2017	National 2017
Adolescent Health	Activity		
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 Adolescent	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	82	NA

Domain	Measure	NYS Medicaid 2017	National 2017
Health			
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