MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 21 (4/1/2019-3/31/2020)
Federal Fiscal Quarter: 4 (7/1/2019-9/30/2019)

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. On April 19, 2019 CMS approved New York's request to exempt MMMC

enrollees from cost sharing by waiving comparability requirements to align with the New York's social services law, except for applicable pharmacy co-payments described in the STCs. On August 2, 2019 CMS approved New York's request to create a streamlined children's model of care for children and youth under 21 years of age with behavioral health (BH) and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities.

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

II. Enrollment: Fourth Quarter

MRT Waiver- Enrollment as of September 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	512,107	12,199	32,413
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	86,498	2,555	6,453
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	12,385	267	1,196
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	2,520	96	298
Population 5 - Safety Net Adults	324,651	13,159	33,648
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)	**23,019**	**722**	**164**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**182,986**	**8,251**	**1,740**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,258**	**266**	**25**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**46,409**	**6,133**	**1,314**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**43,648 or an approximate .4% increase from last Q**

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

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

Compared to the prior quarter there was a slight increase in voluntary disenrollment. This is due to the significant increase in disenrollment due to incarcerations being largely offset by the significant decrease in the category "Enrolled in Other Plan."

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**77,251 or an approximate 14.0% 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.

Involuntary disenrollment declined due to a significant decrease in MAGI case closures that were subsequently sent to NYSoH for redetermination. This decrease was partially offset by a small increase in ordinary case closures.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
July 2019				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**917,881**	**20,132**	**2,717**	**17,415**
Rest of State	**293,679**	**10,335**	**1,294**	**9,041**
Statewide	**1,211,560**	**30,467**	**4,011**	**26,456**
August 2019				
New York City	**903,219**	**15,196**	**1,905**	**13,291**
Rest of State	**290,661**	**9,028**	**949**	**8,079**
Statewide	**1,193,880**	**24,224**	**2,854**	**21,370**
September 2019				
New York City	**890,284**	**23,308**	**2,474**	**20,834**
Rest of State	**288,623**	**11,063**	**1,065**	**9,998**
Statewide	**1,178,907**	**34,371**	**3,539**	**30,832**
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	**51,540**			
Rest of State	**27,118**			
Statewide	**78,658**			

HIV SNP Plans				
July 2019				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	12,925	214	0	214
Statewide	12,925	214	0	214
August 2019				
New York City	12,936	201	0	201
Statewide	12,936	201	0	201
September 2019				
New York City	12,926	210	0	210
Statewide	12,926	210	0	210
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	625			
Statewide	625			

Health and Recovery Plans Disenrollment			
FFY 19 – Q4			
	Voluntary	**Involuntary**	**Total**
July 2019	1,138	1,561	2,699
August 2019	899	1,397	2,296
September 2019	1,137	1,674	2,811
Total:	3,174	4,632	7,806

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 4 (7/1/2019-9/30/2019) Q4 FFY 2018-2019

As of the end of the fourth federal fiscal quarter (end of September 2019), there were 2,468,570 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 67,232 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 seventeen (17) Job Centers (Public Assistance). MAXIMUS reported that 12,602 clients were educated about their enrollment options and 7,641 (61%) clients made an enrollment choice.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Any deficiencies found are reported to MAXIMUS field operation monthly. During the reporting period, 342 Enrollment Counselling sessions were evaluated which generated 342 applications for a total of 409 enrollments.

CMU Monitoring of Field Presentation Report – 4th Quarter 2019	
Enrollment Counseling - One on One	**General Information**
342	1,075

Infractions were observed for 97 (28%) of the 342 enrollment counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA.

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

- Lock in policy
- Good Cause Transfer
- Exemptions
- Confirmation Letter
- Emergency/Urgent Care

Of the 409 enrollments completed during informational sessions, 403 (99%) 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 Calls for Fee-For-Service (FFS) Consumers

Phone Enrollment			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
156	6	162	96	3	99

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 22,531 FFS community clients was reported on the regular auto-assignment list, 3,247 (14%) clients responded to the call and 2,959 (91%) reached made a plan selection. Of the total of 461 FFS NH clients reported on NH auto-assignment list, 35 (8%) clients and/or authorized representatives made a plan selection. The CMU monitored 261 outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 162 (62%) FFS clients made a voluntary enrollment choice for themselves and their family members including six (6) NH clients for a total of 209 enrollments.
    - 203 (97%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 99 (38%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 49 (31%) of the 156 regular FFS AA Phone Enrollment conducted by NYMC FCSRs at HRA sites and none were observed for the six (6) NH outreach calls. Key messages most often omitted were failure to disclose or explain the following:

- Emergency
- Choice of Plans
- Use of plan ID Card/Benefit Card
- Good Cause Transfer

The CMU also randomly selected 230 (1%) clients from the auto-assignment list of 22,531 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 96 (42%) consumers were reached and 86 (90%) of the 96 that responded made a plan choice. The CMU also confirmed that appropriate and timely notices were sent to the 144 clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

NYMC is required to develop, implement and submit a corrective action plan for each infraction identified and a total of 146 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted FCSR monitoring to ensure compliance.

C. NYMC HelpLine Observations July-September 2019

The CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 64,911 calls were received by the Helpline and 59,091 or 91% were answered. Calls answered were handled in the following languages: English: 41,299 (69%); Spanish: 6,835 (11%); Chinese: 2,491 (4%); Russian: 751 (2%); Haitian/Creole: 92 (1%); and other: 7,623 (13%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. The CMU listened to 2,347 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 4th Quarter 2019						
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Removal of Restriction**	**Total**
1,686 (72%)	94 (4%)	170 (7%)	366 (16%)	30 (1%)	1 (0%)	2,347

A total of 699 (30%) recorded calls observed was unsatisfactory including 507 calls with single infraction and 192 calls with multiple infractions, A total of 944 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: 886 (94%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 27 (3%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 31 (3%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 926 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

D. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Year 2019 (10/1/2018-9/30/2019)

As of the end of the federal fiscal 2019 (end of September 2019), there were 2,468,570 New York City Medicaid consumers enrolled in the mainstream Medicaid managed care program and 67,232 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 (FCSRs) conducted outreach in 33 HRA facilities including six (6) HIV/AIDS Services Administration (HASA) sites, ten (10) Community Medicaid Offices (MA Only), and seventeen (17) Job Centers (Public Assistance). MAXIMUS reported that 50,494 clients were educated about their enrollment options and 30,080 (60%) clients made an enrollment choice.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Any deficiencies found are reported to MAXIMUS Field operation monthly. During the reporting period, 1,381 Enrollment Counselling sessions were evaluated which generated 1,381 applications for a total of 1,614 enrollments.

CMU Monitoring of Field Presentation Report – October 2018 to September 2019	
Enrollment Counseling - One on One	**General Information**
1,381	4,112

Infractions were observed for 283 (20%) of the 1,381 Enrollment Counselling sessions conducted by NYMC Field Customer Service Representatives (FCSRs) at HRA.

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

- Lock in policy
- Good Cause Transfer
- Exemptions
- Confirmation Letter
- Emergency/Urgent Care

Of the 1,616 enrollments completed during informational sessions, 1,601 (99%) 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.

E. Auto-Assignment (AA) Outreach Calls for Fee-For-Service (FFS) Consumers

Phone Enrollment			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
627	37	664	344	24	368

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 97,351 FFS community clients was reported on the regular auto-assignment list, 14,216 (15%) clients responded to the call and 12,510 (88%) reached made a plan selection. Of the total of 1,813 FFS NH clients reported on NH auto-assignment list, 159 (9%) clients and/or authorized representatives made a plan selection. The CMU monitored 1,032 outreach calls by FCSRs in HRA facilities. The following captures those observations:

- Phone Enrollment: 664 (60%) FFS clients made a voluntary enrollment choice for themselves and their family members including 37 NH clients for a total of 824 enrollments.
    - 776 (94%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 368 (40%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

Infractions were observed for 139 (22%) of the 627 regular FFS AA Phone Enrollment conducted by NYMC FCSRs at HRA sites and none were observed for the 37 NH outreach calls. Key messages most often omitted were failure to disclose or explain the following:

- Emergency
- Choice of Plans
- Use of plan ID Card/Benefit Card
- Good Cause Transfer

The CMU also randomly selected 725 (1%) clients from the auto-assignment list of 97,351 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 326 (45%) consumers were reached and 296 (91%) of the 326 that responded made a plan choice. The CMU also confirmed that appropriate and timely notices were sent to the 420 clients who were auto-assigned due to no phone number, unavailable or client declined to make a selection. No infractions were found.

NYMC is required to develop, implement and submit a corrective action plan for each infraction identified and a total of 329 corrective action plans were implemented for the reporting period. Corrective actions include, but are not limited to, staff training and an increase in targeted FCSR monitoring to ensure compliance.

F. NYMC HelpLine Observations October 2018 to September 2019

The CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 246,223 calls were received by the Helpline and 227,195 or 92% were answered. Calls answered were handled in the following languages: English: 168,718 (74%); Spanish: 30,729 (13%); Chinese: 10,476 (5%); Russian: 3,261 (1%); Haitian/Creole: 450 (1%); and other: 13,561 (6%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. The CMU listened to 8,150 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – October 2018 to September 2019						
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Total**
5,744 (70%)	328 (4%)	464 (6%)	1,490 (18%)	124 (1.5%)	1 (0.5%)	8,151

A total of 2,480 (33%) recorded calls observed was unsatisfactory including 1,752 calls with single infraction and 728 calls with multiple infractions, A total of 3,362 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: 3,117 (93%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 69 (2%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 176 (5%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 2,396 corrective action plans were implemented for the reporting quarter. 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

For the fourth quarter, on October 9, 2019, VNS Choice was approved to expand its HIV Special Needs Plan (HIV SNP) service area to include Nassau and Westchester counties. There were four other approved plan expansions that occurred during the other three quarters of fiscal year:

- 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 May 10, 2019, Excellus Health Plan, Inc. was approved to expand its MMC and HARP service areas to include Onondaga county.
- On June 28, 2019, HealthFirst PHSP, Inc. was approved to expand its MMC and HARP service areas to include Orange and Sullivan counties, effective September 1, 2019.

On February 11, 2019, Partners Health Plan, Inc. was issued a contract to operate a MMC product to coincide with the updating of their Certificate of Authority. This contract was submitted to CMS for review on May 13, 2019. On September 27, 2019, CMS sent comments to New York State regarding this contract transaction, which were responded to by New York State on October 8, 2019. At the close of the fiscal year, this contract was still under CMS review for final approval.

On June 28, 2019, Crystal Run Health Plan, LLC was approved to withdraw its MMC product line from Orange and Sullivan counties, effective September 1, 2019.

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

During the first quarter (October 1, 2018 – December 31, 2018), New York commenced negotiation of the new Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) with the Trade Associations that represent the health plans. The contract period for the Model Contract is March 1, 2019 through February 29, 2024. These negotiations continued throughout the first and second quarters of the fiscal year. On April 4, 2019, New York submitted the draft Model Contract to CMS for review. CMS comments were received on August 29, 2019. At the close of the fiscal year, New York was close to finalizing its responses to CMS comments. New York anticipates responding to CMS in the month of November 2019.

C. Health Plans/Changes to Certificates of Authority

Excellus Health Plan, Inc.; COA updated to include Onondaga county for Medicaid and HARP.

D. CMS Certifications Processed

None to report.

E. Surveillance Activity

Surveillance activity completed during the 4th Quarter FFY 2018-2019 (July 1, 2019 – September 30, 2019) include the following:

One (1) Comprehensive Operational Survey and four (4) Targeted Operational Surveys completed during 4th Quarter FFY 2018-2019. Three (3) SODs were issued and Three (3) POCs were accepted. Two (2) Plans were found in compliance.

- IHA (In compliance)
- Yourcare (In compliance)
- Metroplus
- Metroplus SNP
- Affinity Phase II

Fourteen (14) PCP Ratio Surveys were completed during the 4th Quarter FFY 2018-2019 (July 1, 2019 – September 30, 2019). Letters of Concern, requiring a self-directed CAP, were issued to Fourteen (14) Plans.

- Affinity Health Plan, Inc.
- Capital District Physicians' Health Plan, Inc.
- Excellus Health Plan, Inc.
- Fidelis
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York Inc.
- Healthplus
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MVP Health Plan, Inc.
- UnitedHealthcare of New York, Inc.
- WellCare of New York, Inc.
- Yourcare

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during FY 2019. 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 Fiscal Year (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 BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center.

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

1. **Inpatient Denial Report:** Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient behavioral health services based on medical necessity. The report includes aggregated provider level data for service authorization requests and denials, whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (4/1/2019-6/30/2019)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	52,088	1,181	1,130	2.2%
ROS	5,513	72	66	1.2%
Total	57,601	1,253	1,196	2.1%

Note: The summary does not include data from MVP and Crystal Run due to data reporting issues.

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

2. **Outpatient Denial Report:** MCOs are required to submit on a quarterly basis a report to the State on ambulatory service authorization requests and denials for each behavioral health service. Submissions include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (4/1/2019-6/30/2019)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,725	43	27	0.5%
ROS	1,843	28	21	1.1%
Total	7,568	71	48	0.6%

Note: The Summary does not include data from MVP and Crystal Run due to data reporting issues.

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (7/1/2019-9/30/2019)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,326,722	88.29%	11.71%
Rest of State	988,982	90.60%	9.40%
Statewide Total	2,315,704	89.24%	10.76%

Annual Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2018-9/30/2019)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	5,830,149	89.49%	10.51%
Rest of State	4,437,911	89.35%	10.65%
Statewide Total	10,268,060	89.43%	10.57%

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

4. BH HCBS Claims/Encounters 7/1/2019-9/30/2019: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	37	19
Education Support Services	109	59
Family Support and Trainings	2	1
Intensive Crisis Respite	0	0
Intensive Supported Employment	65	23
Ongoing Supported Employment	7	4
Peer Support	850	238
Pre-vocational	102	39
Provider Travel Supplements	381	206
Psychosocial Rehab	261	54
Residential Supports Services	89	28
Short-term Crisis Respite	468	72
Transitional Employment	3	1
TOTAL	2,374	495

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

5. BH HCBS Claims/Encounters 7/1/2019-9/30/2019: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	344	96
Education Support Services	677	243
Family Support and Trainings	40	13
Intensive Crisis Respite	0	0
Intensive Supported Employment	336	120
Ongoing Supported Employment	56	15
Peer Support	2,386	701
Pre-vocational	245	86
Provider Travel Supplements	2,312	701
Psychosocial Rehab	1,233	316
Residential Supports Services	950	248
Short-term Crisis Respite	69	22
Transitional Employment	8	4
TOTAL	8,656	1,575

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

6. BH HCBS Claims/Encounters 10/1/2018-9/30/2019: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	283	45
Education Support Services	795	180
Family Support and Trainings	38	7
Intensive Crisis Respite	0	0
Intensive Supported Employment	504	80
Ongoing Supported Employment	46	8
Peer Support	4,364	457
Pre-vocational	595	98
Provider Travel Supplements	1,646	356
Psychosocial Rehab	1,312	112
Residential Supports Services	593	57
Short-term Crisis Respite	2,435	289
Transitional Employment	54	10
TOTAL	12,665	1,148

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

7. BH HCBS Claims/Encounters 10/1/2018-9/30/2019: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	2,402	225
Education Support Services	4,391	614
Family Support and Trainings	300	56
Intensive Crisis Respite	2	2
Intensive Supported Employment	1,836	283
Ongoing Supported Employment	299	33
Peer Support	13,435	1,430
Pre-vocational	1,478	231
Provider Travel Supplements	11,386	1,340
Psychosocial Rehab	7,338	566
Residential Supports Services	5,019	470
Short-term Crisis Respite	508	132
Transitional Employment	87	20
TOTAL	48,481	3,099

Note: Total of N Recip. is by unique recipient, therefore 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.

Last Quarter (July-Sep 2019)
MCTAC Attendance & Stats
Time Period: 7/1/2019-9/30/2019

Events: MCTAC successfully executed 28 events from July to September 2019. 24 events were held in person and 4 events were held via webinar.

Individual Participation: 864 people attended/participated in our events of which 767 are unique.

OMH Agency Participation
Overall: 241 of 625 (38.6%)
NYC: 74 of 253 (29.3%)
ROS: 169 of 403 (41.9%)

OASAS Agency Participation
Overall: 190 of 545 (34.9%)
NYC: 45 of 200 (22.5%)
ROS: 145 of 372 (38.98%)

See below for Managed Care Technical Assistance Stats during October 1, 2018 to September 30, 2019.

Last Year (2018-2019)
MCTAC Attendance & Stats
Time Period: 10/1/2018 - 9/30/2019
Events: MCTAC successfully executed 114 events from October 1, 2018 to September 30, 2019. 71 events were held in person and 43 events were held via webinar.

Individual Participation: 5,063 people attended/participated in our events of which 2,280 are unique.

OMH Agency Participation
Overall: 383 of 625 (61.3%)
NYC: 116 of 253 (45.9 %)
ROS: 269 of 403 (66.8%)

OASAS Agency Participation
Overall: 319 of 545 (58.5%)
NYC: 72 of 200 (36%)
ROS: 247 of 372 (66.4%)

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.
- Developed training for care managers and BH 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.
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both HH and RCAs).
- Developed required training for BH 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- enhanced to reflect data by RCA and by HH

- 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 and representation on new HH+ Subcommittee Workgroup
- 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 BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. The State on an ongoing basis works with the Managed Care Plans to further operationalize this program and increase access to BH HCBS. Infrastructure contracts have been signed and work is underway.
    - $43.4 million is contracted through 13 HARPs to 100 providers.
- Updates being made to Non-Medical Transportation guidance to improve utilization of this service intended to support participation in BH HCBS and attainment of recovery goals.
- Issued Terms and Conditions for BH HCBS Providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS Providers are actively providing services.
- Enhancing State Adult BH HCBS Provider oversight including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.

To date, 4,726 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between July 1, 2019 and September 30, 2019, 6,921 eligibility assessments have been completed. The total number of eligibility assessments completed for the time period 10/1/2018-9/30/2019 is 28,029.

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

The SBHC Quality Improvement (QI)/Utilization Management (UM) Workgroup met on August 2, 2019 to gather feedback regarding the data sharing activity which took place between the SBHCs and the MMC plans during the period January 2019 thru June 2019. The Department strongly encouraged continued contract negotiation and data exchange between the SBHCs and MMC plans in preparation for the pending transition of SBHC services from Medicaid Fee-for-Service to MMC on January 1, 2021.

Annual: On January 31, 2019, the Department reconvened the workgroup developed for the transition of SBHCs 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. The QI/UM workgroup agreed to meet in August 2019 to gather feedback regarding the data sharing activity, and status of SBHC and MMC plan contracting.

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)

Managed Long-Term Care plans include Partial Capitation, PACE, MAP, MA, FIDA, and FIDA IDD plans. As of October 1, 2019, there are 27 Partial Capitation plans, 9 PACE plans, 8 MAP, three MA plans, six FIDA plans, and one FIDA IDD plan. As of October 1, 2019, there is a total of 276,158 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the July 2019 through September 2019 quarter, one partial capitation plan expanded operations effective August 27, 2019. During the annual period of October 2018 through September 2019, the Department approved a total of one new MAP, and one service area expansions for a partial capitation plan. During that same annual period, the Department approved the closing of one Medicaid Advantage Plan, and two Partial Capitation plans. With the end of the FIDA demonstration 6 FIDA plans will close on December 31, 2019. The FIDA-IDD demonstration is currently scheduled to continue through December 31, 2020.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the July 2019 through September 2019 quarter, post enrollment surveys were completed for nineteen enrollees. Twelve of the sixteen enrollees (75%) who responded indicated that they continued to receive services from the same caregivers once they became members of an MLTCP (five enrollees did not respond to this question). The percentage of affirmative responses remains consistent with the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans grew from 235,945 to 244,158 during the July 2019 through September 2019 quarter, a 3% increase over the last quarter. For that period, 15,521 individuals who were being transitioned into Managed Long-Term Care made an affirmative choice, a 7% decrease from the previous quarter. This brings the 12-month total for affirmative choice to 61,012. Monthly plan-specific enrollment for partial capitation plans during the October 2018 through September 2019 annual period is submitted as an attachment.

Total enrollment for MLTC Pace remains consistent at 5,572. Total enrollment for MLTC MAP grew from 15,977 to 17,391 during the July 2019 through September 2019 quarter, a

9% increase over the previous quarter. Monthly enrollment for MAP and PACE plans during the October 2018 through September 2019 annual period is submitted as an attachment.

2. Significant Program Developments

During the July 2019 through September 2019 quarter:

- The 3nd Quarter Member Services survey was conducted on 26 Partial Capitation Plans and eight MAP Plans. The results were finalized and sent to the plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance.

- Operational Surveys remain in process for four (4) Partial Capitation plans and an operational Survey is ongoing for one (1) MAP plan.

- Processes for Operational and Focused Partial Cap and MAP surveys continue to be refined.

- An extension of the current MLTC Ombudsman contract has been approved and is presently under review.

- Customization of the new survey software is ongoing. The State's efforts to automate data from our survey process are still in production. The Department expects reporting functionality to be operational within the next 6 months.

In addition to the fourth quarter activities discussed above, below is a summary of other activities that have occurred during the October 1, 2018, through September 30, 2019, annual period:

- The Second round of Partial Capitation Operational and Focused Surveys have been initiated. As of September 30, 2019, five (5) Operational Surveys have been initiated and are in various stages of the survey process.

- The First round of MAP Operational Surveys have been initiated. As of September 30, 2019, one (1) Operational survey has been initiated.

- A Focused Survey of the Uniform Assessment Systems reporting data for untimely assessments was conducted. Based on the data four (4) Statements of Deficiencies were issued, and Corrective Action Plans are required;

- Quarterly Member Services Surveys are conducted on all Partial Capitation and MAP Plans (effective 4/1/2019). Quarterly reports are issued to each plan to assist them in improving the overall functioning of their member service department. No response is required, but when necessary the department provides recommendations on areas of improvement.

- The Surveillance tools are continually updated to reflect process changes.

3. Issues and Problems

There were no significant issues or problems to report for the July 2019 through September 2019 quarter nor for the October 2018 through September 2019 annual period.

4. Summary of Self-Directed Options

Self-direction is provided under Consumer Directed Personal Assistance Program (CDPAP) 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 1,422 critical incidents reported for the July 2019 through September 2019 quarter, a slight increase of 5% over the last quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. To date, none of those plans were found to have had critical incidents that should have been reported. For the annual period October 2018 through September 2019, critical incidents decreased significantly. Two plans drove this number in the previous annual period. The State monitored this area of reporting and worked directly with individual plans. In our analysis we identified errors in reporting and worked with the plans to correct those errors, resulting in a 52% decrease. Critical incidents by plan for this quarter are attached.

Complaints* and Appeals: For the July 2019 through September 2019 quarter, the top reasons for complaints/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, and home care aides late/absent on scheduled day of services. This data includes the MLTC enrollees for Partial Capitation, PACE, and MAP enrollees

Period: 7/1/2019 through 9/30/2019 (Percentages rounded to nearest whole number)			
Number of Recipients Partial, PACE, MAP: 264,240	**Complaints**	**Resolved**	**Percent Resolved****
# Same Day	**4,564**	**4,564**	**100%**
# Standard/Expedited	**7,109**	**6,972**	**98%**
Total for this period:	**11,673**	**11,536**	**99%**

*The term "complaint" is replacing the previously used term "grievance" that was previously used in order to match contract language. The definition of the terms is interchangeable.

**Percent Resolved includes grievances opened during previous quarters that are resolved during the current quarter, that may result in creating a percentage greater than 100.

Appeals (Partial, MAP, PACE)	10/2018-12/2018	1/2019-3/2019	4/2019-6/2019	7/2019-9/2019	Average for Four Quarters
Average Enrollment	239,377	246,521	254,155	264,240	251,073
Total Appeals	3,495	4,184	6,383	6,441	5,126
Appeals per 1,000	15	17	25	24	20
# Decided in favor of Enrollee	617	823	1,161	1,595	1,049
# Decided against Enrollee	2,542	3,055	4,567	4,399	3,641
# Not decided fully in favor of Enrollee	148	188	247	306	222
# Withdrawn by Enrollee	110	105	137	135	122
# Still pending	500	583	824	672	645
Average number of days from receipt to decision	12	8	9	9	9

*Complaints and Appeals per 1,000 Enrollees by Product Type July-September 2019					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	232,691	6,691	29	5,342	23
Medicaid Advantage Plus (MAP) Total	15,670	3,296	210	1,001	64
PACE Total	5,794	1,622	280	38	7
Total for All Products:	**254,155**	**11,609**	**46**	**6,381**	**25**

Total complaints increased 2% from 11,420 the previous quarter to 11,609 during the July 2019 through September 2019 quarter. The total number of appeals slightly increased from 6,366 during the last quarter to 6,381 during the July 2019 through September 2019 quarter.

For the annual period October 2018 through September 2019, the number of grievances grew by 4%, and the number of appeals held steady with no growth.

Technical Assistance Center (TAC) Activity

During the July 2019 through September 2019 quarter, TAC opened 260 less cases than in the previous quarter. The call volume in this quarter was consistent with most other quarters. There was a decline in volume of calls from the previous quarter, and this can be attributed to an abnormally high call volume in the previous quarter. TAC issued more corrective action plans during the fourth quarter. TAC continues to work with Surveillance to investigate systemic issues.

There was an increase in complaints surrounding member supplies during the fourth quarter. Much of this was due to issues surrounding continuity of care after plan closure. TAC also saw a decrease in complaints related to aide service.

Call Volume	**7/1/2019-9/30/2019**	**10/1/2018-9/30/2019**
Substantiated Complaints	115	465
Unsubstantiated Complaints	375	1,489
Complaints Resolved Without Investigation	45	160
Inquiries	134	895
Total Calls	**669**	**3,009**

The five most common types of calls were related to:

Call Type	**7/1/2019-9/30/2019**	**10/1/2018-9/30/2019**
Aide Service	19%	20%
Enrollment	15%	13%
Billing	12%	13%
Interdisciplinary Team	8%	10%
DME Issues	5%	6%

These five categories remain the most frequently used. Most complaints are related to aide service and enrollment. Much like the previous quarter, many calls are general benefit questions.

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

During the annual period from October 2018 through September 2019, the TAC Unit took in a total of 3,032 cases and resolved 3,121 cases. Forty-five percent of cases are closed in the same month they are opened. This is down from last year. This includes plan closures and service area changes, budget initiatives, and policy changes.

The new database has been in operation for a little over a year now. As a result, the Department has seen an increase in clerical efficiency, especially for data reporting and export.

TAC has seen a 12.5% increase in complaints compared to last year. This increase is spread over the various types of complaints. There has been a 41% increase in inquiries. TAC has had a 3% increase in unsubstantiated cases, and a 34% decrease in substantiated cases. TAC issued 47% less corrective action plans compared to the previous year. The percentage of complaints remain consistent across aide service, billing, DME/supplies, enrollment/eligibility, and interdisciplinary team. These are categories that affect member's most directly in their day-to-day lives.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the July 2019 through September 2019 quarter, 12,044 people were evaluated, deemed eligible and enrolled into plans, a decrease of 9% from the previous quarter. This brings the total for the annual period October 2018 through September 2019 to 50,123.

Referrals and 30-day assessment: For the July 2019 through September 2019 quarter, MLTC plans conducted 17,084 assessments, a 22% increase from 14,031 the previous quarter. The total number of assessments conducted within 30 days increased 21% from 11,400 the previous quarter to 13,839 this quarter. During the annual period October 2018 through September 2019, a total of 59,660 assessments were completed, with 80% of those assessments being conducted within 30 days of the request, which remains consistent with the previous annual period. The Department continues to monitor data collection, evaluation and reporting of CFEEC activity.

Referrals outside enrollment broker: For the July 2019 through September 2019 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 26,418 a slight decrease from 26,553 the previous quarter. The annual period October 2018 through September 2019 saw a steady decrease totaling 12%, contrary to the increase from the previous annual period (14%).

Rebalancing Efforts	7/2019-9/2019
New Enrollees to the Plan from a nursing home transitioning to the community	279
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,350
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,392

As of September 2019, there were 18,255 current plan enrollees who were in nursing homes as permanent placements, a slight increase from the last quarter.

E. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with behavioral health (BH) and Home and Community Based Service (HCBS) needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS.

Specifically, the Children's 1115 Waiver provides the following:

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current Fee for Service HCBS authorized under the State's newly consolidated 1915c children's waiver in Medicaid Managed Care benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's waiver;
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c children's waiver, including non-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs;
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115; and
- Authority to provide customized goods and services, such as self- direction and financial management services, that are currently approved under the demonstration's HARP's pilot to Fo1 children.
- Authority for Health Home care management monthly monitoring as an HCBS
- Removes managed care exclusion of children placed with Voluntary Foster Care Agencies

Given the recent approval, the New York State Department of Health has been engaged in implementation activities, including, but not limited to the following:

- Drafting policies and guidance to ensure compliance with State and federal requirements;
- Refining data collection and data analysis to ensure accurate reporting;
- Defining performance and quality metrics;
- Drafting the Children's Evaluation Design for submission to CMS;

- Engaging a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative.

The above-listed activities will help to facilitate oversight and the provision of high-quality services, ensure that the goals of the Children's 1115 Waiver are achieved, and provide the necessary data elements to fulfill future reporting requirements.

VI. Evaluation of the Demonstration

A team from RAND Corporation is serving as the independent evaluator. The team has finalized an expanded evaluation plan, which has been approved through the RAND Quality Assurance process. The evaluation is intended to address the following four main questions:

- Is mandatory MLTC enrollment associated with improved access to care, patient safety, quality of care, and satisfaction with care, as well as reduced hospitalizations?
- Did the HCBS expansion population, who moved from institutional settings into the community, have improved access to MLTC, patient safety, and quality of care, as well as reduced emergency department visits?
- Did the expansion of Express Lane Eligibility to TANF-eligible adults increase Medicaid enrollment?
- Did the expansion of 12-month continuous eligibility increase Medicaid enrollment?

Core hypotheses include:

- Mandatory MLTC enrollment is associated with fewer emergency room visits and potentially avoidable hospitalizations, more preventive service utilization among individuals enrolled in Medicaid Advantage Plus, Program for All-Inclusive Care for the Elderly, and Fully Integrated Duals Advantage but not among individuals in the MLTC Partial Capitation Program.
- Mandatory MLTC enrollment is not associated with falls requiring medical intervention, timely access to home care and personal care, or consumer satisfaction with long term services and supports, providers, or MLTC plan.
- Twelve-month continuous eligibility is associated with an increase in the average continuous enrollment duration as well as in the percentage of beneficiaries who were continuously enrolled for 12 months or more.
- Twelve-month continuous eligibility is associated with an increase in outpatient visits but a decrease in emergency room visits, inpatient admissions, and cost.

The RAND team will adopt a difference-in-differences or a comparative time series design to test these hypotheses using individual-level data. Specifically, the team will leverage the staggered roll-out of the mandate throughout the state, which created a series of natural experiments. These individual-level data, not in the original Request for Proposal, were proposed by the evaluation team to allow for more robust evaluation of the relevant research questions for mandatory MLTC and 12-month continuous eligibility. Discussions around access to this data are ongoing.

Express Lane Eligibility is a proven practice that was in place prior to the 1115 waiver and was only included to ensure the legitimacy of the authority. On December 1, 2016, Express Lane Eligibility was included in the State Plan. Due to the inclusion of Express Lane Eligibility in the State Plan the impact of the mechanism is negligible in relation to the 1115 waiver. Therefore, New York State is proposing to drop the evaluation of Express Lane Eligibility and add the following four questions:

- Is overall Fee-For-Service enrollment decreasing over time?
- Is short-term Fee-For-Service enrollment decreasing over time?
- What percent of Medicaid Managed Care (MMC) enrollees remain in the same MMC plan after 12-month recertification?
- What percent of MMC enrollees are auto-assigned to any health plan?

New York State believes that the inclusion of these questions will broaden the scope of the evaluation and contribute to a better understanding of churn within the Medicaid Program.

VII. Consumer Issues

A. MMC, HARP and HIV SNP Plan Reported 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 member complaints they receive on a quarterly basis. The following table outlines the complaints plans reported by category for the most recent quarter and for the last four (4) quarters:

MMCO Product Line	Total Complaints	
	FFY 19 Q4 7/1/2019–9/30/2019	Last 4 Quarters 10/1/2018–9/30/2019
Medicaid Managed Care	7,596	30,465
HARP	631	2,922
HIV SNP	143	641
Total MMCO Complaints	**8,370**	**34,028**

As described in the table, total MMCO complaints/action appeals reported for the current quarter equal 8,370. This represents a 5.9% decrease from the prior quarter's total.

This quarter's plan-reported complaint data shows a decrease of 5.7% for MMCs from the previous quarter, and an increase of 8.7% compared to the first quarter. HARPS show a decrease of 13.2% since the prior quarter and a trend of decreasing complaints over the last four quarters.

This quarter's HIV SNP complaints saw an increase of 30% when compared to the previous quarter's data. Although the HIV SNP complaints show an overall decrease from the first

quarter, DOH is working with the three (3) HIV SNPs to investigate why several categories are elevated for this product line. Should such increase be related to a specific systemic issue at the plans, DOH will require a corrective action plan and monitor for improvement in the impacted area.

The following table outlines the top five (5) most frequent categories of complaints reported for MMC, HARP and HIV SNP, combined, for the most recent quarter and for the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 19 Q4 7/1/2019–9/30/2019	Last 4 Quarters 10/1/2018–9/30/2019
Balance Billing	20%	19%
Pharmacy/Formulary	19%	25%
Difficulty with Obtaining: Dental/Orthodontia	14%	10%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	8%	8%
Reimbursement/Billing	7%	8%

The following table outlines the top five (5) most frequent categories of complaints reported for HARPSs for the most recent quarter and for the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 19 Q4 7/1/2019–9/30/2019	Last 4 Quarters 10/1/2018–9/30/2019
Pharmacy/Formulary	36%	43%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	10%	8%
Dissatisfaction with Quality of Care	10%	9%
Balance Billing	9%	6%
Dental/Orthodontia	6%	6%

The following table outlines the top five (5) most frequent categories of complaints reported for HIV SNPs for the most recent quarter and for the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 19 Q4 7/1/2019–9/30/2019	Last 4 Quarters 10/1/2018–9/30/2019
Dissatisfied with Provider Services (Non-Medical) or MCO Services	35%	26%
Dental/Orthodontia	14%	11%
Pharmacy/Formulary	11%	15%
Balance Billing	8%	8%
Dissatisfied with Quality of Care	7%	4%

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

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

Based on the observed/expected ratio, the Department requests that MMCOs review and analyze categories of complaints where higher than expected complaint patterns persist. During the period of January through June 2019, three (3) plans had observed/expected ratios greater than 2.0 and include: Amida Care, Inc., Molina Healthcare of New York, Inc., and VNS Choice.

MMCO Outliers January 2019 – June 2019 Observed Expected Ratio Calculations	
Plan	O/E All Categories Combined
Amida Care, Inc.	5.6
Molina Healthcare of New York, Inc.	9.9
VNS Choice	10.5

- **Amida Care, Inc.**: This HIV SNP reported higher than expected complaints in four (4) categories in the first half of 2019. In comparison to the second half of 2018, all but one category showed a decrease in observed expected (o/e) reporting of complaints; Problems with Advertising\ Consumer Education\ Outreach\ Enrollment showed an increase from a 0.0 o/e ratio to a 33.4 o/e ratio. The plan identified a trend in complaints filed related to members not receiving incentive program benefits (e.g., rewards cards benefits) due to problems with receiving provider attestations for health goals. The plan reported it is working with its providers to systemically improve the attestation process

and has begun seeing a decline in these complaints. The remaining categories with higher than expected complaints include:

- Dissatisfaction with Provider Services (Non-Medical) or MCO Services (27.8 o/e): decreased from 43.1 o/e
- Difficulty with Obtaining: Dental/ Orthodontia (7.9 o/e): decreased from 11.5 o/e
- Pharmacy\Formulary (2.1 o/e): decreased from 2.7 o/e

While the plan saw an overall decline in the number of complaints in these categories related to systemic issues, the plan did report work with Healthplex, their dental vendor, to improve education to members and providers regarding Medicaid dental benefits, and their pharmacy vendor, Express Scripts, to re-educate network pharmacies regarding responsibility for medication deliveries. The Department will continue to monitor the corrective action plans implemented to address these issues.

- **Molina Healthcare of New York, Inc.**: This plan reported higher than expected complaints in nine (9) categories for the first half of 2019. In comparison to the second half of 2018, all categories showed a decrease in o/e reporting of complaints, as follows:
  - Dissatisfaction with Quality of Care (2.3 o/e): decreased from 4.6 o/e
  - Denial of Clinical Treatment (2.9 o/e): decreased from 5.8 o/e
  - Dissatisfaction with Provider Services (Non-Medical) or MCO Services (5.6 o/e): decreased from 6.4 o/e
  - Difficulty with Obtaining: Specialist and Hospitals (35.1 o/e): decreased from 80.2 o/e
  - Difficulty with Obtaining: Dental/ Orthodontia (3.3 o/e): decreased from 8.1 o/e
  - Pharmacy\Formulary (6.7 o/e): decreased from 12.8 o/e
  - Problems with Advertising\ Consumer Education\ Outreach\ Enrollment (32.8 o/e): decreased from 64.6 o/e
  - Balance Billing (9.0 o/e): decreased from 9.6 o/e
  - All Other (39.8 o/e): decreased from 92.9 o/e

  The Department recognizes the overall downward trends in o/e ratios for multiple complaint categories, including an overall decrease in the o/e ratio for all categories combined (21.3 to 9.9 o/e). According to the plan there are no new trends or systemic issues identified, except that, in the category of Problems with Advertising\ Consumer Education\ Outreach\ Enrollment, the plan received complaints related to phone call "drops" resulting from a phone system issue that has since been corrected, and in the area of Dissatisfaction with Quality of Care, the plan reported over half of the complaints were related to dental services, which were ultimately unsubstantiated.

  However, the plan continues to report similar issues to those identified in the first half of 2018, and issues with dental services across multiple categories. The Department will address with the plan correct reporting of dental issues in the category of Difficulty with Obtaining: Dental/ Orthodontia. In addition, although the plan has implemented effective procedures to timely address enrollee issues arising through the complaint process, such as: resolving provider balance billing; providing provider education regarding enrollment verification; handling pharmacy prior authorization issues; and assisting members in

finding providers; the Department finds the current corrective actions insufficient and will require the plan to identify additional interventions/corrective actions that are specifically targeted to reduce the volume of complaints generated in these areas. The Department will continue to monitor the effectiveness of these corrective actions.

- **VNS Choice:** This plan reported higher than expected complaints in five (5) categories in the first half of 2019. When compared to the second half of 2018, the o/e ratio for three (3) of the categories decreased and for two (2) of the categories increased. Difficulty with Obtaining: Personal Care saw a significant rise in o/e, from a 0.0 to 186.6 ratio. The plan states that the increase was due to confusion regarding required documentation for obtaining consumer directed personal assistance services (CDPAS). The plan resolved these issues through its care management team and is developing a new communication to explain CDPAS requirements. The Department will address with the plan correct reporting of CDPAS issues in the Difficulty with Obtaining: CDPAS category going forward and monitor the impact of the plan's education efforts. The o/e ratio also increased in the All Other category, which rose from 28.4 to 47.2. The remaining categories with higher than expected complaints include:
    - Difficulty with Obtaining: Dental/ Orthodontia (13.5 o/e): decreased from 16.8 o/e
    - Pharmacy\Formulary 9.4 (o/e): decreased from 12.5
    - Balance Billing (6.7 o/e): decreased from 6.9 o/e

  The plan did not identify any new trends or systemic issues in these categories. The plan continues its corrective action to improve member education on dental benefits, including a new dental benefits ID card and benefit summery flyer, which has been submitted for Department approval. The plan expanded its DME service and supplies vendor and ordering platform first piloted in October 2018. The vendor directly assists members experiencing difficulty with obtaining repairs or DME. However, as the plan continues to report similar issues to those identified in the first half of 2018 for DME, the Department finds the corrective action insufficient and will require the plan to identify additional interventions/corrective actions that are specifically targeted to reduce the volume of complaints related to DME. The Department will continue to monitor the effectiveness of these corrective actions.

Long Term Services and Supports (LTSS)

As SSI members typically access long term services and supports, the Department monitors complaints and action appeals filed for this product line with managed care plans. Of the 8,370 total reported complaints/action appeals, mainstream MMCOs reported 962 complaints and action appeals from their SSI members. This compares to 1,033 SSI complaints/action appeals from the previous quarter.

The following table outlines the total number of complaints/action appeals plans reported for SSI members by category for the most recent quarter and for the last four (4) quarters:

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Members	
	FFY 19 Q4 7/1/2019–9/30/2019	Last 4 Quarters 10/1/2018–9/30/2019
Difficulty with Obtaining: Adult Day Care	0	0
Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	7	63
Difficulty with Obtaining: AIDS Adult Day Health Care	1	1
Appointment Availability: PCP	3	8
Appointment Availability: Specialist	4	16
Appointment Availability: BH HCBS	0	4
Balance Billing	79	322
Communications\ Physical Barrier	6	17
Difficulty with Obtaining: CDPAS	3	12
Denial of BH Clinical Treatment	0	8
Denial of Clinical Treatment	39	163
Difficulty with Obtaining: Dental/Orthodontia	169	628
Dissatisfaction with BH Provider Services	1	6
Dissatisfaction with Health Home Care Management	87	135
Difficulty with Obtaining: Emergency Services	7	28
Difficulty with Obtaining: Eye Care	4	17
Access for Family Planning Services	0	0
Difficulty with Obtaining: Home Health Care	10	44
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	0	6
Access to Non-Covered Services	41	137
Difficulty with Obtaining: RHCF Services	5	20
Difficulty with Obtaining: Personal Care	20	68
Difficulty with Obtaining: PERS	0	0
Pharmacy/Formulary	43	211

Difficulty with Obtaining: Private Duty Nursing	0	6
Dissatisfied with Provider Services (Non-Medical) or MCO Services	148	570
Dissatisfied with Quality of Care	134	569
Recipient Restriction Program and Plan Initiated Disenrollment	1	7
Reimbursement/Billing	36	178
Difficulty with Obtaining: Specialist and Hospitals	69	107
Transportation	8	13
Long Wait Time	2	19
All Other	35	175
Total	**962**	**3,587**

The following table outlines the top five (5) most frequent categories of SSI complaints/action appeals plans reported for the most recent quarter and for the last four (4) quarters:

Description of Complaint	**Percentage of Total Complaints/Appeals Reported for SSI Members**	
	FFY 19 Q4 7/1/2019–9/30/2019	**Last 4 Quarters 10/1/2018–9/30/2019**
Difficulty with Obtaining: Dental/Orthodontia	18%	18%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	16%
Dissatisfied with Quality of Care	14%	16%
Dissatisfaction with Health Home Care Management	9%	4%
Balance Billing	8%	9%

The Department requires MMCOs to report the number of members in receipt of LTSS as of the last day of the quarter. The following table outlines the number of LTSS members by plan for each of the last four (4) quarters:

Plan	**Number of LTSS Members**			
	FFY 19 Q4 7/1/2019-9/30/2019	**FFY 19 Q3 4/1/2019-6/30/2019**	**FFY 19 Q2 1/1/2019-3/30/2019**	**FFY 19 Q1 10/1/2018-12/31/2018**
Affinity Health Plan	1,050	383	439	530
Amida Care	0	702	0	1,169
Capital District Physicians Health Plan	50	50	56	411

Crystal Run	0	0	0	0
Excellus Health Plan	1,391	1,407	1,352	1,397
Healthfirst PHSP	7,859	8,209	7,998	7,868
HealthNow	146	140	141	143
HealthPlus	2,671	2,259	1,787	1,776
HIP Health Insurance Plan of Greater New York	470	405	334	340
IHA	424	431	427	424
MetroPlus	0	248	243	230
Molina	14	12	15	17
MVP	952	858	686	718
Fidelis Care	10,496	9,687	9,336	8,663
United	2,878	3,437	2,897	2,545
VNS Choice	356	354	327	316
Wellcare	345	449	460	455
YourCare	392	393	394	0
Total	**29,494**	**29,424**	**26,892**	**27,002**

The following table outlines the total number of complaints/action appeals regarding difficulty with obtaining LTSS that plans reported for each of the last four quarters:

Description of Complaint	**Number of Complaints/Action Appeals Reported**			
	FFY 19 Q4 7/1/2019-9/30/2019	**FFY 19 Q3 4/1/2019-6/30/2019**	**FFY 19 Q2 1/1/2019-3/30/2019**	**FFY 19 Q1 10/1/2018-12/31/2018**
Difficulty with Obtaining: AIDS Adult Day Health Care	1	2	0	2
Difficulty with Obtaining: Adult Day Care	0	0	0	0
Difficulty with Obtaining: CDPAS	3	8	2	1
Difficulty with Obtaining: Home Health Care	10	31	31	29
Difficulty with Obtaining: RHCF Services	5	0	3	1
Difficulty with Obtaining: Personal Care	20	19	14	16
Difficulty with Obtaining: PERS	0	1	0	1
Difficulty with Obtaining: Private Duty Nursing	0	0	0	0
Total	**39**	**61**	**50**	**48**

Critical Incidents:
The Department requires MMCOs to report critical incidents involving members in receipt of LTSS. There were 66 critical incidents reported for the July 1, 2019 through September 30, 2019 period, many of which were falls or incidents resulting in falls with a resolved status.

The following table outlines the total number of LTSS critical incidents reported by MMC, HARP, and HIV SNP for each of the last two (2) quarters, the net change over the last two (2) quarters, and the total for the last four (4) quarters:

Plan Name	Critical Incidents			
	FFY 19 Q4 7/1/2019–9/30/2019	FFY 19 Q3 4/1/2019–6/30/2019	Net Change	Last 4 Quarters 10/1/2018–9/30/2019
Mainstream Managed Care				
Affinity Health Plan	0	0	0	0
Capital District Physicians Health Plan	0	0	0	0
Crystal Run	0	0	0	0
Excellus Health Plan	0	4	-4	11
Fidelis Care	0	0	0	0
Healthfirst PHSP	7	7	0	32
Health Insurance Plan of Greater New York	0	0	0	0
HealthNow	0	0	0	0
HealthPlus	0	0	0	3
Independent Health Association	0	0	0	0
MetroPlus Health Plan	0	0	0	0
Molina Healthcare	0	0	0	2
MVP Health Plan	0	0	0	0
United Healthcare Plan of New York	0	0	0	0
Wellcare of New York	1	1	0	3
YourCare Health Plan	3	3	0	10
Total	**11**	**15**	**-4**	**61**
Health and Recovery Plans				
Affinity Health Plan	0	0	0	0
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	0	0	0	1
Fidelis Care	0	0	0	0

Healthfirst PHSP	52	39	+13	206
Health Insurance Plan of Greater New York	0	0	0	0
HealthPlus	0	0	0	0
Independent Health Association	0	0	0	0
MetroPlus Health Plan	0	0	0	0
Molina Healthcare	0	0	0	1
MVP Health Plan	0	0	0	0
United Healthcare Plan of New York	0	0	0	0
YourCare Health Plan	0	0	0	0
Total	**52**	**39**	**+13**	**208**
HIV Special Needs Plans				
Amida Care	0	0	0	0
MetroPlus Health Plan SNP	0	0	0	0
VNS Choice SNP	3	1	+2	9
Total	**3**	**1**	**+2**	**9**
Grand Total	**66**	**55**	**+11**	**278**

The following table outlines the total number of LTSS critical incidents plans reported by category for each of the last two (2) quarters, the net change over the last two (2) quarters, and the total for the last four (4) quarters:

Category of Incident	**Critical Incidents**			
	FFY 19 Q4 7/1/2019–9/30/2019	**FFY 19 Q3 4/1/2019–6/30/2019**	**Net Change**	**Last 4 Quarters 10/1/2018–9/30/2019**
Mainstream Managed Care				
Any Other Incidents as Determined by the Plan	2	5	-3	17
Crimes Committed Against Enrollee	1	0	+1	3
Crimes Committed by Enrollee	0	0	0	3
Instances of Abuse of Enrollees	1	2	-1	5
Instances of Neglect of Enrollees	0	0	0	2

Medication Errors that Resulted in Injury	0	0	0	1
Other Incident Resulting in Hospitalization	4	3	+1	10
Other Incident Resulting in Medical Treatment Other Than Hospitalization	3	5	-2	19
Use of Restraints	0	0	0	1
Total	**11**	**15**	**-4**	**61**
Health and Recovery Plans				
Any Other Incidents as Determined by the Plan	0	0	0	1
Crimes Committed Against Enrollee	1	1	0	6
Crimes Committed by Enrollee	0	0	0	1
Instances of Abuse of Enrollees	0	0	0	4
Instances of Neglect of Enrollees	0	0	0	1
Other Incident Resulting in Hospitalization	5	7	-2	24
Other Incident Resulting in Medical Treatment Other Than Hospitalization	46	31	+15	170
Use of Restraints	0	0	0	1
Total	**52**	**39**	**+13**	**208**
HIV Special Needs Plans				
Any Other Incidents as Determined by the Plan	0	0	0	4
Other Incident Resulting in Hospitalization	2	0	+2	2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	1	1	0	3
Total	**3**	**1**	**+2**	**9**
Grant Total	**66**	**55**	**+11**	**278**

Member Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 112 member complaints this quarter. This total is a 3.4% decrease from the previous quarter, which reported 116 member complaints.

Annually, the Department directly received 475 MMCO member complaints regarding Medicaid managed care, HARPs and HIV SNPs. The following chart represents previously reported complaints filed directly with NYSDOH, including complaints from members and their representatives.

MMCO Member Complaints Received Directly by the Department				
FFY 19 Q4 7/1/2019-9/30/2019	**FFY 19 Q3 4/1/2019-6/30/2019**	**FFY 19 Q2 1/1/2019-3/30/2019**	**FFY 19 Q1 10/1/2018-12/31/18**	**Total FFY 19 10/1/2018-9/30/2019**
112	**116**	**101**	**146**	**475**

The top five (5) most frequent categories of member complaints received directly at NYSDOH involving MMCOs were as follows:

Description of Complaint	Percentage of Complaints FFY 19 Q4 7/1/2019–9/30/2019
Difficulty with Obtaining: Home Health Care	12%
Difficulty with Obtaining: Dental/Orthodontia	12%
Pharmacy/Formulary	8%
Difficulty with Obtaining: Personal Care	8%
Reimbursement/Billing	6%

The Department monitors and tracks member complaints reported to the Department related to new or changed benefits and populations enrolled into MMCOs. As part of the Children's Medicaid System Transformation, in January 2019, three Children and Family Treatment and Support Services (CFTSS) became part of the MMC and HIV SNP benefit package, including other licensed practitioner, psychosocial rehabilitation, and community psychiatric treatment and support services. In July 2019, family peer support services under CFTSS was added to the benefit package, and coverage for behavioral health for children/youth under 21 years was aligned for MMC and HIV SNP plans (previously some behavioral health services were carved out for children under 21 who had SSI or were certified disabled by NYS). In October 2019, the mainstream MMC and HIV SNPs began covering children's HCBS (as authorized by the 1915c Children's Waiver) and removed the exemption from mandatory enrollment for participants in the 1915c Children's Waiver. Since the carve in of these services, the Department has received one (1) member complaint relating to CFTSS, and one (1) relating to HCBS. Note the Department continues to actively work with providers and other stakeholders regarding implementation progress for the Children's Medicaid System Transformation and will continue to monitor for consumer issues related to these initiatives.

Fair Hearings

There were 395 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of July 1, 2019 through September 30, 2019. The dispositions of these fair hearings as well as the previous three quarters are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)					
Hearing Dispositions	**FFY 19 Q4 7/1/2019-9/30/2019**	**FFY 19 Q3 4/1/2019-6/30/2019**	**FFY 19 Q2 1/1/2019-3/30/2019**	**FFY 19 Q1 10/1/2018-12/31/2018**	**Total FFY 19 10/1/2018-9/30/2019**
In favor of Appellant	168	158	118	148	592
In favor of Plan	178	199	163	133	673
No Issue	49	39	41	36	165
Total	**395**	**396**	**322**	**317**	**1,430**

For fair hearing dispositions occurring during the reporting periods, the following table describes the number of days from the initial request for a fair hearing to the final disposition of the hearing, including time elapsed due to adjournments.

Fair Hearing Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP)					
Decision Days	**FFY 19 Q4 7/1/2019-9/30/2019**	**FFY 19 Q3 4/1/2019-6/30/2019**	**FFY 19 Q2 1/1/2019-3/30/2019**	**FFY 19 Q1 10/1/2018-12/31/2018**	**Total FFY 19 10/1/2018-9/30/2019**
0-29	8	8	14	16	46
30-59	159	187	130	124	600
60-89	104	95	86	98	383
90-119	66	46	45	32	189
=>120	58	60	47	47	212
Total	**395**	**396**	**322**	**317**	**1,430**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on September 19, 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. There were no other agenda items

added to this meeting. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for December 19, 2019.

Annual: The Medicaid Managed Care Advisory Review Panel is required to meet quarterly. Meetings were held on December 6, 2018, February 21, 2019, June 20, 2019, and September 19, 2019.

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

No updates to report this quarter.

Annual: In November 2018, the Department provided Criteria Standards for the Authorization and Utilization Management of Harm Reduction Services to all Medicaid Managed Care (MMC) Plans. Each MMC Plan that chose to adopt criteria for the authorization and utilization management of harm reduction services were required to submit the criteria (and any subsequent amendment to such criteria) electronically to the Department for review and approval prior to use. Throughout the year, there were no significant issues with this transition process.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

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

In November, the Department release to the MLTC plans, their Crude Percent Reports for the time period of January through June 2018. The Crude Percent Reports provide the plans with a distribution of their members compared to the statewide, for many of the components of the functional assessment tool.

In December, we released to the plans the methodology for the 2019 MLTC Quality Incentive.

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

MLTC Quality Incentive Preliminary Results*, 1/29/2019				
Payer	Plan ID	Plan Name	QI Points, adjusted	Tier
MAP	2914056	VNS CHOICE Total	69.8	3
MAP	4682248	VillageCareMAX Total Advantage	63.5	3
partial	3234044	ElderServe dba RiverSpring	62.4	3
MAP	3173113	Elderplan	62.4	3
partial	3466906	MetroPlus MLTC	61.0	3
MAP	2942923	GuildNet Medicaid Advantage Plus	61.0	3
partial	3253707	Elderplan dba Homefirst	59.7	3
MAP	2927631	Fidelis Legacy Plan	59.1	3
partial	3522947	Hamaspik Choice	57.0	3
partial	3420399	VillageCareMAX	57.0	3
PACE	1674982	Eddy Senior Care	55.6	2
partial	3581413	Prime Health Choice	54.7	2
partial	3481927	AgeWell New York	54.3	2
PACE	3114514	ArchCare Senior Life	54.3	2
partial	3475427	Integra MLTC	53.0	2
MAP	2932896	Senior Whole Health	52.6	2
partial	3506989	Centers Plan for Healthy Living	51.6	2
partial	3549135	Extended MLTC	50.3	2
MAP	3420808	MHI Healthfirst Complete Care	50.3	2
partial	2104369	Senior Health Partners	48.9	2
PACE	3072740	Catholic Health - LIFE	48.9	2
PACE	1234037	CenterLight PACE	48.9	2
PACE	3056544	Total Senior Care	46.4	1
partial	1827572	GuildNet	46.2	1
partial	3459881	Senior Whole Health Partial	46.2	1
partial	1750467	VNS CHOICE MLTC	46.2	1
PACE	4190745	Fallon Health Weinberg-PACE	46.1	1
partial	1778523	Senior Network Health	44.9	1
partial	1788325	Fidelis Care	43.5	1
partial	3594052	Montefiore MLTC	43.5	1
PACE	1519162	PACE CNY	43.5	1
partial	3458546	Aetna Better Health	42.2	1
partial	2644562	Empire BCBS HealthPlus MLTC	40.9	1
PACE	3320725	Complete Senior Care	40.5	1
partial	2188296	Fallon Health Weinberg	38.2	0
partial	3439663	United Health Personal Assist	38.2	0
partial	2825230	WellCare Advocate Partial	38.2	0
partial	1865329	Independence Care System	36.8	0
partial	3690851	Kalos Health	36.8	0
PACE	1278899	ElderONE	35.5	0
partial	3466800	ArchCare Community Life	30.6	0
partial	3529059	Nascentia Health Options	30.1	0
partial	1825947	EverCare Choice	27.4	0
partial	3866960	iCircle	24.7	0
partial	4122776	Elderwood Health Plan	22.4	0

*Empire BCBS HealthPlus MAP is excluded due to having less than 50% of possible base points.

The 2018 MLTC Report was publicly released in May. This Report presents information on the 56 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

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

In May, we released Crude Percent Reports for the July through December 2018 time period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each plan's July through December 2018 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month time period.

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

B. Quality Measurement in Medicaid Managed Care

Quality of care remained high for Medicaid Managed Care members for the Demonstration Year. In measurement year 2017 national benchmarks for Medicaid, which are from NCQA's State of Health Care Quality 2018 report were available for 66 measures for Medicaid Managed Care. Out of the 66 measures that New York 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).

The Department conducted a satisfaction survey with children enrolled in Medicaid managed care in the fall of 2018. The CAHPS® CCC questionnaire was administered to the parents/caretakers of Medicaid and Child Health Plus (CHP) managed care plan child members. The survey included 15 managed care plans in New York with a sample of 1,500

children per plan. Questionnaires were sent to 22,500 parents/caretakers of child members following a combined mail and phone methodology during the period October 3, 2018, through January 20, 2019, using a standardized survey procedure and questionnaire. A total of 4,742 eligible and complete responses were received resulting in a 22.0% response rate. The results in the March 2019 reports indicate continuing high levels of satisfaction with providers and plans. There is a statewide summary report for Medicaid and Child Health Plus Managed Care plans and there are fifteen plan specific reports. All reports are available here: https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report/2019/

Quality Assurance Reporting Requirements (QARR)

We had 24 Managed Care Organizations submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2019. This includes 14 of Qualified Health Plans operating through the NY State of Health Marketplace with enough eligible populations to report quality data. Data has been reviewed for completeness and accuracy and final results were published this quarter on our eQARR webpages and our consumer guides data. These reports are available here: http://health.ny.gov/health_care/managed_care/reports/index.htm

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.

Several surveys were initiated, fielded and closed during the four quarters of 2019. These surveys included: Access Survey of Provider Availability (Provider Directory); Member Services; and, High-Volume PCP Ratio. During the 1st quarter of 2019, final reports from the Access Survey of Provider Availability and the Member Services Surveys were distributed to MCOs. The High-Volume PCP Ratio survey was completed, and reports

drafted. For the 2nd quarter of 2019, final reports from the High-Volume PCP Ratio survey were distributed to MCOs. In the 3rd quarter, planning for a new Access Survey of Provider Availability (ASPA), and new Member Services Department (MSD), survey was completed by the DOH. IPRO worked closely with the DOH to aid in finalizing the surveys. A new survey tool was developed for the MSD survey. By the end of the 4th quarter, IPRO had prepared the samples for the new Provider Directory survey and had initiated plan calls. Additionally, IPRO nearly completed all MSD survey calls, and plans to complete the final report by the end of October 2019. IPRO issued the results to the High-Volume PCP Ratio survey during this quarter and will begin planning and initiating the next High-Volume PCP Ratio survey once the new Provider Directory survey is completed.

In the first three quarters of 2019, IPRO oversaw two sub-contracts for the management of a rebuild of the Provider Network Data System (PNDS). The rebuild work included network changes and modifications. Throughout the four quarters of 2019, IPRO continued to facilitate ongoing adjustments and fixes required for the PNDS rebuild. At the end of the year, September 2019, IPRO was addressing any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. A LEAN project, to aid in developing best processes for managing ongoing project activities – including maintenance of portals, data submission, and user sites – continued throughout the four quarters of 2019. In the fourth quarter, IPRO assigned a new staff person to head up their activities for the LEAN initiative. A meeting of LEAN stakeholders was conducted, in the fourth quarter, and a 30/60/90 day LEAN task planner was drafted, and will be implemented for the next year.

Throughout the four quarters of 2019, work was initiated, and progressed, for the 2019/2020 Managed Long-Term Care Performance Improvement Projects (PIPs). IPRO reviewed MLTC plans' PIP proposals, scheduled and conducted plan progress calls, and reviewed and revised, with input from the NYSDOH, interim PIP reports submitted by the MLTC plans. MLTC PIP Interim reports are due to IPRO in January 2020. MLTC PIP final reports will be due in July 2020.

A new MLTC Satisfaction Survey was planned and fielded in the first quarters of the year, with the completion in early August. The new MLTC Satisfaction survey results were obtained and revised based on the oversight of the EQRO.

An MLTC Encounter Data Validation was planned and the methodology was refined and initial communication with MCOs established, during the first quarters of the year. The validation began in August. The validation was ongoing during the 4th quarter of the year, with plans submitting their data to IPRO. Results should be available in the first quarter of 2020.

Final reports from a Focused Clinical Study (FCS) looking at necessity of long-term care were issued to the MCOs in the 2nd quarter. Planning for new FCSs on MLTC Frailty, HARP Intensive Care Management (ICM), and MMC Maternal Sepsis continued, with progress made on methodologies and study design. IPRO continues to research Frailty Indexes, under the direction of the DOH. In the 4th quarter IPRO prepared a draft report for

the Frailty FCS and was set to deliver the report to DOH by the end of the 4th quarter. For the end of the year, IPRO received the HARP FCS case management records and was set to incorporate comments from OMH and DOH into the data analysis plan.

The child CAHPS® survey was fielded and final reports were revised. An Access and Utilization Report was drafted and revised for public dissemination on the NYSDOH Managed Care Reports website.

Contracting with NCQA for plan submission of QARR data was established and planning for the 2018 measurement year reporting cycle finalized in Q2.

In Q3, revisions of the methodology to the upcoming (Fall 2019) Adult CAHPS survey were discussed. IPRO worked with their sub-contractor DataStat, to obtain confirmation of feasibility and new pricing for the revisions, which included oversampling for mailings and discontinuation of follow-up calls. For the fourth quarter, IPRO fielded the Adult CAHPS survey and will notify the DOH when the survey closes, and they begin the data analysis of the survey results.

In Q2 the fielding of a Diabetes Self-Management Education (DSME) survey was completed and analysis plan finalized. In the 4th quarter the final report for the DSME went through IPRO's QA and technical writing review process and was finalized and shared with the DOH for final review and approval.

A HARP perceptions of care survey was also designed/revised based on previous surveys and fielded late in Q2. The survey yielded sub-optimal response rates. A third mailing of the survey was not conducted in the 4th quarter. It was concluded that the small increase in the response rate from a third mailing did not warrant the expense of the additional mailing. IPRO cleaned and prepared the survey data for analysis. In the last quarter of the year, IPRO provided the data analysis plan for the HARP perceptions of care survey, to the Office of Mental Health (OMH), and to DOH.

In the first three quarters of 2019, 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 these quarters can be found under the Performance Improvement Project description. In Q3 IPRO also worked with MCOs to develop final reports on the 2017-2018 PIPs, which were due in August.

EQRO Technical Reports were developed, revised, and finalized in Q2 and Q3. During Q4, IPRO will send out the final EQR Technical Reports to the MMC plans.

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.

2017-18 HARP PIP

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. The 2017-18 PIP process ended in December 2018 with final reports due in July 2019. In June 2019, as plans submitted data for HEDIS 2019 reporting, it was discovered that changes in the HEDIS measure specifications for one of the common PIP measures raised serious concerns about the validity of the data reported by New York State Medicaid plans for the 2018 measurement year. Because the measure was common to all PIP projects, plans were requested to recalculate the final year of measurement for this item using the previous year's specifications and plans were granted a one-month extension for this revision. Final reports for the 2017-18 HARP PIP projects were received in August 2019 and are currently being reviewed and finalized throughout September and October 2019.

2019-20 HIV-SNP PIP

A PIP Planning conference call was conducted on September 12, 2018 with the three HIV SNP plans, IPRO and NYSDOH. The purpose of the call was to provide an overview of the PIP process as well as to discuss potential topics for the 2019-2020 PIP. Follow up conference calls with the HIV SNP plans were conducted in October 2018 to further delineate their 2019-2020 PIP topics. The three HIV SNP Plans submitted their 2019-2020 PIP Proposals by December 21, 2018. The 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 in February 2019. 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. Oversight calls were conducted in June and October 2019 and the MCOs submitted a PIP Update Call Summary Report prior to their call.

2019-20 HARP PIP

The 2019-2020 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. An October 10, 2018 webinar was conducted with the HARP and HIV

SNP plans to discuss the potential areas of opportunity for the PIP. On November 19, 2018 the 2019-2020 HARP PIP background document and the PIP Template was distributed to the HARP plans. The PIP Proposals were due December 21, 2018. All PIP Proposals were 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. Oversight calls were conducted in June and October 2019 and the MCOs submitted a PIP Update Call Summary Report prior to their call.

2019-2020 Medicaid KIDS Quality Agenda

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.

Webinars were held with plans to introduce the PIP (October 23, 2018 and to roll out the implementation of the PIP's three focus areas: Lead Testing (February 19, 2019), Hearing Screening (April 29, 2019), and Developmental Screening (June 25, 2019).

An initial Background Document was distributed to the plans on February 4th with updates on May 7, August 5, and August 21. FAQs were issued on April 4, May 5, July 2, July 18, August 6, and August 21, as follow-up to the all plan Webinars and in conjunction with clarification and final measure specification in the Background Documents.

The PIP Proposals were due in the first quarter of 2019. The Proposals were received and were reviewed by IPRO and NYSDOH. Proposals with updated Baseline Data were submitted by plans on July 23 and are currently under review by both IPRO and NYSDOH.

Regarding the Lead Testing Focus Area Guide to the Plan-Specific Member Level File for Lead Testing results were sent to the plans on February 13, 2019. Plan- Specific Member Level Files have been sent to the plans quarterly beginning on March 29, 2019. The NYSDOH Clinical Guidelines for Healthcare Providers pertaining to Lead Testing is under development.

Regarding the Hearing Screening Focus Area Guide to the Plan Specific Member Level File for Hearing Screening Focus Area was distributed to plans by NYSDOH on May 24. Monthly Hearing Member Level Files have been sent to plans beginning on May 29.

Regarding the Developmental Screening Focus Area, a plan survey on the use of CPT Codes and modifiers for Developmental Screening was completed on April 15.

PIP Progress Oversight calls were held scheduled for all 15 plans to occur in July. Calls to all plans from IPRO and DOH are scheduled in October to review the PIP Proposals with revised baseline data submitted on July 23.

Breast Cancer Selective Contracting

Staff completed the Breast Cancer Selective Contracting process for contract year 2019-2020. This included: updating the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); identifying low-volume facilities for restriction; notifying restricted facilities of their status; conducting the appeals process; posting the list of restricted facilities to the NYS DOH public website; and, supplying the list of restricted facilities to eMedNY staff so that Medicaid fee-for-service payments can be appropriately restricted, as well as, sharing the list with Medicaid managed care health plans' Chief Executive Officers and Medical Directors.

In total, the annual review identified 262 facilities. Facility designations were as follows: 117 high-volume facilities, 22 low-volume access facilities, 84 low-volume restricted facilities, and 39 closed facilities.

Staff also completed the summer review of breast cancer surgical volume data. Provisional volume designations for contract year 2020-2021 were shared with facilities' SPARCS coordinators in August 2019. Release of these data will give facilities ample time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

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

Patient Centered Medical Home (PCMH)

As of September 2019, there were 9,576 NCQA-recognized PCMH providers in New York State. Approximately 48% (4,588) 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 14 providers and 7 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 three quarters, a continuous increase in the recognition under this new standard has been observed. There are 4,870 providers and 1,176 practices recognized. Of the providers that became recognized in September 2019, 21 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 September 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

The number of NCQA-recognized providers in New York State has steadily increased throughout the year. As of October 2018 there were 8,799 NCQA-recognized PCMH providers in New York State. This number grew to 9,576 by the end of the fourth quarter in September 2019. From October 2018 to September 2019, the number of PCMH providers recognized under NYS PCMH standards went from 2% (181) to 51% (4,870). No providers remain under the 2011 standards. The number of NCQA-recognized PCMH practices in New York State also increased throughout the year, going from 2,383 in October 2018 to 2,575 in September 2019.

On April 1, 2018 the New York State Department of Health released a new recognition program called the New York State Patient-Centered Medical Home (NYS PCMH). The NYS PCMH Recognition Program is exclusive to New York State and seeks to establish a uniformed approach of improving primary care across New York State. The first providers and practices achieved NYS PCMH recognition in July 2018. As of September 2019, 1,498 practices have enrolled in NYS PCMH, and 1,176 practices of those enrolled have achieved NYS PCMH recognition.

There were multiple payment changes made throughout the year. Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017 recognized providers. Effective July 1, 2018, the PMPM for 2014 level 3 or 2017-recognized providers increased from $5.75 to $6.00. As of September 2019 incentive payments for 2014 level 2 standards remain discontinued and incentive payments for 2014 level 3, 2017 standards, and NYS PCMH standards are set at $6.00 PMPM.

IX. Transition Plan Updates

The transition is complete and there will not be another update. Please see Attachment 3.

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.

As detailed in STC X.10, the State 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 audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019 with CMS confirming in a subsequent discussion on October 10, 2019 that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all audit findings, however, entry of corrected data for F-SHRP DY6 into MBES is pending approval of a timely filing waiver.

The state budget neutrality team is addressing internal processes to ensure New York remains in compliance with Quarterly Expenditure Reporting requirements going forward. As of August 2019, the State has resumed timely quarterly expenditure reporting for 0-, 3-, and 21-month lag reports and has submitted all outstanding 3-month lag reports.

The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous the full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

B. Designated State Health Programs

No updates this quarter.

XI. Other

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

NYS Compliance

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. In addition, New York State is actively addressing 12 CMS Top Priority Issues (TPIs). In addition, New York has started to review and address TPIs 13-24.

Also, New York State is working closely with CMS's analytics vendors to improve the data quality of its submissions and its reconciliation of T-MSIS data with CMS 64 reporting.

In regard to the state resubmitting 2017 to 2019 files the state is on target to provide the full file refresh by the CMS deadline of January 2020.

B. 1115 Waiver Public Comment Days

With the implementation of the Medicaid Redesign Team in 2011, New York has prioritized transparency and public engagement as a key element of developing and implementing Medicaid policies. The public comments provided at these forums has been shared with the New York teams working on these programs and has informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

On November 29, 2018, the Department of Health conducted a public forum held at the New York Academy of Medicine, Reading Room, 1216 5th Ave, New York, NY 10029. A second public forum was held on June 24, 2019 held at the Empire State Plaza Concourse, Meeting Room 6, Albany, NY 12242.

A recording of the live webcasts, transcript, written public comments, and presentation slides from each public forum are available for viewing at the link below. All written public comments received are shared with program areas within the State for their consideration in shaping policy and procedures.

https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/mrt_pub_comment_days.htm

Attachments:
Attachment 1— MLTC Critical Incidents
Attachment 2— MLTC Partial Capitation Plan, PACE, and MAP Enrollment
Attachment 3— Transition Report/Plan

State Contact:
Phil Alotta
Associate Health Planner
Division of Program Development and Management
Office of Health Insurance Programs
phil.alotta@health.ny.gov
Phone (518) 486-7654
Fax# (518) 473-1764

Submitted via email: December 19, 2019
Uploaded to PMDA: December 19, 2019

Critical Incidents July - September 2019

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that Resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	6	0	1	0	1	0	2	2	0	8,137	0.07%
AgeWell NY	21	0	0	0	3	3	14	1	0	12,123	0.17%
Empire BlueCross BlueShield Healthplus	2	0	0	0	2	0	0	0	0	7,227	0.03%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	12	0.00%
Archcare Community Life	31	0	0	0	2	1	15	13	0	5,123	0.61%
Archcare PACE	2	0	0	0	0	0	1	1	0	837	0.24%
Catholic Health-LIFE	24	0	18	0	0	0	2	4	0	259	9.27%
Centerlight PACE	27	0	0	0	0	0	15	12	0	2688	1.00%
Centers Plan for Healthy Living MAP	0	0	0	0	0	0	0	0	0	14	0.00%
Centers Plan for Healthy Living	20	0	0	0	7	2	8	3	0	36,778	0.05%
Complete Senior Care	3	0	0	0	0	0	1	2	0	125	2.40%
Eddy SeniorCare	4	0	0	0	0	0	3	1	0	210	1.90%
Elant Choice (EverCare)	39	0	0	0	0	0	7	32	0	968	4.03%
Elderplan MAP	0	0	0	0	0	0	0	0	0	1573	0.00%
Elderserve	106	0	0	0	0	3	57	46	0	15,167	0.70%
Extended	89	0	0	0	0	1	27	61	0	7076	1.26%
Fidelis Care at Home	0	0	0	0	0	0	0	0	0	23,664	0.00%
Fidelis MAP	0	0	0	0	0	0	0	0	0	80	0.00%
Hamaspik	21	0	0	0	2	3	13	3	0	2,402	0.87%
Healthfirst CompleteCare	188	0	0	0	0	3	34	151	0	26146	0.72%
HomeFirst, Inc. (Elderplan)	0	0	0	0	0	0	0	0	0	1573	0.00%
Independent Living for Seniors (ILS/ElderOne)	2	0	0	0	0	0	2	0	0	739	0.27%
Integra MLTC	0	0	0	0	0	0	0	0	0	22,377	0.00%
MetroPlus	0	0	0	0	0	0	0	0	0	2,058	0.00%

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that Resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Monefiore	0	0	0	0	0	0	0	0	0	1,757	0.00%
Independent Living Services of CNY (PACE CNY)	13	0	0	0	1	0	9	3	0	632	2.06%
Senior Health Partners	200	0	0	0	0	2	48	150	0	15,320	1.31%
Senior Network Health, LLC	14	0	0	0	0	0	7	7	0	589	2.38%
Senior Whole Health	3	0	0	0	1	0	0	2	0	15,105	0.02%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	85	0.00%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	955	0.00%
Total Senior Care	0	0	0	0	0	0	0	0	0	124	0.00%
United Healthcare	0	0	0	0	0	0	0	0	0	12	0.00%
Village Care	120	0	0	0	6	0	46	68	0	12,051	1.00%
Village Care MAP	19	0	0	1	3	0	6	9	0	1599	1.19%
VNA Homecare Options (Nascentia Health Options)	191	0	0	0	4	1	77	109	0	7,953	2.40%
VNS Choice MAP TOTAL	19	0	0	0	0	0	9	10	0	2368	0.80%
VNS Choice MLTC	154	0	0	0	1	1	80	72	0	19,502	0.79%
WellCare Advocate	32	0	0	1	0	0	11	20	0	5,893	0.54%
Kalos ErieNiagara DBA: First Choice Health	4	0	0	0	2	0	2	0	0	1,484	0.27%
Prime	60	0	0	0	0	0	14	46	0	524	11.45%
Icircle	0	0	0	0	0	0	0	0	0	4,189	0.00%
Elderwood	8	0	0	0	0	0	4	4	0	882	0.91%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	138	0.00%
total	1422	0	19	2	35	20	514	832	0		

Managed Long Term Care Partial Capitation Plan Enrollment Oct 2018- Sept 2019												
Plan Name	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Aetna Better Health	6,587	6,798	7,034	7,265	7,370	7,417	7,505	7,571	7,643	7,788	7,948	8,137
AgeWell New York	9,915	10,135	10,464	10,824	11,022	11,187	11,355	11,489	11,656	11,824	12,004	12,123
ArchCare Community Life	4,160	4,286	4,418	4,513	4,545	4,578	4,604	4,682	4,797	4,903	5,031	5,123
Centers Plan for Healthy Living	30,606	30,978	31,716	32,212	32,550	33,006	33,428	33,956	34,655	35,324	36,002	36,778
Elant	966	976	975	952	953	954	946	950	961	964	973	968
Elderplan	13,325	13,504	13,881	14,125	14,129	14,070	14,042	14,152	14,398	14,560	14,704	14,842
Elderserve	12,738	13,071	13,654	14,053	14,271	14,429	14,574	14,670	14,784	14,901	15,013	15,167
Elderwood	383	414	452	496	591	617	644	707	761	808	849	882
Extended MLTC	5,122	5,327	5,663	5,995	6,155	6,322	6,492	6,697	6,913	7,017	7,051	7,076
Fallon Health Weinberg (TAIP)	788	801	810	827	843	862	881	886	926	947	960	955
Fidelis Care at Home	22,140	22,353	22,729	23,107	23,331	23,412	23,469	23,561	23,732	23,526	23,581	23,664
Guildnet	6,668	5,471	2,734	23	11	2	0	0	0	0	0	0
Hamasp k Choice	2,225	2,232	2,251	2,252	2,266	2,287	2,299	2,315	2,354	2,350	2,382	2,402
HealthPlus- Amerigroup	5,345	5,553	5,856	6,111	6,208	6,247	6,335	6,379	6,391	6,524	6,903	7,227
iCircle Services	2,862	2,981	3,067	3,165	3,420	3,495	3,546	3,676	3,803	3,958	4,090	4,189
Independence Care Systems	6,035	5,894	5,825	5,761	5,632	5,252	40	1	0	0	0	0
Integra	13,762	14,444	15,200	15,821	16,388	17,037	17,885	18,749	19,470	20,548	21,351	22,377
Kalos Health- Erie Niagara	1,324	1,350	1,367	1,386	1,381	1,416	1,368	1,399	1,437	1,443	1,470	1,484
MetroPlus MLTC	1,841	1,835	1,901	1,991	1,978	1,962	1,958	1,944	1,948	1,965	2,006	2,058
Montefiore HMO	1,540	1,553	1,592	1,615	1,619	1,648	1,656	1,686	1,699	1,703	1,737	1,757
Prime Health Choice	392	389	397	429	455	456	468	494	496	502	510	524
Senior Health Partners	14,454	14,625	14,788	15,086	15,169	15,104	15,094	15,055	15,149	15,208	15,241	15,320
Senior Network Health	557	555	556	557	584	573	580	577	574	586	588	589
Senior Whole Health	14,034	14,134	14,343	14,497	14,581	14,635	14,719	14,753	14,808	14,852	14,985	15,105
United Healthcare	4,143	4,119	4,163	3,861	2,988	3,003	2,969	2,974	2,978	2,732	1,508	12
Village Care	10,962	11,308	11,745	11,800	11,515	11,308	11,269	11,354	11,468	11,636	11,826	12,051
VNA HomeCare Options	7,067	7,180	7,189	7,289	7,535	7,564	7,525	7,553	7,681	7,782	7,889	7,953
VNS Choice	12,861	12,929	13,184	13,224	13,207	13,214	18,373	18,414	18,645	18,821	19,104	19,502
WellCare	5,504	5,530	5,614	5,620	5,655	5,674	5,687	5,774	5,818	5,842	5,861	5,893
TOTAL	**218,306**	**220,725**	**223,568**	**224,857**	**226,352**	**227,731**	**229,711**	**232,418**	**235,945**	**239,014**	**241,567**	**244,158**

PACE & MAP Enrollment Oct 2018 - Sep 2019												
	Oct-18	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
MLTC Product	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
PACE	5,757	5,776	5,796	5,801	5,809	5,800	5,802	5,804	5,776	5,736	5,760	5,752
MAP	12,360	12,727	13,120	13,904	14,473	14,838	15,345	15,687	15,977	16,442	16,900	17,391

[redacted]

New York State

Partnership Plan Medicaid Section 1115 Demonstration

Transition Report

I. Introduction

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, 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 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period August 1, 2011, through December 31, 2014, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA).

On January 1, 2014, New York will have made considerable progress in implementing the ACA. Specifically, New York will have expanded coverage, made changes to access to care, and reforms to the payment and delivery system. The ACA expands Medicaid eligibility for individuals under the age of 65, with income at or below 133 percent of the Federal Poverty Level (FPL). In New York State, some of these individuals are currently eligible under New York's Partnership Plan 1115 Waiver.

II. Transition Plan

Nearly 90 percent of individuals currently covered under New York's Partnership Plan 1115 waiver will transition to a State Plan eligibility group with coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. For most enrollees in Family Health Plus, the transition to Medicaid using MAGI eligibility rules will occur at renewal. Ideally, the State would choose to switch coverage for the waiver population from Family Health Plus to Medicaid on January 1, 2014. However, this is not possible for all enrollees because not enough information is known to the system about parent/caretaker enrollees to automatically switch them to a MAGI budget on January 1, 2014.

New York intends to stop accepting new applications for Family Health Plus after December 31, 2013. Anyone who submits an application prior to or on that date and are found eligible, will be enrolled in Family Health Plus for 12 months. Effective January 1, 2014, new applications will be evaluated using MAGI eligibility rules, and if eligible, applicants will be enrolled in Medicaid under an Alternative Benefit Plan. New York has chosen the Medicaid State Plan benefit as its Alternative Benefit Plan and will be submitting a SPA for Secretary Approval.

Family Health Plus single and childless couples will have their coverage changed to the Alternative Benefit Plan effective January 1, 2014. Family Health Plus parents and caretaker relatives with income up to 138% FPL will transition to the Alternative Benefit

Plan as they renew, effective April 1, 2014. Family Health Plus parents and caretaker relatives with income over 138% FPL to 150% FPL will transition to a qualified health plan, however the State will pay the enrollee's share of the premium, this does not include the individual's cost sharing.

Effective January 1, 2016, New York will offer Essential Plan, a Basic Health Plan product on the Exchange. The Exchange will determine eligibility for Essential Plan for individuals up to 200% FPL. With the implementation of Essential Plan, New York will no longer pay the enrollee's share of the premium for a qualified health plan for parents and caretakers relatives with income over 138% FPL to 150% FPL. Individuals with income over 138% FPL to 150% FPL will transition to Essential Plan with no premium, they will have access to additional benefits such as vision and dental at a nominal additional cost.

As authorized by the waiver under section 1902(e)(14)(A) of the Social Security Act using existing rules, individuals renewing coverage from October 1, 2013 through March 31, 2014, if determined eligible, will enroll in the current plan under the waiver (e.g. Family Health Plus or Medicaid) for twelve months but no longer than through December 31, 2014 for Family Health Plus. Individuals determined ineligible from October 1, 2013 through December 31, 2014, will be sent a notice referring the person to apply for coverage through the Exchange. Individuals renewing from January 1, 2014 through March 31,2014, if found ineligible using existing rules (pre-ACA), must be budgeted using MAGI-like rules following the system migration on February 18, 2014.

New York is building a new eligibility system that automates the MAGI eligibility rules for Medicaid, CHIP, and Advance Premium Tax Credits. The State anticipates over one million individuals are eligible to obtain coverage during the open enrollment period that begins October 1, 2013, and even more may apply. Given the complexity of the system build, the short time for adequately testing all the eligibility permutations and the data services available through the Federal Hub, and the reality that rules and interfaces will continue to be built 3-6 months after open enrollment, New York has decided to mitigate risk by maintaining current Medicaid enrollees in the legacy system until the State is confident it has the automation and system stability to transition over three million current enrollees without a disruption in coverage. New York is prioritizing the ability to provide coverage on January 1, 2014 to the newly eligible populations while doing no harm to current Medicaid enrollees.

To maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI-like eligibility using the current legacy system for those individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI-like rules in the legacy system for at least six months or until the new eligibility system is fully automated and is stable enough to handle the transition of over 3 million current recipients. The legacy logic will include:

- No longer counting child support as income

- Not applying income disregards/deductions
- Increased federal poverty levels to comply with ACA income levels
- New AID categories for claiming
- Revised client notices

The current renewal form will be used.

New applications submitted to local departments of social services from October 2013 through December 2013, will have eligibility determined under existing rules in the legacy system and, if eligible, individuals will be enrolled for 12 months of coverage. Individuals that are not eligible due to income will be instructed to reapply through the Exchange. Applications submitted to the Exchange from October 2013 through December 2013, will be determined using MAGI rules and if determined eligible, coverage will be effective January 1, 2014. Applications submitted on or after January 1, 2014, will have eligibility determined through the Exchange under the ACA rules. Individuals who have medical bills or are in need of coverage in the three month period prior to January 1, 2014, will be referred to the local department of social services for a determination of eligibility for payment/reimbursement of medical bills.

Although New York will transition individuals from the waiver to coverage under the ACA, the State intends to maintain the authority included in the waiver to mandatorily enroll individuals into managed care in counties **other than** Allegany, Cortland, Duchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

A. Seamless Transitions

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status with income at or below 133 percent of the FPL;

The following chart outlines the current waiver population, current coverage, and the coverage options for individuals between 133% FPL and 150% FPL currently enrolled in Family Health Plus. These options include transitioning Family Health Plus enrollees to Advanced Premium Tax Credits. Regardless of which options are available in 2014, all populations will have eligibility determined under the ACA.

Table 1: Groups Transitioning from Demonstration to ACA

Demonstration Eligible Group	Current Federal Poverty Level	Current Coverage	2014 Coverage
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income based on Statewide standard of need, approximately 0%-78% FPL	Medicaid	0% ≤ 133% Benchmark
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 100% FPL	Family Health Plus	0% ≤133% Benchmark
Children 19 and 20 years old [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Standard coverage > 133% ≤150% Standard coverage >150% APTC

Parents and caretaker relatives of a child under the age of 21 (who could otherwise be eligible under section 1931 of the Medicaid State Plan) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Benchmark > 133%≤150% State will pay enrollee's share of APTC premiums and seek federal participation as a designated state health program >150% APTC (no state assistance)

*The current Partnership Plan 1115 approved NYS comparing income to 160% FPL, but this has not been implemented.

ii. Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

All populations currently covered under the waiver will have coverage options under the ACA. In addition, New York plans to implement 12-months of continuous coverage for adults in conjunction with the implementation of the ACA.

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 2, regardless of the delivery system through which they receive Medicaid benefits. Once the State begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with the Medicaid State plan, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under the Medicaid State plan, the individual is guaranteed a subsequent 12-month continuous eligibility period.

This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Authority for this population's eligibility during the 12 month continuous eligibility period is only in the 1115 waiver and therefore, individuals during this period would be eligible for expanded Medicaid levels and benchmark under ACA, and are also subject to continuous coverage. The Department is in the process of exploring the necessary system and program changes and anticipates implementing in January 2014.

Table 2: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	**Statutory Reference**
Pregnant women aged 19 or older	• 1902(a)(10)(A)(i)(III) or (IV); and • 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children	1931 and 1925

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

- Local departments of social services will process new applications for Medicaid using current eligibility rules through December 31, 2013.
- New applications submitted to the Exchange from October 2013 through December 2013, will have eligibility determined through the Exchange under ACA rules and, if eligible, enrollment will be effective January 1, 2014. The acceptance notice will inform individuals who have medical bills or are in need of coverage prior to January 1, 2014 to apply at the LDSS. Applicants will be informed of this process online so they may go directly to the LDSS rather than apply through the Exchange before January 1, 2014.
- Beginning January 1, 2014, new applications will go through the Exchange and will be processed through the new integrated eligibility system.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the ACA and the authorities the State identifies that may be necessary to continue coverage for these individuals;

Nearly all of the populations covered under the waiver will be covered under the ACA and those populations who are subject to continuous coverage will also have it applied under the waiver.

Parents/caretakers with MAGI income between 138% and 150% of FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for a tax credit under the ACA provided they do not have access to affordable coverage. CMS approved expenditure authority to allow the state to claim federal matching dollars for the designated state health program (DSHP), this will provide premium subsidies to parents and caretaker relatives with incomes between 138%-150% FPL, who enroll in a silver level Qualified Health Plan using Advanced Premium Tax Credits.

19 and 20 year olds who are living with parents with MAGI income between 138% and 155% of the FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for Medicaid under MOE requirements.

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

New York is developing a new eligibility system that will automate program eligibility based on the MAGI eligibility rules as defined by CMS. All applications submitted to the Exchange after January 1, 2014 will be processed using the MAGI eligibility rules in the new system.

As described above, to maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI-like eligibility using the current legacy system for individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI-like rules in the legacy system for at least six months, or, until the new eligibility system is fully automated and is stable enough to handle the transition of over three million current recipients.

New York opted for CMS to develop a modified adjusted gross income (MAGI) equivalency level for converting existing net eligibility levels to MAGI eligibility levels. New York received converted eligibility levels and they are currently in effect.

B. Access to Care and Provider Payments

i. Provider Participation. The State must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition;

The service delivery network for a Managed Care Organization ("MCO") is county specific and is comprised of primary, specialty and ancillary providers as well as related institutions consistent with the benefit package. Each county network must include at least one hospital, one inpatient and outpatient mental health facility as well as at least one substance abuse inpatient and outpatient facility. This applies to HMOs participating in government programs and those that have exclusive commercial membership.

The behavioral health network is required to have both individual providers, outpatient facilities and inpatient facilities. The facilities must include mental health and substance abuse services. In the case of outpatient mental health, at least one facility in the county must be licensed by the Office of Mental Hygiene pursuant to Article 31 of the Mental Hygiene Law, or be a facility operated by the Office of Mental Hygiene. The mental health inpatient facility can be either a psychiatric center under the jurisdiction of the Office of Mental Hygiene, or, a unit or part of a hospital operating under Article 28 of the Public Health Law.

The provision of alcohol and substance abuse services must also be provided in an outpatient facility and an inpatient facility. These facilities must have the capacity to provide substance abuse treatments. The inpatient facilities must have the capacity to provide detoxification and rehabilitation services.

In addition to the above, Medicaid networks must also include traditional Medicaid providers, i.e., presumptive eligibility providers, Designated AIDS

Centers and Federally Qualified Health Centers (FQHCs), where available. With the implementation of the homeless population into Medicaid managed care, we also require the MCO to contract with available federally qualified 330 H providers in every county they are available in.

ii. Adequate Provider Supply. The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013;

The MCO is required to have the full array of contracted providers in each county. However, in rural counties, this may not be possible due to a lack of resources within the county. When there is a lack of a provider type in a county the MCOs may contract with providers in adjacent counties, or service area, to fulfill the network requirements. In some cases where counties border neighboring states and the normal access and referral pattern for obtaining medical services in those areas is to go across state boundaries, MCOs may request approval to augment their networks by adding those out of state providers. Attachment 1 provides a listing of the core provider types for all lines of business.

In addition to the full array of required health care providers, the network must include sufficient numbers of each provider type, be geographically distributed and ensure choice of primary and specialty care providers. The Public Health Law requires the MCO member a choice of at least three geographically accessible primary care providers. It is the department's policy that MCOs are required to contract minimally with two of each required specialist provider types per county. However, additional providers may be required based on enrollment and to ensure geographic accessibility.

The Department of Health has developed time and distance standards for provider networks to which MCOs are required to adhere. For all Medicaid, HIV Special Needs Plans, and Child Health Plus health products, the time and distance standard is as follows:

- metropolitan areas - 30 minutes by public transportation;
- non-Metropolitan areas - 30 minutes or 30 miles by public transportation or by car;
- in rural areas transportation requirements may exceed these standards if justified.

The provider networks for the Medicaid, HIV Special Needs Plans, and Child Health Plus managed care products are reviewed on a quarterly basis. The Department of Health maintains a database and MCOs are required to submit their networks electronically at schedule dates. The submitted data goes through an editing process to ensure the data contains all required information prior to accepting the network. Prior to a network analysis the information is matched against state and federal disciplinary files to remove

providers unauthorized from participation in government programs. Subsequently, the network is analyzed for the presence of core provider types and sufficient numbers of providers to ensure choice of primary and specialty providers.

The first part of the review is an electronic analysis based upon program parameters established by the Department to determine if each county has an adequate number of the required core providers. The second part of the analysis is a manual review of reports that are produced. Examples of these reports include whether there are a sufficient number of providers in the county to provide a choice of primary and specialty providers and a comparison of providers not contracting with a specific MCO but who have contracts with other MCOs in the same county. The reports are then summarized and MCOs are notified of any access issues identified within their certified areas of operation. MCOs are required to review the summaries and report back to the Department. The Department will then have MCOs sign an attestation that members may obtain services on an out of network basis to the nearest provider, but not greater than 30 minutes or 30 miles from the members' residence. This attestation remains in place until the MCO is able to successfully address the noted provider inadequacy.

iii. Provider Payments. The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive rate (e.g., certain Indian Health providers);

The State will pay the PPS rate through the eMedNY FFS system for eligible Medicaid enrollees. For enrollees in Medicaid managed care, the State will make supplemental payments to eligible FQHC/RHC's to make up the difference between the PPS rate and the average managed care payment.

C. **System Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: i. Replacing manual administrative controls with automated processes to help support a smooth interface among coverage and delivery system options that is seamless to beneficiaries;**

New York is working to simplify and align both our rules and processes in accordance with the ACA requirements, and to automate MAGI eligibility determinations and verifications to the maximum extent practicable, and to promote a more seamless customer experience.

D. Progress Updates. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed;

The State will provide quarterly and annual reports.

E. **Implementation**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application;

As described above, New York will transition eligible childless adult enrollees in the Demonstration to Medicaid on January 1, 2014. Parents/caretakers will be transitioned at their renewal beginning April, 2014 to either Medicaid or QHP coverage.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees;

New York plans to provide appropriate notices that minimize demands on enrollees to the maximum extent possible.

Attachment 1

Core Provider Types for All Lines of Business.

NOTE: Data will be provided when