DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

December 18, 2025

Amir Bassiri
Medicaid Director, Deputy Commissioner
New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Director Amir Bassiri:

The Centers for Medicare & Medicaid Services (CMS) completed its review of New York's Final Report for the COVID-19 Public Health Emergency (PHE) amendment for the demonstration entitled, "Medicaid Redesign Team" (Project Number 11-W-00114/2). This report covers the demonstration period from April 1, 2020, through March 31, 2021. CMS determined that the Final Report, submitted on April 22,2025 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website. CMS will also post the Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration under these extraordinary circumstances. We look forward to our continued partnership on New York's section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
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Date: 2025.12.18 12:07:03 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Melvina Harrison, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

New York State Managed Care Risk Mitigation Arrangements COVID-19 Public Health Emergency

Evaluation Report

Report prepared by the Public Consulting Group

Report Submittal Date: 4/22/2025

PUBLIC CONSULTING GROUP

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A. EXECUTIVE SUMMARY

DEMONSTRATION BACKGROUND AND GOALS

The Centers for Medicare and Medicaid Services (CMS) approved the State of New York's application for a Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) section 1115 demonstration amendment to the state's existing section 1115 demonstration in January 2022. The state applied the flexibilities allowed under the PHE amendment during the state's 2020—2021 fiscal year, from April 1, 2020, through March 31, 2021.

In response to the unprecedented emergency circumstances of the COVID-19 pandemic, CMS allowed New York an exemption from the regulatory prohibition in 42 C.F.R. § 438.6(b)(1) to add or modify Medicaid Managed Care risk sharing mechanisms after the start of risk rate periods.

Allowing these risk mitigation flexibilities through the PHE amendment was intended to allow for equitable and appropriate payments to support the stability of the state's managed care arrangements and maintain provider capacity and beneficiary access to care.

FINDINGS

In the absence of the PHE amendment's flexibilities, the New York Medicaid Managed Care program, health plans, and beneficiaries may have all experienced adverse outcomes. While the PHE amendment allowed an exemption from the regulatory prohibition to add or modify Medicaid Managed Care risk sharing mechanisms after the start of risk rate periods, the only risk sharing mechanism impacted in New York by the PHE amendment was the COVID-19 two-sided risk corridor. The risk corridor allowed the health plans the ability to provide services to Medicaid beneficiaries and maintain access, quality, and coverage.

The accuracy of payments to the Managed Care plans was assessed by reviewing the remittances associated with the COVID-19 risk corridor. Across the Medicaid Managed Care programs (Mainstream Managed Care (MMC), Health and Recovery Plan (HARP), HIV Special Needs Plan (HIV SNP), Managed Long Term Care Partial Capitation (MLTC) and Medicaid Advantage Plus (MAP)), the state received a total of approximately $16.0 million in remittances from the health plans. This represents 0.03% of the total premiums (approximately $43.8 billion) the health plans collected in SFY 2020-2021. The net $16.0 million in payments to the state indicates that actual service expenditures incurred by health plans during the PHE period were slightly lower than premium funding provided by the state, resulting in net risk corridor payments to the state.

CONCLUSIONS

Under the PHE amendment, the state successfully implemented a retroactive, two-sided COVID-19 risk corridor that supported the Medicaid Managed Care program and plans' ability to provide appropriate services to Medicaid beneficiaries and maintain access, quality, and coverage during the PHE. If health plans were uncertain that they would be adequately reimbursed, they may have been more reluctant to provide services, leading to beneficiaries not receiving needed care. The state closely monitored the implementation of the PHE amendment. The COVID-19 risk corridor resulted in net payments to the state that make up less than 1% of the total aggregate premiums collected by the health plans during the relevant rate period. The corridor results at the Medicaid Managed Care Program level (MMC, HARP, HIV SNP, MLTC, and MAP) ranged from less than 1% to 2% of premiums with both payments to the state and payments to health plans.

B. GENERAL BACKGROUND INFORMATION

A.1. DEMONSTRATION NAME AND TIMING

On January 18, 2022, CMS approved the State of New York's application for a Managed Care Risk Mitigation COVID-19 PHE section 1115 demonstration amendment to the state's "New York Medicaid Redesign Team" section 1115(a) demonstration. For the purposes of this report, the Managed Care Risk Mitigation COVID-19 PHE section 1115 demonstration amendment will be referred to as the "PHE amendment."

The PHE amendment was authorized to be in effect retroactively from March 1, 2020, through 60 days after the end of the COVID-19 PHE. The COVID-19 PHE ended on May 11, 2023. New York State applied the managed care risk mitigation strategies of the PHE amendment during the state's 2020-2021 fiscal year, from April 1, 2020, through March 31, 2021.

A.2. DEMONSTRATION AMENDMENT GOALS

In response to the unprecedented emergency circumstances of the COVID-19 pandemic, CMS allowed New York an exemption from the regulatory prohibition in 42 C.F.R. § 438.6(b)(1) to add or modify Medicaid Managed Care risk sharing mechanisms after the start of risk rate periods.

New York State's Medicaid Managed Care program seeks to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. Allowing these risk mitigation flexibilities through the PHE amendment was intended to allow for equitable and appropriate payments to support the stability of the state's managed care arrangements and maintain provider capacity and beneficiary access to care.

A.3 DEMONSTRATION AMENDMENT CONTEXT

The COVID-19 PHE was in effect in the United States from late January 2020 through May 2023. In response to the widespread disruption and uncertainty associated with the novel 2019 coronavirus pandemic, the PHE allowed for numerous flexibilities in both public and private health insurance enrollment, coverage, and access to care. Medicare and Medicaid beneficiaries had access to testing, treatment, and vaccines for COVID-19 without any cost-sharing. Medicaid followed a continuous enrollment provision, providing continuous eligibility and no increases in premiums for beneficiaries throughout the duration of the PHE.[1] The impact of the COVID-19 pandemic on utilization of services for beneficiaries enrolled in New York's Medicaid Managed Care program was largely unknown due to the unprecedented nature of the pandemic. The Managed Care Risk Mitigation COVID-19 PHE amendment was one of many flexibilities implemented by the state's Medicaid program during this period.

[1] What Happens When COVID-19 Emergency Declarations End? Implications for Coverage, Costs, and Access | KFF

C. EVALUATION QUESTIONS

The evaluation report examines the overarching hypothesis that the implementation of the PHE amendment and its flexibility with risk mitigation arrangements supported the New York Medicaid Managed Care program's ability to provide appropriate, equitable payments during the COVID-19 PHE to help maintain provider capacity and beneficiary access to care.

The evaluation questions addressed in this final report are grouped into four categories: PHE amendment implementation, monitoring and documentation, impact, and lessons learned.

1. PHE AMENDMENT: IMPLEMENTATION

1.1: In what ways during the COVID-19 PHE did the PHE amendment support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

1.2: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid Managed Care plans?

1.3: What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?

2. PHE AMENDMENT: MONITORING AND DOCUMENTATION

2.1: Did New York State Medicaid agency appropriately monitor the effectiveness of the risk mitigation arrangements implemented as part of the state's response to the COVID-19 PHE during the rate periods affected by the COVID-19 PHE?

3. PHE AMENDMENT: IMPACT

3.1: In the context of the COVID-19 PHE, did an exemption from the regulatory prohibition of retroactive risk sharing promote the objectives of the NYS Medicaid Managed Care program?

3.2: Did the implementation of risk mitigation after the start of the rating period outweigh the harms of not allowing retroactive risk sharing during a public health emergency?

3.3: Was there any adverse impact to the eligibility, enrollment, and coverage of Medicaid Managed Care beneficiaries because of this demonstration?

3.4: To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the Managed Care plans?

4. PHE AMENDMENT: LESSONS LEARNED

4.1 What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?

C. METHODOLOGY

C.1. DATA SOURCES

The evaluation utilized the following qualitative and quantitative data sources:

- Qualitative interviews with New York State Medicaid agency staff (Appendix A: Qualitative Interview Guide)
- Background materials developed by New York State Medicaid Managed Care program describing the PHE Amendment flexibilities around retroactive risk mitigation arrangements and the COVID-19 Risk Corridor
- SFY 2020-2021 Medical Loss Ratio (MLR) Reporting for Managed Care Programs (MMC, HARP, HIV-SNP, MLTC, MAP)
- SFY 2020-2021 COVID-19 Two-Sided Risk Corridor Results for Managed Care Programs (MMC, HARP, HIV-SNP, MLTC, MAP)

C.2. ANALYTIC METHODS

The evaluation synthesized information gathered from qualitative interviews with agency staff, contextual background information from program materials, and quantitative data extracted from the MLR and COVID-19 Risk Corridor reports.

Interview guides were developed based on the evaluation design document and evaluation questions. Key findings around successes, challenges, and lessons learned were extracted and grouped from the qualitative data gathered from the semi-structured interviews.

Descriptive statistics were applied to analyze the MLR and COVID-19 Risk Corridor reports.

C.3. LIMITATIONS

In accordance with CMS guidance for the design of this evaluation, PCG did not engage in extensive primary data collection that would prove burdensome or impractical. The evaluation does not include qualitative data collection directly from health plans. Additionally, PCG did not produce the MLR reports or COVID-19 Risk Corridor calculations. The evaluation relies on data produced by the state.

D. FINDINGS

1. PHE AMENDMENT: IMPLEMENTATION

Evaluation Question 1.1: In what ways during the COVID-19 PHE did the PHE amendment support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

The state Medicaid Managed Care program applied the flexibilities allowed by the PHE amendment during SFY 2020-2021, from April 1, 2020, through March 31, 2021. Under the amendment, the state introduced a new risk mitigation arrangement during this period: COVID-19 Two-Sided Risk Corridor. A target MLR was selected for each managed care program, and the MCO and New York/Federal Government gain/loss during SFY 2020-2021 was calculated based on the actual MLR. The state was able to settle the COVID-19 Risk Corridor for SFY 2020-2021 after the rate periods had closed, under the guidelines of the amendment.

Additional risk mitigation and adjustment arrangements that the state applies in the Medicaid Managed Care program, including Behavioral Health Expenditure Targets, Clotting Factor Products and Services Reconciliation, Health Home Reconciliation, Minimum Wage Reconciliation, Nursing Home Transition Add On, Nursing Home Price Mitigation Pool, Risk Corridor VNS and Stop Loss were not altered or impacted by the PHE amendment.

COVID-19 Risk Corridor Calculation (MMC, HARP, HIV SNP, MAP)		
MLR Corridor Definition	**MCO Share of Gain/Loss in the Corridor**	**New York/Federal Government Share of Gain/Loss in the Corridor**
Less than target MLR – 4%	0%	100%
Target MLR – 4% to target MLR -2%	50%	50%
Target MLR -2% to target MLR +2%	100%	0%
Target MLR +2% to target MLR +4%	50%	50%
Greater than Target MLR +4%	0%	100%

Table 1: Methodology New York State used to calculate the COVID-19 Risk Corridor for the MMC, HARP, HIV SNP, and MAP Managed Care Programs

COVID-19 Risk Corridor Calculation (MLTC)		
MLR Corridor Definition	**Contractor Share of Gain/Loss in the Corridor**	**New York/Federal Government Share of Gain/Loss in the Corridor**
Less than target MLR – 4%	0%	100%
Target MLR – 4% to target MLR -2%	50%	50%
Target MLR -2% to target MLR +5%	100%	0%
Target MLR +2% to target MLR +7%	50%	50%
Greater than Target MLR +7%	0%	100%

Table 2: Methodology New York State used to calculate the COVID-19 Risk Corridor for the MLTC Program

Evaluation Question 1.2: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid Managed Care plans?

Agency stakeholders identified several challenges associated with implementing the PHE amendment, primarily related to deviating from the typical or standardized procedures and practices for the Medicaid Managed Care program. They noted that due to the changes in standard operating procedures, it took longer to close out reporting from this period. Finalizing the methodology to set the target MLR took several rounds of iteration between the state, their actuarial partners, and CMS.

Evaluation Question 1.3: What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?

Stakeholders emphasized the importance of consistent, regular communication with their partners and the health plans was critical to addressing the challenges associated with deviating from standard processes and retroactively applying a COVID-19 risk corridor.

2. PHE AMENDMENT: MONITORING AND DOCUMENTATION

Evaluation Question 2.1: Did New York State Medicaid agency appropriately monitor the effectiveness of the risk mitigation arrangements implemented as part of the state's response to the COVID-19 PHE during the rate periods affected by the COVID-19 PHE?

The state provided the evaluator with the MLR reports and COVID-19 risk corridor reconciliation reports required to assess the effectiveness of the risk mitigation arrangements implemented as part of the state's response to the COVID-19 PHE during SFY 2020-2021, the only rate period during which the state implemented the provisions allowed under the PHE amendment.

3. PHE AMENDMENT: IMPACT

Evaluation Question 3.1: In the context of the COVID-19 PHE, did an exemption from the regulatory prohibition of retroactive risk sharing promote the objectives of the NYS Medicaid Managed Care program?

Evaluation Question 3.2: Did the implementation of risk mitigation after the start of the rating period outweigh the harms of not allowing retroactive risk sharing during a public health emergency?

In qualitative interviews with agency stakeholders involved with the implementation of the PHE amendment, staff noted that in the absence of the PHE amendment's flexibilities, the Medicaid Managed Care program, health plans, and beneficiaries may have all been negatively impacted. Medicaid Managed Care program staff observed that as a result of the uncertainty in utilization of services and costs associated with the pandemic, the Medicaid Managed Care program may have experienced undue cost if the health plans were unable to provide the services that were initially built into the rates. State staff shared their views that if health plans were uncertain that they would be adequately reimbursed, they may have been more reluctant to provide services, leading to beneficiaries not receiving needed care.

The exemption from the regulatory prohibition of retroactive risk sharing, and the retroactive implementation of the COVID-19 two-sided risk corridor, allowed the health plans the ability to provide services to Medicaid beneficiaries and maintain access, quality, and coverage. Without the provisions of this PHE amendment, the Medicaid Managed Care program may have experienced a risk to global capitation and overall funding for the program.

Evaluation Question 3.3: Was there any adverse impact to the eligibility, enrollment, and coverage of Medicaid Managed Care beneficiaries because of this demonstration?

The PHE amendment did not have any impact on eligibility, enrollment, or coverage of Medicaid Managed Care beneficiaries. The following table includes the state's enrollment projections for the

Medicaid Managed Care programs (extracted from the amendment application) and the actual enrollment during SFY 2020-2021.

	Enrollment Projections (Member Months)	
Program	**SFY 2020-2021 (Projected)**	**SFY 2020-2021 (Actual)**
Mainstream Managed Care (MMC)	57,111,538	56,139,407
Health and Recovery Plan (HARP)	1,638,854	1,765,214
HIV Special Needs Plan (HIV SNP)	214,848	182,678
Managed Long Term Care Partial Capitation (MLTCP)	2,903,583	2,915,947
Medicaid Advantage Plus (MAP)	268,583	271,631
Total	**62,137,406**	**61,274,877**

Table 3: Medicaid Managed Care Program SFY 2020-2021 Enrollment: Projections and Actual

Evaluation Question 3.4: To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the Managed Care plans?

The accuracy of payments to the Managed Care plans can be evaluated by assessing the remittances associated with the COVID-19 risk corridor. Across the Medicaid Managed Care programs (MMC, HARP, HIV SNP, MLTC, and MAP), the state received a total of approximately $16.0 million in remittances from the health plans. This represents 0.03% of the total premiums (approximately $43.8 billion) the health plans collected in SFY 2020-2021. The net $16.0 million in payments to the state indicates that the actual service expenditures incurred by health plans during the PHE period were slightly lower than premium funding provided by the state, resulting in net risk corridor payments to the state.

The tables below stratify the remittances by Medicaid Managed Care program. The MMC and HIV SNP programs received net payments from the state, while the HARP, MLTC, and MAP programs owed net remittances to the state.

Mainstream Managed Care (MMC)

The target MLR for the MMC program for SFY 2020-2021 was 86%; the Risk Corridor Target was 90%.

Program name	MCO, PHP, or PAHP Name	Adjusted MLR SFY 2020-2021	Remittance
MMC	Affinity Health Plan, Inc.	92.37%	($4,275,022)
MMC	Capital District Physicians Health Plan, Inc	93.00%	($32,077,250)
MMC	Excellus Health Plan, Inc	93.00%	($19,235,000)
MMC	New York Quality Healthcare Corporation (Fidelis Care)	91.27%	$0
MMC	Health Insurance Plan of Greater New York (Emblem)	90.83%	$0
MMC	Healthfirst PHSP, Inc.	92.56%	($36,768,616)
MMC	Highmark Western and Northeastern New York Inc. (formerly Healthnow)	91.94%	$0
MMC	HealthPlus HP, LLC	93.98%	($62,505,212)
MMC	Independent Health Association, Inc	93.00%	($29,356,949)
MMC	MVP Health Plan, Inc.	93.00%	($51,792,753)
MMC	MetroPlus Health Plan, Inc	89.94%	$0
MMC	Molina Healthcare of New York, Inc	89.28%	$0
MMC	United Healthcare of New York, Inc	92.06%	($1,271,785)

MMC	WellCare of New York, Inc	94.60%	($6,694,125)
MMC	YourCare Health Plan, Inc	94.91%	($667,051)
MMC	**Total**		**($244,643,763)**

The net remittance for the MMC program during SFY 2020—2021 was $244,643,763 in payments to the plans. This represents less than 1% of the total premiums for the MMC plans during this period.

Health and Recovery Plans (HARPs)

The target MLR for the HARP program in SFY 2020-2021 was 89%; the Risk Corridor Target was 93%.

Program name	MCO, PHP, or PAHP Name	Adjusted MLR SFY 2020-2021	Remittance
HARP	Affinity Health Plan, Inc.	92.53%	$5,608,687
HARP	Capital District Physicians Health Plan, Inc	95.44%	$0
HARP	Excellus Health Plan, Inc	91.85%	$2,749,264
HARP	New York Quality Healthcare Corporation (Fidelis Care)	90.0%	$82,067,672
HARP	Health Insurance Plan of Greater New York (Emblem)	97.98%	($516,947)
HARP	Healthfirst PHSP, Inc.	92.46%	$0
HARP	HealthPlus HP, LLC	92.87%	$470,435
HARP	Independent Health Association, Inc	95.14%	$0
HARP	MVP Health Plan, Inc	98.19%	($9,690,020)
HARP	MetroPlus Health Plan, Inc	91.90%	$3,522,770
HARP	Molina Healthcare of New York, Inc	96.85%	$0
HARP	United Healthcare of New York, Inc	91.87%	$3,286,938
HARP	YourCare Health Plan, Inc	98.38%	$80,719
HARP	**Total**		**$87,579,518**

The net remittance for the HARP program during SFY 2020—2021 was $87,579,518 in remittances to the state. This represents 2% of the total premiums for HARP plans during this period.

HIV Special Needs Plans (HIV SNPS)

The target MLR for the HIV SNP program for SFY 2020-2021 was 86%; the Risk Corridor target was 90%.

Program name	MCO, PHP, or PAHP Name	Adjusted MLR SFY 2020-2021	Remittance
HIV SNP	Amida Care Inc.	90.29%	$0
HIV SNP	MetroPlus Health Plan, Inc	95.84%	($7,521,388)
HIV SNP	VNS (d/b/a VNSNY Choice) and Subsidiary	95.9%	($859,902)
HIV SNP	**Total**		**(8,381,289)**

The net remittance for the HIV SNP program during SFY 2020—2021 was $8,381,289 in payments to the plans. This represents less than 1% of the total premiums for the HIV SNP plans during this period.

Managed Long-Term Care (MLTC)

The target MLR for the MLTC program for SFY 2020—2021 was 86%; the Risk Corridor target was 91.5%.

Program name	MCO, PHP, or PAHP Name	Adjusted MLR SFY 2020-2021	Remittance
MLTC	Aetna Better Heath, Inc.	87.14%	$3,840,741
MLTC	AgeWell New York, LLC	87.05%	$7,710,272
MLTC	Catholic Managed Long Term Care, Inc.	90.22%	$0
MLTC	Centers Plan for Healthy Living, LLC	88.20%	$0
MLTC	Elderplan Inc. d/b/a Homefirst	87.00%	$49,966,027
MLTC	Elderserve Health, Inc.	93.31%	$0
MLTC	Niagara Advantage Health Plan, LLC (Elderwood Health Plan)	87.00%	$4,030,242
MLTC	Erie Niagara MLTCP, Inc. (dba Kalos Health)	89.00%	$5,854,832
MLTC	EverCare, Inc.*	81.59%	$4,782,921
MLTC	Extended MLTC, LLC	95.04%	($126,815)
MLTC	Fallon Health Weinberg, Inc. (frmly TAIPP)	89.13%	$9,376,112
MLTC	New York Quality Healthcare Corporation (Fidelis Care)	88.14%	$0
MLTC	Hamaspik Choice, Inc.	88.39%	$13,524,814
MLTC	Healthfirst PHSP, Inc. (Senior Health Partners)	90.35%	$0
MLTC	HealthPlus HP, LLC	86.52%	$6,773,095
MLTC	iCircle Services of the Finger Lakes, Inc. - d/b/a iCircle Care	88.31%	$0
MLTC	Integra MLTC, Inc	89.64%	$0
MLTC	MetroPlus Health Plan, Inc	93.63%	$0
MLTC	Montefiore HMO LLC	91.91%	$0
MLTC	Prime Health Choice, LLC	89.64%	$2,811,484
MLTC	Senior Network Health, LLC	90.01%	$2,428,386
MLTC	Village Senior Services Corp. (VillageCare Max)	87.00%	$28,215,854
MLTC	Senior Whole Health of New York, Inc	87.00%	$22,251,254
MLTC	VNA Homecare Options, LLC (d/b/a Nascentia Health Options	87.00%	$3,506,637
MLTC	VNS (d/b/a VNSNY Choice) and Subsidiary	87.28%	$11,638,767
MLTC	WellCare of New York, Inc.	98.20%	($1,621,008)
MLTC	**Total**		**$174,963,615**

The net remittance for the MLTC program during SFY 2020-2021 was $174,963,615 in payments to the state. This represents 1% of the total premiums for the MLTC plans during this period.

Medicaid Advantage Plus (MAP)

The target MLR for the MAP program for SFY 2020—2021 was 86%; the Risk Corridor target was 91.5%.

Program name	MCO, PHP, or PAHP Name	Adjusted MLR SFY 2020-2021	Remittance
MAP	AgeWell New York, LLC MAP	101.58%	($275,877)
MAP	Centers Plan for Healthy Living, LLC	96.58%	($110,532)
MAP	Elderplan, Inc. d/b/a Homefirst	89.54%	$6,621,025
MAP	Elderserve MAP dba Riverspring	100.76%	($434,038)
MAP	New York Quality Healthcare Corporation (Fidelis Care)	99.08%	($446,256)
MAP	Healthfirst Healthplan, Inc.	91.75%	$0
MAP	HealthPlus HP, LLC	89.64%	$0
MAP	Senior Whole Health of New York, Inc.	98.96%	($1,219,470)
MAP	Village Senior Services Corp. (VillageCare Max)	90.36%	$2,354,174
MAP	VNS (d/b/a VNSNY Choice) and Subsidiary	91.93%	$0
MAP	**Total**		**$6,489,025**

The net remittance for the MAP program during SFY 2020—2021 was $6,489,025 in payments to the state. This represents less than 1% of the total premiums for the MAP plans during this period.

4. PHE AMENDMENT: LESSONS LEARNED

Evaluation Question 4.1: What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?

According to interviews with New York state agency staff, the state found the PHE amendment flexibilities to be critical to protecting the Medicaid Managed Care program, the health plans, and beneficiaries during the uncertainty of the PHE. The state identified several lessons learned from implementing the PHE amendment, primarily surrounding the critical importance of communication;

- Clear, consistent, organized communication between all stakeholders, including the state Medicaid Managed Care program, the health plans, and CMS
- The need to maintain communication throughout the duration of the amendment, and not just at the beginning of the PHE or amendment implementation

E. CONCLUSIONS

New York State utilized the flexibilities of the PHE amendment to successfully implement a retroactive, two-sided COVID-19 risk corridor during SFY 2020—2021. They minimized risk for both the Medicaid Managed Care program and the health plans, ensuring that service delivery, access, quality, and coverage was preserved for Medicaid beneficiaries during the PHE. If health plans were uncertain that they would be adequately reimbursed, they may have been more reluctant to provide services, leading to beneficiaries not receiving needed care. The COVID-19 risk corridor resulted in net payments to the state that make up less than 1% of the total premiums collected by the health plans during the relevant rate period. The corridor results at the Medicaid Managed Care Program level (MMC, HARP, HIV SNP, MLTC, and MAP) ranged from less than 1% to 2% of premiums with both payments to the state and payments to health plans.

APPENDIX A: QUALITATIVE INTERVIEW GUIDE

New York State Evaluation of Managed Care Risk Mitigation Arrangements during the COVID-19 Public Health Emergency (PHE)

Semi-Structured Qualitative Interview Guide

Introductions and Background Information

1. What is your current role at the New York State Department of Health? What are your primary responsibilities?
2. If different, what was your role at the time that this Managed Care Risk Mitigation waiver was being implemented (March 2020 through the end of the Public Health Emergency in May 2023)

Waiver Implementation

3. What was your involvement in the design or implementation of New York's Managed Care Risk Mitigation COVID-19 PHE amendment?
4. Were there any changes made to member eligibility because of the demonstration?
5. How did the state communicate with health plans around waiver implementation?
6. What were the greatest challenges associated with implementing the retroactive risk sharing mitigation strategies?
    a. Decision-making
    b. Communication
    c. Timing
    d. Deviation from typical procedures
7. How did the state address these challenges?
8. Were there other state Medicaid initiatives related to the PHE response that may have had an impact on the design or implementation of this amendment?

Waiver Impact

9. If the demonstration and risk mitigation flexibilities were not allowed during the Public Health Emergency, what might have been the likely impacts or potential harms to:
    a. The Medicaid Managed Care program
    b. Health Plans
    c. Beneficiaries
10. In what ways did the exemption from the regulatory prohibition of retroactive risk sharing promote the objectives of the New York State Medicaid Managed Care Program?
    a. Access to care
    b. Quality of health services delivered
    c. Expanded coverage to eligible New Yorkers
    d. Advances in health equity, reduction of health disparities, and delivery of HRSN services

Lessons Learned

11. In reflecting on your experience implementing this demonstration, what were the most valuable lessons learned?