MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 25 (4/1/2023-3/31/2024)
Federal Fiscal Quarter: 3 (4/1/2023-6/30/2023)

I. Introduction

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

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

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

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

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

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

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

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

New York submitted a three-year waiver extension request to CMS on March 5, 2021. CMS granted a temporary extension of the 1115 waiver through March 31, 2022. On October 5, 2021, CMS approved an amendment that transitions a set of BH HCBS into Community Oriented Recovery and Empowerment (CORE) rehabilitative services (as such term is defined in Section 1905(a)(13) of the Social Security Act) for Health and Recovery Plans (HARP) and HIV Special Needs Plans (HIV SNP) members.

On March 23, 2022, CMS approved a five-year extension of the New York MRT demonstration. As part of the extension, CMS approved the state's second component of its MLTC amendment request to allow dual eligible 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: Third Quarter

MRT Waiver- Enrollment as of June 2023

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 – TANF Child 1 – 20 years in Mandatory Counties as of 10/1/06	**507,360**	**7,435**	**38,836**
Population 2 – TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06	**74,736**	**1,681**	**8,353**
Population 3 – TANF Child 1 – 20 ('new' MC Enrollment)	**9,408**	**91**	**1,304**

Population 4 – TANF Adults 21 – 64 ('new' MC Enrollment)	**43,208**	**766**	**4,367**
Population 5 – Safety Net Adults	**251,095**	**8,720**	**31,864**
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)	**154,546**	**2,001**	**71**
Population 9 – Disabled Adults and Children 0 – 64 ('new' MC enrollment)	**60,314**	**4,061**	**204**
Population 10 – Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**79,360**	**415**	**26**
Population 11 – Aged or Disabled Elderly ('new' MC enrollment)	**14,277**	**2,535**	**132**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**27,705 or an approximate 19.3% 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 both incarcerations and the "Undetermined" category of disenrollment. Undetermined refers to cases where a manual review would be needed to determine the specific reason for disenrollment.

Involuntary Disenrollments	
Total # Involuntary Disenrollment's in Current Demonstration Year	**85,157 or an approximate 1,052.3% 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 a significant increase in the number of Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
April 2023				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**747,940**	**19,421**	**4,353**	**15,068**
Rest of State	**401,897**	**8,160**	**1,148**	**7,012**
Statewide	**1,149,837**	**27,581**	**5,501**	**22,080**
May 2023				
New York City	**758,168**	**24,228**	**5,288**	**18,940**
Rest of State	**355,302**	**8,961**	**1,536**	**7,425**
Statewide	**1,113,470**	**33,189**	**6,824**	**26,365**
June 2023				
New York City	**757,154**	**17,856**	**4,443**	**13,413**
Rest of State	**325,712**	**7,713**	**1,096**	**6,617**
Statewide	**1,082,866**	**25,569**	**5,539**	**20,030**

Third Quarter	
Region	**Total Affirmative Choices**
New York City	47,421
Rest of State	21,054
Statewide	68,475

HIV SNP Plans				
April 2023				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	13,027	247	1	246
Rest of State	23	0	0	0
Statewide	13,050	247	1	246
May 2023				
New York City	13,079	225	0	225
Rest of State	22	1	0	1
Statewide	13,101	226	0	226
June 2023				
New York City	13,132	229	0	229
Rest of State	20	1	0	1
Statewide	13,152	230	0	230
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	700			
Rest of State	2			
Statewide	702			

Health and Recovery Plans Disenrollment			
FFY 23 – Q3			
	Voluntary	**Involuntary**	**Total**
April 2023	**693**	**761**	**1,454**
May 2023	**753**	**1,706**	**2,459**
June 2023	**578**	**5,050**	**5,628**
Total:	**2,024**	**7,517**	**9,541**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 3 (4/1/2023-6/30/2023) Q3 FFY 2023

As of the end of the first federal fiscal quarter (end of June 2023), there were 3,147,981 New York City Medicaid consumers enrolled in MMMC Program and 77,867 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 31 HRA facilities including 6 HIV/AIDS Services Administration (HASA) sites, 9 Community Medicaid Offices (MA Only), and 16 HRA Benefits Access Centers (Public Assistance). MAXIMUS reported that 7,594 clients were educated about enrollment options and made an enrollment choice including 570 clients in person and 7,024 clients through phone.

Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Deficiencies are reported to MAXIMUS Field operation monthly. During the reporting period, 86 Enrollment Counselling sessions were evaluated which generated two applications for a total of two enrollments.

CMU Monitoring of Field Presentation Report – 3rd Quarter 2023	
Enrollment Counseling – One on One	General Information
86	84

Of the two enrollments completed during informational sessions, two (100%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 31,513 FFS community clients were reported on the regular auto-assignment list, 8,156 clients responded to the call that generated 4,098 enrollments. Of the total of 47 FFS NH clients reported on NH auto-assignment list, 0 (0%) clients and/or authorized representatives made a Plan selection. CMU monitored 570 outreach calls by FCSRs in HRA facilities. The following captures those observations:

Phone Enrollment			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
305	0	305	262	3	265

- Phone Enrollment: 305 (54%) FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 396 enrollments.
    - 305 (100%) were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in plan selected timely.
- Undecided: 265 (46%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

C. NYMC HelpLine Observations April 2023- June 2023

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that **46,740** calls were received by the Helpline and **45,746** or **98%** were answered. Calls answered were handled in the following languages: **English: 28,927 (63%); Spanish: 6,299 (14%); Chinese: 1,839 (4%); Russian: 1,161 (2.50%); Creole: 76 (0.50%); and other: 7,444 (16%).**

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to **5,516** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 3rd Quarter 2023								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
3,070 (56%)	**590 (11%)**	**453 (8%)**	**1,306 (24%)**	**97 (1%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**5,516**

A total of **1,611 (29%)** recorded calls observed were unsatisfactory. **710** calls had a single infraction and **523** calls had multiple infractions. A total of **2,276** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,944 (85%)** – CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: **155 (7%)** – CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of primary care provider (PCP); and referrals for specialists.
- Customer Service: **177 (8%)** – Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **2,276** 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 third 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 May 11, 2023, 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 Suffolk County.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Three Comprehensive Operational Surveys were completed during 3rd QTR FFY 2022-2023. An SOD was issued and a POC was accepted for two plans:

- HealthFirst
- Molina

One Plan was found in Compliance

- Excellus

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 behavioral health [mental health (MH) and substance use disorder (SUD)] and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered behavioral health 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.

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

In Fiscal Year (FY) 2018, NYS engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the New York State of Health (Exchange). This enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State identified and implemented a policy to allow State Designated Entities to assess and link HARP enrollees to BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center (MCTAC).

Effective April 1, 2023, the Medicaid pharmacy benefit was carved out of MMC to Medicaid fee-for-service (FFS). Medicaid members enrolled in Mainstream Managed Care Organizations (MCOs), HARPs, and HIV SNPs now receive pharmacy benefits through the Medicaid FFS pharmacy program, NYRx. MMC Plans began sending notices to members and their providers about the Pharmacy benefit transition in 2022. Transitioning the pharmacy benefit from MMC to FFS provides NYS visibility into prescription drug costs, allows benefit centralization, and provides a single drug formulary with standardized utilization management protocols, simplifying and streamlining the drug benefit for Medicaid members.

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

Additionally, NYS resumed annual Medicaid recertifications in April 2023, having paused since March 2020 due to the federal PHE.

On June 29, 2023, NYS received approval from CMS for the Crisis Intervention State Plan Amendment (SPA) #22-0026. NYS intends to formally implement Mobile Crisis and Crisis Residence program and billing changes to effectuate the Crisis Intervention SPA.

The Crisis Intervention SPA consolidates and aligns Medicaid authority, coverage, and reimbursement policies for existing children and adults Mobile Crisis and Crisis Residence services. The Crisis Intervention SPA also authorizes coverage of Crisis Stabilization Center services.

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

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

NYS MH & SUD authorization requests and denials for Inpatient (1/1/2023-3/31/2023)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	32,565	212	195	0.60%
ROS	6,051	27	27	0.45%
Total	38,616	239	222	0.57%

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

NYS MH & SUD authorization requests and denials for Outpatient (1/1/2023-3/31/2023)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,784	85	65	1.12%
ROS	158	18	18	11.39%
Total	5,942	103	83	1.40%

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

[1] Q3 data is not available and will be submitted with the next quarterly update.
[2] Q3 data is not available and will be submitted with the next quarterly update.

MH & SUD Claims (4/1/2023-6/30/2023)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,435,917	96.07%	3.93%
ROS	728,512	95.32%	4.68%
Totals	2,164,429	95.82%	4.18%

Note: IHA June 2023 data has been excluded due to submission issue

Behavioral Health Adults CORE/HCBS Claims/Encounters 4/1/2023-6/30/2023: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	**155**	**39**
Education Support Services	**39**	**12**
Family Support and Trainings	**322**	**25**
Intensive Supported Employment	**64**	**17**
Ongoing Supported Employment	**3**	**1**
Peer Support	**2,350**	**536**
Pre-vocational	**35**	**6**
Provider Travel Supplements	**35**	**19**
Psychosocial Rehab	**2,923**	**438**
Residential Supports Services	**41**	**10**
Transitional Employment	**0**	**0**
TOTAL	**5,967**	**937**

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 4/1/2023-6/30/2023: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	**1,270**	**278**
Education Support Services	**98**	**37**
Family Support and Trainings	**357**	**36**
Intensive Supported Employment	**64**	**18**
Ongoing Supported Employment	**13**	**4**
Peer Support	**4,373**	**1,090**
Pre-vocational	**25**	**5**
Provider Travel Supplements	**4,047**	**1,009**
Psychosocial Rehab	**4,547**	**920**
Residential Supports Services	**653**	**125**
Transitional Employment	**0**	**0**
TOTAL	**15,447**	**2,156**

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 3 MCTAC Attendance & Statistics (4/1/2023 to 6/30/2023)

Events: MCTAC successfully executed **37** events from 4/1/2023 to 6/30/2023.
All 37 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):*

4,618 people attended/participated in MCTAC events/viewed resources of which **3,073** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 346 of 721 **(47.99%)**

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: 201 of 434 **(46.31%)**

** *Please note, as of May 2023, MCTAC has included pre-recorded offerings in the total count of events.*

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, NYS 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, NYS 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.

To address the identified challenges, NYS made efforts to ramp up utilization and improve access to BH HCBS. NYS effectuated the following:

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

- Implemented 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
- Disseminated consumer education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS OMH contracted with the New York Association Psychiatric Rehabilitation Services (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for HARPs and Adult BH HCBS.
        - NYAPRS conducted outreach in two ways:
            - 45-90-minute training presentations delivered by peers
            - 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. NYS worked with the MCOs on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all HARPs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in an increase of members utilizing BH HCBS; NYS 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.
- Enhanced NYS Adult BH HCBS Provider oversight, including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.
- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, Health Homes, CMAs, and BH HCBS provider agencies. Developed and provided a variety of tools to support care manager referrals to BH HCBS, on behalf of the NYS Health Home/MCO Workgroup.
- Established a process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments. This was in response to challenges in securing a care management workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,274 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between April 1, 2023, and June 30, 2023, 927 eligibility assessments were completed.

Transition to Community Oriented Recovery and Empowerment Services

Despite the 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 remained 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, NYS 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. Public comment resulted in positive feedback, and NYS finalized the proposal and submitted to CMS in September 2020. 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 access barriers.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through the American Rescue Plan Act, NYS revised the September 2020 proposal to comply with 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. Currently, all HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible Medicaid Advantage Plus (MAP) 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, for new and existing recipients (HARP enrollees and HARP-eligible HIV-SNP 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 are available on the OMH CORE website and were distributed via provider listserv. In January 2022, OMH participated in a Townhall series hosted by the Access 2 Recovery Coalition with a goal of educating HARP members about benefit changes. NYS 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. NYS 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 website.

In January 2023, in collaboration with NYAPRS, a CORE Peer Navigator Project was launched. This project is funded for two years through the Mental Health Block Grant, and focuses on outreach, education, and service navigation to support access to CORE and BH HCBS.

As of January 1, 2023, HARP-eligible MAP enrollees can also access CORE Services with an LPHA recommendation. NYS continues to provide technical assistance on this benefit carve-in. NYS provided MAP Plans with CORE Services guidance and training, in addition to MAP benefit package trainings for CORE Service providers and care managers.

NYS 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, NYS 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. NYS will continue its efforts to increase access to behavioral health rehabilitation services through working collaboratively with Health Homes.

In addition, in 2021, NYS extended the Adult BH HCBS Infrastructure funding initiative to support behavioral health providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allowed HARPs to contract for remaining, unspent funds totaling approximately $31.9 million. Based on a thorough network needs assessment, HARPs competitively awarded the funds to eligible providers. Infrastructure Program Extension contracts were executed between May and September 2022, with contracted activities currently underway. OMH and OASAS continue to work closely with the HARPs to further monitor and operationalize the program.

- 11 HARPs executed 80 provider contracts which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $20.9 million in initial contract base awards and subsequent milestone payments were distributed to providers.
- The program is expected to conclude in July 2024.
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS, and CORE Service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.

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

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

C. Managed Long-Term Care Program (MLTCP)

MLTC plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), MAP, and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of July 1, 2023, there are 23 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of July 1, 2023, there are a total of 316,332 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the April 2023 through June 2023 quarter, the DOH approved a service area expansion for one MAP plan, and one PACE plan two zip code expansion.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For April 2023 through June 2023 quarter, post enrollment surveys were completed for 3 enrollees. Of the 3 surveyed, 100% indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 260,207 to 266,332 during the April 2023 through June 2023 quarter, a 2% increase from the last quarter. For that period, 13,784 individuals who were being transitioned into MLTC made an affirmative choice, an 8% increase from the previous quarter and brings the 12-month total for affirmative choice to 50,745.

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

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

- PHE unwind-related communications were distributed by the Department through guidance and monthly plan meetings including updating member addresses, outreach, and education to MLTC plans on member recertification reminders and working with the LDSS on eligibility recertification issues.

- The 2nd Quarter Member Services survey was conducted on 23 Partial Capitation Plans and 12 MAP Plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but, when necessary, the Department provided recommendations on areas of improvement.

- The Desk Review for six Partial Capitation Operational Surveys were completed and reported in prior reporting periods. The Corrective Action Plans (CAP) for two Partial Capitation plans have been approved by the department. A Statement

of Deficiency (SOD) was issued to one Partial Capitation plan, their CAP has been received and is still awaiting department approval. A SOD was issued to one Partial Capitation plan, their CAP has been received and is still awaiting department approval. A SOD was issued to one Partial Capitation plan, their CAP has been received and is still awaiting department approval. A SOD was issued to one Partial Capitation plan, their CAP has been received and is still awaiting department approval.

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

- The Focused Survey initiated on all Partial Capitation and MAP Plans (on 10/28/2022) focusing on PCSP Template compliance was completed. Analysis of plan submissions determined an overall lack of compliance. The plans were educated on PCSP requirements and a follow up Focused Survey will be initiated.

- The follow up Focused Survey on all Partial Capitation and MAP Plans focusing on PCSP Template compliance that was reported in the prior reporting period remains ongoing. All PCSP Templates reviewed were determined to be out of compliance. Follow up with the plans continues in order to approve compliant templates for the plans to use.

- One Focused Survey was initiated on one Partial Capitation plan based on Technical Assistance Center (TAC) Complaints (Rate Change). A SOD was issued to the plan and a CAP has been received, however the Plan still has outstanding rate negotiations. Once all rate negotiations are completed, the CAP can be accepted.

- One Focused Survey was initiated on one Partial Capitation plan based on their late MSA / IPA Contract submission. A SOD was issued to the plan and the department is reviewing their Corrective Action Plan.

- One Focused Survey was initiated on one Partial Capitation plan based on TAC complaints received for inappropriate SDC denial notices. A SOD was issued to the Plan and the Department is reviewing their Corrective Action Plan.

- One TAC Investigation was initiated on one Partial Capitation plan, TAC complaints received for inappropriate SDC reduction notices. A SOD was issued to the Plan and the Department is working with Legal to address the Plans concerns.

- One compliance investigation was opened for one PACE plan during this quarter.

Matter of Routine Course:

- Processes for Operational Partial Capitation and MAP surveys continue to be refined;
- The Surveillance tools continue to be updated to reflect process changes; and
- There are no significant issues or problems to report, however survey training continues for the two new team members.

3. Issues and Problems

There were no issues or problems to report for the April 2023 through June 2023 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within MLTC plans as a consumer choice and gives individuals and families greater control over services received. The DOH began a procurement process in December 2019 which was subsequently amended in the Executive Budget in April 2022. The amended legislation directly provided 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). In June 2023 the Department made additional awards under this criterion and has begun the contracting process for all awardees. Once contracts are executed, managed care plans will then enter into separate administrative service agreements with these Department-contracted FIs.

5. Required Quarterly Reporting

Critical incidents: There were 3,139 critical incidents reported for the April 2023 through June 2023 quarter, an increase of 9% from the previous quarter. The increase is due to both reminder instructions issued in how the Critical Incidents should be reported and two partial cap plans that reported increased Critical Incidents for Q3. 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 April 2023 through June 2023 quarter, the top reasons for complaints/appeals stayed the same as last quarter: Dissatisfaction With Transportation, Dissatisfaction With Quality Of Other Covered Services, Dissatisfaction With Quality of Homecare (Other than Lateness or Absences), Dissatisfaction With Member Services and Plan Operations, Dissatisfaction with Care Management.

Period: 4/1/2023–6/30/2023 (Percentages rounded to nearest whole number)			
Number of Recipients: 316,332	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**8**	**8**	**100%**
# Same Day	**2,612**	**2,612**	**100%**
# Standard/Expedited	**8,577**	**6,146**	**72%**
Total for this period:	**11,197**	**8,766**	**78%**

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

Appeals	7/2022-9/2022	10/2022-12/2022	1/2023-3/2023	4/2023-6/2023	Average for Four Quarters
Average Enrollment	291,381	297,328	304,375	313,672	301,689
Total Appeals	8,473	10,284	10,461	12,228	10,362
Appeals per 1,000	29	36	34	39	35
# Decided in favor of Enrollee	966	1,081	1,224	1,331	1,151
# Decided against Enrollee	6,252	7,143	8,103	8,571	7,517
# Not decided fully in favor of Enrollee	880	845	871	921	879
# Withdrawn by Enrollee	190	236	263	300	247
# Still pending	185	979	1,195	1,105	866
Average number of days from receipt to decision	8	10	7	6	8

Complaints and Appeals per 1,000 Enrollees by Product Type April 2023- June 2023					
	Enrollment*	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	264,508	6,784	26	9,153	35
Medicaid Advantage Plus (MAP) Total	38,468	3,042	79	2,932	76
PACE Total	8,978	1,371	153	143	16
Total for All Products:	**311,954**	**11,197**	**36**	**12,228**	**39**

***Total is average of 3 months**

Total complaints decreased 11% from 12,549 the previous quarter to 11,197 during the April 2023 through June 2023 quarter.

The total number of appeals increased 19% from 10,284 during the last quarter to 12,228 during the April 2023 through June 2023 quarter.

Technical Assistance Center (TAC) Activity

During the April 2023 through June 2023 quarter, TAC opened 756 cases and closed 778 cases. This is higher than the 730 cases opened, and 723 cases closed from the previous quarter. Upon examination, this quarter's increase in cases is equally spread across the different types of case dispositions, outlined in the table below. There was not one specific disposition that caused the increase.

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	**4/1/2023 – 6/30/2023**
Substantiated Complaints	91
Substantiated Complaints with Corrective Action Plan	0
Unsubstantiated Complaints	256
Resolved Without Investigation	21
Inquiries	410
Total Cases Closed	778

The five most common types of calls were related to:

Q3	**4/1/2023 - 6/30/2023**
General	34%
Aide Service	16%
Enrollment	11%
Grievance	9%
Billing	8%

79% of Q3 TAC cases were closed in the same month they were opened. This is a 6% increase from last quarter's percentage of 73%.

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 April 2023 through June 2023 quarter, 7,405 people were evaluated, deemed eligible and enrolled into plans, an increase of 1% from the previous quarter.

Rebalancing Efforts	4/2023-6/2023
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	494
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,538

As of June 30, 2023, there were 3,484 current plan enrollees who were in nursing homes as permanent placements, a 16% 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 HCBS needs, including medically fragile children, children with a BH needs, 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 CMS in January 2022, and extended in April 2022, was **approved on June 29**, **2022,** for an effective date of April 1, 2022.

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

- Managed care authority for HCBS provided to medically fragile children and/or with developmental disabilities, developmental disability in foster care, and children with a serious emotional disturbance;
- Authority to include current FFS HCBS authorized under the State's newly consolidated 1915c Children's Waiver in MMC benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's Waiver;
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c Children's Waiver, including non-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs;
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115;
- Authority for Health Home care management monthly monitoring as an HCBS; and
- Removes managed care exclusion of children placed with Voluntary Foster Care Agencies.

Given the approval, the NYS DOH has been engaged in implementation activities, including, but not limited to the following:

- Continuing to refine data collection and data analysis to ensure accurate reporting;

- Engaging a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative;
- Submitting the Preliminary Interim Evaluation Report to CMS, as drafted by the vendor;
- Submitting the Interim Evaluation Report to CMS, as drafted by the vendor;
- Drafting policies and guidance to ensure compliance with State and Federal requirements, as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification;
- Updating manuals, guidance documents, and online resources as indicated
- Reassessing, streamlining, and removing unnecessary or duplicative forms to alleviate administrative burden;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers, including additional resources and technical assistance with person-centered planning;
- Facilitating relationship building between MCOs, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of MCOs and FFS billing and claiming data;
- Defining performance and quality metrics;
- Responding to the COVID-19 pandemic and implementing emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and continuing to support the recovery of impacted providers and consumers;
- Assisting with a strategic plan for the unwind of the COVID-19 PHE;
- Conducting annual case reviews of both Health Homes, C-YES, and HCBS providers;
- Working with Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process;
- Engaging with providers to understand barriers to service delivery – such as workforce challenges, lack of referral sources / lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers;
- Engaging with providers, consumers, and NYS agency partners to determine how best to use the eFMAP authorized by the American Rescue Act to improve access to children's services and reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure;
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between MCOs, Health Homes, and HCBS providers;

- Organizing and conducting workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral process;
- Engaging with Health Homes, MCOs, and HCBS providers while redesigning the Plan of Care in preparation for digitization;
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process;
- Submitting the 1915c Children's Waiver Extension to CMS;
- Submitting the 1915c Children's Waiver Renewal to CMS;
- Submitting a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitting a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure;
- Working with MCOs and providers to disseminate ARPA funding through the directed payment process;
- Scheduling and facilitating regional meetings with HCBS providers, Health Homes, care management agencies, Medicaid MCOs to resume in-person collaboration and dialogue.
- Updating the IRAMS and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- Engaging with HCBS providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if they are not currently able to actively deliver HCBS;
- Drafting documentation guidance to ensure compliance with documentation of services being delivered to Children's Waiver participants, progress toward goals, significant life events, and medical necessity requirements for each HCBS;
- Submitting additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental and Vehicle Modifications & Adaptive and Assistive Technology.

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

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

service and also broadens the definition of caregivers eligible for training to include all individuals who supervise and care for members;
- Broadening Children and Youth Evaluation Services' (C-YES') Nurse qualifications by requiring two years *relevant* experience. The previous requirement that was two years' experience *specifically* in home care;
- Reducing the required years of experience for Palliative Care: Expressive Therapists from three years to one year;
- Adding a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity;
- Adding a 5.4% COLA increase for providers;
- NYS support of the continued 25% enhanced HCBS rates on October 1, 2022.
- Developed Electronic Children's Services Staff Compliance Tracker;
- Updated Children's Care Management Authorization Form ensuring it's inclusive of all requirements per stakeholder feedback;
- Developing Electronic Children's Referral System which would streamline, standardize, and ensure timely completion of referral per policy;
- Updating Children's Plan of Care Policy Workflow documentation to align and streamline policies and ensure language is comprehensive of the newly developed timeframes and follow Person-Centered Service Planning Guidelines;
- Drafting an Authorization Workflow Policy that will be circulated to stakeholders for feedback; and
- Drafting a Referral Workflow Policy that will be circulated to stakeholders.

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

The following table demonstrated the number of children enrolled in the 1915c Children's Waiver identified by NYS restriction exception (RE) code of K1 and the current claims for services for these enrolled children/youth. Additionally, as outlined in the 1115 amendment, NYS is tracking the enrollment of children/youth who obtained Medicaid through Fo1 Medicaid budgeting as identified by NYS RE code KK. Therefore, the table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
April	15,255	7,106	6,863	851
May	15,136	6,205	6,859	776
June	14,710	3,503	6,887	541
Quarterly Average	**15,034**	**5,605**	**6,870**	**723**

**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 3rd Quarter of FY2023.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 evaluation design to CMS for review and approval. CMS returned the evaluation design with comments on April 18, 2023. DOH submitted a revised evaluation design to CMS on June 30, 2023 pending their 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 Q3 4/1/2023-6/30/2023	**FFY 23 Q2 1/1/2023-3/31/2023**
MMC	5,403	7,224
HARP	727	960
HIV SNP	86	75
Total MCO Complaints	**6,216**	**8,259**

As described in the table, MCOs reported 6,216 total enrollee complaints for the current quarter. This represents a 24.7% decrease from the prior quarter's total of 8,259 enrollee complaints.

MCOs reported 5,403 MMC complaints this quarter, which is a 25.2% decrease from the 7,224 of the previous quarter. The number of HARP complaints decreased 24.3%, from 960 in the prior quarter to 727 this quarter. There were 86 HIV SNP complaints this quarter, which is an increase of 14.7% when compared to the 75 from the previous quarter.

The Department reviewed the decrease in MMC, and HARP enrollee complaints received from the MCOs. Upon examination, the percentage decrease in enrollee complaints stemmed from the decrease in enrollee complaints in the Pharmacy/Formulary complaint category. This is due to the pharmacy benefit transitioning from Managed Care to fee-for-service through the New York State Medicaid NYRx Pharmacy program effective April 1, 2023.

The following table outlines the top five 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 Q3 4/1/2023-6/30/2023	FFY 23 Q2 1/1/2023-3/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	16%	15%
Balance Billing	14%	12%
Difficulty with Obtaining: Dental/Orthodontia	13%	9%
Reimbursement/Billing	8%	9%
Dissatisfaction with Quality of Care	6%	5%

The following table outlines the top five 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 Q3 4/1/2023-6/30/2023	FFY 23 Q2 1/1/2023-3/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	22%	22%
Dissatisfaction with Quality of Care	12%	7%
Difficulty with Obtaining: Dental/Orthodontia	7%	5%
Difficulty with Obtaining: Specialist and Hospitals	5%	5%
Balance Billing	5%	4%

The following table outlines the top five 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 Q3 4/1/2023-6/30/2023	FFY 23 Q2 1/1/2023-3/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	26%	23%
Problems with Advertising/Consumer Education/ Outreach/Enrollment	21%	1%
Difficulty with Obtaining: Dental/Orthodontia	19%	12%
Dissatisfaction with Quality of Care	8%	12%
Difficulty with Obtaining: Personal Care	6%	8%

The Department reviewed the increase in HIV/SNP enrollee complaints received from the MCOs regarding Problems with Advertising/ Consumer Education/ Outreach/ Enrollment. Upon examination, the increase stemmed from the number of HIV/SNP enrollee complaints in that

complaint category reported by one MCO. The Department is following up with that particular MCO regarding the differences between the most recent quarter compared to the previous quarter.

Capital District Physicians Health Plan had errors in their reported complaint submission numbers. Therefore, the totals for the categories in this section of the report may be one percentage point higher or lower than reported. The MCO is aware of their error and will address it for future submissions.

B. Monitoring of Plan Reported Complaints

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

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

Based on the OE ratio over a six-month period, the Department requests that MCOs review and analyze applicable categories in which the reported number of complaints was more than twice the expected amount. Where a persistent trend or an operational concern contributing to complaints is confirmed, the MCO is required to develop a corrective action plan.

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

The Department is in the process of calculating the OE ratio for the six-month period of January 1, 2023, through June 30, 2023.

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, the Department monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 6,216 total reported complaints/action appeals, MCOs reported 513 complaints and action appeals from their SSI recipients. This compares to 469 SSI complaints/action appeals from the previous quarter, representing a 9.4% increase.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 23 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023
Appointment Availability: PCP	0	2
Appointment Availability: Specialist	2	4
Appointment Availability: BH HCBS	0	0
Long Wait Time	1	2
Dissatisfaction with Quality of Care	36	40
Denial of Clinical Treatment	14	19
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	180	137
Dissatisfaction with BH Provider Services	2	0
Dissatisfaction with Health Home Care Management	4	4
Difficulty with Obtaining: Specialist and Hospitals	29	21
Difficulty with Obtaining: Eye Care	3	5
Difficulty with Obtaining: Dental/Orthodontia	44	29
Difficulty with Obtaining: Emergency Services	3	1
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	2	0
Difficulty with Obtaining: RHCF Services	5	0
Difficulty with Obtaining: Adult Day Care	1	0
Difficulty with Obtaining: Private Duty Nursing	10	5
Difficulty with Obtaining: Home Health Care	7	2
Difficulty with Obtaining: Personal Care	49	17
Difficulty with Obtaining: PERS	0	1
Difficulty with Obtaining: CDPAS	21	8
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	4	52
Access to Non-Covered Services	6	5
Access for Family Planning Services	0	1
Communications/ Physical Barrier	4	3
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	3	5
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	41	59
Balance Billing	17	24
Transportation	0	2
All Other	25	21
Total	**513**	**469**

The following table outlines the top five 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 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	35%	29%
Difficulty with Obtaining: Personal Care	10%	4%
Difficulty with Obtaining: Dental/Orthodontia	9%	6%
Reimbursement/Billing	8%	13%
Dissatisfaction with Quality of Care	7%	9%

The Department requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of April 1, 2023, through June 30, 2023, MCOs reported LTSS enrollment of 56,020 enrollees. This compares to 53,931 LTSS enrollees from the previous quarter, representing a 3.9% 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 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023
Amida Care	1,271	1,318
Capital District Physicians Health Plan	774	771
Excellus Health Plan	1,640	1,640
Fidelis Care	20,375	19,562
Healthfirst	14,448	14,033
Highmark	255	242
HealthPlus	3,643	3,292
HIP of Greater New York	493	642
Independent Health Association	709	670
MetroPlus Health Plan	3,280	2,805
Molina Healthcare	2,851	2,936
MVP Health Plan	2,435	2,347
United Healthcare	3,384	3,266
VNS Choice	462	407
Total	**56,020**	**53,931**

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 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023
Difficulty with Obtaining: AIDS Adult Day Health Care	1	0
Difficulty with Obtaining: Adult Day Care	3	3
Difficulty with Obtaining: CDPAS	59	69
Difficulty with Obtaining: Home Health Care	58	50
Difficulty with Obtaining: RHCF Services	7	1
Difficulty with Obtaining: Personal Care	157	162
Difficulty with Obtaining: PERS	3	3
Difficulty with Obtaining: Private Duty Nursing	16	21
Total	**304**	**309**

Capital District Physicians Health Plan had errors in their reported complaint submission numbers. Therefore, the totals for the categories in this section of the report may be one percentage point higher or lower than reported. The MCO is aware of their error and will address it for future submissions.

D. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 126 critical incidents reported for the April 1, 2023, through June 30, 2023, period most of which have a resolved status. Many of the incidents stemmed from falls. The Department continues to work with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

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

Plan	Critical Incidents		
	FFY 23 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023	Net Change
Mainstream Medicaid Managed Care Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	3	18	-15
Fidelis Care	2	7	-5
Healthfirst	72	51	+21
HIP of Greater New York	0	0	0
Highmark	0	0	0

HealthPlus	1	0	+1
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	3	0	+3
MVP Health Plan	0	1	-1
United Healthcare	0	0	0
Total	**81**	**77**	**+4**
Health and Recovery Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	0	0
Fidelis Care	0	0	0
Healthfirst	40	28	+12
HIP of Greater New York	0	0	0
HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**40**	**28**	**+12**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	5	7	-2
Total	**5**	**7**	**-2**
Grand Total	**126**	**112**	**+14**

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 Q3 4/1/2023–6/30/2023	FFY 23 Q2 1/1/2023–3/31/2023	Net Change
Mainstream Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	5	7	-2
Crimes Committed Against Enrollee	0	3	-3
Crimes Committed by Enrollee	2	0	+2
Instances of Abuse of Enrollees	0	6	-6
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	3	3	0

Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	10	11	-1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	60	45	+15
Use of Restraints	0	0	0
Wrongful Death	1	2	-1
Total	**81**	**77**	**+4**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	1	0	+1
Crimes Committed Against Enrollee	1	0	+1
Crimes Committed by Enrollee	2	0	+2
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	6	5	+1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	28	22	+6
Use of Restraints	1	1	0
Wrongful Death	0	0	0
Total	**40**	**28**	**+12**
HIV Special Needs Plans			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	1	-1
Instances of Exploitation of Enrollees	1	0	+1
Instances of Neglect of Enrollees	2	4	-2
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	0	0	0
Other Incident Resulting in Medical Treatment Other Than Hospitalization	2	2	0
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**5**	**7**	**-2**
Grand Total	**126**	**112**	**+14**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 101 enrollee complaints this quarter. This total is a 2.0% increase from the previous quarter, which reported 99 enrollee complaints.

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

MCO Enrollee Complaints Received Directly by the Department	
FFY 23 Q3 4/1/2023–6/30/2023	**FFY 23 Q2 1/1/2023–3/31/2023**
101	**99**

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

Percentage of MCO Enrollee Complaints Received Directly by the Department		
Description of Complaint	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**
Reimbursement/Billing	15%	10%
Pharmacy/Formulary	15%	9%
Difficulty with Obtaining: Home Health Care	9%	12%
Difficulty with Obtaining: Dental/Orthodontia	7%	4%
Difficulty with Obtaining: Specialist and Hospitals	6%	4%

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

F. Fair Hearings

There were 271 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of April 1, 2023, through June 30, 2023. The dispositions of these fair hearings for the most recent quarter and for the previous quarter are as follows:

Fair Hearing Decisions (includes MMC, HARP, and HIV SNP)		
Hearing Dispositions	**FFY 23 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**
In favor of Appellant	78	79
In favor of Plan	171	168
No Issue	22	17
Total	**271**	**264**

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 Q3 4/1/2023–6/30/2023**	**FFY 23 Q2 1/1/2023–3/31/2023**
0-29	1	8
30-59	57	44
60-89	67	43
90-119	54	52
=>120	92	117
Total	**271**	**264**

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

The MMCARP met on June 15, 2023. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment, and an update on the status of the MLTC program. There were three additional agenda items, an Applied Behavior Analysis (ABA) Services update given by Jassen Eide, NYS DOH, OHIP, a BH/HARP/Health Home update given by Lynne Schaefer, NYS, Office of Mental Health, and an Integrated Benefit for Dually Eligibles (IB-Dual) update given by Stacey Blair-Greenfield, NYS DOH, OHIP, and Andrew Dujack, NYS DOH, OHIP. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for September 21, 2023.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

During the reporting period, staff activities were focused on calculating MLTC quality, satisfaction, and compliance measures. Activities included: running measures, drafting the 2022 MLTC report, sharing preliminary measurement data with health plans for their review and feedback, and determining cut points for the tiers used in the MLTC quality incentive. Additionally, the Department's EQRO, IPRO, sent the second mailing of the 2023 MLTC Satisfaction Survey to eligible members. Finally, staff actively managed the MLTC_OQPS@health.ny.gov mailbox to ensure timely response to stakeholder inquires.

B. Quality Measurement in Medicaid Managed Care

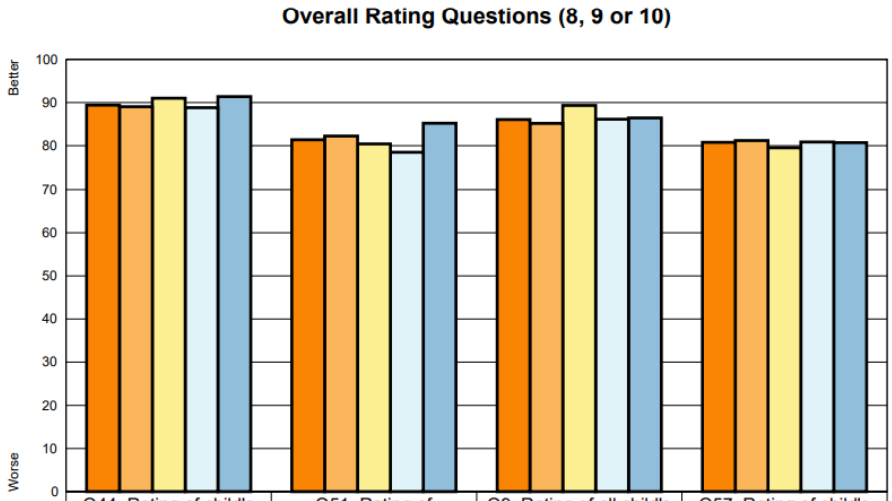
Quality Measure Benchmarks 2021 (Measurement Year 2021)
Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2021, national benchmarks were available for 64 measures for Medicaid. Out of the 64 measures that NYS Medicaid plans reported, 80% of measures met or exceeded national benchmarks. NYS consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid, rates exceed the national benchmarks for BH on adult measures (e.g., receiving follow-up within seven and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and

adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). NYS managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, and cervical cancer). Considering this was during a period of COVID-19 impacts in New York, the data demonstrates that many aspects of quality of care remained high for New Yorkers on Medicaid.

2022 Satisfaction Survey

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

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



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

2021 Quality Incentive for Medicaid Managed Care

The 2021 Quality Incentive Awards calculations were finalized in February 2023 which covered the measurement year period for 2021. The quality incentive is calculated on the percentage of

total points a plan earned in the areas of Quality of Care and Experience of Care. Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. Plans had the opportunity to earn ten bonus points by submitting a "COVID-19 Vaccination Equity Plan (CVEP)" that summarized their progress towards improving vaccination rates of their members through 2022. Plans were classified into five tiers based on the distribution of the final percentage points before the bonus points were awarded. Plans can only move up a maximum of one tier due to the CVEP bonus points. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and CMS. The results for the 2021 Incentive included three plans in Tier 1, one plan in Tier 2, seven plans in Tier 3, and two plans in Tier 5.

Quality Assurance Reporting Requirements (QARR)
In June, 26 health plans submitted reporting requirements to stakeholders as identified in QARR (e.g., NYS, IPRO, National Committee on Quality Assurance). Data was being collated and reviewed through the month. Data will be published in November 2023.

C. Quality Improvement

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

Annual EQRO Technical Reports
In the start of the third quarter the 2021 ATR reports were going through EDCC review. All reports were submitted to CMS on April 28, 2023. By the end of the third quarter, annual technical reports planning meetings have been conducted to go over the new 2022 technical reports.

Provider Related and Access Activities
In the beginning of the third quarter, The EQRO started Access survey. IPRO, the EQRO, called more than 2,000 providers and was near about 50% completion of the goal. By May, the calls for the survey were completed and the data entry for the results was being completed. In June, all calls, data entry, and quality assurance were complete. IPRO will be in the process of drafting the final reports and completing analysis leading into the 4th quarter.

IPRO sent the Member Services survey final reports to DOH throughout April and May. For the PCP ratio survey, calls began in May and were completed by June. IPRO began working with the vendor to capture data for the Essential Plan (EP) survey. DOH gave approval and IPRO drafted a project plan with a timeline for completion of the required tasks. During the month of May, there were some technical issues with the survey data, but those issues were resolved. In June, IPRO started the process of conducting calls for the EP survey along with the Quality Assurance for the calls. IPRO will be updating the project plan for the eligible population.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 400 active networks in NYS. IPRO and their subcontractors- RMCI and Quest Analytics, 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 1 2023 PNDS submission deadline was April 28, 2022; plans submitted data based on version 11 of data dictionary.

Provider and Health Plan LOOK-UP
The New York State Provider & Health Plan Look-Up website helps consumers in their health plan network and provider search. IPRO continues to refresh the data twice a month. The site has more than 1.8 million distinct users as of May 2022.

PANEL
Panel data submission opened on 5/1/2023 and yielded 7,194,258 rows of data (up ~2.38%). Technical assistance was provided by DOH and IPRO throughout the submission, particularly around new edits implemented. DOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)
During the third quarter, the initial interim reports have been completed and reviewed. Some of the plans have received their reports back with revisions. By May, The EQRO reviewed all the reports and by June all reports were given back to the plans.

Member Satisfaction Survey
At the start of the third quarter the EQRO sent out first mailing of the satisfaction survey. From the beginning of the quarter there was a response rate of 8% to 9%. By May, the response rate rose to 10.6% within two weeks of when the survey went out. The EQRO started to draft the data analysis plan for the survey. By June, the second mailing was sent out. IPRO, the EQRO, noted that the response rate rose to 11.7%.

Focused Clinical Study
At the start of the third quarter the EQRO has conducted 14 completed assessment pairs. By May, the number of completed assessments stands. IPRO has had trouble with members going through with conducting the telehealth and in-person assessments. In June, the assessment

total reached 15 assessment pairs completed. IPRO wants to make at least 20 assessment pairs completed by the end of the study.

Quality Measurement
In the beginning of the third quarter, the CAHPS kids final report was posted to the DOH website. IPRO and DOH had a meeting with DataStat to discuss the next CAHPS survey. In May, the QARR data and analytics team were working to prepare for the June submission. By June 15, 2023, IPRO received all patient level files, enhancement files, QHP, and CAHPS files from the plans and vendors. IPRO will review the documentation and will report any significant findings to DOH.

PIPs for MMCs:

2022-2023 Medicaid Managed Care and HIV SNP PIP: Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members
On October 27, 2021, a WebEx meeting with Medicaid managed care and HIV SNP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The PIP Proposals were submitted by December 8, 2021. The PIP Proposals reviewed and finalized by IPRO and NYSDOH. The approved interventions began implementation in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 15, 2022. The updates have been reviewed by IPRO and finalized by the plans then distributed to DOH. Dental PIP Interim reports were submitted by the plans to IPRO by 1/30/23. IPRO then sent finalized reports to the DOH for review and they were approved. IPRO conducted plan-specific oversight calls with the plans in January 2023. Prior to the oversight calls the plans submitted updates on their intervention tracking measures. An all-plan Webinar for selected plans to report progress on the PIP is planned for April 27, 2023. IPRO approved plan submissions for the April 27, 2023, all-plan webinar and sent them to the DOH for review. IPRO conducted plan-specific oversight calls with the plans in May 2023. Prior to the oversight calls the plans submitted updates on their intervention tracking measures. An all-plan webinar for selected plans to report progress on their PIP is planned for July 28, 2023.

2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus
For the month of April, IPRO reminded the plans that interim reports were due on April 28. DOH and IPRO has set up the next HARP webinar for May 17th which was a success. In June, the HARP progress calls were conducted and completed.

Breast Cancer Selective Contracting
Staff completed the summer review of breast cancer surgical volume data. Provisional volume designations for contract year 2024-2025 were shared with facilities' SPARCS coordinators in June 2023. Release of these data will give facilities ample time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

Patient Centered Medical Home (PCMH)
As of June 2023, there were 8,976 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,238 PCMH practices in NYS. All providers are recognized under the standards of NYS PCMH, which is an NCQA program that is exclusive to NYS and was released on April

1,2018. To achieve NYS PCMH recognition, practices must meet all requirements of the NCQA recognition program, which includes implementing both core criteria and elective criteria. The NYS PCMH program stipulates that practices implement the core criteria as defined by NCQA and meet the elective criteria requirement in part through the implementation of 11 NYS-required criteria which focus on NYS priorities such as BH, care management, population health, and health information technology capabilities. Of the 8,976 providers that became recognized in June 2023, 40 were new to the NYS PCMH program.

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

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued. The commitment across payers and providers continues through 2023, as well as the discussions around alignment of methods for shared savings models.

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 the issues associated with the new Outcomes Based Assessment (OBA) compliance criteria.

Status as of July 7, 2023:

Critical-Priority:	100%	(Target 100%)
High-Priority:	97%	(Target ≥ 99%)
Expenditures:	96%	(Target ≥ 95%)

As of June 2023, the State data meets the Critical-Priority and Expenditures criteria target of OBA and is 2% below the target for High-Priority criterion. The state is actively working on addressing the identified high priority issues to meet the High-Priority criterion of OBA.

In addition, the state is targeting to implement the Phase one File Layout changes in **November 2023.** This change includes adding, renaming, deprecating, and modifying data element segments and types. This will make the files compliant with the newer DDv3.0.0 layout. CMS requires the states to implement this change by December 31, 2023.

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

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

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

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Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	11	0	0	0	0	0	9	2	0	5600	0.20%
AgeWell NY	0	0	0	0	0	0	0	0	0	0	0%
AgeWell MAP	0	0	0	0	0	0	0	0	0	117	0.00%
Archcare Community Life	51	1	0	0	12	0	0	23	15	5499	0.93%
Archcare PACE	7	0	0	0	0	2	4	1	0	708	0.99%
Catholic Health-LIFE	0	0	6	0	0	0	5	6	0	238	0.00%
Centerlight PACE	0	0	0	0	0	0	0	0	0	5789	0.00%
Centers Plan for Healthy Living	826	0	0	1	20	1	281	523	0	49231	1.68%
Centers Plan for Healthy Living MAP	30	0	0	0	1	1	10	18	0	1432	2.09%
Complete Senior Care	3	0	0	0	0	0	1	1	1	127	2.36%
Eddy SeniorCare	6	0	0	0	0	0	6	0	0	317	1.89%
Elant Choice (EverCare)	43	0	0	0	0	0	8	35	0	852	5.05%
Elderplan MAP	7	0	0	1	6	0	0	0	0	3170	0.22%
Elderserve	348	0	0	1	3	1	146	194	4	16041	2.17%
Elderserve MAP	4	0	0	0	0	0	3	1	0	171	2.34%
Elderwood	39	0	0	0	0	0	5	10	24	1079	3.61%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	50938	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	190	0.00%
Extended	50	0	0	0	0	0	36	14	0	5666	0.88%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	834	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	143	0.00%
Fidelis Care at Home	27	0	1	1	2	0	13	9	1	17132	0.16%
Fidelis MAP	1	0	0	0	0	1	0	0	0	737	0.14%
Hamaspik	64	0	0	0	3	1	22	27	11	1937	3.30%
Hamaspik MAP	29	0	0	0	1	3	17	5	3	665	4.36%
Healthfirst CompleteCare	163	0	0	0	3	12	42	74	32	24026	0.68%
HomeFirst, Inc. (Elderplan)	15	0	0	0	14	0	0	1	0	17498	0.47%
Icircle	1	1	0	0	0	0	0	0	0	3475	0.03%

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

Managed Long Term Care Partial Capitation Plan Enrollment April 2022 to March 2023												
	Apr-22	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5463	5446	5402	5399	5398	5421	5459	5514	5550	5585	5597	5620
AgeWell New York	13093	13198	13188	13246	13027	12725	52	14	0	0	0	0
ArchCare Community Life	4795	4876	4917	4943	4974	5049	5142	5285	5381	5435	5499	5562
Centers Plan for Healthy Living	46826	47298	47669	47750	47725	47794	47775	48144	48662	49023	49090	49581
Elant	903	909	911	912	909	890	873	862	865	866	845	846
Elderplan	14082	14319	14664	14797	15084	15504	15885	16236	16781	17169	17457	17867
Elderserve	15263	15274	15325	15401	15417	15536	15608	15789	15950	15978	16041	16104
Elderwood	1011	1026	1029	1038	1048	1062	1064	1081	1093	1082	1076	1079
Extended MLTC	5437	5425	5437	5483	5491	5514	5526	5607	5657	5660	5650	5688
Fallon Health Weinberg (TAIP)	851	852	849	849	847	851	829	834	834	836	831	835
Fidelis Care at Home	18186	18068	17991	17935	17710	17548	17278	17124	17239	17329	17070	16998
Hamaspik Choice	1985	1967	1984	1962	1960	1940	1954	1943	1953	1940	1938	1932
HealthPlus- Amerigroup	4771	4727	4726	4734	4684	4641	5426	6795	50128	50655	50970	51189
iCircle Services	3501	3518	3527	3554	3565	3547	3527	3519	3497	3497	3461	3466
Integra	41775	42219	42838	43228	43657	44287	43954	43043	0	0	0	0
Kalos Health- Erie Niagara	551	555	551	553	550	536	523	539	543	543	551	565
MetroPlus MLTC	1330	1328	1309	1305	1306	1300	1325	1321	1331	1338	1344	1348
Montefiore HMO	1429	1416	1424	1413	1402	1398	1383	1370	1370	1361	1340	1338
Prime Health Choice	545	553	545	549	544	553	560	568	574	573	572	580
Senior Health Partners	9564	9400	9344	9244	9145	9176	9190	9211	9263	9263	9199	9212
Senior Network Health	345	341	343	340	339	339	333	330	331	327	313	315
Senior Whole Health	13575	13781	13982	13951	13912	13929	24107	24146	26110	26065	25961	26093
Village Care	14010	14267	14499	14663	14765	15114	15533	15988	16450	16676	16763	16888
VNA HomeCare Options	3411	3455	3518	3524	3490	3537	3575	3621	3683	3728	3768	3732
VNS Choice	21783	21917	21970	22142	22291	22481	22672	23017	23312	23382	23363	23369
Total	**244,485**	**246,135**	**247,942**	**248,915**	**249,240**	**250,672**	**249,553**	**251,901**	**256,557**	**258,311**	**258,699**	**260,207**

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

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

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