NEW YORK STATE DEPARTMENT OF HEALTH

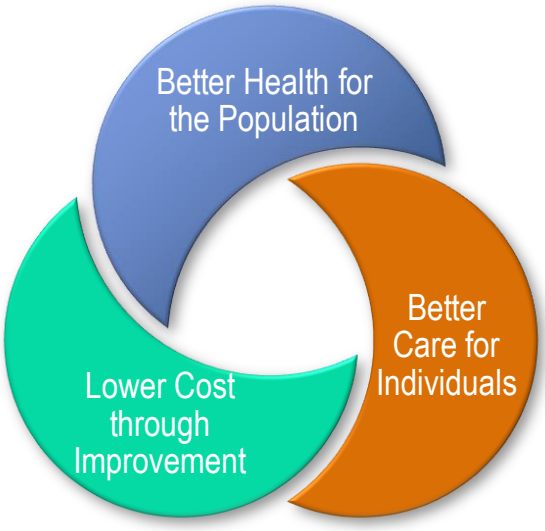
PARTNERSHIP PLAN MEDICAID SECTION 1115 DEMONSTRATION (NO. 11-W-00114/2)

INTERIM EVALUATION REPORT

March 20, 2014

EXECUTIVE SUMMARY

New York has experienced great success with its Partnership Plan Demonstration (a Medicaid Section 1115 Waiver) and is seeking an extension to continue to realize improvements in access, quality and cost effectiveness, consistent with the Triple Aim.



The Partnership Plan has achieved significant results in support of its major goals:

- Improvement in access and coverage.
- Improvement in quality.
- Improvement in cost effectiveness.

Measures of success for major components of the Partnership Plan over the past four years are discussed in this Interim Evaluation Report.

Figures are for the four year period ending September 2013 unless otherwise noted.

MEDICAID MANAGED CARE (MMC)

- 3 million Temporary Assistance for Needy Families (TANF) and Safety Net beneficiaries enrolled.
- 23.9 percent increase in enrollment.
- 86 percent of national quality benchmarks met.
- Without the Partnership Plan, projected expenditures would have been 235 percent higher for TANF children and 164 percent higher for TANF adults.

FAMILY HEALTH PLUS (FHP)

- 434,600 individuals enrolled.
- 12.5 percent increase in enrollment.
- 91 percent of national quality benchmarks exceeded.
- Without the Partnership Plan, projected expenditures for the FHP Adults with Children would have doubled.

FAMILY PLANNING BENEFIT PROGRAM (FPBP)

- 114,500 beneficiaries served.
- Reduction in unintended pregnancies.

MANAGED LONG TERM CARE (MLTC)

- 110,400 beneficiaries enrolled.
- 89 percent increase in enrollment from 2012 to 2013.
- Without the Partnership Plan, projected expenditures would have been 3.1 percent higher in 2013 than they were in 2012 for all age groups.

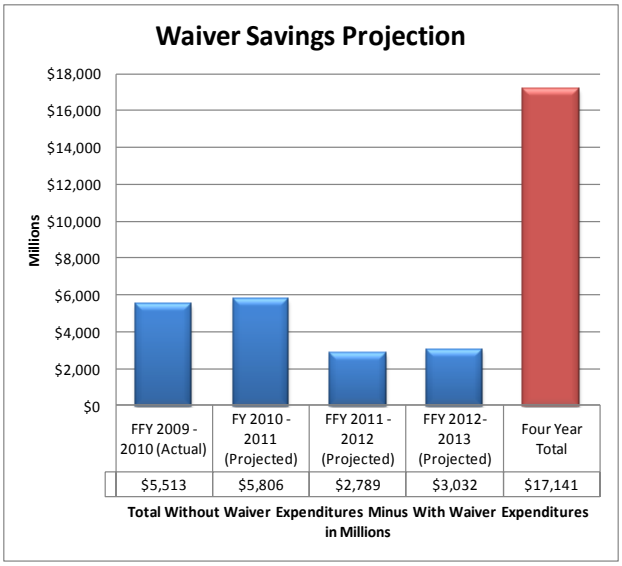
CONCLUSIONS

The Partnership Plan Demonstration has significantly expanded health coverage to previously underinsured and uninsured populations.

- Four million Medicaid beneficiaries enrolled in Managed Care programs.
- 75.9 percent of Medicaid recipients enrolled in Managed Care.

The Partnership Plan Waiver has achieved budget neutrality and realized significant savings.

- Projected savings over the last four years are $17.1 billion as shown in the graph below.



NEXT STEPS

The Partnership Plan has well-prepared New York to undertake a major reform of its health care service delivery system. New York's Medicaid Redesign Team Action Plan builds on the many successful components of the Partnership Plan Demonstration. In the coming years, the State plans to continue its successful partnership with the Centers for Medicare and Medicaid (CMS) to incorporate the following new initiatives:

- Health System Transformation for Individuals with Developmental Disabilities: to shift the Medicaid health system from a fee-for-service delivery system to a Medicaid managed care system, to assure person-centered services, and to create an integrated care coordination model.
- Delivery System Reform Incentive Payment Plan (DSRIP): A proposed investment of $7.3 billion to rebalance the delivery system as well as reduce hospitalizations and emergency department use by 25 percent over the next five years
- Behavioral Health System Transformation: to integrate all Medicaid covered services for mental illness, substance use disorders, and physical health conditions while transitioning these services to Medicaid Managed Care.

New York State will continue to seek and implement options for improving access, coverage, quality and cost effectiveness of the Medicaid program.

TABLE OF CONTENTS

EXHIBITS

ATTACHMENTS

ACRONYMS

ACA	Affordable Care Act
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CHPlus	Child Health Plus
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
D&TC	Diagnostic and Treatment Center
DANY	Doctors Across New York
DHSP	Designated State Health Programs
DISCO	Developmental Disabilities Individual Support and Care Coordination Organizations
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment Plan
DY	Demonstration Year
EQRO	External Quality Review Organization
ESHI	Employer Sponsored Health Insurance
ESRD	End Stage Renal Disease
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHPlus	Family Health Plus
FHP-PAP	FHPlus Premium Assistance Program
FHPBI	FHPlus Buy-In
FPBP	Family Planning Benefit Program
FPL	Federal Poverty Level
F-SHRP	Federal-State Health Reform Partnership
H-MH	Hospital-Medical Home
HCBS	Home and Community-Based Services
ICP	Indigent Care Pool
IPRO	Island Peer Review Organization
LDSS	Local Department of Social Services
LTHHCP	Long Term Home Health Care Program
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MCP	Managed Care Plan
MEDS	Medicaid Encounter Data System
MEG	Medicaid Eligibility Group
MEQC	Medicaid Eligibility Quality Control
MLTC	Managed Long Term Care
MMC	Medicaid Managed Care
MMCARP	Medicaid Managed Care Advisory Review Panel
MMIS	Medicaid Management Information System
MMMC	Mainstream Medicaid Managed Care
MRT	Medicaid Redesign Team
NCQA	National Committee on Quality Assurance
NHTD	Nursing Home Transition and Diversion
NYMC	New York Medicaid Choice
NYS	New York State
OHIP	Office of Health Insurance Programs
PCCM	Primary Care Case Management
PCP	Primary Care Physician or Primary Care Provider
PCMH	Patient Centered Medical Home
PDF	Portable Document Format
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PQI	Prevention Quality Indicators
PPR	Potential Preventable Readmission
QARR	Quality Assurance Reporting Requirements
QI	Quality Incentive/Quality Improvement
QSIP	Quality and Safety Improvement Project
RFA	Request for Application
SAAM	Semi-Annual Assessment of Members
SCHIP	State Children's Health Insurance Program
SCP	Specialty Care Provider
SEIU	Service Employees International Union
SN	Safety Net
SNP	Special Needs Plan
SPARCS	Statewide Planning and Research Cooperative System
SSA	Social Security Act/Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
UAS-NY	Uniform Assessment System for New York
UFT	United Federation of Teachers

1.0 INTRODUCTION

New York State Department of Health (the Department) has experienced great success with its current Medicaid Section 1115 Waivers (Partnership Plan and Federal-State Reform Partnership (F-SHRP) Demonstrations) and is seeking an extension of the Partnership Plan Demonstration in order to continue to realize improvements in access, quality and cost effectiveness. When a state requests an extension of a Medicaid Section 1115 Waiver under the authority of Section 1115(a), (e) or (f) of the Social Security Act (SSA), the Federal Government requires that the state submit an Interim Report describing the progress of the Demonstration to date. To address this requirement, the Department commissioned Island Peer Review Organization (IPRO), an independent not-for-profit company, to prepare this Interim Report.

This report briefly describes the history of New York State's Partnership Plan Demonstration and the Department's strategy to ensure achievement of the goals of enhanced access and coverage, quality improvement and cost neutrality. It then summarizes accomplishments as they pertain to the most significant components of the demonstration. It concludes with a brief overview of recently approved components and pending amendment requests of the demonstration. The period covered by this report, data permitting, is the four years between October 1, 2009 and September 30, 2013.[1]

In preparing this report, IPRO reviewed a wide range of documents including quarterly and annual reports, Special Terms and Conditions, member satisfaction surveys, contract surveillance tools and reports. IPRO also consulted with the Department's senior managers and staff. A complete list of reference materials in provided in Attachment 6, Technical Notes and Reference Materials.

1.1. Partnership Plan Overview

The State's goal in implementing the Partnership Plan is to improve the health status of low income New Yorkers by improving access to health care, improving the quality of health services delivered and expanding coverage to additional low income New Yorkers via the Medicaid program. Through the original Demonstration, the State implemented a mandatory Medicaid Managed Care (MMC) program in counties with sufficient managed care capacity and the infrastructure to manage the enrollment processes essential to a mandatory program. The Demonstration has also enabled the expansion of coverage to certain individuals who would otherwise be without health insurance.

These objectives remain consistent with the State's overall Medicaid Redesign Team Action Plan and the Centers for Medicare and Medicaid Services (CMS) Triple Aim, illustrated in Exhibit 1: The CMS Triple Aim.

[1] This is the period covered by Federal Fiscal Year (FFY) 2009-2010 through FFY 2012-2013, or Partnership Plan Demonstration Years 12 through 15.

Exhibit 1: The CMS Triple Aim

This report focused on four major program components of the Partnership Plan, some of which expired at the end of December 2013:

1. **Mainstream Medicaid Managed Care:** provides Medicaid State Plan benefits through comprehensive managed care organizations (MCOs) to most recipients eligible under the State Plan. MMC expired for Safety Net adults December 31, 2013.
2. **Family Health Plus**: provides a more limited benefit package of Medicaid State Plan benefits, with cost-sharing imposed, for adults with and without children with specified income. Although FHPlus technically ended in December 31, 2013 some enrollees are still in the process of transitioning to alternate coverage.
3. **Family Planning Benefit Program:** provided services to men and women who are in need of family planning services but were otherwise not eligible for Medicaid. FPBP expired December 31, 2013.
4. **Managed Long Term Care**: provides some Medicaid state plan services including personal care and home and community-based waiver services through a managed care delivery system to individuals eligible who require more than 120 days of community-based long-term care services.

1.2. Coverage and Program Expansions

In July 1997, New York State received approval from the CMS (formerly the Health Care Financing Administration) for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times, most recently through December 31, 2013. The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care. There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997:

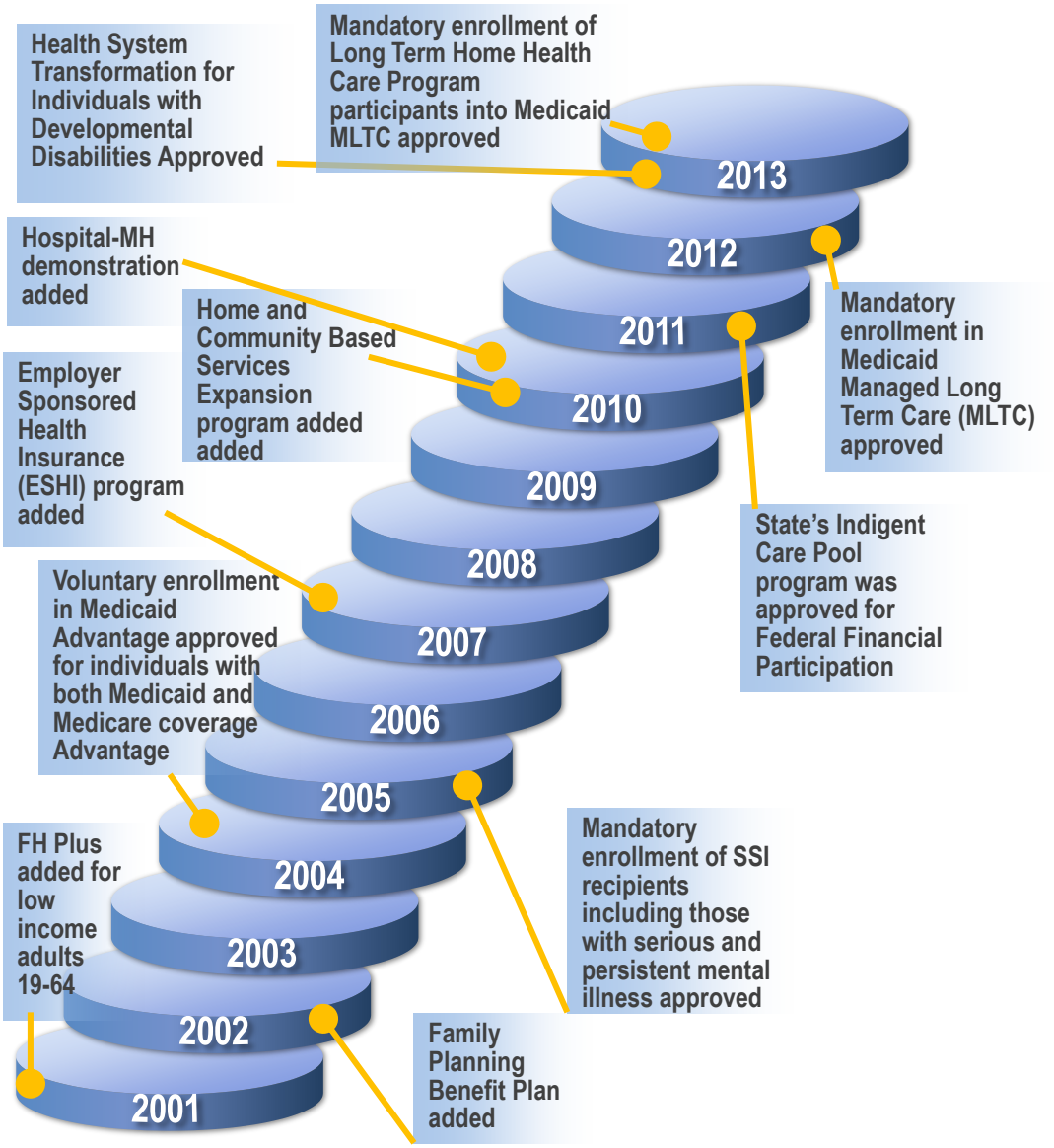
- 2001 – Family Health Plus (FHPlus) was added for low income adults between the ages of 19 and 64 who do not have health insurance, but have incomes too high to qualify for Medicaid.
- 2002 – Family Planning Expansion Program was added to provide family planning services to women who would lose eligibility at the conclusion of their 60-day postpartum period, and to certain other men and women.
- 2004 – Individuals eligible for Medicare and Medicaid were permitted to enroll in Medicaid Advantage.
- 2005 – Mandatory enrollment of the Supplemental Security Income (SSI) population began and was expanded to include those with serious and persistent mental illness.
- 2006 – SSI recipients and new MMC enrollees in 14 counties were moved to the Federal-State Health Reform Partnership (F-SHRP) Waiver.
- 2007 – FHPlus was expanded to include the Employer-Sponsored Health Insurance program.
- 2010 – The Home and Community-Based Services (HCBS) Expansion program was added to provide in-home and community-based services to certain adults with significant medical needs as an alternative to institutional care.
- 2010 – The Hospital-Medical Home (H-MH) demonstration was added to assist outpatient departments in teaching hospitals achieve national standards and certification as Patient Centered Medical Homes (PCMH).
- 2011 – Federal Financial Participation (FFP) was approved for the Indigent Care Pool (ICP) program for clinic uncompensated care.
- 2012 – The Managed Long-Term Care (MLTC) program became mandatory for individuals who require more than 120 days of community-based long-term care.
- 2013 – The transition of Long-Term Home Health Care Program (LTHHCP) participants from New York's 1915(c) Waiver into the MLTC program was approved.
- 2013 – The exclusion of foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled from MMMC was eliminated.
- 2013 – Federal Financial Participation for certain Designated State Health Programs (DSHP) was approved.[2] These include:
    - Health System Transformation for Individuals with Developmental Disabilities and the following twelve programs[3]:

[2] Continuation of these DSHPs is contingent upon discussions with CMS regarding the MRT waiver amendment.
[3] During this period, the Department must submit several deliverables to demonstrate that transformation of the health system for individuals with developmental disabilities is proceeding on schedule.

- Homeless Health Services
- HIV-Related Risk Reduction
- Childhood Lead Poisoning Primary Prevention
- Healthy Neighborhoods
- Local Health Department Lead Poisoning Prevention
- Cancer Services
- Obesity and Diabetes
- TB Treatment, Detection and Prevention
- TB Directly Observed Therapy
- Tobacco Control
- General Public Health Work
- Newborn Screening

A summary of the coverage and program changes is illustrated in Exhibit 2: Summary of Coverage and Program Changes.

Exhibit 2: Summary of Coverage and Program Changes



1.3. Coverage and Programs Ending in 2013 and 2014[4]

As previously mentioned, some Partnership Plan components are scheduled to phase-out or expire in the next year. The status of the Department's requests related to these components is summarized below.

Expired December 31, 2013

- Family Health Plus (FHPlus). As of December 2013, no new applications were accepted. Current enrollees will be transitioned into alternate coverage by April

[4] *http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf*

2014. Individuals renewing coverage between October 2013 and March 2014, if determined eligible, may be authorized coverage for up to twelve months while obtaining alternate coverage, but not to extend beyond December 31, 2014.

- Medicaid Managed Care for Safety Net (SN) adults. The Demonstration Eligible Group Safety Net Adults expires in the Partnership Plan on December 31, 2013. The Department is seeking approval to continue coverage through the Partnership Plan's managed care program for Safety Net Adults through December 31, 2014.
- Indigent Care Pool and Clinic Uncompensated Care Funding. New York has requested an amendment to extend the Indigent Care Pool/Clinic Uncompensated Care Funding. The proposed amendment would extend the federal funding agreement through December 31, 2014.
- Family Planning Benefit Program has been incorporated into the State Plan as a covered service in the State's Medicaid program.

Expiring March 31, 2014

- Medicaid Managed Care. The Department is seeking an extension of Medicaid Managed Care (MMC) until December 2014 in order to: continue enrollment of some populations in the managed care delivery system, transition the nursing home benefit into mainstream managed care, and to integrate behavioral health benefits and populations into managed care.
- HCBS Expansion Program. Extension of the Home and Community-Based Services (HCBS) Expansion Program until the end of the Partnership Plan. The HCBS Expansion Program allows for the provision of cost-effective home and community based services to certain adults with significant medical needs as an alternative to institutional care, and allows for the provision of spousal budgeting for certain populations.
- Facilitated Enrollment. The Department is seeking an extension of these services until December 2014, and permission to offer these services to individuals enrolling in the Child Health Plus program.
- Designated State Health Programs (DHSP). The state has proposed the extension of at least some previously approved DSHPs on a continuing basis. Which of these programs will be extended is subject to further discussion with CMS.

Expiring December 31, 2014

- Hospital-Medical Home Demonstration.

1.4. Goals and Measures of Success

The overarching goals of the Partnership Plan are to expand access to coverage, improved quality and maintain budget neutrality.

1.4.1. Coverage and Access

Measures of success in the areas of coverage and access include enrollment growth, managed care penetration rates, policy changes that affect coverage, the ratio of primary and specialty care physicians to enrollees, action and strategies to inform consumer choice.

1.4.2. Quality

The Department employs a multi-faceted approach to ensuring accountability and improving the quality of care provided to plan enrollees. The Department assesses the program through analysis of the quality and appropriateness of care and services delivered to enrollees, and by monitoring MCO activities on an on-going or periodic basis. Evaluating progress towards meeting objectives is based on a review of data that reflects: health plan quality performance, access to covered services, extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care. Measures used in this approach are largely based on Quality Assurance Reporting Requirements (QARR) – a set of measures based on The National Committee for Quality Assurance's (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), the Medicaid Encounter Data System (MEDS), Prevention Quality Indicators (PQIs)-measures developed by the Agency for Healthcare Research and Quality (AHRQ), Semi-Annual Assessment of Members (SAAM) datasets, as well as, consumer satisfaction surveys including the Consumer Assessment of Health Care Provider Systems (CAHPS®) Survey – a survey instrument that asks health plan members about experiences with access to care, health care providers and health plans.[5] In addition to national measures obtained from these sources, the Department's evaluation includes State-specific measures. State specific sources of data include the Department's Statewide Planning and Research Cooperative System (SPARCS), data reporting from New York Medicaid Choice (NYMC), the State's contracted Managed Care enrollment broker, surveys conducted by its External Quality Review agent, IPRO, and the results of quality improvement initiatives.

1.4.2.1. External Quality Review Surveys and Technical Reports

IPRO, New York State's External Quality Review Organization, conducts multiple surveys of each MCO and prepares a Plan-Specific Report for each. In accordance with federal requirements, these reports are completed every three years. Thus far the reports have been created for the mainstream and HIV/SNP plans with MLTC plans forthcoming. The reports include information on trends in plan enrollment, provider network characteristics, QARR performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies and other on-site survey findings, focused clinical study findings and financial data. Every year, the reports are updated for a subset of this information focusing on strengths and weaknesses.

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[5] The results of the 2013 Survey (Child CAHPS) can be found at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/docs/c_statewide_2013.pdf*** . The results of the 2012 Survey (Adult CAHPS) can be found at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm*** The 2013 Plan-level surveys are available at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/index.htm*** .

The most recent reports published in May 2013 reflect 2012 data. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment and disenrollment data, provider network description, encounter data summaries, quality/satisfaction points and incentive, appeals summaries and financial ratios.[6]

1.4.2.2. Monitoring of Provider Networks

On a quarterly basis, MCOs must also submit updated information on their contracted provider network to the Department. As part of these quarterly reports, MCOs provide information on the number of Medicaid enrollees empanelled to each network Primary Care Physician (PCP). In addition, any material change in network composition must be reported to the State 45 days prior to the change.

Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turnover.

1.4.2.3. Performance Improvement Projects (PIPs)

The Department requires MMC and MLTC plans to conduct one Performance Improvement Project each year and encourages plans to participate in collaborative quality improvement initiatives with other plans.

1.4.3. Budget Neutrality

The Special Terms and Conditions that govern the Partnership Plan Demonstration require that it be budget neutral, that is, it must cost no more than the cost would have been without the changes made as part of the Partnership Plan Demonstration. The formula for determining budget neutrality consists of two components: "Without Waiver" expenditures and "With Waiver" expenditures. Both components include expenditures for six categories of eligible populations:

- TANF children under the age of 1 to age 20,
- TANF adults ages 21 to 64,
- FHPlus adults with children,
- Family Planning Benefit Program participants,
- MLTC adult age 18 to 64 duals, and
- MLTC adult age 65+ duals.

"With Waiver" expenditures consist primarily of medical costs for individuals eligible under the waiver, but also include additional Partnership Plan population groups (Safety Net adults and FHPlus Adults without children) and programs (Home and Community

[6] These reports are available on the New York State Department of Health public website at ***http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports***

Based Services (HCBS) Expansion, Indigent Care Pool Direct Expenditures, and Designated State Health Programs). The additional populations and programs were authorized by CMS with the provision that they be paid for with savings accrued from other Partnership Plan initiatives. The figures for budget neutrality presented in this report already account for the costs of enrolling these additional populations and operating these additional programs. Figures presented reflect net savings. [See Attachment 5, New York State Partnership Plan Projected 1115 Waiver Budget Neutrality Impact through December 2013.]

2.0 MEDICAID MANAGED CARE PROGRAM

The Medicaid Managed Care (MMC) component of the Partnership Plan Demonstration provides comprehensive health care services (including all benefits available through the Medicaid State Plan) to low income uninsured individuals. It offers enrollees the opportunity to select a managed care organization (MCO) whose focus is on preventive health care. The MCO partners with the enrollee's primary care provider to provide primary care case management (PCCM) for the purpose of better coordinating patient care, helping enrollees navigate the medical delivery system and attending to the enrollee's overall health and well-being. The State's original MMC program has enrolled three distinct populations into MCOs as part of the Demonstration:

- Temporary Assistance for Needy Families (TANF) children under age 1 to age 20;
- TANF adults age 21 through 64; and
- Safety Net (SN) adults

2.1. Accomplishments: Coverage and Access

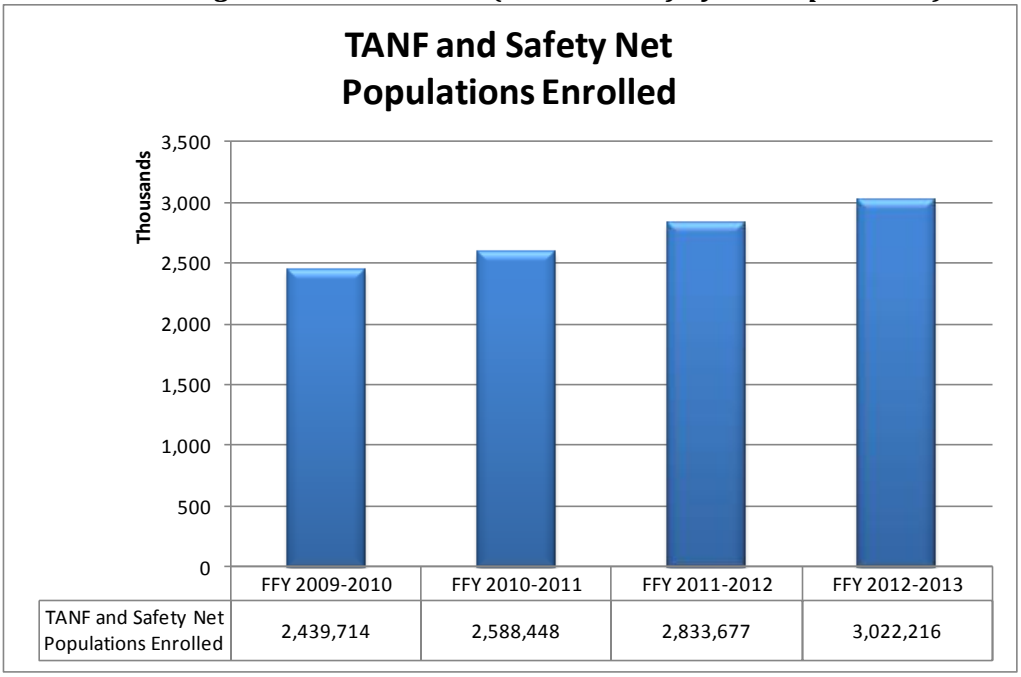
The Medicaid Managed Care (MMC) program accomplishments in the area of coverage and access include increased enrollment, expansion of mandatory enrollment, policy changes to increase access to and continuity of care and meeting standards for primary care practitioner to enrollee ratios.

2.1.1. Increased Enrollment

As of September 2013, New York had enrolled 3 million people in MMC under the Partnership Plan Demonstration.[7] From September 2010 through September 2013, enrollment in the MMC program increased by 23.9 percent, or more than 580,000 beneficiaries statewide, as illustrated in Exhibit 3: Medicaid Managed Care Enrollment (TANF and Safety Net Populations).

[7] This figure only includes individuals enrolled through the Partnership Plan Demonstration. It does not include all Medicaid beneficiaries enrolled in MCOs, such as those enrolled through Family Health Plus (discussed in the following section), the F-SHRP Demonstration, or Managed Long Term Care Plans, as discussed in Section 5.

Exhibit 3: Medicaid Managed Care Enrollment (TANF and Safety Net Populations)



	FFY 2009-2010	FFY 2010-2011	FFY 2011-2012	FFY 2012-2013
TANF and Safety Net Populations Enrolled	2,439,714	2,588,448	2,833,677	3,022,216

2.1.2. Expansion of Mandatory Enrollment

The State's goal of geographic expansion of mandatory MMC to all counties of the state for TANF and SN populations was accomplished in November 2012.

In 2013, the state legislature eliminated all previous exclusions or exemptions from mandatory enrollment into MMC. The Commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits were established, and required Federal approvals were obtained. The State is in the process of establishing and obtaining required Federal approvals for two new types of managed care arrangements within the Medicaid program to address the unique needs of previously excluded populations: Developmental Disability Individual Support and Care Coordination Organizations (DISCOs) for people with developmental disabilities and Health and Recovery Plans (HARPs) for people with behavioral health needs, such as severe and persistent mental illness and substance abuse disorders.

2.1.3. Policy Changes to Increase Access and Continuity of Care

With the approval of CMS, the Department has implemented a number of policy changes to improve quality and efficiency.

- **Eliminated exemption for "look-alike" populations.** In October 2012, the exemption for "look-alike" populations, i.e., individuals with characteristics and needs similar to those receiving services through certain 1915(c) waivers and those

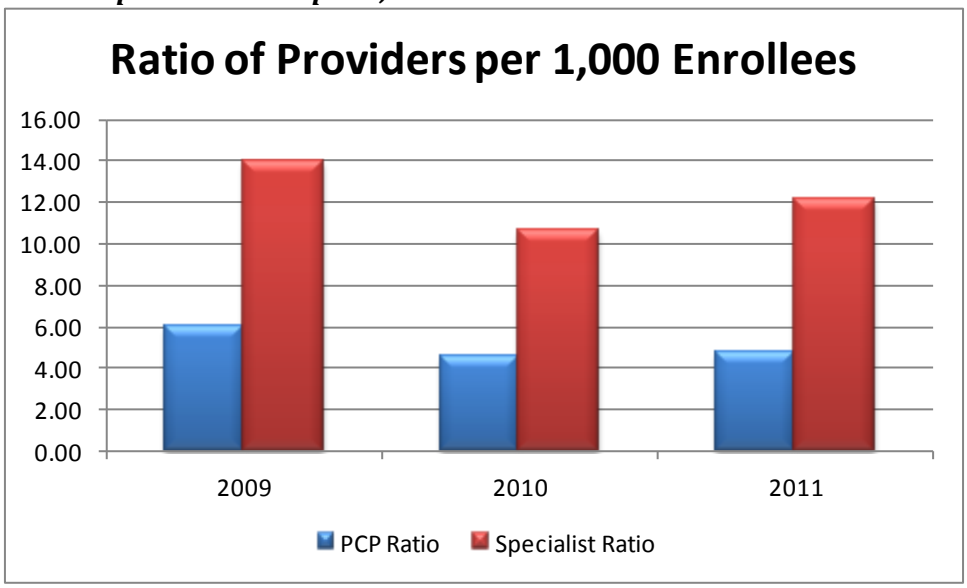
in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) was eliminated.

- **Enrollment of individuals in foster care.** CMS authorized for MMMC enrollment of individuals in foster care who are placed in the community directly by the local department of social services (LDSS). (This does not include: individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution.)
- **Enrollment of individuals in the MBI-WPD program.** CMS authorized managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

2.1.4. Meeting Standards for Primary Care Physician to Enrollee Ratios

The State's MMC program exceeds the standard of one primary care practitioner (PCP) for every 1,500 enrollees. The PCP to 1,000 enrollee ratio increased from 4.54 in 2010 to 4.79 in 2011 while the specialty physician ratio per 1,000 enrollees increased from 10.60 to 12.16 in the same period, as shown in Exhibit 4: PCP and Specialist Ratio per 1,000 Enrollees.

Exhibit 4: PCP and Specialist Ratio per 1,000 Enrollees



The total participation level of PCPs and specialty care physicians (SCPs) in Medicaid Managed Care is nearly twice the number that participated in the Medicaid Fee-For-Service (FFS) program.[8]

[8] Physician participation in Medicaid managed care taken from internal reports generated by the Department of Health, Office of Insurance Program, Division of Health Plan Contracting and Oversight for the years 2009 through 2011.

The number of PCPs between 2009 and 2011 remained relatively stable, at about 17,000 practitioners. The PCP to enrollee ratio dropped significantly from 6.02 per 1,000 in 2009 to 4.79 per 1,000 in 2011. This is likely explained by a large increase in Medicaid Managed Care enrollment which grew 32.2 percent, from 2.9 million in 2009 to 3.8 million in 2010 and then decreased to 3.5 million in 2011. A similar pattern occurred for specialist physicians. [9]

The Department monitors physician participation in both Medicaid MCOs and the Medicaid fee-for-service program. In recent years, the Department has taken significant steps to increase physician participation in the Medicaid program. For example:

- In 2009, the State increased physicians' fees by 80 percent over the 2007 levels.
- In August 2012, the State awarded $2 million in grants under the Doctors Across New York (DANY) Physician Loan Repayment and Practice Support program, which assists in the training and placement of physicians in rural and inner-city areas where a shortage of health care providers has been identified.[10]
- As part of its waiver amendment request, New York has requested $250 million in order to broaden the DANY's program and expand the Primary Care Service Corp, which focuses on recruiting non-physician primary care providers to underserviced areas as well as to support other key workforce recruiting and retention programs for underserved areas. In the near term, the Department believes these efforts will make a substantial contribution to closing the nearly 1,100 primary care physician gap as well as gaps in other primary care and some specialty physician occupations. [11]

2.2. Accomplishments: Quality

The MMC program accomplishments include exceeding national standards for quality outcomes, MCOS engaged in the required annual performance improvement projects, indications of enrollee satisfaction, activities to support informed choice and engage stakeholders, and an increase in the number of MCOS receiving quality incentive payments.

2.2.1. Exceeding National Standards for Quality Outcomes

New York exceeds the national standards for quality outcomes. New York has met or exceeded 89 percent of the national QARR benchmarks and 87 percent of the 2007 measures[12]. (See Attachment 1 for the New York State 2012 comparison with the national benchmarks and with the 2007 New York State measures). IPRO asked the Department to

[9] New York State Department of Health, Office of Health Insurance Programs, August 20, 2012.
[10] More information about the increase in physician reimbursement can be found at: ***http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/presentations/vendor-7_22_2009.pdf***. The press release announcing the DANY grant awards can be found at ***http://www.health.ny.gov/press/releases/2012/2012-08-30_state_health_department_award.htm***.
[11] ***http://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf***
[12] For the overall Medicaid managed care quality strategy see: http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

explain the strategy for improving the measures that did not meet or exceed the national standards. In a communication from the Department's Office of Quality and Patient Safety, February 27, 2014, it cited the multifaceted strategy the Department uses to improve quality. These include:

- Publish quality data comparing plans to encourage MCOs to use this information in the competitive marketplace;
- Produce consumer guides that use quality data comparing MCOs to support consumer choice (see Section 2.2.4. below);
- Use quality data as a basis for determining financial incentives (see Section 2.2.5. below); and,
- Working with poorly performing individual MCOs to improve quality through application of root cause analysis and the development of a corrective action plan.

Other activities that contribute to quality improvement include focused clinical studies, Performance Improvement Projects, and collaborative efforts to prevent, or improve treatment of, chronic diseases.

2.2.2. MCOs Engaged in the Required Annual Performance Improvement Projects

The Department and IPRO, the State's External Quality Review organization (EQRO), work together to engage Managed Care Plans in annual Performance Improvement Projects (PIPS). From 2009 – 2010, eighteen (18) plans participated in a PIP focused on improving the prevention of childhood obesity. From 2011- 2012 MCOs engaged in two collaborative projects. The first, Eliminating Disparities in Asthma Care, engaged five (5) health plans in Brooklyn. The second, Reducing Potentially Preventable Readmissions, engaged ten (10) health plans from across the state. An additional three (3) health plans, examined various topics: timely case management; retaining HIV/AIDS members with CD4 counts more than 200; and enhancing smoking cessation interventions. Of the ten (10) plans working to reduce readmissions, five (5) successfully met their pre-study goals; the other five (5) did not. Of the five (5) plans testing strategies to eliminate disparities in asthma care, four (4) successfully met their goals and one (1) did not. The one plan investigating timely case management was successful in meeting pre-study goals; the plan utilizing strategies to retain members was also successful; and the plan attempting to enhance smoking cessation did not meet their goals.

The PIP project for the study period 2013-2014, has two parts. Part 1, Medicaid Incentives for the Prevention of Chronic Disease, includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in four clinical areas: diabetes prevention, diabetes management, smoking cessation and hypertension management. Part 2 focuses on implementing interventions to improve care in one of the four clinical areas noted above. These projects are still in progress. A majority of health plans are working on diabetes management. All MCOs are participating in Part 1, while eighteen MCOs are participating in Part 2.

2.2.3. Indications of Enrollee Satisfaction

In general, Medicaid beneficiaries enrolled in managed care report satisfaction with their care and experiences. A comparison of the satisfaction ratings from the CAHPS® 4.0 surveys of adults conducted in 2009, 2011, and again in 2013 suggests a slight trend toward increasing enrollee satisfaction with Medicaid Managed Care plans, see Exhibit 5: Comparison of 2009, 2011, and 2013 MMC Satisfaction Ratings.

Exhibit 5: Comparison of 2009, 2011, and 2013 MMC Satisfaction Ratings

QARR 2012 Medicaid Managed Care Satisfaction Ratings, 2009, 2011, and 2013			
Measure of Satisfaction	**2009 Ratings**	**2011 Ratings***	**2013 Ratings** (Preliminary)**
Getting Needed Care	74	75	78
Care Coordination	74	68	78
Customer Service	80	81	82
Getting Needed Counseling or Treatment	66	71	70
Rating of Overall Healthcare	65	67	71
Getting Care Quickly	77	76	78
Rating of Treatment or Counseling	57	59	61
Rating of Health Plan	69	71	76
Wellness Discussion	52	55	71

2012 New York State Managed Care Plan Performance, p.110,* ***http://www.health.ny.gov/publications/3346_2012.pdf* for 2009 and 2011 ratings.

**Preliminary 2013 satisfaction ratings are from the 2013 CAHPS® 4.0 survey of adult MMC enrollees. This data was received via communication with Office of Quality and Patient Safety, February 27, 2014. This data is scheduled to be published during the second quarter of 2014.

2.2.4. Activities to Support Informed Choice and Engage Stakeholders

A *Medicaid Managed Care Regional Consumer Guide* has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at ***http://www.health.ny.gov/health_care/managed_care/consumer_guides/***

To support informed choice for the consumer, the state has contracted with facilitated enrollment service contractors to provide health insurance information to interested individuals and afford the opportunity for interested individuals to apply for health care coverage. The Department contracts with facilitated enrollers in a variety of setting which includes MCOs, health care providers, community-based organizations, and other entities. Local departments of social services, which are ultimately responsible for determining Medicaid eligibility for people living in their jurisdictions, monitor facilitated enrollment service contractors by to ensure that choice counseling activities are provided to those seeking information and to minimize adverse risk selection.

The Department has established processes and forums for stakeholder engagement. It has established a Managed Care Operational Issues Workgroup which provides an open forum

for the discussion and clarification of operational issues related to Medicaid Managed Care.[13]

A Medicaid Managed Care Advisory Review Panel (MMCARP) appointed by the Governor and the New York State legislature generally meets on a quarterly basis. This Panel was established to assess and evaluate multiple facets of the MMC Program, including provider participation and capacity, enrollment targets, phase-in of mandatory enrollment, the impact of marketing, enrollment and education strategies, and the cost implications of exclusions and exemptions.

The Department also reports to stakeholders through webinars, conference calls, and surveys.

2.2.5. Increase in the Percentage of MCOs Receiving Quality Incentive Payments

In 2002, the Department began rewarding MMC plans that have superior performance by adding up to an additional 3.0 percent to plan per member per month (PMPM) premiums. This Quality Incentive (QI) program uses a standardized algorithm to awards points to plans for high quality in the categories of: Effectiveness of Care, Access and Availability and Use of Services. Points are deducted for any Statements of Deficiency (SOD) issued for lack of compliance with managed care requirements. Assessment of quality and satisfaction are derived from HEDIS® measures in NYS's QARR, satisfaction data from CAHPS®, and from Prevention Quality Indicators (PQIs).[14]

The following table, from the Department's 2012 Quality Strategy Report, provides a summary of the number of plans that received the maximum incentive percentage, a partial incentive, and no incentive, as well as the expenditures associated with the awards.

Number of Plans	QI 2007	QI 2008	QI 2009	QI 2010	QI 2011	QI 2012
Full Award (3% PMPM)	2	3	1	1	1	2
Partial Award (any tier between full and none)	12	17	13	13	11	10
No Award (0%	11	3	6	4	6	6

[13] Minutes of the Managed Care Operational Issues Workgroup can be found at: ***http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_and_man_care_workshop.htm***

[14] ***https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map;jsessionid=D1521FA4C421803E144AD3F5739A9E64***

PMPM)						
Dollars (million)	**$62.3**	**$76.7**	**$49.5**		**$159.5**	**$181**

Quality Strategy for the New York State Medicaid Managed Care Program 2012, Department of Health, OQPS, November 30, 2012; p.15.

The percentage of New York's Medicaid Managed Care plans receiving a quality incentive payment increased from 56.0 percent in 2007 to 66.7 percent in 2012.[15]

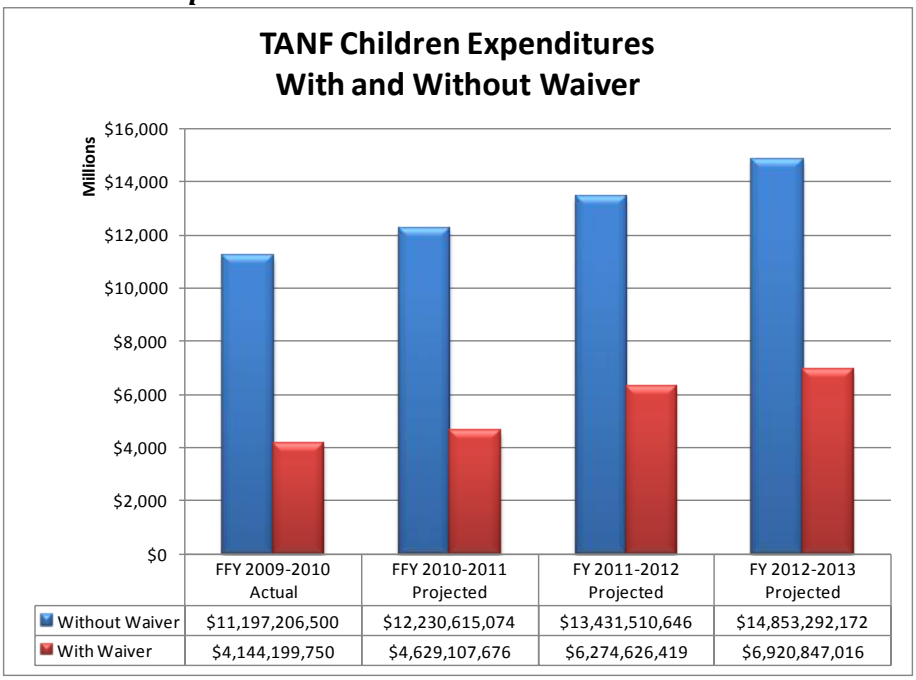
To collect the information underlying the QI program as well as other ratings of performance, the Department conducts multiple surveys a year per MMC plan. An Access and Availability survey is conducted once per year, a Provider Directory survey is conducted twice per year, a Member Services survey is conducted quarterly and a Primary Care Ratio Access Validation survey is conducted quarterly. The Access and Availability and Provider Directory surveys are tied to the QI program algorithm.

2.3. Accomplishments: Cost

From a cost effectiveness standpoint, the MMC program has been highly successful. Accomplishments include projected savings for both TANF children and TANF Adults.

For TANF children, expenditures without the waiver would have been 235 percent greater. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded $29.7 billion in projected savings, as illustrated in Exhibit 6: TANF Children Expenditures.

Exhibit 6: TANF Children Expenditures

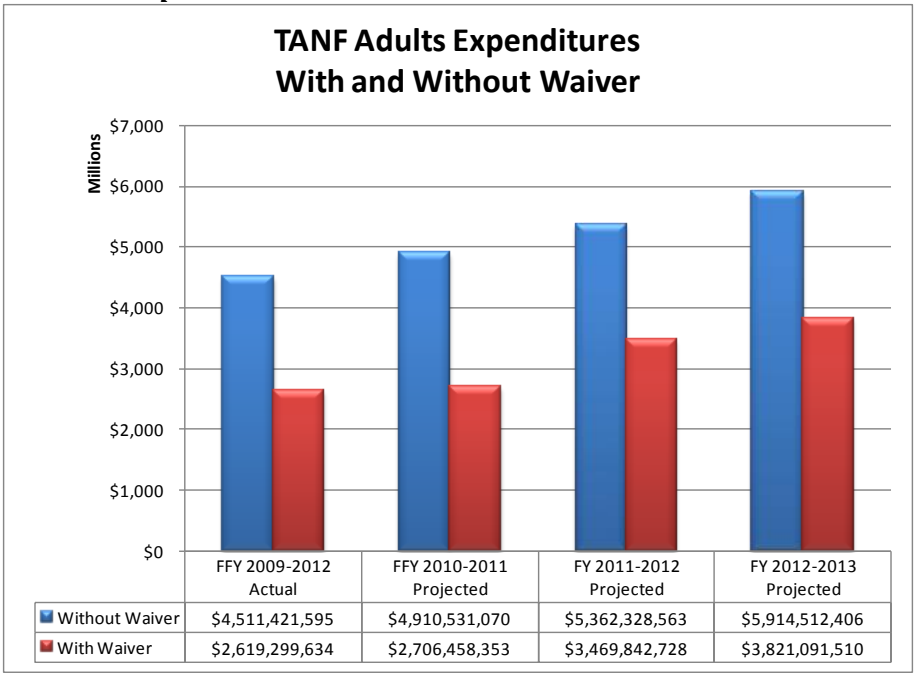


	FFY 2009-2010 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected	FY 2012-2013 Projected
Without Waiver	$11,197,206,500	$12,230,615,074	$13,431,510,646	$14,853,292,172
With Waiver	$4,144,199,750	$4,629,107,676	$6,274,626,419	$6,920,847,016

[15] ***https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf***

For TANF adults, expenditures without the waiver would have been nearly 164 percent greater than with the waiver. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded nearly $8.1 billion in projected savings for the TANF adult population, as illustrated in Exhibit 7: TANF Adults Expenditures.

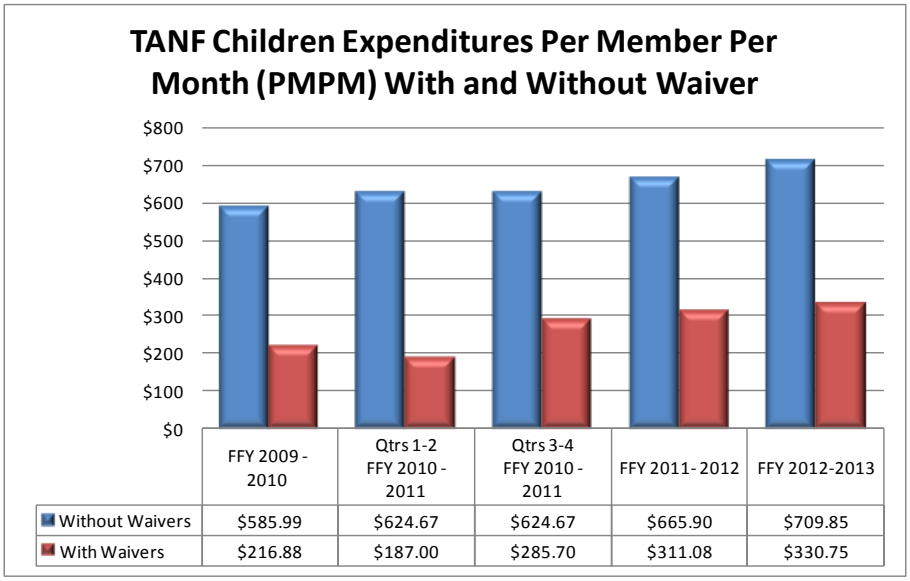
Exhibit 7: TANF Adults Expenditures



	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected	FY 2012-2013 Projected
Without Waiver	$4,511,421,595	$4,910,531,070	$5,362,328,563	$5,914,512,406
With Waiver	$2,619,299,634	$2,706,458,353	$3,469,842,728	$3,821,091,510

Per Member Per Month (PMPM) payments for TANF children without the waiver would have been a projected 215 percent greater than with the waiver in FFY 2012-0213, as illustrated in Exhibit 8: TANF Children PMPM.

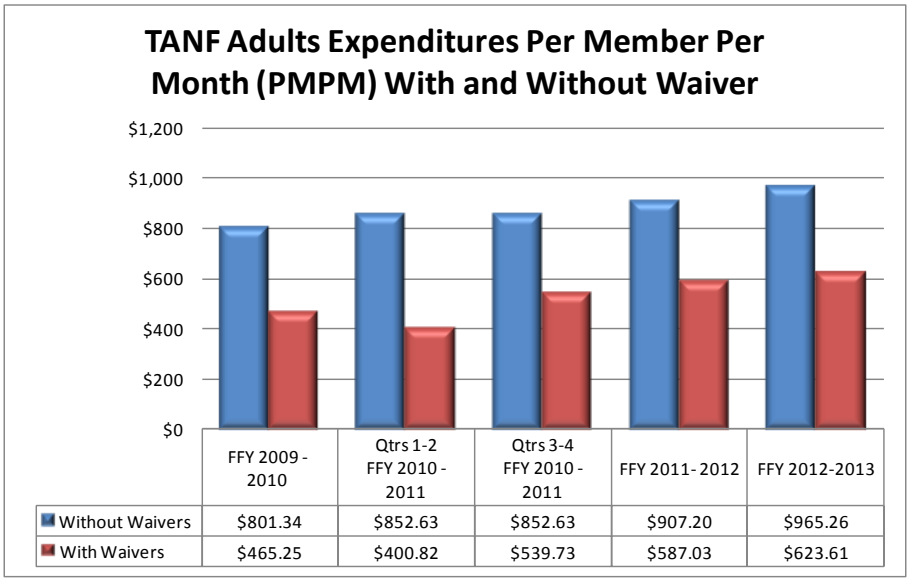
Exhibit 8: TANF Children PMPM



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$585.99	$624.67	$624.67	$665.90	$709.85
With Waivers	$216.88	$187.00	$285.70	$311.08	$330.75

Similarly, for TANF adults the PMPM payments would be a projected 155 percent higher without the Partnership Plan, as illustrated in Exhibit 9: TANF Adults PMPM.

Exhibit 9: TANF Adults PMPM



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$801.34	$852.63	$852.63	$907.20	$965.26
With Waivers	$465.25	$400.82	$539.73	$587.03	$623.61

Taking these two waiver demonstration groups (TANF children and adults) together, total projected savings for the period FFY 2009-2010 through FFY 2012-2013 are $37.8 billion.

3.0 FAMILY HEALTH PLUS

Family Health Plus (FHPlus), enacted by the State legislature in December 1999 and approved by CMS in May 2001, is a public health insurance program for adults aged 19 to 64 who have income too high to qualify for Medicaid. Due to changes under the Affordable Care Act (ACA), the FHPlus program is being phased out. Beginning January 1, 2014, individuals were asked to apply for health insurance coverage through the New York State health insurance marketplace; the State is no longer accepting applications for the program.

The primary objective of the FHPlus program is to improve access to care. It is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories. FHPlus was provided through participating MCOs and provided comprehensive coverage, including prevention, primary care, specialty care, hospitalization, prescriptions and other services. There were minimal co-payments for FHPlus services.

3.1. Transition from FHPlus to Medicaid Under ACA

Approximately 90 percent of current program enrollees will transition to Medicaid State Plan coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. This transition will occur for most program enrollees when their eligibility is renewed.

Family Health Plus adults without children were transferred to an Alternative Benefit Plan on January 1, 2014. Family Health Plus adults with children with income up to 138 percent FPL will transition to the Alternative Benefit Plan as they renew on and after April 1, 2014. Family Health Plus adults with children with incomes between 138 percent and 150 percent FPL will transition to a qualified health plan.

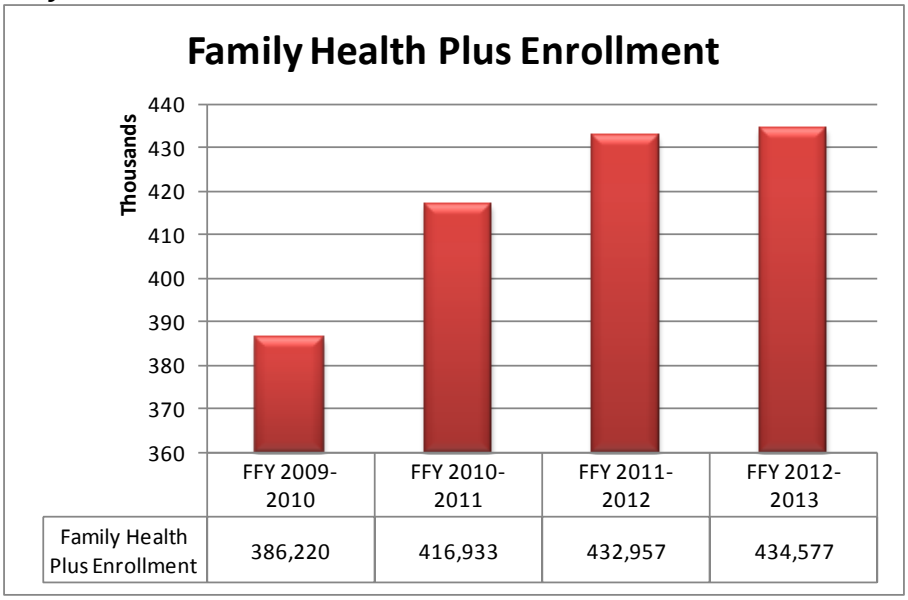
3.2. Accomplishments: Coverage and Access

The FHPlus program accomplishments in the area of coverage and access include a significant expansion of coverage, and enrollment growth in the Employer Sponsored Health Insurance Initiative (ESHI).

3.2.1. Significant Expansion of Coverage

FHPlus has resulted in a significant expansion of coverage to previously uninsured and underinsured New Yorkers. At the end of FFY 2012-2013, program enrollment was nearly 435,000. In the last four years of the program, enrollment increased more than 12.5 percent. The growth in enrollment is illustrated in Exhibit 10: Family Health Plus Enrollment.

Exhibit 10: Family Health Plus Enrollment



	FFY 2009-2010	FFY 2010-2011	FFY 2011-2012	FFY 2012-2013
Family Health Plus Enrollment	386,220	416,933	432,957	434,577

Note: Enrollment figures are for the two Demonstration populations (eligible adults with children and adults without children) for the period FFY 2009-2010 through FFY 2012-2013.

3.2.2. Enrollment Growth in the Employer Sponsored Health Insurance Initiative

To further increase coverage rates among uninsured but employed New York State residents with access to private insurance, State legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative (ESHI) through the FHPlus Premium Assistance Program (FHP-PAP). This program helps low-income workers who are eligible for FHPlus to access insurance offered by their employers. It allows the State to recognize the savings by maximizing the use of private, employer sponsored insurance coverage.

Enrollees in FHP-PAP are entitled to the services that FHPlus covers but which are not covered by ESHI plans, such as dental services and prescription drugs. These services are sometimes referred to as "wrap around benefits." The State requires that FHPlus eligible individuals who have access to ESHI enroll in FHP-PAP. Adults in this program use ESHI as their primary insurance policy. The State reimburses deductibles and co-pays to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

Enrollment in the FHPlus-PAP program has also grown fairly rapidly from 1,800 to 3,080 in the period from FFY 2009-2010 through June of FFY 2012-2013.[16]

[16] Although data about cost-effectiveness of the FHP-PAP program was not obtainable, a cost effectiveness determination was required for each applicant. The first test is to confirm that the ESHI includes the eight essential "benchmark" services. If all services were included in the ESHI plan, the application proceeds to the second test. If all benchmark services were not provided, payment of this insurance was denied and the applicant was enrolled in FHPlus and referred to a participating managed care plan. For the second test, the cost effectiveness calculation accounted for the cost of the ESHI premiums, deductibles, and co-payments. The calculator determined if the cost of the ESHI premium plus the cost of

At the end of FFY 2012-2013, there were also 1,239 unsubsidized United Federation of Teachers (UFT) members enrolled in the FHPlus Buy-In program. For child care workers who are eligible for Medicaid or FHPlus, the premium is paid by the state. The FHPlus Buy-In Program ended December 31, 2013.

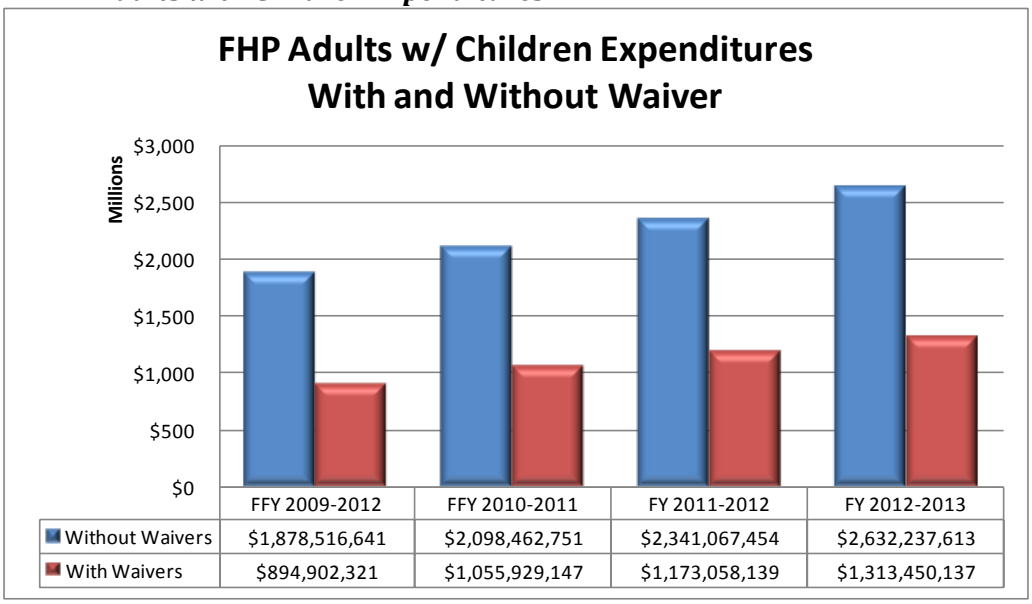
3.3. Accomplishments: Quality

The FHPlus program performed above the national average of on a majority of quality measures. A comparison of the national HEDIS® quality measures for 2012 with FHPlus QARR data for 2011 indicates that FHPlus performed above the national average for 91 percent of the quality measures (i.e., 21/23 measures).[17] Impressively, for several of these measures the FHPlus performance score was much greater than the HEDIS® national average. For example, the Breast Cancer Screening measure indicates that nationally Medicaid HMOs are only at 52 percent while FHPlus is at 72 percent. This large difference is also evident with testing for COPD, postpartum care, and ambulatory follow-up for mental illness. (See Attachment 2, FHPlus QARR/HEDIS National Benchmark 2012 Comparison.)

3.4. Accomplishments: Cost

The FHPlus program accomplishments in the area of cost are confirmed by expenditure data. In the absence of the Partnership Plan, projected expenditures for FHP Adults with Children population would have doubled, as illustrated in Exhibit 11: FHP Adults with Children Expenditures.

Exhibit 11: FHP Adults with Children Expenditures



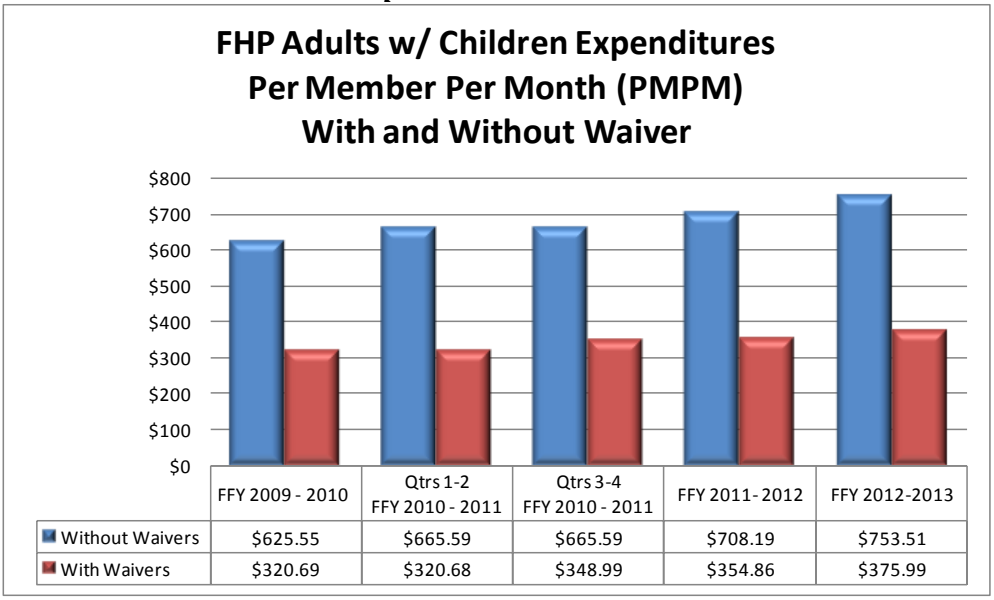
	FFY 2009-2012	FFY 2010-2011	FY 2011-2012	FY 2012-2013
Without Waivers	$1,878,516,641	$2,098,462,751	$2,341,067,454	$2,632,237,613
With Waivers	$894,902,321	$1,055,929,147	$1,173,058,139	$1,313,450,137

the Medicaid wrap-around services (optional services not included in the ESHI plan), deductibles and co-payments were less than the regional FHPlus managed care rates for adults and Medicaid managed care rates for eligible children.

[17] The HEDIS® data was taken from the NCQA *The State of Health Care Quality 2012*; specifically, the Medicaid HMO section which represents data from 2011.

Consistent with overall expenditures, PMPM payments with waiver are approximately half the amount of PMPM payments without the waiver, as illustrated in Exhibit 12: FHP Adults with Children Expenditures.

Exhibit 12: FHP Adults with Children Expenditures



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$625.55	$665.59	$665.59	$708.19	$753.51
With Waivers	$320.69	$320.68	$348.99	$354.86	$375.99

From a cost effectiveness standpoint, FHPlus has been highly successful. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded an estimated $4.5 billion in savings.

4.0 FAMILY PLANNING BENEFIT PROGRAM

The intent of the Family Planning Benefit Program (FPBP), also known as the Family Planning Expansion Program, is to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies. [18]

FPBP has been moved into the Medicaid State Plan.

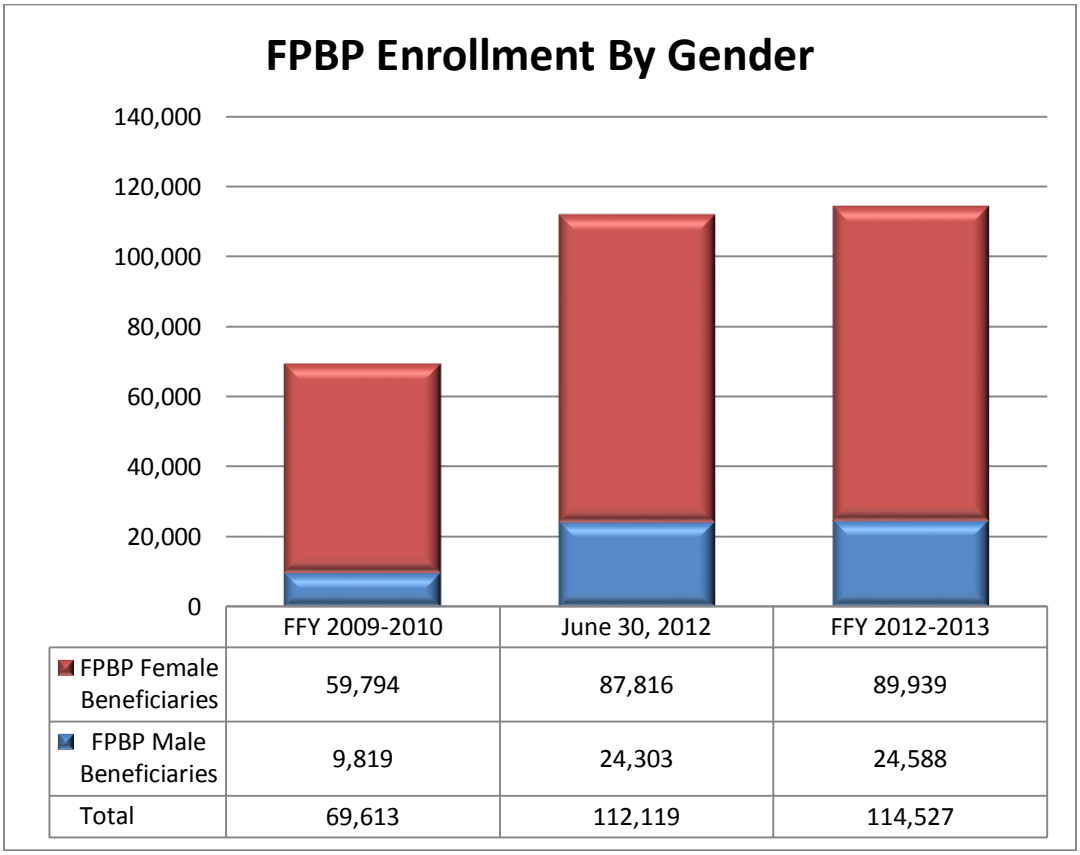
4.1. Accomplishments: Coverage and Access

FPBP accomplishments in the area of coverage and access are significant enrollment growth in program participation and a reduction in unintended pregnancies.

4.1.1. Significant Enrollment Growth

FPBP participation has grown quickly from 69,613 in 2009 to 114,527 by the end of September 2013, as illustrated in Exhibit 13: FPBP Enrollment.

Exhibit 13: FPBP Enrollment



	FFY 2009-2010	June 30, 2012	FFY 2012-2013
FPBP Female Beneficiaries	59,794	87,816	89,939
FPBP Male Beneficiaries	9,819	24,303	24,588
Total	69,613	112,119	114,527

[18] This program provides only family planning and family planning-related services to men and women with net incomes at or below 200 percent of the FPL who are not otherwise eligible for Medicaid and to women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum. Once eligible, participants remain eligible for the program for 12 months and recertification is required.

4.1.2. Reduction in Unintended Pregnancies

The FPBP contributed to more than 5,300 averted pregnancies in 2011.[19]

4.2. Accomplishments; Quality

While there has not been an evaluation of clinical quality that has focused specifically on the FPBP beneficiary population, the State has taken steps to ensure and improve program quality by ensuring that program policies, procedures and referral lists are in place. The State has also introduced policy changes to ensure that the federal Medicaid share is claimed appropriately. For example, changes were made to procedure and billing codes in both 2008 and 2010. These changes help to ensure that only CMS-approved family planning procedures are claimed for FPBP and that the federal share is claimed appropriately.

4.3. Accomplishments: Cost

The FPBP program accomplishments in the area of cost are suggested by a significant reduction in avoided delivery costs. The program has averted more than 5,300 births in 2011. The average cost of a Medicaid delivery in New York State in 2011 was $6,800.[20]

[19] NYSDOH, Office of Health Insurance Programs, January 28, 2013.
[20] NYSDOH, Office of Health Insurance Programs, Data Mart (Claims as of December-2013).

5.0 MANAGED LONG TERM CARE (MLTC)

As part of its overall strategy to better coordinate care for high need Medicaid beneficiaries, New York has mandated that dual eligible Medicare and Medicaid recipients who are in need of home and community based care for more than 120 days enroll in a Managed Long Term Care Plan.

The program's goals are:

- Improved care coordination for Medicaid's highest risk/highest cost population.
- Improved patient safety and quality of care for consumers.
- Reduced preventable acute hospital and nursing home admissions.
- Improved satisfaction, safety and quality of life for consumers.

In August 2012, the Department received CMS approval to mandate enrollment for dual eligible recipients, 21 years of age or older. In April 2013, the state received CMS approval to mandate enrollment into a MLTC plan for dually eligible Long Term Home Health Care Program (LTHHCP) participants over age 21. The mandate only applies to counties which have a choice of plans and is currently effective, on a phase-in implementation schedule in all five boroughs of New York City, and Nassau, Suffolk or Westchester Counties. Dually eligible LTHHCP participants aged 18 to 20 and non-duals of any age may voluntarily enroll.

The initiative offers beneficiaries a choice of three (3) models of MLTC plans: partially capitated; the Program of All-Inclusive Care for the Elderly (PACE); and, Medicaid Advantage Plus (MAP). Both PACE and MAP include Medicare and Medicaid covered services in the benefit package and require the participant to be nursing home eligible; partially capitated plans include only Medicaid covered benefits. Recipients must choose a plan to receive services. If no choice is made, the recipient is enrolled into a partially capitated plan.

In order to ensure a smooth transition of the thousands of Medicaid recipients who were previously accessing services through the State's fee-for-service programs, such as the Medicaid Personal Care Program, the Department opted to phase-in the mandate geographically. Phase I began in June 2012 in New York City[21]; Phase II began in January 2013 in Nassau, Suffolk and Westchester counties; Phase III began in September 2013 in Rockland and Orange counties; and, Phase IV began December 2013 in Albany, Erie, Onondaga, and Monroe counties. Phase V is scheduled to begin April 2014 in Columbia, Putnam, Sullivan and Ulster counties.

[21] Phase I beneficiary notifications began prior to final CMS approval.

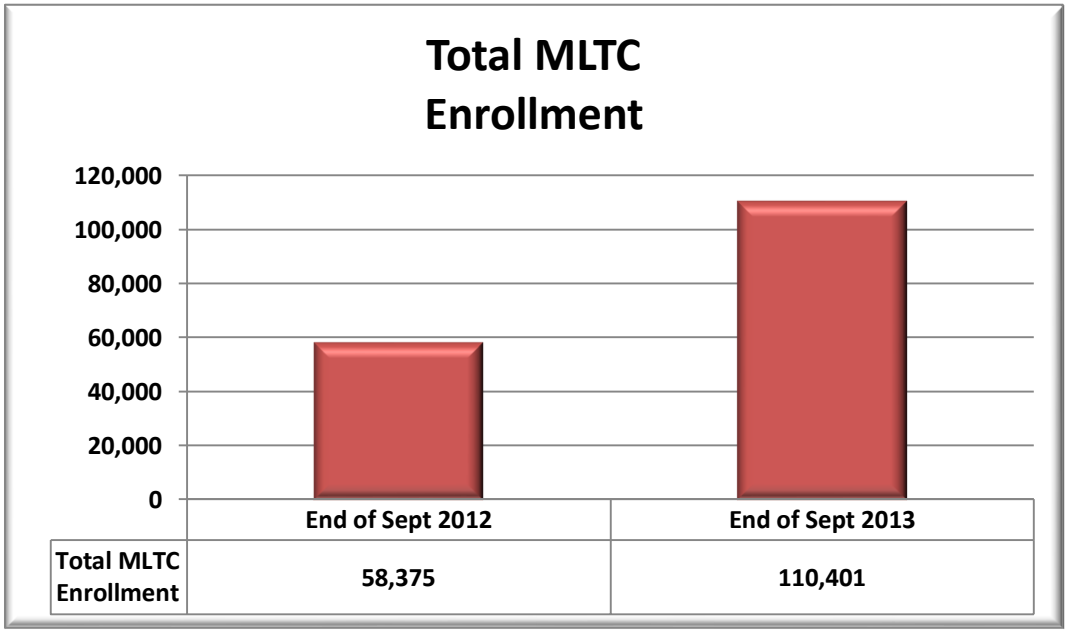
5.1. Accomplishments: Access and Coverage

Accomplishments in the areas of access and coverage include increased enrollment and the availability of information to inform choice.

5.1.1. Increased Enrollment

As of September 2013, there were 110,401 people enrolled in the State's Medicaid Managed Long Term Care program. From September 2012 through September 2013, enrollment in the MLTC program has increased by 89 percent, as illustrated in Exhibit 14: Managed Long Term Care Enrollment.

Exhibit 14: Managed Long Term Care Enrollment



5.2. Accomplishments: Quality

Accomplishments in the area of quality[22] include member satisfaction surveys being completed, continuity of care for all services provided under the plan of care transition from FFS to managed care, the introduction of a standardized assessment and activities to support informed choice and engage stakeholders.

5.2.1. Member Satisfaction Surveys Being Completed

The Department conducts an annual survey of member satisfaction. The most recent survey was distributed to a random sample of members from 25 MLTC plans. The response rate was 27 percent. The survey results are available on the Department's web

[22] For the overall Medicaid managed care quality strategy see:
http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

site and select measures are available by plan in the regional Consumer Guides[23] and will be available in the 2013 Managed Long-Term Care Report.

5.2.2. Continuity of Care in Personal Care Provider During Transition to Managed Care

To better understand member's experiences as they transition from FFS to MLTC, New York's Enrollment Broker, New York Medicaid Choice, conducted a post enrollment Outreach survey which contains questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86 percent of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86 percent of the respondents are receiving services from the same home attendant (personal care) agency[24].

The Department has also commissioned IPRO to conduct an additional survey focused on members' initial experiences with their new health plan. IPRO will also be analyzing measure of quality, timeliness and access to care, before and after the member joined the plan. A random sample of 1,500 newly enrolled members was selected to receive the survey. The survey was mailed in November, 2013. Survey results will be available in 2014.

5.2.3. Introduction of a Standardized Assessment

The Department has made a significant investment in standardizing needs assessments across all of its home and community-based long term care programs. As of October 2013, all MLTC plans use the Uniform Assessment System for New York (UAS-NY. The UAS-NY is a web-based, uniform data set based on the InterRAI Minimum Data Set (MDS). It provides a comprehensive assessment of an individual's health status, strengths, care needs, and preferences to guide the development of individualized long-term care service plans.

5.2.4. Activities to Support Informed Choice and Engage Stakeholders

A *Medicaid Managed Care Regional Consumer Guide* has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at ***http://www.health.ny.gov/health_care/managed_care/consumer_guides/***

To support informed choice for the consumer, the Department has contracted with Maximus, New York Medicaid Choice, to act as an Enrollment Broker in geographic areas targeted for transition to MLTC. The enrollment broker provides information to consumers related to all MLTC plans regarding provision of service and network providers both to assist informed choice and to minimize adverse risk selections by Medicaid recipients. The

[23] The Report in available on the Department's website at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/*** , and select measures are reported in the Regional Consumer Guides at ***http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/***

[24] Partnership Plan Annual Report for DemonstrationYear:15(10/1/2012-9/30/2013), December 2013.

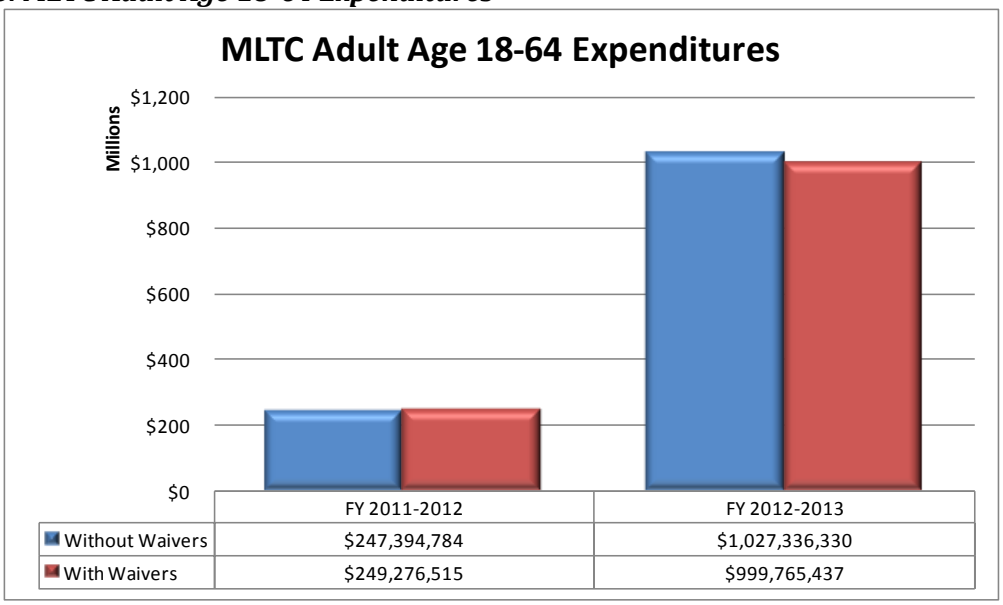
enrollment broker also provides both stakeholder and provider training throughout the state. The Department monitors choice counseling activities as well as training for stakeholders, providers and Local Department of Social Services staff to ensure accuracy of information shared.

5.3. Accomplishments: Cost

The Managed Long Term Care program meets the budget neutrality requirement. Projected expenditures for both population groups served by the program Adults Age 18-64 Duals and Adult Age 65 + duals are lower than they would have been without the Partnership Managed Long Term Care Program. As illustrated in Exhibit 15: MLTC Adult Age 18-64 Expenditures:

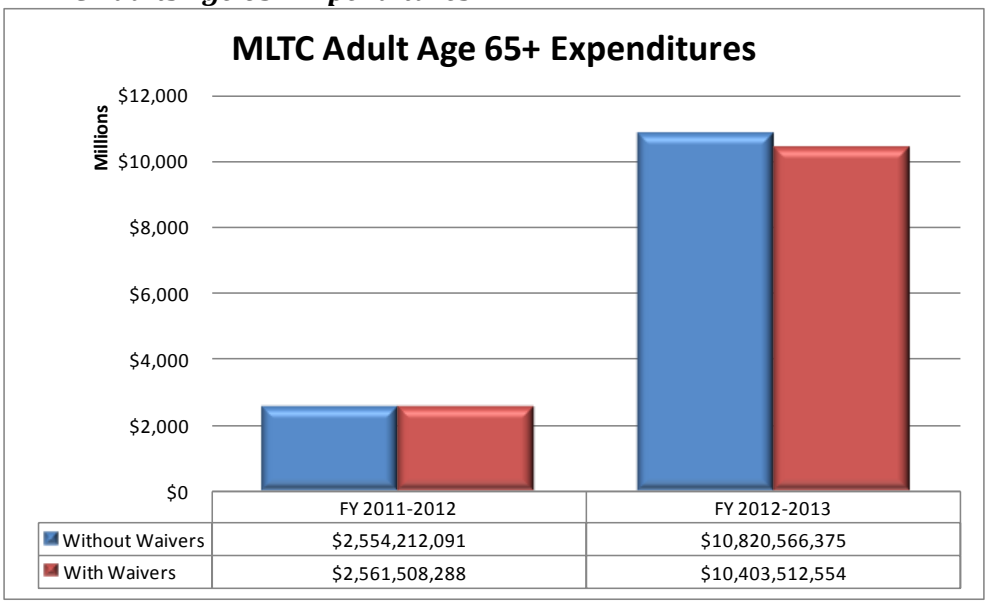
For MLTC Adults Age 18-64 Duals, expenditures without the waiver would have been 2.1 percent greater than with the waiver. For the one year period FFY 2011-2012 through FFY 2012-2013, the waiver has yielded $25.7 million in projected savings.

Exhibit 15: MLTC Adult Age 18-64 Expenditures



For the MLTC Adult population Age 65+ Duals, expenditures would have been 3.2 percent greater. For the two year period FFY 2011-2012 through FFY 2012-2013, the waiver has yielded $409.7 million in projected savings, as illustrated in Exhibit 16: MLTC Adults Age 65+ Expenditures.

Exhibit 16: MLTC Adults Age 65+ Expenditures



The difference between per member per month (PMPM) payments with the waiver and without the waiver is consistent with the analysis of program expenditures for both MLTC age groups. As illustrated in Exhibit 17: MLTC Adult Age 18-64 Expenditures PMPM and Exhibit 18: MLTC Adult Age 65+ PMPM Expenditure:

For the MLTC population Age 18-64, PMPM payments without the waiver are projected to be 2.8 percent greater than with the waiver in FFY 2012-2013. For the MLTC population Age 65+, PMPM payments without the waiver are projected to be 4.0 percent greater than with the waiver in FFY 2012-2013.

Exhibit 17: MLTC Adult Age 18-64 Expenditures PMPM

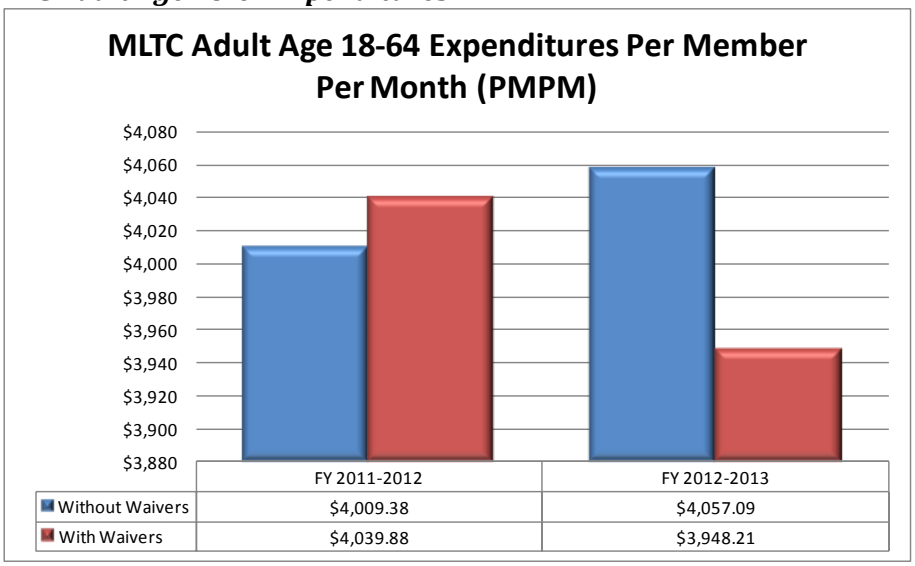
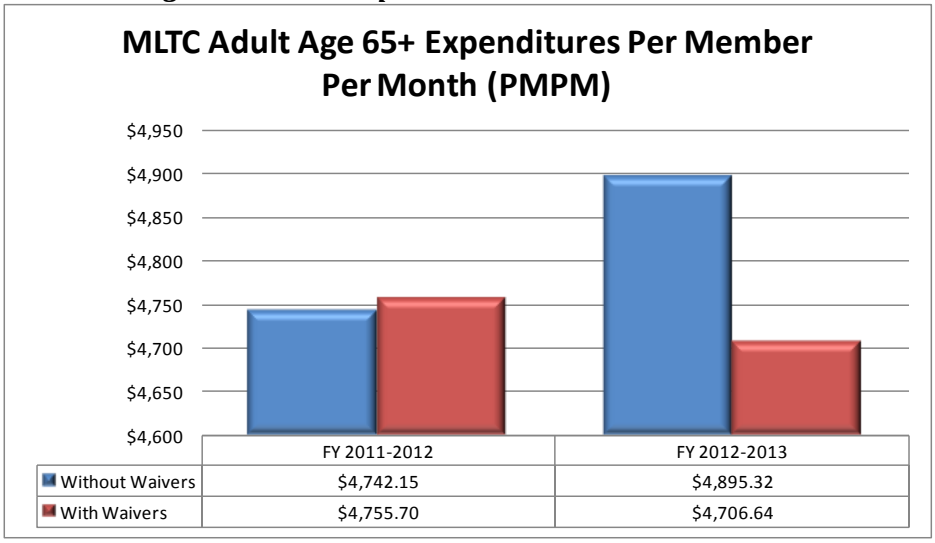


Exhibit 18: MLTC Adult Age 65+ PMPM Expenditure



Taking these two waiver demonstration groups together, total savings for the period FFY 2011-2012 through FFY 2012-2013 are projected to be $435.4 million.

6.0 OTHER NOTABLE PARTNERSHIP PLAN COMPONENTS

6.1. Home and Community-Based Services Expansion Program

The Home and Community-Based Services (HCBS) Expansion program eliminated a barrier to receiving care at home posed by eligibility rules that would otherwise lead to spousal impoverishment. The program allows special spousal budgeting provisions. [25]
This program is available in three waiver demonstrations: the Nursing Home Diversion and Transition Program, the Traumatic Brain Injury Program and the Long Term Home Health Care Program.

More than 1,400 Medicaid beneficiaries have gained access to home and community-based services as a result of the HCBS Expansion program.

For the period from April 1, 2011 through September 30, 2013 total projected program expenditures of $11,097,324.

6.2. Indigent Care Pool/Clinic Uncompensated Care Funding

Up until 2012, the Department provided state funded grants to voluntary, non- profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured through the state's Health Care Reform Act (HCRA) for the D&TC Indigent Care Pool (ICP) program. In 2012, CMS authorized Federal Financial Participation (FFP) for the state's program to address clinic uncompensated care through its ICP. In order to received ICP funds, each facility must have a comprehensive range of primary health care or mental health care services; provide at least 5 percent of their visits to uninsured individuals; and have a process to collect payments from third-party payers.

Cumulative disbursements through June 30, 2013, total $153.9 million of which $76.9 million was FFP.

6.3. Hospital-Medical Home Demonstration[26]

The Hospital-Medical Home (H-MH) Demonstration is designed to improve primary care quality, continuity and coordination in ambulatory care settings associated with primary care residency training programs. Goals include better care of chronic disease, increased preventive screenings and immunizations, increased access to care for acute conditions, better health for individual Medicaid members seen in training clinics, and improved performance on population health. A second overarching goal of the demonstration is to

[25] Under normal Medicaid eligibility rules, spouses living together at home are treated as a household of two and the basic two-person income and resource standards are applied. However, under SSA § 1924, when an institutionalized person with a spouse in the community applies for Medicaid, special spousal budgeting provisions allow the community spouse to retain a specified amount of the couple's combined income and resources. This Federal policy is intended to prevent the community spouse, who is legally responsible for the institutionalized spouse, from becoming impoverished by exhausting all of the couple's resources to help pay for institutional care.
[26] As of this writing, reports on only three quarters of the first year of the demonstration are available with many participating programs lagging in submitting reports. IPRO considers the data available to be insufficient for evaluative purposes.

prepare primary care residents for the new primary care job description: team-based, patient-centered, continuous care, with a focus on care transitions and population health.

Sixty-two New York State teaching hospitals and 119 primary care residency programs operating in 162 outpatient primary care sites are participating in this program[27]. Roughly, 1 in 3 physicians-in-training in New York State will be trained in PCMH principles and care coordination through this project, and more than half of all teaching hospitals and 25 percent of total hospitals in New York State are participating.

Hospitals submitted work plans in December 2012 for review and began their approved projects in January 2013. Hospitals are required to work on specific projects related to improving resident training, measuring health outcomes, care coordination, and improving the quality and safety of inpatient health care. In addition, participating hospitals are implementing at least two of six evidence-based Quality and Safety Improvement Projects (QSIPs). Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. These QSIPs are:

- Severe Sepsis Detection and Management;
- Central Line-Associated Bloodstream Infection Prevention;
- Surgical Complications Core Processes;
- Venous Thromboembolism Prevention and Treatment;
- Neonatal Intensive Care Unit Safety and Quality; and,
- Avoidable Preterm Births.

Participating hospitals are required to achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by July 2014.[28] This demonstration expires December 31, 2014.

[27] A list of participating hospitals and primary care residency programs is included as Attachment 4.
[28] The date for achieving this recognition was changed from March 2014 to July 2014.

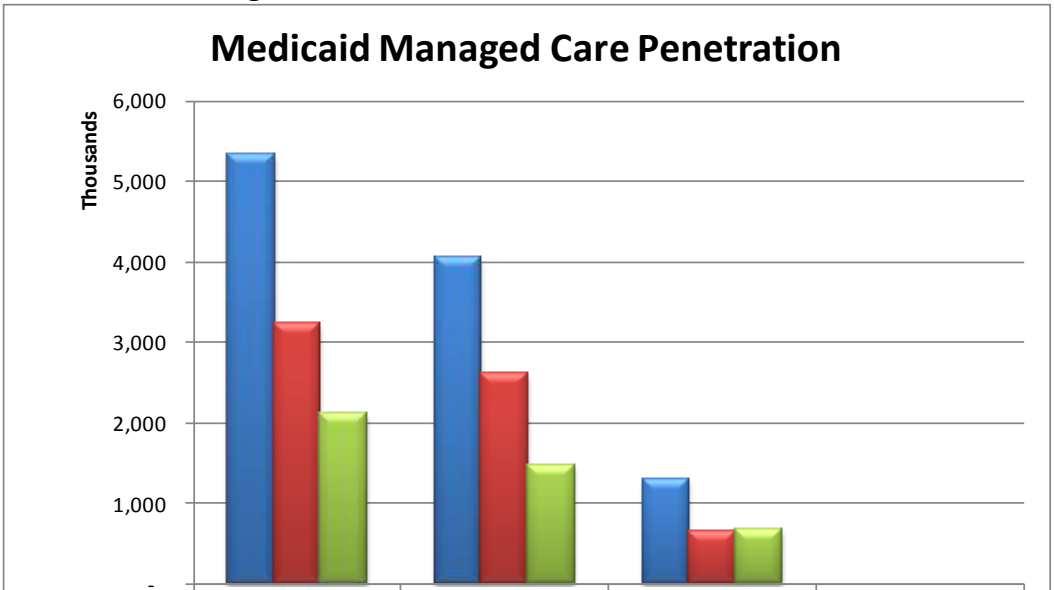
7.0 CONCLUSION AND NEXT STEPS

The Partnership Plan Demonstration has significantly expanded health care coverage to previously underinsured and uninsured populations. It has also prepared New York State to take a lead role in implementing federal health care reform initiatives supported by the ACA and to continue moving forward with compatible reforms such as expanding managed care enrollment, developing innovative ways to expand health care coverage, and improving the quality of care.

7.1. Penetration Rates

More than 4 million of the State's 5.3 million Medicaid recipients are enrolled in managed care. As of December 2013, the penetration rate of Medicaid recipients enrolled in managed care was 75.9 percent of total Medicaid enrollment statewide (80.7 percent in New York City and 68.7 percent in the rest of the State), as illustrated in Exhibit 19: Medicaid Managed Care Penetration Rates.

Exhibit 19: Medicaid Managed Care Penetration Rates



	Total Medicaid Enrollment	Managed Care	Fee for Service	Rate
Statewide	5,339,347	4,054,806	1,284,541	75.94%
NYC	3,220,083	2,598,758	651,325	80.70%
Rest of State	2,119,264	1,456,048	663,216	68.71%

The 24 percent of Medicaid enrollment still receiving care on a fee-for-service basis is comprised of populations that to this point are either not subject to mandatory enrollment or excluded from MMC. The state is addressing this issue by:

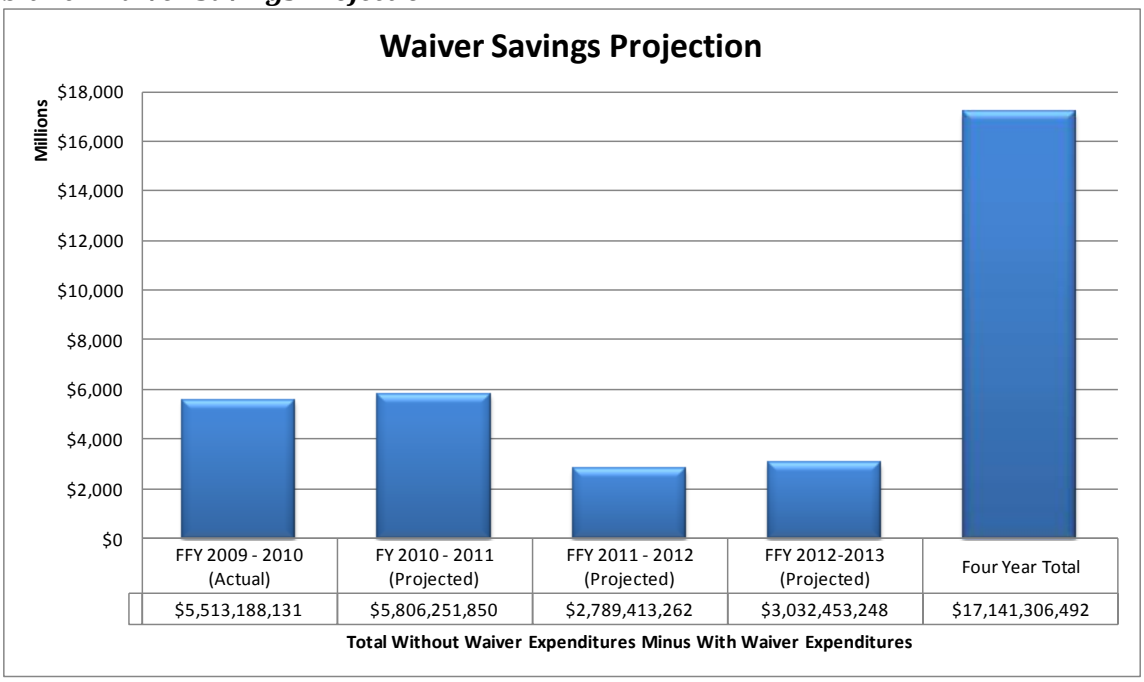
- Continuing the geographic expansion of MLTC mandatory enrollment (see Section 5.0., above);

- Continuing the implementation of the Fully Integrated Dual Advantage (FIDA) Demonstration to bring dually eligible individuals (Medicaid and Medicare) into fully-integrated managed care products.
- Continuing the implementation of the Health System Transformation for Individuals with Intellectual and Developmental Disabilities component of the Partnership Plan Demonstration (see Section 7.3.1., below); and,
- Amending the Partnership Plan to allow MCOs to include Medicaid enrollees with behavioral healthcare needs (see Section 7.3.3., below).

7.2. Cost Effectiveness

Between October 1, 2009 and September 30, 2013, the Department projects that the waiver will have saved an estimated $17.1 billion (The Department's budget neutrality impact analysis is appended as Attachment 5), as illustrated in Exhibit 20: Waiver Savings Projection, below.

Exhibit 20: Waiver Savings Projection



Review of the Department's budget neutrality analysis for the Partnership Plan indicates that the Department has been successful in producing savings for both the State and federal Medicaid programs. Implementation of the MMC mandate and the addition of FHPlus have successfully demonstrated that moving low income populations out of Fee for Service (FFS) care and into managed care models is cost effective with expenditures well below the level that would have been expected without the Partnership Plan Demonstration, as illustrated in Exhibit 21: Partnership Plan: Summary of Key Accomplishments.

Exhibit 21: Partnership Plan: Summary of Key Accomplishments

DEMONSTRATION GOALS	ACHIEVED?	KEY ACCOMPLISHMENTS
Goal 1: To expand managed care enrollment	✓	1. MMC enrollment increased by 23.9 percent between September 2010 and September 2013 2. MLTC enrollment increased by 89 percent between September 2012 and September 2013
Goal 2: To improve health care access for Medicaid beneficiaries in New York	✓	3. PCP ratio increased from 4.54 in 2010 to 4.79 in 2011 per 1,000 enrollees while specialty physicians ration per 1,000 enrollees increased from 10.6 to 12 in the same period. 4. All QARR measures of adult access to care improved between 2010 and 2012.
Goal 3: To continue to improve the quality of care	✓	5. State measures met or exceeded national measures in 2012 NCQA QARR. 6. 91 percent of the national quality benchmarks met for FHPlus.
Goal 4: Expanded Health Care Coverage	✓	7. FHPlus enrollment increased by 12.6 percent between September 2009 and September 2013.
Waiver Requirement: Budget Neutrality	✓	8. Projected Medicaid savings of approximately $17.1 billion over the last four years

Building on these key accomplishments, the State is taking further steps to improve access, quality and cost efficiency in the Medicaid Program and is working closely with CMS to obtain approval to reinvest some of the savings from the Partnership Plan and complimentary activities implemented as part of the State's Medicaid Redesign Action plan into the new initiatives described in the next section.

7.3. New Initiatives

The following initiatives are in the initial implementation phase or have yet to gain CMS approval. Therefore, more detailed analysis of program activities, performance and progress is not available at this time.

7.3.1. Health System Transformation for Individuals with Developmental Disabilities

The Health System Transformation for Individuals with Intellectual and Developmental Disabilities component of the Partnership Plan Demonstration is intended to identify goals that will improve opportunities for individuals with intellectual and developmental disabilities in the areas of employment, integrated living, and self-direction of services. The Department's Transformation Agreement[29] with CMS specifies expenditure authority beginning April 1, 2013 through March 31, 2014 and describes the following goals for this transformation including:

- Developing new service options to better meet the needs of individuals and families in a person-centered paradigm, including allowing for more self-direction of services;

[29] The Transformation Agreement can be found at ***http://www.opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment***

- Creating a specialized managed care system that recognizes the unique needs of people with disabilities, and is focused on a habilitative model of services and supports;
- Ensuring that individuals with disabilities live in the most integrated community settings;
- Increasing the number of individuals who are competitively employed; and
- Working to make funding in the system sustainable and transparent.

The Transformation Agreement also specifies a schedule of deliverables to submit to CMS that serve as milestones in the areas of self-direction, competitive employment and deinstitutionalization. This schedule is represented in the table below.

Transformation Agreement Deliverables Submitted to CMS	
April 2013	Waiver applications submission (1915(c) amendment and 1915(b) application)
	Approved protocol for Money Follows the Person
May 2013	Submit educational/training materials for participant self-direction
	Report on the baseline count of enrollees receiving supported employment (8,773) and the number of people in competitive employment (5,882)
	Draft Cost Containment Strategy submitted
June 2013	No new admissions to sheltered workshops (Directive, FAQ and other guidance issued in June)
July 2013	First Quarterly Report on Transformation Agreement deliverables 1,500 stakeholders educated on self-direction (actual number 1,844) • Assisted in the transition of 8 residents out of Finger Lakes and Taconic ICFs • Report on the baseline of workshop enrollees • Report on baseline of individual self directing
	Draft Evaluation Plan
August 2013	Draft de-institutionalization transition timeline (campus and non-campus ICFs to community settings)
	Draft accountability plan
	Draft cost containment strategy
September 2013	Draft Balancing Incentive Program Work Plan – baseline housing data, assurance of compliance with HCBS settings standards, review process for person-centered planning
	Progress Report – Practice Guidelines for CQL Personal Outcome Measures in care coordination

Transformation Agreement Deliverables Submitted to CMS	
October 2013	Draft Plan for Increasing Participation in Competitive Employment
	Second Quarterly Report on Transformation Agreement deliverables • Increased the number of new beneficiaries self-directing by 394, meeting the goal of 350 new beneficiaries self-directing their services by October 1, 2013 • Educated 1,500 additional stakeholders about self-direction • Assisted in the transition of 23 residents out of Finger Lakes and Taconic ICFs • Increase of 273 individuals engaged in competitive employment.

As of September 30, 2013, the state had met all scheduled deliverables to CMS.[30]

7.3.2. The Delivery System Reform Incentive Payment Plan

The Department is in the final stages of negotiating approval from CMS for a five year waiver amendment to the Partnership Plan for its proposed Delivery System Reform Incentive Payment Plan (DSRIP). By reinvesting some of the federal savings that have been achieved though MRT initiatives, the Department proposes to invest $7.3 billion to rebalance the delivery system as well as reduce hospitalizations and emergency department use by 25 percent over the next five years.

The Department plans to assist safety net institutions by allowing them to both downsize unneeded inpatient capacity as well as to transform service delivery systems to provide the right mix of services necessary in the communities in which they serve. In addition, the programs would help community-based providers expand and provide additional, vital services so that lower cost alternatives to inpatient care and emergency room services are available statewide. DSRIP is designed to encourage collaboration among providers in order to reduce system fragmentation.

7.3.3. Behavioral Health System Transformation

In December 2013, the Department submitted an amendment to the Partnership Plan to enable qualified MCOs to more comprehensively meet the needs of participants with behavioral health needs. The Department is proposing to integrate all Medicaid covered services for mental illness, substance use disorders, and physical health conditions. The state plans to enroll adult populations with serious and persistent mental illness and substance use disorders, in specialty lines of business within the qualified mainstream MCOs, called Health and Recovery Plans (HARPs).

The goals of this managed care service delivery model are to improve clinical and recovery outcomes for enrollees, slow the growth in costs through a reduction in unnecessary emergency and inpatient care, and increase MCO capacity to deliver community-based recovery services and supports.

[30] Transformation expenditures under the Partnership Plan are not included in budget neutrality calculations.

ATTACHMENT 1. MEDICAID MANAGED CARE (MMC) QARR/NATIONAL BENCHMARK COMPARISON OF 2012 DATA & COMPARISON OF MMC QARR 2007 AND 2012 DATA

Medicaid Managed Care QARR/National Benchmark Comparison of 2012 Data &Comparison of MMC QARR 2007 and 2012 Data

Seventeen Medicaid Managed Care (MMC) plans submitted 2012 QARR data in June 2013. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for QARR 2007 and 2012 are displayed in the following table and QARR 2012 data is also compared with the NCQA HEDIS® National benchmark measures for 2012 Medicaid HMOs in the NCQA *The State of Health Care Quality 2013*. For comparative purposes, the measures listed in the table are limited to those that are common to either both QARR 2007 and 2012 or both QARR 2012 and the HEDIS® 2012 data. For the QARR Reports, Medicaid plans submitted 2012 data in June 2013 and 2007 data in June of 2008.

New York's MMC Care 2012 average exceeded the 2007 average for 27 of 31 measures as indicated by a check mark (☑) in the fourth column. New York's 2012 average exceeded the national benchmarks for 31 of 35 measures as indicated by a check mark (☑) in the sixth column (**gray** cells indicate that national benchmarks were not available, and **yellow** cells indicate that 2007 measures were not available).

Measure	2012 NYS Medicaid Managed Care (MMC) Average	2007 NYS Medicaid Managed Care (MMC) Average	2012 MMC Measures Above the 2007 NYS Average	National HEDIS 2012 Medicaid HMO Average*	2012 MMC Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	93	88	✓	88	✓
Children and Adolescents' Access to PCPs Ages 12-24 months	97	95		96	✓
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	93	90	✓	88	✓
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	96	93	✓	90	✓
Follow-Up for ADHD Medication: Continuation Phase	63	59	✓	45	✓
Follow-Up for ADHD Medication: Initiation Phase	57	53	✓	39	✓
Adults' Access to Care Age 20-44 Yrs	84	80	✓		
Adults' Access to Care Age 45-64 Yrs	90	87	✓		
Adults' Access to Care Age 65 and over	90	88	✓		
Adult BMI Assessment (ABA)	79			68	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	79	77	✓	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	65	60	✓	44	✓
Antidepressant Medication Management-180 Day Effective Continuation Phase Treatment	37	29	✓	37	
Antidepressant Medication Management-84 Day Acute Phase Treatment	53	46	✓	53	
Drug Therapy in Rheumatoid Arthritis	78	74	✓	70	✓
Use of Imaging Studies for Low Back Pain	78	81		76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	24	27		24	
Cervical Cancer Screening	71			65	✓
Chlamydia Screening (Ages 16-20)	71	53	✓	55	✓
Chlamydia Screening (Ages 21-24)	73	60	✓	64	✓
Frequency of Ongoing Prenatal Care 81-100%	70			60	✓

Measure	2012 NYS Medicaid Managed Care (MMC) Average	2007 NYS Medicaid Managed Care (MMC) Average	2012 MMC Measures Above the 2007 NYS Average	National HEDIS 2012 Medicaid HMO Average*	2012 MMC Measures Above the National Average
Controlling High Blood Pressure (Ages 18-85)	63			56	✓
Persistence of Bete-Blocker Treatment After a Heart Attack	77			82	
Breast Cancer Screening	68	68		52	✓
Annual Monitoring for Patients on Persistent Medications-ACE inhib/ARBs	92	85	✓	86	✓
Annual Monitoring for Patients on Persistent Medications-Anticonvulsant	68	65	✓	66	✓
Annual Monitoring for Patients on Persistent Medications-Combined	90	84	✓	85	✓
Annual Monitoring for Patients on Persistent Medications-Digoxin	93	91	✓	90	✓
Annual Monitoring for Patients on Persistent Medications-Diuretics	91	84	✓	86	✓
Pharmacotherapy Management of COPD Exacerbation-Bronchodilator	88	77	✓	82	✓
Pharmacotherapy Management of COPD Exacerbation-Corticosteroid	72	50	✓	65	✓
Appropriate Testing for Pharyngitis	87	73	✓	68	✓
Postpartum Care	70			63	✓
Timeliness of Prenatal Care	88			83	✓
Use of Spirometry Testing for COPD	53	40	✓	32	✓
Appropriate Treatment for URI	93	89	✓	85	✓
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	82	81	✓	72	✓
Adolescent Well-Care Visits	59	58	✓	50	✓
Total Indicators	***38***	***31***	***27***	***35***	***31***

N/A - not applicable to the product
QARR 2013 data from Partnership Plan Annual Report (10/1/2012-9/30/2013), pp.28-30
**National benchmarks from NCQA's 2013 State of Health Care Quality report*

ATTACHMENT 2. FAMILY HEALTH PLUS 2011 QARR/HEDIS® NATIONAL BENCHMARK 2011 COMPARISON

Family Health Plus 2011 QARR/National Benchmark 2011 Comparison

The Department provided IPRO with Family Health Plus (FHPlus) data[31] disaggregated from the full Medicaid Managed Care plan QARR data. IPRO constructed the following table to represent a comparison of the national HEDIS® quality measures to the FHPlus data where these measures were in common.

As indicated in the final column of the table below, FHPlus exceeded the national quality metric for 91.3 percent of the measures (i.e., 21/23 measures).[32] New York's scores are notably higher than the national average in some areas. For example, New York's Medicaid Managed Care plans completed recommended Breast Cancer Screening for 72 percent of FHP enrollees compared to the national average of 50 percent. This large difference is also evident with testing for COPD, postpartum care, and ambulatory follow-up for mental illness. For the few measures that are not above the national metric, NYS was within five percentage points with the exception of adolescent well-care visits at a seven percentage point difference.

[31] Family Health Plus data was taken from the 2012 New York State Demographic Variation in Medicaid Managed Care,.
[32] The HEDIS data was taken from the NCQA *The State of Health Care Quality 2013*; specifically, the Medicaid HMO section which represents data from 2012.

Measure	2011 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2011 Medicaid HMO Average*	FHPlus Measures Above the National Average
Adult BMI Assessment (ABA)	70	53	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	86	65	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	75	47	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	35	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	53	51	✓
Drug Therapy in Rheumatoid Arthritis	81	69	✓
Use of Imaging Studies for Low Back Pain	78	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	29	24	✓
Cervical Cancer Screening	74	67	✓
Frequency of Ongoing Prenatal Care 81-100%	77	61	✓
Controlling High Blood Pressure (Ages 18-85)	69	57	✓
Breast Cancer Screening	72	50	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	91	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	61	65	
Annual Monitoring for Patients on Persistent Medications- Combined	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	91	90	✓
Annual Monitoring for Patients on Persistent Medications- Diuretics	89	85	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	82	80	✓
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	73	64	✓
Postpartum Care	77	64	✓
Timeliness of Prenatal Care	92	83	✓
Use of Spirometry Testing for COPD	58	32	✓
Adolescent Well-Care Visits	43	50	
Total Indicators	***23***	***23***	***21***

ATTACHMENT 3. NEW YORK STATE DEPARTMENT OF HEALTH COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS

ORGANIZATION & MANAGEMENT	
QUESTION	**CITATIONS**
1. Does the plan have an effective mechanism for input by enrollees to the board of directors?	98-1.17(a)(4)
2. Is the board of directors comprised of at least 1/3 of New York State residents and are at least 20% MCO members? Are member representatives, or in the case of a PHSP, consumer representatives from an advisory council representing the membership, given prior notice and invited to board meetings? In the case of an HIV SNP, is there at least one person with HIV infection serving as a consumer representative? Note: Article 43s with Article 44 lines of business do not need to comply with this requirement.	98-1.6(a) 98-1.11 (g) (1),(2)
3. Does the MCO have any new board members, managers of an LLC, officers, or medical director? Has the MCO notified the department of those new individuals and the names of those individuals that are leaving their positions?	98-1.5 (b)(2)(ii)
4. Does the board of directors meet to conduct business at least four times a year, once in each quarter?	98-1.6(a)
5. If the plan has a management contract: (a) Does the MCO retain its authority in key areas described in 98-1.11(i)? (b) Has the contract received Health Department approval?	98-1.11(i) 98-1.11(j) 98-1.11(k)
6. Does the MCO conduct audits or other monitoring activities of its management contractors?	98-1.11(h) MMC/FHP Contract: Sections 22.1, 22.4(b), 22.5(a),(i), Appendix R(5)
7. (a) Is there evidence that the governing authority is responsible for the establishment and oversight of the MCO's policies, management and overall operation? (b) Do board minutes reflect that the board is managing its operation?	PHL §4404(1) 98-1.11(h)

QUALITY ASSURANCE	
QUESTION	**CITATIONS**
8. Does the MCO have a comprehensive quality management program that is approved by the MCO board of directors and the Department?	98-1.12
9. Does the MCO's medical director supervise the quality and utilization management programs?	98-1.12(a) 98-1.2(bb)
10. (a) Does the MCO have an internal quality assurance committee? (b) Does the committee composition include healthcare providers and other appropriate MCO staff? (c) Is the Board kept apprised of quality management activities by the QA committee? Is there evidence that the board is actively involved in the oversight of the quality management program?	98-1.12(e) 98-1.12(f)(1) 98-1.12(i)
11. What sources and strategies does the MCO use to identify and examine actual and potential problems in health care administration?	98-1.5(b)(16) 98-1.12(a), (b), (c), (g), (h) 98-1.12(f)(2) MMC/FHP Contract Sections 10.4, 16.2, 35.7
12. Does the MCO develop and implement appropriate recommendations and corrective actions to address problems identified?	98-1.12(i), (j)
13. How does the MCO evaluate whether problem areas are resolved?	98-1.12(a) 98-1.12(f)(iv) 98-1.12(i)(1), (2), (3) 98-1.12(j)(1), (2), (3)
14. Does the MCO have a peer review committee responsible for monitoring provider performance?	98-1.12(f)(2)
15. What method is used by the MCO to determine the clinical study(ies) that should be undertaken by the MCO to improve the health of its enrollees?	98-1.12(g)
16. Has the plan integrated QARR results into their ongoing procedures?	98-1.12 (b), (i) MMC/FHP Contract Section 18.5(a)(x)
17. Does the plan have a case management program for individuals with chronic diseases and for high risk pregnant women to promote coordination of care amongst providers and other support services?	MMC/FHP Contract Sections 10.19 10.20 98-1.13(h)
18. Does each member have a primary care provider who is responsible for managing and facilitating care?	98-1.13 (d), (h) MMC/FHP Contract Sections 21.8, 21.11

QUALITY ASSURANCE	
QUESTION	**CITATIONS**
19. Has the plan developed medical record standards and are these standards disseminated to and applied to providers?	98-1.13(k), (l) MMC/FHP Contract Sections 19.1(a)(i), 20.2, 20.3
20. Does the plan take appropriate actions to ensure the confidentiality of medical records and other specific information?	PHL 4410.2 PHL 2782 MMC/FHP Contract Section 20.3 PHL 4902.1(g) PHL 4905.1, 2, 8
21. Does the MCO provide HIV testing and counseling to all pregnant women? (a) Is HIV counseling/testing provided to each prenatal enrollee with clinical recommendation for HIV testing? (b) Is HIV post-test counseling provided to all women who are HIV tested?	PHL Chapter 220
22. Does the plan have effective credentialing and recredentialing processes that are overseen by the medical director?	98-1.12(k) 98-1.12(l) MMC/FHP Contract Sections 21.4, 21.1(b) 4408-1.(r) 4406(d)-1
23. (a) Does the MCO have a process to identify, on an ongoing basis, healthcare providers that have been sanctioned by regulatory agencies or providers whose license or registration has expired or been revoked? (b) Does the process include removal of providers from the network who are unable to provide services due to final disciplinary action, sanction by regulatory agency, or due to an expired license/registration?	98-1.12(l) MMC/FHP Contract Sections 21.1(b), 21.4(b), 21.5
24. **PRENATAL Medicaid Only:** Are risk assessments conducted initially and periodically throughout the prenatal period, and is appropriate follow-up conducted?	MMC/FHP Contract Section 13.6(a)(ii), (v)
25. **PRENATAL Medicaid Only**: Are prenatal diagnostic and treatment services and postpartum services provided according to accepted standards?	MMC/FHP Contract Section 10.11 SSL 365-k.

SERVICE DELIVERY NETWORK	
QUESTION	**CITATIONS**
26. Does the Plan have a Provider Manual which is distributed to all providers?	See Provider Manual Checklist 98-1.12 (o) requires a provider manual
27. (a) Does the plan have a mechanism to monitor clinical access to PCPs 24 hours a day, 7 days a week (including for pregnant women)? (b) Medicaid Only: Does the MCO monitor appointment availability?	Appointment and Availability Study PHL 4408(1)(h) 98-1.6(f) 98-1.6(f) 98-1.13 (d) and (h) MMC/FHP Contract Section 18.5(a)(ix)
28. (a) Does the MCO allow each member to choose a PCP? (b) If the member does not select a PCP, does the plan assign a PCP? (c) Does the MCO allow member to change PCPs?	PHL 4403(5)(a)(i) (ii) 98-1.13(d) MMC/FHP Contract Sections 13.6 21.8(a),(b),(c) 21.9 21.10(c) 21.14(d) and (e) 21.15(c)
29. Does the Plan have contracts for all providers that are listed on the HPN?	PHL 4402(2)(a) PHL 4403(5) 98-1.2(aa) 98-1.5(b)(6) 98-1.13 (a) 98-1.18(a) MMC/FHP Contract: Sections 21.1, 22.1, 22.3, 22.4
30. (a) Does the Plan have a process to update the provider directory? (b) Does the MCO notify enrollees and providers of changes to the directory?	PHL 4403(5)(a)(b) PHL 4408(1)(r) 98-1.16(i) MMC/FHP Contract Section 13.1
31. Does the plan have an internal process to identify capacity problems and augment the network as needed?	PHL 4403(5)(a)(b) 98-1.6 (f) 98-1.13 (h) MMC/FHP Contract Section 21.1
32. (a) Does the MCO notify DOH appropriately upon large contract assignments, terminations or non-renewals? (b) Are contracts that were assigned to the MCO through a purchase or acquisition updated?	98-1.13(c) MMC/FHP Contract Section 22.12
33. Does the MCO implement procedures to address health care professional (provider) terminations and due process?	PHL 4406-d(2) PHL 4406-d(5)

MEMBER SERVICES/ACCESS TO SERVICES	
QUESTION	**CITATIONS**
34. How does the MCO provide care to members with life threatening or degenerative and disabling conditions needing access to specialty care centers?	PHL 4403(6)(d) MMC/FHP Contract Sections 10.19, 10.20, 15.9, 21.14(b)
35. How does the plan provide access to specialty care outside of the plan's contracted network, as needed?	PHL 4403(6)(a) 98-1.13(a) MMC/FHP Contract Section 21.2
36. Does the MCO have procedures in place to allow a specialist to act as the PCP for enrollees with a life-threatening condition or disease or a degenerative and disabling condition or disease which requires specialized medical care?	PHL 4403(6)(c)
37. a) Does the plan have policies and procedures to allow transitional care to new members upon joining the MCO? **<u>Medicaid Only:</u>** b) What does the plan do to promote continuity of care for new enrollees who have a life threatening disease or condition or a disabling degenerative condition, specifically as it relates to home health care and private duty nursing?	PHL 4403(6)(f) MMC/FHP Contract Section 15.6
38. Does the plan have policies and procedures to address continuity of care when a provider leaves a network?	PHL 4403(6)(e)(1) PHL 4408(4) 98-1.2(oo)
39. Does the MCO have a process for the resolution of requests for services to be provided by out-of-network providers for medically necessary services not available in network?	98-1.13(a), (b), (i)
40. Is the plan issuing member handbooks and policies and procedures to address all requirements prescribed in regulation and law?	PHL 4408 98-1.14
41. Does the plan have a mechanism to provide health and childbirth education to prenatal enrollees?	MMC/FHP Contract Section 10.11 SSL 365-k.
42. Does the MCO have a toll-free telephone number to accept oral complaints on a 24-hour basis?	PHL 4408-a(3)(d)
43. Does the MCO have an acceptable toll-free telephone number which connects callers to UR personnel?	PHL 4902.1(f)
44. Is the complaint process accessible and usable to the non-English speaking, or by persons with mobility, auditory, visual, and cognitive impairments?	PHL 4408-a(2)(c) PHL 4403(5)(b)(ii) 98-1.16(k) MMC/FHP Contract Sections 12.2, 12.3, Appendix F.2(2)(a)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
45. Are there procedures for enrollee filing of a complaint or grievance?	PHL 4408-a PHL 4403 (1) (g) PHL 4403(5) (b)(iii) 98-1.14 (c), (d), (e) 98-1.16(k) MMC/FHP Contract App F.2 (1), (2), and (6)-(9) Section 12.2, 12.3
46. Are the MCO's grievance, complaint and appeal notifications accessible to and usable by persons with auditory, visual, and cognitive impairments and by persons who speak a language other than English?	PHL 4403.5(b)(ii) 98-1.16(k) MMC/FHP Contract Appendix F F.1 (5)(a) F.2 (5)(a) Appendix J (IV) (B4)
47. **Medicaid Only:** a) Does the MCO handle service or referral requests and claim submissions for contracted benefits consistent with the MMC/FHP contract? b) Are qualified personnel reviewing requests for benefits/referrals and claims?	MMC/FHP Contract Section 14.1, 14.2(a), (b) Appendix F F.1(2)(a)(iii) F.1(6) F.2 (2)(f) F.2 (3)(a)(vii)
48. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	Medicaid Advantage Contract Appendix F F.1 (2)(c)
49. **Commercial /CHP Only:** Is written notice of grievance procedure provided to the enrollee when a request for referral or service is denied or claim is denied in whole or in part, because the MCO determines the service is not covered?	PHL 4408-a (2)(a)& (b) PHL 4408-a(3) (a),(b), & (d)
50. Does the plan have designated personnel to accept review and make determinations on all complaints/grievances and as applicable, Action appeals?	4408a-(3)(d) 4408-a (5) 4408-a(10) MMC/FHP Contract Appendix F F.1(2)(a)(iii) F.2 (2)(b) F.2(3)(a)(vii) F.2 (6)(a)(iii) and (iv) F.2 (9)(a)(iii)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
51. **Medicaid Only:** Does the enrollee have the ability to file standard Action appeals?	MMC/FHP Contract, Appendix F F.1 (d)(v) F.2(3)(a)(i), (ii), (iii) and (iv) F.2 (4) F.2 (5) F.2(10)
52. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
53. Are grievances and complaints, other than immediately resolved oral complaints, acknowledged within 15 business days? b) Are appeals of the MCO's grievance and complaint determinations acknowledged within 15 business days? c) Medicaid Only: Are Action appeals acknowledged within 15 calendar days?	PHL 4408-a(4) PHL 4408-a(3)(c) PHL4408-a(9) 98-1.14(e) MMC/FHP Contract Appendix F F.2 (3)(a)(iii) F.2 (6)(a)(ii) F.2 (9)(a)(ii)
54. Does the MCO review grievances and investigate complaints in accordance with statute and, if applicable, the MMC/FHP Contract? b) Medicaid Only; Does the MCO review Action Appeals in accordance with statute and the MMC/FHP Contract?	PHL 4408-a(1) PHL 4408-a(2)(b) PHL 4408-a(4) PHL 4408-a(6) PHL 4408-a(13) 98-1.14(c), (e) MMC/FHP Contract App F.2 (2), (3), (4), (5), (6) and (7)
55. **Medicaid Only**: Does the MCO extend reviews of referral/ benefit requests, claims and Action appeals in accordance with the MMC/FHP Contract?	MMC/FHP Contract App F.1 (3)(c)(i) and (ii) F.1 (3)(d) F.2(4)(a)(iii) F.2(10)(vii)
56. Does the MCO issue appropriate resolution notices to the enrollee, or their designee, for complaints and grievances, and, as applicable, Action appeals?	PHL 4408-a(6) PHL 4408-a(7) 98-1.14(e) MMC/FHP Contract App F.2 (5)(a)(iii) F.2 (8)
57. Does the enrollee have the ability to file an appeal of the MCO's grievance or complaint determination?	PHL 4408-a (8), (9) 98-1.14(e) MMC/FHP Contract Appendix F.2 (9)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
58. Are grievance and complaint appeal determinations issued in accordance with all requirements?	PHL 4408-a(12) MMC/FHP Contract App F.2 (9)(a)(vi)
59. Is there a complete file for each complaint/ grievance, appeal and as applicable Action appeal?	PHL 4408-a(14) 98-1.14(d) MMC/FHP Contract App F.2 (10)
60. Does the MCO have procedures in place to address provider complaint/grievances?	PHL 4406-c(3),(4) PHL 4406-d PHL 4408-a(1) MMC/FHP Contract Section 22.7(a)(ii) and (iii)
61. Does the MCO report incidents of probable health care provider professional misconduct to appropriate professional disciplinary agencies?	PHL 4405-b MMC/FHP Contract Section 18.8
62. Does the MCO report complaints regarding fraud and abuse to DOH?	98-1.21(d) MMC/FHP Contract Section 18.5(a)(vi)
63. **Medicaid Only:** Are accurate reports on Medicaid complaints and Action Appeals sent to SDOH on a quarterly basis?	PHL 4408-a (14) 98-1.16(h) MMC/FHP Contract Section 18.5(a)(vi) App F.2 (7)(a)(i)
64. Does the plan trend complaints/grievances to identify administrative problems and issues regarding the provision of health care services?	PHL4403(5)(b) (iii) PHL 4408-a(14) 98-1.12 (g), (h),(i), and (j)
65. Does the MCO monitor complaints, grievances, and as applicable, Action appeals, related to accessibility issues for enrollees, including persons with disabilities? b) Does the MCO routinely identify enrollee special needs, and respond to complaints regarding accessibility in a manner consistent with identified needs?	PHL 4403(5)(b)(i) 98-1.12 (g), (h),(i), and (j) MMC/FHP Contract Appendix J (IV) (B4)

UTILIZATION REVIEW (with MMC/FHP Actions)	
QUESTION	**CITATIONS**
66. Does the MCO have written Utilization Review procedures that are compliant with statute, regulation, and, as applicable, the MMC/FHP contract?	PHL 4902 PHL 4903 PHL 4904 PHL 4905 PHL 4910 PHL 4900(9) 98-2.3(a) 98-1.13(n) 98-2.9 MMC/FHP Contract Section 14.1, 14.2(a),(b) and Appendix F
67. Are notices of initial UR adverse determinations issued in accordance with all requirements?	PHL 4903(5) PHL 4902(1)(e) MMC/FHP Contract App F.1 (2)(a)(iv) F.1 (5)(a)(iii) F.2(3)(a)(iv)
68. Are notices of UR final adverse determinations issued in accordance with all requirements?	98-2.9(e) 98-2.9(h) PHL 4904(5) PHL 4904(3) MMC/FHP Contract App F.2(4)(a)(v) F.2(5)(a) F.2 (5)(a)(iii)
69. Are requests for pre-authorization or continuation/ extension of services reviewed in accordance with statute and, as applicable, the MMC/FHP contract?	PHL 4903(2) PHL 4903(3) PHL 4903(7) MMC/FHP Contract App F.1(1), (2) F.1 (3)(a), (b)
70. Is retrospective utilization review done in accordance with statute, and as applicable, the MMC/FHP contract?	PHL 4903(4) PHL 4903(7) PHL 4905(5) 98-1.13(n) MMC/FHP Contract App F.1(4)(b), (c) F.1(6)(b)
71. Does the plan have qualified personnel who perform utilization review?	4900.2 (a) 4903.1 4904.4
72. **Medicaid Only:** Does the MCO identify and review initial requests for authorization of services requiring expedited review in accordance with the MMC/FHP contract?	MMC/FHP Contract App F.1(2)(a)(i)
73. When more information is needed to render a determination, does the MCO request necessary information prior to making an adverse determination or upholding an appeal?	4903.5(c) 4905.11 4408-a(3)(c)

UTILIZATION REVIEW (with MMC/FHP Actions)	
QUESTION	**CITATIONS**
	98-2.9(b) MMC/FHP Contract App F.1 (2)(a) [42CFR 438.210 (b)(2)(ii)] F.1 (3)(c)(ii) F.2(4)(a)(iii)(B) F.2(10)
74. Does the MCO notify enrollees and providers when services are authorized?	4903.2 4903.3 MMC/FHP Contract App F.1(2)(iv)
75. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	MA Advantage Contract App F.1 (2)(c)
76. Do providers have the ability to request timely reconsideration of a UR adverse determination of a service they recommended?	4903.6 4903.5
77. Does the enrollee have the ability to file standard appeals of adverse determinations?	4904.3 4903.5 MMC/FHP Contract App F.2(3)(a)(i), (ii), (iii) and (iv) F.2(10)
78. Does the enrollee and/or the enrollee=s health care provider have the opportunity to engage in an expedited appeal?	4904.2 (a) and (b) 4903.5(b) 98-2.9 (e)(f) 98-1.14 (c) MMC/FHP Contract App F.2(3), (4), (10)
79. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
80. Does the MCO adequately cover emergency services?	4902.1(c),(h) 4903.4 4903.5 4904.1 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(2)
81. Does the MCO adequately cover the provision of post-stabilization care and inpatient admissions resulting from an ER visit? b) How does the MCO facilitate the transfer of patients from non-participating to participating hospitals after stabilization?	4902.1(d) 4902.1(h) 4903.3 4903.6 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(3), (4)

MANAGEMENT INFORMATION SYSTEMS	
QUESTION	**CITATIONS**
82. Does the MCO have the system capacity to produce and submit all required reports?	364-j(8)(d) 98-1.17(a)(2)
83. Does the plan produce mgmt. reports which summarize denials in order to monitor utilization review activities?	98-1.6(f) 98-1.8(a)
84. How does the plan track pended claims to ensure timely resolution?	98-1.6(c) 98-1.8(a) NYS INS Law 3224-a
85. Does the plan's information systems, or those used by delegated entities, integrate the utilization management and claims adjudication systems to promote accurate processing.	98-1.6(c) 98-1.8(a)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
Note-- This entire section applies to: • *Commercial MCOs with Medicaid product and over 10,000 enrollees* • *Medicaid only plans with over 10,000 enrollees* • *Commercial only MCOs with over 60,000 enrollees (certain exceptions noted).* ***As indicated, only select questions apply to Medicaid Only plans with less than 10,000 enrollees***	
86. Does the MCO have a separate and distinct full time Special Investigation Unit (SIU) distinct from any other MCO unit or function?	98-1.21(b)(1)
87. Does the MCO have a designated officer or director position? who has responsibility for carrying out the provisions of the FAPP who reports directly to senior management? (b) **For Medicaid Only plans with less than 10,000 enrollees:** Does the MCO have a designated compliance officer and compliance committee that are accountable to senior management?	98-1.21(a) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
88. Does the MCO dedicate resources to support the functions of the SIU and the implementation of the FAPP?	98-1.21(b)(2)
89. **For all applicable MCOs, including Medicaid Only with less than 10,000 enrollees:** Do relationships exist between: • the Fraud & Abuse Director and the SIU; • the Fraud & Abuse Director and the SIU and law enforcement agencies; and • Staff in other units of the MCO, such as claims, UR, quality, etc, and the SIU?	98-1.21(b)(4) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
90. Is there a process for case referrals to the SIU, DOH and other law enforcement agencies?	98-1.21(b)(6)
91. How does the MCO prevent, detect, and conduct case investigations of fraud or abuse?	98-1.21(b)(5)
92. **For applicable MCOs, including Medicaid only MCOs with less than 10,000 enrollees:** How has the MCO Improved performance or modified processes as a result of fraud and abuse investigations?	98-1.21(b)(11) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
93. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees**: (a) Does the plan have written policies, procedures and standards of conduct that are distributed to all affected employees and appropriate delegated entities? (b) Do they reflect the MCO's commitment to comply with all applicable federal and state standards and identify and address specified areas of risk and vulnerability? (c) Does the plan conduct internal audits to ensure compliance with standards of conduct?	98-1.21(a) 98-1,21(b)(7), (11)&(12) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608) Section 1902(a) of the Social Security Act
94. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees:** Does the MCO have provisions for in-service training programs for investigative, claims, quality, UM and other personnel with periodic	98-1.21(b)(9) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
refreshers?	
95. Does the MCO have a Fraud and Abuse Awareness program?	98-1.21(b)(13)
96. Does the MCO have a fraud and abuse detection manual that is available to its employees?	98-1.21(b)(14) Section 1902(a) of the Social Security Act
97. If the MCO accepts paper claim forms, other than standardized federal claim forms such as the HCFA1500, do such forms include appropriate c warning statement against fraudulent acts?	98-1.22(a), (b)
98. Has the plan submitted to the State information about certain business transactions within wholly owned suppliers or any subcontractors?	MMC/FHP Section 18.6 (c) , 18.10(c) (42 CFR 455.105)
99. (a) Is the plan prepared to disclose to the State the identity of any person who has ownership or control interest in the MCO or is an agent or managing employee of the plan and has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or Title XX? (b) Has the plan required its providers to disclose health care related criminal conviction information from all parties affiliated with the provider? (c) Has the plan refused to enter into or renew an agreement with the provider or with parties affiliated with the provider because of criminal convictions related to the Medicare, Medicaid or Title XX programs?	(a) MMC/FHP Section 18.12(a) & (b) (42 CFR 455.106) (b)MMC/FHP Section 18.12(a), (b) & (c) (42 CFR 455.106) (c) Section 18.12(c). (42 CFR 455. 106(c)
100. Does the plan report to the State and HHS-OIG any adverse actions taken against providers for program integrity reasons, such as providers denied MCO participation?	MMC/FHP Section 18.8(c) (42 CFR 1002.3(b) and CMS 2010 Best Practice Bulletin)
101. Has the plan implemented a service verification process?	MMC/FHP Section 23.3 (42 CFR 455.20)
102. (a)Does the plan capture information on any employee that is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations. The information shall be checked against the exclusionary lists (including List of Excluded Individuals and Entities (LEIE), Medicare Exclusion Database (MED), Excluded Parties List System (EPLS), Social Security Administration Death Master File and the National Plan Provider Enumeration System (NPPES) (b) Does the plan check new providers, re-enrolled providers against the excluded provider lists, which includes updates from the LEIE, MED, EPLS, Social Security Administration Death Master File and the NPPES? (c) Does the MCO also conduct monthly verifications on all participating	MMC/FHP Section 18.9(a) &(b) (42 CFR 455.101 and 455.436)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
providers? (d) Does the plan require all network providers to monitor staff and managing employees against the exclusionary lists and report any exclusions to the MCO on a monthly basis?	
103. (a) Does the plan collect all required ownership and control disclosure information from persons with an ownership or control interest of 5 % or more in the MCO or any subcontractor, or who are managing employees of the plan? (b) Do the reporting individuals in (a) above disclose if they are related to another disclosing entity (MCO, provider, subcontractor) or owner as a spouse, parent, child or sibling? (c) Does the plan collect updated disclosure from disclosing entities, regarding persons with an ownership and control interest, or who are managing employees of the disclosing entity, at intervals within contract periods and or contract renewals and prepared to submit the information to the Sate or CMS within 35 days of a written request? . **NOTE:** All parts of question 104 apply to providers as well. A disclosing entity includes all providers with the exception of an individual provider or group of health care practitioners. Therefore See 42 CFR 455.101.	(a) MMC/FHP Section 18.10(a) 42 CFR 455.104 (b) and (c) MMC/FHP Section 18.6(b) 42 CFR 455.104

Revised 2/13/14

ATTACHMENT 4. HOSPITALS AND PRIMARY CARE RESIDENCY PROGRAMS PARTICIPATING IN THE HOSPITAL-MEDICAL HOME DEMONSTRATION

Hospitals and Residencies Participating in the Hospital Medical Home Demonstration

ALBANY MEDICAL CENTER HOSPITAL	INTERNAL MEDICINE
ALBANY MEDICAL CENTER HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
ALBANY MEDICAL CENTER HOSPITAL	PEDIATRICS
BELLEVUE HOSPITAL CENTER	INTERNAL MEDICINE
BELLEVUE HOSPITAL CENTER	PEDIATRICS
BETH ISRAEL MEDICAL CENTER - PETRIE CAMPUS	INTERNAL MEDICINE
BETH ISRAEL MEDICAL CENTER - PETRIE CAMPUS	FAMILY MEDICINE
BRONX-LEBANON HOSPITAL CENTER	INTERNAL MEDICINE
BRONX-LEBANON HOSPITAL CENTER	FAMILY MEDICINE
BRONX-LEBANON HOSPITAL CENTER	PEDIATRICS
BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	PEDIATRICS
CITY HOSPITAL CENTER AT ELMHURST	INTERNAL MEDICINE
CITY HOSPITAL CENTER AT ELMHURST	PEDIATRICS
CONEY ISLAND HOSPITAL	INTERNAL MEDICINE
CONEY ISLAND HOSPITAL	PEDIATRICS
ELLIS HOSPITAL	FAMILY MEDICINE
ERIE COUNTY MEDICAL CENTER	INTERNAL MEDICINE
ERIE COUNTY MEDICAL CENTER	FAMILY MEDICINE
FLUSHING HOSPITAL MEDICAL CENTER	INTERNAL MEDICINE
FLUSHING HOSPITAL MEDICAL CENTER	PEDIATRICS
GLEN COVE HOSPITAL	FAMILY MEDICINE
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	PEDIATRICS
HARLEM HOSPITAL CENTER	INTERNAL MEDICINE
HARLEM HOSPITAL CENTER	PEDIATRICS
HIGHLAND HOSPITAL	FAMILY MEDICINE
INTERFAITH MEDICAL CENTER	INTERNAL MEDICINE
JACOBI MEDICAL CENTER	INTERNAL MEDICINE
JACOBI MEDICAL CENTER	PEDIATRICS
JAMAICA HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
JAMAICA HOSPITAL MEDICAL CENTER	INTERNAL MEDICINE

KALEIDA HEALTH - BUFFALO GENERAL MEDICAL CENTER	FAMILY MEDICINE
KALEIDA HEALTH - BUFFALO GENERAL MEDICAL CENTER	INTERNAL MEDICINE
KALEIDA HEALTH - MILLARD FILLMORE SUBURBAN HOSPITAL	FAMILY MEDICINE
KALEIDA HEALTH - WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO	PEDIATRICS
KALEIDA HEALTH - WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO	INTERNAL MEDICINE-PEDIATRICS
KINGS COUNTY HOSPITAL CENTER	INTERNAL MEDICINE
KINGS COUNTY HOSPITAL CENTER	PEDIATRICS
KINGS COUNTY HOSPITAL CENTER	FAMILY MEDICINE
KINGSBROOK JEWISH MEDICAL CENTER	INTERNAL MEDICINE
KINGSTON HOSPITAL	FAMILY MEDICINE
KINGSTON HOSPITAL/INSTITUTE FOR FAMILY HEALTH	FAMILY MEDICINE
LINCOLN MEDICAL & MENTAL HEALTH CENTER	INTERNAL MEDICINE
LINCOLN MEDICAL & MENTAL HEALTH CENTER	PEDIATRICS
LUTHERAN MEDICAL CENTER	FAMILY MEDICINE
LUTHERAN MEDICAL CENTER	INTERNAL MEDICINE
MAIMONIDES MEDICAL CENTER	INTERNAL MEDICINE
MERCY HOSPITAL OF BUFFALO	INTERNAL MEDICINE
METROPOLITAN HOSPITAL CENTER	INTERNAL MEDICINE
METROPOLITAN HOSPITAL CENTER	PEDIATRICS
MONTEFIORE MEDICAL CENTER	FAMILY MEDICINE
MONTEFIORE MEDICAL CENTER	INTERNAL MEDICINE
MONTEFIORE MEDICAL CENTER	PEDIATRICS
MOUNT VERNON HOSPITAL	INTERNAL MEDICINE
NASSAU UNIVERSITY MEDICAL CENTER	PEDIATRICS
NASSAU UNIVERSITY MEDICAL CENTER	INTERNAL MEDICINE
NASSAU UNIVERSITY MEDICAL CENTER	PEDIATRICS
NEW YORK METHODIST HOSPITAL	INTERNAL MEDICINE
NEW YORK METHODIST HOSPITAL	PEDIATRICS
NIAGARA FALLS MEMORIAL MEDICAL CENTER	FAMILY MEDICINE
NORTH CENTRAL BRONX HOSPITAL	INTERNAL MEDICINE
NORTH SHORE UNIVERSITY HOSPITAL	INTERNAL MEDICINE
PECONIC BAY MEDICAL CENTER	FAMILY MEDICINE
PHELPS MEMORIAL HOSPITAL ASSOCIATION	FAMILY MEDICINE
QUEENS HOSPITAL CENTER	INTERNAL MEDICINE
RICHMOND UNIVERSITY MEDICAL CENTER	INTERNAL MEDICINE
RICHMOND UNIVERSITY MEDICAL CENTER	PEDIATRICS
ROCHESTER GENERAL HOSPITAL	INTERNAL MEDICINE
ROCHESTER GENERAL HOSPITAL	PEDIATRICS
SAMARITAN MEDICAL CENTER	INTERNAL MEDICINE
SAMARITAN MEDICAL CENTER	FAMILY MEDICINE
SISTERS OF CHARITY HOSPITAL	INTERNAL MEDICINE
SISTERS OF CHARITY HOSPITAL	FAMILY MEDICINE

SOUND SHORE MEDICAL CENTER OF WESTCHESTER	INTERNAL MEDICINE
SOUND SHORE MEDICAL CENTER OF WESTCHESTER	PEDIATRICS
SOUTH NASSAU COMMUNITIES HOSPITAL	FAMILY MEDICINE
ST BARNABAS HOSPITAL	INTERNAL MEDICINE
ST BARNABAS HOSPITAL	FAMILY MEDICINE
ST BARNABAS HOSPITAL	PEDIATRICS
ST JOSEPH'S HOSPITAL HEALTH CENTER	FAMILY MEDICINE
ST. JOSEPH'S MEDICAL CENTER	FAMILY MEDICINE
ST. LUKE'S - ROOSEVELT HOSPITAL CENTER	INTERNAL MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	INTERNAL MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	FAMILY MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	FAMILY MEDICINE
STONY BROOK UNIVERSITY HOSPITAL	PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	INTERNAL MEDICINE
STRONG MEMORIAL HOSPITAL	INTERNAL MEDICINE
STRONG MEMORIAL HOSPITAL	PEDIATRICS
STRONG MEMORIAL HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
THE MOUNT SINAI MEDICAL CENTER	INTERNAL MEDICINE
THE MOUNT SINAI MEDICAL CENTER	PEDIATRICS
THE MOUNT SINAI MEDICAL CENTER	FAMILY MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	INTERNAL MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	FAMILY MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	PEDIATRICS
THE NEW YORK AND PRESBYTERIAN HOSPITAL	INTERNAL MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	PEDIATRICS
THE NEW YORK HOSPITAL MEDICAL CENTER OF QUEENS	INTERNAL MEDICINE
THE NEW YORK HOSPITAL MEDICAL CENTER OF QUEENS	PEDIATRICS
UNITY HOSPITAL	INTERNAL MEDICINE
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	PEDIATRICS
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	PEDIATRICS
WESTCHESTER MEDICAL CENTER	INTERNAL MEDICINE
WESTCHESTER MEDICAL CENTER	PEDIATRICS
WINTHROP-UNIVERSITY HOSPITAL	PEDIATRICS
WOODHULL MEDICAL & MENTAL HEALTH CENTER	INTERNAL MEDICINE
WOODHULL MEDICAL & MENTAL HEALTH CENTER	PEDIATRICS
WYCKOFF HEIGHTS MEDICAL CENTER	INTERNAL MEDICINE
WYCKOFF HEIGHTS MEDICAL CENTER	PEDIATRICS

ATTACHMENT 5. NEW YORK STATE PARTNERSHIP PLAN PROJECTED 1115 WAIVER BUDGET NEUTRALITY IMPACT THROUGH DECEMBER 2013

Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Medicaid Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver must not be more than the cost that would have occurred without the waiver.

The neutrality formula consists of two components: "Without Waiver" expenditures and "With Waiver" expenditures. Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) multiplied by the trended Per Member Per Month allowance approved by CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

The six agreed upon MEGs for the purposes of establishing Without Waiver expenditures are as follows:

- TANF children under the age of 1 to 20,
- TANF adults ages 21 to 64,
- FHPlus adults with children,
- Family Planning Benefit Program participants,
- MLTC adult age 18 to 64 duals, and
- MLTC adult age 65+ duals.

With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future medical costs.

Expenditures for the six agreed upon MEGs are included in the With Waiver calculations as well as expenditures for Safety Net adults, FHPlus without children, Home and Community Based Services (HCBS) Expansion, Indigent Care Pool Direct Expenditures, and Designated State Health Programs.

Therefore, the savings achieved for the Without Waiver MEGs are used to expand access and quality as well as service volume for With Waiver populations, programs and initiatives. After all the With Waiver expenditures are subtracted from the Without Waiver estimated costs do we achieve the net savings for the waiver as a whole (see below).

Between October 2009 and September 2013, the Department projects that the waiver will have saved $17,141,306,492. After subtracting the With Waiver expenditures from the Without Waiver calculation of expenditures, the Partnership Plan yields $17.1 billion in projected savings, and pays for five more programs than are included in the Without Waiver populations. (The Department's budget neutrality impact analysis is at the end of this attachment.)

Review of the budget neutrality analysis for the Partnership Plan indicates that the Department has been successful in producing savings for both the State and federal Medicaid programs. Implementation of the MMC mandate and addition of FHPlus have successfully demonstrated that moving low income populations out of FFS care and into managed care models is cost effective with expenditures well below the level that would have been expected had the Partnership Plan Demonstration not occurred.

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A (10/1/10-3/31/11) Actual	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/06 - 12/31/13) Projected	DY 1 - 16
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$10,048,004,954	$11,197,206,500	$6,105,699,488	$6,124,915,586	$13,431,510,646	$14,853,292,172	$7,950,225,796	$87,438,675,151	
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,511,421,595	$2,467,348,368	$2,443,182,702	$5,362,328,563	$5,914,512,406	$3,159,849,805	$33,978,117,234	
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,746,457,301	$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$14,927,293,206	
Demonstration Group 8 - Family Planning Expansion							$0	$10,702,271	$1,856,551	$0	$12,558,822	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$247,394,784	$1,027,336,330	$260,284,563	$1,535,015,677	
Demonstration Group 11 - MLTC Adult Age 65+ Duals								$2,554,212,091	$10,820,566,375	$2,796,750,566	$16,171,529,032	
W/O Waiver Total	**$144,639,878,523**	**$13,378,994,890**	**$14,117,434,787**	**$15,651,219,786**	**$17,587,144,736**	**$9,616,095,275**	**$9,623,513,619**	**$23,947,215,809**	**$35,249,801,447**	**$14,891,768,772**	**$154,063,189,121**	**$298,703,067,644**

Budget Neutrality Cap (With Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A (10/1/10-3/31/11) Actual	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/09 - 12/31/13) Projected	DY 1 - 16
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$4,828,196,168	$4,144,199,750	$1,827,792,863	$2,801,314,813	$6,274,626,419	$6,920,847,016	$3,682,227,594	$38,898,045,563	
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,619,299,634	$1,159,889,284	$1,546,569,069	$3,469,842,728	$3,821,091,510	$2,038,979,725	$21,494,890,982	
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,024,374,518	$1,864,361,807	$2,829,518,468	$6,893,620,899	$8,184,495,364	$2,210,213,971	$36,055,996,465	
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$963,020,020	$502,539,894	$553,389,253	$1,173,058,139	$1,313,450,137	$360,124,780	$7,458,988,303	
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$313,222,949	$155,882,395	$173,575,211	$352,894,110	$401,041,648	$110,970,648	$3,073,837,039	
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$9,839,735	$4,164,485	$5,460,394	$11,576,340	$2,045,425	$0	$65,294,983	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$249,276,515	$999,765,437	$249,927,129	$1,498,969,081	
Demonstration Group 11 - MLTC Adult Age 65+ Duals								$2,561,508,288	$10,403,512,554	$2,629,869,736	$15,594,890,578	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)							$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)							$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)							$0	$133,400,000	$133,300,000	$33,300,000	$300,000,000	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)							$0	$5,000,000	$6,700,000	$1,600,000	$13,300,000	
Demonstration Population 5: Designated State Health Programs (Various)											$0	
With Waiver Total	**$123,931,127,812**	**$10,499,291,132**	**$11,309,400,341**	**$12,518,840,868**	**$12,073,956,605**	**$5,514,630,728**	**$7,918,726,316**	**$21,157,802,546**	**$32,217,348,199**	**$11,324,938,360**	**$124,534,935,096**	**$248,466,062,908**
Expenditures (Over)/Under Cap	**$20,708,750,711**	**$2,879,703,758**	**$2,808,034,446**	**$3,132,378,918**	**$5,513,188,131**	**$4,101,464,547**	**$1,704,787,303**	**$2,789,413,262**	**$3,032,453,248**	**$3,566,830,412**	**$29,528,254,026**	**$50,237,004,737**

ATTACHMENT 6. TECHNICAL NOTES AND REFERENCE MATERIALS

In preparing this interim report, IPRO reviewed a wide range of documents including Partnership Plan and CMS 273 Quarterly and Annual Reports, Special Terms and Conditions, Contract Surveillance Tools and reports, and consulted with the Department's senior managers and staff as follows:

- Partnership Plan Medicaid Section 1115 Annual Reports for Federal Fiscal Year (FFY) 2008-2009, FFY 2009-2010, FFY 2010-2011, FFY 2011-2012, and FFY 2012-2013.
- Partnership Plan Medicaid Section 1115 Quarterly Reports for FFY 2012-2013.
- Application for Extension, New York State Medicaid Section 1115 Demonstration, December 31, 2013.
- Special Terms and Conditions for the Partnership Plan Medicaid Section 1115 Demonstration effective April 2013.
- Medicaid Managed Care and Family Health Plus MCO Contract Surveillance Tool, Revised October 2007; New York State, Office of Health Insurance Programs (OHIP), Division of Managed Care and Program Evaluation.
- Quality Strategy for the New York State Medicaid Managed Care Program 2012, November 30, 2012.
- Primary Care/Specialty Care Participation Rate Report, New York State Department of Health , Division of Health Plan Contracting and Oversight, Calendar Years 2009, 2010, and 2011.
- Managed Care Plan Performance: A Report on the Quality, Access to Care, and Consumer Satisfaction (QARR); New York State Department of Health, 2008, 2009, 2010, 2011 and 2012.
- Demographic Variation in Medicaid Managed Care, New York State Department of Health, 2011 and 2012.
- Managed Care Access and Utilization Report, New York State Department of Health, 2009, 2010, 2011, and 2012.
- CAHPS® 4.0 Adult Medicaid Survey, Medicaid Managed Care Program, New York State Department of Health, April 2010
- New York State Medicaid Redesign Team Waiver Amendment, New York State Department of Health, December 2013.
- Partnership Plan Evaluation, Program Evaluation of Medicaid Section 1115 Waiver Program – Final Report, Delmarva Foundation, January 2010.
- Managed Long Term Care Plan Member Satisfaction Survey Report, IPRO, September 2011.
- The State of Health Quality, 2012; National Committee for Quality Assurance, 2012.
- The State of Health Quality, 2013; National Committee for Quality Assurance, 2013.

IPRO reviewed the following websites:

http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

http://www.health.ny.gov/health_care/managed_care/appextension/

http://www.health.ny.gov/health_care/medicaid/redesign/

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

http://www.health.ny.gov/health_care/managed_care/consumer_guides/

http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2012/

http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm

http://www.health.ny.gov/health_care/managed_care/reports/docs/2011_pip_abstract_compendium.pdf

http://www.ncqa.org/tabid/836/Default.aspx

https://hospitalmedicalhome.ipro.org/

http://www.opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment

IPRO consulted with mangers and staff in the following Offices of the Department:

- Office of Health Insurance Programs
  - Executive Office
  - Division of Program Development & Management
  - Division of Health Plan Contracting & Oversight
  - Division of Long Term Care
- Office of Audit, Fiscal and Program Planning
- Office of Quality and Patient Safety