MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 22 (4/1/2020-3/31/2021)
Federal Fiscal Quarter: 1 (10/1/2020-12/31/2020)

I. Introduction

In July 1997, New York State 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; and
- 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 Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's 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, New York State 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 Medicaid Redesign Team (MRT) Waiver. On April 19, 2019 CMS approved New York's request to exempt 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 behavioral health (BH) and 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 is well positioned to lead the nation in Medicaid reform. Governor Cuomo´s Medicaid Redesign Team (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: First Quarter

MRT Waiver- Enrollment as of December 2020

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	494,451	4,548	5,472
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	89,901	1,305	1,438
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	13,417	182	173
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	2,679	66	24
Population 5 - Safety Net Adults	326,111	7,291	2,718

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 (SSI 0-64 Current MC)	**20,010**	**431**	**50**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**184,176**	**4,921**	**727**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**1,637**	**46**	**11**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**56,535**	**1,894**	**174**

***Due to a lack of data availability, recipients re-instated to the February 2021 roster were not excluded from the December 2020 disenrollment count.**

MRT Waiver – Voluntary and Involuntary Disenrollment*

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**20,684 or an approximate 13.9% increase from last Q**

Reasons for voluntary disenrollment: Enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

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

The quarter's increase in voluntary disenrollment is largely due to the increase in the category "Enrolled in Other Plan." This includes an increase in the plan's passive enrollment of its HARP eligible enrollees into its affiliated HARP plan.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**10,787 or an approximate 50.9% decrease from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid eligibility including death, plan termination, and retro-disenrollment.

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

Involuntary disenrollment declined due to significant decreases in both ordinary case closures and MAGI case closures that were subsequently sent to NYSoH for redetermination.

***Due to a lack of data availability, recipients re-instated to the February 2021 roster were not excluded from the December 2020 disenrollment count.**

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
October 2020				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**869,925**	**12,366**	**2,889**	**9,477**
Rest of State	**295,583**	**5,547**	**741**	**4,806**
Statewide	**1,165,508**	**17,913**	**3,630**	**14,283**
November 2020				
New York City	**872,335**	**12,258**	**2,844**	**9,414**
Rest of State	**298,522**	**6,609**	**879**	**5,730**
Statewide	**1,170,857**	**18,867**	**3,723**	**15,144**
December 2020				
New York City	**875,609**	**10,791**	**1,987**	**8,804**
Rest of State	**300,213**	**5,832**	**743**	**5,089**
Statewide	**1,175,822**	**16,623**	**2,730**	**13,893**
First Quarter				
Region	**Total Affirmative Choices**			
New York City	**27,695**			
Rest of State	**15,625**			
Statewide	**43,320**			

HIV SNP Plans				
October 2020				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**12,979**	**103**	**0**	**103**
Rest of State	**10**	**2**	**0**	**2**
Statewide	**12,989**	**105**	**0**	**105**
November 2020				
New York City	**13,027**	**139**	**0**	**139**
Rest of State	**11**	**1**	**0**	**1**
Statewide	**13,038**	**140**	**0**	**140**
December 2020				
New York City	**13,080**	**140**	**0**	**140**
Rest of State	**15**	**1**	**0**	**1**
Statewide	**13,095**	**141**	**0**	**141**
First Quarter				
Region	**Total Affirmative Choices**			
New York City	**382**			
Rest of State	**4**			
Statewide	**386**			

Health and Recovery Plans Disenrollment*			
FFY 21 – Q1			
	Voluntary	Involuntary	Total
October 2020	506	247	753
November 2020	692	279	971
December 2020	555	321	876
Total:	1,753	847	2,600

***Due to a lack of data availability, recipients re-instated to the February 2021 roster were not excluded from the December 2020 disenrollment count.**

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 1 (9/1/2020-12/31/2020) Q1 FFY 2021

As of the end of the first federal fiscal quarter (end of December 2020), there were 2,818,821 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 74,343 Medicaid consumers enrolled in Health and Recovery Plan (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 14 HRA facilities open to the public and has suspended outreach activities at 17 HRA facilities temporarily closed due to COVID-19. MAXIMUS reported that 11,331 clients were educated about enrollment options and made an enrollment choice including 370 clients in person and 10,961clients through phone.

Contract Monitoring Unit (CMU) is responsible for monitoring outreach activities conducted by FCSRs to ensure that approved presentation script is followed and required topics are explained. Deficiency found is reported to MAXIMUS Field operation monthly. Due to COVID-19, CMU field monitoring has been suspended since 3/23/2020; therefore, no activity was conducted for the reporting period.

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 21,461 FFS community clients were reported on the regular auto-assignment list, 2,997 clients responded to the call that generated 3,627 enrollments. Of the total of 87 FFS NH clients reported on NH auto-assignment list, 12 (14%) clients and/or authorized representatives made a plan selection.

C. NYMC HelpLine Observations October 2020-December 2020

NYMC reported that 53,580 calls were received by the Helpline and 49,356, or 92%, were answered. Calls answered were handled in the following languages: English: 34,829 (70%); Spanish: 6,223 (12%); Chinese: 2,387 (5%); Russian: 570 (1%); Creole: 59 (1%) and other: 5,288 (11%).

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. Call observation was also suspended, and no activity was recorded for the reporting period.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

During the first quarter of FFY 2020-2021:

- On November 1, 2020, HealthFirst PHSP, Inc. was approved to expand its Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) service areas to include Rockland County.

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

The March 1, 2019 Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) was submitted to CMS for approval in federal fiscal year (FFY) 2018-2019. During FFY 2019-2020, nine of the resultant MCO contracts were executed by New York State and submitted to CMS for final approval. During the first quarter of FFY2020-2021, an additional nine MCO contracts were submitted to CMS for final approval. At the close of the first quarter, these 18 contracts await final CMS approval.

C. Health Plans/Changes to Certificates of Authority

Below is a listing of the transactions completed by BMCCS 10/1/2020 – 12/31/2020:

- HealthPlus HP, LLC received an updated Certificate of Authority (COA) to add an Integrated Dual Benefit (ID-B) line of business.
- MetroPlus Health Plan Inc. received an updated Certificate of Authority (COA) to add an Integrated Dual Benefit (ID-B) line of business.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

BMCCS Surveillance activity completed during the 1st Quarter FFY 2020-2021 includes the following:

One (1) Targeted Operational Survey was completed during 1st Quarter FFY 2020-2021. The Plan was found in compliance.

- HIP Emblem

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

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

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators
  No activities were conducted during the quarter 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 Services into Managed Care and Development of Health and Recovery Plans (HARPs):

In October 2015 New York State began transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and substance use disorder) and physical health service system that provides comprehensive, accessible, and recovery-oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are specialized plans that include staff with enhanced behavioral health expertise. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called behavioral health Home and Community Based Services (BH HCBS). For Medicaid Managed Care (MMC), all Medicaid- funded behavioral health services for adults, except for services in Community Residences, are part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) began phasing in enrollment of current MMC enrollees throughout New York State 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 Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care.

In Fiscal Year (FY) 2018, New York State engaged in multiple activities to enhance access to behavioral health services and improve quality of care for recipients in Medicaid Managed Care. In June of 2018, HARP became an option on the New York State of Health (Exchange). 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 to assess and link HARP enrollees to BH HCBS, and allocated quality and infrastructure dollars to MCOs in efforts to expand and accelerate access to adult BH HCBS. Additionally, the State continually offers ongoing technical assistance to the behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center.

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

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

NOTE: As previously messaged to CMS in the Q4 and annual reports, these reports were delayed allowing Plans the ability to shift resources and implement all COVID-19 guidance issued by the State. The State resumed reporting in October 2020. At this time the State has completed summaries for Q1 and Q2 of 2020. The State is currently working on processing the Q3 and Q4 2020 submissions and will provide the updated information with the next quarterly submission to CMS.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (1/1/2020-3/31/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	27,245	643	625	2.29%
ROS	4,842	28	28	0.58%
Total	32,087	671	653	2.04%

Note: HealthFirst data was excluded in this table due to data integrity issue.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (4/1/2020-6/30/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	17,658	100	90	0.51%
ROS	3,311	4	4	0.12%
Total	20,969	104	94	0.45%

Note: HealthFirst data was excluded in this table due to data integrity issue.

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

   NOTE: As previously messaged to CMS in the Q4 and annual reports, these reports were delayed allowing Plans the ability to shift resources and implement all COVID-19 guidance issued by the State. The State resumed reporting in October 2020. At this time the State has completed summaries for Q1 and Q2 of 2020. The State is currently working on processing the Q3 and Q4 2020 submissions and will provide the updated information with the next quarterly submission to CMS.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (1/1/2020-3/31/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	8,548	58	28	0.33%
ROS	2,847	23	20	0.70%
Total	11,395	81	48	0.42%

Note: HealthFirst data was excluded in this table due to data integrity issue.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (4/1/2020-6/30/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	7,085	24	17	0.24%
ROS	2,048	18	12	0.59%
Total	9,133	42	29	0.33%

Note: HealthFirst data was excluded in this table due to data integrity issue.

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (10/1/2020-12/31/2020)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	1,080,239	93.57%	6.43%
Rest of State	972,011	93.46%	6.54%
Statewide Total	2,052,250	93.52%	6.48%

Note: WellCare Claims Data for December 2020 has been excluded due to data integrity issue.

BH Adults HCBS Claims/Encounters 10/1/2020-12/31/2020: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	76	23
Education Support Services	593	165
Family Support and Trainings	31	4
Intensive Crisis Respite	0	0
Intensive Supported Employment	420	109
Ongoing Supported Employment	27	8
Peer Support	2,615	554
Pre-vocational	268	62

Provider Travel Supplements	**40**	**26**
Psychosocial Rehab	**513**	**97**
Residential Supports Services	**297**	**42**
Short-term Crisis Respite	**353**	**56**
Transitional Employment	**3**	**3**
TOTAL	**5,236**	**975**

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

BH Adults HCBS Claims/Encounters 10/1/2020-12/31/2020: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	**910**	**181**
Education Support Services	**1,015**	**295**
Family Support and Trainings	**58**	**17**
Intensive Crisis Respite	**0**	**0**
Intensive Supported Employment	**614**	**160**
Ongoing Supported Employment	**73**	**22**
Peer Support	**5,282**	**1,176**
Pre-vocational	**359**	**107**
Provider Travel Supplements	**2,477**	**725**
Psychosocial Rehab	**2,200**	**461**
Residential Supports Services	**1,984**	**387**
Short-term Crisis Respite	**148**	**35**
Transitional Employment	**7**	**5**
TOTAL	**15,127**	**2,370**

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

Provider Technical Assistance

Managed Care Technical Assistance Center 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 Managed Care Technical Assistance Stats during October 1, 2020 to December 31, 2020.

Quarter 1 MCTAC Attendance & Stats (10/1/2020 to 12/31/2020)

Events: MCTAC successfully executed 35 events from 10/1/2020 to 12/31/2020. All 35 events were held via webinar.

Individual Participation: 1,141 people attended/participated in our events of which 841 are unique.

***There were an additional 179 attendees who were unregistered in MCTAC system, of which 101 were unique participants.*

OMH Agency Participation
Overall: 293 of 635 **(46.14%)**
NYC: 159 of 331 **(48.04%)**
ROS: 211 of 434 **(48.62%)**

OASAS Agency Participation
Overall: 198 of 547 **(36.20%)**
NYC: 88 of 240 **(36.67%)**
ROS: 149 of 379 **(39.31%)**

Efforts to Improve Access to Behavioral Health Home and Community Based Services (BH HCBS)

All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (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, New York 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, the State and key stakeholders identified challenges, including: difficulty with enrolling HARP members in Health Homes (HH); 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.

The State previously made efforts to ramp up utilization and improve access to BH HCBS by addressing the challenges identified. These efforts included:

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

- BH HCBS Performance – fine-tuned MCO Reporting template to improve Performance Dashboard data for the BH HCBS workflow (Nov 2018, streamlining data collection for both HH and RCAs).
- Developed required training for BH HCBS providers that the State can track in a Learning Management System.
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhancing 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 HH. These services are provided by State Designated Entities (SDE) through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with State-designated entities 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 (RCA) 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
        - Ongoing technical assistance
        - Creation of statewide RCA performance dashboard- enhanced to reflect data by RCA and by HH

- Continuing efforts to increase HARP enrollment in HH 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 HH enrollment
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management
    - DOH approval of MCO plans for incentivizing enrollment into HH (eg, Outreach Optimization)

- Ongoing work to strengthen the capacity of HH 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 HHs, representation on new HH+ Subcommittee Workgroup.
- Implementing 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.

- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS Office of Mental Health has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for Medicaid Managed Care Health and Recovery Plans (HARPs) and Adult Behavioral Health (BH) Home and Community Based Services (BH HCBS).
        - NYAPRS conducts outreach in two ways:
            - Through 45-90-minute training presentations delivered by peers.
                - OMH approves the PowerPoint before significant changes are made.
            - Through 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. The State has worked with the Managed Care Plans on an ongoing basis to further monitor and operationalize this program and increase access and utilization of BH HCBS. Infrastructure contracts have been signed and work is underway.
    - 13 HARPs distributed over $32 million through 93 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all MCOs 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; the State also shared a summary of best and promising practices with MCOs.
- Updates were made to Non-Medical Transportation guidance to improve utilization of this service intended to support participation in BH HCBS and attainment of recovery goals.
- 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.
- Enhancing State 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.
- Continued work with the HARP/ BH HCBS Subcommittee (since 2017) – consisting of representatives from MCOs, HHs, CMAs, and BH HCBS Provider agencies - charged with identifying barriers and solutions for improved access to BH HCBS, on behalf of NYS' HH/MCO Workgroup.
- A process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments was established, in response to challenges in securing a CM workforce meeting both the education and experience criteria and need for more assessors.

To date, 4,737 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between October 1, 2020 and December 31, 2020 6,472 eligibility assessments were completed.

Despite 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 remain 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, the State released a draft proposal for public comment in June 2020 to transition 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package for HARP enrollees and HARP eligible HIV-SNP enrollees, which to date has resulted in positive feedback. The State finalized the proposal and submitted to CMS in September 2020. The objectives of this transition are two-fold: to simplify and allow creativity in service delivery of community-based rehabilitation services tailored to the specific needs of the behavioral health population, and to eliminate barriers to access.

If approved by CMS, access to these adult rehabilitation services will no longer require an independent eligibility assessment, will remove settings restrictions, and will enable all HARP and HARP eligible HIV-SNP enrollees to access services with a recommendation from a licensed practitioner of the healing arts (LPHA). Enrollment in Health Home Care Management will continue to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by Health Home. 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 the MCO and service providers.

The Adult Rehabilitation Services will be branded Community Oriented Recovery and Empowerment (CORE) services. Pending CMS approval, the State will implement CORE services over several months. Transition planning is underway, and the State is providing ongoing opportunities for stakeholder input through multiple forums. The State is developing consumer education materials and targeted trainings and technical assistance for providers, MCOs, and other stakeholders impacted by this transition.

In addition, the State is planning to extend the Infrastructure initiative to support the behavioral health provider system's transition from BH HCBS to the new CORE service array.

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

The Department resumed the Gap Report focus group calls in October and November 2020. Currently, this focus group consists of four MMC plans, and six SBHCs. As previously mentioned, the goal of this Gap Report Pilot focus group is to test the data exchange process for participating SBHCs to share student rosters with all contracted MMC plans. These calls provide the opportunity for the MMC plans and SBHCs participating in the pilot to discuss

successes and barriers which have been identified during the data exchanges between the MMC plan and the SBHC. The Department is planning to compile best practices from the feedback from this focus group. A copy of the gap report template, instructions, and additional information about the transition can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_8401.htm.

C. Managed Long-Term Care Program (MLTCP)

Managed Long-Term Care plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of January 1, 2021, there are 25 Partial Capitation plans, 9 PACE plans, 10 MAP, 3 MA plans, and 1 FIDA IDD plan. As of January 1, 2021, there are total of 277,970 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the October 2020 through December 2020 quarter, 1 new MAP was approved for enrollment.

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 October 2020 through December 2020 quarter, post enrollment surveys were completed for 11 enrollees. Of the 9 who responded to the question, 7 (78%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP (2 enrollees did not respond to this question). The percentage of affirmative responses is relatively consistent with the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 238,955 to 244,202 during the October 2020 through December 2020 quarter, a 2% increase from the last quarter. For that period, 11,672 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a 1% decrease from the previous quarter and brings the 12-month total for affirmative choice to 46,285.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, and MAP plans, during the January 2020 through December 2020 annual period is submitted as an attachment.

2. Significant Program Developments

During the October 2020 through December 2020 quarter:

- The 4th Quarter Member Services survey was conducted on 25 Partial Capitation Plans and 8 MAP Plans. This survey was intended to provide feedback on the

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

- 6 Operational Surveys are ongoing on Partial Capitation Plans;

- Based on the results of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), report entitled New York's Oversight of Medicaid Managed Care Organizations Did Not Ensure Providers Complied With Health and Safety Requirements at 18 of 20 Adult Day Care Facilities Reviewed, Statements of Deficiencies were issued to 3 Partial Capitation Plans to address the identified deficiencies. The Corrective Actions Plans are in progress;

- Of the 15 Statements of Deficiencies issued to 1 Partial Capitation Plan in 2019 Quarter 1, based on complaints received by the Technical Assistance Center (TAC), the final 5 Corrective Action Plans have been accepted; and

- The Community Service Society of New York was selected to function as the NYS MLTC Ombudsman and as a component of the Beneficiary Support System required by the 438 Final Rule. The organization for this contract has continued under the name Independent Consumer Advocacy Network (ICAN) and the contract has been executed.

As a matter of routine course:

- Processes for Operational Partial Capitation and MAP surveys continue to be refined;

- The Surveillance tools continue to be updated to reflect process changes; and

- Reports have been developed/implemented to assist with summarizing survey findings.

3. Issues and Problems

There were no issues or problems to report for the October 2020 through December 2020 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within the MLTCP as a consumer choice and gives individuals and families greater control over services received. The Department published a Request for Offers in December 2019 to procure fiscal intermediary (FI) administrative services for the Consumer Directed Personal Assistance Program (CDPAP). After award and a transition process, only entities that have contracts with the Department may provide FI administrative

services. Managed care plans will enter into separate administrative service agreements with Department-contracted FIs.

5. Required Quarterly Reporting

Unless otherwise noted, decreases from last quarter are presumed to be due to COVID-19 pandemic.

Critical incidents: There were 1,502 critical incidents reported for the October 2020 through December 2020 quarter, a decrease of 11% from the last quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. To date, none of those plans were found to have had critical incidents that should have been reported.

Complaints* and Appeals: For the October 2020 through December 2020 quarter, the top reasons for complaints/appeals changed from last quarter to: Dissatisfaction with quality of other covered services, Dissatisfaction with quality of home care, Dissatisfaction with Transportation, Home care aide late/absent on dates of service, Dissatisfaction with member services and plan operations.

Period: 10/1/2020 through 12/31/2020 (Percentages rounded to nearest whole number)			
Number of Recipients: 270,539	**Complaints**	**Resolved**	**Percent Resolved****
# Expedited	**14**	**5**	**36%**
# Same Day	**2,728**	**2,728**	**100%**
# Standard/Expedited	**8,293**	**8,474**	**102%**
Total for this period:	**11,035**	**11,207**	**102%**

*The term "complaint" is replacing the previously used term "grievance" that was previously used in order to match contract language. The definition of the terms is interchangeable.
**Percent Resolved includes grievances opened during previous quarters that are resolved during the current quarter, that can create a percentage greater than 100.

Appeals	**1/2020-3/2020**	**4/2020-6/2020**	**7/2020-9/2020**	**10/2020-12/2020**	**Average for Four Quarters**
Average Enrollment	279,048	281,967	270,489	270,539	275,511
Total Appeals	9,655	5,804	8,044	7,934	7,859
Appeals per 1,000	35	21	30	29	29
# Decided in favor of Enrollee	1,854	917	876	1,101	1,187
# Decided against Enrollee	6,713	5,373	5,121	5,906	5,778

# Not decided fully in favor of Enrollee	727	523	452	604	577
# Withdrawn by Enrollee	200	199	169	204	193
# Still pending	1,752	528	1,050	544	969
Average number of days from receipt to decision	9	9	15	9	10

***Complaints and Appeals per 1,000 Enrollees by Product Type October 2020-December 2020**					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	241,939	6,063	25	6,663	28
Medicaid Advantage Plus (MAP) Total	23,043	3,991	173	1,140	49
PACE Total	5,557	997	179	58	10
Total for All Products:	**270,539**	**11,051**	**41**	**7,861**	**29**

Total complaints decreased 18% from 13,496 the previous quarter to 11,051 during the October 2020 through December 2020 quarter.

The total number of appeals increased 14% from 6,921 during the last quarter to 7,861 during the October 2020 through December 2020 quarter.

Technical Assistance Center (TAC) Activity

During the October 2020 through December 2020 quarter, call volume was a bit lower than usual. TAC averaged about 182 calls per month. The typical range is about 200-250. We typically see a decrease in complaint calls during the holiday season. Also, member's needs have changed during the COVID pandemic. The unit's case closure rate was average. TAC closed 62% of cases in the same month they were opened.

Aide service continues to be TAC's most frequent complaint category. This is even more true during COVID, where we have experienced home health aide shortages due to aides being quarantined. We have also seen an increase in general calls for information and questions. This is partially due to questions regarding COVID-related policies.

Call Volume	**10/1/2020- 12/31/2020**
Substantiated Complaints	48
Unsubstantiated Complaints	255
Complaints Resolved Without Investigation	13
Inquiries	231
Total Calls	**547**

The five most common types of calls for the quarter were related to:

Aide Service- Agency Problems	13%
General- Referral to Other Department/Agency	11%
IDT- Dissatisfaction	7%
Billing- Denied Claims	7%
Aide Service- Plan Not Providing Hours	5%

Home health care complaints are investigated based upon a member's subjective experience and do not necessarily represent neglect or abuse.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the October 2020 through December 2020 quarter, 9,178 people were evaluated, deemed eligible and enrolled into plans, a decrease of 17% from the previous quarter.

Referrals and 30-day assessment: For the October 2020 through December 2020 quarter, MLTC plans conducted 31,785 assessments, an increase of 22% from 24,848 the previous quarter. The total number of assessments conducted within 30 days increased 9% from 21,683 the previous quarter to 23,601 this quarter.

Referrals outside enrollment broker: For the October 2020 through December 2020 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 26,426 a 49% increase from 17,772 the previous quarter.

Rebalancing Efforts	10/2020-12/2020
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	180
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	2,401
Individuals who are permanently placed in a nursing home and are new to plan	129

As of January 2021, there were 3,580 current plan enrollees who were in nursing homes as permanent placements, a 22% 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 behavioral health (BH) and Home and Community Based Service (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, by allowing managed care authority for their HCBS.

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

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current Fee for Service HCBS authorized under the State's newly consolidated 1915c Children's Waiver in Medicaid Managed Care 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 to provide customized goods and services, such as self- direction and financial management services, that are currently approved under the demonstration's HARP's pilot to Fo1 children;
- 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 New York State Department of Health has been engaged in implementation activities, including, but not limited to the following:

- Receiving approval from CMS for the Children's 1115 Evaluation Design as of April 16, 2020;
- 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;
- Drafting policies and guidance to ensure compliance with State and federal requirements;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers;

- Facilitating relationship building between Managed Care Organizations, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from Managed Care Organizations, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Defining performance and quality metrics; and
- Responding to the COVID-19 pandemic and implementing emergency 1135 and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers.

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

	With K1 Flag - HCBS LOC		With KK Flag - Family of One	
Month	Enrolled Children	Enrolled Children w/ HCBS Claims	Enrolled Children	Enrolled Children w/ HCBS Claims
Oct	6,782	1,847	3,724	181
Nov	6,819	1,528	3,708	132
Dec	6,974	595	3,716	51
Q1 Avg	**6,858**	**1,323**	**3,716**	**121**

This table includes data from the 1st Quarter of FY2021; however, the data from November and December is still within the 90-day claim lag period. Data from this quarter continues to be impacted by the COVID-19 pandemic, which likely resulted in significantly decreased utilization and/or claiming. This data will continue to be reviewed in relation to the claim lag, and data will continue to be analyzed to understand the impact of the pandemic, especially in relation to utilization.

VI. Evaluation of the Demonstration

During this quarter ending December 31, 2020, four Independent Evaluations (IE) are now ongoing. The fourth IE contract was finalized in October 2020 for the RAND Corporation to

conduct the Independent Evaluation of the Children's waiver. Thus, the RAND Corporation now has four separate IE teams conducting Independent Evaluations of the 1115 waiver, the Health and Recovery Program (HARP), the Self Directed Care (SDC) pilot program and the Children's waiver. Updated progress on each is described below.

The research team at RAND that is conducting the 1115 Demonstration Waiver Independent Evaluation prepared a draft and final Preliminary Interim Evaluation report during this quarter. The 1115 Preliminary Interim Evaluation report was previewed by CMS November 23, 2020 and posted to the NYS DOH MRT 1115 Waiver Extension Request website on December 16, 2020 for public comment. The RAND team and NYS DOH staff are ready to address any incoming public comments from the posted 1115 Preliminary Interim Evaluation report and from the virtual public hearings scheduled in January 2021. The 1115 report contained preliminary findings on Domain 1 research questions related to Component 1 Managed Long Term Care enrollment and Component 2 Individuals Moving from Institutional to Community Based Settings. For the separate Domain 2 Component, to Limit Gaps in Continuous Enrollment, the RAND team was provided data access to support the ten research questions related to Continuous Eligibility and Enrollment. Between October and December, the RAND team transitioned to a new Project Manager and continued to meet weekly to discuss preliminary analysis of data with DOH subject matter experts, refine interpretations, and prepare draft specifications to assess cost and utilization. The findings and conclusions for these specific Domain 2 research questions, as well as, a complete and updated 1115 Interim Evaluation report are due to NYS DOH in the Spring of 2021.

During this quarter October 1 through December 31, 2020, the Heath and Recovery Program (HARP) and Self-Directed (SDC) pilot program team at RAND gained access to many updated and outstanding data tables, data sources and program experts. The RAND team continues to update a data tracker for each of the 17 HARP and 12 SDC research questions and discuss and verify data received, time periods available, and plans to supplement and update tables as needed for missing periods or partial data received. Staff from the Office of Health Insurance Programs (OHIP), Office of Quality and Patient Safety (OQPS), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and the Division of Operations and Systems (DOS) continue to assist weekly the Rand researchers with HARP and SDC questions on data access and data verification. In October this RAND team also prepared draft and final Preliminary Interim Evaluation reports for both the HARP and the SDC programs. These two Preliminary Interim Evaluation reports were previewed by CMS on November 23, 2020. Both Preliminary Interim Evaluation reports for the HARP and SDC were then posted to the NYS DOH MRT 1115 Waiver Extension Request website on December 16, 2020 for public comment. The RAND team and NYS DOH are ready to address any incoming public comments from the posted HARP and SDC Preliminary Interim Evaluation reports and from the two virtual public hearings scheduled in January 2021. These two reports do not yet contain preliminary findings. Early contract and data use agreements for the HARP and SDC IE activities were impacted in Spring and Summer 2020 by the reprioritization of resources to address the NYS COVID-19 pandemic. Thus, this IE team's implementation activities were delayed. A one-year contract extension beyond February 11, 2021 is underway for this RAND team to continue the HARP and SDC IE research tasks and reports development in Spring 2021.

The DOH contract for the Independent Evaluation of the Children's Waiver was formally launched on October 15, 2020 with the RAND Corporation. Data access, weekly touch points with the subject matter experts and quantitative and qualitative research activities began quickly in late October and continued throughout this quarter. This RAND team also prepared a draft and final Preliminary Interim Evaluation report which was previewed by CMS on November 23, 2020. The Children's Preliminary Interim Evaluation report was posted to the NYS DOH MRT 1115 Waiver Extension Request website on December 16, 2020 for public comment. Since that contract and research activities had just begun, that report did not yet contain preliminary findings. The RAND team conducting the Independent Evaluation of the Children's Waiver is on track to submit an Interim Evaluation report in Spring of 2021, which will address 7 research questions.

VII. Consumer Issues

A. MMC, HARP and HIV SNP Plan Reported Complaints

Medicaid managed care organizations (MMCOs), including mainstream managed care plans (MMCs), Health and Recovery Plans (HARPs), and HIV Special Needs Plans (HIV SNPs) are required to report the number and types of member complaints they receive on a quarterly basis.

The following table outlines the complaints plans reported by category for the most recent quarter and for the previous quarter:

MMCO Product Line	Total Complaints	
	FFY 21 Q1 10/1/2020- 12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Medicaid Managed Care	7,546	7,287
HARP	867	882
HIV SNP	119	98
Total MMCO Complaints	**8,532**	**8,267**

As described in the table, total MMCO complaints/action appeals reported for the current quarter total 8,532. This represents a 3.2% increase from the prior quarter's total.

This quarter's plan-reported complaint data shows an increase of 3.6% for MMCs from the previous quarter. HARPs show a decrease of 1.7% since the prior quarter.

This quarter's HIV SNP complaints saw an increase of 21.4% when compared to the previous quarter's data.

The following table outlines the top five (5) most frequent categories of complaints reported for MMC, HARP and HIV SNP, combined, for the most recent and previous quarters:

Description of Complaint	Percentage of Complaints	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	18%
Balance Billing	16%	17%
Reimbursement/Billing	11%	9%
Difficulty with Obtaining: Dental/Orthodontia	10%	9%
Pharmacy/Formulary	8%	5%

The following table outlines the top five (5) most frequent categories of complaints reported for HARPSs for the most recent and previous quarters:

Description of Complaint	Percentage of Complaints	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	29%	22%
Pharmacy/Formulary	10%	7%
Dissatisfaction with Quality of Care	8%	10%
Difficulty with Obtaining: Personal Care	7%	13%
Difficulty with Obtaining: Dental/Orthodontia	7%	7%

The following table outlines the top five (5) most frequent categories of complaints reported for HIV SNPs for the most recent and previous quarters:

Description of Complaint	Percentage of Complaints	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Dissatisfied with Provider Service (Non-Medical) or MCO Services	18%	17%
Pharmacy/Formulary	15%	6%
Difficulty with Obtaining: Dental/Orthodontia	13%	15%

Problems with Advertising\ Consumer Education\ Outreach\ Enrollment	8%	6%
Balance Billing	8%	6%

Monitoring of Plan Reported Complaints
The Department engages in the following analysis to identify trends and potential problems.

The observed/expected ratio is a calculation for each MMCO, which represents a comparison of the number of observed complaints to the number that were expected, based on the MMCO's average enrollment for the quarter as a portion of total enrollment for all MMCOs. For example, an observed/expected of 6.15 means that there were more than six times the number of complaints reported than were expected. An observed/expected of 0.50 means that there were only half as many complaints reported as expected.

Based on the observed/expected ratio over a six-month period, the Department requests that MMCOs review and analyze categories of complaints where two times, or more, higher than expected complaint patterns persist. Where a persistent trend or an operational concern contributing to complaints is confirmed, the plan is required to develop a corrective action plan.

The Department is in the process of calculating the observed/expected ratio for the six-month period of June 1, 2020 through December 31, 2020.

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

Long Term Services and Supports (LTSS)
As SSI members typically access long term services and supports, the Department monitors complaints and action appeals filed for this product line with managed care plans. Of the 8,532 total reported complaints/action appeals, mainstream MMCOs reported 996 complaints and action appeals from their SSI members. This compares to 1,314 SSI complaints/action appeals from the previous quarter, representing a 24.2% decrease.

The following table outlines the total number of complaints/action appeals plans reported for SSI members by category for the most recent and previous quarters:

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Members	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Appointment Availability: PCP	13	22
Appointment Availability: Specialist	4	9
Appointment Availability: BH HCBS	0	0
Long Wait Time	4	5
Dissatisfied with Quality of Care	83	80

Denial of Clinical Treatment	33	31
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	342	475
Dissatisfaction with BH Provider Services	4	1
Dissatisfaction with Health Home Care Management	1	1
Difficulty with Obtaining: Specialist and Hospitals	9	16
Difficulty with Obtaining: Eye Care	9	5
Difficulty with Obtaining: Dental/Orthodontia	37	39
Difficulty with Obtaining: Emergency Services	2	6
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	3	1
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	1
Difficulty with Obtaining: Private Duty Nursing	7	18
Difficulty with Obtaining: Home Health Care	19	77
Difficulty with Obtaining: Personal Care	122	208
Difficulty with Obtaining: PERS	2	8
Difficulty with Obtaining: CDPAS	20	60
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	75	46
Access to Non-Covered Services	13	11
Access for Family Planning Services	0	0
Communications/ Physical Barrier	2	5
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	5	17
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	76	42
Balance Billing	68	66

Transportation	15	27
All Other	28	37
Total	**996**	**1,314**

The following table outlines the top five (5) most frequent categories of SSI complaints/action appeals plans reported for the most recent and previous quarters:

Description of Complaint	Percentage of Total Complaints/Appeals Reported for SSI Members	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	34%	36%
Difficulty with Obtaining: Personal Care	12%	16%
Dissatisfied with Quality of Care	8%	6%
Reimbursement/Billing	8%	3%
Pharmacy/Formulary	8%	4%

The Department requires MMCOs to report the number of members in receipt of LTSS as of the last day of the quarter. During the current reporting period of October 1, 2020 through December 31, 2020, MMCOs reported LTSS enrollment of 42,773 members. This compares to 39,799 members from the previous quarter, representing a 7.5% increase. The following table outlines the number of LTSS members by plan for the most recent and previous quarters:

Plan	Number of LTSS Members	
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020
Affinity Health Plan	870	475
Amida Care	1,471	1,427
Capital District Physicians Health Plan	605	596
Excellus Health Plan	1,542	1,519
Healthfirst	11,187	9,546
HealthNow	176	175
HealthPlus	2,989	2,878
Health Insurance Plan of Greater New York	335	373
Independent Health Association	452	441
MetroPlus Health Plan	3,074	3,490
Molina Healthcare	1,323	1,122
MVP Health Plan	1,755	1,559
Fidelis Care	14,005	13,249
United Healthcare	2,644	2,608

VNS Choice	345	341
Total	**42,773**	**39,799**

The following table outlines the total number of complaints/action appeals received from all enrollees regarding difficulty with obtaining LTSS that plans reported for the most recent and previous quarters.

Description of Complaint	**Number of Complaints/Action Appeals Reported**	
	FFY 21 Q1 10/1/2020-12/31/2020	**FFY 20 Q4 7/1/2020-9/30/2020**
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Difficulty with Obtaining: Adult Day Care	0	2
Difficulty with Obtaining: CDPAS	41	118
Difficulty with Obtaining: Home Health Care	43	146
Difficulty with Obtaining: RHCF Services	0	5
Difficulty with Obtaining: Personal Care	264	442
Difficulty with Obtaining: PERS	7	14
Difficulty with Obtaining: Private Duty Nursing	10	21
Total	**365**	**748**

B. Critical Incidents:

The Department requires MMCOs to report critical incidents involving members in receipt of LTSS. There were 93 critical incidents reported for the October 1, 2020 through December 31, 2020 period, most of which have a resolved status. Many of the incidents stemmed from falls. The Department continues to work with MMCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

The following table outlines the total number of LTSS critical incidents reported by MMC, HARP, and HIV SNP for each of the last two (2) quarters, and the net change over the last two (2) quarters:

Plan Name	Critical Incidents		
	FFY 21 Q1 10/1/2020-12/31/2020	FFY 20 Q4 7/1/2020-9/30/2020	Net Change
Mainstream Managed Care			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	21	4	+17
Fidelis Care	0	0	0
Healthfirst	16	31	-15
Health Insurance Plan of Greater New York	0	0	0
HealthNow	0	0	0
HealthPlus	2	2	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	1	0	+1
MVP Health Plan	2	4	-2
United Healthcare	0	0	0
WellCare	0	0	0
YourCare Health Plan	0	0	0
Total	**42**	**41**	**+1**
Health and Recovery Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	7	4	+3
Fidelis Care	0	0	0
Healthfirst	41	25	+16
Health Insurance Plan of Greater New York	0	0	0
HealthPlus	0	0	0
Independent Health Association	0	0	0
MetroPlus Health Plan	0	0	0
Molina Healthcare	0	0	0
MVP Health Plan	1	1	0
United Healthcare	0	0	0
VNS Choice	0	2	-2

YourCare Health Plan	0	0	0
Total	**49**	**32**	**+17**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	2	0	+2
Total	**2**	**0**	**+2**
Grand Total	**93**	**73**	**+20**

The following table outlines the total number of LTSS critical incidents plans reported by category for each of the last two (2) quarters, and the net change over the last two (2) quarters:

Category of Incident	**Critical Incidents**		
	FFY 21 Q1 10/1/2020-12/31/2020	**FFY 20 Q4 7/1/2020-9/30/2020**	**Net Change**
Mainstream Managed Care			
Any Other Incidents as Determined by the Plan	5	0	+5
Crimes Committed Against Enrollee	6	2	+4
Crimes Committed by Enrollee	2	3	-1
Instances of Abuse of Enrollees	2	11	-9
Instances of Exploitation of Enrollees	4	0	+4
Instances of Neglect of Enrollees	0	1	-1
Medication Errors that Resulted in Injury	1	0	+1
Other Incident Resulting in Hospitalization	12	9	+3
Other Incident Resulting in Medical Treatment Other Than Hospitalization	10	15	-5
Wrongful Death	0	0	0
Total	**42**	**41**	**+1**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	4	2	+2
Crimes Committed Against Enrollee	1	1	0
Crimes Committed by Enrollee	0	2	-2
Instances of Abuse of Enrollees	0	0	0
Instances of Exploitation of Enrollees	0	1	-1
Instances of Neglect of Enrollees	1	0	+1

Medication Errors that Resulted in Injury	1	0	+1
Other Incident Resulting in Hospitalization	8	4	+4
Other Incident Resulting in Medical Treatment Other Than Hospitalization	32	21	+11
Use of Restraints	1	1	0
Wrongful Death	1	0	+1
Total	**49**	**32**	**+17**
HIV Special Needs Plans			
Instances of Abuse of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	0	0
Other Incident Resulting in Hospitalization	1	0	+1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	1	0	+1
Total	**2**	**0**	**+2**
Grand Total	**93**	**73**	**+20**

C. Member Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 81 member complaints this quarter. This total is a 52.8% increase from the previous quarter, which reported 53 member complaints.

MMCO Member Complaints Received Directly by the Department	
FFY 21 Q1 10/1/2020-12/31/2020	**FFY 20 Q4 7/1/2020-9/30/2020**
81	**53**

The top six (6) most frequent categories of member complaints received directly at NYSDOH involving MMCOs were as follows:

Percentage of MMCO Member Complaints Received Directly by the Department		
Description of Complaint	**FFY 21 Q1 10/1/2020–12/31/2020**	**FFY 20 Q4 7/1/2020–9/30/2020**
Reimbursement/Billing	16%	9%
Pharmacy/Formulary	9%	6%
Difficulty with Obtaining: Dental/Orthodontia	7%	8%
All Other Complaints	7%	13%
Denial of Clinical Treatment	4%	2%
Difficulty with Obtaining: Personal Care	4%	0%

The Department monitors and tracks member complaints reported to the Department related to new or changed benefits and populations enrolled into MMCOs.

In compliance with the Families First Coronavirus Response Act, loss of Medicaid coverage was suspended on March 18, 2020, unless a member cancelled their coverage or moved out of New York State. Since March, the Department has carefully monitored any complaints regarding plan enrollment issues related to suspended loss of Medicaid coverage, and addressed these issues in accordance with maintenance of effort requirements during this period.

D. Fair Hearings

There were 288 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of October 1, 2020 through December 31, 2020. The dispositions of these fair hearings are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)		
Hearing Dispositions	**FFY 21 Q1 10/1/2020-12/31/2020**	**FFY 20 Q4 7/1/2020-9/30/2020**
In favor of Appellant	96	119
In favor of Plan	153	148
No Issue	39	37
Total	**288**	**304**

For fair hearing dispositions occurring during the reporting periods, the following table describes the number of days from the initial request for a fair hearing to the final disposition of the hearing, including time elapsed due to adjournments.

Fair Hearing Days from Request Date till Decision Date (includes MMC, HARP and HIV SNP)		
Decision Days	**FFY 21 Q1 10/1/2020-12/31/2020**	**FFY 20 Q4 7/1/2020-9/30/2020**
0-29	18	28
30-59	55	73
60-89	42	36
90-119	60	49
=>120	113	118
Total	**288**	**304**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 17, 2020. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the Medicaid Managed Care program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment; an update on the status of the Managed Long Term Care (MLTC) program; and an update on Behavioral Health, Health and Recovery Plans (HARPs) and Health Homes. One additional agenda item included a presentation on the transition of the pharmacy benefit from Medicaid Managed Care (MMC) to the Medicaid Fee-for-Service (FFS) Pharmacy Program effective April 1, 2021. This pharmacy carve-out applies to MMC plans, including Mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs). Due to time constraints a public comment period was not offered at this meeting. The next MMCARP meeting is scheduled for February 18, 2021.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

The 2019 MLTC Report was publicly released in October. This Report presents information on the 50 plans that were enrolling members during the data collection period. This Report is the basis for the Consumer Guides and the Quality Incentive.

The 2019 MLTC Consumer Guides were released in December on the Department's website. The Guides are also printed by Maximus, our facilitated Medicaid enroller, for inclusion in new member's packets. The Guides help new members to choose a managed long-term care plan that meets their health care needs. The Guides offer information about the quality of care offered by the different plans, and people's opinions about the care and services the plans provide.

B. Quality Measurement in Medicaid Managed Care

1. Quality Assurance Reporting Requirements (QARR)

Attachment 3 reflects the NYS overall quality results for Medicaid Managed Care for measurement year 2019 along with the national benchmarks for Medicaid, which are from NCQA's State of Health Care Quality 2020 report. National benchmarks were available for 62 measures for Medicaid. Out of the 61 measures that Medicaid plans reported, 80% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in Medicaid managed care. The NYS Medicaid, rates exceed the national benchmarks for behavioral health on adult measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postpartum care, as well as screening for Chlamydia, cervical cancer, and breast cancer).

C. Quality Improvement

External Quality Review

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, Part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including: performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and, providing data processing and analytical support to the Department. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, FIDAs, FIDA-IIDs, HARPs, and BHOs, 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.

During the 1st quarter of 2021, the completed final report of the Access Survey of Provider Availability survey, remained in internal review and approval processes at the NYSDOH

Office of Health Insurance Programs. The final reports will be issued to the plans during the 2nd quarter of 2021. The Member Services Survey final report also remained in OHIP internal review and approval processes during the 1st quarter of 2021. The High-Volume PCP Ratio Survey was conducted in the previous quarter, and in the 1st. quarter of 2021 a final report of the survey is being reviewed by IPRO.

IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). The PNDS collects network information from around 300 active networks in NYS. IPRO facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. The quarter 3 2020 PNDS submission deadline was at the end of October 2020; plans submitted data based on the new version of data dictionary (version 10).

Significant edits to the New York State Provider & Health Plan Look-Up website increased consumers' access to data such as deciding which health plan to enroll in or when looking for a provider. The site surpassed 1 million distinct users in November 2020 and open enrollment has seen higher than usual traffic with over 55k distinct users per month.

Provider network panel data submission opened on 11/2/2020 and yielded 6,252,526 rows of data (up ~6%). IPRO developers worked to incorporate new thresholds and dictionary edits effective 2/1/2021 which were implemented successfully. Technical assistance was provided by DOH and IPRO throughout the submission in addition to DOH providing detailed analytics to plans at risk of failing the newly updated requirements. IPRO and DOH are continuously updating and strengthening the Standard Operating Procedure (SOP) to automate processes and in the midst of a project improvement process in conjunction with NYS Lean.

The MLTC PIP has been extended another year – now ending 12/31/2021. During the 1st quarter of 2021, IPRO conducted plan progress calls with the MLTC plans for their PIP. IPRO sent reminders to the plans regarding the January 2021 due date of their PIP interim reports. OQPS is revising the draft template that IPRO provided, for the MLTC EQR Technical Report. When completed the aggregated technical report will include data years 2016 thru 2019.

A final report of the MLTC Satisfaction Survey was completed and finalized in the 4th quarter of 2020. The report was posted to the NYSDOH public website in the 1st quarter of 2021.

The MTLC Encounter Data Validation Survey, with a focus on dental services, was conducted in the 4th quarter of 2020. During the 1st quarter of 2021, IPRO reviewed dental records provided by the MLTC plans, for the survey. Many plans did not have recorded dental encounters, and IPRO was able to obtain only 56 records. For the mainstream portion of the Encounter Data Validation Survey, the NYSDOH was providing data to IPRO for analysis.

A Child CAHPS survey was prepared in the 4th quarter of 2020. In the 1st quarter of 2021, the survey was conducted and the survey vendor, DataStat, worked with IPRO, in distribution of the survey. Survey analysis will be conducted in the 2nd quarter of 2021.

The final report of the Diabetes Self-Management Education (DSME) Survey remained in DOH review and approval process in the 1st quarter of 2021. Once approved, the final report will be entered into the DOH EDCC/IPR approval process for posting to the NYSDOH public website.

IPRO prepared the final reports of the HARP Non-CAHPS Survey (Perceptions of Care) Survey during the 4th quarter of 2020. During the 1st quarter of 2021 the final report was in OMH's review and approval process.

The final report of the 2019 HARP Focused Clinical Study (FCS) remained in state staff review during quarter 1 of 2021.

A draft template of the dy2019 EQR Technical Report was in DOH and IPRO review throughout the 1st quarter of 2021. When the report is finalized by DOH, IPRO will populate the report with data provided by the DOH. The dy 2018 EQR Technical Reports were being reviewed by the DOH during the 1st quarter of 2021, in preparation for the EDCC/IPR approval process.

Performance Improvement Projects (PIPs) for Medicaid Managed Care Plans (MMC)

2017-18 HARP PIP
For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic was Inpatient Care Transitions. Final reports for the 2017-18 HARP PIP projects were received in August 2019 and were finalized and approved in October 2019. A PIP Compendium of Abstracts was prepared by IPRO and was reviewed by the NYSDOH and finalized in August 2020 and is currently under review by NYSDOH.

2017-18 Perinatal Care
For the 2017-2018 PIP for the MMC plans, the selected common topic was Perinatal Care. There were four priority focus areas addressed in this PIP: history of prior spontaneous preterm birth; unintended pregnancy suboptimal birth spacing; maternal smoking; and maternal depression. The PIP Final Reports were received in July 2019 and were finalized and reviewed. A PIP Compendium of Abstracts was prepared by IPRO and was reviewed by the NYSDOH and finalized in August 2020 and is currently under review by NYSDOH.

2019-20 HIV-SNP PIP
The three HIV SNP Plans submitted their 2019-2020 PIP Proposals by December 21, 2018. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH in February 2019. One of the three HIV SNP's will participate in the HARP PIP topic. The other two HIV SNPs are each conducting separate PIP topic areas. In June 2020 the MCOs

were notified that the 2019-2020 PIPs were extended through December 31, 2021. Oversight calls were conducted in October 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report will be due in February 2021. IPRO and NYSDOH will review and finalize the Interim Reports with the MCOs.

2019-20 HARP PIP

The 2019-2020 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. The HARP PIP Proposals were due December 21, 2018. The submitted PIP Proposals were reviewed and finalized by IPRO, NYSDOH and partners (including OASAS and OMH). In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Oversight calls were conducted in October 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report will be due in February 2021. IPRO and NYSDOH will review and finalize the Interim Reports with the MCOs.

2019-2020 Medicaid KIDS Quality Agenda

The 2019-2020 Medicaid managed care (MMC) PIP topic is the KIDS Quality Agenda Performance Improvement Project. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. The PIP Proposals were due in the first quarter of 2019. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. Oversight calls were conducted in November 2020. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report will be submitted in January 2020. IPRO and NYSDOH will review and finalize the Interim Reports with the MCOs. Plan-Specific Member Level Files for Lead Testing results data were sent to the plans quarterly beginning on March 29, 2019. Plan Specific Member Level Files for Hearing Screening data were distributed to plans monthly by NYSDOH beginning on May 29, 2019.

Breast Cancer Selective Contracting

The Department began the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2017-2019 to calculate facility-level breast cancer surgical volume and identify low-volume facilities with a 3-year average of fewer than 30 surgeries. The process involved extracting inpatient and outpatient surgical data, as well as, facility-level data from the Health Facilities Information System (HFIS). A total of 232 facilities were identified as having performed at least one breast cancer surgery from 2017-2019. Preliminary facility volume designations were as follows: 112 high-volume; 23 low-volume that are allowed to perform surgeries to ensure adequate access; and, 97 low-volume restricted facilities.

Letters were drafted to notify low-volume facilities that the Department will not reimburse claims for breast cancer surgeries provided to Medicaid fee-for-service beneficiaries during state fiscal year 2021-22, nor can Medicaid managed care plans contract with low-volume

facilities to perform breast cancer surgeries. In addition, the letters will also include a copy of the appeal form for facilities that want to appeal the decision to be placed on the low-volume restricted list. The letters will be mailed out in January 2021.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 1 (10/1/2020-12/31/2020)

As of December 2020, there were 8,551 NCQA-recognized PCMH providers in New York State. Approximately 4.65% (398) are recognized under the 2014 set of standards. In PCMH 2014 standards, practices received a higher score or level if they demonstrated more elements of patient-centered care.

On April 1, 2017, NCQA released their 2017 recognition standards, eliminating the leveling structure and making recognition valid for one-year periods instead of the previous three-year period to measure performance more frequently. There are no providers and practices recognized under the 2017 standards.

On April 1, 2018 the New York State Department of Health released a new recognition program called the New York State Patient-Centered Medical Home (NYS PCMH). NYS PCMH is based on the PCMH 2017 recognition but requires practices to achieve a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, value-based payment arrangements, and health information technology capabilities. There are 8,153 providers and 2,013 practices recognized under NYS PCMH. Of the providers that became recognized in December 2020, 109 were new to the NYS PCMH program.

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of December 2020 are:

- 2014 level 2: $0 PMPM
- 2014 level 3: $6.00 PMPM
- 2017 recognition: $6.00 PMPM
- NYS PCMH recognition: $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 2020 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 issues with the reporting template and PMDA system and in eliminating delays in the utilization of the Budget Neutrality Reporting Tool for quarterly timely reporting.

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

- As detailed in STC X.10, the State identified a contractor, KPMG, to complete a certified and audited final assessment of budget neutrality for the October 1, 2011 through March 31, 2016 period. The audit was completed over the summer of 2018. A final audit report was submitted to CMS on September 19, 2019, with CMS confirming in a subsequent discussion on October 10, 2019, that all corrective action requirements outlined in the STCs have been satisfied. The State has addressed all audit findings, however, entry of corrected data for F-SHRP DY6 into MBES is pending approval of a timely filing waiver.
- The State has also requested a timely filing waiver to address an issue with reporting for DY18 Q1-4 and DY19 Q1 resulting from an error in the query language used to pull data for this time period which resulted in the exclusion of F-SHRP counties for these quarters. This error was not uncovered until all DY18 quarters were processed, allowing for comparisons to previous full data years that had already been reported, and the source of the issue was not identified until DY19Q1 was already processed.

X. Other

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

NYS Compliance

The 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. Moreover, New York State is actively working on addressing the Top 32 Priority Issues (TPIs) identified and prioritized by CMS for 2021. New York stands in the highest compliance category (Blue) as defined by CMS for 2020.

New York State continues to work closely with CMS and its analytics vendors to define, identify and prioritize new issues.

The State is also working closely with CMS to address new T-MSIS reporting requirements in relation to the COVID-19 public health emergency.

Attachments:
Attachment 1— MLTC Critical Incidents
Attachment 2— MLTC Partial Capitation Plan, PACE, and MAP Enrollment
Attachment 3— NYS Medicaid Managed Care Statewide Rates - 2019, Compared to 2019 National Rates

State Contact:
Phil Alotta
Associate Health Planner
Division of Program Development and Management
Office of Health Insurance Programs
phil.alotta@health.ny.gov
Phone (518) 486-7654
Fax# (518) 473-1764

Submitted via email: February 25, 2021
Uploaded to PMDA: February 25, 2021

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	4	0	0	0	3	0	1	0	0	8,137	0.05%
AgeWell NY	6	0	0	0	1	0	5	0	0	12,123	0.05%
Archcare Community Life	24	2	0	0	2	0	7	13	0	5,123	0.47%
Archcare PACE	17	0	0	0	3	0	8	6	0	837	2.03%
Catholic Health-LIFE	15	0	8	0	0	0	1	6	0	259	5.79%
Centerlight PACE	38	0	0	0	0	0	13	25	0	2688	1.41%
Centers Plan for Healthy Living	139	1	0	1	35	1	39	62	0	36,778	0.38%
Centers Plan for Healthy Living MAP	0	0	0	0	0	0	0	0	0	14	0.00%
Complete Senior Care	1	0	0	0	0	0	0	1	0	125	0.80%
Eddy SeniorCare	12	0	0	0	0	0	6	6	0	210	5.71%
Elant Choice (EverCare)	30	0	0	0	0	0	5	25	0	968	3.10%
Elderplan MAP	1	0	0	0	0	0	1	0	0	1573	0.06%
Elderserve	199	3	0	1	3	7	81	104	0	15,167	1.31%
Elderwood	16	0	0	0	0	1	2	13	0	882	1.81%
Empire BlueCross BlueShield Healthplus	10	0	0	0	0	0	0	10	0	7,227	0.14%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	12	0.00%
Extended	66	0	0	0	0	0	26	40	0	7076	0.93%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	955	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	138	0.00%
Fidelis Care at Home	0	0	0	0	0	0	0	0	0	23,664	0.00%
Fidelis MAP	0	0	0	0	0	0	0	0	0	80	0.00%
Hamaspik	24	0	0	1	0	1	5	17	0	2,402	1.00%
Healthfirst CompleteCare	100	0	0	0	0	2	34	64	0	26146	0.38%
HomeFirst, Inc. (Elderplan)	2	0	0	0	0	0	1	1	0	1573	0.13%
Icircle	0	0	0	0	0	0	0	0	0	4,189	0.00%
Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	739	0.00%
Independent Living Services of CNY (PACE CNY)	23	0	0	0	0	0	14	9	0	632	3.64%

Integra MLTC	0	0	0	0	0	0	0	0	0	22,377	0.00%
Kalos ErieNiagara DBA: First Choice Health	2	0	0	0	1	0	1	0	0	1,484	0.13%
MetroPlus	0	0	0	0	0	0	0	0	0	2,058	0.00%
Monefiore	2	0	0	0	0	0	1	1	0	1,757	0.11%
Prime	47	0	0	0	0	5	8	34	0	524	8.97%
Senior Health Partners	89	0	0	0	0	1	34	54	0	15,320	0.58%
Senior Network Health, LLC	18	0	0	0	0	0	10	8	0	589	3.06%
Senior Whole Health	1	0	0	0	1	0	0	0	0	15,105	0.01%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	85	0.00%
Total Senior Care	11	0	0	0	0	0	3	8	0	124	8.87%
Village Care	291	0	0	0	28	0	58	205	0	12,051	2.41%
Village Care MAP	87	0	0	0	14	0	14	59	0	1599	5.44%
VNA Homecare Options (Nascentia Health Options)	99	1	0	1	0	0	49	48	0	7,953	1.24%
VNS Choice MAP TOTAL	9	0	0	0	0	1	6	2	0	2368	0.38%
VNS Choice MLTC	119	0	0	0	5	0	38	76	0	19,502	0.61%
Total	1502										

Managed Long Term Care Partial Capitation Plan Enrollment January 2020 - December 2020												
	Jan-20	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
Plan Name	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment	Enrollment
Aetna Better Health	8,266	8,251	8,159	8,068	7,956	7,751	7,606	7,139	6,951	6,708	6,585	6,496
AgeWell New York	12,526	12,694	12,773	12,873	12,784	12,579	12,534	11,942	11,983	12,089	12,123	12,312
ArchCare Community Life	5,005	4,972	4,951	4,924	4,890	4,804	4,752	4,501	4,496	4,525	4,526	4,556
Centers Plan for Healthy Living	39,183	39,762	40,467	41,047	41,477	41,774	42,006	41,739	42,189	42,574	42,937	43,344
Elant	1,022	1,056	1,068	1,068	1,067	1,099	1,117	1,107	1,104	1,106	1,099	1,101
Elderplan	15,502	15,563	15,638	15,715	15,834	15,610	15,389	14,293	14,258	14,280	14,307	14,465
Elderserve	15,455	15,491	15,537	15,631	15,676	15,547	15,511	15,077	15,115	15,154	15181	15268
Elderwood	962	981	985	977	1,003	985	988	806	837	913	905	913
Extended MLTC	6,948	6,983	6,994	6,986	6,972	6,880	6,788	6,640	6,587	6,602	6,596	6,558
Fallon Health Weinberg (TAIP)	992	1,001	1,001	1,016	1,023	1,011	1,001	880	892	904	890	887
Fidelis Care at Home	23,088	22,647	22,273	22,160	21,911	26,042	25,548	21,848	21,625	21,494	20,732	20,665
Hamaspik Choice	2,376	2,370	2,354	2,311	2,298	2,255	2,256	2,170	2,147	2,151	2,118	2,138
HealthPlus- Amerigroup	7,132	7,124	7,076	7,010	6,914	6,596	6,363	5,952	5,889	5,830	5,802	5,748
iCircle Services	4,660	4,728	4,803	4,863	4,861	4,860	4,867	3,995	4,061	3,929	3834	3826
Integra	26,069	26,914	27,885	28,626	29,430	29,977	30,626	31,288	32,694	33,820	35,269	36,786
Kalos Health- Erie Niagara	1,544	1,544	1,483	1,470	1,480	1,437	1,410	974	952	936	872	842
MetroPlus MLTC	2,076	2,088	2,084	2,081	2,080	2,026	1,978	1,652	1,634	1,630	1,606	1,606
Montefiore HMO	1,796	1,812	1,811	1,803	1,800	1,772	1,744	1,621	1,612	1,607	1,592	1,595
Prime Health Choice	555	572	578	579	592	587	586	574	581	593	598	615
Senior Health Partners	15,281	15,240	15,198	15,163	15,030	14,585	14,298	13,286	13,301	13,104	13,085	13,045
Senior Network Health	575	579	577	584	584	576	571	429	428	423	423	424
Senior Whole Health	14,734	14,443	14,183	14,029	14,065	13,901	13,712	13,239	13,125	13,062	13,094	13,193
Village Care	12,542	12,609	12,709	12,841	13,025	13,015	12,985	12,887	12,851	13,012	13,242	13,400
VNA HomeCare Options	7,793	7,693	7,416	7,350	7,279	7,029	6,860	3,410	3,390	3,449	3,248	3,283
VNS Choice	20,264	20,458	20,556	20,798	21,158	21,066	20,936	19,859	20,253	20,581	20,775	21,136
TOTAL	**246,346**	**247,575**	**248,559**	**249,973**	**251,189**	**253,764**	**252,432**	**237,308**	**238,955**	**240,476**	**241,439**	**244,202**

PACE & MAP Enrollment January 2020 - December 2020												
	Jan-20	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
PACE	5,724	5,769	5,748	5,727	5,720	5,633	5,585	5,567	5,559	5,568	5,552	5,552
MAP	20,241	20,452	20,732	20,888	21,086	21,391	21,754	21,941	22,369	23,133	23,019	22,978

NYS Medicaid Managed Care Statewide Rates - 2019, Compared to 2019 National Rates

Domain	Measure	NYS Medicaid 2019	National 2019
Access to primary care	Appropriate Testing for Pharyngitis (Ages 18-64)	59	64
Adult Health	Adult BMI Assessment	90	88
Adult Health	Advising Smokers to Quit	79	77
Adult Health	Annual Dental Visit (Ages 19-20)	45	38
Adult Health	Asthma Medication Ratio (Ages 19-64)	57	NA
Adult Health	Colorectal Cancer Screening	64	NA
Adult Health	Controlling High Blood Pressure	67	61
Adult Health	Discussing Smoking Cessation Medications	62	54
Adult Health	Discussing Smoking Cessation Strategies	56	49
Adult Health	Flu Vaccination for Adults Ages 18-64	46	44
Adult Health	Managing Diabetes Outcomes - Blood pressure controlled (lower than 140/90 mm Hg)	67	62
Adult Health	Managing Diabetes Outcomes - HbA1C Control (less than 8.0%)	61	50
Adult Health	Managing Diabetes Outcomes -Poor HbA1c Control	27	40
Adult Health	Medication Management for People with Asthma 50% Days Covered (Ages 19-64)	69	NA
Adult Health	Medication Management for People with Asthma 75% Days Covered (Ages 19-64)	46	NA
Adult Health	Monitoring Diabetes - Dilated Eye Exam	68	57
Adult Health	Monitoring Diabetes - HbA1c Testing	93	88
Adult Health	Monitoring Diabetes - Nephropathy Monitoring	93	90
Adult Health	Monitoring Diabetes - Received All Tests	63	NA
Adult Health	Persistence of Beta-Blocker Treatment	87	81
Adult Health	Pharmacotherapy Management of COPD Exacerbation-Bronchodilator	89	82
Adult Health	Pharmacotherapy Management of COPD Exacerbation-Corticosteroid	76	70
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Adherent	70	68
Adult Health	Statin Therapy for Patients with Cardiovascular Disease - Received	80	78
Adult Health	Statin Therapy for Patients with Diabetes - Adherent	63	64
Adult Health	Statin Therapy for Patients with Diabetes - Received	70	64
Adult Health	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	52	30
Adult Health	Viral Load Suppression	78	NA

Behavioral Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64	61
Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	54	55
Behavioral Health	Antidepressant Medication Management-Effective Continuation Phase Treatment	38	39
Behavioral Health	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	89	77
Behavioral Health	Diabetes Monitoring for People with Diabetes and Schizophrenia	80	71
Behavioral Health	Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	82	82
Behavioral Health	Follow-Up After Emergency Department Visit for Mental Illness Within 30 days	72	56
Behavioral Health	Follow-Up After Emergency Department Visit for Mental Illness Within 7 days	59	41
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 30 Days	79	57
Behavioral Health	Follow-Up After Hospitalization for Mental Illness Within 7 Days	64	36
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication:Continuation Phase	67	53
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication:Initiation Phase	58	42
Behavioral Health	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days	27	20
Behavioral Health	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days	21	13
Behavioral Health	Metabolic Monitoring for Children and Adolescents on Antipsychotics	43	38
Behavioral Health	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	74	62
Child and Adolescent Health	Adolescent Immunization	86	80
Child and Adolescent Health	Adolescent Immunization (Combo 2)	45	38
Child and Adolescent Health	Adolescent Well-Care Visits	69	56
Child and Adolescent Health	Annual Dental Visit (Ages 2-18)	64	NA
Child and Adolescent Health	Appropriate Testing for Pharyngitis (Ages 3-17)	89	80
Child and Adolescent Health	Assessment, Counseling or Education: Alcohol and Other Drug Use	71	NA
Child and Adolescent Health	Assessment, Counseling or Education: Depression	68	NA
Child and Adolescent Health	Assessment, Counseling or Education: Sexual Activity	68	NA

Child and Adolescent Health	Assessment, Counseling or Education: Tobacco Use	75	NA
Child and Adolescent Health	Asthma Medication Ratio (Ages 5-18)	66	NA
Child and Adolescent Health	Childhood Immunization Status (Combo 3)	74	70
Child and Adolescent Health	Counseling for Nutrition	84	68
Child and Adolescent Health	Counseling for Physical Activity	76	64
Child and Adolescent Health	Lead Testing	89	70
Child and Adolescent Health	Medication Management for People with Asthma 50% Days Covered (Ages 5-18)	60	NA
Child and Adolescent Health	Medication Management for People with Asthma 75% Days Covered (Ages 5-18)	33	NA
Child and Adolescent Health	Weight Assessment- BMI Percentile	88	77
Child and Adolescent Health	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	86	74
Child and Adolescent Health	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	83	NA
Provider Network	Satisfaction with Personal Doctor	81	83
Provider Network	Satisfaction with Provider Communication	92	93
Provider Network	Satisfaction with Specialist	82	84
Satisfaction with Care	Access to Prescription Medicines for Children	90	NA
Satisfaction with Care	Access to Specialized Services for Children	75	NA
Satisfaction with Care	Care Coordination	81	NA
Satisfaction with Care	Coordination of Care for Children with Chronic Conditions	75	NA
Satisfaction with Care	Customer Service	87	89
Satisfaction with Care	Customer Service for Children	86	NA
Satisfaction with Care	Family-Centered Care: Personal Doctor Who Knows Child	90	NA
Satisfaction with Care	Getting Care Needed	81	83
Satisfaction with Care	Getting Care Needed for Children	84	NA
Satisfaction with Care	Getting Care Quickly	81	82
Satisfaction with Care	Getting Care Quickly for Children	88	NA

Satisfaction with Care	Getting Needed Counseling or Treatment	71	NA
Satisfaction with Care	Rating of Counseling or Treatment	62	NA
Satisfaction with Care	Rating of Health Plan	76	79
Satisfaction with Care	Rating of Health Plan for Children	85	NA
Satisfaction with Care	Rating of Overall Healthcare	75	76
Satisfaction with Care	Rating of Overall Healthcare for Children	87	NA
Satisfaction with Care	Satisfaction with Personal Doctor for Children	90	NA
Satisfaction with Care	Satisfaction with Provider Communication for Children	93	NA
Satisfaction with Care	Satisfaction with Specialist for Children	84	NA
Satisfaction with Care	Shared Decision Making	80	NA
Satisfaction with Care	Shared Decision Making for Children	76	NA
Satisfaction with Care	Wellness Discussion	75	NA
Women's Health	Breast Cancer Screening	71	58
Women's Health	Cervical Cancer Screening	75	60
Women's Health	Chlamydia Screening (Ages 16-20)	75	55
Women's Health	Chlamydia Screening (Ages 21-24)	77	64
Women's Health	Postpartum Care	83	75
Women's Health	Timeliness of Prenatal Care	NA	87

NA = Data Not available