MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 24 (4/1/2022-3/31/2023)
Federal Fiscal Quarter: 2 (1/1/2023-3/31/2023)

I. Introduction

In July 1997, New York State (NYS) 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 the Governor's Medicaid Redesign Team (MRT). CMS approved the Delivery System Reform Incentive Payment (DSRIP) and Behavioral Health (BH) amendments to the Partnership Plan Demonstration on April 14, 2014, and July 29, 2015, respectively.

The NYS 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, NYS 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 MRT Waiver. On April 19, 2019, CMS approved New York's request to exempt Mainstream Medicaid Managed Care (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 BH and Home and Community Based Services (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. On October 5, 2021, CMS approved an amendment that transitions a set of BH HCBS into Community Oriented Recovery and Empowerment (CORE) rehabilitative services (as such term is defined in Section 1905(a)(13) of the Social Security Act) for Health and Recovery Plans (HARP) and HIV Special Needs Plans (HIV SNP) members.

On March 23, 2022, CMS approved a five-year extension of the New York MRT demonstration. As part of the extension, CMS approved the state's second component of its MLTC amendment request to allow dual eligibles to stay in MMMC Plans that offer Dual Eligible Special Needs Plans (D-SNPs) once they become eligible for Medicare.

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

II. Enrollment: Second Quarter

MRT Waiver- Enrollment as of March 2023

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	502,703	6,655	2,710
Population 2 - TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06	72,279	1,599	768
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	10,328	94	37

Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**43,193**	**756**	**423**
Population 5 - Safety Net Adults	**237,369**	**6,872**	**2,972**
Population 6 - Family Health Plus Adults with Children	**0**	**0**	**0**
Population 7 - Family Health Plus Adults without Children	**0**	**0**	**0**
Population 8 - Disabled Adults and Children 0 - 64 ('old' voluntary MC Enrollment)	**152,716**	**1,524**	**81**
Population 9 - Disabled Adults and Children 0 - 64 ('new' MC enrollment)	**61,375**	**3,002**	**234**
Population 10 - Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**77,209**	**363**	**36**
Population 11 - Aged or Disabled Elderly ('new' MC enrollment)	**13,828**	**2,359**	**129**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollment's	
Total # Voluntary Disenrollments in Current Demonstration Year	**23,224 or an approximate 4.4% 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 (NYSoH). Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in voluntary disenrollment.

Voluntary disenrollment decreased due to a decline in the "Undetermined" category of disenrollment. Undetermined refers to cases where a manual review would be needed to determine the specific reason for disenrollment.

Involuntary Disenrollment's	
Total # Involuntary Disenrollment's in Current Demonstration Year	7,390 or an approximate 71.4% 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 NYSoH. Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in involuntary disenrollment.

Involuntary disenrollment decreased due to a decline in the number of Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination. In addition, there was also a decrease in lost eligibility cases due to such factors as a change in residency and not specifically due to any type of case closure.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
January 2023				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	703,890	21,211	2,819	18,392
Rest of State	328,755	8,052	879	7,173
Statewide	1,032,645	29,263	3,698	25,565
February 2023				
New York City	696,210	22,351	4,086	18,265
Rest of State	332,798	8,845	1,422	7,423
Statewide	1,029,008	31,196	5,508	25,688
March 2023				
New York City	699,448	19,915	3,284	16,631
Rest of State	336,019	7,808	1,136	6,672
Statewide	1,035,467	27,723	4,420	23,303

Second Quarter	
Region	Total Affirmative Choices
New York City	53,288
Rest of State	21,268
Statewide	74,556

HIV SNP Plans				
January 2023				
Region	Roster Enrollment	New Enrollment	Auto Assigned	Affirmative Choices
New York City	12,901	203	1	202
Rest of State	19	0	0	0
Statewide	12,920	203	1	202
February 2023				
New York City	12,796	216	0	216
Rest of State	20	1	0	1
Statewide	12,816	217	0	217
March 2023				
New York City	12,822	237	0	237
Rest of State	20	1	0	1
Statewide	12,842	238	0	238
Second Quarter				
Region	Total Affirmative Choices			
New York City	655			
Rest of State	2			
Statewide	657			

Health and Recovery Plans Disenrollment			
FFY 23 – Q2			
	Voluntary	Involuntary	Total
January 2023	625	798	1,423
February 2023	723	728	1,451
March 2023	554	731	1,285
Total:	1,902	2,257	4,159

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2023-3/31/2023) Q2 FFY 2023

As of the end of the second federal fiscal quarter (end of March 2023), there were 3,112,981 New York City Medicaid consumers enrolled in MMMC Program and 77,052 Medicaid consumers enrolled in 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 15 HRA facilities including 3 HIV/AIDS Services Administration (HASA) sites, 2 Community Medicaid Offices (MA Only), and 10 Job Centers (Public Assistance). MAXIMUS reported that 9,885 clients were educated about enrollment options and made an enrollment choice including 341 clients in person and 9,544 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. Deficiencies are 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 31,339 FFS community clients were reported on the regular auto-assignment list, 7,139 clients responded to the call that generated 3,578 enrollments. Of the total of 62 FFS NH clients reported on NH auto-assignment list, 4 (6%) clients and/or authorized representatives made a Plan selection.

C. NYMC HelpLine Observations January- March 2023

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 **49,954** calls were received by the Helpline and **48,982** or **98%** were answered. Calls answered were handled in the following languages: **English: 32,307 (66%); Spanish: 6,419 (13%); Chinese: 2,040 (4%); Russian: 1,235 (2%); Haitian/Creole: 63 (1%); and other: 6,918 (14%).**

MAXIMUS recorded 100% of the calls received by the NYMC HelpLine. CMU listened to **5,656** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 2nd Quarter 2023								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
3,104 (55%)	442 (8%)	298 (5%)	1,746 (31%)	61 (1%)	0 (0%)	4 (0%)	1 (0%)	5,656

A total of **1,394 (25%)** recorded calls observed was unsatisfactory. 605 calls had a single infraction and 789 calls had multiple infractions. A total of 2,173 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,676 (77%)** - 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: **180 (8%)** - 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: **317 (15%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **2,173** 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

During the second quarter of FFY 2022-2023, there were no plan expansions, withdrawals or new Plans.

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

On March 4, 2022, NYS submitted to CMS amendment #2 to the March 1, 2019, Model Contract that includes contract provisions related to State Directed Payments. On March 31, 2022, this amendment was issued to 15 MCOs for signature. At the close of the first quarter of FFY 2022-2023, all 15 contracts have been executed by NYS and will be submitted shortly to CMS for final approval.

C. Health Plans/Changes to Certificates of Authority

Effective February 16, 2023, the Department updated the Certificate of Authority to reflect that New York Quality Healthcare Corporation, Inc. is certified to provide Medicaid Advantage Plus services in the counties of Nassau, Suffolk, and Westchester.

Effective March 30, 2023, the Department updated the Certificate of Authority to reflect that Molina Healthcare of New York, Inc. is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, and Westchester.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

No Survey activity to report.

No Operational POCs accepted, or EQRO POCs accepted for the purposes of this report.

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

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

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

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

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability
  The final summary report was forwarded to the regional 34 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 (BH) Services into Managed Care and Development of Health and Recovery Plans (HARPs):

In October 2015 NYS began transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health [mental health (MH) and substance use disorder (SUD)] and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered BH services in MMC, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of 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 BH HCBS. For MMC, all Medicaid-funded behavioral health services for adults, except for services in Community Residences, are part of the benefit package.

Effective April 1, 2023, Medicaid members enrolled in Mainstream Managed Care Organizations (MCO), HARPs and HIV SNPs, will receive pharmacy benefits through the Medicaid fee-for-service (FFS) pharmacy program, NYRx, rather than MCOs. Starting in March 2023, MMC Plans began sending notices to their members about the Pharmacy transition. Transitioning the pharmacy benefit from Managed Care to FFS will provide the State visibility into prescription drug costs, allow centralization of the benefit, and provide a single drug formulary with standardized utilization management protocols simplifying and streamlining the drug benefit for Medicaid members.

Office of Mental Health (OMH) Providers received notice that when the Public Health Emergency (PHE) expires on May 11, 2023, the flexibilities afforded to providers regarding minimum billing standards and documentation requirements will end, unless otherwise specified by OMH through formal regulatory waivers. The areas impacted by the end of the PHE include telehealth, documentation, utilization review, billing standards, Health Insurance Portability and Accountability Act (HIPAA) enforcement, hospital conditions of participants, and program specific guidance for community-based services and residential services.

Additionally, NYS will resume annual Medicaid recertifications in April 2023, having paused them since March 2020 due to the federal PHE

As part of the transition, the NYS Department of Health (DOH) began phasing in enrollment of current MMC enrollees throughout NYS 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 SNPs now provide all covered services available through MMC.

In Fiscal Year (FY) 2018, NYS engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the NYSoH (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 (MCTAC).

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 MH & SUD authorization requests and denials for Inpatient (10/1/2022-12/31/2022)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	28,847	182	169	0.59%
ROS	2,268	11	11	0.49%
Total	31,115	193	180	0.58%

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 MH & SUD authorization requests and denials for Outpatient (10/1/2022-12/31/2022)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,617	48	31	0.55%
ROS	177	16	16	9.04%
Total	5,794	64	47	0.81%

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

MH & SUD Claims (1/1/2023-3/31/2023)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,344,150	95.02%	4.98%
ROS	1,191,019	94.81%	5.19%
Totals	2,535,169	94.92%	5.08%

[1] Q2 data is not available and will be submitted with the next quarterly update.
[2] Q2 data is not available and will be submitted with the next quarterly update.

Behavioral Health Adults CORE/HCBS Claims/Encounters 1/1/2023-3/31/2023: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	123	32
Education Support Services	68	19
Family Support and Trainings	414	25
Intensive Supported Employment	69	21
Ongoing Supported Employment	7	1
Peer Support	2,390	512
Pre-vocational	49	12
Provider Travel Supplements	18	14
Psychosocial Rehab	2,986	462
Residential Supports Services	79	13
Transitional Employment	0	0
TOTAL	6,203	947

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 1/1/2023-3/31/2023: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	1,301	269
Education Support Services	241	62
Family Support and Trainings	87	12
Intensive Supported Employment	162	35
Ongoing Supported Employment	47	14
Peer Support	4,922	1,069
Pre-vocational	32	12
Provider Travel Supplements	3,747	940
Psychosocial Rehab	5,101	890
Residential Supports Services	867	149
Transitional Employment	0	0
TOTAL	16,507	2,143

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

Provider Technical Assistance

MCTAC 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 MCTAC.

Quarter 2 MCTAC Attendance & Statistics (1/1/2023 to 3/31/2023)

Events: MCTAC successfully executed 8 events from 1/1/2023 to 3/31/2023.
All 8 events were held via webinar.

Individual Participation/Attendance/Viewing of Resource:*(this includes all the individuals that attended the MCTAC offerings or viewed a resource online):*

1,767 people attended/participated in MCTAC events/viewed resources of which **1,203** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 267 of 720 **(37.08%)**

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: 141 of 434 **(32.49%)**

*** Please note the MCTAC registration system was updated in February 2023 and has resulted in a new denominator for OMH and OASAS agency counts midway during this quarter.*

Efforts to Improve Access to Behavioral Health Home and Community Based Services

All HARP enrollees are eligible for individualized care management. In addition, 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; 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 identified challenges. These efforts included:

- Streamlining the BH HCBS assessment process.
    - Effective March 7, 2017, the full portion of the NYS 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 Health Homes 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 Health Homes. 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)
- Continuing efforts to increase HARP enrollment in Health Homes 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 Health Homes 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 Health Homes (e.g., Outreach Optimization).
- Ongoing work to strengthen the capacity of Health Homes 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 Health Homes, 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 OMH has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for MMC HARPs and Adult 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.
    - 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 HARPs 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 the HARPs.
- 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, Health Homes, 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' Health Home/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, 5,246 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2023, and March 31, 2023, 1,040 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, called CORE Services, for HARP enrollees and HARP eligible HIV-SNP enrollees, which resulted in positive feedback. The State finalized the proposal and submitted to CMS in September 2020. The objectives of this transition were two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the BH population, and to eliminate barriers to access.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through the American Rescue Plan Act (ARPA), 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 CORE Services on October 5, 2021. CORE 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 CORE Services does not require an independent eligibility assessment and these services do not have settings restrictions. All HARP and HARP eligible HIV-SNP enrollees can access CORE Services with a recommendation from a licensed practitioner of the healing arts (LPHA). Enrollment in Health Home Care Management continues to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by Health Homes. 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 MCOs and service providers.

CORE Services went live on February 1, 2022 and are available to new and existing enrollees. The transition period for existing recipients of BH HCBS CPST, PSR, FST and Peer Support to CORE CPST, PSR, FST and Peer Support ended April 30, 2022.

Consumer education materials have been released via the OMH website and a provider listserv. In January 2022, OMH also participated in a Townhall series hosted by the Access 2 Recovery Coalition with a goal of educating HARP members about changes to their benefits. The State conducted a series of implementation trainings in partnership with MCTAC. After a transitional period of provisional designation and attestation, 115 providers received full designation for CORE Services The State engaged providers in a significant amount of outreach and technical assistance to ensure the provider system was prepared for this transition, supporting and prioritizing continuity of care for members receiving these services. A list of fully designated CORE providers is available on the OMH CORE webpage.

Beginning January 1, 2023, HARP eligible Medicaid Advantage Plus (MAP) enrollees can access CORE Services with an LPHA recommendation. The State continues to provide technical assistance on this benefit carve-in. The State provided MCOs with CORE Services guidance and training, in addition to MAP benefit package trainings for CORE Service providers and care managers.

The State continues to consult CORE providers and MCOs to inform future guidelines around MCO responsibilities and oversight, such as utilization management of 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 Adult BH HCBS Infrastructure funding initiative to support 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 allowed HARPs to contract for remaining, unspent funds totaling approximately $31.9 million. Based on a thorough network needs assessment, HARPS competitively awarded the funds to eligible providers. Infrastructure Program Extension contracts were executed between May and September 2022, with contracted activities currently underway. OMH and OASAS continue to work closely with the HARPs to further monitor and operationalize the program.

- 11 HARPs executed 80 provider contracts which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $17 million in initial contract base awards and subsequent milestone payments were distributed to providers.
- The program is expected to conclude in July 2024.
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS and CORE Service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.

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

Based on stakeholder input and timing of other managed care initiatives, the Department has recently decided to amend the carve-in date for SBHC services into the MMC benefit package. The target implementation date has been changed to no sooner than April 1st, 2024.

C. Managed Long-Term Care Program (MLTCP)

MLTC plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of March 1, 2023, there are 23 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of March 31, 2023, there are a total of 307,852 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the January 2023 through March 2023 quarter, the DOH approved a service area expansion for 1 MAP plan, and a service area expansion for 2 PACE plans.

New York’s Enrollment Broker, New York Medicaid Choice (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 January 2023 through March 2023 quarter, post enrollment surveys were completed for 4 enrollees. Of the 4 surveyed, 2 (50%) indicated that they continued to receive services from the same

caregivers once they became members of an MLTCP. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 256,557 to 260,207 during the January 2023 through March 2023 quarter, a slight increase from the last quarter. For that period, 12,762 individuals who were being transitioned into MLTC made an affirmative choice, a 3% decrease from the previous quarter and brings the 12-month total for affirmative choice to 50,148.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the April 2022 through March 2023 annual period is submitted as an attachment.

2. Significant Program Developments during the January 2023 through March 2023 quarter:

- The 1st Quarter Member Services survey was conducted on (23) Partial Capitation Plans and (12) 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.

- The Desk Review for four (4) Partial Capitation Operational Surveys were completed and reported in prior reporting periods. The Corrective Action Plan for 1 Partial Capitation plan has been received and is still awaiting Department approval. The Corrective Action plan for 1 Partial Capitation plan has been approved by the department. A Statement of Deficiency (SOD) was issued to 2 Partial Capitation plans, their Corrective Action Plan has been received and is still awaiting Department approval.

- The Desk Review for 1 Partial Capitation plan has been completed. A SOD was issued to the plan, their Corrective Action Plan has been received and is still awaiting Department approval.

- Operational Surveys are ongoing for 2 more Partial Capitation plans.

- The Focused Survey conducted on a Partial Capitation plan regarding a Technical Assistance Center (TAC) Complaint during the 1st quarter has been completed. The additional documentation submitted was determined to be sufficient.

- The Focused Survey initiated on all Partial Capitation and MAP Plans (on 10/28/2022) focusing on Person Centered Service Planning (PCSP) Template compliance was completed. Analysis of plan submissions during Q2 determined an overall lack of compliance and follow up will be provided to plans to resubmit compliant templates in Q3. The plans were educated on PCSP requirements and a follow up Focused Survey will be initiated.

- A Focused Survey was initiated in a prior reporting period on all Partial Capitation MAP Plans focusing on Health Homes Administrative Service Agreements. All plan submissions were received, and an updated list was posted to the DOH website.

- One (1) Focused Survey was initiated on 1 Partial Capitation plan based on TAC Complaints (Rate Change). A SOD has been drafted and is awaiting approval.

- One (1) Focused Survey was initiated on 1 Partial Capitation plan based on a late MSA / IPA Contract submission requiring Department review and approval. A SOD was issued to the plan and the Department is awaiting their Corrective Action Plan.

- One (1) Focused Survey was initiated on 1 Partial Capitation plan based on TAC complaints received for inappropriate Social Adult Day Care (SDC) denial notices. A SOD has been drafted and is awaiting final approval.

- One (1) TAC Investigation was initiated on 1 Partial Capitation plan TAC complaints received for inappropriate SDC reduction notices. A SOD has been drafted and is awaiting final approval.

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

- There are no significant issues or problems to report, however survey training continues for the three new team members.

3. Issues and Problems

There were no issues or problems to report for the January 2023 through March 2023 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 DOH began a procurement process in December 2019 which was subsequently amended in the Executive Budget in April 2022. The amended legislation now directly provides the criteria a Fiscal Intermediary (FI) must meet to contract with the DOH to continue to provide fiscal intermediary administrative services for the Consumer Directed Personal Assistance Program (CDPAP). The Department has developed a process by which each FI will attest to meeting the legislatively mandated criteria. The DOH will begin contracting with those FIs that meet the criteria in 2023. Managed care plans will then enter into separate administrative service agreements with these Department-contracted FIs.

5. Required Quarterly Reporting

Critical incidents: There were 2,887 critical incidents reported for the January 2023 through March 2023 quarter, an increase of 20% from the previous quarter. The large increase is due to both reminder instructions issued in how the Critical Incidents should be reported and two partial cap plans that reported increased Critical Incidents for Q2. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey.

Critical incidents by plan for this quarter are attached.

Complaints and Appeals: For the January 2023 through March 2023 quarter, the top reasons for complaints/appeals stayed the same as last quarter: Dissatisfaction With Transportation, Dissatisfaction With Quality Of Other Covered Services, Dissatisfaction With Quality of Homecare (Other than Lateness or Absences), Dissatisfaction With Member Services and Plan Operations, Dissatisfaction with Care Management.

Period: 1/1/2023–3/31/2023 (Percentages rounded to nearest whole number)			
Number of Recipients: 301,711	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**13**	**13**	**100%**
# Same Day	**2,945**	**2,945**	**100%**
# Standard/Expedited	**9,591**	**7,208**	**75%**
Total for this period:	**12,549**	**10,166**	**81%**

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

Appeals	4/2022-6/2022	7/2022-9/2022	10/2022-12/2022	1/2023-3/2023	Average for Four Quarters
Average Enrollment	286,152	291,381	297,328	304,375	294,809
Total Appeals	8,803	8,473	10,284	10,461	9,505
Appeals per 1,000	31	29	36	34	33
# Decided in favor of Enrollee	1,241	966	1,081	1,224	1,128
# Decided against Enrollee	6,323	6,252	7,143	8,103	6,955
# Not decided fully in favor of Enrollee	912	880	845	871	877
# Withdrawn by Enrollee	247	190	236	263	234
# Still pending	80	185	979	1,195	610
Average number of days from receipt to decision	7	8	10	7	8

Complaints and Appeals per 1,000 Enrollees by Product Type January 2023- March 2023					
	Enrollment*	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	259,072	7,662	30	7,728	30
Medicaid Advantage Plus (MAP) Total	36,593	3,584	98	2,632	72
PACE Total	8,710	1,303	150	101	12
Total for All Products:	**303,375**	**12,549**	**41**	**10,468**	**35**

***Total is average of 3 months**

Total complaints increased slightly from 12,531 the previous quarter to 12,549 during the January 2023 through March 2023 quarter.

The total number of appeals increased 2% from 10,284 during the last quarter to 10,468 during the January 2023 through March 2023 quarter.

Technical Assistance Center (TAC) Activity

During the January 2023 through March 2023 quarter, TAC opened 730 cases and closed 723 cases. This is higher than the 460 cases opened, and 437 cases closed from the previous quarter. The Department recognizes a similar seasonal increase in previous years. This increase is spread across multiple dispositions. Upon examination, the increase was comparable across the different types of case dispositions.

Most of TAC's cases for this quarter were for general inquiries and questions. Complaints regarding home health care services continue to be the highest complaint category.

Call Volume	**1/1/2023 – 3/31/2023**
Substantiated Complaints	95
Substantiated Complaints with Corrective Action Plan	16
Unsubstantiated Complaints	223
Resolved Without Investigation	7
Inquiries	382
Total Cases Closed	723

The five most common types of calls were related to:

Q2	**1/1/2023-3/31/2023**
General	31%
Aide Service	15%
Enrollment	12%
Billing	8%
Grievance	8%

73% of Q2 TAC cases were closed in the same month they were opened. This is a 7% increase from last quarter's percentage of 68%.

Evaluations for enrollment: The New York Independent Assessor (NYIA) is conducting initial assessments and clinical exams for personal care and consumer directed personal assistance services as well as continuing to determine MLTC eligibility. For January 2023 through March 2023 quarter, 7,325 people were evaluated, deemed eligible and enrolled into plans, a decrease of 1% from the previous quarter. NYS continues to see quarter to quarter variability in the number of individuals requesting assessments and the number who are deemed eligible.

Rebalancing Efforts	**1/2023-3/2023**
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	1,764
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	2,955

As of March 31, 2023, there were 3,004 current plan enrollees who were in nursing homes as permanent placements, a 29% decrease from the previous quarter. This percentage decrease is due to the batch disenrollment of members in Partial Capitation plans who have met their Nursing Home Benefit Limit and are not returning to the community.

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 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. **The Children's Waiver Renewal** that was submitted to the Centers for Medicare and Medicaid Services (CMS) in January 2022, and extended in April 2022, was **approved on June 29, 2022**, for an effective date of April 1, 2022.

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

- Managed care authority for HCBS provided to medically fragile children and/or with developmental disabilities, developmental disability in foster care, and children with a serious emotional disturbance;
- Authority to include current FFS HCBS authorized under the State's newly consolidated 1915c Children's Waiver in MMC 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 NYS DOH has been engaged in implementation activities, including, but not limited to the following:

- 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;
- Updating manuals, guidance documents, and online resources as indicated
- Reassessing, streamlining, and removing unnecessary or duplicative forms to alleviate administrative burden;
- 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 MCOs, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of MCOs and FFS 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;
- Assisting with a strategic plan for the unwind of the COVID-19 PHE;
- Conducting annual case reviews of both Health Homes, C-YES, and HCBS providers;
- 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 workforce challenges, lack of referral sources / lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers;
- Engaging with providers, consumers, and NYS agency partners to determine how best to use the enhanced FMAP authorized by the ARPA to improve access to children's services and reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure;
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between MCOs, Health Homes, and HCBS providers;
- Organizing and conducting workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral process;

- Engaging with Health Homes, MCO, and HCBS providers while redesigning the Plan of Care in preparation for digitization;
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process;
- Submitting the 1915c Children's Waiver Extension to CMS;
- Submitting the 1915c Children's Waiver Renewal to CMS;
- Submitting a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitting a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure;
- Working with MCOs and providers to disseminate ARPA funding through the directed payment process;
- Scheduling and facilitating regional meetings with HCBS providers, Health Homes, care management agencies, Medicaid MCOs to resume in-person collaboration and dialogue.
- Updating the IRAMS and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- 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 they are not currently able to actively deliver HCBS.
- Drafting documentation guidance to ensure compliance with documentation of services being delivered to Children's Waiver participants, progress toward goals, significant life events, and medical necessity requirements for each HCBS.
- Submitting additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental and Vehicle Modifications & Adaptive and Assistive Technology.

Given the Waiver renewal approval, the NYS DOH has been implementing and altering activities and services, including, but not limited to, the following:

- Submitting Disaster SPA 21-0054, which is pending approval for the assessment fee retroactive to April 1, 2021;
- Submitted a SPA 22-0088, which would continue the assessment fee effective October 1, 2022;
- Updating documentation and providing guidance to providers regarding the HCBS name changes for "Palliative Care: Counseling and Support Services" (previously "Palliative Care: Bereavement") and "Adaptive and Assistive Technology" (previously "Adaptive and Assistive Equipment");
- Updating documentation and providing guidance to providers regarding the consolidated HCBS of "Caregiver and Family Support and Services" and "Community Self-Advocacy Support" into a new service referred to as "Caregiver/Family Advocacy and Support Services". This combination will allow for a broader array of providers to deliver the service and also broadens the definition of caregivers eligible for training to include all individuals who supervise and care for members;

- Broadening Children and Youth Evaluation Services' (C-YES') Nurse qualifications by requiring two years relevant experience. The previous requirement that was two years' experience *specifically* in home care;
- Reducing the required years of experience for Palliative Care: Expressive Therapists from 3 years to 1 year;
- Adding a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity;
- Adding a 5.4% COLA increase for providers;
- NYS support of the continued 25% enhanced HCBS rates on October 1, 2022.

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 1915c Children's Waiver identified by NYS restriction exception (RE) code of K1 and the current claims for services for these enrolled children/youth. Additionally, as outlined in the 1115 amendment, NYS is tracking the enrollment of children/youth who obtained Medicaid through Fo1 Medicaid budgeting as identified by NYS 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**
January	16,005	6,872	6,669	814
February	15,775	4,408	6,635	710
March	15,543	1,682	6,663	372
Quarterly Average	**15,774**	**4,321**	**6,656**	**632**

**There is an expected 3-month lag for claims data that may impact the enrolled children with an HCBS claim data.*

This table includes data from the 2nd Quarter of FY2023. The number of children/youth enrolled in HCBS has decreased at a consistent rate. The claims count mirrors that steady decrease.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 evaluation design to CMS for review and approval.

VII. Consumer Issues

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

MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to the Department of Health (department) 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 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**
MMC	7,224	7,667
HARP	960	512
HIV SNP	75	89
Total MCO Complaints	**8,259**	**8,268**

As described in the table, MCOs reported 8,259 total enrollee complaints for the current quarter. This represents a 0.1% decrease from the prior quarter's total of 8,268 enrollee complaints.

MCOs reported 7,224 MMC complaints this quarter, which is a 5.8% decrease from the 7,667 of the previous quarter. The number of HARP complaints increased 87.5%, from 512 in the prior quarter to 960 this quarter. There were 75 HIV SNP complaints this quarter, which is a decrease of 15.7% when compared to the 89 from the previous quarter.

The Department reviewed the increase in HARP enrollee complaints received from the MCOs. Upon examination, the percentage increase in HARP enrollee complaints stemmed from the number of HARP enrollee complaints reported by one MCO. No individual complaint category stood out as an outlier. The Department is following up with the MCO regarding the differences between the most recent quarter compared to 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 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**
Pharmacy/Formulary	16%	14%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	19%
Balance Billing	12%	12%
Reimbursement/Billing	9%	8%
Difficulty with Obtaining: Dental/Orthodontia	9%	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 23 Q2 1/1/2023-3/31/2023	FFY 23 Q1 10/1/2022-12/31/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	22%	22%
Pharmacy/Formulary	20%	20%
Dissatisfaction with Quality of Care	7%	8%
Difficulty with Obtaining: Specialist and Hospitals	5%	2%
Difficulty with Obtaining: Dental/Orthodontia	5%	7%

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 23 Q2 1/1/2023-3/31/2023	FFY 23 Q1 10/1/2022-12/31/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	24%
Pharmacy/Formulary	16%	11%
Dissatisfaction with Quality of Care	12%	13%
Difficulty with Obtaining: Dental/Orthodontia	12%	11%
Difficulty with Obtaining: Personal Care	8%	8%

B. Monitoring of Plan Reported Complaints

The Department has been monitoring the complaint activity for New York State's Medicaid Section 1115 MRT Waiver. As part of this initiative, the Department analyzes enrollee complaints by using an Observed to Expected (OE) ratio, to identify trends and potential problems across categories.

The OE ratios are 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 applicable categories in which the reported number of complaints was more than twice the expected amount. 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.

Amida Care FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**OE Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	11.0	The trend identified from the complaints received was regarding concerns with the quality of transgender treatments. The issue identified was that enrollees were dissatisfied with gender transformation surgery or procedures.	The MCO will address quality of care complaints by having their Gender Identity Support Team (GIST) educate members about gender affirmation surgery experiences and schedule member town hall meetings to share information and experiences. The MCO will encourage enrollees to reach out to their Care Coordinator if assistance is needed for any health-related concerns.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	8.4	The trend identified from the complaints received was that the MCO's call center representatives and provider offices were not providing adequate customer service to enrollees. The issues identified were poor communication from providers regarding changes in appointment times and availability, and poor customer service from MCO call center representatives including rudeness and responsiveness.	The MCO will address dissatisfaction with provider customer service by having Provider Services staff educate providers regarding communicating changes with appointments and transportation and by following up with individual providers to address enrollee complaints. The MCO will address dissatisfaction with call center representatives by consistently coaching on best practices and standards for serving enrollees and receiving performance feedback from speaking with enrollees on the phone. The Department will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.9	The trend identified from the complaints received was that enrollees were	The MCO will address pharmacy complaints by conducting audits and reviews of pharmacies and

		unable to obtain their medication from the pharmacy. The issues identified were that enrollees did not receive their medication delivery, multiple pharmacies did not process prescriptions correctly, and enrollees were unable to pick up their medication on their first attempt at the pharmacy.	remove any from its network that are not meeting contractual requirements. The MCO will also provide education and guidance to any pharmacies to advise of standards and requirements that need to be met.

Capital District Physicians Health Plan FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.2	There were no trends identified from the complaints received. The issues identified were related to the quality of care received, including if the level of care received was adequate to address enrollees' needs.	The MCO will address the quality-of-care concerns by reviewing medical documentation and continuing to monitor for trends.

Healthfirst FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Long Wait Time	2.3	The trend identified from the complaints received was that enrollees were dissatisfied with extended wait times during dental appointments, some of which were over thirty minutes after the scheduled appointment time. There were no issues identified.	The MCO will address long wait times for enrollees by re-educating providers regarding the importance of appropriately spacing scheduled appointments to reduce excessive wait time.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.4	The trends identified from the complaints received were that enrollees had issues communicating with MCO call center staff and	The MCO will address call center communication issues by conducting retraining of staff with a focus on addressing enrollee inquiries and

		that enrollees were experiencing issues related to durable medical equipment (DME). The issues identified were that MCO call center staff were not communicating clearly; there was a lack of communication regarding DME supplies; incorrect paperwork was utilized by providers for DME services; and inquiries were misclassified as complaints by the MCO, causing its reported numbers in this category to be higher than expected.	complaints, correctly categorizing enrollee inquiries and complaints, and providing talking points for common issues that enrollees may bring up. The MCO will address DME related issues by enforcing vendor agreements regarding redelivery and replacement of items and improving communication with enrollees.
Difficulty with Obtaining: Emergency Services	3.2	The trend identified from the complaints received was that enrollees were being billed by out of network facilities for emergency services rendered. The issues identified were that out-of-network facilities were billing enrollees for services without submitting a claim to the health plan; enrollees were being balance billed when the facilities were dissatisfied with the claim amount paid by the health plan; and enrollee inquiries regarding EOBs were being misidentified as complaints by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO addressed difficulty with obtaining emergency services by holding a training to reeducate call center staff on correctly categorizing complaints and addressing enrollee EOB concerns. The Department will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.1	The trends identified from the complaints received were that enrollees were unable to receive their requested medication, enrollees were dissatisfied	The MCO will address out-of-stock medications by having their call center representatives follow a new process whenever medications are out of stock, including offering mail order

		with which medications were covered, enrollees were dissatisfied with their inability to refill medications early, and there were long wait times for prescriptions to be filled. The issues identified were that medications were out of stock due to nationwide shortages, the formulary did not cover some requested medications, providers were not requesting prior authorization when necessary for some medications, and enrollees were exhausting their override and early refill thresholds.	medications, assisting enrollees in locating a pharmacy in network that has the medication in stock, and allowing for formulary exception overrides of the brand version of the out-of-stock medication. The MCO will address formulary design complaints by informing enrollees that the pharmacy benefit will be carved out effective April 1, 2023, and it can no longer change the formulary. The MCO will address early refill rejections by allowing for overrides in certain circumstances.
Reimbursement/Billing	2.6	The trend identified from the complaints received was that enrollees were dissatisfied with being billed for services rendered. The issues identified were that enrollees were dissatisfied with being billed for non-covered services when private pay agreements had been signed; enrollees were unfamiliar with services listed on EOBs; out-of-network labs were billing enrollees for services rendered; and enrollee inquiries were being misidentified as complaints by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will address misidentification of complaints by providing training to have its call center representatives correctly categorize enrollee inquiries and complaints. The MCO addressed enrollee questions about services listed on EOBs by conducting a training which improves how call center representatives will guide enrollees to help them understand the information contained within an EOB. The MCO will address enrollees being billed for out-of-network lab services by working with their Delivery Systems Engagement team to work with the providers to ensure they are not billing enrollees for services that are covered in the benefit package.
Recipient Restriction Program Plan Initiated Disenrollment	3.6	The trend identified from the complaints received was that enrollees were dissatisfied with their	The MCO will address enrollee dissatisfaction with the Recipient Restriction Program by updating their job aids for call center

		inability to change pharmacies. The issue identified was that enrollees were unaware of how to request a pharmacy change when they were restricted to a specific pharmacy.	representatives to better educate enrollees on the actions they can take regarding pharmacy restrictions. The MCO will address enrollee dissatisfaction by better communicating enrollee restrictions.
Difficulty with Obtaining: Private Duty Nursing	3.6	The trend identified from the complaints received was that enrollees were dissatisfied with their Private Duty Nursing (PDN) agencies. The issues identified were that there continues to be a PDN staff shortage, enrollees stated that nurses did not report to work, and enrollees stated that they did not receive advance notice that staff were unavailable to provide services.	The MCO will address PDN shortages by working with out-of-network providers and creating single case agreements to provide needed services. The MCO will address nurses not reporting to work and not providing advance notice by reaching out to agencies with these reported issues. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Personal Care	3.5	The trend identified from the complaints received was that enrollees were dissatisfied with their personal care agencies and aides. The issues identified were that personal care aides were absent or tardy, personal care aides were not able to speak in the enrollee's preferred language, personal care aides were not the enrollee's preferred gender, and enrollees were not able to contact their personal care agency.	The MCO will address enrollee dissatisfaction with their personal care aides by following up with agencies with repeated complaints and implementing action plans to improve personal care services. The MCO will address personal care aide availability issues by working with out-of-network providers and creating single case agreements to provide needed services.
Difficulty with Obtaining: CDPAS	3.7	The trends identified from the complaints received were that enrollees were having problems with their CDPAS applications being processed, including delays in authorization for	The MCO will address disruptions in services by enhancing and revising their communications with enrollees and aides. The MCO will continue to ensure that care managers are working with

		services and delays in aides receiving payment for services, and enrollees were experiencing difficulties contacting their fiscal intermediaries. The issues identified were that fiscal intermediaries were not timely in processing authorization and payment due to misrouted paperwork, starting services for some cases, and returning calls from enrollees.	Appeals & Grievances Quality Committee to ensure enrollees understand the CDPAS program and the approval process required for hiring aides. The Department will continue to monitor progress in the next reporting period.

Highmark FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: Specialist	16.8	The trend identified from the complaints received was that enrollees were trying to receive care from out-of-network providers. The issues identified were that enrollees were trying to receive care from out-of-network providers who either did not submit the required documentation for approval or submitted documentation incorrectly.	The MCO will address out-of-network providers not submitting the required documentation and submitting documentation incorrectly by educating them on the proper process for requesting specialty services as well as helping direct enrollees to in-network providers.
Difficulty with Obtaining: Specialist and Hospitals	3.3	The trend identified from the complaints received was that enrollees were having difficulty finding new providers after their previous providers left the network. The issues identified were that providers that used to participate with the plan are no longer in network and that enrollees were unaware of how to locate new in-network providers.	The MCO will address providers leaving the network by building their relationships with their providers and listening to their concerns, resolving their issues, and escalating issues to its leadership team. The MCO will address enrollee difficulty locating in-network providers by reviewing out-of-network authorizations for care and educating and redirecting the enrollee to in-network providers when available.

Balance Billing	6.0	The trend identified from the complaints received was that enrollees were being billed by providers for services rendered. The issues identified were that enrollees were not providing their plan identification information at the time of service and out-of-state providers were billing enrollees after the MCO adjudicated their claims.	The MCO will address providers balance billing enrollees by educating enrollees on providing proper identification information when seeking treatment and by contacting providers who balance bill, giving them updated insurance information for proper billing, and educating them on the importance of obtaining coverage information before providing services. The Department will continue to monitor progress in the next reporting period.

Health Insurance Plan of Greater New York FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	7.0	The trends identified from the complaints received were that enrollees were dissatisfied with covered dental benefits, enrollees were dissatisfied with the treatment planned or provided, and enrollees were dissatisfied with the duration of the dental cleanings. The issue identified was that providers were not managing the expectations of their enrollees as to what is covered by the dental benefit.	The MCO will address provider knowledge of the benefit package by maintaining a provider's reference manual on its provider portal that lists and describes covered procedures and explains the steps needed before rendering treatment. The MCO will address enrollee knowledge of the benefit package by educating enrollees regarding non-covered services via their website's Member Education section.
Reimbursement/Billing	2.4	The trend identified from the complaints received was that enrollees were dissatisfied with the EOBs they received. The issue identified was that enrollees were receiving EOBs in which services were being denied due to being referred to out-of-	The MCO will address the enrollee dissatisfaction with EOBs by reeducating providers on referring enrollees to in-network providers and reeducating enrollees on receiving services from in-network providers.

		network providers without authorization.	

Independent Health Association FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.1	The complaints received were regarding general enrollee dissatisfaction with providers and provider care. There were no trends or issues identified by the MCO.	The MCO will address enrollee complaints by continuing to conduct provider outreach to identify provider issues and will address those provider issues by utilizing plans of correction. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	4.3	The trend identified from the complaints received was that enrollees were dissatisfied with being denied services. The issue identified was that enrollees were requesting non-covered services.	The MCO will address enrollee requests for non-covered services by working with their dental vendor to monitor any trends that they find and will continue to send handbooks to new enrollees which contain a list of covered dental services. The Department will continue to monitor progress in the next reporting period.

MetroPlus Health Plan FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	2.7	The trend identified from the complaints received was that enrollees were dissatisfied with the process of scheduling appointments. The issues identified were that enrollees were having difficulty scheduling appointments, felt a lack of empathy/understanding by providers, and were dissatisfied with the length of time between the call to schedule an appointment	The MCO will address enrollee difficulty with scheduling by increasing accessibility to their providers by having call center representatives schedule appointments for enrollees when asked.

		and the next available appointment.	
Difficulty with Obtaining: Eye Care	3.2	The trend identified from the complaints received was that enrollees were being held liable for frames and material upgrades that were not covered. The issue identified was that enrollees and providers were unaware of what was covered under the insurance benefit.	The MCO will address complaints about denials of non-covered frames and material upgrades by having its customer service representatives educate enrollees on what services are covered, advising providers to sign up for the provider portal or call customer service to get benefit information, and partnering with its Network Relations team to ensure its providers are providing eye care that is covered under the insurance benefit.

Molina Healthcare FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	3.5	The trend identified from the complaints received was that enrollees were having difficulty locating primary care providers. The issues identified were that enrollees were unfamiliar with navigating the MCO website to search for primary care providers and providers were not meeting access and availability standards.	The MCO will address enrollees' difficulty searching for primary care providers by continuing to provide a tutorial for navigating the member web portal during new enrollee orientation. The MCO will address inadequate appointment availability for enrollees by continuing to reach out to PCP offices to evaluate access and availability standards.
Difficulty with Obtaining: Specialist and Hospitals	4.8	The trend identified from the complaints received was that enrollees were having difficulty locating specialist providers. The issues identified were that enrollees were unfamiliar with navigating the MCO website to search for specialist providers and providers were not meeting access and availability standards.	The MCO will help enrollees locate specialist providers by continuing to provide a tutorial for navigating the member web portal during new enrollee orientation. The MCO will continue to reach out to specialist offices to evaluate access and availability standards to ensure adequate appointment availability for enrollees.

Pharmacy/Formulary	3.6	The trend identified from the complaints received was that enrollees were being denied their prescription requests. The issues identified were that pharmacy prior authorization requirements were not being met and enrollees had coordination of benefits eligibility issues.	The MCO will address providers not submitting prior authorizations correctly by reaching out to them and educating on submitting the correct documentation and by educating its call center representatives on the necessary information required for prior authorization requests.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9.2	The trend identified from the complaints received was that there was enrollee confusion regarding the transition from the Affinity plan to the Affinity by Molina plan. The issue identified was that enrollees misunderstood the plan change and had questions about it.	The MCO will address enrollee confusion regarding the Affinity/Molina transition by advertising its online member tutorial on its public website, providing tools to use its new mobile app, and providing information on registering and accessing its member portal and member ID access.
All Other	12.6	The trend identified from the complaints received was that there was enrollee dissatisfaction regarding the transition to the Affinity by Molina plan. The issue identified was that enrollees were unhappy with changes under the new plan, including authorization requirements.	The MCO will continue to address enrollee dissatisfaction and inquiries by providing education and helping enrollees or providers navigate the new authorization requirements with which they may be having difficulty.
Balance Billing	8.5	The trend identified from the complaints received was that enrollees were being balance billed. The issues identified were that enrollees were not presenting their insurance cards or otherwise informing providers that they were enrolled in Medicaid and providers were not verifying Medicaid eligibility prior to billing enrollees.	The MCO will continue to reeducate providers on ensuring that they verify Medicaid eligibility and to not balance bill Medicaid enrollees. The MCO will continue to remind enrollees to present their insurance cards upfront for appointments.

Difficulty with Obtaining: Home Health Care	5.8	The trend identified from the complaints received was that enrollees were not submitting the appropriate documentation. The issue identified was that enrollees needed more guidance and education on the proper forms submitted to request services.	The MCO addressed issues with confusion on documentation by providing education to enrollees on the home health care process and the proper documentation that needs to be submitted.

MVP Health Plan FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	2.4	The trend identified from the complaints received was that enrollees had quality of care concerns. The issue identified was that providers were not meeting the enrollees' quality of care expectations.	The MCO will address enrollee quality of care concerns by reeducating providers on communicating treatment plans so the enrollees are fully aware of the services that they will be receiving.

United Healthcare FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	3.2	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were that providers failed to properly diagnose enrollees, fully explain medical results and treatment plans, and efficiently document medical records.	The MCO will address quality of care concerns by determining which providers need corrective action and sending out corrective action plan letters; providing verbal or written counseling; conducting focused medical care reviews; and restricting, suspending, or terminating network participation, if necessary.
Denial of Clinical Treatment	10.6	The trend identified from the complaints received was that enrollees were being denied treatment. The issues identified were that enrollees did not have referrals on file for the	The MCO will address denials by providing education to providers and enrollees on referral requirements and continuing to engage providers and enrollees when reeducation is warranted. The MCO remediated any

		services they were seeking and enrollee complaints regarding dental were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	misalignment between claims processing and referral entry in its systems. The Department will continue to monitor progress in the next reporting period.

VNS Choice FFY 22 Q4–FFY 23 Q1 (7/1/2022–12/31/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	13.8	The trend identified from the complaints received was that enrollees were receiving denials. The issue identified was that enrollees were requesting services that were not covered by the dental benefit.	The MCO will address coverage denials by continuing to provide educational materials to enrollees, including welcome kit inserts detailing the benefit and scope of coverage.

C. 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 8,259 total reported complaints/action appeals, MCOs reported 469 complaints and action appeals from their SSI recipients. This compares to 404 SSI complaints/action appeals from the previous quarter, representing a 16.1% increase.

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 23 Q2 1/1/2023-3/31/2023	FFY 23 Q1 10/1/2022-12/31/2022
Appointment Availability: PCP	2	2
Appointment Availability: Specialist	4	2
Appointment Availability: BH HCBS	0	0
Long Wait Time	2	1
Dissatisfied with Quality of Care	40	56
Denial of Clinical Treatment	19	23
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	137	75
Dissatisfaction with BH Provider Services	0	1

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**
Dissatisfaction with Health Home Care Management	4	5
Difficulty with Obtaining: Specialist and Hospitals	21	16
Difficulty with Obtaining: Eye Care	5	2
Difficulty with Obtaining: Dental/Orthodontia	29	34
Difficulty with Obtaining: Emergency Services	1	0
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	0	2
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	5	0
Difficulty with Obtaining: Home Health Care	2	2
Difficulty with Obtaining: Personal Care	17	5
Difficulty with Obtaining: PERS	1	0
Difficulty with Obtaining: CDPAS	8	2
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	52	80
Access to Non-Covered Services	5	8
Access for Family Planning Services	1	0
Communications/ Physical Barrier	3	0
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	5	0
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	59	50
Balance Billing	24	25
Transportation	2	0
All Other	21	13
Total	**469**	**404**

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 23 Q2 1/1/2023-3/31/2023	FFY 23 Q1 10/1/2022-12/31/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	29%	19%
Reimbursement/Billing	13%	12%
Pharmacy/Formulary	11%	20%
Dissatisfied with Quality of Care	9%	14%
Difficulty with Obtaining: Dental/Orthodontia	6%	8%

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 January 1, 2023 through March 31, 2023, MCOs reported LTSS enrollment of 53,931 enrollees. This compares to 52,751 LTSS enrollees from the previous quarter, representing a 2.2% increase. 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 23 Q2 1/1/2023-3/31/2023	FFY 23 Q1 10/1/2022-12/31/2022
Amida Care	1,318	1,252
Capital District Physicians Health Plan	771	755
Excellus Health Plan	1,640	1,547
Fidelis Care	19,562	19,170
Healthfirst	14,033	13,986
Highmark	242	219
HealthPlus	3,292	2,941
HIP of Greater New York	642	630
Independent Health Association	670	625
MetroPlus Health Plan	2,805	3,021
Molina Healthcare	2,936	2,742
MVP Health Plan	2,347	2,284
United Healthcare	3,266	3,164
VNS Choice	407	415
Total	**53,931**	**52,751**

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 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Difficulty with Obtaining: Adult Day Care	3	4
Difficulty with Obtaining: CDPAS	69	93
Difficulty with Obtaining: Home Health Care	50	29
Difficulty with Obtaining: RHCF Services	1	1
Difficulty with Obtaining: Personal Care	162	164
Difficulty with Obtaining: PERS	3	3
Difficulty with Obtaining: Private Duty Nursing	21	24
Total	**309**	**318**

D. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 112 critical incidents reported for the January 1, 2023 through March 31, 2023 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	Critical Incidents		
	FFY 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**	**Net Change**
Medicaid Managed Care Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	18	8	+10
Fidelis Care	7	0	+7
Healthfirst	51	58	-7
HIP of Greater New York	0	0	0
Highmark	0	1	-1
HealthPlus	0	0	0

Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	1	-1
MVP Health Plan	1	1	0
United Healthcare	0	0	0
Total	**77**	**69**	**+8**
Health and Recovery Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	0	0
Fidelis Care	0	0	0
Healthfirst	28	55	-27
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	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**28**	**55**	**-27**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	7	8	-1
Total	**7**	**8**	**-1**
Grand Total	**112**	**132**	**-20**

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 23 Q2 1/1/2023-3/31/2023	**FFY 23 Q1 10/1/2022-12/31/2022**	**Net Change**
Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	7	3	+4
Crimes Committed Against Enrollee	3	1	+2
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	6	1	+5
Instances of Exploitation of Enrollees	0	2	-2
Instances of Neglect of Enrollees	3	7	-4
Medication Errors that Resulted in Injury	0	0	0

Other Incident Resulting in Hospitalization	6	10	-4
Other Incident Resulting in Medical Treatment Other Than Hospitalization	45	45	0
Use of Restraints	0	0	0
Wrongful Death	2	0	+2
Total	**77**	**69**	**+8**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	1	-1
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	0	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	5	8	-3
Other Incident Resulting in Medical Treatment Other Than Hospitalization	22	46	-24
Use of Restraints	1	0	+1
Wrongful Death	0	0	0
Total	**28**	**55**	**-27**
HIV Special Needs Plans			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	1	0	+1
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	4	6	-2
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	0	1	-1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	2	1	+1
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**7**	**8**	**-1**
Grand Total	**112**	**132**	**-20**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 99 enrollee complaints this quarter. This total is a 73.7% increase from the previous quarter, which reported 57 enrollee complaints.

The following chart represents previously reported complaints filed directly with the Department from enrollees and their representatives:

MCO Enrollee Complaints Received Directly by the Department	
FFY 23 Q2 1/1/2023–3/31/2023	**FFY 23 Q1 10/1/2022–12/31/2022**
99	**57**

The Department reviewed the increase in the number of enrollee complaints it received. Upon examination, the increase was consistent across all complaint categories. The Department recognizes a similar seasonal increase in previous years.

The following table outlines the top five (5) most frequent categories of enrollee complaints 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 23 Q2 1/1/2023-3/31/2023**	**FFY 23 Q1 10/1/2022-12/31/2022**
Difficulty with Obtaining: Home Health Care	12%	12%
Reimbursement/Billing	10%	21%
Pharmacy/Formulary	9%	11%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	8%	9%
Difficulty with Obtaining: CDPAS	7%	11%

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, MCO enrollees have remained eligible for and enrolled in Medicaid. This has been in effect since March 18, 2020, with exceptions including enrollees who move out of state, elect to cancel their coverage, or are enrolled in comprehensive commercial Third Party Health Insurance. 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.

F. Fair Hearings

There were 264 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2023 through March 31, 2023. 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 23 Q2 1/1/2023-3/31/2023**	**FFY 23 Q1 10/1/2022-12/31/2022**
In favor of Appellant	79	68
In favor of Plan	168	121
No Issue	17	10
Total	**264**	**199**

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.

Days Between Fair Hearing Request and Decision Date (includes MMC, HARP, and HIV SNP)		
Decision Days	**FFY 23 Q2 1/1/2023-3/31/2023**	**FFY 23 Q1 10/1/2022-12/31/2022**
0-29	8	4
30-59	44	45
60-89	43	39
90-119	52	50
=>120	117	61
Total	**264**	**199**

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

The MMCARP met on March 16, 2023. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC 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 MLTC program. There were two additional agenda items, a 2023-2025 Medicaid Quality Strategy presentation given by Kate Bliss, NYS DOH, OHIP, and an Applied Behavior Analysis (ABA) Services presentation given by Jassen Eide and Mathew Tierno, NYS DOH, OHIP. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for June 15, 2023.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in MLTC

During the reporting period, preparations began for calculating MLTC quality, satisfaction, and compliance measures. Activities included: attributing MLTC members to accountable health plans based on annual assessment data per 2021 requirement changes, securing all data sources necessary for the calculation of the 2022 MLTC Quality Incentive, and updating the programs used to calculate measures to ensure agreement with the publicly released methodology. Additionally, the Department's EQRO, IPRO, sent the first mailing of the 2023

MLTC Satisfaction Survey to eligible members. Finally, staff actively managed the MLTC_OQPS@health.ny.gov mailbox to ensure timely response to stakeholder inquiries.

B. Quality Measurement in Medicaid Managed Care

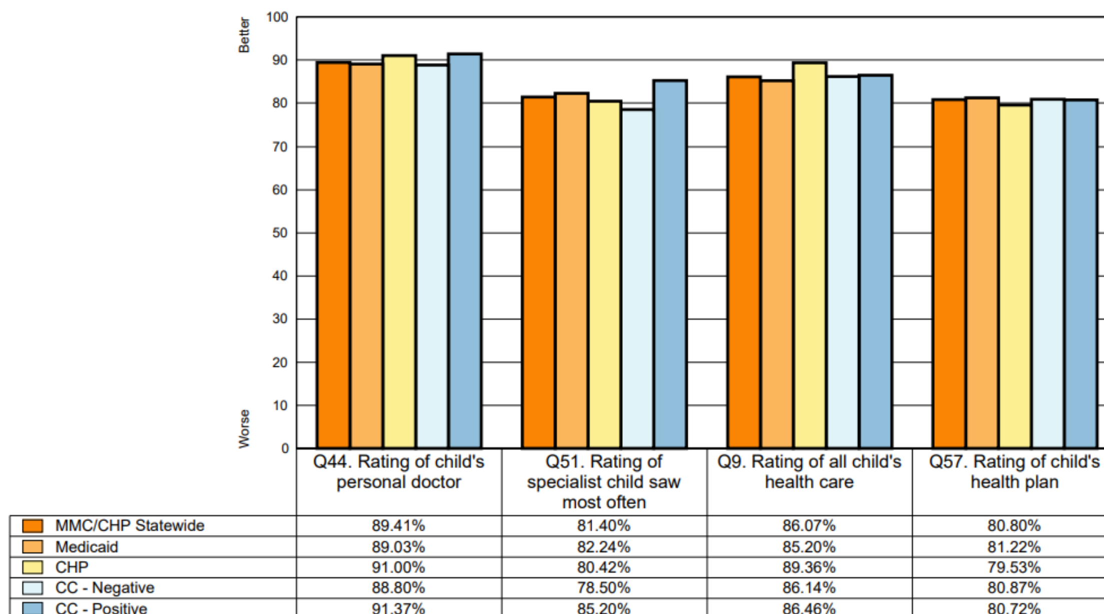
Quality Measure Benchmarks 2021 (Measurement Year 2021)

Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2021, national benchmarks were available for 64 measures for Medicaid. Out of the 64 measures that NYS Medicaid plans reported, 80% of measures met or exceeded national benchmarks. NYS consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid, rates exceed the national benchmarks for BH on adult measures (e.g., receiving follow-up within seven 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). NYS 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.

2022 Satisfaction Survey

In the fall of 2022, the DOH conducted a satisfaction survey of children enrolled in MMC. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 child survey was administered children aged 0-17 years who were enrolled in Medicaid. The administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The survey included 12 managed care plans in New York with a sample of 1,750 children per plan. Questionnaires were sent to 21,000 parents/caretakers of child members following a combined mail and web methodology during the period October 21, 2022, through January 20,2023, using a standardized survey procedure and questionnaire. A total of 2,467 eligible and complete responses were received resulting in a 13.1% response rate.

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.



	Q44. Rating of child's personal doctor	Q51. Rating of specialist child saw most often	Q9. Rating of all child's health care	Q57. Rating of child's health plan
MMC/CHP Statewide	89.41%	81.40%	86.07%	80.80%
Medicaid	89.03%	82.24%	85.20%	81.22%
CHP	91.00%	80.42%	89.36%	79.53%
CC - Negative	88.80%	78.50%	86.14%	80.87%
CC - Positive	91.37%	85.20%	86.46%	80.72%

2021 Quality Incentive for Medicaid Managed Care

The 2021 Quality Incentive Awards calculations were finalized in February 2023 which covered the measurement year period for 2021. The quality incentive is calculated on the percentage of total points a plan earned in the areas of Quality of Care and Experience of Care. Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. Plans had the opportunity to earn ten bonus points by submitting a "COVID-19 Vaccination Equity Plan (CVEP)" that summarized their progress towards improving vaccination rates of their members through 2022. Plans were classified into five tiers based on the distribution of the final percentage points before the bonus points were awarded. Plans can only move up a maximum of one tier due to the CVEP bonus points. 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 CMS. The results for the 2021 Incentive included three plans in Tier 1, one plan in Tier 2, 7 plans in Tier 3, and 2 plans in Tier 5. These results have not yet been released to plans.

Quality Assurance Reporting Requirements (QARR)

We had 27 health plans submit QARR data on July 15, 2022. Data were published in November 2022.

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

Annual EQRO Technical Reports

By the beginning of Q2, the EQRO gave the DOH all first drafts of the Annual Technical Reports. Both parties have been reviewing the reports and adding comments throughout the quarter and the drafts were finalized by the end of March. EDCC review started mid-March for the April 30th due date.

Provider Related and Access Activities

In Q2, the EQRO continued work with DOH on the verification of provider directories. For the Provider Access and Appointment Availability survey, DOH has received the data file for the enrollment numbers and the provider count and sent to the EQRO survey team. These calls will begin in Q3. The EQRO finished the remaining calls for the MCP Member Services survey. Preparations is underway for the High-Volume PCP to Member Ratio Survey. During this quarter a new survey, the Essential Plan survey started and IPRO, the EQRO was working on a new data file. IPRO received assistance from the vendor correct any errors with the datafile and they are currently reviewing the information.

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 and its subcontractors 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 4 2022 PNDS submission deadline was Jan 26, 2022; plans submitted data based on version 11 of data dictionary. This was the first quarter with telehealth information being submitted as part of the new dictionary update.

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 has over 1.7 million distinct users as of May 2022.

PANEL:

Panel data submission opened on 2/1/2023 and yielded 7,022,351rows of data (up ~0.64%). Technical assistance was provided by DOH and IPRO throughout the submission particularly

around new edits implemented. DOH provided detailed analytics to plans at of failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)
During the second quarter, the MCP's received their reminders for the submissions for the first-year interim reports for the Social Determinants of Health (SDoH) PIP. Interim reports were due by the end of January. The EQRO started to receive the reports by February 1st and anticipated completing the reviews by the beginning of Q3.

Member Satisfaction Survey
At the beginning of Q2, the EQRO made a sample of members in which they will receive the Member Satisfaction Survey. By February the English version of the survey was sent to the mailing phase. By the end of March, the English version of the survey went out for mailing and the secondary languages (Spanish, Russian, and Chinese) followed. It is anticipated that the survey will remain in the field in Q3.

Focused Clinical Study
The ongoing focused study seeks to validate and assess interrater reliability of telehealth assessment as compared to in-person assessments for home care services. This study continues with ongoing recruitment of new members for dual assessments (telehealth and in-person). At the end of Q2, 12 completed pirs of assessments had been recorded. This work will continue in Q3.

Quality Measurement
For the 2nd quarter quality measurement was quiet. Throughout the second quarter the EQRO has spent its time communicating with DOH to update their contact lists for their meeting with NCQA. By March, IPRO configured a website page that allows the plans and vendors to upload data to the site. The plans and vendors will be notified in April. The CAHPS – Kids survey is in its third mailing.

Annual EQRO Technical Reports
By the beginning of Q2, the EQRO gave the DOH all first drafts of the Annual Technical Reports. Both parties have been reviewing the reports and adding comments throughout the quarter and the drafts were finalized by the end of March. EDCC review started mid-March for the April 30th due date.

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

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 MMC 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 PIP Proposals were submitted by December 8, 2021. The PIP Proposals reviewed and finalized by IPRO and NYSDOH. The approved interventions began implementation in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 15, 2022. The updates have been

reviewed by IPRO and finalized by the plans then distributed to DOH. Dental PIP Interim reports were submitted by the plans to IPRO by 1/30/23. IPRO then sent finalized reports to the DOH for review and they were approved. IPRO conducted plan-specific oversight calls with the plans in January 2023. Prior to the oversight calls the plans submitted updates on their intervention tracking measures. An all-plan Webinar for selected plans to report progress on the PIP is planned for April 27, 2023.

2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus
HARP PIP progress calls were held during the month of February. Prior to the progress calls the plans submitted their updates on their intervention measures. The HARP interim reports will be due on April 28th. Planning started for the HARP PIP all-plan webinar, and the EQRO and DOH/OQPS will be planning for a date in quarter 3.

Breast Cancer Selective Contracting
The Department completed its annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2019-2021 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 326 facilities were designated as follows: 121 high-volume facilities, 5 low-volume unrestricted facilities, and 200 low-volume restricted facilities.

New for State Fiscal Year 2023-24, all low-volume facilities with appeals approved before April 1, 2021, were required to re-appeal and demonstrate the continued need for an exemption from the Department's policy. Five facilities appealed the decision to be placed on the low-volume restricted list, and four of the appeals were approved. Administrators at these facilities were notified via email of their decisions. In addition, letters regarding final volume designation for state fiscal year 2023-24 were sent to health plan chief executive officers, and health plan trade organizations via the Department's Integrated Health Alerting and Notification System (IHANS). The list of low-volume restricted facilities and the list of facilities approved to provide breast cancer surgery were posted on the Department's website and included in the 2023 March Medicaid Update.

Patient Centered Medical Home (PCMH)
Federal Fiscal Quarter 2: 1/1/2023-3/31/2023

As of March 2023, there were 9,027 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,167 practices in NYS. All providers are recognized under the standards of NYS PCMH, a 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 9,027 providers that became recognized in March 2023, 429 were new to the NYS PCMH program.

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of March 2023 is $6.00 per member per month.

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 2022 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 the Performance Metrics Database and Analytics (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 Budget Neutrality 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 the Medicaid Budget and Expenditure System (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. After successfully maintaining data quality based on the Top Priority Issues (TPIs) criteria, NYS is now addressing issues based upon the new Outcomes Based Assessment (OBA) compliance criteria adopted by CMS.

Status as of March 28, 2023:

Critical-Priority:	100%	(Target 100%)
High-Priority:	98%	(Target ≥ 99%)
Expenditures:	96%	(Target ≥ 95%)

As of March 2023, state data meets the Critical-Priority and Expenditures criteria target of OBA and is just 1% below the target for High-Priority criterion. The state is actively working on addressing the identified high priority issues to meet the High-Priority criterion of OBA.

The State is currently in development of the new Original Source Data Submitter system (OSDS) to replace the existing Encounter Intake System (EIS). This project will lead to the creation of a new process that enhances the existing encounter data quality and ensures data integrity as well the completeness of the data set. The OSDS system underwent T-MSIS User Acceptance Testing (UAT) during which the T-MSIS files extracts from the OSDS system were compared against the extracts of the previously submitted encounter data from the current EIS system. The state passed UAT from CMS. The tentative implementation date of the new OSDS system is May 11, 2023.

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.

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

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Uploaded to PMDA: May 23, 2023

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	11	0	0	0	0	0	9	2	0	5600	0.20%
AgeWell NY	0	0	0	0	0	0	0	0	0	0	0%
AgeWell MAP	0	0	0	0	0	0	0	0	0	117	0.00%
Archcare Community Life	51	1	0	0	12	0	0	23	15	5499	0.93%
Archcare PACE	7	0	0	0	0	2	4	1	0	708	0.99%
Catholic Health-LIFE	0	0	6	0	0	0	5	6	0	238	0.00%
Centerlight PACE	0	0	0	0	0	0	0	0	0	5789	0.00%
Centers Plan for Healthy Living	826	0	0	1	20	1	281	523	0	49231	1.68%
Centers Plan for Healthy Living MAP	30	0	0	0	1	1	10	18	0	1432	2.09%
Complete Senior Care	3	0	0	0	0	0	1	1	1	127	2.36%
Eddy SeniorCare	6	0	0	0	0	0	6	0	0	317	1.89%
Elant Choice (EverCare)	43	0	0	0	0	0	8	35	0	852	5.05%
Elderplan MAP	7	0	0	1	6	0	0	0	0	3170	0.22%
Elderserve	348	0	0	1	3	1	146	194	4	16041	2.17%
Elderserve MAP	4	0	0	0	0	0	3	1	0	171	2.34%
Elderwood	39	0	0	0	0	0	5	10	24	1079	3.61%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	50938	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	190	0.00%
Extended	50	0	0	0	0	0	36	14	0	5666	0.88%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	834	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	143	0.00%
Fidelis Care at Home	27	0	1	1	2	0	13	9	1	17132	0.16%
Fidelis MAP	1	0	0	0	0	1	0	0	0	737	0.14%
Hamaspik	64	0	0	0	3	1	22	27	11	1937	3.30%
Hamaspik MAP	29	0	0	0	1	3	17	5	3	665	4.36%
Healthfirst CompleteCare	163	0	0	0	3	12	42	74	32	24026	0.68%
HomeFirst, Inc. (Elderplan)	15	0	0	0	14	0	0	1	0	17498	0.47%
Icircle	1	1	0	0	0	0	0	0	0	3475	0.03%

Independent Living for Seniors (ILS/ElderOne)	1	0	0	0	0	0	0	0	1	733	0.14%
Independent Living Services of CNY (PACE CNY)	28	0	0	0	0	0	9	19	0	527	5.31%
Integra MLTC	0	0	0	0	0	0	0	0	0	0	0%
Kalos ErieNiagara DBA: First Choice Health	2	0	0	1	0	0	1	0	0	553	0.36%
MetroPlus MAP	0	0	0	0	0	0	0	0	0	67	0.00%
MetroPlus	0	0	0	0	0	0	0	0	0	1343	0.00%
Montefiore	0	0	0	0	0	0	0	0	0	1346	0.00%
Prime	33	0	0	0	0	0	2	31	0	575	5.74%
Senior Health Partners	54	0	0	0	0	2	14	38	0	9225	0.59%
Senior Network Health, LLC	4	0	0	0	0	0	3	1	0	318	1.26%
Senior Whole Health	1	0	0	0	0	0	1	0	0	26040	0.00%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	143	0.00%
Total Senior Care	8	0	0	0	0	0	1	7	0	129	6.20%
Village Care	195	0	0	0	16	0	33	146	0	16776	1.16%
Village Care MAP	46	0	0	0	7	0	7	32	0	2597	1.77%
VNA Homecare Options (Nascentia Health Options)	190	5	0	4	3	3	76	99	0	3728	5.10%
VNS Choice MAP TOTAL	84	0	0	1	22	0	23	38	0	3276	2.56%
VNS Choice MLTC	516	0	0	0	27	3	108	378	0	23371	2.21%
total	2887	7	7	10	140	30	886	1733	92	304359	0.95%

Managed Long Term Care Partial Capitation Plan Enrollment April 2022 to March 2023

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5463	5446	5402	5399	5398	5421	5459	5514	5550	5585	5597	5620
AgeWell New York	13093	13198	13188	13246	13027	12725	52	14	0	0	0	0
ArchCare Community Life	4795	4876	4917	4943	4974	5049	5142	5285	5381	5435	5499	5562
Centers Plan for Healthy Living	46826	47298	47669	47750	47725	47794	47775	48144	48662	49023	49090	49581
Elant	903	909	911	912	909	890	873	862	865	866	845	846
Elderplan	14082	14319	14664	14797	15084	15504	15885	16236	16781	17169	17457	17867
Elderserve	15263	15274	15325	15401	15417	15536	15608	15789	15950	15978	16041	16104
Elderwood	1011	1026	1029	1038	1048	1062	1064	1081	1093	1082	1076	1079
Extended MLTC	5437	5425	5437	5483	5491	5514	5526	5607	5657	5660	5650	5688
Fallon Health Weinberg (TAIP)	851	852	849	849	847	851	829	834	834	836	831	835
Fidelis Care at Home	18186	18068	17991	17935	17710	17548	17278	17124	17239	17329	17070	16998
Hamaspik Choice	1985	1967	1984	1962	1960	1940	1954	1943	1953	1940	1938	1932
HealthPlus- Amerigroup	4771	4727	4726	4734	4684	4641	5426	6795	50128	50655	50970	51189
iCircle Services	3501	3518	3527	3554	3565	3547	3527	3519	3497	3497	3461	3466
Integra	41775	42219	42838	43228	43657	44287	43954	43043	0	0	0	0
Kalos Health- Erie Niagara	551	555	551	553	550	536	523	539	543	543	551	565
MetroPlus MLTC	1330	1328	1309	1305	1306	1300	1325	1321	1331	1338	1344	1348
Montefiore HMO	1429	1416	1424	1413	1402	1398	1383	1370	1370	1361	1340	1338
Prime Health Choice	545	553	545	549	544	553	560	568	574	573	572	580
Senior Health Partners	9564	9400	9344	9244	9145	9176	9190	9211	9263	9263	9199	9212
Senior Network Health	345	341	343	340	339	339	333	330	331	327	313	315
Senior Whole Health	13575	13781	13982	13951	13912	13929	24107	24146	26110	26065	25961	26093
Village Care	14010	14267	14499	14663	14765	15114	15533	15988	16450	16676	16763	16888
VNA HomeCare Options	3411	3455	3518	3524	3490	3537	3575	3621	3683	3728	3768	3732
VNS Choice	21783	21917	21970	22142	22291	22481	22672	23017	23312	23382	23363	23369
Total	**244,485**	**246,135**	**247,942**	**248,915**	**249,240**	**250,672**	**249,553**	**251,901**	**256,557**	**258,311**	**258,699**	**260,207**

Managed Long Term Care MAP Enrollment April 2022 to March 2023												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Fidelis	195	271	372	379	427	495	500	494	619	618	754	840
Hamaspik	251	294	339	359	409	465	520	543	586	633	664	699
Agewell	112	124	130	70	79	91	94	97	108	118	116	118
Centers	1179	1220	1235	1260	1285	1316	1323	1286	1250	1390	1446	1461
Elderplan	2884	2932	3005	3051	3074	3106	3131	3125	3131	3151	3169	3191
Elderserve	97	105	102	118	126	131	126	140	152	167	171	175
Healthfirst Complete Care	21810	22198	22671	22899	22786	22944	22925	22993	23265	23737	24026	24316
Healthplus	192	200	209	193	186	180	186	185	206	197	192	182
Metroplus	19	19	20	20	21	21	32	36	41	50	71	79
Senior Whole Health	112	124	130	134	145	144	144	139	138	140	143	147
VNS	3047	3054	3068	3090	3083	3089	3094	3055	2988	3189	3254	3385
Village Care	2798	2810	2802	2784	2734	2707	2689	2624	2577	2625	2593	2572
Total	**32696**	**33351**	**34083**	**34357**	**34355**	**34689**	**34764**	**34717**	**35061**	**36015**	**36599**	**37165**

Managed Long Term Care PACE Plan Enrollment April 2022 to March 2023												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Archcare	675	661	658	653	653	656	668	675	670	695	711	712
CHS Buffalo Life	246	244	241	242	240	238	242	241	247	241	236	238
Complete Senior Care	118	121	123	122	122	123	124	125	125	124	126	130
Comprehensive Care Management	3584	3795	4041	4236	4452	4686	4934	5307	5523	5698	5838	5832
Eddy Senior Care	312	311	312	314	315	315	320	325	317	316	318	318
Fallon Health Weinberg PACE	129	132	135	140	143	137	139	140	137	140	142	146
Independent Living For Seniors	719	724	726	734	731	736	736	730	734	731	733	736
Pace CNY	500	502	504	506	503	507	508	511	523	530	525	526
Total Senior Care	138	136	137	137	139	136	136	132	132	130	130	128
Total	**6421**	**6626**	**6877**	**7084**	**7298**	**7534**	**7807**	**8186**	**8408**	**8605**	**8759**	**8766**

Managed Long Term Care FIDA-IDD Plan Enrollment April 2022 to March 2023												
	Apr-22	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1674	1674	1667	1656	1659	1655	1668	1677	1685	1704	1699	1714