

Medicaid Managed Care Advisory Review Panel (MMCARP)

(Approved 3/5/2026)

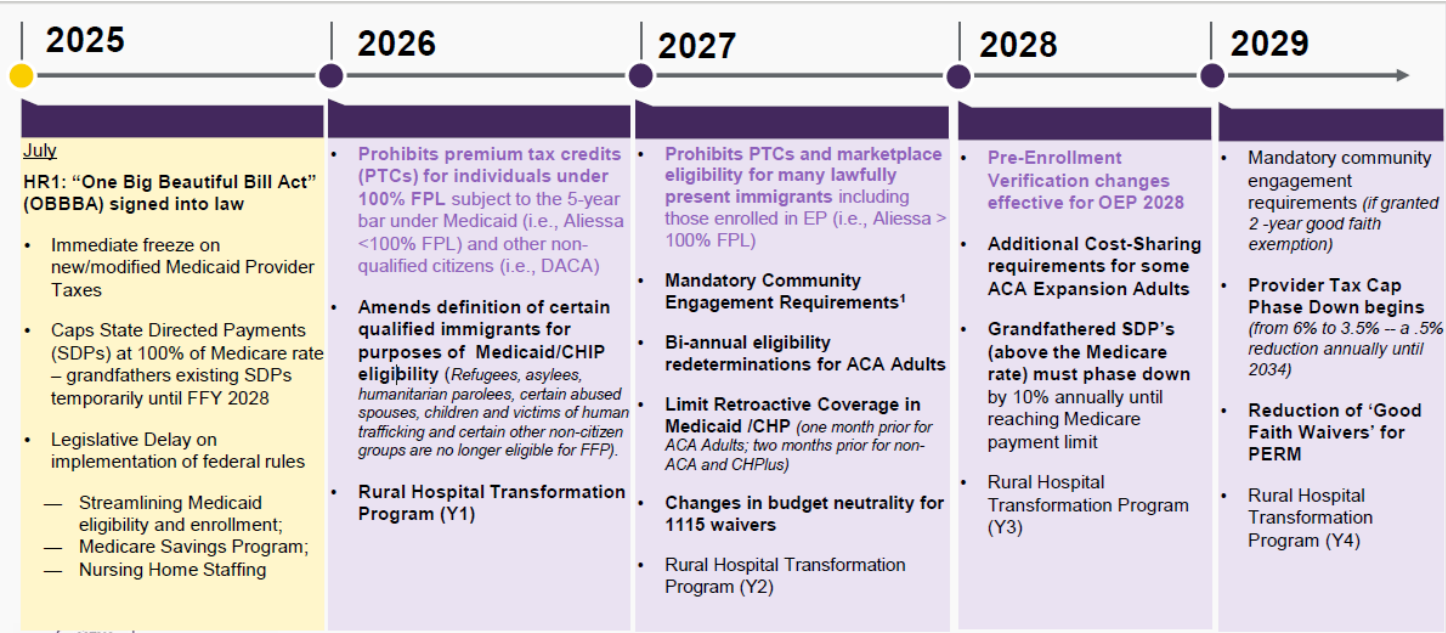
December 18, 2025
Videoconference
11:00 AM to 1:00 PM
Meeting Minutes

Panel Members: Frederick Cohen, *Chair*; Elisabeth Benjamin *Vice Chair*; Kathryn Haslanger; Sheila Nelson; Jay Silverman; Amber Decker (joined at 12:39pm); Frederick Riccardi; Jane Velazquez; Colleen Rose.

NYS DOH Staff: Susan Montgomery; Gayle Emrich; Krysten Bissaillon; Emily Engel; Susan McCauley; Alda Osinaga; Gabrielle Armenia; Sarina Master; Jessica Alexandre; Jesse Farkas; Patricia Sheppard; Sara McGrath

Presenters/Guests: Susan Montgomery, New York State Department of Health (DOH); Gayle Emrich (DOH); Alyssa Altschul (OMH); Emily Engel (DOH); Susan McCauley (DOH); Alda Osinaga (DOH); Gabrielle Armenia (DOH); Sarina Master (DOH); Jessica Alexandre (DOH)





Medicaid Managed Care Advisory Review Panel (MMCARP)

Agenda Items	Discussion	Action Items
Discussion and review of minutes	Frederick Cohen, Chair, welcomed the panel members, and completed roll call. Quorum was achieved at 12:39pm.	Motion: Panel approved the May 22, 2025, minutes. Quorum was achieved at 12:39pm.
Federal Policy Changes (HR1)	<p>Gabrielle Armenia, Director, Division of Eligibility and Marketplace Integration (NYSDOH), reported on the following:</p> <p>HR1- Overview of Key Provisions</p>  <p>Potential Implications for New York State</p> <p>Loss of Coverage</p> <ul style="list-style-type: none"> ➤ Up to 1.5M New Yorkers may become uninsured or see changes in their coverage <p>Fiscal Impact to New York</p> <ul style="list-style-type: none"> ➤ ~\$13B in estimated annual impacts for NYS <p>Increased State Share of Medicaid</p> <ul style="list-style-type: none"> ➤ \$3B in new state funded Medicaid costs in FY2027 	

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<p>Federal Policy Changes (HR1)</p>	<p>Provider Losses</p> <ul style="list-style-type: none"> ➤ Up to \$8B in potential losses for NYS hospitals and ~300M for health centers <p>Key Eligibility Provisions</p> <p>Amends the definition of Qualified Alien Amends the definition of qualified aliens eligible for Federal Financial Participation (FFP) under Medicaid:</p> <ul style="list-style-type: none"> ➤ Restricts FFP for Medicaid to certain groups including citizens/naturalized citizens, legal permanent residents who meet the five- year bar, certain Cuban and Haitian entrants, and individuals who reside in the United States in accordance with a Compact of Free Association (COFA). ➤ Certain categories historically eligible for FFP will no longer be eligible including refugees, asylees, humanitarian parolees, and persons in temporary protected status. ➤ Effective date is October 1, 2026. <p>Eligibility Redeterminations Requires more frequent eligibility determinations:</p> <ul style="list-style-type: none"> ➤ Changes eligibility redetermination from every 12-months to every six-months. ➤ Applies to the adult Medicaid expansion population. ➤ Effective date is December 31, 2026. <p>Community Engagement Requirements Mandatory Community Engagement Requirement for able bodied adults ages 19-64</p> <ul style="list-style-type: none"> ➤ Applies to the adult Medicaid expansion population. ➤ Individual meets the requirement by working, engaging in community service, participating in a work or education program or a combination of the activities for at least 80 hours in a month. ➤ Required to meet this requirement at application and at six-month renewal. ➤ Includes an extensive list of exemptions including adults with who are parents or caregivers of children under age 13, pregnant women, and individuals considered medically frail (blind or disabled, have a chronic substance use disorder or a serious and complex medical condition). ➤ Effective date is January 1, 2027. 	

Medicaid Managed Care Advisory Review Panel (MMCARP)

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<p>Federal Policy Changes (HR1)</p>	<p>Retroactive Eligibility Changes in retroactive Eligibility:</p> <ul style="list-style-type: none"> ➤ Limits retroactive coverage from three-months to one-month for the adult expansion population and two-months for the non-expansion population. ➤ Also applies to Child Health Plus (two-months). ➤ Effective date is applications submitted on or after January 1, 2027 <p>New York Approach to HR 1</p> <div style="background-color: #e0e0e0; padding: 10px; border: 1px solid #ccc;"> <p>HR 1 will necessitate that New York work harder, smarter, and more collaboratively</p> <p>New York will:</p> <ul style="list-style-type: none">  Do everything in its power to minimize disruption for impacted enrollees, providers and communities  Convene stakeholders to provide updates on planning and implementation  Collaborate across state agencies and leverage existing partners at the regional and local level  Retain process improvements, technology enhancements and automation from Public Health Emergency </div>	
<p>Self-Directed Care Pilot</p>	<p>Alyssa Altschul, Director, Bureau of Rehab Services, Treatment, and Care Coordination, Office of Mental Health (OMH), reported on the following:</p> <p>Ending of the SDC Pilot</p> <ul style="list-style-type: none"> ➤ Procurement rules prevent the extension of the pilot. OMH is currently looking to sustain services similar to the SDC pilot and make it available to more individuals. <p>Individuals Served</p> <ul style="list-style-type: none"> ➤ 356 individuals served by the pilot with an average length of enrollment in the pilot of over three years <p>Discharge Timeframes</p> <ul style="list-style-type: none"> ➤ Pilot ends at the end of 2026 due to procurement rules. 	











Medicaid Managed Care Advisory Review Panel (MMCARP)

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<p>Auto-Assignment Report</p>	<p>Gayle Emrich, Medical Assistance Specialist, Division of Health Plan Contracting & Oversight (NYSDOH) and panel members discussed the November 2025 Medicaid Managed Care Auto Assignment Report.</p>	
<p>Social Care Networks</p>	<p>Emily Engel, Director, Bureau of Social Care and Community Supports (NYSDOH), reported the following:</p> <p>Social Care Networks</p> <div style="border: 1px solid #ccc; padding: 10px; margin: 10px 0;"> </div> <div style="border: 1px solid #ccc; padding: 10px; margin: 10px 0;"> <p>Focus for today</p> <ol style="list-style-type: none"> 1 How SCNs are reaching and supporting members 2 Examples of SCN-led impact and innovation 3 Ongoing approach to tracking impact </div> <p>Driving Impact: Social Care Networks</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%; border: 1px solid #ccc; padding: 5px;"> <p>Reaching Medicaid members¹</p> <p>Over 400,000 members have been screened across the 9 SCNs</p> <p>~2.5X growth in weekly screening rates from June-November 2025³</p> <p>~3000 social care navigators connecting members to services³</p> </div> <div style="width: 30%; border: 1px solid #ccc; padding: 5px;"> <p>Building community networks²</p> <p>1200+ organizations contracted to provide screening, navigation and enhanced HRSN services</p> <p> Of those 435 providers offer at least 2 or more services</p> <p> ~500 community-based organizations (CBOs) received capacity funding to expand services</p> <p> Enhanced services across Housing, Nutrition, and Transportation are available across 17 subcategories⁵</p> </div> <div style="width: 30%; border: 1px solid #ccc; padding: 5px;"> <p>Access to new services</p> <ul style="list-style-type: none"> Housing supports Food and nutrition assistance Transportation Enhanced Care management Navigation to new and existing local, state, and federal programs </div> </div>	







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<p>Social Care Networks</p>	<h2 style="margin-top: 0;">Reaching and Supporting Members</h2> <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 10px;"> <div style="width: 30%; padding-right: 20px;"> <p style="font-size: 1.2em; font-weight: bold; color: #0056b3;">400,000+</p> <p>Waiver-eligible members screened</p> <p style="font-size: 1.2em; font-weight: bold; color: #0056b3;">44%</p> <p>of screened members had at least 1 unmet HRSN</p> <p style="font-size: 1.2em; font-weight: bold; color: #0056b3;">61%</p> <p>of screened members had multiple needs</p> </div> <div style="width: 65%;"> <p style="text-align: center; font-weight: bold;">% of Members Screened with an Unmet HRSN by Need Domains</p> <table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Need Domain</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Nutrition</td> <td>76%</td> </tr> <tr> <td>Housing</td> <td>60%</td> </tr> <tr> <td>Transportation</td> <td>36%</td> </tr> <tr> <td>Employment</td> <td>21%</td> </tr> <tr> <td>Educational</td> <td>15%</td> </tr> <tr> <td>Interpersonal Safety</td> <td>3%</td> </tr> </tbody> </table> </div> </div> <div style="margin-top: 20px;"> <h3>Example Impacts: Member Stories</h3> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <h4>Stories from SCNs</h4> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“We had a mother who had lost her job and home and was living in her car with her daughter and managing a high-risk pregnancy. We were able to get her into temporary housing.”</p> <p style="text-align: right; font-size: 0.8em;">- Case manager</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“People really appreciate the service. Many experiencing food insecurity tell us they would not be able to access healthy foods without the program.”</p> <p style="text-align: right; font-size: 0.8em;">- Navigator</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“We had a person recovering from cancer surgery who needed nutrition support. By coordinating with the hospital to quickly set up meal deliveries.”</p> <p style="text-align: right; font-size: 0.8em;">- Program development officer</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px;"> <p>“We supported a client who had been homeless for three years and living with lupus. We were able to connect her to stable housing for herself and her children.”</p> <p style="text-align: right; font-size: 0.8em;">- Case manager</p> </div> </div> </div> <div style="width: 48%;"> <h4>Stories from members</h4> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“I became homeless. When I told the navigator my situation, they helped me get into a place. The program did my deposit and first month rent. I was so grateful.”</p> <p style="text-align: right; font-size: 0.8em;">- Member, North Country</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“After working with the SCN, I was connected to enhanced housing services and now have a safe home for my granddaughter and me.”</p> <p style="text-align: right; font-size: 0.8em;">- Member, Long Island</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px; margin-bottom: 5px;"> <p>“I’m now getting help covering my light bill. The process was simple and manageable. It’s given me space to focus on my family and other responsibilities.”</p> <p style="text-align: right; font-size: 0.8em;">- Member, New York City</p> </div> <div style="width: 50%; padding: 5px; background-color: #f0f0f0; border-radius: 5px;"> <p>“I didn’t know about this program until it was mentioned by my doctor, and it has been very helpful with food and support for me finding work [...] it really has made a difference.”</p> <p style="text-align: right; font-size: 0.8em;">- Member, Staten Island</p> </div> </div> </div> </div> </div>	Need Domain	Percentage	Nutrition	76%	Housing	60%	Transportation	36%	Employment	21%	Educational	15%	Interpersonal Safety	3%	
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<p>Social Care Networks</p>	<p>Example Impacts: SCN Innovation</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="width: 18%; text-align: center;">  <p>Real-time member communication</p> <p>Multiple SCNs have deployed a real-time communication platform that enables direct communication with members (e.g., text, email), allowing members to complete screenings and self-assessments</p> </div> <div style="width: 18%; text-align: center;">  <p>Smarter identification of eligible members</p> <p>SCNs are using hot spotting to pinpoint where Medicaid members and service gaps overlap. This allows networks to prioritize outreach and direct resources to communities where they can have the greatest impact</p> </div> <div style="width: 18%; text-align: center;">  <p>Expanded capacity through partnerships</p> <p>Where hospitals complete screenings but lack sufficient CHW capacity for eligibility assessments and navigation, SCNs leverage nearby CBO partners to perform these functions and to ensure that members are connected to services</p> </div> <div style="width: 18%; text-align: center;">  <p>Automated off-platform screening capture</p> <p>HIXNY has developed an app that integrates into provider EHR system systems. It enables member screening data to be routed to the correct SCN and the provider to have the screening data within their EHR</p> </div> <div style="width: 18%; text-align: center;">  <p>Deeper integration with providers</p> <p>One SCN is embedding navigators in maternal and child health clinics to support screenings, close referral loops, and coordinate services during patient visits, resulting in higher follow-through and more members connected to support on site</p> </div> </div> <p style="margin-top: 20px;">Tracking Impact Across the Program</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="width: 18%; text-align: center;">  <p>Indicator category</p> <p>Infrastructure & Capacity</p> <ul style="list-style-type: none"> • Breadth of network • Service availability • IT and data infrastructure • CBO capacity </div> <div style="width: 18%; text-align: center;">  <p>Member engagement & experience</p> <ul style="list-style-type: none"> • Member screenings and assessments completed • Enhanced populations reached • Program awareness </div> <div style="width: 18%; text-align: center;">  <p>Service delivery</p> <ul style="list-style-type: none"> • Services delivered • Timeliness of service delivery • Loop closure rate </div> <div style="width: 18%; text-align: center;">  <p>Population health outcomes</p> <ul style="list-style-type: none"> • Improvements in health status • Reduction in member unmet needs • Reduced unnecessary healthcare utilization </div> <div style="width: 18%; text-align: center;">  <p>Program Sustainability</p> <ul style="list-style-type: none"> • Reduction in overall cost of care • Longevity of CBO, provider, and MCO services • Expansion of services over time </div> </div>	

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<p>Social Care Networks</p>	<p>SCN Program Resources</p> <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="width: 45%;"> <p>New York Social Care Networks Website: Information for Health Care Providers </p> <p>Video: Role of Health Care and Behavioral Health Providers in the SCN Program </p> <p>Social Care Networks: Introduction for Health Care Providers </p> <p>SCN Data and IT Fact Sheet for Providers </p> <p>For questions about the SCN program, email SDH@health.ny.gov </p> </div> <div style="width: 45%; border: 1px solid black; border-radius: 15px; padding: 10px;"> <p style="text-align: center;">Information for Medicaid members</p> <ul style="list-style-type: none"> • SCN video for members (in English and Spanish) • SCN factsheets (in English and Spanish)  </div> </div> <p>➤ <u>Information for Medicaid members</u></p>	
<p>Performance Improvement Project Cancer Screening and Prevention</p>	<p>Susan McCauley, Office of Health Services Quality and Analytics (NYSDOH), reported on the following:</p> <p>Performance Improvement Project</p> <ul style="list-style-type: none"> ➤ A Performance Improvement Project (PIP), mandated by the Centers for Medicare & Medicaid Services (CMS), involves systematic activities that are organized and implemented by Medicaid and Child Health Plus Managed Care Plans (MCPs) to monitor, assess, and improve their quality of health care. ➤ MCPs implement evidence-based and evidence-informed interventions based on analysis of barriers specific to their own systems or as experienced by enrollees and providers. ➤ The interventions are tested by MCPs over a two-year period to determine which interventions are effective in improving the processes and outcomes of health care provided by the MCP. ➤ During the PIP, individual MCPs report the impact (positive or negative) and the results of the interventions, as well as barriers encountered. 	

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<p>Performance Improvement Project Cancer Screening and Prevention</p>	<p>2024-2025 PIP Collaboration on Cancer Screening and Prevention</p> <ul style="list-style-type: none"> • Cancer Screening and Prevention PIP 2024-2025 with Mainstream Medicaid Managed Care, Child Health Plus, and HIV Special Needs Plans • New York State Department of Health: <ul style="list-style-type: none"> ➤ Office of Health Services Quality and Analytics, Clinical Center ➤ Office of Health Insurance Programs ➤ Office of Public Health ➤ AIDS Institute • External Quality Review Organization: IPRO • Partners: American Cancer Society <p>Cancer Screening and Prevention PIP</p> <ul style="list-style-type: none"> • Two-year PIP to improve cancer screening and prevention based on nationally recognized guidelines and quality improvement interventions. • Focus on improving rates of screening for breast, cervical, and colorectal cancers and of HPV vaccinations in adolescents. • Timeline: Proposal February 2024 Interim Report July 2025 Final Report July 2026 <p>PIP Performance Indicators Healthcare Effectiveness Data and Information Set (HEDIS) Measures:</p> <ul style="list-style-type: none"> • Breast Cancer Screening (BCS-E) • Cervical Cancer Screening (CCS) • Colorectal Cancer Screening (COL-E) • Immunizations for Adolescents (IMA) Human Papillomavirus Vaccine <p>Barrier Analysis and Interventions</p> <ul style="list-style-type: none"> • Identify barriers to screening for breast, cervical, and colorectal cancers and of HPV vaccinations in adolescents through a barrier analysis. • Implement evidence-based and evidence-informed interventions that address the barriers and track improvement progress using intervention tracking measures. • Identify and address health disparities in cancer screening and prevention. 	

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<p>Performance Improvement Project Cancer Screening and Prevention</p>	<p>Health Disparities</p> <ul style="list-style-type: none"> • Report stratified data in one performance indicator to identify at least one disparity in the following categories: sex, age, race, ethnicity, and region • Conduct a barrier analysis to identify any specific barriers the subgroup may be experiencing and the needs of the subgroup with an identified health disparity • Develop at least one targeted intervention to reduce the identified disparity • Track the stratified performance indicator annually <p>Interventions</p> <ul style="list-style-type: none"> • MCP level—any intervention that is directed at a change in processes within the MCP, e.g., development/maintenance of a member registry or case management services. • Provider level—any intervention directed at the providers in the MCP network, e.g., onsite academic detailing or gaps-in-care report distribution. • Member level—any intervention directed at the members, e.g., member incentives or outreach to members for assistance in coordinating care that is “missing”. <p>Managed Care Plan Intervention Examples</p> <ul style="list-style-type: none"> • New members who have had a PCP visit –review for Gaps in Care and include members in outreach interventions. • MCP provides an imaging center with a member listing for outreach to coordinate and complete Breast Cancer screening. • Communication Guide for MCP staff to align common messaging for HPV vaccination starting at 9 years of age. • Predictive analytics to identify members who may be in need of more support to close a gap in care. <p>Provider Intervention Examples</p> <ul style="list-style-type: none"> • Monthly/quarterly reports to providers <ul style="list-style-type: none"> ○ Quality Reports comparing provider performance to MCP performance ○ Gaps in Care (GIP) Reports • Best practice education material and CME trainings • Physician engagement team on-site • Provider Cancer Screening Toolkit 	

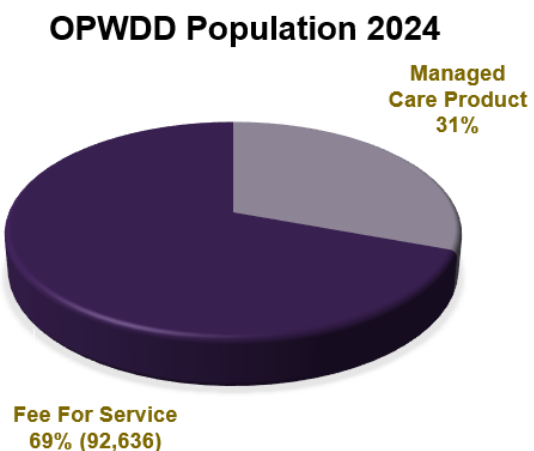
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<p>Performance Improvement Project Cancer Screening and Prevention</p>	<p>Member Intervention Examples</p> <ul style="list-style-type: none"> • Monthly gaps-in-care (GIC) reports are shared with the case management staff for targeted outreach. • Educate members and develop messaging on the importance of screening and reminders. • Initiate member incentive programs. • Assist members in getting connected to care. • Mail Fecal Immunochemical Test (FIT) kits to members who providers confirm are eligible to receive a kit. <p>Disparity Intervention Examples</p> <ul style="list-style-type: none"> • Targeted community outreach events in the Bronx for Breast Cancer screening. • Gap in care reports for members 45 to 49 years of age for colorectal cancer screening. • Mailer campaigns with co-branded materials from American Cancer Society (ACS) including racially/ethnically appropriate messaging based off member’s identified race. • Email members 21 to 29 years who have not been screened for cervical cancer to provide assistance with scheduling. <p>Performance Indicator Baseline Data: Medicaid and Child Health Plus Medicaid and Child Health Plus Baseline Data 2022 Measure Year –Statewide Rates</p> <ul style="list-style-type: none"> • Breast Cancer Screening 66% • Cervical Cancer Screening 70% • Colorectal Cancer Screening 47% • HPV Vaccine 46% <p>Performance Indicator Interim Data: Medicaid and Child Health Plus Medicaid and Child Health Plus Interim Data 2024 Measure Year –Statewide Rates</p> <ul style="list-style-type: none"> • Breast Cancer Screening 68% increase 2 percentage points • Cervical Cancer Screening 68% decrease 2 percentage points • Colorectal Cancer Screening 55% increase 8 percentage points • HPV Vaccine 44% decrease 2 percentage points <p>Performance Indicator Baseline Data: HIV Special Needs Plans HIV Special Needs Plans Baseline Data 2022 Measure Year –Statewide Rates</p> <ul style="list-style-type: none"> • Breast Cancer Screening 68% • Cervical Cancer Screening 75% • Colorectal Cancer Screening 56% 	


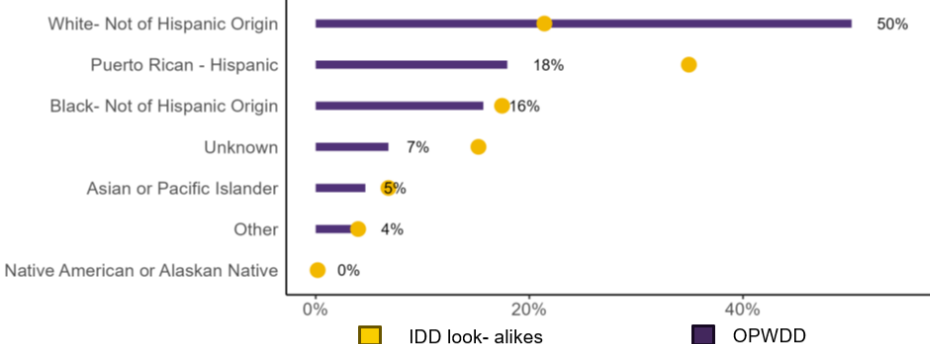
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<p>Performance Improvement Project Cancer Screening and Prevention</p>	<p>Performance Indicator Interim Data: HIV Special Needs Plans HIV Special Needs Plans Interim Data 2024 Measure Year –Statewide Rates</p> <ul style="list-style-type: none"> • Breast Cancer Screening 71% increase 3 percentage points • Cervical Cancer Screening 68% decrease 7 percentage points • Colorectal Cancer Screening 64% increase 8 percentage points <p>Performance Indicator Interim Data Interim Data 2024 Measure Year</p> <ul style="list-style-type: none"> • Breast Cancer Screening: 69% of plans improved with 18% of these plans meeting their 2025 goal. • Cervical Cancer Screening: 56% of plans improved with 11% of these plans meeting their 2025 goal. • HPV Vaccine: 25% of plans improved with none of these plans meeting their 2025 goal. • Colorectal Cancer Screening: 100% of plans improved with 84% of these plans meeting their 2025 goal. • Disparity specific indicators: 81% of plans improved with 82% of these plans meeting their 2025 goal. <ul style="list-style-type: none"> ○ This progress reflects all the MCPs progress on varied performance indicators and disparate subgroups. ○ The disparity subgroups included one or more of the following categories: sex, age, race, ethnicity, and region. <p>Next Steps</p> <ul style="list-style-type: none"> • Interventions continue through December 2025 • Sustainability Planning <ul style="list-style-type: none"> ○ maintenance of interventions with a positive impact ○ standardize the intervention, support with resources and documentation • Final Report in July 2026 <ul style="list-style-type: none"> ○ 2025 Measure Year data 	

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<p>Individuals with IDD in Managed Care</p>	<p>Sarina Master, Director, Bureau of Adult Special Populations and Jessica Alexandre, Bureau of Adult Special Populations (NYSDOH), reported the following:</p> <p>OPWDD Members in Managed Care</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #002060; color: white;"> <th colspan="2">Managed Care Enrollment Numbers (As of Nov 2024)</th> </tr> </thead> <tbody> <tr style="background-color: #0070C0; color: white;"> <td style="padding: 5px;">Mainstream Managed Care</td> <td style="padding: 5px;">39,255</td> </tr> <tr style="background-color: #008080; color: white;"> <td style="padding: 5px;">FIDA-IDD</td> <td style="padding: 5px;">1,708</td> </tr> <tr style="background-color: #00A0E0; color: white;"> <td style="padding: 5px;">Total</td> <td style="padding: 5px;">40,963</td> </tr> </tbody> </table> <p style="margin-left: 40px;">In 2024 there were a total of 133,599 people being served by OPWDD</p> <div style="text-align: center; margin-top: 20px;"> <p>OPWDD Population 2024</p>  <p>Managed Care Product 31%</p> <p>Fee For Service 69% (92,636)</p> </div> <p>IDD Look-Alikes</p> <div style="margin-left: 20px; margin-bottom: 10px;"> <div style="background-color: #4B3681; color: white; padding: 10px; border-radius: 10px; display: flex; align-items: center;"> <p style="margin: 0;">Medicaid members who are diagnosed with an IDD but are not enrolled in the OPWDD waiver</p> </div> </div> <div style="margin-left: 20px; margin-bottom: 10px;"> <div style="background-color: #FFD700; padding: 10px; border-radius: 10px; display: flex; align-items: center;"> <p style="margin: 0;">Uses Medicaid claims data for identification</p> </div> </div> <div style="margin-left: 20px;"> <div style="background-color: #D3D3D3; padding: 10px; border-radius: 10px; display: flex; align-items: center;"> <p style="margin: 0;">Developed by NYSDOH BASP, Bureau of Enterprise and Data Governance, OHIP medical directors, and subject matter experts.</p> </div> </div> <div style="margin-left: 100px; margin-top: 20px;"> <div style="background-color: #FFD700; padding: 10px; border: 2px solid black; border-radius: 10px; width: fit-content;"> <p>~ 140,000 Medicaid members have been identified as an "IDD Look- alike"</p> </div> </div>	Managed Care Enrollment Numbers (As of Nov 2024)		Mainstream Managed Care	39,255	FIDA-IDD	1,708	Total	40,963	
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<p>Individuals with IDD in Managed Care</p>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <h3>IDD Look-Alike Definition</h3> <p>Population Cohorts:</p> <ul style="list-style-type: none"> ○ No RRE Code indicating OPWDD enrollment ○ 2 + claims with I/DD diagnosis within 2 years/ 2+ claims at any point in Medicaid history ○ Neuropsychological evaluation with an IDD diagnosis ○ 3+ specialist visits over a <u>2 year</u> period ○ Early intervention (EI) diagnosis and participated in the EI program </div> <div style="width: 5%; text-align: center; font-size: 2em;">➔</div> <div style="width: 45%; border: 1px solid gray; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p><i>The Look-Alike Population may not be appropriate for OPWDD waiver services</i></p> <p>Possible reasons for not being enrolled in OPWDD:</p> <ul style="list-style-type: none"> • Did not meet OPWDD eligibility criteria (ex. no documented diagnosis before age 22, incomplete or missing required assessments) • Does not meet the level of need required for OPWDD enrollment • Never applied/ not interested in applying to enroll in waiver </div> </div> <div style="margin-top: 20px;">  </div> <div style="margin-top: 20px;"> <h3>Racial Disparities</h3>  <table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Racial Disparities Data</caption> <thead> <tr> <th>Race/Ethnicity</th> <th>OPWDD (%)</th> <th>IDD look-alikes (%)</th> </tr> </thead> <tbody> <tr> <td>White- Not of Hispanic Origin</td> <td>50%</td> <td>~22%</td> </tr> <tr> <td>Puerto Rican - Hispanic</td> <td>18%</td> <td>~35%</td> </tr> <tr> <td>Black- Not of Hispanic Origin</td> <td>16%</td> <td>~18%</td> </tr> <tr> <td>Unknown</td> <td>7%</td> <td>~15%</td> </tr> <tr> <td>Asian or Pacific Islander</td> <td>5%</td> <td>~5%</td> </tr> <tr> <td>Other</td> <td>4%</td> <td>~5%</td> </tr> <tr> <td>Native American or Alaskan Native</td> <td>0%</td> <td>0%</td> </tr> </tbody> </table> <p style="margin-top: 10px;"><i>People identifying as white non-hispanic are disproportionately represented in the OPWDD waiver population, the majority of people in the look-alike population identify as People of Color. This may be due to structural disparities.</i></p> </div>	Race/Ethnicity	OPWDD (%)	IDD look-alikes (%)	White- Not of Hispanic Origin	50%	~22%	Puerto Rican - Hispanic	18%	~35%	Black- Not of Hispanic Origin	16%	~18%	Unknown	7%	~15%	Asian or Pacific Islander	5%	~5%	Other	4%	~5%	Native American or Alaskan Native	0%	0%
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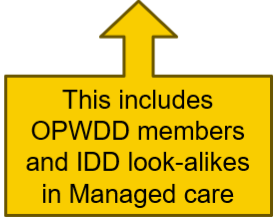
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<p>Individuals with IDD in Managed Care</p>	<p>IDD Look-Alike Data</p> <p>Managed care vs FFS</p> <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> <table border="1" style="margin-top: 10px; border-collapse: collapse; font-size: small;"> <caption>Managed care vs FFS Data</caption> <thead> <tr> <th>Group</th> <th>Managed Care</th> <th>FFS</th> </tr> </thead> <tbody> <tr> <td>OPWDD</td> <td>69%</td> <td>31%</td> </tr> <tr> <td>IDD Look-alike</td> <td>91%</td> <td>9%</td> </tr> </tbody> </table> </div> <div style="text-align: center;"> <p>IDD Look-alike members across NY</p> <p style="font-size: x-small; margin-top: 10px;">Cohort Members as % of Statewide Members</p> <table border="1" style="margin-top: 5px; border-collapse: collapse; font-size: x-small;"> <tr> <td style="background-color: #e0e0e0;">0.51%-1.10%</td> <td style="background-color: #808080;">1.26%-1.42%</td> <td style="background-color: #404040;">1.52%-2.07%</td> </tr> <tr> <td style="background-color: #c0c0c0;">1.10%-1.26%</td> <td style="background-color: #606060;">1.42%-1.52%</td> <td></td> </tr> </table> </div> </div>	Group	Managed Care	FFS	OPWDD	69%	31%	IDD Look-alike	91%	9%	0.51%-1.10%	1.26%-1.42%	1.52%-2.07%	1.10%-1.26%	1.42%-1.52%		
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<p>Individuals with IDD in Managed Care</p>	<p>% Spend By Category of Service</p> <ul style="list-style-type: none"> Waiver enrollees appear to have much a much larger percentage of outpatient spend because waiver services are counted as outpatient services. If we remove outpatient spend for both to account for this difference, the ratios of spend begin to look more similar. While the Look Alike group has lower ED % spend, it has higher inpatient % spend. Waiver participants have higher spend ratios in pharmacy and professional services. <div style="margin-top: 20px;"> <table border="1" style="margin-top: 10px; width: 100%; text-align: center; border-collapse: collapse;"> <caption>% Spend By Category of Service</caption> <thead> <tr> <th>Category</th> <th>Emergency</th> <th>Inpatient</th> <th>Outpatient</th> <th>Pharmacy</th> <th>Professional</th> <th>Skilled Nursing Facility</th> </tr> </thead> <tbody> <tr> <td>IDD Look-alike</td> <td>2%</td> <td>35%</td> <td>35%</td> <td>12%</td> <td>16%</td> <td>11%</td> </tr> <tr> <td>OPWDD</td> <td>2%</td> <td>2%</td> <td>89%</td> <td>5%</td> <td>4%</td> <td>1%</td> </tr> </tbody> </table> </div> <p>Behavioral Health Utilization</p> <p>The IDD population in managed care accesses mental health services at a slightly higher rate than the IDD population in Fee- for-Service (FFS).</p> <ul style="list-style-type: none"> Percent of OPWDD members accessing A. 31 services: <ul style="list-style-type: none"> FFS: 7%; MCO: 11% Percent of IDD Look-alike members accessing A.31 services: <ul style="list-style-type: none"> FFS: 13%; MCO: 15% Substance Use (services provided in OASAS Article 32 clinics): <ul style="list-style-type: none"> Only about 1% of OPWDD and IDD Look–alike members utilize A.32 SUD services (regardless of managed care enrollment) 	Category	Emergency	Inpatient	Outpatient	Pharmacy	Professional	Skilled Nursing Facility	IDD Look-alike	2%	35%	35%	12%	16%	11%	OPWDD	2%	2%	89%	5%	4%	1%	
Category	Emergency	Inpatient	Outpatient	Pharmacy	Professional	Skilled Nursing Facility																	
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<p>Individuals with IDD in Managed Care</p>	<p>IDD in 1115 NYHER Waiver</p> <ul style="list-style-type: none"> Targeted High-Need Populations Eligible for Enhanced Health Related Social Needs Services: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Medicaid High Utilizers</td> <td style="padding: 5px;">Substance Use Disorder</td> <td style="padding: 5px;">Serious Mental Illness</td> <td style="padding: 5px;">Post- release justice-involved with serious chronic conditions</td> </tr> <tr> <td style="padding: 5px;">Individuals with serious chronic conditions</td> <td style="padding: 5px;">Pregnant persons, up to 12 months postpartum</td> <td style="padding: 5px;">Children aged 0-6</td> <td style="padding: 5px;">Children under 18 with a chronic condition</td> </tr> <tr> <td style="padding: 5px;">Foster care youth</td> <td style="padding: 5px;">Juvenile justice- involved</td> <td style="padding: 5px;">Kinship care</td> <td style="padding: 5px;">Intellectual/Developmental disabilities</td> </tr> </table> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;"> <div style="text-align: center;">  Nutrition </div> <div style="text-align: center;">  Transportation </div> </div> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;"> <div style="text-align: center;">  Housing </div> <div style="text-align: center;">  Case Management </div> </div> <div style="text-align: center; margin-top: 20px;">  </div> <div style="text-align: center; margin-top: 20px;">  </div> <ul style="list-style-type: none"> Bureau of Adult Special Populations Participants: <ul style="list-style-type: none"> Sarina.Master@health.ny.gov Jessica.Alexandre@health.ny.gov 	Medicaid High Utilizers	Substance Use Disorder	Serious Mental Illness	Post- release justice-involved with serious chronic conditions	Individuals with serious chronic conditions	Pregnant persons, up to 12 months postpartum	Children aged 0-6	Children under 18 with a chronic condition	Foster care youth	Juvenile justice- involved	Kinship care	Intellectual/Developmental disabilities	
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<p>Mainstream Medicaid Managed Care Program Update</p>	<p>Due to time constraints, the Mainstream Medicaid Managed Care Program Update was not reviewed. Please see materials sent out prior to the meeting.</p>	<p>Action Item: Fred Cohen inquired about “services included in postpartum care covered for up to 6 months”.</p> <p>DOH response: Please see the <i>Timely Postpartum Visit Incentive Coding</i> article in the May 2025 Medicaid Update.</p>												

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Agenda Items	Discussion	Action Items
Managed Long Term Care (MLTC) Program Update	Due to time constraints, the Managed Long Term Care (MLTC) Program Update was not reviewed. Please see materials sent out prior to the meeting.	
Public Comment	No Public Comment	
	Motion Passed: Meeting adjourned at 1:01pm.	

ACRONYMS & INITIALISMS

ABA	Applied Behavior Analysis
ADL	Activity of Daily Living
ADM	Administrative Directive Memorandum
ARPA	American Rescue Plan Act
BH	Behavioral Health
CBAA	Certified Behavior Analyst Assistant
CBLTC	Community Based Long Term Care
CBLTSS	Community Based Long Term Services and Supports
CBO	Community Based Organization
CDC	Centers for Disease Control
CDPAP	Consumer Directed Personal Assistance Program
CDPAS	Consumer Directed Personal Assistance Services
CFCO	Community First Choice Option
CFEEC	Conflict-Free Evaluation and Enrollment Center
CFTSS	Children and Family Treatment and Support Services
CHA	Community Health Assessment
CHP	Child Health Plus
CMA	Care Management Agency
CMHA	Community Mental Health Assessment

DME	Durable Medical Equipment
DOH	Department of Health
DOL	Department of Labor
D-SNP	Dual Eligible Special Needs Plans
EP	Essential Plan
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FI	Fiscal Intermediary
FIDA	Fully Integrated Duals Advantage
FIDA-IDD	Fully Integrated Duals Advantage-Individuals with Intellectual and Developmental Disabilities
FLSA	Fair Labor Standards Act
FY	Fiscal Year
HARP	Health and Recovery Plan
HCBS	Home and Community Based Services
HERO	Health Equity Regional Organization
HIV SNP	HIV Special Needs Plan
HRSN	Health-Related Social Needs
IADL	Instrumental Activity of Daily Living

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IB-Dual	Integrated Benefits for Dually Eligible Enrollees
IPP	Independent Practitioner Panel
IRP	Independent Review Panel
JAC	Joint Advisory Council
LBA	Licensed Behavior Analyst
LDSS	Local Department of Social Services
LGU	Local Government Unit
LHCSA	Licensed Home Care Services Agencies
LTNHS	Long Term Nursing Home Stay
MARO	Metropolitan Area Regional Office
MCO	Managed Care Organization
MLTC	Managed Long Term Care
MMC	Medicaid Managed Care
MMCARP	Medicaid Managed Care Advisory Review Panel
MOU	Memorandum of Understanding
MRT	Medicaid Redesign Team
NHTD	Nursing Home Transition and Diversion Waiver
NYC	New York City
NYHER	New York Health Equity Reform
NYIAP	New York Independent Assessor Program
NYSDOH	New York State Department of Health
OASAS	Office of Alcoholism and Substance Abuse Services

OHIP	Office of Health Insurance Programs
OMH	Office of Mental Health
OMIG	Office of Medicaid Inspector General
OTC	Over the Counter (Drug)
PACE	Program of All-Inclusive Care for the Elderly
PCS	Personal Care Services (Medicaid State Plan)
PHIP	Population Health Improvement Program
PNDS	Provider Network Data System
POC	Plan of Care
PPS	Performing Provider System
RFP	Request for Proposals
ROS	Rest of State
RPC	Regional Planning Consortium
SBHC	School-Based Health Center
SCN	Social Care Network
SDHN	Social Determinants of Health Network
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
VBP	Value Based Payment
WIO	Workforce Investment Organizations