MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 22 (4/1/2020-3/31/2021)
Federal Fiscal Quarter: 2 (1/1/2021-3/31/2021)

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 submitted a three-year waiver extension request to CMS on March 5, 2021. CMS granted a temporary extension of the 1115 waiver through March 31, 2022.

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: Second Quarter

MRT Waiver- Enrollment as of March 2021

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	**494,858**	**8,581**	**2,375**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**57,410**	**1,217**	**543**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**28,086**	**504**	**75**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**38,481**	**671**	**290**

Population 5 - Safety Net Adults	**343,251**	**7,662**	**1,829**
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)	**68,387**	**940**	**53**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**142,269**	**3,266**	**125**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**7,692**	**162**	**9**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**57,184**	**859**	**28**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**23,862 or an approximate 15.4% 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.

Voluntary disenrollment increased due to a significant increase in disenrollment due to incarcerations that were only partially offset by a decrease in the plan's passive enrollment of its HARP eligible population into its affiliated HARP plan.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	5,327 or an approximate 50.6% 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 a significant decrease in case closures that were only partially offset by an increase in other types of lost eligibility.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2021				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	880,359	11,831	2,314	9,517
Rest of State	305,382	6,195	795	5,400
Statewide	1,185,741	18,026	3,109	14,917
February 2021				
New York City	928,364	13,448	2,674	10,774
Rest of State	337,689	7,929	935	6,994
Statewide	1,266,053	21,377	3,609	17,768
March 2021				
New York City	922,240	12,537	2,647	9,890
Rest of State	337,921	6,694	853	5,841
Statewide	1,260,161	19,231	3,500	15,731

Second Quarter	
Region	**Total Affirmative Choices**
New York City	**30,181**
Rest of State	**18,235**
Statewide	**48,416**

HIV SNP Plans				
January 2021				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**13,141**	**174**	**0**	**174**
Rest of State	**18**	**4**	**0**	**4**
Statewide	**13,159**	**178**	**0**	**178**
February 2021				
New York City	**13,178**	**184**	**0**	**184**
Rest of State	**17**	**1**	**0**	**1**
Statewide	**13,195**	**185**	**0**	**185**
March 2021				
New York City	**13,188**	**165**	**0**	**165**
Rest of State	**17**	**1**	**0**	**1**
Statewide	**13,205**	**166**	**0**	**166**
Second Quarter				
Region	**Total Affirmative Choices**			
New York City	**523**			
Rest of State	**6**			
Statewide	**529**			

Health and Recovery Plans Disenrollment			
FFY 21 – Q2			
	Voluntary	Involuntary	Total
January 2021	598	556	1,154
February 2021	678	441	1,119
March 2021	912	331	1,243
Total:	2,188	1,328	3,516

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2021-3/31/2021) Q2 FFY 2021

As of the end of the second federal fiscal quarter (end of March 2021), there were 2,856,810 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 75,080 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 12 HRA facilities open to the public and has suspended outreach activities at 17 HRA facilities temporarily closed due to COVID-19. MAXIMUS reported that 12,684 clients were educated about enrollment options and made an enrollment choice including 394 clients in person and 12,290 clients 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 21,916 FFS community clients were reported on the regular auto-assignment list, 2,997 clients responded to the call that generated 3,221 enrollments. Of the total of 123 FFS NH clients

reported on NH auto-assignment list, 31 (25%) clients and/or authorized representatives made a plan selection.

C. NYMC HelpLine Observations January- March 2021

CMU resumed NYMC HelpLine observations effective January 2021. CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observing all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 57,406 calls were received by the Helpline and 54,834 or 95% were answered. Calls answered were handled in the following languages: English: 36,596 (66%); Spanish: 6,798 (12%); Chinese: 2,518 (4%); Russian: 639 (2%); Haitian/Creole: 94 (1%); and other: 8,189 (15%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 4,209 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 2nd Quarter 2021						
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Total**
2,594 (62%)	199 (5%)	297 (7%)	893 (21%)	225 (5%)	1 (0%)	4,209

A total of 1,951 (46%) recorded calls observed were unsatisfactory including 1,785 calls with a single infraction and 166 calls with multiple infractions. A total of 2,327 infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: 2,221 (95%) - CSRs did not correctly document or failed to document the issues presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 34 (2%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 72 (3%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 2,327 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

During the second quarter of FFY 2020-2021 there were no plan expansions, withdrawals or new Plans.

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. Currently, all 19 resultant contracts have been executed by New York State and have been submitted to CMS for final approval.

C. Health Plans/Changes to Certificates of Authority

- **HealthNow New York, Inc.-** The Department approved a change of control and name change for HealthNow New York. The Certificate of Authority has been updated to reflect a new legal name of **Highmark Western and Northeastern New York Inc.**

- **New York Quality Healthcare Corporation dba Fidelis**- The Department revised the Certificate of Authority to reflect that Fidelis is *conditionally* certified to provide Integrated Benefits for Dually Eligible Enrollees program services in the counties of Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Kings, Lewis, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Suffolk, Sullivan, Tioga, Ulster, Warren, Washington, Westchester, Wyoming, Yates counties.

- **MetroPlus Health Plan, Inc.-** The Department of Health revised the Certificate of Authority (COA) to reflect that MetroPlus Health Plan Inc.is *conditionally* certified to provide the Integrated Benefits for Dually Eligible Enrollees Program in the counties of Bronx, Kings, New York, Queens and Richmond counties. Additionally, the counties of Orange and Putnam have been removed as an update to the service area for the Medicaid Advantage Plus line of business.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Please note that Operational Survey Activity was on hold as the 2nd Quarter was devoted to Readiness Reviews for the integration of Foster Care Services per MRT carve ins.

Surveillance activity completed during the 2nd Quarter FFY 2020-2021 includes the following:

One (1) Comprehensive Operational Survey was completed during 2nd Quarter FFY 2020-2021. An SOD was issued and a POC was accepted for one (1) Plan.

- CDPHP

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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (7/1/2020-9/30/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	24,474	322	311	1.27%
ROS	4,009	16	16	0.40%
Total	28,483	338	327	1.15%

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 (10/1/2020-12/31/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	23,703	268	263	1.11%
ROS	3,759	21	21	0.56%
Total	27,462	289	284	1.03%

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

NOTE: For the Inpatient Denial Reports, the State has provided data for Q4 2020 and Q1 2021, which includes a previously PAUSED report due to COVID-19 State of Emergency. Going forward, with the completion of all PAUSED reports now submitted to CMS, the State will resume submission of the report with a 1-quarter lag (representing data collection timing difference with CMS reporting). Q2 2021 data will be made available on the next submission.

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.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (7/1/2020-9/30/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	8,823	64	47	0.53%
ROS	2,056	33	18	0.88%
Total	10,879	97	65	0.60%

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 (10/1/2020-12/31/2020)

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	8,497	51	26	0.31%
ROS	1,857	29	16	0.86%
Total	10,354	80	42	0.41%

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

NOTE: For the Outpatient Denial Reports, the State has provided data for Q4 2020 and Q1 2021, which includes a previously PAUSED report due to COVID-19 State of Emergency. Going forward, with the completion of all PAUSED reports now submitted to CMS, the State will resume submission of the report with a 1-quarter lag (representing data collection timing difference with CMS reporting). Q2 2021 data will be made available on the next submission.

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 (1/1/2021-3/31/2021)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
New York City	**1,105,725**	**92.76%**	**7.24%**
Rest of State	**917,133**	**94.02%**	**5.98%**
Statewide Total	**2,022,858**	**93.32%**	**6.68%**

Note: IHA Claims Data for March 2021 has been excluded due to data submission issue.

BH Adults HCBS Claims/Encounters 1/1/2021-3/31/2021: NYC

BH HCBS SERV GROUP	N Claims	N Recip
CPST	104	30
Education Support Services	605	173
Family Support and Trainings	15	3
Intensive Crisis Respite	0	0
Intensive Supported Employment	412	111
Ongoing Supported Employment	32	10
Peer Support	2,235	515
Pre-vocational	271	58
Provider Travel Supplements	19	16
Psychosocial Rehab	501	92
Residential Supports Services	349	46
Short-term Crisis Respite	39	6
Transitional Employment	10	6
TOTAL	4,592	932

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

BH Adults HCBS Claims/Encounters 1/1/2021-3/31/2021: ROS

BH HCBS SERV GROUP	N Claims	N Recip
CPST	1,053	190
Education Support Services	1,312	361
Family Support and Trainings	81	18
Intensive Crisis Respite	0	0
Intensive Supported Employment	662	154
Ongoing Supported Employment	80	27
Peer Support	5,927	1,235
Pre-vocational	383	100
Provider Travel Supplements	1,813	533
Psychosocial Rehab	2,457	475
Residential Supports Services	2,371	414
Short-term Crisis Respite	56	17
Transitional Employment	11	5
TOTAL	16,206	2,445

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 Statistics.

Quarter 2 MCTAC Attendance & Stats (1/1/2021 to 3/31/2021)

Events: MCTAC successfully executed **19 events** from 1/1/2021 to 3/31/2021
All 19 were held via webinar.

Individual Participation: 1,520 people attended/participated in our events of which **1,004** are unique participants.

OMH Agency Participation
Overall: 297 of 635 **(46.77%)**
NYC: 169 of 331 **(51.06%)**
ROS: 202 of 434 **(46.54%)**

OASAS Agency Participation
Overall: 200 of 547 **(36.56%)**
NYC: 57 of 240 **(23.75%)**
ROS: 150 of 379 **(39.58%)**

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 $34 million through 95 provider contracts to support the focused and streamlined administration of BH HCBS, including coordination of supports from assessment to service provision.
    - Outreach to all 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, 4,778 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2021 and March 31, 2021 6,494 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):

In response to competing priorities due to the COVID-19 public health emergency, the Gap Report focus group calls are currently on hold. The Department would like to take more time to reflect on where we are and review the feedback the Department has received so far to re-evaluate next steps for the pilot and the transition at large. The Department is planning to compile best practices from the feedback from this focus group and disseminate these findings to the larger stakeholder group. 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 April 1, 2021, there are 25 Partial Capitation plans, 9 PACE plans, 10 MAP, 3 MA plans, and 1 FIDA IDD plan. As of April 1, 2021, there are a total of 280,106 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the January 2021 through March 2021 quarter, 1 MA plan expanded service area operations. 1 MAP plan expanded service area operations.

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 January 2021 through March 2021 quarter, post enrollment surveys were completed for 6 enrollees. Of the 5 who responded to the question, all of them (100%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP (1 enrollee 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 decreased from 244,202 to 243,237 during the January 2021 through March 2021 quarter, a slight decrease from the last quarter. For that period, 10,261 individuals who were being transitioned into Managed Long Term Care made an affirmative choice, a 12% decrease from the previous quarter and brings the 12-month total for affirmative choice to 43,602.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, and MAP plans, during the April 2020 through March 2021 annual period is submitted as an attachment.

2. Significant Program Developments

During the January 2021 through March 2021 quarter:

- The 1st 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;

- The Desk Review for (4) Partial Capitation Operational Surveys have been completed. Corrective Action Plans have been completed by the plans, and are awaiting department approval;

- Four (4) 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, SODs were issued to 3 plans to address the identified deficiencies. The Corrective Actions Plans have all been accepted; and

- A Focused Survey was conducted on (25) Partial Capitation and MAP plans targeting Social Day Care management practices. The survey results are being analyzed.

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 January 2021 through March 2021 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, changes from last quarter are presumed to be due to COVID-19 pandemic.

Critical incidents: There were 1,464 critical incidents reported for the January 2021 through March 2021 quarter, a decrease of 3% 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 January 2021 through March 2021 quarter, the top reasons for complaints/appeals stayed the same as last quarter: 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: 1/1/2021 through 3/31/2021 (Percentages rounded to nearest whole number)			
Number of Recipients: 274,366	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**13**	**11**	**85%**
# Same Day	**3,135**	**3,135**	**100%**
# Standard/Expedited	**11,163**	**9,711**	**87%**
Total for this period:	**14,311**	**12,857**	**90%**

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

Appeals	4/2020-6/2020	7/2020-9/2020	10/2020-12/2020	1/2021-3/2021	Average for Four Quarters
Average Enrollment	281,967	270,489	270,539	274,366	274,328
Total Appeals	5,804	8,044	7,934	7,948	7,433
Appeals per 1,000	21	30	29	29	27
# Decided in favor of Enrollee	917	876	1,101	923	954
# Decided against Enrollee	5,373	5,121	5,906	5,909	5,577
# Not decided fully in favor of Enrollee	523	452	604	575	539
# Withdrawn by Enrollee	199	169	204	206	195
# Still pending	528	1,050	544	766	722
Average number of days from receipt to decision	9	15	9	8	10

Complaints and Appeals per 1,000 Enrollees by Product Type January 2021-March 2021					
	Enrollment	**Total Complaints**	**Complaints per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plan Total	243,361	5,466	22	6,575	27
Medicaid Advantage Plus (MAP) Total	25,598	4,821	18	1,321	51
PACE Total	5,407	885	16	52	10
Total for All Products:	**274,366**	**11,172**	**41**	**7,948**	**29**

Total complaints increased 1% from 11,051 the previous quarter to 11,172 during the January 2021 through March 2021 quarter.

The total number of appeals increased 1% from 7,861 during the last quarter to 7,948 during the January 2021 through March 2021 quarter.

Technical Assistance Center (TAC) Activity

During the January 2021 through March 2021 quarter, call volume was very similar to Q1. TAC averaged about 178 calls per month. The typical range is about 200-250. As member's needs change due to COVID and COVID-related policy changes, TAC continues to see variation in the types of calls and complaints received. 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 there continues to be home health aide shortages. We have also seen

an increase in general calls for information and questions, typically about COVID-related policies.

Call Volume	**1/1/2021- 3/31/2021**
Substantiated Complaints	66
Unsubstantiated Complaints	236
Complaints Resolved Without Investigation	27
Inquiries	206
Total Calls	**535**

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

Aide Service- Agency Problems	20%
IDT- Dissatisfaction	9%
Billing- Denied Claims	7%
General- Referral to Other Department/Agency	7%
Enrollment- Eligibility/Coding	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 January 2021 through March 2021 quarter, 8,502 people were evaluated, deemed eligible and enrolled into plans, a decrease of 7% from the previous quarter.

Referrals and 30-day assessment: For the January 2021 through March 2021 quarter, MLTC plans conducted 31,733 assessments, a slight decrease from 31,785 the previous quarter. The total number of assessments conducted within 30 days decreased 7% from 23,601 the previous quarter to 21,905 this quarter.

Referrals outside enrollment broker: For the January 2021 through March 2021 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 26,176 a 1% decrease from 26,426 the previous quarter.

Rebalancing Efforts	**1/2021- 3/2021**
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	184
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	2,268
Individuals who are permanently placed in a nursing home and are new to plan	133

As of March 31, 2021, there were 3,632 current plan enrollees who were in nursing homes as permanent placements, a 1% increase from the previous quarter.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with 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 – as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers – including additional resources and technical assistance with person-centered planning;
- Facilitating relationship building between 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;
- Evaluating accuracy of Managed Care Organizations and Fee-for-Service billing and claiming data;
- 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.

Month	With K1 Flag - HCBS LOC		With KK Flag - Family of One	
	Enrolled Children	Enrolled Children w/ HCBS Claims	Enrolled Children	Enrolled Children w/ HCBS Claims
Jan	7,281	3,013	3,953	309
Feb	7,500	2,596	3,988	281
Mar	7,795	1,162	4,006	133
Q2 Avg.	**7,525**	**2,257**	**3,982**	**241**

This table includes data from the 2nd Quarter of FY2021; however, the data from February and March 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 March 31, 2021, five Independent Evaluations are in process. The first Independent Evaluation (IE) that is coming to conclusion is the DSRIP Independent Evaluation activity. This five year analysis and DSRIP IE contract has been conducted by SUNY Albany School of Public Health Research Foundation. During this quarter, the DSRIP IE team prepared responses to the CMS comments, received on January 11, 2021, to the Preliminary Evaluation report submitted September 30, 2020 to CMS. The DSRIP IE also finished more current analysis needed from that previous Preliminary Evaluation report and concluded biweekly meetings with Department of Health (DOH), Office of Health Insurance Program (OHIP) and Office of Quality and Patient Safety (OQPS) staff. The meetings clarified any outstanding questions for the seven research questions and updates needed for the draft Summative report. In March, the DSRIP IE team updated and finalized the Draft Summative Evaluation report including feedback to the January comments from CMS and the report was submitted to CMS on March 23, 2021. Per the STCs Section VII ss24, CMS is expected to return comments within 60 days. The DSRIP IE and DOH are eager to receive the CMS comments on the draft Summative report and to submit the FINAL DSRIP Summative Evaluation report by the end of next quarter as required by the STCs.

Activities have also continued in parallel for the four additional Independent Evaluations (IE) supported by each of the RAND Corporation research teams. RAND has contracts to conduct each of the Independent Evaluations including the Children's waiver, the 1115 waiver, the Health and Recovery Program (HARP) and the Self Directed Care (SDC) pilot program. The goals and deliverables for these four IE activities are for each RAND team to produce an Interim Evaluation report for each of the waiver programs per the CMS approved evaluation design plans.

Two public hearings were held early this quarter to gather public input and comments on the 1115 Medicaid Redesign Team Waiver Extension Request. As part of the extension application process, Preliminary Evaluation reports, written by each of the RAND teams, were publicly posted on December 16, 2020. Public comments and questions were encouraged by mail, email or via WebEx at the virtual Medicaid Redesign Team public hearings conducted January 21 and January 27, 2021. While each of the RAND research teams and NYS Department of Health were prepared to address any comments received on each of the Preliminary Evaluation reports during this quarter that may have impacted further evaluation activities, no comments were received. Progress continued on each IE and described below.

On March 16, 2021 the RAND team conducting the Independent Evaluation of the 1115 Demonstration Waiver provided a full draft Interim Evaluation report to NYS for review. The draft report contained updated county enrollment findings on the Domain 1 research question related to Component 1 Managed Long Term Care enrollment and also provided preliminary findings for the ten research questions related to the Domain 2 Component, to Limit Gaps in Continuous Enrollment. Previous findings for Domain 1 Component 2, Individuals Moving from Institutional to Community Based Settings in need of Long Term Services and Supports, remain unchanged as reflected in the Preliminary Evaluation report shared with CMS in December 2020.

Those preliminary findings for both Domain 1 updates and all of Domain 2 were reviewed and discussed with NYS Department of Health staff in the Office of Health Insurance Programs (OHIP), Office of Quality and Patient Safety (OQPS), Division of Eligibility and Marketplace Innovations (DEMI), the Division of Health Plan Contracting and Oversight (DHPCO), and the Division of Operations and Systems (DOS). Comments were returned to RAND on March 30, 2021. RAND is expected to address those questions and submit an updated version 2 full draft of the Interim Evaluation report to NYS reviewers in the next reporting quarter. After all internal reviews are concluded, the 1115 Interim Evaluation report for all 22 research questions will be submitted to CMS.

In February 2021, the Heath and Recovery Program (HARP) and Self-Directed (SDC) pilot program teams at RAND gained access to all data tables for all 17 HARP and 13 SDC research questions. During this quarter, RAND also conducted and concluded all qualitative interviews with stakeholders, agencies, and beneficiaries and will begin integrating analysis of both qualitative and quantitative findings were appropriate. 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 the RAND researchers weekly with HARP and SDC questions on data limitations and analysis. During this quarter, this RAND contract was also extended an additional year through February 11, 2022 to finalize all HARP and SDC Pilot Interim Evaluation activities. All data access and data use agreements were also extended in parallel through February 11, 2022. The contract extension was necessary due to the early impacts, last Spring and Summer 2020, when resources were reprioritized to address the NYS COVID-19 pandemic. Thus, this IE team's implementation activities for RAND were delayed and timelines have been updated. The RAND team is currently at the phase of data analysis and interpretation for each HARP and SDC research question. The HARP and SDC Pilots will have separate draft Interim Evaluation reports prepared for review to NYS.

During February and March 2021, the RAND team conducting the Independent Evaluation of the Children's Waiver submitted a preliminary draft of the required Interim Evaluation report for NYS review and approval. This Interim Evaluation report included preliminary findings on the 7 required interim research questions related to the Children's waiver. Six remaining research questions will be addressed in the future Summative Evaluation for the Children's waiver per the STC requirements. The Interim Evaluation report for the Children's Wavier is expected to be finalized with RAND and submitted to CMS when complete.

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Medicaid Managed Care	7,035	7,546
HARP	866	867
HIV SNP	134	119
Total MMCO Complaints	**8,035**	**8,532**

As described in the table, total MMCO complaints/action appeals reported for the current quarter total 8,035. This represents a 5.8% decrease from the prior quarter's total.

This quarter's plan-reported complaint data shows a decrease of 6.8% for MMCs from the previous quarter. HARPs show no change since the prior quarter.

This quarter's HIV SNP complaints saw an increase of 12.6% 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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	18%	19%
Balance Billing	17%	16%
Reimbursement/Billing	12%	11%
Difficulty with Obtaining: Dental/Orthodontia	12%	10%
Dissatisfied with Quality of Care	7%	6%

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	30%	29%
Pharmacy/Formulary	10%	10%
Difficulty with Obtaining: Personal Care	10%	7%
Difficulty with Obtaining: Dental/Orthodontia	8%	7%
Dissatisfaction with Quality of Care	8%	8%

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	30%	18%
Pharmacy/Formulary	15%	15%
Difficulty with Obtaining: Dental/Orthodontia	10%	13%
Balance Billing	7%	8%
Dissatisfied with Quality of Care	5%	7%

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 8,035 total reported complaints/action appeals, mainstream MMCOs reported 1,253 complaints and action appeals from their SSI members. This compares to 996 SSI complaints/action appeals from the previous quarter, representing a 25.8% increase.

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Appointment Availability: PCP	8	13
Appointment Availability: Specialist	9	4
Appointment Availability: BH HCBS	0	0
Long Wait Time	2	4
Dissatisfied with Quality of Care	85	83
Denial of Clinical Treatment	34	33
Denial of BH Clinical Treatment	3	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	435	342
Dissatisfaction with BH Provider Services	1	4
Dissatisfaction with Health Home Care Management	0	1
Difficulty with Obtaining: Specialist and Hospitals	26	9
Difficulty with Obtaining: Eye Care	3	9
Difficulty with Obtaining: Dental/Orthodontia	41	37
Difficulty with Obtaining: Emergency Services	1	2

Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	6	3
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	17	7
Difficulty with Obtaining: Home Health Care	29	19
Difficulty with Obtaining: Personal Care	180	122
Difficulty with Obtaining: PERS	3	2
Difficulty with Obtaining: CDPAS	31	20
Difficulty with Obtaining: AIDS Adult Day Health Care	0	0
Pharmacy/Formulary	73	75
Access to Non-Covered Services	15	13
Access for Family Planning Services	4	0
Communications/ Physical Barrier	3	2
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	13	5
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	102	76
Balance Billing	59	68
Transportation	17	15
All Other	53	28
Total	**1,253**	**996**

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Dissatisfied with Provider Services (Non-Medical) or MCO Services	35%	34%
Difficulty with Obtaining: Personal Care	14%	12%
Reimbursement/Billing	8%	8%
Dissatisfied with Quality of Care	7%	8%
Pharmacy/Formulary	6%	8%

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 January 1, 2021 through March 31, 2021, MMCOs reported LTSS enrollment of 44,103 members. This compares to 42,773 members from the previous quarter, representing a 3.1% 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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Affinity Health Plan	905	870
Amida Care	1,705	1,471
Capital District Physicians Health Plan	630	605
Excellus Health Plan	1,555	1,542
Healthfirst	11,528	11,187
HealthNow	182	176
HealthPlus	2,892	2,989
Health Insurance Plan of Greater New York	333	335
Independent Health Association	484	452
MetroPlus Health Plan	3,380	3,074
Molina Healthcare	1,412	1,323
MVP Health Plan	1,691	1,755
Fidelis Care	14,328	14,005
United Healthcare	2,730	2,644
VNS Choice	348	345
Total	**44,103**	**42,773**

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. Regarding the jump in Difficulty with Obtaining: Personal Care, one of the MMCOs reported a large increase in complaints in this category compared to last quarter. The Department will be following up with the plan regarding the reason for this increase.

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 21 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020
Difficulty with Obtaining: AIDS Adult Day Health Care	1	0
Difficulty with Obtaining: Adult Day Care	2	0
Difficulty with Obtaining: CDPAS	66	41
Difficulty with Obtaining: Home Health Care	53	43
Difficulty with Obtaining: RHCF Services	1	0
Difficulty with Obtaining: Personal Care	435	264
Difficulty with Obtaining: PERS	11	7
Difficulty with Obtaining: Private Duty Nursing	25	10
Total	**594**	**365**

B. Critical Incidents:

The Department requires MMCOs to report critical incidents involving members in receipt of LTSS. There were 81 critical incidents reported for the January 1, 2021 through March 31, 2021 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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020	Net Change
Mainstream Managed Care			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0

Excellus Health Plan	21	21	0
Fidelis Care	0	0	0
Healthfirst	21	16	+5
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	2	1	+1
MVP Health Plan	1	2	-1
United Healthcare	0	0	0
WellCare	0	0	0
YourCare Health Plan	0	0	0
Total	**47**	**42**	**+5**
Health and Recovery Plans			
Affinity Health Plan	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	5	7	-2
Fidelis Care	0	0	0
Healthfirst	25	41	-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	1	0	+1
MVP Health Plan	0	1	-1
United Healthcare	0	0	0
VNS Choice	1	0	+1
YourCare Health Plan	0	0	0
Total	**32**	**49**	**-17**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	2	2	0
Total	**2**	**2**	**0**
Grand Total	**81**	**93**	**-12**

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 Q2 1/1/2021-3/31/2021	FFY 21 Q1 10/1/2020-12/31/2020	Net Change
Mainstream Managed Care			
Any Other Incidents as Determined by the Plan	4	5	-1
Crimes Committed Against Enrollee	2	6	-4
Crimes Committed by Enrollee	2	2	0
Instances of Abuse of Enrollees	7	2	+5
Instances of Exploitation of Enrollees	0	4	-4
Instances of Neglect of Enrollees	2	0	+2
Medication Errors that Resulted in Injury	0	1	-1
Other Incident Resulting in Hospitalization	16	12	+4
Other Incident Resulting in Medical Treatment Other Than Hospitalization	11	10	+1
Use of Restraints	2	0	+2
Wrongful Death	1	0	+1
Total	**47**	**42**	**+5**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	0	4	-4
Crimes Committed Against Enrollee	1	1	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	2	0	+2
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	1	-1
Medication Errors that Resulted in Injury	0	1	-1
Other Incident Resulting in Hospitalization	7	8	-1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	21	32	-11
Use of Restraints	0	1	-1
Wrongful Death	1	1	0
Total	**32**	**49**	**-17**

HIV Special Needs Plans			
Instances of Abuse of Enrollees	0	0	0
Instances of Neglect of Enrollees	2	0	+2
Other Incident Resulting in Hospitalization	0	1	-1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	1	-1
Total	**2**	**2**	**0**
Grand Total	**81**	**93**	**-12**

C. Member Complaints Received Directly at NYSDOH

In addition to the MMCO reported complaints, the Department directly received 92 member complaints this quarter. This total is a 13.6% increase from the previous quarter, which reported 81 member complaints.

MMCO Member Complaints Received Directly by the Department	
FFY 21 Q2 1/1/2021-3/31/2021	**FFY 21 Q1 10/1/2020-12/31/2020**
92	**81**

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 Q2 1/1/2021-3/31/2021**	**FFY 21 Q1 10/1/2020-12/31/2020**
Pharmacy/Formulary	17%	9%
Difficulty with Obtaining: Dental/Orthodontia	9%	7%
Reimbursement/Billing	8%	16%
All Other Complaints	5%	7%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	5%	5%
Difficulty with Obtaining: Specialist and Hospitals	5%	4%

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 256 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2021 through March 31, 2021. The dispositions of these fair hearings are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)		
Hearing Dispositions	**FFY 21 Q2 1/1/2021-3/31/2021**	**FFY 21 Q1 10/1/2020-12/31/2020**
In favor of Appellant	79	96
In favor of Plan	157	153
No Issue	20	39
Total	**256**	**288**

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 Q2 1/1/2021-3/31/2021**	**FFY 21 Q1 10/1/2020-12/31/2020**
0-29	14	18
30-59	31	55
60-89	32	42
90-119	29	60
=>120	150	113
Total	**256**	**288**

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on February 18, 2021. 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; and an update on the status of the Managed Long Term Care (MLTC) program. One additional

agenda item included a presentation on the MMCARP General Information, and Bylaws Subcommittee Update given by Erin Kate Calicchia, Associate Counsel, Bureau of Program Counsel Division of Legal Affairs, NYS Department of Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for June 17, 2021.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

No updates to report.

B. Quality Measurement in Medicaid Managed Care

The Department conducted a satisfaction survey with children enrolled in Medicaid managed care in the fall of 2020. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 Child survey was administered to parents of children, ages 0 to 17, enrolled in Medicaid. The administration methodology consisted of a two-wave mailing protocol, with telephone follow up for non-responders. The overall response rate was 21.9% (with a range of 16% to 30% for response rates by plan). This return rate was slightly higher than the previous child survey that was fielded in 2018. The responses to the survey are still being analyzed and findings will be presented in the next quarterly report.

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 2nd quarter of 2021, the final report of the Access Survey of Provider Availability (Provider Directory) was prepared by the NYS EQRO, IPRO. The Office of Health Insurance Programs (OHIP) reviewed the report and provided feedback comments to IPRO. IPRO included OHIP's comments in the report. At the end of the 2nd quarter, the report was in IPRO's internal quality assurance process, and when completed will be sent to OHIP for their approval. A full second Access & Availability(A&A) Survey will not be conducted in the remainder of the year. A condensed version of the survey might be conducted, it will be a re-survey of the failed providers from the previous A&A survey. The final report of the Member Services Survey was prepared by IPRO during the 1st quarter, and in the 2nd quarter OHIP was putting the report through their internal quality assurance review. IPRO will start a new Member Services Survey when they have confirmation from OHIP to begin. The High Volume PCP Ratio Survey was completed in the 1st quarter, and in the 2nd quarter, the final report is in OHIP'S internal quality assurance review process. IPRO is waiting for confirmation from OHIP to begin a new High Volume PCP Ratio survey.

In the 2nd quarter of 2021, IPRO began the Behavioral Health Access & Availability (BH A&A) Survey, on behalf of the NYS Office of Mental Health (OMH). IPRO conducted the BH A&A survey calls and will provide this data to OMH when the calls are completed.

Provider Network Data System (PNDS)
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the Provider Network Data System (PNDS). 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 4 2020 PNDS submission deadline was at the end of January 2021. The PNDS collects network information from around 400 active networks in NYS.

Provider and Health Plan LOOK-UP Website
The website has surpassed 1.2 million users and remains a consistent resource for consumers when deciding which health plan to enroll in or when looking for a provider, for example a hospital or doctor. To help New Yorkers through the pandemic the United Hospital Fund (UHF) has updated their free consumer guide to obtaining insurance with practical advice on how to replace lost insurance coverage or find a new health plan including naming the New York State Provider & Health Plan Look-Up to learn which providers and facilities participate in the different health plans:
https://uhfnyc.org/publications/publication/maintaining-coverage-duringpandemic/

Provider Network Panel
The Panel data submission opened on 2/1/2020-2/26/2020 and yielded 6,457,633 rows of data (up nearly 1 million enrollees since Q1 2020). Continuous efforts to work with health insurance plans to increase validation thresholds checks on data elements have shown to be successful with incorporating quarterly analytics to plans at risk of failing the newly updated requirements. The upload process is currently undergoing a lean improvement project to further identify efficiencies for end users.

The Managed Long-Term Care (MLTC) Performance Improvement Project (PIP) was extended until 12/31/21, due to the pandemic. During the 2nd quarter, IPRO received all the MLTC PIP interim reports from the plans, by the 1/29/21 due date. IPRO reviewed the MLTC plan PIP interim reports throughout the 2nd quarter and will have completed the review by the end of March 2021. During the 2nd quarter IPRO made revisions to the template of the MLTC EQR Technical Report for Reporting Year 2016-2019 and provided DOH with the report. DOH and IPRO conducted a call to discuss the proposed changes to the report template, and IPRO will make the changes and provide DOH with a revised template. It was decided that the report will only include data for the reporting year of 2019.

In the 2nd quarter of 2021, IPRO conducted a new MLTC Satisfaction Survey. After the first mailing of the survey, IPRO received approximately 600 survey responses, for a response rate of 12%-13%. A second mailing of the survey will also be conducted during the 2nd quarter.

For the 2nd quarter of 2021, IPRO reviewed approximately 64 dental records for the MLTC Encounter Data Validation Survey. IPRO prepared a preliminary analysis report of the survey data for DOH review. For the mainstream portion of the Encounter Data Validation Survey, the NYSDOH was providing data to IPRO for analysis, during the 1st quarter. In the 2nd quarter, DOH provided IPRO with a larger data sample for the survey, and IPRO will use this to conduct the survey.

IPRO conducted survey analysis in the 2nd quarter, for the Child CAHPS survey data. DOH worked with survey vendor, DataStat, and IPRO, on revisions to the survey data file. Survey analyses and a draft report of results will be done by IPRO in the 3rd quarter.

The final report of the Diabetes Self-Management Education (DSME) Survey was finalized in quarter 1 and was in internal DOH review and approval processes during the 2nd quarter.

During the 2nd quarter, IPRO and DOH conducted calls with a few plans whose data for the Access and Utilization (A&U) report was questionable. IPRO worked with these plans to correct their data. IPRO then prepared a draft A&U report for DOH review/approval. In the 2nd quarter, DOH worked with IPRO to prepare and finalize plan contact information for the Quality Assurance Reporting Requirements (QARR) submission scheduled for June 2021.

The final report of the HARP Non-CAHPS Survey (Perceptions of Care) was finalized by OMH in the 2nd quarter.

The final report of the 2019 HARP Focused Clinical Study (FCS) was finalized in the 2nd quarter.

IPRO and DOH worked on the finalizing the draft template of the reporting year 2019 EQR Annual Technical Report (ATR) in the 2nd quarter. DOH approved the final template and IPRO began populating the report with data provided by DOH. DOH and IPRO conducted weekly conference calls to discuss the status and progress of the EQR ATR. DOH, IPRO

and OHIP also conducted conference calls to discuss operational and focused survey data for the EQR ATR. IPRO will have a final draft EQR ATR for DOH's review, by the end of the 2nd quarter, March 31, 2021.

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 initially reviewed by the NYSDOH. Final edits were sent to IPRO in March 2021 and is currently under revision by IPRO.

2017-18 Perinatal Care PIP
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. The PIP Compendium was approved by the NYSDOH and distributed to the MCOs on March 30, 2021.

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 February 2021. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. A second Interim Report was due in February 2021. IPRO and NYSDOH reviewed and finalized 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 February 2021. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. An Interim Report was due in February 2021. IPRO and NYSDOH reviewed and finalized 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 February and March 2021. One MCO will have an oversight call in April 2021. The MCOs submitted a PIP Update Call Summary Report prior to the oversight calls. Interim Reports were due March 8, 2021 and were submitted by all plans. IPRO and NYSDOH are currently reviewing and finalizing 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 completed its annual review of breast cancer surgical volume using all-payer Statewide Planning and Research Cooperative System (SPARCS) data from 2017-2019 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 232 facilities were designated as follows: 113 high-volume facilities, 23 low-volume unrestricted facilities, and 96 low-volume restricted facilities.

Four facilities appealed the decision to be placed on the low-volume restricted list; and all were denied. Administrators at these facilities were notified via mail of their decisions. In addition, letters regarding final volume designation for state fiscal year 2021-22 were sent to health plan chief executive officers, and health plan trade organizations. The list of low-volume restricted facilities was posted on the Department's website and included in the 2021 March Medicaid Update.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 2 (1/1/2021-3/31/2021)

As of March 2021, there were 9,239 NCQA-recognized PCMH providers in New York State. 9,201 are recognized under the NYS PCMH standard and only 38 (0.41%) are recognized under the 2014 set of standards. The NYS PCMH program is a new recognition program that was developed by the New York State Department of Health and released in April 2018. The program is based on NCQA's 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, and health information technology capabilities. There are 2,298 practices recognized under NYS PCMH standards. Of the 9,201 providers that became recognized in March 2021, 158 were new to the NYS PCMH program.

The incentive rates for the New York Medicaid PCMH Statewide Incentive Payment Program as of March 2021 are:

- 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 bimonthly meetings for participating payers. There is still a commitment across payers and providers to continue through March 2021. Discussions around alignment of methods for shared savings models are continuing but have not been 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 including various waivers that have related TPI issues. New York stands in the highest compliance category (Blue) as defined by CMS for 2020. The state has also initiated efforts to align with the new Measure Based Assessment Compliance Criteria proposed by CMS for 2022.

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

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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	2	0	0	0	0	0	2	0	0	8,137	0.02%
AgeWell NY	13	0	0	0	2	5	5	1	0	12,123	0.11%
Archcare Community Life	42	0	0	0	3	0	15	24	0	5,123	0.82%
Archcare PACE	15	0	0	0	0	0	14	1	0	837	1.79%
Catholic Health-LIFE	11	0	2	0	0	0	8	1	0	259	4.25%
Centerlight PACE	40	0	0	0	0	0	20	20	0	2688	1.49%
Centers Plan for Healthy Living	93	2	0	0	17	2	33	39	0	36,778	0.25%
Centers Plan for Healthy Living MAP	1	0	0	0	0	0	0	1	0	14	7.14%
Complete Senior Care	2	0	0	0	0	0	2	0	0	125	1.60%
Eddy SeniorCare	7	0	0	0	0	0	3	4	0	210	3.33%
Elant Choice (EverCare)	43	0	0	0	0	0	10	33	0	968	4.44%
Elderplan MAP	2	0	0	1	1	0	0	0	0	1573	0.13%
Elderserve	230	3	0	0	0	3	100	123	0	15,167	1.52%
Elderwood	31	0	0	0	0	0	8	22	0	882	3.51%
Empire BlueCross BlueShield Healthplus	2	0	0	0	2	0	0	0	0	7,227	0.03%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	12	0.00%
Extended	59	0	0	0	0	0	41	18	0	7076	0.83%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	955	0.00%
Fallon Health (TAP) PACE	42	0	0	0	3	0	15	24	0	138	30.43%
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	16	0	0	0	1	0	8	7	0	2,402	0.67%
Healthfirst CompleteCare	69	0	0	0	1	0	20	48	0	26146	0.26%
HomeFirst, Inc. (Elderplan)	4	0	0	0	4	0	0	0	0	1573	0.25%
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)	20	0	0	0	0	0	12	8	0	632	3.16%

Integra MLTC	0	0	0	0	0	0	0	0	0	22,377	0.00%
Kalos ErieNiagara DBA: First Choice Health	3	0	0	0	1	0	2	0	0	1,484	0.20%
MetroPlus	0	0	0	0	0	0	0	0	0	2,058	0.00%
Monefiore	1	0	0	0	0	0	0	1	0	1,757	0.06%
Prime	53	0	0	0	0	0	7	46	0	524	10.11%
Senior Health Partners	70	0	0	0	1	0	22	47	0	15,320	0.46%
Senior Network Health, LLC	13	0	0	0	0	0	4	9	0	589	2.21%
Senior Whole Health	0	0	0	0	0	0	0	0	0	15,105	0.00%
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	4	7	0	124	8.87%
Village Care	245	0	0	0	43	0	54	148	0	12,051	2.03%
Village Care MAP	71	0	0	0	14	1	17	39	0	1599	4.44%
VNA Homecare Options (Nascentia Health Options)	91	1	0	1	1	2	37	49	0	7,953	1.14%
VNS Choice MAP TOTAL	17	0	0	0	0	0	12	5	0	2368	0.72%
VNS Choice MLTC	145	1	0	0	18	0	49	77	0	19,502	0.74%
total	1464										

Managed Long Term Care Partial Capitation Plan Enrollment April 2020 - March 2021												
	Apr-20	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	8,068	7,956	7,751	7,606	7,139	6,951	6,708	6,585	6,496	6,415	6,322	6,257
AgeWell New York	12,873	12,784	12,579	12,534	11,942	11,983	12,089	12,123	12,312	12,442	12,453	12,558
ArchCare Community Life	4,924	4,890	4,804	4,752	4,501	4,496	4,525	4,526	4,556	4,564	4,518	4,524
Centers Plan for Healthy Living	41,047	41,477	41,774	42,006	41,739	42,189	42,574	42,937	43,344	43,360	43,333	43,623
Elant	15,715	15,834	15,610	15,389	14,293	14,258	14,280	14,307	14,465	14,259	14,061	14,008
Elderplan	15,631	15,676	15,547	15,511	15,077	15,115	15,154	15181	15268	15305	15159	15133
Elderserve	977	1,003	985	988	806	837	913	905	913	946	943	973
Elderwood	6,986	6,972	6,880	6,788	6,640	6,587	6,602	6,596	6,558	6,538	1,065	6,420
Extended MLTC	1,068	1,067	1,099	1,117	1,107	1,104	1,106	1,099	1,101	1,083	6,467	1,066
Fallon Health Weinberg (TAIP)	1,016	1,023	1,011	1,001	880	892	904	890	887	871	865	858
Fidelis Care at Home	22,160	21,911	26,042	25,548	21,848	21,625	21,494	20,732	20,665	20,516	20,174	20,085
Hamaspik Choice	2,311	2,298	2,255	2,256	2,170	2,147	2,151	2,118	2,138	2,135	2,114	2,112
HealthPlus- Amerigroup	15,163	15,030	14,585	14,298	13,286	13,301	13,104	13,085	13,045	12,573	12,202	11,929
iCircle Services	7,010	6,914	6,596	6,363	5,952	5,889	5,830	5,802	5,748	5,686	5,591	5517
Integra	4,863	4,861	4,860	4,867	3,995	4,061	3,929	3834	3826	3823	3799	3,801
Kalos Health- Erie Niagara	28,626	29,430	29,977	30,626	31,288	32,694	33,820	35,269	36,786	37,535	37,960	38400
MetroPlus MLTC	1,470	1,480	1,437	1,410	974	952	936	872	842	825	792	772
Montefiore HMO	2,081	2,080	2,026	1,978	1,652	1,634	1,630	1,606	1,606	1,586	1,547	1,518
Prime Health Choice	1,803	1,800	1,772	1,744	1,621	1,612	1,607	1,592	1,595	1,584	1,550	1,535
Senior Health Partners	579	592	587	586	574	581	593	598	615	614	616	625
Senior Network Health	584	584	576	571	429	428	423	423	424	424	413	409
Senior Whole Health	14,029	14,065	13,901	13,712	13,239	13,125	13,062	13,094	13,193	13,222	13,313	13,394
Village Care	12,841	13,025	13,015	12,985	12,887	12,851	13,012	13,242	13,400	13,161	13,092	13,080
VNA HomeCare Options	7,350	7,279	7,029	6,860	3,410	3,390	3,449	3,248	3,283	3,286	3,284	3,290
VNS Choice	20,798	21,158	21,066	20,936	19,859	20,253	20,581	20,775	21,136	21,240	21,219	21,350
TOTAL	**249,973**	**251,189**	**253,764**	**252,432**	**237,308**	**238,955**	**240,476**	**241,439**	**244,202**	**243,993**	**242,852**	**243,237**

PACE & MAP Enrollment April 2020 - March 2021												
	Apr-20	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**
PACE	5,727	5,720	5,633	5,585	5,567	5,559	5,568	5,552	5,552	5,508	5,391	5,321
MAP	20,888	21,086	21,391	21,754	21,941	22,369	23,133	23,019	22,978	24,672	25,564	26,557