Partnership Plan
Section 1115 Quarterly/Annual Report
Demonstration Year: 14 (10/1/2011 – 9/30/2012)
Federal Fiscal Quarter: 4 (07/01/2012 – 09/30/2012)

I. Introduction

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period 8/1/11 through 12/31/14, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team.

II. Accomplishments

- Mandatory enrollment has been implemented in 53 counties including New York City.

- Fifteen years after the Partnership Plan was first approved, New York State is poised to have mandatory Medicaid managed care programs operational in every county in the State. During the demonstration year, six counties began mandatory programs. The final five voluntary counties were fully trained during the demonstration year and statewide implementation will occurr in September, October and November 2012.

- An unprecedented number of program initiatives were implemented during the demonstration year, reflecting Medicaid Redesign Team (MRT) recommendations. New benefits were added to the managed care benefit package, including pharmacy/medical supplies and Personal Emergency Response Systems (PERS). The dental benefit became mandatory for all Medicaid managed care plans, while the transportation benefit began phasing out on a regional basis. Many formerly exempt or excluded populations were mandated to enroll, including the homeless, disabled and low birth weight infants and individuals who have characteristics and needs similar to participants in certain 1915(c) waiver programs. The choice window was also reduced and many benefits were either restricted or expanded to encourage more appropriate utilization.

- As 2012 comes to a close, the Department completed the following tasks associated with the Hospital-Medical Home Demonstration:

    - Held meetings with representatives from the hospital associations, professional associations, and hospital and residency program administrators;
    - Created an electronic application made up of both narrative and discrete searchable data element fields;
    - Conducted a web conference and a teleconference to educate potential applicants in the use of the electronic application;

- Provided individual assistance through the application phase for potential applicants;
- Conducted a review of the applications;
- Created multiple data summaries for current and future review and planning;
- Completed the application review process;
- Finalized the funding allocation methodology;
- Announced preliminary award amounts, pending CMS approval;
- Developed and released electronic work plan template and instructions;
- Conducted web conferences and a teleconference to educate participants in the completion of the electronic work plan; and
- Assembled and begun meetings with an eight member Work Plan Review Team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from Island Peer Review Organization (IPRO) and within the Department.

The due date for work plan submission was extended from November 15, 2012 to December 3, 2012 due to the effects of Super Storm Sandy. The Department is currently developing an electronic data reporting tool for tracking and reporting milestones and measures data for the prospective demonstration period. Review of work plans will take place from December 3, 2012 through mid January 2013. Hospitals will begin implementing the work plans as soon as possible.

- In 2012, the Department began the process of developing a Request for Applications (RFAs) for the Potentially Preventable Readmissions (PPR) Demonstration. While the implementation of this demonstration is compressed, the Department has developed an outline for the RFA and plans to begin the internal departmental approval process in the near future. The Department continues to evaluate the development of an RFA.

  Anticipated implementation schedule on PPR demonstration:

Date	Action
2013	Develop RFA materials and documents
2013	Announce RFA

- The expected time line for the Family Planning Benefit Program (FPBP) to be moved into the State Plan is on November 1, 2012. Also, effective with the move to the State Plan, transportation will be added to the FPBP benefit package.

- Through the Partnership Plan, the Department has greatly expanded access for Medicaid beneficiaries to appropriately credentialed physicians, nurse practitioners and physician extenders.

- In 2011, the Department conducted a pilot study to assess member satisfaction and the utility of a standard tool for measuring provider-level surveys. Ten large health centers in New York City with high volumes of Medicaid patients were selected as study centers and 1,000 Medicaid enrollees with at least one primary care visit at one of the ten centers were randomly selected to be part of the study population. Overall, members appeared relatively satisfied with their experience of care at large health centers in New York City.

- In 2007, the Department developed a satisfaction survey for Managed Long Term Care (MLTC) plan enrollees. The survey addressed the respondents'

satisfaction with access to and timeliness of plan services as well as overall satisfaction with the plan and providers. The survey was repeated in 2011 and the Department anticipates administering it on a biennial basis. A summary of 2011 results are shown in the table below.

MLTC Member Satisfaction	
Satisfaction Measures	**Rate of MLTC Members Statewide**
Rating of Health Plan (Good or Excellent)	85%
Rating of Care Manager (Good or Excellent)	87%
Rating of Regular Visiting Nurse (Good or Excellent)	86%
Would Recommend Their Plan to a Friend (Yes)	91%
Access to Urgent Care with a Dentist (Same Day)	26%
Spoke to Their Health Plan About Advanced Directives (Yes)	63%

III. Enrollment

Fourth Quarter

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 – TANF Child under 1 through 20 in mandatory counties	**1,565,841**	**27,123**	**57,839**
Population 2 - TANF Adults aged 21-64 in mandatory counties	**470,819**	**10,765**	**21,301**
Population 3 – Safety Net Adults	**797,017**	**18,060**	**25,854**
Population 4 – Family Health Plus Adults with children	**338,949**	**6,650**	**19,696**
Population 5 – Family Health Plus Adults without children	**94,008**	**1,941**	**6,027**

Demonstration Year – Voluntary Disenrollment

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	FFY 2011 Total
Population 1 – TANF Child under 1 through 20 in mandatory counties	**21,510**	**27,239**	**29,254**	**27,123**	**105,126**
Population 2 - TANF Adults aged 21-64 in mandatory counties	**10,142**	**11,151**	**11,882**	**10,765**	**43,940**
Population 3 – Safety Net Adults	**15,993**	**18,982**	**22,155**	**18,060**	**75,190**
Population 4 – Family Health Plus Adults with children	**8,178**	**6,932**	**7,800**	**6,650**	**29,560**
Population 5 – Family Health Plus Adults without children	**2,021**	**1,934**	**2,154**	**1,941**	**8,050**

Demonstration Year – Involuntary Disenrollment

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	FFY 2011 Total
Population 1 – TANF Child under 1 through 20 in mandatory counties	**69,407**	**62,641**	**64,189**	**57,839**	**254,076**
Population 2 - TANF Adults aged 21-64 in mandatory counties	**23,181**	**22,333**	**22,252**	**21,301**	**89,067**
Population 3 – Safety Net Adults	**26,729**	**26,753**	**26,217**	**25,854**	**105,553**
Population 4 – Family Health Plus Adults with children	**22,005**	**21,911**	**21,512**	**19,696**	**85,124**
Population 5 – Family Health Plus Adults without children	**6,658**	**7,349**	**6,913**	**6,027**	**26,947**

Explanation of Populations:

- Population 1 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 1-20
- Population 2 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 21-64
- Population 3 - Safety Net Adults
- Population 4 - Family Health Plus Adults with Children

- Population 5 - Family Health Plus Adults without Children

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year[1]	**261,866**

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

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year[1]	**560,767**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility; eligibility transfers between Family Health Plus (FHPlus) and Medicaid; inappropriate enrollment and death.

IV. Outreach/Innovative Activities

The Department, Maximus and the local departments of social services (LDSS) continue to provide education and outreach in the areas of enrollment and health plan selection to Medicaid eligibles that are not enrolled in managed care.

A. Progress of Mandatory Managed Care Expansion

As of September 30, 2012, Medicaid managed care is mandatory in 53 New York State counties including New York City, and five counties are poised to start mandatory programs in October. New York State will hit a milestone in November 2012 when the remaining voluntary county begins a mandatory program, making mandatory Medicaid managed care operational in every county in the State.

During the first quarter of the Demonstration period, Clinton and Chenango counties implemented mandatory programs effective December 1, 2011. Steuben and Schuyler became mandatory in May 2012. Tioga County implemented a mandatory program in July and Wyoming followed in August 2012. Four more counties - Lewis, Jefferson, Warren and St. Lawrence - are scheduled to implement mandatory programs as of October 1, 2012. Chemung County implementation date will be in November 2012. See **Attachment 1**: NYS Medicaid Managed Care Map.

During the reporting period, staff was involved in much training for both county staff and providers in each of these counties to prepare for implementation. Clinton, Chenango, Steuben, Schuyler, and Tioga counties chose to accept the assistance of the enrollment broker while Wyoming County operates their program without the use of the broker.

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in New York City is approximately three million, of which 2,289,389 are eligible for Medicaid managed care. Nine percent or approximately

[1] Demonstration year to date: 10/01/2011 – 09/30/2012

216,204 of the consumers eligible for Medicaid managed care are Supplemental Security Income (SSI) recipients. Currently, 2,175,789 individuals, including eligible SSI recipients, are enrolled in a managed care plan.

The MRT changes implemented during the reporting period have had a significant impact on the work of New York Medicaid Choice (NYMC) the enrollment broker for the City of New York. During the reporting period, dental services were included for health plans that previously did not cover this benefit.

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover six (6) HIV/AIDS Services Administration (HASA) sites, thirteen (13) Medicaid offices and eighteen (18) Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 74% of the total consumers engaged by NYMC in the last Demonstration quarter.

Maximus provides assistance to Medicaid consumers visiting the Medicaid Office. The overall activities at Medicaid offices remained constant, averaging 17 consumers per work session. Work sessions equal a half day at a specific site; thus on average, Maximus assists 17 consumers in a 3 or 4 hour span.

A total of 2,703 presentations were scheduled by NYMC. Five hundred and five (505) or 19% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

C. New York State (outside of NYC) Outreach Activities

During the Demonstration year, Fidelis (New York State Catholic Health Plan) began accepting enrollments in Schuyler, Steuben, St. Lawrence and Chemung counties, while Excellus Health Plan began accepting enrollments in Jefferson and St. Lawrence counties. In addition, UnitedHealthcare transitioned into Clinton, Chenango, Tioga, Warren and Jefferson counties, which provided the necessary choice of plans for implementing mandatory programs. At the request of the nine counties, training was held with county staff to provide an overview of the Medicaid managed care program.

During the quarter, the Department hosted six Medicaid Managed Care Coalition meetings, a statewide conference and two webinars to provide information on the following systems and program changes:

- MRT # 1458, including: changing the dental benefit from an optional to a mandatory Medicaid managed care plan benefit effective 7/1/12; orthodontics to be included in the benefit package of all Medicaid managed care plans as of October 1; and, mandatory enrollment of individuals with end stage renal disease, the homeless population and infants under six months of age born disabled or weighing under 1200 grams.
- Status of the 1115 waiver and projected implementation of new mandatory counties.
- Enrollment center progress on the Health Care Eligibility and Assessment Renewal Tool (HEART tool). The HEART tool is used by the Enrollment Center to do Medicaid eligibility renewals.
- Managed care plan expansions and partial capitation programs (Primary Care Case Management - PCCMs) ended in Erie, Steuben and Schuyler Counties during the past six months. Chemung County ended in September 2012.

Several Medicaid updates were published and Managed Care Technical Advisory Group conference calls were held to update the counties on changes to the program as a result of the MRT roll-out.

In addition, several consumer advocate trainings were held addressing particular populations that are no longer exempt Upstate such as HIV+, Seriously and Persistently Mentally Ill (SPMI)/ Seriously Emotionally Disturbed (SED), and pregnant women.

V. Operational/Policy Developments/Issues

1. Partnership Plan Waiver Amendments

Three waiver amendments provided authorization for the State to implement initiatives of the Governor's Medicaid Redesign Team (MRT), which was tasked with redesigning the provision of Medicaid services to contain costs, create efficiencies and improve the quality of care provided to Medicaid beneficiaries. Approved initiatives implemented during the demonstration year included:

- For 2011 implementation: 1) thirty day choice window for existing Medicaid beneficiaries to choose a managed care plan; 2) six month limitation on the exemption period for beneficiaries with a chronic illness; and, 3) mandatory enrollment of several populations who were previously excluded or exempt from enrolling in managed care.
- For April 2012 implementation: elimination of exclusions and exemptions for, 1) infants under 6 months of age born disabled or under 1200 grams; 2) individuals with End Stage Renal Disease (ESRD); and, 3) homeless individuals.
- For September/October 2012 implementation: 1) elimination of exemption for "look-alike" populations, i.e., individuals with characteristics and needs similar to those receiving services through certain 1915c waivers and those in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); 2) mandatory enrollment of individuals in need of community based long term care services in managed long term care programs; and, 3) housing disregard for single individuals who were living in a nursing home willing to enroll in managed long term care programs.

2. Health Plan Participation

1. Changes to Certificates of Authority (COA):

During FFY 2011/2012 there were several expansions, one health plan name change, one Certificate of Authority updated to reflect an address change, one COA updated to reflect a new line of business being added and one acquisition.

- Health Plus PHSP, Inc. changed its name OHP PHSP, Inc. The change was effective May 1, 2012. The plan is precluded from marketing activities and enrolling new members. The plan is limited to close out related activities.
- Health First PHSP, Inc. changed the address on its COA to 100 Church St., New York, NY, effective September 19, 2011. *
- WellCare of New York, Inc. had its COA updated to include the Medicaid Advantage program in Bronx, Queens and New York counties, effective September 27, 2011.*

- VNS Choice acquired New York Presbyterian System Select, LLC. a Medicaid managed care HIV special needs plan. The COA was effective as of June 1, 2012 for Bronx, Queens, Kings and New York counties.

Expansions include:

- New York State Catholic Health Plan, Inc. has been approved for expansion into Chemung County for Medicaid managed care and Family Health Plus, effective November 28, 2011.

- WellCare of New York, Inc. has been approved for expansion for the Medicaid Advantage program in Broome, Oneida, Qswego, Richmond, and Saratoga counties, effective March 26, 2012.

- UnitedHealthcare has been approved for expansion into Orange County for Medicaid managed care and Family Health Plus, effective June 22, 2012.

- Excellus Health Plan, Inc. has been approved for expansion into Cheumg County for Medicaid managed care, effective August 1, 2012.

2. Routine surveillance activity for the quarter included operational surveys for the following plans:

- HealthNow New York, Inc. Survey was conducted on July 13, 2012 to August 15, 2012. No deficiencies were cited.

- WellCare of New York, Inc. Survey was conducted on September 19, 2012 to September 21, 2012. A Statement of Deficiencies is pending.

3. Routine provider directory surveys were conducted for health plans in the second half of 2012 with the following results. Where deficiencies were found, plans were required to provide plans of corrections:

- The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:

Affinity Health Plan, Inc.
Amerigroup New York, LLC.
Amida Care, Inc.
Capital District Physicians Health Plan, Inc.
Excellus Health Plan, Inc.
HealthFirst PHSP, Inc.
Health Now New York, Inc.
Health Insurance Plan of Greater New York.
Hudson Health Plan, Inc.
Independent Health Association, Inc.
Metro Plus Health Plan, Inc.
MVP Health Plan, Inc
Neighborhood Health Providers, Inc.
UnitedHealthcare of New York, Inc.
Univera Community Health Plan, Inc.

4. Starting in the second quarter of 2011, the Department has delegated the member services survey to its agent, IPRO. No problems were found with access to health plan telephone lines.

5. Waiver Deliverables

1. Employer Sponsored Health Insurance (ESHI) Initiative

Family Health Plus (FHPlus) Premium Assistance Program

The FHPlus Premium Assistance Program (PAP) for individuals who are eligible for FHPlus and have access to cost effective health insurance went into effect on January 1, 2008. Total enrollment as of September 30, 2012 is 2,981 individuals. This is a decrease in enrollment from the previous quarter by 99 individuals.

New York developed and tested a new software tool, the Health Insurance Premium Payment (HIPP) Calculator, designed to assist local departments of social services and New York Health Options with evaluating the cost-effectiveness of a third-party health insurance product to determine whether individuals ought to be enrolled in the FHP-PAP and to facilitate the issuance of premium payments. This standardization of cost-effectiveness analyses through HIPP will improve quality control statewide. To date, a full-day training has been provided to the Enrollment Center and local district staff in 21 counties on how to use the tool.

Enrollment in ESHI Through FHPlus PAP	**New Enrollment 07/01/12-09/30/12**	**Total Enrollment September 30, 2012**
FHPlus Adults with children	**54**	**584**
FHPlus Adults without children	**274**	**2,254**
Total	**328**	**2,981**

Age group for reporting Quarter 07/01/12-09/30/12	**Number of Enrollees**
19-44	**2,514**
45-64	**467**

2. Family Health Plus Buy-in Program

Development Activities

The United Federation of Teachers (UFT) contracted with New York State to provide up to 2,500 of their 25,000 child care providers with access to health insurance through the Family Health Plus Employer Buy-In. UFT will partner with the Health Insurance Plan of Greater New York to provide a network of services to their members. The child care workers are licensed and registered home based child care providers in New York City and provide services to low-income families. During the demonstration year, a total of 707 unsubsidized UFT members were enrolled into the FHPlus Buy-In Program. For child care workers who are eligible for Medicaid or FHPlus, the premium will be paid through the State.

Civil Service Employees Association (CSEA) also received legislative authority and appropriations to provide health insurance coverage through the FHPlus Employer Buy-In Program. CSEA is actively seeking a plan to provide coverage to their member population.

FidelisCare, present in almost every county of the State, is seeking to contract with a vendor, U.S. Fire and Unified Life, to provide family planning services so that FidelisCare can participate in the FHPlus Employer Buy-in program. As a Catholic health plan, FidelisCare does not provide these services. U.S. Fire and Unified Life are working with the State to complete the necessary steps to be approved as a vendor for family planning with FidelisCare for the FHPlus Employer Buy-In program.

The Department continues to receive inquiries from small employers about the FHPlus Buy-in Program. However, many of these inquiries are from counties where there is no health insurance plan participation.

Information on the FHPlus Employer Buy-in program for both managed care plans and potential employers is available on the Department website at:

http://www.nyhealth.gov/health_care/managed_care/family_health_plus_employer_buy-in/index.htm.

3. Medicaid Eligibility Quality Control Plan (MEQC)

- MEQC 2008 – Appropriateness of Applications Forwarded to LDSS Offices by Enrollment Facilitators:

  Review activities were transitioned to Department review staff for completion because the project agreement that supported this review expired. Department of Health (DOH) review staff continued to draft a summary of the review results.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance:

  The Pacific Health Policy Group (PHPG), the contractor hired to assist the New York State Department of Health with multiple MEQC reviews, continued to work with State program and system staff to establish proper protocols for generating the universes of cases that meet the review requirements. These protocols are more complicated than usual because several multi-step edit processes are needed to accurately identify the universes of cases from which to pull the review samples.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability:

  Issues were identified with the universe specifications. PHPG worked with Department program staff to resolve the issues. It is expected that samples of cases will be re-pulled and cases requested the appropriate LDSS offices during the next reporting quarter.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

  PHPG continued to request eligibility records from the appropriate LDSS offices. PHPG began reviewing case record information, and making initial case assessments.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

  PHPG began working with Department program staff to systematically identify the universes of cases from which to pull the required samples.

D. State Health Access Program Grant (SHAP)

As previously reported, there will be no new Health Research and Services Administrations (HRSA) appropriations to support SHAP-funded programs for years three through five; this decision affected all SHAP states. The Department received approval to use unexpended SHAP funds. SHAP funds are currently being used, in part, to help support Enrollment Center operations. The Enrollment Center began operations on June 13, 2011, and consolidated the FHPlus, Medicaid, and Child Health Plus (CHPlus) call centers. The Enrollment Center is also processing certain upstate renewals, and is preparing to expand processing to include a subset of NYC Premium Assistance cases as well as statewide presumptive eligibility FPBP applications.

E. Benefit Changes/Other Program Changes

1. Benefit Changes

- Pharmacy/Medical Supplies - Effective 10/1/11

  The Pharmacy and Medical/Surgical Supply benefit was bundled into the Medicaid managed care and FHPlus benefit package effective October 1, 2011. To ensure that members obtained all necessary prescriptions during the transition, the State held daily conference calls with health plans and bi-weekly calls with stakeholders. Conference calls were also held weekly with internal Department staff to work out issues and policies. The Department used post implementation processes to address member and provider issues, and provide appropriate oversight and issue identification tracking and resolution. The implementation issues that arose were addressed with the managed care plans and stakeholders.

  Based on statutory changes made during the 2012 Legislative Session, the Department is working to implement two changes to the managed care pharmacy program – Exclusive Pharmacy Networks and Prescriber Prevails.

  Exclusive Pharmacy Networks

  As directed by statute, the Department developed a list of drugs that, based on clinical, professional and/or cost criteria, are considered “specialty drugs” and may be made available to managed care enrollees through a limited pharmacy network. The statute prohibits plans from limiting their pharmacy networks for any drugs not included on the specialty drug list. Originally scheduled for implementation on October 8, this initiative is on hold. Pursuant to an October 5, 2012 order of Justice Roger McDonough, State Supreme Court, Albany County, issued against the Department of Health in the Matter of the Pharmacists’ Society of the State of New

York et al. v. State of New York, et al., the Department agreed that it will not implement the final criteria or the exclusive pharmacy network drug list that was scheduled to take effect on October 8, 2012, pending further hearing and order of the Court.

Prescriber Prevails

Policies and procedures are being developed to implement a prescriber prevails process which allows a prescriber's professional judgment to prevail for second generation atypical antipsychotics that are non-preferred or not on a plan's formulary. The plan must approve the use of these drugs upon demonstration by the prescriber, after consulting with the managed care provider, that the drug is medically necessary and warranted. Plans may use prior authorization and/or utilization management tools, but may not ultimately deny a drug in opposition to the prescriber's professional judgment if the appropriate justification and/or documentation is provided. This initiative is scheduled for implementation on January 1, 2013.

- Limitations on Physical Therapy/Occupational Therapy/Speech Therapy - Effective 10/1/11

  As of October 1, 2011, outpatient physical, occupational and speech therapy is limited to 20 visits each per calendar year for Medicaid managed care and FHPlus enrollees. The visit limits do not apply to Medicaid managed care members who are under the age of 21 or developmentally disabled.

- Personal Emergency Response Systems (PERS) - Effective 1/1/12

  PERS services were included in the Medicaid managed care benefit package effective January 1, 2012. PERS is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. These systems are typically connected to a patient's phone and signal a response center when a "help" button is activated.

- Transportation Removed from Benefit Package – Phase-out Starting 1/1/12

  The Medicaid managed care emergency and non-emergency transportation benefit is being carved out to Medicaid fee-for-service according to a regional phase-out schedule. The first phase began in January 2012, when twenty-four upstate counties in the Hudson Valley Region were phased out. Additional Hudson Valley Region counties were phased out in March 2012 (8 counties) and September 2012 (3 counties). Preparations are underway to carve out the entire New York City Region effective January 1, 2013. A meeting with NYC based managed care plans and LogistiCare, the non-emergency transportation manager in the NYC Region, will be held in November to discuss strategies for minimizing disruption for enrollees during the transition.

  This carve-out also applies to non-emergency transportation services for FHPlus enrollees aged 19 through 20.

- Low Back Pain Treatments - Effective 6/1/12

  Coverage is eliminated for certain treatments of chronic low back pain that are considered ineffective or experimental/investigational. Non-covered treatments

include systemic corticosteroids, therapeutic or diagnostic facet steroid injections, steroid injections into intervertebral discs and traction.

- Knee Arthroscopy Treatments – Effective 6/1/12

  Coverage of knee arthroscopy using debridement and lavage is discontinued as a treatment for osteoarthritis (OA).

- Growth Hormone - Effective 6/1/12

  Coverage of growth hormone injections is discontinued for idiopathic short stature (ISS) in children when there is no alternate diagnosis to account for short stature. Coverage remains available in cases of documented growth hormone deficiency.

- Dental – Mandatory Benefit Effective 7/1/12

  Dental became a mandatory Medicaid managed care benefit effective July 1, 2012. Most Medicaid managed care enrollees already received dental services through their health plan before that date, but seven mainstream plans and the three HIV SNPs did not offer dental in any service area. In preparation for the transition, the Department held a webinar on June 12, in which there were 528 participants, and worked with health plans on development of dental networks. The primary network issues have been refusal by dental providers to enter into provider contracts and shortage of dental specialists in some counties. To the extent dental networks are not adequate to provide timely access to enrollees, plans are required to refer enrollees to providers who are out of network and/or out of the service area.

- Preparations for Including Orthodontia in Benefit Package

  In preparation for including the orthodontic benefit in the Medicaid managed care benefit package effective October 1, 2012, the Department held biweekly internal planning and policy development meetings with the Division of Health Plan Contracting & Oversight (formerly the Division of Managed Care), the Director of the Division of Office of Health Insurance Programs (OHIP) Operations and the Medicaid Dental Director. A meeting with orthodontic providers was held on May 31 in New York City to discuss the transition, as well as new procedures for fee-for-service providers related to closure of the New York City Orthodontic Rehabilitation Program (NYC ORP). On June 12, the Department held a webinar for providers to discuss both the dental and orthodontia transitions. Questions and answers were posted on the Department's web site. Another meeting was held on July 12 including orthodontists, health plans and dental benefits managers which allowed a dialogue amongst all stakeholders.

- Preparations for Including Consumer Directed Personal Assistance Program (CDPAP) in Benefit Package – Effective 11/1/10

  The Consumer Directed Personal Assistance Program (CDPAP) includes some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

In preparation for including the CDPAP in the Medicaid managed care benefit package effective November 1, 2012, the Department worked with consumers of CDPAP services who are enrolled in managed care, fiscal intermediaries (FIs) and managed care organizations (MCOs) to facilitate a smooth transition. Three workgroup meetings were held with stakeholders to identify and address potential issues in the transition of the benefit. The MCOs were provided the model memorandum of understanding (MOU) currently used by the local social services districts and FIs. The plan associations met with the Consumer Directed Personal Assistance Association of New York State (CDPAANYS) to assist in the drafting of a model agreement between the MCOs and the FIs. The agreement was provided to the workgroup at a meeting on August 7, 2012.

The Department provided each MCO with the names of those MCO members currently in receipt of CDPAP, including the associated FI, on August 6, 2012. This allowed the MCOs to reach out to the FIs regarding a provider contract. MCOs are required to identify each FI they have a contract with by county.

Policies and procedures for MCOs on contracting with FIs, responsibilities of the MCO, the FI and the consumer in the administration of the CDPAP benefit and the model agreement between the MCO and the FI will be provided to MCOs in early October.

2. Other Program Changes

- New Mandatory Populations – Mainstream Medicaid Managed Care

CMS approved three waiver amendments during the demonstration year eliminating formerly excluded and exempt populations from enrollment into Medicaid managed care.

October 2011 New Populations

On September 30, 2011, CMS approved a waiver amendment which require the following previously excluded/exempt populations to enroll in Medicaid managed care as of October 1, 2011:

- Individuals receiving Mental Health Family Care
- Non-disabled Seriously and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED) children
- Individuals for whom a managed care provider is not geographically accessible
- Pregnant women receiving care from a prenatal care provider not participating in any Medicaid managed care plan
- Individuals with a language barrier
- Individuals temporarily residing outside of their home district
- Individuals with a chronic medical condition who are under active treatment for at least six months with a specialist who does not participate in any Medicaid managed care plan are limited to a six month exemption

April 2012 New Populations

In April, notices were sent to the following populations informing them that their exclusion or exemption was eliminated and they must choose a plan within 30 days or request an exemption under another exemption category:

- ❖ Infants under 6 months of age born disabled or under 1200 grams
- ❖ Individuals with End Stage Renal Disease (ESRD)
- ❖ Homeless individuals

The Department worked closely with stakeholders to ensure a smooth transition of the homeless population into Medicaid managed care beginning April 1. Stakeholder meetings were held in November 2011 with homeless services providers (including Federally Qualified Health Center (FQHCs)), advocates, county managed care staff and the State Office of Temporary and Disability Assistance to obtain recommendations for program features. Based on these meetings, as well as issue-oriented work groups and follow-up conference calls with NYC and Upstate stakeholders and the NYC Department of Homeless Services, the Department developed operational requirements in such areas as: identifying homeless individuals; education and enrollment of the homeless; education of health plan staff and providers; lock-in; communication; provider credentialing; health plan/provider contracting; access to care; case/care management; authorizations and referrals; reimbursement for case management/shelter screening/assessment; Health Homes; and outcome measures. Through periodic conference calls, the Department identified and worked to resolve outstanding issues related to primary care physician assignments, open and closed panels, and plan review of provider credentials for panel participation. The homeless population in NYC was phased in over a period of six months, beginning in April with families in shelters, then singles and adult families in shelters and, finally, the undomiciled homeless in August/September.

September 2012 New Populations

On August 31, 2012 the Department received written approval from CMS to eliminate the exemption for individuals whose characteristics and needs are similar to individuals enrolled in certain Section 1915(c) waiver programs and individuals in an Intermediate Care Facility for the Developmentally Disabled (ICF/MR). These populations are referred to as “look-alikes”. In early August, based on verbal approvals from CMS, the Department sent “end of exemption” notices to approximately 3,200 individuals notifying them that their exemption would be ending and they would be receiving an enrollment packet upon expiration of their exemption. The Enrollment Broker and local social services districts are trained to advise these individuals of their options, including seeking an Office for People with Developmental Disabilities (OPWDD) designation, enrollment in an Home and Community Based Services (HCBS) waiver program or a six month chronic illness exemption, as applicable. Individuals who request another exemption or exclusion, or enrollment in a waiver program, will be required to enroll pending a determination on their request.

F. Twelve Month Continuous Coverage

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide continuous coverage for certain Medicaid beneficiaries and FHPlus enrollees for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. The Department is in the process of developing and implementing systems and program changes and anticipates an effective date of November 1, 2012.

G. Federally Qualified Health Services (FQHC) Lawsuit

Community Health Care Association of New York State (*CHCANYS), et al vs NYS Dept of Health, et al* is currently pending in federal court (U.S. District Court, Southern District of NY). Discovery has been completed and both sides have moved for summary judgment. Submission of all papers related to the motions for summary judgment has been completed. We are awaiting a decision to be issued

VI. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

See **Attachment 2**: NYS Partnership Plan Projected 1115 Waiver Budget Neutrality Impact.

B. Designated State Health Programs

There was no expenditure activity for Designated State Health Programs during the quarter.

C. Hospital Demonstration and Clinic Uncompensated Care

NYSDOH processed Clinic Uncompensated Care distributions in the amount of $34,165,504, $17,082,754 FFP, during the quarter ended March 31, 2012.

NYSDOH processed Clinic Uncompensated Care distributions in the amount of $9,196,209, $4,598,105 FFP, during the quarter ended June 30, 2012.

NYSDOH processed Clinic Uncompensated Care distributions in the amount of $1,790,919, $895,459 FFP, during the quarter ended September 30, 2012.

Cumulative distributions to date total $45,152,632, $22,576,316 FFP.

VII. Update on Progress Activities Related to Quality Demonstrations and Clinic Uncompensated Care Funding

In the course of the fourth quarter, the Department completed the application review process for the Hospital-Medical Home Demonstration Program. The Department also finalized the funding distribution formula including the methodology to up-weight funding for those programs deemed to be community-based. The individual award amounts were completed and the awards and the methodology are currently under review by the CMS.

Working with IPRO, the Department additionally completed the development of an online standardized work plan during the fourth quarter. The work plan includes a set of instructions and a template for electronic tracking and reporting milestones and measures data. The work plan will be available to participants on October 3, 2012 on the website created for the Demonstration project. Work plans were originally due for submission to the Department on November 15, 2012. Work plan due dates for all hospitals were extended due to super storm Sandy to December 3, 2012. A second extension was granted to hospitals effected by the storm until December 17, 2012. All hospital submitted their work plans, except for Staten Island University Hospital which withdrew from the demonstration.

The Department planned two webinars and a conference call to educate participants and answer questions regarding the work plan components and data requirements. These sessions are expected to take place in the next quarter and will be timed with the release of the work plan and due date. The Department continues to provide work plan technical assistance to participants as needed. During the next quarter, the work plan will be released and hospitals will complete it and submit it to the Department. In addition, a work plan review tool will be developed, and the work plan review process will begin. The Department is also exploring the process of developing an Request for Applications (RFA) for the Potentially Preventable Readmissions (PPR) Demonstration Program.

VIII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 4,368 complaints and action appeals this quarter, an 11% increase from the previous quarter. Of these complaints and appeals, 667 were FHPlus complaints and appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 28% of the total. There were 101 complaints and appeals reported by the HIV Special Needs Plans (SNPs), the majority of which (23) were in the category of reimbursement and billing. The Department directly received 114 Medicaid managed care complaints and 6 FHPlus complaints this quarter. The most frequent category of complaints was reimbursement/billing.

During the quarter, the Department completed analysis of complaints reported by plans for the period January through June 2011 and plans engaged in corrective actions as follows:

- In response to higher than expected complaints for transportation and reimbursement and billing, HealthFirst improved linkages between member services and network management, providing details on complaints to be addressed with the providers. Where enrollees file five or more complaints per quarter, the plan will request corrective action from the providers.

- Wellcare identified the majority of complaints regarding emergency services and balance billing as resulting from members not presenting Identification (ID) cards or otherwise indicating Wellcare coverage at the time of service. In response, Wellcare published reminder articles in member and provider newsletters in July 2011 and September 2011, respectively, regarding the need to identify as a plan member and the prohibition against balance billing.

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

The MMCARP met four times during the demonstration year, in December 2011 and in April, June and September of 2012. Topics of discussion included: progress of MRT #1458 eliminating exclusions and exemptions and moving benefits into the managed care benefit package; the status of the Health Exchange/Health Care Reform; Health Homes; the status of mandatory managed long term care enrollment; Care Coordination Model (CCM) guidelines; progress of the Dual Integration Initiative; auto-assignment rates; the risk adjusted rate methodology; Quality Assurance Reporting Requirements (QARR) results; and, mainstream and HIV SNP satisfaction survey results.

C. Managed Care Policy and Planning Meetings

Beginning in October 2011, the Medicaid Managed Care Operational Issues Workgroup began meeting monthly and the name was changed to Managed Care Policy and Planning Meetings. The monthly meetings provide a forum for discussion of issues related to the many Medicaid Redesign Team changes affecting both mainstream managed care plans and Managed Long Term Care Plans (MLTCPs). As such, the participant list was expanded to include MLTCPs. Each meeting consists of two sections – Finance Issues and Program Issues.

The finance portions of the meetings were devoted to discussions of: rate adjustments for mainstream plans related to new benefits, benefit changes and new populations (e.g., inclusion of pharmacy in the managed care benefit, rate setting for SSI infants); the global cap; rate setting for MLTCs in a mandatory environment; the MLTC risk corridor; rate trends; mental health government rates; Ambulatory Patient Groups (APGs); and, stop loss.

Program issues included discussions of: the Behavioral Health Organization (BHO) initiative; MLTC quality reporting; Health Homes; the Dual Integration initiative; the Recipient Restriction Program; MLTC mandatory enrollment; new benefits transitioning into managed care; the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) demonstration; implementation of potentially preventable negative outcomes in hospital settings; Executive Order 38 (Executive Compensation Regulation); and, Health Exchange/Health Care Reform implementation.

VIII. Quality Assurance/Monitoring

A. Quality Measurements

1 - Annual QARR Reporting

All Medicaid and Child Health Plus (CHP) plans reported the annual quality measures on June 15, 2012. Following are the rates of performance. New York's Medicaid managed care plans continue to improve performance, not only reducing the gap between commercial performances, but also achieving results that are above national benchmarks.

Measure	Medicaid Average	HIV SNP Average
Children and Adolescents' Access to PCPs Ages 12-24 months	97	89
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Years	93	88
Children and Adolescents' Access to PCPs Ages 7-11 Years	95	96
Children and Adolescents' Access to PCPs Ages 12-19 Years	92	96
Adults' Access to Care Ages 20-44 Years	83	97
Adults' Access to Care Ages 45-64 Years	90	98
Adults' Access to Care Ages 65 and over	90	98
Use of Imaging Studies for Low Back Pain	79	81
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	28	N/A
Advising Smokers to Quit	78	91
Discussing Smoking Cessation Medications	56	82

Measure	Medicaid Average	HIV SNP Average
Discussing Smoking Cessation Strategies	48	72
Colon Cancer Screening	56	60
Flu Shot for Adults	41	72
Cholesterol Screening Test	90	98
Cholesterol Level Controlled (<100 mg/dL)	52	62
Persistence of Beta-Blocker Treatment	77	SS
Drug Therapy for Rheumatoid Arthritis	77	N/A
Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	91	99
Annual Monitoring for Patients on Persistent Medications- Digoxin	94	SS
Annual Monitoring for Patients on Persistent Medications- Diuretics	90	99
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	66	82
Annual Monitoring for Patients on Persistent Medications- Combined Rate	90	98
Use of Appropriate Medications for People with Asthma (Ages 5-18)	89	SS
Use of Appropriate Medications for People with Asthma (Ages 19-64)	84	71
Use of Appropriate Medications for People with Asthma (Ages 5-64)	87	72
Appropriate Asthma Medications- 3+ Controllers (Ages 5-18)	71	SS
Appropriate Asthma Medications- 3+ Controllers (Ages 19-64)	74	64
Appropriate Asthma Medications- 3+ Controllers (Ages 5-64)	72	63
Medical Management for People with Asthma 50% Covered (Ages 5-18)	50	SS
Medical Management for People with Asthma 50% Covered (Ages 19-64)	68	77
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	50	26
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	68	59
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	84	84
Monitoring Diabetes - HbA1c Testing	89	92
Monitoring Diabetes - Lipid Profile	87	95
Monitoring Diabetes - Dilated Eye Exam	64	52
Monitoring Diabetes - Nephropathy Monitoring	83	78
Monitoring Diabetes - Received All Tests	51	N/A
Managing Diabetes Outcomes -Poor HbA1c Control	33	31
Managing Diabetes Outcomes - HbA1C Control (<8.0%)	58	63
Managing Diabetes Outcomes - HbA1C Control (<7.0%) for Selected Populations	41	49
Managing Diabetes Outcomes - Lipids Controlled (<100 mg/dL)	47	53
Managing Diabetes Outcomes - Blood pressure controlled (<140/80 mm Hg)	44	50
Managing Diabetes Outcomes - Blood pressure controlled (<140/90 mm Hg)	66	69
Managing Diabetes Outcomes - HbA1c and Lipids Controlled	37	N/A
HIV/AIDS Comprehensive Care-Engaged in Care	84	90
HIV/AIDS Comprehensive Care-Viral Load Monitoring	64	84

Measure	Medicaid Average	HIV SNP Average
HIV/AIDS Comprehensive Care-Syphilis Screening	66	78
Annual Dental Visit(Ages 2-21)	54	N/A
Antidepressant Medication Management-Effective Acute Phase Treatment	51	53
Antidepressant Medication Management-Effective Continuation Phase Treatment	34	32
Follow-Up After Hospitalization for Mental Illness Within 7 Days	72	34
Follow-Up After Hospitalization for Mental Illness Within 30 Days	83	51
Childhood Immunization Status (Combo 3:4-3-1-3-3-1-4)	74	86
Lead Testing	89	97
Adolescent immunization-Combo	67	SS
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	83	SS
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	83	77
Adolescent Well-Care Visits	59	51
Appropriate Treatment for Upper Respiratory Infection (URI)	92	96
Appropriate Testing for Pharyngitis	86	SS
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	59	SS
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	66	SS
Weight Assessment- BMI Percentile	73	82
Weight Assessment- Counseling for Nutrition	77	72
Weight Assessment- Counseling for Physical Activity	66	63
Adolescents' Assessment or Counseling or Education- Sexual Health	66	66
Adolescents' Assessment or Counseling or Education- Depression	59	67
Adolescents' Assessment or Counseling or Education- Tobacco Use	70	61
Adolescents' Assessment or Counseling or Education- Substance Use	67	65
Breast Cancer Screening	67	70
Cervical Cancer Screening	71	82
Chlamydia Screening (Ages 16-20)	70	79
Chlamydia Screening (Ages 21-24)	72	80
Chlamydia Screening (Ages 16-24)	71	79
Recommend Plan to Others	91	85

2 - Behavioral Health Measurement

New York State Department of Health (NYSDOH) continued to expand its performance measurement activities by collaborating with the Offices of Mental Health and Alcohol and Substance Abuse Services to develop an expanded behavioral health measurement set which will be used to measure not only Medicaid managed care recipients, but also enrollees in health homes and Behavioral Health Organizations. A report is being drafted for discussion with stakeholders

3 - Case Management

The second annual submission of care management data occurred in April 2012. Eighteen Medicaid managed care plans submitted information about the membership involved in care management services during 2011. The preliminary results are being analyzed and are being shared with the plans. Plans submitted information for over 111,000 members who were either identified as possibly benefitting from care management services or who were enrolled in care management programs. The table below demonstrates some preliminary results from process measures from the data. Additional analyses will be conducted over the next six to nine months.

Measure	Definition	2010 Result	2011 Result	
Identifying for Case Management				
Trigger Rate	# triggered / # enrolled in plan		3. 4%	3. 2%
Contact Rate	# contacted / # triggered - # not appropriate		37. 1%	47. 4%
Appropriateness Rate	# deemed appropriate / # contacted		76. 3%	93. 5%
Refusal Rate	# refused / # contacted/appropriate		7. 6%	15. 2%
Enrolling in Case Management				
Total Number Enrolled				
…Annually	Total enrolled in calendar year		25,559	41,020
Percent Enrolled…				
…of Total Plan Membership	# enrolled in CM / # enrolled in plan		0. 9%	1. 2%
…of Triggered	# enrolled in CM / # triggered		25. 7%	36. 9%
…of Contacted	# enrolled in CM / # successfully contacted		69. 4%	78. 8%
…of Appropriate	# enrolled in CM / # deemed appropriate		90. 9%	84. 3%
Provision of Case Management				
CM Program Type….				
…By Enrollment				
Behavioral Health	Percent Enrolled in Program (of all enrollees)		9. 4%	7. 1%
Catastrophic			8. 9%	6. 8%
Chronic Adult			35. 2%	47. 1%
High Risk OB			25. 5%	23. 4%
HIV/AIDS			0. 7%	2. 0%
Oncology			0. 3%	0. 4%
Pediatrics			7. 2%	10. 0%

Measure	Definition	2010 Result	2011 Result	
Provider-based			0. 0%	0. 0%
Utilization-based			5. 2%	3. 2%
Missing/Invalid/Not Reported			7. 6%	0. 0%

Length of Time in Case Management			
Enrollment to Closure			
Mean Days to Closure	Number of days between CM enrollment and closing of CM case	66. 1	62. 3
Range of Days to Closure		-122 to 488	0 to 453
Closed Before Enrolled	Percent of CM cases closed within the specified number of days of enrollment in CM	0. 02%	0. 0%
Closed Same Day		14. 0%	31. 0%
Closed between 1-14 Days		12. 0%	7. 8%
Closed between 15-30 Days		12. 0%	8. 7%
Closed between 31-60 Days		21. 0%	15. 2%
Closed between 61-90 Days		13. 9%	11. 5%
Closed After 90 Days		27. 1%	25. 7%

4 - Managed Long-term Care

The second annual performance report is in development and will be publicly reported in 2012. The NYSDOH also created a Consumer Guide to Managed Long Term Care for New York City to assist enrollees, especially those who are being mandatorily enrolled, in choosing a plan. A third consumer satisfaction survey was developed and will be administered in November 2012.

B. Quality Improvement Activities

Health plans participated in a variety of quality improvement activities including performance improvement projects, and special studies.

1 - Performance Improvement Projects (PIPs)

The Department's external quality review organization, IPRO, assisted managed care plans with completing the Performance Improvement Projects (PIPs). For the 2011 – 2012 study period, two collaborative PIP projects are in progress: 1) Eliminating Disparities in Asthma Care (EDAC) which involved six Medicaid managed care plans in the Brooklyn, NY service area and 2) Reducing Potentially Preventable Readmissions (PPR) which has 10 health plans from across the state participating. A conference is being scheduled for 2012 for the Readmission PIP.

A two-year collaborative PIP is in the planning stage which will have two parts: 1) implementing interventions to improve care in diabetes prevention and management, smoking cessation and hypertension management, and 2) testing the effectiveness of patient incentives on improving health behaviors and outcomes in the above-noted clinical areas.

2 - Focused Clinical Studies

Our external review organization, IPRO, is expanding its work on the Adherence to the Medicaid Prenatal Care Standards study. Three large prenatal care centers will test a Prenatal Medical Record Review Tool to facilitate practice and provider self-evaluation. The chlamydia medical record review, whose purpose was to validate the use of administrative data to identify women asymptomatically screened at routine visits, as well as, those women tested in the presence of signs and symptoms of disease, is complete and data will be available shortly. The draft report for the medical record review for the prenatal care study is being finalized.

3 - Pay for Performance and Quality Oversight

The Quality Incentive, based on 2010 QARR data, was implemented in 2012. Staff and the Medicaid Director met with five plans whose quality performance as measured by 2010 and 2011 QARR data did not qualify them for the Quality Incentive. One plan's performance improved in 2011 and will receive the Incentive, while the remaining plans are being monitored and will need to show improvement in 2012.

Following the submission of 2011 QARR data in June 2012, the plans were given their annual performance matrices and required to develop root cause analyses and action plans for measures where performance was under the statewide average and lower than the previous year's performance.

4 - External Quality Review

The External Quality Review extension expires on March 31, 2013. Due to a statewide effort to review and streamline procurement practices, a request for an extension until March 31, 2014 is being requested.

C. Quality Outcomes Evaluation

1 - Selective Contracting

Staff continues to work with hospital representatives regarding the Department's policy on Medicaid reimbursement for breast surgery and hospital eligibility for the performance of such surgery. In addition, staff continues to field questions regarding the Department's policy that only CMS certified bariatric centers may be reimbursed for bariatric surgical services to Medicaid recipients. Both policies remain in effect.

2 - Inpatient Outcomes Evaluation

Potentially Preventable Hospitalizations: Staff completed work designing databases that will make Medicaid, Medicare, and all-payer hospital inpatient data more widely available to Department analysts, and will also include discharge indicators for potentially preventable readmissions (PPRs), potentially preventable complications (PPCs), and prevention quality indicators (PQIs). These databases will include not only all the inpatient information

historically collected, but indicators for these potentially preventable events as well. Such databases will not only make inpatient information much more widely available to all Department staff authorized to access such data, but will also make the indicators for potentially preventable hospital admissions available for wider analysis. Staff has begun the process of loading historical data into the new databases and running these data through the PPR, PPC, and PQI logic.

Prevention Quality Indicators for Managed Care Plans: Staff received 2011 managed care plan inpatient data and ran these data through the latest version of the PQI logic. Staff used these data to develop crude and risk-adjusted managed care plan PQI rates and, as has been the case for the previous two years, will use such rates to define plan performance in the annual Quality Incentive effort for managed care plans. Staff continues to work with these data in order to share the results with managed care plan representatives.

3 - Nursing Home Quality Improvement

The Department will use a measure of potentially avoidable hospital admissions from nursing homes as part of the Nursing Home Quality Improvement effort. Staff has completed analyses of MDS data to define nursing home "episodes" for residents during the 2010 calendar year, and to identify those episodes during which one or more potentially avoidable hospitalizations took place. Work has begun on defining risk-adjusted potentially avoidable hospitalization rates for nursing homes, using the methodology developed in the CMS sponsored Nursing Home Value Based Purchasing Demonstration.

4 - Development of Medicaid Behavioral Health Outcome Measures

As part of an ongoing effort to develop a set of publically reportable performance measures, staff worked with representatives from the Office of Mental Health and the Office of Alcohol and Substance Abuse Services to refine measures of the utilization of behavioral health and substance services for the Medicaid population.

5 - Asthma Disparities Grant

Eliminating Disparities in Asthma Care (EDAC) grant activities focused on the following: conducting site visits at partnering practice sites, holding two quality improvement webinars, presenting project progress for a Centers for Disease Control and Prevention (CDC) site visit, and overseeing data collection and reporting in support of quality improvement efforts.

EDAC's quality improvement consultant conducted site visits at partnering practices to provide on-site quality improvement coaching. The content of webinars held on July 13, 2012 and September 14, 2012, was focused on teams discussing action period progress and next steps in response to the coaching received.

Asthma project officers from the CDC conducted a site visit for the NYSDOH Asthma Control Program (ACP) in Albany, New York on July 25 and 26, 2012. As EDAC is an expended component of the NYSDOH ACP, EDAC leadership staff presented an overview of project goals, design, progress and results to date.

NYSDOH staff continuously monitors the data submission process to ensure data are submitted timely and accurately by all teams. The following reports were generated and posted to the Institute of Healthcare Improvement (IHI) Extranet in September 2012: a Group II measure report, comprised of health plan level measures; the fourth quarterly

report of community level measures, and 2012 Asthma Disparities Report Cards (ADRC), stratified by partnering health plans and New York City boroughs.

IX. Family Planning Expansion Program

Family Planning Benefit Program Enrollment Summary

Fourth Quarter FFY 2012 (July 1, 2012 – September 30, 2012)

	Female	Male	Total
New Enrollees This Quarter	4,665	1,655	6,320
Total Enrollees This Quarter	34,456	8,008	42,464
Enrollees Using Services This Quarter	11,829	108	11,937
Cumulative Enrollment Since 1/01/10	86,846	24,420	111,266
Enrollees Using Services Since 1/01/10	44,536	1,597	46,133
Continuous Enrollment Since 1/01/10	4,009	335	4,344

Source of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart, Report Date 01 Sep-2012

Family Planning Benefit Program Utilization by Category of Service
Fourth Quarter FFY 2012 (July 1, 2012 – September 30, 2012)

TOTAL Medicaid Eligibles	**42,464**
TOTAL Medicaid Recipients	**11,937**
TOTAL Medicaid Expenditures	**2,033,157**
TOTAL Medicaid Eligible Months	**111,562**
AVERAGE Expenditures per Eligible	**48**
AVERAGE Months per Eligible	**2.6**
PMPM	**18**

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims / Days per Recipient	COS Recipients
Physician	16,968	0.15	80	503	Claims	2	212
Podiatry	12	0.00	6	5	Claims	3	2
Psychology	225	0.00	225	5	Claims	5	1
Nursing	485	0.00	49	14	Claims	1	10
OPD Clinic (hospital outpatient)	43,699	0.39	321	163	Claims	1	136
FS Clinic (D&T center)	759,210	6 81	209	4,181	Claims	1	3,633
Inpatient	1,156	0.01	1,156	0	Claims	0	1
Pharmacy	1,135,127	10.17	119	18,715	Claims	2	9,521
Laboratory	28,255	0.25	44	1,285	Claims	2	639
Transportation	838	0.01	210	18	Claims	5	4
CTHP	1,058	0.01	81	14	Claims	1	13
DME & Hearing Aid	393	0.00	56	14	Claims	2	7

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims / Days per Recipient	COS Recipients
Referred Ambulatory	43,796	0.39	85	866	Claims	2	518

Source Of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart (Report Date: 01-Sep. - 2012)

As required by Item 65 of the Partnership Plan STCs, **Attachment III** provides data on expenditures for Medicaid funded FFS deliveries, births and 1st year of life for the Medicaid funded Family Planning Expansion Program (FPEP).

X. Transition Plan Updates

There are no updates to the transition plan for this quarter. The Department continues to explore the necessary system and program changes needed to implement the Affordable Care Act.

Attachments

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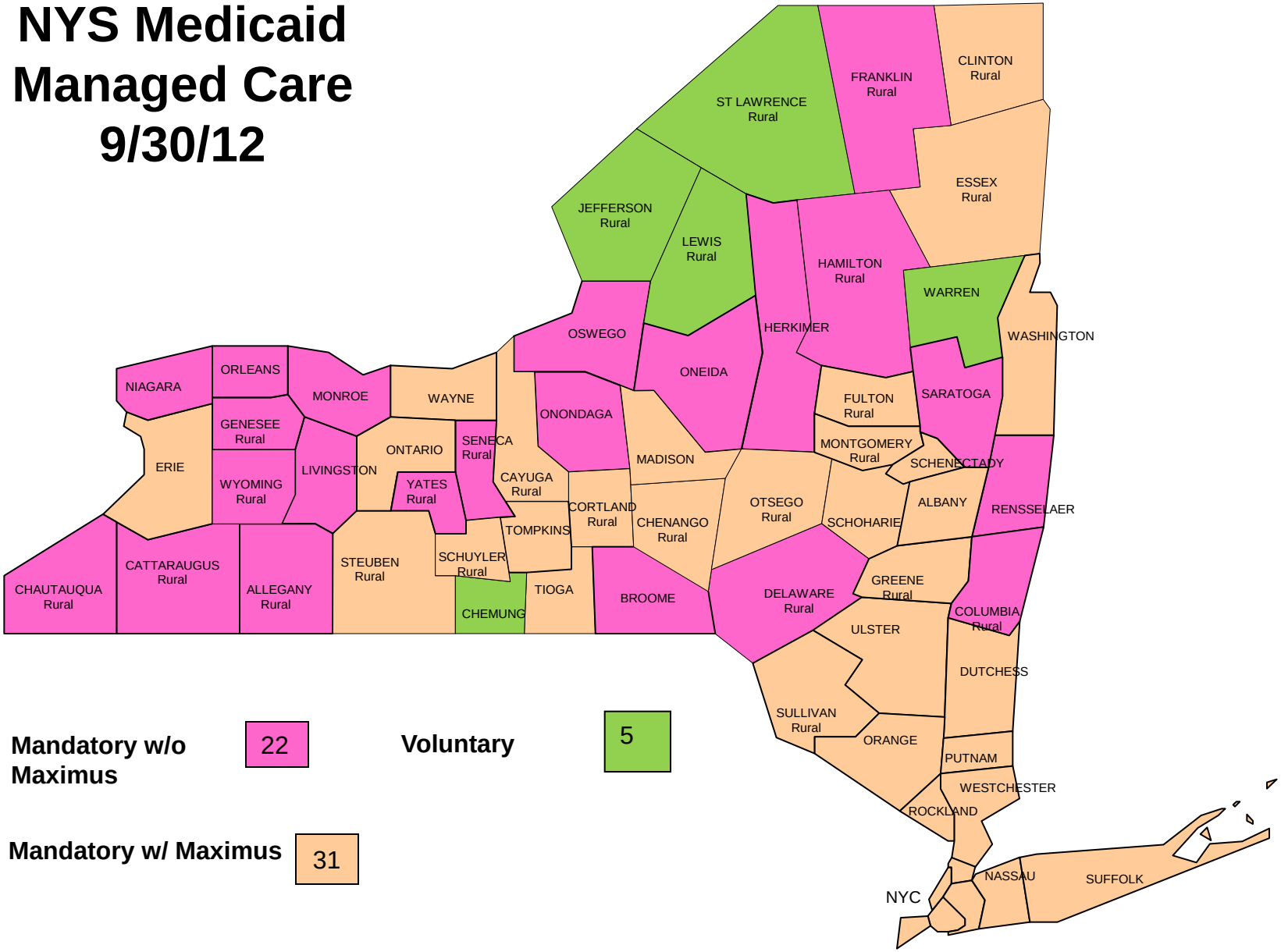
NYS Medicaid Managed Care 9/30/12



Mandatory w/o Maximus 22

Voluntary 5

Mandatory w/ Maximus 31

ATTACHMENT 2
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 - 15 (10/1/97 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,981,603,311	$15,455,268,043	$4,137,807,371	$57,001,115,405	
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,635,908,331	$6,224,033,160	$1,663,421,971	$22,956,500,500	
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,061,365,979	$2,344,366,724	$2,609,395,833	$713,869,831	$9,650,562,428	
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271	$11,139,306	$2,897,896	$29,879,714	
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,644,403,988**	**$21,972,580,637**	**$24,299,836,341**	**$6,517,997,069**	**$89,638,058,047**	**$277,028,633,187**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 - 14 (10/1/97 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$4,144,199,750	$1,827,792,863	$2,601,977,167	$6,033,438,430	$6,651,329,935	$1,767,244,953	$23,025,983,098	
Demonstration Group 2 - TANF Adults 21-64		$2,619,299,634	$1,159,889,284	$1,487,941,873	$3,497,627,598	$3,860,574,983	$1,028,253,292	$13,653,586,664	
Demonstration Group 5 - Safety Net Adults		$4,024,374,518	$1,864,361,807	$3,400,994,019	$8,410,811,517	$10,144,634,210	$2,690,451,564	$30,535,627,635	
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$963,020,020	$502,539,894	$560,735,692	$1,179,549,495	$1,307,464,677	$356,244,880	$4,869,554,658	
Demonstration Group 7 - FHP Adults without Children up to 100%		$313,222,949	$155,882,395	$154,684,278	$330,264,237	$374,046,202	$103,281,236	$1,431,381,296	
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0	$0	$0	$0	
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340	$12,272,547	$3,252,352	$46,565,853	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101	
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	
With Waiver Total	**$151,007,816,586**	**$12,073,956,605**	**$5,514,630,728**	**$8,220,692,530**	**$19,634,666,726**	**$22,521,421,662**	**$5,991,353,054**	**$73,956,721,305**	**$224,964,537,890**
Expenditures (Over)/Under Cap	**$36,382,758,554**	**$5,513,188,131**	**$4,101,464,547**	**$1,423,711,458**	**$2,337,913,911**	**$1,778,414,679**	**$526,644,016**	**$15,681,336,742**	**$52,064,095,296**

New York State Partnership Plan
PMPM's and Member Months

WITHOUT WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr)
TANF Kids	$585.99	$624.67	$624.67	$665.90	$709.85	$756.70
TANF Adults	$801.34	$852.63	$852.63	$907.20	$965.26	$1,027.04
FHPlus Adults with Children	$625.55	$665.59	$665.59	$708.19	$753.51	$801.73
Family Planning Expansion			$20.23	$21.06	$21.92	$22.81

WITH WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr)
TANF Kids	$216.88	$187.00	$265.43	$287.35	$305.49	$323.18
TANF Adults	$465.25	$400.82	$516.90	$563.01	$598.72	$634.87
SN - Adults	$539.39	$454.35	$806.53	$924.53	$1,035.36	$1,088.75
FHPlus Adults with Children	$320.69	$320.68	$351.64	$356.32	$377.55	$400.09
FHPlus Adults without Children	$352.04	$361.75	$353.78	$358.59	$379.64	$402.08
Family Planning Expansion	$20.27	$16.39	$21.49	$22.78	$24.15	$25.60

MEMBER MONTHS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr)
TANF Kids	19,108,187	9,774,280	9,802,825	20,996,551	21,772,583	5,468,227
TANF Adults	5,629,847	2,893,809	2,878,584	6,212,421	6,448,038	1,619,627
SN Adults	7,460,970	4,103,355	4,216,837	9,097,365	9,798,142	2,471,136
FHPlus Adults with Children	3,002,984	1,567,102	1,594,624	3,310,364	3,462,988	890,412
FHPlus Adults without Children	889,734	430,909	437,231	921,016	985,257	256,870
Family Planning Expansion	485,446	254,090	254,090	508,180	508,180	127,045

Appendix 3
NYS Medicaid Program
Expenditures for Medicaid Funded FFS Deliveries, Births and 1st Year of Life
Based on Dates of Service in FFY '11

Prenatal and Delivery FFS Medicaid Expenditures (Age 18 - 44)

# of FFS Deliveries	Prenatal Dollars	Average Prenatal Dollars	Delivery Stay Dollars	Average Delivery Stay Dollars
22,927	70,162,462	3,060	169,030,253	7,373

"Prenatal" Dollars refers to all Expenditures incurred during the Prenatal Period (270 days prior to the delivery admit date)

Birth Expenditures (all FFS births, regardless of mothers' age)

# of FFS Births	Birth Stay Dollars	Average Birth StayDollars
27,844	209,415,949	7,521

"Birth Stay" Dollars refers to all Expenditures incurred during the Birth Inpatient Stay

Expenditures during 1st Year of Life

# of FFS Births	Age 0 - 1 Dollars	Average Age 0 - 1 Dollars
27,844	302,100,189	10,850

"1st Year of Life" Expenditures include the "Birth Stay" Expenditures"

Source: NYS/DOH/OHIP Datamart (reflects claims paid through November '11)
Questions: Please call Hisam Syed @(518) 473-2230