MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 26 (4/1/2024-3/31/2025)
Federal Fiscal Quarter: 3 (4/1/2024-6/30/2024)

I. Introduction

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

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

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

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

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

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

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

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

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

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

On January 9, 2024, CMS approved a three-year amendment to the 1115 demonstration through March 31, 2027. Approval of this demonstration amendment will allow the state to advance health equity, reduce health disparities, support the delivery of health-related social needs (HRSN) services, and promote workforce development. In addition, the amendment provides the state with Substance Use Disorder (SUD) demonstration authority.

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

II. Enrollment: Third Quarter

MRT Waiver- Enrollment as of June 2024

Demonstration Populations (As hard coded in the CMS 64)	Current Enrollees (To date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 – TANF Child 1 – 20 years in Mandatory Counties as of 10/1/06	**340,862**	**4,772**	**24,692**
Population 2 – TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06]	**65,158**	**1,419**	**2,088**

Population 3 – TANF Child 1 – 20 ('new' MC Enrollment)	**3,477**	**38**	**330**
Population 4 – TANF Adults 21 – 64 ('new' MC Enrollment)	**32,929**	**620**	**992**
Population 5 – Safety Net Adults	**231,559**	**7,916**	**24,640**
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)	**160,504**	**1,922**	**112**
Population 9 – Disabled Adults and Children 0 – 64 ('new' MC enrollment)	**55,248**	**4,456**	**499**
Population 10 – Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**86,564**	**433**	**58**
Population 11 – Aged or Disabled Elderly ('new' MC enrollment)	**11,164**	**3,097**	**562**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollment's in Current Demonstration Year	**24,673 or an approximate 16.14% increase from last Q**

Reasons for voluntary disenrollment:

Voluntary disenrollments have increased by 16.14%. The increase is due to the disenrollment categories of "Undetermined" and "Code 93 Client or LDSS Initiated/Excluded or Exempt."

Involuntary Disenrollment	
Total # Involuntary Disenrollment's in Current Demonstration Year	**53,973 or an approximate 62.85% decrease from last Q**

Reasons for involuntary disenrollment:

Involuntary disenrollments have decreased by 62.85%. This is primarily due to a decrease in Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to New York State of Health (NYSOH) for redetermination.

There was also a further decrease 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.

MRT Waiver – Affirmative Choices

Mainstream Medicaid Managed Care				
April 2024				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**661,562**	**30,149**	**4,998**	**25,151**
Rest of State	**243,184**	**11,854**	**1,374**	**10,480**
Statewide	**904,746**	**42,003**	**6,372**	**35,631**
May 2024				
New York City	**668,527**	**22,503**	**3,814**	**18,689**
Rest of State	**241,655**	**10,774**	**1,097**	**9,677**
Statewide	**910,182**	**33,277**	**4,911**	**28,366**
June 2024				
New York City	**660,237**	**21,034**	**3,668**	**17,366**
Rest of State	**239,068**	**10,770**	**1,209**	**9,561**
Statewide	**899,305**	**31,804**	**4,877**	**26,927**

Third Quarter	
Region	**Total Affirmative Choices**
New York City	61,206
Rest of State	29,718
Statewide	90,924

HIV SNP Plans				
April 2024				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	13,325	272	0	272
Rest of State	30	2	0	2
Statewide	13,355	274	0	274
May 2024				
New York City	13,401	248	0	248
Rest of State	31	3	0	3
Statewide	13,432	251	0	251
June 2024				
New York City	13,412	255	0	255
Rest of State	31	2	0	2
Statewide	13,443	257	0	257
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	775			
Rest of State	7			
Statewide	782			

Health and Recovery Plans Disenrollment			
FFY 24 – Q3			
	Voluntary	Involuntary	Total
April 2024	546	1,374	1,920
May 2024	564	1,109	1,673
June 2024	476	1,902	2,378
Total:	1,586	4,385	5,971

Reasons for disenrollment:

Voluntary HARP disenrollments have increased by 10.12%. The primary reason for the increase was “Clients enrolling in other plans” and the “Undetermined” category of disenrollment. Undetermined refers to cases where a manual review would be needed to determine the specific reason for disenrollment.

Involuntary HARP disenrollments decreased by 13.61%. This was primarily due to a decrease in MAGI case closures that were subsequently sent to NYSOH for redetermination. There was also a further decrease 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.

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 3 (4/1/2024-6/30/2024) Q3 FFY 2024

As of the end of the third federal fiscal quarter (end of June 2024), there were 2,631,291 New York City Medicaid consumers enrolled in the MMMC Program and 74,931 Medicaid consumers enrolled in a HARP. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 31 HRA facilities including 6 HIV/AIDS Services Administration (HASA) sites, 9 Community Medicaid Offices (MA Only), and 16 HRA Benefits Access Centers (Public Assistance). MAXIMUS reported that 4,976 clients were educated about enrollment options and made an enrollment choice including 818 clients in person and 4,158 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, 135 Enrollment Counselling sessions were evaluated which generated four applications for a total of four enrollments.

CMU Monitoring of Field Presentation Report – 3rd Quarter 2024	
Enrollment Counseling – One on One	General Information
135	131

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

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

In addition to face-to-face informational sessions, FCSRs make outreach calls to FFS community clients and FFS Nursing Home (NH) clients identified for plan auto-assignment. A total of 30,406 FFS community clients were reported on the regular auto-assignment list; 10,735 clients responded to the call that generated 5,261 enrollments. Of the total of 23 FFS NH clients reported on NH auto-assignment list, 0 (0%) client and/or authorized representatives made a plan selection. CMU monitored 1,042 outreach calls by FCSRs in HRA facilities. The following captures those observations:

Phone Enrollment Applications			General Information (undecided)		
Regular FFS	Nursing Home FFS	Total	Regular FFS	Nursing Home FFS	Total
580	0	580	462	0	462

- Phone Enrollment Applications: 580 (56%) FFS clients made a voluntary enrollment choice for themselves and their family members including 0 NH clients for a total of 821 enrollments.
    - 815 (78%) enrollments were randomly chosen to track for timely and correct processing and CMU confirmed that consumers were timely enrolled in the plan they selected.
- Undecided: 462 (44%) FFS and NH clients did not make an enrollment choice for several reasons that include having to consult a family member and/or physician. No infractions were observed for these calls.

C. NYMC HelpLine Observations April 2024- June 2024

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that **49,770** calls were received by the Helpline and **48,874** or **98%** were answered. Calls answered were handled in the following languages: **English: 28,668 (59%); Spanish: 7,552 (15%); Chinese: 2,064 (4%); Russian: 1,170 (2%); Creole: 265 (1%); and other: 9,155 (19%).**

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to **6,144** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 3rd Quarter 2024								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
3,485 (57%)	**633 (10%)**	**320 (5%)**	**1,655 (27%)**	**46 (1%)**	**0 (0%)**	**4 (0%)**	**1 (0%)**	**6,144**

A total of **1,933 (31%)** recorded calls observed were unsatisfactory. **1,006** calls had a single infraction and **927** calls had multiple infractions. A total of **3,917** infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: **2,721 (70%)** – 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: **206 (5%)** – 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: **990 (25%)** – Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **3,917** 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 third quarter of FFY 2023-2024, there were no new plans, plan expansions or withdrawals.

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

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

C. Health Plans/Changes to Certificates of Authority

No changes to Certificates of Authority during the time frame.

D. CMS Certifications Processed

Not applicable during this time frame.

E. Surveillance Activities

CMS Reporting 3rd QTR (4/1/2024-6/30/2024)

Surveillance activity completed during the 3rd quarter FFY 2023-2024 (April 1, 2024-June 30,2024) include the following:

Three Comprehensive Operational Surveys were completed during 3rd Quarter FFY 2023-2024.Three Statements of Deficiency (SOD) were issued, and three Plans of Correction (POCs) were accepted:

- Amida Care, Inc.
- Capital District Physicians' Health Plan, Inc.
- United Healthcare of New York, Inc.

Two Targeted Operational Surveys were completed during 3rd Quarter FFY 2023-2024. One SOD was issued and one POC was accepted. One plan was found in compliance:

- Molina Healthcare of New York, Inc.
- Excellus Health Plan, Inc.-In compliance.

15 PCP Ratio Surveys were completed during 3rd Quarter FFY 2023-2024. Letters of Concern, requiring a self-directed CAP, were issued to 11 Plans. 4 plans were exempt:

- Amida Care, Inc. (Exempt)
- Anthem HP, LLC (fka HealthPlus)
- Capital District Physicians' Health Plan, Inc.
- Excellus Health Plan, Inc. (Exempt)
- Health Insurance Plan of Greater NY, Inc. (HIP Emblem)
- Healthfirst PHSP, Inc.
- Highmark of Western and Northeastern NY, Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Special Needs Plan, Inc. (Exempt)
- Molina Healthcare of New York, Inc.
- MVP Health Plan, Inc.
- New York Quality HealthCare Corporation (NYQHC/Fidelis)
- United HealthCare of New York, Inc.
- VNS Choice (Exempt),

12 Provider Access and Availability Surveys were completed during 3rd Quarter FFY 2023-2024. 12 SODs were issued and 12 POCs were accepted:

- Amida Care, Inc.
- Excellus Health Plan, Inc.
- Health Insurance Plan of Greater NY, Inc. (HIP Emblem)
- Healthfirst PHSP, Inc.

- Highmark of Western and Northeastern NY, Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Special Needs Plan, Inc.
- Molina Healthcare of New York, Inc.
- New York Quality HealthCare Corporation (NYQHC/Fidelis)
- United HealthCare of New York, Inc.
- VNS Choice.

12 Provider Directory Surveys were completed during 3rd Quarter FFY 2023-2024. 12 SODs were issued and 12 POCs were accepted:

- Amida Care, Inc.
- Excellus Health Plan, Inc.
- Health Insurance Plan of Greater NY, Inc. (HIP Emblem)
- Healthfirst PHSP, Inc.
- Highmark of Western and Northeastern NY, Inc.
- Independent Health Association, Inc.
- MetroPlus Health Plan, Inc.
- MetroPlus Special Needs Plan, Inc.
- Molina Healthcare of New York, Inc.
- New York Quality HealthCare Corporation (NYQHC/Fidelis)
- United HealthCare of New York, Inc.
- VNS Choice.

12 Member Services Phase II Surveys were completed during 3rd Quarter FFY 2023-2024. 12 SODs were issued and 12 POCs were accepted:

- Amida Care, Inc.
- Anthem HP, LLC (fka HealthPlus)
- Capital District Physicians' Health Plan, Inc.
- Excellus Health Plan, Inc.
- Health Insurance Plan of Greater NY, Inc. (HIP Emblem)
- Healthfirst PHSP, Inc.
- Highmark of Western and Northeastern NY, Inc.
- Independent Health Association, Inc.
- Molina Healthcare of New York, Inc.
- MVP Health Plan, Inc.
- New York Quality HealthCare Corporation (NYQHC/Fidelis)
- United HealthCare of New York, Inc.

V. Waiver Deliverable

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS.

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

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

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

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

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

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

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

B. Benefit Changes/Other Program Changes

Transition of Behavioral Health (BH) Services into Managed Care and Development of Health and Recovery Plans (HARPs):

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

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

In FY 2018, NYS engaged in multiple activities to enhance access to BH services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the NYSoH. This enabled 21,000 additional individuals to gain access to the enhanced benefits offered in the HARP product line. The State identified and implemented a policy to allow State Designated Entities (SDE) to assess and link HARP enrollees to BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the 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 Public Health Emergency (PHE) would expire on May 11, 2023. The notice detailed flexibilities afforded to providers regarding minimum billing standards and documentation requirements coming to an end, unless otherwise specified by OMH through formal regulatory waivers. Areas impacted by the end of the PHE include telehealth, documentation, utilization review, billing standards, Health Insurance Portability and Accountability Act (HIPAA) enforcement, hospital conditions of participants, and program specific guidance for community-based services and residential services.

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

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

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

1. **Inpatient Denial Report:** Each month, MCOs are required to electronically submit a report to the State on all denials of inpatient 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 (1/1/2024-3/31/2024)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	24,549	138	127	0.52%
ROS	6,075	44	40	0.66%
Total	30,624	182	167	0.49%

***Due to data integrity issue, Healthfirst January 2024 utilization review Inpatient data has been excluded in this report**

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

NYS MH & SUD authorization requests and denials for Outpatient (1/1/2024-3/31/2024)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	3,203	170	57	1.78%
ROS	543	28	28	5.16%
Total	3,746	198	85	2.27%

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

MH & SUD Claims (4/1/2024-6/30/2024)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	845,033	88.51%	11.49%
ROS	966,424	90.56%	9.44%
Totals	1,811,457	89.61%	10.39%

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 4/1/2024-6/30/2024: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	289	56
Education Support Services	29	7
Family Support and Trainings	405	25
Intensive Supported Employment	9	5
Ongoing Supported Employment	10	3
Peer Support	3,049	593
Pre-vocational	15	4
Provider Travel Supplements	158	68
Psychosocial Rehab	5,465	621
Residential Supports Services	87	9
Transitional Employment	0	0
TOTAL	9,516	1,145

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 4/1/2024-6/30/2024: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	2,141	383
Education Support Services	89	20
Family Support and Trainings	597	44
Intensive Supported Employment	49	8
Ongoing Supported Employment	11	2
Peer Support	5,483	1,031
Pre-vocational	17	3
Provider Travel Supplements	5,956	1,239
Psychosocial Rehab	6,655	1,227
Residential Supports Services	618	65
Transitional Employment	0	0
TOTAL	21,616	2,360

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

Provider Technical Assistance

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

Quarter 3 MCTAC Attendance & Statistics (4/1/2024 to 6/30/2024)

Events: MCTAC successfully executed **28** events from 4/1/2024 to 6/30/2024. 23 events were held via webinar and 5 were held in-person. 4 of the 23 webinars 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)*

6,423 people attended/participated in MCTAC events/viewed resources of which **2,963** were unique participants.

OMH Agency Participation/Attendance/Viewing of Resource
Overall: 66.73% (355 of 532 total employees)

OASAS Agency Participation/Attendance/Viewing of Resource
Overall: **56.45%** (245 of 434 total employees)

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

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

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

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

- Streamlined the BH HCBS assessment process.
    - Effective March 7, 2017, the full portion of the NYS Community Mental Health assessment is no longer required. Only the brief portion (NYS Eligibility Assessment) is required to establish BH HCBS eligibility and provide access to these services.
- Developed training for care managers and BH HCBS providers to enhance the quality and utilization of integrated, person-centered plans of care and service provision, including developing a Health Home training guide for key core competency trainings to serving the high need SMI population.

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

- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both Health Homes and RCAs).
- Developed required training for BH HCBS providers that NYS can track in a Learning Management System.
- Implemented rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhanced technical assistance efforts for BH HCBS providers including workforce development and training.
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in Health Homes. These services are provided by SDEs through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDEs to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCAs) for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (completed)
        - Ongoing technical assistance (completed)
- Continued efforts to increase HARP enrollment in Health Homes including:
    - Best practices for embedded care managers in ERs, Clinics, shelters, CPEPS and Inpatient units and engagement and retention strategies.
    - Existing quality improvement initiative within clinics to encourage Health Homes enrollment.
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings.
    - Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management.
    - DOH approval of MCO plans for incentivizing enrollment into Health Homes (e.g., outreach optimization).
- Continued work to strengthen the capacity of Health Homes to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead Health Homes, representation on new HH+ Subcommittee Workgroup.
- Implemented Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members.
- Disseminated consumer education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS OMH contracted with the New York Association Psychiatric Rehabilitation Services (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for HARPs and Adult BH HCBS.
        - NYAPRS conducted outreach in two ways:
            - 45-90-minute training presentations delivered by peers.

        - Direct one-to-one outreach in community spaces (such as in homeless shelters or on the street near community centers).
- Implemented Quality and Infrastructure initiative to support targeted BH HCBS workflow processes and increase in BH HCBS utilization. In-person trainings completed June 2018. NYS worked with the MCOs on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS.
    - 13 HARPs distributed over $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all HARPs was conducted to discuss best practices identified through the use of Quality and Infrastructure initiative funds that resulted in an increase of members utilizing BH HCBS; NYS also shared a summary of best and promising practices with the HARPs.
- Issued Terms and Conditions for BH HCBS providers to standardize compliance and quality expectations of BH HCBS provider network and help clarify for MCOs which BH HCBS providers are actively providing services.
- Enhanced NYS Adult BH HCBS Provider oversight, including development of oversight tools and clarifying service standards for BH HCBS provider site reviews, including review of charts, interviews with staff or clients and review of policy and procedures.
- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, Health Homes, CMAs, and BH HCBS provider agencies. Developed and provided a variety of tools to support care manager referrals to BH HCBS, on behalf of the NYS Health Home/MCO Workgroup.
- Established a process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments. This was in response to challenges in securing a care management workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,409 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between April 1, 2024, and June 30, 2024, 42 eligibility assessments were completed.

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

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

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

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

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

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

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

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

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

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

forums based on stakeholder feedback. 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. OMH and OASAS are also planning regional networking events in 2024 for CORE providers, MCOs, and care managers, and other local service providers to promote collaboration and referral connections.

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

From March 2023 to February 2024, 6,013 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 40.7%, from 1,935 (January 2022, the month before HCBS/CORE transition) to 2,723 (February 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 continue to work closely with the HARPs to further monitor and operationalize the program.

- 11 HARPs executed 80 provider contracts which account for 59% of all designated BH HCBS and CORE providers to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $28.3 million in initial contract base awards and subsequent milestone payments were distributed to providers.
- The program is expected to conclude on July 31,2024. As of July 5,2024, 32 out of 80 contracts have concluded.
- NYS developed an Infrastructure Program Extension dashboard which monitors BH HCBS, and CORE Service claims and unique recipients served by BH HCBS and CORE Service providers during the measurement period. The dashboard compares BH HCBS and CORE providers in Infrastructure Program Extension contracts with HARPs to those not in Infrastructure Program Extension contracts. NYS solicited and incorporated feedback from HARPs on the development of the dashboard.
- In July 2024, NYS distributed a compiled list of “best practices”, informed by HARPs and providers as they jointly developed innovative solutions to engage HARP members, expedite the BH HCBS and CORE Services workflow, and address barriers to receiving BH HCBS and CORE services.

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

No activity has occurred during this reporting period.

C. Managed Long-Term Care Program (MLTCP)

MLTC plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of July 1, 2024, there are 15 active Partial Capitation plans, 9 PACE plans, 11 MAP, and 1 FIDA IDD plan. During this quarter, there were 5 plans that exited via a merger from their Partial Capitation line of business and their membership was transferred to the acquiring plan. As of July 1, 2024, there are a total of 350,207 members enrolled across all MLTC products.[4]

1. Accomplishments/Updates

During the April 2024 through June 2024 quarter, DOH approved five Partial Capitation plans' mergers and acquisitions and membership was transferred to the acquiring plan. One Partial Capitation plan separately acquired three Partial Capitation plans.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the April 2024 through June 2024 quarter, post enrollment surveys were completed for 14 enrollees. Of the 13 surveyed, 9 (69%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation plans increased from 286,262 to 293,378 during the April 2024 through June 2024 quarter, a 2% increase from the previous quarter. During this period, 17,535 individuals who were being transitioned into MLTC made an affirmative choice, a 4% increase from the previous quarter and brings the 12-month total for affirmative choice to 60,103.

Year to Date monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the Year-to-Date July 2023 through June 2024 annual period is submitted as an attachment.

2. Significant Program Developments

During the April 2024 through June 2024 quarter:

- The April-June 2024 quarter Member Services survey was conducted on 15 Partial Capitation Plans and 11 MAP Plans. This survey was intended to provide feedback on

[4] The Enrollment attachment reflects YTD activity of all Partial Capitation, MAP, PACE and FIDA IDD plans. The month that membership transfers occurred due to mergers, acquisitions and withdrawals of Partial Capitation and MAP plans are reflected with zero enrollment.

the overall functioning of the plans' member service performance. No response was required, but, when necessary, DOH provided recommendations on areas of improvement.

- Operational Surveys were initiated for three Partial Capitation plans in prior reporting periods, and are as follows:
    - First Partial Capitation plan: the CAP has been reviewed and accepted.
    - Second Partial Capitation plan: The Desk Review has been completed and the SOD has been issued. We are awaiting the submission of a CAP.
    - Third Partial Capitation plan: The Desk Review is still in progress.
- One Focused Survey was initiated on all Partial Capitation Plans based on an analysis of their 2023 Q1 PNDS Submissions in a prior reporting period. SODs were issued to 19 Plans and their CAPs have been received. The four plans from the prior reporting period that did not have acceptable CAPs, have now submitted acceptable CAPs. This focused Survey is complete.
- One Focused Survey was initiated on all PACE Plans based on an analysis of their 2023 Q1 PNDS Submissions in a prior reporting period. SODs were issued to seven Plans, and CAPs have been approved.
- Based on the findings of the Focused Survey regarding inappropriate Social Day Care denials from the prior reporting period a follow up Focused Survey was initiated on all Partial Capitation and MAP plans specific to Social Adult Day Care (SADC) / Person-Centered Service Planning (PCSP) Policies and Procedures to ensure all plans develop or update their policies and procedures to be conform with the PCSP requirements under the HCBS Final Rule. All Plan policies and procedures have been reviewed and approved.
- Two Focused Surveys were initiated on one plan for their Partial Capitation and PACE lines of business resulting in two SODs based on the identification of expired MSA Agreements. CAPs were received and are being reviewed.
- One Focused Survey was initiated on one plan for their MAP line of business resulting in a SOD based on the identification of an expired MSA Agreement. The CAP is due 7/17/2024.
- One Focused Survey was initiated on all Partial Capitation and MAP Plans based on the Office of the State Comptroller (OSC) Audit, Improper MMC Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies on Behalf of Recipients in Nursing Homes (Report 2023-F-12) to evaluate Plan policies and controls. The requested information is due 7/3/2024.
- One Focused Survey was initiated on one Partial Capitation plan based on their self-disclosure regarding 2,267 notices not being sent out to members, which included approvals, extensions, acknowledgments but also 300 plus denials where the member did not receive FH rights, resulting in a SOD. The CAP has been received and is under review.

3. Issues and Problems

There were no issues or problems to report for the April 2024 through June 2024 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within MLTC plans as a consumer choice and gives individuals and families greater control over services received. The DOH began a procurement process in December 2019 which was subsequently amended in the Executive Budget in April 2022. This procurement process was ultimately repealed in the enacted 2024-25 NYS Budget and was replaced with legislation to procure a single statewide fiscal intermediary. The procurement was issued in June 2024. Once the single statewide fiscal intermediary contract is executed, managed care plans will then enter into an administrative service agreement with the contracted single statewide fiscal intermediary.

5. Required Quarterly Reporting

Critical incidents: There were 3,270 critical incidents reported for the April 2024 through June 2024 quarter, a 6% decrease from the previous quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. Critical incidents by plan for this quarter are attached.

Complaints and Appeals: For the April 2024 through June 2024 quarter, the main reasons for complaints/appeals changed from last quarter: Dissatisfaction with Quality of Other Covered Services, Dissatisfaction with Member Services and Plan Operations, Dissatisfaction with Quality of Home Care (other than lateness or absences), Dissatisfaction with Care Management, Dissatisfaction with Transportation.

Period: 4/1/2024–6/30/2024 (Percentages rounded to nearest whole number)			
Number of Recipients: 348,752 (Qtr. Average)	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**4**	**4**	**100%**
# Same Day	**2,029**	**2,029**	**100%**
# Standard/Expedited	**5,238**	**3,767**	**72%**
Total for this period:	**9,867**	**8,572**	**80%**

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

Appeals	7/2023-9/2023	10/2023-12/2023	1/2024-3/2024	4/2024-6/2024	Average for Four Quarters
Average Enrollment	321,917	331,288	339,930	348,752	335,471
Total Appeals	10,762	10,065	10,918	11,347	10,773
Appeals per 1,000	33	30	32	33	32
# Decided in favor of Enrollee	1,220	1,168	1,150	1,291	1,207
# Decided against Enrollee	8,263	6,765	7,407	8,572	7,752
# Not decided fully in favor of Enrollee	915	1,805	2,004	1,209	1,483
# Withdrawn by Enrollee	329	327	357	275	322
# Still pending	1,099	1,000	1,200	1,232	1,133
Average number of days from receipt to decision	7	7	10	8	8

Complaints and Appeals per 1,000 Enrollees by Product Type April 2024 – June 2024					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	291,558	4,222	14	8,668	30
Medicaid Advantage Plus (MAP) Total	47,714	1,986	42	2,568	54
PACE Total	9,480	1,063	112	111	12
Total for All Products:	**348,752**	**7,271**	**21**	**11,347**	**33**

Total complaints decreased 26% from 9,867 the previous quarter to 7,271 during the April 2024 through June 2024 quarter.

Total appeals increased 4% from 10,918 during the last quarter to 11,347 during the April 2024 through June 2024 quarter.

Technical Assistance Center (TAC) Activity

During the April 2024 through June 2024 quarter, TAC opened 845 cases and closed 805 cases. This is lower than the 1,258 cases opened, and 1,335 cases closed from the previous quarter. Upon examination, this quarter's decrease in cases was seen in all case disposition categories, with cases that were Resolved Without Investigation having the largest relative decrease. This decrease is a return to the typical quarterly case numbers after the increase seen in the previous quarter.

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

Call Volume	4/1/2024 – 6/30/2024
Substantiated Complaints	97
Substantiated Complaints with CAP	0
Unsubstantiated Complaints	257
Resolved Without Investigation	24
Inquiries	427
Total Cases Closed	805

The five most common types of calls were related to:

Call Type	4/1/2024 – 6/30/2024
General	23%
Aide Service	17%
Grievance	16%
Enrollment	14%
Billing	7%

73% of Q3 TAC cases were closed in the same month they were opened. This is an increase from last quarter's percentage of 65%.

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 April 2024 through June 2024 quarter, 9,219 people were evaluated, deemed eligible and enrolled into plans, a 3% increase from the previous quarter.

Rebalancing Efforts	4/2024-6/2024
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	326
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,615

As of June 30, 2024, there were 3,375 current plan enrollees who were in a nursing home as permanent placements, a 4% 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 a BH needs, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. **The Children's Waiver Renewal** that was submitted to CMS in January 2022, and extended in April 2022, was **approved on June 29**,

2022, for an effective date of April 1, 2022. Additionally, two new Children's Waiver Amendments were approved by CMS on November 1, 2023, and March 1, 2024, to amend a number of activities detailed in the sections below.

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

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

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

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

- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, Regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation.
- Evaluating accuracy of MCOs and FFS billing and claiming data.
- Defining performance and quality metrics.
- Responded to the COVID-19 pandemic and implementing emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and supported the recovery of impacted providers and consumers.
- Assisted with a strategic plan for the unwind of the COVID-19 PHE.
- Released a PHE Unwind plan for flexibilities related to the Medicaid Children's Waiver and Health Home Services.
- Working with Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process.
- Engaging with providers to understand barriers to service delivery – such as workforce challenges, lack of referral sources/lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, allow for provider reporting and assess metrics regarding highly utilized HCBS, underutilized HCBS, and overutilized providers.
- Modified the state-wide capacity tracking system, which is based on provider self-reporting, to enhance the understanding of the HCBS waitlist and who is being served by HCBS. An electronic referral and authorization portal 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.
- Collecting stakeholder feedback (from consumers, HCBS providers, Health Homes, MCOs, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between MCOs, Health Homes, and HCBS providers.
- Organizing and conducting workgroups of Health Homes, MCOs, and HCBS Providers to ensure feedback is addressed relating to the referral process.
- Engaging with Health Homes, MCOs, and HCBS providers while redesigning the Plan of Care in preparation for digitization.
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process.
- Submitted the 1915c Children's Waiver Extension to CMS.
- Submitted the 1915c Children's Waiver Renewal to CMS.
- Submitted a State Transition Plan to CMS to detail how agencies providing services under the 1915c Waiver comply with the HCBS Final Rule.
- Submitted a preprint to CMS for the disbursement of ARPA funding to support and enhance HCBS workforce and infrastructure.
- Working with MCOs and providers to disseminate ARPA funding through the directed payment process.
- Scheduled and facilitated regional meetings with HCBS providers, Health Homes, care management agencies, Medicaid MCOs to resume in-person collaboration and dialogue.

- Updating the Incident and Reporting Management System (IRAMS) and Children's Capacity Tracker to have updated functionalities to track service delivery and waitlist information.
- Engaging with HCBS providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if they are not currently able to actively deliver HCBS.
- Submitted additional preprint to CMS for the disbursement of ARPA funding to support children in need of receiving Environmental Modifications (EMod), Vehicle Modifications (VMod) & Adaptive and Assistive Technology (AATs).
- Conducted Final Rule compliance reviews with newly designated HCBS providers.
- Monitoring staff compliance with training and background check requirements through IRAMS.

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

- Submitted Disaster SPA 21-0054, for Health Home one-time assessment fee per member retroactive April 1, 2021, to September 30, 2022.
- Submitted a SPA 22-0088, which would continue the assessment fee effective October 1, 2022.
- Updated documentation and provided guidance to providers regarding the HCBS name changes for "Palliative Care: Counseling and Support Services" (previously "Palliative Care: Bereavement") and "Adaptive and Assistive Technology" (previously "Adaptive and Assistive Equipment").
- Updated documentation and provided guidance to providers regarding the consolidated HCBS of "Caregiver and Family Support and Services" and "Community Self-Advocacy Support" into a new service referred to as "Caregiver/Family Advocacy and Support Services". This combination allowed for a broader array of providers to deliver the service and also broadens the definition of caregivers eligible for training to include all individuals who supervise and care for members.
- Broadened Children and Youth Evaluation Services' (C-YES') Nurse qualifications by requiring two years *relevant* experience. The previous requirement that was two years' experience *specifically* in home care.
- 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.
- Implemented a 4% COLA increase for Children's HCBS rates retroactive to November 1, 2023.
- Effective December 1, 2023, rural rate for seven counties was implemented to improve access to services.

- Transitioned the EMod, VMod, Adaptive and AAT to a Financial Management Service, starting March 1, 2024, based upon approval for Children's Waiver amendment.
- Developed Electronic Children's Services Staff Compliance Tracker.
- Updated and issued the Children's Care Management Authorization and Referral Forms ensuring it's inclusive of all requirements per stakeholder feedback.
- Updated IRAMS User Guide used by HH, CMA, HCBS Providers, and C-YES to report critical incidents and complaints/grievances as appropriate for the various populations served to ensure the health, safety, and well-being of members.
- Released the Electronic Children's Referral System, which streamlines, standardizes, and ensures timely completion of HCBS referrals.
- Updated and posted the HCBS Referral and Authorization Portal User Guide and FAQ.
- Updating Children's Plan of Care Policy Workflow documentation.
- Drafting an Authorization and Workflow Policy that will be circulated to stakeholders for feedback.
- Updated and posted documentation and guidance related to HCBS eligibility and enrollment.

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

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

This table includes Quarter 3 data from 4/1/2024-6/30/2024 of FY2024.

	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
April	10,186	5,588	1470	319
May	10,170	5,494	1452	309
June	10,102	4,220	1453	235
Total	**10,670**	**6,209**	**1506**	**390**

Note: There is an expected 3-months lag for claims data that may impact the enrolled children with an HCBS claim data. The decrease in enrolled children for the Family of One population since the previous quarterly report is due to all instances of KK (Family of One) without a K1 (Children's Waiver) have been dropped from the analysis as they are not the Children's Waiver population.

E. New York Health Equity Reform (NYHER) Amendment

The NYHER 1115 Amendment was approved by CMS on January 9, 2024, and will remain in effect throughout the remainder of the demonstration period. The primary goal of the amendment is “to advance health equity, reduce health disparities, and support the delivery of HRSN.” The State seeks to build on the investments, achievements, and lessons learned from the DSRIP 1115 waiver program to scale delivery system transformation, improve population health and quality, deepen integration across the delivery system, and improve access to HRSN services. This will be achieved through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These investments are focused on HRSN services, population health improvement, and increasing workforce capacity.

1.HRSN

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

Through a competitive Request for Application (RFA) procurement process, NYS DOH has awarded nine SCN lead entities who will create and maintain a network of contracted HRSN service providers and collaborate with regional ecosystem partners. A total of 32 qualified applications were received in response to the Social Care Network Lead Entity procurement released on January 16, 2024. Applications were evaluated competitively based on organizational experience, proposed approach to HRSN screening and navigation to services, network administration, capacity building, and partnerships, payment, and performance evaluation, data and IT infrastructure, and budget. The nine successful SCN Lead Entities will be able to enroll as Medicaid billing social care providers and contract with MCOs in their region to facilitate and coordinate Medicaid member eligible assessments of HRSN services. NYS DOH will begin contract development and negotiation with each SCN throughout July and August and expects contract execution by September 1, 2024.

NYS DOH aims to ensure that each Medicaid member will receive an HRSN screening annually or following a major life event. Members will be screened using a New York State-standardized version of the Accountable Health Communities (AHC) HRSN screening tool to assess member needs across a range of HRSN domains. Each SCN will be required to embed the screening tool and associated assessment questions in their IT Platform and have different modalities for conducting screening to ensure broad access. The IT Platform will also have a closed-loop referral functionality to ensure that members with identified needs receive timely navigation to social care services to address their needs and track service referral outcomes. NYS DOH has been working to adopt standardized coding that will be used for screening, assessment, service referral, and referral outcomes. During this quarter, NYS DOH has moved closer to fully mapping HRSN screening questions and responses to standardized codes. NYS DOH will mandate these national social care data standards be adopted into the SCN’s conventions for the following program activities: screening (LOINC), assessing (SNOMED-CT, ICD-10), referral

(SNOMED-CT), and provisioning enhanced HRSN services (SNOMED-CT, HCPCS). NYS DOH is on track for a complete mapping by the end of next quarter. NYS DOH will mandate these national social care data standards be adopted into the SCN's IT Platform. By using these national terminology and exchange data standards, the State can track HRSN program activities from screenings to services and report metrics accordingly.

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

The HRSN Protocol and HRSN Implementation Plan were submitted during this quarter. NYS DOH is on track to begin HRSN service delivery, including Screening, Navigation, and Enhanced HRSN Services, no later than January 1, 2025.

2.Workforce

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

Student Loan Repayment

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

CPT Program

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

individuals newly entering the healthcare workforce, and Healthcare Career Advancement, for individuals currently in the healthcare workforce. Professional titles eligible for this program include nursing, professional technical, and frontline public health workers.

Workforce Investment Organizations (WIOs)

The State has selected three WIOs to participate in the CPT program (subject to executing the agreement in quarter four) and will be notifying the selected WIOs by the middle of August 2024. The selected WIOs are:

- 1199SEIU Training and Employment Funds
- Iroquois Healthcare Association
- Finger Lakes Performing Provider System.

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

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

The State has been engaged in program design work and planning for contracting with the WIOs. In late June, each of the WIOs submitted pre-implementation plans with detailed proposals for operational structure, staffing and IT, educational and provider partnerships, outreach and enrollment, payment, program oversight, reporting, and monitoring of the service commitment. The State is currently completing program guidance documents to further outline expectations and parameters around these key areas. The State expects to execute contracts with the WIOs and begin program implementation in quarter four 2024.

3.Statewide Health Equity Regional Organization (HERO)

The HERO will be an independent statewide entity that will be responsible for data aggregation for health and social care data to support population health improvement activities; regional needs assessment and planning to identify health equity-related needs, service delivery, and

workforce-related gaps contributing to health disparities; value-based payment (VBP) design and development that addresses health, behavioral health and HRSNs; and program evaluation through an ongoing review of waiver programs and access to new services to support continuous improvement in program design, implementation, and impact. The State is working to build out the HERO design, activities, and requirements and execute contracts. HERO health equity planning work is anticipated to begin in October 2024.

4. Medicaid Hospital Global Budget Initiative (MHGBI)

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

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

On March 26, 2024, the State submitted a Letter of Intent (LOI) expressing the desire to partner with CMS to design and implement the AHEAD model. This submission also included the LOI's from all hospitals eligible for HGB Payment Initiative. The State aligned on a region definition for the NYS AHEAD model on **May 29th, 2024**, though noted the possibility of expanding to additional counties in the future. The State also aligned on decisions for timing of the Medicaid HGB model on **June 21st, 2024.** The State submitted its application to participate in the AHEAD demonstration during the second Notice of Funding Opportunity (NOFO) period in Cohort 3 on August 12, 2024. The first year MHGBI funding was sent out in March 2024. On March 31, 2024, the State submitted a detailed plan for how participating hospitals will collect beneficiary demographic and HRSN data and related metrics. The State will begin engaging and recruiting providers for the AHEAD model after the award announcement in October 2024.

F. IMD Transformation Demonstration

State and National Medicaid Redesign initiatives recognized the critical role of SUD services; including residential treatment services, within the full continuum of services required to meet the triple aim of (1) improving the quality/experience of care, (2) improving the health of populations, and (3) reducing per capita costs of health care.

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

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

OASAS Certified Title 14 NYCRR Part 820 Residential Service Programs: Service Description

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

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

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

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

(OTP) certified by OASAS to facilitate patient access to full opioid agonist medication, if clinically appropriate.

Developing the Title 14 NYCRR Part 820 Provider Network:

- Effective 2015, OASAS began the process of re-designating all approved OASAS certified residential programs from Title 14 NYCRR Part 819 and Title 14 NYCRR Part 816.9 to Title 14 NYCRR Part 820 programs.
- Comprehensive Title 14 NYCRR Program regulations were enacted to define the Part 820 Program model and related operations requirements.
- Programs must complete and receive approval of the required application documents to obtain OASAS certification as Title 14 NYCRR Part 820 and complete the application for designation to provide each of the three elements (stabilization; rehabilitation; or reintegration). Programs may seek designation to offer any or all of the elements. Designation will be based upon a program's assessment of its current and future patient needs and overall program vision for the services it is best positioned to deliver to the community. Programs converting from the prior models are required to submit the Part 820 conversion application[6] and new programs must follow the certification process for new programs.[7]
- To support programs development/conversion to the Part 820 residential model, OASAS provided technical assistance sessions and developed a comprehensive set of technical assistance tools: readiness guidance documents, clinical manuals and fiscal modeling tools.[8]
- As of July 2024, statewide, there are a total of 150 Part 820 Programs. There are 52 remaining programs to convert from the previous residential or medically monitored model.

Service	Total Number of Programs	Total Number of Beds
Stabilization	9	227
Rehabilitation	10	491
Reintegration	69	1,717
Stabilization and Rehabilitation	16	658
Rehab and Reintegration	16	492
Stabilization Rehab and Reintegration	30	1,882
Grand Total	150	5,467

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

- Under the NYS 1115 MRT waiver, Title 14 NYCRR Part 820 services and programs were incorporated into the MMC benefit package and became a required network provider type.
- The current model contract[9] network requirements are:

  Urban counties: The network must include two providers per county.

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

Rural counties: The network must include two providers per region.

- NYS monitors network adequacy of Part 820 as part of routine plan compliance reviews.

Level of Care Determination

NYS utilizes the LOCADTR[10] tool to support level of care determination. The tool has been utilized over 2 million times by SUD providers and managed care utilization managers since 2014. The tool is a web-based decision algorithm that includes the full continuum of care and has a continuing care module to support continuing care decisions. OASAS supports the tool with asynchronistic training available and webinar trainings to support updates. Providers, MMC and commercial payers in NYS are required to use LOCADTR (unless otherwise approved by OASAS).

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

The Bureau of Narcotic Enforcement (BNE) continues to enhance and support clinicians in their usage of the NYS PMP registry with improved functionality and education, through combined support from NYSDOH and the CDC funded Overdose Data to Action – States Grant. The BNE works closely with NYS Information Technology Service (ITS) to build out the technical architecture to the PMP as needed for functionality. This includes the continuous monitoring of the NYS PMP registry for potential enhancements and weekly status meetings with NYS ITS. To enhance clinicians in their usage of the NYS PMP registry through education, BNE has reviewed the Opioid Prescriber Training for any language and technical deficiencies, which satisfies educational requirements in Public Health Law Article 33 §3309-a to raise healthcare provider awareness of the risks associated with prescribing and taking opioid pain medications. BNE will work with the contracted entity, State University of New York at Buffalo, to implement these necessary changes. When a healthcare provider takes the Opioid Prescriber Training course, there is a required pre and post-test. During the timeframe of 4/1/2024 through 6/30/2024, more than 9,600 healthcare providers took the Opioid Prescriber Training across nine different provider types. There was significant improvement in knowledge when comparing pre and post test scores, ranging from an increase of 11.54% to 31.36% for each category type. The 11.54% increase is an outlier for a single enrolled candidate for one role type. Without the outlier, the range is 19.52% to 31.36%.

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 6/30/2024, BNE has data sharing agreements with 36 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi and RxCheck hubs. This demonstrates an increase of one new interoperable state during

[10] https://oasas.ny.gov/locadtr
[11] https://commerce.health.state.ny.us

this time. BNE continues to work with the RxCheck Governance Board to aid in identification of state partners for interstate data sharing. In May 2022, BNE successfully integrated with the US Department of Veterans Affairs (VA). BNE continues to monitor the integration and collaborate with the VA, as needed.

In 2019, BNE directly integrated a pilot site's Electronic Health Records (EHR) system with the NYS PMP. Since then, BNE has expanded the number of users for this site from 13 to more than 6,500. The pilot site has continued to keep the Bureau apprised of successes and challenges. By assessing the challenges, BNE has determined two viable options for enhancing clinical workflow for prescribers and other state and federal stakeholders via EHR integration. The first option is integrating with the RxCheck hub. As of 6/30/2024, NYS ITS built the technical architecture to begin testing this option. The Division of Legal Affairs provides ongoing reviews of data use agreements pertaining to EHR integration. The second option for EHR integration is via the NYS Health Information Exchanges (HIEs). During the reporting period of April 2024 to June 2024, BNE in collaboration with the NYS Information Systems and Health Statistics Group (ISHSG), onboarded one additional NYS HIE, totaling two HIEs. Between both onboarded HIEs, more than 35 entities have access to the NYS PMP Registry. BNE continues to work with the NYS ISHSG to onboard additional HIEs and increase the number of users querying the PMP via this method.

VI. Evaluation of the Demonstration

On December 14, 2022, DOH submitted the 1115 evaluation design to CMS for review and approval. CMS returned the evaluation design with comments on April 18, 2023. DOH submitted a revised evaluation design to CMS on June 20, 2023, pending their review and approval. The evaluation design for the Managed Care Risk Mitigation COVID-19 PHE amendment was approved by CMS on January 10, 2023. The evaluation design for the Reasonable Opportunity Period (ROP) Extension COVID-19 PHE amendment was approved by CMS on October 25, 2023.

VII. Consumer Issues

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

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

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

MCO Product Line	Total Complaints	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
MMC	5,677	5,594
HARP	718	619
HIV SNP	67	87
Total MCO Complaints	**6,462**	**6,300**

As described in the table, MCOs reported 6,462 total enrollee complaints for the current quarter. This represents a 2.6% increase from the prior quarter's total of 6,300 enrollee complaints.

MCOs reported 5,677 MMC complaints this quarter, which is a 1.5% increase from the 5,594 of the previous quarter. The number of HARP complaints increased 16.0%, from 619 in the prior quarter to 718 this quarter. There were 67 HIV SNP complaints this quarter, which is a decrease of 23.0% when compared to the 87 from the previous quarter.

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

Description of Complaint	Percentage of Complaints	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Balance Billing	15%	15%
Difficulty with Obtaining: Dental/Orthodontia	12%	9%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	12%	14%
Reimbursement/Billing	7%	8%
Dissatisfaction with Obtaining: Specialist and Hospitals	5%	6%

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

Description of Complaint	Percentage of Complaints	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	23%
Difficulty with Obtaining: Personal Care	7%	3%
Dissatisfaction with Quality of Care	7%	9%
Difficulty with Obtaining: Dental/Orthodontia	6%	4%
Difficulty with Obtaining: Specialist and Hospitals	6%	5%

While reviewing data reported, DOH discovered a substantial increase in the number of complaints reported by two MCOs in the Difficulty with Obtaining: Personal Care category. The DOH is following up with these MCOs regarding the differences between the most recent quarter compared to the previous quarter.

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

Description of Complaint	Percentage of Complaints	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Dissatisfied with Provider Services (Non-Medical) or MCO Services	24%	24%
Dissatisfaction with Quality of Care	13%	3%
Difficulty with Obtaining: Dental/Orthodontia	12%	13%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	10%	16%
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	5%	16%

The DOH reviewed the increase in HIV/SNP enrollee complaints received from the MCOs regarding Dissatisfaction with Quality of Care. Upon examination, the increase stemmed from the number of HIV/SNP enrollee complaints in that complaint category reported by one MCO. DOH is following up with that particular MCO regarding the differences between the most recent quarter compared to the previous quarter.

B. Monitoring of Plan Reported Complaints

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

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

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

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

The DOH is in the process of calculating the OE ratio for the six-month period of January 1, 2024, through June 30, 2024.

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, DOH monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 6,462 total reported complaints/action appeals, MCOs reported 571 complaints and action appeals from their SSI recipients. This compares to 484 SSI complaints/action appeals from the previous quarter, representing an 18.0% increase.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Appointment Availability: PCP	2	0
Appointment Availability: Specialist	6	4
Appointment Availability: BH HCBS	2	1
Long Wait Time	1	2
Dissatisfaction with Quality of Care	42	33
Denial of Clinical Treatment	21	9
Denial of BH Clinical Treatment	1	1
Dissatisfied with Provider Services (Non-Medical) or MCO Services	121	130
Dissatisfaction with BH Provider Services	8	5
Dissatisfaction with Health Home Care Management	4	6
Difficulty with Obtaining: Specialist and Hospitals	31	25

Difficulty with Obtaining: Eye Care	5	1
Difficulty with Obtaining: Dental/Orthodontia	43	22
Difficulty with Obtaining: Emergency Services	1	0
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	3	0
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	7	14
Difficulty with Obtaining: Home Health Care	14	4
Difficulty with Obtaining: Personal Care	49	48
Difficulty with Obtaining: PERS	0	1
Difficulty with Obtaining: CDPAS	13	21
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	9	3
Access to Non-Covered Services	9	2
Access for Family Planning Services	0	0
Communications/ Physical Barrier	5	0
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	8	9
Recipient Restriction Program and Plan Initiated Disenrollment	0	1
Reimbursement/Billing	45	54
Balance Billing	48	43
Transportation	1	3
All Other	72	42
Total	**571**	**484**

DOH has reviewed the increase in overall complaints/action appeals MCOs reported for SSI recipients. The two categories with the largest changes were Difficulty with Obtaining: Dental/Orthodontia and All Other. This increase is limited to a select number of MCOs. DOH is following up with those MCOs regarding the differences reported.

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

Description of Complaint	**Percentage of Total Complaints/Appeals Reported for SSI Recipients**	
	FFY 24 Q3 4/1/2024–6/30/2024	**FFY 24 Q2 1/1/2024–3/31/2024**
Dissatisfied with Provider Services (Non-Medical) or MCO Services	21%	27%
Difficulty with Obtaining: Personal Care	9%	10%
Balance Billing	8%	9%
Reimbursement/Billing	8%	11%
Difficulty with Obtaining: Dental/Orthodontia	8%	5%

The DOH requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of April 1, 2024, through June 30, 2024, MCOs reported LTSS enrollment of 60,223 enrollees. This compares to 58,207 LTSS enrollees from the previous quarter, representing a 3.5% increase. The following table displays the number of LTSS enrollees by MCO for the most recent quarter and for the previous quarter:

Plan	Number of LTSS Enrollees	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Amida Care	1,260	1,265
Anthem	3,601	3,684
Capital District Physicians Health Plan	655	346
Excellus Health Plan	1,800	1,800
Fidelis Care	21,154	20,680
Healthfirst	16,604	15,718
Highmark	322	315
HIP of Greater New York	617	431
Independent Health Association	743	769
MetroPlus Health Plan	4,045	3,646
Molina Healthcare	3,311	3,107
MVP Health Plan	2,260	2,586
United Healthcare	3,425	3,414
VNS Choice	426	446
Total	**60,223**	**58,207**

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

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 24 Q3 4/1/2024–6/30/2024	FFY 24 Q2 1/1/2024–3/31/2024
Difficulty with Obtaining: AIDS Adult Day Health Care	0	1
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: CDPAS	64	58
Difficulty with Obtaining: Home Health Care	43	26
Difficulty with Obtaining: RHCF Services	6	4
Difficulty with Obtaining: Personal Care	178	129
Difficulty with Obtaining: PERS	5	2
Difficulty with Obtaining: Private Duty Nursing	12	20
Total	**308**	**240**

The DOH is noting an increase in enrollee complaints received from the MCOs throughout the above categories. Upon examination, the increase was consistent among MCOs. The DOH will begin tracking this to see if any trends emerge.

D. Critical Incidents

The DOH requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 270 critical incidents reported for the April 1, 2024, through June 30, 2024, period, most of which have a resolved status. Many of the incidents stemmed from enrollee falls.

The DOH works with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers. Corrective guidance has been provided to one plan which was not reporting information in line with expected metrics based upon the plan's size and population spread throughout the state. This has resulted in an increase in the reporting of incidents by this plan.

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

Plan	Critical Incidents		
	FFY 24 Q3 4/1/2024–6/30/2024	**FFY 24 Q2 1/1/2024–3/31/2024**	**Net Change**
Mainstream Medicaid Managed Care Plans			
Anthem	4	3	+1
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	7	12	-5
Fidelis Care	66	2	+64
Healthfirst	74	61	+13
HIP of Greater New York	0	0	0
Highmark	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	1	0	+1
United Healthcare	0	0	0
Total	**152**	**78**	**+74**
Health and Recovery Plans			
Anthem	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	1	2	-1
Fidelis Care	51	0	+51
Healthfirst	63	28	+35
HIP of Greater New York	0	0	0

Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**115**	**30**	**+85**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	3	2	+1
Total	**3**	**2**	**+1**
Grand Total	**270**	**110**	**+160**

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

Category of Incident	Critical Incidents		
	FFY 24 Q3 4/1/2024–6/30/2024	**FFY 24 Q2 1/1/2024–3/31/2024**	**Net Change**
Mainstream Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	14	4	+10
Crimes Committed Against Enrollee	3	5	-2
Crimes Committed by Enrollee	4	2	+2
Instances of Abuse of Enrollees	8	2	+6
Instances of Exploitation of Enrollees	0	2	-2
Instances of Neglect of Enrollees	8	2	+6
Medication Errors that Resulted in Injury	1	1	0
Other Incident Resulting in Hospitalization	42	15	+27
Other Incident Resulting in Medical Treatment Other Than Hospitalization	67	45	+22
Use of Restraints	5	0	+5
Wrongful Death	0	0	0
Total	**152**	**78**	**+74**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	16	2	+16
Crimes Committed Against Enrollee	12	2	+14
Crimes Committed by Enrollee	1	0	+1

Instances of Abuse of Enrollees	3	1	+2
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	3	0	+3
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	14	3	+11
Other Incident Resulting in Medical Treatment Other Than Hospitalization	56	22	+34
Use of Restraints	10	0	+10
Wrongful Death	0	0	0
Total	**115**	**30**	**+85**
HIV Special Needs Plans			
Any Other Incidents as Determined by the Plan	0	0	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	0	0
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	2	0	+2
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	0	0	0
Other Incident Resulting in Medical Treatment Other Than Hospitalization	1	2	-1
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**3**	**2**	**+1**
Grand Total	**270**	**110**	**+160**

The DOH has reviewed the increase in overall critical incidences and has found that these are mainly focused on two specific plans. This office is following up with these particular MCOs regarding the differences between the information reported this quarter and last quarter.

E. Enrollee Complaints Received Directly by the DOH

In addition to the MCO reported complaints, the DOH directly received 80 enrollee complaints this quarter. This total is a 19.2% decrease from the previous quarter, which reported 99 enrollee complaints.

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

MCO Enrollee Complaints Received Directly by the DOH	
FFY 24 Q3 4/1/2024–6/30/2024	**FFY 24 Q2 1/1/2024–3/31/2024**
80	**99**

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

Percentage of MCO Enrollee Complaints Received Directly by the DOH		
Description of Complaint	**FFY 24 Q3 4/1/2024–6/30/2024**	**FFY 24 Q2 1/1/2024–3/31/2024**
Difficulty with Obtaining: Home Health Care	26%	18%
Difficulty with Obtaining: Dental/Orthodontia	10%	9%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	8%	14%
Difficulty with Obtaining: CDPAS	6%	3%
All Other	6%	3%

We are continuing to see increases within the Difficulty with Obtaining: Home Health Care category. This increase looks more pronounced due to an overall decrease in the amount of all complaints. The Problems with Advertising/ Consumer Education/ Outreach/ Enrollment category has returned to previously reported levels.

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

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

F. Fair Hearings

There were 188 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of April 1, 2024, through June 30, 2024. The dispositions of these fair hearings for the most recent quarter and for the previous quarter are as follows:

Fair Hearing Decisions (Includes MMC, HARP, and HIV SNP)		
Hearing Dispositions	**FFY 24 Q3 4/1/2024–6/30/2024**	**FFY 24 Q2 1/1/2024–3/31/2024**
In favor of Appellant	74	93
In favor of Plan	105	104
No Issue	9	15
Total	**188**	**212**

For fair hearing dispositions occurring for the most recent quarter and for the previous quarter, the following table displays the number of days from the initial request for a fair hearing to the final disposition of the hearing, including time elapsed due to adjournments:

Days Between Fair Hearing Request and Decision Date (Includes MMC, HARP, and HIV SNP)		
Decision Days	**FFY 24 Q3 4/1/2024–6/30/2024**	**FFY 24 Q2 1/1/2024–3/31/2024**
0-29	0	2
30-59	28	32
60-89	42	45
90-119	25	27
=>120	93	106
Total	**188**	**212**

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

The MMCARP met on June 20, 2024. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment, and an update on the status of the MLTC program. There was one additional agenda item, a BH update presented by staff from the OMH, Sarah Kuriakose, Meredith Ray-Labatt, and Stacey Hale. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for September 19, 2024.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

During the reporting period, staff activities were focused on calculating MLTC quality, satisfaction, efficiency, and compliance measures. Activities included: testing over time quality and potentially avoidable hospitalizations measures that had not been calculated since before the COVID pandemic when assessments were performed every six months, running satisfaction measures, and sharing output with health plans for review and feedback. Additionally, DOH staff work closely with IPRO on developing the 2023 MLTC Satisfaction Survey Report. Finally, staff actively managed the MLTC_OQPS@health.ny.gov mailbox to ensure timely response to stakeholder inquiries.

B. Quality Measurement in Medicaid Managed Care

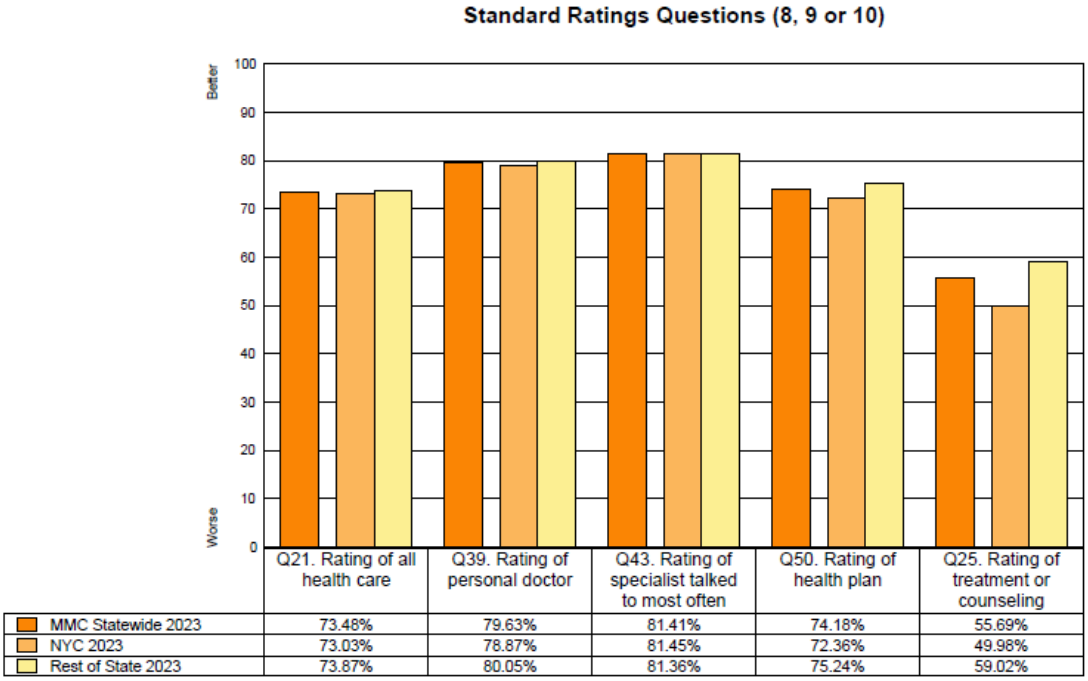
Quality Measure Benchmarks 2022 (Measurement Year 2022)

Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2022, national benchmarks were available for 64 measures for Medicaid. Out of the 64 measures that NYS Medicaid plans reported, 75% of measures met or exceeded national benchmarks. NYS consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid rates exceed the national benchmarks for BH on adult measures (e.g., receiving follow-up within seven and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). NYS managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, and cervical cancer), and children and adolescent preventative measures (Well-child visits during first 30 months of life, well-care visits among children aged 3-21 years old, and immunization). Considering this was during a period of COVID-19 impacts in New York, the data demonstrates that many aspects of quality of care remained high for New Yorkers on Medicaid.

2023 Satisfaction Survey

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

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



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

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

C. Quality Improvement

External Quality Review
IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and

validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities administering additional surveys of enrollee experience; and providing data processing and analytical support to the DOH. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, and HARPs, and include the state's Child Health Insurance Program (CHP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

Annual EQRO Technical Reports
In the month of April, IPRO completed their edits to the Mainstream/Child Health Plus/HIV SNP/HARP and Managed Long-Term Care reports. The DOH reviewed the edits and submitted the reports to CMS and posted them on the NYSDOH website by the April 30 due date. In June, DOH and IPRO started the process for the next cycle of the 2023 Annual Technical Reports.

Provider Related and Access Activities
At the beginning of the third quarter, the Access and Availability & Provider Directory survey results were issued to the MMC plans. IPRO is preparing to start the next iteration of survey calls. As of August 2024, the provider directory and appointment availability activities survey will be separated into two parts.

For the next member services survey, the DOH team was at work revising the data collection tool and the questions for the survey. The final reports of the Member Survey were completed. In June, IPRO followed up with one plan to provide technical assistance and submitted an updated and revised report.

IPRO shared the PCP ratio survey results with DOH and the plans during the month of April. In early June, DOH and IPRO met to discuss this year's rollout of the PCP survey.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the PNDS. The PNDS collects network information from approximately 400 active networks in NYS. IPRO and their subcontractors, RMCI and Quest Analytics, facilitated ongoing adjustments and fixes and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion, and maintenance. The quarter 2 2024 (April-June 2024) PNDS submission deadline was July 30th, 2024; plans submit data based on version 11 of the data dictionary.

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

PANEL:
Panel data submission opened for Q1 2024 data collection on May 1st and yielded 6,756,973 rows of data, which is approximately 1% less than previous quarter. Technical assistance was provided by DOH and IPRO throughout the submission, particularly around new edits

implemented. DOH provided detailed analytics to plans about failing newly updated requirements.

Managed Long-Term Care:

Performance Improvement Projects (PIPs)
The 2023 Social Determinants of Health (SDoH) PIP final reports were reviewed and finalized by IPRO in the month of April. In June, the 2023 final reports were approved by DOH. IPRO continued to work on the final report summaries for DOH. In June, all the new 2024-2025 Depression Screening PIP proposals were submitted, and their initial reviews were conducted.

MLTC Member Satisfaction Survey
In April, IPRO received comments and edits to the Satisfaction Survey report. In June, IPRO finalized the Satisfaction Survey report and sent the report to the plans including their plan-specific results.

Focused Clinical Study: Focused Clinical Study of Reliability of the Telehealth Mode for Uniform Assessment System for New York (UAS-NY) Community Health Assessment (CHA) in the Managed Long-Term Care Population.
The Telehealth clinical study final report has been completed. IPRO is awaiting DOH executive approval of the report.

Quality Measurement
IPRO has confirmed this year's contacts for all plans and vendors and confirmed that the product lines matched. The list was provided to the DOH QARR team in April. The EQRO finished setting up the QARR 2023 folder for submissions. By May, IPRO updated the validation programs. During this time, the National Committee for Quality Assurance (NCQA) submissions have been delayed and were due on June 28; this was due to the Change Healthcare cyber-attack.

DataStat has sent in some of the reports for the CAHPS Adult Survey. The CAHPS Adult survey was published on the NYS site by June. IPRO reached out to DataStat about starting the new set of Surveys this fall.

PIPs for MMCs:

2022-2023 MMC and HIV SNP PIP: Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members
The 2022-2023 PIP was completed in December 2023. The Managed Care Plans worked on preparing the submitted Final Reports and will send them to Office of Health Services Quality and Analytics (OHSQA) for review by 7/9/2024.

2024-2025 MMC, CHP and HIV SNP PIP: Improving Rates of Cancer Screening and Prevention for MMC, CHP, and HIV SNP Members
The PIP Proposals were all submitted and reviewed by IPRO and NYSDOH from April and continuing through June. Feedback was provided to the health plans and any necessary revisions were made. In May, IPRO prepared and distributed a Frequently Asked Questions (FAQ) document to the health plans to answer PI-related questions.

2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus
The 2022-2023 PIP was completed in December 2023. IPRO were in the process of reviewing the submitted Final Reports and will send them to OHSQA for review by 7/9/2024.

2024-2025 HARP PIP: 2024-2025 Continuous Engagement in Care and Treatment
On April 11, 2024, IPRO held a Webex to introduce the HARP plans to the topic of the 2024-2025 HARP PIP: Continuous Engagement in Care and Treatment. The background document, and additional resources were provided to the plans following the webinar. Subsequently, there was another Webex on April 17, 2024, presented by the NYS OMH, to introduce the HARP plans to the PSYCKES platform for their data monitoring. The HARP plans submitted their HARP PIP proposals to OHSQA on May 23, which were shared with IPRO, OMH, and NYS OASAS. The PIP Proposals were reviewed by OHSQA, OMH, and OASAS and the feedback was provided to IPRO to combine with their feedback for the HARP plans. Currently the HARP plans are revising their Proposals and the due date for finalizing the Proposals is August 8, 2024.

Breast Cancer Selective Contracting
In April, staff met with the Medical Director from the OHSQA and a coding expert from the Office of Health Insurance Programs (OHIP) to review current methodologies and explore if modifications were needed. Based on this review, it was decided to remove ICD-10-PCS destruction codes from the breast cancer surgical volume calculation criteria since these codes are not typically used for mastectomies and lumpectomies. An internal analysis determined that destruction codes were reported on just one breast cancer surgery performed from January 1, 2020, through December 31, 2022, therefore the impact to volume calculations will be negligible.

Staff began updating statical programs and project documents in preparation for the summer review of breast cancer surgical volume data which will be pulled in early July.

Patient Centered Medical Home (PCMH)
Federal Fiscal Quarter: 3 (4/1/2024-6/30/2024)

As of June 2024, there were 8,941 NCQA-recognized Patient-Centered Medical Home (PCMH) providers and 2,156 practices in NYS. All providers are recognized under the standards of NYS PCMH, a recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, VBP arrangements, and health information technology capabilities. Of the 8,941 recognized providers in June, 60 were newly enrolled in the program in April and May.

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

The Adirondack Medical Home demonstration (‘ADK’), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2024 but discussions around alignment of methods for shared savings models are still not finalized.

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

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

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

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 May,2024:

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

As of the May 2024 reporting month, NYS data meets the Critical-Priority and Expenditures criteria target of OBA and is 2% below the target for High-Priority criterion. The State is actively working on addressing the identified high priority issues to meet the High-Priority criterion of OBA. NYS continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues, and engage in efforts to resolve identified data quality issues.

The state has also instituted a Data Governance workgroup for T-MSIS, to help facilitate the resolution of identified data issues. This group works with the state's T-MSIS team and the SMEs (subject matter experts) to determine when data quality issues are flagged due to reporting

nuances as an outcome of program or policy under the state's approved Medicaid plan. The Data Governance workgroup supports the team's SME review(s) and provides supplemental state guidance documentation.

All these joint efforts are used to facilitate a better understanding of the NYS Medicaid program and service population(s) as reflected in the T-MSIS data submissions.

The NYS T-MSIS files are now compliant with the newer DD v3.0.0 layout as per the CMS requirement. The T-MSIS File Layout v4.x.x Specifications are currently under evaluation for implementation in near future.

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

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Uploaded to PMDA: August 28, 2024

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	8	0	0	0	0	0	5	3	0	6254	0.13%
Archcare Community Life	23	0	0	0	2	0	12	9	0	3710	0.62%
Archcare PACE	15	0	0	0	0	0	6	8	1	821	1.83%
Catholic Health-LIFE	13	0	4	0	0	1	5	3	0	233	5.58%
Centerlight PACE	84	0	0	0	0	0	30	43	11	6291	1.34%
Centers Plan for Healthy Living	904	1	0	1	21	5	256	620	0	53037	1.70%
Centers Plan for Healthy Living MAP	52	0	0	0	4	3	13	32	0	1836	2.83%
Complete Senior Care	5	0	0	0	0	0	0	5	0	135	3.70%
Eddy SeniorCare	13	0	0	0	0	0	9	4	0	402	3.23%
Elant Choice (EverCare)	2	0	0	0	0	0	1	1	0	240	0.83%
Elderplan MAP	6	0	0	0	4	0	0	2	0	4241	0.14%
Elderserve	483	0	0	1	4	4	271	203	0	18779	2.57%
Elderserve MAP	11	0	0	0	0	0	3	8	0	313	3.51%
Elderwood	28	0	0	0	0	0	2	6	20	391	7.16%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	58030	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	154	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	158	0.00%
Fidelis Care at Home	68	0	0	1	5	9	31	22	0	18749	0.36%
Fidelis MAP	9	0	0	0	0	0	2	7	0	1456	0.62%
Hamaspik	203	0	0	0	3	6	75	75	44	7993	2.54%
Hamaspik MAP	32	0	0	2	1	1	14	11	3	932	3.43%
Healthfirst CompleteCare	263	0	0	0	5	6	123	110	19	30588	0.86%
HomeFirst, Inc. (Elderplan)	5	0	0	0	4	0	0	1	0	24144	0.02%
Icircle	0	0	0	0	0	0	0	0	0	3988	0.00%
Independent Living for Seniors (ILS/ElderOne)	1	0	0	0	1	0	0	0	0	749	0.13%
Independent Living Services of CNY (PACE CNY)	17	0	0	0	0	0	9	8	0	564	3.01%
Kalos ErieNiagara DBA: First Choice Health	10	0	0	0	2	0	8	0	0	987	1.01%
MetroPlus MAP	5	0	0	0	0	0	0	5	0	193	2.59%
MetroPlus	7	0	0	0	0	1	1	5	0	2007	0.35%
Prime	5	0	0	0	0	0	1	4	0	182	0.05%

Senior Health Partners	0	0	0	0	0	0	0	0	0	9495	0.00%
Senior Network Health, LLC	1		0	0	0	0	1	0	0	225	0.44%
Senior Whole Health	76	0	0	1	0	2	33	29	11	28782	0.26%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	297	0.00%
Total Senior Care	14	0	0	0	0	0	5	9	0	127	11.02%
Village Care	139	0	0	0	7	0	35	97	0	24135	0.58%
Village Care MAP	42	0	0	0	6	0	11	25	0	3122	1.35%
VNA Homecare Options (Nascentia Health Options)	208	0	0	2	8	1	73	124	0	5785	3.60%
VNS Choice MAP TOTAL	62	0	0	0	8	1	14	39	0	4583	1.35%
VNS Choice MLTC	456	0	0	0	31	1	99	325	0	24645	1.85%
total	3270	1	4	8	116	41	1148	1843	109	348753	0.94%

Managed Long Term Care Partial Capitation Plan Enrollment Jul 2023 to Jun 2024												
	Jul-23	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5791	5825	5885	5919	6000	6070	6089	6078	6120	6184	6264	6313
ArchCare Community Life	5824	5865	5885	5858	5858	5870	5830	5796	5756	5651	5480	0
Centers Plan for Healthy Living	50814	51037	51311	51557	52051	52418	52712	52623	52674	52982	53051	53079
Elant	780	776	782	779	775	767	762	754	741	720	0	0
Elderplan	19460	19877	20184	20598	21083	21444	21918	22146	22676	23188	24438	24806
Elderserve	16452	16615	16728	16793	16949	17098	18367	18374	18478	18624	18813	18900
Elderwood	1130	1137	1121	1123	1135	1169	1248	1238	1228	1172	0	0
Extended MLTC	5583	0	0	0	0	0	0	0	0	0	0	0
Fallon Health Weinberg (TAIP)	806	799	783	728	642	467	0	0	0	0	0	0
Fidelis Care at Home	16688	16774	16853	16962	17436	17665	17800	18330	18456	18653	18817	18776
Hamaspik Choice	1982	7516	7474	7490	7533	7649	7706	7735	7811	7907	8006	8066
HealthPlus- Amerigroup	53251	54024	54488	55260	56160	56458	56466	56431	57019	57534	58036	58521
iCircle Services	3539	3538	3563	3568	3602	3624	3682	3683	3771	3911	3999	4054
Kalos Health- Erie Niagara	599	625	647	710	780	850	938	942	935	956	997	1007
MetroPlus MLTC	1382	1430	1472	1527	1565	1620	1652	1735	1777	1878	2002	2141
Montefiore HMO	1313	1295	1302	1281	1267	1235	0	0	0	0	0	0
Prime Health Choice	582	585	587	581	578	572	575	571	563	546	0	0
Senior Health Partners	9122	9117	9120	9118	9113	9182	9157	9455	9460	9460	9515	9509
Senior Network Health	327	336	342	344	341	342	343	343	346	344	331	0
Senior Whole Health	26394	26603	26882	26870	27079	27410	27672	27796	28297	28648	28900	28799
Village Care	18329	18682	19156	19523	20095	20608	20796	20998	21389	21885	22387	28132
VNA HomeCare Options	4305	4482	4596	4751	4870	5026	5199	5328	5448	5670	5772	5914
VNS Choice	23703	23727	23640	23498	23664	23789	23568	23335	23317	23438	25137	25361
Total	**268,156**	**270,665**	**272,801**	**274,838**	**278,576**	**281,333**	**282,480**	**283,691**	**286,262**	**289,351**	**291,945**	**293,378**

Managed Long Term Care MAP Enrollment Jul 2023 to Jun 2024												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	878	904	956	1035	1050	1075	1118	1116	1131	1152	1181	1283
Hamaspik	746	778	798	834	831	829	840	848	852	849	900	916
Agewell	121	117	116	122	125	123	117	109	85	0	0	0
Centers	1463	1524	1560	1592	1642	1634	1641	1588	1553	1698	1745	1768
Elderplan	3243	3301	3331	3379	3422	3462	3485	3524	3647	3795	3927	4005
Elderserve	178	185	193	196	205	219	245	261	282	278	279	291
Healthfirst Complete Care	24657	25098	25509	25789	26159	26536	26897	27297	27649	28341	28866	29416
Healthplus	179	172	167	166	147	127	119	113	116	121	130	135
Metroplus	87	109	125	131	142	149	159	168	173	172	170	177
Senior Whole Health	153	169	170	179	188	201	221	227	249	252	265	286
VNS	3485	3575	3634	3707	3802	3886	3957	3946	3886	4172	4308	4393
Village Care	2553	2578	2591	2594	2635	2650	2689	2672	2629	2787	2869	2952
Total	**37743**	**38510**	**39150**	**39724**	**40348**	**40891**	**41488**	**41869**	**42252**	**43617**	**44640**	**45622**

Managed Long Term Care FIDA-IDD Plan Enrollment Jul 2023 to Jun 2024												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1710	1720	1724	1733	1728	1723	1717	1711	1703	1690	1683	1699

Managed Long Term Care PACE Plan Enrollment Jul 2023 to Jun 2024												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	715	742	765	782	786	793	793	805	799	807	803	809
CHS Buffalo Life	240	239	233	235	236	231	226	227	228	229	233	233
Complete Senior Care	127	129	128	131	130	134	137	135	133	136	138	135
Comprehensive Care Management	5873	6032	6116	6156	6278	6322	6333	6372	6379	6331	6313	6348
Eddy Senior Care	319	335	338	345	351	344	341	357	370	360	375	383
Fallon Health Weinberg PACE	145	147	149	152	155	152	115	154	161	156	157	161
Independent Living For Seniors	730	736	734	741	753	754	752	749	750	748	744	755
Pace CNY	523	519	530	533	542	548	556	559	558	551	546	545
Total Senior Care	130	128	133	133	132	133	131	129	127	131	128	129
Total	**8802**	**9007**	**9126**	**9208**	**9363**	**9411**	**9384**	**9487**	**9505**	**9293**	**9280**	**9337**