MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 24 (4/1/2022-3/31/2023)
Federal Fiscal Quarter: 1 (10/1/2022-12/31/2022)

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: First Quarter

MRT Waiver- Enrollment as of December 2022

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	**501,067**	**6,066**	**10,196**
Population 2 - TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06	**68,908**	**1,589**	**748**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**11,630**	**116**	**286**

Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**42,825**	**733**	**435**
Population 5 - Safety Net Adults	**234,650**	**7,559**	**13,728**
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)	**151,021**	**1,843**	**82**
Population 9 - Disabled Adults and Children 0 - 64 ('new' MC enrollment)	**62,155**	**3,527**	**222**
Population 10 - Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**75,222**	**412**	**29**
Population 11 - Aged or Disabled Elderly ('new' MC enrollment)	**13,361**	**2,453**	**158**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollment's	
Total # Voluntary Disenrollments in Current Demonstration Year	**24,298 or an approximate 9.9% increase from last Q**

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

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

Voluntary disenrollment increased due to an increase 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	**25,884 or an approximate 357.2% increase 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 increased due to an increase in the number of Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination. In addition, there was also an increase 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				
October 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**738,015**	**15,823**	**2,568**	**13,255**
Rest of State	**356,821**	**7,899**	**921**	**6,978**
Statewide	**1,094,836**	**23,722**	**3,489**	**20,233**
November 2022				
New York City	**725,489**	**19,080**	**3,352**	**15,728**
Rest of State	**361,071**	**9,110**	**1,308**	**7,802**
Statewide	**1,086,560**	**28,190**	**4,660**	**23,530**
December 2022				
New York City	**727,160**	**16,639**	**2,908**	**13,731**
Rest of State	**364,534**	**8,698**	**1,311**	**7,387**
Statewide	**1,091,694**	**25,337**	**4,219**	**21,118**

First Quarter	
Region	**Total Affirmative Choices**
New York City	42,714
Rest of State	22,167
Statewide	64,881

HIV SNP Plans				
October 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	12,902	182	0	182
Rest of State	25	1	0	1
Statewide	12,927	183	0	183
November 2022				
New York City	12,843	228	0	228
Rest of State	27	3	0	3
Statewide	12,870	231	0	231
December 2022				
New York City	12,884	241	0	241
Rest of State	25	0	0	0
Statewide	12,909	241	0	241
First Quarter				
Region	**Total Affirmative Choices**			
New York City	651			
Rest of State	4			
Statewide	655			

Health and Recovery Plans Disenrollment			
FFY 23 – Q1			
	Voluntary	Involuntary	Total
October 2022	672	817	1,489
November 2022	728	1,162	1,890
December 2022	640	785	1,425
Total:	2,040	2,764	4,804

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (10/1/2022-12/31/2022) Q1 FFY 2023

As of the end of the first federal fiscal quarter (end of December 2022), there were 3,077,103 New York City Medicaid consumers enrolled in the MMMC Program and 77,159 Medicaid consumers enrolled in HARPs. 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 5,866 clients were educated about enrollment options and made an enrollment choice including 355 clients in person and 5,511 clients through phone.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation scripts are 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 24,017 FFS community clients were reported on the regular auto-assignment list, 4,073 clients responded to the call that generated 2,401 enrollments. Of the total of 54 FFS NH clients Plan selection.

C. NYMC HelpLine Observations October - December 2022

The CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 47,989 calls were received by the Helpline and **46,831** or **98%** were answered. Calls answered were handled in the following languages: **English: 31,102 (66%); Spanish: 6,099 (13%); Chinese: 1,965 (4%); Russian: 1,060 (2%); Haitian/Creole: 54 (1%); and other: 6,551 (14%).**

MAXIMUS recorded 100% of the calls received by the NYMC HelpLine. The CMU listened to **3,500** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 1st Quarter 2023								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
1,950 (56%)	**267 (7%)**	**188 (5%)**	**1,049 (30%)**	**37 (1%)**	**0 (0%)**	**9 (1%)**	**0 (0%)**	**3,500**

A total of **894 (25%)** recorded calls observed was unsatisfactory. **398** calls had a single infraction and **496** calls had multiple infractions. A total of **1,540** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,191 (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: **272 (18%)** - 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: **77 (5%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **1,540** 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 first 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 December 9, 2022, the Department updated the Certificate of Authority to reflect that HealthFirst PHSP, Inc. is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Sullivan, and Westchester.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Surveillance activity completed during the 1st Quarter FFY 2022-2023 (October 1- December 31, 2022) include the following:

Two (2) Targeted Operational Surveys were completed during 1st Quarter FFY 2022-2023.

- Highmark - One (1) SOD was issued and one (1) POC was accepted.
- Amida Care – Plan found to be in compliance.

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 BH system to managed care. The goal is to create a fully integrated BH [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 BH 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 BH services for adults, except for services in Community Residences, are part of the benefit package.

Beginning in January 2019, children's BH services were transitioned into MMC as part of the Children's Medicaid System Redesign. Transitioned BH services included six new Children and Family Treatment and Support Services (CFTSS) and the 1915(c) Children's Consolidated Waiver (BH HCBS). Additionally, the Children's Medicaid System Redesign focused on the transition of children in foster care to MMC and integrated the delivery of the Health Home care management model for children.

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 BH services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the NYS of Health (Exchange). This enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State identified and implemented a policy to allow State Designated Entities (SDE) 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 BH 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 BH 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 (7/1/2022-9/30/2022)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	38,657	170	156	0.40%
ROS	5,665	22	21	0.37%
Total	44,322	192	177	0.40%

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 BH 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 (7/1/2022-9/30/2022)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,709	98	33	0.58%
ROS	341	34	34	9.97%
Total	6,050	132	67	1.11%

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

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

MH & SUD Claims (10/1/2022-12/31/2022)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,005,802	93.32%	6.68%
ROS	908,851	94.92%	5.08%
Totals	1,914,653	94.08%	5.92%

Behavioral Health Adults CORE/HCBS Claims/Encounters 10/1/2022-12/31/2022: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	**119**	**29**
Education Support Services	**110**	**25**
Family Support and Trainings	**407**	**19**
Intensive Supported Employment	**74**	**18**
Ongoing Supported Employment	**22**	**4**
Peer Support	**2,313**	**454**
Pre-vocational	**44**	**12**
Provider Travel Supplements	**56**	**40**
Psychosocial Rehab	**3,329**	**453**
Residential Supports Services	**130**	**23**
Transitional Employment	**0**	**0**
TOTAL	**6,604**	**890**

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 10/1/2022-12/31/2022: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	**1,335**	**292**
Education Support Services	**324**	**81**
Family Support and Trainings	**126**	**16**
Intensive Supported Employment	**171**	**34**
Ongoing Supported Employment	**37**	**10**
Peer Support	**5,337**	**1,076**
Pre-vocational	**54**	**13**
Provider Travel Supplements	**3,979**	**936**
Psychosocial Rehab	**5,236**	**859**
Residential Supports Services	**842**	**166**
Transitional Employment	**0**	**0**
TOTAL	**17,441**	**2,163**

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 1 MCTAC Attendance & Statistics (10/1/2022 to 12/31/2022)

Events: MCTAC successfully executed 13 events from 10/1/2022 to 12/31/2022.
All 13 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):*

2,676 people attended/participated in MCTAC events/viewed resources of which **1,824** were unique participants.

OMH Agency Participation
Overall: 297 of 652 **(45.55%)**

OASAS Agency Participation
Overall: 172 of 562 **(30.60%)**

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 serious mental illness (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 SDE through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (completed)
        - Ongoing technical assistance (completed)
        - Creation of statewide RCA performance dashboard- enhanced to reflect data by RCA and by Health Homes
- 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 Office of Mental Health (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. Infrastructure contracts have been signed and work is underway.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all 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 s, 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, 5,210 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between October 1, 2022, and December 31, 2022, 896 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, 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 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 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 BH 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 $16 million in initial contract base awards and subsequent milestone payments were distributed to providers.
- The program is expected to conclude in July 2024.

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

The transition of SBHC services from Medicaid Fee-for-Service to MMC has been postponed indefinitely. There will be no further reporting on this item.

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 January 1, 2023, there are 23 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of January 1, 2023, there are a total of 301,711 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the October 2022 through December 2022 quarter, the DOH approved 1 service area expansions for a MAP. Two plans merged for October 1, 2022, and 2 plans merged for December 1, 2022.

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 the October 2022 through December 2022 quarter, post enrollment surveys were completed for 4 enrollees. Of the 3 surveyed, none (0%) indicated that they continued to receive services from the same

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

Enrollment: Total enrollment in MLTC partial capitation plans increased from 250,672 to 256,557 during the October 2022 through December 2022 quarter, a slight increase from the last quarter. For that period, 13,164 individuals who were being transitioned into MLTC made an affirmative choice, a 19% increase from the previous quarter and brings the 12-month total for affirmative choice to 30,117.

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

2. Significant Program Developments

During the October 2022 through December 2022 quarter:

- The 4th Quarter Member Services survey was conducted on 25 Partial Capitation Plans and 3 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 DOH provided recommendations on areas of improvement.

- The Desk Review for three 3 Partial Capitation Operational Surveys were completed and reported in prior reporting periods. Corrective Action Plans (CAP) have been completed by the plans and are still awaiting Department approval, except for 1, whose CAP has been approved by the department.

- Operational Surveys are ongoing for five Partial Capitation plans.

- A Focused Survey was conducted on 1 Partial Capitation plan based on a Technical Assistance Center (TAC) Complaint during the 1st quarter. A Statement of Deficiencies (SOD) was issued, and after the submission of several unacceptable CAPs their final CAP was accepted by the Department on 1/18/2022. Additional documentation is still required from the plan, as the CAP is being monitored every month to ensure compliance and may be concluded next quarter.

- A Focused Survey was initiated on all Partial Capitation and MAP Plans focusing on PCSP Template compliance. Analysis of plan submissions is being conducted.

- A Focused Survey was initiated on all Partial Capitation and MAP Plans focusing on Health Homes Administrative Service Agreements. Analysis of plan submissions is being conducted.

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

- One Focused Survey was initiated on 1 Partial Capitation plan based on a TAC Complaint. Although an SOD was drafted after further investigation it was determined the plan immediately rectified the identified issue. A SOD was not necessary.

As a matter of routine course:

- Processes for Operational Partial Capitation and MAP surveys continue to be refined;
- The Surveillance tools continue to be updated to reflect process changes; and
- There are no significant issues or problems to report, 2 new staff were hired and are being trained.

3. Issues and Problems

There were no issues or problems to report for the October 2022 through December 2022 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 2,409 critical incidents reported for October 2022 through December 2022 quarter, an increase of 2% from the previous quarter. 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 October 2022 through December 2022 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction With Transportation, Dissatisfaction With Quality Of Other Covered Services, Dissatisfaction With Quality of Homecare, Dissatisfaction With Member Services and Plan Operations, Dissatisfaction with Care Management.

Period: 10/1/2022–12/31/2022 (Percentages rounded to nearest whole number)			
Number of Recipients: 301,711	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**5**	**5**	**100%**
# Same Day	**3,581**	**3,577**	**100%**
# Standard/Expedited	**8,945**	**6,865**	**77%**
Total for this period:	**12,531**	**10,447**	**83%**

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

Appeals	1/2022-3/2022	4/2022-6/2022	7/2022-9/2022	10/2022-12/2022	Average for Four Quarters
Average Enrollment	281,668	286,152	291,381	297,328	289,132
Total Appeals	8,489	8,803	8,473	10,284	9,012
Appeals per 1,000	30	31	29	36	32
# Decided in favor of Enrollee	1,375	1,241	966	1,081	1,166
# Decided against Enrollee	5,751	6,323	6,252	7,143	6,367
# Not decided fully in favor of Enrollee	808	912	880	845	861
# Withdrawn by Enrollee	269	247	190	236	236
# Still pending	286	80	185	979	383
Average number of days from receipt to decision	8	7	8	10	8

Complaints and Appeals per 1,000 Enrollees by Product Type October 2022- December 2022					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	252,670	7,712	31	7,632	30
Medicaid Advantage Plus (MAP) Total	34,847	3,630	104	2,570	74
PACE Total	8,134	1,189	146	82	10
Total for All Products:	**295,651**	**12,531**	**42**	**10,284**	**35**

Total complaints increased 20% from 10,415 the previous quarter to 12,531 during the October 2022 through December 2022 quarter.

The total number of appeals increased 22% from 8,437 during the last quarter to 10,284 during the October 2022 through December 2022 quarter.

Technical Assistance Center (TAC) Activity

During the October 2022 through December 2022 quarter, TAC opened 460 cases and closed 437 cases. This is lower than the 590 cases opened, and 651 cases closed from the previous quarter. The Department recognizes the seasonal drop from previous years as well. This decrease is spread across multiple dispositions, primarily inquiries, substantiated cases, and unsubstantiated cases.

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	**10/1/2022 – 12/31/2022**
Substantiated Complaints	34
Substantiated Complaints with Corrective Action Plan	1
Unsubstantiated Complaints	188
Closed as Duplicate	0
Resolved Without Investigation	7
Inquiries	207
Total	437

The five most common types of calls were related to:

Q1	**10/1/2022-12/31/2022**
General	29%
Aide Service	17%
Enrollment	12%
Billing	8%
Grievance	7%

Sixty-eight (68%) of Q1 TAC cases were closed in the same month they were opened. This is an 8% decrease from last quarter's percentage of 74%. Overall, the number of TAC cases has decreased when compared to the previous few quarters.

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 October 2022 through December 2022 quarter, 7,433 people were evaluated, deemed eligible and enrolled into plans, a decrease of 11% 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.

Referrals and 30-day assessment: Due to the transition of assessment duties from CFEEC to NYIA, plans are no longer required to report assessments related to CFEEC as of July 15, 2022.

Referrals outside enrollment broker: Due to the transition of assessment duties to NYIA, plans are no longer required to report referrals outside the enrollment broker.

Rebalancing Efforts	10/2022-12/2022
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	222
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,768

As of December 31, 2022, there were 4,196 current plan enrollees who were in nursing homes as permanent placements, an 43% increase from the previous quarter.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with BH and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, 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**.

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

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current 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-SSI 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 Managed Care Organizations, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from Managed Care Organizations, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of Managed Care Organizations and Fee-for-Service billing and claiming data;
- Defining performance and quality metrics;
- Responding to the COVID-19 pandemic and implementing emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and continuing to support the recovery of impacted providers and consumers;
- Assisting with a strategic plan for the future unwind of the COVID-19 Public Health Emergency;
- 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 American Rescue Plan Act (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, Managed Care Organizations, 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 Managed Care Organizations, Health Homes, and HCBS providers;
- Organizing and conducting workgroups of Health Homes, Managed Care Organizations, and HCBS Providers to ensure feedback is addressed relating to the referral process;
- Engaging with Health Homes, Managed Care Organization, 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 American Rescue Plan Act funding to support and enhance HCBS workforce and infrastructure;
- Scheduling regional meetings with HCBS providers to resume in-person collaboration and dialogue.
- Updating the IRAMS and Children's Capacity Tracker to have updated functionalities.
- 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.

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 HCBS/level of care eligibility determination annual assessment fee for Health Homes 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;
- NYS support of the continued 25% enhanced HCBS rates on October 1, 2022;
- Adding Medical Respite as a new HCBS service; and
- Developing the program designed to add Transitional Care Coordination to assist institutional child/youth returning home.

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 restriction exception (RE) code KK.
Therefore, the table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Fo1	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
October	15,491	7,542	6,642	895
November	15,857	5,900	6,695	799
December	16,077	2,458	6,718	370
Quarterly Average	**15,808**	**5,300**	**6,685**	**688**

**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 4th Quarter of FY2022. The number of children/youth enrolled in HCBS has increased at a consistent rate. The claims count mirrors that steady increase.

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 DOH 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 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
MMC	7,667	8,496
HARP	512	788
HIV SNP	89	91
Total MCO Complaints	**8,268**	**9,375**

As described in the table, MCOs reported 8,268 total enrollee complaints for the current quarter. This represents an 11.8% decrease from the prior quarter's total of 9,375 enrollee complaints.

MCOs reported 7,667 MMC complaints this quarter, which is a 9.8% decrease from the 8,496 of the previous quarter. The number of HARP complaints decreased 35.0%, from 788 in the prior quarter to 512 this quarter. There were 89 HIV SNP complaints this quarter, which is a decrease of 2.2% when compared to the 91 from the previous quarter.

DOH reviewed the decrease in HARP enrollee complaints received from the MCOs. Upon examination, the percentage decrease in HARP enrollee complaints was comparable across all MCOs with HARP enrollees. No individual complaint category stood out as an outlier.

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 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	15%
Pharmacy/Formulary	14%	10%
Balance Billing	12%	14%
Difficulty with Obtaining: Dental/Orthodontia	9%	7%
Reimbursement/Billing	8%	9%

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

Description of Complaint	Percentage of Complaints	
	FFY 23 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	22%	15%
Pharmacy/Formulary	20%	20%
Dissatisfaction with Quality of Care	8%	9%
Difficulty with Obtaining: Dental/Orthodontia	7%	4%
Balance Billing	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 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	24%	27%
Dissatisfaction with Quality of Care	13%	14%
Pharmacy/Formulary	11%	11%
Difficulty with Obtaining: Dental/Orthodontia	11%	8%
Difficulty with Obtaining: Personal Care	8%	7%

B. Monitoring of Plan Reported Complaints

DOH has been monitoring the complaint activity for NYS'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 DOH 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, DOH 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.

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

The DOH is in the process of calculating the OE ratio for the six-month period of July 1, 2022 through December 31, 2022.

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, the DOH monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 8,268 total reported complaints/action appeals, MCOs reported 404 complaints and action appeals from their SSI recipients. This compares to 443 SSI complaints/action appeals from the previous quarter, representing an 8.8% decrease.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 23 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Appointment Availability: PCP	2	1
Appointment Availability: Specialist	2	2
Appointment Availability: BH HCBS	0	0
Long Wait Time	1	2
Dissatisfied with Quality of Care	56	66
Denial of Clinical Treatment	23	26
Denial of BH Clinical Treatment	0	1

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 23 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	75	85
Dissatisfaction with BH Provider Services	1	0
Dissatisfaction with Health Home Care Management	5	0
Difficulty with Obtaining: Specialist and Hospitals	16	23
Difficulty with Obtaining: Eye Care	2	5
Difficulty with Obtaining: Dental/Orthodontia	34	27
Difficulty with Obtaining: Emergency Services	0	1
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	2	4
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	0	2
Difficulty with Obtaining: Home Health Care	2	6
Difficulty with Obtaining: Personal Care	5	9
Difficulty with Obtaining: PERS	0	0
Difficulty with Obtaining: CDPAS	2	1
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	80	82
Access to Non-Covered Services	8	11
Access for Family Planning Services	0	0
Communications/ Physical Barrier	0	2
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	0	2
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	50	37
Balance Billing	25	32
Transportation	0	2
All Other	13	14
Total	**404**	**443**

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 Q1 10/1/2022-12/31/2022	FFY 22 Q4 7/1/2022-9/30/2022
Pharmacy/Formulary	20%	15%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	19%
Dissatisfied with Quality of Care	14%	19%
Reimbursement/Billing	12%	8%
Difficulty with Obtaining: Dental/Orthodontia	8%	6%

DOH requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of October 1, 2022 through December 31, 2022, MCOs reported LTSS enrollment of 52,751 enrollees. This compares to 49,795 LTSS enrollees from the previous quarter, representing a 5.9% 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 Q1 10/1/2022–12/31/2022	FFY 22 Q4 7/1/2022–9/30/2022
Amida Care	1,252	1,199
Capital District Physicians Health Plan	755	737
Excellus Health Plan	1,547	1,545
Fidelis Care	19,170	16,548
Healthfirst	13,986	13,910
HealthNow	219	212
HealthPlus	2,941	2,972
HIP of Greater New York	630	459
Independent Health Association	625	598
MetroPlus Health Plan	3,021	3,126
Molina Healthcare	2,742	2,845
MVP Health Plan	2,284	2,166
United Healthcare	3,164	3,071
VNS Choice	415	407
Total	**52,751**	**49,795**

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 Q1 10/1/2022–12/31/2022	FFY 22 Q4 7/1/2022–9/30/2022
Difficulty with Obtaining: AIDS Adult Day Health Care	0	3
Difficulty with Obtaining: Adult Day Care	4	1
Difficulty with Obtaining: CDPAS	93	73
Difficulty with Obtaining: Home Health Care	29	35
Difficulty with Obtaining: RHCF Services	1	1
Difficulty with Obtaining: Personal Care	164	200
Difficulty with Obtaining: PERS	3	7
Difficulty with Obtaining: Private Duty Nursing	24	27
Total	**318**	**347**

D. Critical Incidents

DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 132 critical incidents reported for the October 1, 2022 through December 31, 2022 period, most of which have a resolved status. Many of the incidents stemmed from falls. DOH 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 Q1 10/1/2022–12/31/2022	FFY 22 Q4 7/1/2022–9/30/2022	Net Change
Medicaid Managed Care Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	8	7	+1
Fidelis Care	0	0	0
Healthfirst	58	65	-7
HIP of Greater New York	0	0	0
HealthNow	1	0	+1
HealthPlus	0	1	-1

Independent Health Association	0	0	0
MetroPlus Health Plan	0	1	-1
Molina Healthcare	1	0	+1
MVP Health Plan	1	0	+1
United Healthcare	0	0	0
Total	**69**	**74**	**-5**
Health and Recovery Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	0	0
Fidelis Care	0	0	0
Healthfirst	55	41	+14
HIP of Greater New York	0	0	0
HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	1	-1
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**55**	**42**	**+13**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	1	-1
VNS Choice	8	7	+1
Total	**8**	**8**	**0**
Grand Total	**132**	**124**	**+8**

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

Category of Incident	Critical Incidents		
	FFY 23 Q1 10/1/2022–12/31/2022	FFY 22 Q4 7/1/2022–9/30/2022	Net Change
Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	3	6	-3
Crimes Committed Against Enrollee	1	3	-2
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	1	1	0
Instances of Exploitation of Enrollees	2	3	-1
Instances of Neglect of Enrollees	7	0	+7
Medication Errors that Resulted in Injury	0	0	0

Other Incident Resulting in Hospitalization	10	8	+2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	45	15	+30
Use of Restraints	0	38	-38
Wrongful Death	0	0	0
Total	**69**	**74**	**-5**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	0	1	-1
Crimes Committed Against Enrollee	0	2	-2
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	0	0	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	8	5	+3
Other Incident Resulting in Medical Treatment Other Than Hospitalization	46	9	+37
Use of Restraints	0	25	-25
Wrongful Death	0	0	0
Total	**55**	**42**	**+13**
HIV Special Needs Plans			
Any Other Incidents as Determined by the Plan	0	1	-1
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	0	0
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	6	7	-1
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	1	0	+1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	1	0	+1
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**8**	**8**	**0**
Grand Total	**132**	**124**	**+8**

DOH reviewed the changes in the Other Incident Resulting in Medical Treatment Other Than Hospitalization and Use of Restraints categories. Upon examination, the changes stemmed from the number of critical incidents reported from one MCO for these two categories. DOH is following up with the MCO regarding the differences between the most recent quarter compared to the previous quarter.

E. Enrollee Complaints Received Directly by DOH

In addition to the MCO reported complaints, the DOH directly received 57 enrollee complaints this quarter. This total is a 46.2% decrease from the previous quarter, which reported 106 enrollee complaints.

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

MCO Enrollee Complaints Received Directly by DOH	
FFY 23 Q1 10/1/2022–12/31/2022	**FFY 22 Q4 7/1/2022–9/30/2022**
57	**106**

DOH reviewed the decrease in the number of enrollee complaints it received. Upon examination, the decrease was consistent across all complaint categories.

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

Percentage of MCO Enrollee Complaints Received Directly by the DOH		
Description of Complaint	**FFY 23 Q1 10/1/2022–12/31/2022**	**FFY 22 Q4 7/1/2022–9/30/2022**
Reimbursement/Billing	21%	23%
Difficulty with Obtaining: Home Health Care	12%	16%
Difficulty with Obtaining: CDPAS	11%	8%
Pharmacy/Formulary	11%	7%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9%	7%

DOH 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, MMC enrollees have remained eligible for and enrolled in Medicaid. This has been in effect since March 18, 2020, with exceptions being enrollees who move out of state or who elect to cancel their coverage. Since March of 2020 the DOH 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 199 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of October 1, 2022 through December 31, 2022. 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 Q1 10/1/2022–12/31/2022**	**FFY 22 Q4 7/1/2022–9/30/2022**
In favor of Appellant	68	68
In favor of Plan	121	120
No Issue	10	14
Total	**199**	**202**

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 Q1 10/1/2022–12/31/2022**	**FFY 22 Q4 7/1/2022–9/30/2022**
0-29	4	14
30-59	45	51
60-89	39	43
90-119	50	34
=>120	61	60
Total	**199**	**202**

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

The MMCARP met on December 15, 2022. 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 Managed Long Term Care program. There were four additional agenda items. A FY 2023 Medicaid Global Cap presentation given by Mike Spitz, Director, Bureau of Global Cap, Rebates, and Supplemental Programs, Acting Director, Bureau of Public Hospital Reimbursement & Health Care Revenue. Division of Finance and Rate Setting (DFRS), NYS DOH, OHIP, and Mark Shutts, DFRS, OHIP. A Public Health Emergency Wind Down presentation given by Lisa Sbrana, Director, Division of Eligibility and Marketplace Integration, NYS DOH, OHIP. A BH/HARP/Health Home Update given by Alyssa Altschul and Julie Lloyd, Division of Managed Care, NYS OMH. Lastly, a New York State Independent Assessor (NYIA) update given by Susan Montgomery, Bureau of MLTC, Division of Health Plan Contracting and Oversight, NYS DOH, OHIP. A public comment

period is offered at every meeting. The next MMCARP meeting is scheduled for March 16, 2023.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in MLTC

In December, the DOH released to the plans the methodology for the 2023 MLTC Quality Incentive.

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 overall response rate will be calculated in January of 2023.
The responses to the survey will be analyzed in February 2023 released to the health plans in May 2023.

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.

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

In Q1, the EQRO worked with DOH to begin verification of verification of plan provider directories. DOH began preparing enrollment data to begin the survey of Primary Care Provider Access and Appointment Availability. Results from the first phase of the Plan Member Services survey were sent to plans in September 2022; the EQRO began phase two follow-up calls in Q1. During Q1, the DOH began to compile the data needed for the Access & Availability survey of High-Volume providers. Calls area anticipated to begin in the next quarter.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 400 active networks in NYS. IPRO facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. The quarter 3 2022 PNDS submission deadline was Oct 20, 2022; plans submitted data based on version 10 of data dictionary. A new data dictionary, version 11, will be released to health plans in August 2022 and health plans are expected to submit in the new format starting Nov 2022. IPRO, PMCI and Quest analytics are presently working on the implementation and edits for PNDS data dictionary version 11.

Provider and Health Plan LOOK-UP:
Significant edits to the NYS 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 1.5 million distinct users as of May 2022.

PANEL:
Panel data submission opened on 11/1/2022 and yielded 6,977,589 rows of data (up ~3.9%). 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
The MLTC performance Improvement Project (PIP) had its PIP training during this quarter, on November 16th. Group calls were held during the beginning of November. The EQRO has received reports from all MLTC plans that summarize their PIP updates. All MLTC plans were notified the interim reports for the 2022-2023 1/31/2023.

The MLTC Satisfaction Survey was in preparation by the end of the first quarter. The EQRO has sent in the survey for translation and is working to prepare for mailing. The surveys will be printed and will be sent out for mailing in the beginning of the second quarter.

For the MLTC Focus Clinical Study, the EQRO completed 11 telehealth and in-person assessments by the end of the 1st quarter 12/31/2022. In the second quarter there will be more nurses available and additional member sample size. The EQRO will continue to recruit members in an effort to increase the number of assessments to validate.

Quality Measurement
During the first quarter the EQRO had a meeting with the certified CAHPS vendor (DataStat) to discuss planning for the 2022 CAHPS survey. The DOH prepared the survey materials and sample. DataStat notified DOH that the survey was sent on October 21st 2022 and the second mailing will be sent out in November. A third mailing will be sent during the second quarter.

The annual performance measurement data collection cycle began in early October with the technical workshop for managed care plans. The EQRO led the workshop to present the requirements for plan data collection and submission.

Annual EQRO Technical Reports
During Q1, the EQRO and DOH continued preparation and collection of data for the Annual Technical Reports (ATR) for measurement year 2021. Final versions of the ATR will be prepared by the EQRO and submitted to DOH for review and approval. The MY2021ATR will be posted to the DOH public website by April 30, 2023.

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

2019-21 HARP PIP
The 2019-2021 HARP PIP topic was Care Transitions after Emergency Department and Inpatient Admissions. The HARP PIP Proposals were submitted December 21, 2018. The submitted PIP Proposals were reviewed and finalized by IPRO, NYSDOH and partners (including OASAS and OMH). Plan interventions began in early 2019. In June 2020, the MCOs

were notified that the 2019-2020 PIPs were extended through December 31, 2021. The HARP PIP Final Reports were submitted to IPRO in July 2022. IPRO and DOH have reviewed and approved all of the Final Reports.

2019-2020 Medicaid KIDS Quality Agenda PIP

The 2019-2020 MMC PIP topic was the KIDS Quality Agenda Performance Improvement Project. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. The PIP Proposals were due in the first quarter of 2019. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. The MMC plans PIP Final Reports were submitted to IPRO in July 2022. The PIP Final Reports were submitted to IPRO in July 2022. IPRO and DOH have reviewed and approved all of the Final Reports.

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. IPRO conducted plan-specific oversight calls with the plans in May and September 2022. Prior to the oversight calls the plans submitted an updated PIP Proposal with intervention tracking measure updates. On Nov. 16, 2022, a WebEx with MMC and HIV SNP plans was conducted by IPRO. Supportive resources were distributed to assist the MCPs with the implementation of their PIPS.

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

On November 19, 2021, a WebEx meeting with HARP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The PIP Proposals were submitted by January 10, 2022. The PIP Proposals were reviewed and finalized by IPRO and NYS DOH. The interventions began implementation in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 29, 2022. The updates have been reviewed by IPRO and finalized by the plans then distributed to DOH. IPRO conducted plan-specific oversight calls with the plans in June 2022. November oversight calls were conducted. Prior to the oversight calls the plans submitted an updated PIP Proposal with intervention tracking measure updates. On Nov. 16, 2022, a WebEx with MMC and HIV SNP plans was conducted by IPRO. Supportive resources were distributed to assist the MCPs with the implementation of their PIPS.

Breast Cancer Selective Contracting
DOH began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2019-2021 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as facility-level data from the Health Facilities Information System (HFIS).

Staff worked on updating the appeals process, revised the appeal form, and created a new scoring matrix to standardize the review process. Documents were shared with the appeals committee for comment. In addition, new for State FY 2023-24, all low-volume facilities with appeals approved prior to April 1, 2021, will be required to reappeal and demonstrate the continued need for an exemption from the Department's policy if they wish to provide mastectomy and lumpectomy procedures to Medicaid beneficiaries. Letters explaining this change were drafted and will also notify low-volume facilities that the DOH will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state FY 2023-24, nor can MMC plans contract with low-volume facilities to perform breast cancer surgeries.

Patient Centered Medical Home (PCMH)
Federal Fiscal Quarter 1: 10/1/2022-12/31/2022

As of December 2022, there were 8,359 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,129 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 BH, care management, population health, value-based payment arrangements, and health information technology capabilities. Of the 8,359 providers that became recognized in December 2022, 6 were new to the NYS PCMH program.

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of December 2022 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) methodology, NYS is now addressing data quality metrics associated with the Outcomes Based Assessment (OBA) compliance criteria. As of December 2022, New York's data meets the Critical Priority (100%), and Expenditures (99%) criteria target of OBA and is 1% below the target for High Priority (99%) 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 developing the Original Source Data Submitter (OSDS) system to replace the existing Encounter Intake System (EIS). The OSDS will result in a process that enhances the existing encounter data quality, ensures data integrity and the completeness of the data set. The OSDS system is currently undergoing T-MSIS User Acceptance Testing (UAT). In this UAT, T-MSIS files extracts from the EIS are compared to processing files from the OSDS. The expected deployment timeline of the new OSDS system is May of 2023.

NYS 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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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	10	0	0	0	0	0	2	6	2	5507	0.18%
AgeWell MAP	0	0	0	0	0	0	0	0	0	100	0.00%
Archcare Community Life	45	0	1	0	7	0	18	19	0	5269	0.85%
Archcare PACE	0	0	0	0	0	0	0	0	0	671	0.00%
Catholic Health-LIFE	13	0	6	0	0	0	1	6	0	243	5.35%
Centerlight PACE	74	0	0	0	0	0	49	16	9	5255	1.41%
Centers Plan for Healthy Living	772	0	0	0	45	2	262	463	0	48194	1.60%
Centers Plan for Healthy Living MAP	44	0	0	0	3	0	27	14	0	1286	3.42%
Complete Senior Care	4	0	0	0	0	0	2	2	0	125	3.20%
Eddy SeniorCare	3	0	0	0	0	0	1	2	0	321	0.93%
Elant Choice (EverCare)	60	0	0	0	0	0	15	45	0	867	6.92%
Elderplan MAP	6	0	0	0	4	0	1	1	0	3129	0.19%
Elderserve	351	0	0	0	12	3	130	206	0	15782	2.22%
Elderserve MAP	3	0	0	0	0	0	2	1	0	3129	0.10%
Elderwood	11	0	0	0	0	0	3	5	3	1079	1.02%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	20783	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	192	0.00%
Extended	52	0	0	0	0	2	34	16	0	5597	0.93%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	832	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	139	0.00%
Fidelis Care at Home	12	0	0	0	2	0	3	7	0	17214	0.07%
Fidelis MAP	1	0	0	0	0	0	0	1	0	538	0.19%
Hamaspik	66	0	0	0	2	2	20	30	12	1950	3.38%
Hamaspik MAP	20	0	0	0	0	0	14	5	1	550	3.64%
Healthfirst CompleteCare	44	0	0	0	0	0	11	33	0	23061	0.19%
HomeFirst, Inc. (Elderplan)	11	0	0	0	6	0	2	2	1	16300	0.07%
Icircle	1	1	0	0	0	0	0	0	0	3514	0.03%
Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	733	0.00%
Independent Living Services of CNY (PACE CNY)	18	0	0	0	0	0	12	6	0	514	3.50%
Integra MLTC	0	0	0	0	0	0	0	0	0	2899	0.00%
Kalos ErieNiagara DBA: First Choice Health	0	0	0	0	0	0	0	0	0	535	0.00%

MetroPlus MAP	0	0	0	0	0	0	0	0	0	36	0.00%
MetroPlus	0	0	0	0	0	0	0	0	0	1325	0.00%
Montefiore	0	0	0	0	0	0	0	0	0	1374	0.00%
Prime	43	0	0	0	0	2	7	34	0	567	7.58%
Senior Health Partners	41	0	0	0	0	1	17	23	0	9221	0.44%
Senior Network Health, LLC	5	0	0	0	0	0	2	3	0	331	1.51%
Senior Whole Health	0	0	0	0	0	0	0	0	0	24788	0.00%
Senior Whole Health MAP	0		0	0	0	0	0	0	0	140	0.00%
Total Senior Care	9	0	0	0	0	0	4	5	0	133	6.77%
Village Care	171	0	0	0	18	1	47	105	0	15990	1.07%
Village Care MAP	55	0	0	0	17	0	10	28	0	2630	2.09%
VNA Homecare Options (Nascentia Health Options)	177	0	0	3	1	2	69	102	0	3626	4.88%
VNS Choice MAP TOTAL	37	0	0	0	13	0	8	16	0	3046	1.21%
VNS Choice MLTC	250	0	0	0	32	0	72	146	0	23000	1.09%
total	2409	1	7	3	162	15	845	1348	28	272515	0.88%

Managed Long Term Care Partial Capitation Plan Enrollment Jan 2022 to Dec 2022												
	Jan-22	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5,612	5,498	5,478	5463	5446	5402	5399	5398	5421	5459	5514	5550
AgeWell New York	13,151	13,070	13,075	13093	13198	13188	13246	13027	12725	52	14	0
ArchCare Community Life	4,667	4,656	4,751	4795	4876	4917	4943	4974	5049	5142	5285	5381
Centers Plan for Healthy Living	46,868	46,459	46,401	46826	47298	47669	47750	47725	47794	47775	48144	48662
Elant	935	912	908	903	909	911	912	909	890	873	862	865
Elderplan	13,787	13,718	13,849	14082	14319	14664	14797	15084	15504	15885	16236	16781
Elderserve	15,361	15,213	15,218	15263	15274	15325	15401	15417	15536	15608	15789	15950
Elderwood	1,031	1,015	1,016	1011	1026	1029	1038	1048	1062	1064	1081	1093
Extended MLTC	5,678	5,559	5,497	5437	5425	5437	5483	5491	5514	5526	5607	5657
Fallon Health Weinberg (TAIP)	869	863	850	851	852	849	849	847	851	829	834	834
Fidelis Care at Home	18,643	18,374	18,254	18186	18068	17991	17935	17710	17548	17278	17124	17239
Hamaspik Choice	2,008	1,968	1,970	1985	1967	1984	1962	1960	1940	1954	1943	1953
HealthPlus- Amerigroup	4,945	4,847	4,830	4771	4727	4726	4734	4684	4641	5426	6795	50128
iCircle Services	3,570	3,529	3,497	3501	3518	3527	3554	3565	3547	3527	3519	3497
Integra	41,242	41,421	41,528	41775	42219	42838	43228	43657	44287	43954	43043	0
Kalos Health- Erie Niagara	564	549	544	551	555	551	553	550	536	523	539	543
MetroPlus MLTC	1,359	1,345	1,343	1330	1328	1309	1305	1306	1300	1325	1321	1331
Montefiore HMO	1,491	1,451	1,434	1429	1416	1424	1413	1402	1398	1383	1370	1370
Prime Health Choice	567	559	549	545	553	545	549	544	553	560	568	574
Senior Health Partners	10,009	9,843	9,682	9564	9400	9344	9244	9145	9176	9190	9211	9263
Senior Network Health	369	362	355	345	341	343	340	339	339	333	330	331
Senior Whole Health	13,464	13,398	13,454	13575	13781	13982	13951	13912	13929	24107	24146	26110
Village Care	13,763	13,709	13,774	14010	14267	14499	14663	14765	15114	15533	15988	16450
VNA HomeCare Options	3,355	3,306	3,393	3411	3455	3518	3524	3490	3537	3575	3621	3683
VNS Choice	21,706	21,507	21,543	21783	21917	21970	22142	22291	22481	22672	23017	23312
Total	**245,014**	**243,131**	**243,193**	**244,485**	**246,135**	**247,942**	**248,915**	**249,240**	**250,672**	**249,553**	**251,901**	**256,557**

Managed Long Term CareMAP Plan Enrollment Jan 2022 to Dec 2022												
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	178	185	180	195	271	372	379	427	495	500	494	619
Hamaspik	189	179	218	251	294	339	359	409	465	520	543	586
Agewell	68	67	66	112	124	130	70	79	91	94	97	108
Centers	994	1089	1148	1179	1220	1235	1260	1285	1316	1323	1286	1250
Elderplan	2838	2816	2844	2884	2932	3005	3051	3074	3106	3131	3125	3131
Elderserve	85	88	97	97	105	102	118	126	131	126	140	152
Healthfirst Complete Care	20921	21167	21466	21810	22198	22671	22899	22786	22944	22925	22993	23265
Healthplus	156	175	187	192	200	209	193	186	180	186	185	206
Metroplus	1	16	19	19	19	20	20	21	21	32	36	41
Senior Whole Health	113	110	111	112	124	130	134	145	144	144	139	138
VNS	3086	3076	3051	3047	3054	3068	3090	3083	3089	3094	3055	2988
Village Care	2887	2825	2796	2798	2810	2802	2784	2734	2707	2689	2624	2577
Total	**31516**	**31793**	**32183**	**32696**	**33351**	**34083**	**34357**	**34355**	**34689**	**34764**	**34717**	**35061**

Managed Long Term Care PACE Plan Enrollment Jan 2022 to Dec 2022												
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	703	686	681	675	661	658	653	653	656	668	675	670
CHS Buffalo Life	250	249	247	246	244	241	242	240	238	242	241	247
Complete Senior Care	127	122	118	118	121	123	122	122	123	124	125	125
Comprehensive Care Management	3066	3192	3360	3584	3795	4041	4236	4452	4686	4934	5307	5523
Eddy Senior Care	300	310	307	312	311	312	314	315	315	320	325	317
Fallon Health Weinberg PACE	128	130	126	129	132	135	140	143	137	139	140	137
Independent Living For Seniors	713	707	713	719	724	726	734	731	736	736	730	734
Pace CNY	517	509	505	500	502	504	506	503	507	508	511	523
Total Senior Care	137	136	138	138	136	137	137	139	136	136	132	132
Total	**5941**	**6041**	**6195**	**6421**	**6626**	**6877**	**7084**	**7298**	**7534**	**7807**	**8186**	**8408**

Managed Long Term Care FIDA-IDD Plan Enrollment Jan 2022 to Dec 2022												
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1698	1687	1689	1674	1674	1667	1656	1659	1655	1668	1677	1685