NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER

Project Number #11-W-00114/2

Section 1115 Second Quarter Report

New York State Department of Health Office of Health Insurance Programs

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NEW YORK STATE | Department of Health

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I. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Enrollment: Second Quarter

MRT Waiver- Enrollment Second Quarter of FFY 2025

Demonstration Populations (As hard coded in the CMS 64)	Current Enrollees (To date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 – Temporary Assistance for Needy Families (TANF) Child 1 – 20 years in Mandatory Counties as of 10/1/06	349,270	4,285	18,214
Population 2 – TANF Adults 21-64 years in Mandatory Counties as of 10/1/06	69,318	1,348	2,258
Population 3 – TANF Child 1 – 20 ('new' MC Enrollment)	2,709	23	179
Population 4 – TANF Adults 21 – 64 ('new' MC Enrollment)	30,202	453	1,162
Population 5 – Safety Net Adults	234,651	6,631	23,740
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)	159,798	1,079	77
Population 9 – Disabled Adults and Children 0 – 64 ('new' MC enrollment)	51,487	3,311	339
Population 10 – Aged or Disabled Elderly ('old' voluntary MC Enrollment)	77,478	202	32
Population 11 – Aged or Disabled Elderly ('new' MC enrollment)	9,616	1,763	311

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**19,095 or an approximate 41.27% decrease from last quarter**

Reasons for voluntary disenrollment:

Voluntary disenrollments have decreased by 41.27%. The decrease can be attributed to the higher volume of members that were disenrolled last quarter by New York Medicaid Choice (NYMC) due to the Public Health Emergency (PHE) Unwind resuming disenrollments of members with Medicare.

Involuntary Disenrollment	
Total # Involuntary Disenrollment's in Current Demonstration Year	**46,312 or an approximate 13.51% increase from last quarter**

Reasons for involuntary disenrollment:

Involuntary disenrollments have increased by 13.51%. The increase is primarily due to the "Eligibility Ended" cases which represent a loss of eligibility due to such factors as a failure to recertify and not specifically due to any type of case closure.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
January 2025				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**669,961**	**21,301**	**4,352**	**16,949**
Rest of State	**258,112**	**11,366**	**1,406**	**9,960**
Statewide	**928,073**	**32,667**	**5,758**	**26,909**
February 2025				
New York City	**657,469**	**22,148**	**4,117**	**18,031**
Rest of State	**257,381**	**10,997**	**1,118**	**9,879**
Statewide	**914,850**	**33,145**	**5,235**	**27,910**
March 2025				
New York City	**663,018**	**20,777**	**4,236**	**16,541**
Rest of State	**259,970**	**12,753**	**1,221**	**11,532**

Statewide	**922,988**	**33,530**	**5,457**	**28,073**

Second Quarter	
Region	**Total Affirmative Choices**
New York City	**51,521**
Rest of State	**31,371**
Statewide	**82,892**

HIV SNP Plans				
January 2025				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**13,979**	**298**	**0**	**298**
Rest of State	**42**	**3**	**0**	**3**
Statewide	**14,021**	**301**	**0**	**301**
February 2025				
New York City	**13,963**	**338**	**0**	**338**
Rest of State	**41**	**3**	**0**	**3**
Statewide	**14,004**	**341**	**0**	**341**
March 2025				
New York City	**14,069**	**289**	**0**	**289**
Rest of State	**53**	**20**	**0**	**20**
Statewide	**14,122**	**309**	**0**	**309**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**925**			
Rest of State	**26**			
Statewide	**951**			

Health and Recovery Plans Disenrollment			
Federal Fiscal Year (FFY) 2025 – Quarter 2			
	Voluntary	**Involuntary**	**Total**
January 2025	**540**	**917**	**1,457**
February 2025	**446**	**2,061**	**2,507**
March 2025	**450**	**1,303**	**1,753**
Total:	**1,436**	**4,281**	**5,717**

Reasons for disenrollment:

Voluntary HARP disenrollments have decreased by 12.06%. The primary reason for the decrease was due to disenrollment code 93 “Client or LDSS Initiated/Excluded or Exempt.”

Involuntary HARP disenrollments increased by 5.65%. This was primarily due to an increase in the “Eligibility Ended” cases which represent a loss of eligibility due to such factors as a failure to recertify and not specifically due to any type of case closure. Another factor was “No PCP Coverage or Eligibility Expired.”

III. Outreach/Innovative Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2025 – 3/31/2025) Q2 FFY 2025

At of the end of the second federal fiscal quarter (end of March 2025), there were 2,554,547 New York City Medicaid consumers enrolled in the MMMC program, and 74,146 New York City Medicaid consumers enrolled in a HARP. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 31 HRA facilities including 6 HIV/AIDS Services Administration (HASA) sites, 9 Community Medicaid Offices (MA Only), and 16 HRA Benefits Access Centers (Public Assistance). MAXIMUS reported that 5,044 clients were educated about enrollment options and made an enrollment choice, including 667 clients in person and 4,377 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, 171 Enrollment Counseling sessions were evaluated which generated 3 applications for a total of 5 enrollments.

CMU Monitoring of Field Presentation Report –Second Quarter 2025	
Enrollment Counseling – One on One	**General Information**
171	168

Of the 5 enrollments completed during informational sessions, 5 (100%) were randomly chosen to track for timely and correct processing. CMU reported that 100% of the clients were enrolled in a health plan of their choice and appropriate notices were mailed in a timely manner.

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan AA. A total of 36,172 FFS community clients were reported on the regular AA list; 11,557 clients responded to the call that generated 4,873 enrollments. Of the total of 18 FFS NH clients reported on NH AA, 0 (0%) client and/or authorized representative(s) made a plan selection.

Of the 36,172 clients on the regular AA list, CMU monitored a total of 3,814 outreach calls conducted by FCSRs in HRA facilities; 1,234 clients responded to these calls. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)			No Response
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total	Regular FFS
465	0	465	769	0	769	2,580

- Phone Enrollment Applications: 465 (38%) Regular FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 759 enrollments.
    - 758 (100%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were enrolled in the plan they selected in a timely manner.
- Undecided: 769 (62%) 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-March 2025

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 46,970 calls were received by the Helpline and 45,713, or 97%, were answered. Calls answered were handled in the following languages: **English**: 28,351 (62%); **Spanish:** 6,930 (15%); **Chinese:** 1,476 (3%); **Russian:** 747 (2%); **Creole:** 145 (1%); **and other:** 8,064 (17%).

MAXIMUS records 100% of the calls received by the NYMC Helpline. CMU listened to 5,184 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – Second Quarter 2025								
General Information	Phone Enrollment	Phone Transfer	Public Calls	Disenrollment Calls	Dual Segment	Exemption	Removal	Total
2,772 (53%)	508 (10%)	231 (4%)	1,639 (32%)	26 (1%)	0 (0%)	8 (0%)	0 (0%)	5,184

A total of 1,632 (31%) recorded calls observed were unsatisfactory. 789 calls had a single infraction, and 843 calls had multiple infractions. A total of 3,434 infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: **2,481 (72%)** - 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: **134 (4%)** - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and referrals for specialists.
- Customer Service: **819 (24%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 3,434 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 2025, there were no new plans, plan expansions, or withdrawals.

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

On January 26, 2024, NYS submitted to CMS the March 1, 2024, MMC/HIV SNP/HARP Model Contract. On February 7, 2024, this Model Contract was issued to 14 Managed Care Organizations (MCOs) for signature. At the close of the third quarter of FFY 2023 – 2024, all 14 contracts were executed by NYS and submitted to CMS for final approval.

C. Health Plans/Changes to Certificates of Authority

During the second quarter of FFY 2025, the Certificate of Authority for AmidaCare, Inc. was updated to accurately reflect the line of business in NYS whereby the plan is currently certified.

D. CMS Certifications Processed

United Healthcare of New York, Inc. was issued a State Certification.

E. Surveillance Activities

Surveillance activity completed during the second quarter FFY 2025 (January 1 – March 31, 2025) include the following:

One Comprehensive Operational survey was completed during the second quarter of FFY 2025. The plan was found in compliance:

- Independent Health Association, Inc. (Compliant, Results 1/24/2025)

Two Targeted Operational Surveys were completed during the second quarter of FFY 2025. One Statement of Deficiencies (SOD) was issued, and one Plan of Correction (POC) was accepted. One Plan was found in compliance:

- Capital District Physicians' Health Plan, Inc. (Compliant, Results 3/26/2025)
- VNS Choice (Acceptable Plan of Correction (APOC) 3/7/2025)

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

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 BH Services into Managed Care and Development of HARPs:

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

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

In FY 2018, NYS engaged in multiple activities to enhance access to BH services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the New York State of Health (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 BH provider community through its collaboration with the Managed Care Technical Assistance Center (MCTAC).

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

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

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

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

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

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

NYS MH & SUD authorization requests and denials for Inpatient (10/1/2024-12/31/2024)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	22,624	89	65	0.29%
Rest of State	5,391	63	61	1.13%
Totals	28,015	152	126	0.45%

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

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

NYS MH & SUD authorization requests and denials for Outpatient (10/1/2024-12/31/2024)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	4,796	211	82	1.71%
Rest of State	266	9	9	3.38%
Totals	5,062	220	91	1.80%

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

MH & SUD Claims (1/1/2025-3/31/2025)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	696,508	89.55%	10.45%
Rest of State	1,029,894	91.01%	8.99%
Totals	1,726,402	90.42%	9.58%

Behavioral Health Adults CORE/HCBS Claims/Encounters (1/1/2025-3/31/2025): NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
Community Psychiatric Support and Treatment (CPST)	**660**	**94**
Education Support Services	**20**	**5**
Family Support and Trainings	**454**	**36**
Intensive Supported Employment	**7**	**1**
Ongoing Supported Employment	**14**	**2**
Peer Support	**4,831**	**667**
Pre-vocational	**26**	**4**
Provider Travel Supplements	**301**	**107**
Psychosocial Rehab	**7,085**	**652**
Residential Supports Services	**124**	**8**
Transitional Employment	**0**	**0**
TOTAL	**13,522**	**1,188**

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 (1/1/2025-3/31/2025): Rest of State

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	2,678	386
Education Support Services	45	14
Family Support and Trainings	525	40
Intensive Supported Employment	35	7
Ongoing Supported Employment	1	1
Peer Support	6,248	1,022
Pre-vocational	0	0
Provider Travel Supplements	7,330	1,200
Psychosocial Rehab	7,421	1,163
Residential Supports Services	353	49
Transitional Employment	0	0
TOTAL	24,636	2,275

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

Provider Technical Assistance

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

Quarter 2 MCTAC Attendance & Statistics (1/1/2025-3/31/2025)

Events: MCTAC successfully executed **15** events from 1/1/2025 to 3/31/2025. Of these, 12 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):*

3,257 people attended/participated in MCTAC events/viewed resources of which **1,625** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 47.27% (251 of 531 total employees)

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: **36.26%** (157 of 433 total employees)

Efforts to Improve Access to Behavioral Health HCBS

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

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

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 Severe Mental Illness (SMI) population.
- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both Health Homes and Recovery Coordination Agencies (RCAs)).
- Developed required training for BH HCBS providers that NYS can track in a Learning Management System.
- Implemented rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhanced technical assistance efforts for BH HCBS providers including workforce development and training.
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in Health Homes. These services are provided by SDEs through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDEs to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted RCAs for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (completed)
        - Ongoing technical assistance (completed)
- Continued efforts to increase HARP enrollment in Health Homes including:
    - Best practices for embedded care managers in emergency rooms, clinics, shelters, Comprehensive Psychiatric Emergency Programs (CPEPS), and inpatient units and engagement and retention strategies.

    - Existing quality improvement initiative within clinics to encourage Health Homes enrollment.
    - Emphasis on warm hand-off to Health Home from emergency room and inpatient settings.
    - Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management.
    - DOH approval of MCO plans for incentivizing enrollment into Health Homes (e.g., outreach optimization).
- Continued work to strengthen the capacity of Health Homes to serve high-need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead Health Homes, representation on new HH+ Subcommittee Workgroup.
- Implemented performance management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets and key quality metrics for access to BH HCBS for HARP members.
- Disseminated consumer education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
- NYS OMH contracted with the New York Association Psychiatric Rehabilitation Services (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for HARPs and Adult BH HCBS.
- NYAPRS conducted outreach in two ways:
    - 45-90-minute training presentations delivered by peers.
    - Direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers).
- Implemented Quality and Infrastructure initiative to support targeted BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. NYS worked with the MCOs on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all HARPs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in an increase of members utilizing BH HCBS; NYS also shared a summary of best and promising practices with the HARPs.
- Issued Terms and Conditions for BH HCBS providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS providers are actively providing services.
- Enhanced NYS Adult BH HCBS provider oversight, including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.
- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, Health Homes, Care Management Agencies (CMAs), and BH HCBS provider agencies. Developed and provided a variety of tools to support

care manager referrals to BH HCBS, on behalf of the NYS Health Home/MCO Workgroup.

- Established a process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments. This was in response to challenges in securing a care management workforce meeting both the education and experience criteria and need for more assessors.

There are ongoing opportunities for care managers in NYS to complete required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2025, and March 31, 2025, 592 eligibility assessments were completed.

Transition to Community Oriented Recovery and Empowerment Services

Despite the extensive efforts outlined above, and stakeholder participation to implement strategies for improved utilization of BH HCBS, the number of HARP enrollees successfully engaged with BH HCBS overall remained very low. NYS reviewed a significant amount of feedback from MCOs, Health Homes, care managers and other key stakeholders, and determined the requirements for accessing BH HCBS were too difficult to standardize among 15 MCOs and 30 Health Homes.

As a result, NYS released a draft proposal for public comment in June 2020 to transition 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package, called CORE Services, for HARP enrollees and HARP eligible HIV SNP enrollees. Public comment resulted in positive feedback, and NYS finalized the proposal and submitted to CMS in September 2020. Objectives of this transition were two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the BH population, and to eliminate access barriers.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through the American Rescue Plan Act (ARPA), NYS revised the September 2020 proposal to comply with eFMAP requirements and resubmitted to CMS in July 2021. CMS approved NYS' 1115 waiver amendment request for CORE Services on October 5, 2021. CORE is a rehabilitation and recovery service array which includes four services previously available through BH HCBS: Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Family Support and Training (FST), and Empowerment Services – Peer Support.

Access to CORE Services does not require an independent eligibility assessment and these services do not have settings restrictions. Currently, all HARP enrollees, HARP-eligible HIV SNP enrollees, and HARP-eligible Medicaid Advantage Plus (MAP) enrollees can access CORE Services with a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

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

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

Consumer education materials are available on the OMH CORE website and were distributed via provider listserv. In January 2022, OMH participated in a townhall series hosted by the

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

In January 2023, in collaboration with Alliance for Rights and Recovery (formerly NYAPRS), a CORE Peer Navigator Project was launched. This project is funded through the Mental Health Block Grant, and focuses on outreach, education, and service navigation to support access to CORE and BH HCBS. In August 2024, the project was approved for a no cost contract extension through February 28, 2025. In March 2025, an additional extension with federal funding was allocated to this contract to continue supporting this work through 9/30/2025.

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.

In April 2024, updates were published to the CORE Services Benefit and Billing Guidance and to the CORE Service Initiation Notification Template to bring information current and to add clarifications in response to stakeholder feedback. From September through December 2024, OMH and OASAS hosted 14 regional networking events for CORE providers. In attendance were over 430 people, including regional coordinators from MCOs, care managers, and other local service providers to promote collaboration and referral connections. CORE provider feedback from the events was positive, and the events were successful in helping CORE providers make new community connections to receive referrals.

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

NYS continues to consult CORE providers and MCOs to inform future guidelines around MCO responsibilities and oversight, such as utilization management of CORE Services. In August 2023, NYS held its first CORE Summit, a one-day training and networking event for CORE providers and MCOs. A second CORE Summit was held in August 2024. NYS is currently planning the third CORE Summit, scheduled for July 2025.

OMH and OASAS continue to provide education via trainings, conference presentations, and regional provider forums based on stakeholder feedback. Feedback received during the August 2024 CORE Summit included the need for more service-specific trainings. In 2025, NYS, in partnership with MCTAC, announced a new CORE Refresher Training Series. The goal of these service-specific trainings is to further develop CORE staff’s understanding of each service and how to address an individual’s goals with concrete, person-centered objectives and interventions at the appropriate frequency and intensity. A Psychosocial Rehabilitation recorded training was released in February 2025, followed by an Empowerment Services - Peer Support training in March 2025. Trainings for Family Support and Training and for Community Psychiatric Support and Treatment are under development. Each recorded training has an accompanying one-page reference sheet for providers to summarize key takeaways.

Additionally, in January 2025, MCTAC and The Alliance for Rights and Recovery offered CORE providers an opportunity to apply for 5 hours of technical assistance, tailored to meet unique agency needs. Topics included policy and procedure development, infrastructure development, sustainability planning, workforce development, staff engagement and retention, fiscal modeling and service delivery. A total of 29 agencies applied and 15 were selected. NYS is connecting with the remaining 14 agencies to offer additional technical assistance.

From December 2023 to November 2024, 5,862 unique recipients received CORE Services. Specifically, the count of monthly recipients for the four transitioned services from Adult BH HCBS to CORE Services increased by 33.2% from 1,936 (January 2022, the month before HCBS/CORE transition) to 2,579 (November 2024).

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

- 11 HARPs executed 80 provider contracts which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- The program concluded on July 31, 2024. As of March 31, 2025, all contracts have concluded. NYS is in process of obtaining final reports and metrics from HARPs.
- Approximately $31 million in initial contract base awards and subsequent milestone payments were distributed to providers.[4]
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS, and CORE service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.
- In July 2024, NYS distributed a compiled list of “best practices,” informed by HARPs and providers as they jointly developed innovative solutions to engage HARP members, expedite the BH HCBS and CORE Services workflow, and address barriers to receiving BH HCBS and CORE Services.

Self-Directed Care (SDC) Pilot

The SDC program is a pilot that has been extended several times as multiple avenues were explored for sustaining the program. The State has worked with consultants and other states on how to use Medicaid to sustain SDC for the BH populations. While there are grant-funded approaches, no other state has been able to do this under Medicaid for the BH population. Consultants and other states acknowledge the challenges faced with the federal HCBS rules, which is the primary approach used for other populations. NYS has shaped the final years of the pilot to give the best data to determine how aspects of the SDC program could be incorporated into existing rehab service infrastructure. The pilot as it is today will end in December 2026.

[4] Q2 2025 award amounts are not yet available and will be submitted with the next quarterly update.

Enrollment Statistics:

- Total recipients enrolled in SDC pilot since 2017
- 317 total
- Community Access (111)
- Independent Living (206)

Transition of Pharmacy Benefits from MMC to FFS

Effective April 1, 2023, the NYS DOH transitioned all Medicaid members enrolled in MMC plans, HARPs, and HIV SNPs to the NYRx Medicaid Pharmacy Program under the FFS model. Prior to this transition, members received pharmacy benefits through individual MCOs, resulting in fragmented coverage, inconsistent formularies, complex claims processing, and limited purchasing power for NYS DOH. Providers and members faced difficulties navigating varying formularies, while claims for 340B drugs were often submitted above the federal ceiling price, creating compliance risks. Additionally, MCOs were frequently non-compliant with NYS DOH's formulary requirements despite oversight efforts. Many members were also receiving pharmacy services from providers not enrolled in the NY Medicaid program, which is non-compliant with Medicaid policy. In preparation for the transition, NYS DOH conducted targeted provider outreach to enroll these pharmacies and member outreach to support continuity of care by transitioning members to enrolled providers. Stakeholder engagement was a significant focus pre-transition, requiring coordinated efforts to ensure that providers, members, and MCOs were informed and prepared.

Post-transition, NYRx established a single uniform formulary, improving transparency, streamlining coverage, and strengthening compliance. Claims are now reimbursed based on actual drug acquisition cost plus a dispensing fee, and ceiling price edits have been implemented to prevent overpayments on 340B claims. NYRx also gained enhanced purchasing power, enabling direct manufacturer negotiations and increased savings. NY Medicaid now operates the largest statewide pharmacy network, with over 5,000 enrolled pharmacies. Members retained access to their pre-transition Medicaid providers, ensuring care continuity and compliance and can now search for enrolled pharmacy providers at the dedicated NYRx member website[5]. While post-transition challenges included third-party liability processing, Restricted Recipient Program (RRP)-related claim issues, and provider unfamiliarity with NYRx billing requirements, NYS DOH responded with continued stakeholder education, claim edit messaging, and dashboard driven outreach to resolve issues and promote provider compliance.

Transition of Non-Emergency Medical Transportation (NEMT) from MMC to FFS

A "carve out" of NEMT from the NYS MLTC program occurred on March 1, 2024. Originally intended to be a phased carve out beginning in February 2023, the transition was changed to use a single statewide effective date. This change was due to a 12-month delay in the transportation broker contract and the broker's assessment of readiness to transition all MLTC members on March 1, 2024. Additionally, switching to a single statewide effective date streamlined communication and minimized confusion among MLTC members. In the four months prior to the carve out, the DOH and the contracted transportation broker (MAS) held data transition meetings with each MLTC plan and received trip data needed to provide a seamless transition. There were two notable challenges that occurred during this transition:

- An unprecedented number of non-English language phone calls led to increased call hold times. With staffing increases and natural decrease in calls, call hold times were back to normal levels within four weeks of the carve out being implemented. Call hold times continue to be monitored on a monthly basis.

[5] Member Dashboard - New York State Medicaid Members

- Trips to Social Adult Day Programs required special handling during the transition. A small minority of Social Adult Day Programs were not equipped to provide transportation for their participants and the DOH offered programs several months to make necessary accommodations.

In the first year post-carve out, the DOH has seen a full transition of MLTC members to using the statewide transportation broker, MAS. As ongoing program monitoring, DOH reviews internal transportation utilization data on at least a monthly basis and reviews contractually required monthly reports from MAS.

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

Activities within NYS DOH continue to prepare for SBHC services to be included in the MMC benefit package no sooner than April 1, 2026. The guidance documents, billing guidance, and FAQs, have all been posted to the DOH website. The Office of Health Insurance Programs (OHIP), and the Division of Family Health (DFH) staff continue to meet every two weeks to assist with continued planning for the no sooner than April 1, 2026, transition of this benefit into the MMC benefit package. DOH has been providing ongoing updates to MMC plans during the monthly managed care policy and planning meetings, and DOH staff attend ongoing meetings with DFH and the SBHC operators. In addition, DOH shared a list of MMC plan points of contact for benefit, billing, and contracting questions with DFH to distribute to the SBHCs.

As a result of state legislative action, in an effort to support a seamless transition, the SBHC transition into the MMC benefit package was extended. Originally scheduled for April 1, 2025, the transition will now occur no sooner than April 1, 2026.

C. Managed Long-Term Care (MLTC) Program

MLTC plans include Partial Capitation, Program of All-Inclusive Care for the Elderly (PACE), MAP, and Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA IDD) plans. As of January 1, 2025, there are 14 Partial Capitation plans, 10 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of April 1, 2025, there are a total of 378,904 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the January 2025 through March 2025 quarter, NYS DOH facilitated the opening of a new PACE plan, and two MAP service area expansions.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers may maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the January 2025 through March 2025 quarter, post enrollment surveys were completed for 15 enrollees. Of the 13 responses received, 11 (85%) indicated that they continued to receive services from the same caregivers once they became members of an MLTC plan. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation plans decreased from 310,527 to 308,235 during the January 2025 through March 2025 quarter, a 1% decrease from the previous quarter. For this period, 13,056 individuals who were being transitioned into MLTC made an affirmative choice and brings the 12-month total for affirmative choice to 63,694.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the April 2024 through March 2025 annual period is submitted as Attachment 1.

2. Significant Program Developments

During the January 2025 through March 2025 quarter:

- The First Quarter Member Services survey was conducted on 14 Partial Capitation plans and 12 MAP plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but, when necessary, DOH provided recommendations on areas of improvement.
- Round 2: An Operational Survey was initiated for one Partial Capitation plan in a prior reporting period. The CAP has been received and is under review.
- Round 3: Operational Surveys were initiated for two plans on their Partial Capitation and MAP lines of business in the prior reporting period. Survey documentation has been received and the Desk Review is still in progress.
- Two Focused Surveys were initiated for one Plan for their Partial Capitation and PACE lines of business resulting in two SODs based on the identification of expired MSA Agreements in a prior reporting period. Since the Partial Capitation line of business closed effective 12/31/2023 and the CAP was missing vital elements, no further action was requested. The PACE CAP remains under review.
- One Focused Survey was initiated on one plan based on their non-compliance with annual site evaluation requirements. SODs were issued for their Partial Cap and MAP lines of business in a prior reporting period. The CAPs were received and are under review.
- Two Focused Surveys were initiated on two plans based on their failure to develop an acceptable quality assurance program, and failure to meet required timeliness deadlines. SODs were issued, CAPs were received and are under review.
- N.Y. Public Health Law § 4403-f. (l l-b) Post Transaction Reporting:
    - Two Partial Capitation Merger Post Transaction Reviews were initiated. Files were requested and are under review.

As a matter of routine course:

- The processes for Operational Surveys have been streamlined to include both the Partial Capitation and MAP lines of business simultaneously.
- The Operational Survey process has been modified to survey each plan simultaneously focusing on one compliance topic at a time.
- New/promoted staff members continue to be trained on the Surveillance processes and interviews are being held to fill vacant positions.

3. Issues and Problems

There were no issues or problems to report for the January 2025 through March 2025 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within MLTC plans as a consumer choice and gives individuals and families greater control over services received. The enacted 2024-25 NYS Budget included legislation to procure a single statewide fiscal intermediary. The procurement was issued in June 2024 and a vendor, Public Partnerships LLC (PPL) was awarded the contract on September 30, 2024. The contract with PPL began January 1, 2025, and consumers have been transitioning to PPL through the first quarter of 2025. All managed care plans have Administrative Service Agreements in place with PPL.

5. Required Quarterly Reporting

Critical incidents: There were 8,722 critical incidents reported for the January 2025 through March 2025 quarter, an increase of 146% from the previous quarter. This increase in critical

incident reporting is due to plan education throughout 2024 on critical incident reporting requirements. DOH will continue to monitor the numbers to ensure accurate reporting.

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 below (Attachment 2).

The NYS DOH continues to report the volume of MLTC plans' critical incidents, issued updated instructions in 2023 and 2024 to the MLTC plans in proper reporting, and continues to follow up with MLTC plans that have continuously reported zero critical incidents. DOH will be conducting reviews of the resulting investigations by each plan in 2025 and report those procedural findings in FFY Quarter 1-2.

Complaints and Appeals: For the January 2025 through March 2025 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with other covered services, Dissatisfaction with quality of home care (other than lateness or absences), Dissatisfaction with member services and plan operations, Dissatisfaction with Care Management, and Wait too long to get an appointment or service.

Period: 1/1/2025–3/31/2025 (Percentages rounded to nearest whole number)			
Number of Recipients: 370,055	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	14	12	86%
# Same Day	2,036	2,036	100%
# Standard/Expedited	6,277	4,077	65%
Total for this period:	8,327	6,125	74%

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

Appeals	4/2024-6/2024	7/2024-9/2024	10/2024-12/2024	1/2025-3/2025	Average for Four Quarters
Average Enrollment	348,752	359,307	370,055	376,806	363,730
Total Appeals	11,347	11,994	12,711	12,174	12,057
Appeals per 1,000	33	33	34	32	33
# Decided in favor of Enrollee	1,291	1,487	1,228	1,369	1,344
# Decided against Enrollee	8,572	9,101	9,978	9,396	9,262
# Not decided fully in favor of Enrollee	1,209	1,083	1,186	1,136	1,154
# Withdrawn by Enrollee	275	323	319	273	298
# Still pending	1,232	1,331	822	931	1,079
Average number of days from receipt to decision	8	8	9	7	8

Complaints and Appeals per 1,000 Enrollees by Product Type January 2025 – March 2025					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	309,354	4,676	15	8,866	29
MAP Total	57,478	2,533	44	3,260	57
PACE Total	9,974	1,118	112	48	5
Total for All Products:	**376,806**	**8,327**	**22**	**12,174**	**32**

Total complaints increased 16% from 7,154 the previous quarter to 8,327 during the January 2025 through March 2025 quarter.

Total appeals decreased 4% from 12,711 during the last quarter to 12,174 during the January 2025 through March 2025 quarter.

Technical Assistance Center (TAC) Activity

During the January 2025 through March 2025 quarter TAC opened 975 cases and closed 953 cases. This is more than the 710 opened cases and the 727 closed cases from the previous quarter. Inquiries shows a moderate increase from the previous quarter's 365 to this quarter's 478. This quarter's change in cases is spread across the different types of case dispositions, outlined in the table below.

78% of Q2 TAC cases were closed in the same month they were opened; this is a slight increase from last quarter's 72%.

Call Volume	**1/1/2025 – 3/31/2025**
Substantiated Complaints	114
Substantiated Complaints with CAP	0
Unsubstantiated Complaints	348
Resolved Without Investigation	13
Inquiries	478
Total Cases Closed	953

The five most common types of calls were related to:

Call Type	**1/1/2025 – 3/31/2025**
Aide Service	24%
General	20%
Coverage Concerns	15%
Enrollment Untimely	12%
Grievance (Service Interruption)	11%

Aide service and general inquiries made up majority of TAC's calls for this quarter. Home health services continue to be the highest complaint category. There was an increase in home health service complaints from the previous quarter; this is likely due to the statewide fiscal intermediary transition.

Evaluations for enrollment: The New York Independent Assessor Program (NYIAP) is conducting initial assessments and clinical exams for personal care and consumer directed

personal assistance services as well as continuing to determine MLTC eligibility. For the January 2025 through March 2025 quarter, 6,953 people were evaluated, deemed eligible, and enrolled into plans, a decrease of 16% from the previous quarter.

Rebalancing Efforts	1/2025-3/2025
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	349
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,716

As of March 31, 2025, there were 3,208 current plan enrollees who were in nursing homes as permanent placements, a 3% decrease from the previous quarter.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with HCBS needs, including medically fragile children, children with BH needs, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. **The Children's Waiver Renewal** that was submitted to CMS in January 2022, and extended in April 2022, was **approved on June 29, 2022,** for an effective date of April 1, 2022. Additionally, two new Children's Waiver Amendments were approved by CMS on November 1, 2023, and March 1, 2024, to amend a number of activities detailed in the sections below.

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

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

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

- Continuing to refine data collection and data analysis to ensure accurate reporting.
- Engaged a contract vendor for performance and quality monitoring for all elements of the Children's Redesign, including the Children's 1115 Waiver, to ensure consistency and quality in all elements of the initiative.
- Submitted the Preliminary Interim Evaluation Report to CMS, as drafted by the vendor.
- Submitted the Interim Evaluation Report to CMS, as drafted by the vendor.
- Drafting policies and guidance to ensure compliance with State and Federal requirements, as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification (EVV).
- Updating manuals, guidance documents, forms, and online resources as indicated.
- Reassessing, streamlining, and removing unnecessary or duplicative forms to alleviate administrative burden.
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers, including additional resources and technical assistance with person-centered planning.
- Facilitating relationship building between Medicaid Managed Care Plans (MMCP), HCBS providers, and care managers to improve communication and care coordination.
- Coordinating stakeholder meetings to obtain feedback from MMCP, Health Homes, HCBS providers, advocate groups, Regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation.
- Evaluating accuracy of MMCP and FFS billing and claiming data.
- Defining performance and quality metrics.
- Responded to the COVID-19 pandemic and implemented emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and supported the recovery of impacted providers and consumers.
- Assisted with a strategic plan for the unwind of the COVID-19 PHE.
- Released a PHE Unwind plan for flexibilities related to the Medicaid Children's Waiver and Health Home Services.
- Working with Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process.
- Working with HCBS providers and MMCP to streamline the authorization process.
- Engaged with providers to understand barriers to service delivery – such as workforce challenges, lack of referral sources/lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers.
- Modified the state-wide capacity tracking system, which is based on provider self-reporting, to enhance the understanding of the HCBS waitlist and who is being served by HCBS. An electronic referral and authorization portal was launched, which will provide more accurate information that is not dependent upon self-reports of providers.
- Engaged with providers, consumers, and NYS agency partners to determine how best to use the eFMAP authorized by ARPA to improve access to children's services and

reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure.

- Collected stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the managed care processes and improve communication between MMCP, Health Homes, and HCBS providers.
- Organized and conducted workgroups of Health Homes, MMCP, and HCBS Providers to ensure feedback is addressed relating to the referral and authorization process.
- Engaged with Health Homes, MMCP, and HCBS providers while redesigning the Plan of Care in preparation for digitization.
- Updated public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process.
- Submitted the 1915c Children's Waiver Extension to CMS.
- Submitted the 1915c Children's Waiver Renewal to CMS.
- Submitted a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitted a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure.
- Worked with MCOs and providers to disseminate ARPA funding through the directed payment process.
- Scheduled and facilitated regional meetings with HCBS providers, Health Homes, CMAs, MMCPs to resume in-person collaboration and dialogue.
- Updated the Incident Reporting and Management System (IRAMS) to build an HCBS Referral and Authorization Portal and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- Engaged with HCBS providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if they are not currently able to actively deliver HCBS.
- Submitted an additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental Modifications (EMod), Vehicle Modifications (VMod) & Adaptive and Assistive Technology (AATs).
- Conducted Final Rule compliance reviews with newly designated HCBS providers.
- Monitored staff compliance with training and background check requirements through IRAMS.
- Updated and issued the Children's Care Management Authorization and Referral Forms ensuring inclusivity of all requirements per stakeholder feedback.
- Updated HCBS Referral and Authorization Portal User Guide used by Health Home, CMA, HCBS Providers, and Children and Youth Evaluation Services' (C-YES) to report critical incidents and complaints/grievances as appropriate for the various populations served to ensure the health, safety, and well-being of members.
- Updated and posted various iterations of the HCBS Referral and Authorization Portal User Guide and associated FAQ.

- Hosted webinars providing training and technical assistance on use of the Referral and Authorization Portal.
- Updated and posted documentation and guidance related to HCBS eligibility and enrollment.
- Hosted HCBS Collaborative Stakeholder meetings to share reminders and information on Waiver requirements with HCBS providers, Health Home, and MMCPs.
- Updated the process of assigning participant eligibility codes (K codes) to case files to ensure service provision only to enrolled and eligible children/youth.
- Refreshed the list of designated HCBS providers to more accurately reflect agencies ready to accept referrals and provide HCBS.
- Built a MMCP role in HCBS Referral and Authorization Portal and granted MMCPs access to pertinent member information within the system.

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 continues 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 C-YES’ Nurse qualifications by requiring two years relevant experience. The previous requirement that was two years’ experience specifically in home care.
- Reduced the required years of experience for Palliative Care: Expressive Therapists from three years to one year.
- Added a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity.
- Added a 5.4% COLA increase for providers starting April 1, 2022.
- NYS supported the continued 25% enhanced HCBS rates on October 1, 2022.
- Added a 4% COLA increase for providers effective November 1, 2023.
- Effective December 1, 2023, rural rates for seven counties were implemented to improve access to services.
- Transitioned the EMod, VMod, and AAT to a Financial Management Service, starting March 1, 2024, based upon approval for Children’s Waiver amendment.
- Implemented a 2.84.% COLA increase for Children’s HCBS effective April 1, 2024.
- Effective October 1, 2024, MMCP capitation payments were adjusted to include risk-based premium adjustments for Children’s Waiver HCBS.
- Developed Electronic Children’s Services Staff Compliance Tracker.

- Released the Electronic Children's HCBS Referral and Authorization Portal, which streamlines, standardizes, and ensures timely completion of HCBS referrals and authorizations.
- Launched a FFS authorization process for HCBS. Issued an FFS authorization policy and hosted an FFS authorization webinar.

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

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

This table includes Quarter 2 data from 1/1/2025 – 3/31/2025:

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children with HCBS Claims**	**Enrolled Children**	**Enrolled Children with HCBS Claims**
1/1/2025	8,692	4,776	1,421	314
2/1/2025	8,444	4,443	1,414	297
3/1/2025	8,293	2,895	1,410	232
Quarter 2 Unique	**9,095**	**5,282**	**1,460**	**381**

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

E. Social Care Networks and HRSN Services

NYS is integrating physical, behavioral, and social care for Medicaid members through regional Social Care Networks (SCNs). Nine SCN Lead Entities (LEs) have created regional networks of contracted HRSN service providers and healthcare and behavioral health providers via shared and/or interoperable technology platforms. SCNs screen Medicaid members for unmet needs, navigate them to services through existing programs or to enhanced HRSN services, and facilitate payment for services. Enhanced HRSN services span the domains of housing, nutrition, care management, and transportation.

Since launching on January 1, 2025, NYS DOH has focused on expanding program reach, improving operations, strengthening data-driven performance management, and overseeing service delivery. In Q2, DOH deepened engagement across all nine regions by collaborating with MCOs, healthcare and behavioral health providers, and community-based organizations (CBOs). All nine SCNs are actively screening and navigating members to both existing and enhanced HRSN services; and delivering enhanced services to eligible members. SCNs are also focused on expanding workforce capacity, optimizing and scaling HRSN service provider networks, and advancing platform functionality and data sharing.
Key accomplishments from Q2 include, but are not limited to:

- **Demonstrated program impact by activating screening, navigation, and HRSN service delivery**. Members are actively receiving these services across all nine regions,

supported by dedicated Social Care Navigators embedded at SCNs and partner organizations.

- **Launched cross-sector data and IT infrastructure** that creates real-time connectivity across SCNs, MCOs, healthcare providers, and HRSN providers to enable data driven decision making and improved care coordination.
- **Strengthened multi-stakeholder coordination and governance**, aligning SCNs, MCOs, and IT platform vendors through shared infrastructure, consistent workflows, and collaborative forums.
- **Built program awareness among Medicaid members and** stakeholders by delivering member and provider communications, expanding public-facing resources, and reinforcing trust through broad-based stakeholder engagement.
- **Launched performance management and continuous improvement,** including end of quarter performance dialogues and SCN one-on-one's to drive continuous improvement and targeted support.

Q2 HRSN Detailed Implementation Activities

Following program launch in January 2025, the State completed the following program implementation activities in Q2.

SCN Lead Entity Operational Success

- **Supported SCNs in implementing operational workflows to effectively scale service delivery across all nine regions**
    - Enabled full program activation across all SCNs, providing comprehensive operational guidance and support to launch screening, navigation, and service delivery workflows statewide.
    - Reinforced care continuity and member experience, including training support for warm hand-off protocols and ensuring SCNs maintained member-friendly websites, contact tools, and self-screening access.
    - Reinforced SCN operational readiness and member engagement by supporting baseline outreach capabilities and providing targeted performance guidance to accelerate ramp-up where needed.
    - Expanded screening and navigation capacity and workforce infrastructure through targeted office hours with Workforce Investment Organizations (WIOs) and SCNs to support ramp-up of Social Care Navigators, including community health workers.
    - Advanced analytic preparations for reconciliation calculations, laying the groundwork to validate SCN per-member-per-month payments and expenditures for services delivered.
    - Continued to support the claiming/billing structure for MMC and FFS.

Data and Technology

- **Provided expanded technical guidance and tools to support SCN implementation and IT platform vendor alignment with program policy**
    - Distributed member-level data such as member and plan unique identifiers, tags for frequent healthcare users, and individuals with chronic conditions to all SCNs to support timely eligibility assessment and service delivery, therein enhancing the member experience.

    - In addition to this data, published a set of additional critical IT guidance documents for various ecosystem stakeholders:
        - Fast Healthcare Interoperability Resources (FHIR) Implementation Guide: Guide for IT platform vendors on the exchange of HRSN data.
        - Data and Systems Implementation Guide (DSIG): Guide for SCN Lead Entities that provides Member enrollment and population identification, HRSN billing, claims, and data management guidance.
        - Platform Resource Pack: Guide for SCN IT platforms which includes platform implications from the Operations Manual, additional resources requested to help platforms implement workflows, and other clarifications.
    - Delivered a detailed technical guide translating program policy into platform logic to the four IT platform vendors standardizing eligibility assessments and referral workflows.
    - Conducted live meetings with IT platform vendors to support them in enabling platform functionality across all SCNs, ensuring consistency across IT platform vendors.
    - Published a publicly available Provider IT Guide to expand Provider participation in the SCN program by clarifying how health care organizations can connect to SCN technology platforms and regional Qualified Entities (QEs). The guide outlines available integration options, eligibility and reimbursement requirements, and practical steps for data sharing, including screening via electronic health record systems (EHRs) or SCN platforms, to promote statewide interoperability across MCOs, SCNs, providers, and QEs.
- **Continued to lead oversight and testing efforts to ensure data quality, privacy, and security for Medicaid members**
    - Initiated data flow of FHIR bundles from IT vendor platforms to the State, enabling ingestion of screening and eligibility assessment data, and supporting ongoing data quality review.
    - Provided oversight and technical guidance to expand data exchange between contracted healthcare providers and SCN LEs, with screenings submitted through both native SCN IT platforms and provider EHRs, enabling providers to more easily participate in the program.
    - Provided testing and issue resolution support to New York eHealth Collaborative (NYeC), QEs, and IT platform vendors to increase the volume of screenings ingested into SCN systems, enabling Social Care Navigators to complete eligibility assessments and navigate members to needed services.
    - Created a range of flexible options for healthcare providers to participate and share data, including through the use of IT platform vendors and data exchange with QEs.

Stakeholder Engagement and Transparency

- **Shared a comprehensive set of public-facing materials and facilitated outreach and events to support SCN, CBO, member, and provider engagement and expanded awareness of SCN services**
    - **Publicly available materials and resources:**
        - Enhanced public access to program information by redesigning the NYS DOH website, launching dedicated pages for members, providers, and

HRSN organizations, and publishing translated materials to support broad stakeholder engagement.
        - Prepared key member-facing materials, including updated factsheets and a customized SCN member video, to support local engagement, all of which were made accessible on the newly updated OHIP website.
        - Supported SCN outreach by finalizing DOH and SCN-specific social media kits, including targeted messaging and guidance on how to access housing and nutrition resources, as well as content SCNs can use to engage and attract housing and nutrition service providers.
    - **One-on-one stakeholder and platform engagement**:
        - Developed Platform Readiness Packs and hosted live meetings to guide IT platform vendors in executing operational guidance.
        - Developed and released new resources, including an eligibility criteria summary by service and regional SCN member contact information.
    - **Public communications and events:**
        - Hosted a webinar for HRSN service providers with over 1,000 registrants and another for current and prospective Medical Respite Providers, with published resource guides and instructional materials.
        - Presented program updates at statewide convenings, such as the Patient-Centered Medical Homes Webinar and the 1115 Waiver Annual Public Forum; industry convenings, such as the Managed Care Organizations' Medical Directors Meeting and the HANYS Forum; and non-profit sector convenings, such as the New York State Association of Counties (NYSAC) Public Health and Mental Health Committee Meeting.
        - Shared SCN program information for the April New York State Assistor Newsletter, outlining how Assistors can connect Medicaid members to HRSN services by directing members to SCNs.
- **Facilitated forums for collaboration, learning, and peer support across SCN LEs**
    - Facilitated the first of a series of monthly, statewide SCN Learning Collaboratives (beginning February 2025) that provide opportunities for SCN LEs to share insights and exchange best practices from early program operations.

Performance Measurement

- **Launched performance infrastructure to enable data-driven oversight and continuous improvement across SCNs**
    - Launched weekly executive briefings to drive program accountability and continuous quality monitoring
    - Conducted first quarter SCN LE one-on-one performance dialogues as part of the program’s continuous improvement and performance management strategy
    - Received and analyzed submissions of a series of performance management reports from SCNs that focus on key performance indicators, network composition, and spending.
- **Developed key milestones to use to measure SCN progress.**

Across every component of the program (e.g., operations, data and technology, stakeholder engagement, and performance measurement) NYS is scaling a more connected and accountable system of care. As SCNs continue to expand member engagement and service delivery, the NYS is shifting its focus toward outcome measurement, performance management, and program efficiency. With a foundational set of data and operational tools now in place, NYS is well-positioned to monitor impact, identify gaps, and continuously refine the program to improve health outcomes and reduce avoidable Medicaid spending.

Q2 Implementation Challenges

Throughout Q2, NYS DOH continued to support SCNs in building out their capacity and networks. SCNs made meaningful progress over the quarter and are continuing to scale operations, strengthen partnerships, and expand service delivery across their regions.

Complaints and Appeals

There were no member complaints during the January 1, 2025, through March 31, 2025 quarter.

F. Workforce Initiatives

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

1. Career Pathways Training (CPT) Program

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

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

Three Workforce Investment Organizations (WIOs) are administering the CPT Program in three distinct regions of the State. In the past quarter, the WIOs have significantly increased recruitment and enrollment, resulting in enrollment jumping to more than 2,000 students. WIOs have also continued to roll out multimedia recruitment campaigns, including launching a series of videos designed to familiarize prospective students with potential job titles.

The WIOs continue to provide critical support for participants to ensure program completion, including case management, tutoring, and other academic support; coordinated educational

programs; payments for books and academic fees; and backfill for current employees' time spent in training programs. As the first group of students completes the first semester of enrollment, WIOs are also ramping up infrastructure for job placement and career supports to prepare students to begin their service commitments.

Q2 CPT Program Implementation Activities

During Q2 2025, NYS DOH focused on continuing to drive recruitment and enrollment of program participants and expansion of support services. The CPT program has been continuously gaining traction, reflecting the WIOs' dedicated efforts to expand the program's reach and effectiveness.

WIO Engagement and Enablement

The following section highlights ongoing initiatives aimed at enhancing program strategies and support. Key undertakings and accomplishments include:

- Continued regular one-on-one meetings with WIOs to provide program guidance and technical support to address implementation issues, such as expanding outreach and recruitment, executing educational contracts, expanding access to support services, and ensuring academic and career success for participants.
- Continued collaborative efforts across all WIOs to share program strategies, successes and improvements to support recruitment efforts. This has resulted in innovative multi-media marketing campaigns and joint agreements with educational institutions to simplify the contracting process and make programs more readily available to students.
- Qualitative and quantitative reporting provided by the WIOs has allowed NYS DOH to quickly identify areas in need of support as well as have up to date information on the pace of recruitment and enrollment.
- Extensive engagement and coordination between the WIOs and the SCNs, including NYS DOH facilitating a joint session between the WIOs and SCNs to improve communication and answer programmatic questions on both sides. NYS DOH has been working in close coordination with both the WIOs and the SCNs to ensure that the CPT program supports training and recruitment efforts to build necessary screening capacity at SCNs across the state.

Communications and Broader Stakeholder Engagement

Stakeholder engagement initiatives have been deliberately focused on identifying, cultivating, and strengthening relationships with a diverse spectrum of stakeholders throughout the State. Detailed below are several examples of such initiatives.

- Conducted in-person and virtual engagement sessions with employers, including the SCNs, provider associations, CBOs, educational institutions, health systems, Federally Qualified Health Centers (FQHC), and long-term care providers.
- Established partnerships and executed contracts with educational institutions to facilitate enrollment across all 13 titles in all 3 WIO regions covering the entirety of the state.
- Attended meetings with various employers to discuss opportunities for career growth for their current employees as well as strategies for recruiting new employees via the CPT program.
- Hosted monthly check-ins with SCNs to facilitate regular resource sharing, increase awareness/ reach of recruitment efforts, and build a clear pipeline and career pathway for critical roles to increase SCN screening and navigation capacity.

- Hosted bi-monthly cross collaborative WIO meetings to ensure program continuity across NYS and share best practices.

Recruitment and Enrollment

The WIOs continued increased efforts on recruiting and enrolling program participants across the 13 titles in their respective regions. Most recent quarterly reports from the WIOs show significant strides in both areas.

- Approximately **2,400 participants** have been enrolled in the program, with more than 2,000 of those enrolling in the last quarter. About 58% of participants are enrolled in the Career Advancement pipeline compared to 42% in the New Careers pipeline. More than 70% of those enrolled are pursuing careers in nursing (NP, RN, BSN, LPN).
- Approximately $49.1M has been collectively expended across the WIOs resulting in approximately $126.7M rolling over from DY26 funding into DY27. Program spending remained low in the early months of the program as the WIOs were focused on building organizational capacity. Additionally, enrollment for many of the titles is concentrated in the fall semester. Since the program roll out was after the start of the fall semester, there was a small first cohort in the fall of 2024. Spending ticked up significantly in the last quarter and is expected to grow rapidly in the coming quarter. The rollover funding will be used primarily to cover growing tuition and support services in the second year of the program.

Strengthening Educational Partnerships

The WIOs have collectively partnered with dozens of educational institutions across their regions. These partnerships have been pivotal in offering a broad spectrum of educational programs across the thirteen titles available in the CPT curriculum. By forging these relationships, the WIOs have created tailored educational pathways that not only support participants' personal and professional ambitions but also align with the overarching goal of enhancing the healthcare workforce.

Marketing and Outreach Initiatives

A series of comprehensive marketing and outreach initiatives were utilized to enhance the visibility of the CPT Program and drive participant enrollment. The WIOs' dedicated program websites have provided a central hub for information and application processing, streamlining the participant journey from initial recruitment to active enrollment in the program, receiving tens of thousands of site views. Digital marketing campaigns, including targeted social media advertising on platforms such as Facebook and LinkedIn, have proven to be highly effective in reaching a wider audience. These campaigns, combined with press releases and media coverage, have broadened the program's reach across NYS to attract attention from community stakeholders and potential participants.

Technological Enhancements and Support Services

In addition to strengthening educational partnerships and launching marketing initiatives, the WIOs have been diligently working to implement robust technological systems to support program operations, including the integration of advanced Learning Management Systems (LMS), allowing for sophisticated program data reporting and participant tracking. Tracking at the participant level will be used to identify at-risk students and develop customized interventions to keep students on track.

The WIOs are continuing progress in the implementation of comprehensive support services. The WIOs have been onboarding new staff, including full-time case managers, educational partnership specialists, and administrative support personnel. Tutoring services have been

launched to support participants on their respective academic courses to ensure they receive individualized guidance and assistance, as necessary. In the following quarter, the WIOs are set to further expand their academic and career support services to ensure participants can receive the necessary supports to successfully complete the program, including providing more tutoring support services and expanded access to online learning tools.

Workforce Data Reporting

DOH is working with the WIOs to standardize data definitions and enhance the accuracy and consistency of quarterly reporting. This effort includes providing targeted technical assistance to support WIOs in refining and improving their data collection, management, and reporting processes. This will ensure that data is consistent across WIOs as well as across quarterly reports. NYS is currently collecting key program metrics across the WIOs, including recruitment and enrollment numbers, completion rates, detailed spending across titles, geographic distributions of enrollees, and other metrics intended to help track the program and develop targeted interventions as necessary.

As part of its broader mandate to coordinate data aggregation across the waiver and conduct regional needs assessments, NYS will be engaging the HERO to facilitate a statewide vacancy rate survey. The survey will collect data across all the target titles in the CPT and SLR program. Work on the survey will commence in the next monitoring quarter.

2. Student Loan Repayment Program

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

Q2 SLR Program Implementation Activities

In Q2, NYS DOH continued working to develop the framework for the SLR program focusing on the program components necessary to launch applications later this year. NYS is currently working to establish a timeline and procedure for application review and finalize programmatic guidance documents, application materials and criteria, a marketing plan, and outreach materials to advertise the program to potential enrollees.

As required by STC 12.7.a, the State is hereby notifying CMS that it did not expend the funds authorized for the Student Loan Repayment program in DY26 and that it will carry forward the full $12.08 million to be spent in subsequent demonstration years.

G.HERO

NYS finalized the scope of work for the facilitator of HERO facilitator activities. During this period the State facilitated key processes to support the HERO facilitator to begin work on the activities outlined in the STCs, reported below. The HERO facilitator began building the infrastructure necessary to support those activities and began to identify and work with key collaborating partners necessary to effectively complete the activities.

Data Aggregation

The HERO facilitator worked closely with NYS and its data partners to develop secure access to aggregated HRSN screening, assessment, and referral data. The HERO facilitator analyzed synthetic test data for purposes of coding the raw data into organized tables for future analysis. The HERO facilitator collaborated with the State and its data partners on developing the data use agreements and associated business associates and contractual agreements necessary to support access to Medicaid data. The HERO facilitator also worked closely with an academic partner to define an analytic plan and process for analyzing claims data and aggregating and integrating key data points across the claims and HRSN datasets. Analysis of live data will commence in the next monitoring quarter. In addition to the workforce survey data noted above in Workforce Data Reporting, the HERO facilitator has been collecting additional data sources to use for workforce capacity evaluation

Regional Needs Assessment and Planning

The HERO facilitator conducted an exhaustive search for existing needs assessment and planning documentation across NYS resulting in the collection of more than 500 needs and planning documents. A sample of those documents were reviewed by multiple staff, each of which identified key themes and items for inclusion in health needs and planning documents. Staff then combined their findings to develop a regional needs assessment template that was delivered to the State for review and comment. Work then commenced on compiling the publicly available data necessary for key portions of the regional needs assessment template. A potential collaborating partner with a history of analyzing vital statistics for needs assessment and planning outside of New York City was identified to support completion of the regional needs assessments.

A similar process began during this monitoring quarter with the collection of population health plans from across the state and nation. Work on the resulting NYS population health plan template will be detailed in the next quarterly monitoring report.

Data sharing arrangements with MCOs do not appear necessary at this time given the process by which MCOs are providing data to the state data-lake which UHF will be accessing in the secure environment described above.

Stakeholder Engagement

On March 7, 2025, NYS facilitated a presentation to all SCNs outlining the activities to be conducted by the HERO facilitator. The HERO facilitator also began discussions with potential partners that could be well-positioned to support regional stakeholder engagement sessions. The HERO facilitator met individually with multiple SCNs, WIOs, and other regional and statewide stakeholders to further its understanding of regional stakeholders, their needs, and the perceived statewide and unique regional needs that might need to be addressed in future regional stakeholder engagement sessions.

Future VBP Arrangements

The HERO facilitator began landscape research in support of initial ideas for arrangements and processes for how they will be developed. This process includes research into how other states have developed VBP arrangements, the data that has been used in support of arrangement development, and what types of arrangements are showing promising outcomes in both the Medicaid and commercial markets. The HERO facilitator also reviewed the AHEAD model and other CMMI demonstrations recognizing the desire for long-term alignment across payers and

CMS programs. The research will continue in the next monitoring period quarter with a focus on developing initial arrangement ideas for discussion with the State and key stakeholders.

Program Analysis

The HERO facilitator began research work in support of the development of a population health plan template, see brief description in Regional Needs Assessment and Planning above. The HERO facilitator leveraged its existing access to Medicaid claims and publicly available vital statistics data to begin assessing health factor baselines at the regional level.

G. Medicaid Hospital Global Budget Initiative (MHGBI)

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

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

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

In Q2, NYS drove meaningful progress in the development and implementation planning of the Medicaid Hospital Global Budget (HGB) Model under the AHEAD program, including developing the first version of the Medicaid HGB methodology. To support operationalizing the HGB model, NYS established a preliminary roadmap and aligned on the draft structure and scope of the AHEAD operating model. In parallel, the team began defining data and IT requirements to support payment calculations and monitoring.

NYS completed the State Insights Report, drawing on detailed analysis of state and hospital fact bases. NYS also engaged internal stakeholders, prepared foundational materials for external engagement, and shaped the strategic direction for hospital technical assistance. These achievements laid the groundwork for a coordinated and actionable implementation phase.

Q2 MHGBI Implementation Activities:

Medicaid HGB Model Design

- **Developed v1 Medicaid HGB methodology**, addressing key components across volume adjustments (market shift, service line), annual adjustments (inflation, demographic, social risk), performance adjustments (quality, total cost of care), and other components (re-baselining, transformation incentive adjustment, shared savings). The v1 Medicaid HGB methodology was informed by a comprehensive analysis

encompassing assessment of the v2 Medicare FFS HGB methodology, comparative research of peer state models, analysis of the Centers for Medicare and Medicaid Services (CMS) Virtual Research Data Center (VRDC) data and other external sources, and collaborative working sessions with NYS DOH Subject Matter Experts (SMEs) and OHIP leadership.
- **Developed detailed methodology and specifications document of the v1 Medicaid HGB methodology across HGB components for OHIP use**, including all decisions made, steps to calculate, example calculations, changes from Medicare FFS HGB, and supporting rationale.

Medicaid HGB Model Operations

- **Developed preliminary operational roadmaps** with key activities / milestones required for AHEAD implementation, across design, payment calculations/pathways, data and IT, and regulatory.
- **Developed draft AHEAD operating model structure and scope** across AHEAD leadership and OHIP functional groups (data/IT, analytics and reporting, finance, hospital engagement and support, quality and health equity, Primary Care AHEAD).
- **Identified technical-related program components** of AHEAD.
- **Drafted detailed data attributes for HGB** for tech-related program components of AHEAD.

Hospital Technical Assistance

- **Completed the review of all March 1115 waiver deliverables from hospitals** (hospital fact base, roadmaps, Health Equity Plans, and planned budgets).
- **Drafted a State Insights Report as a State resource on waiver hospitals** that codifies the hospital fact base, including performance relative to benchmarks, analysis across HGB transformation categories, and key implications for hospital TA vendor.

Stakeholder Engagement

- **Drafted approach for stakeholder engagement** with near-term prioritization of internal groups.
- **Drafted outreach and material for initial meetings with relevant groups (e.g., finance and quality teams)** that detail AHEAD and HGB overview, AHEAD program milestones, and preliminary activities in pre-implementation and implementation phases of AHEAD.

H. Institutions for Mental Disease (IMD) Transformation Demonstration

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

Historically, federal and NYS Medicaid funding authorities (e.g., SPA and 1115 waivers) did not provide coverage for residential treatment. As such, this level of treatment was not included in either the Medicaid FFS or MMC benefit package. Therefore, individuals were frequently served

in higher levels of care than clinically appropriate (i.e., withdrawal management and inpatient treatment), and care coordination was fragmented between physical and BH services. Individuals experienced difficulty with transitioning from the hospital/inpatient setting to the residential LOC and often had re-admissions to higher levels of care.

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

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

- Part 820 programs are designed to help persons who lack a safe and supportive residential option in the community to achieve changes in their SUD behaviors within an appropriate setting. The Part 820 Residential Model has three elements of care:
    - **Stabilization:** Requires the supervision of a physician and clinical monitoring to address mild to moderate withdrawal, severe cravings, psychiatric and medical symptoms, and emotional crisis. Individuals will receive medically directed care to stabilize acute medical, mental health, and addiction symptoms. For patients who seek services at the emergency department and who are not in need of a hospital-level detox, the stabilization element will offer an alternative and provide these patients a safe place to stabilize and engage in treatment.
    - **Rehabilitation:** Staffing to provide monitoring, support, and case management. Designed for individuals with significant functional impairment related to social skills, employment, inability to follow social norms, and maintaining housing.
    - **Reintegration:** In a congregate setting or scattered site setting, will provide opportunities to actualize skills learned in treatment in the community; linkages to community services/resources; and services for those transitioning to long term recovery and independent living. Staffing includes case managers, housing experts, employment supports, and recovery wellness.
- Medication for addiction treatment – the Part 820 Programs Regulations[6] 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

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

least one Opioid Treatment Program (OTP) certified by OASAS to facilitate patient access to full opioid agonist medication, if clinically appropriate.

Developing the Title 14 NYCRR Part 820 Provider Network:

- Effective 2015, OASAS began the process of re-designating all approved OASAS certified residential programs from Title 14 NYCRR Part 819 and Title 14 NYCRR Part 816.9 to Title 14 NYCRR Part 820 programs.
- Comprehensive Title 14 NYCRR Program regulations were enacted to define the Part 820 Program model and related operations requirements.
- Programs must complete and receive approval of the required application documents to obtain OASAS certification as Title 14 NYCRR Part 820 and complete the application for designation to provide each of the three elements (stabilization; rehabilitation; or reintegration). Programs may seek designation to offer any or all of the elements. Designation will be based upon a program's assessment of its current and future patient needs and overall program vision for the services it is best positioned to deliver to the community. Programs converting from the prior models are required to submit the Part 820 conversion application[7] and new programs must follow the certification process for new programs.[8].
- During the demonstration timeframe OASAS provided Part 820 residential programs with technical assistance sessions and developed a comprehensive set of technical assistance tools, including readiness guidance documents, clinical manuals and fiscal modeling tools.[9]. For the remainder of the demonstration year, OASAS will continue to work with the remaining providers to transition to the part 820 model.
- As of April 2025, statewide, there are a total of 171 Part 820 Programs. There are 33 remaining programs to convert from the previous residential or medically monitored model (aka Part 819).
- OASAS is targeting February 2026 for completing conversion of the current residential or medically monitored model (aka Part 819) to part 820 programs. In December 2024, communications were sent to the current residential or medically monitored model outlining this plan. OASAS is working with the part 819 providers to implement a successful conversion.

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

- Under the NYS 1115 MRT waiver, Title 14 NYCRR Part 820 services and programs were incorporated into the MMC benefit package and became a required network provider type.
- The current model contract[10] 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.

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

Quarter 2: 1/1/2025 to 3/31/2025		
Service	**Total Number of Programs**	**Total Number of Beds**
Stabilization	9	214
Rehabilitation	14	575
Reintegration	87	2,072
Stabilization and Rehabilitation	16	658
Rehab and Reintegration	11	424
Stabilization Rehab and Reintegration	36	2,306
Grand Total	**173**	**6,249**

LOC Determination

NYS utilizes the LOC Determination (LOCADTR)[11] tool to support LOC determination. The tool has been utilized over three million times by SUD providers and managed care utilization managers since 2014. The tool is a web-based decision algorithm that includes the full continuum of care and has a continuing care module to support continuing care decisions. OASAS supports the tool with asynchronistic training available and webinar trainings to support updates. Providers, MMC, and commercial payers in NYS are required to use LOCADTR (unless otherwise approved by OASAS).

Summary of Milestones:

As requested in the March 2017 letter to Governors[12], NYS' initiative focuses on improving quality, accessibility, and outcomes in the most cost-effective manner through a comprehensive and coordinated approach. This report provides an update on State's ongoing efforts to meet the goals and milestones outlined in the State Applications and Implementation Plans related to SUD treatment and prevention.

Please see attached tables (Attachment 3), which details the State's progress achieving the required milestones, including increasing access to critical levels of care, adopting evidence-based standards and placement criteria, expanding provider capacity, implementing opioid prevention strategies, and strengthening care coordination and transitions. The table outlines the milestones, specific activities, outcome of the milestone, and summary of actions needed.

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

Effective August 27, 2013, prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances, with limited exceptions. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP Registry is available 24 hours a day/7-days a week via an application on the Health Commerce System (HCS)[13]. 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

[11] https://oasas.ny.gov/locadtr
[12] SMD #17–003
[13] https://commerce.health.state.ny.us

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 NYS DOH and the Centers for Disease Control and Prevention (CDC) funded Overdose Data to Action – States Grant. The BNE works closely with NYS Information Technology Service (ITS) to build out the technical architecture to the PMP as needed for functionality. This includes the continuous monitoring of the NYS PMP Registry for potential enhancements and weekly status meetings with NYS ITS. To enhance clinicians in their usage of the NYS PMP Registry through education, BNE has reviewed the Opioid Prescriber Training for any language and technical deficiencies, which satisfies educational requirements in Public Health Law Article 33 §3309-a[14] to raise health care provider awareness of the risks associated with prescribing and taking opioid pain medications. BNE will work with the contracted entity, State University of New York at Buffalo, to implement these necessary changes. When a health care provider takes the Opioid Prescriber Training course, there is a required pre- and post-test. During the timeframe of 1/1/2025 to 3/31/2025, more than 5,281 health care 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 15.39% to 40.38% for each category type.

BNE continues to enhance interstate data sharing. BNE has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021, BNE began interstate data sharing through the RxCheck hub. As of 3/31/2025, BNE has data sharing agreements with 40 states, as well as Puerto Rico, Washington DC, the Northern Mariana Islands, Veterans Affairs, and Military Health Services through the PMPi and RxCheck hubs. During this timeframe, BNE successfully connected with Louisiana and South Dakota through the PMPi hub. BNE continues to work with the RxCheck Governance Board and NABP PMP InterConnect Steering Committee to aid in identification of state partners for interstate data sharing for both RxCheck and PMPi hubs. In May 2022, BNE successfully integrated with the US Department of Veterans Affairs (VA). BNE continues to monitor the integration and collaborate with the VA, as needed.

In 2019, BNE directly integrated a pilot site’s Electronic Health Records (EHR) system with the NYS PMP Registry. Since then, BNE has expanded the number of users for this site from 13 to more than 6,500. The pilot site has continued to keep the Bureau apprised of successes and challenges. By assessing the challenges, BNE has determined two viable options for enhancing clinical workflow for prescribers and other state and federal stakeholders via EHR integration. The first option is integrating with the RxCheck hub. As of 3/31/2025, NYS ITS has moved from internal testing to testing with RxCheck. The Division of Legal Affairs provides ongoing reviews of data use agreements pertaining to EHR integration. The second option for EHR integration is via the NYS Health Information Exchanges (HIEs). During the reporting period of January 2025 to March 2025, BNE in collaboration with the NYS Information Systems and Health Statistics Group (ISHSG), continued to work with two NYS HIEs to establish EHR integration. All connected facilities from one HIE have access to this functionality. The second HIE has seven facilities that have access and is currently expanding. BNE continues to work with the NYS ISHSG to onboard additional HIEs and increase the number of users querying the PMP via this method. BNE will continue to collaborate with integrated HIEs to increase usage and will discuss the expansion of integration to the remaining NYS HIEs. Lastly, additional methods for integration are being discussed.

[14] NYS Open Legislation | NYSenate.gov

I. Continuous Eligibility for Children Ages 0-6

While NYS' Children's Continuous coverage, until age six, is still in its infancy stages, the State has taken long strides to ensure children under the age of six, maintain their coverage. The loss of health coverage, even temporarily, can have negative long-term repercussions on mental, physical, and social development. Ensuring continuous enrollment will foster better health outcomes throughout the state and supports a more productive population.

NYSoH routinely monitors enrollment and renewals for children who may be scheduled to have their Medicaid and Child Health Plus (CHPlus) coverage terminated. Multiple reports are monitored to ensure that no child is having coverages terminated preemptively. If a child is found to be closing, coverage is evaluated and given the appropriate coverage or extensions. There are several systems in place to help DOH verify a beneficiary's residency and that they are not deceased:

- NYSoH systematically terminates Medicaid and CHPlus enrolled children (including those under age six) when self-reported by parent or caretaker to no longer be a NYS resident or deceased.
- NYSoH systematically processes renewals for children across all programs annually, during which residency is confirmed.
    - If the residency is unable to be confirmed because eligibly notices are returned with an out of state address, notification will go out to the account holder requesting the information to confirm child is a NYS resident.
- NYSoH systemically provides enrollees reminders of continuous eligibility at renewal and upon change in circumstances that are not an exception to continuous eligibility.
- NYSoH Assistors and MCOs outreach to Medicaid and CHPlus enrollees with reminders to update their NYSoH account and provide support as needed.
- MCOs are required to inform DOH when they identify an enrollee is no longer a NYS resident or deceased.
- The Public Assistance Reporting Information System (PARIS) is a quarterly match used to identify instances where Medicaid beneficiaries may be accessing public benefits in more than one state. Consumers appearing on the PARIS match are given an opportunity to verify their NYS residency. If they fail to respond, the consumer is disenrolled from Medicaid.
- A separate monthly process compares the Social Security Administration (SSA) death records to consumers in receipt of Medicaid, terminating coverage for deceased individuals. Additionally, NYS is working on a project to use the National Change of Address (NCOA) information to help facilitate outreach to beneficiaries who have changed their mailing address with the United States Postal Service (USPS). Accessing the NCOA will help ensure the DOH has updated mailing address information for beneficiaries as well as facilitate outreach regarding a beneficiary's residential address. This project is planned for Fall 2025.
- There are also Medicaid enrolled children who maintain their coverage at the local district of social services who may need manual intervention. New York's Welfare Management System updates are ongoing. Children, under age six, who are losing Medicaid eligibility due to the termination of SSI, children being discharged from Foster Care and children who are being terminated from public assistance may need manual intervention. DOH is monitoring reports of children

within the State who are losing coverage, reviewing those consumers and reevaluating them for appropriate ongoing continuous coverage.

- DOH is currently in the final stages of producing an automated annual beneficiary update, with an official Administrative Directive coming soon to advise LDSS of proper procedures for the Medicaid population that remain on county systems.

Overall, the program has a been successful in maintaining coverage for children.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 waiver evaluation design to CMS for review and approval. CMS returned the evaluation design with comments on April 18, 2023. DOH submitted a revised evaluation design to CMS on June 20, 2023, pending their review and approval. The evaluation design for the Managed Care Risk Mitigation COVID-19 PHE amendment was approved by CMS on January 10, 2023. The evaluation design for the Reasonable Opportunity Period (ROP) Extension COVID-19 PHE amendment was approved by CMS on October 25, 2023. On July 5, 2024, DOH submitted a revised 1115 evaluation design, that incorporated the NYHER and IMD waiver amendments, to CMS for review and approval. The contract for the Independent Evaluator was approved on 3/20/2025 and is effective 1/1/2025-12/31/2029.

VII. Consumer Issues

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

MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to NYS DOH on the number and type of enrollee complaints/action appeals that 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 compared to the previous quarter:

MCO Product Line	Total Complaints	
	FFY 25 Q2 1/1/2025–3/31/2025	FFY 25 Q1 10/1/2025–12/31/2024
MMC	5,766	5,908
HARP	736	674
HIV SNP	85	77
Total MCO Complaints	**6,587**	**6,659**

As described in the table, MCOs reported 6,587 total enrollee complaints for the current quarter. This represents a 1.1% decrease from the prior quarter's total of 6,659 enrollee complaints.

MCOs reported 5,766 MMC complaints this quarter, which is a 2.4% decrease from the 5,908 of the previous quarter. The number of HARP complaints increased 9.2%, from 674 in the prior quarter to 736 this quarter. There were 85 HIV SNP complaints this quarter, which is an increase of 10.4% when compared to the 77 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 compared to the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024–12/31/2024
Balance Billing	16%	16%
Difficulty with Obtaining: Dental/Orthodontia	15%	16%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	19%
Reimbursement/Billing	7%	6%
Dissatisfaction with Quality of Care	6%	5%

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 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024–12/31/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	23%	21%
Dissatisfaction with Quality of Care	10%	11%
Difficulty with Obtaining: Personal Care	10%	8%
Difficulty with Obtaining: Specialist and Hospitals	6%	5%
Difficulty with Obtaining: Dental/Orthodontia	6%	9%

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

Description of Complaint	Percentage of Complaints	
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024–12/31/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	39%	23%
Mental Health or Substance Abuse/ Treatment	11%	14%
Dissatisfaction with Quality of Care	9%	5%
Difficulty with Obtaining: Dental/Orthodontia	8%	12%
Difficulty with Obtaining: Eye Care	6%	1%

The DOH reviewed the increase in HIV/SNP enrollee complaints received from the MCOs regarding Dissatisfied with Provider Services (Non-Medical) or MCO Services. Upon examination, the majority of 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

NYS DOH has been monitoring the complaint activity for NYS Medicaid Section 1115 MRT Waiver. As part of this initiative, NYS 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 NYS DOH for each MCO to determine which categories, if any, had a higher-than-expected number of enrollee complaints over a six-month period. The OE ratio compares the number of enrollee complaints the MCO reported to the number that is expected, based on the relative size of the MCO's Medicaid population and its share of enrollee complaints for each category compared to other MCOs. For example, an OE ratio of 6.2 means that the number of enrollee complaints reported for a category was over six times more than what was expected. An OE ratio of 0.5 means that there were half as many enrollee complaints reported for a given category as what was expected.

Based on the OE ratio over a six-month period, 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 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)**			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	9.6	No trends were identified from the complaints received from enrollees. The issue was that members services reps displayed poor behavior and enrollees being concerned with the Gender Identity Support Team and, high-risk team data efficiency.	The MCO has one dedicated Quality Team Lead to provide feedback and coaching to reps and provide real time coaching on performance. Weekly huddles will be held to ensure reps are aware of any updates and coaching on trends. Management will review best practices with the High-Risk Team to ensure accuracy of information and remind the employee the importance of verifying enrollees using multiple identifiers and documenting information accurately.
Difficulty with Obtaining: Dental/ Orthodontia	2.6	No trends were identified from the complaints received.	The MCO communicated to the provider the resolution determination

		The issues identified were the provider billing for services not performed, the provider performing a service different from what was requested by the enrollee, and for providers timely filing for pre-authorizations.	and recommendations, reminded providers to be diligent on submitting claims only for services performed, thoroughly discuss treatment plans with patients, submit pre-authorizations promptly to avoid delays, verify eligibility timely and notify consumers of non-participation with their dental plan.
Difficulty with Obtaining: Mental Health or Substance Abuse Services\ Treatment	149.7	No trends were identified from the complaints received. Most items were found to be unsubstantiated with the exception of one. The issue identified was the appropriateness of treatment provided to the member involved and the provider's failure to respond to the Member Safety Team.	The MCO's Quality of Care team will track this specific provider for future complaints. The member involved has also been provided with contact information to report any future complaints.

Capital District Physicians Health Plan FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Denial of Clinical Treatment	4.2	There were no trends identified by the MCO. The issues identified from the complaints received were enrollees being denied DME as well as requests to see specialist of non-participating providers.	The MCO will carefully monitor OON requests as well as appeal overturns to ensure network adequacy. Additionally, high volume appeal complaint categories will be monitored monthly.
Reimbursement/ Billing	2.2	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, enrollees were unaware that their eligibility was not active at the time of service, and enrollees had coordination of benefit issues.	The MCO will increase monitoring of all billing issues from monthly to biweekly and provide internal education as quickly as possible. The MCO has also created an article that can be viewed by enrollees in their quarterly newsletter which aims to increase awareness and avoid unnecessary billing issues.

Fidelis Care FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Health Home Care Management	2.1	No trends were identified by the MCO. The issue identified was complaints are incorrectly categorized by Member Services and Grievances and Appeals.	The MCO will retrain staff in proper categorization of cases, reporting guidelines, process improvement and accuracy of reporting. Additionally, both departments have implemented either a QA review or increased the review frequency to weekly from quarterly to ensure immediate correction of mis-categorization of complaints and will log each occurrence.

Healthfirst FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Long Wait Time	2.9	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 dental appointments. The issue identified was that appointments were overbooked without adequate staffing.	The MCO distributed reminders regarding Access and Availability standards to its provider network multiple times through email, fax, and updates to the provider manual. The MCO will complete its survey of all its dental providers which now includes an access and availability question confirming whether they meet the one hour wait time limit. The MCO will reach out to providers who are identified during its review process for reeducation.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.3	The trend identified from the complaints received was enrollees dissatisfied with Best Women's Medical as the provider was no longer in network with the MCO. The issue identified was the MCO determined the provider steered enrollees to sign complaints which were submitted to the MCO. The provider was not re-credentialed for various	The MCO continues to meet all regulatory and network adequacy standards. Members has been provided with 3-4 INN providers to ensure there is no interruption to services.

		reasons including submitting false claims.	
Difficulty with Obtaining: Emergency Services	3.5	There were no trends identified from the complaints received. The issues identified were that enrollees were not presenting their insurance card during ER visit, emergency rooms were balance billing enrollees, and enrollees travel OOS and visits OON facilities who refuse to submit claims to MCO.	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. DOH will continue to monitor progress in the next reporting period.
Reimbursement/Billing	2.6	No trends were identified from the complaints received. The issues identified were that members misinterpret EOB as a bill, providers bill members when they are unsatisfied with the reimbursement rate, OON providers fail to verify eligibility and bills members directly, and member insistence on non-covered services while signing a private pay agreement.	The MCO continues to educate providers regarding billing issues. Official notification is regularly sent outlining scenarios where member financial responsibility is acceptable as well as incorporated this topic in annual training sessions. Data is also share with DSE to ensure providers aren't billing members that are covered in the benefit package and is the plans responsibility.
Difficulty with Obtaining: RHCF Services	3.8	No trends were identified from the complaints received. The issues identified were enrollees' dissatisfaction with living conditions, lack of supplies as well as negative interactions with staff.	The MCO will reach out to providers to discuss concerns and reinforce requirements for adequate living conditions. Feedback will be requested from providers on the challenges they face regarding obtaining necessary supplies. Providers will be obligated to provide an action plan outlining preventative measure that will be taken. MCO will also monitor complaints to ensure compliance and provide additional training and support as needed.

Difficulty with Obtaining: Private Duty Nursing	3.9	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 the agency not communicating to the enrollee if there was adequate staffing to replace or backfill the shift on short notice, high caseloads contributing to frequent call outs, and billing issues due to providers not registering with HHAexchange.	The MCO completed a network analysis in September 2024. One new provider was contracted effective 12/1/2024 with two additional PDN providers in contracting discussion. The MCO began reassigning members to INN providers to reduce reliance on OON services. DSE established a monitoring system to identify registration gaps before service initiation. Oversight has also been enhanced to ensure acceptable provider performance and service quality is improved.
Difficulty with Obtaining: Personal Care	2.7	The trend identified from the complaints received was that enrollees were dissatisfied the quality of service received. The issues identified were language barriers with care givers, coordinators lacking professionalism, and aides not providing ADL services.	The MCO's DSE has implemented performance monitoring to track underperforming agencies. The MCO met with targeted providers to reinforce service expectations.
Difficulty with Obtaining: CDPAS	2.4	No trends were identified from the complaints received. The issues identified were delays in start dates due to missing and/or incorrect paperwork, and payment delays from fiscal intermediaries due to PA's untimely submission of paperwork while continuing to service the member after authorization has expired.	The MCO's DSE continue to call members one month prior to authorization expiration and mailing required forms. Email blasts are also issued to providers reinforcing the importance of submitting MD orders on time. MCO continues to monitor team coordinators CM's and FI's to ensure active outreach is occurring.
Dissatisfaction with BH Provider Services	2.83	The trend identified from the complaints received were delays with ABA services There were no issues identified.	The MCO sent email reminders to internal staff reinforcing provider obligations outlined in the latest agreement. As an additional reinforcement the MCE has held regular meeting and Joint Operation Calls with providers.

HealthPlus FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	3.4	The trends identified from the complaints received were regarding access and availability. The issues identified were the IVR system not recognizing verbal commands. This contributed to difficulty navigating the system. Other issues involved new staff who incorrectly referred enrollees to the wrong department.	The MCO will provide comprehensive training to new hires to ensure they handle calls efficiently. Monitoring and support are provided to new staff during training periods. Staff has also been cross trained as well as increased to reduce call wait times. The MCO has improved the telephone system to better recognize verbal commands.

Highmark FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	31.0	The trends identified from the complaints received were members having trouble finding their INN care with the specialist. The issues identified were members needing assistance using the Find a doctor tool.	The MCO will be proactive in assisting members with finding a vendor including providing at least 3 vendors during calls as well as offer to call to verify INN status. MCO's will update directories quarterly and online directories will be updated within 15 days of communicated changes.
Denial of Clinical Treatment	8.6	No trends were identified from the complaints received. The issue identified was the policy of some healthcare facilities is to refuse treatment when there is an outstanding balance. Communication of this policy may be unclear to members when going for treatment.	The MCO will distribute additional education to participating providers concerning rules and regulations surrounding balance billing, minimizing barriers to care and maintaining their contractual requirements in terms of notification obligations prior to closing panels
Difficulty with Obtaining: Specialist and Hospitals	6.7	No trends were identified from the complaints received. The issue identified was the omission of COP codes from providers and early request for refills with ongoing DME	The MCO has reached out to providers in question to review the service authorization process, clarify required information, and discuss submission methods to ensure a timely turnaround with service requests. Refresher

		supplies beyond the permitted timeframe.	trainings have also been conducted with staff to connect members and providers with proper resources.
Difficulty with Obtaining: Eye Care	8.5	The trends identified from the complaints received were challenges in finding INN providers The issues identified were inaccurate provider information in the online directories and members dissatisfaction with coverage limitations.	The MCO is currently in the early stages of onboarding Superior Vision to manage vison benefits. The project will include regulatory approval, member notification/ education. Reps will assist members to locate INN providers and offer to verify INN status.
Balance Billing	5.9	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-network providers do not follow guidelines and continue to balance bill members.	The MCO will have Wellpoint Partnership Plan distribute targeted communication to all participating providers detailing NYS DOH rules and regulations prohibiting providers from balance billing NYS Medicaid members, including referrals to collection agencies.

Health Insurance Plan of Greater New York FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	9.4	The trend identified from the complaints received was billing issues, dissatisfaction with the provider, and dissatisfaction of quality of care. The issues identified were lack of proper information and communication from providers, eligibility verification failures from providers, and member education.	The MCO emphasized the importance of providers submitting predeterminations promptly and thoroughly reviewing treatment plans with members. Providers will be required to respond to request for narratives or be provided a resolution letter with recommendations. As a final step, the network team will be engaged to review providers contractual obligations and remind providers of their due diligence.
Difficulty with Obtaining: Mental Health or Substance Abuse Services\Treatment	10.6	The trends identified from the complaints received were access to care and dissatisfaction of service. The issues identified were issues related to the	The MCO is intensifying its efforts to validate provider availability and enhance the accuracy of its practitioner directories by reminding providers to update their information in directories as

		provider directory and the availability of providers for short-term appointments.	well as communicate instructions on how to comply. Outreach to every provider to attest to their information occurs every 90 days. Necessary updates will show in the provider database within two business days.
Reimbursement/Billing	6.1	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 and enrollees were being balance billed by contracted and non-contracted providers.	The MCO will educate enrollees on the differences between bills and EOBs and educate providers on not balance billing Medicaid enrollees.
Difficulty with Obtaining: Home Health Care	5.8	The trend identified from the complaints received was that enrollees were dissatisfied with the number of hours approved for home health care. The issue identified was that enrollees felt that additional hours of service were needed after agreeing to the initial assessment.	The MCO will educate enrollees that approved hours are based on clinical needs and if a change in their needs occurs, a reassessment can be completed.

Independent Health Association FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.9	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 miscommunications.	The MCO will continue to conduct provider outreach to identify issues and will institute corrective action plans as needed. DOH will continue to monitor progress in the next reporting period.

MetroPlus Health Plan FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Balance Billing	2.4	The trend identified from the complaints received was that enrollees were being balance billed. The issues identified were that providers were not verifying enrollee eligibility and enrollees were using out-of-network providers.	The MCO will update its provider onboarding process to emphasize the importance of collecting and verifying enrollee insurance information at the time of service.

Molina Healthcare FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	4.0	The trend identified from the complaints received was that enrollees were having difficulty finding in-network physicians within a reasonable distance from their homes. The issue identified was that enrollees were unaware of how to locate participating PCPs.	The MCO will continue to promote the use of the provider online directory to locate a provider within a reasonable distance. The MCO's provider network teams monitor and conduct reviews of the networks, and in the case of deficiencies, guidance is given to direct enrollees to surrounding counties or work on single-case agreements. DOH will continue to monitor progress in the next reporting period.
Appointment Availability: Specialist	2.0	The trend identified from the complaints received was that enrollees were having difficulty finding in-network specialists within a reasonable distance from their homes. The issue identified was that enrollees were unaware of how to locate participating specialists.	The MCO will continue to promote the use of the provider online directory to locate a provider within a reasonable distance. The MCO's provider network teams monitor and conduct reviews of the networks, and in the case of deficiencies, guidance is given to direct enrollees to surrounding counties or work on single-case agreements.
Dissatisfaction with Quality of Care	3.3	The trend identified from the complaints received was that enrollees disliked their treatment plans and care received by the provider or hospital.	The MCO has created a Professional Review Committee (PRC) to provide oversight of the peer review for quality-of-care concerns. The PRC is responsible for making decisions about provider

		There were no issues identified.	participation, evaluating quality of care issues related to individual providers, and evaluating enrollee satisfaction concerns.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.1	The trends identified from the complaints received were that enrollees disliked their treatment plans and how the providers performed services. There were no issues identified.	The MCO will implement quarterly provider town halls starting in April 2025. The MCO encourages enrollees to speak with their providers to accommodate specific requests and to allow them other options if they seek a second opinion. The MCO will continue to escalate any other provider-related issues to the Provider Relations Department where the provider is contacted and educated.
Difficulty with Obtaining: Specialist and Hospitals	6.5	The trend identified from the complaints received was that enrollees were having difficulty finding specialists and hospitals. The issues identified were that enrollees were unaware that they could use the online tool to locate specialists and hospitals, and enrollees had difficulty utilizing the online directory.	The MCO will continue to promote the online directory as a resource to locate a provider within a reasonable distance. The MCO's provider network teams monitor and conduct reviews of the networks, and in the case of deficiencies, guidance is given to direct enrollees to surrounding counties or work on single-case agreements. DOH will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Eye Care	6.7	The trends identified from the complaints received were that enrollees were unable to locate in-network vision providers, and enrollees had eligibility concerns. The issue identified was enrollees experienced difficulty navigating the online directory.	The MCO will continue to have its customer service representatives address enrollee concerns and questions about the vision benefit and warm transfer enrollee calls to the vision vendor when necessary. The MCO will continue to promote the use of the provider online directory to locate a provider within a reasonable distance. The MCO's provider network teams monitor and conduct reviews of the networks, and in the case of deficiencies, guidance is given to direct enrollees to surrounding

			counties or work on single-case agreements.
Pharmacy/Formulary	13.9	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 there was insufficient information provided during PA requests to meet the criteria requirement, systemic errors during the eligibility and benefit verification process, and issues with medication availability of specific drugs.	The MCO will have its pharmacy team review all pharmacy-related knowledge articles to enhance member support and continue to collaborate with the enrollee-facing teams to ensure that any gaps are addressed. DOH will continue to monitor progress in the next reporting period.
Communications/ Physical Barrier	6.1	The trend identified from the complaints received was that enrollees were dissatisfied with communications. The issue identified was that enrollees experienced cultural or language barriers when contacting the MCO's call center.	The MCO has contracted with an interpretation service vendor and instructed call center representatives to follow the documented process to ensure an interpreter is engaged when needed. This includes a telecommunications relay and ASL interpreter service for deaf or hearing-impaired enrollees.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	9.6	The trend identified from the complaints received was that enrollees were having enrollment issues. The issues identified were that information provided on state enrollment files was inaccurate, enrollees did not receive their ID cards, and enrollee eligibility information was unclear.	The MCO will continue to submit tickets for enrollment issues to their Enrollment Department for research and correction. This department is also responsible for reissuing plan ID cards and collaborating with the state if there is a discrepancy with information received.
All Other	14.1	There were no trends identified. The issues identified were that enrollees requested to change their auto-assigned PCP and did not receive their ID cards.	The MCO will continue to submit tickets to address issues for ID cards and reissue them when needed. The MCO will also assist enrollees in changing their assigned PCP to another in-network provider. DOH will continue to monitor progress in the next reporting period.

Balance Billing	6.5	The trend identified from the complaints received was that providers were billing enrollees for services received. The issues identified were that enrollees did not have active coverage during the dates of service, providers did not submit the claims to the plan, enrollees received bills from providers for copayment, and enrollees were balance billed for services rendered.	The MCO will contact providers who balance bill and remind them that this is not allowed and remind them to submit the claim to the MCO to be reviewed and paid. The MCO will educate enrollees at enrollment and when they are balance billed to remind them to provide their insurance information. DOH will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Home Health Care	6.8	The trends identified from the complaints received were that enrollees were not familiar with or unaware of their assigned care manager and did not know the process for requesting home health care. The issues identified were that enrollees did not submit the necessary forms for home health care and did not have the required assessment completed.	The MCO will utilize their Care Management department to have case managers contact enrollees with information on how to get in contact with their assigned care manager. DOH will continue to monitor progress in the next reporting period.

MVP Health Plan FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: CDPAS	3.9	The trend identified from the complaints received was that enrollees were dissatisfied with their CDPAS hours being reduced. There were no issues identified.	The MCO will utilize their LTSS Department which was reorganized in September 2024 to reduce the number of complaints and appeals.

United Healthcare FFY 24 Q4–FFY 25 Q1 (7/1/2024–12/31/2024)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability-PCP	2.8	The trends identified from the complaints received were that enrollees were unable to find a PCP within	The MCO will work with enrollees to locate in-network providers who best suit their care needs. The MCO will assist enrollees

		a reasonable distance, enrollees had long wait times when attempting to contact their PCP's office by phone, enrollees wanted to keep their previous PCP who is out-of-network with the MCO, and enrollees were dissatisfied with seeing another health professional than the PCP. The issues identified were network gaps for enrollees in rural areas with limited PCPs in the area causing them to travel further than preferred and enrollees changing MCOs when their preferred PCP was in-network with the former MCO.	with requesting out-of-network care if in-network providers are unavailable or do not have the experience needed to care for the enrollee.
Appointment Availability-Specialist	8.4	The trend identified from the complaints received was that enrollees could not find in-network providers (including dermatology, dental, endodontic, periodontic, plastic surgery, ENT, PT/OT, and psychology) and enrollees wanting to continue receiving care from a provider who is out-of-network. The issue identified was that provider network changes caused providers to remove themselves or be discontinued from the network.	The MCO will work with enrollees to locate in-network specialists who best suit their care needs. The MCO will assist enrollees with requesting out-of-network care if in-network specialists are unavailable or do not have the experience needed to care for the enrollee.
Dissatisfaction with Quality of Care	2.5	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were unsatisfactory and incomplete dental work, and quality of care for hospital services, home health care, outpatient visits, pharmacy, and vision services. There were no specific trends among providers.	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	11.9	The trend identified from the complaints received was that enrollees were receiving denials for services. There were no issues identified as almost all of these denials were for services that were not covered under the plan.	The MCO will continue to monitor denials. DOH will continue to monitor progress in the next reporting period.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	2.8	The trends identified from the complaints received were that enrollees received materials in the incorrect language, received paper correspondence after requesting paperless correspondence, did not receive the member handbook, and were dissatisfied with the member ID cards. Many complaints in this category were miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will remediate to resolve discrepancies between coding and reporting complaints moving forward.
Balance Billing	5.4	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.

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 6,587 total reported complaints/action appeals, MCOs reported 728 complaints and action appeals from their SSI recipients. This compares to 642 SSI complaints/action appeals from the previous quarter, representing a 13.4% increase.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024-12/31/2024
Appointment Availability: PCP	1	1
Appointment Availability: Specialist	3	8
Appointment Availability: BH HCBS	1	0
Long Wait Time	6	2
Dissatisfaction with Quality of Care	61	30
Denial of Clinical Treatment	14	12
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	172	149
Dissatisfaction with BH Provider Services	3	2
Dissatisfaction with Health Home Care Management	1	9
Difficulty with Obtaining: Specialist and Hospitals	43	35
Difficulty with Obtaining: Eye Care	9	7
Difficulty with Obtaining: Dental/Orthodontia	69	78
Difficulty with Obtaining: Emergency Services	3	2
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	10	0
Difficulty with Obtaining: RHCF Services	2	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	5	5
Difficulty with Obtaining: Home Health Care	11	10
Difficulty with Obtaining: Personal Care	91	76
Difficulty with Obtaining: PERS	0	1
Difficulty with Obtaining: CDPAS	43	25
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	6	3
Access to Non-Covered Services	12	6
Access for Family Planning Services	0	0
Communications/ Physical Barrier	10	4
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	14	8
Recipient Restriction Program and Plan Initiated Disenrollment	1	1

Reimbursement/Billing	50	42
Balance Billing	45	60
Transportation	1	0
In Lieu of Services	1	0
All Other	40	66
Total	**728**	**642**

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

Description of Complaint	Percentage of Total Complaints/Appeals Reported for SSI Recipients	
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024-12/31/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	24%	23%
Difficulty with Obtaining: Personal Care	13%	12%
Difficulty with Obtaining: Dental/Orthodontia	9%	12%
Dissatisfied with Quality of Care	8%	5%
Reimbursement/Billing	7%	7%

NYS DOH requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of January 1, 2025, through March 31, 2025, MCOs reported LTSS enrollment of 62,500 enrollees. This compares to 64,123 LTSS enrollees from the previous quarter, representing a 2.5% decrease. 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 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024 – 12/31/2024
Amida Care	1,008	1,102
Capital District Physicians Health Plan	690	714
Excellus Health Plan	1,569	1,800
Fidelis Care	21,697	21,971
Healthfirst	18,524	18,504
Highmark	330	335
Anthem	4,463	4,528
HIP of Greater New York	611	646

Independent Health Association	730	767
MetroPlus Health Plan	4,317	4,326
Molina Healthcare	2,876	3,620
MVP Health Plan	1,575	1,672
United Healthcare	3,499	3,552
VNS Choice	611	586
Total	**62,500**	**64,123**

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

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024 – 12/31/2024
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Difficulty with Obtaining: Adult Day Care	0	1
Difficulty with Obtaining: CDPAS	134	73
Difficulty with Obtaining: Home Health Care	33	33
Difficulty with Obtaining: RHCF Services	5	2
Difficulty with Obtaining: Personal Care	245	188
Difficulty with Obtaining: PERS	0	1
Difficulty with Obtaining: Private Duty Nursing	5	6
Total	**422**	**304**

DOH reviewed the increase in enrollee complaints regarding difficulty obtaining CDPAS. Upon examination, the increase stemmed from the number of enrollee complaints in these categories reported by one MCO.

D. Critical Incidents

NYS DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 297 critical incidents reported for the January 1, 2025, through March 31, 2025, 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 total number of LTSS critical incidents reported by MMCs, HARPs, and HIV SNPs for the most recent quarter and for the previous quarter, and the net change over those quarters:

Plan	Critical Incidents		
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024 - 12/31/2024	Net Change
MMC			
Anthem	1	2	-1
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	3	8	-5
Fidelis Care	78	92	-14
Healthfirst	85	60	+25
HIP of Greater New York	0	0	0
Highmark	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	3	9	-6
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	1	0	+1
Total	**171**	**171**	**0**
HARP			
Anthem	0	0	0
Capital District Physicians Health Plan	1	0	+1
Excellus Health Plan	2	3	-1
Fidelis Care	31	33	-2
Healthfirst	61	59	+2
HIP of Greater New York	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	2	7	-5
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**97**	**102**	**-5**
HIV SNP			
Amida Care	0	0	0
MetroPlus Health Plan	3	3	0
VNS Choice	26	26	0
Total	**29**	**29**	**0**
Grand Total	**297**	**302**	**-5**

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

Category of Incident	Critical Incidents		
	FFY 25 Q2 1/1/2025-3/31/2025	FFY 25 Q1 10/1/2024 – 12/31/2024	Net Change
MMC Plans			
Any Other Incidents as Determined by the Plan	10	6	+4
Any other incidents as determined by NYS DOH	1	8	-7
Crimes Committed Against Enrollee	6	6	0
Crimes Committed by Enrollee	4	1	+3
Instances of Abuse of Enrollees	4	5	-1
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	3	2	+1
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	51	46	+5
Other Incident Resulting in Medical Treatment Other Than Hospitalization	81	96	-15
Use of Restraints	10	1	+9
Wrongful Death	1	0	+1
Total	**171**	**171**	**0**
HARPs			
Any Other Incidents as Determined by the Plan	2	1	+1
Any other instances as determined by NYS DOH	7	11	-4
Crimes Committed Against Enrollee	5	3	+2
Crimes Committed by Enrollee	0	1	-1
Instances of Abuse of Enrollees	4	1	+3
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	14	17	-3
Other Incident Resulting in Medical Treatment Other Than Hospitalization	54	59	-5

Use of Restraints	11	9	+2
Wrongful Death	0	0	0
Total	**97**	**102**	**-5**
HIV SNP			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	1	1	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	0	0
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	8	3	+5
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	5	7	-2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	15	18	-3
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**29**	**29**	**0**
Grand Total	**297**	**302**	**-5**

The following tables display the number of each critical incident type reported by the plans and their respective lines of business for the current reporting quarter:

Plan Name and Line	Any Other Incidents as Determined by the Plan	Any Other Incidents as Determined by DOH	Crimes Committed Against Enrollees	Crimes Committed by Enrollee
Amida Care – HIVSNP	0	0	0	0
Anthem HP – MMC	1	0	0	0
Anthem HP – HARP	0	0	0	0
CDPHP – MMC	0	0	0	0
CDPHP – HARP	0	0	0	0
Excellus – MMC	2	0	0	0
Excellus – HARP	1	0	0	0
Fidelis Care – MMC	0	1	1	1
Fidelis Care – HARP	0	1	0	0
Healthfirst PHSP – MMC	7	0	4	3
Healthfirst PHSP – HARP	1	6	4	0
Highmark – MMC	0	0	0	0
Highmark - HARP	0	0	0	0
HIP Emblem – MMC	0	0	0	0

HIP Emblem – HARP	0	0	0	0
IHA – MMC	0	0	0	0
IHA - HARP	0	0	0	0
MetroPlus – MMC	0	0	1	0
MetroPlus – HARP	0	0	1	0
MetroPlus – HIVSNP	0	0	0	0
Molina – MMC	0	0	0	0
Molina – HARP	0	0	0	0
MVP – MMC	0	0	0	0
MVP – HARP	0	0	0	0
United – MMC	0	0	0	0
United – HARP	0	0	0	0
VNS Choice - HIVSNP	0	0	1	0
Total	**12**	**8**	**12**	**4**

Plan Name and Line	Instances of Abuse of Enrollees	Instances of Exploitation of Enrollees	Instances of Neglect of Enrollees	Medication Errors that Resulted in Injury
Amida Care – HIVSNP	0	0	0	0
Anthem HP – MMC	0	0	0	0
Anthem HP – HARP	0	0	0	0
CDPHP – MMC	0	0	0	0
CDPHP – HARP	1	0	0	0
Excellus – MMC	0	0	0	0
Excellus – HARP	1	0	0	0
Fidelis Care – MMC	1	0	0	0
Fidelis Care – HARP	1	0	0	0
Healthfirst PHSP – MMC	2	0	3	0
Healthfirst PHSP – HARP	1	0	0	0
Highmark – MMC	0	0	0	0
Highmark - HARP	0	0	0	0
HIP Emblem – MMC	0	0	0	0
HIP Emblem – HARP	0	0	0	0
IHA – MMC	0	0	0	0
IHA - HARP	0	0	0	0
MetroPlus – MMC	0	0	0	0
MetroPlus – HARP	0	0	0	0
MetroPlus – HIVSNP	0	0	0	0
Molina – MMC	0	0	0	0
Molina – HARP	0	0	0	0
MVP – MMC	0	0	0	0
MVP – HARP	0	0	0	0

United – MMC	1	0	0	0
United – HARP	0	0	0	0
VNS Choice - HIVSNP	0	0	8	0
Total	**8**	**0**	**11**	**0**

Plan Name and Line	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other Than Hospitalization	Use of Restraints	Wrongful Death
Amida Care – HIVSNP	0	0	0	0
Anthem HP – MMC	0	0	0	0
Anthem HP – HARP	0	0	0	0
CDPHP – MMC	0	0	0	0
CDPHP – HARP	0	0	0	0
Excellus – MMC	0	0	0	1
Excellus – HARP	0	0	0	0
Fidelis Care – MMC	28	46	0	0
Fidelis Care – HARP	5	24	0	0
Healthfirst PHSP – MMC	22	34	10	0
Healthfirst PHSP – HARP	8	30	11	0
Highmark – MMC	0	0	0	0
Highmark - HARP	0	0	0	0
HIP Emblem – MMC	0	0	0	0
HIP Emblem – HARP	0	0	0	0
IHA – MMC	0	0	0	0
IHA - HARP	0	0	0	0
MetroPlus – MMC	1	1	0	0
MetroPlus – HARP	1	0	0	0
MetroPlus – HIVSNP	2	1	0	0
Molina – MMC	0	0	0	0
Molina – HARP	0	0	0	0
MVP – MMC	0	0	0	0
MVP – HARP	0	0	0	0
United – MMC	0	0	0	0
United – HARP	0	0	0	0
VNS Choice - HIVSNP	3	14	0	0
Total	**70**	**150**	**21**	**1**

E. Enrollee Complaints Received Directly by NYS DOH

In addition to the MCO reported complaints, NYS DOH directly received 101 enrollee complaints this quarter. This total is a 165.8% increase from the previous quarter, which reported 38 enrollee complaints. NYS DOH will be reviewing this data for any anomalies.

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 DOH	
FFY 25 Q2 1/1/2025-3/31/2025	**FFY 25 Q1 10/1/2024-12/31/2024**
101	**38**

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

Percentage of MCO Enrollee Complaints Received Directly by DOH		
Description of Complaint	**FFY Q2 1/1/2025-3/31/2025**	**FFY 25 Q1 10/1/2024 – 12/31/2024**
Reimbursement/Billing	16%	24%
Difficulty with Obtaining: CDPAS	15%	15%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	13%	8%
Difficulty with Obtaining: Dental/Orthodontia	7%	11%
Difficulty obtaining covered Home Health Care services	7%	3%

We are seeing substantial increases within the Difficulty with Obtaining: Home Health Care category. This increase was spread amongst several MCOs. DOH will continue to monitor this.

F. Fair Hearings

There were 193 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2025, through March 31, 2025. 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 25 Q2 1/1/2025-3/31/2025**	**FFY 25 Q1 10/1/2024-12/31/2024**
In favor of Appellant	69	41
In favor of Plan	117	104
No Issue	7	8
Total	**193**	**153**

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 25 Q2 1/1/2025-3/31/2025**	**FFY 25 Q1 10/1/2024-12/31/2024**
0-29	3	0
30-59	11	9
60-89	53	17
90-119	23	26
=>120	103	101
Total	**193**	**153**

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

The MMCARP met on February 20, 2025. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program, current AA statistics and state and local district outreach and other activities aimed at reducing AA; and an update on the status of the MLTC program. There was one additional agenda item, a presentation on Quality Assurance Reporting Requirements and Consumer Guides given by DOH staff Raina Josberger and Paloma Luisi, from the Office of Health Services Quality and Analytics. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for May 22, 2025.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

During the reporting period, preparations began for calculating MLTC quality and compliance measures. Activities included: revising attribution logic to appropriately classify the assessments of members involved in health plan acquisitions, updating the programs used to calculate quality measures to ensure agreement with the publicly released methodology, and conceptualizing two research studies to (1) understand the lasting impact of falls on New York's MLTC population, develop an algorithm to identify members at increased risk of falling, and determine the extent to which falls are underreported on the Community Health Assessment (CHA), and (2) Investigate the impact of social adult day care (SADC) services on loneliness and determine if a loneliness scale can be developed and added to the CHA.

Staff also finalized the 2025 MLTC Satisfaction Survey questionnaire and cover letter, approved the translation of both documents into Chinese, Russian, and Spanish, and pulled the survey sample. The first wave of the survey is scheduled for release in May 2025.

MLTC plans also submitted Interim Reports in support of the current Performance Improvement Project, "Decreasing Rates of Depression among Medicaid Managed Long Term Care Members". By the end of the reporting period, all plans had submitted their Interim Reports.

Finally, staff actively managed the MLTC_OQPS@health.ny.gov mailbox to ensure timely response to stakeholder inquiries.

B. Quality Measurement in MMC

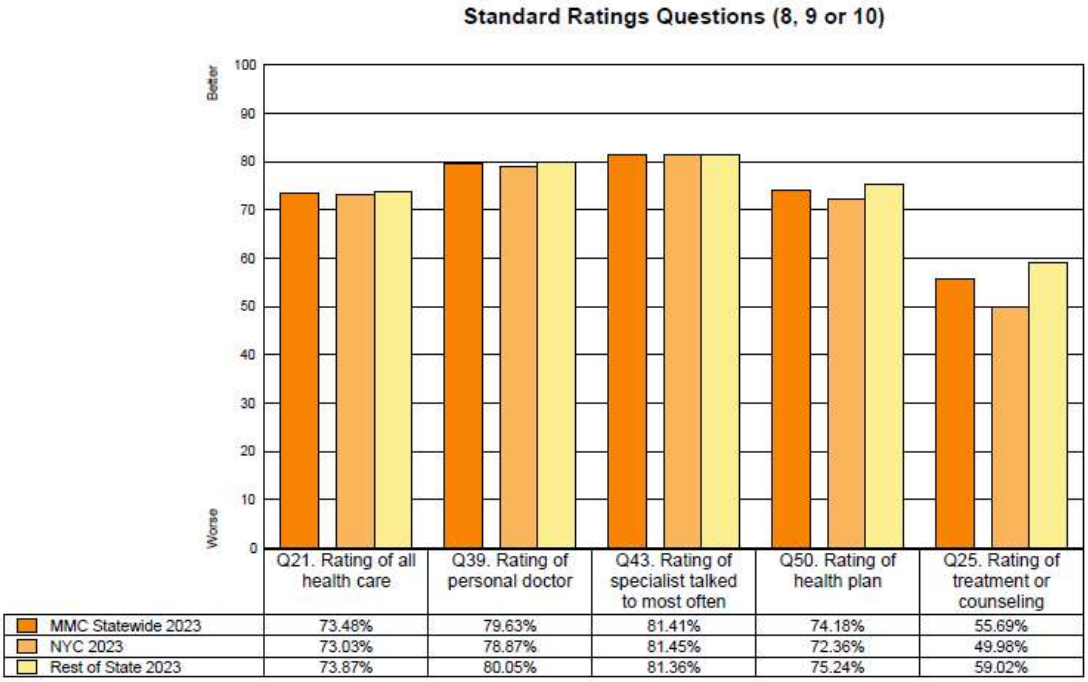
Quality Measure Benchmarks 2023 (Measurement Year 2023)

Quality of care remained high for MMC members for the demonstration year. In measurement year 2023, national benchmarks were available for 55 measures for Medicaid. Out of the 55 measures that NYS Medicaid MCOs reported, 85% of measures met or exceeded national benchmarks. NYS consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid rates exceed the national benchmarks for BH on adult measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness) and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). NYS managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, breast cancer, and cervical cancer) and children and adolescent preventative measures (well-child visits during first 30 months of life, well-care visits among children aged 3-21 years old, and adolescent immunization).

2023 Satisfaction Survey

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

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



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

2022 Quality Incentive for Medicaid Managed Care

The 2022 Quality Incentive Awards calculations were finalized in May 2024, which covered the measurement year period for 2022. The quality incentive is calculated on the percentage of total points a plan earned in the areas of Quality of Care and Experience of Care. Points are subtracted from the plan's total points if the plan had SODs in the Compliance category. Plans were classified into five tiers based on the distribution of the final percentage points. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and CMS. The results for the 2022 Incentive included two plans in Tier 1, one plan in Tier 2, six plans in Tier 3, one plan in Tier 4, and two plans in Tier 5.

Quality Assurance Reporting Requirements (QARR)

In June 26 MCOs submitted reporting requirements to stakeholders as identified in QARR (e.g., NYS, IPRO, National Committee on Quality Assurance). Data was being collated and reviewed through the subsequent months. 2023 Data was published in December 2024.

C. Quality Improvement

External Quality Review

IPRO continues to provide External Quality Review (EQR) services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, part 438, Subparts D and E, expounded upon in NYS' consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO EQR Annual Technical Reports (ATRs). In addition to these specified activities, NYS DOH requires our External Quality Review Organization (EQRO) to also conduct activities administering additional surveys of enrollee experience; and

providing data processing and analytical support to NYS DOH. EQR activities cover services offered by New York's MMC plans, HIV SNPs, MLTC plans, and HARPs, and include CHPlus. Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

Annual EQRO Technical Reports

At the start of the second quarter IPRO was in the process of writing the preliminary draft of the Mainstream and Managed Long-Term Care 2023 EQR ATRs. IPRO provided aggregate final reports by late February. Throughout March, the DOH reviewed the final reports.

Provider Related and Access Activities

At the start of the second quarter the Provider Directory and Access Survey final reports were produced and shared with the DOH. DOH then reviewed the Provider Directory and Access Survey final reports for accuracy. By February, the second round of survey final reports were produced and shared with DOH. In March, DOH scheduled exit calls for the plans to discuss survey performance and share the results.

IPRO continued to work on the data needed to conduct the primary care provider (PCP) ration survey. The survey will begin when the 2025 PNDS data is available.

Provider Network Data System (PNDS):

PNDS

IPRO continues to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the PNDS. The PNDS collects network information from approximately 400 active networks in NYS. IPRO, RMCI and Quest Analytics continue to facilitate ongoing adjustments and fixes and address any issues relative to use, expansion, and maintenance of the rebuild of the PNDS network. The January to March PNDS submission deadline is April 24th; plans submitted data based on version 12 of the data dictionary.

Provider and Health Plan Look-Up:

The NYS Provider & Health Plan Look-Up website helps consumers search for providers in their health plan network. 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 February 3, 2025 – February 26, 2025, and yielded 6,757,059 rows of data which is ~1% less than previous quarter. Technical assistance was provided by NYS DOH and IPRO throughout the submission, particularly around new edits implemented. NYS DOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)

The MLTC Interim PIP reports were submitted in February. IPRO then conducted a thorough evaluation of the reports and will send comments to the plans in the beginning of quarter three.

MLTC Member Satisfaction Survey

In January, the Member Satisfaction Survey questionnaire was approved along with the cover letter. By early February IPRO received both from the translator. Preparations will get started to mail out the survey by Quarter 3.

Focused Clinical Study: Patient Centered Service Plan

At the start of January, IPRO started to populate the abstraction tool along with member sample list and records. At the start of March, DOH and IPRO have not completed their review as they are waiting for more documentation from the plans.

Quality Measurement

During the second quarter, IPRO provided the DOH with edits to the Patient-Centered Medical Home (PCMH) file submission and the value-based reporting technical specification for measurement year 2024. DOH had a kickoff meeting for the annual Health Commerce System (HCS) meeting with NCQA. DOH and IPRO were provided an overview of the changes that will be made to this year's HCS deliverable.

By the end of March, IPRO contacted the plans for their QARR contacts. IPRO made contact folders for each of the plans.

The CAHPS Children's and Adult surveys were in their third mailing. The survey was concluded in March. IPRO had a meeting with the vendor, DataStat, to discuss creating the final report. DOH will be discussing internally on how to proceed after their follow-up.

PIPs for MMCs:

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

The third series of progress calls were conducted by IPRO and held from February 13 through March 28, 2025, with participation by IPRO, and the DOH. Prior to the oversight calls the plans submitted updates on their intervention tracking measures. IPRO facilitated the second series of all-plan webinars with 2a on March 25, 2025, and 7 out of 14 plans presented. The purpose of the webinar was for the Managed Care Plans (MCPs) to report out to all the plans the status of key interventions, challenges in implementing interventions, and steps taken to address those challenges. All plan webinar 2b is scheduled for April 11, 2025. The remaining 7 of 14 MCPs will present.

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

Work continues on the 2024-2025 HARP PIP Proposals approved by IPRO, DOH, OMH, and OASAS in October of 2024. The second round of HARP PIP progress calls, attended by IPRO, DOH OMH, and OASAS, started in March and will conclude in April 2025. The second HARP PIP All Plan Webinars have been scheduled for May 2025 and will address key intervention tracking measure data related to the Engagement in Care (EIC) and Continuous Engagement in Treatment (CET) measures; successes, challenges and next steps in addressing identified health disparities, and successes and challenges in operationalizing interventions.

Breast Cancer Selective Contracting

DOH completed its annual review of all-payer Statewide Planning and Research Cooperative System (SPARCS) breast cancer surgical data from 2021-2023 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. A total of 347 facilities were designated as follows: 109 high-volume facilities, 7 low-volume unrestricted facilities, 215 low-volume restricted facilities, and 16 new unrestricted facilities. Staff also implemented a "no longer eligible" category for facilities that discontinued surgical services and had a volume of zero breast cancer surgeries during the evaluation period.

For State Fiscal year 2025-26, three facilities appealed the decision to be placed on the low-volume restricted list: one of the appeals was approved. Decision letters were sent via email to administrators at these facilities. In addition, letters regarding final volume designation for state

fiscal year 2025-26 were sent to health plan Chief Executive Officers and Medical Directors via the 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 on the DOH website and included in the 2025 March Medicaid Update.

Staff are completing the analysis of Medicaid encounter data to assess health plan compliance with the policy. An additional analysis evaluating methods to refine the algorithm used to restrict Medicaid FFS payment to low-volume, restricted facilities is also being finalized. Results and recommendations from both analyses are expected later this year.

D. Patient Centered Medical Home (PCMH)

As of March 2025, there were 8,891 National Committee for Quality Assurance (NCQA)-recognized PCMH providers and 2,097 practices in NYS.

- 8,889 providers and 2,096 practices are recognized under the standards of NYS PCMH, a recognition program 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 8,889 recognized NYS PCMH providers in March, none were newly recognized.
- Two providers in one practice are recognized under the standards of NCQA PCMH because they are 100% virtual.

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

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

All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the NYS DOH website[15].

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

Quarterly budget neutrality reporting is up to date and on schedule. NYS continues to utilize the Budget Neutrality Reporting Tool to fulfill quarterly quantitative reporting requirements.

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

X. Other

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

New York State sends the following files to CMS monthly:

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

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 March 2025:

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

As of the March 2025 reporting month, NYS data meets the Critical-Priority and Expenditures criteria target of OBA and is 2% below the target for High-Priority criterion. NYS is actively working to address the identified high priority issues to meet the High-Priority criterion in the OBA.

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

NYS also continues to engage its Data Governance workgroup for T-MSIS, to help facilitate the investigation and remediation of identified data quality issues in coordination with DOH Program Subject Matter Experts (SMEs). These joint efforts are utilized to support a robust understanding of the NYS Medicaid program, and its service population(s) as reflected in the T-MSIS data submissions.

The state completed T-MSIS historical file(s) resubmissions for reporting periods November 2019 through October 2024 (60 months).
The NYS T-MSIS files are now compliant with the newer DD v3.0.0 layout as per the CMS requirement. The T-MSIS v4.0.0 File Layout implementation in progress with a target implementation date of October 8, 2025.

B. HCBS Quality Measures

NYS is currently working with CMS' contractor to formulate a technical assistance plan to align with the HCBS quality measures and reporting requirements outlined in the 2014 CMCS Informational Bulletin (CIB), Modifications to Quality Measures and Reporting in §1915(c) HCBS Waivers, regarding Quality Improvement Strategy. In January 2025, the technical assistance plan was submitted to CMS for review and approval.

C. 1115 Annual Public Forum

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 informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

On March 26, 2025, NYS DOH conducted a virtual public forum on 1115 waiver programs. During the public forum DOH received insightful comments from 9 speakers, as well as 16 written comments. Comments covered a range of topics, including managed care, MLTC, HRSN services, and workforce initiatives. 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 on the NYS 1115 Webpage[16].

Attachments:

Attachment 1— MLTC Partial Capitation Plan, MAP, PACE, MA and FIDA IDD Enrollment
Attachment 2— MLTC Critical Incidents
Attachment 3- SUD Summary of Milestones

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Uploaded to PMDA: May 30, 2025

[16] New York 1115 Medicaid Waiver Information Page, MRT Public Comment Days and Written Submissions

Attachment 1: MLTC Partial Capitation Plan, MAP, PACE, MA & FIDA IDD Enrollment

Managed Long Term Care Partial Capitation Plan Enrollment April 2024 to March 2025												
Plan Name	**Enrollment**											
	Apr-24	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
Aetna Better Health	6184	6264	6313	6394	6471	6535	6563	6563	6563	6600	6512	6444
Centers Plan for Healthy Living	52982	53051	53079	53315	53596	53885	53993	54152	54381	54269	53941	53768
Elderplan	23188	24438	24806	25399	25743	26201	26691	27069	27623	27765	27739	27900
Elderserve	18624	18813	18900	19083	19300	19488	19651	19868	20089	20243	20302	20428
Fidelis Care at Home	18653	18817	18776	18957	19278	19406	19415	19783	20150	20074	19737	19394
Hamaspik Choice	7907	8006	8066	8216	8220	8262	8312	8366	8440	8498	8491	8410
HealthPlus- Amerigroup	57534	58036	58521	59250	60000	60531	61059	61585	62184	62412	62170	61776
iCircle Services	3911	3999	4054	4159	4221	4307	4380	4468	4547	4602	4598	4652
Kalos Health- Erie Niagara	956	997	1007	1033	1038	1049	1050	1030	0	0	0	0
MetroPlus MLTC	1878	2002	2141	2284	2392	2481	2573	2640	2731	2771	2808	2853
Senior Health Partners	9460	9515	9509	9624	9804	9889	9993	10241	10577	10513	10629	10662
Senior Whole Health	28648	28900	28799	28488	28261	28014	27673	27443	27221	26775	26260	25646
Village Care	21885	22387	28132	28581	28941	29308	29988	30732	31751	32026	32021	32344
VNA HomeCare Options	5670	5772	5914	6087	6269	6436	6562	6637	6669	6707	6751	6771
VNS Choice	23438	25137	25361	25594	25774	25887	25901	26189	27601	27420	27204	27187
Total	**280,918**	**286,134**	**293,378**	**296,464**	**299,308**	**301,679**	**303,804**	**306,766**	**310,527**	**310,675**	**309,163**	**308,235**

Managed Long Term Care FIDA-IDD Enrollment April 2024 to March 2025												
Plan Name	**Enrollment**											
	Apr-24	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
Partners Health Plan	1694	1689	1688	1703	1702	1703	1687	1707	1683	1686	1708	1713

Managed Long Term Care MAP Enrollment April 2024 to March 2025												
Plan Name	Enrollment											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Fidelis	1379	1456	1533	1612	1692	1791	1905	1909	1918	1976	2150	2613
Hamaspik	928	925	943	975	980	974	988	992	1022	1023	1062	1102
Centers	1803	1846	1858	1866	1895	1900	1904	1866	1831	1955	1997	2056
Elderplan	4136	4238	4348	4437	4558	4658	4761	4901	4973	5142	5336	5506
Elderserve	297	316	327	334	353	369	382	382	399	403	425	478
Healthfirst Complete Care	29962	30568	31233	31745	32326	32777	33330	33610	33737	34748	35440	35730
Healthplus	141	149	171	204	212	205	193	193	203	214	234	285
Metroplus	187	196	196	198	197	201	207	216	231	238	272	289
Senior Whole Health	300	298	294	289	284	283	278	283	282	275	264	263
VNS	4487	4585	4676	4714	4823	4910	5039	5069	5036	5551	5701	5929
Village Care	3061	3118	3188	3297	3478	3635	3768	3791	3752	4395	4587	4793
United	0	0	0	0	0	0	0	0	0	0	0	1
Total	**46681**	**47695**	**48767**	**49671**	**50798**	**51703**	**52755**	**53212**	**53384**	**55920**	**57468**	**59044**

Managed Long Term Care PACE Enrollment April 2024 to March 2025												
Plan Name	Enrollment											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Archcare	807	822	835	821	823	828	828	847	849	832	826	818
CHS Buffalo Life	233	231	235	240	241	244	242	239	242	248	251	251
Complete Senior Care	135	134	135	136	135	137	138	138	139	138	138	140
Comprehensive Care Management	6295	6311	6267	6297	6360	6418	6516	6594	6654	6653	6620	6554
Eddy Senior Care	393	405	408	414	411	416	422	420	421	428	435	431
Fallon Health PACE	157	161	164	168	173	181	181	184	195	209	216	217
Independent Living For Seniors	749	749	748	740	753	757	769	770	768	771	772	773
Pace CNY	561	568	564	576	581	588	591	594	603	661	614	614
Total Senior Care	127	127	126	128	126	130	127	124	123	122	118	114
PACE At Hudson Headwaters	0	0	0	0	0	0	0	0	0	0	2	5
Total	**9457**	**9508**	**9482**	**9520**	**9603**	**9699**	**9814**	**9910**	**9994**	**10062**	**9990**	**9912**

Attachment 2: MLTC Critical Incidents

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse of Enrollees	Instances of Neglect of Enrollees	Instances of Exploitation of Enrollees	Crimes Committed Against Enrollee	Crimes Committed by Enrollee	Falls (Hospitalization)	Falls (Non-Hospitalization)	Self Neglect/Abuse	Transport Accidents	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other Than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	32	0	0	0	0	0	0	1	0	11	12	0	0	2	2	4	4539	0.71%
Archcare Community Life	13	0	0	0	0	0	0	0	0	0	0	0	0	9	4	0	825	1.58%
Catholic Health-LIFE	17	0	7	0	0	0	0	0	0	3	1	0	0	0	6	0	250	6.80%
Centerlight PACE	41	0	0	0	0	0	0	0	0	22	15	0	0	1	1	2	6609	0.62%
Centers Plan for Healthy Living	1190	2	2	1	5	3	1	7	0	280	832	4	2	12	39	0	53993	2.20%
Centers Plan for Healthy Living MAP	76	0	0	0	2	0	0	1	1	11	55	0	0	0	6	0	2003	3.79%
Complete Senior Care	11	0	0	0	0	0	0	0	0	6	3	0	0	1	1	0	138	7.97%
Eddy SeniorCare	8	0	0	0	0	0	0	0	0	5	1	0	0	0	2	0	431	1.86%
Elderplan MAP	7	0	0	0	1	6	0	0	0	0	0	0	0	0	0	0	5328	0.13%
Elderserve	1092	2	0	0	1	4	1	5	2	93	660	0	2	106	216	0	20324	5.37%
Elderserve MAP	26	0	0	0	0	0	0	1	0	0	19	0	0	1	5	0	435	5.98%
Empire BlueCross BlueShield Healthplus	4018	0	0	0	1	0	0	0	0	288	2465	11	0	1251	2	0	62119	6.47%
Empire BlueCross BlueShield Healthplus MAP	16	0	0	0	0	0	0	0	0	1	7	1	0	7	0	0	244	6.56%
Fallon Health Weinberg	95	0	0	0	0	0	0	0	0	6	89	0	0	0	0	0	214	44.39%
Fidelis Care at Home	61	0	0	0	3	2	0	2	0	21	18	1	0	6	6	2	19735	0.31%
Fidelis MAP	22	0	0	0	0	0	0	0	0	2	10	0	0	4	6	0	2246	0.98%
Hamaspik	156	0	0	1	9	0	0	1	0	0	0	0	0	49	76	20	8466	1.84%
Hamaspik MAP	7	0	0	0	0	0	0	0	0	0	0	0	0	2	5	0	1062	.66%
Healthfirst CompleteCare	109	0	0	0	0	0	0	2	0	0	0	0	0	50	44	13	35306	0.31%
HomeFirst, Inc. (Elderplan)	8	0	0	0	1	5	0	0	0	0	0	0	0	1	0	1	27801	0.03%
Icircle	2	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	4617	0.04%

Independent Living for Seniors (ILS/ElderOne)	22	1	0	0	0	0	0	0	3	15	2	0	0	0	0	1	772	2.85%
Independent Living Services of CNY (PACE CNY)	28	0	0	0	0	0	0	0	0	14	2	1	0	0	11	0	630	4.44%
MetroPlus MAP	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	266	0.38%
MetroPlus	4	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	2811	0.14%
Senior Health Partners	63	0	0	0	0	0	0	1	0	0	0	0	0	23	30	9	10601	0.59%
Senior Whole Health	2	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	26227	0.01%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	267	0.00%
Total Senior Care	15	0	0	0	0	0	0	0	0	5	10	0	0	0	0	0	118	12.71%
Village Care	76	0	0	0	5	37	4	0	1	4	22	1	1	0	1	0	32130	0.24%
Village Care MAP	16	0	0	0	0	8	0	0	0	3	3	1	1	0	0	0	4592	0.35%
VNA Homecare Options (Nascentia Health Options)	788	2	0	3	8	0	1	6	1	93	651	1	2	9	11	0	6743	11.69%
VNS Choice MAP TOTAL	81	0	0	0	0	17	0	0	0	16	47	0	0	1	0	0	5727	1.41%
VNS Choice MLTC	619	0	0	0	2	19	1	4	1	80	498	0	0	2	12	0	27270	2.27%
PACE At Hudson Headwaters	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	50.00%
United MAP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0.00%
Total	**8722**	**7**	**9**	**5**	**38**	**101**	**8**	**33**	**9**	**985**	**5423**	**21**	**8**	**1537**	**486**	**52**	**374839**	**2.33%**

Attachment 3: SUD Summary of Milestones

Milestones from 17-003 document: 1. Access to critical levels of care for OUD and other SUDs			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
Coverage of outpatient services	NYS Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan using the LOCADTR LOC criteria: • Outpatient hospital (SPA 06-61, 08-39) • FQHC • Physician services • Rehabilitation services (3.1-a (3b-37).	All LOCADTR levels are covered.	No further action needed
Coverage of intensive outpatient services	NYS Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the state Plan: • Outpatient hospital • FQHC • Rehabilitation Services	All LOCADTR levels are covered.	No further action needed
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	NYS Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the state Plan: • Physician services • Rehabilitation Services • MAT 1905(a)(29) Page 3.1-a (8)	All MAT is covered.	No further action needed
Coverage of medically supervised withdrawal management	NYS Medicaid covers medically supervised withdrawal management in a hospital and non-hospital setting. • Inpatient withdrawal management in a general hospital setting • Inpatient withdrawal management in a non- hospital setting • Ambulatory withdrawal management under the following authorities: • Outpatient hospital • Rehabilitative Free- standing services • FQHC services	All LOCADTR levels are covered.	No further action needed

Coverage of intensive levels of care in residential and inpatient settings	NYS Medicaid covers residential SUD in a non- hospital setting under the Rehabilitative Services Option. (Page Attachment 3.1-A 3b-37(v)-(viii)) NYS Medicaid covers the following inpatient SUD treatment: • Inpatient hospital services Inpatient hospital for individuals aged 65 or older in institutions for mental diseases • Inpatient psychiatric facility services for individuals under 22 years of age	NYS Medicaid enrollees do not have access to residential services under the LOCADTR LOC for Reintegration (similar to ASAM 3.1). Under this demonstration, the state will begin authorizing Medicaid coverage of this residential LOC delivered in IMDs as providers enroll in Medicaid.	NYS has authorized and begun to reimburse for Medicaid individuals to receive services for the LOCADTR LOC for Reintegration services provided in an IMD. Since approval of the NYHER waiver and as of Q2 quarterly report 134 reintegration programs have been enrolled.

Milestones from 17-003 document: 2. Widespread use of evidence-based, SUD-specific patient placement criteria			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
Implementation of requirement that providers assess treatment needs based on SUD- specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	NYS providers are required to utilize assessments that are directly tied to the LOCATDR criteria for treatment planning. NYS has implemented a universal training program for providers to assess treatment needs based on the LOCATDR's multi- dimensional tools and to base treatment needs on those assessments. NYS requires all Medicaid SUD providers through regulation to use the for LOC assessments using the LOCADTR, consistent with provider training. Under the regulations, providers are required to develop recommendations for placement in appropriate levels of care based on the LOCADTR and multi- dimensional assessments.	NYS requires all Medicaid SUD providers through regulation to use the for LOC assessments using the LOCADTR, consistent with provider training.	No further action needed
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate LOC	Regardless of payor type, all providers are required to utilize the LOCADTR as the utilization management tool for all Medicaid SUD services, as well as the patient placement criteria to review residential placements using the LOCADTR placement criteria. NYS has ensured that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the LOCADTR dimensions of care. NYS already requires through MMCP	The LOCADTR 3.0 is the NYS OASAS-approved tool used by addiction treatment providers, managed care plans, and other referral sources to determine the most appropriate LOC for	No further action needed

	contract language that for utilization management MMCPs use LOCADTR language consistent with provider training. All website, provider information and internal documentation are consistent with the LOCATR. OASAS has a website with a provider search function for Medicaid beneficiaries and providers at all LOCADTR LOCs.	individuals with addiction and/or problem gambling/gambling disorder. Use of LOCADTR is required for: OASAS-certified treatment programs Medicaid, HIV/SNP, and HARP, MAP for initial placement notifications and ongoing/ concurrent review discussions between and among providers and plans. LOCADTR Concurrent Review module: Required by providers and MMCPs when determining continued stay for LOC. Providers are required to use the concurrent review module when making or considering LOC changes from one LOC to another. Furthermore, the current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions.	
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and LOC	Today, MMCPs and FFS providers utilize the LOCADTR to review utilization for ambulatory, residential care and inpatient hospital care. NYS has developed program standards to ensure that providers' interventions are appropriate for the diagnosis and each LOCADTR LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.		No further action needed
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions. Oversight agency regulation of billing and certification requirements through 14 NYCRR Part 841, onsite chart reviews and general oversight of LOCADTR and placement as part of normal site review process. The placement criteria currently in use can be found on the OASAS website[17] NYS uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR. Additionally, plans are prohibited by state law from requiring prior authorization for addiction services but conduct retrospective review to ensure services were clinically appropriate, consistent with LOCADTR.		No further action needed

[17] https://oasas.ny.gov/locadtr

Milestones from 17-003 document: 3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
NYS program regulations Title 14 NYCRR Part 820 set residential treatment provider qualifications. LOCADTR incorporates residential treatment provider.	NYS program regulations Title 14 NYCRR Part 820 and residential clinical guidance incorporates components of the ASAM criteria.	NYS program regulations Title 14 NYCRR Part 820, OASAS clinical guidance for residential programs incorporates components with ASAM criteria[18]. The NYS LOCADTR 3.0 is OASAS-approved tool used by addiction treatment providers, managed care plans, and other referral sources to determine the most appropriate LOC for individuals with addiction and/or problem gambling/ gambling disorder including residential treatment provider.	No further action needed

Milestones from 17-003 document: 4. Sufficient provider capacity at each LOC			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT: • Outpatient Services;	At present, program capacity is monitored internally by the OASAS Regional Office (RO), State Opioid Treatment Authority (SOTA) and the Addiction Treatment and Recovery division (ATAR).	NYS will examine the potential to enhance access monitoring reporting under the Demonstration, including the provision of data related to Medicaid enrolled providers accepting new patient. This initiative will leverage the current dashboard for ongoing access monitoring and	OASAS will work with NYS DOH to complete an availability assessment of providers accepting new patients in the critical levels of care.

[18] https://oasas.ny.gov/system/files/documents/2020/02/clinical-pathway-residential-redesign.pdf

• Intensive Outpatient Services; • MAT (medications as well as counseling and other services); • Intensive Care in Residential and Inpatient Settings; • Medically Supervised Withdrawal Management.		recruitment and enrollment of new facilities as needed.	

Milestones from 17-003 document: 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	NYS Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the state Plan: • Physician services • Rehabilitation Services • MAT 1905(a)(29) Page 3.1-a (8)	All MAT is covered.	No further action needed

Milestones from 17-003 document: 6. Improved care coordination and transitions between levels of care			
Milestone Criteria	**State of milestone criteria at time of NYHER approval**	**Satisfaction of Milestone**	**Summary of Actions Needed**
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate LOC	Regardless of payor type, all providers are required to utilize the LOCADTR as the utilization management tool for all Medicaid SUD services, as well as the patient placement criteria to review residential placements using the LOCADTR placement criteria NYS has ensured that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the LOCADTR dimensions of care. NYS already requires through MMCP contract language that for utilization management MMCPs use LOCADTR language consistent with provider training. All	The LOCADTR 3.0 is the NYS OASAS-approved tool used by addiction treatment providers, managed care plans, and other referral sources to determine the most appropriate LOC for individuals with addiction and/or problem gambling/	No further action needed

	website, provider information and internal documentation are consistent with the LOCATR. OASAS has a website with a provider search function for Medicaid beneficiaries and providers at all LOCADTR LOCs.	gambling disorder. Use of LOCADTR is required for: OASAS-certified treatment programs Medicaid, HIV/SNP, and HARP MAP for initial placement notifications and ongoing/concurrent review discussions between and among providers and plans. LOCADTR Concurrent Review module: Required by providers and Medicaid managed care plans when determining continued stay for LOC. Providers are required to use the concurrent review module when making or considering LOC changes from one LOC to another.	
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and LOC	Today, MMCPs and FFS providers utilize the LOCADTR to review utilization for ambulatory, residential care and inpatient hospital care. NYS has developed program standards to ensure that providers' interventions are appropriate for the diagnosis and each LOCADTR LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.		No further action needed