MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 23 (4/1/2021-3/31/2022)
Federal Fiscal Quarter: 1 (10/1/2021-12/31/2021)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for its Partnership Plan Medicaid Section 1115 Demonstration. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five-year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2016.

There have been several amendments to the Partnership Plan Demonstration since its initial approval in 1997. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. A final draft evaluation report was submitted to CMS on February 11, 2015 and was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30-day public comment period. A temporary extension was granted on December 31, 2014 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 31, 2021. At the time of renewal, the Partnership Plan was renamed New York Medicaid Redesign Team (MRT) Waiver. On April 19, 2019 CMS approved New York's request to exempt MMMC enrollees from cost sharing by waiving comparability requirements to align with the New York's social services law, except for applicable pharmacy co-payments described in the STCs. On August 2, 2019 CMS approved New York's request to create a streamlined children's model of care for children and youth under 21 years of age with behavioral health (BH) and HCBS

needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities. On December 19, 2019 CMS approved New York's request to limit the nursing home benefit in the partially capitated Managed Long Term Care (MLTC) plans to three months for enrollees who have been designated as "long-term nursing home stays" (LTNHS) in a skilled nursing or residential health care facility. The amendment also implements a lock-in policy that allows enrollees of partially capitated MLTC plans to transfer to another partially capitated MLTC plan without cause during the first 90 days of a 12-month period and with good cause during the remainder of the 12-month period.

New York submitted a three-year waiver extension request to CMS on March 5, 2021. CMS granted a temporary extension of the 1115 waiver through March 31, 2022.

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

II. Enrollment: First Quarter

MRT Waiver- Enrollment as of December 2021

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	463,147	5,217	2,261
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	56,871	1,056	593
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	16,917	183	45
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	38,062	522	300
Population 5 - Safety Net Adults	202,866	5,349	2,522
Population 6 - Family Health Plus Adults with	0	0	0

Children			
Population 7 - Family Health Plus Adults without Children	**0**	**0**	**0**
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	**144,474**	**1,725**	**78**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**65,340**	**3,001**	**173**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**64,574**	**313**	**36**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**10,064**	**1,701**	**81**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**19,067 or an approximate -7.14% decrease from last Q**

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

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

Voluntary disenrollment declined primarily due to a decline in disenrollment due to incarcerations.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**6,089 or an approximate -95.45% decrease from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid eligibility including death, plan termination, and retro-disenrollment.

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

Involuntary disenrollment decreased primarily due to a decrease in MAGI case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
October 2021				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**680,812**	**10,991**	**1,896**	**9,095**
Rest of State	**320,568**	**5,887**	**654**	**5,233**
Statewide	**1,001,380**	**16,878**	**2,550**	**14,328**
November 2021				
New York City	**683,334**	**47,449**	**2,295**	**45,154**
Rest of State	**322,713**	**14,835**	**882**	**13,953**
Statewide	**1,006,047**	**62,284**	**3,177**	**59,107**
December 2021				
New York City	**690,343**	**16,560**	**2,400**	**14,160**
Rest of State	**325,105**	**7,119**	**800**	**6,319**
Statewide	**1,015,448**	**23,679**	**3,200**	**20,479**
First Quarter				
Region	**Total Affirmative Choices**			
New York City	**68,409**			
Rest of State	**25,505**			
Statewide	**93,914**			

HIV SNP Plans				
October 2021				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	12,782	133	0	133
Rest of State	19	3	0	3
Statewide	12,801	136	0	136
November 2021				
New York City	12,808	170	0	170
Rest of State	20	1	0	1
Statewide	12,828	171	0	171
December 2021				
New York City	12,838	193	0	193
Rest of State	20	0	0	4
Statewide	12,858	193	0	193
First Quarter				
Region	**Total Affirmative Choices**			
New York City	496			
Rest of State	4			
Statewide	500			

Health and Recovery Plans Disenrollment			
FFY 22 – Q1			
	Voluntary	**Involuntary**	**Total**
October 2022	424	649	1,073
November 2022	492	584	1,076
December	493	486	979

2022			
Total:	**1409**	**1,719**	**3,128**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (10/1/2021-12/31/2021) Q1 FFY 2022

As of the end of the first federal fiscal quarter (end of December 2021), there were 2,969,657 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 77,362 Medicaid consumers enrolled in Health and Recovery Plan (HARP). MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 12 HRA facilities open to the public and has suspended outreach activities at 17 HRA facilities temporarily closed due to COVID-19. MAXIMUS reported that 10,705 clients were educated about enrollment options and made an enrollment choice including 375 clients in person and 10,330 clients through phone.

Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Deficiency found is reported to MAXIMUS Field operation monthly. Due to COVID-19, CMU field monitoring has been suspended since 3/23/2020; therefore, no activity was conducted for the reporting period.

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 24,857 FFS community clients were reported on the regular auto-assignment list, 3,107 clients responded to the call that generated 3,519 enrollments. Of the total of 58 FFS NH clients reported on NH auto-assignment list, 1 (2%) client and/or authorized representatives made a Plan selection.

C. NYMC HelpLine Observations October-December 2021

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 56,594 calls were received by the Helpline and 51,838 or 92% were answered. Calls answered were handled in the following languages: English: 36,556 (70%); Spanish: 6,180 (12%); Chinese: 2,907 (5%); Russian: 434 (1%); Haitian/Creole: 63 (1%); and other: 5,698 (11%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 1,233 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 4rd Quarter 2021								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
802 (65%)	**60 (5%)**	**71 (5%)**	**285 (23%)**	**4 (1%)**	**1(0%)**	**8 (1%)**	**2 (0%)**	**1233**

A total of 774 (63%) recorded calls observed was unsatisfactory including calls with 205 single infraction and 569 calls with multiple infractions, A total of 1343 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: 1140 (85%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.

- Key Messages: 30 (2%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.

- Customer Service: 173 (13%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 1343 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

On November 1, 2021, Molina Healthcare of New York, Inc. was approved to expand its Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) service areas to include Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester counties. This expansion is the result of the acquisition of Affinity Health Plan, Inc.

On November 1, 2021, Affinity Health Plan, Inc. (Affinity) was approved to withdraw its MMC and HARP products from Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester counties. This withdrawal was the result of the acquisition of Affinity by Molina Healthcare of New York, Inc.
The Asset Purchase of Affinity Health Plan, by Molina Healthcare, Inc. closed. Affinity members migrated to Molina Healthcare of New York effective 11/1/21.

On November 29, 2021, HealthPlus HP, LLC was approved to expand its Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) service areas to include Dutchess, Orange, Rockland, Suffolk, Ulster and Westchester counties.

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

The March 1, 2019, Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) was submitted to CMS for approval in federal fiscal year (FFY) 2019-2020. All 19 resultant contracts have been executed by New York State and have been submitted to CMS for final approval. At the close of the quarter, the Model Contract and these resultant executed contracts remained under review by CMS.

On June 18, 2021, New York State submitted to CMS an amendment to the March 1, 2019 Model Contract that includes emergency contract provisions related to the COVID-19 public health emergency. On December 20, 2021, this amendment was issued to Managed Care Organizations for signature.

C. Health Plans/Changes to Certificates of Authority

- Molina's COA was changed to reflect the expansion for Molina.
- Affinity Health Plan's COA was changed to restrict Affinity to close out activities only.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Surveillance activity completed during the 1st QTR FFY 2021-2022 includes the following:

One (1) Comprehensive Operational Survey, and one (1) Target Operational Survey were completed during 1st QTR FFY 2021-2022. An SOD was issued and a POC was accepted for two (2) Plans:

- United Target Operational Survey
- Excellus Comprehensive Operational Survey

Sixteen (16) Member Services Surveys were completed 1st QTR FFY 2021-2022. An SOD was issued and a POC was accepted for thirteen (13) Plans. Three (3) Plans were found in compliance:

- Affinity Health Plan, Inc.
- HealthPlus
- Amida Care, Inc.
- Capital District Physicians' Health Plan, Inc.
- Excellus Health Plan, Inc.

- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York Inc.-The Plan was in compliance
- Independent Health Association, Inc. - The Plan was in compliance
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan
- MVP Health Plan, Inc.
- Fidelis
- Molina -The Plan was in compliance
- UnitedHealthcare of New York, Inc.
- VNS CHOICE

Eighteen (17) PCP Ratio Surveys were completed 1st QTR FFY 2021-2022. No citations were issued, but a Letter of Concern was sent twelve (12) plans. Five (5) Plans were determined exempt from the survey.

- Affinity Health Plan, Inc.
- Healthplus
- Amida Care, Inc. -Exempt
- Capital District Physicians' Health Plan, Inc.
- Excellus Health Plan, Inc. - Exempt
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan -Exempt
- MVP Health Plan, Inc. - Exempt
- Molina -Exempt
- UnitedHealthcare of New York, Inc.
- VNS CHOICE -Exempt
- WellCare of New York, Inc.
- Yourcare

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during this quarter. Final reports were previously submitted for all reviews except for the one involved in an open legal matter.

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted during the quarter due to a legal matter that is still open.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance
  The final summary report was forwarded to the regional CMS office and CMS Central Office on July 1, 2015.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability
  The final summary report was forwarded to the regional CMS office on January 31, 2014 and CMS Central Office on December 3, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations
  The final summary report was forwarded to the regional CMS office on June 28, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications
  The final summary report was forwarded to the regional CMS office on July 25, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding
  The final summary report was forwarded to the regional CMS office on August 1, 2014 and CMS Central Office on December 3, 2014.

B. Benefit Changes/Other Program Changes

Transition of Behavioral Health Services into Managed Care and Development of Health and Recovery Plans (HARPs):
In October 2015 New York State began transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and substance use disorder) and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are specialized plans that include staff with enhanced behavioral health expertise. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called behavioral health Home and Community Based Services (BH HCBS). For Medicaid Managed Care (MMC), all Medicaid- funded behavioral health services for adults, except for services in Community Residences, are part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) began phasing in enrollment of current MMC enrollees throughout New York State into HARPs beginning with adults 21 and over in New York City in October 2015. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care.

In Fiscal Year (FY) 2018, New York State engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in Medicaid Managed Care. In June of 2018, HARP became an option on the New York State of Health (Exchange). This

enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State identified and implemented a policy to allow State Designated Entities to assess and link HARP enrollees to BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center.

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

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

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (7/1/2021-9/30/2021)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	36,356	252	240	0.66%
ROS	4,835	22	22	0.45%
Total	41,191	274	262	0.64%

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

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (7/1/2021-9/30/2021)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	9,153	65	14	0.15%

[1] Q1 data is not available and will be submitted with the next quarterly update.
[2] Q1 data is not available and will be submitted with the next quarterly update.

ROS	945	22	22	2.33%
Total	10,098	87	36	0.36%

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2021-12/31/2021)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	**1,135,854**	**90.22%**	**9.78%**
Rest of State	**935,049**	**93.61%**	**6.39%**
Statewide Total	**2,070,903**	**91.73%**	**8.27%**

BH Adults HCBS Claims/Encounters 10/1/2021-12/31/2021: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	**41**	**13**
Education Support Services	**438**	**114**
Family Support and Trainings	**36**	**11**
Intensive Crisis Respite	**0**	**0**
Intensive Supported Employment	**269**	**65**
Ongoing Supported Employment	**40**	**10**
Peer Support	**2,276**	**473**
Pre-vocational	**281**	**41**
Provider Travel Supplements	**39**	**16**
Psychosocial Rehab	**629**	**84**
Residential Supports Services	**466**	**61**
Short-term Crisis Respite	**10**	**2**
Transitional Employment	**6**	**3**
TOTAL	**4,531**	**768**

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

BH Adults HCBS Claims/Encounters 10/1/2021-12/31/2021: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	**1,007**	**199**
Education Support Services	**923**	**231**
Family Support and Trainings	**41**	**14**

Intensive Crisis Respite	**0**	**0**
Intensive Supported Employment	**480**	**107**
Ongoing Supported Employment	**128**	**26**
Peer Support	**5,038**	**1,064**
Pre-vocational	**388**	**68**
Provider Travel Supplements	**3,374**	**841**
Psychosocial Rehab	**2,835**	**490**
Residential Supports Services	**2,138**	**359**
Short-term Crisis Respite	**0**	**0**
Transitional Employment	**2**	**2**
TOTAL	**16,354**	**2,152**

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

Provider Technical Assistance

Managed Care Technical Assistance Center is a partnership between the McSilver Institute for Poverty Policy and Research at New York University School of Social Work and the National Center on Addiction and Substance Abuse (CASA) at Columbia University, as well as other community and State partners. It provides tools and trainings that assist providers to improve business and clinical practices as they transition to managed care. See below for Managed Care Technical Assistance Statistics.

Quarter 1 MCTAC Attendance & Stats (10/01/2021 to 12/31/2021)

Events: MCTAC successfully executed **21 events** from 10/01/2021 to 12/31/2021. All 21 were held via webinar.

Individual Participation:
2511 people attended/participated in MCTAC events of which **1247** are unique participants.

OMH Agency Participation
Overall: 308 of 653 **(47.17%)**
NYC: 117 of 272 **(43.01%)**
ROS: 225 of 434 **(51.84%)**

OASAS Agency Participation
Overall: 204 of 563 **(36.23%)**
NYC: 65 of 240 **(24.64%)**
ROS: 151 of 389 **(38.82%)**

Efforts to Improve Access to Behavioral Health Home and Community Based Services (BH HCBS)

All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) were made available to eligible HARP and HIV SNP enrollees. These services were designed to provide enrollees with

specialized supports to remain in the community and assist with rehabilitation and recovery. Enrollees were required to undergo an assessment to determine BH HCBS eligibility. Effective January 2016 in NYC and October 2016 for the rest of the state, BH HCBS were made available to eligible individuals.

As discussed with CMS, New York experienced slower than anticipated access to BH HCBS for HARP members and actively sought to determine the root cause for this delay. Following implementation of BH HCBS, the State and key stakeholders identified challenges, including: difficulty with enrolling HARP members in Health Homes (HH); locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process; ensuring care managers have understanding of BH HCBS (including person-centered care planning) and capacity for care managers to effectively link members to rehab services; and difficulty launching BH HCBS due to low number of referrals to BH HCBS providers.

The State previously made efforts to ramp up utilization and improve access to BH HCBS by addressing the challenges identified. These efforts included:

- Streamlining the BH HCBS assessment process
    - Effective March 7, 2017, the full portion of the New York State Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Developed training for care managers and BH HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision, including developing a Health Home training guide for key core competency trainings to serving the high need SMI population
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both HH and RCAs)
- Developed required training for BH HCBS providers that the State can track in a Learning Management System
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in HH. These services are provided by State Designated Entities (SDE) through direct contracts with the MCO
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS
    - Additional efforts to support initial implementation of RCAs include
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (completed)
        - Ongoing technical assistance (completed)

        - Creation of statewide RCA performance dashboard- enhanced to reflect data by RCA and by HH
- Continuing efforts to increase HARP enrollment in HH including:
    - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies
    - Existing quality improvement initiative within clinics to encourage HH enrollment
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management
    - DOH approval of MCO plans for incentivizing enrollment into HH (eg, Outreach Optimization)
- Ongoing work to strengthen the capacity of HH to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead HHs, representation on new HH+ Subcommittee Workgroup
- Implementing Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS Office of Mental Health has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for Medicaid Managed Care Health and Recovery Plans (HARPs) and Adult Behavioral Health (BH) Home and Community Based Services (BH HCBS).
        - NYAPRS conducts outreach in two ways:
            - Through 45-90-minute training presentations delivered by peers
                - OMH approves the PowerPoint before significant changes are made
            - Through direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers)
- Implemented Quality and Infrastructure initiative to support targeted BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. The State has worked with the Managed Care Plans on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS. Infrastructure contracts have been signed and work is underway.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all MCOs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in an increase of members utilizing BH HCBS; the State also shared a summary of best and promising practices with MCOs.
- Issued Terms and Conditions for BH HCBS Providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS Providers are actively providing services.

- Enhancing State Adult BH HCBS Provider oversight including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.
- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, HHs, CMAs, and BH HCBS Provider agencies – which developed and provided a variety of tools to support care manager referrals to BH HCBS, on behalf of NYS' HH/MCO Workgroup.
- A process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments was established, in response to challenges in securing a CM workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,021 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between October 1, 2021, and December 31, 2021, 4,133 eligibility assessments were completed.

Despite extensive efforts outlined above and stakeholder participation to implement strategies for improved utilization of BH HCBS, the number of HARP enrollees successfully engaged with BH HCBS overall remain very low. NYS reviewed a significant amount of feedback from MCOs, Health Homes, Care Managers and other key stakeholders and determined the requirements for accessing BH HCBS were too difficult to standardize among 15 MCOs and 30 Health Homes.

As a result, the State released a draft proposal for public comment in June 2020 to transition 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package for HARP enrollees and HARP eligible HIV-SNP enrollees, which to date has resulted in positive feedback. The State finalized the proposal and submitted to CMS in September 2020. The objectives of this transition are two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the behavioral health population, and to eliminate barriers to access.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through the American Rescue Plan Act, the State revised the September 2020 proposal to comply with the eFMAP requirements and resubmitted to CMS in July 2021. CMS approved NYS's 1115 Waiver Amendment Request for Community Oriented Recovery and Empowerment (CORE) Services on October 5, 2021. CORE Services is a rehabilitation and recovery service array which includes four services previously available through BH HCBS: Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support).

Access to these CORE Services will no longer require an independent eligibility assessment, will remove settings restrictions, and will enable all HARP and HARP eligible HIV-SNP enrollees to access services with a recommendation from a licensed practitioner of the healing arts (LPHA). Enrollment in Health Home Care Management will continue to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by Health Home. Care managers will always have the important role of ensuring timely access to services reflective of the member's preferences and individual needs, in continued collaboration with the MCO and service providers.

CORE Services went live on February 1, 2022 and will be implemented over several months. Consumer education materials have been released via the OMH website and a provider listserv. The State has conducted a series of implementation trainings in partnership with MCTAC, and all active BH HCBS CPST, PSR, FST, and Peer Support providers have been provisionally designated to provide CORE Services.

Habilitation, Education Support Services, Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, and Non-Medical Transportation remain in the BH HCBS benefit package. In January 2022, the State issued revised Adult BH HCBS Workflow guidance for care managers to reflect this change, as well as training for care managers that included a full overview of the CORE Services. The State will continue its efforts to increase access to BH rehab services through working collaboratively with Health Homes.

In addition, in 2021 the State extended the Infrastructure initiative to support the behavioral health providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allows MCOs to contract for remaining, unspent funds totaling approximately $31M.

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

Quarter 1: No activity to report during this quarter. The transition of SBHC services from Medicaid Fee-for-Service to MMC has been moved to 2023. Additional information about the transition can be found at:
https://www.health.ny.gov/health_care/medicaid/redesign/mrt_8401.htm.

C. Managed Long-Term Care Program (MLTCP)

Managed Long-Term Care plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of January 1, 2022, there are 25 Partial Capitation plans, 9 PACE plans, 13 MAP, and 1 FIDA IDD plan. As of December 31, 2021, there are a total of 286,283 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the October 2021 through December 2021 quarter, 3 MA plans began wind down activities, with the goal to sunset operations on December 31, 2021. This included member notices explaining choices to transfer to another plan or change to fee for service (FFS) Medicaid coverage.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the October 2021 through December 2021 quarter, post enrollment surveys were completed for 12 enrollees. Of the 10 who responded to the question, 7 (70%) indicated that they continued to receive services from the same

caregivers once they became members of an MLTCP, The remaining 3 had case specific reasons why they did not continue, and 2 enrollees did not respond to this question. The percentage of affirmative responses is lower than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased slightly from 244,809 the previous quarter to 245,571 during the October 2021 through December 2021 quarter. For that period, 9,044 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a 4% increase from the previous quarter and brings the 12-month total for affirmative choice to 37,649.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, MA plans, and FIDA IDD plans during the January 2021 through December 2021 annual period is submitted as an attachment.

2. Significant Program Developments

During the October 2021 through December 2021 quarter:

- The 4th Quarter Member Services survey was conducted on 25 Partial Capitation plans and 13 MAP plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but when necessary, the Department provided recommendations on areas of improvement. A Statement of Deficiencies was issued to a Partial Capitation plan for failure to provide a reachable member services department for assistance to applicants and members.

- The Desk Review for 2 Partial Capitation Operational Surveys has been completed and Statements of Deficiencies were issued. Corrective Action Plans (CAP) have been completed by the plans and are awaiting Department approval.

- The Desk Review for 3 Partial Capitation Operational Surveys were completed and reported in the prior reporting period. Corrective Action Plans have been completed by the plans and are still awaiting Department approval.

- Operational Surveys were initiated for 2 Partial Capitation plans. The Desk Review was initiated and is in progress.

- A Focused Survey was conducted on 1 MAP plan targeting MAP appeal notices during the 1st quarter. A Statement of Deficiencies was issued, and the CAP was accepted December 3, 2021. A follow up review of their MAP appeal notices will be initiated on January 14, 2022, to ensure compliance.

- A Focused Survey was conducted on 1 Partial Capitation plan based on a TAC Complaint during the 1st quarter. A Statement of Deficiencies was issued, and after the submission of several unacceptable CAPs their final CAP was accepted by the Department on January 18, 2022. Additional documentation is required from the plan no later than March 19, 2022, otherwise further action will be taken.

- A Focused Survey was conducted on 1 Partial Capitation plan based on a TAC Complaint during the 2nd quarter. A Statement of Deficiencies was issued, and the CAP was accepted by the Department on December 7, 2021.

- A Focused Survey was conducted on 25 Partial Capitation and 13 MAP plans focusing on Internal Appeal and Fair Hearing management practices. A review of plan files was completed, and Statement of Deficiencies have been drafted for 15 plans.

As a matter of routine course:

- Processes for Operational Partial Capitation and MAP surveys continue to be refined;

- The Surveillance tools continue to be updated to reflect process changes; and

- Reports have been developed/implemented to assist with summarizing survey findings.

3. Issues and Problems

There were no issues or problems to report for the October 2021 through December 2021 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within MLTC plans as a consumer choice and gives individuals and families greater control over services received. The Department published a Request for Offers in December 2019 to procure fiscal intermediary (FI) administrative services for the Consumer Directed Personal Assistance Program (CDPAP). After award and a transition process, only entities that have contracts with the Department may provide FI administrative services. Managed care plans will enter into separate administrative service agreements with Department-contracted FIs.

5. Required Quarterly Reporting

Unless otherwise noted, changes from last quarter are presumed to be due to COVID-19 pandemic.

Critical incidents: There were 2,205 critical incidents reported for the October 2021 through December 2021 quarter, an increase of 56% from the previous quarter. There are 5 plans that reported zero critical incidents last quarter and are now reporting data. The Department continues to reach out to plans for education and correcting data reporting. The names of plans reporting no critical incidents are shared with the Surveillance unit for follow up on survey. To date, none of those plans were found to have had critical incidents that should have been reported.

Complaints and Appeals: For the October 2021 through December 2021 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with

Transportation, Dissatisfaction with Quality Home Care (Other than lateness or absences), Dissatisfaction with Other Covered Services, Dissatisfied with Choice of Providers in Network, Other.

Period: October 1, 2021 - December 31, 2021 (Percentages rounded to nearest whole number)			
Number of Recipients: 281,667	**Complaint**	**Resolved**	**Percent Resolved***
#Expedited	**8**	**5**	**63%**
# Same Day	**3,222**	**3,222**	**100%**
# Standard/Expedited	**9,157**	**8,471**	**93%**
Total for this period:	**12,387**	**11,698**	**94%**

*Percent Resolved includes grievances opened during previous quarters that are resolved during the current quarter, that can create a percentage greater than 100.

Appeals	**1/2021-3/2021**	**4/2021-6/2021**	**7/2021-9/2021**	**10/2021-12/2021**	**Average for Four Quarters**
Average Enrollment	274,366	275,540	279,060	281,667	277658
Total Appeals	7,948	8,957	8,424	8,695	8,506
Appeals per 1,000	29	32	30	32	31
# Decided in favor of Enrollee	923	1088	1,496	1,310	1204
# Decided against Enrollee	5,909	6,820	6,168	6,062	6,240
# Not decided fully in favor of Enrollee	575	652	612	1,066	726
# Withdrawn by Enrollee	206	288	231	233	240
# Still pending	766	118	886	746	629
Average number of days from receipt to decision	8	7	8	8	8

***Complaints and Appeals per 1,000 Enrollees by Product Type October 2021 - December 2021**					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	245,571	8,084	33	7,063	29

Medicaid Advantage Plus (MAP) Total	30,256	3,489	115	1,545	51
PACE Total	5,840	814	139	87	15
Total for All Products:	**281,667**	**12,387**	**44**	**8,695**	**31**

Total complaints decreased 12% from 14,155 the previous quarter to 12,387 during the October 2021 through December 2021 quarter.

The total number of appeals increased 3% from 8,424 during the last quarter to 8,695 during the October 2021 through December 2021 quarter.

Technical Assistance Center (TAC) Activity

During the October 2021 through December 2021 quarter, TAC opened 420 cases. This is a bit lower than the previous quarter. TAC has seen a decrease in unsubstantiated cases. Substantiated cases have increased since the previous quarter.

Most of TAC's calls for this quarter were for general inquiries and questions. Changes and developments in the public health emergency continue to be a source of concern for MLTC members. TAC continues to receive a high number of calls regarding aide services. This is mostly due to worker availability during the public health emergency.

Call Volume	**10/1/2021- 12/30/2021**
Substantiated Complaints	45
Unsubstantiated Complaints	214
Complaints Resolved Without Investigation	7
Inquiries	163
Total Calls	**429**

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

General	30%
Aide Service	25%
Enrollment	15%
Billing	8%
Grievance	6%

62% of Q4 TAC cases are closed in the same month they are opened, down 1% from last quarter. Overall, TAC's complaint numbers have remained consistent when compared to the previous few quarters.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For October 2021 through December 2021 quarter, 11,618 people were evaluated, deemed eligible and enrolled into plans, an increase of 62% from the previous quarter.

Referrals and 30-day assessment: For the October 2021 through December 2021 quarter, MLTC plans conducted 19,273 assessments, a 22% decrease from 24,864 the previous quarter. The total number of assessments conducted within 30 days decreased 20% from 19,143 the previous quarter to 15,216 this quarter.

Referrals outside enrollment broker: For the October 2021 through December 2021 quarter, the number of people who were not referred by the Enrollment Broker and who contacted the plan directly was 21,613 a 2% decrease from 22,145 the previous quarter.

Rebalancing Efforts	10/2021-12/2021
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	138
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	2,015
Individuals who are permanently placed in a nursing home and are new to plan	187

As of December 31, 2021, there were 3,583 current plan enrollees who were in nursing homes as permanent placements, a 4% decrease from the previous quarter.

D. Children's Waiver

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

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

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current Fee for Service HCBS authorized under the State's newly consolidated 1915c Children's Waiver in Medicaid Managed Care benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's Waiver;
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a

result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c Children's Waiver, including non-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs;
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115;
- Authority to provide customized goods and services, such as self- direction and financial management services, that are currently approved under the demonstration's HARP's pilot to Fo1 children;
- Authority for Health Home care management monthly monitoring as an HCBS; and
- Removes managed care exclusion of children placed with Voluntary Foster Care Agencies.

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

- Receiving approval from CMS for the Children's 1115 Evaluation Design as of April 16, 2020;
- Continuing to refine data collection and data analysis to ensure accurate reporting;
- Engaging a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative;
- Submitting the Preliminary Interim Evaluation Report to CMS, as drafted by the vendor;
- Submitting the Interim Evaluation Report to CMS, as drafted by the vendor;
- Drafting policies and guidance to ensure compliance with State and federal requirements – as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers – including additional resources and technical assistance with person-centered planning;
- Facilitating relationship building between Managed Care Organizations, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from Managed Care Organizations, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of Managed Care Organizations and Fee-for-Service billing and claiming data;
- Defining performance and quality metrics;
- Responding to the COVID-19 pandemic and implementing emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and continuing to support the recovery of impacted providers and consumers;
- Conducting case reviews;

- Working with Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process;
- Engaging with providers to understand barriers to service delivery – such as work force challenges, lack of referral sources / lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including the development of a state-wide capacity tracking system, which is currently underway;
- Engaging with providers, consumers, and New York State agencies partners to determine how best to use the enhanced FMAP authorized by the American Rescue Act to improve access to children's services and reduce administrative burden on providers;
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, Managed Care Organizations, and advocate groups) to inform the 1915(c) Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between Managed Care Organizations, Health Homes, and HCBS providers;
- Posting the draft 1915(c) Children's Waiver Renewal for public review and feedback; and
- Engaging with HCBS Providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if the providers are not currently able to actively deliver HCBS.

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

The following table demonstrated the number of children enrolled in the 1915(c) Children's Waiver identified by NYS restriction exception (RE) code of K1 and the current claims for services for these enrolled children. Additionally, as outlined in the 1115 amendment, NYS is tracking the enrollment of children/youth who obtained Medicaid through "Family of One" Medicaid budgeting as identified by NYS restriction exception (RE) code KK. Therefore, the table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
October	9,282	3,932	5,307	570
November	9,792	3,608	5,345	563
December	10,279	2,396	5,415	503
Quarterly Average	**9,784**	**3,312**	**5,356**	**545**

This table includes data from the 1st Quarter of FY2022. Data from this quarter continues to be impacted by the COVID-19 pandemic, which likely resulted in significantly decreased utilization and/or claiming, although this trend is improving, and utilization of these services is increasing. This data will continue to be reviewed and analyzed to understand the impact of the pandemic, especially in relation to utilization.

VI. Evaluation of the Demonstration

During this quarter ending December 31, 2021, two Independent Evaluations are in process and three have concluded. The first Independent Evaluation (IE) that has concluded is the DSRIP Independent Evaluation activity. This five year analysis and DSRIP IE contract has been conducted by SUNY Albany School of Public Health Research Foundation. The DSRIP Draft Summative Evaluation Report was submitted to CMS on March 23, 2021. CMS returned the DSRIP Draft Summative Evaluation report with comments on July 13, 2021 with a return date of August 12, 2021. The DSRIP Final Summative Evaluation Report along with responses to CMS comments on the Draft Summative Evaluation report were submitted to CMS on August 10, 2021. The DSRIP IE and DOH received CMS approval on the Final Summative Evaluation on December 10, 2021.

Activities have also continued in parallel for the four additional Independent Evaluations (IE) supported by each of the RAND Corporation research teams. RAND has contracts to conduct each of the Independent Evaluations including the Children's waiver, the 1115 waiver, the Health and Recovery Program (HARP) and the Self Directed Care (SDC) pilot program. The goals and deliverables for these four IE activities are for each RAND team to produce an Interim Evaluation report for each of the waiver programs per the CMS approved evaluation design plans.

On March 16, 2021 the RAND team conducting the Independent Evaluation of the 1115 Demonstration Waiver provided a full draft Interim Evaluation report to NYS for review. The draft report contained updated county enrollment findings on the Domain 1 research question related to Component 1 Managed Long Term Care enrollment and also provided preliminary findings for the ten research questions related to the Domain 2 Component, to Limit Gaps in Continuous Enrollment. Previous findings for Domain 1 Component 2, Individuals Moving from Institutional to Community Based Settings in need of Long Term Services and Supports, remain unchanged as reflected in the Preliminary Evaluation report shared with CMS in December 2020.

Those preliminary findings for both Domain 1 updates and all of Domain 2 were reviewed and discussed with NYS Department of Health staff in the Office of Health Insurance Programs (OHIP), Office of Quality and Patient Safety (OQPS), Division of Eligibility and Marketplace Innovations (DEMI), the Division of Health Plan Contracting and Oversight (DHPCO), and the Division of Operations and Systems (DOS). Comments were returned to RAND on March 30, 2021. RAND addressed those questions and submitted an updated version 3 full draft of the Interim Evaluation report to NYS reviewers last quarter. After all internal reviews concluded, the 1115 Interim Evaluation report for all 22 research questions was submitted to CMS on August 4, 2021. CMS returned the 1115 Interim Evaluation report with comments on September 10, 2021. CMS also requested clarity on the availability of individual-level data which was discussed further on the September 20, 2021 Monitoring Call with CMS and DOH. On November 2, 2021

RAND provided responses to CMS comments. RAND and DOH are looking forward to receiving approval of the draft Interim Evaluation.

In February 2021, the Heath and Recovery Program (HARP) and Self-Directed (SDC) pilot program teams at RAND gained access to all data tables for all 17 HARP and 13 SDC research questions. During this quarter, RAND also conducted and concluded all qualitative interviews with stakeholders, agencies, and beneficiaries and will begin integrating analysis of both qualitative and quantitative findings were appropriate. Staff from the Office of Health Insurance Programs (OHIP), Office of Quality and Patient Safety (OQPS), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and the Division of Operations and Systems (DOS) continue to assist the RAND researchers weekly with HARP and SDC questions on data limitations and analysis. During this quarter, this RAND contract was also extended an additional year through February 11, 2022 to finalize all HARP and SDC Pilot Interim Evaluation activities. All data access and data use agreements were also extended in parallel through February 11, 2022. The contract extension was necessary due to the early impacts, last Spring and Summer 2020, when resources were reprioritized to address the NYS COVID-19 pandemic. Thus, this IE team's implementation activities for RAND were delayed and timelines have been updated. The RAND team is currently at the phase of data analysis and interpretation for each HARP and SDC research question. The HARP and SDC Pilots will have separate draft Interim Evaluation reports prepared for review to NYS.

During February and March 2021, the RAND team conducting the Independent Evaluation of the Children's Waiver submitted a preliminary draft of the required Interim Evaluation report for NYS review and approval. This Interim Evaluation report included preliminary findings on the 7 required interim research questions related to the Children's waiver. Six remaining research questions will be addressed in the future Summative Evaluation for the Children's waiver per the STC requirements. The Interim Evaluation report for the Children's Wavier was submitted to CMS on July 27, 2021. CMS did not have any further comment on the report.

VII. Consumer Issues

A. MMC Plan, HARP and HIV SNP Plan Reported Complaints

Medicaid Managed Care Organizations (MCOs), including Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARPs), and HIV Special Needs Plans (HIV SNPs) are required to report quarterly to the Department of Health on the number and type of enrollee complaints/action appeals that they received. MCOs are also required to report on the number and type of complaints that they received regarding enrollees who are in receipt of SSI.

The following table outlines the complaints MCOs reported by category for the most recent quarter and for the previous quarter:

MCO Product Line	Total Complaints	
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
MMC	6,659	7,380
HARP	851	934

HIV SNP	139	112
Total MCO Complaints	**7,649**	**8,426**

As described in the table, MCOs reported 7,649 total enrollee complaints for the current quarter. This represents a 9.2% decrease from the prior quarter's total of 8,426 enrollee complaints.

MCOs reported 6,659 MMC complaints this quarter, which is a 9.8% decrease from the 7,380 of the previous quarter. The number of HARP complaints decreased 8.9%, from 934 in the prior quarter to 851 this quarter. There were 139 HIV SNP complaints this quarter, which is an increase of 24.1% when compared to the 112 from the previous quarter.

The following table outlines the top five (5) most frequent categories of complaints reported for MMCs, HARPs, and HIV SNPs, combined, for the most recent quarter and compared to the previous quarter:

Description of Complaint	**Percentage of Complaints**	
	FFY 22 Q1 10/01/2021–12/31/2021	**FFY 21 Q4 07/01/2021–09/30/2021**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	14%
Reimbursement/Billing	15%	14%
Balance Billing	9%	10%
Pharmacy/Formulary	8%	11%
Difficulty with Obtaining: Dental/Orthodontia	8%	9%

The following table outlines the top five (5) most frequent categories of complaints reported for HARPs for the most recent quarter and compared to the previous quarter:

Description of Complaint	**Percentage of Complaints**	
	FFY 22 Q1 10/01/2021–12/31/2021	**FFY 21 Q4 07/01/2021–09/30/2021**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	21%
Pharmacy/Formulary	12%	12%
Dissatisfaction with Quality of Care	11%	12%
Difficulty with Obtaining: Specialist and Hospitals	9%	9%
Difficulty with Obtaining: Dental/Orthodontia	6%	8%

The following table outlines the top five (5) most frequent categories of complaints reported for HIV SNPs for the most recent quarter and compared to the previous quarter:

Description of Complaint	**Percentage of Complaints**

	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	21%	15%
Pharmacy/Formulary	12%	27%
Difficulty with Obtaining: Dental/Orthodontia	12%	12%
Difficulty with Obtaining: Personal Care	10%	8%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9%	7%

A. Monitoring of Plan Reported Complaints

The Department analyzes enrollee complaints by using an Observed to Expected (OE) ratio, to identify trends and potential problems.

The OE ratio is calculated by the Department for each MCO to determine which categories, if any, had a higher-than-expected number of enrollee complaints over a six-month period. The OE ratio compares the number of enrollee complaints the MCO reported to the number that is expected, based on the relative size of the MCO's Medicaid population and its share of enrollee complaints for each category compared to other MCOs. For example, an OE ratio of 6.2 means that the number of enrollee complaints reported for a category was over six times more than what was expected. An OE ratio of 0.5 means that there were half as many enrollee complaints reported for a given category as what was expected.

Based on the OE ratio over a six-month period, the Department requests that MCOs review and analyze categories of complaints where more than two times higher than expected complaint patterns persist. Where a persistent trend or an operational concern contributing to complaints is confirmed, the MCO is required to develop a corrective action plan.

The Department continues to monitor the progress of all corrective actions and requires additional intervention if the identified trend/issue persists.

The Department is in the process of calculating the OE ratio for the six-month period of July 1, 2021 through December 31, 2021.

B. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, the Department monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 7,649 total reported complaints/action appeals, MCOs reported 1,140 complaints and action appeals from their SSI recipients. This compares to 1,171 SSI complaints/action appeals from the previous quarter, representing a 2.6% decrease.

The following table outlines the total number of complaints/action appeals MCOs reported for SSI recipients by category for the most recent quarter and for the previous quarter:

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
Appointment Availability: PCP	8	7
Appointment Availability: Specialist	5	10
Appointment Availability: BH HCBS	0	0
Long Wait Time	1	0
Dissatisfied with Quality of Care	105	105
Denial of Clinical Treatment	22	27
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	377	347
Dissatisfaction with BH Provider Services	4	0
Dissatisfaction with Health Home Care Management	4	6
Difficulty with Obtaining: Specialist and Hospitals	103	80
Difficulty with Obtaining: Eye Care	4	8
Difficulty with Obtaining: Dental/Orthodontia	44	35
Difficulty with Obtaining: Emergency Services	3	0
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	4	3
Difficulty with Obtaining: RHCF Services	0	1
Difficulty with Obtaining: Adult Day Care	1	0
Difficulty with Obtaining: Private Duty Nursing	22	25
Difficulty with Obtaining: Home Health Care	22	22
Difficulty with Obtaining: Personal Care	73	99
Difficulty with Obtaining: PERS	1	3
Difficulty with Obtaining: CDPAS	82	58
Difficulty with Obtaining: AIDS Adult Day Health Care	0	1
Pharmacy/Formulary	76	117
Access to Non-Covered Services	13	7
Access for Family Planning Services	0	0
Communications/ Physical Barrier	5	2
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	13	22
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	88	86
Balance Billing	33	53
Transportation	8	28
All Other	19	19
Total	**1,140**	**1,171**

The following table outlines the top five (5) most frequent categories of SSI recipient complaints/action appeals MCOs reported for the most recent quarter and compared to the previous quarter:

Description of Complaint	Percentage of Total Complaints/Appeals Reported for SSI Recipients	
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	33%	30%
Dissatisfied with Quality of Care	9%	9%
Difficulty with Obtaining: Specialist and Hospitals	9%	7%
Reimbursement/Billing	8%	7%
Difficulty with Obtaining: CDPAS	7%	5%

The Department requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of October 1, 2021 through December 31, 2021, MCOs reported LTSS enrollment of 44,604 enrollees. This compares to 45,258 LTSS enrollees from the previous quarter, representing a 1.4% decrease. The following table outlines the number of LTSS enrollees by MCO for the most recent quarter and for the previous quarter:

Plan	Number of LTSS Enrollees	
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
Affinity Health Plan	828	987
Amida Care	1,298	1,366
Capital District Physicians Health Plan	729	699
Excellus Health Plan	1,440	1,526
Fidelis Care	15,218	15,517
Healthfirst	12,540	12,314
HealthNow	200	206
HealthPlus	2,691	2,896
HIP of Greater New York	339	367
Independent Health Association	525	512
MetroPlus Health Plan	2,497	2,757
Molina Healthcare	1,145	1,094
MVP Health Plan	1,870	1,825
United Healthcare	2,930	2,850
VNS Choice	354	342
Total	**44,604**	**45,258**

The following table outlines the total number of complaints/action appeals received from all enrollees, regardless of product line, regarding difficulty with obtaining LTSS that MCOs reported for the most recent quarter and for the previous quarter.

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021
Difficulty with Obtaining: AIDS Adult Day Health Care	3	5
Difficulty with Obtaining: Adult Day Care	3	2
Difficulty with Obtaining: CDPAS	141	106
Difficulty with Obtaining: Home Health Care	51	60
Difficulty with Obtaining: RHCF Services	4	3
Difficulty with Obtaining: Personal Care	176	257
Difficulty with Obtaining: PERS	7	9
Difficulty with Obtaining: Private Duty Nursing	29	35
Total	**414**	**477**

The changes in Difficulty with Obtaining: CDPAS and Difficulty with Obtaining: Personal Care from last quarter were due to one MCO's changes in reported complaints for the categories. The Department is actively monitoring the complaint categories.

C. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 111 critical incidents reported for the October 1, 2021 through December 31, 2021 period, most of which have a resolved status. Many of the incidents stemmed from falls. The Department continues to work with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

The following table outlines the total number of LTSS critical incidents reported by MMCs, HARPs, and HIV SNPs for the most recent quarter and for the previous quarter, and the net change over those quarters:

Plan Name	Critical Incidents		
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021	Net Change
Medicaid Managed Care Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	5	3	+2
Fidelis Care	0	0	0
Healthfirst	50	32	+18
HIP of Greater New York	0	0	0

HealthNow	0	0	0
HealthPlus	2	2	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	1	-1
Molina Healthcare	0	0	0
MVP Health Plan	0	1	-1
United Healthcare	0	0	0
Total	**57**	**39**	**+18**
Health and Recovery Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	1	6	-5
Fidelis Care	0	0	0
Healthfirst	52	54	-2
HIP of Greater New York	0	0	0
HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	0	2	-2
United Healthcare	0	0	0
VNS Choice	1	0	+1
Total	**54**	**62**	**-8**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	0	2	-2
Total	**0**	**2**	**-2**
Grand Total	**111**	**103**	**+8**

The following table outlines the total number of critical incidents MCOs reported for enrollees in receipt of LTSS by category for the most recent quarter and for the previous quarter, and the net change over those quarters:

Category of Incident	Critical Incidents		
	FFY 22 Q1 10/01/2021–12/31/2021	FFY 21 Q4 07/01/2021–09/30/2021	Net Change
Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	4	2	+2
Crimes Committed Against Enrollee	1	1	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	1	1	0

Instances of Exploitation of Enrollees	0	1	-1
Instances of Neglect of Enrollees	2	2	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	4	6	-2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	33	26	+7
Use of Restraints	12	0	+12
Wrongful Death	0	0	0
Total	**57**	**39**	**+18**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	0	3	-3
Crimes Committed Against Enrollee	0	1	-1
Crimes Committed by Enrollee	0	2	-2
Instances of Abuse of Enrollees	1	1	0
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	1	1	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	7	5	+2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	44	49	-5
Use of Restraints	1	0	+1
Wrongful Death	0	0	0
Total	**54**	**62**	**-8**
HIV Special Needs Plans			
Instances of Abuse of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	1	-1
Other Incident Resulting in Hospitalization	0	0	0
Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	1	-1
Total	**0**	**2**	**-2**
Grand Total	**111**	**103**	**+8**

D. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 85 enrollee complaints this quarter. This total is a 70.0% increase from the previous quarter, which reported 50 enrollee complaints. The Department examined the increase in the number of complaints and discovered that the increase was consistent between categories.

MCO Enrollee Complaints Received Directly by the Department	
FFY 22 Q1 10/01/2021–12/31/2021	**FFY 21 Q4 07/01/2021–09/30/2021**
85	**50**

The following table outlines the top five (5) most frequent categories of enrollee complaints/action appeals received directly by the Department involving MCOs for the most recent quarter and compared to the previous quarter:

Percentage of MCO Enrollee Complaints Received Directly by the Department		
Description of Complaint	**FFY 22 Q1 10/01/2021–12/31/2021**	**FFY 21 Q4 07/01/2021–09/30/2021**
Reimbursement/Billing	16%	16%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	14%	12%
Pharmacy/Formulary	9%	8%
Difficulty with Obtaining: Home Health Care	8%	8%
All Other	7%	2%

The Department monitors and tracks enrollee complaints reported to the Department related to new or changed benefits and populations enrolled into MCOs.

In compliance with the Families First Coronavirus Response Act, Medicaid Managed Care enrollees have remained eligible for and enrolled in Medicaid. This has been in effect since March 18, 2020, with exceptions being enrollees who move out of state or who elect to cancel their coverage. Since March of 2020 the Department has carefully monitored any complaints regarding MCO enrollment issues related to suspended loss of Medicaid coverage, and addressed these issues in accordance with maintenance of effort requirements during this period.

E. Fair Hearings

There were 294 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of October 1, 2021 through December 31, 2021. The dispositions of these fair hearings for the most recent quarter and for the previous quarter are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)		
Hearing Dispositions	**FFY 22 Q1 10/01/2021–12/31/2021**	**FFY 21 Q4 07/01/2021–09/30/2021**
In favor of Appellant	82	91
In favor of Plan	195	272
No Issue	17	29
Total	**294**	**392**

For fair hearing dispositions occurring for the most recent quarter and for the previous quarter, the following table describes the number of days from the initial request for a fair hearing to the final disposition of the hearing, including time elapsed due to adjournments.

Fair Hearing Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP)		
Decision Days	**FFY 22 Q1 10/01/2021–12/31/2021**	**FFY 21 Q4 07/01/2021–09/30/2021**
0-29	6	13
30-59	75	93
60-89	60	90
90-119	35	54
=>120	118	142
Total	**294**	**392**

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

Note: The September MMCARP meeting was postponed to October 2021. This is the reason for two meetings held during this quarter.

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on October 7, 2021. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the Medicaid Managed Care program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; and an update on the status of the Managed Long-Term Care (MLTC) program. There were three additional agenda items. A MMCARP Bylaws Subcommittee Update given by Erin Kate Calicchia, Associate Counsel, Bureau of Program Counsel Division of Legal Affairs, NYS Department of Health. A presentation regarding the 1115 Medicaid Waiver given by Jonathan Bick, Director, Division of Health Plan Contracting and Oversight, Office of Health Insurance Programs, NYS Department of Health. Lastly, a Behavioral Health/HARP/Health Home Update given by Lynne Schafer, Division of Managed Care, NYS Office of Mental Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for December 16, 2021.

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 16, 2021. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the Medicaid Managed Care program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; and an update on the status of the Managed Long Term Care (MLTC) program. There was one additional agenda item. A MMCARP Bylaws Subcommittee Update given by Erin Kate Calicchia, Associate Counsel, Bureau of Program Counsel Division of Legal Affairs, NYS Department of Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for February 17, 2022.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

Due to COVID-19 and the moratorium on reassessments of the MLTC populations, the Department cannot compute the 2020 or 2021 Quality Measures. The MLTC Report, Consumer Guides and Incentive will not be computed.

B. Quality Measurement in Medicaid Managed Care

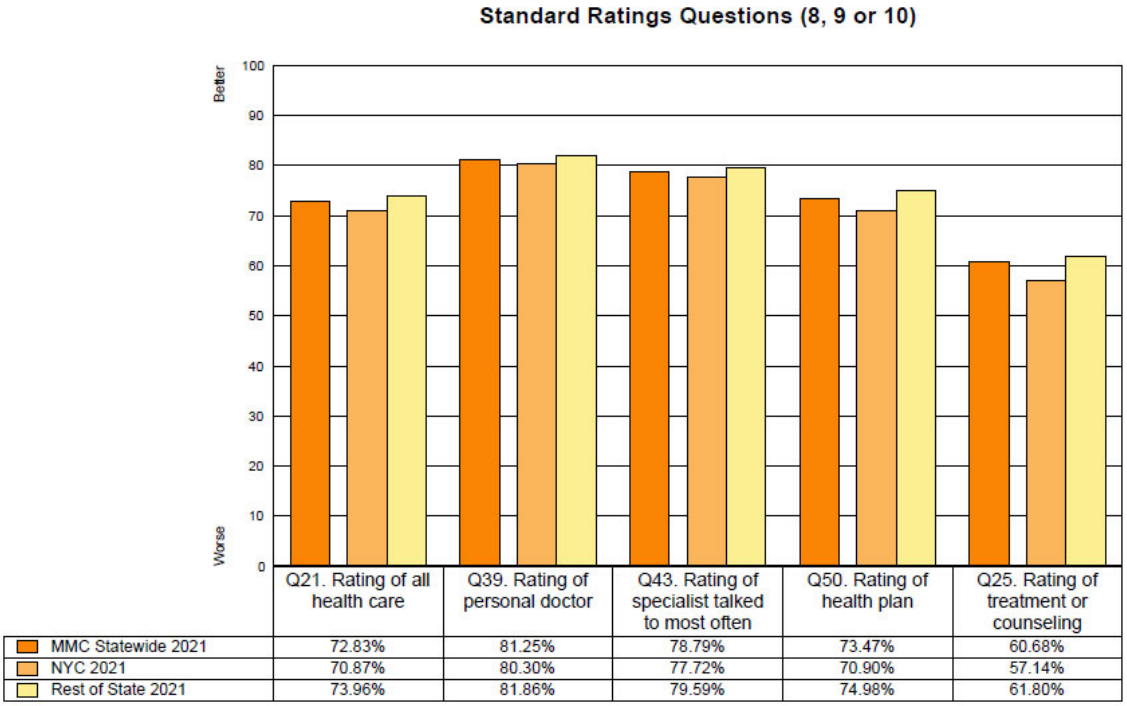
Quality Measure Benchmarks 2021 (Measurement Year 2020)

Quality of care remained high for Medicaid Managed Care members for the Demonstration Year. In measurement year 2020 national benchmarks were available for 55 measures for Medicaid. Out of the 55 measures that NYS Medicaid plans reported, 85% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in Medicaid managed care. The NYS Medicaid, rates exceed the national benchmarks for behavioral health on adult measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, and cervical cancer). Considering this was during a period of covid-19 impacts in New York, the data demonstrates that many aspects of quality of care remained high for New Yorkers on Medicaid.

2020 Satisfaction Survey

The Department conducted a satisfaction survey with adults enrolled in Medicaid managed care in the fall of 2021. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 Adult survey was administered adults 18-64 enrolled in Medicaid, HARP, and SNP. The administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The overall response rate was 11.8% (with a range of 8% to 14% for response rates by plan). This return rate was slightly lower than the previous adult survey that was fielded in 2019. The responses to the survey were analyzed and will be released to the plans in May 2022.

Response options for overall rating questions ranged from 0 (worst) to 10 (best). In the table below, the achievement score represents the proportion of members who responded with a rating of "8", "9", or "10". These results are presented as Medicaid overall, New York City, and Rest of State.



	Q21. Rating of all health care	Q39. Rating of personal doctor	Q43. Rating of specialist talked to most often	Q50. Rating of health plan	Q25. Rating of treatment or counseling
MMC Statewide 2021	72.83%	81.25%	78.79%	73.47%	60.68%
NYC 2021	70.87%	80.30%	77.72%	70.90%	57.14%
Rest of State 2021	73.96%	81.86%	79.59%	74.98%	61.80%

2020 Quality Incentive for Medicaid Managed Care

The 2020 Quality Incentive Awards calculations were finalized in July 2021. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, and Prevention Quality Indicators. Points for issues with Compliance are subtracted from the total plan points before calculating the percentage of total points. Plans were classified into 5 Tiers based on their total score. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and the Center for Medicare and Medicaid Services (CMS). The results for the 2020 Incentive included no plans in Tier 1, ten plans receiving some portion of the award (Tier 2-3), four plans in Tier 4, and one plan in Tier 5.

MMC Quality Incentive 2020

Quality Points NORMALIZED to 100 based on highest score
June 9, 2021

Incentive Premium Award (%)	Plan Name	Normalized Quality Points = Quality Points/Highest Score	Satisfaction Points (30 points possible)	PQI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Total Points	Percent (up to 100%)
Tier 1							
Tier 2	MetroPlus Health Plan	100	15	5	0	120	80
Tier 2	Healthfirst PHSP, Inc.	92.96	15	5	0	112.96	75.31
Tier 2	Independent Health	71.83	20	20	0	111.83	74.55
Tier 2	Empire BlueCross BlueShield HealthPlus	78.87	15	7.5	0	101.37	67.58
Tier 3	Fidelis Care New York, Inc.	77.46	20	5	-4	98.46	65.64
Tier 3	MVP Health Care	59.15	25	12.5	0	96.65	64.44
Tier 3	CDPHP	63.38	25	10	-2	96.38	64.25
Tier 3	HealthNow New York Inc.	59.15	15	17.5	-2	89.65	59.77
Tier 3	Affinity Health Plan	76.06	15	0	-4	87.06	58.04
Tier 3	Excellus BlueCross BlueShield	61.97	20	0	0	81.97	54.65
Tier 4	HIP (EmblemHealth)	61.97	15	0	-4	72.97	48.65
Tier 4	YourCare Health Plan	60.56	10	0	-4	66.56	44.38
Tier 4	UnitedHealthcare Community Plan	40.85	10	12.5	0	63.35	42.23
Tier 4	Molina Healthcare	45.07	15	5	-2	63.07	42.05
Tier 5	WellCare of New York	30.99	15	10	-2	53.99	35.99

Quality Assurance Reporting Requirements (QARR)

We had 26 health plans submit Quality Assurance Reporting Requirement (QARR) data on June 15, 2021. Data was published in November and December 2021.

C. Quality Improvement

External Quality Review

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, Part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including: performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and, providing data processing and analytical support to the Department. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, and HARPs, and include the state's Child Health

Insurance Program (CHP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

For the 1st quarter of 2022 the EQRO completed the final report of the Access Survey of Provider Availability (Provider Directory) (A&A PD), and the report remained with OHIP's review and approval process. The EQRO should start another A&A PD survey after the January PNDS submission. Medicaid managed care plans submitted their Plans of Correction (POC) for the Member Services Survey, to OHIP during the 1st quarter of 2022. OHIP gave the EQRO authorization to initiate a new Member Services Survey during the 1st quarter of 2022. The High Volume PCP Ratio survey was completed by the EQRO during 2021, and the final report was with OHIP's executive level review process during the 1st quarter of 2022.

The Behavioral Health Access & Availability Survey was completed in 2021, and in the 1st quarter of 2022 the final report was being used for information purposes only.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 400 active networks in NYS. IPRO facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. The quarter 3 2021 PNDS submission deadline was October 15, 2021; plans submitted data based on version 10 of data dictionary and work has started on version 11.

Provider and Health Plan LOOK-UP:
Significant edits to the New York State Provider & Health Plan Look-Up website increased consumers' access to data such as deciding which health plan to enroll in or when looking for a provider. The site surpassed 1.29 million distinct users in October 2021 and additional usability enhancements were added this quarter.

PANEL:
Panel data submission opened on 11/1/2021 and yielded 6,637,036 rows of data (up ~3%). Technical assistance was provided by DOH and IPRO throughout the submission particularly around new edits implemented. DOH provided detailed analytics to plans at risk of failing the newly updated requirements.

The Managed Long-Term Care (MLTC) Performance Improvement Project (PIP) ended on 12/31/21. Durng the 1st quarter of 2022 the EQRO conducted group summary calls with the plans and provided DOH with the plans feedback from those calls. The due date for the final reports from the plans for the current PIP, is February 2022. The EQRO also conducted calls with the DOH during the 1st quarter of 2022, to discuss the topic for the new 2022-2023 MLTC PIP. The MLTC External Quality Review Annual Technical Report (EQR ATR) was being drafted by the EQR, in preparation for the April 30, 2022 report submission deadline to CMS. During the 1st quarter of the 2022 the DOH and the EQRO conducted weekly conference calls to discuss the progress of the MLTC EQR ATR. The EQRO will

provide DOH with a first draft of the report in January 2022. The MLTC EQR ATR will refer to measurement years 2019 and 2020.

The MLTC Satisfaction Survey was conducted, and closed, in 2021. During the 1st quarter of 2022, the EQRO provided DOH with the draft final report of the survey, and DOH provided the EQRO with feedback/comments. The EQRO incorporated DOH's feedback into the report and returned it to DOH for final review and comment. DOH reviewed the report data during the 1st quarter of 2022.

The MLTC Encounter Data Validation Survey was conducted in 2021. A survey was conducted for mainstream MMC plans and for MTLC plans. During the 1st quarter of 2022, the final report for the mainstream encounter validation survey was finalized by DOH and entered DOH's executive review and approval process. The MLTC encounter validation survey was completed in 2021, and in the 1st quarter of 2022 the final report of the survey was sent to the plans by the EQRO.

A Focused Clinical Study (FCS) for the Inter-rater Reliability for Telehealth Assessments for MLTC plans, was drafted during the 1st quarter of 2022. Calls were conducted between DOH and the EQRO to discuss hiring nurse assessors to conduct the assessments, either in person or by phone. The FCS should be in place during the 2nd quarter of 2022.

A Child CAHPS survey was conducted in 2021. In the 1st quarter of 2022, planning for the Adult CAHPS survey was initiated and implemented. The subcontractor, DataStat, sent out the first and second mailing of the survey during the 1st quarter of 2022.

In the 1st quarter of 2022, the EQRO completed any analyses of the QARR data that was submitted by the plans on June 15, 2021, and provided the data to the DOH. During the 2nd quarter of 2022, the EQRO will plan and conduct a Webex of the QARR Technical Specifications.

In the 1st quarter of 2022, the EQRO and DOH continued bi-weekly calls to track the progress of the preparation of the draft EQR Annual Technical Reports for mainstream MMC plans, HIV/SNP plans, HARP plans, and MLTC plans. DOH continued to provide the EQRO with data files needed to populate the reports. The EQRO will provide the DOH with the first draft EQR ATR reports at the beginning of the2nd quarter of 2022.

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

2017-18 HARP PIP

For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic was Inpatient Care Transitions. Final reports for the 2017-18 HARP PIP projects were received in August 2019 and were finalized and approved in October 2019. A PIP Compendium of Abstracts was prepared by IPRO and was initially reviewed by the NYSDOH. Final edits were sent to IPRO in March 2021 and the revised version was received September 8, 2021 and is under review.

2019-21 HARP PIP

The 2019-2021 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. The HARP PIP Proposals were submitted December 21, 2018. The submitted PIP Proposals were reviewed and finalized by IPRO, NYSDOH and partners (including OASAS and OMH). Plan interventions began in early 2019. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Oversight calls were conducted in Sept./Oct. 2021. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls.

2019-2020 Medicaid KIDS Quality Agenda PIP

The 2019-2020 Medicaid managed care (MMC) PIP topic is the KIDS Quality Agenda Performance Improvement Project. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. The PIP Proposals were due in the first quarter of 2019. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Oversight calls were conducted in November 2021. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. Plan-Specific Member Level Files for Lead Testing results data were sent from NYSDOH to the plans quarterly. The most recent Lead data was distributed to plans in September 2021. Plan Specific Member Level Files for Hearing Screening data were sent from NYSDOH to plans monthly. The most recent Hearing Screening data were distributed in January 2022 for the December 2021 period.

2022-2023 Medicaid Managed Care and HIV SNP PIP: Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members

On October 27, 2021 a WebEx meeting with Medicaid managed care and HIV SNP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The due date for the PIP Proposals was December 8, 2021. One health plan had an extension to submit their PIP Proposal by Jan. 5, 2022. The remaining 14 health plans submitted their PIP Proposal and IPRO and DOH reviewed the Proposals with the goal of sending feedback to the health plans in early January 2022.

2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus

On November 19, 2021 a WebEx meeting with HARP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The due date for the PIP Proposals was January 10, 2022.

Breast Cancer Selective Contracting

The Department began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2018-2020 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as, facility-level data from the Health Facilities Information System (HFIS). A total of 319 facilities were identified. Preliminary facility volume designations were as follows: 114 high-volume; 23 low-volume that are allowed to perform surgeries to ensure adequate access; and,182 low-volume restricted facilities.

Letters were drafted to notify low-volume facilities that the Department will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state fiscal year 2022-23, nor can Medicaid managed care plans contract with low-volume facilities to perform breast cancer surgeries. In addition, the letters will also include a copy of the appeal form for facilities that want to appeal the decision to be placed on the low-volume restricted list. The letters will be sent electronically via the Department's Integrated Health Alerting and Notification System (IHANS).

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 1 (10/1/21-12/31/21)

As of December 2021, there were 9,057 NCQA-recognized PCMH providers and 2,240 practices in New York State (NYS). All providers are recognized under the standards of NYS Patient-Centered Medical Home (NYS PCMH), a new recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, value-based payment arrangements, and health information technology capabilities. Of the 9,057 providers that became recognized in December 2021, 45 were new to the NYS PCMH program.

Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017-recognizerd providers. Current information on PCMH incentives in Medicaid can be found here: https://www.health.ny.gov/health_care/medicaid/program/update/medup-pa-pn.htm#patiented.

The incentive rate for the New York Medicaid PCMH Statewide Incentive Payment Program as of December 2021 is $6.00 PMPM.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2021 but discussions around alignment of methods for shared savings models are still not finalized.

All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the NYSDOH website, available here: https://www.health.ny.gov/technology/nys_pcmh/.

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

Quarterly budget neutrality reporting is up to date and on schedule. The State continues to work with CMS in resolving any emergent issues with the reporting template and PMDA system and in eliminating delays in the utilization of the Budget Neutrality Reporting Tool for quarterly reporting.

The State is also awaiting further guidance on two timely filing waivers submitted to correct reporting errors noted in previous quarterly reports. These expenditures, though not currently represented on the Schedule C, are included in the BN reporting tool workbook to accurately reflect the state's Budget Neutrality position:

- As detailed in STC X.10, the State identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011 through March 31, 2016 period. The audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019, with CMS confirming in a subsequent discussion on October 10, 2019, that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all audit findings, however, entry of corrected data for F-SHRP DY6 into MBES is pending approval of a timely filing waiver.
- The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

X. Other

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

NYS Compliance

The State sends the following files to CMS monthly:

- Eligibility
- Provider
- Managed Care
- Third Party Liability
- Inpatient Claims
- Long-Term Care Claims
- Prescription Drug Claims

- Other Types of Claims

The State is current in its submission of these files. Moreover, New York State is actively working on addressing the Top 32 Priority Issues (TPIs) identified and prioritized by CMS. The state is also addressing the issues associated with the new Outcomes Based Assessment Compliance Criteria proposed by CMS for 2022. New York stands in the highest compliance category (Blue) for the TPIs 1 through 23 as defined by CMS for 2021.

New York State continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues.

To help facilitate resolution of identified data issues, the state has instituted a Data Governance workgroup for T-MSIS. The group's focus is to address data issues and specific processes/policies that are unique to NY and provide narration to aid in the understanding of these state processes/policies.

The State has been resubmitting historical claim files for the period July 2015 through June 2021 per CMS's request. The resubmission is scheduled to be completed by end of February 2022.

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

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Managed Long Term Care Partial Capitation Plan Enrollment January 2021 - December 2021												
	Jan-21	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	6,415	6,322	6,257	6,116	6,071	6,023	5975	5909	5,872	5,800	5,737	5,687
AgeWell New York	12,442	12,453	12,558	12,532	12,616	12,739	12825	12954	13,065	13,040	13,107	13,167
ArchCare Community Life	4,564	4,518	4,524	4,507	4,518	4,538	4565	4590	4,592	4,590	4,615	4,651
Centers Plan for Healthy Living	43,360	43,333	43,623	43,694	44,141	44,448	44701	44993	45,421	45,723	46,220	46,943
Elant	1,083	1,065	1,066	1,046	1,054	1,034	1012	999	991	968	967	954
Elderplan	14259	14061	14008	13,824	13,831	13,826	13808	13781	13,792	13,727	13,687	13,721
Elderserve	15,305	15,159	15,113	15,033	15,132	15,200	15266	15335	15,425	15,343	15,344	15,426
Elderwood	946	943	973	967	992	1,005	1005	1009	1,012	1,006	1,028	1,034
Extended MLTC	6,538	6,467	6,420	6,234	6,094	6,035	5993	5970	5,931	5,858	5,801	5,734
Fallon Health Weinberg (TAIP)	871	865	858	846	860	868	872	872	881	876	876	874
Fidelis Care at Home	20,516	20,174	20,085	19,703	19,664	19,588	19474	19398	19,303	19,006	18,836	18,750
Hamaspik Choice	2,135	2,114	2,112	2,063	2,044	2,047	2045	2064	2,068	2,042	2,026	2,021
HealthPlus- Amerigroup	5,686	5,591	5,517	5,413	5,401	5,315	5268	5226	5,159	5,052	4,999	4,981
iCircle Services	3,823	3,799	3801	3,735	3,747	3,714	3706	3703	3,693	3,613	3,600	3,600
Integra	37535	37960	38,400	38,526	38,870	39,180	39457	39776	40,041	40,100	40,386	40,902
Kalos Health- Erie Niagara	825	792	772	724	709	704	690	680	663	615	592	578
MetroPlus MLTC	1,586	1,547	1,518	1,483	1,491	1,473	1448	1427	1,429	1,423	1,409	1,397
Montefiore HMO	1,584	1,550	1,535	1,525	1,532	1,532	1525	1522	1,517	1,494	1,485	1,486
Prime Health Choice	614	616	625	627	624	617	612	578	580	579	574	571
Senior Health Partners	12,573	12,202	11,929	11,526	11,381	11,180	10946	10719	10,570	10,402	10,337	10,275
Senior Network Health	424	413	409	403	406	402	393	392	386	374	373	376
Senior Whole Health	13,222	13,313	13,394	13,339	13,428	13,541	13645	13673	13,702	13,642	13,550	13,526
Village Care	13,161	13,092	13,080	12,967	13,011	13,097	13151	13358	13,436	13,491	13,637	13,787
VNA HomeCare Options	3,286	3,284	3,290	3,199	3,214	3,262	3286	3313	3,329	3,276	3,280	3,336
VNS Choice	16,289	21,219	21,350	21,281	21,393	21,593	21699	21808	21,951	21,725	21,712	21,794
Total	**239,042**	**242,852**	**243,217**	**241,313**	**242,224**	**242,961**	**243,367**	**244,049**	**244,809**	**243,765**	**244,178**	**245,571**

MAP Enrollment January 2021 - December 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	63	60	59	58	72	78	106	117	138	156	175	185
Hamaspik	0	0	0	0	0	0	37	92	135	147	158	177
Agewell	24	25	38	44	51	53	53	55	58	57	62	62
Centers	162	528	402	435	1032	1126	612	659	687	744	718	705
Elderplan	2418	2465	2475	2606	2685	2730	2771	2801	2833	2834	2789	2813
Elderserve	44	51	61	63	64	66	69	67	72	79	78	79
Healthfirst Complete Care	16107	16556	17160	17655	18144	18629	19019	19406	19746	19976	19983	20140
Healthplus	11	8	27	64	63	82	88	100	117	115	112	133
Senior Whole Health	125	120	119	114	115	112	117	118	119	122	117	110
VNS	3105	3050	3020	3014	3035	3088	3122	3127	3141	3144	3050	3023
Village Care	2613	2701	2794	2882	2949	3001	3024	3047	3043	3033	2915	2829
Total	**24672**	**25564**	**26155**	**26935**	**28210**	**28965**	**29018**	**29589**	**30089**	**30407**	**30157**	**30256**

PACE Enrollment January 2021 - December 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	726	715	702	692	731	751	747	741	699	696	708	705
CHS Buffalo Life	255	249	250	250	253	253	256	262	265	266	258	256
Complete Senior Care	130	126	126	125	126	127	125	127	126	123	125	130
Comprehensive Care Management	2433	2408	2360	2402	2372	2378	2386	2435	2518	2592	2769	2934
Eddy Senior Care	303	293	294	294	295	295	297	296	293	300	304	306
Fallon Health Weinberg PACE	144	141	139	131	132	131	132	125	125	128	123	126
Independent Living For Seniors	763	744	733	736	732	726	730	729	728	720	722	712
Pace CNY	611	578	580	574	568	568	567	561	559	553	550	532
Total Senior Care	143	137	137	139	143	140	143	144	144	144	139	139
Total	**5508**	**5391**	**5321**	**5343**	**5352**	**5369**	**5383**	**5420**	**5457**	**5522**	**5698**	**5840**

MA Enrollment January 2021 - December 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis Legacy	1122	1089	1063	1041	1045	1030	1009	999	983	973	963	954
Wellcare	1030	992	953	926	900	882	862	859	846	834	824	820
United Healthcare	1254	1242	1232	1215	1205	1191	1177	1164	1156	1140	1129	1125
Total	**3406**	**3323**	**3248**	**3182**	**3150**	**3103**	**3048**	**3022**	**2985**	**2947**	**2916**	**2899**

FIDA-IDD Enrollment January 2021 - December 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1746	1748	1743	1740	1738	1744	1734	1724	1720	1720	1717	1717

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	6	0	0	0	4	0	1	1	0	5,687	0.11%
AgeWell NY	5	0	0	0	1	1	3	0	0	13,167	0.04%
AgeWell MAP	0	0	0	0	0	0	0	0	0	62	0.00%
Archcare Community Life	56	1	0	1	10	0	19	25	0	4,651	1.20%
Archcare PACE	15	0	0	0	0	0	10	5	0	705	2.13%
Catholic Health-LIFE	17	0	7	0	0	0	6	3	1	705	2.41%
Centerlight PACE	42	0	0	0	0	0	18	22	2	256	16.41%
Centers Plan for Healthy Living	710	1	0	0	16	0	232	461	0	46,943	1.51%
Centers Plan for Healthy Living MAP	3	0	0	0	0	0	0	3	0	705	0.43%
Complete Senior Care	0	0	0	0	0	0	0	0	0	130	0.00%
Eddy SeniorCare	6	0	0	0	0	0	5	1	0	306	1.96%
Elant Choice (EverCare)	57	0	0	0	0	2	14	41	0	954	5.97%
Elderplan MAP	2	0	0	0	1	0	0	1	0	2,813	0.07%
Elderserve	298	4	0	0	7	2	132	153	0	15,426	1.93%
Elderserve MAP	5	0	0	0	2	0	0	3	0	79	6.33%
Elderwood	16	0	0	0	0	3	9	4	0	1,034	1.55%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	4,981	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	133	0.00%
Extended	63	0	0	0	0	0	46	17	0	5734	1.10%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	874	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	126	0.00%
Fidelis Care at Home	22	0	0	2	4	0	3	13	0	18,750	0.12%
Fidelis MAP	1	0	0	0	0		0	0	1	185	0.54%
Hamaspik	34	0	0	0	2	4	15	12	1	2,021	1.68%
Hamaspik MAP	2	0	0	0	0	0	1	1	0	177	1.13%
Healthfirst CompleteCare	97	0	0	0	0	0	25	72	0	20,140	0.48%
HomeFirst, Inc. (Elderplan)	3	0	0	0	2	0	1	0	0	13721	0.02%
Icircle	1	1	0	0	0	0	0	0	0	3,600	0.03%
Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	712	0.00%
Independent Living Services of CNY (PACE CNY)	28	0	0	0	0		15	13	0	532	5.26%
Integra MLTC	1	1	0	0	0	0	0	0	0	40,902	0.00%

Kalos ErieNiagara DBA: First Choice Health	3	0	0	0	1	0	2	0	0	578	0.52%
MetroPlus	0	0	0	0	0	0	0	0	0	1,397	0.00%
Monefiore	0	0	0	0	0	0	0	0	0	1,486	0.00%
Prime	53	0	0	0	0	0	7	46	0	571	9.28%
Senior Health Partners	46	0	0	0	0	0	14	32	0	10,275	0.45%
Senior Network Health, LLC	11	0	0	0	0	0	2	9	0	376	2.93%
Senior Whole Health	1	0	0	0	0	0	0	1	0	13,526	0.01%
Senior Whole Health MAP	1	0	0	0	0	0	0	0	1	133	0.75%
Total Senior Care	0	0	0	0	0	0	0	0	0	139	0.00%
Village Care	247	0	0	0	13	1	75	158	0	13,787	1.79%
Village Care MAP	66	1	0	0	12	1	10	42	0	2,829	2.33%
VNA Homecare Options (Nascentia Health Options)	127	0	0	1	6	1	46	73	0	21,794	0.58%
VNS Choice MAP TOTAL	24	0	0	0	1	0	10	13	0	3,023	0.79%
VNS Choice MLTC	136	0	0	0	2	2	50	82	0	21,794	0.62%
total	2205	9	7	4	84	17	771	1307	6	297919	0.74%