MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 23 (4/1/2021-3/31/2022)
Federal Fiscal Quarter: 2 (1/1/2022-3/31/2022)

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 the Governor's Medicaid Redesign Team (MRT). CMS approved the Delivery System Reform Incentive Payment (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 Mainstream Medicaid Managed Care (MMMC) enrollees from cost sharing by waiving comparability requirements to align with the New York's social services law, except for applicable pharmacy co-payments described in the STCs. On August 2, 2019, CMS approved New York's request to create a streamlined children's model of care for children and youth

under 21 years of age with behavioral health (BH) and Home and Community Based Services (HCBS) needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities. On December 19, 2019, CMS approved New York's request to limit the nursing home benefit in the partially capitated Managed Long Term Care (MLTC) plans to three months for enrollees who have been designated as "long-term nursing home stays" (LTNHS) in a skilled nursing or residential health care facility. The amendment also implements a lock-in policy that allows enrollees of partially capitated MLTC plans to transfer to another partially capitated MLTC plan without cause during the first 90 days of a 12-month period and with good cause during the remainder of the 12-month period.

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

On March 23, 2022, CMS approved a five-year extension of the New York Medicaid Redesign Team demonstration. As part of the extension, CMS approved the state's second component of its managed long-term care (MLTC) amendment request to allow dual eligibles to stay in Mainstream Managed Care Plans that offer Dual Eligible Special Needs Plans (D-SNPs) once they become eligible for Medicare.

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

II. Enrollment: 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	477,326	6,740	9,480
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	60,640	1,402	710

Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**15,830**	**156**	**718**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**39,933**	**707**	**413**
Population 5 - Safety Net Adults	**218,927**	**6,265**	**17,434**
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)	**146,559**	**1,426**	**77**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**65,004**	**3,084**	**143**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**67,357**	**291**	**17**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**11,144**	**1,951**	**84**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**22,022 or an approximate 15.5% 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 primarily due to an increase in the “Enrolled in Other Plan” disenrollment category.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**29,076 or an approximate 377.5% increase 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 (NYSoH). Consequently, the disenrollment numbers now draw on a smaller WMS population contributing to an overall general decline in involuntary disenrollment.

Involuntary disenrollment increased due to an increase in Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
January 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**704,245**	**21,347**	**2,855**	**18,492**
Rest of State	**351,767**	**8,579**	**951**	**7,628**
Statewide	**1,056,012**	**29,926**	**3,806**	**26,120**
February 2022				
New York City	**696,454**	**22,379**	**4,097**	**18,282**
Rest of State	**356,063**	**9,438**	**1,547**	**7,891**
Statewide	**1,052,517**	**31,817**	**5,644**	**26,173**
March 2022				
New York City	**697,259**	**19,101**	**3,307**	**15,794**
Rest of State	**359,786**	**8,262**	**1,235**	**7,027**
Statewide	**1,057,045**	**27,363**	**4,542**	**22,821**

Second Quarter	
Region	Total Affirmative Choices
New York City	52,568
Rest of State	22,546
Statewide	75,114

HIV SNP Plans				
January 2022				
Region	Roster Enrollment	New Enrollment	Auto-assigned	Affirmative Choices
New York City	12,901	203	1	202
Rest of State	19	0	0	0
Statewide	12,920	203	1	202
February 2022				
New York City	12,796	216	0	216
Rest of State	20	1	0	1
Statewide	12,816	217	0	217
March 2022				
New York City	12,818	235	0	235
Rest of State	21	2	0	2
Statewide	12,839	237	0	237
Second Quarter				
Region	Total Affirmative Choices			
New York City	653			
Rest of State	3			
Statewide	656			

Health and Recovery Plans Disenrollment			
FFY 22 – Q2			
	Voluntary	Involuntary	Total
January 2022	505	623	1,128
February 2022	636	1,310	1,946
March 2022	735	756	1,491
Total:	1,876	2,689	4,565

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 2 (1/1/2022-3/31/2022) Q2 FFY 2022

As of the end of the second federal fiscal quarter (end of March 2022), there were 3,008,068 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Programs and 77,240 Medicaid consumers enrolled in Health and Recovery Plans (HARPs). 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 15 HRA facilities including 3 HIV/AIDS Services Administration (HASA) sites, 2 Community Medicaid Offices (MA Only), and 10 Job Centers (Public Assistance). MAXIMUS reported that 9,538 clients were educated about enrollment options and made an enrollment choice including 182 clients in person and 9,356 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 31,614 FFS community clients were reported on the regular auto-assignment list, 2,991 clients responded to calls that generated 3,563 enrollments. Of the total of 86 FFS NH clients reported on NH auto-assignment list, 5 (6%) clients and/or authorized representatives made a Plan selection.

C. NYMC HelpLine Observations January-March 2022

CMU is responsible for observing calls made by Downstate residents, including residents enrolled in managed care, and is committed to observe all Customer Service Representatives (CSRs) answering New York City calls every month. NYMC reported that 66,209 calls were received by the Helpline and 61,678 or 93% were answered. Calls answered were handled in the following languages: English: 40,648 (66%); Spanish: 6,698 (10%); Chinese: 3,149 (5%); Russian: 497 (1%); Haitian/Creole: 54 (1%); and other: 10,632 (17%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 3,609 recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 2nd Quarter 2022								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
2,158 (60%)	**343 (9%)**	**193 (5%)**	**854 (24%)**	**37 (1%)**	**0 (0%)**	**24 (1%)**	**0 (0%)**	**3,609**

A total of 1,356 (38%) recorded calls observed was unsatisfactory including calls with 244 single infraction and 1,112 calls with multiple infractions, A total of 2,305 infractions/issues were reported to MAXIMUS. The following summarizes those observations:

- Process: 1,816 (79%) - 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: 215 (9%) - 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: 274 (12%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 2,305 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

No updates to expansions, withdrawals, or certification of new plans this Quarter.

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) 2019-2020. All 19 resultant contracts have been executed by New York State and have been submitted to CMS for final approval. On February 22, 2022, CMS issued an approval letter indicating approval of all 19 contracts.

On June 18, 2021, New York State submitted to CMS amendment #1 to the March 1, 2019 Model Contract that includes emergency contract provisions related to the COVID-19 public health emergency. On December 20, 2021, this amendment was issued to 16 Managed Care Organizations for signature. At the close of the quarter, New York State was in the process of executing these contracts.

On March 4, 2022, New York State submitted to CMS amendment #2 to the March 1, 2019 Model Contract that includes contract provisions related to State Directed Payments. On March 31, 2022, this amendment was issued to 15 Managed Care Organizations for signature. At the close of the quarter, New York State was in the process of executing these contracts.

C. Health Plans/Changes to Certificates of Authority

None to report.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Surveillance activity completed during the 2nd QTR FFY 2021-2022 includes the following:

One (1) Comprehensive Operational Survey was completed during 2nd QTR FFY 2021-2022. A Statement of Deficiency (SOD) was issued and a Plan of Correction (POC) was accepted for one (1) Plan:

- Fidelis Comprehensive Operational Survey

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during this quarter. Final reports were previously submitted for all reviews except 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 (10/1/2021-12/31/2021)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	33,627	216	207	0.62%
ROS	4,084	21	17	0.42%
Total	37,711	237	224	0.59%

Note: Metroplus is excluded from this quarter's analysis due to data integrity issues

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

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 (10/1/2021-12/31/2021)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	9,041	126	43	0.48%
ROS	1,120	34	31	2.77%
Total	10,161	160	74	0.73%

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

Mental Health (MH) & Substance Use Disorder (SUD) Claims (1/1/2022-3/31/2022)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,096,095	90.28%	9.72%
ROS	930,114	91.80%	8.20%
Totals	2,026,209	90.97%	9.03%

Note: VNS March 2022 data has been excluded due to late submission.

BH Adults HCBS Claims/Encounters 1/1/2022-3/31/2022: NYC

BH HCBS SERV GROUP	N Claims	N Recip.
CPST	**43**	**11**
Education Support Services	**382**	**98**
Family Support and Trainings	**87**	**26**
Intensive Crisis Respite	**0**	**0**
Intensive Supported Employment	**297**	**74**
Ongoing Supported Employment	**35**	**7**
Peer Support	**1,290**	**309**
Pre-vocational	**234**	**35**
Provider Travel Supplements	**16**	**10**
Psychosocial Rehab	**671**	**90**

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

Residential Supports Services	354	48
Short-term Crisis Respite	6	2
Transitional Employment	5	2
Totals	3,420	598

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

BH Adults HCBS Claims/Encounters 1/1/2022-3/31/2022: ROS

BH HCBS SERV GROUP	N Claims	N Recip.
CPST	638	163
Education Support Services	709	214
Family Support and Trainings	24	9
Intensive Crisis Respite	0	0
Intensive Supported Employment	376	86
Ongoing Supported Employment	101	24
Peer Support	3,509	819
Pre-vocational	258	52
Provider Travel Supplements	2,106	601
Psychosocial Rehab	2,424	420
Residential Supports Services	1,686	300
Short-term Crisis Respite	0	0
Transitional Employment	3	2
Totals	11,834	1,776

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

Quarter 2 MCTAC Attendance & Stats (1/1/2022 to 3/31/2022)

Events: MCTAC successfully executed 12 events from 1/1/2022 to 3/31/2022.
All 12 were held via webinar.

Individual Participation: *(this includes all the individuals that attended the MCTAC offerings)*
3,639 people attended/participated in our events, of which **3,238** are unique participants.

OMH Agency Participation
Overall: 312 of 653 **(47.78 %)**
NYC: 126 of 272 **(46.32 %)**
ROS: 216 of 434 **(49.77 %)**

OASAS Agency Participation
Overall: 271 of 563 **(48.13%)**
NYC: 96 of 211 **(45.50 %)**
ROS: 195 of 389 **(50.13 %)**

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, 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 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 Recovery Coordination Agencies (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 (SDEs) through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with SDEs to provide recovery coordination of BH HCBS for those not enrolled in HH.
    - Developed documentation and claiming guidance for MCOs and contracted RCAs for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (completed)
        - Ongoing technical assistance (completed)
        - 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, Comprehensive Psychiatric Emergency Programs (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 HH 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 (e.g., Outreach Optimization)
- Ongoing work to strengthen the capacity of HH to serve high need severe mental illness (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 HHs 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 New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS) to conduct peer-focused outreach and training to possible eligible members for Medicaid Managed Care Health and Recovery Plans (HARPs) and Adult 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.
- 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.
- Worked with the HARP/BH HCBS Subcommittee (2017-2019) – consisting of representatives from MCOs, HHs, CMAs, and BH HCBS Provider agencies – which developed and provided a variety of tools to support care manager referrals 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 care management workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,088 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between January 1, 2022, and March 31, 2022, 2,929 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, HHs, Care Managers and other key stakeholders and determined the requirements for accessing BH HCBS were too difficult to standardize among 15 MCOs and 30 HHs.

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.

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

(PSR), Community Psychiatric Support and Treatment (CPST), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support).

Access to CORE Services do not require an independent eligibility assessment and do not have settings restrictions. All HARP and HARP eligible HIV-SNP enrollees can access CORE Services with a recommendation from a licensed practitioner of the healing arts (LPHA). Enrollment in HH Care Management will continue to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by HH. 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.

CORE Services went live on February 1, 2022 and are being implemented over several months and are available to new enrollees. The transition period for existing recipients of BH HCBS CPST, PSR, FST and Peer Support to CORE CPST, PSR, FST and Peer Support ended April 30, 2022. Billing for these four services will only be available through CORE as of May 1, 2022.

Consumer education materials have been released via the OMH website and a provider listserv. In January 2022, OMH also participated in a Townhall series hosted by the Access 2 Recovery Coalition, with a goal of educating HARP members about changes to their benefits. The State has conducted a series of implementation trainings in partnership with MCTAC, and all active BH HCBS CPST, PSR, FST, and Peer Support providers have been provisionally designated to provide CORE Services. Provisionally designated providers must attest to CORE readiness by the end of the provisional designation period, July 31, 2022, to become fully designated CORE providers on August 1, 2022.

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

In addition, in 2021, the State extended the Infrastructure initiative to support the behavioral health providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allows MCOs to contract for remaining, unspent funds totaling approximately $31M. Funds will be competitively awarded by the MCOs. OMH and OASAS continue to work closely with the MCOs to monitor the application and contracting process.

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

Quarter 2: No activity to report during this quarter. The transition of SBHC services from Medicaid Fee-for-Service to MMC has been moved to 2023. 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 (MLTC) Program

Managed Long-Term Care plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of April 1, 2022, there are 25 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of March 31, 2022, there are a total of 283,260 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the January 2022 through March 2022 quarter, there were no withdrawals, expansions or new plans.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the January 2022 through March 2022 quarter, post enrollment surveys were completed for 10 enrollees. Of the 8 who responded to the question, 7 (88%) indicated that they continued to receive services from the same caregivers once they became members of an MLTC plan, the remaining enrollee had case specific reasons why they did not continue, and 2 enrollees did not respond to this question. The percentage of affirmative responses is higher than the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation plans decreased 1% from 245,571 the previous quarter to 243,193 during the January 2022 through March 2022 quarter. For that period, 7,875 individuals who were being transitioned into MLTC made an affirmative choice, a 13% decrease from the previous quarter and brings the 12-month total for affirmative choice to 35,263.

Monthly plan-specific enrollment for Partial Capitation plans, PACE plans, MAP plans, and FIDA IDD plans during the April 2021 through March 2022 annual period is submitted as an attachment.

2. Significant Program Developments

During the January 2022 through March 2022 quarter:

- The 1st Quarter Member Services survey was conducted on 25 Partial Capitation plans and 12 MAP plans. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required but, when necessary, the Department provided recommendations on areas of improvement.

- The Statement of Deficiencies issued to 1 Partial Capitation plan in SFY Q1 for failure to provide a reachable member services department for assistance to

applicants and members has been resolved. The Plan's Corrective Action Plan (CAP) was accepted 2/18/2022.

- The Desk Review for 6 Partial Capitation Operational Surveys were completed and reported in prior reporting periods. CAPs have been completed by the plans and are still awaiting Department approval, except for three plans, whose CAPs have been approved by the Department.

- The Operational Surveys for 2 Partial Capitation plans are ongoing.

- Operational Surveys were initiated on 3 Partial Capitation plans.

- A Focused Survey was conducted on 1 MAP plan targeting MAP appeal notices during the 1st quarter. A Statement of Deficiencies was issued, and the CAP was accepted on 12/3/2021. A follow up review of their MAP appeal notices was initiated on 1/14/2022 to ensure compliance. The follow up review has been satisfactorily completed.

- A Focused Survey was conducted on 1 Partial Capitation plan based on a TAC Complaint during the 1st quarter. A Statement of Deficiencies was issued, and after the submission of several unacceptable CAPs their final CAP was accepted by the Department on 1/18/2022. The plan is required to submit monthly documentation to demonstrate compliance.

- A Focused Survey was conducted on 25 Partial Capitation and 12 MAP Plans focusing on Internal Appeal and Fair Hearing management practices. A review of plan files was completed, and Statement of Deficiencies were issued to 15 plans. CAPs for all 15 plans were received and are under review.

- 2 Focused Surveys were conducted on 1 Partial Capitation plan on TAC Complaints, and 2 Statements of Deficiencies were issued to the plan. The plan has submitted CAPs, which are under review.

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 2022 through March 2022 quarter.

4. Summary of Self-Directed Options

Self-direction is provided within MLTC plans as a consumer choice and gives individuals and families greater control over services received. The 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 1,969 critical incidents reported for the January 2022 through March 2022 quarter, a decrease of 11% from the previous quarter. There are 2 plans that reported zero critical incidents last quarter and are now reporting data. The Department continues to reach out to plans for education and correcting data reporting. 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 2022 through March 2022 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with Transportation, Quality of Other Homecare Services, Dissatisfaction with Quality Home Care (Other than lateness or absences), Home Care Aides Late or Absent, Dissatisfaction with Care Management.

Period: January 1, 2022 – March 31, 2022 (Percentages rounded to nearest whole number)			
Number of Recipients: 283,260	**Complaint**	**Resolved**	**Percent Resolved***
#Expedited	**20**	**13**	**65%**
# Same Day	**2,782**	**2,782**	**100%**
# Standard/Expedited	**8,809**	**8,376**	**95%**
Total for this period:	**11,611**	**11,171**	**96%**

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

Appeals	4/2021-6/2021	7/2021-9/2021	10/2021-12/2021	1/2022-3/2022	Average for Four Quarters
Average Enrollment	275,540	279,060	281,667	281,668	279,484
Total Appeals	8,957	8,424	8,695	8,489	8,641
Appeals per 1,000	32	30	32	30	31
# Decided in favor of Enrollee	1,088	1,496	1,310	1,375	1,317
# Decided against Enrollee	6,820	6,168	6,062	5,751	6,200
# Not decided fully in favor of Enrollee	652	612	1,066	808	784
# Withdrawn by Enrollee	288	231	233	269	255
# Still pending	118	886	746	286	509
Average number of days from receipt to decision	7	8	8	8	8

Complaints and Appeals per 1,000 Enrollees by Product Type January 2022 - March 2022					
	*Enrollment	Total Complaints	Complaints per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	243,779	6,954	29	6,886	28
Medicaid Advantage Plus (MAP) Total	31,830	3,812	120	1,514	48
PACE Total	6,059	845	139	89	15
Total for All Products:	**281,668**	**11,611**	**288**	**8,489**	**90**

*Enrollment number is the average of the 3 months in the quarter

Total complaints decreased 6% from 12,387 the previous quarter to 11,611 during the January 2022 through March 2022 quarter.

The total number of appeals decreased 2% from 8,695 during the last quarter to 8,489 during the January 2022 through March 2022 quarter.

Technical Assistance Center (TAC) Activity

During the January 2022 through March 2022 quarter, TAC opened 566 cases. This is a slightly higher than the previous quarter. TAC has seen an increase in general questions and inquiries. Substantiated cases have also increased since the previous quarter.

Most of TAC's cases for this quarter were for general inquiries and unsubstantiated cases.

Call/Case Volume	1/1/2022 - 3/31/2022
Substantiated Complaints	38
Unsubstantiated Complaints	219
Complaints Resolved Without Investigation	9
Inquiries	302
Total Cases Resolved	**568**

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

Aide Service	28%
General	24%
Enrollment	13%
Billing	7%
Grievance/IDT/Transportation*	5%

*Grievance, IDT, and Transportation all had the same amount of closed complaints and were tied for the fifth most frequently used category.

67% of Q2 TAC cases are closed in the same month they are opened. This is up 3% from last quarter. Overall, TAC's complaint numbers have remained consistent when compared to the previous few quarters.

Evaluations for enrollment: The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For January 2022 through March 2022 quarter, 9,859 people were evaluated, deemed eligible and enrolled into plans, a decrease of 15% from the previous quarter.

Referrals and 30-day assessment: For the January 2022 through March 2022 quarter, MLTC plans conducted 23,062 assessments, a 20% increase from 19,273 the previous quarter. The total number of assessments conducted within 30 days increased 35% from 15,216 the previous quarter to 20,596 this quarter.

Referrals outside enrollment broker: For the January 2022 through March 2022 quarter, the number of people who were not referred by the Enrollment Broker and who contacted the plan directly was 24,055 an 11% increase from 21,613 the previous quarter.

Rebalancing Efforts	1/2022-3/2022
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	111
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,793
Individuals who are permanently placed in a nursing home and are new to plan	164

As of March 31, 2022, there were 3,462 current plan enrollees who were in nursing homes as permanent placements, a 3% decrease from the previous quarter.

D. Children's Waiver

On August 2, 2019, CMS approved the Children's 1115 Waiver, with the goal of creating a streamlined model of care for children and youth under 21 years of age with 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 1915(c) Children's Waiver in Medicaid Managed Care benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915(c) 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 1915(c) service due to case management now being covered outside of the 1915(c) 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 Waiver;
- 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 HH 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;
- Submitting the Interim Evaluation Report to CMS, as drafted by the vendor;
- Drafting policies and guidance to ensure compliance with State and federal requirements – as well as working with service providers to confirm understanding and compliance with requirements such as the CMS HCBS Settings Final Rule and Electronic Visitor Verification;
- Reassessing and removing unnecessary or duplicative forms to alleviate administrative burden;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers – including additional resources and technical assistance with person-centered planning;
- Facilitating relationship building between Managed Care Organizations, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from Managed Care Organizations, HHs, 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;
- Responding to the COVID-19 pandemic and implementing emergency 1135 waivers and Appendix K, inclusive of a Retainer Payment for Day and Community Habilitation providers – and continuing to support the recovery of impacted providers and consumers;
- Conducting case reviews;
- Working with HHs and HCBS providers to enhance capacity monitoring and streamline the referral process;
- Engaging with providers to understand barriers to service delivery – such as work force challenges, lack of referral sources / lack of service awareness, travel time for families in rural areas, etc. – and solutions to address these concerns, including launching a state-wide capacity tracking system to monitor waitlists, provider capacity, and assess metrics regarding highly utilized HCBS and underutilized HCBS;
- Engaging with providers, consumers, and New York State agencies partners to determine how best to use the enhanced FMAP authorized by the American Rescue Act to improve access to children's services and reduce administrative burden on providers – including increasing rates for HCBS and directing funding to service providers for workforce development and IT infrastructure;

- Collecting stakeholder feedback (from consumers, HCBS providers, HHs, Managed Care Organizations, and advocate groups) to inform the 1915(c) Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between Managed Care Organizations, Health Homes, and HCBS providers;
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process;
- Submitting the 1915(c) Children's Waiver Extension to CMS;
- Submitting the 1915(c) Children's Waiver Renewal to CMS; and
- Engaging with HCBS Providers to re-designate for the Children's Waiver, including collecting updated attestations confirming providers understand and will adhere to all policies and compliance requirements; also provided technical assistance and connection to referral sources for providers who are working to get their HCBS programs up-and running and/or de-designated agencies for all or some services if they are not currently able to actively deliver HCBS.

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

The following table demonstrated the number of children enrolled in the 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 RE code KK. Therefore, the table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
January	10,662	4,961	5,580	687
February	10,754	4,328	5,609	687
March	10,822	1,110*	5,612	206*
Quarterly Average	**10,746**	**3,466**	**5,600**	**527**

**There is an expected 3-month lag for claims data that impacts the decrease in enrolled children with an HCBS claim for this month*

This table includes data from the 2nd Quarter of FY2022. Data from this quarter continues to be impacted by the COVID-19 pandemic, although the service utilization trend is improving. The number of children enrolled in HCBS is increasing and utilization of these services remains steady. This data will continue to be reviewed and analyzed to understand the impact of the pandemic, especially in relation to utilization.

VI. Evaluation of the Demonstration

During the quarter ending December 31, 2021, two Independent Evaluations are in process and three have concluded. The first Independent Evaluation (IE) that has concluded is the DSRIP IE activity. This five-year analysis and DSRIP IE contract has been conducted by SUNY Albany School of Public Health Research Foundation. The DSRIP Draft Summative Evaluation Report was submitted to CMS on March 23, 2021. CMS returned the DSRIP Draft Summative Evaluation report with comments on July 13, 2021 with a return date of August 12, 2021. The DSRIP Final Summative Evaluation Report along with responses to CMS comments on the Draft Summative Evaluation report were submitted to CMS on August 10, 2021. The DSRIP IE and DOH received CMS approval on the Final Summative Evaluation on December 10, 2021.

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.

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 MLTC 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 addressed those questions and submitted an updated version 3 full draft of the Interim Evaluation report to NYS reviewers last quarter. After all internal reviews concluded, the 1115 Interim Evaluation report for all 22 research questions was submitted to CMS on August 4, 2021. CMS returned the 1115 Interim Evaluation report with comments on September 10, 2021. CMS also requested clarity on the availability of individual-level data which was discussed further on the September 20, 2021 Monitoring Call with CMS and DOH. On November 2, 2021, RAND provided responses to CMS comments. CMS approved the 1115 Interim Evaluation report on February 22, 2022.

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. The HARP Interim Evaluation Report was submitted to CMS on February 14, 2022. CMS provided feedback on the HARP Interim Evaluation Report on March 22, 2022. RAND and DOH are working on submitting an updated report to CMS by May 21, 2022. The SDC Interim Evaluation Report was submitted to CMS on March 9, 2022. RAND and DOH are looking forward to receiving CMS feedback on the report.

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 was submitted to CMS on July 27, 2021. CMS did not have any further comment on the report. CMS Approved the Children's Design Interim Evaluation report on February 22, 2022.

VII. Consumer Issues

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

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

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

MCO Product Line	Total Complaints	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
MMC	8,740	6,659
HARP	1,114	851
HIV SNP	89	139
Total MCO Complaints	**9,943**	**7,649**

As described in the table, MCOs reported 9,943 total enrollee complaints for the current quarter. This represents a 30.0% increase from the prior quarter's total of 7,649 enrollee complaints.

MCOs reported 8,740 MMC complaints this quarter, which is a 31.3% increase from the 6,659 of the previous quarter. The number of HARP complaints increased 30.9%, from 851 in the prior quarter to 1,114 this quarter. There were 89 HIV SNP complaints this quarter, which is a decrease of 36.0% when compared to the 139 from the previous quarter.

The Department reviewed the increase in enrollee complaints received from the MCOs and identified a large increase in complaints reported by HealthPlus and Molina Healthcare, which acquired Affinity Health Plan. The Department will follow up with these MCOs to identify causes for the complaint increases.

The following table outlines the top five (5) most frequent categories of complaints reported for MMCs, HARPs, and HIV SNPs, combined, for the most recent quarter and compared to the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	19%
Reimbursement/Billing	15%	15%
Balance Billing	11%	9%
Difficulty with Obtaining: Dental/Orthodontia	8%	8%
Dissatisfied with Quality of Care	7%	7%

The following table outlines the top five (5) most frequent categories of complaints reported for HARPs for the most recent quarter and compared to the previous quarter:

Description of Complaint	Percentage of Complaints	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	21%	23%
Dissatisfaction with Quality of Care	12%	11%
Pharmacy/Formulary	8%	12%
Difficulty with Obtaining: Specialist and Hospitals	7%	9%
Difficulty with Obtaining: Dental/Orthodontia	6%	6%

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

Description of Complaint	Percentage of Complaints	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	27%	21%
Difficulty with Obtaining: Dental/Orthodontia	20%	12%
Pharmacy/Formulary	11%	12%
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	8%	2%
Balance Billing	6%	3%

B. Monitoring of Plan Reported Complaints

The Department analyzes enrollee complaints by using an Observed to Expected (OE) ratio, to identify trends and potential problems.

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

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

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

Amida Care FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**OE Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	5.9	The trend identified from the complaints received was that enrollees were dissatisfied with their gender affirmation surgeries or procedures. The issue identified was that enrollees were not aware that multiple surgeries and revisions may be needed before the desired outcome is achieved.	The MCO's Gender Identity Support Team is developing pre- and post-operative educational materials and classes, and conducting outreach such as calls and surveys, to improve enrollee understanding and satisfaction regarding the gender affirmation surgery process.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	10.8	The trends identified from the complaints received were that provider and MCO customer service staff were not meeting customer service standards, including enrollees experiencing difficulties contacting or receiving follow-up calls from customer service staff, a lack of communication regarding information on appointments, and a lack of communication from providers on updates to their office including hours and provider availability. The issues identified were that providers were not communicating with enrollees and the MCO	The MCO will continue to provide targeted provider education on communicating appointment and provider availability to enrollees, to meet customer service standards. The MCO will have its vendor handle incoming calls and will conduct quality control assessments on enrollee calls to improve customer service standards and enrollee satisfaction. The Department will continue to monitor progress in the next reporting period due to this category's persistently high OE ratio.

		had a small shortage of customer service staff.	
Difficulty with Obtaining: Dental/ Orthodontia	8.2	The trend identified from the complaints received was that enrollees were dissatisfied with dental benefits covered. The issue identified was a lack of understanding by enrollees of their dental benefit, including what dental services were non-covered.	The MCO worked with its vendor to develop and send out materials, and is working on conducting a dental event, to educate its enrollees and improve awareness on what their dental coverage includes.
Pharmacy\Formulary	8.9	The trends identified from the complaints received were that enrollees were not receiving medication deliveries and there were delays with pharmacies receiving prescriptions. The issues identified were that enrollees were not answering phone calls to confirm availability for their medication deliveries and that providers did not initially submit or call in the required information for prior authorizations for prescriptions.	The MCO will conduct town halls to educate enrollees regarding the pharmaceutical delivery process and reduce the number of instances of incomplete pharmaceutical deliveries. The MCO will contact providers to advise on what information they need to submit for prior authorizations, including the phone number for them to start the process, to reduce delays in pharmacies receiving prescriptions for enrollees. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Personal Care	16.8	The trends identified from the complaints received were that enrollees were dissatisfied due to not receiving the services they expected, not having the same aide each day, and not receiving notification from their agency on service changes. The issues identified were that enrollees had expectations that differed from their plan of care and had a lack of understanding of the requirements and processes for receiving a permanent aide.	The MCO will continue to participate with more agencies to improve staffing availability, perform more expected services, and increase continuity of care. The MCO will provide education to enrollees on proper expectations for aides and the process for requesting a permanent aide, to improve enrollee understanding on staffing expectations and continuity. The Department will continue to monitor progress in the next reporting period.

Excellus Health Plan FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	2.5	The trend identified from the complaints received was that enrollees were being denied routine vision exams or eyewear due to benefit exhaustion. The issue identified was that the MCO's websites contained misinformation regarding the benefit.	The MCO updated its websites to address the misinformation being presented to correct enrollee understanding.
Difficulty with Obtaining: Dental/ Orthodontia	2.3	The trend identified from the complaints and action appeals received was that enrollees were being denied services due to no prior authorization and the lack of information being submitted with prior authorization requests. The issue identified was that enrollees and providers were unaware when authorization was needed and unaware of all the information needed to obtain approval.	The MCO sent out enrollee and provider communication to improve understanding on when authorization is needed and what information is needed with prior authorization requests.

Healthfirst FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Long Wait Time	2.7	The trend identified from the complaints received was that enrollees were dissatisfied with delays in being seen by providers. The issues identified were that providers reduced in-office practice hours due to COVID-19, dealt with staffing shortages, and that providers tried to accommodate patients	The MCO worked with its vendor to communicate to its providers, through their preferred method of communication, the importance of contractual service level agreements and enrollee wait times for providing timely services. The MCO reviewed provider schedules to ensure appropriate amount of time between appointments. The MCO continued to inform

		without appointments.	enrollees on the availability of telehealth appointments to reduce wait times.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	3.0	The trends identified from the complaints received were that enrollees were experiencing issues related to durable medical equipment (DME), including delivery delays, and that provider staff were not meeting customer service standards. The issues identified were supply chain issues with receiving certain types of DME and that provider staff were rude and did not return calls.	The MCO established weekly meetings with DME vendor leadership, implemented weekly submission of complaints to the DME vendor for review and analysis, added a new DME supplier under the DME vendor, and had orders from low performing DME suppliers routed to high performing ones, to reduce the timeframe for enrollees to receive DME supplies and improve enrollee satisfaction.
Difficulty with Obtaining: Specialist and Hospitals	3.5	The trends identified from the complaints received were that enrollees were dissatisfied with providers' timeliness and willingness with prescribing medications, as well as the protocols and policies providers had in place for their office. The issues identified were that providers were unwilling to prescribe specific medications, enrollees were generally frustrated with provider office conditions, and that complaints regarding prescriptions and office policies in this category were miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO's quality committee will evaluate the complaints correctly categorized under this category, to evaluate trends and create corrective action plans, to lower the number of complaints in the category. The MCO will provide refresher training for its customer service representatives on how to correctly categorize complaints and grievances, to reduce incorrect categorization of enrollee complaints.
Difficulty with Obtaining: Emergency Services	2.6	The trend identified from the complaints received was that enrollees were being billed, or balance	The MCO will reduce balance billing and inappropriate billing for emergency services by identifying inappropriate billing

		billed, for emergency services rendered. The issues identified were that facilities were billing enrollees when no claim was submitted to the MCO, out of network providers were billing enrollees, and enrollees were unsure of their financial responsibility once they received an explanation of benefit (EOB).	trends among providers, then reaching out to those facilities and providers to provide reeducation. The MCO will reeducate its call center representatives on addressing EOB concerns from enrollees, to educate enrollees on their financial responsibility. The Department will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.6	The trend identified from the complaints received was that enrollees were receiving rejections when they went to fill their prescriptions due to coordination of benefits (COB) issues. The issue identified was that the MCO's vendor that checks for third-party coverage was incorrectly utilizing other carriers' pharmacy benefit manager coverage data, causing incorrect COB.	The MCO worked with its vendor to correct the errors stemming from COB issues, to reduce point of sale rejections. The MCO worked with its vendor to help it start a call center for addressing COB issues, to reduce enrollee pharmacy complaints. The Department will continue to monitor progress in the next reporting period.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	3.8	There were no trends identified by the MCO. The issue identified was that some complaints regarding pharmacy COB issues were miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will reeducate its staff to ensure proper categorization of complaints.
Reimbursement/Billing	3.2	The trends identified from the complaints received were that enrollees were being billed for services rendered, enrollees thought they were receiving a bill from the MCO, and out of network providers and facilities	The MCO will reduce balance billing and inappropriate billing for services rendered by identifying inappropriate billing trends among providers, then reaching out to those facilities and providers to provide reeducation. The MCO will reeducate its call center

		were balance billing enrollees. The issues identified were that providers were unaware of enrollees' insurance coverage, enrollees were mistaking EOBs as bills, and enrollees were seeing out of network providers.	representatives on addressing EOB concerns from enrollees, to educate enrollees on their financial responsibility. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Private Duty Nursing	4.5	The trends identified from the complaints received were that enrollees were not receiving their private duty nursing (PDN) services in a timely manner, and they were dissatisfied with aide changes from the PDN agencies. The issues identified were that there was a PDN aide shortage and the PDN agencies were not meeting service standards.	The MCO will continue to follow up with agencies it identifies as having repeated complaints to improve PDN services. The MCO will work with out of network providers and create single case agreements to provide needed PDN services.
Difficulty with Obtaining: Home Health Care	3.6	The trends identified from the complaints received were that enrollees were not receiving their home health care services in a timely manner, and they were dissatisfied with the inconsistency of home care services provided. The issue identified was that there was a home health care aide shortage.	The MCO will continue to follow up with agencies it identifies as having repeated complaints to improve home health care services. The MCO will work with out of network providers and create single case agreements to provide needed services.
Difficulty with Obtaining: Personal Care	4.0	The trends identified from the complaints received were that enrollees were not receiving their personal care services in a timely manner, and they were dissatisfied with personal care services not being provided for the full amount authorized. The issue identified was that there was a personal care	The MCO will continue to follow up with agencies it identifies as having repeated complaints to improve personal care services. The MCO will work with out of network providers and create single case agreements to provide needed services.

		aide shortage.	
Difficulty with Obtaining: PERS	4.5	The trend identified from the complaints received was the enrollees were not receiving their PERS device in a timely manner. The issue identified was that there were delays in delivering PERS devices to enrollees.	The MCO will continue to address each individual instance of delivery delay of PERS devices with its vendor, to help ensure enrollees receive their PERS devices timely.
Difficulty with Obtaining: CDPAS	4.3	The trends identified from the complaints received were that enrollees were having processing problems with CDPAS, including payment and registration for services, and authorization issues with CDPAS, including starting and continuing services. The issues identified were that fiscal intermediaries did not process authorization and payment for services in a timely manner.	The MCO will continue to follow up with the fiscal intermediaries it identifies as having repeated complaints to improve access to CDPAS. The Department will continue to monitor progress in the next reporting period.

HealthNow FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.1	The trend identified from the complaints received was that enrollees were dissatisfied with services received. The issue identified was that enrollees received inadequate care.	The MCO connected enrollees to case management so that they could receive adequate care and services. The MCO conducted peer to peer conferences between medical directors and providers to address quality of care related issues.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.7	The trend identified from the complaints received was that provider customer service staff were not meeting customer service standards. The issues identified were that provider office staff had	The MCO referred enrollee complaints of poor provider office customer service to its provider relations department, to follow up with providers.

		poor dispositions during appointments, did not submit requests on behalf of enrollees, and had untimely responses to enrollees.	
Difficulty with Obtaining: Specialist and Hospitals	7.9	The trend identified from the complaints received was that enrollees were dissatisfied with delays in being seen by specialist providers. The issues identified were that providers were out of network, delayed in submitting authorization requests and paperwork, and had a lack of new patient availability.	The MCO will redirect enrollees to participating providers, will follow up with providers who do not submit authorization requests on the procedures to do so, and will follow up with providers on appointment availability, to reduce delays in enrollee services.
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	26.5	The trend identified from the complaints received was that enrollees were denied access to a particular out of network provider. The issue identified was that enrollees were requesting access to a specific out of network provider.	The MCO is working to contract with the requested provider, to ensure enrollees receive access to participating providers. The MCO is approving single case agreements until participating status is determined to give enrollees access to the requested provider.
Pharmacy\Formulary	2.8	The trend identified from the complaints received was that enrollees were dissatisfied with delays in obtaining medication. The issues identified were that enrollees were requesting medications that were not covered by the formulary, there were COB errors, and there were delays or errors in providers submitting authorization requests and supporting documents.	The MCO will educate providers who do not submit authorization requests timely or properly to reduce delays in enrollees receiving medications.
Reimbursement/Billing	5.2	The trend identified from the complaints received was that enrollees were receiving bills for COVID-	The MCO will follow up with enrollees to educate them on providing their insurance ID card before receiving care and to

		19 testing. The issues identified were that providers were unaware of enrollees' insurance coverage and enrollees were seeking treatment at out of network testing sites.	inform them of participating testing sites. The MCO will follow up with providers to educate them on checking enrollees' coverage status before providing care.
Balance Billing	5.3	The trend identified from the complaints received was that enrollees were being billed by providers and facilities for services rendered. The issue identified was that providers were unaware of enrollees' insurance coverage.	The MCO will follow up with enrollees to educate them on providing their insurance ID card before receiving care. The MCO will follow up with providers to educate them on checking enrollees' coverage status before providing care. The Department will continue to monitor progress in the next reporting period.

Health Insurance Plan of Greater New York FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Reimbursement/Billing	2.2	The trends identified from the complaints received were that out of network providers and facilities were billing enrollees, and enrollees thought they were receiving a bill from the MCO. The issues identified were that enrollees were seeing out of network providers who were unaware of enrollees' insurance coverage and enrollees were mistaking EOBs as bills.	The MCO will reduce enrollees being billed for out of network services by updating their website and conducting outreach via phone calls and emails, to educate enrollees on the importance of using participating providers and reeducate participating providers on not referring enrollees to out of network providers. The MCO will reeducate its call center representatives on addressing EOB concerns from enrollees, and to educate enrollees on their financial responsibility.

Independent Health Association FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	3.8	The complaints received were of general enrollee dissatisfaction with	The MCO will continue to conduct provider outreach to identify provider issues and to

		providers and provider care. There were no trends or issues identified by the MCO.	address enrollee complaints. The MCO will institute provider corrective action plans as needed to correct identified provider issues. The Department will continue to monitor progress in the next reporting period.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.1	The trends identified from the complaints received were that enrollees were dissatisfied with MCO customer service hold time, the MCO IVR system, and the PCP auto-assignment process. The issues identified were that there were too few customer service representatives, the IVR system needed to be updated, and enrollees were not aware of the PCP selection process.	The MCO improved its customer service representative attrition rate by improving the hiring process and increasing starting pay for customer service representatives; the MCO updated its IVR technology to better understand enrollees entering their ID number; and the MCO reeducated its customer service representatives on the PCP selection process to better inform enrollees of their PCP selection process and timeframe to improve customer service for enrollees.
Difficulty with Obtaining: Dental/ Orthodontia	4.1	The trend identified from the complaints received was that enrollees were being denied coverage for non-covered services. The issue identified was a lack of understanding by providers and enrollees of the dental benefit, including what dental services were non-covered.	The MCO worked with its vendor to send out materials to remind providers to check enrollee benefits and eligibility, to improve awareness on what dental benefits are covered for enrollees. The Department will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.7	The trend identified from the complaints received was that enrollees were being denied coverage for non-covered medications. The issue identified was a lack of understanding by providers and enrollees of the covered and non-covered medications.	The MCO will continue to communicate changes to its formulary to affected enrollees to inform them of changes to their medications. The MCO will notify providers of any policy changes and will notify specific providers for certain changes to inform them of changes to the MCO formulary. The Department will continue to

			monitor progress in the next reporting period.

MetroPlus Health Plan FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	2.3	The trends identified from the complaints received were that enrollees were dissatisfied with the timeliness of obtaining new lenses and being denied new eye wear. The issues identified were that providers were not being timely with filling enrollee eye wear prescriptions, and that providers were not aware of enrollee benefit and eligibility information.	The MCO will reach out to providers on meeting timeliness standards, to ensure enrollees receive their eye wear in a timely manner. The MCO will remind providers of the multiple ways to check enrollee benefit and eligibility information through its IVR and website, to make sure enrollees receive proper eye care.
Difficulty with Obtaining: Emergency Services	3.4	The trend identified from the complaints received was that providers were incorrectly billing enrollees for emergency services. The issue identified was that providers were unaware of enrollees' insurance coverage.	The MCO will educate enrollees on the multiple ways to access their insurance ID cards, including through an enrollee portal, to assist providers in billing the correct insurance. The Department will continue to monitor progress in the next reporting period.
Balance Billing	4.0	The trend identified from the complaints received was that enrollees had concerns or questions regarding bills they received. The issue identified was that inquiries were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will work to ensure proper categorization of inquiries and complaints. The MCO will follow up with providers so that the correct insurance is billed for services. The Department will continue to monitor progress in the next reporting period.

Molina Healthcare FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	11.4	The trend identified from the complaints received was that enrollees were having trouble locating PCP providers. The issues identified were that enrollees were unable to navigate the MCO website to search for PCP providers and providers were not following access and availability standards.	The MCO will provide tutorials for navigating the MCO website during new enrollee orientations to help enrollees locate providers. The MCO will reach out to PCP providers via email, phone, and regular meetings to reeducate them regarding the importance of meeting access and availability standards, to ensure adequate appointment availability for enrollees.
Appointment Availability: Specialist	14.7	The trend identified from the complaints received was that enrollees were having trouble locating providers for specialist treatments, including cardiology, ophthalmology, and anti-addiction treatments. The issues identified were that there was a shortage of participating providers and providers were not following access and availability standards.	The MCO will reach out to specialist providers via email, phone, and regular meetings to reeducate them regarding the importance of meeting access and availability standards, and will attempt to contract with new specialist providers, to ensure adequate appointment availability for enrollees.
Difficulty with Obtaining: Eye Care	4.0	The trend identified from the complaints received was that enrollees were having trouble locating eye care providers. The issue identified was that enrollees were unable to navigate the MCO website to search for eye care providers.	The MCO will provide tutorials for navigating the MCO website during new enrollee orientation to help enrollees locate providers.
All Other	22.1	The trend identified from the complaints received was that enrollees were dissatisfied with the MCO's authorization requirements. The issue identified was that enrollees and	The MCO will reach out to providers via email, phone, and regular meetings to reeducate them regarding authorization requirements to help ensure they are completed correctly. The Department will continue to

		providers from the Affinity acquisition were still adjusting to the new authorization process.	monitor progress in the next reporting period.
Balance Billing	3.5	There were no trends identified from the complaints received. The issues identified were that providers were billing enrollees for services received and providers were not aware of enrollee benefit and eligibility information.	The MCO will reach out to providers via email, phone, and regular meetings to reeducate them regarding enrollees being billed as well as making sure that they have the correct enrollee information, to ensure enrollees are not balance billed.

MVP Health Plan FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	4.7	The trends identified from the complaints received were that enrollees' customer service expectations were not being met and enrollees were not able to get timely dental appointments. The issues identified were that there were staffing shortages at dental offices, dental offices were not returning phone calls, prior authorizations were not being submitted timely or at all, and there was limited dental appointment availability.	The MCO educated dental providers' office staff to help them meet customer service expectations and complete administrative tasks timely. The Department will continue to monitor progress in the next reporting period.

United Healthcare FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.9	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were	The MCO reached out to providers and sent out corrective action plan letters, to ensure enrollees' quality of care issues were addressed. The

		that providers were not thorough or accurate with their care and did not have comprehensive treatment plans.	Department will continue to monitor this category.
Denial of Clinical Treatment	11.2	The trend identified from the complaints received was that enrollees were receiving denials for services. The issues identified were that providers were not following the prior authorization process and were not informed about enrollees' benefits.	The MCO will provide coaching and education regarding claims processes, benefit evaluations and authorization reviews to its providers to decrease the number of service denials. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	2.1	The trends identified from the complaints received were that dental services were not performed for enrollees and enrollees paid out of pocket for dental procedures. The issue identified was that providers were not informed of enrollees' dental benefits.	The MCO communicated to providers the enrollee benefit information, to have dental services provided for enrollees. The MCO reached out to providers when enrollees paid out of pocket for dental procedures, to have providers submit authorization requests and bill the plan so enrollees were not held liable.
Balance Billing	2.4	The trend identified from the complaints received was that enrollees were being billed by providers and facilities for services rendered. The issue identified was that providers were unaware of enrollees' insurance coverage.	The MCO reached out to providers and sent cease and desist letters, to have providers bill the MCO instead of enrollees. The MCO will provide education to providers as needed.

VNS Choice FFY 21 Q4–FFY 22 Q1 (7/1/2021–12/31/2021)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	22.3	The trends identified from the complaints received were that enrollees were receiving denials for non-covered dental services and enrollees were not able	The MCO will continue to send out educational materials to help educate its enrollees on their covered dental benefit and how to find dental providers in their area, to improve enrollee benefit

		to locate participating providers. The issues identified were that enrollees were unaware of what services were covered under their dental benefit and had difficulty looking up participating providers in their area.	understanding and awareness of available dental providers.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	33.0	The trends identified from the complaints received were that enrollees were dissatisfied with, or not aware of, reward incentives and general benefit or plan rules. The issue identified was that more information is needed to be captured by customer service representatives when conducting enrollee surveys and gauging enrollee satisfaction.	The MCO will provide additional training and education to its customer service representatives to better capture details when proactively conducting enrollee surveys to better identify enrollee issues.
Other	20.5	The trends identified from the complaints received were that enrollees had issues with DME and personal care and had inaccurate EOBs. The issue identified was that more information is needed to be captured by customer service representatives when conducting enrollee surveys and gauging enrollee satisfaction.	The MCO will provide additional training and education to its customer service representatives to better capture details when proactively conducting enrollee surveys to better identify enrollee issues.
Difficulty with Obtaining: Personal Care	66.3	The trends identified from the complaints received were that enrollees did not receive personal care and they were dissatisfied with personal care received. The issues identified were that enrollees were not informed of the steps to request services, providers did not process requests correctly or timely, and	The MCO will follow up with agencies to reeducate providers and issue corrective action plans, as needed, to ensure enrollees receive personal care and service standards are met. The Department will continue to monitor progress in the next reporting period.

		personal care aides did not meet service standards.	

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, the Department monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 9,943 total reported complaints/action appeals, MCOs reported 1,084 complaints and action appeals from their SSI recipients. This compares to 1,140 SSI complaints/action appeals from the previous quarter, representing a 5.0% decrease.

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

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q2 10/1/2021-12/31/2021
Appointment Availability: PCP	6	8
Appointment Availability: Specialist	16	5
Appointment Availability: BH HCBS	0	0
Long Wait Time	1	1
Dissatisfied with Quality of Care	92	105
Denial of Clinical Treatment	20	22
Denial of BH Clinical Treatment	0	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	418	377
Dissatisfaction with BH Provider Services	5	4
Dissatisfaction with Health Home Care Management	5	4
Difficulty with Obtaining: Specialist and Hospitals	78	103
Difficulty with Obtaining: Eye Care	10	4
Difficulty with Obtaining: Dental/Orthodontia	31	44
Difficulty with Obtaining: Emergency Services	4	3
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	1	4
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	1
Difficulty with Obtaining: Private Duty Nursing	17	22
Difficulty with Obtaining: Home Health Care	33	22
Difficulty with Obtaining: Personal Care	70	73
Difficulty with Obtaining: PERS	0	1
Difficulty with Obtaining: CDPAS	16	82
Difficulty with Obtaining: AIDS Adult Day Health Care	1	0
Pharmacy/Formulary	63	76

Access to Non-Covered Services	15	13
Access for Family Planning Services	0	0
Communications/ Physical Barrier	2	5
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	11	13
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	85	88
Balance Billing	34	33
Transportation	9	8
All Other	41	19
Total	**1,084**	**1,140**

The following table outlines the top five (5) most frequent categories of SSI recipient complaints/action appeals MCOs reported for the most recent quarter and compared to the previous quarter:

Description of Complaint	Percentage of Total Complaints/Appeals Reported for SSI Recipients	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Dissatisfied with Provider Services (Non-Medical) or MCO Services	39%	33%
Dissatisfied with Quality of Care	8%	9%
Reimbursement/Billing	8%	8%
Difficulty with Obtaining: Specialist and Hospitals	7%	9%
Difficulty with Obtaining: Personal Care	6%	6%

The Department requires MCOs to report the number of enrollees in receipt of LTSS as of the last day of the quarter. During the current reporting period of January 1, 2022 through March 31, 2022, MCOs reported LTSS enrollment of 47,178 enrollees. This compares to 44,604 LTSS enrollees from the previous quarter, representing a 5.8% increase. The following table outlines the number of LTSS enrollees by MCO for the most recent quarter and for the previous quarter:

Plan	Number of LTSS Enrollees	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Affinity Health Plan*	0	828
Amida Care	1,243	1,298
Capital District Physicians Health Plan	730	729
Excellus Health Plan	1,553	1,440
Fidelis Care	16,197	15,218
Healthfirst	12,839	12,540
HealthNow	200	200
HealthPlus	2,812	2,691
HIP of Greater New York	423	339

Independent Health Association	557	525
MetroPlus Health Plan	2,549	2,497
Molina Healthcare	2,788	1,145
MVP Health Plan	1,971	1,870
United Healthcare	2,936	2,930
VNS Choice	380	354
Total	**47,178**	**44,604**

*Effective 10/25/2021 Affinity Health Plan was acquired by Molina Healthcare

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

Description of Complaint	Number of Complaints/Action Appeals Reported	
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021
Difficulty with Obtaining: AIDS Adult Day Health Care	2	3
Difficulty with Obtaining: Adult Day Care	0	3
Difficulty with Obtaining: CDPAS	52	141
Difficulty with Obtaining: Home Health Care	86	51
Difficulty with Obtaining: RHCF Services	1	4
Difficulty with Obtaining: Personal Care	195	176
Difficulty with Obtaining: PERS	4	7
Difficulty with Obtaining: Private Duty Nursing	28	29
Total	**368**	**414**

The change in Difficulty with Obtaining: CDPAS from last quarter was due to one MCO's changes in reported complaints for the categories. The Department is actively monitoring the complaint categories.

D. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 106 critical incidents reported for the January 1, 2022 through March 31, 2022 period, most of which have a resolved status. Many of the incidents stemmed from falls. The Department continues to work with MCOs to maintain accuracy in reporting of their LTSS critical incident numbers.

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

Plan Name	Critical Incidents		
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021	Net Change
Medicaid Managed Care Plans			
Affinity Health Plan*	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	7	5	+2
Fidelis Care	0	0	0
Healthfirst	42	50	-8
HIP 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	0	+2
MVP Health Plan	1	0	+1
United Healthcare	0	0	0
Total	**54**	**57**	**-3**
Health and Recovery Plans			
Affinity Health Plan*	0	0	0
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	1	-1
Fidelis Care	0	0	0
Healthfirst	46	52	-6
HIP 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	4	0	+4
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	1	-1
Total	**50**	**54**	**-4**
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	2	0	+2
Total	**2**	**0**	**+2**
Grand Total	**106**	**111**	**-5**

*Effective 10/25/2021 Affinity Health Plan is no longer a NYS MCO

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

Category of Incident	Critical Incidents		
	FFY 22 Q2 1/1/2022-3/31/2022	FFY 22 Q1 10/1/2021-12/31/2021	Net Change
Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	8	4	+4
Crimes Committed Against Enrollee	0	1	-1
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	1	-1
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	2	2	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	6	4	+2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	27	33	-6
Use of Restraints	11	12	-1
Wrongful Death	0	0	0
Total	**54**	**57**	**-3**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	1	0	+1
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	0	1	-1
Instances of Exploitation of Enrollees	1	0	+1
Instances of Neglect of Enrollees	0	1	-1
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	6	7	-1
Other Incident Resulting in Medical Treatment Other Than Hospitalization	42	44	-2
Use of Restraints	0	1	-1
Wrongful Death	0	0	0
Total	**50**	**54**	**-4**
HIV Special Needs Plans			
Instances of Abuse of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	0	0
Other Incident Resulting in Hospitalization	2	0	+2

Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	0	0
Total	**2**	**0**	**+2**
Grand Total	**106**	**111**	**-5**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 164 enrollee complaints this quarter. This total is a 92.9% increase from the previous quarter, which reported 85 enrollee complaints. The Department examined the increase in the number of complaints and discovered that the increase was consistent between most categories. The only category with a substantial percentage increase was Difficulty with Obtaining: Dental/Orthodontia. Upon examination, there was no trend identified among the cases.

MCO Enrollee Complaints Received Directly by the Department	
FFY 22 Q2 1/1/2022-3/31/2022	**FFY 22 Q1 10/1/2021-12/31/2021**
164	**85**

The following table outlines the top five (5) most frequent categories of enrollee complaints/action appeals received directly by the Department involving MCOs for the most recent quarter and compared to the previous quarter:

Percentage of MCO Enrollee Complaints Received Directly by the Department		
Description of Complaint	**FFY 22 Q2 1/1/2022-3/31/2022**	**FFY 22 Q1 10/1/2021-12/31/2021**
Reimbursement/Billing	16%	16%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	13%	14%
Pharmacy/Formulary	10%	9%
Difficulty with Obtaining: Dental/Orthodontia	6%	1%
All Other	5%	7%

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

In compliance with the Families First Coronavirus Response Act, Medicaid Managed Care enrollees have remained eligible for and enrolled in Medicaid. This has been in effect since March 18, 2020, with exceptions being enrollees who move out of state or who elect to cancel their coverage. Since March of 2020 the Department has carefully monitored any complaints regarding MCO enrollment issues related to suspended loss of Medicaid coverage and

addressed these issues in accordance with maintenance of effort requirements during this period.

F. Fair Hearings

There were 243 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of January 1, 2022 through March 31, 2022. The dispositions of these fair hearings for the most recent quarter and for the previous quarter are as follows:

Fair Hearing Decisions (includes MMC, HARP and HIV SNP)		
Hearing Dispositions	**FFY 22 Q2 1/1/2022-3/31/2022**	**FFY 22 Q1 10/1/2021-12/31/2021**
In favor of Appellant	68	82
In favor of Plan	160	195
No Issue	15	17
Total	**243**	**294**

For fair hearing dispositions occurring for the most recent quarter and for the previous quarter, 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 22 Q2 1/1/2022-3/31/2022**	**FFY 22 Q1 10/1/2021-12/31/2021**
0-29	7	6
30-59	48	75
60-89	55	60
90-119	34	35
=>120	99	118
Total	**243**	**294**

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

The MMCARP met on February 17, 2022. 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 MLTC program. There were three additional agenda items. A MMCARP Bylaws Subcommittee Update given by Erin Kate Calicchia, Associate Counsel, Bureau of Program Counsel Division of Legal Affairs, NYS Department of Health. A presentation regarding the Children's Waiver Utilization Data given by April Hamilton, Deputy Director, Division of Program Development and Management, Office of Health Insurance Programs, NYS Department of Health. Lastly, a Behavioral Health/HARP/Health Home Update given by Lynne Schafer, Division of Managed Care, NYS Office of Mental Health. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for June 16, 2022.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

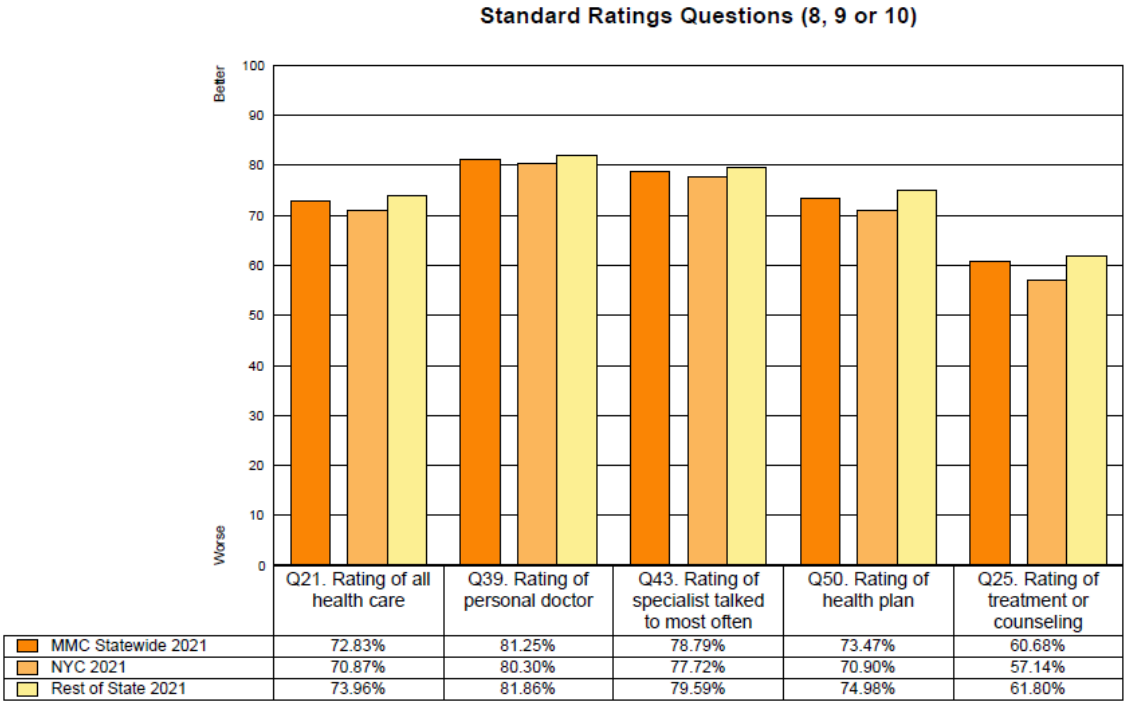
In March, we updated the dataset **Managed Long-Term Care Performance Data: Beginning 2014** on Health Data NY with January to June 2021 Satisfaction data. It can be viewed or downloaded from the following link: https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp/data. Data dictionary, measure definitions, and more for this dataset may be found by clicking on the "About" tab, and then scrolling half way down to find the PDF documentation. Charts may be found by clicking on "More Views"

B. Quality Measurement in Medicaid Managed Care

Quality Measure Benchmarks 2021 (Measurement Year 2020)
Quality of care remained high for Medicaid Managed Care members for the Demonstration Year. In measurement year 2020 national benchmarks were available for 55 measures for Medicaid. Out of the 55 measures that NYS Medicaid plans reported, 85% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in Medicaid managed care. The NYS Medicaid, rates exceed the national benchmarks for behavioral health on adult measures (e.g., receiving follow-up within 7 and 30 days after an emergency department visit for mental illness), and child measures (e.g., metabolic monitoring for children and adolescents on antipsychotics, the initiation/continuation of follow-care for children prescribed ADHD medication, and the use of first-line psychosocial care for children and adolescents on antipsychotics). New York State managed care plans also continue to surpass national benchmarks in several women's preventive care measures (e.g., postnatal care, as well as screening for Chlamydia, and cervical cancer). Considering this was during a period of COVID-19 impacts in New York, the data demonstrates that many aspects of quality of care remained high for New Yorkers on Medicaid.

2020 Satisfaction Survey
The Department conducted a satisfaction survey with adults enrolled in Medicaid managed care in the fall of 2021. The Consumer Assessment of Healthcare Providers and systems (CAHPS®) Medicaid 5.0 Adult survey was administered adults 18-64 enrolled in Medicaid, HARP, and SNP. The administration methodology consisted of a three-wave mailing protocol, with telephone follow up for non-responders. The overall response rate was 11.8% (with a range of 8% to 14% for response rates by plan). This return rate was slightly lower than the previous adult survey that was fielded in 2019. The responses to the survey were analyzed and will be released to the plans in May 2022.

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



	Q21. Rating of all health care	Q39. Rating of personal doctor	Q43. Rating of specialist talked to most often	Q50. Rating of health plan	Q25. Rating of treatment or counseling
MMC Statewide 2021	72.83%	81.25%	78.79%	73.47%	60.68%
NYC 2021	70.87%	80.30%	77.72%	70.90%	57.14%
Rest of State 2021	73.96%	81.86%	79.59%	74.98%	61.80%

2020 Quality Incentive for Medicaid Managed Care

The 2020-2021 Quality Incentive Awards calculations were finalized in March 2022 which covered the measurement year period for 2020. The quality incentive is calculated on the percentage of total points a plan earned in the areas of quality, satisfaction, and Prevention Quality Indicators. Points for issues with Compliance are subtracted from the total plan points before calculating the percentage of total points. Plans were classified into five Tiers based on their total score. T For the 2020-2021 Incentive, the score thresholds for each tier were adjusted to blunt impacts in quality due to the COVID-19 pandemic. Tier 1 indicate scores higher than 70, Tier 2 indicates scores between 60-69.99, and Tier 3 indicates scores between 50-59.99. There were no Tiers 4 or 5 assigned to the 2020-2021 incentive results. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and CMS. The results for the 2020-2021 Incentive included one plan in Tier 1, ten plans receiving some portion of the award (Tier 2), and two plans in Tier 2.

MMC QUALITY INCENTIVE 2020-2021

December 15, 2021

INCENTIVE PREMIUM AWARD (%)	PLAN NAME	INITIAL QUALITY POINTS	INITIAL SATISFACTION POINTS	POINTS (10 POINTS FOR SUBTRACTION)	80% OF QUAL POINTS	20% OF SATISFACTION POINTS	TOTAL SCORE (UP TO 100%)
TIER 1	Independent Health	77.42	13.32	-1	61.94	13.32	74.26
TIER 2	CDPHP	74.09	9.99	-1	59.27	9.99	68.26
TIER 2	Highmark Western and Northeastern New York, Inc.	69.93	13.32	-1	55.94	13.32	68.26
TIER 2	MetroPlus Health Plan	77.42	6.66	-1	61.94	6.66	67.60
TIER 2	Excellus BlueCross BlueShield	71.6	9.99	-1	57.28	9.99	66.27
TIER 2	UnitedHealthcare Community Plan	66.6	13.32	-1	53.28	13.32	65.60
TIER 2	Fidelis Care New York, Inc.	69.93	9.99	-1	55.94	9.99	64.93
TIER 2	Affinity Health Plan	67.43	9.99	-1	53.95	9.99	62.94
TIER 2	MVP Health Care	62.44	13.32	-1	49.95	13.32	62.27
TIER 2	Healthfirst PHSP, Inc.	66.6	9.99	-1	53.28	9.99	62.27
TIER 2	Molina Healthcare	68.27	6.66	-1	54.61	6.66	60.27
TIER 3	Empire BlueCross BlueShield HealthPlus	61.61	9.99	-1	49.28	9.99	58.27
TIER 3	HIP (EmblemHealth)	65.77	6.66	-3	52.61	6.66	56.27

Quality Assurance Reporting Requirements (QARR)
We had 26 health plans submit QARR data on June 15, 2021. Data was published in November and December 2021.

C. Quality Improvement

External Quality Review (EQR)
Island Peer Review Organization, Inc. (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 External Quality Review Organization (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, and HARPs, and include the state's Child Health Insurance Program (CHP). Some projects may also include the Medicaid FFS population, or, on occasion, the commercial managed care population for comparison purposes.

In the 2nd quarter of 2022, the EQRO is waiting for OHIP to give them approval to begin a new Access & Availability (Provider Directory) Survey. For the second Quarter of 2022 the EQRO received the corrective action plans (CAP's) from the plans to complete the previous survey. When the EQRO receives the disclosure documents for the health plans, they will begin the next Member Services survey. After the quarter one PNDS submission (March 2021), the EQRO can begin the next High Volume PCP Ratio survey.

Provider Network Data System (PNDS):

PNDS
IPRO continued to oversee two sub-contracts, RMCI and Quest Analytics, for the management of the rebuild of the PNDS. The PNDS collects network information from around 400 active networks in NYS. IPRO facilitated ongoing adjustments and fixes required for the PNDS rebuild and addressed any continuing issues with the rebuild of the PNDS network, relative to use, expansion and maintenance. The quarter 4 2021 PNDS submission deadline was January 21, 2021; plans submitted data based on version 10 of data dictionary. PNDS data dictionary version 11 will be released in later half of 2022 and IPRO has already started on it.

Provider and Health Plan LOOK-UP:
Significant edits to the New York State Provider & Health Plan Look-Up website increased consumers' access to data such as deciding which health plan to enroll in or when looking for a provider. The site surpassed 1.37 million distinct users by the end of 2021.

PANEL:
Panel data submission opened on 2/1/2022 and yielded 6,760,202 rows of data (up ~2%). Technical assistance was provided by DOH and IPRO throughout the submission particularly around new edits implemented. DOH provided detailed analytics to plans at of failing newly updated requirements.

The final report for the 2019/2021 MLTC PIP was due during the second quarter of 2022, January 2022. The EQRO reviewing the final reports of the MLTC PIP. The EQRO received the MLTC plan PIP proposals for the 2022/2023 MLTC PIP during the second quarter of 2022. During the second quarter of 2022 the EQRO continued drafting the MLTC EQR Annual Technical Report for RY 2020. The report is due to CMS on the third quarter of 2022.

For the second quarter of 2022, the EQRO worked with DOH to improve the number of survey responses for the MLTC focus clinical study. The samples pulled will be enlarged to increase the geographic area of the survey. The nurse assessors have been trained by the EQRO to administer the survey.

Preparation for the 2022 QARR submission (June 15th, 2022), was started by the EQRO in the second quarter of 2022. The EQRO will receive the final report of the adult CAHPS survey, from the vendor, DataStat, during the second quarter of 2022.

In the second Quarter of 2022, the EQRO continued preparing the draft report of the mainstream MMC EQR Annual Technical Report. DOH provided comments and feedback on the drafts of the report. The final report is due to CMS on 4/30/2022.

PIPs for MMC

2017-18 HARP PIP

For the 2017-2018 HARP and HIV 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 the revised version was received September 8, 2021 and is under review.

2019-21 HARP PIP

The 2019-2021 HARP PIP topic is Care Transitions after Emergency Department and Inpatient Admissions. The HARP PIP Proposals were submitted December 21, 2018. The submitted PIP Proposals were reviewed and finalized by IPRO, NYSDOH and partners (including OASAS and OMH). Plan interventions began in early 2019. In June 2020, the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. The HARP plans have been notified the PIP Final Reports are due to IPRO in July 2023.

2019-2020 Medicaid KIDS Quality Agenda PIP

The 2019-2020 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. The MMC plans have been notified the PIP Final Reports are due to IPRO in July 2023.

2022-2023 Medicaid Managed Care and HIV SNP PIP: Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members

On October 27, 2021, a WebEx meeting with Medicaid managed care and HIV SNP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The due date for the PIP Proposals was December 8, 2021. One health plan had an extension to submit their PIP Proposal by Jan. 5, 2022, and it was submitted Jan. 3, 2022. The PIP Proposals have been reviewed by IPRO and NYSDOH. All of the PIP Proposals have been finalized. The approved interventions have been planned to begin in March 2022. A baseline data update report is due to IPRO by April 15, 2022.

2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus

On November 19, 2021 a WebEx meeting with HARP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The due date for the PIP Proposals was January 10, 2022. The HARP plans submitted PIP Proposals by the due date, with the exception of one plan who was granted an extension until January 24, 2022. The one plan did submit their PIP Proposal by January 24, 2022. The PIP Proposals have been reviewed by IPRO and NYSDOH. All of the PIP Proposals have been finalized. The approved interventions have been planned to begin in March 2022. A baseline data update report is due to IPRO by April 29, 2022.

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 2018-2020 to identify low-volume facilities (those with a three-year average of fewer than 30 surgeries per year). A total of 319 facilities were designated as follows: 114 high-volume facilities, 25 low-volume unrestricted facilities, and 180 low-volume restricted facilities.

Six facilities appealed the decision to be placed on the low-volume restricted list; and two of the appeals were approved. Administrators at these facilities were notified via mail of their decisions. In addition, letters regarding final volume designation for state fiscal year 2022-23 were sent to health plan chief executive officers, and health plan trade organizations via the Department's Integrated Health Alerting and Notification System (IHANS). The list of low-volume restricted facilities and the list of facilities approved to provide breast cancer surgery were posted on the Department's website and included in the 2022 March Medicaid Update.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 2 (1/1/2022-3/31/2022)

As of March 2022, there were 9,567 NCQA-recognized PCMH providers and 2,297 practices in New York State (NYS). All providers are recognized under the standards of NYS Patient-Centered Medical Home (NYS PCMH), a new recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on behavioral health, care management, population health, value-based payment arrangements, and health information technology capabilities. Of the 9,567 providers that became recognized in March 2022, 85 were new to the NYS PCMH program.

Due to budget constraints, effective May 1, 2018, NYS discontinued PCMH incentive payments to providers recognized at level 2 under the 2014 standards, and reduced the incentive for 2014 level 3, and 2017-recognizerd providers. Current information on PCMH incentives in Medicaid can be found here: https://www.health.ny.gov/health_care/medicaid/program/update/medup-pa-pn.htm#patiented.

The incentive rate for the New York Medicaid PCMH Statewide Incentive Payment Program as of March 2022 is $6.00 PMPM.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has continued with monthly meetings for participating payers. There is still a commitment across payers and providers to continue through 2021 but discussions around alignment of methods for shared savings models are still not finalized.

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

IX. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

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

The State is also awaiting further guidance 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 Budget Neutrality reporting tool workbook to accurately reflect the state's Budget Neutrality position:

- As detailed in STC X.10, the State identified a contractor, Klynveld Peat Marwick Goerdeler (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 the Medicaid Budget and Expenditure System (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. The State is also addressing the issues associated with the new Outcomes 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.

To help facilitate resolution of identified data issues, the state has instituted a Data Governance workgroup for T-MSIS. The group's focus is to address data issues and specific processes/policies that are unique to NY and provide narration to aid in the understanding of these state processes/policies.

The State has completed the resubmission of historical claim files for the period July 2015 through June 2021 per CMS's request.

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

State Contact:
Phil Alotta
Health Program Administrator II
Strategic Operations and Planning
Office of Health Insurance Programs
phil.alotta@health.ny.gov
Phone (518) 486-7654
Fax (518) 473-1764

Uploaded to PMDA: May 26, 2022

Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	4	0	0	0	0	0	4	0	0	5,529	0.07%
AgeWell NY	7	0	0	0	1	3	3	0	0	13,099	0.05%
AgeWell MAP	0	0	0	0	0	0	0	0	0	67	0.00%
Archcare Community Life	77	1	0	0	17	1	19	39	0	4,691	1.64%
Archcare PACE	15	0	0	0	0	0	9	6	0	690	2.17%
Catholic Health-LIFE	14	0	9	0	0	0	1	4	0	249	5.62%
Centerlight PACE	72	0	0	0	2	1	24	32	13	3206	2.25%
Centers Plan for Healthy Living	681	4	0	0	14	0	243	420	0	46,576	1.46%
Centers Plan for Healthy Living MAP	14	0	0	0	1	0	8	5	0	1,077	1.30%
Complete Senior Care	2	0	0	0	0	0	1	1	0	122	1.64%
Eddy SeniorCare	6	0	0	0	0	0	3	2	1	306	1.96%
Elant Choice (EverCare)	0	0	0	0	0	0	0	0	0	918	0.00%
Elderplan MAP	6	0	0	0	3	1	0	1	1	2,833	0.21%
Elderserve	0	0	0	0	0	0	0	0	0	15,264	0.00%
Elderserve MAP	1	0	0	0	0	0	0	1	0	90	1.11%
Elderwood	16	0	0	0	0	1	4	10	1	1,021	1.57%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	4,874	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0		173	0.00%
Extended	51	0	0	0	0	0	38	13	0	5578	0.91%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	861	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	128	0.00%
Fidelis Care at Home	29	0	0	0	1	0	5	23	0	18,424	0.16%
Fidelis MAP	0	0	0	0	0	0	0	0	0	181	0.00%
Hamaspik	0	0	0	0	0	0	0	0	0	1,982	0.00%
Hamaspik MAP	4	0	0	0	0	1	1	0	2	195	2.05%
Healthfirst CompleteCare	82	0	0	0	0	0	29	53	0	21,185	0.39%
HomeFirst, Inc. (Elderplan)	18	0	0	0	10	0	3	4	1	13785	0.13%
Icircle	4	0	0	0	3	0	0	0	1	3,532	0.11%

Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	711	0.00%
Independent Living Services of CNY (PACE CNY)	15	0	0	0	0	0	8	7	0	510	2.94%
Integra MLTC	0	0	0	0	0	0	0	0	0	41,397	0.00%
Kalos ErieNiagara DBA: First Choice Health	5	0	0	0	0	0	0	5	0	552	0.91%
MetroPlus	0	0	0	0	0	0	0	0	0	1,349	0.00%
Monefiore	0	0	0	0	0	0	0	0	0	1,459	0.00%
Prime	46	0	0	0	1	1	8	36	0	558	8.24%
Senior Health Partners	27	0	0	0	0	0	0	27	0	9,845	0.27%
Senior Network Health, LLC	4	0	0	0	0	0	2	2	0	362	1.10%
Senior Whole Health	0	0	0	0	0	0	0	0	0	13,439	0.00%
Senior Whole Health MAP	1	0	0	1	0	0	0	0	0	111	0.90%
Total Senior Care	13	0	0	0	0	0	2	11	0	137	9.49%
Village Care	269	0	0	1	19	2	66	181	0	13,749	1.96%
Village Care MAP	63	0	0	0	8	0	12	43	0	2,836	2.22%
VNA Homecare Options (Nascentia Health Options)	129	1	0	1	1	0	60	66	0	3,351	3.85%
VNS Choice MAP TOTAL	37	0	0	0	0	1	13	23	0	3,071	1.20%
VNS Choice MLTC	257	0	0	0	9	3	87	158	0	21,585	1.19%
total	1969	6	9	3	90	15	653	1173	20	281658	0.70%

Managed Long Term Care Partial Capitation Plan Enrollment April 2021 - March 2022												
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	6,116	6,071	6,023	5975	5909	5,872	5,800	5,737	5,687	5,612	5,498	5,478
AgeWell New York	12,532	12,616	12,739	12825	12954	13,065	13,040	13,107	13,167	13,151	13,070	13,075
ArchCare Community Life	4,507	4,518	4,538	4565	4590	4,592	4,590	4,615	4,651	4,667	4,656	4,751
Centers Plan for Healthy Living	43,694	44,141	44,448	44701	44993	45,421	45,723	46,220	46,943	46,868	46,459	46,401
Elant	1,046	1,054	1,034	1012	999	991	968	967	954	935	912	908
Elderplan	13,824	13,831	13,826	13808	13781	13,792	13,727	13,687	13,721	13,787	13,718	13,849
Elderserve	15,033	15,132	15,200	15266	15335	15,425	15,343	15,344	15,426	15,361	15,213	15,218
Elderwood	967	992	1,005	1005	1009	1,012	1,006	1,028	1,034	1,031	1,015	1,016
Extended MLTC	6,234	6,094	6,035	5993	5970	5,931	5,858	5,801	5,734	5,678	5,559	5,497
Fallon Health Weinberg (TAIP)	846	860	868	872	872	881	876	876	874	869	863	850
Fidelis Care at Home	19,703	19,664	19,588	19474	19398	19,303	19,006	18,836	18,750	18,643	18,374	18,254
Hamaspik Choice	2,063	2,044	2,047	2045	2064	2,068	2,042	2,026	2,021	2,008	1,968	1,970
HealthPlus- Amerigroup	5,413	5,401	5,315	5268	5226	5,159	5,052	4,999	4,981	4,945	4,847	4,830
iCircle Services	3,735	3,747	3,714	3706	3703	3,693	3,613	3,600	3,600	3,570	3,529	3,497
Integra	38,526	38,870	39,180	39457	39776	40,041	40,100	40,386	40,902	41,242	41,421	41,528
Kalos Health- Erie Niagara	724	709	704	690	680	663	615	592	578	564	549	544
MetroPlus MLTC	1,483	1,491	1,473	1448	1427	1,429	1,423	1,409	1,397	1,359	1,345	1,343
Montefiore HMO	1,525	1,532	1,532	1525	1522	1,517	1,494	1,485	1,486	1,491	1,451	1,434
Prime Health Choice	627	624	617	612	578	580	579	574	571	567	559	549
Senior Health Partners	11,526	11,381	11,180	10946	10719	10,570	10,402	10,337	10,275	10,009	9,843	9,682
Senior Network Health	403	406	402	393	392	386	374	373	376	369	362	355
Senior Whole Health	13,339	13,428	13,541	13645	13673	13,702	13,642	13,550	13,526	13,464	13,398	13,454
Village Care	12,967	13,011	13,097	13151	13358	13,436	13,491	13,637	13,787	13,763	13,709	13,774
VNA HomeCare Options	3,199	3,214	3,262	3286	3313	3,329	3,276	3,280	3,336	3,355	3,306	3,393
VNS Choice	21,281	21,393	21,593	21699	21808	21,951	21,725	21,712	21,794	21,706	21,507	21,543
Total	**241,313**	**242,224**	**242,961**	**243,367**	**244,049**	**244,809**	**243,765**	**244,178**	**245,571**	**245,014**	**243,131**	**243,193**

Managed Long Term Care MAP Enrollment April 2021 - March 2022												
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	58	72	78	106	117	138	156	175	185	178	185	180
Hamaspik	0	0	0	37	92	135	147	158	177	189	179	218
Agewell	44	51	53	53	55	58	57	62	62	68	67	66
Centers	435	1032	1126	612	659	687	744	718	705	994	1089	1148
Elderplan	2606	2685	2730	2771	2801	2833	2834	2789	2813	2838	2816	2844
Elderserve	63	64	66	69	67	72	79	78	79	85	88	97
Healthfirst Complete Care	17655	18144	18629	19019	19406	19746	19976	19983	20140	20921	21167	21466
Healthplus	64	63	82	88	100	117	115	112	133	156	175	187
Metroplus	0	0	0	0	0	0	0	0	0	1	16	19
Senior Whole Health	114	115	112	117	118	119	122	117	110	113	110	111
VNS	3014	3035	3088	3122	3127	3141	3144	3050	3023	3086	3076	3051
Village Care	2882	2949	3001	3024	3047	3043	3033	2915	2829	2887	2825	2796
Total	**26935**	**28210**	**28965**	**29018**	**29589**	**30089**	**30407**	**30157**	**30256**	**31516**	**31793**	**32183**

Managed Long Term Care PACE Enrollment April 2021 - March 2022												
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	692	731	751	747	741	699	696	708	705	703	686	681
CHS Buffalo Life	250	253	253	256	262	265	266	258	256	250	249	247
Complete Senior Care	125	126	127	125	127	126	123	125	130	127	122	118
Comprehensive Care Management	2402	2372	2378	2386	2435	2518	2592	2769	2934	3066	3192	3360
Eddy Senior Care	294	295	295	297	296	293	300	304	306	300	310	307
Fallon Health Weinberg PACE	131	132	131	132	125	125	128	123	126	128	130	126
Independent Living For Seniors	736	732	726	730	729	728	720	722	712	713	707	713
Pace CNY	574	568	568	567	561	559	553	550	532	517	509	505
Total Senior Care	139	143	140	143	144	144	144	139	139	137	136	138
Total	**5343**	**5352**	**5369**	**5383**	**5420**	**5457**	**5522**	**5698**	**5840**	**5941**	**6041**	**6195**

Managed Long Term Care MA Enrollment April 2021 - March 2022												
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis Legacy	1041	1045	1030	1009	999	983	973	963	954	0	0	0
Wellcare	926	900	882	862	859	846	834	824	820	0	0	0
United Healthcare	1215	1205	1191	1177	1164	1156	1140	1129	1125	0	0	0
Total	**3182**	**3150**	**3103**	**3048**	**3022**	**2985**	**2947**	**2916**	**2899**	**0**	**0**	**0**

Managed Long Term Care FIDA-IDD Enrollment April 2021 - March 2022												
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1740	1738	1744	1734	1724	1720	1720	1717	1717	1698	1687	1689