MRT Demonstration
Section 1115 Quarterly Report
Demonstration Year: 24 (4/1/2022-3/31/2023)
Federal Fiscal Quarter: 3 (4/1/2022-6/30/2022)

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 (BH) 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 MRT Waiver. On April 19, 2019, CMS approved New York's request to exempt Mainstream Medicaid Managed Care (MMMC) enrollees from cost sharing by waiving comparability requirements to align with the New York's social services law, except for applicable pharmacy co-payments described in the STCs. On August 2, 2019, CMS approved New York's request to create a streamlined children's model of care for children and youth under 21 years of age with BH and Home and

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

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

On March 23, 2022, CMS approved a five-year extension of the New York MRT demonstration. As part of the extension, CMS approved the state's second component of its MLTC amendment request to allow dual 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: Third Quarter

MRT Waiver- Enrollment as of June 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	480,820	7,824	1,488
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	63,486	1,736	416
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	13,891	175	49

Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**41,043**	**882**	**280**
Population 5 - Safety Net Adults	**216,270**	**7,855**	**1,857**
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)	**147,923**	**1,963**	**70**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**64,043**	**3,986**	**178**
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**70,197**	**371**	**11**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**11,885**	**2,328**	**98**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollment's	
Total # Voluntary Disenrollments in Current Demonstration Year	**27,120 or an approximate 23.2% 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 disenrollment due to incarcerations and an increase in the "Undetermined" category of disenrollment. Undetermined referring to cases where a manual review would be needed to determine the specific reason for disenrollment

Involuntary Disenrollment's	
Total # Involuntary Disenrollments in Current Demonstration Year	4,447 or an approximate 84.7% decrease from last Q

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

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

Involuntary disenrollment decreased primarily due to a decrease in Modified Adjusted Gross Income (MAGI) case closures that were subsequently sent to NYSoH for redetermination.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
April 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto assigned**	**Affirmative Choices**
New York City	705,794	17,557	2,620	14,937
Rest of State	338,319	7,819	926	6,893
Statewide	1,044,113	25,376	3,546	21,830
May 2022				
New York City	713,932	20,076	3,507	16,569
Rest of State	342,537	8,608	1,331	7,277
Statewide	1,056,469	28,684	4,838	23,846
June 2022				
New York City	717,773	15,301	2,084	13,217
Rest of State	344,966	7,638	880	6,758
Statewide	1,062,739	22,939	2,964	19,975

Third Quarter	
Region	**Total Affirmative Choices**
New York City	44,723
Rest of State	20,928
Statewide	65,651

HIV SNP Plans				
April 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto assigned**	**Affirmative Choices**
New York City	12,925	268	0	268
Rest of State	19	1	0	1
Statewide	12,944	269	0	269
May 2022				
New York City	12,969	219	0	219
Rest of State	20	1	0	1
Statewide	12,989	220	0	220
June 2022				
New York City	13,001	210	0	210
Rest of State	22	2	0	2
Statewide	13,023	212	0	212
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	697			
Rest of State	4			
Statewide	701			

Health and Recovery Plans Disenrollment			
FFY 22 – Q3			
	Voluntary	Involuntary	Total
April 2022	709	587	1,296
May 2022	789	565	1,354
June 2022	666	538	1,204
Total:	2,164	1,690	3,854

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 3 (4/1/2022-6/30/2022) Q3 FFY 2022

As of the end of the third federal fiscal quarter (end of June 2022), there were 3,015,343 New York City Medicaid consumers enrolled in MMMC Program and 77,480 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education and enrollment activities in Human Resources Administration (HRA) facilities throughout the five boroughs of New York City.

During the reporting period, MAXIMUS Field Customer Service Representatives (FCSRs) conducted personal and phone outreach in 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 5,644 clients were educated about enrollment options and made an enrollment choice including 296 clients in person and 5,348 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. Deficiencies are 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 30,417 FFS community clients were reported on the regular auto-assignment list, 2,556 clients responded to the call that generated 3,761 enrollments. Of the total of 48 FFS NH clients Plan selection.

C. NYMC HelpLine Observations April-June 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 **55,176** calls were received by the Helpline and **53,010** or **96%** were answered. Calls answered were handled in the following languages: **English: 35,719 (67%); Spanish: 6,606 (12%); Chinese: 2,703 (5%); Russian: 495 (1%); Haitian/Creole: 61 (1%); and other: 7,426 (14%).**

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to **3,623** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 3rd Quarter 2022								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
2,040 (56%)	**314 (9%)**	**212 (6%)**	**1,017 (28%)**	**33 (1%)**	**1 (0%)**	**6 (0%)**	**0 (0%)**	**3,623**

A total of **1,133 (31%)** recorded calls observed was unsatisfactory. **605** calls had a single infraction and **528** calls had multiple infractions. A total of **1,973** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,486 (75%)** - 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: **228 (12%)** - 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: **259 (13%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **1,973** 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

Health Insurance Plan of New York dba Emblem Healthcare was approved to provide Integrated Benefits for the Dually Eligible population in the following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.

HealthPlus HP was approved to provide Integrated Benefits for the Dually Eligible population in the following counties: Orange, Rockland, Suffolk, and Westchester.

New York Quality Healthcare Corporation dba Fidelis Care was approved to offer Medicaid Advantage Plus in the following counites: Allegany, Broome, Cattaraugus, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Lewis, Niagara, Oneida, Onondaga, Orange, Orleans, Oswego, Otsego, Putnam, Rockland, Saratoga, Schoharie, Schuyler, Seneca, St Lawrence, Steuben, Sullivan, Tioga, Ulster, Warren, Washington, Wyoming, Yates.

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

The March 1, 2019, Medicaid Managed Care (MMC)/HIV SNP/HARP 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 (MCOs) 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 MCOs 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

Four (4) Comprehensive Operational Surveys were completed during 3rd QTR FFY 2021-2022. A Statement of Deficiency (SOD) was issued, and a Plan of Correction (POC) was accepted for four (4) Plans:

- Independent Health Association Comprehensive Operational Survey
- Health Insurance Plan of New York Comprehensive Operational Survey
- HealthPlus (Amerigroup) Comprehensive Operational Survey
- Amida Care Comprehensive Operational Survey

Two (2) Target Surveys were completed during 3rd QTR FFY 2021-2022. An SOD was issued and a POC was accepted for one (1) Plan:

- CDPHP Target Operational Survey

One (1) Plan was found in compliance:

- Healthfirst Target 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 BH system to managed care. The goal is to create a fully integrated BH (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 BH services in MMC, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of HARPs. HARPs are specialized plans that include staff with enhanced BH expertise. In addition, individuals who are enrolled in a HARP can be assessed to access additional specialty services called BH HCBS. For MMC, all Medicaid- funded BH services for adults, except for services in Community Residences, are part of the benefit package.

Beginning in January 2019, children's BH services were transitioned into MMC as part of the Children's Medicaid System Redesign. Transitioned BH services included six new Children and Family Treatment and Support Services (CFTSS) and the 1915(c) Children's Consolidated Waiver. Additionally, the Children's Medicaid System Redesign focused on the transition of children in foster care to MMC and integrated the delivery of the Health Home care management model for children.

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 SNPs now provide all covered services available through MMC.

In Fiscal Year (FY) 2018, New York State engaged in multiple activities to enhance access to BH services and improve quality of care for recipients in MMC. In June of 2018, HARP became an option on the 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 BH 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 BH services based on medical necessity. The report includes aggregated provider level data for service authorization requests and denials, whether the denial was Pre-Service, Concurrent, or Retrospective, and the reason for the denial.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (1/1/2022-3/31/2022)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	34,187	211	199	0.58%
ROS	5,260	27	27	0.51%
Total	39,447	238	226	0.57%

Note: MVP March data is excluded from this quarter's analysis due to data integrity issues.

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 BH service. Submissions include counts of denials for specific service authorizations, as well as administrative denials, internal, and fair hearing appeals. In addition, HARPs are required to report authorization requests and denials of BH HCBS.

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Outpatient (1/1/2022-3/31/2022)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	6,252	150	43	0.69%
ROS	1,617	56	56	3.46%
Total	7,869	206	99	1.26%

Note: MVP March data is excluded from this quarter's analysis due to data integrity issues.

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 (4/1/2022-6/30/2022)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,253,876	94.46%	5.54%
ROS	955,711	94.83%	5.17%
Totals	2,209,587	94.62%	5.38%

[1] Q3 data is not available and will be submitted with the next quarterly update.
[2] Q2 data is not available and will be submitted with the next quarterly update.

BH Adults CORE/HCBS Claims/Encounters 4/1/2022-6/30/2022: NYC

BH CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	75	21
Education Support Services	134	42
Family Support and Trainings	138	11
Intensive Supported Employment	91	28
Ongoing Supported Employment	25	6
Peer Support	1,861	331
Pre-vocational	74	19
Provider Travel Supplements	5	5
Psychosocial Rehab	1,635	243
Residential Supports Services	158	30
Transitional Employment	2	1
TOTAL	4,198	611

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

BH Adults CORE/HCBS Claims/Encounters 4/1/2022-6/30/2022: ROS

BH HCBS SERV GROUP	N Claims	N Recip.
CPST	999	202
Education Support Services	450	132
Family Support and Trainings	21	9
Intensive Supported Employment	304	76
Ongoing Supported Employment	73	19
Peer Support	4,561	935
Pre-vocational	80	27
Provider Travel Supplements	2,926	749
Psychosocial Rehab	3,451	600
Residential Supports Services	1,467	253
Transitional Employment	0	0
TOTAL	14,332	1,912

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 3 MCTAC Attendance & Stats (4/1/2022 to 6/30/2022)

Events: MCTAC successfully executed 21 events from 4/1/2022 to 6/30/2022
All 21 were held via webinar.

Individual Participation/Attendance/Viewing of Resource *(this includes all the individuals that attended the MCTAC offerings or viewed a resource online):*
2,634 people attended/participated in our events/viewed resources of which **1,835** were unique participants.

OMH Agency Participation
Overall: 289 of 653 **(44.26 %)**

OASAS Agency Participation
Overall: 183 of 563 **(32.50%)**

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; locating enrollees and keeping them engaged throughout the lengthy assessment and Plan of Care development process; ensuring care managers have understanding of BH HCBS (including person-centered care planning) and capacity for care managers to effectively link members to rehab services; and difficulty launching BH HCBS due to low number of referrals to BH HCBS providers.

The State previously made efforts to ramp up utilization and improve access to BH HCBS by addressing the identified challenges. 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 Health Homes and RCAs).
- Developed required training for BH HCBS providers that the State can track in a Learning Management System.
- Implementing rates that recognize low volume during implementation to help providers ramp up to sustainable volumes.
- Enhancing Technical Assistance efforts for BH HCBS providers including workforce development and training.
- Obtained approval from CMS to provide recovery coordination services (assessments and care planning) for enrollees who are not enrolled in Health Homes. These services are provided by State Designated Entities (SDE) through direct contracts with the MCO.
    - Developed and implemented guidance to MCOs for contracting with State-designated entities to provide recovery coordination of BH HCBS for those not enrolled in Health Home.
    - Developed Documentation and Claiming guidance for MCOs and contracted Recovery Coordination Agencies (RCA) for the provision of assessments and development of plans of care for BH HCBS.
    - Additional efforts to support initial implementation of RCAs include:
        - In-person trainings (completed June 2018)
        - Weekly calls with MCOs (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, CPEPS and Inpatient units and engagement and retention strategies
    - Existing quality improvement initiative within clinics to encourage Health Homes enrollment
    - Emphasis on warm hand-off to Health Home from ER and inpatient settings
    - PSYCKES quality initiatives incentivizing MCOs to improve successful enrollment of high-need members in care management
    - DOH approval of MCO plans for incentivizing enrollment into Health Homes (e.g., Outreach Optimization)
- Ongoing work to strengthen the capacity of Health Homes to serve high need SMI individuals and ensure their engagement in needed services through expansion of Health Home Plus (HH+) effective May 2018.
    - Provided technical assistance to lead Health Homes s, representation on new HH+ Subcommittee Workgroup.
- Implementing Performance Management efforts, including developing enhanced oversight process for Health Homes who have not reached identified performance targets for and key quality metrics for access to BH HCBS for HARP members.
- Disseminating Consumer Education materials to improve understanding of the benefits of BH HCBS and educating peer advocates to perform outreach.
    - NYS Office of Mental Health has contracted with NYAPRS to conduct peer-focused outreach and training to possible eligible members for MMC 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, Health Homes s, 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' Health Home/MCO Workgroup.
- A process for care managers and supervisors to apply for a waiver of staff qualifications for administering the NYS Eligibility Assessments was established, in response to challenges in securing a CM workforce meeting both the education and experience criteria and need for more assessors.

To date, 5,141 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between April 1, 2022, and June 30, 2022, 1,391 eligibility assessments were completed.

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

As a result, the State released a draft proposal for public comment in June 2020 to transition 1115 Waiver BH HCBS into a State Adult Rehabilitation Services package for HARP enrollees and HARP eligible HIV-SNP enrollees, which to date has resulted in positive feedback. The State finalized the proposal and submitted to CMS in September 2020. The objectives of this transition are two-fold: to simplify and allow creativity in service delivery of community-based

rehabilitation services tailored to the specific needs of the BH population, and to eliminate barriers to access.

To receive the enhanced Federal Medical Assistance Percentage (eFMAP) available through Section 9817 of 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 Health Home Care Management will continue to be an important piece of the HARP benefit package for the comprehensive, integrated coordination of the care offered by Health Home. Care managers will always have the important role of ensuring timely access to services reflective of the member's preferences and individual needs, in continued collaboration with the MCO and service providers.

CORE Services went live on February 1, 2022 and were 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 is only 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. In the months and weeks leading up to August 1, the State has engaged providers in a significant amount of outreach and technical assistance to ensure the provider system is prepared for this transition, supporting continuity of care for members receiving these services.

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 Health Homes.

In addition, in 2021 the State extended the Adult BH HCBS Infrastructure funding initiative to support BH providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allows MCOs to contract for remaining,

unspent funds totaling approximately $31M. Funds have been competitively awarded by the MCOs and contracting activity is currently underway. 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 3: The transition of SBHC services from Medicaid Fee-for-Service to MMC has been postponed indefinitely. There will be no further reporting on this item.

C. Managed Long-Term Care (MLTC) Program

MLTC plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of July 1, 2022, there are 25 Partial Capitation plans, 9 PACE plans, 12 MAP, and 1 FIDA IDD plan. As of June 30, 2022, there are a total of 290,569 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the April 2022 through June 2022 quarter, 1 MAP plan expanded service area operations.

New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the degree to which consumers could maintain their relationship with the services they were receiving prior to mandatory transitions to MLTC. For the April 2022 through June 2022 quarter, post enrollment surveys were completed for 2 enrollees. Of the 2 surveilled, 1 (50%) 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. The percentage of affirmative responses is lower than the previous quarter.

Enrollment: Total enrollment in MLTC Partial Capitation plans increased 2% from 243,193 the previous quarter to 247,942 during the April 2022 through June 2022 quarter. For that period, 13,187 individuals who were being transitioned into MLTC made an affirmative choice, a 63% increase from the previous quarter, and brings the 12-month total for affirmative choice to 38,782.

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

2. Significant Program Developments

During the April 2022 through June 2022 quarter:

- The 3rd 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 Desk Review for 3 Partial Capitation Operational Surveys were completed and reported in prior reporting. Corrective Action Plans (CAP) have been completed by the plans and are still awaiting department approval, except for 1 plan, whose CAP has already been approved by the department.

- The Desk Reviews for 2 Partial Capitation Operational Surveys were completed. A Statement of Deficiencies was issued to 1 plan and the Statement of Deficiencies for another plan is being drafted.

- Operational Surveys are ongoing for 3 Partial Capitation plans.

- 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. For the April to June Quarter, additional documentation is still required from the plan, as the CAP is being monitored every month to ensure completion.

- 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 13 Partial Capitation Plans and 2 MAP plans. CAPS for 11 Partial Capitation Plans and 1 MAP Plan have been accepted; the remaining 3 CAPs are still under review.

- 2 Focused Surveys were conducted on 1 Partial Capitation plan based on TAC Complaints and two 2 Statements of Deficiencies were issued to the plan. The Plan has submitted CAPs, which have been accepted by the department.

- 1 Focused Survey was conducted on 1 PACE plan based on the re-licensure survey; 1 Statements of Deficiencies was issued to the plan. The Plan has submitted a CAP, which has been accepted by the department.

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 April 2022 through June 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 began a procurement process in December 2019 which was subsequently amended in the executive budget in April 2022. The amended legislation now directly provides the criteria a fiscal intermediary must meet to contract with the Department to continue to provide fiscal intermediary administrative services for the Consumer Directed Personal Assistance Program (CDPAP). The Department is developing the process by which each FI will attest to meeting the legislatively mandated criteria and will then begin contracting with the FIs that meet the criteria. Managed care plans will enter into separate administrative service agreements with these 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 2,314 critical incidents reported for the April 2022 through June 2022 quarter an increase of 18% from the previous quarter. There are 4 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 April 2022 through June 2022 quarter, the top reasons for complaints/appeals changed from last quarter: Dissatisfaction with Transportation, Dissatisfaction with quality of other covered services, Dissatisfaction with Quality Home Care (Other than lateness or absences), Dissatisfaction with member services and plan operations, Home Care Aides Late or Absent

Period: April 1, 2022 – June 30, 2022 (Percentages rounded to nearest whole number)			
Number of Recipients: 290,569	**Complaint**	**Resolved**	**Percent Resolved***
#Expedited	**21**	**13**	**62%**
# Same Day	**3,256**	**3,256**	**100%**
# Standard/Expedited	**8,977**	**8,451**	**94%**
Total for this period:	**12,254**	**11,720**	**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	7/2021-9/2021	10/2021-12/2021	1/2022-3/2022	4/2022-6/2022	Average for Four Quarters
Average Enrollment	279,060	281,667	281,668	286,152	282,137
Total Appeals	8,424	8,695	8,489	8,803	8,603
Appeals per 1,000	30	32	30	31	31
# Decided in favor of Enrollee	1,496	1,310	1,375	1,241	1,356
# Decided against Enrollee	6,168	6,062	5,751	6,323	6,076
# Not decided fully in favor of Enrollee	612	1,066	808	912	850
# Withdrawn by Enrollee	231	233	269	247	245
# Still pending	886	746	286	80	500
Average number of days from receipt to decision	8	8	8	7	8

Complaints and Appeals per 1,000 Enrollees by Product Type April 2022 - June 2022					
	*Enrollment	Total Complaints	Complaints per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	246,187	7,533	31	6,765	27
Medicaid Advantage Plus (MAP) Total	33,323	3,547	106	1,953	59
PACE Total	6,641	1,174	177	85	13
Total for All Products:	**286,151**	**12,254**	**314**	**8,803**	**99**

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

Total complaints increased 6% from 11,611 the previous quarter to 12,254 during the April 2022 through June 2022 quarter.

The total number of appeals increased 4% from 8,489 during the last quarter to 8,803 during the April 2022 through June 2022 quarter.

Technical Assistance Center (TAC) Activity

During the April 2022 through June 2022 quarter, TAC opened 514 cases. This is a about the same as the previous quarter. TAC has seen an increase in enrollment-base (+7%) complaints and a decrease in aide service complaints (-3%) and general questions (-4%). TAC's case dispositions were similar to the previous quarter.

Call/Case Volume	4/1/2022 – 6/30/2022
Substantiated Complaints	32
Substantiated w/CAP	1
Unsubstantiated Complaints	214
Closed As Duplicate	0
Complaints Resolved Without Investigation	22
Inquiries	245
Total Cases Resolved	**514**

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

Aide Service	25%
Enrollment	21%
General	20%
IDT Dissatisfaction	4%
Billing	3%

70% of Q3 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 eligibility: On May 16, 2022, the CFEEC began to be replaced by the New York Independent Assessor (NYIA) which is now conducting initial assessments and clinical exams for personal care and consumer directed personal assistance services as well as continuing to determine MLTC eligibility. During the April 2022 through June 2022 period, while transitioning to the new NYIA process, CFEEC evaluated 8,699 people who were deemed eligible and enrolled into plans. In addition, NYIA evaluated 2,328 people deemed eligible for MLTC and enrolled into plans. That combined total of 11,027 evaluations is a 12% increase from the previous quarter.

Referrals and 30-day assessment post enrollment: For the April 2022 through June 2022 quarter, MLTC plans conducted 27,766 assessments upon enrollment, a 20% increase from 23,062 the previous quarter. The total number of assessments conducted within 30 days decreased slightly from 20,596 the previous quarter to 20,179 this quarter.

Referrals outside enrollment broker: For the April 2022 through June 2022 quarter, the number of people who were not referred by the Enrollment Broker and who contacted the plan directly was 29,305 a 22% increase from 24,055 the previous quarter.

Rebalancing Efforts	4/2022-6/2022
Partial Capitation enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	138
Partial Capitation enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,165

As of June 30, 2022, there were 2,107 current plan enrollees who were in nursing homes as permanent placements, a 39% 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 BH and HCBS

needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. **The Children's Waiver Renewal** that was submitted to CMS in January 2022, and extended in April 2022, was **approved on June 29, 2022**. This five-year renewal of the Children's Waiver is retroactively effective from April 1, 2022, to March 31, 2027.

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

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

Given the approval, the New York State DOH 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 MCOs, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from MCOs, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of MCOs and Fee-for-Service billing and claiming data;
- Defining performance and quality metrics;
- Responding to the COVID-19 pandemic and implementing emergency 1135 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 Health Homes and HCBS providers to enhance capacity monitoring and streamline the referral process;
- Engaging with providers to understand barriers to service delivery – such as 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, Health Homes, MCOs, 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 MCOs, 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 1915c 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.

Given the Waiver renewal approval, the New York State DOH has been implementing and altering activities and services, including, but not limited to, the following:

- Submitting Disaster SPA 21-0054, which is pending approval for the assessment fee retroactive to April 1, 2022;
- Updating documentation and providing guidance to providers regarding the HCBS name changes for "Palliative Care: Counseling and Support Services" (previously "Palliative Care: Bereavement") and Adaptive and Assistive Technology" (previously "Adaptive and Assistive Equipment");
- Updating documentation and providing guidance to providers regarding the consolidated HCBS of "Caregiver and Family Support and Services" and "Community Self-Advocacy Support" into a new service referred to as "Caregiver/Family Advocacy and Support Services". This combination will allow for a broader array of providers to deliver the service and broadens the definition of caregivers eligible for training to include all individuals who supervise and care for members;
- Broadening Children and Youth Evaluation Services' (C-YES') Nurse qualifications by requiring two years relevant experience. The previous requirement that was two years' experience *specifically* in home care;
- Reducing the required years of experience for Palliative Care: Expressive Therapists from three years to one year; and
- Adding a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity.

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 Fo1 Medicaid budgeting as identified by NYS restriction exception (RE) code KK. Therefore, the table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
April	20,090	12,792	6,887	1,581
May	18,804	9,592	6,943	1,533
June	16,751	5,380*	6,541	868
Quarterly Average	**18,548**	**9,255**	**6,790**	**1,327**

**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 3rd Quarter of FY2022.The number of children/youth enrolled in HCBS is has almost doubled since Q2, and utilization of these services is

increasing at an even greater rate. 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 (IEs) are in process and three have concluded. The first 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 IEs supported by each of the RAND Corporation research teams. RAND has contracts to conduct each of the IEs including the Children's waiver, the 1115 waiver, the 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 IE 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 (LTSS), 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 DOH 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 reviewer's 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 HARP and 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, with DOH response due to CMS by May 21, 2022. RAND provided response to CMS on May 18, 2022. RAND and DOH are looking forward to receiving CMS approval on the HARP Interim Report.

The SDC Interim Evaluation Report was submitted to CMS on March 9, 2022. CMS returned one comment on the report on April 25, 2022, with DOH response due to CMS by June 23, 2022. RAND provided a response to CMS on June 8, 2022. RAND and DOH are looking forward to receiving CMS approval on the SDC Interim Report.

During February and March 2021, the RAND team conducting the IE 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

Medicaid MCOs, including MMC plans, HARPs, and HIV SNPs, are required to report quarterly to the Department of Health (Department) 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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
MMC	9,026	8,740
HARP	1,048	1,114
HIV SNP	124	89
Total MCO Complaints	**10,198**	**9,943**

As described in the table, MCOs reported 10,198 total enrollee complaints for the current quarter. This represents a 2.6% increase from the prior quarter's total of 9,943 enrollee complaints.

MCOs reported 9,026 MMC complaints this quarter, which is a 3.3% increase from the 8,740 of the previous quarter. The number of HARP complaints decreased 5.9%, from 1,114 in the prior quarter to 1,048 this quarter. There were 124 HIV SNP complaints this quarter, which is an increase of 39.3% when compared to the 89 from the previous quarter.

The Department reviewed the increase in HIV SNP enrollee complaints received from the MCOs. Upon examination, the percentage increase in HIV SNP enrollee complaints was comparable across all MCOs with HIV SNP enrollees. No individual complaint category stood out as an outlier.

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	16%	15%
Reimbursement/Billing	11%	15%
Balance Billing	10%	11%
Pharmacy/Formulary	10%	6%
Difficulty with Obtaining: Dental/Orthodontia	8%	8%

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Pharmacy/Formulary	18%	8%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	17%	21%
Dissatisfaction with Quality of Care	8%	12%
Difficulty with Obtaining: Dental/Orthodontia	6%	6%
Reimbursement/Billing	6%	3%

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Pharmacy/Formulary	19%	11%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	18%	27%
Difficulty with Obtaining: Dental/Orthodontia	8%	20%
Difficulty with Obtaining: Personal Care	8%	4%
Dissatisfaction with Quality of Care	6%	3%

B. Monitoring of Plan Reported Complaints

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

The OE ratios are calculated by 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 applicable categories in which the reported number of complaints was more than twice the expected amount. Where a persistent trend or an operational concern contributing to complaints is confirmed, the MCO is required to develop a corrective action plan.

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

The Department is in the process of calculating the OE ratio for the six-month period of January 1, 2022, through June 30, 2022.

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 10,198 total reported complaints/action appeals, MCOs reported 765 complaints and action appeals from their SSI recipients. This compares to 1,084 SSI complaints/action appeals from the previous quarter, representing a 29.4% decrease.

The decrease in the number of SSI complaints from last quarter was due to a decrease in the number of reported SSI complaints from one MCO. The Department is actively monitoring the change.

The following table outlines the total number of complaints/actions 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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Appointment Availability: PCP	0	6
Appointment Availability: Specialist	3	16
Appointment Availability: BH HCBS	1	0
Long Wait Time	1	1
Dissatisfied with Quality of Care	89	92
Denial of Clinical Treatment	28	20
Denial of BH Clinical Treatment	1	0
Dissatisfied with Provider Services (Non-Medical) or MCO Services	249	418
Dissatisfaction with BH Provider Services	1	5
Dissatisfaction with Health Home Care Management	5	5
Difficulty with Obtaining: Specialist and Hospitals	26	78
Difficulty with Obtaining: Eye Care	3	10
Difficulty with Obtaining: Dental/Orthodontia	17	31
Difficulty with Obtaining: Emergency Services	2	4
Difficulty with Obtaining: Mental Health or	0	1

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 22 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Substance Abuse Services/Treatment		
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	0
Difficulty with Obtaining: Private Duty Nursing	6	17
Difficulty with Obtaining: Home Health Care	9	33
Difficulty with Obtaining: Personal Care	21	70
Difficulty with Obtaining: PERS	1	0
Difficulty with Obtaining: CDPAS	16	16
Difficulty with Obtaining: AIDS Adult Day Health Care	0	1
Pharmacy/Formulary	86	63
Access to Non-Covered Services	12	15
Access for Family Planning Services	0	0
Communications/ Physical Barrier	2	2
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	15	11
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	79	85
Balance Billing	40	34
Transportation	5	9
All Other	47	41
Total	**765**	**1,084**

The decrease in the number of SSI complaints in the Dissatisfied with Provider Services (Non-Medical) or MCO Services category from last quarter was due to one MCO's decrease in the number of reported SSI complaints for the category, the same MCO as referenced above. The Department is actively monitoring the complaint categories.

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	33%	39%
Dissatisfied with Quality of Care	12%	8%
Pharmacy/Formulary	11%	6%
Reimbursement/Billing	10%	8%
Balance Billing	5%	3%

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 April 1, 2022, through June 30, 2022, MCOs reported LTSS enrollment of 51,412 enrollees. This compares to 47,178 LTSS enrollees from the previous quarter, representing a 9.0% increase. The following table outlines the number of LTSS enrollees by MCO for the most recent quarter and for the previous quarter:

Plan Name	Number of LTSS Enrollees	
	FFY 22 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Amida Care	1,353	1,243
Capital District Physicians Health Plan	713	730
Excellus Health Plan	1,545	1,553
Fidelis Care	16,594	16,197
Healthfirst	15,790	12,839
HealthNow	203	200
HealthPlus	2,917	2,812
HIP of Greater New York	458	423
Independent Health Association	578	557
MetroPlus Health Plan	2,887	2,549
Molina Healthcare	2,845	2,788
MVP Health Plan	2,101	1,971
United Healthcare	3,042	2,936
VNS Choice	386	380
Total	**51,412**	**47,178**

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Difficulty with Obtaining: AIDS Adult Day Health Care	1	2
Difficulty with Obtaining: Adult Day Care	3	0
Difficulty with Obtaining: CDPAS	59	52
Difficulty with Obtaining: Home Health Care	39	86
Difficulty with Obtaining: RHCF Services	1	1
Difficulty with Obtaining: Personal Care	164	195
Difficulty with Obtaining: PERS	7	4
Difficulty with Obtaining: Private Duty Nursing	24	28
Total	**298**	**368**

D. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 85 critical incidents reported for the April 1, 2022, through June 30, 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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022	Net Change
Medicaid Managed Care Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	4	7	-3
Fidelis Care	1	0	+1
Healthfirst	43	42	+1
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	0	2	-2
MVP Health Plan	0	1	-1
United Healthcare	0	0	0
Total	**50**	**54**	**-4**
Health and Recovery Plans			
Capital District Physicians Health Plan	0	0	0
Excellus Health Plan	0	0	0
Fidelis Care	2	0	+2
Healthfirst	29	46	-17
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	1	4	-3
MVP Health Plan	0	0	0
United Healthcare	0	0	0
VNS Choice	0	0	0
Total	**32**	**50**	**-18**

Plan Name	Critical Incidents		
	FFY 22 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022	Net Change
HIV Special Needs Plans			
Amida Care	0	0	0
MetroPlus Health Plan	0	0	0
VNS Choice	3	2	+1
Total	**3**	**2**	**+1**
Grand Total	**85**	**106**	**-21**

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022	Net Change
Medicaid Managed Care Plans			
Any Other Incidents as Determined by the Plan	5	8	-3
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	1	0	+1
Instances of Exploitation of Enrollees	0	0	0
Instances of Neglect of Enrollees	0	2	-2
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	4	6	-2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	28	27	+1
Use of Restraints	12	11	+1
Wrongful Death	0	0	0
Total	**50**	**54**	**-4**
Health and Recovery Plans			
Any Other Incidents as Determined by the Plan	1	1	0
Crimes Committed Against Enrollee	0	0	0
Crimes Committed by Enrollee	0	0	0
Instances of Abuse of Enrollees	2	0	+2
Instances of Exploitation of Enrollees	0	1	-1
Instances of Neglect of Enrollees	0	0	0
Medication Errors that Resulted in Injury	0	0	0
Other Incident Resulting in Hospitalization	8	6	+2

Category of Incident	Critical Incidents		
	FFY 22 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022	Net Change
Other Incident Resulting in Medical Treatment Other Than Hospitalization	21	42	-21
Use of Restraints	0	0	0
Wrongful Death	0	0	0
Total	**32**	**50**	**-18**
HIV Special Needs Plans			
Instances of Abuse of Enrollees	1	0	+1
Instances of Neglect of Enrollees	2	0	+2
Other Incident Resulting in Hospitalization	0	2	-2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	0	0
Total	**3**	**2**	**+1**
Grand Total	**85**	**106**	**-21**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 100 enrollee complaints this quarter. This total is a 39.0% decrease from the previous quarter, which reported 164 enrollee complaints.

MCO Enrollee Complaints Received Directly by the Department	
FFY 22 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
100	**164**

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 Q3 4/1/2022-6/30/2022	FFY 22 Q2 1/1/2022-3/31/2022
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	14%	13%
Reimbursement/Billing	13%	16%
Pharmacy/Formulary	13%	10%

Percentage of MCO Enrollee Complaints Received Directly by the Department		
Description of Complaint	**FFY 22 Q3 4/1/2022-6/30/2022**	**FFY 22 Q2 1/1/2022-3/31/2022**
Difficulty with Obtaining: Home Health Care	9%	3%
Difficulty with Obtaining: Dental/Orthodontia	7%	6%

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, MMC 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 238 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of April 1, 2022, through June 30, 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 Q3 4/1/2022-6/30/2022**	**FFY 22 Q2 1/1/2022-3/31/2022**
In favor of Appellant	77	68
In favor of Plan	151	160
No Issue	10	15
Total	**238**	**243**

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.

Days Between Fair Hearing Request and Decision Date (Includes MMC, HARP and HIV SNP)		
Decision Days	**FFY 22 Q3 4/1/2022-6/30/2022**	**FFY 22 Q2 1/1/2022-3/31/2022**
0-29	14	7
30-59	70	48
60-89	47	55
90-119	32	34
=>120	75	99
Total	**238**	**243**

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

The MMCARP met on June 16, 2022. The meeting included presentations provided by state staff and discussions of the following: updates on the status of the MMC program, current auto-assignment statistics and state and local district outreach and other activities aimed at reducing auto-assignment and an update on the status of the MLTC program. There 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 DOH. 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 DOH. Lastly, a presentation regarding the 2022-2023 Enacted Executive Budget given by Amir Bassiri, Director, NYS Medicaid, Office of Health Insurance Programs, NYS DOH. A public comment period is also offered at every meeting. The next MMCARP meeting is scheduled for September 22, 2022.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

In April 2022, the Department released the 2022 MLTC Quality Incentive methodology to the health plans.

B. Quality Measurement in Medicaid Managed Care

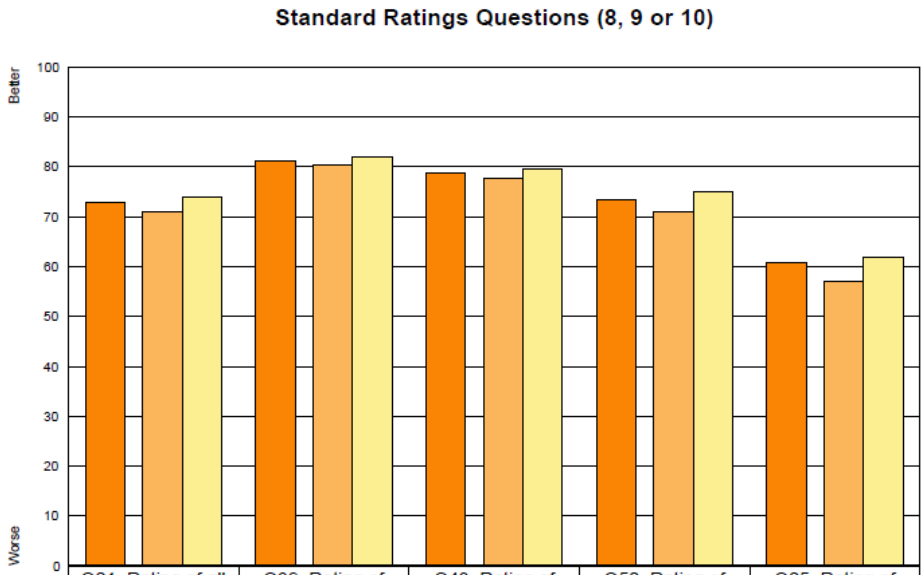
Quality Measure Benchmarks 2020-2021 (Measurement Year 2020)
Quality of care remained high for MMC members for the Demonstration Year. In measurement year 2020 national benchmarks were available for 55 measures for Medicaid. Out of the 55 measures that NYS Medicaid plans reported, 85% of measures met or exceeded national benchmarks. New York State consistently met or exceeded national benchmarks across measures, especially in MMC. The NYS Medicaid, rates exceed the national benchmarks for BH 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.

2020-2021 Satisfaction Survey

The Department conducted a satisfaction survey with adults enrolled in MMC 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. 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 indicates 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 27 health plans submit QARR data on July 15, 2022. Data will be published in November 2022.

C. Quality Improvement

External Quality Review (EQR)

IPRO continues to provide EQR services related to required, optional, and supplemental activities, as described by CMS in 42 CFR, Part 438, Subparts D and E, expounded upon in NYS's consolidated contract with IPRO. Ongoing activities include: 1) validation of performance improvement projects (PIPs); 2) validation of performance measures; 3) review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement; 4) validating encounter and functional assessment data reported by the MCOs; 5) overseeing collection of provider network data; 6) administering and validating consumer satisfaction surveys; 7) conducting focused clinical studies; and 8) developing reports on MCO technical performance. In addition to these specified activities, NYSDOH requires our EQRO to also conduct activities including: performing medical record reviews in MCOs, hospitals, and other providers; administering additional surveys of enrollee experience; and providing data processing and analytical support to the Department. EQR activities cover services offered by New York's MMC plans, HIV-SNPs, MLTC plans, 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 3rd quarter the EQRO waited for OHIP to resolve the corrective action plans (CAP's) from the previous survey before initiating the next Access Survey of Provider Availability (Provider Directory). IPRO needs to be sure to use the most accurate information if it's taken from the web directory due to the directory updating every 15 days. For the Member Services survey in the third quarter, Member service survey calls are finished. Most of the reports were taken to IPRO Technical team writers for quality assurance review. The EQRO will provide the completed/reviewed reports in batches to DOH. Lastly in the 3rd quarter, for the PCP 1500:1 ratio survey, more data needs to be gathered. IPRO has more staff and are ready to make more calls and waiting further instruction from OHIP.

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 Provider Network Data System (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 1 2022 PNDS submission deadline was April 21, 2022; plans submitted data based on version 10 of data dictionary. A new data dictionary, version 11, will be released to health plans in August 2022 and health plans are expected to submit in the new format starting Nov 2022. IPRO, PMCI and Quest analytics are presently working on the implementation and edits for PNDS data dictionary version 11.

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 has over 1.5 million distinct users as of May 2022.

PANEL:
Panel data submission opened on 05/02/2022 and yielded 6,633,335 rows of data (down ~0.1%). IPRO and DOH continues to provide technical assistance and troubleshoot data submission issues, particularly around newly implemented edits. The DOH team provided detailed analytics to health plans about their data issues to due to updated submission requirements.

In the 3rd quarter, the EQRO began to review the 34 MLTC PIP proposals and continues to complete final reviews and submissions and resubmissions of those proposals. The sample size and location has been expanded for the IRR FCS of Telehealth Assessments to improve the survey response rate, during the 3rd quarter. During this quarter the EQRO made preparations for the June 15th, 2022, QARR data submission by the MCO's. The EQRO will conduct the necessary cleaning and analysis of the QARR data files during the 4th quarter. The CAHPS survey has no real updates. The reports of the recent survey were posted to the site, talks with DataStat will begin in July. The technical reports were completed and submitted early 3rd quarter. The MLTC report still not submitted yet, and there are discussions for submission to CMS. with the EQRO, DOH and OHIP. The Baseline data updates have been reviewed and all oversight has been completed. The Oversight calls will begin during the end of the 3rd quarter.

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 2022.

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 MMC 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. The PIP Proposals have been finalized and reviewed by IPRO and NYSDOH. The approved interventions have been planned to begin in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 15, 2022. The updates have been reviewed by IPRO and finalized by the plans then distributed to DOH. IPRO conducted plan-specific oversight calls with the plans in May 2022. Prior to the oversight calls the plans submitted an updated Proposal with any intervention tracking measure updates.

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 which were reviewed by IPRO and NYSDOH. All of the PIP Proposals have been finalized and approved. The approved interventions have been planned to begin in March 2022. Baseline data update reports were submitted by the plans to IPRO by April 29, 2022. The updates have been reviewed by IPRO and finalized by the plans then distributed to DOH. IPRO conducted plan-specific oversight calls with the plans in June 2022. Prior to the oversight calls the plans submitted an updated Proposal with any intervention tracking measure updates.

Breast Cancer Selective Contracting

Staff began the summer review of breast cancer surgical volume data and will share results with facilities via the Department's Integrated Health Alerting and Notification System (IHANS) in early July.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 3 (4/1/2022-6/30/2022)

As of June 2022, there were 9,182 NCQA-recognized PCMH providers and 2,272 practices in New York State (NYS). All providers are recognized under the standards of NYS Patient-Centered Medical Home (NYS PCMH), a recognition program that was released on April 1, 2018. NYS PCMH is based on NCQA PCMH 2017 recognition standards but requires NYS practices to meet a higher number of criteria to achieve recognition, with emphasis placed on BH, care management, population health, value-based payment arrangements, and health information technology capabilities. Of the 9,182 providers that became recognized in June 2022, one was 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 June 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, 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.

CMS has introduced a new record segment ("ELG-IDENTIFIERS-ELG00022") in the T-MSIS Eligible file to enable linking and managing effectively of the various identifiers associated with a beneficiary over the course of his/her involvement with the Medicaid/CHIP programs. The State is in the process of creating and populating the ELG00022 segment in T-MSIS Eligibility File for each Medicaid/CHIP program beneficiary with the implementation target of August 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.

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

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Plan Name	Number of Critical Incidents	Wrongful Death	Use of Restraints	Medication errors that resulted in injury	Instances of Abuse, Neglect and/or Exploitation of Enrollees	Involvement with the Criminal Justice System	Other Incident Resulting in Hospitalization	Other Incident Resulting in Medical Treatment Other than Hospitalization	Any Other Incidents as Determined by the Department	Enrollment	Critical Incidents as a Percentage of Enrollment
Aetna Better Health	5	0	0	0	0	0	5	0	0	5437	0.09%
AgeWell NY	14	0	0	0	0	5	1	7	1	13160	0.11%
AgeWell MAP	0	0	0	0	0	0	0	0	0	122	0.00%
Archcare Community Life	20	0	0	0	1	0	12	7	0	4863	0.41%
Archcare PACE	0	0	0	0	0	0	0	0	0	665	0.00%
Catholic Health-LIFE	18	0	8	0	0	0	5	5	0	244	7.39%
Centerlight PACE	63	0	0	0	1	0	32	23	7	3807	1.65%
Centers Plan for Healthy Living	765	0	0	0	32	3	269	461	0	47264	1.62%
Centers Plan for Healthy Living MAP	30	0	0	0	2	0	10	18	0	1211	2.48%
Complete Senior Care	2	0	0	0	0	0	1	1	0	121	1.66%
Eddy SeniorCare	9	0	0	0	0	0	5	4	0	312	2.89%
Elant Choice (EverCare)	29	0	0	0	0	0	11	18	0	908	3.20%
Elderplan MAP	15	0	0	0	6	0	3	2	4	2940	0.51%
Elderserve	284	0	0	1	9	4	122	148	0	15287	1.86%
Elderserve MAP	0	0	0	0	0	0	0	0	0	101	0.00%
Elderwood	12	0	0	0	0	0	3	7	2	1022	1.17%
Empire BlueCross BlueShield Healthplus	0	0	0	0	0	0	0	0	0	4741	0.00%
Empire BlueCross BlueShield Healthplus MAP	0	0	0	0	0	0	0	0	0	200	0.00%
Extended	50	0	0	0	0	0	36	14	0	5433	0.92%
Fallon Health (TAP) MLTC	0	0	0	0	0	0	0	0	0	851	0.00%
Fallon Health (TAP) PACE	0	0	0	0	0	0	0	0	0	132	0.00%
Fidelis Care at Home	22	0	0	0	1	0	6	14	1	18082	0.12%
Fidelis MAP	1	0	0	0	0	0	0	1	0	279	0.36%
Hamaspik	57	0	0	0	1	0	18	34	4	1979	2.88%
Hamaspik MAP	0	0	0	0	0	0	0	0	0	295	0.00%
Healthfirst CompleteCare	79	0	0	0	0	0	15	64	0	22226	0.36%
HomeFirst, Inc. (Elderplan)	17	0	0	0	9	0	3	3	2	14355	0.12%
Icircle	2	0	0	0	0	1	0	0	1	3515	0.06%

Independent Living for Seniors (ILS/ElderOne)	0	0	0	0	0	0	0	0	0	723	0.00%
Independent Living Services of CNY (PACE CNY)	12	0	0	0	0	0	4	8	0	502	2.39%
Integra MLTC	0	0	0	0	0	0	0	0	0	42277	0.00%
Kalos ErieNiagara DBA: First Choice Health	3	0	0	0	2	0	1	0	0	552	0.54%
MetroPlus	0	0	0	0	0	0	0	0	0	1322	0.00%
Monefiore	0	0	0	0	0	0	0	0	0	1423	0.00%
Prime	45	0	0	0	0	3	13	29	0	548	8.22%
Senior Health Partners	38	0	0	0	1	1	9	27	0	9436	0.40%
Senior Network Health, LLC	2	0	0	0	0	0	0	2	0	343	0.58%
Senior Whole Health	0	0	0	0	0	0	0	0	0	13779	0.00%
Senior Whole Health MAP	0	0	0	0	0	0	0	0	0	122	0.00%
Total Senior Care	11	0	0	0	0	0	2	9	0	137	8.03%
Village Care	195	0	0	0	25	0	26	144	0	14259	1.37%
Village Care MAP	61	0	0	0	11	0	8	42	0	2803	2.18%
VNA Homecare Options (Nascentia Health Options)	168	0	0	0	6	0	54	108	0	3461	4.85%
VNS Choice MAP TOTAL	47	1	0	0	9	0	11	26	0	3056	1.54%
VNS Choice MLTC	238	0	0	0	8	1	69	160	0	21890	1.09%
total	2314	1	8	1	124	18	754	1386	22	286186	0.81%

Managed Long Term Care Partial Capitation Plan Enrollment July 2021 to June 2022												
	Jul-21	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Aetna Better Health	5975	5909	5,872	5,800	5,737	5,687	5,612	5,498	5,478	5463	5446	5402
AgeWell New York	12825	12954	13,065	13,040	13,107	13,167	13,151	13,070	13,075	13093	13198	13188
ArchCare Community Life	4565	4590	4,592	4,590	4,615	4,651	4,667	4,656	4,751	4795	4876	4917
Centers Plan for Healthy Living	44701	44993	45,421	45,723	46,220	46,943	46,868	46,459	46,401	46826	47298	47669
Elant	1012	999	991	968	967	954	935	912	908	903	909	911
Elderplan	13808	13781	13,792	13,727	13,687	13,721	13,787	13,718	13,849	14082	14319	14664
Elderserve	15266	15335	15,425	15,343	15,344	15,426	15,361	15,213	15,218	15263	15274	15325
Elderwood	1005	1009	1,012	1,006	1,028	1,034	1,031	1,015	1,016	1011	1026	1029
Extended MLTC	5993	5970	5,931	5,858	5,801	5,734	5,678	5,559	5,497	5437	5425	5437
Fallon Health Weinberg (TAIP)	872	872	881	876	876	874	869	863	850	851	852	849
Fidelis Care at Home	19474	19398	19,303	19,006	18,836	18,750	18,643	18,374	18,254	18186	18068	17991
Hamaspik Choice	2045	2064	2,068	2,042	2,026	2,021	2,008	1,968	1,970	1985	1967	1984
HealthPlus- Amerigroup	5268	5226	5,159	5,052	4,999	4,981	4,945	4,847	4,830	4771	4727	4726
iCircle Services	3706	3703	3,693	3,613	3,600	3,600	3,570	3,529	3,497	3501	3518	3527
Integra	39457	39776	40,041	40,100	40,386	40,902	41,242	41,421	41,528	41775	42219	42838
Kalos Health- Erie Niagara	690	680	663	615	592	578	564	549	544	551	555	551
MetroPlus MLTC	1448	1427	1,429	1,423	1,409	1,397	1,359	1,345	1,343	1330	1328	1309
Montefiore HMO	1525	1522	1,517	1,494	1,485	1,486	1,491	1,451	1,434	1429	1416	1424
Prime Health Choice	612	578	580	579	574	571	567	559	549	545	553	545
Senior Health Partners	10946	10719	10,570	10,402	10,337	10,275	10,009	9,843	9,682	9564	9400	9344
Senior Network Health	393	392	386	374	373	376	369	362	355	345	341	343
Senior Whole Health	13645	13673	13,702	13,642	13,550	13,526	13,464	13,398	13,454	13575	13781	13982
Village Care	13151	13358	13,436	13,491	13,637	13,787	13,763	13,709	13,774	14010	14267	14499
VNA HomeCare Options	3286	3313	3,329	3,276	3,280	3,336	3,355	3,306	3,393	3411	3455	3518
VNS Choice	21699	21808	21,951	21,725	21,712	21,794	21,706	21,507	21,543	21783	21917	21970
Total	**243,367**	**244,049**	**244,809**	**243,765**	**244,178**	**245,571**	**245,014**	**243,131**	**243,193**	**244,485**	**246,135**	**247,942**

Managed Long Term Care MAP Enrollment July 2021 to June 2022												
	Jul-21	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis	106	117	138	156	175	185	178	185	180	195	271	372
Hamaspik	37	92	135	147	158	177	189	179	218	251	294	339
Agewell	53	55	58	57	62	62	68	67	66	112	124	130
Centers	612	659	687	744	718	705	994	1089	1148	1179	1220	1235
Elderplan	2771	2801	2833	2834	2789	2813	2838	2816	2844	2884	2932	3005
Elderserve	69	67	72	79	78	79	85	88	97	97	105	102
Healthfirst Complete Care	19019	19406	19746	19976	19983	20140	20921	21167	21466	21810	22198	22671
Healthplus	88	100	117	115	112	133	156	175	187	192	200	209
Metroplus	0	0	0	0	0	0	1	16	19	19	19	20
Senior Whole Health	117	118	119	122	117	110	113	110	111	112	124	130
VNS	3122	3127	3141	3144	3050	3023	3086	3076	3051	3047	3054	3068
Village Care	3024	3047	3043	3033	2915	2829	2887	2825	2796	2798	2810	2802
Total	**29018**	**29589**	**30089**	**30407**	**30157**	**30256**	**31516**	**31793**	**32183**	**32696**	**33351**	**34083**

Managed Long Term Care PACE Enrollment July 2021 to June 2022												
	Jul-21	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Archcare	747	741	699	696	708	705	703	686	681	675	661	658
CHS Buffalo Life	256	262	265	266	258	256	250	249	247	246	244	241
Complete Senior Care	125	127	126	123	125	130	127	122	118	118	121	123
Comprehensive Care Management	2386	2435	2518	2592	2769	2934	3066	3192	3360	3584	3795	4041
Eddy Senior Care	297	296	293	300	304	306	300	310	307	312	311	312
Fallon Health Weinberg PACE	132	125	125	128	123	126	128	130	126	129	132	135
Independent Living For Seniors	730	729	728	720	722	712	713	707	713	719	724	726
Pace CNY	567	561	559	553	550	532	517	509	505	500	502	504
Total Senior Care	143	144	144	144	139	139	137	136	138	138	136	137
Total	**5383**	**5420**	**5457**	**5522**	**5698**	**5840**	**5941**	**6041**	**6195**	**6421**	**6626**	**6877**

Managed Long Term Care MA Enrollment July 2021 to June 2022												
	Jul-21	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Fidelis Legacy	1009	999	983	973	963	954	0	0	0	0	0	0
Wellcare	862	859	846	834	824	820	0	0	0	0	0	0
United Healthcare	1177	1164	1156	1140	1129	1125	0	0	0	0	0	0
Total	**3048**	**3022**	**2985**	**2947**	**2916**	**2899**	**0**	**0**	**0**	**0**	**0**	**0**

Managed Long Term Care FIDA-IDD Enrollment July 2021 to June 2022												
	Jul-21	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Plan Name	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**	**Enrollment**
Partners Health Plan	1734	1724	1720	1720	1717	1717	1698	1687	1689	1674	1674	1667