NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

Project Number #11-W-00114/2

Section 1115 First Quarter Report

New York State Department of Health Office of Health Insurance Programs

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Demonstration Year: 26 (4/1/2024-3/31/2025)
Federal Fiscal Quarter: 1 (10/1/2024-12/31/2024)

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.
- 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, 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 Special Terms and Conditions. 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.

On January 9, 2024, CMS approved a three-year amendment to the 1115 demonstration through March 31, 2027. Approval of this demonstration amendment will allow the state to scale healthcare delivery system transformation, improve access to services, advance health outcomes, and generate Medicaid cost savings. This is being achieved through a series of investments in HRSN services, population health, and workforce capacity that augment each other and are tied to accountability measures. In addition, the amendment provides the state with Substance Use Disorder (SUD) demonstration authority.

On November 14, 2024, CMS approved New York's request to provide continuous eligibility to all children (including children in the state's separate Children's Health Insurance Program (CHIP)) up to age six, from birth through the end of the month in which their sixth birthday falls.

New York is well positioned to lead the nation in Medicaid reform. Significant federal savings have already been realized through New York´s MRT process and substantial savings will also accrue as part of the 1115 waiver.

II. Enrollment: First Quarter

MRT Waiver- Enrollment as of December 2024

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 – Temporary Assistance for Needy Families (TANF) Child 1 – 20 years in Mandatory Counties as of 10/1/06	346,530	4,566	16,672
Population 2 – TANF Adults 21-64 years in Mandatory Counties as of 10/1/06]	67,717	1,685	1,786
Population 3 – TANF Child 1 – 20 (‘new’ MC Enrollment)	2,895	36	256
Population 4 – TANF Adults 21 – 64 (‘new’ MC Enrollment)	31,082	581	992
Population 5 – Safety Net Adults	229,296	9,253	20,328
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)	158,732	1,896	84
Population 9 – Disabled Adults and Children 0 – 64 (‘new’ MC enrollment)	52,268	5,786	325
Population 10 – Aged or Disabled Elderly (‘old’ voluntary MC Enrollment)	74,960	932	26
Population 11 – Aged or Disabled Elderly (‘new’ MC enrollment)	9,092	7,776	331

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**32,511 or an approximate 17.33% decrease from last quarter**

Reasons for voluntary disenrollment:

Voluntary disenrollments have decreased by 17.33%. The decrease can be attributed to the higher volume of members that were disenrolled last quarter by Local Departments of Social Services (LDSS) due to the Public Health Emergency (PHE) Unwind resuming disenrollments of members with Medicare.

Involuntary Disenrollment	
Total # Involuntary Disenrollment's in Current Demonstration Year	**40,800 or an approximate 10.97% increase from last quarter**

Reasons for involuntary disenrollment:

Involuntary disenrollments have increased by 10.97%. The increase is primarily due to the "Eligibility Ended" cases which represent a loss of eligibility due to such factors as a failure to recertify and not specifically due to any type of case closure.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
October 2024				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**654,830**	**20,210**	**3,778**	**16,432**
Rest of State	**232,204**	**11,090**	**1,170**	**9,920**
Statewide	**887,034**	**31,300**	**4,948**	**26,352**
November 2024				
New York City	**657,046**	**22,027**	**4,176**	**17,851**
Rest of State	**248,142**	**10,582**	**1,195**	**9,387**
Statewide	**905,188**	**32,609**	**5,371**	**27,238**

December 2024				
New York City	659,513	25,634	5,476	20,158
Rest of State	249,955	12,776	1,607	11,169
Statewide	909,468	38,410	7,083	31,327

First Quarter	
Region	Total Affirmative Choices
New York City	54,441
Rest of State	30,476
Statewide	84,917

HIV SNP Plans				
October 2024				
Region	Roster Enrollment	New Enrollment	Auto Assigned	Affirmative Choices
New York City	13,750	310	0	310
Rest of State	37	2	0	2
Statewide	13,787	312	0	312
November 2024				
New York City	13,846	340	0	340
Rest of State	37	2	0	2
Statewide	13,883	342	0	342
December 2024				
New York City	13,847	285	1	284
Rest of State	42	5	0	5
Statewide	13,889	290	1	289

First Quarter	
Region	**Total Affirmative Choices**
New York City	**934**
Rest of State	**9**
Statewide	**943**

Health and Recovery Plans Disenrollment			
Federal Fiscal Year (FFY) 2025 – Quarter 1			
	Voluntary	**Involuntary**	**Total**
October 2024	**585**	**1,262**	**1,847**
November 2024	**510**	**1,351**	**1,861**
December 2024	**538**	**1,439**	**1,977**
Total:	**1,633**	**4,052**	**5,685**

Reasons for disenrollment:

Voluntary HARP disenrollments have decreased by .37%. The primary reason for the increase was “Clients enrolling in other plans.”

Involuntary HARP disenrollments increased by 7.82%. This was primarily due to an increase in the “Eligibility Ended” cases which represent a loss of eligibility due to such factors as a failure to recertify and not specifically due to any type of case closure. Another factor was “No PCP Coverage or Eligibility Expired.”

III. Outreach/Innovative Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (10/1/2024 – 12/31/2024) Q1 FFY 2025

At of the end of the first federal fiscal quarter (end of December 2024), there were 2,569,379 New York City Medicaid consumers enrolled in the MMMC program, and 74,364 New York City Medicaid consumers enrolled in a 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 4,732 clients were educated about enrollment options and made an enrollment choice, including 657 clients in person and 4,075 clients through phone outreach.

The Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that the approved presentation script is followed and required topics are explained. Deficiencies are reported to MAXIMUS Field Operation monthly. During the reporting period, 122 Enrollment Counseling sessions were evaluated which generated 7 applications for a total of 14 enrollments.

CMU Monitoring of Field Presentation Report – 1st Quarter 2025	
Enrollment Counseling – One on One	**General Information**
122	115

Of the seven enrollments completed during informational sessions, seven (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 AA. A total of 36,664 FFS community clients were reported on the regular AA list; 10,480 clients responded to the call that generated 4,910 enrollments. Of the total of 24 FFS NH clients reported on NH AA, 1 (4%) client and/or authorized representative(s) made a plan selection.

Of the 36,664 clients on the regular AA list, CMU monitored a total of 2,965 outreach calls conducted by FCSRs in HRA facilities; 1,018 clients responded to these calls. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)			No Response
Regular FFS	**Nursing Home FFS**	**Total**	**Regular FFS**	**Nursing Home FFS**	**Total**	**Regular FFS**
434	0	434	584	0	584	1,947

- Phone Enrollment Applications: **434 (43%)** Regular FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 664 enrollments.

    - 662 (100%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in the plan they selected in a timely manner.
- Undecided: **584 (57%)** 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 October- December 2024

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 47,786 calls were received by the Helpline and 46,071, or 96%, were answered. Calls answered were handled in the following languages: **English**: 27,424 (59%); **Spanish:** 6,789 (15%); **Chinese:** 1,417 (3%); **Russian:** 830 (2%); **Creole:** 201 (1%); **and other:** 9,410 (20%).

MAXIMUS records 100% of the calls received by the NYMC Helpline. CMU listened to 4,724 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – First Quarter 2025								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
2,588 (55%)	407 (8%)	201 (4%)	1,500 (32%)	19 (1%)	0 (0%)	9 (0%)	0 (0%)	4,724

A total of 1,492 (31%) recorded calls observed were unsatisfactory. 653 calls had a single infraction, and 839 calls had multiple infractions. A total of 3,728 infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: **2,561 (69%)** - 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: **150 (4%)** - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and referrals for specialists.
- Customer Service: **1,017 (27%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 3,728 corrective action plans (CAP) were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

During the first quarter of FFY 2025, there were no new plans, plan expansions, or withdrawals.

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

On January 26, 2024, NYS submitted to CMS the March 1, 2024, Model Contract. On February 7, 2024, this Model Contract was issued to 14 managed care organizations (MCOs) for signature. At the close of the third quarter of FFY 2023 – 2024, all 14 contracts were executed by NYS and submitted to CMS for final approval.

C. Health Plans/Changes to Certificates of Authority

During the first quarter of FFY 2025, the Certificate of Authority for United Healthcare of New York, Inc. was updated to accurately reflect the counties in NYS whereby the plan is currently certified to provide Integrated Benefits for Dually Eligible Enrollees (IB-Dual) benefits to eligible enrollees.

D. CMS Certifications Processed

Not applicable during this time frame.

E. Surveillance Activities

Surveillance activity completed during the first quarter FFY 2025 (October 1 – December 31, 2024) include the following:

One Targeted Operational Survey was completed during the first quarter of FFY 2025. One Statement of Deficiencies (SOD) was issued, and one Plan of Correction (POC) was accepted:

- Health Insurance Plan of Greater NY, Inc. (HIP Emblem) (Acceptable Plan of Correction (APOC) 10/3/2024)

One Provider Access and Availability Survey was completed during first quarter of FFY 2025. One SOD was issued and one POC was accepted:

- MVP Health Plan, Inc. (APOC 10/8/2024)

One Provider Directory Survey was completed during first quarter of FFY 2025. One SOD was issued and one POC was accepted:

- MVP Health Plan, Inc. (APOC 10/8/2024)

V. Waiver Deliverable

A. Medicaid Eligibility Quality Control (MEQC) Reviews

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

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

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

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

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

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

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

B. Benefit Changes/Other Program Changes

Transition of BH Services into Managed Care and Development of HARPs:

In October 2015 NYS began transitioning the full Medicaid BH system to managed care. The goal is to create a fully integrated BH [mental health (MH) and SUD] and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered BH services in MMC, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of HARPs. HARPs are specialized plans that include staff with enhanced BH expertise. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called BH HCBS. For MMC, all Medicaid-funded BH services for adults, except for services in Community Residences, are part of the benefit package.

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

Effective April 1, 2023, the Medicaid pharmacy benefit was carved out of MMC to Medicaid FFS. Medicaid members enrolled in Mainstream 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 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.

Effective November 1, 2023, NYS will implement Evidence Based Practices (EBPs), pending State Plan Amendment (SPA) approval from CMS. The State will authorize a selected number of qualified Children and Family Treatment and Supports (CFTSS) providers to receive EBP training and bill for new EBP rates. NYS is committed to the promotion and support of EBPs, specific research supported psychotherapeutic interventions with demonstrated outcomes, within CFTSS.

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

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

NYS MH & SUD authorization requests and denials for Inpatient (7/1/2024-9/30/2024)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	23,156	78	63	0.27%
Rest of State	4,926	17	17	0.35%
Totals	28,082	95	80	0.28%

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

NYS MH & SUD authorization requests and denials for Outpatient (7/1/2024-9/30/2024)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	4,863	220	83	1.71%
Rest of State	178	3	3	1.69%
Totals	5,041	223	86	1.71%

3. **Monthly Claims Report:** Monthly, MCOs are required to submit the following for all OMH and Office of Addiction Services and Supports (OASAS) licensed and certified services.

MH & SUD Claims (10/1/2024-12/31/2024)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	802,747	90.89%	9.11%
Rest of State	984,386	90.84%	9.16%
Totals	1,787,133	90.86%	9.14%

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

Behavioral Health Adults CORE/HCBS Claims/Encounters (10/1/2024-12/31/2024): NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
Community Psychiatric Support and Treatment (CPST)	550	90
Education Support Services	11	5
Family Support and Trainings	335	30
Intensive Supported Employment	7	1
Ongoing Supported Employment	11	2
Peer Support	2,945	540
Pre-vocational	17	3
Provider Travel Supplements	251	99
Psychosocial Rehab	5,556	584
Residential Supports Services	100	8
Transitional Employment	0	0
TOTAL	9,783	1,035

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

Behavioral Health Adults CORE/HCBS Claims/Encounters (10/1/2024-12/31/2024): Rest of State

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	2,024	364
Education Support Services	28	13
Family Support and Trainings	379	32
Intensive Supported Employment	27	7
Ongoing Supported Employment	1	1
Peer Support	4,787	923
Pre-vocational	0	0
Provider Travel Supplements	5,707	1,117
Psychosocial Rehab	5,870	1,097
Residential Supports Services	316	48
Transitional Employment	0	0
TOTAL	19,139	2,126

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 updates.

Quarter 1 MCTAC Attendance & Statistics (10/1/2024-12/31/2024)

Events: MCTAC successfully executed **17** events from 10/1/2024 to 12/31/2024. All 17 events were held via webinar.

Individual Participation/Attendance/Viewing of Resource[3] *(this includes all the individuals that attended the MCTAC offerings or viewed a resource online):*

4,775 people attended/participated in MCTAC events/viewed resources of which **2,582** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 60.83% (323 of 531 total employees)

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: **50.12%** (217 of 433 total employees)

Efforts to Improve Access to Behavioral Health HCBS

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.

[3] As of May 2023, MCTAC included pre-recorded offerings in the total count of events.

- 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 Severe Mental Illness (SMI) population.
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both Health Homes and Recovery Coordination Agencies (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 SDEs through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDEs to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted RCAs 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 emergency rooms, clinics, shelters, Comprehensive Psychiatric Emergency Programs (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 emergency room and inpatient settings.
    - Psychiatric Services and Clinical Knowledge Enhancement System (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, Care Management Agencies (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.

There are ongoing opportunities for care managers in NYS to complete required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between October 1, 2024, and December 30, 2024, 287 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 (ARPA), NYS revised the September 2020 proposal to comply with eFMAP requirements and resubmitted to CMS in July 2021. CMS approved NYS' 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.

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 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 Alliance for Rights and Recovery (formerly NYAPRS), a CORE Peer Navigator Project was launched. This project is funded through the Mental Health Block Grant, and focuses on outreach, education, and service navigation to support access to CORE and BH HCBS. In August 2024, the project was approved for a no cost contract extension through February 28, 2025.

As of January 1, 2023, HARP-eligible Medicaid Advantage Plus (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. In August 2023, NYS held its first CORE Summit, a one-day training and networking event for CORE providers and MCOs. A second CORE Summit was held in August 2024. OMH and OASAS continue to provide education via trainings, conference presentations, and regional provider forums based on stakeholder feedback. In April 2024, updates were published to the CORE Services Benefit and Billing Guidance and to the CORE Service Initiation Notification Template to bring information current and to add clarifications in response to stakeholder feedback. From September through December 2024, OMH and OASAS hosted 14 regional networking events for CORE providers. In attendance were over 430 people, including regional coordinators from MCOs, care managers, and other local service providers to promote collaboration and referral connections. CORE provider feedback from the events was positive, and the events were successful in helping CORE providers make new community connections to receive referrals.

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 BH rehabilitation services through working collaboratively with Health Homes.

From September 2023 to August 2024, 5,971 unique recipients received CORE Services. Specifically, the count of monthly recipients for the four transitioned services from Adult BH HCBS to CORE Services increased by 44.3% from 1,936 (January 2022, the month before HCBS/CORE transition) to 2,793 (August 2024).

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

contracted activities currently underway. OMH and OASAS worked 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.
- The program concluded on July 31, 2024. As of December 31, 2024, all contracts have concluded. NYS is in process of obtaining final reports and metrics from HARPs.
- Approximately $30 million in initial contract base awards and subsequent milestone payments were distributed to providers.[4]
- 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.
- In July 2024, NYS distributed a compiled list of "best practices," informed by HARPs and providers as they jointly developed innovative solutions to engage HARP members, expedite the BH HCBS and CORE Services workflow, and address barriers to receiving BH HCBS and CORE Services.

Transition of School-based Health Center (SBHC) Services from Medicaid FFS to MMC:

Activities within NYS DOH continue to prepare for SBHC services to be included in the MMC benefit package effective April 1, 2025. The guidance document, billing guidance, frequently asked questions (FAQs), and member materials have all been updated. DOH staff continue to meet every two weeks to assist with continued planning for the April 1, 2025, transition of this benefit into the MMC benefit package.

C. Managed Long-Term Care (MLTC) Program

MLTC plans include Partial Capitation, Program of All-Inclusive Care for the Elderly (PACE), MAP, and Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA IDD) plans. As of January 1, 2025, there are 14 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of January 1, 2025, there are a total of 375,588 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the October 2024 through December 2024 quarter, NYS DOH facilitated a Partial Capitation plan's acquisition of another Partial Capitation plan, which included a Service Area Expansion for the acquiring Partial Capitation plan.

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 may maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the October 2024 through December 2024 quarter, post enrollment surveys were

[4] Q1 2025 award amounts are not yet available and will be submitted with the next quarterly update.

completed for 15 enrollees. Of the 12 surveyed, 10 (83%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is the same as the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation plans increased from 301,679 to 310,527 during the October 2024 through December 2024 quarter, a 3% increase from the last quarter. For this period, 16,317 individuals who were being transitioned into MLTC made an affirmative choice, a 3% decrease from the previous quarter and brings the 12-month total for affirmative choice to 67,548.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the January 2024 through December 2024 annual period is submitted as an attachment.

2. Significant Program Developments

During the October 2024 through December 2024 quarter:

- The First Quarter member Services survey was conducted on 16 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, DOH provided recommendations on areas of improvement.
- Round 2 Operational Surveys were initiated for two Partial Capitation plans in prior reporting periods, and activities this quarter are as follows:
- For one Partial Capitation plan, the Corrective Action Plan (CAP) has been received and is under review.
- For one Partial Capitation plan: The CAP has been accepted.
- Round 3 Operational Surveys were initiated for two plans on both their Partial Capitation and MAP lines of business in the prior reporting period. Initial survey documentation has been received and the Desk Review is in progress.
- One Focused Survey was initiated for all MAP Plans based on an analysis of their 2023 Q1 PNDS Submissions in a prior reporting period. Statement of Deficiencies (SODs) were issued to nine plans. Of the nine plans, two plans were required to submit CAPs. Both CAPs have been reviewed and accepted.
- Two Focused Surveys were initiated on one plan's Partial Capitation and PACE lines of business resulting in two SODs based the identification of expired Master Service Agreement (MSA) in a prior reporting period. CAPs were received and are still being reviewed.
- One Focused Survey was initiated on one MAP line of business resulting in a SOD based on the identification of an expired MSA Agreement in a prior reporting period. The CAP has been reviewed and accepted.
- One Focused Survey was initiated on one plan based on their non-compliance with annual Social Adult Day Care site evaluation requirements. SODs were issued for the plan's Partial Capitation and MAP lines of business in a prior reporting period. The CAPs were received and are under review.

- One Focused Survey was initiated on one Partial Capitation plan based on the incomplete and improper completion of person-centered service plans (PCSPs). A SOD was issued, and the CAP was reviewed and approved.
- One Focused Survey was initiated on one PACE plan based on their failure to develop an acceptable quality assurance program, and failure to meet required timeliness deadlines. A SOD was drafted and is under review.
- N.Y. Public Health Law § 4403-f. (l l-b) Post Transaction Reporting:
    - A Partial Capitation Merger Post Transaction Review was initiated in a prior reporting period and has been reviewed, approved, and posted to the NYS DOH website.

As a matter of routine course:

- The processes for Operational Surveys have been streamlined to include both the Partial Capitation and MAP lines of business simultaneously.
- The Surveillance tools continue to be updated to reflect any necessary process changes.
- New/promoted staff members continue to be trained on the Surveillance processes and interviews are being held to fill vacant positions.

3. Issues and Problems

There were no issues or problems to report for the October 2024 through December 2024 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 enacted 2024-25 NYS Budget included legislation to procure a single statewide fiscal intermediary. The procurement was issued in June 2024 and a vendor, Public Partnerships LLC (PPL) was awarded the contract on September 30, 2024. The contract with PPL will begin January 1, 2025, and NYS DOH and PPL will engage in a transition process that will end on April 1, 2025, when PPL becomes the only statewide fiscal intermediary. PPL is in the process of negotiating administrative service agreements with all managed care plans.

5. Required Quarterly Reporting

Critical incidents: There were 3,551 critical incidents reported for the October 2024 through December 2024 quarter, an increase of 7% from the previous quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. Critical incidents by plan for this quarter are attached.

Complaints and Appeals: For the October 2024 through December 2024 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with other covered services, Dissatisfaction with quality of home care (other than lateness or absences), Dissatisfaction with member services and plan operations, Dissatisfaction with Care Management, and Dissatisfaction with Transportation.

Period: 10/1/2024–12/31/2024 (Percentages rounded to nearest whole number)			
Number of Recipients: 370,055	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**8**	**8**	**100%**
# Same Day	**2,001**	**2,001**	**100%**
# Standard/Expedited	**5,145**	**3,969**	**77%**
Total for this period:	**7,154**	**5,978**	**84%**

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

Appeals	1/2024-3/2024	4/2024-6/2024	7/2024-9/2024	10/2024-12/2024	Average for Four Quarters
Average Enrollment	339,930	348,752	359,307	370,055	354,511
Total Appeals	10,918	11,347	11,994	12,711	11,743
Appeals per 1,000	32	33	33	34	33
# Decided in favor of Enrollee	1,150	1,291	1,487	1,228	1,289
# Decided against Enrollee	7,407	8,572	9,101	9,978	8,765
# Not decided fully in favor of Enrollee	2,004	1,209	1,083	1,186	1,371
# Withdrawn by Enrollee	357	275	323	319	319
# Still pending	1,200	1,232	1,331	822	1,146
Average number of days from receipt to decision	10	8	8	9	9

Complaints and Appeals per 1,000 Enrollees by Product Type October 2024 – December 2024					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	307,032	4,132	13	9,469	31
Medicaid Advantage Plus (MAP) Total	53,117	1,936	36	3,174	60
PACE Total	9,906	1,086	110	68	7
Total for All Products:	**370,055**	**7,154**	**19**	**12,711**	**34**

Total complaints decreased 12% from 8,131 the previous quarter to 7,154 during the October 2024 through December 2024 quarter.

Total appeals increased 6% from 11,994 during the last quarter to 12,711 during the October 2024 through December 2024 quarter.

Technical Assistance Center (TAC) Activity

During the October 2024 through December 2024 quarter, TAC opened 710 cases and closed 727 cases. This is less than the 922 opened cases, and the 915 cases closed from the previous quarter. This quarter's change in cases is equally spread across the different types of case dispositions, outlined in the table below.

72% of Q1 TAC cases were closed in the same month in which they were opened. This is a slight decrease from last quarter's 73%.

Call Volume	**10/1/2024 – 12/31/2024**
Substantiated Complaints	84
Substantiated Complaints with CAP	0
Unsubstantiated Complaints	263
Resolved Without Investigation	15
Inquiries	365
Total Cases Closed	727

The five most common types of calls were related to:

Call Type	**10/1/2024 – 12/31/2024**
General	21%
Aide Service	18%
Enrollment	15%
Coverage Concerns	11%
Grievance	10%

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

Evaluations for enrollment: The New York Independent Assessor Program (NYIAP) 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 the October 2024 through December 2024 quarter, 8,316 people were evaluated, deemed eligible and enrolled into plans, a decrease of 7% from the previous quarter.

Rebalancing Efforts	10/2024-12/2024
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	413
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,627

As of December 31, 2024, there were 3,291 current plan enrollees who were in nursing homes as permanent placements, a 3% decrease from the previous quarter.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with HCBS needs, including medically fragile children, children with 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. Additionally, two new Children's Waiver Amendments were approved by CMS on November 1, 2023, and March 1, 2024, to amend a number of activities detailed in the sections below.

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-SSI Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs.
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115.
- Authority 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.
- Engaged 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.
- Submitted the Preliminary Interim Evaluation Report to CMS, as drafted by the vendor.
- Submitted 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 (EVV).
- Updating manuals, guidance documents, forms 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.
- Responded to the COVID-19 pandemic and implemented emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and supported the recovery of impacted providers and consumers.
- Assisted with a strategic plan for the unwind of the COVID-19 PHE.
- Released a PHE Unwind plan for flexibilities related to the Medicaid Children's Waiver and Health Home Services.
- Working with Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process.
- Working with HCBS providers and MMC plans to streamline the authorization process.
- Engaged 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.
- Modified the state-wide capacity tracking system, which is based on provider self-reporting, to enhance the understanding of the HCBS waitlist and who is being served by HCBS. An electronic referral and authorization portal was launched, which will provide more accurate information that is not dependent upon self-reports of providers.

- Engaged with providers, consumers, and NYS agency partners to determine how best to use the eFMAP authorized by ARPA to improve access to children's services and reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure.
- Collected 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.
- Organized and conducted workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral and authorization process.
- Engaged with Health Homes, MCOs, and HCBS providers while redesigning the Plan of Care in preparation for digitization.
- Updated public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process.
- Submitted the 1915c Children's Waiver Extension to CMS.
- Submitted the 1915c Children's Waiver Renewal to CMS.
- Submitted a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitted a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure.
- Worked with MCOs and providers to disseminate ARPA funding through the directed payment process.
- Scheduled and facilitated regional meetings with HCBS providers, Health Homes, care management agencies, Medicaid MCOs to resume in-person collaboration and dialogue.
- Updated the Incident Reporting and Management System (IRAMS) and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- Engaged 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.
- Submitted an additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental Modifications (EMod), Vehicle Modifications (VMod) & Adaptive and Assistive Technology (AATs).
- Conducted Final Rule compliance reviews with newly designated HCBS providers.
- Monitored staff compliance with training and background check requirements through IRAMS.
- Updated and issued the Children's Care Management Authorization and Referral Forms ensuring inclusivity of all requirements per stakeholder feedback.

- Updated IRAMS User Guide used by HH, CMA, HCBS Providers, and C-YES to report critical incidents and complaints/grievances as appropriate for the various populations served to ensure the health, safety, and well-being of members.
- Updated and posted the HCBS Referral and Authorization Portal User Guide and FAQ.
- Hosted webinars providing training and technical assistance on use of the Referral and Authorization Portal.
- Updated and posted documentation and guidance related to HCBS eligibility and enrollment.
- Hosted an HCBS Collaborative Stakeholder meeting to share reminders and information on Waiver requirements with HCBS providers, HH, and MMCPs.

Additionally, the NYS DOH has been implementing and altering activities and services, including, but not limited to, the following:

- Submitted Disaster SPA 21-0054, for Health Home one-time assessment fee per member retroactive April 1, 2021, to September 30, 2022.
- Submitted a SPA 22-0088, which would continue the assessment fee effective October 1, 2022.
- Updated documentation and provided 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”).
- Updated documentation and provided 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 allowed for a broader array of providers to deliver the service and broadens the definition of caregivers eligible for training to include all individuals who supervise and care for members.
- Broadened 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.
- Reduced the required years of experience for Palliative Care: Expressive Therapists from three years to one year.
- Added a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity.
- Added a 5.4% COLA increase for providers starting April 1, 2022.
- NYS supported the continued 25% enhanced HCBS rates on October 1, 2022.
- Added a 4% COLA increase for providers effective November 1, 2023.
- Effective December 1, 2023, rural rates for seven counties were implemented to improve access to services.
- Transitioned the EMod, VMod, and AAT to a Financial Management Service, starting March 1, 2024, based upon approval for Children’s Waiver amendment.
- Implemented a 2.84.% COLA increase for Children’s HCBS effective April 1, 2024.

- Effective October 1, 2024, MMCP capitation payments were adjusted to include risk-based premium adjustments for Children's Waiver HCBS.
- Developed Electronic Children's Services Staff Compliance Tracker.
- Released the Electronic Children's HCBS Referral and Authorization Portal, which streamlines, standardizes, and ensures timely completion of HCBS referrals and authorizations.
- Launched a FFS authorization process for HCBS. Issued an FFS authorization policy and hosted an FFS authorization webinar.

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

The following table demonstrates 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 tracked 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.

This table includes Quarter 1 data from 10/1/2024 – 12/31/2024 of FFY 2025:

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children with HCBS Claims**	**Enrolled Children**	**Enrolled Children with HCBS Claims**
10/1/2024	9,407	5,106	1,446	324
11/1/2024	8,996	4,763	1,420	289
12/1/2024	8,958	3,051	1,408	235
Quarter 1 Unique	**9,784**	**5,626**	**1,476**	**386**

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

E. 2024 1115 Waiver Amendment

The 2024 1115 amendment was approved by CMS on January 9, 2024, and will remain in effect throughout the remainder of the demonstration period. The State seeks to scale healthcare delivery system transformation, improve access to services, advance health outcomes, and generate Medicaid cost savings. This is being achieved through a series of investments in health-related social need (HRSN) services, population health, and workforce capacity that augment each other and are tied to accountability measures.

1. Social Care Networks and HRSN Services

NYS aims to integrate physical, behavioral, and social care for Medicaid members in the state through regional Social Care Networks (SCNs) that provide screening, navigation, and delivery of HRSN services to high-risk and/or high cost Medicaid members, including those with severe chronic conditions. The nine lead entities are creating regional networks of contracted HRSN service providers, healthcare providers, and behavioral health providers with shared and/or interoperable technology platforms. SCNs are screening Medicaid members for unmet needs, providing navigation to existing programs or to enhanced HRSN services through SCNs, and facilitating payment for HRSN services. Enhanced HRSN services are available to a targeted subset of the MMC population in domains of housing, nutrition, and transportation.

The role of SCNs is to demonstrate sustainable impact for the Medicaid program within and beyond the demonstration period, as measured in access to services, health outcomes and Medicaid savings. NYS DOH aims to ensure that each Medicaid member will receive an HRSN screening annually and following a major life event, if applicable. Members are being screened using the Accountable Health Communities (AHC) HRSN screening tool. Each SCN has embedded the screening tool in its IT Platform and there are a range of modalities for conducting screening by Social Care Navigators, community-based organizations, providers, and others.

In Q1, NYS DOH focused on enabling SCN program launch. Accomplishments included:

- **Enabling readiness of SCNs to deliver services efficiently** through active performance measurement and improvement and providing strategic, technical, and operational guidance.
- **Completing program design and developing actionable guidance and tools** (e.g., Operations Manual) **for SCNs to stand up operations and activate service delivery** on 1/1/25.
- **Achieving** multi-sector data/IT system integration across SCNs, providers, the State, and other stakeholders with Statewide Health Information Network of New York (SHIN-NY) as the statewide, cross-sector backbone for data sharing.
- Engaging with stakeholders to support **timely** issue resolution as the program was stood up including SCN Lead Entities, MCOs, health care providers, behavioral health providers, non-profits, and other key stakeholders.

Q1 HRSN Implementation Activities:

To prepare for program launch in January 2025, the State engaged in the following program implementation activities in Q1, leading up to program start.

SCN Lead Entity Operational Readiness

- **Turned conceptual program design into operational workflows**
  - Designed and standardized dozens of technology-driven workflows for member-facing navigators to get members access in a seamless, personalized way.
  - Created simple and standardized ways for providers to give clinical input so members receive appropriate services based on their health condition(s).
- **Enabled SCN Lead Entities to quickly ramp up member-facing operations**

    - Set high bar for performance upon program launch including assessing each SCN against a launch readiness checklist (e.g., progress in building IT platforms).
    - Managed technical and operational issue resolution across nine SCNs, four external vendors, the statewide HIE, and broad range of internal stakeholders.
- **Set up claiming/billing structure for Medicaid managed care and FFS**

Additional Stakeholder Engagement and Transparency

- **Engaged MCOs as key partners in the SCN program**
    - Oversaw completion of all MCO/SCN contracts to ensure timely access to services
    - Engaged with MCOs on issues critical to their participation and offered strategic, technical, and operational guidance.
    - 100+ MCO and SCN contracts were executed prior to program launch.
- **Engaged and provided transparency for physical, behavioral, and other providers**
    - Provided transparency on program objectives and how to get involved for thousands of providers through webinars (>1,000 organizations attended), one-on-one stakeholder meetings, and website content.
    - Produced a provider-facing marketing toolkit (factsheets, introductory guide, video content, social media) for SCN Lead Entities to use in engaging providers.
- **Engaged and provided transparency to HRSN service providers - including CBOs**
    - Provided transparency on program objectives and how to get involved for thousands of community organizations through webinars (>1,000 organizations attended), 1-1 stakeholder meetings, and website content
    - Delivered presentations to representative groups at conferences and convenings (e.g., Food as Medicine coalition).
    - Produced factsheets, video, and social media content tailored to community organizations to engage consumers in their regions.
- **Supported technology sector to build statewide, multi-sector data and IT infrastructure to integrate health and social care**
    - Conducted demo and issue resolution sessions with four IT platform vendors (Unite Us, FindHelp, Channels 360, Together Now).
    - Assessed technical readiness of each platform using a standardized set of measures across domains such as user functionality, fidelity to program design, and privacy and security.
- **Engaged State agency partners and local Departments of Social Services**
    - Clarified roles, responsibility, and funding eligibility.
    - Made connections with different providers and stakeholders through these entities to spread program awareness.

Data and Technology Development

- **Provided in-depth technical guidance to SCN Lead Entities and MCOs**
    - Published the Data and Systems Implementation Guide (DSIG) (and other ongoing technical resources) for SCN Lead Entities and MCOs including guidance on topics across member enrollment and population identification, HRSN billing, claims, and data management.

    - Convened biweekly cross-stakeholder workgroups, including through the New York eHealth Collaborative (NYeC), to support implementation of Fast Healthcare Interoperability Resources (FHIR) standards and claims/billing/systems across SCNs, MCOs, and IT platform vendors.
    - Facilitated the production and transmission of critical files for HRSN services, including, but not limited to Medicaid Eligibility Files (MEF) and Enhanced Services Member File (ESMF). These files integrate multiple clinical, social, enrollment, and other health plan data to enable personalized and appropriate service delivery.
- **Oversaw robust testing for data quality, privacy, and security for 7 million members**
    - Standardized exchange of data across nine SCN lead entities, four IT platform vendors, and provider ecosystem through SHIN-NY (Qualified Entities).
    - Facilitated data quality testing processes (social care data, ESMF and MEF data, transactions); these types of data can now flow for 7 million members.
    - Provided a "Tech by Design Help Desk Repository" to provide support for QEs.
- **Continued collaboration with other state agencies (especially on housing and nutrition supports) to streamline service delivery and prevent any duplication**
    - Developed and shared with SCNs a directory of existing NYS housing and nutrition programs / resources and encouraged SCNs to consider contracting entities into each regional Network, as appropriate, or include in SCN's directory when referring members to existing state and local resources.

Performance Measurement and Improvement

- Stood up performance measurement and improvement function to generate timely and actionable data (e.g., dashboard of SCN activity along the member journey) for continuous improvement.
- Facilitating ongoing performance dialogues with SCN Lead Entities based on early indicators of program performance (starting in January 2025).

2. **Workforce**

NYS is implementing two statewide workforce initiatives, the Career Pathways Training (CPT) Program and the Student Loan Repayment (SLR) program to support workforce recruitment and retention and increase supply of high-demand physical health, behavioral health, and social care providers.

Career Pathways Training (CPT) Program

To spur economic development and address workforce shortages, the CPT Program is funding education and training and providing job placement support, as well as connection to apprenticeship and mentorship, for health workers newly entering the workforce or advancing their careers. Participants in the CPT Program make a three-year commitment of service to providers who serve at least 30 percent Medicaid members and/or uninsured individuals. The program is organized to support two career pipelines, (1) New Careers in Health Care for individuals newly entering the health care workforce, and (2) Health Care Career Advancement

for individuals currently in the health care workforce. Professional titles eligible for this program span physical health, behavioral health, and social care in areas with the greatest shortages for NYS, including:

- **Nursing** – Licensed Practical Nurse, Associate Registered Nurse, Registered Nurse to B.S. in Nursing, Nurse Practitioner
- **Professional technical** – Certified Medical Assistant, Alcoholism and Substance Abuse Counselor, Master of Social Work, Licensed Mental Health Counselor, Certified Pharmacy Technician, Physician Assistant, Respiratory Therapist
- **Frontline public health** – Community Health Worker, Patient Care Manager

Three Workforce Investment Organizations (WIOs) are administering the CPT Program in three distinct regions of the State. In the past quarter, the WIOs have significantly ramped up implementation, including enrolling the program's first students in academic programs, rolling out multimedia recruitment campaigns to reach prospective students, educational facilities, and employers, and coordinating closely with the State's newly-launched Social Care Networks.

The WIOs are providing critical support for participants to ensure program completion, including case management, tutoring, and other academic support; coordinated educational programs; payments for books and academic fees; and backfill for current employees' time spent in training programs. They are also providing support in job placement and career supports to prepare for future service commitment obligations.

Q1 CPT Program Implementation Activities:

In Q1 2025, NYS DOH focused on finalizing detailed program guidance for the three WIOs and on providing technical support to each WIO as they work to implement the program and begin actively supporting students. This quarter saw the first students enroll in the fall academic semester and the launch of support services for participants. Activities included but were not limited to the following:

Detailed Program Design and Guidance

- Aligned on program design decisions including provider organizations eligible for placement, allowable expenditures, and other topics.
- Issued updated program guidance document to all WIOs to codify additional design decisions and expectations, including program eligibility, required support services, and reporting requirements.

WIO Engagement and Enablement

- Engaged WIOs in recurring one-on-one meetings to assess readiness and provide technical support for any questions or challenges encountered (e.g., connections to educational institutions, strategies for employee retention to ensure service commitment is met over time).
- Convened leaders across all three WIOs and encouraged sharing of implementation best practices.

- Finalized and distributed to WIOs a complete set of reporting templates (cost, narrative, and metrics templates) to be filled out regularly through duration of the demonstration.
- Received and analyzed Q1 reports from WIOs to review early program performance and provide feedback to WIOs.
- Worked on developing year two performance metrics and milestones for the WIOs, including statewide performance targets and milestones based on year one baseline data.

Communications and Broader Stakeholder Engagement

- Launched a CPT Program landing page on the NYS DOH website to provide prospective applicants and other stakeholders (e.g., potential employers) with additional information on the program.
- Held multiple information sessions with stakeholders including provider association partners and other key state agencies.

Recruitment and Enrollment

- The WIOs were focused heavily on outreach and recruitment throughout the quarter, working to engage partner academic institutions and providers across the health, behavioral health, and social care workforces. This included presenting at conferences, provider associations, and to each region's SCNs.
- WIOs also engaged in extensive participant recruitment efforts, launching their own websites, holding mass recruitment sessions in person and virtually, and responding to thousands of inquiries from interested participants.
- This quarter saw the program's first enrollment, with about 200 students enrolled in the fall semester, about 85% of whom were in nursing titles.

CPT Program Metrics and Reporting:

NYS DOH is committed to supporting and enabling the WIOs, which requires understanding their progress, strengths, and any needs that the State can help address. To ensure this, NYS DOH has put in place a robust reporting and accountability structure that includes quarterly cost reports, narrative reports, and metrics reports designed to allow the State to track individual WIO progress across all titles and identify key implementation issues for intervention.

Student Loan Repayment Program

The Student Loan Repayment Program is designed to fill gaps in key high-demand titles and improve retention rates at providers that service the Medicaid population to boost access to care. Participants who receive loan repayment will be expected to make a four-year commitment to maintain a personal practice panel or work at an organization that serves at least 30 percent Medicaid and/or uninsured individuals. Health care titles eligible for repayment include psychiatrists, with priority for child/adolescent psychiatrists; primary care physicians and dentists; and nurse practitioners and pediatric clinical nurse specialists.

Q1 SLR Program Implementation Activities:

In Q1, NYS DOH continued working to develop the policies and procedures that will serve as the framework for the SLR program. A key piece of this has involved setting up the administrative infrastructure necessary to process applications and payments to loan servicers, including loan validation and verification, and monitor the required service commitment. The State has conducted extensive research into existing student loan repayment programs operated by New York State agencies and other state Medicaid programs to identify best practices and to avoid implementation challenges faced by similar initiatives.

The State is currently working to develop programmatic guidance documents and application materials and criteria, finalize its approach to open policy and procedural questions, and build the administrative team that will manage application review payment processing. Currently, the State is planning for the first round of applications to open in Summer 2025.

3. NYS HERO

The NYS HERO is wholly dedicated to advancing population health and access to care in a data-driven way across NYS. The HERO is an independent statewide entity responsible for aggregation of health, behavioral health, and social care data to support the broader waiver demonstration aspirations of a more accessible and integrated delivery system. More specifically, the HERO is tasked with population health improvement activities; regional needs assessment and planning to identify health access related needs and gaps; advancing value-based payment (VBP) design and development to address health, behavioral health, and HRSNs; and program evaluation through an ongoing review of waiver programs to support continuous improvement in program design, implementation, and impact.

In Q1, the State continued to build out the HERO design, activities, and requirements. The HERO will play an integral role in bringing together stakeholders in each region of the State, which will require convening a diverse group of both clinical and non-clinical stakeholders to provide feedback on regional needs. This will include medical and behavioral health providers, managed care organizations, SCNs and their CBOs, consumers, and other relevant entities.

The HERO will also be serving a critical role in coordinating, aggregating, and analyzing HRSN data from the SCNs and additional workforce data from the WIOs to inform real-time learnings from waiver programs to improve implementation and access to services. The HERO will also be developing customized dashboards for regional stakeholders to assess progress on waiver priorities and goals.

Q1 saw the development of a comprehensive scope and work plan for building out the HERO's core functions in data aggregation, analysis, and stakeholder engagement, as well as building capacity for the HERO's longer-term plans to support advanced value-based payment design and development.

4. Medicaid Hospital Global Budget Initiative (MHGBI)

The goal of the MHGBI is to stabilize and transform targeted financially distressed hospitals to advance healthcare access and improve population health in the communities they serve. The MHGBI creates market-driven incentives to stabilize safety net hospitals that serve Medicaid patients and develop necessary capabilities to advance access; transition to global budget models; participate in advanced VBP arrangements; and deepen integration with primary care, behavioral health, and HRSN services. By providing fixed global budgets, MHGBI is intended to

support fiscal independence of health systems, including safety net providers, through financial sustainability and predictability.

On March 26, 2024, NYS submitted a Letter of Intent (LOI) expressing the desire to partner with CMS to design and implement the AHEAD model. This submission also included the LOI's from all hospitals eligible for MHGBI. On March 31, 2024, the State submitted a detailed plan for how participating hospitals will collect member demographic and HRSN data and related metrics. On August 12, 2024, NYS filed its application to participate in the AHEAD demonstration during the second Notice of Funding Opportunity (NOFO) period with Cohort 3. On October 28, 2024, CMS announced that NYS had been selected to participate in the AHEAD model with Cohort 3.

Participating hospitals will be required to submit data-backed assessment of operations, submit plans to narrow greatest disparities, participate in quality improvement activities, and create a roadmap outlining activities required to transition to a global budget.

NYS focused quarter 1 on pre-implementation activities for AHEAD such as designing the Medicaid Hospital Global Budget (HGB) methodology in alignment with the Medicare specifications, developing operational roadmaps for successful HGB implementation, and providing technical assistance to support hospitals in meeting 1115 Waiver requirements. Additional examples of this pre-implementation focus are below:

Q1 MHGBI Implementation Activities:

Medicaid HGB Model Design

- Developed version one of the Medicaid HGB methodology with perspectives across all HGB design components, based on input from subject matter experts, research on peer states, and outside-in claims analytics testing using Virtual Research Data Center (VRDC) data. This methodology will undergo further testing, refinement, and stakeholder engagement, and will inform future CMS submission.
- Began preparing for more detailed empirical testing of preliminary Medicaid HGB methodology using State Medicaid data sources.

Medicaid HGB Model Operations

- Defined key operational decisions to support model implementation (e.g., HGB payment calculation and adjudication, system updates, and contract updates (incl. authorities).
- Engaged stakeholders and hospitals to support participating hospitals in accessing technical assistance in 2025.
- Began developing operational roadmaps to prepare for Medicaid HGB implementation in 2027.
- Began engaging Centers for Medicaid and Children's Health Insurance Program Services (CMCS) regarding necessary federal and State payment authorities for implementation of HGB payments.

Hospital Technical Assistance

- Crafted an approach to hospital technical assistance, intended to support the 12 participating hospitals in completing 1115 Waiver deliverables and preparing for the transition to HGB via diagnostic and transformation support.
- Held discussions with CMMI to ensure alignment on the approach for 1115 Waiver deliverables for the LOI hospitals, due in March 2025.
- Created templates for hospitals to complete 1115 Waiver deliverables, including the fact-based assessment, roadmap, and health equity plan.
- Led hospital orientation sessions on the approach to 1115 Waiver deliverables.

F. Institutions for Mental Disease (IMD) Transformation Demonstration

State and national Medicaid redesign initiatives recognized the critical role of SUD services, including residential treatment services, within the full continuum of services required to meet the triple aim of improving the quality/experience of care, improving the health of populations, and reducing per capita costs of health care.

Historically, federal and NYS Medicaid funding authorities (e.g., SPA and 1115 waivers) did not provide coverage for residential treatment. As such, this level of treatment was not included in either the Medicaid FFS or MMC benefit package. Therefore, individuals were frequently served in higher levels of care than clinically appropriate (i.e., withdrawal management and inpatient treatment), and care coordination was fragmented between physical and BH services. Individuals experienced difficulty with transitioning from the hospital/inpatient setting to the residential level of care and often had re-admissions to higher levels of care.

To address this gap in the treatment continuum, The Federal Affordable Care Act (ACA)/Parity Legislation, the NYS 1115 MMC Waiver Program, and New York SPA's 16-0004, 21-0064, and NY-23-0003 were amended to support strengthening residential services within the full continuum of services. Collectively, these required OASAS Certified residential SUD programs and their treatment services to be covered by Medicaid and included within the required MMC benefit package. NYS received comprehensive federal approval for the residential redesign initiative via this amendment approval. The collective federal approvals support NYS' community-based residential levels of care that provide a safe environment for Medicaid recipients who are: beginning opioid treatment, experiencing mild to moderate withdrawal or significant urges or cravings that cannot be managed, or have mental health symptoms that are not stable. Residential redesign is a cornerstone to NYS' ability to respond to this need by strengthening community service access as alternatives to detoxification and providing recovery oriented, supportive residential step downs.

OASAS Certified Title 14 New York Codes, Rules and Regulations (NYCRR) Part 820 Residential Service Programs: Service Description:

- Part 820 programs are designed to help persons who lack a safe and supportive residential option in the community to achieve changes in their SUD behaviors within an appropriate setting. The Part 820 Residential Model has three elements of care:

- **Stabilization:** Requires the supervision of a physician and clinical monitoring to address mild to moderate withdrawal, severe cravings, psychiatric and medical symptoms, and emotional crisis. Individuals will receive medically directed care to stabilize acute medical, mental health, and addiction symptoms. For patients who seek services at the emergency department and who are not in need of a hospital-level detox, the stabilization element will offer an alternative and provide these patients a safe place to stabilize and engage in treatment.
- **Rehabilitation:** Staffing to provide monitoring, support, and case management. Designed for individuals with significant functional impairment related to social skills, employment, inability to follow social norms, and maintaining housing.
- **Reintegration:** In a congregate setting or scattered site setting, will provide opportunities to actualize skills learned in treatment in the community; linkages to community services/resources; and services for those transitioning to long term recovery and independent living. Staffing includes case managers, housing experts, employment supports, and recovery wellness.

- Medication for addiction treatment – the Part 820 Programs Regulations[5] require that individuals receive medically directed care to stabilize acute medical, mental health, and addiction symptoms. For patients who seek services at the emergency department and who are not in need of a hospital-level detox, the stabilization element will offer an alternative and provide these patients a safe place to stabilize and engage in treatment. To facilitate access to full opioid agonist medication for patients who are maintained on such medication at the time of admission or who choose to start such medication during admission, the program shall develop a formal agreement with at least one Opioid Treatment Program (OTP) certified by OASAS to facilitate patient access to full opioid agonist medication, if clinically appropriate.

Developing the Title 14 NYCRR Part 820 Provider Network:

- Effective 2015, OASAS began the process of re-designating all approved OASAS certified residential programs from Title 14 NYCRR Part 819 and Title 14 NYCRR Part 816.9 to Title 14 NYCRR Part 820 programs.
- Comprehensive Title 14 NYCRR Program regulations were enacted to define the Part 820 Program model and related operations requirements.
- Programs must complete and receive approval of the required application documents to obtain OASAS certification as Title 14 NYCRR Part 820 and complete the application for designation to provide each of the three elements (stabilization; rehabilitation; or reintegration). Programs may seek designation to offer any or all of the elements. Designation will be based upon a program's assessment of its current and future patient needs and overall program vision for the services it is best positioned to deliver to the community. Programs converting from the prior models are required to submit the Part 820 conversion application[6] and new programs must follow the certification process for new programs.[7]

[5] https://oasas.ny.gov/system/files/documents/2022/09/part820.pdf
[6] https://oasas.ny.gov/system/files/documents/2022/05/resredesignapp_0.pdf
[7] https://oasas.ny.gov/providers/program-certification

- During the demonstration timeframe OASAS provided Part 820 residential programs with technical assistance sessions and developed a comprehensive set of technical assistance tools, including readiness guidance documents, clinical manuals and fiscal modeling tools.[8] For the remainder of the demonstration year, OASAS will continue to work with the remaining providers to transition to the part 820 model.
- As of December 2024, statewide, there are a total of 164 Part 820 Programs. There are 44 remaining programs to convert from the previous residential or medically monitored model (aka Part 819).
- OASAS is targeting February 2026 for completing conversion of the current residential or medically monitored model (aka Part 819) to part 820 programs. In December 2024, communications were sent to the current residential or medically monitored model outlining this plan. OASAS is working with the part 819 providers to implement a successful conversion.

Managed Care Coverage of Title 14 NYCRR Part 820 Residential Service Programs

- Under the NYS 1115 MRT waiver, Title 14 NYCRR Part 820 services and programs were incorporated into the MMC benefit package and became a required network provider type.
- The current model contract[9] network requirements are:
  - Urban counties: The network must include two providers per county.
  - Rural counties: The network must include two providers per region.
- NYS monitors network adequacy of Part 820 as part of routine plan compliance reviews.

Quarter 1: 10/1/2024 to 12/31/2024		
Service	**Total Number of Programs**	**Total Number of Beds**
Stabilization	9	227
Rehabilitation	13	555
Reintegration	79	1,900
Stabilization and Rehabilitation	16	658
Rehab and Reintegration	16	424
Stabilization Rehab and Reintegration	31	1,902
Grand Total	**164**	**5,666**

[8] https://oasas.ny.gov/residential-services
[9] https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

Level of Care Determination

NYS utilizes the Level of Care Determination (LOCADTR)[10] tool to support level of care determination. The tool has been utilized over three million times by SUD providers and managed care utilization managers since 2014. The tool is a web-based decision algorithm that includes the full continuum of care and has a continuing care module to support continuing care decisions. OASAS supports the tool with asynchronistic training available and webinar trainings to support updates. Providers, MMC, and commercial payers in NYS are required to use LOCADTR (unless otherwise approved by OASAS).

NYS Prescription Monitoring Program (PMP) Registry Integration and Interoperability Efforts

Effective August 27, 2013, prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances, with limited exceptions. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP Registry is available 24 hours a day/7-days a week via an application on the Health Commerce System (HCS).[11] Patient drug utilization reports include all controlled substances that were dispensed in NYS and reported by the pharmacy/dispenser for the past year. This information allows practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be misuse or non-medical use.

The Bureau of Narcotic Enforcement (BNE) continues to enhance and support clinicians in their usage of the NYS PMP Registry with improved functionality and education, through combined support from NYSDOH and the Centers for Disease Control and Prevention (CDC) funded Overdose Data to Action – States Grant. The BNE works closely with NYS Information Technology Service (ITS) to build out the technical architecture to the PMP as needed for functionality. This includes the continuous monitoring of the NYS PMP Registry for potential enhancements and weekly status meetings with NYS ITS. To enhance clinicians in their usage of the NYS PMP Registry through education, BNE has reviewed the Opioid Prescriber Training for any language and technical deficiencies, which satisfies educational requirements in Public Health Law Article 33 §3309-a[12] to raise health care provider awareness of the risks associated with prescribing and taking opioid pain medications. BNE will work with the contracted entity, State University of New York at Buffalo, to implement these necessary changes. When a health care provider takes the Opioid Prescriber Training course, there is a required pre- and post-test. During the timeframe of 10/1/2024 to 12/31/2024, more than 4,156 health care providers took the Opioid Prescriber Training across nine different provider types. There was significant improvement in knowledge when comparing pre and post test scores, ranging from an increase of 19.23% to 47.44% for each category type.

BNE continues to enhance interstate data sharing. BNE has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021, BNE began interstate data sharing through the RxCheck hub. As of 12/31/2024, BNE has data sharing agreements with 38 states, as well as Puerto Rico, Washington DC, the Northern Mariana Islands, Veterans Affairs, and Military Health Services through the PMPi and RxCheck hubs. During this

[10] https://oasas.ny.gov/locadtr
[11] https://commerce.health.state.ny.us
[12] NYS Open Legislation | NYSenate.gov

timeframe, BNE successfully connected with Oklahoma and New Mexico through the PMPi hub. In addition, the Northern Mariana Islands was successfully connected via the RxCheck hub. BNE continues to work with the RxCheck Governance Board to aid in identification of state partners for interstate data sharing. In May 2022, BNE successfully integrated with the US Department of Veterans Affairs (VA). BNE continues to monitor the integration and collaborate with the VA, as needed.

In 2019, BNE directly integrated a pilot site's Electronic Health Records (EHR) system with the NYS PMP Registry. Since then, BNE has expanded the number of users for this site from 13 to more than 6,500. The pilot site has continued to keep the Bureau apprised of successes and challenges. By assessing the challenges, BNE has determined two viable options for enhancing clinical workflow for prescribers and other state and federal stakeholders via EHR integration. The first option is integrating with the RxCheck hub. As of 12/31/2024, NYS ITS built the technical architecture to begin testing this option. The Division of Legal Affairs provides ongoing reviews of data use agreements pertaining to EHR integration. The second option for EHR integration is via the NYS Health Information Exchanges (HIEs). During the reporting period of October 2024 to December 2024, BNE in collaboration with the NYS Information Systems and Health Statistics Group (ISHSG), continued to work with two NYS HIEs to establish EHR integration. All connected facilities from one HIE have access to this functionality. The second HIE has seven facilities that have access and is currently expanding. BNE continues to work with the NYS ISHSG to onboard additional HIEs and increase the number of users querying the PMP via this method. BNE will continue to collaborate with integrated HIEs to increase usage. Lastly, BNE will discuss the expansion of integration to the remaining NYS HIEs.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 waiver 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 20, 2023, pending their review and approval. The evaluation design for the Managed Care Risk Mitigation COVID-19 PHE amendment was approved by CMS on January 10, 2023. The evaluation design for the Reasonable Opportunity Period (ROP) Extension COVID-19 PHE amendment was approved by CMS on October 25, 2023. On July 5, 2024, DOH submitted a revised 1115 evaluation design, that incorporated the NYHER and IMD waiver amendments, to CMS for review and approval.

VII. Consumer Issues

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

MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to NYS 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 SS).

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

MCO Product Line	Total Complaints	
	FFY 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024
MMC	5,908	6,277
HARP	674	746
HIV SNP	77	76
Total MCO Complaints	**6,659**	**7,099**

As described in the table, MCOs reported 6,659 total enrollee complaints for the current quarter. This represents a 6.2% decrease from the prior quarter's total of 7,099 enrollee complaints.

MCOs reported 5,908 MMC complaints this quarter, which is a 5.8% decrease from the 6,277 of the previous quarter. The number of HARP complaints decreased 9.6%, from 746 in the prior quarter to 674 this quarter. There were 77 HIV SNP complaints this quarter, which is an increase of 1.3% when compared to the 76 from the previous quarter.

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 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	13%
Difficulty with Obtaining: Dental/Orthodontia	16%	15%
Balance Billing	16%	17%
Reimbursement/Billing	6%	6%
Dissatisfaction with Quality of Care	5%	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 25 Q1 10/1/2024–12/31/2024	FFY 24 Q4 7/1/2024–9/30/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	21%	20%
Dissatisfaction with Quality of Care	11%	8%
Difficulty with Obtaining: Dental/Orthodontia	9%	7%
Difficulty with Obtaining: Personal Care	8%	7%
Balance Billing	5%	6%

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 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	41%
Mental Health or Substance Abuse/ Treatment	14%	4%
Difficulty with Obtaining: Dental/Orthodontia	12%	9%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	12%	5%
Dissatisfaction with Quality of Care	5%	5%
Difficulty with Obtaining: Personal Care	5%	5%

NYS DOH notes a significant decrease in the percentage of complaints reported in the Dissatisfied with Provider Services (Non-Medical) or MCO Services category, compared to the previous quarter. Though there is a decrease, this category remains the top category for complaint submissions. Reports show a 10% increase in the Mental Health or Substance Abuse/Treatment category compared to the previous quarter. NYS DOH will continue to monitor this to identify ongoing trends.

B. Monitoring of Plan Reported Complaints

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

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

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

NYS DOH continues to monitor the progress of all corrective actions and requires additional intervention if the identified trend/issue persists.
NYS DOH is in the process of calculating the OE ratio for the six-month period of July 1, 2024, through December 31, 2024.

C. Long-Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, DOH monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 6,659 total reported complaints/action appeals, MCOs reported 642 complaints and action appeals from their SSI recipients. This compares to 676 SSI complaints/action appeals from the previous quarter, representing a 5% decrease.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024
Appointment Availability: PCP	1	2
Appointment Availability: Specialist	8	7
Appointment Availability: BH HCBS	0	1
Long Wait Time	2	4
Dissatisfaction with Quality of Care	30	34

Denial of Clinical Treatment	12	17
Denial of BH Clinical Treatment	0	1
Dissatisfied with Provider Services (Non-Medical) or MCO Services	149	171
Dissatisfaction with BH Provider Services	2	6
Dissatisfaction with Health Home Care Management	9	9
Difficulty with Obtaining: Specialist and Hospitals	35	45
Difficulty with Obtaining: Eye Care	7	7
Difficulty with Obtaining: Dental/Orthodontia*	78	49
Difficulty with Obtaining: Emergency Services	2	1
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	0	0
Difficulty with Obtaining: RHCF Services	0	4
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	5	13
Difficulty with Obtaining: Home Health Care	10	12
Difficulty with Obtaining: Personal Care	76	71
Difficulty with Obtaining: PERS	1	1
Difficulty with Obtaining: CDPAS	25	17
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	3	4
Access to Non-Covered Services	6	9
Access for Family Planning Services	0	0
Communications/ Physical Barrier	4	3
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	8	13
Recipient Restriction Program and Plan Initiated Disenrollment	1	0
Reimbursement/Billing	42	47
Balance Billing	60	57
Transportation	0	1
All Other	66	70
Total	**642**	**676**

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 25 Q1 10/1/2024–12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	25%
Difficulty with Obtaining: Dental/Orthodontia	12%	7%
Difficulty with Obtaining: Personal Care	12%	11%
Balance Billing	9%	8%
Reimbursement/Billing	7%	7%

NYS DOH requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of October 1, 2024, through December 31, 2024, MCOs reported LTSS enrollment of 64,123 enrollees. This compares to 62,310 LTSS enrollees from the previous quarter, representing a 2.9% increase. The following table outlines the number of LTSS enrollees by MCO for each of the last four quarters:

Plan	Number of LTSS Enrollees			
	FFY 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024	FFY 24 Q3 4/1/2024 – 6/30/2024	FFY 24 Q2 1/1/2024 – 3/31/2024
Amida Care	1,102	1,043	1,260	1,265
Anthem	4,528	4,210	3,601	3,684
Capital District Physicians Health Plan	714	680	655	346
Excellus Health Plan	1,800	1,800	1,800	1,800
Fidelis Care	21,971	21,297	21,154	20,680
Healthfirst	18,504	17,994	16,604	15,718
Highmark	335	333	322	315
HIP of Greater New York	646	652	617	431
Independent Health Association	767	751	743	769
MetroPlus Health Plan	4,326	4,350	4,045	3,646
Molina Healthcare	3,620	3,235	3,311	3,107

MVP Health Plan	1,672	1,911	2,260	2,586
United Healthcare	3,552	3,485	3,425	3,414
VNS Choice	586	569	426	446
Total	**64,123**	**62,310**	**60,223**	**58,207**

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 each of the last four quarters:

Description of Complaint	Number of Complaints/Action Appeals Reported			
	FFY 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024	FFY 24 Q3 4/1/2024 – 6/30/2024	FFY 24 Q2 1/1/2024 – 3/31/2024
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0	0	1
Difficulty with Obtaining: Adult Day Care	1	2	0	0
Difficulty with Obtaining: CDPAS	73	46	64	58
Difficulty with Obtaining: Home Health Care	33	58	43	26
Difficulty with Obtaining: RHCF Services	2	13	6	4
Difficulty with Obtaining: Personal Care	188	213	178	129
Difficulty with Obtaining: PERS	1	3	5	2
Difficulty with Obtaining: Private Duty Nursing	6	14	12	20
Total	**304**	**349**	**308**	**240**

D. Critical Incidents

NYS DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 302 critical incidents reported for the FFY Q1 period, most of which have a resolved status. Many of the incidents stemmed from falls requiring medical attention. NYS DOH continues to work with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

The following table outlines the total number of LTSS critical incidents reported by MMCs, HARPs, and HIV SNPs for each of the last two quarters, the net change over the last two quarters:

Plan	Critical Incidents		
	FFY 25 Q1 10/1/2024 - 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024	Net Change
MMC			
Anthem	2	1	+1
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	8	3	+5
Fidelis Care	92	93	-1
Healthfirst	60	80	-20
HIP of Greater New York	0	0	0
Highmark	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	9	2	+7
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
Total	**171**	**179**	**-8**
HARP			
Anthem	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	3	1	+2
Fidelis Care	33	48	-15
Healthfirst	59	63	-4
HIP of Greater New York	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	7	0	0
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**102**	**112**	**-10**
HIV SNP			
Amida Care	0	0	0

MetroPlus Health Plan	3	0	+3
VNS Choice	26	24	+2
Total	**29**	**24**	**+5**
Grand Total	**302**	**315**	**-13**

The following table outlines the total number of critical incidents MCOs reported for enrollees in receipt of LTSS by category for each of the last two quarters and the net change over the last two quarters:

Category of Incident	Critical Incidents		
	FFY 25 Q1 10/1/2024 – 12/31/2024	FFY 24 Q4 7/1/2024 – 9/30/2024	Net Change
MMC Plans			
Any Other Incidents as Determined by the Plan	6	11	-5
Any other incidents as determined by NYS DOH	8	0	+8
Crimes Committed Against Enrollee	6	2	+4
Crimes Committed by Enrollee	1	2	-1
Instances of Abuse of Enrollees	5	7	-2
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	2	2	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	46	52	-6
Other Incident Resulting in Medical Treatment Other Than Hospitalization	96	89	+7
Use of Restraints	1	14	-13
Wrongful Death	0	0	0
Total	**171**	**179**	**-8**
HARPs			
Any Other Incidents as Determined by the Plan	1	13	-12
Any other instances as determined by NYS DOH	11	0	+11

Crimes Committed Against Enrollee	3	3	0
Crimes Committed by Enrollee	1	4	-3
Instances of Abuse of Enrollees	1	5	-4
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	17	27	-10
Other Incident Resulting in Medical Treatment Other Than Hospitalization	59	56	+3
Use of Restraints	9	4	+5
Wrongful Death	0	0	0
Total	**102**	**112**	**-10**
HIV SNP			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	1	1	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	0	0
Instances of Exploitation of Enrollees	0	1	-1
Instances of Neglect of Enrollees	3	7	-4
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	7	1	+6
Other Incident Resulting in Medical Treatment Other Than Hospitalization	18	14	+4
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**29**	**24**	**+5**
Grand Total	**302**	**315**	**-13**

NYS DOH notes a minor decrease in critical incidences reported from Q4 to Q1 by MCOs.

E. Enrollee Complaints Received Directly by NYS DOH

In addition to the MCO reported complaints, NYS DOH directly received 38 enrollee complaints this quarter. This total is a 52% decrease from the previous quarter, which reported 79 enrollee

complaints. NYS DOH will continue to monitor to see if this decrease is an ongoing trend or if this was a standalone drop in the complaints received.

The following table represents previously reported complaints filed directly with DOH, including complaints from enrollees and their representatives:

MCO Enrollee Complaints Received Directly by DOH				
FFY 25 Q1 10/1/2024 – 12/31/2024	**FFY 24 Q4 7/1/2024 – 9/30/2024**	**FFY 24 Q3 4/1/2024 – 6/30/2024**	**FFY 24 Q2 1/1/2024 – 3/31/2024**	**FFY 24 Q1 10/1/2023 – 12/31/2023**
38	**79**	**80**	**99**	**107**

The following table outlines the top six most frequent categories of enrollee complaints/action appeals received directly by NYS DOH involving MCOs for the most recent quarter and compared to the last four quarters:

Percentage of MCO Enrollee Complaints Received Directly by DOH				
Description of Complaint	**FFY 25 Q1 10/1/2024 – 12/31/2024**	**FFY 24 Q4 7/1/2024 – 9/30/2024**	**FFY 24 Q3 4/1/2024 – 6/30/2024**	**FFY 24 Q2 1/1/2024 – 3/31/2024**
Reimbursement/Billing	7%	10%	5%	7%
Difficulty with Obtaining: Specialist and Hospitals	16%	9%	4%	3%
Difficulty with Obtaining: CDPAS	13%	9%	6%	3%
Difficulty with Obtaining: Dental/Orthodontia	11%	9%	10%	9%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	8%	13%	8%	14%

DOH monitors and tracks enrollee complaints reported to NYS DOH related to new or changed benefits and populations enrolled into MCOs.

F. Fair Hearings

There were 153 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of October 1, 2024, through December 31, 2024. The dispositions of these fair hearings for each of the last four quarters are as follows:

Fair Hearing Decisions (includes MMC, HARP, and HIV SNP)				
Hearing Dispositions	**FFY 25 Q1 10/1/2024-12/31/2024**	**FFY 24 Q4 7/1/2024–9/30/2024**	**FFY 24 Q3 4/1/2024–6/30/2024**	**FFY 24 Q2 1/1/2024–3/31/2024**
In favor of Appellant	41	60	74	93
In favor of Plan	104	98	105	104
No Issue	8	18	9	15
Total	**153**	**176**	**188**	**212**

For fair hearing dispositions occurring for each of the last four quarters, 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 25 Q1 10/1/2024-12/31/2024**	**FFY 24 Q4 7/1/2024–9/30/2024**	**FFY 24 Q3 4/1/2024–6/30/2024**	**FFY 24 Q2 1/1/2024–3/31/2024**
0-29	0	1	0	0
30-59	9	21	28	8
60-89	17	27	42	23
90-119	26	26	25	41
=>120	101	101	93	159
Total	**153**	**176**	**188**	**231**

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

The MMCARP met on December 19, 2024. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program; current AA statistics and state and local district outreach and other activities aimed at reducing AA; and an update on the status of the MLTC program. There was one additional agenda item, an SCN Implementation Update given by DOH staff Selena Hajiani and Emily Engel. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for February 20, 2025.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

The 2023 MLTC Consumer Guides were released in October on the NYS DOH website[13] and Health Data NY[14]. The Guides are also printed by New York Medicaid Choice, our facilitated

[13] https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/
[14] https://health.data.ny.gov/Health/Managed-Long-Term-Care-Regional-Consumer-Guide/yupb-4vts

Medicaid enroller, for inclusion in new member's packets. The Guides help new members choose a managed long-term care plan that meets their health care needs. The Guides offer information about the quality of care offered by the different plans, and people's opinions about the care and services the plans provide.

The 2023 Quality Incentive awards were announced in November. The Quality Incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, and compliance. Since the MLTC is budget neutral, the bottom tier did not receive any contributed monies back, all the other tiers received back a portion or full amount of contributed monies plus additional award.

2023 Managed Long-Term Care Quality Incentive Results

Award Tier	Plan Name*	Quality Points (50-points possible)	Satisfaction Points (30-points possible)	Compliance Points (10-points possible)	Efficiency Points (10-points possible)	Total Points	Base Points	Ranking Percent (up to 100%)
3	VNS Health Total	47.6	17.5	10.0	5.0	80.1	100.0	80.1
3	CenterLight PACE	42.0	15.0	10.0	10.0	77.0	100.0	77.0
3	Empire BCBS HealthPlus MAP	36.4	SS	8.0	5.0	49.4	64.4	76.7
3	Senior Whole Health MAP	36.4	SS	8.0	5.0	49.4	64.4	76.7
3	Empire BCBS HealthPlus MLTC	29.4	20.0	8.0	10.0	67.4	100.0	67.4
3	Senior Whole Health MLTC	30.8	15.0	8.0	10.0	63.8	100.0	63.8
3	Elderplan MAP	25.2	17.5	10.0	10.0	62.7	100.0	62.7
2	Catholic Health - LIFE	21.0	SS	8.0	10.0	39.0	64.4	60.5
2	Centers Plan MAP	25.2	15.0	10.0	10.0	60.2	100.0	60.2
2	ArchCare Senior Life	33.6	15.0	6.0	5.0	59.6	100.0	59.6
2	Homefirst MLTC	22.4	20.0	10.0	5.0	57.4	100.0	57.4
2	Extended MLTC	28.0	15.0	8.0	5.0	56.0	100.0	56.0
2	Eddy Senior Care	25.2	17.5	8.0	5.0	55.7	100.0	55.7
2	VNS Health MLTC	29.4	17.5	8.0	0.0	54.9	100.0	54.9
2	VillageCareMAX	26.6	12.5	10.0	5.0	54.1	100.0	54.1
1	Aetna Better Health	28.0	15.0	10.0	0.0	53.0	100.0	53.0
1	Centers Plan for Healthy Living	25.2	12.5	10.0	5.0	52.7	100.0	52.7
1	Hamaspik Choice	23.8	15.0	8.0	5.0	51.8	100.0	51.8
1	MetroPlusHealth Ultracare	18.2	SS	10.0	SS	28.2	54.4	51.8
1	Hamaspik MAP	22.4	15.0	8.0	5.0	50.4	100.0	50.4
1	Healthfirst CompleteCare	15.4	20.0	10.0	5.0	50.4	100.0	50.4
1	RiverSpring at Home	12.6	22.5	10.0	5.0	50.1	100.0	50.1
1	VillageCareMAX Total Advantage	22.4	12.5	10.0	5.0	49.9	100.0	49.9
1	RiverSpring MAP	18.2	SS	8.0	5.0	31.2	64.4	48.4
1	Wellcare Fidelis MAP	14.0	15.0	8.0	10.0	47.0	100.0	47.0
1	Senior Health Partners	16.8	15.0	10.0	5.0	46.8	100.0	46.8

Award Tier	Plan Name*	Quality Points (50-points possible)	Satisfaction Points (30-points possible)	Compliance Points (10-points possible)	Efficiency Points (10-points possible)	Total Points	Base Points	Ranking Percent (up to 100%)
1	PACE CNY	21.0	12.5	8.0	5.0	46.5	100.0	46.5
1	AgeWell New York Advantage Plus	11.2	SS	10.0	5.0	26.2	58.9	44.5
1	Prime Health Choice	21.0	15.0	8.0	0.0	44.0	100.0	44.0
0	Kalos Health	14.0	15.0	8.0	5.0	42.0	100.0	42.0
0	ElderONE	22.4	10.0	8.0	0.0	40.4	100.0	40.4
0	Nascentia Health Options	8.4	17.5	8.0	5.0	38.9	100.0	38.9
0	Montefiore Diamond Care MLTC	11.2	17.5	10.0	0.0	38.7	100.0	38.7
0	Fidelis Care at Home	15.4	12.5	10.0	0.0	37.9	100.0	37.9
0	Fallon Health Weinberg-PACE	11.2	SS	8.0	5.0	24.2	64.4	37.6
0	MetroPlusHealth MLTC	16.8	12.5	8.0	0.0	37.3	100.0	37.3
0	ArchCare Community Life	11.2	17.5	8.0	0.0	36.7	100.0	36.7
0	EverCare Choice	8.4	15.0	8.0	5.0	36.4	100.0	36.4
0	Complete Senior Care	9.8	SS	8.0	5.0	22.8	64.4	35.4
0	Senior Network Health	2.8	17.5	10.0	5.0	35.3	100.0	35.3
0	Elderwood Health Plan	0.0	17.5	10.0	5.0	32.5	100.0	32.5
0	Total Senior Care	2.8	SS	8.0	10.0	20.8	64.4	32.3
0	Fallon Health Weinberg	0.0	17.5	8.0	5.0	30.5	100.0	30.5
0	iCircle	0.0	15.0	6.0	0.0	21.0	100.0	21.0

*Please note that calculations are carried out with many decimal places and rounded only for presentation.

The 2023 MLTC Report was publicly released in December.[15] This report presents information on the 43 plans that were enrolling members during the data collection period. Data contained in the Report are the basis for the Consumer Guides and the Quality Incentive and are available as a downloadable file on Health Data NY[16].

Also in December, DOH released to the plans the methodology for the 2025 MLTC Quality Incentive.

B. Quality Measurement in MMC

Quality Measure Benchmarks 2023 (Measurement Year 2023)

Quality of care remained high for MMC members for the demonstration year. In measurement year 2023, national benchmarks were available for 55 measures for Medicaid. Out of the 55 measures that NYS Medicaid MCOs reported, 85% 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

15 https://www.health.ny.gov/health_care/managed_care/mltc/reports.htm

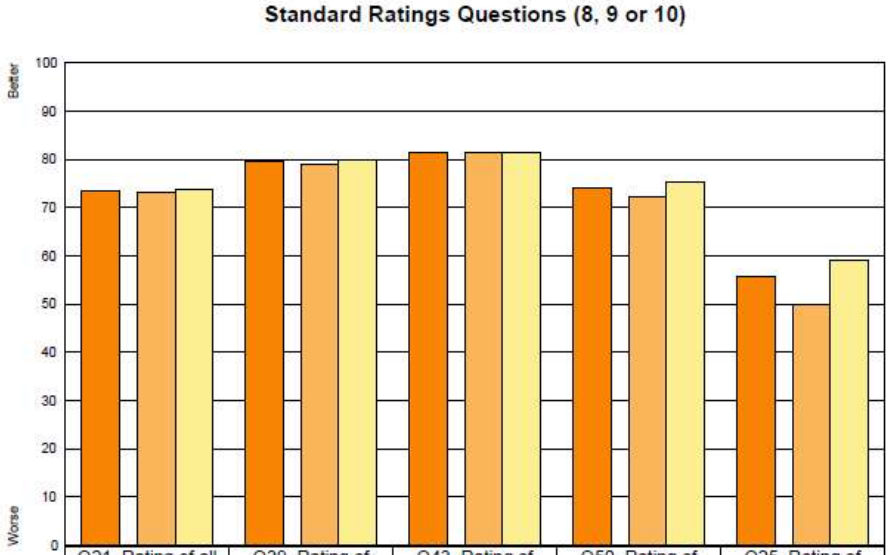
16 https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp

measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness) and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). 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, breast cancer, and cervical cancer) and children and adolescent preventative measures (well-child visits during first 30 months of life, well-care visits among children aged 3-21 years old, and adolescent immunization).

2023 Satisfaction Survey

In the fall of 2023, NYS DOH conducted a satisfaction survey of adults enrolled in MMC, HARP, and SNP plans. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Adult Medicaid survey was administered. The administration methodology consisted of a five-wave mixed-mode (mailing and web) protocol, with postcard reminder after the first two questionnaire packets. The survey included 12 MMC plans in New York with a sample of 2,000 members per plan. Questionnaires were sent to 24,000 adult members following a combined mail and web methodology during the period October 30, 2023, through January 22, 2024, using a standardized survey procedure and questionnaire. A total of 2,735 eligible and complete responses were received resulting in a 13.2% 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.



	Q21. Rating of all health care	Q39. Rating of personal doctor	Q43. Rating of specialist talked to most often	Q50. Rating of health plan	Q25. Rating of treatment or counseling
MMC Statewide 2023	73.48%	79.63%	81.41%	74.18%	55.69%
NYC 2023	73.03%	78.87%	81.45%	72.36%	49.98%
Rest of State 2023	73.87%	80.05%	81.36%	75.24%	59.02%

2022 Quality Incentive for Medicaid Managed Care

The 2022 Quality Incentive Awards calculations were finalized in May 2024, which covered the measurement year period for 2022. 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 SODs in the Compliance category. Plans were classified into five tiers based on the distribution of the final percentage 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 2022 Incentive included two plans in Tier 1, one plan in Tier 2, six plans in Tier 3, one plan in Tier 4, and two plans in Tier 5.

Quality Assurance Reporting Requirements (QARR)

In June, 26 MCOs 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 subsequent months. 2023 Data was published in December 2024.

C. Quality Improvement

External Quality Review

IPRO continues to provide External Quality Review (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' 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, NYS DOH requires our External Quality Review Organization (EQRO) to also conduct activities administering additional surveys of enrollee experience; and providing data processing and analytical support to NYS DOH. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, and HARPs, and include the State's Child Health Plus (CHPlus). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

Annual EQRO Technical Reports

IPRO continues to work on the Annual Technical Reports for measurement year 2023. The majority of the sections of the report are completed and IPRO is currently working on building the final aggregate report for review. IPRO and DOH discussed the CMS findings for measurement year 2022 Annual Technical Report. DOH will submit the 2023 Annual Technical Report to CMS by the due date of April 30, 2025.

Provider Related and Access Activities

At the start of the first quarter, IPRO made progress with the access and availability and provider directory survey. IPRO received the sample of providers for the Medicaid and CHPlus plans to conduct the survey. By December, calls were completed for half of the plans.

For the PCP ratio survey, IPRO and DOH discussed which data was needed to conduct the survey. The aim is for the survey to begin in the third quarter.

Provider Network Data System (PNDS):

PNDS

IPRO continues to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the PNDS. The PNDS collects network information from approximately 400 active networks in NYS. IPRO and their subcontractors, RMCI and Quest Analytics, facilitated ongoing adjustments and fixes and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion, and maintenance. The October to December PNDS submission deadline was January 28, 2025; plans submitted data based on version 12 of the data dictionary.

Provider and Health Plan Look-Up:

The NYS 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 close to two million distinct users since its launch in May 2017.

PANEL:

Panel data submission opened for July 1, 2024 – September 30, 2024, data collection on November 4 and yielded 6,652,512 rows of data which is ~1% less than the previous quarter. Technical assistance was provided by NYSDOH and IPRO throughout the submission, particularly around new edits implemented. NYSDOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)

During the first quarter, the PIP group calls were completed in October. For the rest of the quarter, IPRO met with multiple plans to fix their proposals, summaries and data.

MLTC Member Satisfaction Survey

During the quarter, IPRO and NYS DOH worked collaboratively on enhancements to the 2025 MLTC Satisfaction Questionnaire. Once finalized and approved by DOH, IPRO planned to send the survey to a translator by early January.

Focused Clinical Study: Patient Centered Service Plan

IPRO started the preparation for the PCSP Study plan in October. IPRO and DOH discussed timeframes, sampling, methodology and the proposal. By December, IPRO completed the study abstraction tool with edits from DOH.

Quality Measurement

During the first quarter, IPRO was reviewing the PCMH files and submitted those files in November for QARR. In December, ACO and data analysis reports were sent to the Department CARE team. IPRO finalized the subcontract with DataStat for both CAHPS Adult

and Children's survey. By November, DataStat started mailing the survey. DOH confirmed that the survey went out and they received the first report of the Children's survey. The second mailing went out in December.

PIPs for MMCs:

2024-2025 MMC, CHP and HIV SNP PIP: Improving Rates of Cancer Screening and Prevention for MMMC, CHP, and HIV SNP Members

In November 2024, the second series of progress calls were conducted by IPRO and held from November 7 through December 2, 2024, with participation by IPRO and NYS DOH. Prior to oversight calls, the plans submitted updates on their intervention tracking measures.

2024-2025 HARP PIP: 2024-2025 Continuous Engagement in Care and Treatment

In October 2024, the 11 HARP 2024-2025 PIP proposals were approved by IPRO, NYS DOH, OMH, and OASAS. The first HARP PIP All Plan Webinar was coordinated by IPRO and held on October 15, 2024, and October 29, 2024. At the All Plan Webinar, each plan addressed a barrier analysis, key interventions that focus on the identified barriers, the identified health disparities, and how the HARP plans will operationalize the identified interventions. The first series of HARP PIP progress calls were coordinated by IPRO and held from December 5 through December 19, 2024, with participation by IPRO, NYS DOH, OMH, and OASAS. The HARP PIP FAQ Document was updated by IPRO to include a question by one of the HARP health plans on the Continuous Engagement in Treatment (CET) measure.

Breast Cancer Selective Contracting

NYS DOH began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2021-2023 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a three-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as facility-level data from the Health Facilities Information System (HFIS).

Additionally, staff began work on two analyses to evaluate policy, procedures and compliance. The first, evaluated methods to refine the algorithm used to restrict Medicaid FFS payment to low-volume, restricted facilities. The second complemented the first by analyzing Medicaid encounter data to assess health plan compliance with NYS model contracts which stipulate that plans may only reimburse high-volume facilities for these services. Results from both are expected in the first half of 2025.

D. Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 1 (10/1/2024-12/31/2024)

As of December 2024, there were 8,884 National Committee for Quality Assurance (NCQA)-recognized PCMH providers and 2,111 practices in NYS. All providers are recognized under the standards of NYS PCMH, a new recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on BH, care management, population health, VBP arrangements, and health information technology

capabilities. Out of the 8,884 recognized providers in December, no new enrollment in the NYS PCMH program.

The incentive rate for the New York Medicaid PCMH Statewide Incentive Payment Program as of December 2024 is $6.00 Per Member Per Month (PMPM). Retroactive to April 1, 2024, primary care providers recognized under the NYS PCMH program are entitled to an incentive enhancement of $4.00 PMPM for MMC enrollees and CHPlus members under 21 years of age, and $2.00 PMPM for individual 21 years of age and older, in addition to the current $6.00 PMPM payment. Effective April 1, 2025, NYS PCMH providers who develop a workflow to refer patients to an SCN and submit an attestation by March 31, 2025, will continue to receive the incentive enhancement.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with meetings for participating payers. There is still a commitment across payers and providers to continue 2025 and align on quality metrics.

All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the NYSDOH website[17].

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 utilize the Budget Neutrality Reporting Tool to fulfill quarterly quantitative reporting requirements.

X. Other

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

New York 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

[17] https://www.health.ny.gov/technology/nys_pcmh/

The State is current in its submission of these files.

NYS is also addressing the CMS-identified data quality issues associated with the Outcomes Based Assessment (OBA) compliance criteria.

Status as of reporting month of November 2024:

Critical-Priority:	100%	(Target 100%)
High-Priority:	97%	(Target ≥ 99%)
Expenditures:	98%	(Target ≥ 95%)

As of the November 2024 reporting month, NYS data meets the Critical-Priority and Expenditures criteria target of OBA and is 2% below the target for High-Priority criterion. NYS is actively working to address the identified high priority issues to meet the High-Priority criterion in the OBA.

NYS continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues, and engage in efforts to resolve identified data quality issues.

NYS continues to utilize its Data Governance workgroup for T-MSIS, to help facilitate the resolution of identified data issues. This group works with the state's T-MSIS team and the SMEs (subject matter experts) to determine if data quality issues have been flagged due to reporting nuances as an outcome of program or policy under the state's approved Medicaid plan. The Data Governance workgroup supports the team's SME review(s) and provides supplemental state guidance documentation. These joint efforts are used to facilitate a better understanding of the NYS Medicaid program and service population(s) as reflected in the T-MSIS data submissions.

The NYS T-MSIS files are now compliant with the newer DD v3.0.0 layout as per the CMS requirement. The T-MSIS v4.0.0 File Layout implementation is currently in progress with a target completion date of October 8, 2025.

Also, NYS is currently engaged in the T-MSIS historical file(s) resubmissions process. Reporting period of November 2019 through October 2024 (60 months) is covered as part of this project. AS of December 31,2024, files for 7 months out of 60 months have been successfully resubmitted. The historical files resubmission efforts are expected to continue through February 2025.

B. HCBS Quality Measures

NYS is currently working with CMS' contractor to formulate a technical assistance plan to align with the HCBS quality measures and reporting requirements outlined in the 2014 CMCS Informational Bulletin (CIB), Modifications to Quality Measures and Reporting in §1915(c) HCBS Waivers, regarding Quality Improvement Strategy.

Attachments:

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

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Attachment 1: MLTC Critical Incidents

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse of Enrollees	Instances of Neglect of Enrollees	Instances of Exploitation of Enrollees	Crimes Committed Against Enrollee	Crimes Committed by Enrollee	Falls (Hospitalization)	Falls (Non-Hospitalization)	Self Neglect/Abuse	Transport Accidents	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	34	0	0	0	0	0	0	0	0	17	11	2	0	2	2	0	6593	0.52%
Archcare Community Life	18	0	0	0	0	1	0	0	0	10	2	1	0	1	3	0	841	2.14%
Catholic Health-LIFE	15	0	9	0	0	0	0	0	0	0	4	0	0	0	2	0	241	6.22%
Centerlight PACE	72	0	0	0	0	0	0	0	0	25	32	0	0	6	5	4	6588	1.09%
Centers Plan for Healthy Living	1137	1	0	2	20	11	2	7	1	307	658	4	4	17	103	0	54175	2.10%
Centers Plan for Healthy Living MAP	59	0	0	0	0	2	0	0	0	14	36	0	0	3	4	0	1867	3.16%
Complete Senior Care	9	0	0	0	0	0	0	0	0	5	2	0	0	0	2	0	138	6.52%
Eddy SeniorCare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	421	0.00%
Elderplan MAP	6	0	0	0	0	2	0	0	0	0	0	0	0	0	2	2	4878	0.12%
Elderserve	465	1	1	1	0	7	0	2	3	75	72	0	0	95	208	0	19869	2.34%
Elderserve MAP	9	0	0	0	0	0	0	0	1	0	1	0	0	1	6	0	388	2.32%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	61609	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	196	0.00%
Fallon Health Weinberg	60	0	0	0	0	0	0	0	0	5	55	0	0	0	0	0	187	32.09%
Fidelis Care at Home	76	0	0	0	5	2	0	0	0	0	0	0	0	40	29	0	19783	0.38%
Fidelis MAP	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1911	0.10%
Hamaspik	196	2	0	0	0	0	0	2	2	0	0	0	0	92	80	18	8373	2.34%
Hamaspik MAP	43	0	0	0	0	0	0	0	0	0	0	0	0	18	23	2	1001	4.30%
Healthfirst CompleteCare	224	0	0	1	2	1	0	1	2	0	0	0	0	93	109	15	33559	0.67%

HomeFirst, Inc. (Elderplan)	5	0	0	0	0	2	0	0	0	0	0	0	0	2	0	1	27128	0.02%
Icircle	6	0	0	0	3	0	1	2	0	0	0	0	0	0	0	0	4465	0.13%
Independent Living for Seniors (ILS/ElderOne)	24	1	0	0	0	0	0	0	0	17	5	0	0	1	0	0	769	3.12%
Independent Living Services of CNY (PACE CNY)	25	0	0	0	0	0	0	0	0	16	5	0	0	1	3	0	596	4.19%
Kalos ErieNiagara DBA: First Choice Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1040	0.00%
MetroPlus MAP	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	218	0.46%
MetroPlus	3	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	2648	0.11%
Senior Health Partners	56	0	0	0	0	1	0	2	0	0	0	0	0	26	23	4	10270	0.55%
Senior Whole Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27446	0.00%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	281	0.00%
Total Senior Care	12	0	0	0	1	0	0	0	0	0	0	0	0	3	8	0	125	9.60%
Village Care	46	0	0	0	0	19	1	1	0	8	8	0	1	0	8	0	30824	0.15%
Village Care MAP	15	0	0	0	1	8	0	0	0	4	1	0	0	0	1	0	3770	0.40%
VNA Homecare Options (Nascentia Health Options)	186	0	0	2	3	2	0	3	2	60	98	0	1	4	11	0	6623	2.81%
VNS Choice MAP TOTAL	80	0	0	1	2	5	0	0	0	18	52	0	0	0	2	0	5048	1.58%
VNS Choice MLTC	667	0	0	2	7	15	0	0	1	99	520	1	0	3	19	0	26564	2.51%
Total	3551	5	10	9	44	78	4	20	12	680	1562	8	6	411	656	46	370433	0.96%

Attachment 2: MLTC Partial Capitation Plan, MAP, PACE, MA and FIDA IDD Enrollment

Managed Long Term Care Partial Capitation Plan Enrollment Jan 2024 to Dec 2024												
Plan Name	**Enrollment**											
	Jan-24	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**
Aetna Better Health	6089	6078	6120	6184	6264	6313	6394	6471	6535	6563	6563	6563
Centers Plan for Healthy Living	52712	52623	52674	52982	53051	53079	53315	53596	53885	53993	54152	54381
Elderplan	21918	22146	22676	23188	24438	24806	25399	25743	26201	26691	27069	27623
Elderserve	18367	18374	18478	18624	18813	18900	19083	19300	19488	19651	19868	20089
Fidelis Care at Home	17800	18330	18456	18653	18817	18776	18957	19278	19406	19415	19783	20150
Hamaspik Choice	7706	7735	7811	7907	8006	8066	8216	8220	8262	8312	8366	8440
HealthPlus- Amerigroup	56466	56431	57019	57534	58036	58521	59250	60000	60531	61059	61585	62184
iCircle Services	3682	3683	3771	3911	3999	4054	4159	4221	4307	4380	4468	4547
Kalos Health- Erie Niagara	938	942	935	956	997	1007	1033	1038	1049	1050	1030	0
MetroPlus MLTC	1652	1735	1777	1878	2002	2141	2284	2392	2481	2573	2640	2731
Senior Health Partners	9157	9455	9460	9460	9515	9509	9624	9804	9889	9993	10241	10577
Senior Whole Health	27672	27796	28297	28648	28900	28799	28488	28261	28014	27673	27443	27221
Village Care	20796	20998	21389	21885	22387	28132	28581	28941	29308	29988	30732	31751
VNA HomeCare Options	5199	5328	5448	5670	5772	5914	6087	6269	6436	6562	6637	6669
VNS Choice	23568	23335	23317	23438	25137	25361	25594	25774	25887	25901	26189	27601
Total	**273,722**	**274,989**	**277,628**	**280,918**	**286,134**	**293,378**	**296,464**	**299,308**	**301,679**	**303,804**	**306,766**	**310,527**

Managed Long Term Care MAP Enrollment Jan 2024 to Dec 2024												
Plan Name	Enrollment											
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Fidelis	1152	1181	1283	1379	1456	1533	1612	1692	1791	1905	1909	1918
Hamaspik	849	900	916	928	925	943	975	980	974	988	992	1022
Centers	1698	1745	1768	1803	1846	1858	1866	1895	1900	1904	1866	1831
Elderplan	3795	3927	4005	4136	4238	4348	4437	4558	4658	4761	4901	4973
Elderserve	278	279	291	297	316	327	334	353	369	382	382	399
Healthfirst Complete Care	28341	28866	29416	29962	30568	31233	31745	32326	32777	33330	33610	33737
Healthplus	121	130	135	141	149	171	204	212	205	193	193	203
Metroplus	172	170	177	187	196	196	198	197	201	207	216	231
Senior Whole Health	252	265	286	300	298	294	289	284	283	278	283	282
VNS	4172	4308	4393	4487	4585	4676	4714	4823	4910	5039	5069	5036
Village Care	2787	2869	2952	3061	3118	3188	3297	3478	3635	3768	3791	3752
Total	**43617**	**44640**	**45622**	**46681**	**47695**	**48767**	**49671**	**50798**	**51703**	**52755**	**53212**	**53384**

Managed Long Term Care PACE Enrollment Jan 2024 to Dec 2024												
Plan Name	Enrollment											
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Archcare	807	803	809	807	822	835	821	823	828	828	847	849
CHS Buffalo Life	229	233	233	233	231	235	240	241	244	242	239	242
Complete Senior Care	136	138	135	135	134	135	136	135	137	138	138	139
Comprehensive Care Management	6331	6313	6348	6295	6311	6267	6297	6360	6418	6516	6594	6654
Eddy Senior Care	360	375	383	393	405	408	414	411	416	422	420	421
Fallon Health PACE	168	161	159	157	161	164	168	173	181	181	184	195
Independent Living For Seniors	748	744	755	749	749	748	740	753	757	769	770	768
Pace CNY	551	546	545	561	568	564	576	581	588	591	594	603
Total Senior Care	131	128	129	127	127	126	128	126	130	127	124	123
Total	**9461**	**9441**	**9496**	**9457**	**9508**	**9482**	**9520**	**9603**	**9699**	**9814**	**9910**	**9994**

Managed Long Term Care FIDA-IDD Enrollment Jan 2024 to Dec 2024												
Plan Name	Enrollment											
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Partners Health Plan	1690	1683	1699	1694	1689	1688	1703	1702	1703	1687	1707	1683