MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 25 (4/1/2023-3/31/2024)
Federal Fiscal Quarter: 2 (1/1/2024-3/31/2024)

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, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

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

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

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

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

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

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

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

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 advance health equity, reduce health disparities, support the delivery of health-related social needs (HRSN) services, and promote workforce development. In addition, the amendment provides the state with Substance Use Disorder (SUD) demonstration authority.

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

II. Enrollment: Second Quarter

MRT Waiver- Enrollment as of March 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 – TANF Child 1 – 20 years in Mandatory Counties as of 10/1/06	**379,460**	**4,485**	**95,331**
Population 2 – TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06]	**64,071**	**1,357**	**3,292**

Population 3 – TANF Child 1 – 20 ('new' MC Enrollment)	**4,180**	**34**	**550**
Population 4 – TANF Adults 21 – 64 ('new' MC Enrollment)	**34,072**	**551**	**1,938**
Population 5 – Safety Net Adults	**235,145**	**6,272**	**42,812**
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)	**159,105**	**1,366**	**118**
Population 9 – Disabled Adults and Children 0 – 64 ('new' MC enrollment)	**56,433**	**3,403**	**501**
Population 10 – Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**84,925**	**735**	**87**
Population 11 – Aged or Disabled Elderly ('new' MC enrollment)	**11,047**	**2,894**	**641**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**21,097 or an approximate 44.49% decrease from last Q**

Reasons for voluntary disenrollment: Enrollment in another plan; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

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

Voluntary disenrollment decreased due to a decrease in both "Code 93 Client or LDSS Initiated/Excluded or Exempt" and the "Code 97 Moved" category of disenrollment.

Involuntary Disenrollment	
Total # Involuntary Disenrollment's in Current Demonstration Year	**145,270 or an approximate 87.19% increase from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid due to eligibility ending (not renewed) and case closures.

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

Involuntary disenrollment increased due to a significant increase in the number of Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
January 2024				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**679,173**	**22,777**	**3,496**	**19,281**
Rest of State	**268,255**	**12,335**	**1,104**	**11,231**
Statewide	**947,428**	**35,112**	**4,600**	**30,512**
February 2024				
New York City	**652,985**	**30,074**	**5,180**	**24,894**
Rest of State	**267,060**	**12,365**	**1,278**	**11,087**
Statewide	**920,045**	**42,439**	**6,458**	**35,981**
March 2024				
New York City	**656,506**	**29,156**	**4,175**	**24,981**
Rest of State	**263,793**	**13,075**	**1,352**	**11,723**
Statewide	**920,299**	**42,231**	**5,527**	**36,704**

Second Quarter	
Region	**Total Affirmative Choices**
New York City	69,156
Rest of State	34,041
Statewide	103,197

HIV SNP Plans				
January 2024				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	13,148	204	0	204
Rest of State	29	9	0	9
Statewide	13,177	213	0	213
February 2024				
New York City	13,192	285	0	285
Rest of State	28	0	0	0
Statewide	13,220	285	0	285
March 2024				
New York City	13,267	247	0	247
Rest of State	30	3	0	3
Statewide	13,297	250	0	250
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	736			
Rest of State	12			
Statewide	748			

Health and Recovery Plans Disenrollment			
FFY 24 – Q2			
	Voluntary	**Involuntary**	**Total**
January 2024	**464**	**2,146**	**2,610**
February 2024	**487**	**1,504**	**1,991**
March 2024	**512**	**1,501**	**2,013**
Total:	**1,463**	**5,151**	**6,614**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2024-3/31/2024) Q2 FFY 2024

As of the end of the second federal fiscal quarter (end of March 2024), there were 2,774,428 New York City Medicaid consumers enrolled in the MMMC Program and 75,151 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 5,101 clients were educated about enrollment options and made an enrollment choice including 794 clients in person and 4,307 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, 102 Enrollment Counselling sessions were evaluated which generated one application for a total of one enrollment.

CMU Monitoring of Field Presentation Report – 2nd Quarter 2024	
Enrollment Counseling – One on One	General Information
102	101

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

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 39,896 FFS community clients were reported on the regular auto-assignment list, 11,597 clients responded to the call that generated 5,568 enrollments. Of the total of 38 FFS NH clients reported on NH auto-assignment list, 3 (8%) client and/or authorized representatives made a plan selection. CMU monitored 1,010 outreach calls by FCSRs in HRA facilities. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
664	0	664	346	0	346

- Phone Enrollment Applications: 664 (66%) FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 928 enrollments.
    - 918 (99%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were timely enrolled in the plan they selected.
- Undecided: 346 (34%) 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 January 2024- March 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 **52,302** calls were received by the Helpline and **50,664** or **97%** were answered. Calls answered were handled in the following languages: **English: 30,104 (59%); Spanish: 6,762 (13%); Chinese: 1,749 (3%); Russian: 1,363 (3%); Creole: 220 (1%); and other: 10,466 (21%).**

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to **5,798** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 2nd Quarter 2024								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
3,401 (59%)	**687 (12%)**	**307 (5%)**	**1,366 (23%)**	**33 (1%)**	**0 (0%)**	**4 (0%)**	**0 (0%)**	**5,798**

A total of **1,640 (28%)** recorded calls observed were unsatisfactory. **673** calls had a single infraction and **967** calls had multiple infractions. A total of **2,626** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,986 (76%)** – 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: **211 (8%)** – CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and referrals for specialists.
- Customer Service: **429 (16%)** – Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **2,626** 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 second quarter of FFY 2023-2024, there were no plan expansions or withdrawals.

During the second quarter of FFY 2023-2024, there was one new Plan. Highmark HARP started operations in the following eight counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.

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

On March 4, 2022, NYS submitted to CMS amendment #2 to the March 1, 2019 Model Contract that includes contract provisions related to State Directed Payments. On March 31, 2022, this amendment was issued to 15 MCOs for signature. At the close of FFY 2022-2023, all 15 contracts have been executed by NYS and submitted to CMS for final approval. As of the close of the second quarter of FFY 2023-2024, DOH has yet to receive approval from CMS on these contracts.

C. Health Plans/Changes to Certificates of Authority

Anthem HP, LLC. – Corporate Name Change
Anthem Health Choice HMO, Inc. – Corporate Name Change
Molina Health Care of New York – Corporate Address Change

D. CMS Certifications Processed

United Healthcare of New York
VNS Choice
Elderplan, Inc.

E. Surveillance Activities

CMS Reporting 2nd Quarter 2023-2024
Surveillance activity completed during the 2nd quarter FFY 2023-2024 (January 1, 2024-March 31,2024) include the following:

Two Targeted Operational Surveys were completed during 2nd Quarter FFY 2023-2024.Two SODs were issued and two POC's were accepted.

- Health Insurance Plan of Greater New York (HIP Emblem)
- Highmark of Western and Northeastern NY

One Comprehensive Operational Survey was completed 2nd Quarter FFY 2023. A letter of concern was issued to the Plan which required a self-directed CAP.

- VNS

V. Waiver Deliverable

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS.

No activities were conducted during this quarter. Final reports were previously submitted for all reviews except 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 Behavioral Health (BH) Services into Managed Care and Development of Health and Recovery Plans (HARPs):

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

As part of the transition, the NYS 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 NYSoH. 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 behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center (MCTAC).

Effective April 1, 2023, the Medicaid pharmacy benefit was carved out of MMC to Medicaid 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 Public Health Emergency (PHE) would expire on May 11, 2023. The 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 behavioral health services based on medical necessity. The report includes aggregated provider level data for service authorization requests and denials, whether the denial was pre-service, concurrent, or retrospective, and the reason for the denial.

NYS MH & SUD authorization requests and denials for Inpatient (10/1/2023-12/31/2023)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	24,612	124	105	0.43%
ROS	6,205	49	46	0.74%
Total	30,817	173	151	0.49%

***Due to data integrity issue, MVP November utilization review Inpatient data has been excluded in this report**

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 behavioral health service. Submissions include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS.

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

NYS MH & SUD authorization requests and denials for Outpatient (10/1/2023-12/31/2023)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	3,200	93	25	0.78%
ROS	447	11	11	2.46%
Total	3,647	104	36	0.99%

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

MH & SUD Claims (1/1/2024-3/31/2024)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	778,608	94.22%	5.78%
ROS	1,491,270	97.48%	2.52%
Totals	2,269,878	96.36%	3.64%

Behavioral Health Adults CORE/HCBS Claims/Encounters 1/1/2024-3/31/2024: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	**230**	**44**
Education Support Services	**25**	**7**
Family Support and Trainings	**443**	**18**
Intensive Supported Employment	**17**	**6**
Ongoing Supported Employment	**11**	**3**
Peer Support	**2,926**	**539**
Pre-vocational	**29**	**5**
Provider Travel Supplements	**155**	**60**
Psychosocial Rehab	**4,934**	**584**
Residential Supports Services	**69**	**9**
Transitional Employment	**0**	**0**
TOTAL	**8,839**	**1,066**

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

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 1/1/2024-3/31/2024: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	1,984	381
Education Support Services	104	25
Family Support and Trainings	383	37
Intensive Supported Employment	23	5
Ongoing Supported Employment	2	1
Peer Support	5,072	994
Pre-vocational	8	2
Provider Travel Supplements	5,408	1,173
Psychosocial Rehab	5,850	1,084
Residential Supports Services	649	88
Transitional Employment	0	0
TOTAL	19,483	2,208

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

Provider Technical Assistance

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

Quarter 2 MCTAC Attendance & Statistics (1/1/2024 to 3/31/2024)

Events: MCTAC successfully executed **15** events from 1/1/2024 to 3/31/2024. All 15 events were held via webinar and three were pre-recorded.

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

3,391 people attended/participated in MCTAC events/viewed resources of which **1,700** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 48.87% (260 of 532 total employees)

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: **37.1%** (161 of 434 total employees)

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

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

All HARP enrollees are eligible for individualized care management. In addition, BH HCBS were made available to eligible HARP and HIV SNP enrollees. These services were designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery. Enrollees were required to undergo an assessment to determine BH HCBS eligibility. Effective January 2016 in NYC and October 2016 for the rest of the state, BH HCBS were made available to eligible individuals.

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

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

- Streamlined the BH HCBS assessment process.
    - Effective March 7, 2017, the full portion of the NYS Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Developed training for care managers and BH HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision, including developing a Health Home training guide for key core competency trainings to serving the high need SMI population.
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both Health Homes and RCAs).
- Developed required training for BH HCBS providers that NYS can track in a Learning Management System.
- Implemented rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhanced technical assistance efforts for BH HCBS providers including workforce development and training.
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in Health Homes. These services are provided by SDEs through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDE to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (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 ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies.
    - Existing quality improvement initiative within clinics to encourage Health Homes enrollment.
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings.
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management.
    - DOH approval of MCO plans for incentivizing enrollment into Health Homes (e.g., outreach optimization).
- Continued work to strengthen the capacity of Health Homes to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead Health Homes, representation on new HH+ Subcommittee Workgroup.
- Implemented Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members.
- Disseminated consumer education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS OMH contracted with the New York Association Psychiatric Rehabilitation Services (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for HARPs and Adult BH HCBS.
        - NYAPRS conducted outreach in two ways:
            - 45-90-minute training presentations delivered by peers.
            - Direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers).
- Implemented Quality and Infrastructure initiative to support targeted BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. NYS worked with the MCOs on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all HARPs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in an increase of members utilizing BH HCBS; NYS also shared a summary of best and promising practices with the HARPs.
- Issued Terms and Conditions for BH HCBS providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS providers are actively providing services.
- Enhanced NYS Adult BH HCBS Provider oversight, including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.

- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, Health Homes, CMAs, and BH HCBS provider agencies. Developed and provided a variety of tools to support care manager referrals to BH HCBS, on behalf of the NYS Health Home/MCO Workgroup.
- Established a process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments. This was in response to challenges in securing a care management workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,388 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2024, and March 31, 2024, 704 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's 1115 Waiver Amendment Request for CORE Services on October 5, 2021. CORE is a rehabilitation and recovery service array which includes four services previously available through BH HCBS: Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support).

Access to CORE Services does not require an independent eligibility assessment and these services do not have settings restrictions. Currently, all HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees can access CORE Services with a recommendation from a licensed practitioner of the healing arts (LPHA).

Enrollment in Health Home Care Management continues to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by Health Homes. Care managers will always have the important role of ensuring timely access to services reflective of the member's preferences and individual needs, in continued collaboration with MCOs and service providers.

CORE Services went live on February 1, 2022, for new and existing recipients (HARP enrollees and HARP-eligible HIV-SNP enrollees). The transition period for existing recipients of BH HCBS CPST, PSR, FST and Peer Support to CORE CPST, PSR, FST and Peer Support ended April 30, 2022.

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

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

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

NYS continues to consult CORE providers and MCOs to inform future guidelines around MCO responsibilities and oversight, such as utilization management of CORE Services. In August 2023, NYS held its first CORE Summit, a one-day training and networking event for CORE providers and MCOs. The next CORE Summit is scheduled for August 2024. OMH and OASAS continue to provide education via trainings, conference presentations, and regional provider forums based on stakeholder feedback. OMH and OASAS are also planning regional networking events in 2024 for CORE providers, MCOs, and care managers.

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

From December 2022 to November 2023, there were 5,918 unique recipients who received CORE Services. Specifically, the count of monthly recipients for the four transitioned services from Adult BH HCBS to CORE Services increased by 46.5%, from 1,935 (January 2022, the month before HCBS/CORE transition) to 2,835 (November 2023).

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 continue to work closely with the HARPs to further monitor and operationalize the program.

- 11 HARPs executed 80 provider contracts which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $26.3 million in initial contract base awards and subsequent milestone payments were distributed to providers.
    - One HARP concluded two contracts with two lead agencies and 10 partner agencies. A total of $785,610 was distributed.
- The program is expected to conclude in July 2024.
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS, and CORE Service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.

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

No activity has occurred during this reporting period.

C. Managed Long-Term Care Program (MLTCP)

MLTC plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of April 1, 2024, there are 20 Partial Capitation plans, 9 PACE plans, 11 MAP, and 1 FIDA IDD plan. As of April 1, 2024, there are a total of 343,079 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the January 2024 through March 2024 quarter, there were no withdrawals, expansions, or new plans.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For January 2024 through March 2024 quarter, post enrollment surveys were completed for 10 enrollees. Of the nine surveyed, six of them (67%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is lower than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 281,333 to 286,421 during the January 2024 through March 2024 quarter, a 2% increase from the previous quarter. For that period, 16,910 individuals who were being transitioned into MLTC made an affirmative choice, a 15% increase from the previous quarter and brings the 12-month total for affirmative choice to 60,103.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the April 2023 through March 2024 annual period is submitted as an attachment.

2. Significant Program Developments

During the January 2024 through March 2024 quarter:

- The 1st Quarter Member Services survey was conducted on 20 Partial Capitation Plans and 11 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.
- Operational Surveys were initiated for four Partial Capitation plans in prior reporting periods, and are as follows:
    - For one Partial Capitation plan the CAP has been reviewed and accepted.
    - For one Partial Capitation plan the CAP has been received but is still under review.
    - For one Partial Capitation plan the Desk Review has been completed and the Statement of Deficiencies has been issued. We are awaiting the submission of a CAP.
    - For one Partial Capitation plan the Desk Review is still in progress.
- One TAC Investigation was initiated on one Partial Capitation plan TAC complaints received for inappropriate SDC reduction notices, in a prior reporting period. The CAP has been accepted.
- One Focused Survey was initiated on all Partial Capitation Plans based on an analysis of their 2023 Q1 PNDS Submissions in a prior reporting period. SODs were issued to 19 Plans and their CAPs have been received. There are four plans that still have not submitted an acceptable CAP.
- One Focused Survey was initiated on all PACE Plans based on an analysis of their 2023 Q1 PNDS Submissions in a prior reporting period. SODs were issued to 7 Plans, and CAPs have been reviewed and are under review.
- The TAC Investigation initiated on a Partial Capitation TAC complaint (in a prior reporting period) for failure to oversee their Fiscal Intermediary (FI), as well as failure to provide adequate care management remains under review with DOH. The CAP was reviewed and accepted.
- A Focused Survey was initiated on all Partial Capitation and MAP Plans based on multiple TAC complaints received regarding inappropriate Social Day Care denials. An analysis of requested enrollee documentation has been completed, and it was determined that (for all Partial Capitation and MAP Plans) most often, the rationales failed to include the member's specific needs and preferences. The majority were also found to be lacking specific Social Day Care authorization policies or procedures.
- Based on the findings of the Focused Survey above regarding inappropriate Social Day Care denials, a follow up Focused Survey was initiated on all Partial Capitation and MAP

plans specific to social adult day care (SADC)/person centered service planning (PCSP) Policies and Procedures to ensure all plans develop or update their policies and procedures to be in line with the PCSP requirements under the HCBS Final Rule. Plan policies and procedures have been received and are under review.

3. Issues and Problems

There were no issues or problems to report for the January 2024 through March 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 DOH began a procurement process in December 2019 which was subsequently amended in the Executive Budget in April 2022. The amended legislation directly provided the criteria a FI must meet to contract with the DOH to continue to provide FI administrative services for the Consumer Directed Personal Assistance Program (CDPAP). In June 2023 DOH made additional awards under this criterion and has begun the contracting process for all awardees. Once contracts are executed, managed care plans will then enter into separate administrative service agreements with these Department-contracted FIs.

5. Required Quarterly Reporting

Critical incidents: There were 3,473 critical incidents reported for the January 2024 through March 2024 quarter, an increase of 6% 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 January 2024 through March 2024 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with Transportation, Dissatisfaction with Quality of Other Covered Services, Dissatisfaction with Quality of Home Care (other than lateness or absences), Dissatisfaction with Member Services and Plan Operations, Dissatisfaction with Care Management. The increase in the Dissatisfaction with Transportation is due to the March 1, 2024, carve-out of non-emergency medical transportation. DOH and the transportation broker-initiated resolutions to the complaints. The complaint volume began to decrease by the end of the month.

Period: 1/1/2024–3/31/2024 (Percentages rounded to nearest whole number)			
Number of Recipients: 339, 930	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**9**	**9**	**100%**
# Same Day	**2,889**	**2,889**	**100%**
# Standard/Expedited	**6,969**	**5,574**	**81%**
Total for this period:	**9,867**	**8,572**	**87%**

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

Appeals	4/2023-6/2023	7/2023-9/2023	10/2023-12/2023	1/2024-3/2024	Average for Four Quarters
Average Enrollment	313,672	321,917	331,288	339,930	326,702
Total Appeals	12,228	10,762	10,065	10,918	10,993
Appeals per 1,000	39	33	30	32	34
# Decided in favor of Enrollee	1,331	1,220	1,168	1,150	1,217
# Decided against Enrollee	8,571	8,263	6,765	7,407	7,752
# Not decided fully in favor of Enrollee	921	915	1,805	2,004	1,411
# Withdrawn by Enrollee	300	329	327	357	328
# Still pending	1,105	1,099	1,000	1,200	1,101
Average number of days from receipt to decision	6	7	7	10	8

Complaints and Appeals per 1,000 Enrollees by Product Type January 2024 – March 2024					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	284,147	6,005	21	8,344	29
Medicaid Advantage Plus (MAP) Total	44,626	2,737	61	2,481	56
PACE Total	9,466	1,125	119	93	10
Total for All Products:	**338,239**	**9,867**	**29**	**10,918**	**32**

Total complaints decreased 13% from 11,327 the previous quarter to 9,867 during the January 2024 through March 2024 quarter.

Total appeals increased 8% from 10,065 during the last quarter to 10,918 during the January 2024 through March 2024 quarter.

Technical Assistance Center (TAC) Activity

During the January 2024 through March 2024 quarter, TAC opened 1,258 cases and closed 1,335 cases. This is higher than the 873 cases opened, and 807 cases closed from the previous quarter. Upon examination, this quarter's case disposition categories with the largest increase in cases were the Unsubstantiated Complaints and Resolved Without Investigation, outlined in the table below.

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

Call Volume	**1/1/2024 – 3/31/2024**
Substantiated Complaints	141
Substantiated Complaints with CAP	1
Unsubstantiated Complaints	406
Resolved Without Investigation	187
Inquiries	600
Total Cases Closed	1,335

The five most common types of calls were related to:

Q2 2024	**1/1/2024 – 3/31/2024**
Grievance	29%
General	19%
Aide Service	11%
Enrollment	10%
Transportation	9%

65% of Q2 TAC cases were closed in the same month they were opened. This is a decrease from last quarter's percentage of 68%.

Evaluations for enrollment: 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 January 2024 through March 2024 quarter, 8,955 people were evaluated, deemed eligible and enrolled into plans, a 12% increase from the previous quarter.

Rebalancing Efforts	**1/2024-3/2024**
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	262
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,624

As of March 31, 2024, there were 3,503 current plan enrollees who were in NH as permanent placements, a slight increase from the previous quarter.

D. Children's Waiver

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

developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. **The Children's Waiver Renewal** that was submitted to CMS in January 2022, and extended in April 2022, was **approved on June 29**, **2022,** for an effective date of April 1, 2022. 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-Supplemental Security Income Fo1 children. The children will be targeted for Medicaid eligibility based on risk factors and institutional level of care and needs.
- Authority to institute an enrollment cap for Fo1 children who attain Medicaid eligibility via the 1115.
- Authority for Health Home care management monthly monitoring as an HCBS; and
- Removes managed care exclusion of children placed with Voluntary Foster Care Agencies.

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

- Continuing to refine data collection and data analysis to ensure accurate reporting.
- Engaging a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative.
- Submitting the Preliminary Interim Evaluation Report to CMS, as drafted by the vendor.
- Submitting the Interim Evaluation Report to CMS, as drafted by the vendor.
- Drafting policies and guidance to ensure compliance with State and Federal requirements, as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification.
- Updating manuals, guidance documents, and online resources as indicated
- Reassessing, streamlining, and removing unnecessary or duplicative forms to alleviate administrative burden.
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers, including additional resources and technical assistance with person-centered planning.

- Facilitating relationship building between MCOs, HCBS providers, and care managers to improve communication and care coordination.
- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation.
- Evaluating accuracy of MCOs and FFS billing and claiming data.
- Defining performance and quality metrics.
- Responded to the COVID-19 pandemic and implementing 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.
- Engaging with providers to understand barriers to service delivery – such as workforce challenges, lack of referral sources / lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers.
    - 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 is being built which will give more accurate information that is not dependent upon self-reports of providers.
- Engaging 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.
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between MCOs, Health Homes, and HCBS providers.
- Organizing and conducting workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral process.
- Engaging with Health Homes, MCOs, and HCBS providers while redesigning the Plan of Care in preparation for digitization.
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process.
- 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.

- Working 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.
- Updating the IRAMS and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- Engaging with HCBS providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if they are not currently able to actively deliver HCBS.
- Submitted 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 (Ats).
- Conducted Final Rule compliance reviews with newly designated HCBS providers.

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 also 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.
- Reducing 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 rate for seven counties was implemented to improve access to services.
- Transitioned the Environmental Modifications (EMod), Vehicle Modifications (VMod), Adaptive and Assistive Technology (AAT) to a Financial Management Service, starting March 1, 2024, based upon approval for Children's Waiver amendment.

- Developed Electronic Children's Services Staff Compliance Tracker.
- Updated and issued the Children's Care Management Authorization and Referral Forms ensuring it's inclusive 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.
- Developing Electronic Children's Referral System which would streamline, standardize, and ensure timely completion of referral per policy.
- Updating Children's Plan of Care Policy Workflow documentation to align and streamline policies and ensure language is comprehensive of the newly developed timeframes and follow Person-Centered Service Planning Guidelines.
- Drafting an Authorization Workflow Policy that will be circulated to stakeholders for feedback.
- Drafting a Referral Workflow Policy that will be circulated to stakeholders.
- Updated and posted documentation and guidance related to HCBS eligibility and enrollment.

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

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

	With K1 Flag – HCBS LOC	With KK Flag – Family of One		
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
January	10,997	5,287	5,937	302
February	10,868	4,215	5,974	224
March	10,550	2,016	5,974	114
Quarterly Average	**10,805**	**3,839**	**5,962**	**213**

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

This table includes Quarter 2 data from 1/1/2024-3/31/2024 of FY2024.

E. New York Health Equity Reform (NYHER) Amendment

The NYHER 1115 Amendment was approved by CMS on January 9, 2024, and will remain in effect throughout the remainder of the demonstration period. The primary goal of the amendment is "to advance health equity, reduce health disparities, and support the delivery of

health-related social need services (HRSN)." The State seeks to build on the investments, achievements, and lessons learned from the Delivery System Reform Incentive Payment (DSRIP) 1115 waiver program to scale delivery system transformation, improve population health and quality, deepen integration across the delivery system, and improve access to HRSN services. This will be achieved through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These investments are focused on HRSN services, population health improvement, and increasing workforce capacity.

1.HRSN

The State aims to advance HRSN services by leveraging regional Social Care Network (SCN) entities in the implementation of HRSN Services. SCNs will be tasked with creating and maintaining a network of contracted community-based organizations (CBOs) and social service providers with the capacity to screen all Medicaid members for HRSNs (in the domains of housing, nutrition, transportation, and case management); provide navigation services to existing state, federal, and local programs; and enhanced HRSN services to eligible MMC members to address their HRSNs.

Through a competitive Request for Application (RFA) procurement process, NYS DOH will award up to 13 entities across the state to become NYS designated SCN lead entities. Awarded entities will enroll via Electronic Medicaid System of New York State (eMedNY) as SCN Medicaid Providers and will be responsible for fiscal administration, contracting, data collection, referral management, and CBO capacity building in their respective region. During the quarter two reporting period, NYS DOH released the SCN procurement on January 16, 2024. NYS DOH held an applicant conference on January 24th and posted answers to questions on February 27th. Applications were due on April 16th at 4 pm.

NYS DOH aims to ensure that each Medicaid member will receive an HRSN screening annually or following a major life event. Members will be screened using a New York State-standardized version of the Accountable Health Communities (AHC) HRSN screening tool to assess member needs across a range of HRSN domains. Each SCN will be required to embed the screening tool and associated assessment questions in their IT Platform and have different modalities for conducting screening to ensure broad access. The IT Platform will also have a closed-loop referral functionality to ensure that members with identified needs receive timely navigation to social care services to address their needs and track service referral outcomes. NYS DOH has been working to adopt standardized coding that will be used for screening, assessment, service referral, and referral outcomes. We have engaged with Gravity and the Office of the National Coordinator for Health Information Technology (ONC) to align with national standards. NYS DOH will mandate these national social care data standards be adopted into the SCN's conventions for the following program activities: screening (LOINC), assessing (SNOMED-CT, ICD-10), referral (SNOMED-CT), and provisioning enhanced HRSN services (SNOMED-CT, HCPCS). By using these national terminology and exchange data standards, the State can track HRSN program activities from screenings to services and report metrics accordingly.

To support this initiative, the State is providing funding to build out necessary IT infrastructure to accommodate data sharing between the State or partner entities assisting in the administration of the demonstration and social services organizations and contracted providers. During quarter

two, NYS DOH has worked with the New York eHealth Collaborative (NYeC) to build out the interoperability of the Statewide Health Information Network for New York (SHIN-NY) for HRSN data collection. NYeC has established a data lake and a Master Person Index to match Medicaid members. NYeC has been testing connections with SHIN-NY qualified entities (QE) for the movement of Fast Healthcare Interoperability Resources (FHIR) based data from QEs to the statewide data lake. Once SCNs are selected through the RFA process, QEs will be connected with SCN IT infrastructure to receive screening, assessment, and referral information. Included in this work is the development of FHIR based implementation guides to support the consistent and standards-conformant exchange of data between SCNs and healthcare entities. NYS DOH has engaged the relevant NYS Departments/Agencies to establish Data Use Agreements (DUAs) for the purpose of tracking Medicaid beneficiaries who are referred to and successfully connected to SNAP and WIC benefits.

The HRSN FFS Payment Methodology was submitted on March 31, 2024. NYS DOH is on track to begin HRSN service delivery by August 1, 2024. NYS DOH plans to monitor HRSN service utilization trends to determine the feasibility of including HRSN services in MMC and FFS programs.

2.Workforce

The State is working to implement two statewide workforce initiatives, the Student Loan Repayment program and Career Pathways Training (CPT) program to support workforce recruitment and retention and to promote the increased availability of high-demand health, behavioral health, and public health practitioners to serve Medicaid beneficiaries.

Student Loan Repayment

To support recruitment and retention of high-demand practitioners, healthcare professionals who make a four-year commitment to maintain a personal practice panel or work at an organization that includes at least 30% Medicaid and/or uninsured members will be eligible for student loan repayment. Healthcare titles that are eligible for this repayment include psychiatrists, with a priority on child/adolescent psychiatrists; primary care physicians and dentists; and nurse practitioners and pediatric clinical nurse specialists. The State has engaged in the early stages of planning to identify program and eligibility parameters, develop application and monitoring processes, and consider additional aspects of the program's design and implementation. The State is planning to launch this program by the end of 2024 or early 2025.

CPT Program

To address statewide workforce shortages, the CPT program will fund education and participant support services to provide holistic educational and professional placement supports for those newly entering the workforce and those seeking to advance in their careers. Participants in the CPT program will make a three-year commitment of service, in the new professional title, to Medicaid providers that serve at least 30% Medicaid members and/or uninsured individuals. The program is organized to support two career pipelines, New Careers in Healthcare, for individuals newly entering the healthcare workforce, and Healthcare Career Advancement, for individuals currently in the healthcare workforce. Healthcare titles that are eligible for participation in this program include nursing, professional technical, and frontline public health workers.

Workforce Investment Organizations (WIOs)

The State is in the process of selecting three WIOs to manage the CPT program. Each WIO will be responsible for CPT activities in one of three regions: region one covers the Hudson Valley, New York City, and Long Island; region two covers the North Country, Capital Region, Southern Tier, and Central New York; and region three covers the Finger Lakes and Western New York. WIOs were first established as part of the 2018 Managed Long Term Care Workforce Investment Program (MLTC WIP).

The Department has developed criteria for selecting the three WIOs. They must have deep connections to their respective regions; demonstrated success in operationalizing workforce training programs; expansion beyond the MLTC WIP titles; and capacity to stand up the CPT program rapidly and effectively in their region. WIOs will partner with training and educational institutions with programs that are accredited or certified by the State or organizations recognized by the State; health systems; SCNs; and institutional entities that will provide education and training to CPT participants and will be responsible for conducting outreach to recruit prospective students and providers. WIOs will utilize recruitment toolkits and multimedia campaigns, with a goal of targeting a diverse group of participants in their outreach to increase diversity in the healthcare workforce. In addition to CPT program infrastructure and administration, the WIOs will provide meaningful support for participants to ensure successful completion of programs, including case management, tutoring, other academic support, coordinating educational programs; make payments for books, academic fees, and backfill for current employees' time spent in training programs; and aide in job placement to meet service commitments. WIOs will need to monitor students carefully to identify who is succeeding and who is struggling. Once enrolled, WIOs will work with educational partners and require them to notify WIOs of students who are struggling academically as early as possible during the semester.

The State has been engaged in program design work, as well as planning for contracting with the WIOs and implementation. is underway. The State is currently preparing program guidance documents that outline expectations and parameters around operational structure, staffing and IT, educational and provider partnerships, outreach and enrollment, payment, program oversight, reporting, and monitoring of the service commitment. The State expects WIOs to implement the CPT program in July 2024.

3.Health Equity Regional Organization (HERO)

The HERO will be an independent statewide entity that will be responsible for data aggregation for health and social care data to support population health improvement activities; regional needs assessment and planning to identify health equity-related needs, service delivery, and workforce-related gaps contributing to health disparities; value-based payment (VBP) design and development that addresses health, behavioral health and HRSNs; and program evaluation through an ongoing review of waiver programs and access to new services to support continuous improvement in program design, implementation, and impact. The State is working to build out the HERO design, activities, and requirements. HERO health equity planning work is anticipated to begin in July 2024.

4. Medicaid Hospital Global Budget Initiative (MHGBI)

The goal of the MHGBI is to stabilize and transform targeted financially distressed voluntary hospitals to advance health equity and improve population health in communities with the most evidence of health disparities. This goal aligns with the CMMI States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. This initiative will be structured through incentive funding to stabilize Medicaid-dependent financially distressed safety net hospitals and develop necessary capabilities to advance health equity; participate in advanced VBP arrangements; and deepen integration with primary care, behavioral health, and HRSN services.

Participating hospitals will be required to submit hospital health equity plans that align with statewide priorities; participate in quality improvement activities that address community specific health disparities in alignment with health equity plans; and create a roadmap outlining activities required to transition to a global budget and support community wide population health.

On March 26, 2024, the State 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 Hospital Global Budget Payment Initiative. The State intends to apply to participate in the AHEAD demonstration during the second Notice of Funding Opportunity (NOFO) period in Cohort 3 by August 12, 2024. The first year Medicaid Hospital Global Budget payments were sent out in March 2024. On March 31, 2024, the State submitted a detailed plan for how participating hospitals will collect beneficiary demographic and HRSN data and related metrics.

F. 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 (1) improving the quality / experience of care, (2) improving the health of populations, and (3) 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 ACA / Parity Legislation, the NYS 1115 MMC waiver program and New York SPA's: 16-0004, 21-0064, 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. Via the changes to the 1115 waiver and the 1115 waiver NYHER and IMD transformation amendments, NYS received comprehensive Federal approval for the residential redesign initiative. 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's 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 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, 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; Services for those transitioning to long term recovery and independent living. Staffing includes case managers, housing experts, employment supports, recovery wellness.

- Medication for addiction treatment – the Part 820 Programs [4] Regulations:
  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

[4] https://oasas.ny.gov/system/files/documents/2022/09/part820.pdf

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[5] and new programs must follow the certification process for new programs.[6]

- To support programs development/conversion to the Part 820 residential model, OASAS provided technical assistance sessions and developed a comprehensive set of technical assistance tools: readiness guidance documents, clinical manuals and fiscal modeling tools.[7]
- As of April 2024, statewide, there are a total of 148 Part 820 Programs. There are 57 remaining programs to convert from the previous residential or medically monitored model.

Service	Total Number of Programs	Total Number of Beds
Stabilization	9	227
Rehabilitation	10	491
Reintegration	69	1,682
Stabilization and Rehabilitation	15	622
Rehab and Reintegration	14	459
Stabilization Rehab and Reintegration	31	1,890
Grand Total	148	5,371

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[8] 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.

Level of Care Determination

NYS utilizes the LOCADTR[9] tool to support level of care determination. The tool has been utilized over 2 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

[5] https://oasas.ny.gov/system/files/documents/2022/05/resredesignapp_0.pdf
[6] https://oasas.ny.gov/providers/program-certification
[7] https://oasas.ny.gov/residential-services
[8] https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
[9] https://oasas.ny.gov/locadtr

and commercial payers in NYS are required to use LOCADTR (unless otherwise approved by OASAS).

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 is available 24 hours a day/7-days a week via an application on the Health Commerce System (HCS)[10]. 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 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 to raise healthcare 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 healthcare provider takes the Opioid Prescriber Training, there is a required pre and post-test. During the timeframe of 12/1/2023 through 2/29/2024, more than 6,500 healthcare providers took the Opioid Prescriber Training across eight different provider types. * There was significant improvement in knowledge when comparing pre and post test scores, ranging from an increase of 17.48% to 29.55% for each category type.

*The CDC funded Overdose Data to Action – States grant's quarterly reporting was 12/1/2023 - 2/29/2024.

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 3/31/2024, BNE has data sharing agreements with 35 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi and RxCheck hubs. This demonstrates an increase of one new interoperable state during this time. 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. 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

[10] https://commerce.health.state.ny.us

clinical workflow for prescribers and other state and federal stakeholders via EHR integration. The first option is integrating with the RxCheck hub. As of 3/31/2024, NYS ITS built the technical architecture to begin testing this option. 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 September 2023 to February 2024, BNE in collaboration with the NYS Information Systems and Health Statistics Group (ISHSG), onboarded one of six NYS HIEs and had more than 30 facilities within the HIE access the NYS PMP registry**. BNE continues to work with the NYS ISHSG to onboard additional HIEs and increase the number of users querying the PMP via this method.

**The CDC funded Overdose Data to Action – States grants' quarterly reporting was 9/1/2023-11/30/2023 and 12/1/2023 - 2/29/2024.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 evaluation design to CMS for review and approval. CMS returned the evaluation design with comments on April 18, 2023. DOH submitted a revised evaluation design to CMS on June 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.

VII. Consumer Issues

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

MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to the DOH on the number and type of enrollee complaints/action appeals that are received. MCOs are also required to report on the number and type of complaints that are received regarding enrollees who are in receipt of SSI.

The following table displays the number of complaints MCOs reported by category for the most recent quarter and for the previous quarter.

MCO Product Line	Total Complaints	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
MMC	5,594	4,930
HARP	619	560
HIV SNP	87	98
Total MCO Complaints	**6,300**	**5,588**

As described in the table, MCOs reported 6,300 total enrollee complaints for the current quarter. This represents a 12.7% increase from the prior quarter's total of 5,588 enrollee complaints.

MCOs reported 5,594 MMC complaints this quarter, which is a 13.5% increase from the 4,930 of the previous quarter. The number of HARP complaints increased 10.5%, from 560 in the prior quarter to 619 this quarter. There were 87 HIV SNP complaints this quarter, which is a decrease of 11.2% when compared to the 98 from the previous quarter.

The following table displays the top five most frequent categories of complaints reported for MMCs, HARPs, and HIV SNPs, combined, for the most recent quarter and for the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Balance Billing	15%	15%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	14%	13%
Difficulty with Obtaining: Dental/Orthodontia	9%	12%
Reimbursement/Billing	8%	10%
Dissatisfaction with Obtaining: Specialist and Hospitals	6%	6%

The following table displays the top five most frequent categories of complaints reported for HARPs for the most recent quarter and for the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	22%
Dissatisfaction with Quality of Care	9%	11%
Difficulty with Obtaining: Specialist and Hospitals	5%	7%
Balance Billing	5%	5%
Access to Non-Covered Services	5%	1%

The following table displays the top five most frequent categories of complaints reported for HIV SNPs for the most recent quarter and for the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Dissatisfied with Provider Services (Non-Medical) or MCO Services	24%	20%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	16%	33%
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	16%	4%
Difficulty with Obtaining: Dental/Orthodontia	13%	13%
Balance Billing	7%	3%

The DOH reviewed the increase in HIV/SNP enrollee complaints received from the MCOs regarding Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment. Upon examination, the increase stemmed from the number of HIV/SNP enrollee complaints in that complaint category reported by one MCO. DOH is following up with that particular MCO regarding the differences between the most recent quarter compared to the previous quarter.

B. Monitoring of Plan Reported Complaints

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

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

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

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

Amida Care FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**OE Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	13.7	The trend identified from the complaints received was that enrollees were dissatisfied with the medication, treatment, and overall care received at various hospitals and physicians' offices. There were no issues identified.	The MCO will continue to educate enrollees and providers surrounding gender affirming care.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	13.0	The trend identified from the complaints received was that the MCO's call center representatives and provider offices were not providing the best customer service to enrollees. The issues identified were that representatives transferred calls incorrectly, did not provide adequate information, and misgendered the enrollees.	The MCO will address poor customer service by coaching representatives on appropriate call etiquette and by implementing an Escalation queue to allow calls from enrollees to easily be connected to an Escalation Representative, Team Lead, or Supervisor to handle complex enrollee inquiries. The MCO addressed enrollees being misgendered by following up with providers to address the enrollees' complaints accordingly.
Difficulty with Obtaining: Dental/ Orthodontia	6.1	The trends identified from the complaints received were dissatisfaction with covered benefits such as dentures, lack of response from dental providers, a provider office that temporarily closed after submitting a claim for dentures and not informing the enrollee of the closure, and poor customer service from Healthplex representatives. There were no issues identified.	The MCO will provide custom gender sensitivity training as well as an annual cultural awareness training module which also includes a section about gender sensitivity. The MCO will continue to reach out to each individual office and re-educate staff as needed.

Capital District Physicians Health Plan FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	4.8	There were no trends identified by the MCO. The issue identified was that enrollees were dissatisfied with the continuity and quality of care received.	The MCO will review quality of care complaints by sharing feedback with providers, grading incidents based on severity, and review all quality-of-care complaints for any trends or multiple complaints regarding the same provider.
Reimbursement/Billing	2.4	The trend identified from the complaints received was that enrollees were being billed for services. The issues identified were that enrollees were unknowingly being seen by and referred to out-of-network providers.	The MCO will educate enrollees regarding their multiple provider networks depending on the line of business. The MCO will continue to monitor all billing complaint submissions and identify any trends.

Healthfirst FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Long Wait Time	3.0	The trend identified from the complaints received was that enrollees were dissatisfied with the length of time spent waiting in the office upon arriving to their appointments. The issue identified was that appointments were overbooked without adequate staffing.	The MCO reached out to providers with existing complaints during February 2024 and will distribute reminders to the provider network about all NYS Access and Availability Standards in April 2024. The MCO will continue to send monthly email reminders to call center representatives regarding the process of handling enrollee complaints about appointment availability, including long wait times.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.5	The trend identified from the complaints received was that enrollees were experiencing issues related to durable medical equipment (DME), including delivery issues	The MCO revised their handling of enrollee initiated DME requests to require a prescription before processing the authorization and vendor fulfillment, with the goal of reducing DME complaints.

		and lack of prescription. The issue identified was that DME vendors were delayed in their deliveries to enrollees.	
Difficulty with Obtaining: Emergency Services	4.1	The trend identified from the complaints received was that enrollees were being billed, or balance billed, for emergency services rendered. The issues identified were that there was no claim on file for out-of-network emergency room visits, emergency rooms were balance billing enrollees, and enrollees were not presenting their insurance cards which lead to receiving bills for emergency room visits.	The MCO's Delivery System Engagement (DSE) department will continue to contact out-of-network providers/facilities to negotiate reimbursement rates for emergency services. The MCO also enhanced their call center representatives' scripts to include awareness of out-of-network billing issues, including a reminder to present their insurance cards at all visits. The Department will continue to monitor progress in the next reporting period.
Reimbursement/Billing	2.3	The trend identified from the complaints received was that enrollees were dissatisfied with being billed for services rendered. The issues identified were that enrollees were not presenting their insurance cards at their visits, enrollees were being billed for services when private pay agreements had been signed, and out-of-network providers billing enrollees directly.	The MCO is continuing to have their Appeals and Grievances unit to work with DSE to educate and remind providers of the importance of submitting claims timely, the prohibition of balance billing enrollees, and informing enrollees of non-covered services and private pay agreements before rendering services.
Difficulty with Obtaining: Private Duty Nursing	4.3	The trend identified from the complaints received was that enrollees were dissatisfied with their private duty nursing (PDN) agencies and aides. The issues identified were that some PDNs did not show up or were late, and the agency not communicating	The MCO will hold monthly meetings with PDNs starting in Q2 2024 to establish the expectation of communicating staffing issues ahead of time and will develop a remediation plan to rectify how the PDNs should communicate timely to the enrollees.

		to the enrollee if there was adequate staffing to replace or backfill the shift on short notice.	
Difficulty with Obtaining: Personal Care	3.9	The trend identified from the complaints received was that enrollees were dissatisfied with their personal care agencies and aides. The issues identified were that some personal care aides were absent or tardy, unprofessional, inexperienced, and did not provide satisfactory quality of service.	The MCO's DSE department will meet monthly with providers starting in Q2 2024 to establish expectations for level of care and to identify the root causes that impact aide performance and professionalism.
Difficulty with Obtaining: CDPAS	3.4	The trend identified from the complaints received was that enrollees indicated that their aides were unpaid or not paid timely. The issues identified were delays in start dates due to missing and/or incorrect paperwork, and payment delays from fiscal intermediaries (FIs).	The MCO's DSE department will conduct monthly calls/webinars with providers and enrollees regarding CDPAS forms and requirements beginning Q2 2024 to address issues. The Department will continue to monitor progress in the next reporting period.
Dissatisfaction with BH Provider Services	2.59	The trend identified from the complaints received was that enrollees found that therapists, providers, or facility staff were unresponsive, did not listen to concerns, and were unhelpful. There were no issues identified.	The MCO's Call Center Operation (CCO) department will conduct a training in Q3 2024 covering the behavioral health benefit and will provide education to enrollees who call to inquire about using their behavioral health benefits.

Highmark FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: Specialist	17.9	The trend identified from the complaints received was that enrollees were having trouble finding in-network care within their	The MCO will continue to educate and direct enrollees to in-network providers, as well as educate providers on the proper referral process for specialty

		desired distances with certain specialties, such as rheumatology, ENT, pain management, and cardiology. The issues identified were that enrollees were unfamiliar with available tools such as the MCO website's "Find a Doctor" feature, Sydney Health app, and contacting the MCO's Member Services.	services. The MCO has also provided refresher training to Member Services staff and enhanced the Sydney Health app to simplify the process of finding care based on provider name, specialty name, hospital name, or needed procedure.
Difficulty with Obtaining: Specialist and Hospitals	3.9	The trend identified from the complaints received was that enrollees were dissatisfied with authorizations not being approved. The issue identified was that appeals were not submitted in a timely manner, per the initial adverse determination letter, leading enrollees to file complaints to have the authorization reviewed.	The MCO continues to educate and redirect enrollees to in-network providers and educate providers on the correct process to request services for enrollees.
Balance Billing	4.4	The trend identified from the complaints received was that enrollees were being billed by out-of-network providers and facilities for services rendered. The issues identified were that out-of-state providers were sending enrollees bills for claims that were already adjudicated.	The MCO will continue to educate providers on the laws surrounding balance billing. The Department will continue to monitor progress in the next reporting period.

Health Insurance Plan of Greater New York FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Long Wait Time	6.3	There were no trends identified by the MCO. The issues identified were that complaints were being	The MCO will provide a refresher training to appropriate staff on the categorization of complaint data and monitor this

		miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	as part of their monthly quality audit program.
Difficulty with Obtaining: Dental/Orthodontia	6.9	The trend identified from the complaints received was that enrollees were dissatisfied with covered dental benefits. The issue identified was that enrollees were requesting non-covered services.	The MCO and vendor will continue to educate enrollees about what is and is not covered under the dental benefit, by sending welcome kits within 30 days of enrollment.
Reimbursement/Billing	6.3	The trend identified from the complaints received was that enrollees were dissatisfied that they received bills. The issues identified were that enrollees misinterpreted Explanations of Benefits (EOBs) as bills, enrollees were being balance billed by contracted and non-contracted providers, and complaints were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will educate enrollees on the differences between bills and EOBs, educate providers on not balance billing Medicaid enrollees, and retrain staff on proper complaint categorization.

Independent Health Association FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	3.3	The trend identified from the complaints received was that enrollees were dissatisfied with providers and provider care. The issues identified were inappropriate treatment, misdiagnosis, and medication errors.	The MCO will continue to conduct provider outreach to identify issues and will institute CAPs as needed. The Department will continue to monitor progress in the next reporting period.

MetroPlus Health Plan FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	2.9	The trend identified from the complaints received was that enrollees were experiencing difficulty obtaining new or replacement frames. The issues identified were that providers and enrollees were lacking education on the vision benefit and proper billing, providers and enrollees were not properly collaborating to address the enrollees' coverage concerns, and some prescriptions were not completed accurately.	The MCO will proactively educate all vision providers on the vision benefit, billing practices, and verifying eligibility, and will implement targeted training and support initiatives for providers with high complaint volumes. The MCO will highlight their website's vision benefit information and encourage use of its Member Portal to empower enrollees to obtain accurate information regarding their benefit and eligibility.
Balance Billing	2.1	The trend identified from the complaints received was that enrollees were being balance billed. The issues identified were that enrollees were using out-of-network providers, providers were not verifying enrollee eligibility, there was improper coordination of benefits, enrollees were unaware of the benefit limits and sought care that was not covered, and enrollees were billed after claims were filed.	The MCO will educate its enrollees and providers on how preventive care is covered to improve understanding of the benefit and its limits. The MCO will train its providers on utilizing the most current enrollee eligibility information.
Dissatisfaction with Health Home Care Management	5.5	The trends identified from the complaints received were that enrollees were uninformed about the status of their authorization requests despite timely processing, and an enrollee was dissatisfied with their wound care supplies. The issues identified were that there were communication	The MCO will proactively educate providers on how to obtain the most current authorization information from an associate or through its interactive voice assistant. The MCO will educate enrollees on how to access online authorization information through its Member Portal. The MCO will continue to implement

		issues between enrollees and providers regarding authorization timelines and updates, and that care decisions were not being clearly communicated to enrollees.	targeted training and support initiatives for providers with high complaint volumes.

Molina Healthcare FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	5.6	The trends identified from the complaints received were that enrollees were having difficulty finding primary care physicians (PCPs) and that some physicians were not following the Access and Availability standards. The issue identified was that enrollees were unaware of how to locate participating PCPs.	The MCO will recommend that a tutorial on navigating its website be included in the member orientation. The MCO will reach out and educate providers that are not meeting the Access and Availability standards. The MCO will follow a quality improvement process including CAPs if necessary for providers who fail an internal survey. The MCO will closely monitor its network for any gaps and will contract with additional providers when gaps are identified. The Department will continue to monitor progress in the next reporting period.
Dissatisfaction with Quality of Care	3.2	The trends identified from the complaints received were that enrollees disliked their treatment plans, enrollees were dissatisfied with their providers' expertise, and enrollees were having issues with their medications. The issue identified was that inquiries were miscategorized as complaints.	The MCO will identify and retrain its call center representatives on proper categorization of inquiries and complaints. The MCO will provide annual refresher trainings to ensure proper categorization.
Difficulty with Obtaining: Specialist and Hospitals	7.2	The trends identified from the complaints received were that enrollees were having difficulty finding specialists and hospitals	The MCO will recommend that a tutorial on navigating its website be included in the member orientation. The MCO will reach out and educate providers that

		and that some physicians were not following the Access and Availability standards. The issue identified was enrollee difficulty with navigating the MCO website to search for specialist providers.	are not meeting the Access and Availability standards. The MCO will follow a quality improvement process including CAPs if necessary for providers who fail an internal survey. The MCO will closely monitor its network for any gaps and will contract with additional providers when gaps are identified. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Eye Care	2.8	The trends identified from the complaints received were that enrollees were unable to locate vision providers, enrollees were dissatisfied with the customer service of office staff, enrollees were questioning the vision benefit, and enrollees were inquiring about their appeal status. The issue identified was that enrollees were unfamiliar with navigating the MCO's website to search for vision providers.	The MCO will continue to have its customer service representatives address enrollee concerns and questions about the vision benefit. The MCO will outreach providers with complaints and provide CAPs if necessary. The MCO will measure and address provider network adequacy gaps. The MCO will provide training on using its website to locate providers during member orientation and when enrollees request assistance with locating providers.
Pharmacy/Formulary	12.1	The trends identified from the complaints received were delays in prior authorization, reported eligibility issues, and enrollees being unable to fill prescriptions. The issues identified were that enrollees did not fully understand their pharmacy benefit, there were systemic errors during the eligibility and benefit verification process, providers were not submitting authorization requests timely, enrollees were unaware of the steps involved in the	The MCO will have its pharmacy team communicate with provider relations to help implement system updates and assist with prior authorization procedures. The MCO will have its pharmacy team notify its enrollment team of enrollee eligibility issues to minimize service delays. The MCO will provide comprehensive procedure documents to assist with enrollee inquiries. The MCO have regular document reviews to be validated by subject matter experts to address concerns efficiently. The MCO will conduct regular meetings with leadership and its departments to facilitate

		authorization process, and there were issues with medication availability of specific drugs at pharmacies.	collaboration to improve identification and resolution of high-volume issues. The MCO will enhance its resources to provide tailored information regarding its pharmacy concerns.
Communications/ Physical Barrier	5.1	The trends identified from the complaints received were that enrollees were dissatisfied with communications. There were no issues identified, as all complaints were resolved in the same call.	The MCO will share weekly reports of complaints with leadership and identify areas of opportunities to educate enrollees and internal business partners.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	11.7	The trend identified from the complaints received was that enrollees were having enrollment and disenrollment issues. The issues identified were that enrollees were seeking care from out-of-network providers, enrollees did not receive their ID cards, enrollees were unaware of the benefit, there were issues with coordination of benefits, and there were enrollment verification issues.	The MCO will conduct regular meetings with leadership to facilitate collaboration to improve identification and resolution of high-volume issues. The MCO will conduct regular meetings with its business partners to address eligibility issues and trends.
All Other	14.8	The trend identified from the complaints received was that enrollees were dissatisfied with prior authorization requirements. The issue identified was that enrollees and providers did not understand the authorization process.	The MCO will use its website to educate its providers on the authorization process. The MCO will share a report of complaint types with leadership to identify opportunities to educate enrollees. The Department will continue to monitor progress in the next reporting period.

Balance Billing	9.9	The trend identified from the complaints received was that providers were billing enrollees for services received. The issues identified were that enrollees failed to present insurance ID cards.	The MCO will contact providers who balance bill and remind them that this is not allowed. The MCO will educate enrollees at enrollment and when they are balance billed to remind them to provide their insurance information. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Home Health Care	11.8	The trends identified from the complaints received were that enrollees were having difficulty finding home health agencies with available aides and that some agencies were not following the Access and Availability standards. The issue identified was a lack of enrollee education on how to locate home health agencies.	The MCO will educate its care managers and clinical review processors to assist enrollees with the process of finding agencies and to always contact home care vendors to ensure they have availability before sending them an authorization and assigning a different vendor if they do not. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: CDPAS	2.9	The trend identified from the complaints received was that enrollees were having difficulty finding fiscal intermediaries. The issue identified was a lack of enrollee education on the process of receiving CDPAS.	The MCO will educate CDPAS enrollees on the requirements for enrolling in the CDPAS program. The MCO will provide CDPAS enrollees with a list of fiscal intermediaries and offer to have a case manager assist during this process.

MVP Health Plan FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	5.0	The trends identified from the complaints received were that enrollees' dental issues were not being addressed, enrollees were receiving inappropriate treatment, enrollees were receiving bills for their care, enrollees did not have participating providers within a reasonable	The MCO's dental vendor will re-educate its customer service representatives on assisting enrollees with locating dental providers and scheduling appointments and will reach out to its dental providers to assist with billing issues. The MCO's dental vendor will review all dental complaints and address network availability issues. The

		distance from their homes, and enrollees were receiving poor customer service from their providers and their staff. The issues identified were that providers were inappropriately billing enrollees and incorrectly submitting claims, providers and staff were unprofessional towards the enrollees, providers were canceling and rescheduling appointments, and providers were unable to provide dentures that fit after multiple revisions.	MCO's dental vendor will educate providers to improve their service upon receipt of complaints against them. The Department will continue to monitor progress in the next reporting period.

United Healthcare FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.7	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were that enrollees were experiencing pain during or after their dental treatments, enrollees reported unprofessional or substandard treatment, enrollees reported being improperly diagnosed, providers did not fully explain or properly document medical results and treatment plans, and providers refused to see enrollees.	The MCO will determine which providers need corrective action and outreach and provide remediation plans including providing counseling; requesting formal continued medical education, conducting focused medical care reviews; reporting to state boards, and restricting, suspending, or terminating network participation, if necessary.
Denial of Clinical Treatment	14.0	The trend identified from the complaints received was that enrollees were receiving denials for services. The issues identified were that many	The MCO will continue to monitor denials and implement remediation when necessary. The MCO educated its staff regarding appropriate coding of complaints and appeals. The

		dental services were denied due to a guideline that will be removed in future quarters, and that complaints and appeals that should have been categorized under Difficulty Obtaining: Dental/Orthodontia were miscategorized.	Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	2.3	The trends identified from the complaints received were that enrollees were having difficulty finding appointments with in-network providers, enrollees were experiencing delays and long wait times for their appointments, and enrollees were dissatisfied with the quality of their dental care. The issues identified were that some counties in New York's rural areas only had a few in-network dental specialists, dentists in rural areas do not want to participate with Medicaid plans due to the requirement to meet access standards, some providers' staff were unaware of the office's participation with the MCO, some providers were providing poor quality of care to the enrollees, and some complaints were miscategorized.	The MCO will confirm with providers who enrollees report are not participating or accepting new patients, to maintain accurate and up-to-date indicators. The MCO will continue to work with out-of-network providers to create single case agreements. The MCO will continue to reach out to providers with quality-of-care complaints and develop individual action plans to resolve these issues. The MCO educated its staff regarding appropriate coding of complaints and appeals, flagged cases that have been miscoded to ensure the correct coding is submitted in the next report, and created an updated job aid to assist staff in proper coding.
Communications/ Physical Barrier	6.9	The trends identified from the complaints received were rude or unprofessional behavior from providers and MCO staff members, enrollees being assigned a case	The MCO will provide individual coaching to staff members who receive complaints against them. The MCO will continue to educate participating providers on enrollees' rights to be treated with respect and to discuss and

		manager when they did not want one, enrollees receiving notices in the incorrect language, and enrollees being provided incorrect information. There were no issues identified.	make decisions regarding their health care and treatment. The MCO will utilize secret shoppers as fake enrollees to call the MCO call center, who reveal their identity and provide coaching at the end of the call as well as compiling and discussing results monthly to identify trends that need further training or CAPs.
Reimbursement/Billing	2.6	The trend identified from the complaints received was that enrollees were being balance billed. The issue identified was that complaints that should have been categorized under Balance Billing were miscategorized.	The MCO educated its staff regarding appropriate coding of complaints and appeals.
Balance Billing	2.2	The trend identified from the complaints received was that enrollees were being balance billed. The issue identified was that out-of-network providers were not accepting the Medicaid rates of payment and were billing enrollees for the balance, especially surprise anesthesia bills.	The MCO will continue to reach out to providers who balance bill to negotiate an acceptable rate and reprocess claims at that rate. The MCO is discussing ways to prevent surprise anesthesia bills.

VNS Choice FFY 23 Q4–FFY 24 Q1 (7/1/2023–12/31/2023)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	196.0	The trends identified from the complaints received were that enrollees were dissatisfied with the restrictions placed on their rewards card and some enrollees did not receive their rewards card. The issues identified were that the “Final Rule: Medicare and State Health Programs: Fraud and Abuse;	The MCO implemented a new, more flexible card that follows state and federal guidelines but aligns with the enrollees’ needs. The MCO will monitor data regarding the rewards cards to identify underlying issues that need to be addressed.

		Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements" placed restrictions on rewards cards that the MCO was not aware of when sending out the original cards, leading to enrollee dissatisfaction with the cards that were in compliance; enrollees do not shop at the allowed stores or they were located too far; and there were address issues and lack of education regarding timing of mailing of the cards.	

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 6,300 total reported complaints/action appeals, MCOs reported 484 complaints and action appeals from their SSI recipients. This compares to 514 SSI complaints/action appeals from the previous quarter, representing a 5.9% increase.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Appointment Availability: PCP	0	1
Appointment Availability: Specialist	4	2
Appointment Availability: BH HCBS	1	1
Long Wait Time	2	6
Dissatisfaction with Quality of Care	33	31
Denial of Clinical Treatment	9	8
Denial of BH Clinical Treatment	1	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	130	148
Dissatisfaction with BH Provider Services	5	2
Dissatisfaction with Health Home Care Management	6	8
Difficulty with Obtaining: Specialist and Hospitals	25	37

Difficulty with Obtaining: Eye Care	1	4
Difficulty with Obtaining: Dental/Orthodontia	22	31
Difficulty with Obtaining: Emergency Services	0	0
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	0	0
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	14	15
Difficulty with Obtaining: Home Health Care	4	6
Difficulty with Obtaining: Personal Care	48	56
Difficulty with Obtaining: PERS	1	0
Difficulty with Obtaining: CDPAS	21	22
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	3	1
Access to Non-Covered Services	2	5
Access for Family Planning Services	0	1
Communications/ Physical Barrier	0	0
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9	3
Recipient Restriction Program and Plan Initiated Disenrollment	1	0
Reimbursement/Billing	54	60
Balance Billing	43	27
Transportation	3	5
All Other	42	34
Total	**484**	**514**

The following table displays the top five most frequent categories of SSI recipient complaints/action appeals MCOs reported for the most recent quarter and for the previous quarter:

Description of Complaint	**Percentage of Total Complaints/Appeals Reported for SSI Recipients**	
	FFY 24 Q2 1/1/2024–3/31/2024	**FFY 24 Q1 10/1/2023–12/31/2023**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	27%	29%
Reimbursement/Billing	11%	12%
Difficulty with Obtaining: Personal Care	10%	11%
Balance Billing	9%	5%
Dissatisfaction with Quality of Care	7%	6%

The 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 January 1, 2024, through March 31, 2024, MCOs reported LTSS enrollment of 58,207 enrollees. This compares to 58,051 LTSS enrollees

from the previous quarter, representing a 0.3% increase. The following table displays the number of LTSS enrollees by MCO for the most recent quarter and for the previous quarter:

Plan	Number of LTSS Enrollees	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Amida Care	1,265	1,261
Capital District Physicians Health Plan	346	770
Excellus Health Plan	1,800	1,821
Fidelis Care	20,680	20,875
Healthfirst	15,718	15,278
Highmark	315	297
HealthPlus	3,684	3,608
HIP of Greater New York	431	445
Independent Health Association	769	757
MetroPlus Health Plan	3,646	3,544
Molina Healthcare	3,107	3,050
MVP Health Plan	2,586	2,505
United Healthcare	3,414	3,408
VNS Choice	446	432
Total	**58,207**	**58,051**

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

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023
Difficulty with Obtaining: AIDS Adult Day Health Care	1	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: CDPAS	58	69
Difficulty with Obtaining: Home Health Care	26	55
Difficulty with Obtaining: RHCF Services	4	0
Difficulty with Obtaining: Personal Care	129	149
Difficulty with Obtaining: PERS	2	1
Difficulty with Obtaining: Private Duty Nursing	20	19
Total	**240**	**293**

The DOH reviewed the decrease in enrollee complaints regarding difficulty obtaining Home Health Care received from the MCOs. Upon examination, the decrease stemmed from the number of enrollee complaints in these categories reported by one MCO.

D. Critical Incidents

The DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 110 critical incidents reported for the January 1, 2024, through March 31, 2024, period, most of which have a resolved status. Many of the incidents stemmed from falls. DOH continues to work with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

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

Plan	Critical Incidents		
	FFY 24 Q2 1/1/2024–3/31/2024	FFY 24 Q1 10/1/2023–12/31/2023	Net Change
Mainstream Medicaid Managed Care Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	12	16	-4
Fidelis Care	2	0	+2
Healthfirst	61	49	+12
HIP of Greater New York	0	0	0
Highmark	0	0	0
HealthPlus	3	1	+2
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
Total	**78**	**66**	**+12**
Health and Recovery Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	2	2	0
Fidelis Care	0	0	0
Healthfirst	28	26	+2
HIP of Greater New York	0	0	0
HealthPlus	0	1	-1
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0

MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**30**	**29**	**+1**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	2	2	0
Total	**2**	**2**	**0**
Grand Total	**110**	**97**	**+13**

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

Category of Incident	Critical Incidents		
	FFY 24 Q2 1/1/2024–3/31/2024	**FFY 24 Q1 10/1/2023–12/31/2023**	**Net Change**
Mainstream Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	4	7	-3
Crimes Committed Against Enrollee	5	4	+1
Crimes Committed by Enrollee	2	2	0
Instances of Abuse of Enrollees	2	2	0
Instances of Exploitation of Enrollees	2	0	+2
Instances of Neglect of Enrollees	2	2	0
Medication Errors that Resulted in Injury	1	0	+1
Other Incident Resulting in Hospitalization	15	8	+7
Other Incident Resulting in Medical Treatment Other Than Hospitalization	45	41	+4
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**78**	**66**	**+12**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	2	1	+1
Crimes Committed Against Enrollee	2	1	+1
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	1	2	-1
Instances of Exploitation of Enrollees	0	0	0

Instances of Neglect of Enrollees	0	0	0
Medication Errors that Resulted in Injury	0	1	-1
Other Incident Resulting in Hospitalization	3	2	+1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	22	20	+2
Use of Restraints	0	1	-1
Wrongful Death	0	1	-1
Total	**30**	**29**	**+1**
HIV Special Needs Plans			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	0	0
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	0	0	0
Other Incident Resulting in Medical Treatment Other Than Hospitalization	2	2	0
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**2**	**2**	**0**
Grand Total	**110**	**97**	**+13**

E. Enrollee Complaints Received Directly by the DOH

In addition to the MCO reported complaints, the DOH directly received 99 enrollee complaints this quarter. This total is a 7.5% decrease from the previous quarter, which reported 107 enrollee complaints.

The following table displays the number of previously reported complaints filed directly with DOH from enrollees and their representatives, for the most recent quarter and for the previous quarter:

MCO Enrollee Complaints Received Directly by the DOH	
FFY 24 Q2 1/1/2024–3/31/2024	**FFY 24 Q1 10/1/2023–12/31/2023**
99	**107**

The following table displays the top five most frequent categories of enrollee complaints received directly by the DOH involving MCOs for the most recent quarter and for the previous quarter:

Percentage of MCO Enrollee Complaints Received Directly by the DOH		
Description of Complaint	**FFY 24 Q2 1/1/2024–3/31/2024**	**FFY 24 Q1 10/1/2023–12/31/2023**
Difficulty with Obtaining: Home Health Care	18%	11%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	14%	8%
Difficulty with Obtaining: Dental/Orthodontia	9%	8%
Reimbursement/Billing	7%	10%
Pharmacy/Formulary	7%	8%

The categories within the top five remain the same, but we are seeing substantial increases within the Difficulty with Obtaining: Home Health Care and Problems with Advertising/ Consumer Education/ Outreach/ Enrollment categories. This increase was spread amongst several MCOs.

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

Under the Families First Coronavirus Response Act's continuous coverage requirement, NYS Medicaid members did not have to renew their health insurance from early 2020 until the Consolidated Appropriations Act of 2023 required states to begin the process of redetermining eligibility for enrollees with June 30, 2023 coverage end dates. This process will continue each month until every renewal cycle of enrollees, referred to as a cohort, has had their eligibility redetermined. Enrollment numbers continue to be affected by the unwind. The DOH will closely monitor the progress of the unwind as it proceeds.

F. Fair Hearings

There were 212 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2024, through March 31, 2024. The dispositions of these fair hearings for the most recent quarter and for the previous quarter are as follows:

Fair Hearing Decisions (Includes MMC, HARP, and HIV SNP)		
Hearing Dispositions	**FFY 24 Q2 1/1/2024–3/31/2024**	**FFY 24 Q1 10/1/2023–12/31/2023**
In favor of Appellant	93	118
In favor of Plan	104	99
No Issue	15	14
Total	**212**	**231**

For fair hearing dispositions occurring for the most recent quarter and for the previous quarter, the following table displays 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 24 Q2 1/1/2024–3/31/2024**	**FFY 24 Q1 10/1/2023–12/31/2023**
0-29	2	0
30-59	32	8
60-89	45	23
90-119	27	41
=>120	106	159
Total	**212**	**231**

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

The MMCARP met on March 21, 2024. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment, and an update on the status of the MLTC program. There were two additional agenda items, a presentation, Division of Legal Affairs Update, given by Jennifer Sim, Associate Attorney, Division of Legal Affairs, NYSDOH, and a presentation, Community Health Worker Services and Doula Services Benefits, given by Jennifer Mane, Bureau Director, Division of Program Development and Management. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for June 20, 2024.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

During the reporting period, preparations began for calculating MLTC quality, satisfaction, and compliance measures. Activities included: attributing MLTC members to accountable health plans based on annual assessment data, securing all data sources necessary for the calculation of the 2023 MLTC Quality Incentive, and updating the programs used to calculate measures to ensure agreement with the publicly released methodology. Additionally, staff actively managed the MLTC_OQPS@health.ny.gov mailbox to ensure timely response to stakeholder inquiries.

The NYSDOH and our EQRO, IPRO, hosted a meeting on January 16, 2024, to kick-off work with MLTC plans on the 2024-25 PIP topic “Decreasing Rates of Depression among Medicaid Managed Long Term Care Members”. Health plan representatives were provided with topic background and briefed on expectations, measure specifications, timelines, and deliverables. By the end of the reporting period, all health plans had submitted their PIP proposals.

B. Quality Measurement in Medicaid Managed Care

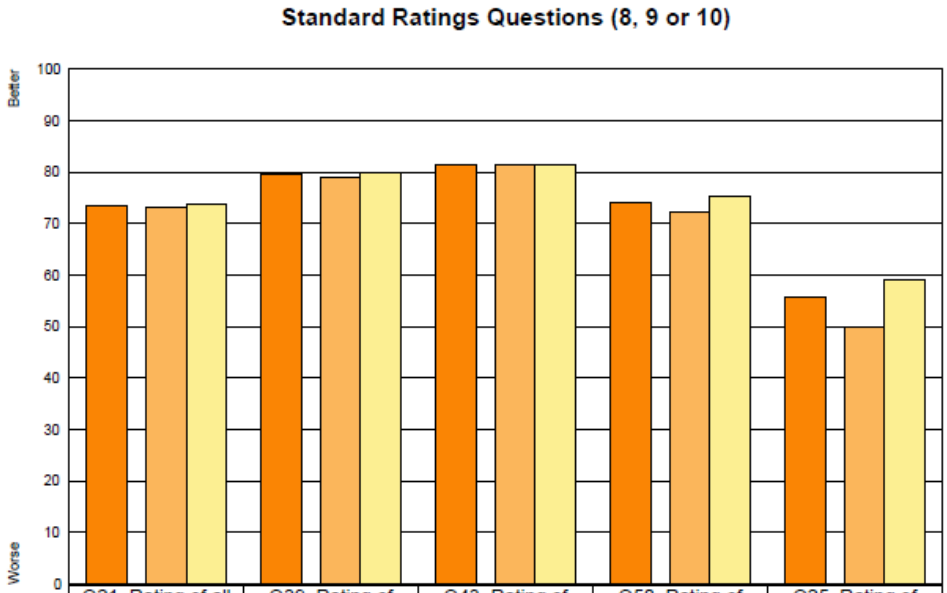
Quality Measure Benchmarks 2022 (Measurement Year 2022)

Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2022, national benchmarks were available for 64 measures for Medicaid. Out of the 64 measures that NYS Medicaid plans reported, 75% of measures met or exceeded national benchmarks. NYS consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid, rates exceed the national benchmarks for BH on adult measures (e.g., receiving follow-up within seven and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). NYS managed care plans also continue to surpass national benchmarks in several women’s preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, and cervical cancer), 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 immunization). Considering this was during a period of COVID-19 impacts in New York, the data demonstrates that many aspects of quality of care remained high for New Yorkers on Medicaid.

2023 Satisfaction Survey

In the fall of 2023, the 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%

2021 Quality Incentive for Medicaid Managed Care

The 2021 Quality Incentive Awards calculations were finalized in February 2023 which covered the measurement year period for 2021. The quality incentive is calculated on the percentage of total points a plan earned in the areas of Quality of Care and Experience of Care. Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. Plans had the opportunity to earn ten bonus points by submitting a "COVID-19 Vaccination Equity Plan (CVEP)" that summarized their progress towards improving vaccination rates of their members through 2022. Plans were classified into five tiers based on the distribution of the final percentage points before the bonus points were awarded. Plans can only move up a maximum of one tier due to the CVEP bonus points. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and CMS. The results for the 2021 Incentive included three plans in Tier 1, one plan in Tier 2, seven plans in Tier 3, and two plans in Tier 5.

Quality Assurance Reporting Requirements (QARR)

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

C. Quality Improvement

External Quality Review

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance

improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and providing data processing and analytical support to 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 Insurance Program (CHIP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

Annual EQRO Technical Reports
In the beginning of the 2nd quarter, IPRO was in the process of completing the Mainstream and Managed Long-Term Care Annual Technical reports. IPRO has sent sections of the report ranging from QARR data, performance measurement tables, and surveys. DOH and IPRO held biweekly meetings to discuss report progress. By the beginning of February, IPRO submitted the first final drafts of the technical reports. In March, the reports were in their final version and were ready for executive review.

Provider Related and Access Activities
In January, IPRO sent the attachments for the Access Survey to DOH for review. DOH will provide edits and feedback by the end of the quarter. For the Member Services Survey, DOH followed up with issues surrounding the disclosure questions based on the survey. At the start of March, DOH submitted the results for IPRO's review. IPRO returned the survey to DOH with the edits completed. IPRO sent the PCP Ratio survey to DOH in early January for review. By March, the reports were still with DOH in executive review.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the PNDS. The PNDS collects network information from around 400 active networks in NYS. IPRO and their subcontractors- RMCI and Quest Analytics, facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion, and maintenance. The quarter 1 2024 PNDS submission deadline is April 29th, 2024; plans will submit data based on version 11 of data dictionary.

Provider and Health Plan LOOK-UP:
The New York State Provider & Health Plan Look-Up website helps consumers in their health plan network and provider search. IPRO continues to refresh the data twice a month. The site has close to two million distinct users since its launch in May 2017.

PANEL:
Panel data submission opened for Q4 2023 data collection on Feb. 1st and yielded 6,833,562 rows of data. Technical assistance was provided by DOH and IPRO throughout the submission,

particularly around new edits implemented. DOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)
The MLTC PIP Template and background document for the new depression screening PIP for 2024-2025 was sent out to the plans at the end of December. The EQRO has contacted the MLTC plans for a follow-up for the kickoff webinar. There were questions regarding the definition of a positive screening and when to intervene. Another question was how to exclude members who are already receiving treatment for positive screenings. IPRO will be meeting internally to over the questions and provide an FAQ for the members. In February, IPRO received the final 2022-2023 PIP reports on the Social Determinants of Health study and are in the clinical review stage. The new 2024-2025 depression screening PIP proposals were due on 3/15/2024. The MLTC plans sent questions to IPRO about the PIP, and IPRO will respond. IPRO's goal is to have the initial reviews completed by the third quarter.

MLTC Member Satisfaction Survey
By the beginning of the 2nd quarter, the response file was submitted before January 1, 2024. IPRO completed the necessary tables to place into the final report. In February, IPRO was starting the satisfaction survey report due to the revised file that was sent and approved. The EQRO also started a telehealth study with the goal to get the telehealth report to DOH by February 16, 2024, with the satisfaction survey reports to follow. The draft of the report was submitted in early March.

Focused Clinical Study
IPRO received an email from DOH about guidance for the report and agree with the findings. IPRO is reviewing the data again to make sure that it is up to date and will notify DOH when the final report is ready; will send a draft report as soon as possible. By March, DOH sent their feedback on the survey and sent out the report by March 15, 2024.

Quality Measurement
For the beginning of the 2nd quarter, QARR slowed down but picked up in March. IPRO is in the process of confirming the plan contacts for this year's QARR cycle. Once the list is complete, DOH will send to IPRO, so they can update submission IDs and make any necessary inclusions or exclusions of plan-specific product lines within our validation programs. For the CHAPS-Adult survey, IPRO received an email from DataStat saying they had completed all mailings of the survey. In February, IPRO recently received their final disposition report from the plans. The response rate was around 13% to 14%. They are working on the final reports. In March, the survey was completed, and the report was in progress. IPRO reached out to DataStat for any corrections that needed to be made. When completed, the report will be returned to DOH.

PIPs for MMCs:

2022-2023 MMC and HIV SNP PIP: Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members
On December 14, 2023, a WebEx meeting with MMC, CHP and HIV SNP plans was conducted to introduce the topic of the 2024-2025 PIP, Improving Rates of Cancer Screening and Prevention for MMC, CHP, and HIV SNP Members. The PIP will focus on improving rates of

screening for colorectal, breast, and cervical cancers, and of HPV vaccinations. MMCPs will be expected to focus on cancer screening and HPV vaccination; CHP Plans will be expected to focus on HPV vaccination, and HIV SNPs will be expected to focus on cancer screening. The background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The PIP Proposals were due to IPRO by Feb. 26, 2024. The PIP Proposals were all submitted and reviewed by IPRO and NYSDOH and feedback was provided to the health plans on any necessary revisions. IPRO prepared and distributed a FAQs document to the health plans to answer PIP related questions. The PIP Proposals are scheduled to be finalized by the end of April 2024.

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

On December 14, 2023, a WebEx meeting with MMC, CHP and HIV SNP plans was conducted to introduce the topic of the 2024-2025 PIP, Improving Rates of Cancer Screening and Prevention for MMC, CHP, and HIV SNP Members. The background document and PIP resources for drafting a proposal were distributed to the health plans after the WebEx. The PIP proposals were due to IPRO by February 26, 2024.

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

The 2022-2023 Cardiometabolic PIP ended at the end of Q1. HARP MCOs completed their final interventions and began data collection and analysis for the final report, which will be due in July 2024. The last webinar was held on December 12, 2023. The post-webinar survey results were compiled and will be sent out by December 22, 2024.The final report will be due in July 2024. The process guide and instructions were sent to all plans by the end of December and reminders will be sent again before the July due date.

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

The 2024-2025 HARP PIP will be Continuous Engagement Care and Treatment. By February, DOH and IPRO are still in the planning stages of the new HARP PIP with finalizing timelines. The group has identified a date for the kickoff webinar for March 28, which was updated later to April 11.

Breast Cancer Selective Contracting

The DOH completed its annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2020-2022 to identify low-volume facilities (those with a 3-year average of fewer than 30 surgeries per year). A total of 345 facilities were designated as follows: 111 high-volume facilities, 6 low-volume unrestricted facilities, 215 low-volume restricted facilities, and 13 new unrestricted facilities.

For State Fiscal Year 2024-25, eight facilities appealed the decision to be placed on the low-volume restricted list, and five of the appeals were approved. Administrators at these facilities were notified via email of their decisions. In addition, letters regarding final volume designation for state fiscal year 2-24-35 were sent to health plan Chief Executive Officers and Medical Directors via DOH's Integrated Health Alerting and Notification System (IHANS), and health plan trade organizations via email. The list of low-volume restricted facilities and the list of facilities approved to provide breast cancer surgery were posted to the DOH website and included in the 2024 March Medicaid Update.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 2 (1/1/2024-3/31/2024)

As of March 2024, there were 8,731 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,145 practices in NYS. All providers are recognized under the standards of NYS PCMH, a recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, VBP arrangements, and health information technology capabilities. Of the 8,731 providers that became recognized in March 2024, No new enrollment in NYS PCMH program.

The incentive rate for the New York Medicaid PCMH Statewide Incentive Payment Program as of March 2024 is $6.00 PM.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers and providers and discussions around alignment of methods for shared savings models continued.

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

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

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

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

- As detailed in STC X.10, the State identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011, through March 31, 2016, period. The audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019, with CMS confirming in a subsequent discussion on October 10, 2019, that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all audit findings, however, entry of corrected data for F-SHRP DY6 into the Medicaid Budget and Expenditure System (MBES) is pending approval of a timely filing waiver.
- The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to

pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

X. Other

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

NYS Compliance

NYS sends the following files to CMS monthly:

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

The State is current in its submission of these files.

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 February 2024:

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

As of the February 2024 reporting month, NYS data meets the Critical-Priority and Expenditures criteria target of OBA and is 1% below the target for High-Priority criterion. The state is actively working on addressing the identified high priority issues to meet the High-Priority criterion of OBA.

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.

The State has also instituted a 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 when data quality issues are 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 provide supplemental state guidance documentation.

All 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.

In addition, NYS has recently completed the T-MSIS historical file(s) resubmissions process with successful resubmission of claim files for reporting period July 2015 through August 2023 (98 months).

B. 1115 Public Comment Days

With the implementation of the Medicaid Redesign Team in 2011, New York has prioritized transparency and public engagement as a key element of developing and implementing Medicaid policies. The public comments provided at these forums have been shared with the New York teams working on these programs and has informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

On February 28, 2024, NYS DOH conducted a virtual public forum, which dually served as a public hearing for an upcoming 1115 amendment request. During the public forum, NYS DOH received insightful comment from six speakers on a range of topics, including the proposed amendment request, the recently approved NYHER amendment, and NY's aging population and long-term care services. Comments were shared with the program areas within the state for their consideration in shaping policy and procedures.

A recording of the live webcast, transcript, and presentation slides from the public forum are available for viewing at the links below.

Slides: https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2024-02-28_ce_0-6_pub_hearing_slides.pdf
Recording: https://www.youtube.com/watch?v=2GRJUpn8XQQ
Transcript:
https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2024-02-28_ce_0-6_pub_hearing_transcript.pdf

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

State Contact:
Simone Milos
Medicaid Redesign Analyst II
Strategic Operations and Planning
Office of Health Insurance Programs
Simone.Milos@health.ny.gov
Phone (518) 473-0868
Fax (518) 473-1764

Uploaded to PMDA: May 30, 2024

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	8	0	0	0	0	0	7	1	0	6096	0.13%
Archcare Community Life	50	0	0	0	8	1	23	18	0	5794	0.86%
Archcare PACE	14	0	1	0	0	0	10	2	1	806	1.74%
Catholic Health-LIFE	11	0	8	0	0	0	0	3	0	232	4.74%
Centerlight PACE	118	0	0	1	0	0	46	63	8	6331	1.86%
Centers Plan for Healthy Living	1015	1	0	0	44	0	297	673	0	52670	1.93%
Centers Plan for Healthy Living MAP	50	0	0	0	11	1	17	21	0	1737	2.88%
Complete Senior Care	0	0	0	0	0	0	0	0	0	136	0.00%
Eddy SeniorCare	9	0	0	0	0	0	7	2	0	373	2.41%
Elant Choice (EverCare)	28	0	0	0	0	0	5	23	0	752	3.72%
Elderplan MAP	6	0	0	1	5	0	0	0	0	3909	0.15%
Elderserve	434	0	1	0	3	4	100	215	111	18406	2.36%
Elderserve MAP	7	0	0	0	0	0	1	4	2	283	2.47%
Elderwood	121	0	0	0	0	0	7	38	76	1238	9.77%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	56639	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	129	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	163	0.00%
Fidelis Care at Home	17	0	0	0	0	1	4	12	0	18195	0.09%
Fidelis MAP	5	0	0	0	0	0	1	4	0	1205	0.41%
Hamaspik	202	0	0	0	0	1	63	102	36	7751	2.61%
Hamaspik MAP	29	0	0	0	1	0	19	7	2	888	3.27%
Healthfirst CompleteCare	195	0	0	0	11	10	63	110	1	28874	0.68%
HomeFirst, Inc. (Elderplan)	13	0	0	9	0	0	2	2	0	22247	0.06%
Icircle	1	0	0	0	0	1	0	0	0	3712	0.03%
Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	749	0.00%
Independent Living Services of CNY (PACE CNY)	22	0	0	0	0	0	11	11	0	547	4.02%
Kalos ErieNiagara DBA: First Choice Health	2	0	0	0	0	1	1	0	0	938	0.21%
MetroPlus MAP	5	0	0	0	0	0	2	3	0	173	2.89%
MetroPlus	13	0	0	1	0	0	3	8	1	1721	0.76%

Prime	31	0	0	0	0	2	7	22	0	570	0.33%
Senior Health Partners	56	0	0	0	2	4	18	32	0	9357	16.28%
Senior Network Health, LLC	4	0	0	0	0	0	4	0	0	344	1.16%
Senior Whole Health	2	0	0	0	0	0	2	0	0	27922	0.01%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	268	0.00%
Total Senior Care	18	0	0	0	0	0	4	14	0	129	13.95%
Village Care	185	1	0	0	15	2	42	125	0	21061	0.88%
Village Care MAP	29	0	0	0	7	0	11	11	0	2869	1.01%
VNA Homecare Options (Nascentia Health Options)	272	1	0	4	2	2	104	159	0	5325	5.11%
VNS Choice MAP TOTAL	41	0	0	0	0	0	9	32	0	4291	0.96%
VNS Choice MLTC	460	0	0	23	0	1	81	355	0	23407	1.97%
total	3473	3	10	39	109	31	971	2072	238	338237	1.03%

Managed Long Term Care Partial Capitation Plan Enrollment Apr 2023 to Mar 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5671	5707	5732	5791	5825	5885	5919	6000	6070	6089	6078	6120
ArchCare Community Life	5621	5693	5771	5824	5865	5885	5858	5858	5870	5830	5796	5756
Centers Plan for Healthy Living	50096	50421	50625	50814	51037	51311	51557	52051	52418	52712	52623	52674
Elant	840	809	798	780	776	782	779	775	767	762	754	741
Elderplan	18266	18730	19022	19460	19877	20184	20598	21083	21444	21918	22146	22676
Elderserve	16236	16293	16371	16452	16615	16728	16793	16949	17098	18367	18374	18478
Elderwood	1077	1093	1115	1130	1137	1121	1123	1135	1169	1248	1238	1228
Extended MLTC	5745	5773	5700	5583	0	0	0	0	0	0	0	0
Fallon Health Weinberg (TAIP)	825	813	812	806	799	783	728	642	467	0	0	0
Fidelis Care at Home	16931	16873	16746	16688	16774	16853	16962	17436	17665	17800	18330	18456
Hamaspik Choice	1937	1932	1956	1982	7516	7474	7490	7533	7649	7706	7735	7811
HealthPlus- Amerigroup	51622	52192	52796	53251	54024	54488	55260	56160	56458	56466	56431	57019
iCircle Services	3468	3495	3517	3539	3538	3563	3568	3602	3624	3682	3683	3771
Kalos Health- Erie Niagara	571	576	588	599	625	647	710	780	850	938	942	935
MetroPlus MLTC	1358	1351	1374	1382	1430	1472	1527	1565	1620	1652	1735	1777
Montefiore HMO	1331	1325	1311	1313	1295	1302	1281	1267	1235	0	0	0
Prime Health Choice	584	587	588	582	585	587	581	578	572	575	571	563
Senior Health Partners	9201	9185	9159	9122	9117	9120	9118	9113	9182	9157	9455	9460
Senior Network Health	313	317	324	327	336	342	344	341	342	343	343	346
Senior Whole Health	26229	26370	26325	26394	26603	26882	26870	27079	27410	27672	27796	28297
Village Care	17173	17544	17913	18329	18682	19156	19523	20095	20608	20796	20998	21389
VNA HomeCare Options	3906	4059	4200	4305	4482	4596	4751	4870	5026	5199	5328	5448
VNS Choice	23477	23577	23589	23703	23727	23640	23498	23664	23789	23568	23335	23317
Total	**262,478**	**264,715**	**266,332**	**268,156**	**270,665**	**272,801**	**274,838**	**278,576**	**281,333**	**282,648**	**283,852**	**286,421**

Managed Long Term Care FIDA-IDD Enrollment Apr 2023 to Mar 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1710	1720	1724	1733	1728	1723	1717	1711	1703	1690	1683	1699

Managed Long Term Care MAP Enrollment Apr 2023 to Mar 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	878	904	956	1035	1050	1075	1118	1116	1131	1152	1181	1283
Hamaspik	746	778	798	834	831	829	840	848	852	849	900	916
Agewell	121	117	116	122	125	123	117	109	85	0	0	0
Centers	1463	1524	1560	1592	1642	1634	1641	1588	1553	1698	1745	1768
Elderplan	3243	3301	3331	3379	3422	3462	3485	3524	3647	3795	3927	4005
Elderserve	178	185	193	196	205	219	245	261	282	278	279	291
Healthfirst Complete Care	24657	25098	25509	25789	26159	26536	26897	27297	27649	28341	28866	29416
Healthplus	179	172	167	166	147	127	119	113	116	121	130	135
Metroplus	87	109	125	131	142	149	159	168	173	172	170	177
Senior Whole Health	153	169	170	179	188	201	221	227	249	252	265	286
VNS	3485	3575	3634	3707	3802	3886	3957	3946	3886	4172	4308	4393
Village Care	2553	2578	2591	2594	2635	2650	2689	2672	2629	2787	2869	2952
Total	**37743**	**38510**	**39150**	**39724**	**40348**	**40891**	**41488**	**41869**	**42252**	**43617**	**44640**	**45622**

Managed Long Term Care PACE Enrollment Apr 2023 to Mar 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	715	742	765	782	786	793	793	805	799	807	803	809
CHS Buffalo Life	240	239	233	235	236	231	226	227	228	229	233	233
Complete Senior Care	127	129	128	131	130	134	137	135	133	136	138	135
Comprehensive Care Management	5873	6032	6116	6156	6278	6322	6333	6372	6379	6331	6313	6348
Eddy Senior Care	319	335	338	345	351	344	341	357	370	360	375	383
Fallon Health Weinberg PACE	145	147	149	152	155	152	115	154	161	168	161	159
Independent Living For Seniors	730	736	734	741	753	754	752	749	750	748	744	755
Pace CNY	523	519	530	533	542	548	556	559	558	551	546	545
Total Senior Care	130	128	133	133	132	133	131	129	127	131	128	129
Total	**8802**	**9007**	**9126**	**9208**	**9363**	**9411**	**9384**	**9487**	**9505**	**9293**	**9280**	**9337**