MRT Demonstration
Section 1115 Quarterly and Annual Report
Demonstration Year: 24 (4/1/2022-3/31/2023)
Federal Fiscal Quarter: 4 (7/1/2022-9/30/2022)

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: Fourth Quarter

MRT Waiver- Enrollment as of September 2022

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	491,482	5,898	2,007
Population 2 - TANF Adults 21- 64 years in Mandatory Counties as of 10/1/06	65,953	1,544	479
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	12,648	117	32

Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**42,070**	**742**	**233**
Population 5 - Safety Net Adults	**228,108**	**6,942**	**2,521**
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 ('old' voluntary MC Enrollment)	**149,711**	**1,452**	**81**
Population 9 - Disabled Adults and Children 0 - 64 ('new' MC enrollment)	**63,363**	**2,720**	**173**
Population 10 - Aged or Disabled Elderly ('old' voluntary MC Enrollment)	**72,832**	**387**	**21**
Population 11 - Aged or Disabled Elderly ('new' MC enrollment)	**12,635**	**2,309**	**115**

MRT Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollment's	
Total # Voluntary Disenrollments in Current Demonstration Year	**22,111 or an approximate 18.5% decrease 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 decreased due to declines in disenrollment due to incarcerations, enrollees choosing to enroll in another plan, and the "undetermined" category of disenrollment.

Underdetermined 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	**5,662 or an approximate 27.3% increase from last Q**

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

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

Involuntary disenrollment increased due to an increase in lost eligibility due to such factors as a change in residency and not specifically due to any type of case closure.

MRT Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
July 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	**726,965**	**16,734**	**2,880**	**13,854**
Rest of State	**348,295**	**7,612**	**1,028**	**6,584**
Statewide	**1,075,260**	**24,346**	**3,908**	**20,438**
August 2022				
New York City	**732,317**	**18,592**	**3,081**	**15,511**
Rest of State	**351,554**	**7,952**	**1,162**	**6,790**
Statewide	**1,083,871**	**26,544**	**4,243**	**22,301**
September 2022				
New York City	**734,614**	**15,515**	**2,465**	**13,050**
Rest of State	**354,686**	**7,528**	**964**	**6,564**
Statewide	**1,089,300**	**23,043**	**3,429**	**19,614**

Fourth Quarter	
Region	**Total Affirmative Choices**
New York City	42,415
Rest of State	19,938
Statewide	62,353

HIV SNP Plans				
July 2022				
Region	**Roster Enrollment**	**New Enrollment**	**Auto Assigned**	**Affirmative Choices**
New York City	13,012	180	0	180
Rest of State	22	0	0	0
Statewide	13,034	180	0	180
August 2022				
New York City	12,975	181	0	181
Rest of State	22	0	0	0
Statewide	12,997	181	0	181
September 2022				
New York City	12,955	219	0	219
Rest of State	24	2	0	2
Statewide	12,979	221	0	221
Fourth Quarter				
Region	**Total Affirmative Choices**			
New York City	580			
Rest of State	2			
Statewide	582			

Health and Recovery Plans Disenrollment			
FFY 22 – Q4			
	Voluntary	Involuntary	Total
July 2022	712	705	1,417
August 2022	576	700	1,276
September 2022	659	753	1,412
Total:	1,947	2,158	4,105

III. Outreach/Innovative Activities

Outreach Activities

A. New York Medicaid Choice (NYMC) Field Observations Federal Fiscal Quarter: 4 (7/1/2022-9/30/2022) Q4 FFY 2022

As of the end of the fourth federal fiscal quarter (end of September 2022), there were 3,039,710 New York City Medicaid consumers enrolled in mainstream Medicaid Managed Care Program and 77,398 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the NYMC program, 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 three HIV/AIDS Services Administration (HASA) sites, two Community Medicaid Offices (MA Only), and 10 Job Centers (Public Assistance). MAXIMUS reported that 3,537 clients were educated about enrollment options and made an enrollment choice including 1,458 clients in person and 2,079 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 24,942 FFS community clients were reported on the regular auto-assignment list, 1,522 clients responded to the call that generated 2,755 enrollments. Of the total of 65 FFS NH clients reported on NH auto-assignment list, one (2%) client and/or authorized representatives made a Plan selection.

C. NYMC HelpLine Observations July - September 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 **54,840** calls were received by the Helpline and **53,711** or **98%** were answered. Calls answered were handled in the following languages: **English**:**35,923 (67%); Spanish: 7059 (13%); Chinese:2,649 (5%); Russian: 812 (1%); Haitian/Creole: 50 (1%); and other: 7,218 (13%).**

MAXIMUS recorded 100% of the calls received by the NYMC HelpLine. CMU listened to **3,551** recorded calls. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – 4th Quarter 2022								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
1,807 (51%)	**312 (9%)**	**200 (5%)**	**1,187 (33%)**	**33 (1%)**	**0 (0%)**	**12 (1%)**	**0 (0%)**	**3,551**

A total of **898 (25%)** recorded calls observed was unsatisfactory. **357** calls had a single infraction and **541** calls had multiple infractions. A total of **1,395** infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: **1,014 (73%)** - 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: **290 (21%)** - 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: **91 (6%)** - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of **1,395** 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.

Annual Outreach Activities

<u>NYMC Field Observations Federal Fiscal Year 2022 (10/1/2021-9/30/2022)</u>
As of the end of the federal fiscal year 2022 (end of September 2022), there were 3,039,710 New York City Medicaid consumers enrolled in the mainstream Medicaid Managed Care Program and 77,398 Medicaid consumers enrolled in HARP. MAXIMUS, the Enrollment Broker for the 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 reported period Maximus Field Customer Service Representatives (FCSR's) conducted personal and phone outreach in 15 HRA facilities open to the public. Maximus reported that 29,424 clients were educated about enrollment options and made an enrollment choice including 2,311 clients in person and 27,113 clients through phone.

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. CMU field monitoring has been suspended since 3/23/2020; therefore, no activity was conducted for the fiscal year.

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 111,830 FFS community clients were reported on the regular auto-assignment list, 10,176 (9%) clients responded to the calls that generated 13,598 enrollments. Of the total of 257 FFS NH clients reported on the NH auto-assignment list, nine (4%) clients and/or authorized representatives made a Plan selection.

NYMC HelpLine Observations October 2021 to September 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 232,819 calls were received by the Helpline and 220,237 or 95% were answered. Calls answered were handled in the following languages: English: 148,846 (67%); Spanish: 26,543 (12%); Chinese: 11,408 (5%); Russian: 2,238 (1%); Haitian/Creole: 228 (1%); and other: 30,974 (14%).

MAXIMUS recorded 100% of the calls received by the NYMC HelpLine 10/1/2021 through-9/30/2022. CMU listened to 12,016 recorded calls for the same period. The call observations were categorized in the following manner:

CMU Monitoring of Call Center Report – October 2021 to September 2022								
General Information	**Phone Enrollment**	**Phone Transfer**	**Public Calls**	**Disenrollment Calls**	**Dual Segment**	**Exemption**	**Removal**	**Total**
6,807 (56%)	1,029 (8%)	676 (6%)	3,343 (28%)	107 (1%)	2 (0%)	50 (1%)	2 (0%)	12,016

A total of 4,161 (35%) recorded calls observed was unsatisfactory including 1,411 calls with single infraction and 2,750 calls with multiple infractions. A total of 7,016 infractions/issues reported to MAXIMUS. The following summarizes those observations:

- Process: 5,456 (78%) - 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: 763 (11%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and obtaining referrals for specialists.

- Customer Service: 797 (11%) - Consumers were put on hold without an explanation or were not offered additional assistance.

A total of 7,016 corrective action plans were implemented for the reporting quarter. Corrective actions include, but are not limited to, staff training and an increase in targeted CSR monitoring to ensure compliance

IV. Operational/Policy Developments/Issues

A. Plan Expansions, Withdrawals, and New Plans

No updates to report for the 4th quarter.

Annual:

During the first quarter of FFY2021-2022:

- On November 1, 2021, Molina Healthcare of New York, Inc. was approved to expand its MMC and HARP service areas to include Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, and Westchester counties. This expansion is the result of the acquisition of Affinity Health Plan, Inc.
- On November 1, 2021, Affinity Health Plan, Inc. (Affinity) was approved to withdraw its MMC and HARP products from Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, and Westchester counties. This withdrawal was the result of the acquisition of Affinity by Molina Healthcare of New York, Inc.
- On November 29, 2021, HealthPlus HP, LLC was approved to expand its MMC and HARP service areas to include Dutchess, Orange, Rockland, Suffolk, Ulster, and Westchester counties.

During the second, third and fourth quarters of FFY2021-2022, there were no plan expansions, withdrawals, or new Plans.

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

The March 1, 2019, Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) was submitted to CMS for approval in federal fiscal year (FFY) 2019-2020. All 19 resultant contracts have been executed by New York State and have been submitted to CMS for final approval. On February 22, 2022, CMS issued an approval letter indicating approval of all 19 contracts.

On June 18, 2021, New York State submitted to CMS amendment #1 to the March 1, 2019, Model Contract that includes emergency contract provisions related to the COVID-19 public health emergency. On December 20, 2021, this amendment was issued to 16 Managed Care Organizations for signature. At the close of the fiscal year, all 16 contracts have been executed by New York State and have been submitted to CMS for final approval.

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

C. Health Plans/Changes to Certificates of Authority

None to report for 4th quarter.

Annual:

- Effective November 1, 2021, the Department updated the Certificate of Authority for Affinity Health Plan to reflect their withdrawal from the Medicaid, Child Health Plus, and HARP lines of business. Language was also revised to reflect the Certificate of Authority is only applicable to maintaining operations to perform close out activities.
- Effective October 21, 2021, the Department updated the Certificate of Authority to reflect that Molina Healthcare of New York is certified to provide Medicaid, Child Health Plus, HARP benefits in the counties of Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, and Westchester counties.
- Effective June 22, 2022, the Department updated the Certificate of Authority to reflect that Health Insurance Plan of Greater New York is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.
- Effective November 29, 2021, the Department updated the Certificate of Authority to reflect that HealthPlus HP, LLC is approved to provide Medicaid, Child Health Plus, and HARP benefits in Dutchess, Orange, Rockland, Suffolk, Ulster, and Westchester counties.
- Effective July 1, 2022, the Department updated the Certificate of Authority to reflect that HealthPlus HP, LLC is certified to provide Integrated Benefits for Dually Eligible Enrollees in the counties of Orange, Rockland, Suffolk, and Westchester.

D. CMS Certifications Processed

None to report.

E. Surveillance Activities

Surveillance activity completed during the 4th Quarter FFY 2021-2022 (July 1 – September 30, 2022) include the following:

Two (2) Comprehensive Operational Surveys and Two (2) Targeted Operational Surveys completed during 4th Quarter FFY 2021-2022. Two (2) SODs were issued and Two (2) POCs were accepted. Two (2) Plans were found in compliance.

- MetroPlus
- MVP
- Metroplus SNP (In compliance)

- Excellus (In compliance)

Sixteen (16) Provider Directory Survey and Provider Access and Availability Surveys were completed during the 4th Quarter FFY 2021-2022 (July 1– September 30, 2022). Sixteen (16) SODs were issued and sixteen (16) POCs were accepted.

- Affinity Health Plan, Inc.
- Amida Care
- Capital District Physicians' Health Plan, Inc.
- Excellus
- NYQHC (Fidelis)
- Emblem (HIP)
- HealthFirst.
- Highmark.
- Healthplus (Amerigroup)
- Independent Health Association, Inc.
- MetroPlus
- MetroPlus SNP
- MVP
- Molina
- UnitedHealthcare of New York, Inc.
- VNS

Fifteen (15) Member Services Phase 1 Surveys were completed during the 4th Quarter FFY 2021-2022 (July 1– September 30, 2022). Letters of Concern, requiring a self-directed CAP, were issued to fifteen (15) Plans.

- Amida Care
- Capital District Physicians' Health Plan, Inc.
- Excellus
- NYQHC (Fidelis)
- Emblem (HIP)
- HealthFirst.
- Highmark.
- Healthplus (Amerigroup)
- Independent Health Association, Inc.
- MetroPlus
- MetroPlus SNP
- MVP
- Molina
- UnitedHealthcare of New York, Inc.
- VNS

Annual:

CMS Reporting 1st Quarter 2021-2022

Surveillance activity completed during the 1st Quarter FFY 2021-2022 (October 1- December 2021) include the following:

One (1) Targeted Operational Survey was completed during 1st Quarter FFY 2021-2022. One (1) SOD was issued and one (1) POC was accepted.

- United Health Care

Eighteen (18) PCP Ratio Surveys were completed during 1st Quarter FFY 2021-2022. Letters of Concern, requiring a self-directed CAP, were issued to twelve (12) Plans. Six (6) Plans were exempt.

- Affinity Health Plan, Inc.
- Amida Care (exempt)
- CDPHP
- Excellus (exempt)
- NYQHC (Fidelis)
- Emblem (HIP)
- HealthFirst PHSP, Inc.
- Highmark
- Healthplus (Amerigroup)
- Independent Health Association, Inc.
- MetroPlus
- MetroPlus SNP (exempt)
- Molina (exempt)
- MVP (exempt)
- UnitedHealthcare of New York, Inc.
- VNS (exempt)
- WellCare of New York, Inc.
- Yourcare

Sixteen (16) Member Services Surveys were completed 1st Quarter FFY 2021-2022. An SOD was issued and a POC was accepted for thirteen (13) Plans. Three (3) Plans were found in compliance:

- Affinity Health Plan, Inc.
- HealthPlus
- Amida Care
- CDPHP
- Excellus
- Health Insurance Plan of Greater New York
- HealthFirst PHSP, Inc.
- HealthNow New York Inc.-The Plan (in compliance)
- Independent Health Association, Inc. – (in compliance)
- MetroPlus Health Plan, Inc.
- MetroPlus Health Plan, Inc. Special Needs Plan
- MVP Health Plan, Inc.
- Fidelis
- Molina – (In Compliance)
- UnitedHealthcare of New York, Inc.
- VNS CHOICE

CMS Reporting 2nd Quarter 2021-2022

Surveillance activity completed during the 2nd Quarter FFY 2021-2022 (January 1-March 31, 2022) include the following:

One (1) Comprehensive Operational was completed 2nd Quarter FFY 2021-2022. One (1) SOD was issued and one (1) POC was accepted.

- NYQHC (Fidelis)

*Please note that survey activity was paused for this quarter to complete a review with the Pharmacy Unit for Sexual Dysfunction and Erectile Dysfunction Pharmacy Claims.

CMS Reporting 3rd Quarter 2021-2022

Surveillance activity completed during the 3rd Quarter FFY 2021-2022 (April 1-June 30, 2022) include the following:

Four (4) Comprehensive Operational Surveys and Two (2) Targeted Operational Surveys completed during 3rd Quarter 2021-2022. Five (5) SODs were issued and Five (5) POCs were accepted. One (1) Plan was found in compliance.

- Amida Care
- Emblem (HIP)
- HealthPlus (Amerigroup)
- CDPHP
- IHA
- Healthfirst (In compliance)

Two (2) Provider Directory Survey and Provider Access and Availability Surveys were completed during the 3rd Quarter FFY 2021-2022 (April 1-June 30, 2022) Letters of Concern, requiring a self-directed CAP, were issued to two (2) Plans.

- WellCare of New York, Inc.
- Yourcare

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

MEQC Reporting requirements under discussion with CMS

No activities were conducted during FY2022. 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 34 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 behavioral health 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 behavioral health Home and Community Based Services (BH HCBS). For MMC, all Medicaid-funded behavioral health services for adults, except for services in Community Residences, are part of the benefit package.

Beginning in January 2019, children's behavioral health services were transitioned into MMC as part of the Children's Medicaid System Redesign. Transitioned behavioral health services included six new Children and Family Treatment and Support Services (CFTSS) and the 1915(c) Children's Consolidated Waiver (BH HCBS). 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 behavioral health 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 behavioral health provider community through its collaboration with the Managed Care Technical Assistance Center (MCTAC).

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

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

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (4/1/2022-6/30/2022)[1]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	34,658	140	129	0.37%
ROS	3,413	11	10	0.29%
Total	38,071	151	139	0.37%

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

NYS MH & SUD authorization requests and denials for Outpatient (4/1/2022-6/30/2022)[2]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	5,229	96	22	0.42%
ROS	1,967	39	39	1.98%
Total	7,196	135	61	0.85%

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

[1] Q4 data is not available and will be submitted with the next quarterly update.
[2] Q4 data is not available and will be submitted with the next quarterly update.

MH & SUD Claims (7/1/2022-9/30/2022)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	1,103,206	94.59%	5.41%
ROS	1,005,637	94.97%	5.03%
Totals	2,108,843	94.77%	5.23%

Behavioral Health Adults CORE/HCBS Claims/Encounters 7/1/2022-9/30/2022: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	102	24
Education Support Services	102	29
Family Support and Trainings	304	14
Intensive Supported Employment	99	21
Ongoing Supported Employment	35	4
Peer Support	2,243	402
Pre-vocational	59	14
Provider Travel Supplements	20	15
Psychosocial Rehab	2,908	380
Residential Supports Services	174	25
Transitional Employment	0	0
TOTAL	6,046	790

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 7/1/2022-9/30/3033: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip.
CPST	1,318	253
Education Support Services	420	97
Family Support and Trainings	56	11
Intensive Supported Employment	239	53
Ongoing Supported Employment	72	17
Peer Support	5,155	993
Pre-vocational	90	19
Provider Travel Supplements	3,773	872
Psychosocial Rehab	4,736	764
Residential Supports Services	1,122	188
Transitional Employment	0	0
TOTAL	16,981	2,046

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

NYS Mental Health (MH) & Substance Use Disorder (SUD) authorization requests and denials for Inpatient (7/1/2021-6/30/2022)[3]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	139,468	849	804	0.58%
ROS	19,703	81	76	0.39%
Totals	159,171	930	880	0.55%

NYS MH & SUD authorization requests and denials for Outpatient (7/1/2021-6/30/2022)[4]

Region	Total Authorization	Total Denials (Admin and Medical Necessity)	Utilization Review (Medical Necessity) Denials	Medical Necessity Denial Rate
NYC	24,953	436	121	0.48%
ROS	5,858	150	150	2.56%
Totals	30,811	586	271	0.88%

MH & SUD Claims (10/1/2021-9/30/2022)

Region	Total Claims	Paid Claims (Percentage of total claims reported)	Denied Claims (Percentage of total claims reported)
NYC	4,575,531	92.45%	7.55%
ROS	3,766,833	93.85%	6.15%
Totals	8,342,364	93.08%	6.92%

[3] Yearly statistics reflect period 7/1/2021-6/30/2022 due to data lag. Q4 data is not available.

[4] Yearly statistics reflect period 7/1/2021-6/30/2022 due to data lag. Q4 data is not available.

Behavioral Health Adults CORE/HCBS Claims/Encounters 10/1/2021-9/30/2022: NYC

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	537	57
Education Support Services	2,632	205
Family Support and Trainings	1,076	68
Intensive Supported Employment	1,915	142
Ongoing Supported Employment	257	17
Peer Support	23,221	846
Pre-vocational	1,676	71
Provider Travel Supplements	215	66
Psychosocial Rehab	12,513	590
Residential Supports Services	2,911	100
Transitional Employment	35	6
TOTAL	46,988	2,168

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

Behavioral Health Adults CORE/HCBS Claims/Encounters 10/1/2021-9/30/2022: ROS

Behavioral Health CORE/HCBS SERV GROUP	N Claims	N Recip
CPST	7,158	375
Education Support Services	4,900	381
Family Support and Trainings	264	24
Intensive Supported Employment	2,355	166
Ongoing Supported Employment	593	45
Peer Support	33,318	1,807
Pre-vocational	1,804	103
Provider Travel Supplements	18,845	1,568
Psychosocial Rehab	22,956	1,130
Residential Supports Services	10,122	470
Transitional Employment	26	3
TOTAL	102,341	2,046

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 4 MCTAC Attendance & Stats (7/1/2022 to 9/30/2022)

Events: MCTAC successfully executed 30 events from 7/1/2022 to 9/30/2022
All 30 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):*

3,823 people attended/participated in our events/viewed resource, of which **2,231** are unique participants

OMH Agency Participation
Overall: 347 of 653 **(53.14%)**

OASAS Agency Participation
Overall: 225 of 563 **(39.96%)**

Annual MCTAC Attendance & Stats (10/1/2021 to 9/30/2022)

Events: MCTAC successfully executed 84 events from 10/1/2021 to 9/30/2022
All 84 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):*

12,607 people attended/participated in our events/viewed resource, of which **5,966** are unique participants.

OMH Agency Participation
Overall: 455 of 653 **(69.68%)**

OASAS Agency Participation
Overall: 367 of 563 **(65.19%)**

Efforts to Improve Access to Behavioral Health Home and Community Based Services

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 Health Homes
- Continuing efforts to increase HARP enrollment in Health Homes 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, 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 HARPs 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 the HARPs.
- 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, 7,073 care managers in NYS have completed the required training for conducting the NYS Eligibility Assessment for BH HCBS. Also, between July 1, 2022, and September 30, 2022, 1,118 eligibility assessments were completed. A total of 9,617 eligibility assessments were completed between October 1, 2021, and September 30, 2022.

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

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

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

Access to CORE Services does not require an independent eligibility assessment and these services 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 Homes. 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 conducted a series of implementation trainings in partnership with MCTAC, and all active BH HCBS CPST, PSR, FST, and Peer Support providers were provisionally designated to provide CORE Services through July 31, 2022. At the end of the provisional designation period, providers attested to CORE readiness to become fully designated CORE providers on August 1,

2022. To ensure the continuity of care for CORE recipients, some of the attesting providers remained in a "current and valid" state of provisional designation through September 14, 2022, while working with the State to reconcile necessary attestation corrections and become fully designated. The State engaged providers in a significant amount of outreach and technical assistance to ensure the provider system was prepared for this transition, supporting and prioritizing continuity of care for members receiving these services. A list of fully designated CORE providers is available on the OMH CORE webpage.

The State is consulting with CORE providers and MCOs to inform future guidelines around MCO responsibilities and oversight, such as utilization management of CORE 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 behavioral health providers transitioning the four services moving from BH HCBS to the new CORE Service array and continuing support of BH HCBS providers. OMH and OASAS distributed guidance for an Infrastructure Program Extension which allowed HARPs to contract for remaining, unspent funds totaling approximately $31.9 million. Based on a thorough network needs assessment, funds were competitively awarded to eligible providers by the HARPs Infrastructure Program Extension contracts were executed between May and August 2022, with contracted activities currently underway. OMH and OASAS continue to work closely with the HARPs to further monitor and operationalize the program.

- 11 HARPs executed 80 provider contracts to support the transition to CORE Services and the continued provision of BH HCBS.
- Approximately $16 million in initial contract base awards were distributed to providers.

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

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 Program (MLTCP)

Managed Long-Term Care plans include Partial Capitation, Program for the All-Inclusive Care of the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plans. As of October 1, 2022, there are 25 Partial Capitation plans, nine PACE plans, 12 MAP, and one FIDA IDD plan. As of October 1, 2022, there are a total of 294,550 members enrolled across all MLTC products.

1. Accomplishments/Updates

During the July 2022 through September 2022 quarter, the Department of Health (Department) approved service area expansions for 2 partial capitation plans that were component to 2 merger and acquisition activities. Two plans merged for October 1, 2022, and 2 plans will be merging for December 1, 2022.

During the annual period of October 2021 through September 2022, the Department of Health approved service area expansions for 2 partial capitation plans, and 1 MAP.

New York's Enrollment Broker, New York Medicaid Choice (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 July 2022 through September 2022 quarter, post enrollment surveys were completed for four enrollees. Of the four surveilled, two of them (50%) indicated that they continued to receive services from the same caregivers once they became members of an MLTCP. The percentage of affirmative responses is lower than the previous quarter.

Enrollment: Total enrollment in MLTC partial capitation plans increased from 247,942 to 250,672 during the July 2022 through September 2022 quarter, a slight increase from the last quarter. For that period, 11,035 individuals who were being transitioned into Managed Long-Term Care made an affirmative choice, a 16% decrease from the previous quarter and brings the 12-month total for affirmative choice to 30,117.

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

2. Significant Program Developments

During the July 2022 through September 2022 quarter:

- The 3rd Quarter Member Services survey was conducted on 25 Partial Capitation plans and 13 MAP plans. One MAP plan had no enrollment. This survey was intended to provide feedback on the overall functioning of the plans' member service performance. No response was required, but, when necessary, the department provided recommendations on areas of improvement.

- The Desk Review for 4 Partial Capitation Operational Surveys were completed and reported in prior reporting periods. Corrective Action Plans (CAP) have been completed by the plans and are still awaiting department approval, except for one, whose CAP has been approved by the department.

- Operational Surveys are ongoing for five Partial Capitation plans.

- A Focused Survey was conducted on one Partial Capitation plan based on a TAC Complaint during the 1st quarter. A Statement of Deficiencies (SOD) was issued, the final CAP was accepted by the Department on 1/18/2022, and

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 in a prior reporting period. A review of plan files was completed, and SODs were issued to 13 Partial Capitation Plans and two MAP plans. CAPS for 11 Partial Capitation plans and one MAP plan were accepted prior; the remaining three CAPs have now been accepted.

- One Focused Survey was initiated on one Partial Capitation plan based on TAC Complaints. A SOD has been drafted and is awaiting approval.

- One Focused Survey was initiated on one Partial Capitation plan based on a TAC Complaint. A SOD has been drafted and is awaiting approval.

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 July 2022 through September 2022 quarter, nor for the October 2021 through September 2022 annual period.

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 has developed a process by which each FI will attest to meeting the legislatively mandated criteria. The Department will begin contracting with the FIs that meet the criteria in 2023. Managed care plans will then 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 2,358 critical incidents reported for the July 2022 through September 2022 quarter, an increase of 2% from the previous quarter. The names of plans reporting no critical incidents are shared with the surveillance unit for follow up on survey. To date, none of those plans were found to have had critical incidents that should have been reported.

Critical incidents by plan for this quarter are attached.

For the annual period October 2021 through September 2022, reporting of critical incidents increased by 52% from the previous annual period. During this annual period DOH issued updated instructions on reporting critical incidents and will continue to monitor plans who report lower than expected.

Complaints and Appeals: For the July 2022 through September 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 of Homecare, Dissatisfaction With Member Services and Plan Operations, Home Care Aides Late/Absent.

Period: 7/1/2022–9/30/2022 (Percentages rounded to nearest whole number)			
Number of Recipients: 294,550	**Complaints**	**Resolved**	**Percent Resolved***
# Expedited	**9**	**9**	**100%**
# Same Day	**2,548**	**2,548**	**100%**
# Standard/Expedited	**7,858**	**5,814**	**74%**
Total for this period:	**10,415**	**8,371**	**80%**

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

Appeals	10/2021-12/2021	1/2022-3/2022	4/2022-6/2022	7/2022-9/2022	Average for Four Quarters
Average Enrollment	281,667	281,668	286,152	291,381	285,217
Total Appeals	8,695	8,489	8,803	8,473	8,615
Appeals per 1,000	32	30	31	29	31
# Decided in favor of Enrollee	1,310	1,375	1,241	966	1,223
# Decided against Enrollee	6,062	5,751	6,323	6,252	6,097
# Not decided fully in favor of Enrollee	1,066	808	912	880	917
# Withdrawn by Enrollee	233	269	247	190	235
# Still pending	746	286	80	185	324
Average number of days from receipt to decision	8	8	7	8	8

Complaints and Appeals per 1,000 Enrollees by Product Type July 2022- September 2022					
	Enrollment	Total Complaints	Complaints per 1,000	Total Appeals	Appeals per 1,000
Partial Capitation Plan Total	249,609	5,823	23	6,626	27
Medicaid Advantage Plus (MAP) Total	34,467	3,513	102	1,787	52
PACE Total	7,305	1,079	148	60	8
Total for All Products:	**291,381**	**10,415**	**35**	**8,473**	**29**

Total complaints decreased 15% from 12,254 the previous quarter to 10,415 during the July 2022 through September 2022 quarter.

The total number of appeals decreased 4% from 8,803 during the last quarter to 8,437 during the July 2022 through September 2022 quarter.

For the annual period October 2021 through September 2022, the number of complaints decreased by 8%, and the number of appeals increased by 4%.

Technical Assistance Center (TAC) Activity

During the July 2022 through September 2022 quarter, TAC opened 590 cases and closed 651 cases. This is a bit higher than the previous quarter. This increase is spread across multiple dispositions, primarily inquires, substantiated cases and unsubstantiated cases.

Most of TAC's calls for this quarter were for general inquiries and questions. The changes due to the public health emergency, as well as other Department policy changes, have increased calls for benefit questions. Complaints regarding home health care services continue to be the most abundant.

Call Volume	**7/1/2022 – 9/30/2022**
Substantiated Complaints	45
Unsubstantiated Complaints	245
Closed as Duplicate	0
Resolved Without Investigation	17
Inquiries	344
Total	651

The five most common types of calls were related to:

Q4 2022	**7/1/2022-9/30/2022**
General	27%
Aide Service	21%
Enrollment	15%
Billing	10%
Coverage Concerns	7%

74% of Q4 TAC cases are closed in the same month they are opened, up 4% from last quarter. Overall, TAC's complaint numbers have slightly increased when compared to the previous few quarters.

During the annual period from October 2021 through September 2022, TAC opened 2,095 cases and closed 2,162 cases. The majority of the closed cases are for general questions and inquiries. About 81% of TAC's complaint investigations are found to be unsubstantiated.

Call Volume	**10/1/2021-9/30/2022**
Substantiated Complaints	160
Unsubstantiated Complaints	892
Resolved Without Investigation	55
Inquiries	1,054
Total	2,161

The five most common types of calls were related to:

Types of Calls	10/1/2021-9/30/2022
General	25%
Aide Service	25%
Enrollment	16%
Billing	8%
Coverage Concerns	5%

For the entire year, 68% of cases were closed in the same month they were opened. This efficiency increased over the course of the year, from 60% in October 2021 to 75% in September 2022.

Evaluations for enrollment: New York Independent Assessor (NYIA) is conducting initial assessments and clinical exams for personal care and consumer directed personal assistance services as well as continuing to determine MLTC eligibility. For July 2022 through September 2022 quarter, 8,331 people were evaluated, deemed eligible and enrolled into plans, a decrease of 25% from the previous quarter. This brings the total for the annual period October 2021 through September 2022 to 40,835. This total for this annual reporting period is a combination of the previous CFEEC process that existed up to when the NYIA initial assessment process began on May 16, 2022. New York State continues to see quarter to quarter variability in the number of individuals requesting assessments and the number who are deemed eligible.

Referrals and 30-day assessment: For the July 2022 through September 2022 quarter, MLTC plans conducted 7,050 assessments, a 75% decrease from 27,766 the previous quarter. The total number of assessments conducted within 30 days decreased 73% from 20,179 the previous quarter to 5,474 this quarter. Due to the transition of assessment duties from CFEEC to NYIA, plans were required to report assessments related to CFEEC up until July 15, 2022, resulting in the large decrease in CFEEC assessments from the previous quarter.

During the annual period October 2021 through September 2022, a total of 77,151 assessments were completed, with 80% of those assessments being conducted within 30 days of the request, which remains consistent with the previous annual period. The Department will continue to monitor data collection, evaluation, and reporting of previously CFEEC and now NYIA activity.

Referrals outside enrollment broker: For the July 2022 through September 2022 quarter, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 19,908, a 32% decrease from 29,305 the previous quarter. The annual period October 2021 through September 2022 saw a decrease totaling 8% by the end of the year, compared to the decrease from the previous annual period (16%).

Rebalancing Efforts	7/2022-9/2022
Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	129
Plan enrollees who are or have been admitted to a nursing home for any length of stay and who return to the community	1,611

As of September 30, 2022, there were 2,940 current plan enrollees who were in nursing homes as permanent placements, an 8% 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.**

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

- Managed care authority for HCBS provided to medically fragile children in foster care and/or with developmental disabilities and children with a serious emotional disturbance;
- Authority to include current Fee-for-Service HCBS authorized under the State's newly consolidated 1915c Children's Waiver in Medicaid Managed Care benefit packages;
- Authority to mandatorily enroll into managed care the children receiving HCBS via the 1915c Children's Waiver;
- Authority to waive deeming of income and resources, if applicable, for all medically needy "Family of One" children (Fo1 children) who will lose their Medicaid eligibility as a result of them no longer receiving at least one 1915c service due to case management now being covered outside of the 1915c Children's Waiver, including non-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:

- 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;
- Updating manuals, guidance documents, and online resources as indicated;
- Reassessing, streamlining, and removing unnecessary or duplicative forms to alleviate administrative burden;
- Conducting refresher training sessions and offering more in-depth training for care managers and HCBS providers, including additional resources and technical assistance with person-centered planning;
- Facilitating relationship building between Managed Care Organizations, HCBS providers, and care managers to improve communication and care coordination;
- Coordinating stakeholder meetings to obtain feedback from Managed Care Organizations, Health Homes, HCBS providers, advocate groups, regional Planning Consortiums, and others regarding the Medicaid Redesign and implementation;
- Evaluating accuracy of Managed Care Organizations and Fee-for-Service billing and claiming data;
- Defining performance and quality metrics;
- 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 workforce 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 allow for provider reporting and assess metrics;
- Engaging with providers, consumers, and New York State agency 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, Managed Care Organizations, and advocate groups) to inform the 1915c Children's Waiver renewal – including suggestions on how to streamline the Managed Care processes and improve communication between Managed Care Organizations, Health Homes, and HCBS providers;
- Engaging with Health Homes, Managed Care Organization, and HCBS providers while redesigning the Plan of Care in preparation for digitization;
- Updating public-facing materials to better inform Medicaid members of the available options and help service recipients understand the process;

- Planning submission of the 1915c Children's Waiver Amendment and corresponding 1915b4 to CMS for an effective date of March 1, 2023;
    - This amendment is in response to stakeholder feedback received through stakeholder engagement relating to the 1915c Children's Waiver Renewal process 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 retroactive approval on June 29, 2022, of the five-year renewal of the Children's Waiver (NY.4125.R06.00) effective from April 1, 2022, to March 31, 2027, the New York State Department of Health 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;
- Adding a temporary 25% rate adjustment consistent with the approved Spending Plan for Implementation of the ARPA Section 9817 to improve service capacity; and
- Adding Medical Respite as a new HCBS service.

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

table below also demonstrates the number of children enrolled with this KK flag and the current claims for services for these enrolled children.

	With K1 Flag – HCBS LOC		With KK Flag – Family of One	
Month	**Enrolled Children**	**Enrolled Children w/HCBS Claims**	**Enrolled Children**	**Enrolled Children w/HCBS Claims**
July	14,697	7,367	6,312	948
August	15,242	5,813	6,356	890
September	15,659	3,076	6,446	718
Quarterly Average	**15,199**	**5,419**	**6,374**	**852**

**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 4th Quarter of FY2022. The number of children/youth enrolled in HCBS has increased at a consistent rate.
Below is a table of the annual numbers, updated to account for claims lag.

	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**
October	9,228	4,118	5,416	582
November	9,717	4,397	5,496	604
December	10,196	4,905	5,616	651
January	11,017	5,323	5,719	711
February	11,798	5,901	5,837	757
March	12,504	6,356	5,953	815
April	12,911	6,781	6,070	845
May	13,510	7,170	6,164	881
June	14,156	7,581	6,249	926
July	14,697	7,367	6,312	948
August	15,242	5,813	6,356	890
September	15,659	3,076	6,446	718
Annual Average	**12,553**	**5,732**	**5,970**	**777**

This annual snapshot of enrolled children/youth is consistent with the steady increase expected. The data from the 3rd Quarter increased from the previously submitted Q3 data due to retroactive claim enhancements and other mechanisms put in place to support providers.

VI. Evaluation of the Demonstration

During the quarter ending September 30, 2022, all five Independent Evaluations (IEs) 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 began integrating analysis of both qualitative and quantitative findings where 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) continued to assist the RAND researchers weekly with HARP and SDC questions on data limitations and analysis. The RAND contract was 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 were updated. The HARP and SDC Pilots had 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. CMS approved the HARP Interim Evaluation report on August 18, 2022.

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. CMS approved the SDC Interim Evaluation Report on August 18, 2022.

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 Managed Care Organizations (MCOs), including Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARPs), and HIV Special Needs Plans (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 last four (4) quarters:

MCO Product Line	Total Complaints	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
MMC	8,496	32,921
HARP	788	3,801
HIV SNP	91	443
Total MCO Complaints	**9,375**	**37,165**

As described in the table, MCOs reported 9,375 total enrollee complaints for the current quarter. This represents an 8.1% decrease from the prior quarter's total of 10,198 enrollee complaints.

MCOs reported 8,496 MMC complaints this quarter, which is a 5.9% decrease from the 9,026 of the previous quarter. The number of HARP complaints decreased 24.8%, from 1,048 in the prior quarter to 788 this quarter. There were 91 HIV SNP complaints this quarter, which is a decrease of 26.6% when compared to the 124 from the previous quarter.

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 for the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 22 Q4 7/1/2022–9/30/2022	Last 4 Quarters 10/1/2021–9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	17%
Balance Billing	14%	11%
Pharmacy/Formulary	10%	8%
Reimbursement/Billing	9%	12%
Difficulty with Obtaining: Dental/Orthodontia*	7%	7%

*MVP Health Plan did not submit all complaint data for MMC Difficulty with Obtaining Dental/Orthodontia category in time for this report. This category is probably one percentage point higher than reported.

The following table outlines the top five (5) most frequent categories of complaints reported for HARPs for the most recent quarter and the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
Pharmacy/Formulary	20%	14%
Dissatisfied with Provider Services (Non-Medical) or MCO Services	15%	19%
Dissatisfaction with Quality of Care	9%	10%
Balance Billing	7%	4%
Difficulty with Obtaining: Dental/Orthodontia*	4%	5%

*MVP Health Plan did not submit all complaint data for HARP Difficulty with Obtaining Dental/Orthodontia category in time for this report. This category is probably one percentage point higher than reported.

The following table outlines the top five (5) most frequent categories of complaints reported for HIV SNPs for the most recent quarter and the last four (4) quarters:

Description of Complaint	Percentage of Complaints	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	27%	23%
Dissatisfaction with Quality of Care	14%	7%
Pharmacy/Formulary	11%	13%
Difficulty with Obtaining: Dental/Orthodontia	8%	12%
Difficulty with Obtaining: Personal Care	7%	8%

B. Monitoring of Plan Reported Complaints

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

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

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

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

Amida Care FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**OE Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	8.1	The trend identified from the complaints received was that the MCO's call center representatives and provider offices were not providing the best	The MCO will continue to conduct sensitivity training to better equip call center representatives to help ensure enrollees are addressed correctly. The MCO will

		customer service to enrollees. The issues identified were that enrollees were being misgendered by call center representatives, and there was confusion surrounding the scheduling of office appointments by provider offices, including dates and times not being communicated accurately and appointments being scheduled with out-of-network providers.	continue to send electronic communications to providers and their offices on appointment scheduling standards, including standards in communicating appointment access and availability. The MCO will continue to update its online provider directory and internal systems monthly so that they reflect up-to-date locations, office hours, and provider participation. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	5.6	The trend identified from the complaints received was that enrollees were dissatisfied with covered dental benefits. The issue identified was a lack of understanding by enrollees of their dental benefit, including what dental services were not covered.	The MCO will continue to work with its vendor to develop and send out materials to educate its enrollees and improve awareness on what their dental coverage includes.
Pharmacy\Formulary	5.5	The trend identified from the complaints received was that enrollees were not receiving their medication from the pharmacy. The issue identified was that there were denials for dispensing opioids and other medications.	The MCO will provide a checklist to providers in their next newsletter or email blast to inform them of the requirements for requesting opioids and for obtaining prior authorization.
Difficulty with Obtaining: Personal Care	20.1	The trends identified from the complaints received were that enrollees were dissatisfied due to not receiving the services they expected. The issues identified were that there was a shortage of available aides, some enrollees were not comfortable with unvaccinated aides, and some enrollees had	The MCO will address staffing limitations by adding more vendors to its personal care services network. The MCO will conduct outreach to enrollees on preferences for obtaining services from unvaccinated aides. The MCO will provide education to enrollees on proper expectations for services and duties performed by aides. The Department will continue to

		expectations for services such as deep cleaning that went beyond duties required of aides.	monitor progress in the next reporting period.

Capital District Physicians Health Plan FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.0	There were no trends identified by the MCO. The issues identified were that enrollees were dissatisfied with the continuity and quality of care received.	The MCO will continue to review quality of care complaints for any trends or multiple complaints regarding the same provider.

Excellus Health Plan FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	2.3	The trend identified from the complaints received was that enrollees were being denied services that were not medically necessary. The issue identified was that enrollees and providers were unaware of the requirements for services to be covered.	The MCO sent out enrollee and provider communication to improve understanding on covered services and remind providers to check enrollee eligibility and benefit information prior to providing services.

Healthfirst FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: Specialist	2.3	The trend identified from the complaints received was that enrollees were having difficulty scheduling appointments with specialists. The issues identified were that enrollee inquiries regarding scheduling specialist appointments were being misidentified as complaints	The MCO conducted audits and training to have its call center representatives correctly identify enrollee inquiries and complaints. The MCO is starting a call center group dedicated to assisting enrollees with scheduling appointments.

		by the MCO, causing its reported numbers in this category to be higher than expected, and enrollees were having difficulty finding specialist appointments in their area.	
Long Wait Time	2.4	The trend identified from the complaints received was that enrollees were dissatisfied with delays in being seen by providers. The issues identified were that enrollees were attempting to be seen without scheduling an appointment and many appointment requests were being made by enrollees who had delayed seeking care during the COVID-19 pandemic.	The MCO will address long wait times for enrollees by working with its vendor to monitor and find opportunities for more appointments. The MCO is requesting that its providers and their office staff communicate with enrollees regarding scheduling appointments and the timeframe in which they will occur.
Dissatisfaction with Provider Services (Non-Medical) or MCO Services	2.7	The trends identified from the complaints received were that enrollees were experiencing issues related to durable medical equipment (DME), including delivery delays and theft, and that enrollees were dissatisfied with the service authorization and appeal processes for personal care assistance (PCA) services and requesting additional hours.	The MCO has worked with its preferred DME vendor to start processes of informing enrollees of any supply chain issues that may cause delays and routing DME requests to pharmacies when the preferred DME vendor cannot meet turnaround times, to improve enrollee satisfaction. The MCO's DME vendor also started logging photos of delivered items, as well as capturing signatures of the accepting person. The MCO is providing additional training and guidance to its call center representatives to better inform enrollees of the required processes for PCA service authorization requests and requests for additional hours.
Difficulty with Obtaining: Specialist and Hospitals	2.8	The trend identified from the complaints received was that enrollees were dissatisfied with providers' responsiveness and	The MCO will continue to communicate with providers, including sending out letters, whenever it is found that a provider does not respond in a

		timeliness with prior authorizations for requesting specific services or treatments. The issues identified were that specific services enrollees were seeking were not included by providers within enrollee treatment plans, and there were delays by providers in submitting service authorization requests.	timely manner to an enrollee request, or delays in submitting an authorization request for services or treatments.
Difficulty with Obtaining: Emergency Services	2.4	The trend identified from the complaints received was that enrollees were being billed, or balance billed, for emergency services rendered. The issues identified were that complaints regarding enrollee bills were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected, and enrollees were interpreting their explanations of benefits (EOBs) as bills.	The MCO will reeducate its call center representatives on correctly categorizing complaints and addressing enrollee EOB concerns. The Department will continue to monitor progress in the next reporting period.
Pharmacy\Formulary	2.2	The trend identified from the complaints received was that enrollees were being denied their prescriptions by pharmacies. The issue identified was that HARP enrollees had an error on their new ID cards stating that they were required to pay a co-pay for prescriptions.	The MCO issued new HARP ID cards to correct the error regarding co-pays. The MCO also reeducated pharmacies on not denying covered medication at the time of sale due to enrollee non-payment.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	2.9	There were no trends identified by the MCO. The issue identified was that complaints regarding pharmacy/formulary were being miscategorized by	The MCO educated its call center representatives and will continue to provide training tools and instructions to ensure proper categorization of complaints.

		the MCO, causing its reported numbers in this category to be higher than expected.	
Reimbursement/Billing	3.0	The trend identified from the complaints received was that enrollees were dissatisfied with being billed for services rendered. The issues identified were that enrollee inquiries were being misidentified as complaints by the MCO, causing its reported numbers in this category to be higher than expected, enrollees were dissatisfied with being billed for non-covered services when private pay agreements had been signed, and out-of-network labs were billing enrollees for services rendered.	The MCO will provide training to have its call center representatives correctly identify enrollee inquiries and complaints, and on how to address complaints regarding non-covered services and private pay agreements. The MCO's Delivery System Engagement team is implementing a process to identify when providers refer enrollees to out-of-network labs, so that in-network labs can be utilized.
Recipient Restriction Program Plan Initiated Disenrollment	3.9	The trend identified from the complaints received was that enrollees were dissatisfied with their inability to change pharmacies. The issues identified were that enrollee inquiries were being misidentified as complaints by the MCO, causing its reported numbers in this category to be higher than expected, and enrollees were unaware of how to request a pharmacy change when they were restricted to a specific pharmacy.	The MCO will provide training to have its call center representatives correctly identify enrollee inquiries and complaints. The MCO is more clearly outlining actions an enrollee can take to request a pharmacy change and is updating job aids for call center representatives to better educate enrollees on their rights regarding pharmacy restrictions.
Difficulty with Obtaining: Private Duty Nursing	4.3	There were no trends identified by the MCO. The issue identified was that there continues to be a PDN aide shortage.	The MCO will work with out-of-network providers and create single case agreements to provide needed PDN services. The Department will continue to

			monitor progress in the next reporting period.
Difficulty with Obtaining: Home Health Care	2.6	The trends identified from the complaints received were that enrollees were not receiving their home health care services in a timely manner, and they were dissatisfied with agency coordinators. The issues identified were that there was a home health care aide shortage, there was poor communication with agency coordinators around scheduling, there was provider failure to submit prescriptions for social worker visits and evaluations, and complaints regarding difficulty with obtaining specialist and hospitals were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will provide training to its call center representatives on correctly categorizing complaints. The MCO will continue to follow up with agencies it identifies as having repeated complaints to improve home health care services. The MCO will work with out-of-network providers and create single case agreements to provide needed home health care services.
Difficulty with Obtaining: Personal Care	4.1	The trends identified from the complaints received were that enrollees were dissatisfied with their personal care agencies and aides. The issues identified were that enrollees were not able to contact their personal care agencies or receive return calls from them, personal care aides were absent or tardy, and personal care aides were not able to speak in the enrollee's preferred language.	The MCO will continue to follow up with agencies it identifies as having repeated complaints and will implement action plans to improve personal care services. The MCO will work with out-of-network providers and create single case agreements to provide needed services.
Difficulty with Obtaining: CDPAS	3.5	The trend identified from the complaints received was that enrollees were having processing	The MCO will continue to follow up with the fiscal intermediaries it identifies as having repeated complaints to improve access to

		problems with CDPAS, including delays in authorization for services and delays in aides receiving payment for services. The issues identified were that fiscal intermediaries were not timely in processing authorization and payment for services due to incorrect forms, misrouted paperwork, and miscommunication between individuals and the fiscal intermediaries.	CDPAS. The MCO will task its care managers with educating enrollees on the approval process required for hiring aides. The Department will continue to monitor progress in the next reporting period.

Highmark FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: Specialist	9.9	The trend identified from the complaints received was that enrollees were requesting to see out-of-network specialists. The issues identified were that enrollees were seeking services from out-of-network providers and out-of-network providers were not following the proper process for providing services to enrollees (e.g., single case agreements).	The MCO will educate enrollees on seeking in-network providers and will assist in obtaining appointments through referring enrollees to the case management team, as needed. The MCO will educate providers on the process to request services for enrollees.
Difficulty with Obtaining: Specialist and Hospitals	2.2	The trend identified from the complaints received was that enrollees were requesting to see out-of-network specialists that were previously in network. The issues identified were that enrollees were seeking services from out-of-network providers and out-of-network providers were not submitting the requests to provide	The MCO will educate and redirect enrollees to in-network providers. The MCO will educate providers on the process to request services for enrollees.

		services to enrollees (e.g., single case agreements).	
Pharmacy\Formulary	2.2	The trend identified from the complaints received was that enrollees were dissatisfied with delays in obtaining medication. The issues identified were that providers were not submitting, or were delayed in submitting, prior authorization requests for enrollees.	The MCO will educate providers who do not submit authorization requests, or do not submit them timely, to reduce delays in enrollees receiving medications.
Reimbursement/Billing	3.9	The trend identified from the complaints received was that enrollees were seeing out-of-network providers and wanted to be reimbursed for services paid out of pocket. The issues identified were that enrollees were seeking services from out-of-network providers and out-of-network providers were not following the proper process for submitting claims to reimburse enrollees.	The MCO will educate enrollees on how to request out-of-network/non-covered services. The Department will continue to monitor progress in the next reporting period.
Balance Billing	4.8	The trend identified from the complaints received was that enrollees were being billed by providers and facilities for services rendered. The issues identified were that providers were unaware of enrollees' insurance coverage, partly due to enrollees not providing their insurance ID card; enrollees were seeking out-of-state care; and enrollees were being directly billed for ambulance services.	The MCO will follow up with enrollees to educate them on providing their insurance ID card when receiving care. The MCO will follow up with providers to educate them on laws surrounding balance billing and the proper processes for claim submission. The Department will continue to monitor progress in the next reporting period.

Health Insurance Plan of Greater New York FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	4.0	The trend identified from the complaints received was that enrollees were dissatisfied with covered dental benefits. The issue identified was a lack of understanding by enrollees and providers of what was covered under the enrollee dental benefit.	The MCO will educate providers regarding non-covered services via their website's provider portal. The MCO will educate enrollees regarding non-covered services via their website's Member Education section.

HealthPlus FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	2.9	The trend identified from the complaints received was that enrollees were having difficulty making appointments with primary care providers. The issues identified were that enrollees were seeking care from out-of-network providers, and out-of-network providers were not submitting the required documentation to the MCO.	The MCO will educate enrollees on seeking in-network providers and will assist in obtaining appointments through referring enrollees to the MCO's case management team. The MCO will educate providers on the process to request services for enrollees.
Appointment Availability: Specialist	2.4	The trend identified from the complaints received was that enrollees were having difficulty making appointments with specialists. The issues identified were that enrollees were seeking care from out-of-network providers, and out-of-network providers were not submitting the required documentation to the MCO.	The MCO will educate enrollees on seeking in-network providers and will assist in obtaining appointments through referring enrollees to the MCO's case management team. The MCO will educate providers on the process to request services for enrollees.

Communications/ Physical Barrier	4.3	The trend identified from the complaints received was that enrollees were complaining about a letter that the MCO sent out. The issue identified was that the contents of the letter were confusing to enrollees, which detailed how out-of-network providers were not permitted to prescribe medications to enrollees.	The MCO conducted training and education within its customer service center on responding to enrollees regarding the letter that was sent out, to provide enrollees with clear direction and assistance in locating in-network providers.
Balance Billing	2.1	The trend identified from the complaints received was that enrollees were being billed by providers and facilities for services rendered. The issues identified were that providers were unaware of enrollees' insurance coverage, enrollees were seeking out-of-state care, and enrollees were being directly billed for ambulance services.	The MCO will follow up with enrollees to educate them on providing their insurance ID card when receiving care. The MCO will follow up with providers to educate them on laws surrounding balance billing and the proper processes for claim submission. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Home Health Care	3.0	The trend identified from the complaints received was that enrollees were unable to get home health care services. The issue identified was a lack of staffing available at agencies the MCO contracted with for providing home health care services.	The MCO will identify instances where enrollees need assistance in establishing home health care services and help them in finding an agency that can provide them.
Dissatisfaction with BH Provider Services	10.91	The trend identified from the complaints received was that enrollees were dissatisfied with providers after services were provided. The issue identified was that providers were requiring a signed release form before	The MCO will continue to ensure its BH provider network meets the needs of its enrollees. The MCO will continue to investigate all complaints and look for any trends to address.

		medical records could be released.	
Dissatisfaction with Health Home Care Management	10.3	The trend identified from the complaints received was that enrollees were unhappy with the customer service provided by their health home care management. The issues identified were that there were language barriers, a lack of available staff, and that complaints regarding home health care were being miscategorized by the MCO, causing its reported numbers in this category to be higher than expected.	The MCO will continue to investigate complaints and look for any trends to address. The MCO will continue to contact health home care managers to address enrollee complaints.

Independent Health Association FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.5	The complaints received were regarding general enrollee dissatisfaction with providers and provider care. There were no trends or issues identified by the MCO.	The MCO will continue to conduct provider outreach to identify provider issues and to address enrollee complaints. The MCO will institute provider corrective action plans as needed to correct identified provider issues. The Department will continue to monitor progress in the next reporting period.
Difficulty with Obtaining: Dental/ Orthodontia	3.6	The complaints received were regarding non-covered services. There were no trends or issues identified by the MCO.	The MCO will continue to investigate complaints and look for any trends to address. The Department will continue to monitor progress in the next reporting period.

MetroPlus Health Plan FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Eye Care	2.4	The trends identified from the complaints received	The MCO advised enrollees that they can locate their benefit

		were that enrollees were dissatisfied with the timeliness of obtaining new glasses and being denied access to non-covered frames and updated materials. The issue identified was that enrollees and providers were unaware of what was covered under the insurance benefit.	information on its website and reminded enrollees what their benefit was. The MCO reminded providers of the multiple ways to check enrollee benefit and eligibility information, such as its IVR and provider portal.
Difficulty with Obtaining: Emergency Services	3.4	The trend identified from the complaints received was that providers were incorrectly billing enrollees for emergency services. The issue identified was that providers were unaware of enrollees' insurance coverage.	The MCO educated enrollees on the multiple ways to access their insurance ID cards, including through an enrollee portal, to assist providers in billing the correct insurance. The Department will continue to monitor progress in the next reporting period.

Molina Healthcare FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Appointment Availability: PCP	6.4	The trend identified from the complaints received was that enrollees were having difficulty locating primary care providers. The issues identified were that enrollees were unfamiliar with navigating the MCO website to search for primary care providers and providers were not meeting access and availability standards.	The MCO provided a tutorial for navigating the member web portal during new enrollee orientation to help enrollees locate providers. The MCO will continue to reach out to PCP offices to evaluate access and availability standards to ensure adequate appointment availability for enrollees.
Long Wait Time	2.5	The trends identified from the complaints received were that enrollees were waiting too long at providers' offices for scheduled appointments. The issue identified was that providers were not	The MCO will continue to reach out to providers' offices to evaluate access and availability standards to ensure adequate appointment availability for enrollees.

		meeting access and availability standards.	
Difficulty with Obtaining: Specialist and Hospitals	3.9	The trend identified from the complaints received was that enrollees were having difficulty locating specialist providers. The issue identified was that enrollees were unfamiliar with navigating the MCO website to search for specialist providers.	The MCO provided a tutorial for navigating the member web portal during new enrollee orientation to help enrollees locate specialist providers.
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	9.8	The trend identified from the complaints received was that enrollees were having difficulty locating behavioral health providers. The issue identified was that enrollees were unfamiliar with navigating the MCO website to search for behavioral health providers.	The MCO provided a tutorial for navigating the member web portal during new enrollee orientation to help enrollees locate behavioral health providers.
Pharmacy/Formulary	3.2	The trend identified from the complaints received was that there was a delay in prior authorizations being processed once submitted by providers. The issue identified was that providers were not including all pertinent clinical information when submitting a prior authorization request.	The MCO will reach out to providers on submitting the correct documentation and will educate its call center representatives on the necessary information required for prior authorization requests to better assist providers and provider offices in submitting requests.
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	4.7	The trend identified from the complaints received was that there was enrollee confusion regarding the transition from the Affinity plan to the Affinity by Molina plan. The issue identified was that enrollees misunderstood the plan change and had questions about it.	The MCO sent out a mailer to enrollees with details regarding the plan change and information on how to access the member web portal.
All Other	14.6	The trend identified from the complaints received	The MCO is educating providers on the authorization process on

		was that enrollees and providers were dissatisfied with prior authorization requirements. The issue identified was that enrollees and providers were not familiar with the new requirements after the transition from Affinity to Molina.	their provider portal to reduce the likelihood of incorrectly submitted requests. The MCO will include more details in each complaint when this category is selected to better understand and better prevent any trending issues. The Department will continue to monitor progress in the next reporting period.
Balance Billing	7.7	There were no trends identified from the complaints received. The issues identified were that providers were billing enrollees for services received due to improper registration or enrollee failure to present insurance ID cards, and that providers were unaware of the process of identifying enrollee insurance.	The MCO will continue to educate providers on ensuring that they have the correct enrollee information and not billing the enrollee. The Department will continue to monitor progress in the next reporting period.

MVP Health Plan FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/ Orthodontia	4.0	The trend identified from the complaints received was that enrollees experienced difficulties in receiving dental care. The issues identified were that there were delays in prior authorizations and scheduling appointments.	The MCO's vendor identified any providers or provider offices in need of corrective action. The vendor provided direction on prior authorization requirements and provided reeducation on standards for scheduling appointments. The Department will continue to monitor progress in the next reporting period.

United Healthcare FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Dissatisfaction with Quality of Care	2.1	The trend identified from the complaints received was that enrollees were dissatisfied with their care. The issues identified were	The MCO will determine which providers need corrective action and send out corrective action plan letters; provide verbal or written counseling; conduct

		that providers failed to properly diagnose enrollees, failed to fully explain medical results and treatment plans, and failed to efficiently document medical records.	focused medical care reviews; and restrict, suspend, or terminate network participation, if necessary, to ensure enrollees' quality of care issues and provider communication concerns are addressed.
Denial of Clinical Treatment	11.5	The trend identified from the complaints received was that enrollees were receiving denials for services. The issue identified was that enrollees did not have referrals on file for the services they were seeking.	The MCO provided education to providers and enrollees on referral requirements to reduce denials for services. The MCO will continue to engage providers and enrollees when reeducation is warranted. The Department will continue to monitor progress in the next reporting period.
Dissatisfied with Provider Services (Non-Medical) or MCO Services	2.4	The trend identified from the complaints received was that enrollees were dissatisfied with the MCO's customer service. The issue identified was that call center representatives were unprofessional and provided incorrect information.	The MCO provided training and coaching to its call center representatives to improve customer service.
Difficulty with Obtaining: Dental/ Orthodontia	2.1	The trend identified from the complaints received was that enrollees were having difficulty finding appointments with in-network providers. The issue identified was that some providers were no longer in network with the plan.	The MCO assisted enrollees in finding appointments with in-network providers. The MCO continues to add providers to its network.

VNS Choice FFY 22 Q2–FFY 22 Q3 (1/1/2022–6/30/2022)			
Complaint Category	**O/E Ratio**	**Issue Identified**	**Plan of Action**
Difficulty with Obtaining: Dental/Orthodontia	30.2	The trend identified from the complaints received was that enrollees were receiving denials for non-covered dental services. The issue identified was that enrollees were	The MCO will continue to provide educational materials to enrollees, including welcome kit inserts, detailing the benefit and scope of coverage.

		unaware of what services were covered under their dental benefit.	
All Other	5.5	The trends identified from the complaints received were that enrollees had issues with DME and obtaining supplies. No issues were identified.	The MCO will work with its call center representatives to better capture details of complaints, to identify issues regarding difficulty obtaining supplies.

C. Long Term Services and Supports (LTSS)

As SSI recipients typically access LTSS, the Department monitors complaints and action appeals filed with MCOs by SSI recipients. Of the 9,375 total reported complaints/action appeals, MCOs reported 443 complaints and action appeals from their SSI recipients. This compares to 765 SSI complaints/action appeals from the previous quarter, representing a 42.1% 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, which included a significant decrease in the number of Dissatisfied with Provider Services (Non-Medical) or MCO Services complaints. The Department is actively monitoring the change.

The following table outlines the total number of complaints/action appeals MCOs reported for SSI recipients by category for the most recent quarter and the last four (4) quarters:

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
Appointment Availability: PCP	1	15
Appointment Availability: Specialist	2	26
Appointment Availability: BH HCBS	0	1
Long Wait Time	2	5
Dissatisfied with Quality of Care	66	352
Denial of Clinical Treatment	26	96
Denial of BH Clinical Treatment	1	2
Dissatisfied with Provider Services (Non-Medical) or MCO Services	85	1,129
Dissatisfaction with BH Provider Services	0	10
Dissatisfaction with Health Home Care Management	0	14
Difficulty with Obtaining: Specialist and Hospitals	23	230
Difficulty with Obtaining: Eye Care	5	22
Difficulty with Obtaining: Dental/Orthodontia*	27	119
Difficulty with Obtaining: Emergency Services	1	10

Description of Complaint	Number of Complaints/Action Appeals Reported for SSI Recipients	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
Difficulty with Obtaining: Mental Health or Substance Abuse Services/Treatment	4	9
Difficulty with Obtaining: RHCF Services	0	0
Difficulty with Obtaining: Adult Day Care	0	1
Difficulty with Obtaining: Private Duty Nursing	2	47
Difficulty with Obtaining: Home Health Care	6	70
Difficulty with Obtaining: Personal Care	9	173
Difficulty with Obtaining: PERS	0	2
Difficulty with Obtaining: CDPAS	1	115
Difficulty with Obtaining: AIDS Adult Day Health Care	0	1
Pharmacy/Formulary	82	307
Access to Non-Covered Services	11	51
Access for Family Planning Services	0	0
Communications/ Physical Barrier	2	11
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	2	41
Recipient Restriction Program and Plan Initiated Disenrollment	0	0
Reimbursement/Billing	37	289
Balance Billing	32	139
Transportation	2	24
All Other	14	121
Total	**443**	**3,432**

*MVP Health Plan did not submit all complaint data for the MMC and HARP Difficulty with Obtaining Dental/Orthodontia category in time for this report. The actual value of this category is probably slightly higher than what is being reported.

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 the last four (4) quarters:

Description of Complaint	Percentage of Total Complaints/Appeals Reported for SSI Recipients	
	FFY 22 Q4 7/1/2022-9/30/2022	Last 4 Quarters 10/1/2021-9/30/2022
Dissatisfied with Provider Services (Non-Medical) or MCO Services	19%	33%
Pharmacy/Formulary	19%	9%
Dissatisfied with Quality of Care	15%	10%
Reimbursement/Billing	8%	8%
Balance Billing	7%	4%

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 July 1, 2022, through September 30, 2022, MCOs reported LTSS enrollment of 49,795 enrollees. This compares to 51,412 LTSS enrollees from the previous quarter, representing a 3.1% decrease. The following table outlines the number of LTSS enrollees by MCO for each of the last four (4) quarters:

Plan	Number of LTSS Enrollees			
	FFY 22 Q4 7/1/2022–9/30/2022	**FFY 22 Q3 4/1/2022–6/30/2022**	**FFY 22 Q2 1/1/2022–3/31/2022**	**FFY 22 Q1 10/1/2021–12/31/2021**
Affinity Health Plan*	0	0	0	828
Amida Care	1,199	1,353	1,243	1,298
Capital District Physicians Health Plan	737	713	730	729
Excellus Health Plan	1,545	1,545	1,553	1,440
Fidelis Care	16,548	16,594	16,197	15,218
Healthfirst	13,910	15,790	12,839	12,540
Highmark	212	203	200	200
HealthPlus	2,972	2,917	2,812	2,691
HIP of Greater New York	459	458	423	339
Independent Health Association	598	578	557	525
MetroPlus Health Plan	3,126	2,887	2,549	2,497
Molina Healthcare	2,845	2,845	2,788	1,145
MVP Health Plan	2,166	2,101	1,971	1,870
United Healthcare	3,071	3,042	2,936	2,930
VNS Choice	407	386	380	354
Total	**49,795**	**51,412**	**47,178**	**44,604**

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

The following table outlines the total number of complaints/action appeals received from all enrollees, regardless of product line, regarding difficulty with obtaining LTSS that MCOs reported for each of the last four quarters:

Description of Complaint	Number of Complaints/Action Appeals Reported			
	FFY 22 Q4 7/1/2022–9/30/2022	FFY 22 Q3 4/1/2022–6/30/2022	FFY 22 Q2 1/1/2022–3/31/2022	FFY 22 Q1 10/1/2021–12/31/2021
Difficulty with Obtaining: AIDS Adult Day Health Care	3	1	2	3
Difficulty with Obtaining: Adult Day Care	1	3	0	3
Difficulty with Obtaining: CDPAS	73	59	52	141
Difficulty with Obtaining: Home Health Care	35	39	86	51
Difficulty with Obtaining: RHCF Services	1	1	1	4
Difficulty with Obtaining: Personal Care	200	164	195	176
Difficulty with Obtaining: PERS	7	7	4	7
Difficulty with Obtaining: Private Duty Nursing	27	24	28	29
Total	**347**	**298**	**368**	**414**

D. Critical Incidents

The Department requires MCOs to report critical incidents involving enrollees in receipt of LTSS. There were 124 critical incidents reported for the July 1, 2022, through September 30, 2022 period, most of which have a resolved status. Many of the incidents stemmed from falls or the use of restraints. 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 each of the last two (2) quarters, the net change over the last two (2) quarters, and the total for the last four (4) quarters:

Plan Name	Critical Incidents			
	FFY 22 Q4 7/1/2022–9/30/2022	FFY 22 Q3 4/1/2022–6/30/2022	Net Change	Last 4 Quarters 10/1/2021–9/30/2022
Medicaid Managed Care Plans				
Affinity Health Plan	0	0	0	0
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	7	4	+3	23
Fidelis Care	0	1	-1	1

Healthfirst	65	43	+22	200
HIP of Greater New York	0	0	0	0
Highmark	0	0	0	0
HealthPlus	1	2	-1	7
Independent Health Association	0	0	0	0
MetroPlus Health Plan	1	0	+1	1
Molina Healthcare	0	0	0	2
MVP Health Plan	0	0	0	1
United Healthcare	0	0	0	0
Total	**74**	**50**	**+24**	**235**
Health and Recovery Plans				
Affinity Health Plan	0	0	0	0
Capital District Physicians Health Plan	0	0	0	0
Excellus Health Plan	0	0	0	1
Fidelis Care	0	2	-2	2
Healthfirst	41	29	+12	168
HIP of Greater New York	0	0	0	0
HealthPlus	0	0	0	0
Independent Health Association	0	0	0	0
MetroPlus Health Plan	1	0	+1	1
Molina Healthcare	0	1	-1	5
MVP Health Plan	0	0	0	0
United Healthcare	0	0	0	0
VNS Choice	0	0	0	1
Total	**42**	**32**	**+10**	**178**
HIV Special Needs Plans				
Amida Care	0	0	0	0
MetroPlus Health Plan	1	0	+1	1
VNS Choice	7	3	+4	12
Total	**8**	**3**	**+5**	**13**
Grand Total	**124**	**85**	**+39**	**426**

The following table outlines the total number of critical incidents MCOs reported for enrollees in receipt of LTSS by category for each of the last two (2) quarters, the net change over the last two (2) quarters, and the total for the last four (4) quarters:

Category of Incident	Critical Incidents			
	FFY 22 Q4 7/1/2022–9/30/2022	FFY 22 Q3 4/1/2022–6/30/2022	Net Change	Last 4 Quarters 10/1/2021–9/30/2022
Medicaid Managed Care Plans				
Any Other Incidents as Determined by the Plan	6	5	+1	23
Crimes Committed Against Enrollee	3	0	+3	4
Crimes Committed by Enrollee	0	0	0	0
Instances of Abuse of Enrollees	1	1	0	3
Instances of Exploitation of Enrollees	3	0	+3	3
Instances of Neglect of Enrollees	0	0	0	4
Medication Errors that Resulted in Injury	0	0	0	0
Other Incident Resulting in Hospitalization	8	4	+4	22
Other Incident Resulting in Medical Treatment Other Than Hospitalization	15	28	-13	103
Use of Restraints	38	12	+26	73
Wrongful Death	0	0	0	0
Total	**74**	**50**	**+24**	**235**
Health and Recovery Plans				
Any Other Incidents as Determined by the Plan	1	1	0	3
Crimes Committed Against Enrollee	2	0	+2	2
Crimes Committed by Enrollee	0	0	0	0
Instances of Abuse of Enrollees	0	2	-2	3
Instances of Exploitation of Enrollees	0	0	0	1
Instances of Neglect of Enrollees	0	0	0	1
Medication Errors that Resulted in Injury	0	0	0	0
Other Incident Resulting in Hospitalization	5	8	-3	26
Other Incident Resulting in Medical Treatment Other Than Hospitalization	9	21	-12	116
Use of Restraints	25	0	+25	26
Wrongful Death	0	0	0	0
Total	**42**	**32**	**+10**	**178**
HIV Special Needs Plans				
Any Other Incidents as Determined by the Plan	1	0	+1	1

Instances of Abuse of Enrollees	0	1	-1	1
Instances of Neglect of Enrollees	7	2	+5	9
Other Incident Resulting in Hospitalization	0	0	0	2
Other Incident Resulting in Medical Treatment Other Than Hospitalization	0	0	0	0
Total	**8**	**3**	**+5**	**13**
Grand Total	**124**	**85**	**+39**	**426**

E. Enrollee Complaints Received Directly by the Department

In addition to the MCO reported complaints, the Department directly received 106 enrollee complaints this quarter. This total is a 6.0% increase from the previous quarter, which reported 100 enrollee complaints.

Annually, the Department directly received 455 MCO member complaints regarding MMCs, HARPs, and HIV SNPs. The following chart represents previously reported complaints filed directly with NYSDOH, including complaints from enrollees and their representatives.

MCO Enrollee Complaints Received Directly by the Department				
FFY 22 Q4 7/1/2022– 9/30/2022	**FFY 22 Q3 4/1/2022– 6/30/2022**	**FFY 22 Q2 1/1/2022– 3/31/2022**	**FFY 22 Q1 10/1/2021– 12/31/2021**	**Total FFY 22 10/1/2021- 9/30/2022**
106	**100**	**164**	**85**	**455**

The following table outlines the top five (5) most frequent categories of enrollee complaints/action appeals received directly by the Department involving MCOs for each of the last four quarters:

Percentage of MCO Enrollee Complaints Received Directly by the Department				
Description of Complaint	**FFY 22 Q4 7/1/2022– 9/30/2022**	**FFY 22 Q3 4/1/2022– 6/30/2022**	**FFY 22 Q2 1/1/2022– 3/31/2022**	**FFY 22 Q1 10/1/2021– 12/31/2021**
Reimbursement/Billing	23%	13%	16%	16%
Difficulty with Obtaining: Home Health Care	16%	9%	3%	8%
Difficulty with Obtaining: CDPAS	8%	4%	1%	5%
Problems with Advertising/ Consumer Education/ Outreach/ Enrollment	7%	14%	13%	14%
Pharmacy/Formulary	7%	13%	10%	9%

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

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

F. Fair Hearings

There were 202 fair hearings involving MMCs, HARPs, and HIV SNPs during the period of July 1, 2022, through September 30, 2022. The dispositions of these fair hearings for the most recent quarter as well as the previous three quarters are as follows:

Fair Hearing Decisions (includes MMC, HARP, and HIV SNP)				
Hearing Dispositions	**FFY 22 Q4 7/1/2022–9/30/2022**	**FFY 22 Q3 4/1/2022–6/30/2022**	**FFY 22 Q2 1/1/2022–3/31/2022**	**FFY 22 Q1 10/1/2021–12/31/2021**
In favor of Appellant	68	77	68	82
In favor of Plan	120	151	160	195
No Issue	14	10	15	17
Total	**202**	**238**	**243**	**294**

For fair hearing dispositions occurring for the most recent quarter as well as the previous three quarters, 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 Q4 7/1/2022–9/30/2022**	**FFY 22 Q3 4/1/2022–6/30/2022**	**FFY 22 Q2 1/1/2022–3/31/2022**	**FFY 22 Q1 10/1/2021–12/31/2021**
0-29	14	14	7	6
30-59	51	70	48	75
60-89	43	47	55	60
90-119	34	32	34	35
=>120	60	75	99	118
Total	**202**	**238**	**243**	**294**

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

The MMCARP met on September 22, 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 two 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. Lastly, a Behavioral Health/HARP/Health Home Update given by Ashley Filler and Joe Katagiri, Division of Managed Care, NYS Office of Mental Health. A public comment period is offered at every meeting. The next MMCARP meeting is scheduled for December 15, 2022.

Annual: The Medicaid Managed Care Advisory Review Panel is required to meet quarterly. Meetings were held on December 16, 2021, February 17, 2022, June 16, 2022, and September 22, 2022.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Managed Long-Term Care

Due to COVID-19 and the moratorium on reassessments of the MLTC populations, the Department cannot compute the 2020 or 2021 Quality Measures. The MLTC Report, Consumer Guides and Incentive will not be computed.

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

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

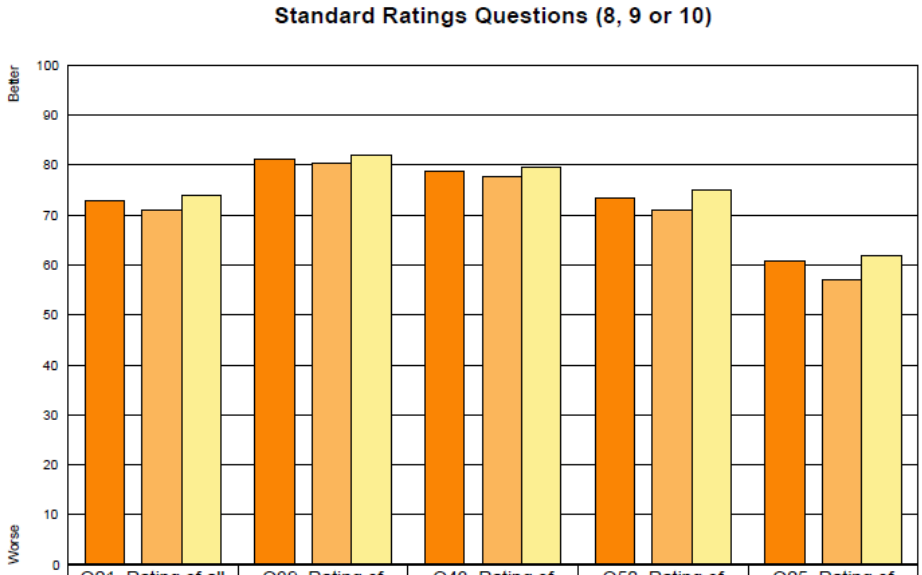
B. Quality Measurement in Medicaid Managed Care

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 seven 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

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. A new 5-year contract to provide EQRO services to the NYS Medicaid program began August 1, 2022. The agreement will run through July 31, 2027.

Provider-Related and Compliance Review Activities

During the first quarter, the EQRO completed the final report for the Access survey and the report remained with OHIP's review and approval process. The EQRO started another Access Survey after the January PNDS submission. The Medicaid Managed Care plans submitted their

plans for correction for the Member Services survey. The high-volume PCP Ratio survey was completed by the EQRO during 2021. In the 2nd quarter, preparations were underway to begin a new Access & Availability (Provider Directory) Survey. For the second Quarter of 2022 the EQRO received the corrective action plans (CAP's) from the plans to complete the previous survey. After the quarter one PNDS submission (March 2022), the EQRO began the next High Volume PCP Ratio survey. Lastly in the 3rd quarter, the EQRO waited for OHIP to resolve the CAP's from the previous survey before initiating the next Access Survey of Provider Availability (Provider Directory). 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. Lastly 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.

In the 4th quarter of 2022, the EQRO prepared a sample file to be used in the next Access Survey of Provider Availability (Provider Directory). DOH shared the Plans of Correction (POC) with the EQRO. DOH prepared enrollment data that was needed for the next A&A (PD) survey and IPRO validated that the providers are still in each plan. For the Member Services Survey, during the 4th quarter the DOH and the EQRO collaborated to resolve issues with the data used in the survey report, in order to improve the time it takes to complete the report. The DOH reviewed the plans' survey reports. Revisions will need to be made to the survey report format, due to unclear prescription information included in the member handbooks. Phase One survey results were sent to the plans in September. The EQRO plans to do the second round for plan follow-up calls in the 1st quarter of 2023. In July, the EQRO prepared the new survey methodology for the PCP: 1500:1 Ratio survey while waiting for the survey data from DOH. DOH provided the EQRO with the necessary data file in September. DOH and the EQRO discussed issues with the inconsistencies found in the data file. When that is resolved the EQRO will begin the survey calls.

MLTC, QARR, ATR and CAHPS

During the first quarter, the MLTC Satisfaction Survey was conducted, and closed, in 2021. During the 1st quarter of 2022, the EQRO provided DOH with the draft final report of the survey, and DOH provided the EQRO with feedback/comments prior to delivery of the final report. This was issued in March of 2022. The MLTC Encounter Data Validation Survey was conducted in 2021. A survey was conducted for mainstream MMC plans and for MTLC plans. During the 1st quarter of 2022, the final report for the mainstream encounter validation survey was finalized by DOH and entered DOH's executive review and approval process. The MLTC encounter validation survey was completed in 2021, and in the 1st quarter of 2022 the final report of the survey was sent to the plans by the EQRO.

A Focused Clinical Study (FCS) for the Inter-rater Reliability for Telehealth Assessments for MLTC plans, was initiated during the 1st quarter of 2022. The goal is to evaluate the validity of telehealth assessments for the long-term care population. Outreach to members in the sample population began in June of 2022 and dual assessments began shortly after. This study is continuing in November of 2022.-In the 1st quarter of 2022, the EQRO completed any analyses of the QARR data that was submitted by the plans on June 15, 2021 and provided the data to the DOH. During the 2nd quarter of 2022, the EQRO will plan and conduct a Webex of the QARR Technical Specifications.

During the 2nd quarter the final report for the 2019/2021 MLTC PIP was due during the second quarter of 2022, January 2022. The EQRO were reviewing the final reports of the MLTC PIP. The EQRO received the MLTC plan PIP proposals for the 2022/2023 MLTC PIP during the second quarter of 2022. The report is due to CMS on the third quarter of 2022. For the second quarter of 2022, the EQRO worked with DOH to improve the number of survey responses for the MLTC focus clinical study. The samples pulled will be enlarged to increase the geographic area of the survey. Preparation for the 2022 QARR submission (June 15th, 2022), was started by the EQRO in the second quarter of 2022. The EQRO will receive the final report of the adult CAHPS survey, from the vendor, DataStat, during the second quarter of 2022. In the second Quarter of 2022, the EQRO continued preparing the draft report of the mainstream MMC EQR Annual Technical Report. DOH provided comments and feedback on the drafts of the report. The final report is due to CMS by 4/30/2023.

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. 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. There was agreement between the EQRO and DOH that the 2020 MLTC ATR report will be used as an example for the plans to be informed about what is in the report. The 2021 MLTC ATR report will be submitted to CMS in April 2023.

Starting in the 4th quarter, the 32 MLTC PIP proposals have been completed for review, while two are currently outstanding. IPRO and DOH are currently working with the two outstanding plans to correct their errors for submission. For the IRR FCS of Telehealth Assessments has completed 10 assessments, both in-person and telehealth. During the study, many members had only one of the assessments done. Throughout the 4 quarters, the EQRO has encountered difficulty in finding respondents to participate in the survey. DOH and IPRO has had bi-weekly meetings about the progress of the ATR report. IPRO has completed the template and was sent to DOH for approval. The CAHPS Adult survey is finalized during the beginning of the 4th quarter. IPRO later had a meeting with DataStat to discuss the next CAHPS survey, which will be the CAHPS Kids survey. IPRO got the proposal to start the survey. DOH is working to prepare the survey materials and sample. Lasty for QARR, IPRO has uploaded the QHP enrollee survey files to the secure transfer site. All enhancement files have been finalized and were sent to the DOH QARR team by the end of July 2022 and were confirmed when they were received. IPRO has sent the utilization data, risk reports and data sets.

Provider Network Data System (PNDS):

PNDS

In Quarter 1, 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 3 2021 PNDS submission deadline was October 15, 2021; plans submitted data based on version 10 of data dictionary and work has started on version 11. For the Quarter 2 update, the quarter 4 2021 PNDS submission deadline was January 21, 2021; plans submitted data based on version 10 of data dictionary. PNDS data dictionary version 11 will be released in later half of 2022 and IPRO has already started on it. 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.

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 2 2022 PNDS submission deadline was July 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 surpassed 1.29 million distinct users in October 2021 and additional usability enhancements were added this quarter. For quarter 1, Panel data submission opened on 11/1/2021 and yielded 6,637,036 rows of data (up ~3%). In quarter 2, the site surpassed 1.37 million distinct users by the end of 2021. For the 4th quarter, the site has over 1.5 million distinct users as of May 2022.

PANEL:
For the first quarter, Panel data submission opened on 11/1/2021 and yielded 6,637,036 rows of data (up ~3%). In the 2nd quarter, panel data submission opened on 2/1/2022 and yielded 6,760,202 rows of data (up ~2%). For the 3rd quarter, panel data submission opened on 5/2/2022 and yielded 6,633,335 rows of data (down ~0.1%). Lastly, in the 4th quarter, panel data submission opened on 8/1/2022 and yielded 6,701,057 rows of data (up ~0.01%). IRPO 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.

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

2017-18 HARP PIP
For the 2017-2018 Health and Recovery Plan (HARP) and HIV Special Needs Plan (SNP) PIP the selected common topic was Inpatient Care Transitions. Final reports for the 2017-18 HARP PIP projects were received in August 2019 and were finalized and approved in October 2019. A

PIP Compendium of Abstracts was prepared by IPRO and was initially reviewed by the NYSDOH. Final edits were sent to IPRO in March 2021 and 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 PIP Final Reports were submitted to IPRO in July 2022. They are currently under review by IPRO and DOH.

2019-2021 Medicaid KIDS Quality Agenda PIP

The 2019-2020 Medicaid managed care (MMC) PIP topic is the KIDS Quality Agenda Performance Improvement Project. The overall goal of the PIP is to optimize the healthy development trajectory by decreasing risks for delayed/disordered development. The areas of focus for the PIP include screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. The PIP Proposals were due in the first quarter of 2019. The submitted PIP Proposals were reviewed and approved by IPRO and NYSDOH. In June 2020 the MCOs were notified that the 2019-2020 PIPs were extended through December 31, 2021. The MMC plans PIP Final Reports were submitted to IPRO in July 2022. They are currently under review by IPRO and DOH.

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

On October 27, 2021, a WebEx meeting with Medicaid managed care and HIV SNP plans was conducted to introduce the topic of the 2022-2023 PIP, Improving Rates of Preventive Dental Care for MMC and HIV SNP Adult Members. A background document and PIP resources for drafting a Proposal were distributed to the health plans after the WebEx. The PIP Proposals were submitted by December 8, 2021. The PIP Proposals reviewed and finalized by IPRO and NYSDOH. The approved interventions began implementation 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 and September 2022. Prior to the oversight calls the plans submitted an updated PIP Proposal with 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 PIP Proposals were submitted by January 10, 2022. The PIP Proposals were reviewed and finalized by IPRO and NYSDOH. The interventions began implementation 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. November oversight calls are also planned. Prior to the oversight calls the plans submitted an updated PIP Proposal with intervention tracking measure updates.

Breast Cancer Selective Contracting

Staff completed the Breast Cancer Selective Contracting process for contract year 2022-2023. This included: updating the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); identifying low-volume facilities for restriction; notifying restricted facilities of their status; conducting the appeals process; posting both the list of facilities that Medicaid will pay and the list of facilities that Medicaid will not pay for breast cancer surgery to the NYS DOH public website; and, supplying the list of restricted facilities to eMedNY staff so that Medicaid fee-for-service payments can be appropriately restricted, as well as, sharing the list with Medicaid managed care health plans' Chief Executive Officers and Medical Directors via the Department's Integrated Health Alerting and Notification System (IHANS).

In total, the annual review identified 319 facilities. Facility designations were as follows: 114 high-volume facilities, 25 low-volume unrestricted facilities, and 180 low-volume restricted facilities.

Staff also completed the summer review of breast cancer surgical volume data. Provisional volume designations for contract year 2023-2024 were shared with facilities' SPARCS coordinators in July 2022. Release of these data will give facilities ample time to identify and correct any discrepancies between facility-calculated volume and SPARCS reported volume.

Patient Centered Medical Home (PCMH)

Federal Fiscal Quarter: 7/1/2022-9/30/2022

As of September 2022, there were 9,257 NCQA-recognized PCMH providers and 2,279 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 9,257 providers that became recognized in September 2022, 28 were new to the NYS PCMH program.

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

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 2022 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/.

Demonstration Year: 10/1/2021-9/30/2022

The old 2014 and 2017 PCMH recognition standards have expired prior to the demonstration year. As of May 2021, NYS PCMH became the only standard available to NYS practices. The program remained relatively stable throughout the year with a slight decrease in the volume. In October 2021, there were 10,055 NCQA-recognized PCMH providers in New York State, this number shrunk to 9,257 by the end of September 2022. The number of NCQA-recognized PCMH practices in New York State also decreased throughout the year, going from 2,411 in October 2021 to 2,279 in September 2022.

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 following files are sent 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. After successfully maintaining its data quality based on the Top Priority Issues (TPIs) methodology, the state is now addressing issues based upon the Outcomes Based Assessment (OBA) compliance methodology. As of September 2022, the state meets the Critical Priority and Expenditures criteria target of OBA and is 2% below the target for High Priority criterion. The state is actively working on addressing the identified high priority issues to achieve the High Priority criterion of OBA.

CMS has introduced a new record segment ("ELG-IDENTIFIERS-ELG00022") in the T-MSIS Eligible file to enable the linking and effective management of identifiers associated with a beneficiary over the course of his/her involvement with the Medicaid/CHIP programs. The state completed the implementation of the ELG00022 segment in the T-MSIS Eligibility File for each Medicaid/CHIP beneficiary in 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.

B. 1115 Waiver Public Comment Days

With the implementation of the Medicaid Redesign Team in 2011, New York has prioritized transparency and public engagement as a key element of developing and implementing Medicaid policies. The public comments provided at these forums have been shared with the New York teams working on these programs and has informed implementation activities. We will continue to consider these issues and engage stakeholders as part of our ongoing efforts.

On September 28, 2022, the Department of Health conducted a virtual public forum.

A recording of the live webcast, transcript, and presentation slides from the public forum are available for viewing at the link below. All written public comments received are shared with the program areas within the State for their consideration in shaping policy and procedures.

https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/mrt_pub_comment_days.htm

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

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